

# 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

<b>Type of meeting:</b>	Rulemaking advisory committee
<b>Date, time, &amp; place:</b>	Nov. 18, 2019, 1:30 p.m. - 4:30 p.m.. PST Room 260 (2nd flr) Labor and Industries Building 350 Winter Street NE, Salem, Oregon 97301  <b>GoToMeeting</b> - to join by computer, tablet, or smartphone: <a href="https://global.gotomeeting.com/join/986769613">https://global.gotomeeting.com/join/986769613</a>  You can also dial in using your phone.  United States (Toll Free): 1 877 309 2073  Access Code: 986-769-613
<b>Facilitators:</b>	Fred Bruyns and Juerg Kunz, Workers' Compensation Division
<b>1:30 to 1:40</b>	Welcome and introductions; meeting objectives
<b>1:40 to 3:00</b>	Discussion of issues – <a href="#">see attachment</a> .
<b>3:00 to 3:15</b>	Break
<b>3:15 to 4:15</b>	Discussion of issues on agenda continued, and request for new issues
<b>4:15 to 4:30</b>	Summing up – next steps – thank you!

Attached: [Issues for discussion](#)

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Chapter 436, Divisions 009, 010, and 015**

**Issue # 1 (Standing)**

**Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2020)**

**Issue:** The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT<sup>®</sup> and HCPCS codes, effective January 1, 2020. However, the Workers' Compensation (WCD) does not publish its permanent fee schedule updates until April 1, 2020. 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.

**Background:**

- 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.
- Adopting the new CPT<sup>®</sup> 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, 2020, and assign maximum payment amounts using the 2019 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.
- As in years past, the temporary rules would not delete any codes from any appendix and providers may continue codes valid in 2019.

**Options:**

- Adopt new CPT<sup>®</sup> codes through a temporary rule, effective January 1, 2020.
- Update appendices B – E with payment amounts for new codes using the 2019 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 2 (Standing)**

**Rule: OAR 436-009-0004 and Appendices B through E (permanent rules, effective April 1, 2020)**

**Issue:**

- ORS 656.248(7) requires that WCD update the fee schedules annually.
- The references listed in OAR 436-009-0004(1) – (9) and the fee schedules published in Appendices B through E will be outdated when the permanent rules become effective on April 1, 2020.

**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 *RVU19A*, effective January 2019. We expect that CMS will publish the file containing the 2020 RVUs in November 2019.
  - 2) Current Appendix C is based on spreadsheets published by CMS in CMS-1695-FC. We expect that CMS will publish CMS-1717-FC, containing the 2020 ASC fee schedule amounts for surgical procedures, in November 2019.
  - 3) Current Appendix D is based on spreadsheets published by CMS in CMS-1695-FC. We expect that CMS will publish CMS-1717-FC, containing the 2020 ASC fee schedule amounts for ancillary services, in November 2019.
  - 4) Current Appendix E is based on the CMS file *DME19-A*, effective January 2019. We hope that CMS will publish the file containing the 2020 DMEPOS fee schedule in November 2019.
- Every year, there are some CPT<sup>®</sup> 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<sup>®</sup> 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/multipliers.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 3 (1751)**

**Rule: ???**

**Issue:** Telemedicine services are not prohibited under the Oregon’s workers’ compensation rules. However, the rules do not include a definition of telemedicine or specific standards for billing and payment of telemedicine services.

