

Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules

OAR 436-009, Oregon Medical Fee and Payment

OAR 436-010, Medical Services

OAR 436-015, Managed Care Organizations

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Nov. 19, 2018, 1:30 to 4:30 p.m. OSHA PFO Training Room – Durham office 16760 SW Upper Boones Ferry Rd, Tigard, Oregon 97224 <i>Please join meeting from your computer, tablet or smartphone.</i> https://global.gotomeeting.com/join/450767709 <i>You can also dial in using your phone.</i> <i>United States (Toll Free): 1 877 309 2073</i> <i>Access Code: 450-767-709</i>
Facilitators:	Fred Bruyns, Juerg Kunz, Workers' Compensation Division
1:30 to 1:40	Welcome and introductions; meeting objectives
1:40 to 3:00	Discussion of issues – see attachment.
3:00 to 3:15	Break
3:15 to 4:20	Discussion of issues on agenda continued Discussion of new issues as time allows
4:20 to 4:30	Summing up – next steps – thank you!

Attached: [Issues document](#)

[Workers' Compensation Fee Schedule / All-Payer-All-Claims database
Reimbursement Study](#)

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2019)

Issue: Should WCD issue a temporary rule, effective January 1, 2019, adopting the new CPT[®] codes for 2019. Should WCD assign maximum payment amounts to new CPT[®] and HCPCS codes in Appendices B – E, where possible?

Background:

- The American Medical Association publishes new CPT[®] codes, effective January 1, 2019.
- The Centers for Medicare and Medicaid Services (CMS) publishes Medicare fee schedule amounts for these CPT[®] codes, also effective January 1, 2019.
- Additionally, CMS publishes a new DMEPOS fee schedule, effective January 1, 2019, that may contain new HCPCS codes.
- In order to allow time for public input, WCD publishes a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), effective April 1 of each year.
- This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if providers use new codes between January 1 and April 1.
- Adopting the new CPT[®] and HCPCS codes would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid new codes.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD could update appendices B – E, effective Jan. 1, 2019, and assign maximum payment amounts using the 2018 conversion factors/multipliers. One should bear in mind that due to time and staffing restraints, it may not be possible to update all appendices.
- WCD began issuing temporary rules in January 2016 to allow providers to bill insurers using new codes for dates of service from January 1 through March 31 of each year.

Options:

- Adopt new CPT[®] codes through a temporary rule, effective January 1, 2019.
- Update appendices B – E with payment amounts for new codes using the 2018 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B through E (permanent rules, effective April 1, 2019)

Issue: ORS 656.248(7) requires that WCD update the fee schedules annually.

- Should WCD adopt updated references listed in OAR 436-009-0004(1) – (9)?
- Should WCD update the fee schedule amounts listed in:
 - 1) Appendix B (Physician fee schedule amounts)
 - 2) Appendix C (ASC fee schedule amounts for surgical procedures)
 - 3) Appendix D (ASC fee schedule amounts for ancillary services)
 - 4) Appendix E (DMEPOS fee schedule amounts)

Background:

- The above listed appendices are based on conversion factors and multipliers developed by DCBS, and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare & Medicaid Services (CMS). In particular:
 - 1) Current Appendix B is based on the CMS file *RVU18A*, effective January 2018. We expect that CMS will publish the file containing the 2019 RVUs sometime in November 2018.
 - 2) Current Appendix C is based on spreadsheets published by CMS in CMS-1678-FC. We expect that CMS will publish CMS-1695-FC, containing the 2019 ASC fee schedule amounts for surgical procedures, in November 2018.
 - 3) Current Appendix D is based on spreadsheets published by CMS in CMS-1678-FC. We expect that CMS will publish CMS-1695-FC, containing the 2019 ASC fee schedule amounts for ancillary services, in November 2019.
 - 4) Current Appendix E is based on the CMS file *DME18-A*, effective January 2018. We hope that CMS will publish the file containing the 2019 DMEPOS fee schedule sometime in November 2018.
- Every year, there are some CPT[®] and HCPCS codes that are deleted and some new codes are introduced. Adopting new billing codes and updating Appendices B through E allows us to stay current with valid CPT[®] and HCPCS codes.
- Every year, DCBS develops updated conversion factors and multipliers taking into account stakeholder input, utilization of medical services, and the new values and fee schedule amounts developed by CMS.

Options:

- Adopt updated references listed in OAR 436-009-0004(1) – (9) and update appendices B through E using more current CMS spreadsheets and updated WCD conversion factors.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 3 (1504/1505)

**Rule: OAR 436-010-0008(3)(c) Form and Required Information and
OAR 436-009-0008(3)(c) Form and Required Information**

Issue: A stakeholder asked that insurers should no longer be required to send an indexed packet for disputes under ORS 656.247, 656.260, or 656.327.

