DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROPOSED OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

OREGON MEDICAL FEE AND PAYMENT RULES

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The Workers' Compensation Division (WCD) adopts, by reference, parts of the Centers for Medicare & Medicaid Services Medicare Resource-Based Relative Value Scale (RBRVS), the American Society of Anesthesiologists (ASA) Relative Value Guide, and Current Procedural Terminology (CPT®). ***See OAR 436-009-0004 for details and updated citations.***

- To order the **RBRVS**, contact:
  United States Government Bookstore
  www.nara.gov
  Ask for: 68 Federal Register No. 216, November 7, 2003

- To order the **ASA Relative Value Guide**, contact:
  American Society of Anesthesiologists
  520 N. Northwest Highway
  Park Ridge, IL 60068-2573
  Phone (847) 825-5586
  Ask for: 2004 Relative Value Guide

- To order the **CPT® 2004**, contact:
  American Medical Association
  515 North State Street
  Chicago, IL 60610
  Phone (800) 621-8335

These rules (OAR 436-009), the RBRVS, and the ASA Relative Value Guide are available from WCD on diskette. See the **Order Form** on the last page of these rules, or on the Web at:

www.cbs.state.or.us/external/wcd/policy/forms/3093.pdf

www.cbs.state.or.us/external/wcd/policy/forms/wdocs/3093.doc (MS Word 97®)

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services, Workers' Compensation Division	OAR CHAPTER 436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	(503) 947- 7717 Fax (503) 947-7581
Rules Coordinator	Telephone

PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879
Address

January 22, 2004	2:00 p.m..	Room 260 (2nd floor), Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	**Time**	**Location**	**Hearings Officer**

NOTE: The hearing will convene at 2:00 p.m. and end when all present who have indicated their intention to testify have been called to present testimony. Written testimony will be accepted until 5:00 p.m., January 27, 2004 (must be received by the Workers' Compensation Division).

The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

ADOPT: 436-001-0300, 436-030-0023

AMEND: OAR chapter 436, divisions 001, 009, 010, 030, 060, and 120

REPEAL: OAR ~~436-001-0025,~~ 436-001-0025, 436-001-0045, 436-001-0055, 436-001-0065, 436-001-0090, 436-001-105, 436-001-120, 436-001-0135, 436-001-0140, 436-001-0171, 436-001-0175, 436-001-0191, 436-001-0195, 436-001-0205, S436-001-0231, 436-001-0255, 436-001-0285, 436-001-0295, 436-010-0350, 436-030-0581, 436-060-0210, 436-120-0920

AMEND AND RENUMBER: OAR 436-030-0045 to 436-060-0018

ORS 656.726(4), 656.704
Stat. Auth.

ORS 183.335; OAR 137-001; OAR 436-001
Other Authority

ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)
Stats. Implemented

RULE SUMMARY

The agency proposes to amend these rules and replace temporary rules issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature:

- Senate Bill 233 changed the time frame for appeal of a proposed order or proposed assessment of civil penalty from 60 days following the party's receipt of notice to 60 days from the date the order is mailed by the department. Related proposed rule changes affect OAR 436-010, 436-030, and 436-120.
- Senate Bill 285 allows an insurer or self-insured employer to contest its Notice of Closure if it disagrees with the findings used to rate impairment, and OAR 436-030 has been revised accordingly.
- Senate Bill 620 requires payment of fees to workers' attorneys when a claimant prevails at the administrative level in certain medical and vocational disputes or when the attorney is instrumental in obtaining a settlement. This fee provision affects OAR 436-001, 436-009, 436-010, and 436-120.
- Senate Bill 914 eliminates the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim, and the director proposes to amend OAR 436-060 to require reporting within 14 days after acceptance or denial of the claim. Senate Bill 914 also clarified the statute regarding the department's obligation both to administer and pay supplemental disability benefits if the

insurer or self-insured employer chooses to have the department do so, and related amendments are proposed to OAR 436-060.

- House Bill 2305 addresses how medical records may be released, consistent with the federal Health Insurance Portability and Accountability Act, and related changes are proposed to OAR 436-010 and 436-060.
- House Bill 3669 gives additional authority to nurse practitioners to treat injured workers and authorize temporary disability payments. Amendments are proposed to OAR 436-009, 436-010, 436-030, 436-060, and 436-120 to reflect this change. This bill was a result of legislative action after development of the legislative concepts by nurse practitioners and the Management Labor Advisory Committee.

In addition, these proposed rules:

436-001

- Update the rulemaking notice rule.
- Update the contested case rules to establish consistency with the Attorney General's Model Rules of Procedure applicable to hearings before the Office of Administrative Hearings, OAR 137-003. Because the model rules control, duplicative or inconsistent rules are proposed to be repealed. Remaining supplementary rules are updated. Significant changes include filing of hearing requests; delegation of authority to the ALJ; clarifications regarding scope of review; admissibility of reproductions of originals; attorney fee matrix to implement SB 620 (2003); and a new process for alternative dispute resolution.

436-009

- Adopt updated medical fee schedules.
- Incorporate data reporting requirements currently published in Bulletin 220.
- Add Group number nine to the fee schedule of Medicare ambulatory service center groups.
- Require insurers and self-insured employers to keep track of dates of receipt of medical bills.
- Provide that if a provider’s usual and customary fee is excessive compared to similar providers, the director may determine a reasonable fee based on the usual and customary fee of similar providers.
- Increase the dollar amount of each conversion factor by 2.33%, based on the annual increase in the physicians’ component of the consumer price index.
- Require electronic billings to include a “zz” modifier.
- Modify the definitions of first and second level physical capacity evaluations and of work capacity evaluation.
- Provide that pharmacy fees shall be paid at 85% of the Average Wholesale Price (AWP) – a reduction from 95% in the current rules -- with a $10 dispensing fee – an increase from $6.70 in the current rules.
- Provide that a brand name drug that has a generic equivalent will be reimbursed at the lesser of 85% of the AWP for the brand name or 85% of the average AWP for a generically equivalent drug, plus dispensing fee, unless the prescribing medical provider writes “Do not substitute” or similar phrase on the prescription.
- Provide that reimbursement for Oxycontin, Vioxx, Celebrex and Neurontin is limited to an initial 5-day supply unless the prescriber writes a clinical justification for the drug.

436-010

- Provide that a dispute may be resolved by agreement between the parties, and that the director may then issue a letter of agreement in lieu of an administrative order.
- Allow reimbursement to medical service providers such as physical therapists even if a physician fails to sign the required treatment plan within 30 days of starting treatment.
- Require that, except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are compensable for a maximum supply of 10 days.
- Require insurers to forward requested medical information to new attending physicians or authorized nurse practitioners within 14 days of a request.
- Require that the insurer forward a copy of the insurer medical examination report to the attending physician or authorized nurse practitioner within 72 hours of the insurer’s receipt of the report.
- Require that the insurer notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim.
- Delete the provision that allows an insurer or the director to request an examination to determine the extent of impairment.

436-030

- Prescribe the conditions under which a Notice of Closure may be corrected or rescinded by the insurer or self-insured employer.

- Move rule 0045, "Disabling/Nondisabling Reporting Requirements and Change in Status Determinations" to OAR 436-060.
- Clarify criteria for determination and periodic review of permanent total disability; define "withdrawn from the workforce"; require that preexisting disability be included in redetermination of permanent total disability status.
- Reorganize procedural requirements for reconsideration of the notice of closure.
- Require that medical arbiter panel requests be received within ten working days of the start of the reconsideration.
- Prescribe the conditions for submission of surveillance videotapes.
- Provide for a medical arbiter deselection process; if the claim qualifies for the process, each party may eliminate one physician from the list of arbiters provided by the director.
- Repeal the rule prescribing how the director issues penalty orders.

436-060

- Revise the requirements and limitations for release of medical information by the insurer.
- Adopt rule 0018, "Nondisabling/Disabling Reclassification (amended and renumbered from 436-030-0045); Requires the insurer to reclassify a non-disabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in rule 0018; simplifies related notification requirements.
- Require that if permanent partial disability is paid monthly, it be paid at 4.35 times the weekly temporary disability rate.
- Require the insurer to send a lump-sum application (for payment of a permanent partial disability award) to the worker or his or her attorney within five business days of a request.
- Clarify actions required if the worker cooperates after the insurer has requested suspension of benefits or if the worker documents that the failure to cooperate was reasonable.
- Require that notices of claim acceptance be copied to the worker's representative and attending physician.
- Require a claim denial notice to include one of three specific statements if the denial was based in whole or in part on an insurer medical examination.
- Require that if the insurer receives medical bills after claim denial, it send a copy of the denial to the medical provider and explain the status of the denial.
- Require the insurer to pay for a worker requested medical examination that the worker fails to attend, but not for a subsequent examination unless the worker failed to attend the first exam for reasons beyond the worker's control.
- Require that if claim responsibility is at issue, insurers share claim information without charge.
- Provide time frames for monetary adjustments among insurers.
- Provide for civil penalties if an insurer intentionally or repeatedly fails to give notice as required by ORS 656.331 and OAR 436-060-0015.

436-120

- Require the insurer to notify the worker in writing, within 14 days of a request for vocational assistance when the insurer is not required to determine eligibility.
- Refer vocational professionals to the *Oregon Wage Information* (OWI) publication in lieu of the *Oregon Automated Reporting System (OARS) Job Order Wage Report*, both published by the Oregon Employment Department. The OARS publication will no longer provide job/wage data effective 4/1/04. When using the OWI wage information data, the presumed standard shall be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate.
- Eliminate the requirement that vocational counselors sign statements that their eligibility determinations were based on substantial handicap assessments.
- Specify the conditions under which training may be terminated for failure to attend.
- State additional circumstances that require vocational eligibility to be redetermined.
- Provide that for workers found to have an exceptional disability or exceptional loss of earning capacity, certain fee schedule spending limits are increased by 30%.
- Increase the direct worker purchase training category fee schedule maximum by 10% due to state-wide tuition increases.
- Provide that to conduct only labor market research and/or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

Request for public comment:

The agency requests public comment on whether other options should be considered for achieving the rules' substantive goals while reducing the negative economic impact of the rules on business.

