Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
Rulemaking Advisory Committee Meeting Minutes
Nov. 3, 2021, 9 a.m.

Location of meeting: Virtual Zoomgov meeting

Committee members attending:

Kirsten Adams	Associated General Contractors
David Barenberg	SAIF Corporation
Kaylee Bond	CorVel Corporation
Dave Boyd	Oregon Loggers
Jeanette Decker	Providence MCO
Adam Fowler	Optum
Jaye Fraser	SAIF Corporation
Michael Hamilton	Medata
Dee Heinz	SAIF Corporation
Tom Hernandez	Pro Language
Ben Johnson PA-C	Oregon Society of Physician Assistants
Richard Katz	Therapeutic Associates & Northwest Rehab Alliance
Ann Klein	Majoris Health Systems Oregon, Inc.
MacJulian Lang	Advanced Arm Dynamics
Billie Lassiat	Zenith Insurance
Joe Martinez	Concentra
Dana Mayes	Enablecomp, Inc.
Jill Molitor	Conduent Inc.
John Powell	John Powell and Associates
David Pyle	CareMark Comp MCO
Sue Quinones	City of Portland
Robert Reyes	Portland Language Services
Julie Riddle	The Hartford
Elaine Schooler	SAIF Corporation
Andrea Seykora	OAHHS
Brent Stephens	Boilermakers Local 242 (Spokane)
DeAnna Tapia	Professional Interpreters Inc.
Jenny Walsh	Providence Health Plan
Lesli Webb	Occupational Orthopedics

Department of Consumer and Business Services staff present:

Rob Andersen	Shawn Haywood
Fred Bruyns	Daneka Karma
Stan Fields	Juerg Kunz
Cara Filsinger	Troy Painter
Tasha Fisher	Matt West
Don Gallogly	

Fred Bruyns welcomed the committee members, described the purposes of the advisory committee, including collection of advice about fiscal impacts of possible rule changes.

Fred guided the committee through the agenda, which has been copied in below. "Minutes" have been added under each issue and at the end.

Note: The committee reviewed Issues #8 and #9 before the other issues on the agenda, and also discussed new issues relevant to language interpreters before reviewing Issues #1 through #7.

Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2022)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2022. However, the Workers' Compensation Division (WCD) does not publish its permanent fee schedule updates until April 1, 2022. This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if providers use new codes between January 1 and April 1.

Background:

- In order to allow time for public input, WCD publishes a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), effective April 1 of each year.
- Adopting the new CPT® and HCPCS codes, effective January 1, 2022, would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid, new codes.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD could update appendices B – E, effective Jan. 1, 2022, and assign maximum payment amounts using the 2021 conversion factors/multipliers. Due to time and staffing restraints, it may not be possible to update all appendices by Jan. 1, 2022.
- Various organizations will publish updates to standards that WCD adopted in OAR 436-009-0004.
- 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 all codes valid in 2021.

Options:

- Adopt new CPT® codes and standards (OAR 436-009-0004) through a temporary rule, effective January 1, 2022; and update appendices B – E with payment amounts for new codes using the 2021 conversion factors/multipliers, where possible.
- Other?

- Not issue a temporary rule.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:
- Fred Bruyns described the issue, background, and options to the committee – see above.
- Jaye Fraser said "yes please."
- Fred asked if there are any concerns about annual issuance of a temporary rule.

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Permanent rules, effective April 1, 2022)

Issues:
- ORS 656.248(7) requires that 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, 2022.

Background:
- Appendices B through E are based on conversion factors and multipliers developed by DCBS, and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare & Medicaid Services (CMS). In particular:
    1) Current Appendix B is based on the CMS file *RVU21A*, effective January 2021. We expect that CMS will publish the file containing the 2022 RVUs in November 2021.
    2) Current Appendix C is based on spreadsheets published by CMS in CMS-1736-FC. We expect that CMS will publish CMS-1753-FC, containing the 2022 ASC fee schedule amounts for surgical procedures, in November 2021.
    3) Current Appendix D is based on spreadsheets published by CMS in CMS-1736-FC. We expect that CMS will publish CMS-1753-FC, containing the 2022 ASC fee schedule amounts for ancillary services, in November 2021.
    4) Current Appendix E is based on the CMS file *DME21-A*, effective January 2021. We hope that CMS will publish the file containing the 2022 DMEPOS fee schedule in November 2021.
- 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.