Background:

- When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, insurers are required to send a record packet to the director and all other parties. The packet must include a complete, indexed copy of the worker’s medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation “Ex.” and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document 10 must be designated “Ex. 10-2.” The index must include the document numbers, description of each document, author, number of pages, and date of the document.
- Soon-to-be proposed changes to division 001 rules will require that a party requesting a hearing in a matter within the director’s jurisdiction (medical services, medical treatment, MCO disputes, and ORS 656.262(11) penalties and fees), appealing MRT’s order, will have to put all documents the party will rely on at hearing in an indexed packet. If we remove the requirement that an insurer submit an indexed record to the division for administrative review, this could substantially increase the burden on the petitioner if a hearing is requested, because the petitioner will have to start from scratch indexing the record. We should keep in mind that MRT orders are often times appealed by workers’ attorneys, and their attorney fee is capped by statute.
- Creating an indexed record for every dispute under ORS 656.247, 656.260, or 656.327, even if an order is not appealed, adds costs to insurers.
- Some MRT reviewers use the index when reviewing the record, and we’ve heard that an index is helpful for physician reviewers.

Options:

- Make the following changes to 436-010-0008(3)(c)(A):
The packet must include a complete, ~~indexed~~ copy of the worker’s medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, ~~and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation “Ex.” and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document 10 must be designated “Ex. 10-2.” The index must include the document numbers, description of each document, author, number of pages, and date of the document.~~ ***

- Make similar change to 436-009-0008(3)(c)(A)
- Make no change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 4 (1562)

Rule: OAR 436-009-0010(13) Missed Appointment (No Show)

Issue: Providers have raised the issue of being able to charge a no show fee.

Background:

- OAR 436-009-0010(13) provides that insurers do not have to pay for missed (no-show) appointments unless the no-show appointment is for an arbiter exam, director required medical exam, independent medical exam, worker requested medical exam, or closing exam, and the worker does not give 48 hours notice.
- Currently, the OAR 436-009 does not specifically address whether a provider may bill a worker a no-show fee.
- CMS describes a no-show fee as follows: “The charge for a missed appointment is not a charge for a service itself, but rather is a charge for a missed business opportunity.”
- Medicare allows providers to charge a no-show fee if the provider applies the same policy to non-Medicare patients. Many commercial insurance plans as well as Washington’s workers’ compensation system have similar policies.

Options:

- Modify OAR 436-009-0010 as follows:
 - (9) Billing the Patient / 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: ***
 - (c) A provider may bill a patient for a missed appointment under section (13) of this rule.**
 - (13) Missed Appointment (No Show)
 - (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 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 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 and/or enforcement of the provider's policy.**
- Make no change

- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 5 (1562)

Rule: OAR 436-009-0040 / Appendix B

Issue: A stakeholder is proposing a 10% fee increase for chiropractic CPT codes (98940 – 98943) and physical medicine/rehab CPT codes 97110 – 97113. This stakeholder is also asking for a reduction of the fee schedule amount for the massage CPT code 97124.

Background:

- Chiropractic CPT codes 98940 -98943:
 - The stakeholder explained that a 10% fee schedule increase for chiropractic codes (\$5.00 to \$8.00) would increase the cost of 18 chiropractic visits by \$90.00 to \$144.00.
 - The fee schedule amounts for the chiropractic CPT codes (98940 – 98943) are not directly linked to CMS’ RVU and have been at the same level since April 2016 when they were raised by three percent.
- Physical medicine/rehab CPT codes 97110 – 97113:
 - The stakeholder stated that CMS arbitrarily reduced the RVU of these codes in 2018.
 - A look at the 2017 and 2018 workers compensation fee schedules shows the following:
 - CPT code 97110: 2017: \$54.19; 2018: \$51.90, a decrease of \$2.29 (4%)
 - CPT code 97112: 2017: \$56.54; 2018: \$59.06, an increase of \$2.52 (4%)
 - CPT code 97113: 2017: \$71.86; 2018: \$66.22, a decrease of \$5.64 (8%)
- Massage therapy CPT code 97124:
 - The stakeholder proposes to decrease the fee schedule amount of this code since it had been debated in the past as too high and CMS had increased the RVU substantially (17% - 18%).
 - A look at the 2017 and 2018 workers compensation fee schedules shows that the 2017 workers’ compensation fee schedule amount increased from \$43.59 to \$51.90 in 2018, a 16% increase.

Options:

- Make changes to the fee schedule amount of some or all of above listed CPT codes.
- Make no change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 6 (1503)

Rule: OAR 436-009-0040(2) Anesthesia

Issue: Unlike Medicare and many private health insurers, Oregon workers' compensation rules have no provision for services billed with anesthesia modifiers QY, QK, or QX.

