Oregon Administrative Rule Revision
Chapter 436

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

Transcript

Stakeholder Rulemaking Advisory Committee Meeting
Nov. 30, 2022, 1:30 p.m.

Attending – stakeholders:

Richard Abraham MD	Cascade Occupational Medicine
Kirsten Adams	AGC
David Barenberg	SAIF Corporation
Kevin Barrett	SAIF Corporation
Karen Betka	Farmers Insurance
Lisa Anne Bickford	Coventry Mitchell
Kaylee Bond	Corvel Corporation
Caitlin Breitbach	Small Business Ombudsman
Travis Brooke	Cascade Health
Robert Davis MD	Kaiser Permanente
Jeanette Decker	Providence MCO
Anita Dekker MD	Anita Dekker MD, LLC
Jennifer Flood	Ombuds for Oregon Workers
Adam Fowler	Optum
Rachel Gibson	Passport To Languages
Dee Heinz	SAIF Corporation
Isabel Hernandez	Healthesystems
Shannon Huey	Passport to Languages
Matthew Jacobsen	Oregon Occupational Medicine
Lisa Johnson	Majoris Health Systems Oregon, Inc.
Ann Klein	Majoris Health System
Luci Kovacevic MD	Cascade Occupational Medicine
Susan Lavier	TriMet
Jennifer Lawlor MD	Rehabilitation Medical Associates | MAC
Erik Lawson	Passport To Languages
Medina Lee	Optum
Leann Lewis	ManageWare
Shawn Miller	American Property Casualty Insurance Association
Dan Miller DC	Oregon Chiropractic Association
Bryan Null	SAIF Corporation
Jovanna Patrick	Oregon Trial Lawyers Association
Halsey Percival	Passport To Languages
David Pyle	CareMark Comp MCO
Jessica Robertson	Concentra
Lisa Rodriguez RN	St. Charles Health System
Dan Schmelling	SAIF Corporation
Elaine Schooler	SAIF Corporation

Paloma Sparks	OBI
Tamie Tlustos-Arnold, RN	Kaiser Permanente
James Washburn	Kaiser Permanente
Connie Whelchel	KPD Insurance
Jule Wind	Anita Dekker MD practice manager

Attending – Department of Consumer and Business Services:

Barb Anderson
Daneka Karma
Don Gallogly
Fred Bruyns
Juerg Kunz
Kirsten Schrock
Matt West
Rob Andersen
Stan Fields
Steve Passantino
Tasha Fisher
Troy Painter
Val Mueller

Note: Numbers at the left in the format 00:00:00 refer to time locations on the audio recording.

00:00:46 [Fred Bruyns] We will go ahead and get started now. So welcome, everyone. Thank you for joining us. My name is Fred Bruyns. I've probably been your point of contact for this meeting. We look forward to talking with you today, very much. In terms of handouts, we don't have many. But for today's meaning you should have an agenda, if possible, and that agenda is posted to the workers compensation division's website, which is WCD.Oregon.gov, under "Laws and rules," and then under "Meetings and hearings." I put a link to this web page in our chat window. I'm going to put another one in again, because I understand that, depending upon when you arrive, it will not appear for you. So, there's another one, and if you're in the room with us today, paper copies of the agenda are at the back of the conference room. However, if you don't have an agenda – say you're on the telephone, you can't get to our website right now, we will describe the issues in some depth, so you should be able to fully participate regardless. This meeting will be quite informal. If you've connected by Zoom you may use the hands up function in the reactions menu. If you are in the meeting room, just raise your hand, and I will call on you. However, the most important thing is to hear from you, so if I miss you, please just find an opening and talk to us. If you remember, please announce yourself before you speak. That will help everyone know who's talking, and also help us when we do the minutes to put the right comments with the right person. However, it's not a big deal if you forget. I know I would. But if you happen to think of it.

00:02:49 [Fred] One ground rule, I'd like us to observe is to describe problems or obstacles in a way that does not identify specific people or organizations, but also please keep in mind that we

are able to hear background noises in your workplace, even keyboarding. Consider muting your PC or phone as needed.

00:03:10 [Fred] As we go through our agenda, please provide advice about fiscal impacts to you or the people or organizations you represent. Your input is also requested about how adoption of related rule changes, if any, will affect racial equity in Oregon. When filing proposed rules with the Secretary of State … okay, we're picking up background noises in someone's office … we're picking up background conversations in someone's office. So, I'd ask you to hit the mute button. So again, we have to provide information about fiscal impacts to the best of our ability, and we rely on your input for that. Also, with a recent change in the Oregon statutes, when filing proposed rules with the Secretary of State, in addition to estimating cost-of-compliance effects of proposed rule changes, agencies must explain how changes will affect racial equity, if in fact that's the case. We may not be in the best position to know that; we do not collect that kind of data, but people out in the field are going be in a better position to give us that kind of advice, and so, we would welcome that.

00:04:23 [Fred] We have some department staff members here today, or most are actually online with us. Our role is primarily to listen and learn. Basically, we take away what you have to give us, and then – and we have to take that back and do the best we can to let the rules reflect that when we can and where we can.

00:04:42 [Fred] So, introductions can be a little bit awkward, since we have so many people on with us. No one knows when to speak, so I will call your names, and then, if I miss you, you can let us know you're here. First, I'm going to call on stakeholders. I'll get to the department staff in just a moment, but I'm going to run down the list, and if you can just let us know you're here by saying "here," that will help us, and we'll proceed. So, Richard Abraham, MD, Cascade Occupational Medicine? Kirsten Adams, Associated General Contractors?

[Kirsten] Here, good afternoon.

[Fred] Welcome. Brian Allen, Mitchell? Kevin Barrett, SAIF Corporation?

[Kevin] Here.

[Fred] Welcome. Karen Betka, Farmers Insurance?

[Karen] Here.

[Fred] Welcome.

[Karen] Thank you.

[Fred] Kaylee Bond, Corvel Corporation?

[Kaylee] Here, thank you.

[Jule Wind] This is Jule Wind, practice manager and Dr. Anita Dekker, who does occ med and workers' comp arbiter.

[Fred] Oh, welcome, Dr. Dekker and … Caitlin Breitbach, Small Business Ombudsman? Debbie Chan, Portland Public schools? Robert Davis MD, Kaiser Permanente?

[Audio unclear]

[Fred] Welcome. Jennifer Flood, Ombuds for Oregon Workers?

[Jennifer] Good afternoon.

[Fred] Welcome. Adam Fowler, Optum?

[Adam] I'm here.

[Fred] Welcome. Vicki Graves, Oregon Insurance Guaranty Association? Elizabeth Gutzwiler, Mitchell? Isabel Hernandez, Healthesystems?

[Isabel] Hello!

[Fred] Welcome. Brian Hoyt, MD, Cascade Medical Associates? Matthew Jacobsen, Oregon Occupational Medicine?

[Matthew] Here.

[Fred] Welcome. Lisa Johnson, Majoris Health Systems?

[Lisa] I'm here – hello.

[Fred] Ann Klein, Majoris Health Systems?

[Ann] I'm here.

[Fred] Welcome. Luci Kovacevic MD, Cascade Occupational Medicine?

[Dr. Kovacevic] Hello, I'm here. This is Dr. Kovacevic, and it looks like Dr. Abraham also [audio unclear] Cascade Medical Associates.

[Fred] Oh, thank you. Again, we're picking up conversations in your office. I'd ask you to mute your telephones or your computer, please. Billy Lassiat, Zenith Insurance? Susan Lavier, TriMet? Erik Lawson, Passport to Languages? Medina Lee, Optum?

[Medina] I'm here, thank you.

[Fred] Welcome. Leann Lewis, ManageWare? Caroline Mandel, Red Cross? Dan Miller, DC, Oregon Chiropractic Association?

[Dr. Miller] Here.

[Fred] Welcome. Jill Molitor, Conduent? Sheri North, Mitchell? Bryan Null, SAIF Corporation? David Pyle, CareMark Comp MCO?

[David] I'm here, thank you, Fred. Julie Riddle, The Hartford? Sabrina Riggs, Oregon Association of Orthopedists? Jessica Robertson Concentra? Lisa Rodriguez, RN, St. Charles Health System. Marc Schnapper, MD? Keith Semple, Oregon Trial Lawyers Association? DeAnna Tapia, Professional Interpreters, Inc.?

[Dr. Abraham] Hey, Fred, Dr. Kovacevic and I will represent Dr. Schnapper. He's one of our partners involved in BestMed Urgent Care, as the medical director too – which is affiliated.

[Fred] Oh, excellent. Addie Thomas, Mitchell? Mica Toups, Medical Care Partners?

[Dr. Abraham] Yeah. Mica – we will also represent Mica. This is Dr. Abraham again from Cascade.

[Fred] Okay, thank you. Eric Van Houten, Cascade Health? David Waki, Small Business Ombudsman? James Washburn, Kaiser Permanente?

[James] Here.

[Fred] Connie Whelchel, KPD Insurance?

[Connie] I'm here, thank you.

[Fred] And, welcome. Now, I've probably missed some people. Obviously, we had a lot of people on our list that may be joining us at some point during the meeting, but we'll get a Zoom report when we're all done anyway. But, who did I miss? If you're on with us today and you'd like to participate in the conversation – if you just want to observe – just want to listen, that's fine too. I won't put anyone on the spot. But, if you'd like to join the conversation today, please let us know that you're with us.

[Dave Barenberg] Dave Barenberg from SAIF.

[Fred] Welcome, Dave.

[Shawn Miller] Hey, Fred, this is Shawn Miller, with the American Property Casualty Insurance Association. Thanks.

[Fred] Welcome.

[Jovanna Patrick] Hi, this is Attorney Jovanna Patrick, with OTLA.

[Dee Heinz] Dee Heinz, with SAIF Corporation

[Fred] Welcome, Dee and Jovanna.

[Lisa Anne Bickford] Fred, this is Lisa Anne Bickford with Coventry Mitchell, how are you.

[Fred] Welcome.

[Rachel Gibson] Fred, hi there, this is Rachel Gibson, with Passport to Languages.

[Fred] Welcome, Rachel.

[Rachel] Thank you.

[Fred] Anyone else?

[Tami Tlustos-Arnold, RN] This is Tami Tlustos-Arnold, with Kaiser Permanente.

[Fred] Welcome Tami, anyone else?

[Shannon Huey] Shannon Huey, Director of Operations for Passport to Languages.

[Fred] Welcome.

[Paloma Sparks] Paloma Sparks, OBI.

[Fred] Welcome, Paloma.

[Elaine Schooler] Elaine Schooler with SAIF Corporation.

[Fred] Welcome Elaine.

[Elaine] Thank you.

[Fred] Anyone else?

[Halsey Percival] This is Halsey Percival, here on behalf of Passport to Languages.

[Fred] Welcome, Halsey.

[Travis Brooke] Travis Brooke, with Cascade Health

[Fred] Welcome, Travis. Additional folks? Okay, hearing a pause. If I missed anyone, I'll ask at the end - I'll ask people to just stay on and let me know that they were there, and we can record

them on the minutes as being with us. So, now I'm going to call on State of Oregon attendees. I don't – I could probably check on Zoom, but I think it'll be faster just to run down my list here. But, Sally Coen, WCD Administrator? Matt West, WCD deputy administrator?

[Matt] I'm here, Fred, thanks.

[Fred] Welcome. Kirsten Schrock, Resolution Section manager?

[Kirsten] Good afternoon, Fred, I'm here.

[Fred] Welcome. Rob Anderson, Sanctions and Medical Resolution manager?

[Rob] I'm here, Fred, thanks.

[Fred] Juerg Kunz, medical policy analyst?

[Juerg] I'm here.

[Fred] Welcome. Stan Fields, managed care specialist?

[Stan] Here, Fred, thanks.

[Fred] Tasha Fisher, lead medical reviewer? Daneka Karma, policy team manager?

[Daneka] I'm here, thank you, Fred.

[Fred] Welcome. Don Gallogly, lead research analyst?

[Don] Here. Thank you.

[Fred] Welcome. Troy Painter, senior auditor?

