Agenda

Rulemaking Advisory Committee

Workers' Compensation 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. 9, 2020, 9 a.m. Pacific Standard Time** **Join meeting from your computer, tablet or smartphone.** https://global.gotomeeting.com/join/989518389 **By phone, U.S. (toll free)**: 1 877 309 2073 **Access Code:** 989-518-389
Facilitator:	Fred Bruyns and Juerg Kunz, Workers' Compensation Division
9:00 to 9:10	Welcome and introductions; meeting objectives
9:10 to 10:30	Discussion of issues
10:30 to 10:45	Break
10:45 to 11:45	Discussion of issues continued
11:45 to 11:55	Summing up – next steps – thank you!

Attached: **Issues document**

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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, 2021)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2021. However, the Workers' Compensation (WCD) does not publish it's permanent fee schedule updates until April 1, 2021. 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, the 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® 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, the WCD could update appendices B – E, effective January 1, 2021, and assign maximum payment amounts using the 2020 conversion factors/multipliers. One should bear in mind that due to time and staffing restraints, it may not be possible to update all appendices.
- The 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 to use codes valid in 2020.
- When billing for services, providers may use CPT® codes only if the codes are listed (a) in the AMA's CPT® codebook that the WCD has adopted, currently CPT® 2020, or (b) in OAR 436-009-0004(3).
- Effective September 21, 2020, the WCD adopted new CPT® codes related to Covid-19 testing that the AMA created midyear. *See* OAR 436-009-0008(3). Since some of these codes (86328, 86769, 87635, and 0202U) are part of CPT® 2021, which the WCD proposes to adopt as part of the updated references listed in OAR 436-009-0004, section (3) does not need to separately list the codes listed in CPT® 2021.
- The WCD has learned that the AMA has created several new codes that are not listed in CPT® 2020, CPT® 2021, or in OAR 436-009-0004(3).
    - CPT® code 86413: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative;
    - CPT® code 87636: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique;
    - CPT® code 87637: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus

disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique;

- CPT® code 87811: Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
- CPT® code 99072: Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease);
- CPT® code 0240U: Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected; and
- CPT® code 0241U: Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected.

Options:

- Adopt new CPT® and HCPCS codes through updated references listed in OAR 436-009-0004 with a temporary rule, effective January 1, 2021, and update appendices B – E with payment amounts for new codes using the 2020 conversion factors/multipliers, where possible.
- Change OAR 436-009-0004(3) as follows:
  The director adopts the following CPT® codes not listed in CPT® ~~2020~~**2021** for billing by medical providers: ~~86328,~~ 86408, 86409, **86413,** ~~86769,~~ 87426, ~~87635,~~ **87636, 87637, 87811, 99072,** ~~0202U,~~ 0223U, 0224U, 0225U, ~~and~~ 0226U**, 0240U, and 0241U**.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B through E (permanent rules, effective April 1, 2021)

Issue:

- ORS 656.248(7) requires that the WCD update the fee schedules annually.
- The references listed in OAR 436-009-0004 and the fee schedules published in Appendices B through E will be outdated when the permanent rules become effective on April 1, 2021.

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:
    - Current Appendix B is based on the CMS file *RVU20A*, effective January 2020. We expect that CMS will publish the file containing the 2021 RVUs in November 2020.
    - Current Appendix C is based on spreadsheets published by CMS in CMS-1717-FC. We expect that CMS will publish CMS-1736-FC, containing the 2021 ASC fee schedule amounts for surgical procedures, in November 2020.
    - Current Appendix D is based on spreadsheets published by CMS in CMS-1717-FC. We expect that CMS will publish CMS-1736-FC, containing the 2021 ASC fee schedule amounts for ancillary services, in November 2020.
    - Current Appendix E is based on the CMS file *DME20-A*, effective January 2020. We hope that CMS will publish the file containing the 2021 DMEPOS fee schedule in November 2020.
- 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.
- When billing for services, providers may use CPT® codes only if the codes are listed (a) in the AMA's CPT® codebook that the WCD has adopted, currently CPT® 2020, or (b) in OAR 436-009-0004(3).
- Effective September 21, 2020, the WCD adopted new CPT® codes related to Covid-19 testing that the AMA created midyear. *See* OAR 436-009-0008(3). Since some of these codes (86328, 86769, 87635, and 0202U) are part of CPT® 2021, which the WCD proposes to adopt as part of the updated references listed in OAR 436-009-0004, section (3) does not need to separately list the codes listed in CPT® 2021.
- The WCD has learned that the AMA has created several new codes that are not listed in CPT® 2021, or in OAR 436-009-0004(3).
    - CPT® code 86413: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative;

- CPT® code 87636: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique;
- CPT® code 87637: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique;
- CPT® code 87811: Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
- CPT® code 99072: Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease);
- CPT® code 0240U: Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected; and
- CPT® code 0241U: Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected.

