Rulemaking advisory committee meeting
Subject: Review of issues affecting medical services, medical fees and payment, and managed care organizations
Nov. 9, 2020, 9 a.m.

Location: Virtual meeting - GoToMeeting

Committee members attending:

David Barenberg	SAIF Corporation
Steven Bennett	American Property Casualty Insurance Association
Lisa Anne Bickford	Coventry Workers' Comp Services
Eric Boling	Matrix Risk Management Solutions
Joy Chand	Takacs Clinic
Timothy Craven MD	Providence MCO | Medical Advisory Committee
Jennifer Davis	HealtheSystems
Jeanette Decker	Providence MCO
Danielle Erb MD	Brain Rehabilitation Medicine
Jennifer Flood	Ombudsman for Injured Workers
Julie Foster	Nurse Practitioners of Oregon
Adam Fowler	Optum
Jaye Fraser	SAIF Corporation
Diana Godwin	Attorney at Law
Dee Heinz	SAIF Corporation
Isabel Hernandez	HealtheSystems
Lisa Johnson	Majoris Health Systems
Rich Katz	Therapeutic Associates | Northwest Rehab Alliance
Ann Klein	Majoris Health Systems
Joe Martinez	Concentra
Ryan McClelland	SAIF Corporation
Sheri North	Mitchell
Sue Quinones	City of Portland
Vern Saboe, DC	Oregon Chiropractic Association
Dan Schmelling	SAIF Corporation
Elaine Schooler	SAIF Corporation
Keith Semple	Johnson Johnson Lucas & Middleton PC
Ramona St. George-Suing	Majoris Health Systems
Jenny Walsh	Providence Health Plan
Lesli Webb	Occupational Orthopedics
Gina Wescott	S | D | A | O
Hasina Wittenberg	Government Relations Strategies

Fred Bruyns, Workers' Compensation Division, welcomed the committee members and asked the members to provide advice about fiscal impacts during review of the issues.

A summary of the discussion has been added below the following agenda items:

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 its 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 436-009-000~~3~~**4**(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:

Minutes:

- Lisa Anne Bickford said that Coventry would support the proposal. It makes it cleaner and helps prevent other problems that would happen if we did not.
- Joe Martinez said he concurs. It has been working since the division started doing this temporary rule in 2016.
- Jaye Fraser said that SAIF would concur with the other two speakers and that this is a great idea.
- Steve Bennett said he understands the reason to keep updated CPT® codes. APCIA just has some concerns because a lot of their members are seeing problems with tests that have many false positives. These are the antigen tests and the antibody tests, so they would prefer the most valid test for Covid-19, which is the PCR test. APCIA would prefer having just the PCR test codes be adopted for workers' compensation. It is bad for everyone – the injured worker, the employer – to have tests that are giving false positives.
- Juerg Kunz, Workers' Compensation Division, said he wanted to give everybody a heads up that it appears that CMS will be very late this year publishing their Jan. 1, 2021 relative value units and fee schedule information, so it is possible that the division cannot publish updated temporary fee schedules until very close to 2021.

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 436-009-000~~3~~**4**(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:

Minutes:

- Juerg Kunz said that he wants everyone to know that the AMA, together with CMS, has made quite big changes to the office visit codes 99201 through 99205 and 99211 through 99215. The main difference is that the history and the exam are no longer used to determine the level of the code to use. Juerg added that he doesn't know if CMS is going to make some significant changes to the relative value units (RVUs) that they assign to these codes. We won't know until CMS publishes the RVUs.

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:

Minutes:

- Vern Saboe said that the Oregon Chiropractic Association would say that 1.6 percent is deficient. They haven't had a fee increase for cost of living in four years. Rental costs have increased in Oregon by three percent. The annual cost of living within the Portland metro area increased by 3.9 percent last year. Another stakeholder suggested a 10 percent increase. Something in between or something at least matching those cost of living increases of 3.9 percent and 3 percent would be more appropriate than the 1.6 percent.
- Fred Bruyns explained that the next issue we are going to cover is a proposal for a 10 percent increase in chiropractic manipulative therapy codes. This one is a little different. It would apply across the board to all of the fee schedules.
- Diana Godwin said that the private practice physical therapists she represents are fully in support of a fee increase. They would like to have it be more than 1.6 percent, because as noted, back in 2016, the fee schedule was increased by three percent except for physical medicine. As we all know, the Covid-19 pandemic has seriously affected physical therapy services, because those are very close and personal services usually. Diana added that her clinics are down by a minimum of 12 percent in terms of visits. All their costs are up, particularly with regard to having to clean their equipment with every single patient and additional PPE costs. Diana said they are going to need a fee increase and added that she has talked with Rich Katz (Therapeutic Associates) and he supports that as well for the clinics he represents.

