Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
Minutes
Rulemaking Advisory Committee Meeting
November 5, 2024, 9 a.m.

Location of meeting: 350 Winter St. NE, Salem, OR; Virtual Teams meeting

Stakeholders attending:

Stakeholders:	
Kevin Anderson	SBH Legal
Antoinette Awuakye	Cambia Health Solutions
Amanda Barlow	Cascade Health
Jenny Bates	SAIF Corporation
Misty Bergenstock	Endeavor Psychiatry
Karen Betka	Farmers' Insurance
Kaylee Bond	CorVel Corporation
Michelle Bremer	Cascade Health
Travis Brooke	Cascade Health
Beth Buckley	Oregon Occupational Medicine
Joy Chand	Takacs Clinic
Natalie Craig	Caregiver Health
Michelle Cross	Multnomah County
Jeanette Decker	Providence MCO
Melanie DeLeon	Interpreting & Transcribing Services
Danielle Ditillio	Enlyte
Jackie Fabrick	Providence
Brad Fauler	CorVel Corporation
Adam Fowler	Evernorth
Constantine Gean	Liberty Mutual
Greg Gilbert	Concentra
Gabrielle Haxby	Cascade Health
Dee Heinz	SAIF Corporation
Elisa Heras	Kroger Risk Management
Isabel Hernandez	Health e Systems
Lon Holston	Medical Advisory Committee
Matthew Jacobsen	Oregon Occupational Medicine
Lisa Johnson	Majoris Health Systems
Heidi Kaiser	Integrity Medical Evaluations
Dustin Karstetter	CIS
Ann Klein	Majoris Health Systems

Krissi Knight	Samaritan Medical Group
Cozetta Knutson	SAIF Corporation
Krista Lenig	PMA Companies
Leann Lewis	ManageWare
Delmi Manzanares	Providence
Ryan McClelland	Washington County
Gayla McClamma	City of Portland
Amber McMurry	AIC
Joshua McNeal	CorVel Corporation
Dan Miller	Oregon Chiropractic Association
Lore Mulders	Coventry
Monica Nassar	Reinsch Wilson
Erin Nielson	City of Portland
Sheri North	Enlyte
Bryan Null	SAIF Corporation
Jovanna Patrick	Hollander, Lebenbaum & Patrick
Lorie Ragsdale	Employers
Jocelyn Rees	Compiq
Monica Rice	Optum
Dr. Joseph Schenck	Occupational Orthopedics
Elaine Schooler	SAIF Corporation
Keith Semple	OTLA
Serena Sison	Concentra
Jim Smith	Select Medical
Malinn Stanton	NW Service Enterprises
Dr. Joan Takacs	Takacs Clinic
DeAnna Tapia	Professional Interpreters Inc.
Bill Timinsky	BET Business Solutions
Ivo Trummer	SAIF Corporation
Anna Wagner	SAIF Corporation
Amanda Waibel	Reinisch Wilson
Jenny Walsh	Providence
James Washburn	Kaiser Permanente
Gina Wescott	SDAO
Connie Whelchel	KPD Insurance
Hasina Wittenberg	Government Relations Strategies

State of Oregon staff members attending:

Matt West
Shawn Haywood
Rob Andersen
Barb Anderson
Stan Fields

Tasha Fisher
Marie Rogers
Juerg Kunz
Val Mueller
Kirsten Schrock
Jennifer Gilbert
Anne Friend
Julie Stratton
Maria Venegas
Troy Painter

Minutes: Marie Rogers welcomed the committee members, asked the members to provide advice about any fiscal impacts of possible rule changes, and also to advise about effects on racial equity in Oregon. Marie called a roll of attendees, including stakeholders and State of Oregon employees.

NOTE: Additional summary minutes are included below each issue.

Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2025)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2025. However, the Workers' Compensation (WCD) does not publish its permanent fee schedule updates until April 1, 2025 (projected effective date). This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if providers use new codes from January 1 through March 31, 2025.

Background:

- In order to allow time for public input, WCD publishes a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), effective April 1 of each year.
- Adopting the new CPT® and HCPCS codes, effective January 1, 2025, would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid, new codes.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD can update appendices B – E, effective Jan. 1, 2025, and assign maximum payment amounts using the 2024 conversion factors/multipliers. One should bear in mind that due to time and staffing restraints, it may not be possible to update all appendices.
- Various organizations will publish updates to standards that WCD adopts in OAR 436-009-0004.
- WCD began issuing temporary rules in January 2016 to allow providers to bill insurers using new codes for dates of service from January 1 through March 31 of each year.
- As in years past, the temporary rules would not delete any codes from any appendix and providers may continue to use all codes valid in 2024.

Options:

- Adopt new CPT® codes and standards (OAR 436-009-0004) through a temporary rule, effective January 1, 2025.
- Update appendices B – E with payment amounts for new codes using the 2024 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- No discussion.

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Permanent rules, effective April 1, 2025)

Issues:

- ORS 656.248(7) requires that WCD update the fee schedules annually.
- The references listed in OAR 436-009-0004 and the fee schedules published in appendices B – E will be outdated when the permanent rules become effective on April 1, 2025.

Background:

- The above listed appendices are based on conversion factors and multipliers developed by DCBS, and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare & Medicaid Services (CMS).
- Every year, there are some CPT® and HCPCS codes that are deleted and some new codes are introduced. Adopting new billing codes and updating Appendices B – E allows us to stay current with valid CPT® and HCPCS codes.
- Every year, DCBS develops updated conversion factors and multipliers taking into account stakeholder input, utilization of medical services, and the new values and fee schedule amounts developed by CMS.
- Various organizations publish updates to standards that WCD adopted in OAR 436-009-0004.

Options:

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

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- No discussion.

Issue # 3 (2104)

Rule: OAR 436-009-0010(12)(i)

Issue: On October 18, 2024, WCD's Medical Advisory Committee recommended that Platelet Rich Plasma (PRP) injections should become a compensable medical service for certain anatomic areas/conditions.

Background:

- PRP has been an excluded treatment since April 1, 2016.
- Based on a thorough review of more recent studies, the committee recommends that PRP should be a compensable medical service for the treatment of:
    - Knee: Osteoarthritis pain, chondral surface injury and non-operative partial thickness meniscal tears after failure of 3 months of conservative care, which may include a standard course of physical therapy.
    - Elbow: Lateral and medial epicondylitis after 3 months of conservative care, which may include a standard course of physical therapy, proves unsuccessful.
    - Shoulder: Tendon, bursa, and muscle injuries, including non-operative partial tears and small tears, and adhesive capsulitis after failure of 3 months of conservative care, which may include a standard course of physical therapy.