Background:

- Anesthesia bills with above modifiers indicate the following:
 - QY: Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.
 - QK: Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals by an anesthesiologist.
 - QX: Qualified nonphysician anesthetist service with medical direction by a physician.
- Generally, only one anesthesia provider at a time is paid per patient.
- However, more than one provider may be paid when the supervised anesthesia services are provided by a qualified nonphysician under the medical direction of a physician. In that case, the supervising physician should use modifiers QY or QK, and the nonphysician provider the modifier QX.
- In other lines of insurance, bills with anesthesia modifiers QY, QK, or QX are paid at 50 percent of the fee schedule amount.
- Anesthesiologists should not perform other services while medically directing anesthesia procedures.

Options:

- Add new subsections to OAR 436-009-0040(2), indicating that
 - Anesthesiologists medically supervising nonphysician providers must bill using modifiers QY (medical direction of one qualified nonphysician anesthetist by an anesthesiologist) or QK (medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals).
 - Anesthesiologists may not perform other services while medically directing anesthesia procedures.
 - Qualified nonphysicians must bill using modifier QX for anesthetist services with medical direction by a physician.
 - Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.
- Make no change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

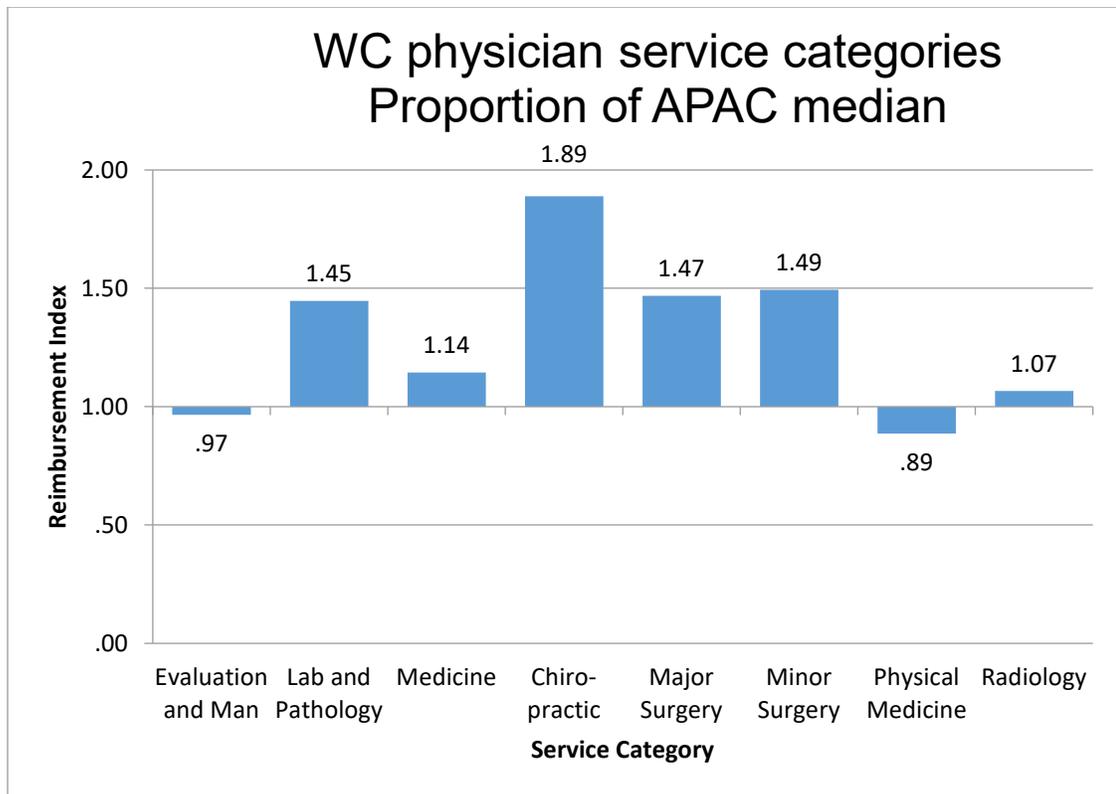
Issue # 7

Rule: OAR 436-009-0040 / Appendix B

Issue: This year the department was granted access to data from the All Payers All Claims (APAC) database, maintained by the Oregon Health Authority. We were able to compare the maximum allowable payments from the workers' compensation (WC) physician fee schedule to the median reimbursements of commercial health insurers. We found that the average fee schedule amounts vary greatly from category to category and that fee schedule amounts for specific codes can vary greatly within a category. The question before us is whether the division should consider the APAC data when updating the WC physician fee schedule, and if so, how.