- Jaye Fraser said that SAIF is comfortable with the proposal.
- Joe Martinez said he concurs with the previous speakers and added that all providers are experiencing costs due to the additional steps they are taking to provide a clean work environment and a clean environment for patients. Some of their facilities go through significant amounts of spraying and cleaning each week to make the environment safe. Increased reimbursement would be greatly appreciated.
- Steve Bennett said that the APCIA supports the proposal. They think 1.6 percent is correct. They appreciate the work of all of the health care providers during the pandemic. The insurance industry has also incurred additional costs.
- Danielle Erb MD said one of the other issues is that patients who are ill or elderly in some outpatient clinics have to go into quarantine, so appointments stop and any income stops. Dr. Erb added that they cannot fill the appointment slots because they need to be available as soon as the patient is off quarantine. It can take a number of days for a Covid-19 test to come back. When staff are feeling ill they have to work from home, and they cannot do a lot of physical therapy from home. There are a lot of losses going on, and these are likely to get worse as counts (Covid-19 positive tests) are rising – about 700 hundred per day. This will increase absences by staff and patients, which means less income. But, their rent doesn't decrease, and other costs are rising. People are requesting more effective masks, such as N95s, due to health conditions. Dr. Erb said she doesn't know if 1.6 percent is enough, but it is a minimum with these increased costs as well as losses.
- Timothy Craven MD asked where the 1.6 percent came from – how was it determined? Also, does it include all services, such as physical medicine, chiropractic, regular physician services, or are there exceptions?
- Juerg Kunz said he doesn't know where the 1.6 percent came from. The stakeholder refers to the most recent cost-of-living estimates. Juerg added that to his understanding, the stakeholder would want it applied to the entire physician fee schedule – all the categories that are listed in the second bullet.
- Dr. Craven replied that it appeared that in past years there were a lot of exceptions. But this year it would be 1.6 percent for everything?
- Juerg Kunz said that the division hasn't made any decisions at this point. This is up for discussion. It is up to stakeholders to tell us what we should do and why.
- Fred Bruyns said the 1.6 percent may reflect the consumer price index, but he added that he doesn't know how relevant that is to the cost of operating a medical practice.
- Joy Chand said she definitely recommends more than 1.6 percent. Joy added that she agrees with others who said it is a lot more work than it used to be when talking about taking care of patients. Also, Joy said they are having a lot of difficulties reaching insurance company adjusters; she has to leave multiple messages.
- Rich Katz said that in physical therapy there are increased costs for personal protective equipment, the 12 percent reduction they have seen in their volumes, the difficulties they are having with insurer representatives due to their staffing changes, credentialing requirements, and everything else are really imposing a lot more costs on them. Rich added that medical cost inflation is typically about double that of the usual CPI value for a market basket of goods. Rich continued that he is for a 1.6 percent increase across the board, but that is minimal, and it should be more in the neighborhood of three percent at

least, in order to keep a level set for the physical therapy community in treating injured workers.

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

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

treatment to the cervical and thoracic region (98940), an additional $56.84 could be charged, bringing the total to $110.66.

"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

services. (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:

Minutes:

- Vern Saboe DC said that a 10 percent increase for chiropractic manipulative therapy codes for one to two areas represents $5.50. A 10 percent increase for chiropractic manipulative therapy codes for three to four areas would be an increase of $7.70. Five areas, which is very rare, would be an increase of $9.80. Not a lot of money.
- Steve Bennett said APCIA would oppose having a 10 percent increase for chiropractic manipulative therapy codes. Steve added he doesn't see that there are access issues of getting chiropractors to participate in the workers' compensation system. Oregon employers already face a lot of costs, and 10 percent seems to be out of line.
- Danielle Erb, MD, explained that she is not a chiropractor but is a physiatrist, and her concern is that while osteopathic manipulations are generally done on a once-per-week basis, chiropractic manipulations are done three to five times per week. So, it is a small increase as mentioned in terms of dollars, but if you multiply that by the number of visits it ends up being a fair amount more.