[Troy] Here.

[Fred] Katherine Hanel, performance coordinator? Val Mueller, business systems analyst? And Steve Passantino, appellate review manager?

[Steve] I'm here, Fred, thank you.

[Fred] Welcome. Did I miss anyone from the department?

[Barb Anderson] Barb Anderson, EST manager.

[Fred] Welcome, Barb.

[Caitlin Breitbach] Caitlin Breitbach, Small Business Ombudsman's Office.

[Fred] Okay, welcome. Caitlin. Anyone else? Okay, unless anyone has any questions before we begin? I would encourage you to come to the table, but that's up to you entirely.

Issue #1

00:15:10 [Fred] Okay, I'm going to begin with issue number one, which is a standing issue that we raise every year. It has to do with temporary rulemaking, and we'd appreciate your feedback. So, this affects rule 0004, in division 009, the Oregon Medical Fee and Payment rules, and it affects appendices – the medical fee schedules – appendices B through E. The American Medical … Let me share my screen. Excuse me. I'm launching into the old-fashioned mode of actually looking at a paper agenda, but will try to bring it up to date here. Is that large enough print for you here to see that here in the conference room?

00:16:10 [Fred] So the American Medical Association, or AMA, and the Centers for Medicare and Medicaid Services published new CPT and HCPCS codes effective Jan. 1, 2023. However, the Workers Compensation Division, WCD, does not publish its permanent fee schedule updates until April 1 of 2023. Now, that's a projected effective date. This prohibits providers from using the latest set of codes for workers compensation billings and forces insures to return bills as unpayable if providers use new codes from Jan. 1 through March 31. In order to allow time for public input, WCD publishes a new physician fee schedule, Appendix B, new ACS fee schedules, which are C and D, the new DMEPOS, that's durable medical equipment, prosthetics, orthotics, and supplies, fee schedule – that's Appendix E, effective April 1 each year. Adopting the new CPT and HCPCS codes effective Jan. 1 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 or RVUs, or payment amounts, WCD would update appendices B through E, effective Jan. 1, 2023, and assigned maximum payment amounts, using the 2022 conversion factors or multipliers. One should bear in mind that due to time and staffing constraints, it may not be possible to update all of the appendices, and I'll add that sometimes CMS may publish some of the appendices quite late in the year.

00:17:45 [Fred] Various organizations will publish updates to the standards that WCD adopted in Rule 0004. So WCD began issuing temporary rules in January of 2016 to allow providers to bill insurers using new codes for dates of service from Jan. 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 2022.

00:18:08 [Fred] So, options for your consideration are to adopt new CPT codes and standards under rule 0004 through a temporary rule effective Jan. 1 of 2023, and update appendices B through E with payment amounts for new codes using the 2022 conversion factors or multipliers, where possible. Or, it's an option not to issue a temporary rule at all. Temporary rules are always – they're generally designed to meet – to address a particular problem at a particular time, and agencies are very careful about how often they adopt them. But again, we did this particular rulemaking at the request of stakeholders, starting in 2016. But, we don't want to assume that that's always going to be the case. There might be something that we're not seeing; something that we haven't heard about. So, let us know if you have any concerns about adopting a

temporary rule to adopt those new codes effective Jan. 1. Okay, hearing no one. I will just move along. If anyone ever has any second thoughts about an issue, don't hesitate to just say something, and we'll go back or revisit something.

Issue #2

00:19:20 [Fred] So, Issue #2 is another standing issue that we bring every year, and it has to do with updating the fee schedules. So, this affects rule 0004, appendices B through E, the fee schedules. So, ORS 656.248, subsection (7) requires that WCD update fee schedules annually. The references listed in rule 0004, and the fee schedules published in Appendices B through E, will be outdated when the permanent rules become effective on April 1, 2023. A little background, and here I've actually highlighted for my own benefit somewhat, but you can also follow along. The green-highlighted sections in any given part of the agenda – I'm only going to read the green. And, some of the detail – it's important detail, but it's rather technical in terms of the source data for these fee schedules.

00:20:13 [Fred] So, the above listed appendices are based on conversion factors and multipliers developed by DCBS – that's the Department of Consumer and Business Services – and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare and Medicaid Services or CMS. Every year there are 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. Again, various organizations publish updates to standards that WCD adopted in rule 0004, and that's where we get the information to do the updates.

00:21:04 [Fred] So the options include adopting updated standards listed in rule 0004 and updating Appendices B through E using more current CMS spreadsheets and updated WCD conversion factors/multipliers. Update rule 0004; that would be section (3), deleting codes that are now included in CPT® 2023, and adding new valid codes that are not listed in CPT® 2023. And, the latest information we have is that there are no new codes. Is that right? Or, there's no new Covid codes. Maybe that's all.

00:21:41 [Juerg Kunz] Yeah, that is correct. Basically, all of the emergency codes that the AMA developed, they are published now in 2023 addition of the CPT® book. So, basically we can delete that whole section.

00:22:02 [Fred] Thanks, Juerg. So, that's the standing agenda item, and appreciate your feedback. Again, sometimes there's things that are not on our radar, and we'd need to know. I think it was a number of years ago, someone told us something about the DMEPOS fee schedule and a change in kind of the background information that determines fees. So, we'd appreciate your feedback on this one, if you would like us to go ahead and make the updates or if there's something that we need to be cautious about.

00:22:38 [Dr. Abraham] Hey? Fred? It's Dr. Abraham. For those of us that don't know exactly what they are, at some point are you going to tell us what the with the current conversion factors and RVUs are for both the E&M and the surgical codes? What the reimbursement – what they're at today?

00:23:02 [Fred] I'm going to turn to my co-worker here, Juerg Kunz, the medical policy analyst, and see if we have that information.

00:23:11 [Juerg] I can go and get the conversion factors that we use for the categories. For the RVUs, I would recommend that you go to the CMS website, because every CPT® code has a different RVU.

00:23:31 [Dr. Abraham] No, I meant the RVU year – like the fee schedule hasn't been adjusted much for quite a while. And, I was just curious what the current conversion factor was for just the E&M code and for the surgical code, and which RVU year you're using, not the individual RVU per CPT® code, just the RVU year, whether it's 2020, 2018, 2021, whatever year, and also the conversion factor. And there's really just two …Go ahead, sorry.

00:24:07 [Juerg] Okay, so currently we use the 2022 RVUs from CMS, the ones that are effective in January of 2022. That's the version that we use, and then we keep that for the whole year. And, I can quickly go and get the conversion factors, and I will be back in five minutes.

00:24:39 [Dr. Abraham] No worries. Thank you so much. I think that would be helpful to a lot of people here to know where we're at now for a base.

00:24:45 [Don Gallogly] This is Don Gallogly. I could look those up here, Juery. I'm at my desk right now, if that helps.

00:24:55 [Fred] Thank you, Don, that'll save us. While we're waiting, does anyone else have additional input on updating the fee schedules? Okay, we'll kind of stand by for a moment. I'm going to scroll down to the next issue, but we're going to wait and see if Don can find that information for us.

00:25:27 [Fred] Issue # 3 is actually relevant, because it has to do with proposals that the department has received for increasing maximum allowable payment under the fee schedules.

00:25:40 [Don] I am back, Fred.

00:25:43 [Fred] Well, go ahead, Don.

00:25:44 [Don] There are two conversion factors for E&M, one specifically for the office visits and one for everything else that is included in the E&M Category. Office visits conversion factor is 67.1, and the rest is 70.59, seven zero point five nine.

00:26:18 [Dr. Abraham] Hey, Don. I thought there was another conversion factor was more like 93, or something, for surgical codes. At least in the past, the surgical codes were kind of dramatically higher than what the E&M codes were for office visits.

00:26:31 [Don] I believe the current minor surgery category conversion factor is 91.51. Major surgery is 76.73, and major surgery is anything that has a global period of 90 days. Everything else is minor surgery.

00:26:57 [Dr. Abraham] Thank you, that's perfect.

00:27:03 [Fred] Thanks again, Dr. Abraham. Did you have any additional questions? Or, was that what you wanted to know at this time?

00:27:09 [Dr. Abraham] Yeah, no, no, that's helpful. I mean I think that gives us a parameter to compare to commercial payers, which certainly for the E&M codes over the last, you know, 10 years have gone up significantly more than that. And, so I don't know at the point we'll have that discussion. But, I think that the surgical codes are probably appropriate in my mind - the minor surgery codes, but I think the other codes have gotten outdated as far as what the level of reimbursement is for the amount of work, time, and effort it takes to deal with workers' comp patients in today's world.

Issue #3

00:27:54 [Fred] Okay, thank you doctor. I think the next issue is the one where we'll perhaps have some of that relevant conversation. So, issue number three is related to rule 0040, and Appendix B in particular, the physician fee schedule. So multiple stakeholders requested that WCD increase the physician fee schedule by up to 20%.

00:28:12 [Fred] The Oregon Chiropractic Association, or OCA, is requesting a 10% increase for chiropractic manipulative therapy or CMT codes. The OCA states that due to the current 18-visit limitation on chiropractic treatment as a type B provider, the fiscal impact of a 10% increase in these codes would be less than $200 per case. And, then I'm going to go down, and I'm going to read some of the input from the OCA. And, then I'm going to go on and address some of the other input from health care providers.

00:28:49 [Fred] CMT fees have not had an increase in over eight years, other than two minor cost-of-living increases. Again, I'm actually quoting from all the input. Cost of living must be included in reasons to increase reimbursement for services, as all other business expenses increase each year, including WC, which is workers' compensation, premiums. Established patient E&M codes have increased 14 to 32% in the past 10 years. CMT codes have embedded office visits, preventing a daily established E&M charge, therefore limiting chiropractors from utilizing the E&M code increases other than an initial visit or formal reexamination. CMT codes are close to 10% less than some similar osteopathic manipulative therapy, or OMT codes. Based upon inflation rates, an increase less than 10% results in a net reduction in payment for these services.

00:29:45 [Fred] Several medical doctors in medical clinics requested an increase in the physician fee schedule of up to 20%. And again, I'm going to read the green text, just because there's some duplication in what the providers provided. It's all good information, and I would encourage you to look at it in the in the longer agenda. But, in the interest of time, I'm just going to go over the points where – so I make sure that I capture all the points.

00:30:09 [Fred] Many providers are dropping out of providing care for injured workers. There are record inflation levels, supply chain disruptions, steeply increasing commercial property costs, drastically increasing skilled medical workforce wages and salaries. And, a provider says to my knowledge there has been no significant increase for providers for a decade or more, and a market correction is overdue. The increases in the state fee for workers' compensation have lagged other commercial carriers significantly. The time consuming nature and additional overhead and labor costs managing workers' compensation patients results in significantly higher costs, I guess, comparatively to caring for non-workers' compensation patients; recruiting and finding skilled health care workers is an issue; spiraling malpractice rates; costs of expensive new electronic medical records or EMR systems and associated IT expenditures; and various issues have created an unsustainable business model without further consideration.

00:31:20 [Fred] There is decimation of the medical field. Record retirement and an exodus of the workforce left us competing at a disadvantage for skilled medical workforce: for providers; nurses; medical assistants; and techs. Shrinking labor pool for key medical staff: registration; records clerks; billing; etc., that can demand the highest pay from other employers that control their fee schedules.

00:32:03 [Fred] And, so I have some input I'm going to read from – so, this came in too late to incorporate into our agenda, and I just – I promised a couple of folks that I would read their input into the meeting record here today, so it that it's before everyone. So, again I'll quote:

> I am Ron Bowman MD, a board-certified Orthopedic Surgeon and Chairman of the Medical Advisory Committee to the WCD from 2004 to the present and have overseen the business aspects of my medical practice. A consistent issue brought to MAC is access to medical care for the injured worker, who find it increasingly difficult to locate medical providers for their industrial injury. Medical providers view Workers' Compensation care as expensive to provide because of administrative costs, claim verification, dealing with disputed claims, and other "hassle factors". To attract providers into the Oregon Workers' Compensation system a significant increase in reimbursement is overdue. During my approximate 20-year tenure as MAC Chairman there has not been a substantial increase to the providers' fee schedule and there have been a few reductions. At the same time the general costs of providing medical care has considerably increased as we watch the increased cost of rent and real estate, wages for office and surgical staff, supplies and equipment necessary to conduct medical practice, and now inflation. I think a 20% increase in the providers' fee schedule is reasonable and will attract the interest of new providers. If a yearly 3% COLA had been applied to a $1,000.00 charge for the medical provider community in 2004, it would be calculated at $1,753.47 today.