Options:

- Amend OAR 436-009-0010(12) as follows:
  The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:
  ***
  (i) Platelet rich plasma (PRP) injections~~.~~**, unless they are for:**

  (A) Knee: Osteoarthritis pain, chondral surface injury and non-operative partial thickness meniscal tears after failure of 3 months of conservative care, which may include a standard course of physical therapy;
  (B) Elbow: Lateral and medial epicondylitis after 3 months of conservative care, which may include a standard course of physical therapy, proves unsuccessful; or
  (C) Shoulder: Tendon, bursa, and muscle injuries, including non-operative partial tears and small tears, and adhesive capsulitis after failure of 3 months of conservative care, which may include a standard course of physical therapy.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Lisa Johnson (Majoris Health Systems) noted that she would like to see language that would qualify the appropriateness of the treatment for the particular injury. For example, she suggests language that would eliminate this treatment as an option if someone had a chronic issue, such as a chronic liver disease. She noted that "unless they are for," as written, could be too all-encompassing.
- Juerg Kunz responded to Lisa by noting that compensability does not address appropriateness. The appropriateness is always required in order for treatment to be compensable. He noted that the rules don't list all compensable treatments. Here, the compensability is noted because there are limitations regarding the specific body part subject to the injury. Treatment for a hip injury, for example, would be excluded. So, Juerg does not believe such qualifying is required, but will take Lisa's suggestion under consideration.
- Jovanna Patrick noted that she was happy to see that these treatments could become compensable. She asked why the new language limited compensability to the knee, shoulder, and elbow. She noted that she has a client (injured worker) who would benefit from this treatment, but he had an impacted ankle; therefore, he would remain ineligible for such treatment.
- Juerg Kunz noted that, at present, there is not enough data or evidence to demonstrate these treatments are effective for other parts of the body. It was the conclusion of the Medical Advisory Committee, therefore, to limit compensability to the shoulder, elbow and knee.
- Jovanna added that the limitations are problematic and suggested additional "catch all" language in which the treatments would be compensable if determined "medically necessary." She suggested the division or a judge could determine compensability if such catch all language were added. She suggested another option be added that would include worker injuries falling outside of the knee, shoulder and elbow.
- Elaine Schooler asked about the specific conditions to be addressed by these treatments. She noted, for example, that "partial meniscus tears" was specific, but "osteoarthritis pain" required more clarification. She wants to make sure conditions are stated with specificity. She noted that SAIF prefers medical conditions rather than general descriptors (like "pain"). She also expressed concern about the potential vagueness of "knee," "shoulder," and "elbow." Elaine also wondered how these services would be billed.
- Juerg Kunz addressed Elaine's question regarding billing: he noted that there is a temporary CPT billing code for use. It is not currently in the fee schedule. And, because this treatment has not been compensable up until this point, we have no data regarding these treatments. He noted that he's heard of a range of $400-$800 per injection, but is unsure of the accuracy of that range. He noted that, personally, he pays $500 for a PRP injection in his knee. He noted that the division will rely on insurers bringing excessive bills to our attention, when necessary. The division will gather data to address the billing

issue with more information in the coming year. After taking the year to collect data, the division could introduce a new fee schedule amount for this treatment next year.

- Elaine asked about the temporary CPT code: is it a percentage? Fixed amount?
- Juerg confirmed that the code would be payable at 80% of billed.

Issue # 4 (2037)

Rule: OAR 436-009-0012(5)(a)

Issue: OAR 436-009-0012(5)(a) requires insurers to pay distant site providers at the non-facility rate, even if the provider's usual fee is less.

Background:

- Payment for medical services at the published fee schedule rate or the provider's usual fee, whichever is less, is a cornerstone of the Oregon workers' compensation physician fee schedule construct.
- The intent of OAR 436-009-0012(5)(a) has been to clarify that payment of the distant site provider should be made at the non-facility rate rather than the facility rate. However, it was never the intent of this subsection to require payment at the non-facility rate when the provider's usual fee is less.

Options:

- Modify 436-009-0012(5)(a) as follows: "Insurers must pay distant site providers at the non-facility rate **or at the provider's usual fee, whichever is less**."

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- No discussion.

Issue # 5 (1994)

Rule: OAR 436-009-0012(2) Scope of telehealth services

Issue: There is no requirement that a telehealth provider ever evaluate a worker with physical injuries in person.

Background:

- Two stakeholders are proposing that telehealth providers should be required to examine a patient in person at regular intervals.
- Telehealth has improved access to medical providers for workers, in particular those who live in remote areas and may not have easy access to specialists.
- For physical injuries, it may be difficult for a telehealth provider to perform objective measurements and document any measurable changes in the physical examination that may impact the worker's recovery and return to work status.
- WCD's Medical Advisory Committee (MAC) met on October 18, 2024, and discussed in-person visits to telehealth providers. While MAC did not make a formal recommendation, the committee members supported a requirement that a telehealth providers should occasionally examine a patient in person.
- WCD's Medical Resolution Team received multiple disputes involving an out-of-state telehealth provider who referred workers to ancillary care providers in Oregon for over a year without ever performing an in-person evaluation.
- Creating a requirement that workers need to see a telehealth provider in person initially(?) or every 60 (or 90?) days, would allow the telehealth provider to perform objective measurements.
- WCD's Medical Advisory Committee also recommends
- Mental health claims should be excluded from such a requirement.
- OAR 436-010-0210(7) provides that an insurer may disapprove a worker's choice of out-of-state attending physician. However, this rules is intended to apply to out-of-state attending physicians who evaluate a worker in person on a regular basis, not to out-of-state telehealth providers. Therefore, it may be reasonable to add a provision to OAR 436-009-0012 that allows an insurer to disapprove an out-of-state telehealth provider who refuses to perform an in-person evaluation initially or at certain intervals.

Options:

- Create a requirement that the first visit to a medical provider for physical conditions must be an in-person visit.

- Create a requirement that an in-person exam must be performed with 14(?) days after an initial telehealth visit for physical conditions.

- Create a requirement that telehealth providers perform an in person physical examination at a specific time interval for physical conditions.

- Add a provision to OAR 436-009-0012 that allows an insurer to disapprove an out-of-state telehealth provider who refuses to perform an in-person evaluation at certain intervals.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Elaine (SAIF) supports in-person evaluations at some regular cadence; SAIF defers to others with more knowledge regarding these medical services to determine the appropriate cadence. She noted that in-person evaluations are important for workers, for example those with modified work releases. Elaine also supports the final option listed, in which an insurer could disapprove of an out-of-state telehealth provider if that provider refuses an in-person evaluation at intervals.
- Juerg asked Elaine to confirm that SAIF's interest/preference is having workers seen in person at regular intervals, and that SAIF is less interested in having the first visit be in-person.
- Elaine confirmed that SAIF is more interested in having workers seen in person at regular intervals rather than requiring the first visit be in person. She noted this would be helpful to validate and verify any limitations workers may be reporting, help confirm restrictions are appropriate, and allow better insight as to whether the worker is healing at the expected rate. She noted that this was for physical injuries, not mental claims.
- Deanna Tapia agreed with Elaine regarding a requirement for regular in-person visits. She noted that, for non-English speakers, in-person evaluations are helpful. She noted that video and phone evaluations are great alternative options, but in-person evaluations allow for better expression and comprehension regarding a worker's conditions. Deanna also supported the final option listed, in which an insurer could disapprove of an out-of-state telehealth provider if that provider refuses an in-person evaluation at intervals.
- Lon Holston noted that, as an injured worker, having the initial visit in-person allows workers to develop a better connection and relationship—greater trust—with the provider. He agreed, too, that having regular evaluations in-person would be better to fulfill the mission of getting the worker back to work. He noted that certain conclusions are required to get a worker back to work, and those conclusions are often easier to reach when evaluations are done in person. He noted the evaluations could be every 14 days or every 60 days—whatever the case may be, those in-person evaluations are important. He also noted that by the time doctors receive diagnostics or other information, it isn't always current. He emphasized the importance of the relationship between worker and provider, and reiterated that meeting in person is better for developing that relationship.