Address questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us **Proposed rules are available on the Workers' Compensation Division's Web site: http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules or from WCD Publications at 503-947-7627 or fax 503-947-7630.**

January 27, 2004 5 p.m.	*/s/ John L. Shilts* December 15, 2003
Last Day for Public Comment	Authorized Signer and Date
	John L. Shilts, Administrator, Workers' Compensation Division
	Printed name

*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

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Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Consumer and Business Services, Workers' Compensation Division	OAR CHAPTER 436
Agency and Division	Administrative Rules Chapter Number

In the Matter of
The Amendment of:
OAR 436-001, Procedural Rules Governing Rulemaking and Hearings
OAR 436-009, Oregon Medical Fee and Payment Rules
OAR 436-010, Medical Services
OAR 436-030, Claims Evaluation, Determination, and Reconsideration
OAR 436-060, Claims Administration
OAR 436-120, Vocational Assistance to Injured Workers

) Statutory Authority,
) Statutes Implemented,
) Statement of Need,
) Principal Documents Relied Upon,
) Statement of Fiscal Impact

Statutory Authority: ORS 656.704, 656.726(4)

Other Authority: ORS 183.335; OAR 137-001; OAR 436-001

Statutes Implemented: ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)

Need for the Rule(s):
Rule revisions are needed to make permanent the changes implemented by temporary rules effective 1/1/04. The temporary rules were issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669. In addition, rule revisions are needed to effectively carry out existing workers' compensation laws: These changes were discussed with advisory committees comprised of people and organizations affected by the rules, and a number of the changes were made at the request of these committees, as well as other customers and stakeholders. Specific substantive changes are listed on the Notice of Proposed Rulemaking Hearing. A number of "housekeeping" changes are proposed. In general, substantive revisions are needed to:

- Carry out the director's duties to publish and update medical fee schedules under ORS 656.248.
- Establish time frames for certain actions required by statutes and rules.
- Require more thorough notification of medical providers and the injured worker regarding decisions and actions affecting the claim.
- Provide for a medical arbiter deselection process in reconsideration proceedings.
- Provide an alternative source of labor market information to be used in determining eligibility for vocational assistance.

Documents Relied Upon: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669; fiscal impact statement forms for SB 285, 620, and 914; advisory committee meeting minutes and audio tapes; issues documents, and medical cost analyses. These documents will be available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7810.

Fiscal and Economic Impact:
SB 233 and HB 2305, in so far as they affect these rules, should have no fiscal impact on any party.

SB 285 is expected to increase the number of reconsideration requests by about 4%, based on historical data. Most of these requests will include a medical arbiter examination. However, a downward trend in reconsideration requests means the net effect will be approximately a 1.7% increase, which will be absorbed by existing division resources. The fiscal impact on insurers and self-insured employers cannot be determined at this time, but may be slightly positive, since appeal will generally only be made if a party thinks it is in the party's financial interest to do so.

SB 620-related rule changes will have a fiscal impact on insurers and self-insured employers, estimated to be $500,000 to $700,000 annually. Currently, the Workers' Compensation Division receives approximately 1,000

disputes (administrative reviews) per year. Workers prevail in nearly 50% of these, for which we estimate a $1,000 attorney fee per case. There is a potential for fees to slightly increase the number of disputes. These dollars will flow to Oregon attorneys, the majority of whom are self-employed or employed by small businesses. The overall cost increase to the workers' compensation system would be about 0.1 to 0.2%.

SB 914-related rule changes should result in savings for insurers, self-insured employers, and the Workers' Compensation Division. Elimination of the reporting of "deferred" claims will reduce the number of documents that must be completed and filed. However, the extent of savings cannot be quantified at this time.

HB 3669 increased the authority of nurse practitioners to provide medical services and authorize temporary disability. This change should positively impact nurse practitioners. Medical payments to nurse practitioners will therefore not go to medical providers who can be attending physicians under Oregon law. We do not know how many workers will choose to treat with nurse practitioners, but we estimate any impact on other provider types will be small, and there should be no fiscal impact to the workers' compensation system as a whole.

The proposed 2.33% increase to the medical conversion factors would increase overall medical payments by between 1.0 and 1.2%. Based on actuarial analysis, expected reductions in other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates.

The proposed change in the pharmacy reimbursement formula and increased dispensing fee is projected to reduce insurers' and self-insured employers' pharmacy costs by at least 6%. Pharmacies, wholesalers, and manufacturers would therefore have decreased revenues equal to insurers' savings.

The proposed incentive to dispense generic drugs should reduce insurers' and self-insurers' costs slightly. Use of generics is already quite common, so savings for insurers and reduced revenues to brand-name manufacturers is expected to be minor.

The proposal to limit Oxycontin, Vioxx, Celebrex and Neurontin to an initial 5-day supply unless the physician provides a clinical justification is expected to reduce costs for insurers and self-insured employers. While these drugs represent approximately 13% of total prescriptions, they account for about 34% of total prescription payments. We do not know how many physicians will write clinical justifications or prescribe a suitable alternative medication. This change would result in reduced revenues for the manufacturers of these brand-name drugs.

The proposed requirements to notify medical providers of certain actions taken regarding claims would slightly increase insurers' and self-insured employers' administrative costs. However, during advisory meetings, insurer representatives told us that certain notifications are already common practice.

The increase in the direct worker purchase training category fee schedule maximum by 10% is estimated to cost insurers and self-insured employers an additional $250,000 to $375,000 annually. The change is proposed because tuition costs have risen sharply, e.g. community college costs rose 12% in the past year. The 30% increase allowed for workers with exceptional disabilities is expected to have a minor effect on costs because very few workers meet the criteria for exceptional disability.

Additional changes to these rules are expected to have no significant fiscal impact on any party.

Administrative Rule Advisory Committee consulted: Yes

October 16, 2003, November 3, 2003, November 17, 2003, November 18, 2003, November 21, 2003

/s/ John L. Shilts December 15, 2003
Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division
Printed name

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of Oregon Administrative Rules, chapter 436, divisions:		
001, Procedural Rules Governing Rulemaking and Hearings	)	
009, Oregon Medical Fee and Payment Rules	)	SUMMARY OF TESTIMONY AND AGENCY RESPONSES
010, Medical Services	)	
030, Claim Closure and Reconsideration	)	
060, Claims Administration	)	
120, Vocational Assistance to Injured Workers	)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to provide the Director with a record of the agency conclusions about the major issues raised.

The amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated January 1, 2004. On January 22, 2004 a public rulemaking hearing was held as announced at 2:00 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, Rules Coordinator, acted as presiding officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through 5:00 p.m. January 27, 2004.

The following individuals gave oral testimony on these rules at the public hearing:

Subject Division	**Testimony received from:**
009	Dave Dery, P.T., Work Injury Management Association of Oregon
009	Mark Healy, O.T., Work Injury Management Association of Oregon
009	Cathy Zarosinski, Oregon Physical Therapy Association
009	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	Colleen Guido, Department of Consumer and Business Services, Workers' Compensation Division
060	Jennifer Flood, Department of Consumer and Business Services, Workers' Compensation Division

The following written testimony was received:

Subject Division	Exhibit #	Testimony received from:
NA	1	Testimony withdrawn at request of submitter
010	2	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009 & 010	3	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009	4	David Silver, M.D.
030	5	Rodger M. Hepburn, Attorney, Reinisch Mackenzie Healey Wilson & Clark, PC
009	6	Karen Elton-Walz, PT, MA, OCS, COMT, Therapeutic Associates; Central Oregon Physical Therapy
060	7	Jennifer Flood, Department of Consumer and Business Services, Workers' Compensation Division
060	8	Bradford A. Vinson, Attorney, Starr & Vinson, P.C.
009	9	Colleen Guido, Department of Consumer and Business Services, Workers' Compensation Division
009	10	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	11	Dave Dery, P.T., and Mark Healy, O.T., Work Injury Management Association of Oregon
009	12	Michael Casey, M.D.
120	13	Nyla L. Jebousek, Attorney
120	14	Robert J. Malone, CPDM, Vocational Unit Supervisor, Liberty Northwest Insurance
009, 010, 030, 060	15	Linda Jefferson, Oregon Self-Insurers Association
010	16	Nancy Bieber, Department of Consumer and Business Services, Information Management Division

009	17	Kevin C. Tribout, PMSI
009	18	Perry Lewis, Third Party Solutions
009	19	Tom Holt, Executive Director, Oregon State Pharmacists Association
001	20	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
030	21	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
060	22	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
120	23	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
009 & 010	24	Linda Olsen, Medical Audit Review Manager, SAIF Corporation
010	25	Morris D. Haney, DPDM, Operations Manager, WMCI Prime Evaluations
009	26	Gene Ogrod, M.D., CEO, Oregon Medical Association

The following is a summary of the testimony received and the agency's responses to that testimony. If oral and written testimony were submitted by the same party, summarized oral testimony is listed separately only if and to the extent it differs from written testimony.

OAR 436-001-0155(1)
Testimony: Exhibit # 20
The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers' Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a):
". . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law."

Response: We agree. Under ORS 656.726(4)(a), "Mailing date" determines timeliness.

OAR 436-001-0240(8)
Testimony: Exhibit # 20
Section (8) of this rule is superfluous. Although this matches the Workers' Compensation Board's requirements affecting document reproductions, it serves no purpose for the Workers' Compensation Division. At the board, all documents are submitted as a group. At the division, the insurer submits most documents as part of the initial review. This rule would require certification of the few additional documents submitted at hearing, and there is no reason for the distinction.

Response: We agree that this proposed requirement is unnecessary. The Workers' Compensation Division has not experienced problems with document reproductions. Section (8) will not be included the permanent rule.

OAR 436-001-0265(2)
Testimony: Exhibit # 20
Two additional factors should be considered in determining attorney fees:
- ' "Attorney time devoted" shall be limited to those hours that a reasonable attorney, well-trained in workers' compensation law, would expend on the matter at issue.'
- 'Proof of "extraordinary circumstances" cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.'

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of "extraordinary circumstances" the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of $10,000.

OAR 436-009-0004
Testimony: (Exhibit #3)
Widely used medical fee schedules take effect January 1st of each year. Medical providers and health insurers generally begin using them for services provided after that date. The Workers' Compensation Division has to adopt fee schedules via rule-making, and updated schedules become effective April 1st, causing a "gap" during which insurers and providers still use the "old" schedules only for injured workers. We propose that rule 0004 be permissive, allowing providers to bill and insurers to pay, using current codes and schedules. This change will not have an effect until January 1, 2004, and any administrative or data collection issues can be addressed prior to that time.

Response: We agree this is a good idea, but believe there are logistical problems that we need to address before this can be done. By making it permissive, there can be disagreement about which codes to use, giving rise potentially to more disputes. In the event of a dispute, which set of standards apply? This is an issue we would like to explore with external advisors at more length prior to the next rule revisions, and leave as is for now.

OAR 436-009-0008
Testimony: (Exhibit #3)
We support the incorporation of the provisions of Senate Bill 620 (Ch. 756, OL2003) and approach for calculating appropriate attorney fees. However, the proposed revisions fail to include attorney fees for represented medical providers who prevail in a medical treatment or fee dispute with an insurer. Section 2 of SB 620 amends ORS 656.385(1) to allow the award of attorney fees to a claimant who prevails, not just a worker. If the Legislature had intended to limit attorney fees to a worker's attorney, it would use the word "worker," as it did elsewhere in the bill. The injured worker benefits if a represented medical provider prevails in a medical dispute; e.g. if a medical provider doesn't challenge an insurer's denial of palliative care (even though it is appropriate and the provider would prevail in a dispute), OAR 436-009-0015(1)(c) allows the provider to bill the worker.