Options:

- Adopt updated references listed in OAR 436-009-0004 and update Appendices B through E using more current CMS spreadsheets and updated WCD conversion factors/multipliers. *See* also issues # 3, 4, and 5.

- Change OAR 436-009-0004(3) as follows:
  The director adopts the following CPT® codes not listed in CPT® ~~2020~~**2021** for billing by medical providers: ~~86328,~~ 86408, 86409, **86413,** ~~86769,~~ 87426, ~~87635,~~ **87636, 87637, 87811, 99072,** ~~0202U,~~ 0223U, 0224U, 0225U, ~~and~~ 0226U**, 0240U, and 0241U**.

- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Issue # 3 (1847)

Rule: OAR 436-009-0040 and Appendix B

Issue: A stakeholder requested that the WCD increase the physician fee schedule by at least 1.6 percent.

Background:

- The stakeholder is asking the WCD to "increase remuneration for all physician services by at least 1.6%, due to the most recent cost-of-living increase estimates. Costs incurred by medical facilities continue to increase accordingly, with regard to rent/lease/mortgage payments, staff remuneration, benefits, etc. The vast majority of clinics in Oregon base their fee schedule upon the Workers' Compensation (WC) fee schedule. The vast majority of insurance companies, the primary payer of medical bills in Oregon, will refuse to pay higher than the WC fee schedule; and will usually pay far less."
- The physician fee schedule consists of several categories (evaluation and management (E/M), major surgery, minor surgery, radiology, laboratory and pathology, medicine, physical medicine, and Oregon specific codes), with the maximum fees published in Appendix B. Additionally, OAR 436-009-0040(2) lists the conversion factor for anesthesia services.
- Over the last five years, the WCD implemented the following fee adjustments:
    - Effective April 1, 2016, the WCD increased the maximum payment amounts for all categories, except physical medicine and anesthesia services by three percent.
    - Effective April 1, 2017, the WCD increased the maximum payment amounts for anesthesia services by three percent
    - Effective April 1, 2019, the WCD increased the maximum payment amounts for E/M services by five percent.
    - Effective March 25, 2020, through a temporary rule, the WCD increased the maximum allowable payment amounts for certain telephonic and digital evaluation/management services delivered on or after March 8, 2020, to levels similar to in-person encounters. This fee increase was then adopted through permanent rules, effective September 21, 2020.
    - Effective April 1, 2020, the WCD increased fees for medical arbiter and physician-review (of disputed medical services) examinations and services by five percent.

Options:

- Increase the maximum payment amounts of the physician fee schedule by 1.6 percent.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Issue # 4 (1849)

Rule: OAR 436-009-0040 and Appendix B

Issue: A stakeholder requested that the WCD increase the maximum payment amounts for chiropractic manipulative therapy (CPT® codes 98940 – 98943) by ten percent.

Background:

- The stakeholder provided the following background information:
  - "There has not been an increase in these codes since the cost of living proposal in 2016. After significant reductions from 2000-2010, these codes were provided increases based upon my proposals that only regained some of the losses seen from the prior years. Therefore, we remain close to the same reimbursement levels from the year 2000.

  - **"Potential violation of Oregon Discrimination Law: ORS 743B.505(2)(a-c)** "It is relevant to compare the chiropractic manipulative therapy (CMT) codes to the osteopathic adjustment codes (OMT) (98925-98927). A comparison of classroom hours between chiropractic and osteopathic schools shows chiropractic has more than 1200 more total classroom hours. Hours specifically dedicated to the service referenced by these codes show 396 chiropractic hours compared to 162 osteopathic hours. And Biomechanics and Palpation, used to determine when and where to treat, is 264 chiropractic hours compared to zero osteopathic hours. Most osteopathic schools have their manipulation classes taught by chiropractors. Yet, the osteopathic manipulation codes are currently close to 10% higher than the CMT codes, which is likely a violation of Oregon's non-discrimination law, ORS 743B.505(c) regarding participation, coverage and reimbursement:
    The code comparisons are listed below with the CPT criteria for each.

