From: Liberty Corman
To: ROGERS Marie A * DCBS
Subject: Written comments
Date: Wednesday, November 4, 2026 11:08:11 AM

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Good morning,

Please see my WCD rulemaking written comments below:

MTSL Group WC Billing Manager: Opposed to the proposed reimbursement rate of $75 for Return-to-Work, amending OAR 436-009-0010 and -0060, issue #6
I am in support of implementing an OSC (or OSCs) with a standardized reimbursement rate for Return-to-Work reports; however, I do not feel that the proposed $75 rate is sufficient. Completing these reports requires significant clinician involvement and medical review, clinical judgment, evaluation of functional capabilities and determination of work restrictions. Reimbursement should reflect the time, expertise, and administrative resources required to complete these reports accurately and effectively. I recommend setting the reimbursement rate in alignment with the two tiers of narrative complexity N0001 and N0002, $122.17 and $243.62 respectively.

MTSL Group WC Billing Manager: Strongly opposed to the proposed amendment of OAR 436-009-0010(2), issue #7
While I agree that accurate and prompt claim submission is important, shortening the billing timely deadline from 12-months to 180 days is unnecessarily restrictive. The result would be a significant financial impact for clinicians and support staff alike. There are many factors that contribute to billing delays for WC claims:

- Determination of whether an injury is work-related
- Identifying the responsible insurer or TPA
- Obtaining claim acceptance information
- Coordinating with MCOs

Then, after bills are sent there are often further delays:

- Changes in CPT are often not implemented by insurers on the effective date leading to incorrect denials and shortpays for which billing staff must request reconsideration to receive correct reimbursement. The 12-month deadline does not apply only to initial billing; rather, it also applies to reconsiderations sent to address such errors on the insurer's side.
- Changes in the OR f/s are often not implemented by insurers on the effective date despite billing staff updating the amount charged accordingly. In my experience, this has taken up to three or more months of sending reconsiderations with explanations across many many claims of the OR f/s change to reliably see implementation on the insurer/TPA side. Again, the 12-month deadline applies to these reconsiderations.

- Adjusters not releasing payable bills for payment after an investigation has concluded and conditions are accepted
    - Recent real-world example: Bill for 99214, DOS 8/3/26, first billed 8/7/26. Bill was not paid stating that the claim was under investigation and remained unpaid two months later despite other DOS for the same worker/claim/condition/DOI since paying. On 10/7/26, I called the carrier's bill review and they confirmed that the bill was still listed under investigation and instructed me to contact the adjuster. I contacted the adjuster and she said that she does not do billing and that I needed to call bill review. I let her know that I had already called them and provided her with the bill review representative's name and reference number. She then asked me to let her know what the EOB reason stated. I sent her the reason code stating that the bill was under investigation and to contact the adjuster. No response. I waited another 1.5 weeks to see if payment had been received (it had not) and reached out to the adjuster again for follow-up on 10/19/26. No response. I waited one more week to see if payment would be received or if I would receive a response from the adjuster. No response, no payment. By this point it was 10/26/26, almost three months after the DOS and I sent this to WCD. Payment was finally received 11/3/26.

  This type of situation, one not created by the clinic staff, the clinicians nor the billing staff, is common and will often take even longer to resolve. We billed an average of 330 workers' compensation encounters per week between 1/1/26 and 10/3026 for this clinic. Our billing staff understands the load carried by busy adjusters. Cutting the current 12-month billing timeline in half would decrease reimbursement of payable bills for clinicians treating injured workers and condense, and therefore increase, the burden on adjusters.

Thank you,

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