00:33:35 [Fred] And, that concludes Dr. Bowman's input. And, he also passed along something from Ted Bucknam, who is the chief operating officer for Unity, MSK, which I think is actually the owner of Dr. Bowman's practice:

> Just found a stat online (AMA is the source) that indicates the cost of running a medical practice increased 39% from 2001-2021. A 20% increase in the fee schedule would barely cover half of the increase in cost. At the same time, a well-managed workers comp injury can save employers 20-60% in total workers' comp costs while achieving better outcomes for the injured worker. None of that can happen without quality medical providers. The 20% increase I am asking for is supported by achieving three goals simultaneously - lower costs for employers, fair compensation for medical provider, and better clinical outcomes for patients.

00:34:29 [Fred] And, that that concludes Ted Bucknam's written input. So now I'm back to – this is – I'm back to the department's agenda now. The physician fee schedule consists of several categories, evaluation and management or 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, rule 0040, section (2) lists the conversion factor for anesthesia services. Generally, the physician fee schedule amount is determined by multiplying the relative Value Unit or RVU for each code, published by CMS, by a conversion factor determined by WCD. Each physician fee schedule category has its own conversion factor. However, WCD assigns a payment amount to each of the four Chiropractic Manipulative Therapy codes as well as the Oregon specific codes, that is, the RVUs are not used to determine the fee schedule amounts for these codes.

0035:37 [Fred] Over the last six years, the division implemented the following fee adjustments: Effective 4/1/2016, WCD increased the maximum payment amounts for all categories, including the CMT codes, except physical medicine and anesthesia services, by three percent. Effective 4/1/2017, WCD increased the maximum payment amounts for anesthesia services by three percent. Effective 4/1/2019, WCD increased the maximum payment amounts for E&M services by five percent. Effective 3/25/2020, through a temporary rule, 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.

00:36:23 [Fred] In 2021, the AMA made dramatic changes to E&M office visit codes, 99201 – 205 and 99211 – 215, and also deleted code 99201. At the same, CMS raised the RVUs for these office visit codes substantially, by as much as 42%. In response to this large RVU increase by CMS, WCD split the office visit E&M codes 99202 –205 and 99211 –215 from the rest of the E&M codes, which are 99217 – 99499, and, effective 4/1/2021, raised the fees for the office visit E&M codes by an average of 10%, and all other codes in the physician fee schedule, including chiropractic codes, by 2%.

00:37:12 [Fred] That's a lot of information, a lot of data. The department expects each one percent change to have the following fiscal impact for each individual category: E&M Office: $400,331; Evaluation & Management: $43,524; Minor Surgery: $61,120; Major Surgery: $218,345; Radiology: $96,555; Lab & Pathology: $1,730; Medicine: $35,174; Chiropractic: $27,938; and Physical Medicine & Rehab: $456,123.

00:37:55 [Fred] So, options for your input for consideration: increase the maximum payment amounts in the physician fee schedule, either as a whole or by individual categories; make no change; or "other" is going to be a pretty much a standing item on all of these, in case you have other ideas entirely that we did not think of, and then we would appreciate hearing about those.

00:38:16 [Fred] So at that, I'll just open it up for your input on, you know, especially, the first bullet here, increasing the maximum payment amounts in the physician fee schedule, either as a whole or by individual categories. So, let us know what you think.

00:38:34 [Dr. Kovacevic] Hello, Fred, this is Dr. Luci Kovacevic, Cascade Medical Associates, Board certified occupational medicine. I do the medical direction and recruiting, and would like to say that it is getting difficult to hire and find providers who are interested in working occupational medicine to offer competitive wages and also keep up with inflation, so I would recommend increasing the fee schedules to help keep up with the pace of change. Thank you.

00:39:06 [Fred] Thank you, doctor. Dee Heinz, I see you had your hand up.

00:39:12 [Dee Heinz] Thank you, Fred. I appreciate it. I just wanted to say that first of all, we want to thank the committee for the opportunity to provide input. On rulemaking, here, historically SAIF has supported reasonable increases in the fee schedule and fair compensation that's consistent with industry standard to our providers with the goal of a sustainable system for all of our stakeholders. We supported multiple fee schedule increases in the past for provider services over the last 10 years, and especially the near tripling of the fee schedule for the telephonic visits in light of Covid efforts. We also supported a Covid office visit fee to support the extra efforts and supplies that are required to ensure infection prevention for patients and staff during visits during the pandemic. SAIF acknowledges a significant impact that Covid has had on health care delivery, not only in workers compensation but in Oregon and, frankly, the whole nation. It's forever changed healthcare. I'm a nurse, and I can see it when I go to the doctor. Shortages of providers is a system-wide challenge. It's a nationwide challenge, and it not only affects workers' compensation. We also acknowledge that workers' compensation is a complex system with many facets to providing care toward our shared common goal to access to quality care and recovery on our system sustainability. To that end, we appreciate how, historically, the division has revised the fee schedule: analyzing data on a micro level, considering industry standards, and the needs of our stakeholders. We continue to support the more nuanced, targeted approach that the division has taken over the past, rather than an across the board cost of living or inflationary-tied method of adjusting the fee schedule. We respectfully suggest additional clarity around some of the request for increases, and that some additional data analysis be done on general reimbursement and its impact on the industry.

00:41:14 [Fred] Thank you, Dee. Additional input Dr. Miller?

00:41:20 [Dr. Miller] So, I've been asking for this increase fairly consistently throughout the years. The last increase we had was as a result of me asking, and it basically got us back to the point of a position we were at 12 years prior when we started seeing reductions in our fee schedule. As a result, we have taken CMT codes., chiropractic codes, out of the RVU conversion

factors just require [audio feedback – audio unclear] … as a result, the last 3 years we haven't been able to have these meetings in person. I haven't been able to be here to answer the questions in person, and some of the things that get brought up is, why are we just, you know, singling out the CMT codes, and as is written down in here, it requires a proposal because we're not using the [audio unclear] to change that. We have the exact same issues dealing with inflation that the MD and every other business in the nation is dealing with. When we were going through the Covid crisis, we didn't have the luxury of doing visits online. I can't give an adjustment over a computer or a telephone, so we had to pay our staff more to, you know, manage the risk that they believed, or they perceived, was happening as in person visits were still required. But, thankfully, we were allowed to do those visits, and the patients were allowed to get, you know, treatment. You know, having a video E&M visit with any provider isn't going to give them the same benefit that they would have in person, even if it's just a matter of getting a prescription. You can't do a physical examination over the phone or a computer, even though they attempted to do it for two and a half years now. The 10% increase that we're asking for again allows us to have our embedded E&M codes addressed, because if you get a 20% increase on an E&M, chiropractors get to use that once for an initial examination, and once for closing examination, and we're pretty much done with our 18 visits. Maybe some would get a third. And, if you're involved in an MCO, then you would be able to get, you know, additional beyond that. And so, you know, I don't want to step on the toes of the people asking for an E&M proposal, but we did see E&M did improve, or did increase over the last 10 years more than apparently perceived, especially in the established visits – maybe not so much on the new patient visit. In the event that the department is considering that 20% increase, I would be glad to accept 20% for the CMT codes as well. One other thing on the expected percent change to have on the fiscal impact, $27,000, almost $28,000, for chiropractic for every 1% change, but it's important to note that that chiropractic monetary value includes our E&M, so it would take, you know, it's not adding an E&M office visit when you're putting chiropractic. It includes our physical therapy because we all bill it under chiropractic. It includes our radiology. So, all of the things that are within our scope of practice are labeled underneath that chiropractic [audio unclear]. And so, even if you just increase the chiropractic codes, that's only a percentage of what the chiropractors truly bill out.

00:45:34 [Fred] So, thank you, Dr. Miller. Additional input? You can raise your electronic hands or you can just speak up. Again. Go ahead.

00:45:49 [Matthew Jacobsen] I'm Matthew Jacobsen with Oregon Occupational Medicine, and I will say that my background is predominantly finance, so I kind of took a different approach with this. I assume that most people will be mentioning the inflation, the inability to find staff, all of which are true, and have been a significant challenge this year. But, my assumption was that maybe some real-world data from an actual practice would be useful as well. So, just looking at my practice, in looking at the actual items that have increased, my labor costs have increased anywhere from 10 to 15%, essentially, just to keep people employed and or to hire new people. This group may not know about the Pay Parity Act, but with that, if I bring in new staff at a higher rate, I have to pay everybody else at least that rate as well, which is applicable with entry level staff in particular. So, that's part of that raise increase is I had to pay more to keep people on board.

00:47:03 [Fred] Okay, I just wanted to remind you again that we'll pick up everything in your workplace, so please use the mute button selectively, so that you can keep your particular conversations in your workplace, just there. So, go ahead, Matthew.

00:47:19 [Matthew] Specifically, let's talk about medical assistants that they do the same work, and those are the hardest people to get, and the ones where I've seen the highest wage increase. It is what I'm talking about there. In addition to overhead expenses, have gone up around 14%. And, you know, from strict accounting standpoint, not everything is technically an overhead expense, but I'm just lumping everything else in there. I'm looking at next year, probably an average of 9%, 9 to 10% increases as well. So, those are all like my real practice expenses. This year, in 2021, the Work Comp Division did split those in E&M codes the 99201 and the 99211 from the higher codes. About 70 or 80% of what we bill is in those lower code range, and those lower code range saw effectively a flat or a 1% decrease. So, that 10% increase across the spectrum of all of them wasn't really effective in those E&M codes for us. And so, when I crunch all the numbers, for me to be at where I was at in 2021 – just flat – I came up with an 18.16% increase that was necessary. So, when I started reading some of these comments here and everybody asking for 20%, I was kind of pleased that I wasn't, because when I first came up with that, I thought I must be crazy - that's kind of a high number. But, seeing everybody else here with that same number, and me coming at that with my – it's not the world at large, this is my world That's where I would be. So, I just wanted to make that comment that I'd be asking for an 18.16% increase, in particular on those lower E&M codes. Thanks.

00:49:00 [Fred] Thank you, Matthew, and Kirsten Adams, I see you have your hand up.

00:49:04 [Kirsten Adams] Hi! Thanks, Fred. Kirsten Adams from Associated General Contractors. I wanted to echo the comments that SAIF made and, you know, obviously supporting fair compensation for the providers that treat injured workers, and then also focusing on how the division has historically looked at data and the fee schedule and encouraging that that be one of the guiding principles as you look at this further.

00:49:30 [Fred] Thank you, Kirsten. Dr. Miller.

00:49:35 [Dr. Miller] I just want to address, you know, some of the numbers that he was relaying on his individual practice that we all are seeing, especially as small business owners. One of the things that you talked about was the lower E&M codes not moving, which is correct, and as a chiropractor, unfortunately, we have a different set of rules. I don't know how that happened other than the fact that maybe the people writing the rules aren't chiropractors. But, we have a different set of rules on what is considered a certain level of E&M. If you look at the back of the CPT® book itself, and they give examples, they can say, for a physical medicine type of an example, you can have a 99213, which is a moderate complexity code of a 13-year-old female with scoliosis. So, that person's history is you know – my mom says I look crooked. That person's exam is they bend over and they see a postural change, and that person's decision making is let's take an X ray, and then go from there, and it can be relatively significant. For a chiropractor, for us to be able to justify 99213, we have to do a 100 different exams going through multiple different systems and having a detailed history, which we would typically do. But we have to go through a lot of different hoops just to get through some of these lower level

E&Ms. So, I would definitely be on board saying that those lower levels need to be increased as well. Even though we may only get 2 or 3 in a case. It's still – that's the majority of our time that we provide to those patients.