- Jaye Fraser said she agrees with Steve Bennett. Jaye added that she isn't saying that no increase is warranted, but the basis for the 10 percent increase did not seem to make a lot of sense to them, and they think it is too much. Jaye said they also concur with Dr. Erb's comments.
- Timothy Craven, MD, asked if this increase would be in addition to the proposed 1.6 percent increase.
- Fred Bruyns said he presumed it would not be both.
- Juerg Kunz replied that his understanding is that if the committee supported this, the chiropractic visits would go 10 percent. That would be all; it wouldn't be 10 percent plus anything else.

Issue # 5 (1852)

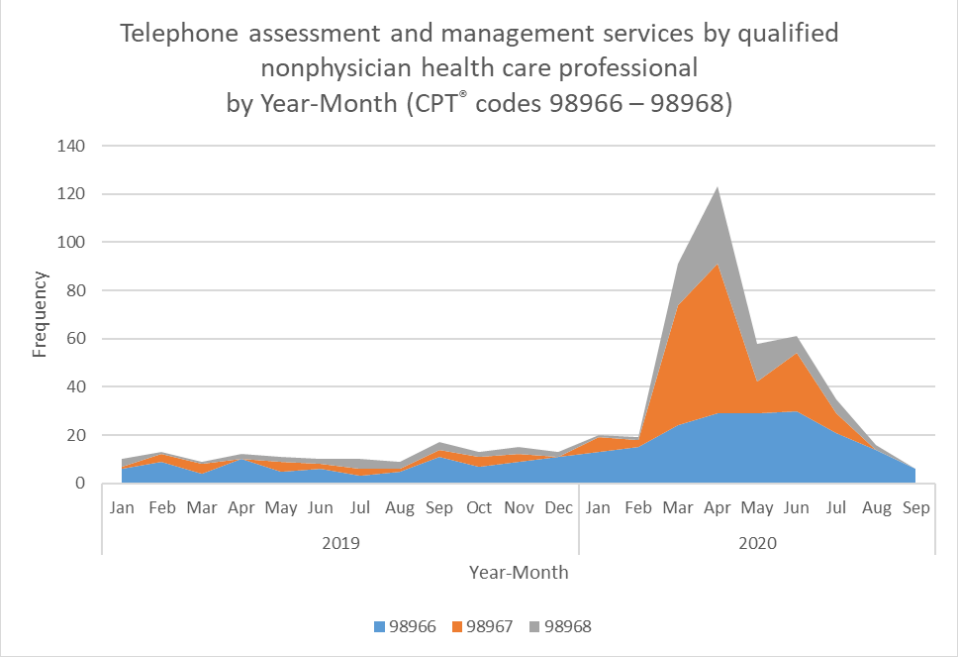
Rule: OAR 436-009-0040 and Appendix B

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:

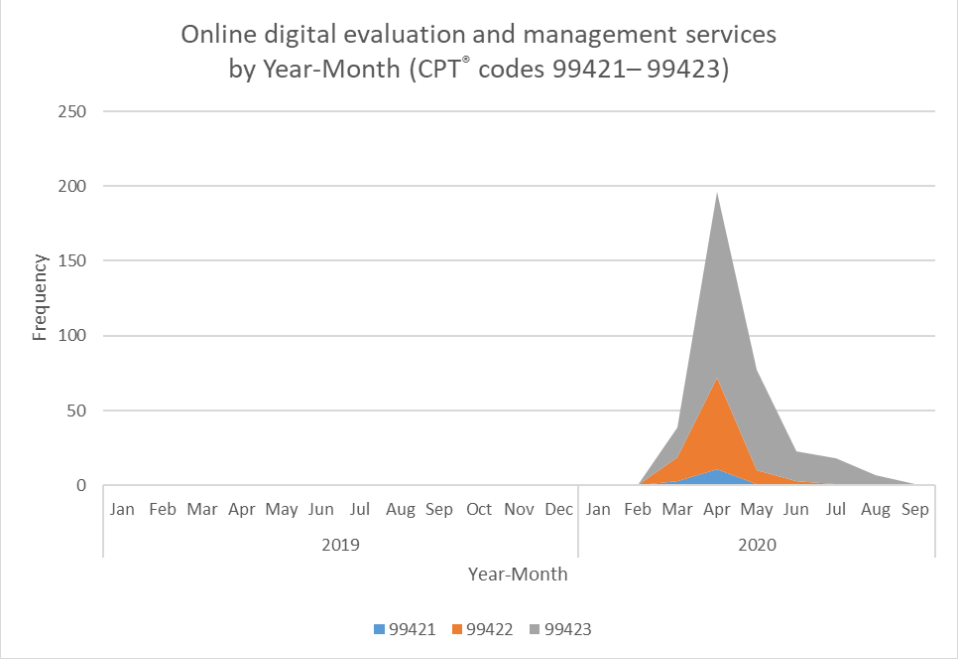
- In March 2020, the WCD published a temporary fee schedule for certain services provided on or after March 8, 2020 (the date Gov. Kate Brown declared a public health emergency). The temporary fee schedule increased the payment rates for telephonic and online digital evaluation/assessment and management 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:

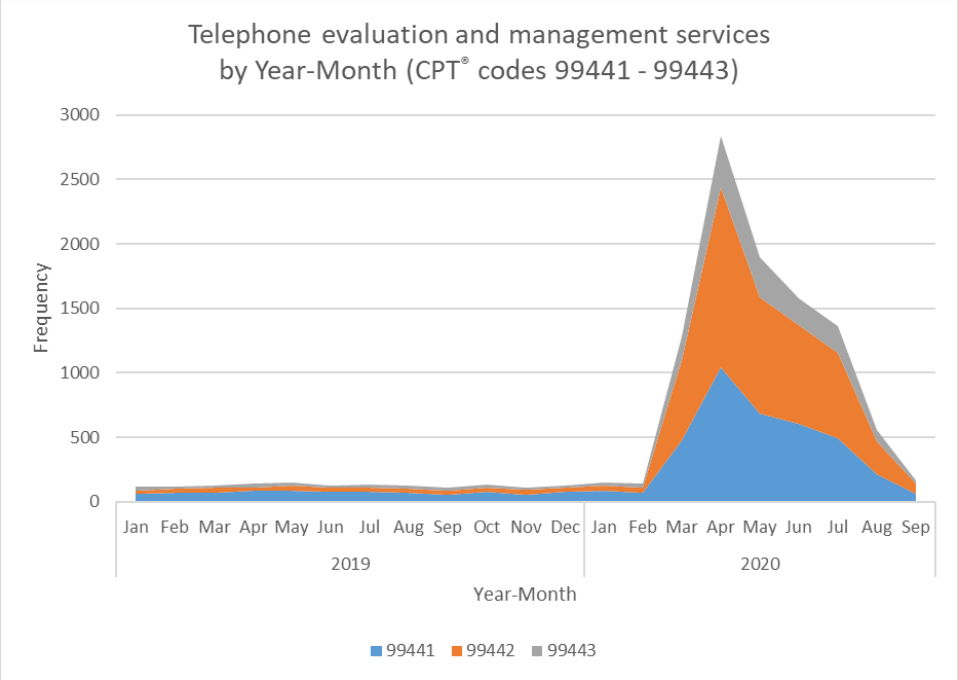


- There were only two instances (dates of service November 1, 2019, and March 25, 2020), where insurers reported online digital evaluation and management services by qualified nonphysician health care professional (CPT® codes 98970 – 98972) to the department.