CMT[1]	2019 Fee	OMT[2]	2019 Fee
98940 1-2 Spinal regions	$56.84	98925 1-2 Body regions	$59.97
98941 3-4 Spinal regions	$79.58	98926 3-4 Body regions	$86.25
98942 5+ Spinal regions	$101.56	98927 5-6 Body regions	$113.20
98943 Extraspinal region	$53.82	98928 7-8 Body regions	$137.48
		98929 9-10 Body regions	$164.41

"The CMT extraspinal region (98943) code is defined as one or more region. The extraspinal regions are defined as head, lower extremity, upper extremity, rib cage and abdomen. This indicates that if chiropractic treatment were provided to the elbow, foot and head (98943), the reimbursement would be $53.82. If you add treatment to the cervical and thoracic region (98940), an additional $56.84 could be charged, bringing the total to $110.66.

[1] Chiropractic manipulative therapy
[2] Osteopathic manipulative therapy

"The OMT codes refer to the following body regions: cervical, thoracic, lumbar, sacral, pelvic, lower extremity, upper extremity, rib cage, abdomen and viscera. Therefore, if an osteopath provides manipulation to the elbow, foot and head (98926), their reimbursement would be $86.25. If the cervical and thoracic area were added, then the code is 98927 and is reimbursed at $113.20.

"It should be noted that CMT code 98942 (5+spinal regions) is rarely reimbursed within the workers' compensation system as the acceptable condition rarely includes all areas. It is also worth noting that extraspinal region code 98943 is also rarely reimbursed as related to the injury when coupled with a spinal manipulation code, but that data should be verified by the Division.

"It is also worth reminding that chiropractors do not get to charge a separate E/M code during their daily treatment visits unless it involves an identifiable separate service like an examination. The osteopaths have the ability to charge additional E/M services each visit without the need for a separate examination as long as they perform other management services including pharmacological questioning, which for a brief office visit (99211) is reimbursed at $47.14, but more likely billed at either a 99212 ($93.54) or 99213 ($153.93).

"There is no logical reason why the discrepancy between these codes other than discrimination amongst provider types. It is the exact same service rendered by different disciplines.

- **"Fiscal Impact of Proposal:**
  "Due to the current 18-visit limitation on chiropractic treatment as a Schedule B provider, the fiscal impact of a 10% increase in these codes would be less than $200 per case. Last year, the division indicated that would be approximately a $320k annual increase. Compare that to the $320 million expenditure of medical care alone…not physical therapy, nor radiology, just medicine.

- **"All Payers, All Claims (APAC):**
  "Last year, this data was utilized to determine that chiropractic reimbursements from commercial policy claims were about 89% lower than the WC fee schedule. This created a presumption about the WC fee amount for chiropractic care already being too high.

  "Personal insurance coverage of chiropractic care has consistently been contested on the State and National levels. Even with the provider non-discrimination law, ORS 743B.505(2)(a-c) regarding participation, coverage and reimbursement, there are still constant battles regarding coverage and reimbursement rates. Commercial health insurers consistently violate Oregon law and continue reimbursing chiropractic physicians at a lower rate than medical or osteopathic physicians for the same covered CPT codes.

"The reimbursement rates also vary greatly between individual policies, even within the same companies. We have seen reimbursement rates range from 50%-80% of allowable amounts (which varies amongst carriers), to $25 per visit, to $2.78 payable, all on a charge of $60. Obviously that would change the level of claim payout to a much lower rate than the WC schedule allows.

"The chiropractic profession is also one of the only health care disciplines that manage a high percentage of cash paying patients due to wellness and prevention care plans. As a result, the chiropractic profession has typically maintained a relatively affordable pay structure across the board. The fee schedule published by the Worker's Compensation Division has been a benchmark for affordable charges that most other health care disciplines do not utilize. Most medical offices significantly exceed the WC fee schedule for their billed services. This is likely due to medical providers reliance upon commercial policies allowing them to accept the policy's percentage of their higher charged amount. This results in an average reimbursed APAC amount for medical providers that is higher than the WC fee schedule. Giving a false interpretation that medical providers are paid too low in the WC system.

- **"Reimbursement Example:**
  "A medical provider bills $200 for a 99212 E/M office visit. They receive 75% from a commercial policy resulting in $150 reimbursed. The same medical provider would receive $87.58 from workers compensation carriers for the same code. The APAC data would conclude Workers Compensation is 58% lower than APAC. A chiropractor will typically charge $85-$90 for the same 99212 code. If the policy covered percentage was 75% it would result in a $65.25 reimbursement. APAC would conclude that chiropractors were being paid 33% more in the Workers Comp fee schedule amount ($87.58), resulting in the false interpretation that chiropractors are paid too high.