**Background:**

- Telemedicine services include two sites; the originating site, where the patient is located; and the distant site, where the practitioner providing the service is located.
- There are two broad types of telehealth. One is telemedicine service rendered via a real-time interactive audio and video telecommunications system (synchronous); the other is store and forward, where the distant site practitioner reviews the transmission at a later date (asynchronous).
- The Workers’ Compensation Division had multiple discussions with stakeholders regarding telemedicine. Although many stakeholders opined that regulations around telemedicine should be kept to a minimum, the majority agreed that it would be beneficial to adopt billing and payment standards by rule.
- WCD has adopted the American Medical Association’s CPT® code book (CPT® 2019). Hence, under the current WCD rules, providers may bill for telemedicine with CPT® codes that are listed in Appendix P of CPT® 2019.
- When the distant site provider bills for synchronous telemedicine services, the place of service should be coded as “02.”
- Generally, distant site providers should add modifier 95 to the CPT® codes used to bill for telemedicine services.
- WCD’s billing and payment data show that most distant site telemedicine services are paid at the non-facility rate. The same holds true for most health care insurers and other states’ workers’ compensation systems. However, our current rules do not specify whether the services of the distant site provider should be paid at the facility or the non-facility rate.
- Generally, an originating site, such as a doctor’s office or hospital, may bill a facility charge using HCPCS code Q3014. Under the current fee schedule this code does not have a maximum payment amount; so payment is 80% of billed.
- Although there is a code for “Telehealth transmission” (HCPCS code T1014), it appears that the vast majority of health plans, including Medicare, do not allow payment for HCPCS code T1014. Under current rules, since it is a valid code, insurers could be required to pay any charges billed with code T1014 at 80% of billed.

**Options:**

- Define telemedicine services as “Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.”
- Clarify that providers may bill for telemedicine with CPT® codes that are listed in Appendix P of CPT® 2020.

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- Clarify that distant site providers must use modifier 95 when billing for telemedicine services with CPT® codes.
- Require the use of “02” for place of service when billing for telemedicine services by the distant site provider.
- Require insurers to pay for telemedicine services at the non-facility rate.
- Require originating providers, when billing a facility fee, to use HCPCS code Q3014.
- Create a maximum fee schedule amount for the facility charge billed with HCPCS code Q3014.
- Clarify that insurers are not required to pay a telehealth transmission fee (HCPCS code T1014).
- Create a new rule in OAR 436-009 titled “Telemedicine services” or distribute the points above throughout division 009 rules, e.g., place the provision regarding modifier 95 into 436-009-0010(5).
- Make no change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 4 (1753)**

**Rule: OAR 436-009-0020**

**Issue:** The criterion that DCBS uses to determine exemption from the hospital cost-to-charge ratio for rural, non critical access hospitals (CAHs), is no longer available.

**Background:**

- ORS 656.248(13) provides that the director may exclude hospitals defined in ORS 442.470 from imposition of a fee schedule upon a determination of economic necessity.
- OAR 426-009-0020(5)(k) prescribes the test for the exemption, “All rural hospitals having a financial flexibility index at or below the median for all critical access hospitals nationwide qualify for the exemption.”
- The 59 hospitals in Oregon fall into three categories: 23 urban hospitals that are paid at their cost-to-charge ratio (CCR), 25 rural CAHs that are exempt from the CCR, and 11 rural, non-CAHs whose exemption status is determined each year by examining their financial records. Hospitals that are exempt from the cost-to-charge ratio are paid as billed.
- There has been an average of 2.5 exempt rural, non-CAHs from October 2011 through 2018, ranging from a low of 1 to a high of 4. Currently, one of the 11 hospitals in this category is exempt on this basis.
- The exemption status for these 11 hospitals is determined by comparing each hospital’s Financial Flexibility Index (FFI), as calculated by DCBS, with the median FFI of all CAHs in the United States, which is calculated by a third party contractor (Optum). Per this agreement, each year DCBS provides Oregon hospital financial records to Optum, and Optum provides DCBS with the median FFI of all CAHs nationwide. Optum is no longer collecting these hospital financial records or calculating the FFIs of hospitals in other states. Therefore, DCBS can no longer use the median FFI of all CAHs nationwide to determine the exemption status for these 11 rural, non-CAHs.
- DCBS is able to calculate the median FFI of all Oregon CAHs. The following table shows how many rural non-CAHs were excluded from the cost-to-charge ratio using the national median and how many would have been excluded had we used the Oregon only median FFI:

	Rural non-CAH excluded from cost-to-charge ratio using:	
	National Median FFI	Oregon Median FFI
2011	1	2
2012	2	2
2013	4	4
2014	3	3
2015	4	6
2016	3	5
2017	2	4
2018	1	3

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- Had the exemption status been determined using the median FFI of all Oregon CAHs, the average number of exempt rural non-CAHs would have been 3.6.