- Kevin Anderson (SBH Legal) noted that his colleague Megan Vaniman had submitted this issue for review after having issues with out-of-state providers. He shared the background, in which there was a worker seeing an attending physician out-of-state with no presence in Oregon. The provider refused/was unable to meet with the worker in person and there was limited information available from the attending physician. Kevin agreed with SAIF that having the first visit in person is less important than having in-person evaluations at regular intervals. He noted that, with telemedicine, when claims are open for a year or two, there is typically a quick chart note stating the worker is in the same condition, and treatment should continue as needed. He acknowledged that telemedicine can be a good tool for getting workers seen faster. He suggested the regularity of in-person evaluations be every 30 or 90 (or some amount of) days, or upon request by the worker. He noted that they have seen this problem increase.
- Jovanna Patrick expressed concerns that these changes would further limit a worker's ability to see a provider. She added that there is already a shortage of providers. She noted that, in a perfect world, a worker would go to a medical doctor immediately post-injury; but, circumstances do not often allow for that. She noted that insurers do not pay for treatment in the first sixty days, generally, while the claim is deferred. If the claim is denied, insurers do not pay. So, at the very least, she noted this should be limited to compensable claims. Jovanna emphasized the difficulties workers face when trying to find doctors. She shared that she has clients (injured workers), many from minority groups and/or non-English speakers, who have no provider or have no insurance; these workers end up going to urgent care or a telemedicine doctor. In some instances, these workers have insurance but their primary care providers refuse to treat them when they learn that the worker suffered the injury at work. As a result, workers are being forced to go to occupational medicine doctors and do not have anything paid for when their claims are denied. Jovanna noted that the Medical Resolution Team could provide a solution when providers are refusing to see workers in person. Changing the rule, she cautioned, would create additional hardships for workers. Telemedicine, she noted, is still helpful for workers when they have the sniffles and doctors do not want to see them for fear of getting Covid-19. Finally, Jovanna noted that it would be extremely unfair to apply this rule before the injury is accepted; the change would make things much harder for workers—especially those in rural areas.
- Dr. Joan Takacs noted that she treats injured workers and appreciates the usefulness of telemedicine—especially when long distances are involved. However, she noted that mistakes are made when an initial visit is done virtually. She noted an accurate history and accurate physical are required to properly diagnose an injured worker. If a worker cannot undergo a proper physical, she explained, problems arise and workers are misdiagnosed. For example, she noted that workers are being over-diagnosed with concussions because workers are having initial visits via telehealth. Even when the worker does not have a concussion, they are treated as if they have one; this then has negative consequences. She emphasized that an accurate diagnosis is critical for many reasons, including providing an accurate diagnosis to ancillary providers such as physical and occupational therapists. She added that telehealth may be warranted for rural folks, but otherwise in-person evaluations (a physical) is necessary to properly diagnose.
- Greg Gilbert (Concentra) noted that they see telemedicine in 43 other states. He noted that he has not generally seen this issue in practice. He noted that typically the clinician

determines what is appropriate for telehealth. The cases discussed here, for example, do not seem appropriate for any telemedicine. Generally, they are using telehealth for minor injuries ("one and done"). The clinician decides whether follow up is required and whether it should be face-to-face. He believes the options listed would effectively eliminate telehealth. He added the New York currently requires in-person visits, but he is unaware of any other state with such a requirement. He suggested that the rule state something in which—after a certain amount of time—if the provider is continuing to treat via telemedicine, there should be a face-to-face visit.

- Joshua McNeal (CorVel Corporation) noted that he is with a third party administrator, claims processor. He referenced the need for telehealth in 24/7 work environments. When a worker is injured at 3am, for example, telehealth is often the best option for a worker to get an evaluation. He added that telehealth can be appropriate for minor injuries that do not warrant a trip to the emergency room. In summary, he noted that he supports telehealth for first visits, especially for those workers with atypical hours.
- Ann Klein (Majoris Health Systems) noted that the dialogue at the rulemaking advisory committee meeting demonstrates the wide scope of this issue. There are questions of a worker's ability to get to an in-person evaluation, what is medically appropriate, etc. She agreed that the system needs parameters for quality care, and there needs to be flexibility within those parameters to meet workers' needs. She noted that Majoris is unsure of the right answer, but proposed taking more time to discuss the issue; she noted that a rulemaking was too static to address this issue, as there were many things to consider and each case could require its own solution.
- Brandi Garcia asked in the chat if the issue pertained to consultant visits.
- Juerg responded that, if the rule required first visits to be in person, it could be interpreted as pertaining to consultation visits. We could exclude consultant visits. If the rule required visits every 90 days, it would not include consultant visits. In summary, we would need to consider the details to determine if, in any particular situation, a consultation would be covered by this rule. Juerg went on to describe our rulemaking process and the next steps of putting together the proposed rules. (We will publish the proposed rules and stakeholders will have an opportunity to provide comment.) He noted that we rely on public comments when drafting new language.

Issue # 6 (2094)

Rule: OAR 436-009-0040 and Appendix B

Issue: The Oregon Chiropractic Association (OCA) is requesting a 10% fee schedule increase for all non-Evaluation and Management (E/M) CPT® codes, but specifically for all physical medicine, including chiropractic codes and radiology CPT® codes.

Background:

- The OCA notes that "[t]wo years ago there were increases in the reimbursement fee schedule for E/M (20%) and Chiropractic Manipulation Therapy (10%). The last two years did not change in our fee schedules, despite the significant inflation within the industry, as well as the overall consumer price index. Average 2023 CPI in Oregon was about 4% and 2024 is between 3-3.5% currently, creating between 7-7.5% inflation since the last increase in our chiropractic codes."
- The table below shows the changes to the physician fee schedule from 2013 through 2024 for each category:

	E/M Office Visits	E/M Other	Minor Surgery	Major Surgery	Radiology	Lab and Pathology	Medicine	Physical Medicine and Rehab	Chiropractic
2013 to 2014	-	-	-	-	-	-	-	-	+5%
2014 to 2015	-	-	-	-	-	-	-	-	-
2015 to 2016	+3%	+3%	+3%	+3%	+3%	+3%	+3%	-	+3%
2016 to 2017	-	-	-	-	-	-	-	-	-
2017 to 2018	-	-	-	-	-	-	-	-	-
2018 to 2019	+5%	+5%	-	-	-	-	-	-	-
2019 to 2020	-	-	-	-	-	-	-	-	-
2020 to 2021	+10%	+2%	+2%	+2%	+2%	+2%	+2%	+2%	+2%
2021 to 2022	-	-	-	-	-	-	-	-	-
2022 to 2023	+18%	-	-	+14%	-	-	-	-	+10%
2023 to 2024	-	-	-	-	-	-	-	-	-
2013 to 2024	**+40%**	**+10%**	**+5%**	**+20%**	**+5%**	**+5%**	**+5%**	**+2%**	**+21%**

- Based on billing and payment data from 2022, the department estimates that a one percent fee schedule increase would have the following annual fiscal impact per category:

Physical Medicine & Rehab	$552,307
E&M_Office	$533,499
Radiology	$92,599
Chiropractic	$30,334
Medicine	$34,746
Evaluation & Management	$54,404
Minor Surgery	$66,543
Major Surgery	$290,228
Lab & Pathology	$1,648

Options:

- Increase the fee schedule for all non-E/M or selected categories by ??%.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Beth Buckley requested a fee increase of 20% for physical medicine. She shared that, at a recent annual work evaluation, she was told that raises were on hold; she was ineligible for a raise because she had reached the maximum amount under the current fee schedule. Beth referenced a chart (provided) reflecting the changes in fee rates over the past four years. She emphasized that the billing code used most often (97530) had actually decreased over time (it was higher in 2018 than it is today). She added that, with inflation, a fee increase is appropriate and necessary. Beth noted that she intended to share additional materials, but those have not yet been received by the division.
- Elaine expressed concern over a 10% increase across the board, not limited to chiropractic care. She noted there was already an increase of 10% in the 2022-2023 time period. She noted that did include manipulation codes, which are part of this issue. She has concerns about the impact this fee increase would have on cost.
- Dan Miller noted that, historically, the chiropractic fee increases occurred because he asked for them. He clarified that E/M increases do not apply to chiropractic services; increases for chiropractic services need to be requested. He further cited statute ORS 656.248 [specifically ORS 656.248(7)(d)]* and noted that, if we followed that statute, the fees would increase each year. Finally, he noted that there were pieces missing in the available data table shown above. The chart does not show decreases, for example.