Background:

- The WC fee schedule model uses the Centers for Medicare & Medicaid services' (CMS) resource-based relative value scale (RBRVS) as the basis for the physician payment system. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system. In this system, payments are determined by the resource costs needed to provide them. These resource costs are expressed as relative value units (RVUs). While CMS assigns the RVUs to the billing codes (CPT codes), WCD establishes the conversion factors for each category (evaluation and management, minor surgery, major surgery, radiology, laboratory and pathology, medicine, and physical medicine and rehabilitation). The maximum payment amounts (also known as the fee schedule amounts) are calculated by multiplying the RVU of a code times the appropriate conversion factor. Where CMS did not establish an RVU, the service is payable at 80% of the billed amount.
- Starting in 2012, the WC fee schedule has contained a few services where the fee schedule amounts are not based on CMS' RBRVS (chiropractic manipulation codes (CPT codes 98940 – 98943), technical components of some MRIs (CPT codes 72121, 72148, 73221, and 73721), surgery CPT code 29826, and various pathology and laboratory codes).
- The following chart compares the utilization-weighted average of the WC physician fee schedule to the median reimbursement amounts of commercial health insurers. In the chart, the value of the median APAC reimbursement for each service category is set to 1.0 and the other values are shown in proportion to it. For example, a WC index value of 0.97 means that the fee schedule amount is 3 percent less than the median reimbursement in commercial health insurance.

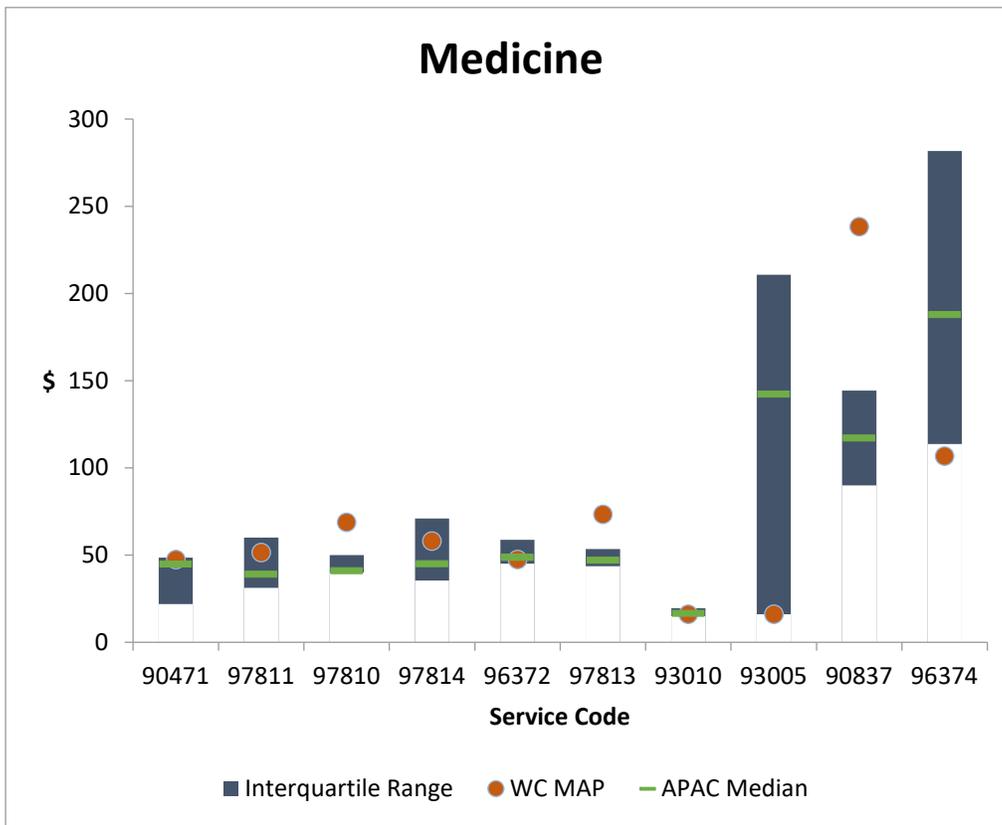


Evaluation and Management and Physical Medicine are both below the APAC median. The other six categories are above the median. Chiropractic is the highest at 189 percent of the APAC median. Physical Medicine is smallest at 89 percent of the APAC median. Both types of surgery as well as Lab and Pathology average slightly less than 150 percent of the APAC median.

The next charts demonstrate the variation in reimbursement for services within categories. The medicine category is used as an illustration. The services shown are the top ten services by frequency in WC.

In the chart, the circles show the WC fee schedule maximum allowable payment (MAP) for the service. The horizontal bars show the median allowed amount from the APAC database for the same code. The allowed amount is the amount that the insurer has determined the provider is owed for the service. The insurer may pay all or part of that amount and the patient may pay the balance in the form of co-pays and deductibles. Half of all reimbursements in commercial healthcare were more expensive and half were less expensive than the amount indicated by the horizontal bar.

The charts below also show a shaded rectangular region for each code that indicates the distribution of values in the APAC data (labeled interquartile range on the graph). The bottom of the shaded region is at the 25th percentile and the top is at the 75th percentile. Thus, half of all APAC reimbursements (the middle half) fall within the range shown by the shaded region. The table below the chart gives actual dollar values for the data points.