- Various organizations publish updates to standards that WCD adopted in OAR 436-009-0004.

Options:

- Adopt updated standards listed in OAR 436-009-0004 and update Appendices B through E using more current CMS spreadsheets and updated WCD conversion factors/multipliers.

- Update OAR 436-009-0004(3): Delete codes that are listed in CPT® 2022 and add new, valid codes that are not listed in CPT® 2022.

- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options to the committee – see above.
- Jaye Fraser said "yes please."
- Fred asked if there were any additional thoughts or concerns.

Issue # 3 (1887)

Rule: OAR 436-009-0004 and Appendix B

Issue: A stakeholder, the Oregon Chiropractic Association (OCA), is proposing a 5% fee schedule increase for chiropractic manipulative treatment (CMT) codes (CPT® codes 98940 – 98943). The OCA states that "[a]lthough there was a 1% increase to these codes last year, which doesn't cover annual cost of living increases, there has not been an increase in these codes since a 3% cost of living proposal in 2016."

Background:

- The OCA provided the following background information:

  "Potential violation of Oregon Discrimination Law: ORS 743B.505(2)(a-c)
  Osteopathic manipulation [treatment (OMT)] 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		**2019 Fee**	**OMT**		**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

"Fiscal Impact of Proposal:
Due to the current 18-visit limitation on chiropractic treatment as a Schedule [type] B provider, the fiscal impact of a 5% increase in these codes would be less than $100 per case.

"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."

- Although the OCA stated that there was a one percent increase, WCD raised the fee schedule amounts for chiropractic manipulative treatment (CPT® codes 98940 – 98943) by two percent, effective April 1, 2021. Also effective April 1, 2021, WCD raised the fee schedule average for evaluation and management (E/M) office visits (CPT® codes 99202 – 99215) by 10 percent.

- Chiropractic manipulative treatment codes are most often used by chiropractic physicians to describe services provided during routine chiropractic visits. Similarly, medical doctors use E/M office visit codes to describe routine medical doctor visits. The American Medical Association's CPT® 2021 explains that the "chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional evaluation and management (E/M) services *** may be reported separately using modifier 25, if patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure."

- Therefore, medical doctors, doctors of osteopathy, and other providers routinely billing CPT® codes 99202 – 99215 saw a fee increase of about 10 percent for routine patient visits, whereas chiropractic physicians only experienced an increase of about two percent.

Options:

- Increase fees for CPT® codes 98940 – 98943 by five percent.

- Other?

- Make no change.

Fiscal Impacts, including cost of compliance for small business:

- The department projects that a five percent increase in the fee schedule amounts of chiropractic manipulative treatment (CPT® codes 98940 – 98943) would increase the system's medical costs by $134,000. Therefore, based on total medical costs of $317,000,000, such an increase would raise the total medical costs by 0.4 percent.

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options to the committee – see above.
- Jaye Fraser said SAIF's concern is that this is associated with a COLA (cost of living adjustment), which we do not do generally in the workers' compensation system. Last year there was a 1.6 percent increase for all across the board – or some of the codes were 1.6 percent. Jaye added that it seems we had this conversation last year. We need to say away from referencing COLA, which is not an appropriate measure for medically-related charges from SAIF's perspective.
- Rich Katz asked if this is only specific to the code sets 98940-98943.
- Fred said that is correct.
- Rich continued that evaluation codes for physical and occupational therapists don't fall in that range, and secondarily their procedure and time codes don't fall in that range either. (Consider) the cost of PPE and inflation. The market now for physical and occupational therapy is at its highest demand and lowest supply in the last decade or two. To confine any increase to such a limited set of providers does not seem to be reflective of the overall costs that the provider community has experienced, especially light of the last five to seven years, but specifically the last two.
- Kirsten Adams said she agrees with Jaye's comments. It doesn't seem to make sense for there to be a different billing for this subset as opposed to other providers.
- Fred said this issue is much as presented by the Oregon Chiropractic Association. They didn't include other codes or recommendations for other types of codes. Fred added that we value the additional advice.