00:51:26 [Fred] Thank you, Dr. Miller. Additional thoughts or input, experience?

00:51:44 [Dr. Abraham] It's Dr. Abraham, Fred. I'm not going to reiterate everything everybody said. I agree with a lot of what's been said. I – you know, I'm a board-certified emergency physician and occupational medicine physician and have practiced emergency medicine for 30 years and occupational medicine for 15 years or so, and, you know, to me, unfortunately, I think workers' comp has lagged the increases that commercial payers have done over the last 10 years. So, I mean, I do all the contract negotiations for our commercial payers, and in our entities, and you know, our contracts for commercial are about 25% higher than what the workers' comp fee schedule is now, other than the minor surgical procedures you referenced at $91. And, I think that, you know, the 18 to 20% number that was given is probably appropriate to play some catch up. I mean, I hate to have that much inflation with everything going on, but we're all experiencing – we have, especially the last 3 years. It's obviously been very painful for everybody. And, you know, had we kept up a little more with, you know, 3% increases annually, we wouldn't be where we are today, but, unfortunately we are. And to me, it strikes me that I get paid, you know, I mean honestly, for a minor surgical procedure, I see somebody with a one centimeter laceration that I suture and get paid more money for that than I do taking care of, you know, a complex, you know, shoulder or back injury, or something else that you know, that may have a bunch of medical records to review that are referred, and we're seeing more complex patients now, because so many fewer people are seeing workers' comp. We're seeing a lot of cases from other cities, and stuff that no one else will see that have been to multiple physicians in the past, and their claims are two or three years old or more, and we kind of get - they kind of get dumped on us, you know, not to say we aren't happy to see them, but the amount of work to see some of these patients compared to doing a minor surgical procedure – I mean, it doesn't make a lot of sense to me, even though I do a lot of the minor surgical procedures, and our group does, so I think, to me, increasing that – that increase in the minor surgical cost at the $91, isn't as much of a factor as the general E&M codes, which do need a, you know, they're just overdue for a substantial increase in order to keep us all in business and keep doing what we're doing. So, I'll just leave it at that in terms of my input goes, and I do empathize with businesses [audio unclear] I mean, we're in the same way, that I have to pay more for medical care, etc. over time. Had these costs been done a little more incrementally, it wouldn't require such a dramatic step this year, as far as making up to a level of the commercial payments. Thank you so much, and thanks for all the input.

55:25 [Fred] Thank you, Dr. Abraham. Go ahead.

55:29 [Dr. Lawlor] Hi. This is Dr. Lawlor. I'm a physiatrist in private practice, Rehab Medicine Associates, in Portland. I also am the medical director at CareMark Comp, but my comments sort of are influenced by both of those roles. One, I would absolutely echo all the prior comments that the cost of private practice has really changed, and I would caution that it's not really as much of a reflection of the inflation that we're seeing all across the economy, but the changes in health care that are a direct response of Covid impact that are not likely to change anytime soon. And

that's just the deficit in people willing to work in health care. It's very challenging, but I will also say that my biggest concern has always been that there is a wide pool of providers willing to see injured workers. When that pool shrinks, the impact is huge. It delays care. The patients get frustrated. They develop more of a disabled mindset. There's just all kinds of difficult-to-measure consequences that greatly concern me. I think that the financial decision is there and it's real. All private practices will be looking very closely at their fee schedules in the coming months, with the anticipated cuts to Medicare, and consequently all other commercial payers. So, I think it's very timely that the work comp fee schedule is being evaluated, because practices and providers will be making decisions to depart from participating in work comp, undoubtedly, if there aren't some changes, so I just agree that decisions should have data driven decisions, but I strongly recommend the increase that – either the one that's been proposed or an increase that can be backed up by data. Thank you.

57:40 [Fred] Thank you. Thank you. Dr. Lawlor: Additional input, anyone? Thank you very much, we'll take that back and we will share that with our administrator. In the nature of these advisory meetings, we don't typically come to a decision and of course we've been advised to check the data to the extent that we can. We certainly will look at the data that we can obtain. If you have additional data that you can send in our direction, you can just send it to my attention, and I'll make sure that we give it to our IT folks – our research department to dig into. So, thanks again. I'll scroll down. If you have additional thoughts on this or any other agenda items today, just send it to my attention. You probably have email from me, and I will make sure to distribute it here.

Issue #4

00:58:35 [Fred] So we're on to Issue #4. This affects rule 0012 and telehealth. The issue is that rule 0012, section (3) instructs providers, when billing for telehealth services, to use the place of service or POS code 02 for telehealth. However, this year, CMS changed the descriptor of POS 02 to telehealth provided other than in a patient's home and introduced the new POS 10 for telehealth provided in the patient's home. So, providers put the POS code in the space of Item Number 24B on the CMS-1500 billing form to identify the location where the service was rendered. Up to now, there was only one POS code, 02, to indicate that the service was a telehealth service. And as we said, starting this year, there are now two POS codes based on the location of the patient that indicate the service is a telehealth service. WCD expects that the AMA will also list the new POS code 10 in the CPT® 2023 codebook. Options for this rule would then be to – and we've got it actually shown here – we would basically just display out these two, so it would explain that a 02 is telehealth provided other than in the patient's home, and 10, telehealth is provided in the patient's home. And, so, appreciate your input or thoughts on that. I know this is a fairly straightforward issue. But sometimes, again, we may not know what you know. Certainly, we often don't, and we would appreciate your thoughts on this in terms of any wrinkles.

Issue #5

01:00:22 [Fred] Okay, I'm just going to keep scrolling along here. Stop me if I ever go on too fast. Now Issue #5; we're up to rule 0020, affecting hospital payments, payments to hospitals,

and section (4), subsection (e) of rule 0020 allows an insurer to bring a dispute to the director if an agreement with an out-of-state hospital cannot be reached, and includes factors the director may consider when ordering payment. When ordering payment, the director may consider factors such as reasonableness and usual fees for similar services by facilities in similar geographic areas. However, the director is unable to determine if an out-of-state hospital has billed an unreasonable amount or not, as the director does not have the ability to compare and review whether these charges are usual fees for similar services by other facilities in that same geographic area. Rule 0020, section (4), subsection (a) specifically addresses how outpatient bills from out-of-state hospitals should be paid. However, it does not address how inpatient bills from out-of-state hospitals should be paid. Subsection (4)(c) states: "Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative." However, outpatient services billed with certain revenue codes must be paid according to, and cannot exceed, the physician fee schedule – and this according to statute. When fee schedule amounts are less than the amount billed, the insurer is prohibited from paying the billed amount under statute.

01:01:50 [Fred] A little background: rule 0020, section (4), subsection (e) provides that if the insurer and the out-of-state hospital are unable to reach – if they are unable to reach an agreement within 45 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution of the dispute. The director may order payment up to the amount billed, considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances. Since the director is unable to determine reasonableness as outlined under the rule, insurers should be required to pay an out-of-state hospital according to the fee schedule if the insurer and the hospital are unable to reach an agreement within 45 days of the receipt of the bill. Again, under rule 0020, that would be under (1)(c), states that the insurer may pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio. Those are published in Bulletin 290, and Bulletin 290 states that "hospitals that are licensed or authorized to be hospitals in another state have a cost-to-charge ratio of 1.0." While subsection (1)(c) applies to inpatient bills from in-state as well as out-of-state hospitals, it may be helpful to clarify in section (4), which is pertinent to out-of-state hospitals, that inpatient bills from out-of-state hospitals are to be paid by applying a cost-to-charge ratio of 1. The fee schedule both for hospital inpatient and many outpatient services is calculated by multiplying the billed amount by the cost-to-charge ratio. Since out-of-state hospitals have a cost-to-charge ratio of 1.000, the fee schedule amount is the same as the billed amount. However, hospital outpatient services billed with revenue codes – and then we list a whole series of codes there. I will not repeat all of those, but are payable under physician fee schedule, not under the cost-to-charge ratio, that is, the fee schedule amount for these services could be less than the amount billed. Subsection (4)(c) states: "Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative." While this subsection refers to payments less than the billed amount, the intent of subsection (4)(c) is that any agreement for payment less than the fee schedule amount, must be in writing.

01:04:14 [Fred] So we put forward some options there for your consideration which would be to rewrite this rule somewhat. And so, the first option would be to begin with a "notwithstanding" one of the other rules, and then we would insert some new language: "The insurer must pay an

out of state hospital for inpatient services as outlined in subsection (1)(c) of this rule, and for outpatient services as outlined in subsection (2)(c) of this rule." Just to kind of delineate those two. And, then we would remove some of the existing current language. Second bullet, we do something similar with, basically, "Unless otherwise agreed upon by the hospital and the insurer, insurers must pay an out-of-state hospital [and then we insert] for inpatient services as outlined in subsection (1)(c) of this rule." And, then it goes on to say, "and for outpatient services as outlined in (2)(c) of this rule." So, the wording would be parallel between those two bullets there, and then the third bullet would be: make the following change to (4)(c), "Any agreement for payment less than [we would cross out the word "billed," and we would have the fee schedule amount] must be in writing and signed by the hospital and insurer representative."

01:05:33 [Fred] So, I know that was quite a mouthful and I ran through that rather quickly. But, again, we would appreciate your thoughts, any concerns about those wording changes, maybe some consequences that we had not considered. So, welcome your feedback. Okay, hearing no one. Let me know, again, if I ever scroll down, and you're just actually waiting to talk.

01:06:07 [Erik Lawson] Oh, sorry. Yeah, can you hear me okay?

01:06:11 [Fred] I can. Yes, please go ahead.

01:06:12 [Erik] Yeah, thanks. And, I don't know if this is the right time. I'm very respectful for a lot of the other medical types of advice that are being supplied here. I'm coming in from an adjunct end, where we supply a voice, basically, through interpreter services to those that have LEP patients, so they have less in English professional type of ability to speak in their – you know in English, and it's hard for them. We will supply an interpreter for them, and we work with a variety of clinics and hospitals throughout the state. Anyhow, my question is more in alignment with the rules that have been on the books for many years, not necessarily pricing. But that is an issue. Is this a good time to bring that up, or should I wait?

01:07:02 [Fred] Are we talking pricing of interpreter services?

01:07:06 [Erik] Well, it's not just pricing. It's also some of the language. For whatever reason, in this particular OAR, our state, which seems to be different than how the industry best practices apply through the Oregon health authority and then for whatever reason, I think the disability rules are not in conjunction with the best practices in general, for how the interpreter market space works. In particular, there is some language in the rulings in the past have been coming up frequently with some of the clinics we work with that state that we are supposed to be billing the patient, which is something that we never do. And, also it's been interpreted that perhaps then the clinic would bill the patient, which is not something that they do, either, unless they can go back to the insurance using the proper CPT® code. So, that is part of what I wanted to bring up in terms of, and thank you for inviting us. Of course – we wouldn't – we've talked about this before, and if you recall, probably in the summer, we've had some discourse about this very topic.

01:08:20 [Fred] Okay, I think the issue is probably relevant to a rule 0110. Would that be right, Juery?

01:08:27 [Juerg Kunz] Yeah.

01:08:28 [Fred] And, we're going to open everything up for new agenda items. I think we'll have time today. As, you know, once we make it through the rest of our agenda. Yes, we'd be glad to talk with you about that. And we have, I think, a couple of other folks on with us who wanted to raise some new issues today. So, I'm not sure about the sequence of that, and I apologize that there'll be a little wait, but I think we should probably go through our established agenda first. But yeah, feel free, and one of the points in these meetings is to surface whatever needs to be surfaced. So, I would appreciate that, but anyway, thanks for joining us, and I'm sure we'll have time – I'm pretty sure we'll have time. There're some meaty issues to go through yet. But appreciate your thoughts. So, any additional thoughts on this hospital – out-of-state hospital. Dr. Miller?

01:09:22 [Dr. Miller] Going to open a can of worms real quick. How does the department justify a cost-to-charge ratio of a "1" to the hospitals that are, you know these are subsidized agencies, when small business owners, you know, have to deal with a fee schedule that can be less than 50% of charged amount on many things, and so that seems to be a more relevant issue than to whether or not an out-of-state hospital should get paid within this amount of time or not.