- **"Co-Pay Effect:**
  "If a chiropractor bills $60 for a 98940 manipulative therapy code, and has agreed to accept 75% of charged amount, but the patient also has a $30 co-pay, the insurance carrier would cover $45 but only have to pay $15 after the co-pay. The same 98940 code under Workers' Comp that is charged $60, would be reimbursed at $56.84 based upon fee schedule. That would show a 74% difference between WC and APAC, thus concluding that the chiropractic codes are too high. These differences between medical and chiropractic billing practices is causing the confusion and erroneous belief that the WC fee schedule should not be raised for chiropractic codes.

  "Chiropractic has often been compared to medical services for neck and back pain with evidence-based results concluding superior outcomes for chiropractic servies. (Schneider, Spine '15; Bishop, Spine '10; Goertz, JAMA, '18). Insurance data from hundreds of thousands of patients also show superior

benefits, reduced costs and superior safety with chiropractic care (Elton, National Academies of Science Presentations, 2018).

- **"Cost of Living:**
  "The 2019 annual increase in real estate rental fees in Portland Oregon was 10.3%. This was after a legislative cap was applied. Historically, the annual rental increase in Portland and other areas around the state has been 10% without added inflation. Commercial lease increases of over 3% per year is typical. The last cost of living increase in the WC fee schedule affecting CMT codes was in 2016, therefore a minimum of 12% has likely been increased in the cost to do business. Some of this may have been addressed with typical CPT codes such as E/M, but failing to address that on a regular basis for chiropractic specific codes is harming a profession that has a high satisfaction rate, high success rate and one of the most cost-efficient services available."

Options:

- Increase maximum payment amounts for CMT (CPT® codes 98940 – 98943) by ten percent.
- Other?
- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Issue # 5 (1852)

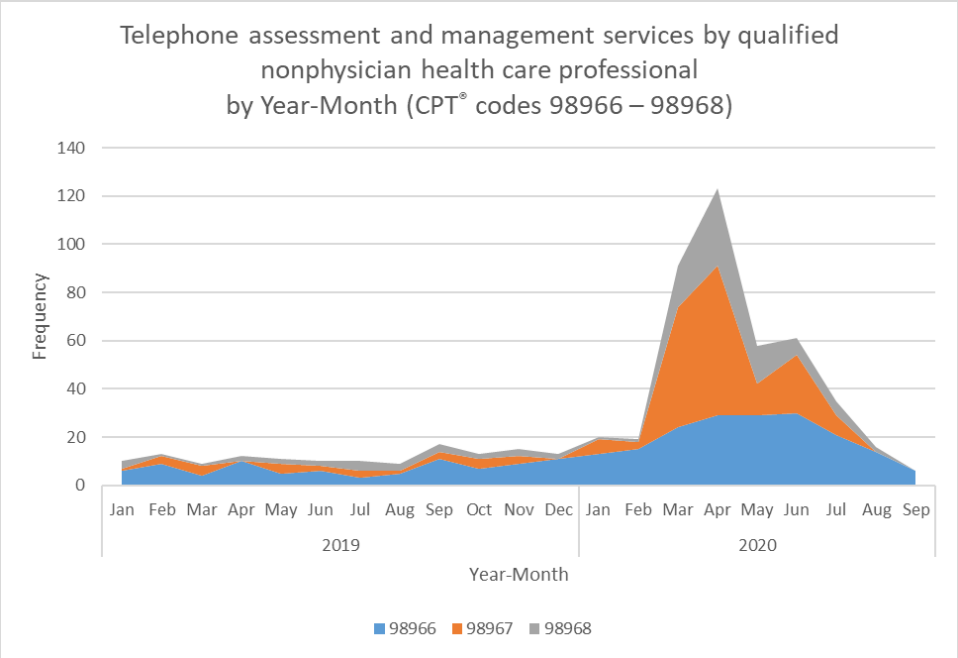
Rule: OAR 436-009-0040 and Appendix B

Issue: A stakeholder asked that the fees for certain telehealth services (CPT® codes 98966 – 98968 (telephone assessment and management services by qualified nonphysician health care professional), 98970 – 98972 (online digital evaluation and management services by qualified nonphysician health care professional), 99421 – 99423 (online digital evaluation and management services), and 99441 – 99443 (telephone evaluation and management services)) be re-evaluated for the April 1, 2021, physician fee schedule.