Issue # 4 (1883)

Rule: OAR 436-009-0020(2) and (4)

Issue: OAR 436-009-0020 is not clear whether the entire outpatient bill from an out-of-state hospital should be paid as billed or only that portion of the bill payable under the cost-to-charge ratio.

Background:

- Bulletin 290 and OAR 436-009-0020(2)(c) state that the cost-to-charge ratio for out-of-state hospitals is 1.000, i.e., those services provided by out-of-state hospitals that are payable under the cost-to-charge ratio are payable as billed.
- The table in OAR 436-009-0020(2)(c) provides that services billed under revenue codes 0320 – 0359, 0400 – 0409, 0420 – 0449, 0610 – 0619, and 0960 – 0989 are payable under the physician fee schedule without differentiating between Oregon hospitals and out-of-state hospitals, i.e., those services provided by out-of-state hospitals that are payable under the physician fee schedule are not payable as billed.
- OAR 436-009-0020(4)(a) – (c) allows insurers and out-of-state hospitals to negotiate and agree on payment for less than the amount billed (without differentiating between services payable under the cost-to-charge ratio and services payable under the physician fee schedule). Any agreement must contain a provision that the hospital not bill the patient for any remaining balance.
- OAR 436-009-0020(4)(d) provides that if the insurer and hospital are unable to reach an agreement, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed. This subsection does also not differentiate between services payable under the cost-to-charge ratio and services payable under the physician fee schedule.
- In summary, OAR 436-009-0020(2)(c) provides that only those services paid under the cost-to-charge ratio are payable as billed, whereas OAR 436-009-0020(4) implies that all services provided by out-of-state hospital are payable as billed.

Options:

- Add a new subsection to OAR 436-009-0020(4): **Unless otherwise agreed upon by the hospital and the insurer, insurers must pay an out-of-state hospital for outpatient services as outlined in subsection (2)(c) of this rule.**

- Other?

- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options to the committee – see above.
- Jaye Fraser said she didn't understand the point, and she doesn't understand the purpose of the additional language.
- Juerg Kunz replied that Jaye is correct – that the current rule basically says this. But, what we have experienced is that quite a few insurers and service companies and out-of-state hospitals have interpreted section (4) to imply that all services provided by out-of-

state hospitals are paid as billed, which is not the case. This change is to make it clear. With out-of-state hospitals, if they decide to balance bill, there is really nothing we can do, but if the insurer and the hospital do have a contract or agreement regarding payment, that is where we can put in language that they can't go after the workers. Even if you pay using codes under the physician fee schedule, that may be less than what the hospital bills, and therefore the hospital could go after the worker, so we want to keep the language about the agreement, so even in those cases, the hospital doesn't go after the worker. This is just to clarify that hospitals are to be paid according to the table in (2)(c).

- Jaye said SAIF would never want to see workers balance billed. That is not okay. They recognize that WCD doesn't have jurisdiction over out-of-state hospitals, and they appreciate the ability to negotiate with out-of-state hospitals. Jaye added that if the intent of the department is simply to clarify the rule, she doesn't think they have an objection, but if the rule already says it, maybe we don't need to say more, and maybe an industry bulletin would be enough, but they don't object to changing the rule.
- Kaylee Bond said she is in favor of the clarifying language.

Issue # 5 (1865)

Rule: OAR 436-009-0060(2)

Issue: Faxing records (using a standard telephone connection and fax machine) has historically not been considered electronic submission, however, many facilities now use e-faxing (using the internet) to send documents. A stakeholder pointed out that the rule is not clear whether copies of documents sent via e-faxing should be billed under Oregon Specific Code (OSC) R0001 or R0002.

Background:

- The table in OAR 436-009-0060(2) provides the following descriptor for R0001:
  "Copies of medical records:
  Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing."
- The table in OAR 436-009-0060(2) provides the following descriptor for R0002:
  "Copies of medical records electronically:
  Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing."
- The payment for copies billed with OSC R0001 is $10.00 for the first page and $0.50 for each page thereafter. The payment for copies billed with OSC R0002 is a flat fee of $35.70.
- WCD created OSC R0002, effective 4/1/2013, in response to more and more providers sending copies of records electronically, in particular by copying records onto a CD. However, since then, uploading copies to an insurer's secure website, or using secure email or e-fax has become more prevalent.