Response: ORS 656.385, as revised by SB 620 refers solely to attorney fees paid to the claimant or the claimant's attorney. We believe the reference uses "claimant" to mean the injured worker. We do not believe the intent was to provide insurer-paid attorney fees to medical providers.

OAR 436-009-0008(1)(b), (2)(a), (2)(b), & (5)
Testimony: Exhibit # 24
All language regarding attorney fees associated with medical billing disputes must be stricken from the Division 009 rules. Senate Bill 620 does not provide authority to award attorney fees when medical fees are the subject in dispute. Division 009 is promulgated under the authority of ORS 656.248, and SB 620 does not refer to ORS 656.248, but only to ORS 656.245, 260, 327, and .340.

Response: We agree and will delete all references to attorney fees from this rule.

OAR 436-009-0008(2)(a)
Testimony: Exhibit #24
Proposed subsection (2)(a) states: "If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director." We do not send fee disputes to MCOs even if they have a dispute resolution process in place. It is our understanding that MCOs do not want to become involved in fee disputes. Providers and workers are already informed of their appeal rights with the director through the explanation of benefits they receive with payment. The proposed language should be deleted as it adds a layer of bureaucracy to a process that already works well.

Response: This concept is not new, but moved from (1)(c) of this rule and simplified**.** The purpose of the rule is to clarify the process that is current practice. While in general the rules require a party to first go through the MCO process, that is not a reasonable requirement if there is no MCO process. Other timelines and procedures then apply. If an insurer is notifying parties with the bill of their entitlement to appeal to the director, that already complies with the new rule, and does not add a layer of bureaucracy.

OAR 436-009-0008(4)(c)(A), (B), & (C)
Testimony: Exhibit #24
We appreciate the department's acknowledgement of the need to allow medical providers and insurers to resolve disputes without going through the formal dispute process. However, the rule states the director may revise the final agreement or reinstate the review under certain conditions. All issues should be addressed before the agreement becomes final. If the department's concern is that workers may not truly understand the process, limit the use of agreements to include insurers, providers, and workers who are represented. A final agreement is just that, final.

Response: We believe that the short list of conditions listed would require a reinstatement of the review except the provision that allows reinstatement if all parties agree. We believe that if all parties agree, the director should allow it. The others allow reinstatement if one or both parties fails to honor the agreement, the agreement becomes infeasible or it was based on a misrepresentation.

OAR 436-009-0010(3)(a)
Testimony: Exhibit #10
The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend this subsection accordingly. Also, delete the language that requests the provider's social security number and instead refer to the option of providing a federal tax reporting identification number.

Response: We will make this change.

OAR 436-009-0010(7)
Testimony: Exhibit #24
We recommend deletion of the second sentence of this section, that states in part that mere submission of the bill by the provider shall serve as warrant that the fee submitted is the provider's usual fee for the services provided. Inconsistent billing patterns may indicate unintentional mistakes or possibly fraud. The language of this rule would make a lack of knowledge defense by the provider difficult to make, when that may in fact be the case. If the department is concerned that insurers will not pay bills because they believe they don't represent the provider's usual fees, there is already a dispute process in place to address that concern. If the department is concerned insurers may misuse this rule, again, there is a process in place that can also result in penalties to insurers.

Response: We believe it is appropriate to expect medical providers to “warrant” that their bill is their usual and customary fee, and have had no complaints from medical providers that this is a potential problem for them.

OAR 436-009-0020(3)(b)(C) & (3)(j)
Testimony: Exhibit #24
This rule requires payment in full to out of state hospitals, and the wording of the rule even inhibits an insurer’s ability to reimburse at the rate of that state. Out of state providers will not negotiate a lower fee when they know they must be reimbursed in full by the insurer. The rule should either be eliminated entirely or revised to say services will be paid as negotiated. If the concern is that the worker should not be billed for balances not paid by Oregon insurers, the rule should require a clause in the agreement stating that the worker will not be billed for the remaining balance for compensable services related to the workers’ compensation claim.

Response: We are concerned about workers being burdened with balance billing if insurers are able to negotiate a lower price with the hospital, but also are concerned about making it difficult for insurers to control costs. This is a complex issue, and we will keep it on the issues document for the next rule revision process.

OAR 436-009-0030 Appendix A language:
Testimony: Exhibit #10
The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend the Appendix accordingly. Delete references to the provider’s social security number and instead refer to the federal tax reporting identification number. See the testimony regarding OAR 436-009-0010(3)(a) for this exhibit number.

Response: We will make this change.

OAR 436-009-0030(9)(b)(B)
Testimony: Exhibit #24
The last sentence should end “ICD-9-CM diagnostic code” rather than procedure code.

Response: We will make this change.

OAR 436-009-0030(9)(d)
Testimony: Exhibit #10
Revise the following sentence as shown: ~~Only i~~Insurers transmitting data for more than one insurer may batch multiple insurer data **files** in one ~~file~~ **transmission** . . . "

Response: We will make this change.

OAR 436-009-0040(3)
Testimony: (Exhibit #3)
We support the revision to allow an insurer to dispute (under OAR 436-009-0008) a provider's "usual and customary" fee as being unreasonably high; however, if the provider prevails, he or she should be able to recover reasonable attorney fees.

Response: Based on past experience, we believe there will be few cases where the provider's usual and customary fee is found to be unreasonably high. Most fees are governed by the fee schedule, and this only applies for the relatively rare cases of "pay as billed," and the insurer believes the provider's charges are unreasonable compared to the industry as a whole. We do not believe the current statute has a provision for an award of attorney fees to medical providers.

OAR 436-009-0040(4)
Testimony: Exhibit #24
We are still concerned about the impact of much higher workers' compensation conversion factors, when compared to healthcare factors, on employer medical and insurance costs. The consumer price index (CPI) relates to what consumers pay, not to what it costs to provide services. It appears you want to automatically apply the medical component of the CPI to the fee schedule each year. The statute requires more rigorous review prior to adjusting fees than to merely apply the CPI automatically without hearing or due process. Consider alternatives to the CPI; at least it should not be the sole determinant to changing the fee schedule each year.

The annualized average rate of increase in the CPI over the last 56 years is 5.3%. Since 1990 it is 3.9%. In only four of the last 56 years has the increase been less than the current 2.3%. Between 65% and 72% of medical dollars paid are subject to the conversion factors. We estimate the 2.3% increase will increase our medical costs by $1.6 million dollars. If over the next four years the rate increase is at the average since 1990 (3.9%), at the end of 5 years, just due to the increase in the conversion factors, we will have an increase of $13.45 per year.

The department's fiscal impact statement said other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates. Our calculations don't come close to offsetting payment of an additional $1.6 million. The 6%+ savings projected based on proposed pharmacy changes appear to be based on the assumption that we reimburse pharmacies at the current rate of AWP minus 5% plus a $6.70 dispensing fee. The assumption is incorrect. SAIF and the other major workers' compensation carrier in Oregon use a Pharmacy Benefits Manager (PBM), and the rates we have negotiated with our pharmacies through the PBM are much more in line with the proposed reimbursement rates than the current rates.

Response: By this current rule revision, we are simply increasing the conversion factor for this year only, for the first time in several years. Each year we will consider an adjustment based on an array of relevant factors. We do believe the increase will be offset by other cost drivers.

OAR 436-009-0040(4)
Testimony: (Exhibit #3)
We support the 2.33% increase in the conversion factors.

Response: We will include this provision in the permanent rules.

OAR 436-009-0070(2) & (3)
Testimony: Exhibit #9
". . . by the attending physician" and "attending physician's" were inadvertently deleted in the proposed rules. The deleted wording should be reinserted, as well as "or authorized nurse practitioner," and thus make the wording match the temporary rule.

Response: We agree and will make the appropriate revisions.

OAR 436-009-0070(4) and (12)
Testimony: Exhibit # 6
See amended testimony submitted as Exhibit #11.

Response: NA

OAR 436-009-0070(4)(a) & (b)
Testimony: Exhibit #24
This rule should make it clear that additional time components should be billed only when multiple or additional body parts are reviewed. Some providers are confused on this issue.

Response: We agree, but believe the proposed language makes this clear.

OAR 436-009-0070(4)(a)
Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski
The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.]
"**This** [first level PCE] **is a limited evaluation to measure the musculoskeletal components of a specific body part as required for claim closure which are: AROM, motor power using 5/5, and 2 point discrimination.**

Response: The proposed rules incorporate these recommended changes, and the changes will be included in the permanent rules.

OAR 436-009-0070(4)(b)
Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski
The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “Additional 15 minute increments ~~(per additional body part) may be necessary to establish endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion)~~ **may be necessary to measure additional body parts, and/or establish endurance, and/or to project tolerances**.”

Response: This change was incorporated in the proposed rule and will be incorporated in the permanent rule.

OAR 436-009-0070(4)(c) & (d)
Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski
The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “**This [work capacity evaluation] is a PCE . . . with special emphasis on 1) the ability to perform essential physical function of the job, based on a specific job analysis as related to the accepted condition, 2) the ability to sustain activity over time and 3) the reliability of the evaluation findings. Other general evaluation information . . . may be included in accordance with requirements for claim closure. This level requires not less than 4 hours of actual claimant contact** [current rule wording requires not less than 6 hours]**. A record review is required before the evaluation begins**.”

Delete subsection (4)(d).

Response: Most of the concepts in this suggestion were incorporated in the proposed rules and will be incorporated in the permanent rules.

OAR 436-009-0070(12)
Testimony: Exhibit #9
The division inadvertently deleted “attending physician” from the table in this section (next to N0001/brief narrative). The deleted wording should be reinserted, as well as “or authorized nurse practitioner.” To be consistent, add to “complex narrative” (Code N0002), “by the attending physician or authorized nurse practitioner.”

Response: We will make the change.

OAR 436-009-0070(12)
Testimony: Exhibit #11
We propose a price increase for physical capacity evaluations (PCEs). Clinics routinely have labor expenses above and beyond the identified evaluation contact time: 10 to 30 minutes authorization process, 15 minutes clerical support, 15-30 minutes of record review by therapist(s), 15-30 minutes of report time by therapist(s), and 15-30 minutes for clerical support to transcribe and mail the report. Under the current fee schedule, therapists perform PCEs for less money than a standard procedure when breaking it down into 15-minute billable units. We request the following fee increases:

Code 99196	First Level PCE	Increase Relative Value to 2.77
Code 99197	Second Level PCE	Increase Relative Value to 5.54
Code 99193	Additional 15 minutes	Increase Relative Value to 0.94

Response: The relative value units for these services were developed by a broad group of stakeholders, and reimbursement for these procedures will be increased by the across-the-board increase in the conversion factors. Any specific change to the relative value units or a particular conversion factor would need to be developed through a thorough interchange between various stakeholders.