01:09:54 [Fred] Yeah, I'm going to defer to my co-worker. I think we don't have jurisdiction, just to some extent. But go ahead, Juery.

01:10:02 [Juerg] Yeah. Don Gallogly probably could talk more about how we figure out the cost-to-charge ratio for each hospital. We have a hard enough time to get the data from the Oregon hospitals. I can't even imagine how it would be for out of state hospitals for us to calculate a cost-to-charge ratio for every hospital in the United States would be totally impossible. And, like Fred said, we don't really have jurisdiction over those hospitals. We have jurisdiction over insurers that pay for hospitals that are out of state, but we don't have jurisdiction over the hospitals themselves. So, why we have a cost to charge ratio – that basically? I think it's actually a really great system to keep the costs of hospitals in check, basically. And, again, Don would be the better person to discuss how exactly the cost charge ratio is calculated, but it is, somewhat, the more profitable a hospital is, the smaller the cost-to-charge ratio is. And, so, it really helps keep the costs of the hospitals in check.

01:11:47 [Fred] In certain rural hospitals – they get a 1, because they're kind of critical needs and critical access, I think, they call them, hospitals, and it's understood that they may not actually be there unless we can [audio unclear].

01:12:02 [Dr. Miller] So, this charge "1" isn't blanketed to all hospitals.

01:12:08 [Juerg] No.

Issue #6

01:12:09 [Fred] No. Good question. Thanks, doctor. Additional thoughts on the hospital billing issue? Okay, I'm going to scroll down to Issue # 6. We're up to rule 0025 dealing with worker reimbursement. So, the issue is that insurers must reimburse workers for travel, meal, lodging expenses at the rates published in Bulletin 112. However, nothing in rule or bulletin states what the rates are based upon. Prior to July 1, 2010, rule 0025 stated that the maximum rate of reimbursement is limited to the rate of reimbursement for State of Oregon classified employees as published in bulletin 112. The rate of reimbursement for State of Oregon classified employees is published by the Department of Administrative Services, or DAS. DAS bases the rates of reimbursement on privately owned vehicle, mileage, reimbursement rates, and per diem rates published by the U.S. General Services Administration or GSA. WCD noticed that DAS' publication of updated rates of reimbursement for State of Oregon classified employees lagged behind updated rates published by the GSA. Therefore, WCD monitors the GSA's website and updates the rates published in Bulletin 112 according to those rates. Bulletin 112 contains a link to GSA's website for stakeholders to locate lodging and meal rates outside of Oregon, however, the bulletin does not mention that mileage rate and the rates of in-state meal and lodging are also based on the rates published by the GSA. It may be in the public's interest to know that WCD bases the worker's rates of reimbursement for travel, meal, and lodging expenses on those GSA rates.

01:13:52 [Fred] So, options include to state in rule 0025 that the reimbursement rates for mileage, meals, and lodging expenses are based on the rates published by the U.S. General Services Administration, and also to state in Bulletin 112 that the reimbursement rates for mileage, meals, and lodging are based on the rates published by the U.S. General Services Administration. And, so, I'd appreciate your input on that. It's a pretty straightforward issue. Basically, we should, to the extent we can, list the source of the information for things that are requirements under our rules. And this is one where we would actually be supplying that information. So, interested, however, again, if there's something that we're not thinking through, or that, it might have an unforeseen consequence. Go ahead, Matthew.

01:14:39 [Matthew Jacobsen] Yeah, Matthew, Oregon Occupational – not entirely related to the questions of the options here, but on the subject matter. We come up with this somewhat frequently at Oregon Occ Med, that patients don't know that they can submit for this and get reimbursement, and we're not entirely sure if they're supposed to self-submit or how. We do have patients from time to time and it may tie in with the racial equity in Oregon question, too, that they can't afford to get to their appointments, and from time to time we pay for them to get to our clinics, where there'd be like Uber, or something like that. So, when we're paying for them to get to our clinics, can we submit for that reimbursement, number one, and, number two, if it's the patient themselves, how are they supposed to self-submit, or how are they supposed to get reimbursed for this?

01:15:35 [Fred] I'd have to defer to maybe some others in workers' comp, maybe Juery could address that?

01:15:40 [Juerg] Yeah, so, when an insurer accepts a claim, the insurer is supposed to inform the worker that they can ask for mileage reimbursement. One problem is, you know, when an insurer accepts a claim, the worker gets a big stack of material, so it may get lost. It is up to the to the

worker to request it from the insurer. If the worker is unable to get transportation, they can contact the adjuster, and oftentimes the adjuster will work with the worker to pre-pay for transportation, or even organize transportation. But, the burden is somewhat on the worker. I would doubt that if you pay for the transportation that you would get paid by the insurer for that. We certainly don't have anything in rule that would specifically address that. But, basically it is up to the worker. But the insurer, really, generally – we don't have an issue with the worker getting reimbursed for that.

01:17:14 [Matthew Jacobsen] They just have to contact their adjuster.

01:17:17 [Juerg] Yeah.

01:17:19 [Fred] Good question, though. Dr. Miller?

01:17:21 [Dr. Miller] So, you said once the claim is accepted, then the adjuster works with them. But the claim, you know, can be 60 days before it's accepted, and if they came to see me, and I have 60 days to see them, maybe I'm done with them in 40 days. And, they didn't get any of that information or any knowledge of that, or had the discrepancy of not being able to make their appointments, and nobody helping them with that. At that stage, who do they contact?

01:17:51 [Juerg] So, I mean, if you, as a provider, are familiar with the regulations, you know, you can advise the worker, even if they, if at the time they come and see you their claim is not accepted yet, you know, you can inform them that can submit that to the injurer. Once the claim is accepted, the insurer will reimburse them for the mileage expenses. A worker can always call the Ombuds Office. I don't have the phone number right now handy, but that's always a resource for the worker. I don't know how insurers deal with requests for reimbursement from workers before the claim is accepted, or if a work asks for transportation being provided, I do not know how insurers handle that.

01:18:57 [Kevin Barrett] This is Kevin Barrett from SAIF. I can just briefly mention that we work with the workers. But, [audio unclear] insurers may vary. There are rules about the worker reimbursement.

01:19:16 [Matthew Jacobsen] So, not to belabor the point, but that first 60-day period actually is a critical one. So, this is what has led us to paying for the trips generally, as we say. If we've told them they can get reimbursement, and they contact, or not, but they're not an accepted claim yet, they don't feel like they can afford to come, and they don't want to bank on the fact that their claim is going to get accepted and have that bill on them afterwards. So, if there was a – I mean, maybe the – at the end, you're talking about introducing other things. But, maybe that's something we could talk about. Thanks.

01:19:55 [Fred] Thank you, Matthew? And, thank you, Dr. Miller. Additional questions, thoughts about this?

01:20:05 [Jennifer Flood] This is Jennifer. Ombuds for Oregon Workers. I did put our phone number in the chat, and just to make the statement that it is concerning prior to claim acceptance

as to whether or not the worker will get reimbursed for that travel if it's an appointment that they have made. Obviously, if it's an IME, or something that the insurer has set up, even if the claim is denied, the insurer would still need to be paying the reimbursement on that.

01:20:38 [Fred] And just because folks here can't see the chat, it's – Ombuds number is 503-378-3351.

01:20:47 [Jennifer] Oh, thank you Fred. I didn't realize people couldn't see the chat.

01:20:52 [Fred] No, despite my best efforts. It's probably just operator error, or my inexperience, but I can't make the chat appear here. But yeah, again, 503-378-3351. But, thanks Jennifer.

Issue #7

01:21:14 [Fred] Okay, I'm going to scroll along now to Issue # 7. We're up to rule 0060, Oregon Specific Codes and Appendix B. WCD is seeing increasingly and significantly shrinking pool of providers willing to perform arbiter exams. An arbiter exam is an impartial examination or panel examination to assess a worker's permanent impairment, provided the worker has timely requested reconsideration of a notice of closure, requests an arbiter exam, and Appellate Review Unit determines the claim has been closed appropriately. An arbiter exam can be requested by the worker or insurer, though the insurer may only request an arbiter exam when the insurer appeals and they can only challenge the impairment findings. If the worker has requested reconsideration and an arbiter exam, both the worker and the insurer can request a panel exam if the request is submitted within the 14-day window for their records response. Generally, the services of arbiters consist of three distinct services billed with Oregon specific codes. A file review is AR021 through 025; the medical exam is AR001 through 004;, and authoring a report is Oregon Specific Code AR011 through AR013, and AR031 and AR032. ARU determines the billing codes. The records review code is based on file size for the record or file review (many are at AR022 and 023). The exam code is based on the exam complexity (consideration of number of accepted conditions, number of body parts examined, specialties needed, etc.). And, the report code is based on the complexity of the exam, therefore, a higher-level exam results in a higher-level report fee. The following table lists the arbiter codes with descriptors and fees, and you can see them there – I'm not going to actually read all of that, but you can see the existing fees.

01:23:13 [Fred] And, Anita Dekker, MD, a physician who performs arbiter exams on a regular basis, but who is unable – oh, actually, it says unable to attend, but it turned out Dr. Dekker could join us today. She provided the following advice, which is in concert with the feedback the Appellate Review Unit has received from many of our arbiter doctors.

01:23:34 [Fred] So, I'll just read that. I don't mean to speak for you, Dr. Dekker, but I'll read through what you've already given us, for the most part, and then let you say anything additional about your input that you'd like.

01:23:44 [Fred] So, File Reviews: AR 021, the lowest code pays only $66.02. Doing these reviews to prep for the exam so I can get to the core of a patient's issues, and then write up for

the medical review, I almost always spend 30-60 minutes on each. I suggest that this should pay a minimum of $150. The AR022 review, which requires 60 to 90 minutes, should be raised from $165 to $250. The AR023 and AR024 are priced well, in my opinion. | Report fees: These are so low that it barely pays to do them. If you want a thoughtful report, extra time should be allotted. AR011 pays only $66.02 but still takes 30 to 60 minutes. It should be raised to at least $150. AR012 pays only $99.01 and takes at least 60 minutes. It should be raised to $200. AR013 pays $132.77, and takes 90 to 120 minutes. It should be $300 to $400. I found no listing for a very complicated report, which could take 2+ hours, and should pay more in the $600 range. | Exam fees: These numbers are well-priced, overall. AR001 is $384.06, 002 is $511.58 and code 003 is $639.86. They seem fair for the time spent. It seems the most complicated exam, AR005? should pay at least in the $750 to $800 range.

01:25:19 [Fred] So at this point – in a moment I'll go on and just describe a little bit more what the department found, but Dr. Dekker, would you like to speak to this issue in addition to what you provided?

01:25:32 [Anita Dekker MD] I will let my manager speak, who is much better versed at this.

01:25:37 [Jule Wind] Well, I was just thinking that one of the things that wasn't said was, the Workers' Comp Department has more than once tried to get us to recruit people, and we knew people who would be very qualified to do this, and they all said, Nope, it doesn't pay enough, and we're going to do IMEs. And so, we're finding, and Dr. Decker works with two doctors who – one who comes from Russia and one who is somewhere in Portland and somewhere in Sun River, and finding somebody here, and we tried to go down once to Medford, and that was also impossible to find somebody who would be willing to do a panel exam. But, they're also just not so much willing to do the arbiter exams. Especially since, you know, it's sort of a – it's an exam where, you know, the doctors are trying to be as impartial as possible and as fair as possible, and the only cases that come this way are already complicated. They're not simple cases or we would never get them. So, anyhow, that's, I think, what we were hoping for.

01:26:45 [Dr. Dekker] And, the most complicated exam, AR005 – we didn't know if that existed, but sometimes we have very complex medical issues or complex reports. I remember we once had an occupation-related cancer case, and that required many more hours than we could bill for, and for once or twice that is maybe fine. But maybe some consideration for a very complex exam would be helpful, too.

01:27:18 [Jule Wind] And the other thing is for the last raise that I remember – things going up – it went up like 92 cents or something. I may have that wrong, but the actual raise, last year, whenever it happened, was very, very small. I think that's all we have.