- In addition to clarifying whether e-faxing should be considered to be an "electronic copy," WCD is asking the committee whether it is reasonable to have the same flat rate fee for copying records to a storage device, such as a CD or thumb drive that is mailed to the insurer, and uploading records to an insurer's secure website, or using secure email or e-fax.

Options:

- Modify the descriptor of OSC R0002, e.g. as follows:
  "Copies of medical records electronically:
  Electronic copies of medical records **provided on a CD or thumb drive, uploaded to an insurer's secure website, or using secure email or e-fax,** requested by the insurer or its representative – does not include chart notes sent with regular billing."

- Have two codes, e.g., R0002 and R0003, for electronic copies with different fee schedule amounts; one for records copied onto a storage device such as a CD or thumb drive and one for copies uploaded to an insurer's secure website, or using secure email or e-fax.

- Other?

- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options to the committee – see above.
- Jaye Fraser said they support the first option. Regarding option two, having one code, as oppose to two, may be better – we have so many codes.

Issue # 6 (1882)

Rule: OAR 436-009-0060(2) and Appendix B

Issues:

- OAR 436-009-0010(13)(a) provides in relevant part that insurers must pay the provider for "no show" director required medical exams 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment. The fee schedule for a director required medical exam or review time (P0001) is $320.30 per hour. So, according to 436-009-0010(13)(a), the fee for a missed appointment should be $160.15 (50 percent of P0001); however, Appendix B lists the fee for a missed director's exam appointment (P0005) at $162.78.
- Although OAR 436-009-0010(13)(a), differentiates between exam/testing and file review for the purpose of payment for missed appointments, OAR 436-009-0060(2) provides the same code (P0001) for the exam part as well as the file review part of a director required medical exam. In case of a missed director required medical exam, the rule does not say how the provider is to bill so that the insurer knows what portion is for the missed exam and what portion is for a file review already performed.

Background:

- OAR 436-009-0010(13)(a) states: "In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment."
- The descriptor of OSC P0001 in OAR 436-009-0060(2) states:
  "Director required medical exam or review time:
  Services by a physician selected under ORS 656.327 to review treatment, perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate up to 6 hours for record review and exam." The fee schedule amount for P0001 is $320.30 as listed in Appendix B.
- The descriptor of OSC P0005 in OAR 436-009-0060(2) states:
  "Director required exam – failure to appear:
  Patient fails to appear for a director required exam." The fee schedule amount for P0005 is $162.78 as listed in Appendix B.
- Splitting OSC P0001 into two codes, e.g., P0001 for the exam/testing and P0002 for the records review, would greatly simplify the correct payment calculation for missed appointments.
- The rule allows for billing up to six hours of exam time and time spent reviewing the record. If the committee recommends having one code for the exam and another code for

the records review, should there be a time limit for each code, e.g., up to two hours for the exam and up to four hours for records review?

- OAR 436-009-0010(13)(a) clearly outlines how to pay for missed director required exams/testing and record review. Is the specific code, P0005, for a missed director required medical exam needed or is the description in OAR 436-009-0010(13)(a) sufficient? There is no specific code for missed arbiter exams.

Options:

- Change the descriptor for OSC P0001 to only include the time for the exam/testing and create a new OSC, e.g., P0002, to bill for record review associated with a director required exam.

- Provide a maximum time period a provider may bill for P0001 (exam/testing) and for a new code (records review), e.g. P0002.

- Delete OSC P0005 (missed appointment).

- Other?

- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options to the committee – see above.

Regarding first option –

- Jaye Fraser said that from their perspective having a flat fee for the file review is what we are really concerned about, so having the two codes probably makes some sense.
- Julie Riddle said she agrees – that makes sense.
- Kaylee Bond said she also agrees.

Regarding second option –

- Jaye said the rule already provides for a six-hour maximum time, so they would support that continuing – that there be a maximum.

Regarding third option –

- Juerg Kunz said that because the rule clearly describes how to pay for missed appointments, he doesn't see a reason why we need to have the P0005 code. It seems to work for arbiter exams just fine without having a specific code for missed arbiter exams, but he wanted to confirm with the committee that they would be okay with deleting that code.