Background:

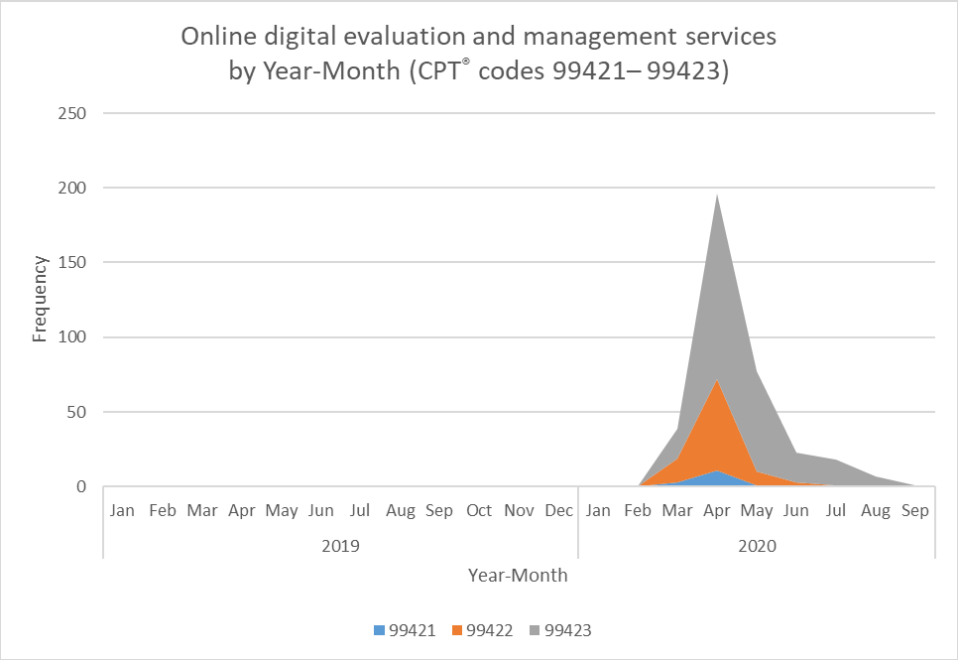
- In March 2020, the WCD published a temporary fee schedule for certain services provided on or after March 8, 2020 (the date Gov. Kate Brown declared a public health emergency). The temporary fee schedule increased the payment rates for telephonic and online digital evaluation/assessment and management services to mirror payment rates for an equivalent office visit as recommended by the Oregon Health Authority (OHA). This allowed providers to increase their capacity to serve patients by telephone and online digital means.
- Effective September 21, 2020, the WCD adopted the increased payment rates for telephonic and online digital evaluation/assessment and management services through permanent rule making.
- Insurers with an average of at least 100 accepted disabling claims per year, based on the average accepted disabling claim volume for the previous three calendar years, are required to electronically submit detailed medical bill payment data to the Department. The list of insurers required to report medical bill data is published in Bulletin 359. The department analyzed medical bill and payment data reported to the department via electronic data interchange (EDI) by October 15, 2020. There may be quite a delay in receiving the insurers' data by the department because a provider has up to 60 days to bill from the date of service, then the insurer has up to 45 days to issue payment, and finally, the insurer has up to 60 days from the date of payment to report the bill to the department.

- The frequency of CPT® codes 98966 – 98968 started to rise significantly in March 2020 and peaked in April 2020 with about 120 telephone services by qualified nonphysician health care professional provided during April. The number of services fell to about 60 per months during May and June, and then further decreased through September 2020:

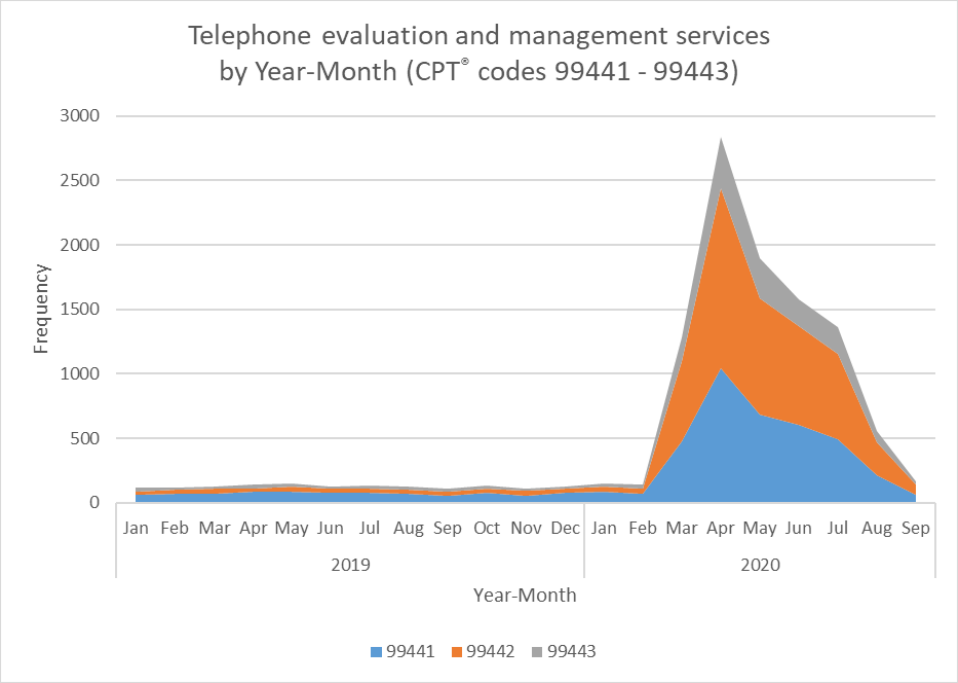


- There were only two instances (dates of service November 1, 2019, and March 25, 2020), where insurers reported online digital evaluation and management services by qualified nonphysician health care professional (CPT® codes 98970 – 98972) to the department.

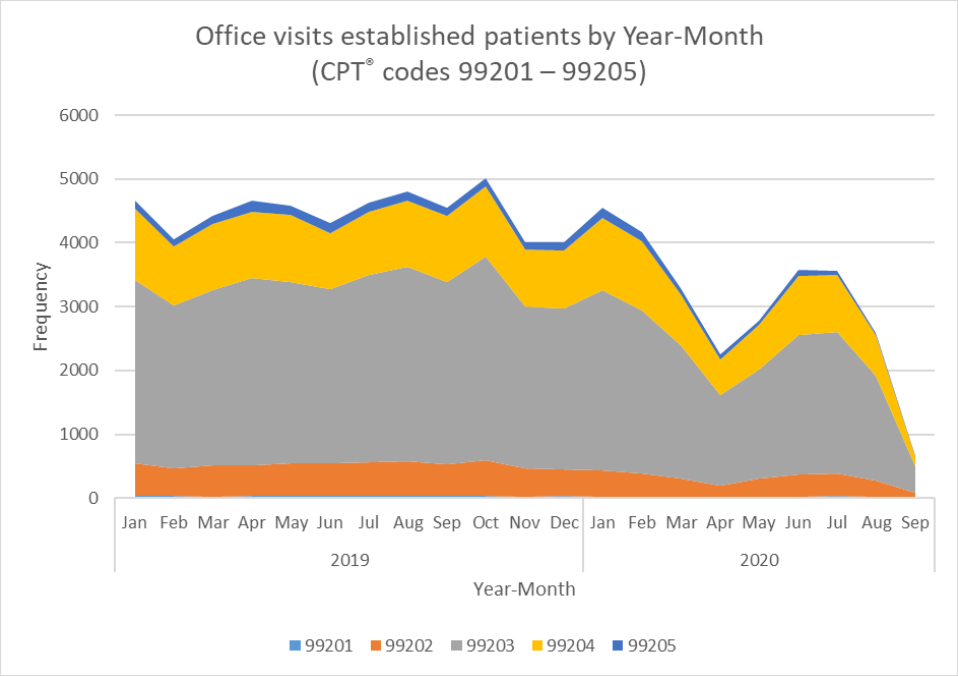
- The frequency of CPT® codes 99421 – 99423 started to rise in March 2020 and also peaked in April 2020 with about 200 online digital evaluation and management services provided during April. The number of services fell significantly in May and June to only about 25 services in June, and then further decreased through September 2020:

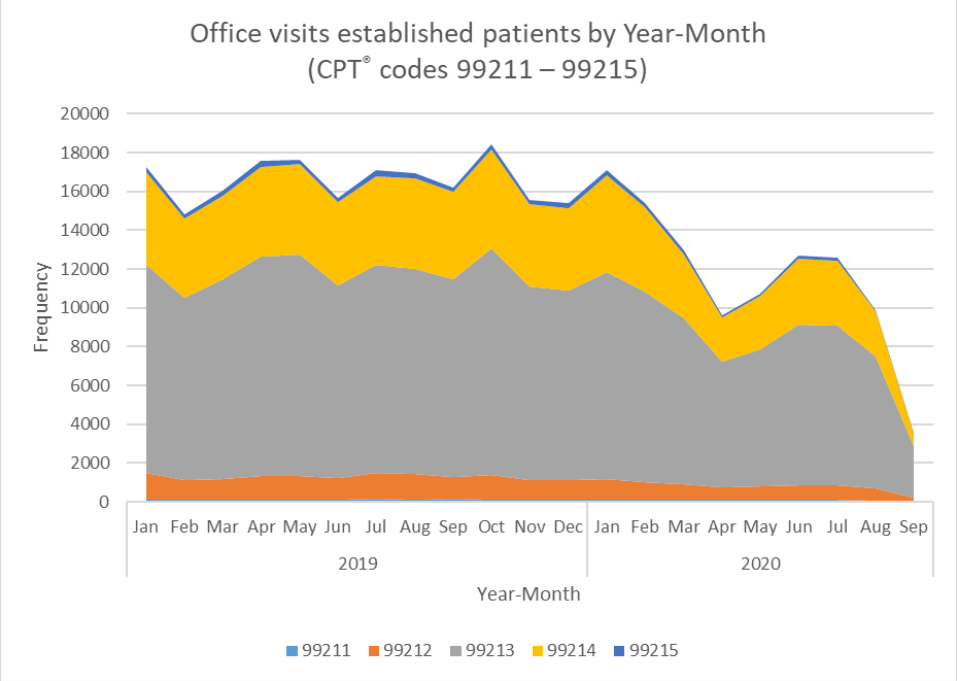


- The frequency of CPT® codes 99441 – 99443 started to rise in March 2020 and also peaked in April 2020 with about 2830 telephone evaluation and management services provided during April. The number of services fell significantly from May through September to only about 65 services in September 2020:

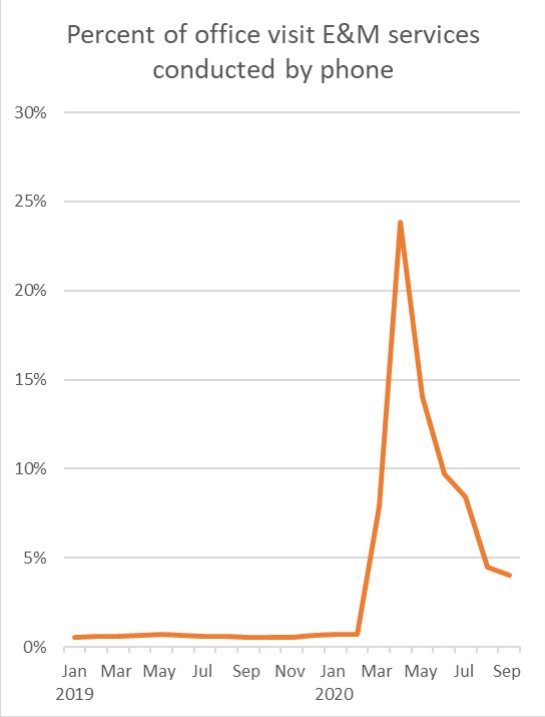


- The department also collected data on office visits (CPT® codes 99201 – 99205 and 99211 – 99215). The two charts below show in-person visits as well as office visits provided via telemedicine. As the charts show, the number of office visits steadily decreased from January 2020 through April 2020, followed by increased numbers during the months of May through July, before falling off again in August and September. The decrease in numbers for the August and September dates of service are, in large part, most likely due to incomplete reporting.





- The next chart shows the percentage of E&M services conducted by phone (CPT® codes 99441-99443). Phone E&M services accounted for about 24% of all E&M office visit services in April, 2020.



- Although it is difficult to draw firm conclusions, we believe the above data show that telephone evaluation and management services were provided in lieu of office visits (CPT® codes 99201 – 99205 and 99211 – 99215), not in addition to regular office visits.

Options:

- Adjust payment level for above cited telehealth codes.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Issue # 6 (1755)

Rules: OAR 436-009-0010(12)(h) and OAR 436-010-0230(16)

Issue: The Medical Advisory Committee (MAC) recommends that a two-level contiguous cervical disc replacement no longer be excluded from compensability and that the contraindications listed in OAR 436-010-0230(16) be deleted from the rule.