OAR 436-009-0090
Testimony: Exhibit #4
Regarding the proposal to limit reimbursement for four drugs – Oxycontin, Vioxx, Celebrex, and Neurontin – to an initial 5-day supply unless the physician writes a clinical justification, this will create more paperwork for providers – in contrast to the goals of the Paperwork Reduction Taskforce, which was formed by the Workers' Compensation Division a few years ago, in recognition of providers' paperwork burdens.

"Clinical justification" is not defined. Who reviews it, the claims examiner? IMEs or file reviews about whether a patient should take a prescribed drug or a less expensive drug will result in more paperwork and expense to "justify the justification."

Only changes in U.S. law can slow the increases in drug prices – pressuring providers to use less desirable drugs is not the answer. The four drugs listed represent improvements over alternatives in many situations. Before Neurontin was available, physicians prescribed carbamazepine, which can cause bone marrow failure, and now use of carbamazapine requires a complete baseline blood screening test and follow-up white blood counts. Celebrex and Vioxx are superior to alternatives in pre-operative patients, as they do not interfere with the effect of platelets on blood clotting. If we keep the list, Bextra, another cox-inhibitor, should be added to the list or it will likely be prescribed in place of Vioxx and Celebrex at no savings to the system (from addendum to Exhibit 4). The cost of Oxycontin is exorbitant. Its value is that it need only be taken twice per day. Some alternatives are less easily controlled, such as methadone, though long acting forms of morphine may be less expensive. It would be useful to provide cost information to providers.

I recommend that the Department consider creating a program that would address the problem of drug costs that relies on clinical studies of comparative effectiveness of drugs and the education of practitioners. I suggest a Pharmacy Review Program, in which the cost and usage information from insurers is shared with a group of physicians, pharmacists, and workers. Publish cost summaries of frequently prescribed medications, along with the costs and suggested dose schedules for alternatives. I respectfully request that this rule not be enacted, and that a program which shares information about drug costs and alternatives be created.

See response to testimony below.

Testimony: Exhibit #12
The division does have an obligation to be concerned about the cost of medications. However, the proposed rule making reimbursement for (more than a five-day supply of) Oxycontin, Vioxx, Celebrex, and Neurontin contingent on the physician's clinical justification, implies that, unless there is a watchdog, physicians routinely prescribe medications that are not "clinically indicated." The only thing these drugs have in common is their cost. It would be more honest to use the term "unless economically indicated."

See response to testimony below.

Testimony: Exhibit #15
The proposed rule does not reflect the consensus of the Pharmacy Fee Advisory Task Force. The minutes from the final meeting show the group favored a dispensing fee somewhere between $6.70 and $8.70. Also, the meeting summary noted general support for limiting certain brand name, cost-driver medications to a three business day supply on the initial prescription, unless clinical justification is provided. We recommend in section (1): an $8.70 dispensing fee; in section (2), a limit of a three-day supply of the named drugs (or a clinical justification) with the qualification "on the initial prescription," and, also in section (2), insertion of the word "generic" as follows: ". . . clinical justification for prescribing that drug [Oxycontin, Vioxx, Celebrex, or Neurontin] rather than a less costly **generic** drug with a similar therapeutic effect.

See response to testimony below.

Testimony: Exhibit #17
We oppose the reduction in the pharmacy reimbursement rate. We feel that the division did not examine the financial impact on the pharmacy provider who may be forced to fill prescriptions at a reimbursement rate below the provider's cost, or the cost savings role proper pharmacy care can provide, in the form of early return to work and fewer surgeries. Finally, we feel the division failed to fully examine the most detrimental impact, reduced worker access to quality pharmacy care, because workers' compensation pharmacy is purely voluntary for the pharmacy provider.

Workers' compensation pharmacy claims require more of a pharmacist's professional time and carry far greater risks than State Medicaid or Group Health prescriptions. In fact, most states today provide a higher reimbursement rate for workers' compensation prescriptions than are paid through Medicaid or Group Health.

Our data shows that once a drug or drug ingredient exceeds $33, the pharmacy begins to lose money on each prescription. Regardless of the proposed increase in the dispensing fee, the reduced reimbursement for the drug ingredient cost will cause pharmacists to lose money on many workers' compensation prescriptions. Pharmacy providers will be unwilling to lose money on high priced prescriptions and begin to withdraw from serving injured workers. California provides an example for Oregon. Effective 1/1/04, reimbursement for workers' compensation prescriptions was reduced to the MediCal rate (AWP – 10%). Several large pharmacy chains have stated that they no longer fill workers' compensation prescriptions. A recent study by the California Pharmacy Association Educational Foundation found that 65 percent of its members said that they would no longer fill workers' compensation prescriptions at the MediCal rate. Oregon has proposed an even more drastic cut that would cause greater access issues for Oregon. An NCCI October 2003 study found reducing fee schedule reimbursements to dangerously low levels would cause pharmacy access issues for injured workers.

Oregon already has one of the lowest reimbursement rates to pharmacists. Reducing reimbursement to the pharmacy does not control the underlying problem: the rising costs of prescription drugs. We suggest that the division look to other health care models and engage in practices that will help control the root problem of rising drug prices by: 1. Creating tighter controls on physician prescribing patterns, 2. Utilizing step therapy programs at the physician and pharmacist level, and 3. Creating non-restrictive formularies or preauthorization controls.

Our data show that nearly 57% of Oregon workers' compensation pharmacy transactions are already generic. This number is very close to what Group Health or State Medicaid programs can achieve with generic mandates, so the intent of the proposed rule to drive more generic utilization will not reduce system costs. Further, our data shows that 83% of brand drug fills have no generic substitute. Pharmacy providers will lose money on nearly all of these transactions because the proposed reimbursement level is below pharmacies' cost of doing business.

We request that the division rescind the proposed rule and that the division postpone any final decision on the proposed rule until more testimony and input from pharmacy providers and other stakeholders can be provided.

See response to testimony below.

Testimony: Exhibit #18
Within our program, generics average around 60% or above of prescriptions dispensed. We expect little increase in generic volume, as the percentages are already relatively high. If proposed rates are implemented, brand fills with no generic available will be dispensed at under cost. We recommend either leaving current reimbursement levels for brand drugs as is, or if need be AWP minus 10% + $10.00. Consider payment for generics at a higher level to support their use. We suggest an AWP plus option: AWP + 5% plus $8.50.

Regarding limitations affecting Oxycontin, Vioxx, Celebrex, and Neurontin, the rules need to address if the justification covers just the initial fill or multiple refills. If repeat justifications are needed, who is responsible to obtain or provide them, the patient, pharmacist, doctor? Any delay in obtaining pain medication needs to be avoided if at all possible.

Within current rules payment will be based upon the lower of either the provider's usual and customary charge or the fee established by this rule. This provision gives the director authority to determine if a submitted U&C is excessive when compared to other providers. This provision is ambiguous and provides interpretation on a case-by-case basis as to what is reasonable for payment if not paid at established rates. In many states disputes have arisen over what constitutes usual & customary. We recommend deletion of the reference to usual & customary and make the rule reflect a true fee based system. Proposed amended language: "Payment will be ~~the lower of either the provider's usual and customary charge or~~ the **fee established by this rule**."

See response to testimony below.

Testimony: Exhibit #19
We participated in the Workers' Compensation Pharmacy Fee Advisory Task force, and the proposed rule appears to be consistent with the recommendations of the Task Force. By increasing the dispensing fee to a level that more appropriately reflects pharmacy dispensing costs, lowering the AWP rate, and requiring clinical justification for the use of certain drugs, the proposed rule provides appropriate incentives for pharmacists and pharmacies to encourage use of *cost-effective* drug therapies. We recommend you clarify the clinical justification process such that once submitted, the justification carries over to any refills authorized the prescribing practitioner.

See response to testimony below.

OAR 436-009-0090(1)
Testimony: Exhibit #24
The Pharmacy Fee Advisory Taskforce made its final recommendation to the Department of Consumer and Business Services to modify the rules as follows: 1) If a brand medication has a generic equivalent, the pharmacist will dispense the generic; 2) If a brand drug has a therapeutic equivalent, the pharmacist would contact the physician to see if the therapeutic substitution could be made, and that a higher dispensing fee -- $10.00 – would be appropriate in these instances, but not across the board; all other fills and refills of the therapeutic equivalent should remain at $6.70; and 3) See OAR 436-010-0230(6) for Exhibit #24.

See response to testimony below.

OAR 436-009-0090
Testimony: Exhibit #26
Regarding the proposal to limit reimbursement of OxyContin, Vioxx, Celebrex, and Neurontin to an initial five-day supply unless the medical provider writes a "clinical justification" for the drug: The Oregon Medical Association (OMA) recently polled a sample of its members who treat workers' compensation patients. The results suggest that adoption of the proposed rule would discourage physicians from seeing workers' compensation patients and that it would affect patients' access to timely care.

"Clinical justification" is not defined in the proposed rules, and the absence of clear definition will erect paperwork barriers, adding unnecessary costs and jeopardizing timely access to care. What criteria will be used to determine what is clinically justified and what is not? Will a physician need to repeat the justification every time he or she writes a script for the same patient?

These drugs are not first line drugs, so other drugs will have been tried first. What is the need for requiring additional documentation? The prescription itself should stand as "clinical justification" by the prescribing physician. The OMA would be interested in exploring other possibilities, such as the Pharmacy Review Program, which was recommended by Dr. David Silver. We request that the proposed rules not be implemented and that other alternatives be discussed.

Response: Revamping the pharmacy fee schedule has indeed required a careful balance between many competing forces. Last year, WCD convened a Pharmacy Fee Advisory Task Force which met four times over several months to review concerns and make recommendations about pharmacy fees. The recommendations were then reviewed by the medical rules External Advisory Committee and the Medical Advisory Committee. Finally, we received a great deal of public comment, much of it directly in contrast to other comment. Some comments have contended the dispensing fee is higher than recommended by the Pharmacy Task Force. Others have expressed concern that the reduction in the percentage of AWP will drive many pharmacies from participation in workers' compensation. We note that the Oregon system already tended to have a lower percentage of AWP than other states' workers' compensation schedules, but also higher dispensing fees. We believe this combination favors and encourages dispensing lower cost alternatives wherever allowable. We have made some adjustments to the rule based on the public comment. We have increased the percentage of AWP from 85% to 88%, while decreasing the dispensing fee from $10 per prescription filled to $8.70 per prescription filled. This will create a somewhat smaller impact on payment to pharmacies. For the less expensive drugs, the new payment will be a little lower than proposed. For example, a drug with an AWP of $20.00 will be paid at $26.30 instead of $27.00. Under the current schedule, it would be paid at $25.70. Higher cost drugs will be cut less than under the proposed rules. For example, a drug with an AWP of $100 will be paid at $96.70 instead of $95.00. Under current rules, it would be paid at $101.70. These changes will still provide incentive to dispense lower cost drugs over higher cost drugs.