01:27:34 [Fred] Well, thank you both. I don't think there is an AA005. I couldn't find one in the table, but thank you for your input.

01:27:44 [Jule Wind] We're proposing it.

01:27:47 [Fred] Okay.

01:27:48 [Jule Wind] In the beginning you asked if there should be more different ones but, for the very complicated reports and the very complicated exams and the very complicated – even the file reviews, it doesn't seem that that's really captured in these you know, in the codes, in the payments that are now currently being used.

01:28:12 [Dr. Dekker] Thank you. Thank you.

01:28:15 [Fred] Okay, again, thank you both. I'm just going to proceed now and read a little bit more about the issue, and then we'll open it up for more comments. But, using the timeframes provided by Dr. Decker, and expressed by many other arbiter doctors, we can calculate the per minute payment for arbitrary file reviews and reports. The per minute payments for codes AR021 and 22 and AR011, 12, and 13 range from $1.10 to $2.72. When comparing per minute payments for arbiter file reviews and reports for office visits, evaluation and management codes 99202 through 99215, we find the per minute payment for office visits is substantially higher at a range of $4.89 to $11.00, and that would be per minute.Payment for arbiter exams varies greatly based on the size of the record and the complexity of the exam and can range from a low of $516.10, and that would be AR001, 11, and 21, to a high of $1,796.56, codes AR003, 13, and 25). Analyzing billing and payment data, the department determined that the average payment for IMEs, which generally also include a records review, an exam, and a report, is $1,319.71. Furthermore, when analyzing arbiter payments, the department found that over 90 percent of the payments to arbiters were below the average payment for IMEs.

01:29:40 [Fred] So, options here, for your consideration, would be to increase the fee schedule amounts for certain arbiter services, in particular file reviews, billed with OSC's, Oregon Specific Codes, AR021 through 23, and arbitrary reports billed with OSC AR011 through 13. Another option would be to create an additional code, such as AR014, for a report that answers standard questions and addresses multiple unique complicating factors. As usual, one of the options is make no change, and then there's an "other" category, so with that, I'd appreciate any and all input from from you folks. Matthew?

01:30:23 [Matthew Jacobsen] I'm willing to comment on that as well. In my experience, I've known a couple doctors that do these. They tend to be semi-retired doctors that have no overhead. If, as a practice, multi-physician practice, you wanted physicians to or that practice engage in it, speaking to this point right here is the per minute rate. We target $600 an hour or $10 a minute for my provider time. And, so I would imagine it would have to be, you know, in that 6 to $10, so I could second her statement there.

01:30:57 [Fred] Thank you. Matthew. Additional input? Okay, hearing no one. Again, if you have additional thoughts please send it to my attention. Just letting you know we have two, I think two more issues on our agenda. And, then we promised to open it up for new issues, additional issues, and we're at a point on our agenda where we have a scheduled 15-minute break. I will defer to the – kind of the wisdom of the group – to see if you'd like to plow ahead or if you could actually use a little break.

01:31:55 [Fred] [Some committee members expressed interest in taking a break.] Well, I think that that was all I needed. Okay, I think it would be, probably in everyone's interest to take – to reconvene at say, you know, 3:17 – something like that. It's 3:03, maybe 3:18 that we're all back together, and then we will complete our two remaining issues on our agenda. I think it's two; maybe there's more than that. But, then we'll open it up for any new issues that you might want to discuss. So, thank you much. I'm going to hit the pause button.

Issue #8

01:33:33 [Fred] We're going to start in with Issue # 8 now, which affects rule 0090, and Bulletin 361, and also Form 4909, and this has to do with the pharmaceutical clinical justification for workers compensation. Currently, it's a required form for certain medications. Since the introduction of Form 4909 and the list of drugs in rule 0090 on April 1, 2011, new generic drugs have come to market and prescribing patterns have changed. Therefore, Form 4909 and rule 0090 may no longer support the intended purpose of reducing the prescribing of high cost drugs. A little background:

01:34:13 [Fred] A stakeholder asked the division to consider updating the Pharmaceutical Clinical Justification Form 4909 and adding current high-cost and frequently abused medications in workers' compensation claims. For instance, ZTLido®, Flector®, Pennsaid®, Duexis®, Vimovo®, various Lidocaine® combinations, and other costly topicals. The division introduced Bulletin 361 and Form 4909 containing seven high cost drugs in 2011. The drugs on Form 4909 and listed in rule 0090 are: Celebrex®, Cymbalta®, Fentora®, Kadian®, Lidoderm®, Lyrica®, and OxyContin®. The purpose is to encourage providers to consider generic substitutes to brand-name drugs. The seven drugs that were chosen were those that had a large volume of total payments and also a high volume of services annually, figuring that this was where the largest impact could be realized. Figure 1 below shows the total payments reported in each year for each of the drugs listed in rule 0090. For each drug, the leftmost column shows total payments for 2011, the years increase moving to the right, and the rightmost column in each group shows 2021 payments. All the listed drugs showed significant declines in payments over the period. There were no payments for Fentora® later than 2012. And, so here we have figure 1. | Figure 2 shows the number of services, or dispenses, for the listed drugs over the period from 2011 to 2021. Although the number of doses per service or dispense can vary, a change in the frequency of dispenses can be in indicator of changes in prescribing patterns. As shown in figure 2, all drugs declined in frequency. | And, then Table 1 shows the rank of the drugs listed in Bulletin 361 among all brand name drugs with payments from WC insurers for prescriptions in that year. In 2011, all the drugs were among those with highest payment volume. In 2021, Oxycontin® was still the number one drug by payments, and Lyrica® and Lidoderm® have mostly held their positions in the ranking despite decreasing in frequency. However, Cymbalta®, Celebrex®, Kadian®, and Fentora® have shown significant declines in payment volume relative to other brand name drugs. In the same period, the total number of brand-name drugs prescribed within the workers' comp system has declined by 18.5 percent. | I apologize. I think I must have been responsible for pushing the table off onto another page, but there you see 2021 is included below there – rank among the brands by total payments. | Table 2 shows the top 20 brand name drugs by total payments in the most recent year for which data are complete. Oxycontin®, Lidoderm® and Lyrica® are all still among them for 2021. Several of the others are low-frequency, high-cost

pharmaceuticals, that are sometimes new to the market or without generic substitutes. Others are prescribed more commonly and have available alternatives. Revlimid® is a cancer drug. Botox® is a neurotoxin. Xarelto® is an anticoagulant. Isentress® is an antiretroviral medication. Horizant is an anti-convulsant of the gabapentinoid class. Eliquis® is an anticoagulant medication. Somatuline Depot® is a medication used in the management of acromegaly and symptoms caused by neuroendocrine tumors. So, there's the chart showing the total payments, number of services, payments per service, by top drugs. OxyContin® still being at the very top. | The Medical Advisory Committee, or MAC, discussed this issue at its Nov. 18, 2022, meeting. The MAC members noted that drug prices do not stay fixed over time due to factors such as generics becoming available. The members also pointed out that there can be huge variations in price based on the prescribed dosage. Overall, the MAC opined that the form was an unnecessary hassle for providers with little benefit and recommends that the form be eliminated.

01:38:31 [Fred] So, options include updating the list of drugs and rule 0090, Form 4909, and Bulletin 361. Or, another option is to eliminate the requirement for providers to complete Form 4909. Then there's an "other" category as usual, and then possibly making no change from where we are currently. So, with that I'd open it up for your comments. Anyone want to speak to this particular issue?

01:39:11 [Adam Fowler] Hi, Fred, this is Adam Fowler from Optum. Can you hear me?

01:39:14 [Fred] Yes I can. Go ahead, Adam.

01:39:16 [Adam] Okay, thanks. I'd raised my hand. But I know sometimes it's hard to see all the screen view and everything with the hands, and if they're on or not.

01:39:23 [Fred] Oh, I apologize.

01:39:35 [Adam] No, that's okay. Thank you. I appreciate it. We were not the – first of all, I'm Adam Fowler, with Optum Workers' Comp and Auto No-Fault. We were not the stakeholder that initially brought the issue to your to your attention in terms of updating it that you mentioned earlier in the agenda, but we did, subsequent to you noticing this meeting, we did submit comments in favor of updating the form, and as part of that, we do have a few recommendations for a few drugs to remove from the form, a few to add, and then a few to keep based upon our data as a larger pharmacy benefit manager in the state. I don't have to go into detail or anything on the call. I don't want to take up any more time than I need to. But we do support keeping the form and – but updating it to be more current with current medication trends.

01:40:22 [Fred] Okay, Thank you very much, Adam. I see. Erik Lawson. You have your hand up, Erik. Did you want to speak to this one? Erik? It's just possible that Erik actually had his hand up from before. Are you still with us, Erik? Okay, I hope you don't mind I'm going to go ahead and lower your hand. But does anyone else have thoughts about this issue? We welcome your help while we have the opportunity. Okay, hearing nothing right now, I'm going to go ahead and scroll down.

Issue # 9

01:41:08 [Fred] This is Issue # 9, affecting – we're in a new division of rules. It's the division 010, Medical Services, rule 0240, affecting medical records and reporting requirements for medical providers, and the issues are that attending physicians are encouraged to discuss potential modified work duties with employers. But, it has come to the division's attention that some medical providers contact employers to discuss not only work activities, but also a patient's diagnoses and treatments. Some background:

01:41:38 [Fred] The attending physician has primary responsibility to determine whether a patient is able to continue regular employment or whether there are any limits on the patient's ability to perform work activities. If the attending physician determines that a patient is unable to continue regular work duties, the division encourages the attending physician to contact the employer or insurer and discuss potential modified work duties the patient is able to perform. The Health Insurance Portability and Accountability Act, HIPAA, permits covered entities, such as health care providers, to disclose protected health information to workers' compensation insurers, state administrators, employers, and other persons or entities involved in workers' compensation systems. However, disclosure of protected health information is subject to the minimum necessary standard. The minimum necessary standard generally requires covered entities to make reasonable efforts to limit uses and disclosures of, as well as requests for, protected health information to the minimum necessary to accomplish the intended purpose. The intended purpose of communication between a provider and an employer is to find appropriate work site accommodations for injured workers who are unable to perform their regular work duties due to their injury. The intended purpose of communication between a provider and an employer is not to manage the medical care a worker receives. Therefore, providers should not discuss diagnoses or treatments with employers.

01:43:02 [Fred] So, an option, for your consideration, would be to create a new subsection (g) of rule 0240, section (4) clarifying that a provider is allowed to discuss medical treatments or diagnoses with insurers or claims administrators and to discuss potential modified work duties with employers, but that providers are not allowed to discuss medical treatments or diagnoses with employers. And, as usual, one of the options is to make no change, or "other." So, I'd appreciate your input on that option, or those options.

01:43:38 [Dr. Kovacevic] Hello, Fred, this is Dr. Luci Kovacevic, and I'd like to make a statement regarding – from a provider standpoint, if there's a change made, it could complicate us following HIPAA, because in HIPAA we can discuss medical aspects, diagnoses, but only to the extent that it affects their ability to work and how that would affect somebody's ability to or need to comply for medical treatments. So, my concern would be maybe new legislation would hamper our ability to be HIPAA compliant. Well, it would be more restrictive than HIPAA, but we wouldn't be able to let the employer know meaningful return-to-work topics, potentially. Thank you.

01:44:27 [Fred] Okay, thank you, doctor. Jovanna Patrick, I see you have your hand up.

01:44:33 [Jovanna Patrick] Yes, thank you, Jovanna Patrick, worker attorney, and also here for OTLA. Keith had to jump off, but he did have – we did have some comments on this. We like

the first option, because we have some serious concerns about employers getting health information. We've had – at least I've had several instances where the employer confronts the worker about findings in their medical records, like, hey, I saw your MRI, and it shows this – you should be able to work, you know, kind of delving into the medical evidence. I've also had workers complain that coworkers have come up to them, not supervisors, not management, and talk to them about their medical details, showing that the supervisor, the managers are sharing that information with coworkers. So, we just don't believe it's appropriate for employers to get that detailed information, because they don't seem to be protecting it properly. Thank you.