*The division added this citation when drafting the minutes. Dan Miller did not specifically cite this statute in his commentary, but was making reference to it.

Issue # 7 (2095)

Rule: OAR 436-009-0060(2) (Oregon Specific Codes (OSCs))

Issue: A stakeholder is requesting a billing code "to bill for records provided by attorneys (both patient and insurance company attorneys) for the provider to review before [a] scheduled phone conference or when insurance adjusters request providers to review records for a new patient visit."

Background:

- OAR 436-009-0060(2) lists an OSC (RECRW) that providers can use to bill for review of medical records on an MCO-enrolled claim by a non-treating physician requested by an insurer or a managed care organization.
- OAR 436-009-0060(2) further lists code D0001 for billing "time spent consulting with an insurer's attorney" and code D0030 for billing "time spent consulting with an insurer."
- Code RECRW is payable at 80% of billed, whereas codes D0001 and D0030 are payable as billed.
- Billing and payment arrangements between workers' attorneys and medical providers is not regulated by WCD.

Options:

- Expand the descriptors of codes RECRW, D0001, and D0030 as follows:
  - RECRW: **Review of records requested by an insurer, or** review of medical records on an MCO-enrolled claim by a non-treating physician requested by an insurer or a managed care organization.
  - D0001: Time spent consulting with an insurer's attorney**, including time spent reviewing records**.
  - D0030: Time spent consulting with an insurer**, including time spent reviewing records**.
- Create new OSCs for review of records in preparation for a consultation with an insurer, insurer attorney, or for review of records requested by an insurer.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Elaine requested clarification regarding the stakeholder's situation (the stakeholder bringing this issue forward). She noted that SAIF does reimburse for these services. She

asked if the stakeholder was not billing, was not being paid, or was not being paid the correct amount.

- Juerg noted that the issue came forward when the stakeholder was unsure what code to use for the situation. Juerg then asked the committee what would be easier: to introduce a new code or to modify an existing code?
- Joy Chand noted that they would like to see a new code, as this is something they see every day and they are receiving a lot more records for review. A new code would make things easier.
- Amanda Barlowe noted that she is a biller for Cascade Health; she had previously been billing for this service for attorney and adjuster conferences; many times this was and denied because it was not documented on their side, so a secondary code may be the better option (this would allow specific documentation regarding the file review time).
- Joy Chand agreed.
- Misty Bergenstock asked in the chat: "Asking about billing code for records review for consultations with other doctors."
- Marie noted that we will take note of her question and circle back with Misty directly after the meeting.

Issue # 8 (2096)

Rule: OAR 436-009-0060(2) (Oregon Specific Codes (OSCs)) and Appendix B

Issue: A stakeholder is proposing to modify the current fee schedule for worker requested medical exams (WRMEs).

Background:

- A worker is entitled to a WRME when the insurer denies a claim based on an independent medical exam (IME) report that the worker's attending physician or authorized nurse practitioner does not concur with, and the worker timely requested a hearing on the denial.
- From a provider's standpoint, a WRME, billed with OSC W0001, is very similar to an IME, billed with OSC D0003, and both are payable "as billed."
- Medical providers performing a WRME bill for their services using OSC W0001.
- The stakeholder is suggesting "an hourly rate per physician specialty and context to physician time vs having the report itself prepared (typing, record prep etc.)."
- Since, from a provider's standpoint, WRMEs and IMEs are similar, it is reasonable to have the same fee schedule for both types of exams.

Options:

- Create an hourly rate for payment of IMEs and WRMEs.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- No discussion.

Issue # 9 (2047)

Rule: OAR 436-009-0060 (Oregon Specific Codes)

Issue: The billing code (W0001) for a worker requested medical exam (WRME) only includes the charges for the exam and the report. However, the code does not include charges for time spent reviewing the record or for authoring an addendum to a report.

Background:

- A WRME is an exam available to a worker under ORS 656.325 and is completed by a medical service provider other than the worker's attending physician or authorized nurse practitioner.
- Similar to an independent medical exam (IME), a WRME medical service provider conducts a file review, performs an exam, and authors a report.
- While the descriptor for code D0001 (IME) includes "file review" and "addendum to a report," the descriptor for code W0001 only includes the exam and the report.

Options:

- Add "file review" and "addendum to a report" to the descriptor of billing code W0001.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Elaine Schooler noted that people are already billing for this review, so perhaps no additional billing code is necessary; she noted an "addendum to a report" would be outside ORS 655.325 regarding WRMEs.
- Juerg Kunz clarified that the division is not suggesting we add a new code; this change would merely add file review under an existing code.

Issue # 10 (1949)

Rule: OAR 436-009-0080(7) Durable Medical Equipment (DME) Rental Rates

Issue: Some of the rental rates for DME, published in OAR 436-009-0080(7) may be outdated.

Background:

- On January 1, 2012, WCD started using CMS' DMEPOS fee schedule as the basis for the new workers' compensation DMEPOS fee schedule.
- Many items covered by the DMEPOS fee schedule are being rented, not purchased. The monthly rental rate is 10% of the fee schedule amount (purchase price), published in appendix E.
- Analysis of WCD's billing and payment data showed that for some items, the calculated rental rate was significantly below the going rental rate, and providers pointed out that they would not be able to provide these items at the calculated rental rate. Therefore, certain DME codes were carved out, and WCD publishes a rental rate in OAR 439-009-0080(7) for these DME codes independent from the purchase price.
- The rental rates for some DME codes published in OAR 436-009-0080(7) may now be lower than 10% of the purchase price.
- It is reasonable to remove those codes whose rental rates are below 10% of the purchase price from OAR 436-009-0080(7), i.e., their rental rates would become 10% of the purchase price published in Appendix E.
- WCD intends to compare the rental rates listed in OAR 436-009-0080(7) to the proposed 2025 DMEPOS fee schedule and remove any codes from OAR 436-009-0080(7) that are below 10% of the fee schedule amount

Options:

- Remove codes whose rental fees published in OAR 436-009-0080(7) are below 10% of the fee schedule amount from OAR 436-009-0080(7).
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- No discussion.

Issue # 11 (2046)

Rule: OAR 436-009-0080(10) (Hearing aids)

Issue: OAR 436-009-0080(10) requires hearing aids to be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. However, generally, audiologists determine the need for hearing aids, not attending physicians, authorized nurse practitioners, or specialist physicians.

Background:

- A stakeholder reported that according to the U.S. Food & Drug Administration (FDA), a medical provider such as an ear-nose-throat (ENT) specialist may perform a medical examination to rule out any medical reason for a hearing loss, such as infection, injury or deformity, and, in rare cases, tumors. On the other hand, an audiologist determines the type and amount of hearing loss.
- Additionally, workers whose only accepted condition is hearing loss, may not need to have an attending physician or authorized nurse practitioner through the life of the claim.