Another change made as the result of the testimony received was to eliminate Neurontin from the list of drugs requiring clinical justification. Unlike the other drugs on the list, this drug was not

part of the studies completed by the Oregon Health Plan, and is not covered by the Oregon Health Plan drug formularies. We added Bextra to the list because it is another cox inhibitor like Celebrex and Vioxx which are on the list. We are also sensitive to the concerns raised by the OMA and medical providers. We not only clarified the language to make it clear that the clinical justification need only be a simple statement explaining why the prescribed drug is the best drug for this patient, but also that the justification is not subject to review and approval by the insurer. The intent, as expressed by the Pharmacy Fee Task Force, is to create a “pause” to let the doctor consider if a therapeutically similar, less expensive drug might be as effective in treating the patient. Oxycontin alone accounts for over 10% of every dollar spent for drugs in Oregon’s workers’ compensation system, and over 1/5th of every dollar is spent on Oxycontin and the cox inhibitors. It was suggested that rather than create this paperwork “hassle,” WCD appoint an advisory council to advise medical providers on the options to prescribing the identified “cost-driver” drugs. We will look into that as an alternative with the OMA and the workers’ compensation Medical Advisory Committee during the upcoming year.

OAR 436-010-0008
Testimony: Exhibit #3
See recommendations regarding OAR 436-009-0008 for Exhibit #3.

OAR 436-010-0008(13)
Testimony: Exhibit #24
“Professional Hours Devoted” should contain the statement about the hours that a reasonable attorney, well trained in workers’ compensation law, would expend on the matter at issue. The rule should also provide that “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix. The attorney fee provisions in Senate Bill 620 do not include ORS 656.247 or 656.248 and therefore do not apply to medical fee disputes.

Response: It was the intent in creating and adopting a matrix system to keep the attorney fee procedure as simple and non-contentious as possible. We believe that qualifiers such as these suggestions will complicate rather than simplify the process and give rise to more disputes.

OAR 436-010-0210(7)
Testimony: Exhibit #24
Nurse practitioners should be required to complete a self-test on the key elements of workers’ compensation law and their responsibilities to treat Oregon injured workers, a concept supported at a recent Nurse Practitioner sub-committee meeting.

Response: A voluntary self-test is included in the packet of materials provided to the nurse practitioners. We do not believe the statute supports a rule requiring it.

OAR 436-010-0220(3)(f)
Testimony: Exhibit #24

Should the referral to an attending physician for completion of the closing examination count as a worker choice? The language in subsection (f) does not cover this scenario.

Response: We agree this referral does not count as a choice and have revised the language.

OAR 436-010-0230(4)(a)
Testimony: (Exhibits #2 and #3)
We support the intent of the proposed change. The current rule provides a basis for insurer denial of payment to a physical therapist if the attending physician fails to sign the treatment plan within 30 days of the beginning of treatment. The attending physician's timeliness is outside the control of the physical therapist, yet it is the therapist who has suffered the financial consequences of the current rule – not the worker or the physician.

However, the rule remains ambiguous. The third sentence in subsection 0230(4)(a) still requires the physician to sign within 30 days. Some insurers will likely deny payment and the therapist will be required to go through a fee dispute resolution process. We propose the alternative of making reimbursement contingent on having the ancillary care provider send the treatment plan to the physician and to the insurer within seven days of beginning treatment. This gives the physician and the insurer an early opportunity to review the plan and raise any concerns or questions. We also propose requiring the physician to sign a copy of the treatment plan within 30 days after treatment begins and send the plan to the insurer.

Response: We have revised the language to add clarity about what is due, when it is due, and what the appropriate consequences are.

OAR 436-010-0230(4)(a)
Testimony: Exhibit #24
The requirement for a signed treatment plan by the attending physician should not be deleted. The current requirement that an attending physician sign the plan within 30 days of the start of ancillary services allows for checks and balances between the ancillary provider and the attending physician. Without a signed plan and a connection to payment for the ancillary services, treatment could continue indefinitely – even if the worker stops treating with his or her attending physician.

Response: The requirement for the attending physician is not deleted, but the rule is changed to make it clear that the attending physician, not the ancillary care provider, is held accountable.

OAR 436-010-0230(6)
Testimony: Exhibit #15
The Pharmacy Fee Advisory Task Force also addressed dispensing of drugs by a physician's office. We believe the group's intent was to limit the amount dispensed to a five-day supply. We recommend this section be revised to include a five-day limit.

Response: There was a lot of discussion about this issue, and 10 days was selected because of the need to dispense an adequate amount of antibiotics to complete a course of therapy.

OAR 436-010-0230(6)
Testimony: Exhibit #24
This section should not be modified but remain as is allowing for medications to be dispensed from physician offices only in the case of an emergency. The Pharmacy Fee Advisory Taskforce unanimously, and all but two members of the Division 009 & 010 Advisory Committee, recommended that this rule not be changed (current wording: "Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.". The proposed rule allows for a maximum supply of 10 days. If the rule was intended to allow patients access to first script medications, the rule doesn't limit fills to first scripts. The rule may promote additional office visits for additional medication, increasing costs for both office visits and dispensing fees. If the physician provides an initial supply and writes a prescription for the longer term, the insurer will pay two dispensing fees instead of one..

Response: The rule allowing a 10-day supply is a compromise between competing interests on this issue. We agree with the physicians who support this concept that there are times when it is medically in the best interests of the patient to assure the patient receives the prescribed drugs. We also understand the concerns about quality control expressed by others. A 10-day supply will allow the doctor to dispense a reasonable starter course of medication or a complete course of antibiotics (in most cases.)

OAR 436-010-0240(12)
Testimony: Exhibit #16
I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

Response: We agree and have modified the language to clarify this requirement.

OAR 436-010-0240(12)
Testimony: Exhibit #24
This rule requires a nurse practitioner to refer a worker to an attending physician for a closing examination, and does not limit the requirement to disabling claims. If closing examinations are required on non-disabling claims, this will add a cost to the system that is unwarranted and unnecessary. In addition, if the nurse practitioner believes the worker has no permanent impairment, the nurse practitioner should be able to state this and not refer to an attending

physician. For each referral, the insurer will have to pay a new patient level office visit fee in addition to a closing examination fee.

Response: As noted above, we have clarified that this rule applies only to disabling claims. The provision that exempts certain claims from the requirement to complete a closing exam when an attending physician finds "no impairment" cannot be applied to claims managed by an authorized nurse practitioner because "no" or "zero" impairment are findings of impairment and cannot legally be made by the nurse practitioner.

OAR 436-010-0240(18)(b)&(c)
Testimony: Exhibit #15
For clarity and consistency, we recommend the following wording change to these subsections: "For the purpose of this rule, '**protected** health information in the medical record' means any oral or written information . . . (c) . . . Upon request, the entire health information record**, including any protected health information,** in the possession of the medical provider . . .

Response: We have modified the rule to add clarity.

OAR 436-010-0250(13)
Testimony: Exhibit #24
Regarding elective surgery notifications, we would like the opportunity to state that more information is needed before deciding if a second surgical opinion is warranted. The current form doesn't allow for any objection, other than to notify the physician a second surgical opinion is being obtained. Also, insurers should have 14 rather than 7 days to respond to an elective surgery request, as seven days does not allow sufficient time to assess the need for a second surgical opinion.

Response: We believe this recommendation is a significant departure from the current process and should be reviewed by a broader group of external advisors. We can include a review of the elective surgery procedure during the next revision of these rules if external parties wish to do so.

OAR 436-010-0265(11)
Testimony: Exhibit #24
We object to the proposed requirement that the insurer send a copy of the insurer medical examination (IME) report to the attending physician within 72 hours of receipt. IME providers can forward the report to the attending physician sooner; by transferring the responsibility to the insurer, the rule adds unnecessary delay to delivery of the report. We also propose the language about the IME should refer to "examining physician or IME company" to more accurately describe whose responsibility it is to send the report to the attending physician.

Response: We revised this requirement in the proposed rules because it is an administrative requirement more properly imposed on the insurer managing the claim than on a doctor

providing an examination. The change is in response to considerable evidence that examining physicians are not fulfilling this requirement, which then interferes with a workers' ability to obtain a Worker Requested Medical Examination. We have modified the language to add "(s)" to physicians to clarify that the responsibility to send a report to the insurer is a collective responsibility of physicians completing the examination and report.

OAR 436-010-0265(11)
Testimony: Exhibit #25
Regarding the proposed requirement that the insurer forward a copy of the insurer medical examination (IME) report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt: I am not opposed to the rule, but note that this rule section already requires the IME physician to send a copy of the report to the attending physician within seven days. Is it really necessary for the treating physician to receive a copy from two sources? This duplicates effort and expense. The insurer usually includes a concurrence request along with the report, whereas the IME physician provides no explanation as to why it has been sent. I propose that the responsibility for sending a copy of the IME report to the treating physician be with the insurer and that OAR 436-010-0265(11) be removed from the medical rules.

Response: We have deleted the requirement for the IME doctor to submit a copy to the attending physician.

OAR 435-010-0270(3)
Testimony: Exhibit #3
This issue was presented to the Medical Advisory Committee as Primary Issue #8 under Division 010. The stated option was to "require the insurer to provide simultaneous notice to the <u>medical providers</u> [Emphasis added] on denials, partial denials or changes in status, whether or not a denial is on appeal." The proposed section only requires notice to the attending physician or authorized nurse practitioner, and not any other medical service providers, such as a physical therapist, who may be the only provider actively treating the worker. Therapists suffer financial losses when they are not informed that a claim has been denied. If notified, the therapist can contact the worker's private health insurer, if any, or discuss payment terms with the worker if treatment is to continue. The insurer should contact any medical service provider known to the insurer when it denies or partially denies a previously accepted claim.

Response: In the Oregon workers' compensation system, the attending physician has a gate-keeper function that makes it imperative for the attending physician to know what the status of the claim is. The AP makes referrals to other providers and has oversight responsibility for care provided. The insurer may not even be aware of everyone who might be providing care until it receives bills for payment. This provision is a compromise to assure the gate-keeper has adequate information to make decisions about a workers' care, while maintaining a reasonable administrative burden on the insurer.

OAR 436-010-0270(4)
Testimony: Exhibit #24

Regarding the addition of a time frame for insurer responses to requests for prior medical records, the rule section should specify that the request be in writing, so insurers can comply with the specific needs of requesters.

Response: To require the request be in writing is not necessary and may be overly prescriptive.

OAR 436-010-0270(7)(a)
Testimony: Exhibit #24
We object to the specificity of this proposed language. Nurse practitioners are probably not as prevalent as other medical practitioners that would also qualify as suitable attending physicians in certain geographic areas. We anticipate this would add additional mileage expense to the claim. We propose you change the language in the first sentence to "Reimbursement . . . for transportation costs . . . may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician or nurse practitioner who is in a geographically closer medical community in relationship to the worker's home."