Service	CPT Code	25 th Percentile	APAC Median	75 th Percentile	WC MAP
Immunization admin	90471	\$ 21.96	\$ 44.80	\$ 48.46	\$ 47.38
Acupunct w/o stimul addl 15m	97811	\$ 31.20	\$ 39.00	\$ 60.04	\$ 51.38
Acupunct w/o stimul 15 min	97810	\$ 40.00	\$ 41.00	\$ 49.98	\$ 68.73
Acupunct w/stimul addl 15m	97814	\$ 35.49	\$ 45.00	\$ 70.98	\$ 58.06
Ther/proph/diag inj sc/im	96372	\$ 45.00	\$ 48.64	\$ 58.82	\$ 47.38
Acupunct w/stimul 15 min	97813	\$ 43.68	\$ 47.04	\$ 53.55	\$ 73.40
Electrocardiogram report	93010	\$ 15.00	\$ 16.44	\$ 19.50	\$ 16.02
Electrocardiogram tracing	93005	\$ 16.07	\$ 142.31	\$ 210.64	\$ 16.02
Psytx pt&/family 60 minutes	90837	\$ 90.00	\$ 117.00	\$ 144.32	\$ 238.23
Ther/proph/diag inj iv push	96374	\$ 113.60	\$ 187.80	\$ 281.60	\$ 106.77

The most frequent service in the medicine category is immunization administration, usually in the form of a tetanus shot. Four of the top 10 most frequent services in the Medicine category are for acupuncture. Note that the medicine category does not include chiropractic or physical medicine services.

Options:

- Make (incremental?) adjustments to entire categories taking APAC data into consideration in future years.

- Make (incremental?) adjustments to individual codes within all or select categories taking APAC data into consideration in future years.
- Wait for additional APAC data, i.e., for follow-up years, before considering adjustment to the fee schedule considering the APAC data.
- Ignore APAC data for future fee schedule adjustments.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 8 (1488)

Rule: OAR 436-010-0210(6)-(8) Out-of-State Attending Physician

Issue: There appears to be some ambiguity what the insurer's notice must contain when disapproving an out-of-state attending physician (AP) vs. withdrawing the approval of an out-of-state AP. Further, section (8) is not clear whether the worker may request director approval if the insurer withdraws the approval of an out-of-state AP.

Background:

- OAR 436-010-0210(6)(b) provides that if the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:
 - (A) Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,
 - (B) Identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, and
 - (C) Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.
- Further, section (7) states that if an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:
 - (a) The reasons for withdrawing the approval,
 - (b) That any future services provided by that physician will not be paid by the insurer, and
 - (c) That the worker may be liable for payment of services provided after the date of notification
- While subsection (6)(b) requires the notice to identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, section (7) does not contain such a requirement.
- Further, subsection (6)(b) requires the notice to inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220. Section (7) does not contain such a requirement.
- Section (7) requires the insurer to notify the worker and the physician in writing that the worker may be liable for payment of services provided after the date of notification.
- Section (8) is silent whether the worker may request director approval when the insurer withdraws the approval of an out-of-state AP.
- The division believes that the notices under subsection (6)(b) and section (7) should contain the same elements and that the worker or the worker's representative should be able to request director approval regardless of whether the insurer disapproves or withdraws approval of an out-of-state AP.

Options:

- Modify section (6)-(8) as follows:

(6) Out-of-State Attending Physicians.

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days. **If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician.**

(6)(b) If the insurer disapproves the worker's out-of-state attending physician **or withdraws a prior approval**, the ~~notice to~~ **insurer must send** the worker ~~must~~ **written notice that:**

- (A) Clearly states the reasons for the disapproval **or withdrawal**, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010;
- (B) Identifies at least two other physicians of the same healing art and specialty in the same area that the insurer would approve; ~~and~~
- (C) Informs the worker that if the worker disagrees with the disapproval **or withdrawal**, the worker may request approval from the director under OAR 436-010-0220; ~~and~~
- (D) Informs the worker that the worker may be liable for payment of services provided after the date of notification if the worker receives further medical services from the disapproved or no longer approved physician.**

~~(7) Additionally, if an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:~~

- ~~(a) The reasons for withdrawing the approval;~~
- ~~(b) That any future services provided by that physician will not be paid by the insurer;~~ ~~and~~
- ~~(c) That the worker may be liable for payment of services provided after the date of notification.~~

~~(8) If the worker disagrees with the insurer's decision to disapprove an out-of-state attending physician, the worker or worker's representative may request approval from the director under OAR 436-010-0220. **if the worker disagrees with the insurer's decision to:**~~

- ~~**(a) Disapprove an out-of-state attending physician or**~~
- ~~**(b) Withdraw the approval of the out-of-state attending physician.**~~

- Make no change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 9 (1507)

Rule: OAR 436-010-0220(5)

Issue: Section (5) of OAR 436-010-0220 makes no mention of the worker’s right to choose an off panel provider if the MCO has less than three medical service providers from each provider category listed in OAR 436-015-0030(6)(a).