**Options:**

- Exclude all rural hospitals from the cost-to-charge ratio.
- Exclude a fixed number of rural non-CAHs, e.g. hospitals with the lowest three FFIs.
- Eliminate the exemption for all rural, non-CAHs.
- Use the median FFI of Oregon CAHs only to determine which rural, non-CAHs are excluded from the cost-to-charge ratio.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 5 (1615)**

**Rule: OAR 436-009-0030(2)(a)**

**Issue:** All original medical provider bills must be submitted on an appropriate billing form that is filled out completely and be accompanied by chart notes documenting services that have been billed. Under OAR 436-009-0020(2)(a), insurers are required to return incomplete bills to the provider within 20 days. Since a rule change in 2013, this rule inadvertently no longer requires chart notes to make billings complete. Also, OAR 436-009-0030(2)(a) does not list a completed billing form as required.

**Background:**

- OAR 436-009-0030(2)(a) provides that insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b) and (2) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill.
- OAR 436-009-0010(1)(b), (3), and (7) list the instructions for medical providers regarding what billing form to use, how to fill out the billing form, and that chart notes must accompany the bill to make it complete.
- It is not clear why OAR 436-009-0030(2)(a) refers to section (2) of 436-009-0010 since that section refers to billing timelines.

**Options:**

- Make the following revision to OAR 436-009-0030(2):  
(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b), ~~and (2)~~, and (7) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill.
- Make no change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 6 (1426)**

**Rule: OAR 436-009-0040 / Appendix B**

**Issue:** Effective April 1, 2019, the department increased the maximum payment amounts for evaluation and management (E/M) services by five percent. However, fees for arbiter and physician reviewer services, which are similar to E/M services, were not raised.

**Background:**

- Providers use Oregon specific codes (OSCs) when billing for arbiter exams (OSC AR001 – AR004), file reviews (OSC AR021 – AR025), and reports (OSC AR011 – AR013, AR031 and AR032).
- When performing a director required exam, such as a physician review for a treatment dispute, providers use OSCs P0001 – P0005 for billing.
- Prior to the 2019 increase in maximum payment amounts for E/M services, the department increased the maximum allowable payment amount for E/M, arbiter, and physician reviewer services by an average of three percent, effective April 1, 2016.
- The department projects that a 5 percent increase of the maximum fee schedule amounts for arbiter or physician reviewer services would increase the medical costs of the workers' compensation system by \$62,760.

**Options:**

- Increase the maximum fee schedule amounts for arbiter and director required exams, file reviews, and reports by 5 percent.
- Make no change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 7 (1752)**

**Rule: OAR 436-009-0060**

**Issue:** A stakeholder, an MCO, is proposing three new Oregon Specific Codes be added to the Oregon Medical Fee Schedule outlined in Division 009 of Chapter 436 of the Oregon Administrative Rules: RECRW, VIDEO, and D0091.

**Background:**

- There are two sets of nationally recognized billing codes to be used by health care providers in the United States that providers treating Oregon workers may use to codify the services provided: The American Medical Association's (AMA) CPT<sup>®</sup> codes and the Centers' for Medicare and Medicaid Services' (CMS) HCPCS codes.
- Although above sets of billing codes are quite comprehensive, there are certain services, in particular as they relate to the treatment of workers' compensation patients, that may not be coded correctly with a CPT<sup>®</sup> or HCPCS codes. For such services, WCD has created Oregon Specific Codes (OSCs) listed in OAR 436-009-0060(2).
- Since the department has no data regarding billing or payment amounts for the proposed codes, WCD will not be able to assign a maximum payment amount to any of the proposed codes.
- This stakeholder proposes three new OSCs (wording provided by stakeholder):
  - **RECRW:** This Oregon Specific Code would be designated for records review provided by a non-treating physician. Currently, the closest CPT code for this purpose would be 99358 (prolonged evaluation and management service before and/or after direct patient care; first hour). This code assumes that the provider has seen, or will see, the patient. However, there are times a provider is requested to review records to provide expert opinion or insight into a case without an associated physical exam of the worker. While this is not common, in those instances where it does occur, having a specific code for this service allows it to be quickly identified as uniquely different from other records review.
  - **VIDEO:** There is no standard CPT code specifically for review of video. Video review is distinctly different from other records review, and the ability to identify the frequency with which a provider is requested to review video, or that video review is required in overall case management, assists with valuable trending analysis. As with RECRW, having a code that directly relates to the service being rendered increases transparency in the billing and payment data and provides for consistency across all medical providers.
  - **D0091:** Having access to the expertise of an addictionologist is highly valuable when managing the medical care for injured workers on opioids for chronic pain. However, it is very difficult to find an addictionologist willing to treat workers' compensation. Consults usually involve a number of different elements, including extensive records review, physical exam, reports, responses to letters and urine drug screening. The standard is to have each of these services billed individually, which increases the risk that the consults are not billed or reimbursed consistently. Having a single code to represent the entire consult would circumvent this issue and ensure the provider receives adequate and appropriate reimbursement. This

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MCO has partnered with two addictionologists in the past 10 years, and both have indicated a preference to this type of approach.

**Options:**

- Create OSC RECRW: Records review by a non-treating physician.
- Create OSC VIDEO: Review of video.
- Create OSC D0091: Services by an addictionologist consultant consisting of an extensive records review, a physical exam, reports, responses to letters, and urine drug screening.
- Make no change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 8 (1376)**

**Rule: OAR 436-009-0110(3)**

**Issue:** Interpreters may not bill any amount for interpreter services or mileage if the worker fails to attend a medical appointment.

**Background:**

- Since April 1, 2019, medical provider may bill workers for missed appointments under certain circumstances.
- OAR 436-009-0010(13)(b) provides, in relevant part, that 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.
- The missed appointment rule states that the implementation and enforcement of the rule is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.
- Interpreters also may not bill any amount for interpreter services or mileage if the provider cancels or reschedules the appointment (OAR 436-009-0110(3)(a)(B)).

**Options:**

- Modify the provision of OAR 436-009-0110(3) to mirror OAR 436-009-0010(13)(b) and (c), which then would allow an interpreter to bill a patient under specific circumstances.

**(3) Billing and Payment Limitations.**

(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if:

~~(A) The patient fails to attend the appointment; or~~

~~(B) The the provider cancels or reschedules the appointment.~~

**(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, an interpreter may bill a workers' compensation client if the client fails to attend the appointment if:**

**(A) The interpreter has a written missed appointment policy that applies not only to workers' compensation clients, but to all clients;**

**(B) The interpreter routinely notifies all clients of the missed appointment policy;**

**(C) The interpreter's written missed policy shows the cost to the client; and**

**(D) The client has signed the missed appointment policy.**

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

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(b~~d~~) The insurer is not required to pay for interpreter services or mileage when the services are provided by:

- (A) A family member or friend of the patient; or
- (B) A medical provider's employee.

- Make no change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**Issue # 9 (1754)**

**Rule: OAR 436-015-0030(6)?**

**Issue:** Not all providers willing and able to accept Managed Care Organization (MCO) enrolled patient are allowed on MCO panels.

**Background:**

- A stakeholder requested that this issue be discussed at the next rules advisory committee meeting.
- The stakeholder stated: “MCOs are utilizing exclusionary contracts with large multi-state corporate PT clinics and refuse to contract with any independent private practices. They cite geographical saturation, however, will automatically enroll and credential any new clinic from the larger chains within a 3 mile proximity despite our efforts to join since 2015. When asked how they assess for “value”, “quality control”, and “cost-saving” they have no answer. Feels very anti-trust and anti-competition.”
- Under current rules, there are no remedies for providers who are not granted panel member status with MCOs. In prior advisory committee meeting discussions about this subject, a majority of committee members was against requiring MCOs to credential any willing provider.
- Under OAR 436-015-0030(6)(a) an 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.
- Above number of a minimum of three providers in each category of providers applies to each geographical service area, regardless of the population size of each area.

**Options:**

- Consider different numbers of providers in each category of providers based on the population size of each geographical service area.
- Make no change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**