01:45:35 [Fred] Thank you, Jovanna. Additional thoughts? Jennifer Flood.

01:45:45 [Jennifer Flood] Yeah Jennifer Flood, I just want to ditto Jovanna's statements. In the Ombuds Office, just even recently, we've had workers concerned because their frontline manager has received their medication lists and all of that. And, we stress that it is important for an employer to know what limitations they may have in performing light duty. But, that is the only extent that the employer should be getting that information, and I believe, even for a self-insured employer, only their – the person that is administrating their claim should be getting all of the detailed information, and the employers should only be having conversations regarding what are their restrictions in their abilities of returning to light duty?

01:46:45 [Fred] Thank you, Jennifer. Matthew?

01:46:48 [Matthew Jacobsen] Yeah, I just want to comment that, I mean, I understand what everybody's saying here. I think that this subject is much more nuanced than this simple kind of statement. One of the things that happens where employers get information of the employees, oftentimes, the employee brings a safety person with them into the clinic, into the room with them. That employee allows that person into the room with them. Therefore, the assumption could be made that at least they're welcoming that release of HIPAA information. If that safety worker goes to work and tells other employees, that's on that company, not on that doctor having disclosed that information. I'm sure there's other ways that that information gets disseminated, and I'm sure there's times where it happens incorrectly, but I just wanted to add that that is where we've seen it happen, is that an employee has come in with somebody that works with them – their safety coordinator, their manager, something like that, and that information is given in that meeting at that time with the employee present.

Issue # 10

01:48:01 [Fred] Thank you, Matthew. Additional thoughts, input regarding this issue? Well, thank you very much. Again, I'm going to scroll down, and see what we have – an Issue # 10, which is – it affects Rule 0270, and the insurers rights and duties. Current rules do not expressly state that insurers may delegate administrative functions to the managed care organization, or MCO, and this has on occasion created confusion over the validity of a specific enrollment notice. This issue was raised by Majoris MCO, and Majoris provided the following background information. And again, I apologize, Ann and Lisa. I'm not meaning to speak for you. But this is just from the written information we received, and then I'll open it up for your additional input in just a moment, but:

01:49:06 [Fred] Per ORS 656.245(4)(a), a worker becomes subject to a managed care organization, or MCO, contract upon the worker's receipt of actual notice of the worker's enrollment in the MCO, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. Historically, this responsibility has at times been delegated to the MCO through the contract held between the MCO and insurer or self-insured employer, similar to how other administrative functions are delegated to a Third Party Administrator or TPA. This practice has been known and approved by the Department as an administrative matter for over thirty years. WCD audited Majoris' files for accuracy and timeliness early on when Majoris began issuing enrollment notices, and again when certain rule changes updated the required language in the notice. The statute does not bar insurers or self-insured employers from delegating the responsibility for giving notice to the MCO that has been engaged to manage the worker's care, and there is no basis to establish the obligation as a non-delegable duty. However, current rules do not expressly state that administrative functions may be delegated to the MCO and this has on occasion created confusion over the validity of a specific enrollment notice. OAR division 010, 0270, section (4) should be updated to include a statement that the insurer or self-insured employer's requirement to send an enrollment notice may be delegated to the contracted managed care organization. The MCO is well positioned to issue these notices, with familiarity on the requirements related to applicable timelines, come-along rules and network provider status. This drives consistency and accuracy for the enrollments issued, ensuring the worker is well-informed as it relates to their enrollment into the MCO. Updating the rule reinforces the validity of a practice that has been utilized without issue for decades and supports clarity and consistency in the process.

01:51:03 [Fred] So, with that, before we go into the options again, Ann Klein or Lisa Johnson, do you have additional thoughts that you'd like to share with the committee?

01:51:15 [Ann Klein] Good afternoon, and thank you for speaking so wonderfully on my behalf, reading that rather lengthy little piece there. That really does cover Majoris's sort of stance on it. To us, we do view it as an administrative matter, that occasionally it just creates a hiccup, and then we go through the clarification process that that the duty has been delegated through the contract. And, there's not a lot of additional information we provide, but we'd be happy to field questions if there's any stakeholder that has concerns or questions about what this proposal would do, but again, I think, the only piece I would also clarify is the intent is not to set it so that it is always delegated to the MCO, but rather just clarifying that it is an appropriate option, should the insurer and MCO choose to do that contractually. But, certainly the insurer can retain the responsibility if they so wish.

01:52:12 [Fred] Okay, thank you, Ann. So, then the options we've presented for your consideration is clarify by rule that the insurer's or self-insured employer's requirement to send an enrollment notice may be delegated to the contracted managed care organization. If the contract between the insurer or self-insured employer and MCO provides for such a delegation. As usual, one of the options is make no change or "other." So, with that I'd open it up for general comments. Go ahead James.

01:52:42 [James Washburn] James Washburn from the Kaiser MCO. I just wanted to say, currently Kaiser does not issue enrollment letters, because they are done through the insurer or self-insurer. But, we have no objection to this rule change.

01:53:01 [Fred] Thank you, James. Additional input?

01:53:08 [David Pyle] David Pyle from CareMark Comp, and I would concur with that. We do not issue enrollment letters, but we have no objection to any change in language that would allow that delegation process.

01:53:23 [Fred] Thank you, Dave. Additional thoughts? Any concerns about that option?

01:53:36 [Jeanette Decker] This is Jeanette with Providence MCO. We don't see any objection to that, either. I think that might make it clear and prevent hiccups in the future.

01:53:52 [Fred] Thanks. Thank you very much, Jeanette. Okay. Any additional comments? Well, thank you very much for your input. I'm going to go ahead and scroll on down and see what we have left. Was that the last? That was the last one. Okay, we have a housekeeping item here, and then I'll open it up for any additional items you might have for us.

Housekeeping item:

01:54:25 [Fred] Bulletin 247 states that this bulletin describes the format for certified MCOs to submit quarterly reports to the Department of Consumer and Business Services, or DCBS, under rule 0040, section (4), and that rule states within 45 days of the end of each calendar quarter, each MCO must provide the following information to the director, current on the last day of the quarter, as prescribed by Bulletin 247. The phrase "as prescribed by Bulletin 247" is not correct, as the rule prescribes what elements the MCO has to submit to DCBS; the bulletin merely describes the format in which the information should be submitted. So, the proposal is to replace the words "prescribed by" with "described in" Bulletin 247. And, I'll just add that bulletins are really not able to prescribe anything, because they don't go through the rulemaking process. But, if you have any concerns, just let us know.

New issue #1

01:55:30 [Fred] And, with that we're open for discussion of anything new, anything that we didn't already have on our agenda. I'm going to check back in to see – Jovanna, I think Keith wanted to raise an issue today. I don't know if you would like to raise an issue at this time or not,

01:55:51 [Jovanna Patrick] Yes, thank you. I do know what issue that was. Let me just locate it in my emails. Then, I should be able to present that. Oh, thank you. So, one of the things that we've noticed is that there's room for improvement in our rules when an MCO approves medical treatment and specifically surgery, and, however, there is not a timeline for the insurance company to then approve it as related. You know, at least, it's my understanding the MCO approves reasonable and necessary and the insurer approves relatedness to the accepted condition or the compensable injury, but there's no timeline for them to do that. When there's not an MCO,

of course there are strict surgical timelines, and I know this – but we did a study years ago about the time for MCO's to approve, especially surgeries or other things. But, that secondary piece of the insurer timely approving the surgery or notifying the worker as to why it's not approved. What I see happen a lot is that the surgery is requested for a condition that's not accepted, and the MCO approves it, and then, crickets. We don't hear anything from the insurance company, and often that's when claimants contact me, because they don't know what's going on with their claim. So, we were hoping to bring that issue forward and discuss what could be done to discover what the timelines are currently for approval, and whether there should be some sort of rule that mandates specific timelines for the insurer.

01:57:38 Thank you, Jovanna, and I apologize for kind of putting you on the spot there. I didn't really think it through, because I knew Keith wanted to talk about something, but then I knew he couldn't join us today. So, thank you very much. Appreciate the input from others here, whether it's from managed care organizations, others, in terms of the ramifications of the options for addressing the matter, anything you'd like to provide would be welcome.

01:58:08 [Fred] Erik Lawson, you have your hand up again.

01:58:12 [Erik Lawson] Yeah, is this a better time to bring up what I was going to bring up?

01:58:16 [Fred] Oh, well we're going to get to that in just a moment. Right now, we're talking about a new agenda item that was just raised by the Oregon Trial Lawyers Association and then we'll address yours next.

01:58:31 [Erik] Okay. I'll put myself back on mute then.

01:58:35 [Fred] Okay, Thanks. Erik. So, again, do you have any – oh, Elaine Schooler? Go ahead.

01:58:43 [Elaine Schooler] Yes, Hi. Thank you, Fred. For the record, Elaine Schooler, SAIF Corporation. I know this is an issue we've discussed in the past. I think it's been a couple of years. As this is a new issue, it's not one that we have discussed internally to provide a position. I know when this was brought up several years ago, some of the pieces that play a role in the insurer's review of surgical requests – it can involve scheduling an IME, and that can take time for that examination and the report to be completed and then provided to the insurer. We're happy to look at this issue again and revisit it, to see, you know, how the system is working and what we see on our end, and then, potentially come back with a more complete response. We're always happy to take a look at these things to make sure access to care is happening and it's appropriate. Thank you.

01:59:57 [Fred] Thank you, Elaine. Additional thoughts?

02:00:03 [Jennifer Flood] This is Jennifer flood, Ombuds for Oregon Workers, and just because I might not have an opportunity to say this down the road. Regarding this issue with MCOs approving of the appropriateness of a surgery, I just ask folks to be mindful as we, as you look at this policy issue, the requirements for non-MCO situations for elective surgery – they don't – my

understanding is it doesn't apply when there's an MCO involved, and it can just leave a worker out there hanging for quite a while, like Jovanna mentioned. Okay, well if the insurer doesn't believe that it's compensably related, making sure that that is communicated back to the worker within a timeframe, so it can be addressed appropriately and timely so the surgery process can move forward.

02:01:04 [Fred] Thank you, Jennifer. Additional thoughts? And again, with new agenda items, I recognize, that as Elaine was explaining, that sometimes people haven't had a chance to kind of field the information within their organization and develop a response or the options or things that they think might be a solution. And, so I would encourage anyone to do that, to actually discuss it, you know, with co-workers, your organization and see if you have, you know, if you have ideas, please pass them along to me. Again, I'll distribute them here, so that, you know, we can look further into the matter. But appreciate any and all input. But, before I move on, any additional thoughts about this elective surgery kind of issue? Okay, hearing nothing now, I'm going to ask Erik, if you're still with us – I think you are – and, go ahead. And, if you could describe the issue to us, and we'll go ahead and open it up for input.

New issue #2 (see also 02:09:11 through 02:10:08)

02:02:29 [Erik Lawson] Okay, great, yeah, thanks. Appreciate your patience with me today as far as bringing in this stuff in at the right time. In some of the discussions that we've had in the past there has been some lack of clarity in terms of how interpreter services itself is fitting into the law, and I'll bring up a couple of specific cases: one, there's some wording in there that gives little latitude in terms of how money is collected and how it works traditionally in the business world are two very different things. And, I'll kind of explain – the wording, it was previously in law, had stated that it was okay to bill the client, which in this case would be a patient. And, in no case do we ever bill directly to any patient. We work with clinics, who then defer back to either reimbursement through private insurance, through the CCO model for Medicaid patients, or through disability – in this case is what we're speaking towards. I've had groups literally tell me, oh no, even though we're contracted with you, you're supposed to go bill the patient yourself. Well, we don't do that, so there is lack of clarity there. In addition to that, even for the place where they were being seen to bill them back for an interpreter service is little bit funky, too, because they would have a proper code to bill to any insurance group for that service, which is basically, under ADA civil rights, a right for them to have that separate language access for equity purposes. So, I just wanted to present that one idea. Maybe leave that up for comment for a minute. There's a couple of other things I did want to address, too, but that's kind of a heavy one for us. I thought I'd maybe defer back to you and take comments off the air for a minute, while you, if you wanted to discuss that.