- Julie asked if there would be a situation where you'd have a missed appointment where you wouldn't have any billing under P0001 or P0002, so you would need to bill under P0005 for the missed appointment only.
- Jaye responded that Julie made a good point. They may need to go back to their billing people and maybe look at some of their data, and can get back to us.
- Juerg said that if we do two codes, P0001 and P0002, if the provider spent three hours reviewing the record, according to rule 0010(13)(a), the insurer would have to pay 100 percent of that time spent reviewing the record, so we would have the P0002 code on the bill. Then, the scheduled exam time would be billed under P0001. So, in the case of a missed appointment, we would see the P0001 and P0002 codes on the bill.

Issue # 7 (1867)

Rule: OAR 436-009-0060(2)

Issue: OSC P0004 is used to bill for director required review - complex case fee: Pre-authorized fee by the director for an extensive review in a complex case. However, it is not clear from the description that this is a one time fee and not hourly based.

Background:

- The director may, in a complex case requiring extensive review by a physician, preauthorize an additional fee. This fee is a one time fee, not hourly based, and is to be billed with OSC P0004.
- The descriptor of OSC P0004 in OAR 436-009-0060(2) states:
  "Director required review - complex case fee:
  Pre-authorized fee by the director for an extensive review in a complex case."
- It is not clear from the descriptor that this is a one time fee and not hourly based.

Options:

- Modify the descriptor of P0004 as follows:
  "Director required review - complex case fee:
  One time, pre-authorized **flat** fee by the director for an extensive review in a complex case."

- Other?

- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options to the committee – see above.
- Jaye Fraser said they like Option 1.

Issue # 8 (1877)

Rule: OAR 436-009-0110(7)

Issue: Interpreters may receive an explanation of benefit (EOB) denying payment for interpreter services because the insurer has not (yet) received a bill or chart notes from the medical provider.

Background:

- Generally, interpreters (as well as medical providers) must bill insurers within 60 days of the date of service. (OAR 436-009-0110(4).)
- OAR 436-009-0110(7)(c)(A) requires insurers to pay interpreters within 14 days of the date of claim acceptance or any action causing the service to be payable, or 45 days of receiving the invoice, whichever is later.
- OAR 436-009-0110(7)(f) provides that if the insurer does not receive all the information to process the invoice, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.
- Insurers must pay interpreter services provided at a worker's compensable medical appointment. Therefore, it is reasonable for the insurer to require proof of the medical appointment, i.e., the insurer should have received a bill or chart notes from the medical provider before issuing payment to the interpreter.
- When the interpreter receives an EOB denying payment, or the insurer returns the invoice to the interpreter, for lack of evidence of a compensable medical appointment, the interpreter is required to rebill the insurer hoping that the medical provider has now billed the insurer.

Options:

- Make the following change to OAR 436-009-0110(7)(c):
  The insurer must **retain the bill and** pay the interpreter within: (A) 14 days of the date of claim acceptance or any action causing the service to be payable, **which includes receiving a bill for or chart note of the corresponding medical appointment,** or 45 days of receiving the invoice, whichever is later;

- Make the following change to OAR 436-009-0110(7)(f):
  If the insurer does not receive all the information to process the invoice, **other than a bill for or chart note of the corresponding medical appointment,** the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.

- Other?

- Make no change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes: *Note: This issue was discussed first, followed immediately by review of new advice relevant to interpreters.*