Response: The intent of SB 3669 was to allow workers access to nurse practitioners in all cases, but was not intended to require a worker to select a nurse practitioner instead of a physician only because the nurse practitioner was closer geographically to the worker. We needed to make this distinction clear in the rule that a worker is entitled to full reimbursement for transportation costs so long as they are receiving care from the closest type of practitioner of their choice.

OAR 436-010-0280(1)
Testimony: Exhibit #16
I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

Response: We have made this clarification.

OAR 436-030-0165(3)(c)
Testimony: Exhibit #5
The three-day response time for the deselection process is not long enough. A longer period, perhaps ten days, would seem more appropriate. In order to respond, the file must be pulled and reviewed to see what conditions are at issue, and arbiter options must be discussed with the client. In the rare occasion where the parties may want to stipulate on an arbiter, there is insufficient time to contact the opposing counsel and come to an agreement.

Response: The medical arbiter deselection process represents a way whereby the parties retain some control over the selection of the arbiter physician. But in implementing this process, a price has been paid, that being in terms of timeliness. The new timelines associated with deselection can be challenging. However, over the past year most attorneys have adjusted to the demands of this new process by restructuring their intake process for referrals from their clients.

Historically, the department did look at various aspects of the deselection process, including timeliness, during the pilot study of 2001. An eleven member advisory committee from the workers' compensation industry provided input at that time, followed by in-depth questioning of the actual participants in the pilot (claims handlers, attorneys, etc.). By consensus, it was decided that a three-day turn around for response to the deselection notification letter was adequate.

Part of the consensus process was the fact that the statute allows the department a period of 60 days within which to process, schedule and obtain a medical arbiter evaluation. While this may seem generous, the reality is that the Appellate Review Unit needs all the time it can garner to ensure the medical arbiter's report is received and they secure any clarification of arbiter findings that may be required in time to be used in the order on reconsideration. The medical arbiter scheduling process diminishes the time rapidly because of numerous steps involved, plus the department's obligation to schedule the exam at least two weeks out from the date of the medical arbiter appointment letter, which is triggered only after the deselection response period has expired. This coupled with the time lag often associated with obtaining the arbiter's written report, makes it impractical to lengthen the period of response as suggested by this testimony.

The rule will remain as proposed.

OAR 436-030-0055(1)(h)
Testimony: Exhibit #15
The proposed definition for "withdrawn from the workforce" needs additional clarification of what constitutes a withdrawal from the workforce by adding "Such withdrawal is considered to be complete and permanent."

Response: Adding the suggested language would not be accurate unless it was applicable to the period in question, which is already addressed in OAR 436-030-0055(3)(d) and (4)(a). The proposed rule will be modified but based on Exhibit #21 testimony.

OAR 436-030-0003(3)(a)
Testimony: Exhibit #21
A verb is required in the second sentence of this rule.

Response: Agreed. The rule will be modified to include a verb.

OAR 436-030-0007(1)(b)
Testimony: Exhibit #21
The proposed change could be construed to give the director authority to abate or amend an Order on Reconsideration at any time even after the case has gone to the Board for a hearing. There is no reason for the director to maintain jurisdiction once a hearing has been requested. We suggest that the current language remain.

Response: The intent of the rule change is to clarify that the director does have and has had the authority to withdraw an order on reconsideration up to the time the order becomes final. The director has been given by the Legislature the plenary authority to decide matters committed to DCBS, unless clearly limited by statute. There is no legislatively imposed limitation on the director's authority to withdraw an order on reconsideration prior to that order becoming final. The rule will remain as proposed.

OAR 436-030-0007(3)(a)
Testimony: Exhibit #21
This rule illustrates the inconsistency in appeal procedures that will exist if all of the rule divisions are adopted as proposed. In other divisions, it is proposed that appeals are timely if received by the due date, rather than mailed by that date. This is a different standard than contained in this rule and a different standard than that used by the Worker's Compensation Board. Stakeholders are best served by a consistent regulatory standard. All rules should use the mailing date, for reasons expressed in Division 001 testimony.

Division 001 (OAR 436-001-0155(1), testimony stated that under the existing rule the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. Recent weather-related problems caused many Oregon Post Offices to suspend service and to add a Sunday delivery to clear a backlog. The new rule would cause filings to be deemed untimely for reasons beyond the control of the party making the filing.

The division 001 proposed rule would create different standards for WCD and WCB. The Board uses mailing date, not date of receipt. DCBS should use consistent procedures, so that it is easier for the public to do business with the department.

Furthermore, ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law". The proposed rule is an impermissible deviation from statute.

Response: We agree. Under ORS 656.726(4)(a), "Mailing date" determines timeliness.

OAR 436-030-0023
Testimony: Exhibit #21
"Rescinding Notice of Closure" is a title understood by regular system participants, but its legalese is likely to confuse an unrepresented worker who receives such a document through the mail. "Withdrawal of Notice of Closure" would be a better title.

Response: The word "rescinding" in the form "Rescinding Notice of Closure" does appear to be legalese but once the worker reads further down the form the intent becomes very clear. The first sentence states, "This is to advise you that your workers' compensation claim closure has been reversed and your claim returned to open status." In addition, the insurer has an area on the form to specifically explain why the worker's closure has been withdrawn and the claim has been reopened. Together, these statements clearly inform the worker what has happened with their claim.

Additionally, the department does not have any evidence that would suggest that "withdrawal" would be a better understood word to use than "rescind". What is known is that the word "rescind" is the common term within workers' compensation and what is used on forms and in brochures. To change these terms would require additional costs and time, which cannot be justified and spent without significant supporting evidence. The rule will remain as proposed.

OAR 436-030-0023(3)
Testimony: Exhibit #21
The term "current date" as used in this rule is confusing. We suggest "the date of the correction or withdrawal."

Response: The director agrees, but with the more general perspective that some modifications are needed to clarify that the "current date" must be the date the document is mailed.

OAR 436-030-0034(1)
Testimony: Exhibit #21
The rule should not require claim closure if there has been no treatment for 30 days. There may be extenuating circumstances, when the best interests of the parties would be served by allowing the claim to remain open. Insurers should have the discretion to make the best judgment in the individual case. We request that the word "may" be left in this rule.

Response: The testimony presents a reasonable argument, but the change in wording from "may" to "must" is required because "may" is in direct conflict with OAR 436-030-0020(1) and ORS 656.268(1). The rule will remain as proposed.

OAR 436-030-0034(6)
Testimony: Exhibit #21
Copies are routinely sent to medical providers. In the infrequent case where the notice is not sent, this should not be grounds to nullify a closure. We suggest adding the following sentence:

"Failure to send a notice required by this rule may subject an insurer to civil penalties, but will not invalidate the closure".

Response: The attending physician's and/or nurse practitioner's input on their patient's claim closure has been and will continue to be a critical part of the workers' compensation system. If the medical providers are not sent the required copies, then the claim closure may be rescinded. How critical the information (on the notification and denial letters) is to claim closure will determine if the closure will be rescinded or not. This is not a new procedure, nor is this a new rule. The rule has just been moved, and nurse practitioner has been added as mandated by House Bill 3669.

The recommendation is not an effective remedy when considering the importance of the medical provider's participation in the claim closure process. Rather than rewrite the rule, review or revision of internal procedures may be necessary to ensure that all necessary documentation is copied to the medical provider. The rule will remain as proposed.

OAR 436-030-0055(1)(h)
Testimony: Exhibit #21
The last sentence of this rule is redundant, but if the rule is to be retained, "retirement" should be defined. Otherwise, it could be interpreted to mean collecting Social Security, collecting a company pension, collecting IRA or 401(k) distributions, ceasing employment without intent to seek new employment, etc.

Response: The director agrees that the term "retirement" is not clearly defined. The intent of the proposed language was to (1) establish the fact that a worker who is receiving retirement benefits (e.g. Social Security, company pension payments, etc.) is not necessarily withdrawn from the workforce, and (2) require an insurer or self-insured employer to use more than the fact a worker is receiving 'retirement benefits' to establish that the worker has withdrawn from the workforce. There are numerous examples of workers who receive such benefits and still are working in the workforce. Individuals may retire from the military, state, or federal government and then get another job in the private sector or return to government work. Individuals may receive Social Security but continue to work. Employees may collect company pensions and return to the workforce to supplement that income. The proposed language will be modified to better reflect such circumstances.

OAR 436-030-0065(1)
Testimony: Exhibit #21
Two changes in the proposed rule seriously undermine the management of Permanent Total Disability claims.

First, the revised rule suggests that an insurer can only re-examine a PTD claim at two-year intervals, despite intervening events that may make the worker employable. The insurer is responsible for monitoring the worker's condition and, if the insurer determines that the worker's physical condition has improved or the vocational situation has changed, should be able to act on the information as soon as it has been developed, and not wait for an arbitrary schedule of reviews.

Second, the revised rule appears to remove the incentive for a worker to cooperate with any reexamination of a PTD award. Currently, a worker who refuses to attend a medical examination may be subject to benefit suspension. The new rule would allow the worker to ignore a reexamination with impunity. As medical evidence is an essential component in any PTD reexamination, this proposed rule would effectively prevent reversal of PTD awards. This rule violates ORS 656.325(1)(a) which clearly states that benefits will be suspended for failure to submit to an examination. The proposed changes also appear to conflict with ORS 656.325(3), which requires the worker to cooperate in the reduction of disability.

Implementation of these rules would not only affect the system cost to employers and insurers, but would also increase cost to the Worker Benefit Fund. Retroactive Reserve payments are the largest single draw on that Fund.

Response: The director agrees with the first position that the insurer is responsible for monitoring their PTD claims and should be able to act on any information that will change the PTD status as soon as possible. It was not the director's intent to limit the insurer in this respect and the changes that have been proposed have not done so. Statute and rule do not prohibit the insurer from reviewing a PTD claim more frequently than every two years. The purpose of removing this language was to eliminate duplication and reduce rules. Since it appears to have created confusion, the director will modify the language to clarify the insurer's existing right to review a PTD claim more frequently than every two years.

The director does not agree with the second position that the deletion of the suspension rule will remove the incentive for the worker to cooperate with any reexamination of a PTD award. The statutes cited in the testimony have given the insurer the right to suspend a worker who does not cooperate with a reexamination. That right cannot be taken away by rule.

The director's intent was not to eliminate the insurer's right to suspend a worker who has not cooperated with the reexamination, but to eliminate redundancy of rule and statute. The reason that the suspension part of this rule was taken out is because it is addressed in OAR 436-060-0095, OAR 436-030-0055, and statute. But to ensure clarity, the deleted suspension portion will be restored and a reference to OAR 436-060-0095 will be inserted.