02:04:31 [Fred] Certainly, we're happy to discuss. Now, was the issue patient billing? Because, under the workers compensation system you are correct – you wouldn't bill the patient, not on an accepted claim, it would be billed to the insurance company. Is this something that you're being advised to do, and are you concerned that our rule may not be clear enough about patient billing?

02:04:58 [Erik] That's right, yeah, because not in all – in some cases, not all, there are people being seen that may or may not have an insurance company to bill it back against. So, we've had

some situations where we've gone directly to certain groups who have a contract with us. They've signed it; it's in writing; they still come back and say, well, we're not paying your bill, because the law states that you're supposed to go bill the patient directly, and they still to this day won't pay those bills. And, you know, we're sitting you know – I'm not going to give you the amount of money, but it's quite substantial. The worst that we've had to eat because of this very rule that's being loosely interpreted in that manner. That's part of the conversation that I had with you earlier in the summertime, directly about that, and then there was another case where even where they would be billing back to the patient directly, and if they didn't get reimbursed, they weren't going to pay us. It's that same mentality. It's like well, we're not really part of that cycle or that process. We work – need to be directly with either a clinic who's getting reimbursed on their own, or we, if they, that patient is verified as having a disability type insurance, and that we're contracted with, then we would bill that back to them. And, that's sort of where the law needs to be altered to the extent that it has better language in it, that there is no loophole for someone to just not have to pay.

02:06:33 [Fred] Yeah, I don't know if they're referring to a law that would have you bill the patient. It's not our law. But it could be laws on, you know, relevant to other agencies, etc. I can't speak to those, but I do know that if there's someone who's not paying you for one of the services provided under our rules, we resolve disputes routinely, and you could submit a request for resolution to the workers' compensation division. Then we'll look into, you know, the nonpayment issue, and certainly that.

02:07:07 [Erik] That would be helpful, but there is specificity in the law itself, because I think you and I even went back and forth and through email and discussed this, where it said something about them billing to the patient, and you clearly stated no, you wouldn't as an interpreter agency bill the patient, but the clinic could, and I think that's where the language needs to be tightened up a little bit. And it – trust me, it's in there somewhere. I'm not exactly sure where; I'd have to go back and find it, and we could talk about it offline. I can point you back to it, and unless Rachel and Halsey are also here with me. I'm not sure if you guys have access to mics, or if you can allow them to quote exactly where it is in the OAR. If neither of you are there to comment, I can just go back later and show you. But, that was one of the bigger points I wanted to bring up.

New issue #3

02:08:10 [Erik Lawson] In terms of matching the market space for the health arena that we operate, there is a minor problem with the ASL, American sign language. They operate at a two-minimum, and I believe that in the law it does not allow for that. They have it set as one hour. That does need to be changed to two to match what the national standard is.

02:08:34 [Fred] Yeah, I do recall that issue, Eric, and I would welcome input. I know we may not have, like, very many interpreters on with us today, just because we didn't have a relevant issue on the agenda. But there are certainly payers with us, and maybe someone can speak to that in terms of whether they've received billings that reflect that two-hour minimum for ASL, and how they deal with it, and whether it's a problem in the industry. Any comments?

02:09:11 [Rachel Gibson, Passport to Languages] Hi, this is Rachel, with Passport to Languages. I'd just like to say that I did find a little clip from the OAR 0110, and I pasted it in the chat room.

Chat message:

OAR 436-009-0110
Thank you for speaking with me. The rule I mentioned is located in the Oregon Administrative Rules (OAR) 436-009-0110. In paragraph (2)(a) Interpreters must charge the usual fee they charge to the general public for the same service. (Emphasis added)
(a) Interpreters must charge the usual fee they charge to the general public for the same service.
(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the patient.

02:09:25 [Erik] Do you want to just tell us what it is?

02:09:30 [Rachel] It goes, okay, so, section (b): Interpreters may only bill an insurer or, if thee provider by contract a managed care organization. However, if the insurer denies the claim, interpreters may bill the patient.

02:09:51 [Erik] Yeah, that's what it was. It's basically saying the interpreter should bill a patient. Thank you, Rachel, for finding that.

02:10:06 [Rachel] Yes, you're welcome.

02:10:08 [Fred] Yes, thank you. Well, thank you very much. We'll look at the wording.

02:10:19 [Erik] Okay, Yeah, that's our ask on that, and then I suppose the other comments you were looking for. I'll wait to see, because I know you were asking other groups that are here if that complies with what they want. But again, this is a national standard. So, I would ask that you put in, if possible, as part of how language access would work.

02:10:49 [Fred] Okay, thank you very much, Eric. We'll certainly look at it and see. With that, I I'd like to just check to see if anybody else has any new agenda items for us while we have the opportunity. We do these meetings approximately once a year. Sometimes we have several, but it is kind of an annual process. So, there's a window of opportunity and like to take advantage of it when we can. Did anyone else have any new issues they'd like to discuss today?

New issue #4

02:11:23 [Connie Whelchel] Fred. This is Connie Whelchel.

02:11:25 [Fred] Connie, go ahead.

02:11:27 [Connie] Alright, thank you. I wanted to address Earlier we talked about – it was the second to the last agenda item in division 010. It was 0240, section (4), release of medical records, and the section after that is section (5), released to return to work, and under that section you have two – you have little (a) and little (b), and it talks about when requested by the insurer the attending physician or authorized nurse practitioner must submit verification of the patient's

medical limitations related to their ability to work resulting from an occupational injury or disease. And, then it goes on to – the attending physician must advise the patient – within 5 days provide the insurer written notice. I bring this up, because I'm not aware of anywhere in the rules, and someone could educate me, that would be great, for the employer, so we have a lot of instances where the employer needs to know promptly what the work restrictions are from the medical provider. So, the insurer does need to know also for time loss purposes, but ultimately it's the employers who provide and create modified duty for the workers, and I don't see any type of rule or timeline provided in the rules for the medical providers to respond to employers for return-to-work inquiries.

02:12:55 [Fred] Off the top of my head. I'm not sure either. There's some general 14-day requirements for, in some cases, providing records, but I don't know if that would apply to the employer.

02:13:07 [Connie] Okay, yeah, and that's kind of what I found as well, and so I just wanted to propose some type of – because again – there's a lot of angst and frustration among employers, especially the more sophisticated ones who are very proactive with return to work, and a lot of times they have modified duly available for their workers, but they're on hold, and they can't offer the modified work until they hear from the medical providers. Now. there's many medical providers do a great job of providing that information about return to work and restrictions to the employers, especially when employers ask. But, there are many times when employers – they may send a modify job description with their workers to the appointment, or the employers themselves may contact the doctor's office, or even on the 827 form, where there's a place for the employer's contact info, and with the 827, the medical providers are required to submit that within 72 hours, but when it comes to just regular work restrictions, there's nothing that says anything in the rules that I know of, that they need to notify the employer as well. And, so, I just want to bring that forward, because again, we have employers that are able to offer modified work. But, then they can't because they're waiting on a doctor's response, or work restrictions from a doctor, and even if they get sent to the insurer, which is great, there's a lag time there because we have employers that say I have modified work. I could put them on right now or tomorrow. The worker just saw the doctor but we haven't heard back from the doctor, and then all of a sudden the claim after three days went disabling, so I'd like to propose something, some kind of timeline or something, where the medical providers do need to respond to employers and or provide work restrictions to employers within a certain timeframe.

02:14:52 [Fred] Okay, well thank you very much, Connie. Yes, there's a gap. We'll look at it and see what kind of – we always have to look at the kind of authority that we have under our rules. But, obviously that's a need, a real need, so thank you.

New issue #5

02:15:09 [Connie] Yes, thank you. And, may I have one more item to bring up Fred?

02:15:14 [Fred] Yes you may.

02:15:17 [Connie] Thank you. And this is – this has to do with division 060. Am I okay to bring up a rule in division 060, Fred?

02:15:25 [Fred] Well, you can, however, there's probably not – we probably don't have the right mix of people here to address it here, since the focus of these meetings is all about medical. I think probably a better approach would be for me to send you – we have what we call a rulemaking issue request form, and I could send you one. You could send it to us, and then, it doesn't have to be too formal. But, you can just give us a little bit of background and why the issue is important. And, I mean I don't – we're certainly willing to hear it. I just don't think that there probably will be necessarily the organizations or people here to address it. But, why don't you just tell us what it is, just in in general, and then and we'll have it. And, then I'll send you a form, so you can you can actually submit it to us and we'll make sure to address it, whether that's through rule or some other way, and then and we'll get back to you.

02:16:21 [Connie] Okay, also, no problem at all. Just, I guess to bring awareness to it then. In division 060, section 0030, this has to do with kind of the BJO, the bona fide job offer, requirements and some of the legal language, and what's required for a bona fide job offer, and there's a certain part there under section (3), and little (i), where it talks about where the offer of the job site needs to be within 50 miles, and all of that, and if you go down to the (3) little (i), it says the offer is not at a work site, so if the offer is not at a work site of the employer injury, the worker can decline the bona fide job offer. And, the reason I bring that up – not at a worksite - because in Colorado at the work comp – Pinnacle over there – they're doing a really great program with modified work, where the employers are able to partner with nonprofits in the local community in the local area of the employer and injured worker, and in some cases the employer is offering modified duty through a local nonprofit, and it's a win-win-win all around. I'm looking at this article right now. So, typically to find modified duty work options, to compare workers with nonprofits, the workers can do a variety of tasks at local nonprofits, such as desk work, sorting, hanging donated clothes, assembling food boxes, stocking food, light cleaning, organizing. So, I just wanted to bring this up, because it's been a fantastic program on Pinnacle. And, the reason we can't do anything like that right now in Oregon is because of this little rule here that talks about how the offer's not at a work site the employer at injury, in which the worker can decline, which I think is unfortunate, because besides a win for the injured worker getting back to work, besides a win for the employer being able to offer modify work, it's also a win for the local community. So, I just want to bring that forward, if there was some way we could take a look at that piece of the rule to see if there's any way we can modify it, so we could try to partner with some local nonprofits for injured workers.

02:18:43 [Fred] Okay, thank you very much, Connie. I think I understand the issue, and I think that one – that's a pretty meaty issue. It would require quite a bit of discussion, I think, with a you know, a committee such as this one, but it would be focused on probably a different division of the rules. An important matter, of course. But appreciate it. And again, I will send you a copy of our form, and we can maybe get a little bit more documentation, and then we'll – we typically either log them for handling when we next have an opportunity, or sometimes, again, they can be addressed in some other way. Sometimes there's a statutory limitation to what we can do by rule, and that's usually that, unless there's a legislative concept that's presented, but appreciate it very much yes.

02:19:31 [Connie] Thank you for letting me share today, Fred. Thank you very much.

02:19:36 [Fred] Any additional agenda items while we have the opportunity? Okay, hearing nothing right now, we typically kind of provide a window of opportunity for anyone who has additional thoughts about agenda items. So, I would encourage you to send anything that you may have, additional thoughts about the agenda items we had today, or anything else. If you could send it our way by, you know, like maybe in in the next two weeks, would that still be timely enough for our [audio unclear]. So, if you can get back with us within two weeks from today, so the second Wednesday out, that would be great and help us to stay timely with the process that we're working on now?

02:20:30 [Fred] But, you've been an excellent group. Thank you very much for working with us. Some of the technology is still a little bit new to me, and so I apologize if you ever had your hand up and I didn't call on you. I just didn't have the right windows that were displaying for me. But finally, towards the end of the meeting, I got the hang of it. But that was a little late for some folks, so I apologize. But, again, thank you very much. If you are on the connection and maybe I've not been in touch with you. So, you've been – maybe the meeting was forwarded by a co-worker, or something like that – feel free to stay with us, and just let me know after the meeting closes what your contact information is, so I can keep you posted going forward, you know, with minutes, proposed rules, when those are ready, that kind of thing. But anyway, thanks again. Stay in touch, and goodbye to everyone.