- Fred Bruyns described the issue, background, and options – see above.
- DeAnna Tapia said it would be a good idea if the insurer would hold the bill. Not all providers send their chart notes right away. Some providers will include a lot of chart notes, or chart notes are grouped together, and the insurer doesn't see the appointment, so the insurer sends back a denial or a request for more evidence. The interpreter may rebill and have the bill rejected as a duplicate charge. It is a good idea if the insurer holds the interpreter's bill until the chart notes come in.
- Tom Hernandez said he likes the options provided and that they appear to be workable and a good approach.
- Jaye Fraser said their concern is not about retaining the bill or not, but the interpreter's bill needs to be attached to a compensable service. It is not just the claim that has to be compensable. The service also has to be compensable. Jaye added that she is concerned about the "or" in the option wording, "bill for or chart note …" The chart note is what they need to tie it to the compensable condition and service.
- DeAnna said she understands what Jaye is talking about. Sometimes there are services provided that are not related to an accepted condition. If the insurer were to hold the interpreter's invoice, they would be able to compare it to the accepted condition. Interpreters don't prepare chart notes, but if the insurer asks for evidence, they will send the signed interpreter form from the provider. DeAnna said she didn't know if that would be acceptable. The insurer would still have to compare it with the accepted injury.
- Fred said that we generally do not resolve issues, but want to get as much information as possible to provide to our administrator before her decision on what rules to propose.
- Ben Johnson asked if a claim has been accepted, can the interpreter submit along with the billing the accepted medical condition – ICD code?
- DeAnna asked if by ICD code, does this mean the interpreter code they send for workers' compensation -D0004 or D0006.
- Ben replied that he meant the ICD code for the accepted medical condition – lumbar strain, etc. – which is what the adjusters are looking to tie it to.
- (Speaker unknown) The interpreter would not know the ICD code.
- Jaye Fraser said she didn't understand the question, but agreed that the interpreter would not know the ICD code.
- Daneka Karma said the ICD code is the diagnosis code that the medical provider is going to use. D0004 is the Oregon Specific Code for interpreters to bill services. To Jaye's

point, when the interpreter is billing the service, the date on the invoice is matched with the medical appointment, ensuring that the service is for the accepted injury. The interpreter is not billing for the typical ICD diagnosis codes with CPT® or HCPCS codes; they have state-specific codes.

- Jaye said it is not about the coding but rather about getting the chart notes that support that the service was associated with the compensable claim. That is what they need. Jaye added she doesn't think they have a problem with retaining the bill, but the "or" may be a problem, as in "or 45 days …"
- Juerg Kunz said there is no change that would require insurers to pay for interpreters no matter what. The only thing this really changes is that the insurer is required to keep the interpreter's bill until they get the bill or the chart notes from the medical provider and then can make a determination whether or not it's a compensable medical service. If the medical service is compensable, then the interpreter service probably would be also. On the other hand, if the chart note shows that the service was not for the compensable injury, then the interpreter service would not be compensable either. That is the case now. The complaint we hear from interpreters is that the insurer gets a bill from the interpreter but does not have a corresponding chart note and then basically denies the interpreter's bill. That's what we are trying to resolve – that the insurer waits to make a decision until they have the chart note from the provider.
- Tom asked who has the responsibility to match the interpreter's bill with the chart notes.
- Juerg replied that this would be the insurer's responsibility.
- DeAnna said some providers group appointments together and then bill for it. Chart notes may not be included for one of the appointments in the group, perhaps because it is just a follow-up visit to see if everything is okay. They do request an interpreter, but do not bill for it because it is part of the previous appointment. DeAnna asked what would be provided for evidence of that visit.
- Tom said he thinks that arises in the case of global billings.
- DeAnna said she thinks that is what it is called.
- Juerg asked if DeAnna has experienced that for workers' compensation.
- DeAnna said yes – with a chiropractic physician. Two follow-up appointments were billed under the first appointment. Even though there was an interpreter at all three appointments, the insurer only has chart notes from the first appointment.
- Juerg said that is bizarre and he would be interested to see such a bill, because he is not sure what their reasoning is. They should bill for each visit and have chart notes with each visit.
- Jaye said this type of billing is not something they see. There are chart notes that would tie to the interpreter bill for every appointment. This is not a problem from their perspective.
- Fred thanked DeAnna for raising this concern. It is something we may be able to look into.