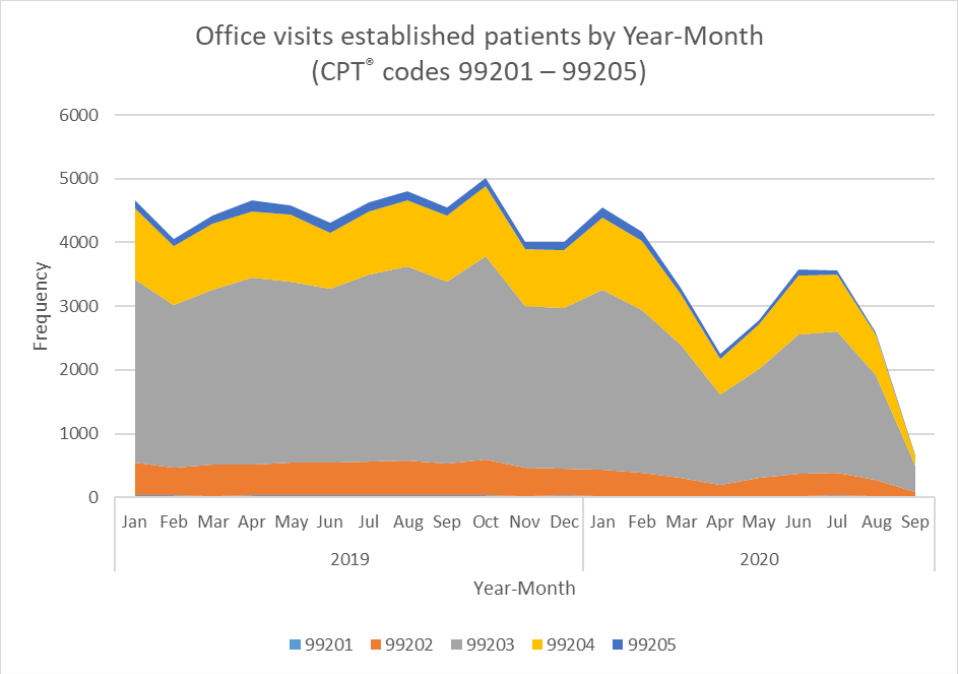
- The frequency of CPT® codes 99421 – 99423 started to rise in March 2020 and also peaked in April 2020 with about 200 online digital evaluation and management services provided during April. The number of services fell significantly in May and June to only about 25 services in June, and then further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

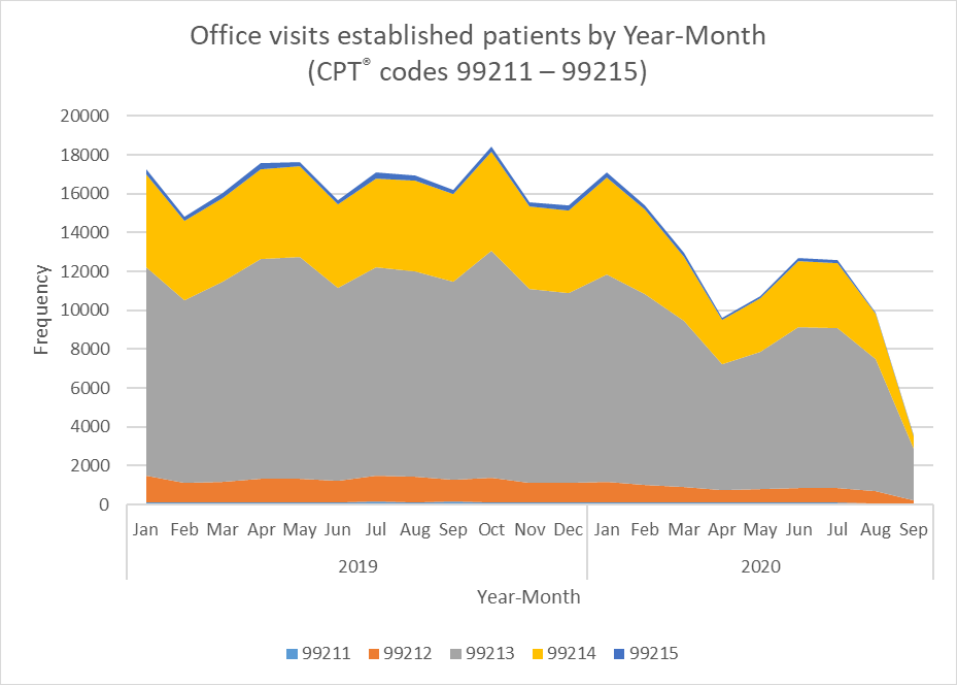


- The frequency of CPT® codes 99441 – 99443 started to rise in March 2020 and also peaked in April 2020 with about 2830 telephone evaluation and management services provided during April. The number of services fell significantly from May through September to only about 65 services in September 2020:

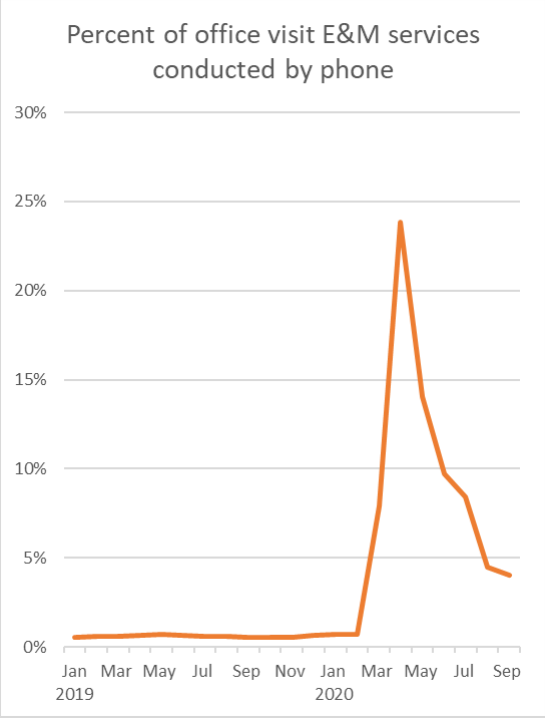


- The department also collected data on office visits (CPT® codes 99201 – 99205 and 99211 – 99215). The two charts below show in-person visits as well as office visits provided via telemedicine. As the charts show, the number of office visits steadily decreased from January 2020 through April 2020, followed 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:

Minutes:

- Steve Bennett said that APCIA members do like and support telehealth services; these serve a purpose. They do have some questions regarding the scope of the services. Formerly telehealth was limited by the rules to the services listed in Appendix P (list of CPT® codes. The APCIA understands why telehealth was needed due to Covid-19, but believes it makes sense to reinstate Appendix P as the country gets away from the Covid-19 problem. There are a lot of workplace injuries that should be treated in person rather than by telehealth. Steve added that APCIA thinks it is a mistake to set the reimbursement rates at the same level as for in-office visits. They don't want to incentivize telehealth over in-office care. In-office care has more associated costs – rent, sanitizing, etc. APCIA does think that telehealth should pay somewhat less.
- Danielle Erb MD said the pandemic is not decreasing anywhere in the country and is increasing dramatically in Oregon. We have a bit of time before we can say this is behind us. Dr. Erb added that she sees patients by video, but does not do new patient evaluations over the phone, though she can do recheck visits – 99211 to 99215. Dr. Erb continued that she still pays rent and other office-related costs whether she can be there or not. Also, when seeing a patient by video, she devotes all of the time to her patient. She cannot hand them the prescription and has to give it to them another way. The patient cannot go to the front desk to make an appointment, so she makes the appointment for them. She spends hours after work handling faxes, etc. because she is working at home without staff. Dr. Erb concluded that it is therefore reasonable for payment to be the same as for services in the office, because the costs are the same and the time required is actually more.
- Lisa Anne Bickford said she thinks it is appropriate to defer to clinical judgment in terms of the scope of services that can be provided during telemedicine, as opposed to adding the appendix from the AMA or any sort of restriction on that. Lisa Anne continued that she agrees with the prior speaker and that it is premature to discuss what may or may not happen when the pandemic is over, because we just aren't there yet. We should defer discussion until it actually is over. Regarding payment parity, we had discussed it before in the telemedicine meetings, but it is much simpler to have one payment level for one

service whether provided by telemedicine or during an in-person visit. Costs are comparable, and Coventry would not support a differential in reimbursement at this time.

