Agenda

Rulemaking Advisory Committee Meeting

Workers' Compensation Division Rules:

- **OAR 436-009, Oregon Medical Fee and Payment**
- **OAR 436-010, Medical Services**
- **OAR 436-015, Managed Care Organizations**

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Nov. 3, 2021, 9 a.m. to noon Join ZoomGov Meeting: https://www.zoomgov.com/j/1603653737?pwd=WGJxZC8zbm81MUlOSUg2S05XS3gyZz09 Meeting ID: 160 365 3737 | Passcode: 217168 Dial 1-833-568-8864 US Toll-free | Meeting ID: 160 365 3737
Facilitators:	Fred Bruyns and Juerg Kunz, Workers' Compensation Division
9:00 to 9:10	Welcome and introductions; meeting objectives
9:10 to 10:30	Discussion of issues – see attachment.
10:30 to 10:45	Break
10:45 to 11:50	Discussion of issues on agenda continued, and request for new issues
11:50 to noon	Summing up – next steps – thank you!

Attached: **Issues document**

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Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
Rulemaking Advisory Committee Meeting Issues Document, Nov. 3, 2021

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:

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:

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:

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:

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:

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:

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:

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:

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:

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).