OAR 436-030-0135(6)
Testimony: Exhibit #21
The word "accepted" as used in this rule is undefined and ambiguous. It would be more appropriate to use "requested and received."

Response: The director agrees, but with the suggestion for some modifications to clarify that the fiscal instrument not only has to be received, but also negotiated by the worker. The reason for this terminology is because a worker may receive the money from the insurer but return it after deciding to request reconsideration. The language has been modified to more clearly reflect the intent of the change.

OAR 436-030-0155(3)
Testimony: Exhibit #21
The proposed rule needs to be restructured to more clearly convey the intent. The proposed rule appears to require that the attending physician has viewed the recordings, but the insurer cannot know with certainty whether anything sent to a physician has actually been reviewed. Written reports are routinely sent, but the insurer has no way of knowing whether they have been read. Surveillance material should be treated the same way as any other information. Suggested language:

"The insurer must submit to the director for arbiter review all surveillance documentation (including any materials supplied by the insurer to the physician(s), such as videotape, investigator field notes, summary or narrative reports regarding the worker's observed activities, cover letters or other forms of recorded documentation) of the injured worker's activities, that were obtained prior to the closure and that were submitted to the attending physician. Surveillance tapes, compact discs or other forms of electronic storage that reflect the worker's activities will be accompanied by documentation indicating the dates the information was obtained and the total time of the recording. This information will be supplied to the arbiter to view and consider in conjunction with the arbiter's medical assessment of the worker's accepted condition and level of disability."

Response: The director agrees that the proposed language does need to be clarified because the insurer cannot be sure if material sent to a medical provider has been reviewed by that provider. The director's intent is to require that the insurer submit to the director any surveillance videotape both obtained prior to claim closure and submitted to any physician(s) involved in the treatment of the injured worker. The proposed language will be modified to clarify the intent.

OAR 436-060-0008(3)(a)
Testimony: Exhibit #22
The proposed change may be more convenient for the Division, but works to the disadvantage of the stakeholders. Under the existing rule, the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. The proposed rule would create different

standards for WCD and the Workers' Compensation Board. DCBS should use consistent procedures, so that it is easier for the public to do business with the Department. ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law." The proposed rule is an impermissible deviation from statute.

Response: The Department of Justice has advised the division that ORS 656.726 controls. The current language will be retained.

OAR 436-060-0010(3)
Testimony: Exhibit #15
The proposed language is extremely vague and too subjective to make it a standard for notice or knowledge of a claim. The worker must retain the responsibility of filing the claim. Suggest modifying the sentence to read, "The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a **worker's intent to file a** claim, **either through written communication from the worker, the worker's representative, or the worker's attending physician.** [or of when enough facts exist to lead a reasonable employer to conclude that workers' compensation liability is a possibility.] (Emphasis in original)

Response: This language is not new. It has been moved from 436-060-0010(10) to (3) in connection with the change from reporting claims to the division within 21 days of the employer's knowledge date to 14 days from the decision to accept or deny the claim. When read in conjunction with 436-060-0010(4), it is clear that the worker retains the responsibility of filing a claim. ORS 656.262(3)(a) reads, in relevant part, "Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer." Emphasis added. The possibility exists that a worker would choose not to file a claim for an accident that may result in a compensable injury claim, but according to the statute the employer should still report the incident to the insurer. However, as a result of this testimony we will add clarification to the rule that it is the employer who must know the facts.

OAR 436-060-0010(12) and (13)
Testimony: Exhibit #7
Senate Bill 914 eliminated the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim. Proposed OAR 436-060-0010(10) clearly indicates that all disabling claims shall now be reported within 14 days of the insurer's decision to either accept or deny the claim.

To be consistent, it is recommended that the reporting timeframe in OAR 436-060-0010(12) & (13) be changed from 21 days to 14 days. This will eliminate any confusion as to how many days an insurer has to file a form 1502.

Response: Consistency is a valid reason to change all 21-day reporting timeframes to 14 days. In addition to the cites referenced in this testimony, there are also 21 day reporting timeframes in

OAR 436-060-0010(14), (15), (16), and 436-060-0018(1). Also, it is not clear in 436-060-0018(1) that this applies only to accepted claims. The language in the proposed rules will be changed to require reporting to the director within 14-days of the action and the language in 436-060-0018(1) will be clarified to apply only to accepted claims.

OAR 436-060-0018(11)
Testimony: Exhibit #22
The rule should be prefaced with the phrase: "Subject to the provisions of subsection (12),…" Exhibit 22. In a follow-up call regarding this testimony, the author stated that (11) implies an insurer can change the classification of the claim anytime. It should be limited to the one year mentioned in (12).

Response: This testimony caused us to look closely at the proposed language and recognize there could be better direction for claim processing in these situations. There have been instances when a claim has been classified as disabling, then closed with a Notice of Closure. When the claim is reopened on aggravation or a new or omitted condition is accepted, the claim status remains disabling even though the aggravation or the new or omitted condition may be non-disabling. We recognize there are times when the original decision to classify the claim as disabling was incorrect because the criteria were never met. Case law (DeGrauw v. Columbia Knit) does not clearly establish a process for such circumstances other than the requirement that the worker have access to recourse if they are dissatisfied. The proposed language will be modified.

OAR 436-060-0035(8)
Testimony: Exhibit #22
The proposed revision to this rule is incorrect. The current version of (8) correctly states that TPD for supplemental temporary disability must be calculated on the combined pre- and post-injury earnings, not calculated independently. The proposed rule does not work whenever maximum or minimum TTD rates are involved. You cannot calculate primary and secondary benefits separately to get the correct amount to pay the worker. The benefit has to be figured based on combined earnings. You figure the benefits from the primary job and the difference is the secondary benefit that is reimbursable from WBF.

Response: This change was made to limit the required involvement of insurers who elect not to process and pay supplemental disability. However, this testimony has pointed out the problems this change would create. With some modification to incorporate the assigned processing agent, the previous language will be restored.

OAR 436-060-0035(18)
Testimony: Exhibit #22
Disputes concerning the rate of disability should be raised before the first closure of the claim. Allowing them "at any time" means that the issue could be raised many years after the initial rate calculation, when evidence of earnings may no longer be available.

Response: There is no statutory limitation on when an injured worker can raise a wage dispute. Similarly, OAR 436-060-0025 does not limit when a wage dispute may be raised. Regardless of when the wage dispute is raised, it is the worker who must supply the wage records for secondary employment. The proposed language will be retained.

OAR 436-060-0060(2)
Testimony: Exhibit 22
We agree that an insurer should respond promptly to a lump sum request. However, we believe the insurer should be allowed ten business days. This would allow the request to be processed within the regular two-week file review cycle. This would allow an average turnaround of five business days, without disrupting the normal review schedule.

Response: When this issue was discussed in the Internal and External Advisory Committees there was general consensus to add a "reasonable timeframe" to the rules. However, what is reasonable was not specifically discussed. Requiring the insurer to send the form within 10 days to coincide with the regular two-week file review cycle seems reasonable. The rule will be modified accordingly.

OAR 436-060-0095
Testimony: Exhibit #22
A proposed revision of OAR 436-030-0065(1) appears to remove the ability to suspend compensation when a worker with a PTD award refuses to attend a medical examination. For the reasons stated in our Division 030 testimony, we oppose that change. It would be logical to move that rule to Division 060, where all other benefit suspension issues are covered.

Response: Suspension of benefits for any worker who refuses to attend a reasonable requested medical examination is currently contained in OAR 436-060-0095. However, the last sentence of OAR 436-030-0065(1) will be added back with a cross-reference to OAR 436-060-0095. This will make it clear that if a worker with a PTD award refuses to attend a medical examination, the process for requesting suspension is under OAR 436-060-0095.

OAR 436-060-0140(9)
Testimony: Exhibit #22
Since claims that have been resolved by a claim disposition agreement are not subject to reopening under any circumstances, the rule should be prefaced with the phrase: "Except for claims resolved by claim disposition agreement under ORS 656.236,…"

Response: Claims that have been resolved by a claim disposition agreement are subject to reopening if a new or omitted condition is later accepted. The rule will remain as proposed.

OAR 436-060-0155(2)
Testimony: Exhibit 8
The right to the penalty is in ORS 656.262(11). The rule terminates claimant's rights after 180 days of the alleged violation. The rule is in direct conflict with ORS 656.319(6), which provides claimant a right to a hearing on this issue for a period of two years after the alleged action or inaction. There is adequate case law that explains when the two-year period begins and ends. There is also adequate case law to support the position that the Director cannot promulgate a rule that takes away a right or limits a statutory right.

Response: This language has existed in these rules for many years. In *Kathryn R. Cook v. Liberty Northwest Insurance Corporation*, 150 Or App 597 (1997), the Court of Appeals held this rule is reasonably required for the director to carry out the performance of his duties. The case also considered the issue the testimony presented concerning ORS 656.319(6). The current language will remain.

OAR 436-060-0180(8)
Testimony: Exhibit #22
The requirement that an insurer's response to WCD be "adequate" is reasonable, but the insurer cannot know what WCD may perceive to be adequate. We suggest rewording to say that the insurer must respond "in good faith".

Response: This language was patterned after OAR 436-060-0155(4) where it's clear that inadequate means failing to answer specific questions or provide requested documents. The language in this rule will be modified to make it clear what the director considers inadequate by more closely mirroring the language in OAR 436-060-0155(4).

OAR 436-120-0004(2)(d)
Testimony: Exhibit # 13
Regarding the statement in the notice text in (d), "If you disagree with this decision, you should contact (person's name and insurer) within five days of receiving this letter to discuss your concerns," if the injured worker is required to contact the insurer to remain eligible, the time allowed should be longer.

Regarding the remaining notice text, add a reference to the worker's attorney, as in "If you are still dissatisfied, you **or your attorney** must contact . . ."

Response: The changes recommended were not included in the proposed rules. The division can not take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

OAR 436-120-0008(2)
Testimony: Exhibit # 13
Regarding statements of services for attorney fees, in addition to the hours spent on the case, consideration should be given to the difficulty involved as well as the likelihood of prevailing, because attorneys are only paid if they win.

The rule should be consistent with awards made by the Workers' Compensation Board, and not start a trend of requiring a statement of services.

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

OAR 436-120-0008(2)
Testimony: Exhibit # 23
Two additional factors should be considered in determining attorney fees:

- ' "Professional hours devoted" shall be limited to those hours that a reasonable attorney, well-trained in workers' compensation law, would expend on the matter at issue.'
- 'Proof of "extraordinary circumstances" cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.'

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of "extraordinary circumstances" the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of $10,000.

OAR 436-120-0008(4)(b)
Testimony: Exhibit #23
The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers'

Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): ". . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law."

Response: The division agrees that the standard should be the one described in ORS 656.726(4)(a). The proposed rule will be changes to reflect agreement with ORS 656.726 (45)(a).