Background:

- OAR 436-010-0220(5) states that an MCO enrolled worker must choose:
 - (a) A panel provider unless the MCO approves a non-panel provider, or
 - (b) A “come-along provider” who provides medical services subject to the terms and conditions of the governing MCO.

- OAR 436-015-0030(6)(a) provides that the MCO must have an adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section’s requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO.

For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

- Adding a subsection (b) to OAR 436-010-0220(5) stating that the worker may choose an off panel provider if the MCO has less than three providers in a category would make section (5) more complete and accurate.

Options:

- Modify OAR 436-010-0220(5) as follows:
 - (5) Managed Care Organization (MCO) Enrolled Workers.
 - (a)** An MCO enrolled worker must choose:
 - (A)** A panel provider unless the MCO approves a non-panel provider, or
 - (B)** A “come-along provider” who provides medical services subject to the terms and conditions of the governing MCO.

(b) Notwithstanding subsection (a) of this section, if the MCO has fewer than three providers in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the workers' geographic service area (GSA), the worker may choose a non-panel providers in that category.

- Make no change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 10 (1416)

Rule: OAR 436-010-0230(7)

Issue: A stakeholder stated that many providers, especially physical therapists (PTs), are accustomed to getting pre-authorization in other insurance situations and often refuse to treat without pre-authorization. Because it is not required that the insurer respond to a request for pre-authorization, the worker sits in limbo, unable to get treatment, because the PT clinic cannot get what they think they need to proceed forward.

Background:

- Interruptions or delays in treatment a worker receives may delay recovery from an injury. Therefore, it may be beneficial to all parties to reduce or avoid delays in treatment, including ancillary services such as physical or occupational therapy, acupuncture, etc.
- Some years ago, the division received a request to create a provision for pre-authorization of diagnostic imaging studies. Since 2014, division 010 rules contain a provision that allows a medical provider to contact the insurer in writing for pre-authorization of diagnostic imaging studies and requires the insurer to respond in writing to the provider's request.
- A provision to require an insurer to respond to a pre-authorization request may lead to an increase in litigation.

Options:

- Create a provision in a new subsection (g) under OAR 436-010-0230(7) that allows ancillary providers to request pre-authorization and requires insurers to respond to such requests similarly to the provision for diagnostic imaging studies (OAR 436-010-0230(12) and 0270(3)):

(7) Ancillary Services – Treatment plan and Pre-authorization.

(g) Unless otherwise provided by an MCO, an ancillary medical service provider may contact an insurer in writing for pre-authorization of ancillary services. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.

Include ancillary services in OAR 436-010-0270(3):

(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 **ancillary services or** diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

- No change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 11 (1424)

Rule: OAR 436-010-0250 Elective Surgery

Issue: Chart notes may not be clear enough to identify that there is an actual request for elective surgery.

Background:

- OAR 436-010-0250(2) requires that a provider must give the insurer at least seven days notice before the date of the proposed elective surgery. This section goes on to state that “[t]he notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.”
- Section (4) of the elective surgery rule requires the insurer to respond to the recommending physician, the worker, and the worker’s representative within seven days of receiving the notice of intent to perform surgery.
- We have heard from stakeholders that often it is not clear whether a chart note is really requesting approval of surgery or not which leads to delays in approval or denial of surgery, multiple phone calls between providers, insurers, and workers, all of which frustrate doctors, workers, and insurers.
- One stakeholder noted that “a lot of frustration and work could be saved if there were a simple form for providers to submit making it very clear that it is a request for approval of surgery.”
- Generally, insurers receive chart notes with the provider billings. Since insurers have 45 days to pay or deny a provider’s charges, an insurer may not analyze a chart note within the seven days that’s required to respond to an elective surgery request.

Options:

- Create an elective surgery form that providers must use when giving seven days notice to the insurer.
- Create an elective surgery form that providers may use when giving seven days notice to the insurer, but allow the providers to use their own form if it contains the necessary information.
- Remove the provision “[a] chart note is considered "notice" if the information required by this section is included in the note” from 436-010-0250(2).
- Other
- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 12

Rule: OAR 436-010-0290(2)(c)

Issue: 4/1/2018 revisions to above rule appear to allow a palliative care provider to appeal an insurer's palliative care disapproval to the director. However, the statute only provides for the worker or the attending physician to appeal to the director.

Background:

- Prior to the 4/1/2018 rules revisions, insurers were required to send a palliative care approval or disapproval to the worker, the worker's attorney, and the attending physician. Since 4/1/2018, insurers are required to also send the notice to the provider who will provide the care.
- Additionally, when disapproving a palliative care request, the insurer's notice must contain the following paragraph:

NOTICE TO ALL PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services in writing within 90 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.
- Since the appeal notice is to "all parties," this includes the provider who will provide the service. However, ORS 656.245(1)(c)(J) only allows for the worker or the attending physician to request approval from the director.