New issues – minutes:

- Fred Bruyns referred to advice sent in on Nov. 2, by John Di Paola, MD, of Occupational Orthopedics, and by Tom Hernandez, of ProLanguage Interpreters LLC.
- Tom Hernandez explained that the **first two issues** on the document he submitted are related. The first applies to noncertified interpreters, and the second to certified interpreters. The maximum rates payable by insurers has not changed in a considerable period of time. For noncertified interpreters, the rate hasn't changed since July 1, 2010, when it was set at $60. The rate for certified interpreters was set in 2017 - $70. The rate of inflation for noncertified interpreters over the 12-year period is almost 26 percent. The $60 rate is now worth $47.69. The $70 rate is now worth $62.55. Inflation over time greatly erodes the value that interpreters receive. Fuel and other costs are rising quite rapidly and it looks like they will increase more. It is becoming unsustainable for interpreters. Tom said he is proposing a $5 rate increase for noncertified interpreters and a $6 rate increase for certified interpreters – 8.6 percent for each, approximately, which is not out of the range of what it should be; insurers' profits have been good over that 12-year period of time, and he would expect that to continue for the foreseeable future. It should not destabilize the workers' compensation system. However, what would destabilize it would be having interpreters unable to continue to provide services for economic reasons.
- DeAnna Tapia said she echoed what Tom said. She is a nationally certified medical interpreter and owns an interpreter agency, so works with interpreters all over the State of Oregon. Especially with the new House Bill that has come down, it has proven difficult to secure qualified and certified interpreters, because of the inability to make a living wage given the inflation of the last couple of years and that appears to be coming down the pipeline.
- Robert Reyes said it is becoming increasingly hard, even with the interpreters that he has (for his agency). It has become more common for them to turn down work. Again, echoing what Tom was saying – to turn down work because it is too far, because it is not worth it to them. He gets that more now than he ever has.
- Tom said he agrees with Robert. They are finding that to be the case also. It's getting a lot more difficult to get people to take appointments. Tom added that he does not blame them.
- Jaye Fraser said that SAIF Corporation absolutely recognizes the importance of interpreters in our system. However, they didn't have the opportunity to assess the increase before today's meeting. They are not saying they wouldn't say it makes sense. They just haven't had the chance to assess the impact to their business. They will go back and do that and provide written advice to the department if that is okay.
- Fred said they had planned to let everyone know that the division would leave a window open for written or telephone advice through Nov. 19 for additional thoughts on the pre-published agenda items or on the additional items.
- Tom said he appreciates Jaye's comment, but added that there is a sense of urgency about the issue, and it may not be resolved until April of next year. He doesn't know if that is a

reasonable amount of time for interpreters to hold off in the face of declining earnings due to inflation.

- Tom introduced his **third new issue** to the committee. He explained that he couldn't find the relevant citation but said he has seen it in the Oregon Administrative Rules – where it says insurers have 60 days to determine whether an injury is compensable. The issue here is that interpreters are used and needed by medical providers and insurers in order to evaluate an injury and determine whether it happened on the job and whether it is a compensable injury. During that period of time, there is usually at least one medical appointment that an interpreter interprets for, and there may be several. If the insurer determines the claim is not compensable, interpreters are denied payment. It seems that the services are really essential for the medical provider, and for the insurer especially, in order to make that determination, but at the same time they are denied payment for that. It makes sense to allow interpreters to be paid for those services that they provide and that the insurers use to determine whether an injury is compensable.
- Jaye said she understands the concern, but they also don't pay for the medical treatment. The medical bills can be charged to someone's medical insurance or Medicaid, so there is an alternative. It is an unfortunate situation, but SAIF would not be comfortable with that change.
- Tom replied that, from experience, trying to get paid – in one case from Medicare, it was unsuccessful. Alternative ways of payment would probably be unsuccessful and a lot of work in addition.
- Fred said he had heard that the medical provider is sometimes paid for the diagnosis, even if it is determined that it might not be a compensable injury. Fred asked if that was correct, and if so, would those services be payable for in interpreter in that situation.
- Elaine Schooler said that on occasion they will pay for certain medical visits during the compensability determination. If the medical provider is paid, then typically they would pay for the interpreter service that accompanied that, if there was one. Elaine added that she is not sure how often this happens, and it is typically within the adjuster's discretion.

Issue # 9 (1863)

Rule: OAR 436-015-0030(6)

Issue: Under OAR 436-015-0030(6)(a), physician assistants (PAs) are not a required category of providers, and managed care organizations (MCOs) are not required to allow workers to receive treatment from a PA.

Background:

- This issue was raised by a stakeholder, who stated: "The section listing which provider categories MCOs must include does not include Physician Assistants (PAs). PAs are integral providers in Oregon in virtually every medicine area, including Primary Care Providers and treating injured workers."