Options:

- Modify OAR 436-009-0080 as follows: **(10) Notwithstanding OAR 436-009-0010(1)(a), a licensed audiologist may prescribe programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel hearing aids without approval of an attending physician.** ~~Hearing aids must be prescribed by the attending physician, authorized nurse practitioner, or specialist~~. Testing must be done by a licensed audiologist or an otolaryngologist.

  ~~The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of~~ Any hearing aids **other than BTEs, ITEs, or CICs** needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

- **Minutes:**
- Marie Rogers described the issue – see above – and asked the committee for advice.

- Lon Holston, speaking as someone with hearing aids, noted that he has tried several different kinds of hearing aids. He was always required to see an audiologist first, before others would examine him. He noted that the audiologist is crucial in determining the type of hearing aid that is best suited for someone. He added that one can get hearing aids for less cost, but they don't work. He supports expanding the language in the way recommended, above.
- Mel DeLeon noted that she works as a sign language interpreter—and has for almost thirty years. She is excited to see this issue on the agenda. She works with immigrants and noted that it would be a positive thing if they have easier access to hearing aids. Finally, Mel noted that she sometimes works with Portland Community College and they often partner with other schools; she believes people in training could help fulfill the need. Therefore, she recommended the language include people "supervised by a licensed audiologist." Expanding the language to include such people, people in training, would lessen the barriers (and cost) for people wishing to obtain hearing aids.

Issue # 12 (2047)

Rule: OAR 436-009-0080(10) (Hearing Aid Fee Schedule)

Issue: A stakeholder is requesting an increase in the hearing aid fee schedule.

Background:

- OAR 436-009-0080(10) provides in relevant part that without approval from the insurer or director, the payment for hearing aids may not exceed $7000 for a pair of hearing aids, or $3500 for a single hearing aid.
- The hearing aid fee schedule was last adjusted on April 1, 2016, when the maximum payment for hearing aids was raised from $2,500 ($5,000 for a pair) to $3,500 ($7,000 for a pair).
- The stakeholder points out that taking the inflation rate since the last fee schedule adjustment into consideration, the hearing aid maximum payments should be raised to $4,600 ($9,200 for a pair).
- The stakeholder opined that the worker should be provided "with the most appropriate technology that best remedies the injury to the state that comes closest to normal auditory performance. This is best achieved with the higher-tech devices, which they are currently not being given access to."

Options:

- Increase the maximum payment amount for hearing aids, without approval from the insurer or director, to $4,600 ($9,200 for a pair).
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

<u>Minutes</u>:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Lon Holston, as someone with hearing aids, supports the increase in the covered amount. He noted that there is a boost in technology every few years, and the improved technology comes with a higher cost. He commented that, a few years ago, his hearing aids cost $7,000/pair.

- Elaine Schooler voiced an interest in seeing more data regarding the costs of hearing aids. She asked, for example, about costs through private health insurance and through Medicare.
- Juerg noted that he did not believe hearing aids were covered under Medicare. He added that the division does not have data regarding the cost through private health insurance. Juerg then asked Lon to further discuss his experience with hearing aid cost; Juerg had previously thought that the cost of hearing aids may have been decreasing, but Lon had noted upon the increase.
- Lon Holston noted that he has a good insurance plan (Medicare Advantage Plan), and that his plan covers $1,000. The remaining cost is out-of-pocket. He compared the insurance to dental insurance, noting that the service cost increases, but the cap covered by insurance does not increase. He added that, the last time he purchased hearing aids, he paid a significant amount out-of-pocket.
- Erin Nielson asked about the cost of hearing aids; she noted she had heard of a wide range: $600 and some? $7000? She noted that she has seen hearing aids at Costco for $3000/pair. She was hoping to learn more regarding the cost.
- Antoinette Awuakye noted that she works with private insurance and addressed the question regarding cost. She noted that there was a mandated coverage amount, but that amount was removed because hearing aids are a medically necessary item. She noted that she believed hearing aid coverage through Medicare was very low. She added that—in the private insurance space— audiologists do not mark up the cost of hearing aids.
- Delmi commented in the chat: "HI: Delmi Manzanares here. Unable to unmute myself. I appreciate the language around ensuring that a licensed audiologist can prescribe the hearing aid, having said that, my recommendation is that we continue to require approval of the attending physician."
- Mel DeLeon added that requiring individuals, especially those from marginalized communities, to see two different providers creates additional barriers to care.
- Anne Friend (speaking on behalf of herself) noted that her husband uses hearing aids and she supports the increased cost coverage; she also noted that requiring multiple providers can be prohibitively expensive. She supports allowing an audiologist to prescribe hearing aids.
- Anne Friend, as a representative of the Secretary of State's Archives Division, she noted it would be helpful to spell out acronyms in the rule for greater reader accessibility.

Issue # 13 (2101)

Rule: OAR 436-009-0110 (Interpreters)

Issue: A stakeholder is requesting an increased fee schedule for interpreter services.

Background:

- The stakeholder states that "[t]he U.S. Bureau of Labor Statistics' CPI Inflation Calculator computes a 3% inflation from December 2023 to August 2024."
- The stakeholder proposes increased interpreter rates as shown under "Option" below. This would be an increase of about 5%.
- WCD increased the maximum interpreter hourly rates on April 1, 2022, by an average of 8.4%, and on April 1, 2024, by an average of 9.2%.

Options:

- Make the following changes to the interpreter fee schedule:

For:	The maximum payment is:
Interpreter services provided by a noncertified interpreter of an hour or less	$~~71.00~~**75.00**
Interpreter service of an hour or less provided by health care interpreters certified by the Oregon Health Authority[1]	$~~83.00~~**87.00**
American sign language interpreter services of an hour or less	$~~83.00~~**87.00**
Interpreter services provided by a noncertified interpreter of more than one hour	$~~17.75~~**18.75** per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Interpreter service of more than one hour provided by health care interpreters certified by the Oregon Health Authority[1]	$~~20.75~~**21.75** per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language interpreter services of more than one hour	$~~20.75~~**21.75** per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	The private vehicle mileage rate published in Bulletin 112
An examination required by the director or insurer that the patient fails to attend or when the provider cancels or reschedules	$~~71.00~~**75.00** no-show fee plus payment for mileage if 15 or more miles round trip

An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage
[1] A list of certified health care interpreters can be found online under the Health Care Interpreter Registry at http://www.oregon.gov/oha/oei/Pages/HCI-Program.aspx .	

- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Mel DeLeon noted that she is a longtime interpreter and that a raise is necessary. She noted there is a nationwide shortage of American Sign Language (ASL) interpreters—Washington has a task force, Oregon has people flying in to cover court cases. The industry is trying to figure out other ways to attract new interpreters, as current interpreters are aging out. Existing interpreters are turning down work related to medical exams because they are not paid a living wage to assist. She noted that the dollar amount may look like a lot, but much of that amount goes to the agency, not the practitioner. And there are costs: driving, parking, etc. She suggested raising the interpreter services to a two-hour minimum. Typical practice, she notes, for ASL interpreters, is to charge about $100/hour, with two-hour minimums, including mileage.
- Deanna Tapia has been in the interpreter business for over 30 years, owns her own business, and is on a committee with Mel DeLeon regarding interpreter services. She agreed with Mel and suggested implementing a two-hour minimum would be very helpful. Deanna cited HB 2359, which requires coordinated care organizations to work with health care interpreters listed on health care interpreter registry in the State of Oregon. She also cited HB 2696, which will set higher requirements for ASL interpreters. Deanna noted that, because of this new legislation, there are higher requirements for interpreters, and there is already a shortage. She noted that there are 1,985 spoken word interpreters in the State of Oregon, but only 265 (or so) are certified. She emphasized that, at present, interpreters are not earning a living wage. She noted that interpreters are aging out and something needs to be done to attract new interpreters to the industry. She noted that Medicaid and Pacific Source and other insurers started paying two-hour minimums in 2023. Now, interpreters require two-hour minimums (which, she added, is good for the interpreters, but very difficult for the agencies paying the interpreters). This results in agencies paying interpreters more than the agency is being reimbursed. So, she is in favor of the increase noted in the issue options, but reiterated strong support for

implementing a two-hour minimum. She reiterated that HB 2359 requires certification by Oregon Health Authority for interpreters, but there is a serious shortage of interpreters. She noted that because the supply is down and the demand is high, there has been an impact on cost. Deanna went on to address the "certified" language in the rule, above. She noted that there is no process for spoken language interpreters to become certified in Oregon. There is a 60-hour course and test, but working through these materials renders an interpreter qualified, not certified. To become certified, interpreters are required to take the national certification, which Oregon then recognizes. Reiterating the shortage of interpreters, she recommended that the language in the rule be changed from "certified" to "qualified or certified" to align with Oregon Health Authority's registry requirements and new legislation. She added that, under new legislation, ASL interpreters will require state licensure. She noted that this licensure is an entirely different set of requirements that DAS is currently working on. We will need to adjust the rule language to accommodate that change, too. She noted a confusion regarding the "80% of payment rule," in which entities are only paying 80% of what has been billed. She listed the existing barriers to obtaining services of certain language interpreters—some languages having no available interpreters on the Oregon Health Authority registry. Some (most) interpreters are charging for two-hour minimums, at high costs, but are providing less than two hours of services. So, Deanna's agency is not reimbursed for the cost of the interpreters, or her agency is unable to provide the interpreter. At times, her agency will provide the interpreter and take the financial hit simply because the community needs those services. Or, when there are no interpreters, they sometimes look out of state for interpreters, although the rules now technically do not allow that practice (as interpreters must be on the OHA registry). Finally, she asked if video or phone interpreter services were billed at the same rate as in-person interpreters. She added that many insurers will deny coverage for phone or video interpreters, although obtaining services by phone or video can be sufficient. She wondered if a code should be added to allow billing for video or telephone interpreter services.

- Mel DeLeon confirmed there is an ASL licensure bill that just passed. She noted that, with additional licensure requirements comes additional cost. Continued education carries a cost, too. Often, these costs are rolled into the service cost. She reiterated again the shortage of interpreters. She put the following links in the chat, noting the language for the Oregon Health Authority registry is "certified" vs. "qualified" health care interpreters:
  https://hciregistry.dhsoha.state.or.us/Search
  https://www.oregon.gov/oha/EI/Pages/HCI-Certification.aspx
- Mel noted that, to become certified at the national level, there are only five languages that have exams. Mel noted, too, that there are so many unique languages (over 200) in Oregon requiring interpreter services. Accordingly, it is important to note the difference between "qualified" and "certified." She stated that, when possible, a certified or licensed interpreter is optimal, as that status means that, not only is their ability to speak and understand a language vetted, but their ability to interpret has been assessed and rated—this is particularly important for medical appointments, which could be life or death.

Issue # 14 (2092)

Rule: OAR 436-009-0110 (Interpreters)

Issue: According to a medical provider, the procurement of reliable medical interpreters has become increasingly difficult.

Background:

- OAR 436-009-0110(3)(d) provides in relevant part that the insurer is not required to pay for interpreter services or mileage when the services are provided by a medical provider's employee.
- The stakeholder noted that "[e]ffective communication stands as a cornerstone in delivering optimal medical care and achieving desirable health outcomes. Ensuring access to proficient interpretation services emerges as a critical component of our practice. However, the scarcity of qualified interpreters within our community poses a significant challenge."
- The stakeholder opines that employing a dedicated certified interpreter within their organization holds promise in mitigating these challenges. The stakeholder would like to be able to bill (and get paid) for interpreter services provided by a certified interpreter employed by the medical provider.

Options:

- Allow a medical provider to bill and get paid for services provided by a certified or authorized interpreter who is employed by the medical provider.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

<u>Minutes</u>:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Michelle Bremer noted that the dialogue regarding interpreters from the previous issue set the stage: there is a serious shortage of reliable interpreters in Oregon. Michelle noted that Cascade Health (occupational clinic, Eugene, OR) was having a problem with interpreters failing to show up, or failing to find an interpreter in the first place. As a result, Cascade posted a position for an Oregon Health Authority licensed interpreter and hired someone to work for them—now, they have an interpreter available for the most common language (Spanish). By hiring an interpreter, Cascade is having way fewer issues with interpreter services and has received much positive feedback regarding this

model. Cascade is able to tell patients that they have an interpreter available or the patient is able to provide their own. Some people do provide their own, she noted, which does work out great, too. They no longer have people crying in the lobby and feeling punished—and they are avoiding the need to push appointments out days or weeks to align with an available interpreter's schedule. Cascade is keeping the workers on track. Most workers' compensation payers have been reimbursing Cascade for these services, but one is not—because of the rule language. So, Cascade requests a rule language change to allow successful reimbursement for this in-house interpreter service.

- Deanna Tapia noted that "reliable" interpreters are hard to come by because they need a pay increase. She expressed concern that having an interpreter as an employee would be a conflict of interest. She suggested this model would work only if the interpreter is only providing interpreter services (versus serving as a medical assistant and an interpreter, for example). She suggested that someone working multiple positions could burn out—which is bad for both the patient and the clinic. Finally, Deanna added that phone or video interpreters could be an alternative option. In the event interpreters fail to appear or one cannot be obtained to come in person, for example, the patient could call to connect with an interpreter by phone or video.
- Mel DeLeon noted that came from an employer interpreter model (Oregon Judicial Department); she is familiar with that model and supports it. She noted that the model raises the bar for the quality of services and professionalism. She noted that such interpreters would need to adhere to a code of ethics, and a code of conduct. She emphasized that the continuity of care is extremely beneficial, too. There are studies, she noted, that demonstrate the benefit of continuity of care. She added that allowing a choice for the worker is important. She would like to see more clinics and hospitals implementing a model like this one.
- Michelle Bremer, addressing Deanna's comment, noted that their interpreter is nationally certified and knows the rules, and she is only providing interpreter services. She reiterated that, as Mel said, there has been loads of positive feedback regarding the continuity of care.
- Deanna agreed with Mel that the continuity of care is very helpful for the workers—especially those non-English speakers.

Issue # 15 (2035)

Rule: OAR 436-010-0240(5)

Issue: A stakeholder stated that "[f]requently medical providers do not respond timely to return-to-work inquiries from employers (and insurers)."

Background:

- The stakeholder opined: "This results in unnecessary delays in a worker's disability, Time Loss costs and employer frustration. It can also unnecessarily cause a work comp claim going from non-disabling to disabling. (Upon initial treatment, if an injured worker is given temporary partial disability – and if the employer has modified work to offer within the worker's work restrictions and can offer the modified work within three days at the worker's full wages – the claim remains non-disabling. But if the employer doesn't find out until at least four days later, the claim unnecessarily gets reclassified to disabling.)"
- The stakeholder further pointed out that "[t]here's nothing in the rules compelling medical providers to respond to **employer** return-to-work inquiries when it's the employers who are the ones creating/coordinating/providing modified duty (not the insurer). Additionally, it's common for employers to receive the return-to-work info before insurers do. In fact, many times insurers are obtaining return-to-work info from employers vs. the medical provider. And when employers are forced to wait to hear from insurers on return-to-work information, this, too, can cause delays in getting workers back to work."
- It should be noted that there are some insurers who request that return-to-work information from providers be sent to the insurer and not the employer.
- The stakeholder proposes specific changes to OAR 436-010-0240(5)(a) and (b) as shown in in the first bullet under Options.

Options:

- (a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the ~~patient's~~ **worker's** medical limitations related to ~~their~~ **the worker's** ability to work result from an occupational injury or disease. If the insurer **or employer** requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form **or respond to a modified job description**, the insurer **or employer** ~~must~~ **may** use Form 3245. **The attending physician or authorized nurse practitioner must respond within two business days.**

  (b) **When the attending physician or authorized nurse practitioner initiates a release to regular or modified work,** ~~The~~ **the** attending physician or authorized nurse practitioner must advise the ~~patient~~ **worker**, and within ~~five~~ **two business** days, provide the insurer **and/or employer** written notice of the date the ~~patient~~ **worker** is released to return to regular or modified work.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Dr. Joan Takacs noted that she recommends the worker get the return to work note from the provider, during the appointment. She noted that often the insurer fails to get the note, or the employer fails to get the note. She expressed frustration that there is so much time wasted getting the return to work notes out. Some providers, she added, simply write "off work" because it is easier than writing out what a worker can or cannot do. She noted they have been seeing surgeons not wanting to deal with this, so they seek another attending; then, it becomes necessary to look for various providers' notes. It would be better, she suggested, if it were the worker's responsibility to get notes to the employer. She noted that the workers may be disabled, and she understands that hardship, but noted that everyone in the private sector—outside of workers' compensation—handles notes in that way. She believes it is generally easier for everyone if the worker has the responsibility to get the information to the employer.
- Joy Chand agreed with Joan Takacs.
- Jovanna Patrick voiced concerns about workers policing their doctors, forcing doctors to respond under tight timelines. She noted that the tight timelines suggested are going to push more doctors out of the workers' compensation system, and there is already a shortage of providers. She appreciates there are MCO doctors who develop systems for these notes, but noted that workers are being seen by doctors all over the state, and some doctors may not be as educated in workers' compensation. Jovanna noted that she tells her clients to get the work note from the doctor; the clients then say the doctor intends to fax the note, but Jovanna does not receive those faxes. Often it is simply difficult for the worker to get the note from the doctor—for various reasons. She emphasized that yes, often these workers are disabled, unable to drive, etc. and are often told by their employers to not return to work until the worker is fully released. She argued that to have the workers hold the responsibility of pushing their doctors, with tight timeframes, when the risk is losing benefits, does not work.
- Gabrielle Haxby noted in the chat "There was an emailed response to both issue 14 and 15 from one of our physicians. I'm not sure if those comments are read here during these meetings or not. Thank you."
- Marie noted that comments should be forwarded to wcd.policy@dcbs.oregon.gov, and we will take them under consideration.

- Connie Whelchel (KPD Insurance, commercial insurance broker) noted that employers are frustrated, too, that doctors are not responding to modified job descriptions, providing work restrictions, etc. As rules are written, workers are to receive work restrictions from providers, but there is nothing in rule compelling providers to respond to employers' specific return-to-work inquiries. Even with 827s, there is a check box regarding return to work, but nowhere to add additional information. Connie added that Joan Takac's practice of offering the note right at the appointment is great practice. She added that employers need to provide modified work restrictions that have been approved by the attending physician in order to stop time loss if the worker decides to not take the modified work. Unfortunately, Connie noted, if we just have generic work restrictions from the medical provider, and the employer offers modified work but the worker refuses to take it, time loss is owed. The only instance in which time loss is not owed is when the employer provides formal, modified work description that is approved by the doctor. Sometimes, the result is unfortunate for providers as they will provide the work restrictions but then the next day, they're given a modified job description to review. Additionally, she added that an Oregon claim becomes disabling after three days of no work. In other states, she noted, there are five days—or even seven days. Oregon offers very little time. So, if employers and providers can work closely together—especially at the beginning of the claim when it matters most, it will help the claim get started smoothly. If items are going only to the insurer, but not the employer, there is a time gap and delays in getting the claim set up. Days go by unnecessarily, when the employer does not have the information they need when they have modified work available immediately—but they are in limbo waiting for work restriction information. These delays result in claims going to disabling when it is unnecessary. She reiterated that it would be ideal if employers could connect with providers for work restrictions and get responses right away.
- Keith Semple noted that a claim becomes disabling within three days. He noted that he cannot think of any other turnaround with such a tight timeline. He does not think it is possible for providers to respond within two business days. He acknowledged that providers are already facing a burden as they are being asked for work restrictions from the insurer and from the employer. He added that workers understand the necessity of modified jobs, however, workers are often told they cannot work for the next month, but will then they suddenly receive a modified work note approved by their doctor between appointments. The back and forth between appointments can cause challenges and frustration.
- Joshua McNeal (CorVel Corporation) added that this issue is problematic from the claim administrator perspective. He appreciates that there are three days to get a note out before a claim becomes disabling. He noted that the options presented here are simplistic and won't resolve the issue as intended. He noted that each insurer and each employer handles return-to-work differently, so there is no real "one size fits all" solution. He highlighted the "and/or" language in the Option (paragraph b) and noted that there should be more certain language—(i.e. "which one is it? 'and' or 'or'?). He reiterated that each insurer has its own practice—some employers want the information directly, others do not. He added that, for the latter, there would be a delay in getting the information to the insurer. He believes that this change would ultimately result in a delay going from the

insurer to the employer. He believes the options are insufficient, but acknowledges that he does not have the right answer to solve the problem.

- Lon Holston recommended making no change until we better study and understand the issue. He noted that a change could make things worse. He noted that the Medical Advisory Committee (MAC) looked at a variety of forms from all over the country to find a better way to report to claims examiners and employers. He believes this issue should be addressed in baby steps.
- Connie Whelchel addressed the comment of the "and/or" language (in paragraph b) by noting that the information should go to both: the insurer and the employer. She noted that making a copy would not pose a large or time-consuming burden. She noted that the Form 3245 is a single form—simple. The modified job description is, at most, two pages—simple. She noted that, when she was an Operations Director for a medical clinic, they would have the form ready for the patient in the file for the patient's appointment. They would go over the form with the patient and then sign it, date it, pass it off with the worker—simple. In the case of electronic communications, no copy is even necessary and there is no reason it could not be sent to both entities at the same time. She sought greater explanation as to how these simple forms were causing such a burden.
- Dr. Joan Takacs noted that, when there is good faith between the worker and the employer, this is a nonissue. She noted there are generally issues with return to work, though. Many times, workers want the time off. Or, employers make jobs that are not really appropriate, such as workers being told to watch videos for weeks until they can't stand it anymore. For providers stuck in the middle under such circumstances, it is wearing. As a result, more surgeons and providers don't want to bother with return to work. Then, she noted, attorneys get involved and there are problems. She hopes someone comes up with a creative solution. She reiterated that not all parties are meeting in good faith when it comes to return to work forms.
- Elaine Schooler noted concerns regarding the administrative burden of a two-day turnaround requirement.
- Misty Bergenstock asked in the chat: "Can providers bill for the completion of these forms? If so, what are the billing codes?"
- Juerg addressed Misty's first question by stating that if a provider completes an examination and then completes the form, they can bill for it. If they do not do an in-person examination, though, they cannot bill for the form. Juerg did not know the code but promised to follow up with Misty regarding the billing code.
- Erin Nielson noted that, as an adjuster, they try their best to get the most recent releases. They can typically do so within a few days. If they don't receive it, they make calls to the worker letting the worker know they don't have the release. She noted there is a lot involved on the adjuster side. She noted that they do like the forms. She noted that she has seen bills for filling out the forms ranging $50-$300.

Issue # 16 (2099)

Rule: OAR 436-010-0240(4)(d)

Issue: A stakeholder is requesting that the time medical providers must respond to requests for progress reports, narrative reports, diagnostic studies, or relevant medical records be changed from "14 days" to "14 business days."

Background:

- The stakeholder noted that on multiple occasions, their medical office has receives fax requests for medical records at the end of the day (e.g. 4:50 pm) on a Friday, with additional calls and requests the following week from the insurance companies.

Options:

- Modify OAR 436-010-0240(4)(d) as follows: "The medical provider must respond within 14 **business** days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. *** "

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Elaine Schooler proposed no change; she noted that 14 business days is almost three weeks. She noted that that is a long time for the adjuster to get records that may be necessary to approve the medical treatment or to fulfill duties to issue time loss payment. A three-week timeline could be problematic and cause delays. She suggested the proposed solution was in conflict with the issue (if the issue is the insurer calling in the timeframe repeatedly, how does extending the timeframe help the matter?).
- Jovanna agreed with Elaine; she noted the concept of business days was confusing and could mean different things to different people. She noted that incorporating that language was not the best way to address this issue.
- Erin Nielson wrote in the chat: "#16 Recommend no change."
- Lorie Ragsdale wrote in the chat: "#16 Recommend no change, unless claims examiners are also approved for responses within 14 BUSINESS days, as well."

Issue # 17 (2093)

Rules: OAR 436-010-0270 (Insurer's Rights and Duties)

Issue: A stakeholder stated that insurers are not returning phone calls despite multiple attempts to contact the adjusters.

Background:

- OAR 436-009-0030(5)(a) provides that an insurer or its representative must respond to a medical provider's inquiry about a medical payment within two days, excluding Saturdays, Sundays, and legal holidays. However, no such requirement exists for inquiries not related to payment.
- Generally, providers contact the insurer before starting treatment with a new patient to get basic information, such as verify a claim and what the accepted conditions are. This provider explained that often times, they receive no response to initial contact with insurers.
- The stakeholder stated that not receiving the basic claim information timely slows the initial treatment down until they get an answer.
- We know of at least one insurer who provides a web portal that provides such information, but other insurers do not.

Options:

- Create a new provision in OAR 436-010-0270 that requires insurers to respond to non-payment questions, such as claim status or accepted condition information, within a certain period of time (two days?).

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Marie Rogers described the issue – see above – and asked the committee for advice.
- Joy Chand noted that this has been a major issue—they sometimes call five to ten times without response. She noted that this has been a particularly big issue after Covid-19.
- Jovanna Patrick agreed that this is a major issue in getting workers the care they need. It causes delays. She noted that the system intends to (1) heal people and (2) get people back to work. Sending people back to work without healing them is not aligned with

Oregon's mission. She noted that it is hard to heal people when workers can't get treatment because adjusters won't return calls. Workers are sometimes at a loss, thinking their provider will close the claim because the insurer won't respond. She added that this issue is the biggest reason workers seek Jovanna's services in the first place. She emphasized the need to get these communications in writing (to be provided to workers or workers' representatives). She will receive calls, for example, in which providers state that adjusters contacted the doctor and are refusing to pay for a treatment, so the provider then refuses to provide the treatment. Because these communications are done by phone, she noted that seeking help from the Medical Resolutions Team (MRT) is not an option when this problem arises. She also receives calls from providers who are giving up because they have not heard back from the insurer. She emphasized it is the duty of the insurers to respond. She noted two days was perhaps a bit short. Finally, she added that there needs to be consequences outlined in rule.

- Joy Chand agreed that consequences should be addressed.
- Erin Nielson, as an adjuster, noted that third party administrators often lack support staff and adjusters in the private industry have heavy claim loads. She added that adjusters will receive calls from providers, three days after the claim has been set up, asking if the adjuster will authorize the treatment. They also receive calls from therapists, etc. with questions regarding bills—those billing-related calls are treated as lower priority than responding to doctors with urgent authorization requests. She suggested sending texts, encrypted emails, or fax messages.
- James Washburn (Kaiser Permanente) noted that requests for claim numbers are needed timely to bill. He noted that there is an insurance company with a web portal and asked recommended creating portals for other insurers in order to get claim numbers faster.
- Keith Semple echoed Jovanna Patrick regarding the importance of getting things in writing. He noted that it would be helpful if workers or workers' representatives have an email address for someone who will respond. He also noted that he wanted to see a timeline in rule regarding pre-authorization requests. He noted that different services require different responses, and different treatments do or do not require pre-authorization. He noted that he suspects pre-authorizations are required when providers need assurance that they will be paid for their services. If the provider won't treat without pre-authorization, the worker then needs to prove that it is required, and it is near impossible to do that if there is no response in the first place. Keith suggests creating a form based on the elective surgery request form that can be provided to the different providers in the system to collect the adjuster's email. Keith noted that this was recently brought up at MLAC: workers are having problems connecting with adjusters.
- Dr. Joan Takacs and Joy Chand noted that people are burning out and something needs to be done.

Housekeeping

Reason for change: Effective April 1, 2023, the requirement for providers to submit Form 4909 to insurers when prescribing certain drugs was removed from OAR 436-009-0090. A reference to Form 4909 was inadvertently left in 436-009-0010(11)(a)(A).

Make the following change to **OAR 436-009-0010:**
(11) Payment Limitations.
(a) Insurers do not have to pay providers for the following:
(A) Completing form 827~~ and 4909~~;

Reason for change: Effective April 1, 2024, rules were revised to update the mandatory notice language that must be included in certain notices to workers. To provide stakeholders time to make adjustments to these notices, the relevant rules specified that the new mandatory notice language did not have to replace the old mandatory language until October 1, 2024. As a result, the rules effective April 1, 2024, contain the old mandatory language that can be used until September 30, 2024, as well as the new replacement language that must have been implemented by October 1, 2024. In this housekeeping rule revisions, the relevant rules are revised to remove the old mandatory notice language, and renumber the rule accordingly.

Remove the old mandatory language from the following rules and renumber the rules accordingly:

- OAR 436-009-0025(1)
- OAR 436-009-0030(3)
- OAR 436-009-0110(7)
- OAR 436-010-0270(4)
- OAR 436-010-0290(2)
- OAR 436-015-0110(4), (5), and (6).

Minutes:
• Marie Rogers described the issue – see above – and asked the committee for advice.
• No discussion.

Minutes:
Marie Rogers thanked attendees for joining and ended the meeting. She invited people to provide feedback regarding the issues via email to wcd.policy@dcbs.oregon.gov. She noted that comments must be received by the end of the day on November 13, 2024.