Options:

- Modify the appeal language required under OAR 436-010-0290(2)(c) as follows:

~~NOTICE TO ALL PARTIES~~ **WORKER, WORKER'S ATTORNEY, AND ATTENDING PHYSICIAN**: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services in writing within 90 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Issue # 13

Rule: OAR 436-009 & 436-010

Issue: Telemedicine services are allowed under Oregon workers' compensation rules and regulations, however, there are currently no rules specifically addressing telemedicine.

Background:

- Telemedicine involves two locations:
 - The originating site is the location where the worker receives medical services via a telecommunication system.
 - Distant site is the location where the medical service provider furnishes medical services to the worker at the originating site.
- CMS allows telemedicine services only if the originating site is a county outside of a Metropolitan Statistical Area or in a rural Health Professional Shortage Area located in a rural census tract. Additionally, CMS restricts originating sites to:
 - Physician or practitioner offices;
 - Hospitals;
 - Rural health clinics;
 - Federally qualified health centers;
 - Hospital-based renal dialysis centers (independent renal dialysis facilities are not eligible originating sites);
 - Skilled nursing facilities; and
 - Community mental health centers.
- CMS also restricts practitioners at the distant site to the following:
 - Physicians;
 - Nurse practitioners;
 - Physician assistants;
 - Nurse-midwives;
 - Clinical nurse specialists;
 - Certified registered nurse anesthetists;
 - Clinical psychologists and clinical social workers; and
 - Registered dietitians or nutritional professionals.
- CMS only pays when an interactive audio and video telecommunications system is used that permits real-time communication between the distant site practitioner and the patient.
- The American Medical Association (AMA) and CMS both publish lists containing codes that can be used for telemedicine services. The lists are not identical, i.e., the AMA's list contains CPT codes that are not Medicare eligible and vice versa. Additionally, CMS' list contains eligible HCPCS codes, whereas the AMA's list does not.
- Generally, two payments are made for telemedicine services, one to the originating site (facility fee) and one to the distant site practitioner:
 - The originating site bills a facility fee for its services using HCPCS code Q3014. CMS increases the telehealth originating site facility fee schedule amount yearly

by the percentage increase in the Medicare Economic Index (MEI). The 2018 Medicare fee schedule amount is \$32.20.

- The distant site provider generally bills on a CMS-1500 billing form and uses “02” in field 24B (Place of Service). The distant site provider is paid at the facility rate of the physician fee schedule.
- Here are some issues for this committee to consider:
 - Should there be some regulation when telemedicine services may be provided?
For example:
 - May the very first visit to a healthcare provider, i.e. when Form 827 is signed as first report of injury, be a telemedicine visit?
 - Should a worker be required to be seen in person by a provider at least once every 30(?) days?
 - Can a closing exam be performed via telemedicine?
 - Should telemedicine services be limited to Oregon providers?
 - Should the originating site be limited, similarly to CMS’s restrictions?
 - Should the distant site practitioner be limited to certain provider types?
 - Should the services eligible for telemedicine be restricted to specific CPT and HCPCS codes?
 - Should telemedicine services be limited to interactive audio and video communication systems that allow real-time communication between the distant site practitioner and the patient? As opposed to asynchronous “store and forward” technologies?
- Additionally, the committee may consider some regulation around billing and payment issues:
 - Should the originating site have to use HCPCS code Q3014 to bill for the facility fee.
 - Should division 009 rules:
 - Contain a provision that requires distant site providers to use Place of Service code “02”?
 - State that services by the distant site provider are payable at the facility rate?
- Any other issues to consider?

Options:

- Add telemedicine regulations to division 009 and/or 010 rules
- Make no change
- Other

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015**

Housekeeping

Reason for change: To better capture purpose of rules

436-009-0001(3) Purpose.

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

Reason for change: To better capture purpose of rules

436-010-0001(3) Purpose.

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

Reason for change: Director is not defined in division 010 rules, even though multiple rules refer to the director.

436-010-0005(xx) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

Reason for change: The terminology used in OAR 436-010-0290(2)(d)(A) is inconsistent with terminology used in (2)(a)(D).

436-010-0290(2) Palliative Care.

(a) *** Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

(D) Explain how the requested care is related to the compensable condition;

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

(A) The palliative care services are not related to the ~~accepted~~ **compensable** condition(s);

Reason for change: The definition of "board" includes the board's "hearings division" (see 436-009-0005(7) and 436-010-0005(5)). Therefore the division is replacing the board's "hearing division" with "board" throughout chapter 436 and is removing the definitions of "hearings division" from rule 0005 of 436-009 and 010.

436-009-0005(19) "~~Hearings Division~~" means the ~~Hearings Division of the Workers' Compensation Board.~~

436-009-0008(1)(b) Except for disputes regarding interim medical benefits under ORS 656.247, *** the parties may file a request for hearing with the ~~Hearings Division of the Workers' Compensation Board~~ to resolve the compensability issue.