- OAR 436-015-0030(6)(a) provides that an MCO must have an adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. *** For categories where the MCO has fewer than three providers within a GSA, or the MCO is unable to provide a list of three providers willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories.
- Further, OAR 436-015-0030(6)(b) requires MCOs to have a process in place that allows workers to select an authorized nurse practitioner. If the MCO has fewer than three authorized nurse practitioners within a GSA or the MCO is unable to provide a list of three authorized nurse practitioners willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from an authorized nurse practitioner, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D).
- ORS 656.260(14) provides in relevant part that a managed care organization contract may designate any medical service provider or category of providers as attending physicians. This means that an MCO is not mandated to designate a provider type of a required category as attending physician.

Options:

- Modify OAR 436-015-0030(6)(a) as follows:
  An MCO must have "[a]n adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, ~~and~~ podiatric physician**, and physician assistant**."

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Minutes:

- Fred Bruyns described the issue, background, and options – see above.
- Ben Johnson said he thinks the first option is appropriate. Ben added he understands this was written as it is quite some time ago and that this appears to be mostly housekeeping – catching up as everyone recognizes that PAs are integral providers in healthcare today.

- DeAnna said that working in the medical field for the last 30 years, she agrees with Ben. Many years ago we didn't see as many physician assistants, but now they are such an important and integral part of the healthcare system. This probably is just a housekeeping issue.
- Ann Klein said they agree that PAs are an integral part of treating injured workers, but they aren't a stand-alone provider, as the other providers on this list are. So, there is some concern that it create an administrative burden of tracking, without it materially changing workers' access to care. If their supervising physician – though in 2022 that will become "collaborating physician" – is on panel, it makes sense to have the physician assistant on panel, assuming that they meet credentialing standards. Likewise, if their supervising or collaborating physician is not on panel, because they really are part of the team, it does not make sense to have them listed independently.
- Ben replied that he agrees that may be something that needs to be considered as well, and perhaps some wording that says "physician assistant and their collaborator," or some way to word it such that whoever they have an agreement with is also involved. Ben added that he agrees they should both be on the panel. Maybe: "physician assistant along with collaborating provider." (something of that nature).

Housekeeping

Reason for change: Make rule language consistent with other rules in chapter 436.

Make the following change to **OAR 436-010-0241(1)(a):**
When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit (Saturdays, Sundays, and **legal** holidays are not counted in the 72-hour period).

Minutes:

- Fred Bruyns described the housekeeping issue– see above.
- Julie Riddle said they have no concerns, but asked if "legal holidays" is defined somewhere else.
- Fred replied that Julie raised a good point. In some other rules we refer to an Oregon Revised Statute that lists the holidays. We will be looking at making a general change throughout chapter 436, that goes beyond this, possibly – something we would take before a committee at some point too. This is only housekeeping in the sense that it brings these rules level with some others. But, there is still an outstanding issue of definition of legal holiday, because maybe someone could point to a federal holiday that is not recognized by the state.
- Julie added it would be very helpful to have it spelled out exactly what we are referring to, because the argument can go on forever about what is legal.
- Jaye Fraser said she agrees with Julie, but perhaps we could say "Oregon's statutory legal holidays" or something like that. Jaye added that she doesn't think we need a definition,

but we need to be clear that it is Oregon's holidays as opposed to federal holidays or other jurisdictions.

- Julie said that Indiana is very kind in this way. They say it is their state holidays, but then they list them – it just makes it easier for everyone.
- Daneka Karma said that if you are accounting for sending a form through the US Postal Service, it may be important to note a federal holiday when the USPS may not be operating, as opposed to an Oregon holiday.
- Fred replied that there is one of those days each year – at least one.

Closing - minutes:

- Fred asked the committee if there are additional new issues to discuss. (no new issues). He thanked the committee members for their time and asked that any additional advice be provided by Nov. 19. Fred added that advice may be sent at any time; sometimes if advice arrives later in a rulemaking process, the division cannot propose related changes without a chance to discuss it with everyone, but it is preserved for the next opportunity. These rules are opened every year. After the division files proposed rules, there will be an opportunity for testimony at a public hearing or in writing.