- Ann Klein said she thinks that a number of relevant observations were made. One is that the pandemic is still very much in flux. It is good to acknowledge that the changes that were made to the rules were made with the pandemic in mind and influencing those decisions. So, it good to keep an eye on when we get to a stable situation to remember to revisit and to continue to track this to make sure it is doing what we wanted it to do. Ann added that she thinks Dr. Erb's observation about the differences between doing a new patient evaluation and doing a recheck are relevant and should be factored in. We should be careful on the distinction between a telemedicine visit that is including video versus a purely telephonic consultation. There is a difference in what is possible when someone is only on the phone with no video interaction.
- Joy Chand said she agrees with everything Dr. Erb said. It is a lot more work for all of us, even if we are doing telemedicine.
- Jaye Fraser said SAIF had wanted to revisit this issue when we would have more data. As the pandemic is not going away for some time, they think it is too early to make significant changes. They specifically want to support the video telehealth and think it is working well; they are seeing it used a lot. SAIF would like the department to come back, hopefully when the pandemic is declining and reconsider the difference between a telephone call and a video call. Jaye continued that SAIF's only concern about treatment over video is about treatment that requires hands-on care. They think as an insurer they have authority to deny those bills, for example acupuncture via video. Jaye added that they agree with most of the comments, especially Ann Klein's comments about coming back to look at this in the future, because things are changing a lot.
- Dr. Erb said she much prefers a video call to a phone call with a patient. However, she has a lot of patients who have nothing but a landline, or poor internet access is a problem. There is no option except a phone call. These visits are not purposely scheduled as phone calls, and they try hard to get them to be done by video. Dr. Erb noted that with distant patients, no one has to pay for mileage.
- Jaye Fraser said the reasons described by Dr Erb are why SAIF concurs with not messing with the fees for just the phone calls, as they recognize that video is challenging for certain populations and certain locations.
- Steve Bennett said he had not wanted to imply that we have rounded the corner with the pandemic or it is almost over. Steve added that he thinks changes made to telehealth should be more on a temporary than a permanent basis while we acquire more information.
- Timothy Craven MD said he seconds what Steve just said. Dr. Craven added that he thought that telehealth and in-person care were going to be reimbursed at the same level, but you have to adjust – maybe the code is a bit different because you are not doing an exam, for instance. He doesn't know why we are adjusting the payment level, because he thought it was already decided that they were going to be the same in a previous temporary rule.
- Fred Bruyns replied that Dr. Craven is correct. If the same codes are billed, they are reimbursed at the same amount regardless whether in person or telehealth. That was adopted by temporary rule earlier this year, and then as a permanent rule in September, as

the temporary rule would have expired and reverted to what it was before. The division had to take action before we had a chance to talk with the committee. The division was asked to revisit it. Fred added that he understands that some committee members do not want the rule to be considered truly permanent, meaning we would not revisit it again. Some committee members would like us to revisit again when the pandemic is finally over.

- Dr. Craven said he didn't know what the payment level would be adjusted from, and he added that telemedicine is a good thing to consider, especially for patients who live far away from their doctor. In certain cases it is probably not appropriate, but telemedicine should have a permanent effect. Dr. Craven said that during the pandemic he agrees with reimbursing at the same level as for an in-person visit.

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 its 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:

Minutes:

- No discussion.

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:

Minutes:

- Keith Semple said he wonders how often this is happening – the department having to make a decision whether a chart note is clear enough to request the pre-authorization or not. OTLA doesn't see the pertinence of the 45-day rule for payment, because other laws require insurers to take actions independently of that 45 days – for example paying lost wages. The provider is going to be required to look at the chart note. Some providers use a separate form; in other cases they don't. But, there is a requirement that the insurer look at what is in the chart notes. If there is a clear indication of a desire for pre-authorization, OTLA doesn't think it needs to be in rule. The department is going to determine that on a case-by-case basis.
- Ann Klein said that this isn't specifically related to the MCO (managed care organization), since this is something the insurer would have to review, but it does have a correlated element to it, in that there is another rule, 436-010-0270, that requires the insurer to forward any requests to the MCO when there is an MCO involved. Ann continued that they recently experienced some confusion about what would constitute a request that would necessitate that, and they have some concerns that with that lack of clarity, they are going to end up fielding even more paperwork and introducing more confusion as to whether this is something they need to be looking at; is this something the provider is actually pursuing or just observing that this is something that he or she may do in the future? It adds another element that is unclear if there is also a precertification element that they should be anticipating. Ann added that having some clarification on what is a request – what is that definition – is helpful. Otherwise you are adding in some additional busy work and confusion that will ultimately result in additional delays to care, costs, and expense, as everyone tries to figure out what they are supposed to be doing. There needs to be a clear indication – to identify what it means rather than leaving it up for interpretation.
- Fred responded to Keith's question about the frequency of disputes that he is unaware how often the department receives related disputes, though this is something that they could look at.
- Jaye Fraser said that one of the difficulties is that SAIF sometimes does not get chart notes for weeks. If the doctor is recommending something, whether diagnostics or opioids or something like that, there is a problem when it is buried in the chart notes that they don't get for 45 days. Jaye added that SAIF would support something that would clarify the notice.
- Keith responded that the rule seems to clearly indicate that the insurer's 14 days doesn't start until the provider contacts them in writing. If the provider submits the chart note on day 30, they haven't contacted the insurer in writing until day 30. It seems like that situation is already addressed by the rule. Keith said he is curious about the point of pre-authorization if it is not a guarantee of payment. He likes pre-authorization because it makes it clear for the providers, but they probably think they are going to get paid.
- Fred Bruyns said that others may be able to address this, and he noted that we added this provision to the rules a few years ago because providers were contacting insurance companies and would not go ahead and do the diagnostic imaging when there was nothing at all to indicate whether they would or would not get paid. If the insurance company actually said it is not approved, in writing, that is significant information. If

they say it is approved, that would assume the claim itself is going to be accepted and therefore paid.