Background:

- Effective 7/1/2009, upon advice from the MAC, the WCD excluded cervical artificial disc replacement from compensability, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:
    - The single level artificial disc replacement is between C3 and C7;
    - The patient is 16 to 60 years old;
    - The patient underwent unsuccessful conservative treatment;
    - There is intraoperative visualization of the surgical implant level; and
    - The procedure is not found inappropriate under OAR 436-010-0230.
- Starting in late 2019, the committee researched and analyzed whether a two-level cervical artificial disc replacement should be a compensable medical service. The committee made the following finding at its August 21, 2020, meeting:

    > After conducting a thorough literature review and determining the most persuasive studies, the committee concludes that a two-level contiguous cervical artificial disc replacement should be a compensable medical service, when using a device that has received Food and Drug Administration (FDA) approval for a two-level contiguous cervical artificial disc replacement.
- The committee also discussed the contraindications it established in 2008 that are listed in OAR 436-010-0230(16). The committee found that cervical artificial disc replacement is now, unlike in 2008, a well established procedure that no longer necessitates a list of contraindications contained in administrative rule, but instead should be guided by standards of practice.
- Following the August 21, 2020, meeting the MAC asked for public testimony. After not receiving any public input, the MAC finalized it's recommendation in October 2020. The MAC makes the following recommendation:
    - Cervical artificial disc replacement should not be a compensable medical service unless the procedure is a single level or a two-level contiguous cervical artificial disc replacement with a device that has FDA approval for the procedure.
    - Delete the cervical artificial disc replacement guidelines listed in OAR 436-010-0230(16).
- The WCD also received a stakeholder request to make changes to OAR 436-009-0010(12)(h) and OAR 436-010-0230(16):
    - "The rules currently provide for a categorical exclusion of cervical artificial discs surgery when worker has a past history of two-level cervical fusion. Medical science and FDA approvals have changed in the decade since this rule was adopted and the rule should be revised to be consistent with contemporary medical practices."

- "Review and revisions of the rule to be sure that it excludes only procedures are not medically accepted."

Options:

- Change OAR 436-009-0010(12) as follows:
  (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~~ **the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure;** and~~:~~

  ~~**(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~~

- Delete OAR 436-010-0230(16), Cervical Artificial Disc Replacement Guidelines.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Issue # 7 (1831)

Rule: OAR 436-010-0230(12)

Issue: Insurers may not be able to respond to a request for pre-authorization of diagnostic imaging studies within 14 days, as required by OAR 436-010-0230(12), when the request is submitted via chart notes. Additionally, it may not be clear that a notation in chart notes regarding diagnostic imaging studies is a request for pre-authorization.

Background:

- OAR 436-010-0230(12) provides that a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. *** 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.
- The WCD has learned that some providers submit a request for diagnostic pre-authorization through chart notes, which are submitted to the insurer with the billing form. Since the insurer has 45 days to pay a bill, they may not be able to respond to a pre-authorization submitted via chart notes within the required 14 days.
- The MRT has seen notations in chart notes regarding diagnostic imaging studies where it is hard to tell if a provider is requesting pre-authorization or just suggesting that maybe in the future they would get some kind of imaging.
- For elective surgery notification, OAR 436-010-0250(2)(a) provides, in relevant part, that to notify the insurer of the proposed surgery, the provider has the option of using Form 5425 (Elective Surgery Notification) or using their own form that includes the data gathered on Form 5425.

Options:

- Require that providers use a form (either their own or a form developed by the WCD) when requesting pre-authorization for diagnostic imaging.

- Modify OAR 436-010-0230(12) as follows: "Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. **The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies.** Pre-authorization is not a guarantee of payment. 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."

- 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: Make rule title consistent throughout chapter 436 and better capture the content of rules 0001.

Rename title of rule 0001 in divisions 009, 010, and 015 as follows:
436-XXX-0001 ~~Administration~~ Purpose and Applicability of These Rules.

Reason for change: Make hyphenation consistent throughout chapter 436.

Make the following change to **OAR 436-009-0025(1)(e)(B):**
The specific reason for ~~non-payment~~ **nonpayment**, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;

Make the following change to **OAR 436-015-0030(2)(b):**
A ~~non-refundable~~ **nonrefundable** fee of $1,500, payable to the Department of Consumer and Business Services, which will be deposited in the Consumer and Business Services Fund;

Reason for change: Correct a grammatical error.

Make the following change to **OAR 436-015-0008(1):**
The process for administrative review **is** as follows:
