Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules

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

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Nov. 5, 2024, 9 a.m. – 12 noon Room F (basement) Labor & Industries Building 350 Winter St NE, Salem, Oregon Or, join virtually: **Microsoft Teams** https://teams.microsoft.com/l/meetup-join/19%3ameeting_MDQ2NzQ1OWEtOWM4YS00YzY4LThmMjktYmM2MDUzZTY5Njc1%40thread.v2/0?context=%7b%22Tid%22%3a%22aa3f6932-fa7c-47b4-a0ce-a598cad161cf%22%2c%22Oid%22%3a%22419bb41f-34a1-4d77-8afc-abd87db857e0%22%7d Meeting ID: 293 608 374 39 Passcode: pUWFiq **Dial in by phone** +1 503-446-4951,,488131107# United States, Portland Phone conference ID: 488 131 107#
Facilitator:	Marie Rogers and Juerg Kunz, Workers' Compensation Division
9:00 to 9:10	Welcome and introductions; meeting objectives
9:10 to 10:30	Discussion of issues
10:30 to 10:45	Break
10:45 to 11:45	Discussion of issues continued
11:45 to 11:55	Summing up – next steps – thank you!

Attached: Issues document

Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
November 5, 2024, Rules Advisory Committee Meeting

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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:

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).