- Juerg Kunz said that on one hand there is the matter of the appropriateness of a service. On the other hand is the matter of the causal relationship of the service. The Workers' Compensation Division has jurisdiction over the question of appropriateness, but not the causal relationship between a medical service and an accepted injury. In its rules, the division could never force an insurer to guarantee payment because of that other aspect of causal relationship, which is in the jurisdiction of the Workers' Compensation Board.
- Keith Semple replied that that makes a lot of sense and added he doesn't want to imply that OTLA doesn't think this is a good rule to have – they were one of the main proponents of having these requests for pre-authorization available for providers to get some clarity on diagnostic services. Keith added that they would like to have them in place for every service, because he still sees confusion about whether they have to respond to the doctor at all or they can just say they don't need to do anything.
- Danielle Erb MD asked, if the chart note plan said "I request the insurer to approve a cervical MRI," would that not matter, or would she have to submit a separate request? Or, if it was clear in her plan, would that be sufficient?
- Fred Bruyns said Dr. Erb's question is actually the question before the committee – about having to do a separate statement or an actual form to request the diagnostic imaging.
- Jaye Fraser said that Dr. Erb said it very clearly. Some chart notes are unclear about what they are being asked to do. Whatever the form of the request, it needs to be clear. Something separate from a chart note, whether it be a form or a letter or whatever, where whoever is making the request is being very direct about it – that's what they are looking for.
- Ramona Suing said that another issue on the timeliness of chart notes that Jaye raised – there are some services, such as a request for opioids, that are put in the chart notes. The worker has already filled the prescription. Majoris doesn't get the chart notes for 30 days, so then it is too late to do a pre-authorization for it. Ramona added that she knows this particular rule applies to diagnostics, but it is also possible that the worker would just go to the radiology facility and the MRI is done before the chart note is submitted. Ramona continued that she is not sure what the insurer's opportunity would be – whether nonpayment is an issue. She agrees with Keith Semple that clarity on this for all services that require pre-authorization makes sense – to define what is a pre-authorization request.
- Jaye Fraser said she agrees with Ramona.

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:

Additional issues?

Minutes:

- Joy Chand said she is having a lot of issues reaching insurance companies during the pandemic, and she is not sure others are having the same issues. Insurers are also taking much longer to pay the bills – up to 90 days.
    - Fred Bruyns asked if others are having the same problem and whether committee members have thoughts about the root causes. Fred added that he assumes it has something to do with adjusters working from remote workstations.
    - Joy said she understands people are working from home and it takes longer to get back to us, but it has been very frustrating.
    - Rich Katz said he agrees with some of the difficulties working with insurance right now. This is happening with both group health and workers' compensation. Rich added that he can only surmise that insurers have had workforce reductions, so there are fewer people with larger caseloads. Consequently they are seeing difficulties with communications as well.
- Rich Katz asked the Workers' Compensation Division to look at ORS 743B.454 that talks about the credentialing period and providers being able to be paid for their services when the credentialing application is with insurance company, and that claims can be submitted and paid during that time. Rich added that he doesn't think the division has recognize this law, nor have insurers. It adds to their costs, as due to Covid they have had providers that had to be terminated and then brought back on, so that regenerates per NCQA rules after 30 days, that the provider undergo initial credentialing again. They are seeing delays with respect to credentialing decisions. Consequently, they are interested in having the division taking up ORS 743B.454 at a future opportunity to ensure that

insurers are complying with that law and providers can rely upon it to be paid for services delivered to patients during the credentialing period.

- Fred Bruyns said the division would look into the applicability of that law (ORS 743B.454) and thanked Rich for bringing it to the division's attention. Fred thanked Joy for describing the responsiveness issue and said the division can help resolve disputes as needed and can also consider what may be possible systemically.

Closing:

- Fred Bruyns asked the committee to send him any additional comments by email or by telephone by Nov. 20. Fred added that the division will keep everyone informed, but that anyone who was not able to say they were present during introductions should get in touch with him so he can keep them updated.