436-009-0008(6)(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the ~~Hearings Division of the board~~ as follows: ***

436-010-0005(16) ~~“Hearings Division” means the Hearings Division of the Workers' Compensation Board.~~

436-010-0008(1)(c) Except for disputes regarding interim medical benefits under ORS 656.247, *** the parties may file a request for hearing with the ~~Hearings Division of the Workers' Compensation Board~~ to resolve the compensability issue.

436-010-0008(3)(c)(E) *** If the insurer issued a denial that has been reversed by the ~~Hearings Division, the Board,~~ or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

436-010-0008(7)(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the ~~Hearings Division of the Workers' Compensation Board~~ as follows: ***

436-010-0265(11)(c) Any party who disagrees with the director's order approving or disapproving a request for an additional IME may request a hearing by the ~~Hearings Division of the Workers' Compensation Board~~ under ORS 656.283 and OAR chapter 438.

436-015-0008(5) Request for Hearing on Proposed Sanctions and Civil Penalties.
Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director under ORS 656.745, or to a civil penalty or cease and desist order issued under ORS 656.260(21), may request a hearing by the ~~Hearings Division of the Workers' Compensation Board~~ as follows: ***

Reason for change: The term “temporary disability” is most frequently used throughout the chapter 436 rules and the statute, chapter 656. However, below listed rules use the term time loss. It seems reasonable to use “temporary disability” consistently throughout chapter 436 rules.

436-009 and 010 Appendices A: Replace “time loss” with “temporary disability.”

436-010-0210(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes ~~time loss~~ **temporary disability**, and prescribes and monitors ancillary care and specialized care.

436-010-0210(3) Emergency Room Physicians.

Emergency room physicians may authorize ~~time loss~~ **temporary disability** for no more than 14 days when they refer the patient to a primary care physician. ***

436-010-0230(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize ~~time loss~~ **temporary disability**. ***

436-010-0240(6) ~~Time Loss~~ Temporary disability and Medically Stationary.

(a) When ~~time loss~~ **temporary disability** is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days.

436-015-0030(8)(a)(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, workers' ~~time loss~~ **temporary disability**, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. ***

Reason for change: Clarify rule: Time frames for type B providers and authorized nurse practitioners start with the date of first visit to any type B provider, any authorized nurse practitioner, respectively. There are a couple places in division 010, where the rule does not include a reference to the type B provider or authorized nurse practitioner, which may lead the reader to wonder the first visit with whom?

436-010-0210(2)(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first, **from the first visit on the initial claim with any type B provider**.

436-009 and 010 Appendices A, row "Authorized nurse practitioner," column "Authorize payment of time loss (temporary disability) and release the patient to work:" Yes, for 180 days from the date of the first visit **with any authorized nurse practitioner** on the initial claim.

Reason for change: Use "division" consistently throughout chapter 436.

436-009-0005(26) "Mailed or mailing date" means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the ~~Workers' Compensation~~ **Ddivision**. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

436-009-0008(6)(c)(A) A written request for a hearing must be mailed to the ~~administrator of the Workers' Compensation~~ **Ddivision**. The request must specify the grounds upon which the proposed order or assessment is contested.

436-009-0008(7)(b) A written request for review must be sent to the ~~administrator of the Workers' Compensation~~ **Ddivision** within 90 days of the disputed action and must specify the grounds upon which the action is contested.

436-009-0110(2)(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the ~~Department of Consumer and Business Services, Workers' Compensation~~ **Ddivision** at 503-947-7814. They may also access insurance policy information at <http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm>.

436-010-0005(22) "Mailed or mailing date" means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the ~~Workers' Compensation~~ **Ddivision**. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

436-010-0008(7)(c)(A) A written request for a hearing must be mailed to the ~~administrator of the Workers' Compensation~~ **Ddivision**. The request must specify the grounds upon which the proposed order or assessment is contested.

436-010-0008(8)(b) A written request for review must be sent to the ~~administrator of the Workers' Compensation~~ **Ddivision** within 90 days of the disputed action and must specify the grounds upon which the action is contested.

436-010-0230(11)(b) Providers should review and are encouraged to adhere to the ~~workers' compensation~~ division's opioid guidelines. See <http://wcd.oregon.gov/medical/Pages/opioid-guidelines.aspx>.

436-010-0265(1)(f) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the ~~Workers' Compensation~~ **Ddivision's** website. If the worker does not have access to the Internet, the worker may call the ~~Workers' Compensation~~ **Ddivision** at 503-947-7606.

436-015-0001(1) Any orders issued by the ~~Workers' Compensation Division (division)~~ in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.

436-015-0005(new) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

436-015-0008(5)(a) The party must file a written request for a hearing with the ~~Workers' Compensation~~ **Ddivision** within 60 days after the mailing date of the proposed order or

assessment. The request must specify the grounds upon which the proposed order or assessment is contested.