OAR 436-120-0340(2)(g)
Testimony: Exhibit #23
Regarding the Oregon Wage Information publication [of the Oregon Employment Department], the rules should require reference to the fifth percentile rather than the 10th percentile as proposed. The 5th percentile is better aligned with the standard now in use.

Response: The division compared the Oregon Wage Information (OWI) 5th and 10th percentile to the current use of the Oregon Automated Reporting System (OARS) median wage (Q2). A review by the Information Management Division of DCBS found the 10th percentile to be the closest to the Q2 statistic. In addition, the Oregon Department of Employment which publishes the OWI will only publish for general circulation statistics starting with the 10th percentile.

Given the divisions analysis of the 5th and 10th percentiles and in order to make the statistics as readily available as possible, the 10th percentile will be the standard.

OAR 436-120-0360(7)
Testimony: Exhibit # 14
Regarding proposed language for this section, "The worker returned to work prior to the worker becoming medically stationary, and the physician **later** [emphasis added] rescinded the release." This section should include a time limit for rescission; otherwise, insurers could be compelled to complete an eligibility evaluation 12 months after the return to work if a physician later rescinds a release – even if the worker has not perfected a claim for aggravation. Recommended replacement language: "The worker returned to work prior to becoming medically stationary, and the physician ***rescinds the release within 60 days of the date of the Notice of Closure***."

Response: This rule is being moved from its present location as 436-120-0360 (9) to 436-120-0360(7). The only other change was change the word rescinds to rescinded. Time frames were not recommended for this rule and no discussions on the effect of adding time frames was part of the internal or external advisory committees. The present wording of this rule has not generated requests for reconsideration under the scenario presented in the testimony. While the recommendation may have merit, the division could not consider implementation of the recommended wording without further public input. The division will file the proposed wording for consideration future rule changes.

OAR 436-120-0710(7)

Testimony: Exhibit #23
This section should not provide for prepayment of the last month's rent, as this is not generally required in today's market and is inconsistent with OAR 436-110.

Response: This rule was not proposed for any changes and as such has not had any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

The current wording does not require the payment of last months rent but does state it is only payable . . ." if required prior to moving in."

OAR 436-120-0720
Testimony: Exhibit # 13
The advisory committee discussed increasing the dollar amount for direct worker purchases for training programs. The need was acknowledged by some of the insurer representative's. The proposed rules do not address this need.

Response: The division is proposing an increase in OAR 436-120-0720(3) for direct worker purchases in training programs. The increase in from $14,256 to $16,157, which is a 10% increase.

OAR 436-120-0720(2)
Testimony: Exhibit # 23
As proposed, this section, a worker may qualify as having an exceptional loss of earning capacity if additional services would yield just a 10% greater wage than a shorter program. For a 21-month training program, the TTD benefit alone may exceed $80,000. The analysis to authorize extended benefits should include whether the program will result in significantly improved earning capacity over the likely period of post-training employment.

Response: The proposed rule recommends changes to the fee schedule for workers found to have an exceptional disability or exceptional loss of earning capacity and the percentage increase to be applied. The change recommended in the testimony proposes a change in how exceptional loss of wage earning capacity is determined, which is in OAR 436-120-0440(2)(b).

No changes were proposed for OAR 436-120-0440 and as such there has not been any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 12th day of March, 2004.

WORKERS' COMPENSATION DIVISION

/s/ Fred Bruyns

Fred Bruyns, Rules Coordinator
Policy Section
Workers' Compensation Division

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

436-009-0001 Authority for Rules

These rules are promulgated under the director's general rulemaking authority of ORS 656.726 (4) and specific authority under ORS 656.248.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01

436-009-0002 Purpose

The purpose of these rules is to establish uniform guidelines for administering the payment for medical services to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96

436-009-0003 Applicability of Rules

(1) These rules [shall be applicable]**apply** to all services rendered on or after the effective date of these rules.

(2) Applicable to these rules, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the Centers for Medicare & Medicaid Services (CMS) 200[3]**4** Medicare Resource-Based Relative Value Scale (RBRVS) Addendum B "Relative Value Units (RVUs) and Related Information" except the "status indicators," and Addendum C "Codes with Interim RVUs," [67 *Federal Register* No. 251, December 31, 2002] **68 Federal Register No. 216, November 7, 2003** as the fee schedule for payment of medical service providers except as otherwise provided in these rules.

(2) The director adopts, by reference, the *American Society of Anesthesiologists (ASA), Relative Value Guide 200**4***[3] as a supplementary fee schedule for payment of anesthesia service providers except as otherwise provided in these rules for those anesthesia codes not found in the Federal Register.

(3) The director adopts *Current Procedural Terminology (CPT® 200**4**[3])*, Fourth Edition Revised, 200**3**[2] for billing by medical providers except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(4) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 shall control over any conflicting provision in Addenda B and C, **68 Federal Register No. 216,**

November 7, 2003 [67 Federal Register No. 251, December 31, 2002], ASA Relative Value Guide 200**4**[3], or CPT® 200**4**[3.]

Stat Auth: ORS 656.248, 656.726(4)
Stats Implemented: ORS 656.248
Hist: Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made part of these rules.

(a) Durable medical equipment (DME) is equipment which is primarily and customarily used to serve a medical purpose, can withstand repeated use, appropriate for use in the home, and not generally useful to a person in the absence of an illness or injury.

(b) Medical supplies are expendable materials including, but not limited to, incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(c) Ambulatory surgical center (ASC) is any distinct entity licensed by the state of Oregon and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization. Any ambulatory surgical center outside of Oregon must meet similar licensing requirements, or be certified by Medicare or a nationally recognized agency.

(2) Abbreviations used in these rules are defined as follows:

(a) [ADA means American Dental Association

(b)] ASA means American Society of Anesthesiologists

[(c)]**(b)** ASC means ambulatory surgical center

[(d)]**(c)** CARF means Commission on Accreditation of Rehabilitation Facilities

[(e)]**(d)** CMS means Centers for Medicare & Medicaid Services (formerly HCFA, Health Care Financing Administration)

[(f)]**(e)** CPT® means Current Procedural Terminology

[(g)]**(f)** DME means Durable Medical Equipment

[(h)]**(g)** DMSO means Dimethyl sulfoxide

[(i) DRG means diagnosis related group

(j)] **(h)** EDI means Electronic Data Interchange

[(k) EMG means electromylography

(l)] **(i)** HCFA means Health Care Financing Administration (former name of CMS)

[(m)]**(j)** HCPCS means Healthcare Common Procedure Coding System

[(n)] **(k)** ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3

[(o)] **(l)** JCAHO means Joint Commission on Accreditation of Healthcare Organizations

[(p)]**(m)** MCO means Managed Care Organization

[(q) MRI means magnetic resonance imaging

(r)]**(n)** NCPDP means National Council for Prescription Drug Programs

[(s) NPI means National Provider Identifier

(t)]**(o)** OSC means Oregon specific code

[(u)]**(p)** PCE means physical capacity evaluation

[(v)]**(q)** RBRVS means Medicare Resource-Based Relative Value Scale

[(w)]**(r)** RVU means relative value unit

[(x) TC means technical component

(y) UB means Universal Billing

(z)]**(s)** WCE means work capacity evaluation

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff.7/1/99
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02

436-009-0008 Administrative Review[, Fee Disputes and Contested Cases]

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical fees and non-payment of compensable medical bills. A party need not be represented to participate in the administrative review before the director except as provided in ORS chapter 183 and OAR chapter 436, division 001.

(b) Any party may request the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. **Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.** If the dispute does not resolve through

mediation, a director's order shall be issued.

[(c) All issues pertaining to disagreement about medical fees or non-payment of bills within an MCO are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting administrative review of the matter by the director. If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director]

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims **where a party disagrees with an action or decision of the MCO**, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. **When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 30 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.** Administrative review by the director must be requested within 60 days of receipt of the MCO's final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. **If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director.**

(b) For all claims not enrolled in an MCO, **or for disputes which do not involve an action or decision of the MCO** , the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. **When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.** For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

(c) The director may, on the director's own motion, initiate a medical services review at any time.

(d) When there is a formal denial of the underlying condition or a denial of the causal relationship between the medical service and the accepted condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.

(3) Parties shall submit requests for administrative review to the director in the form and format prescribed by the director. The requesting party shall simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker's name, date of injury, insurer, and claim number.

(b) Specify the issues in dispute and the relief sought.

(c) Provide the specific dates of the unpaid disputed treatment.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original HCFA/CMS bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that the involved parties have been provided a copy of the request for review and attached supporting documentation and, if known, that there is no issue of causation or compensability of the underlying claim or condition.

(4) The division shall investigate the matter upon which review was requested.

(a) The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider's peers.

(b) Upon receipt of a written request for additional information, the party shall have 14 days to respond.

(c) **A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:**

(A) One or both parties fail to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement.

(d) Pursuant to section [(5)]**(7)** of this rule, within 30 days of the administrative order, any party may appeal to a contested case before the director.

(5) **In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director shall award an attorney fee to be paid as provided in ORS 656.385 (§2, ch. 756, OL 2003) and described in OAR 436-010-0008.**

(6) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party may also request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be received by the director before the administrative order becomes final.

(7) Contested cases before the director: Pursuant to 183.310 through 183.550, as modified

by OAR Chapter 436, Division 001 and ORS 656.704(2), any party that disagrees with an action or order of the director pursuant to these rules, may request a contested case before the director. For purposes of these rules, "contested case" has the meaning prescribed in ORS 183.310(2) and OAR chapter 436 division 001. A party may appeal to the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested and include a copy of the order being appealed.

(b) The appeal must be [made]**received** within 30 days of the mailing date of the order or notice of action being appealed.

[(6)] **(8)** Contested case hearings of sanction and civil penalties: Under ORS 656.740 **(§9, ch. 170, OL 2003)**, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as described in OAR 436-010-0008[(14)]**(15)**.

[(7)] **(9)** Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through [(6] **(8)** of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section [(5)] **(7)** of this rule.

Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented: ORS 656.704
Hist: Renumbered from OAR 436-010-0110(1), (2), (3), (4), and (5) to OAR 436-009-0008(2), (3), (4), and (5); from OAR 436-010-0110(6) to OAR 436-009-0008(1)(b); and,
Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff.7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0010 General Requirements for Medical Billings

(1) Only treatment that falls within the scope and field of the practitioner's license to practice will be paid under a worker's compensation claim.

(2) All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a current UB92 or HCFA/CMS 1500 form, except for:

(a) dental billings which shall be submitted on **American Dental Association** [ADA] dental claim forms;

(b) pharmacy billings, which shall be submitted on the most current NCPDP form;

(c) EDI transmissions of medical bills pursuant to OAR 436-009-0030(3)(c). Computer-generated reproductions of these forms may also be used. Billings shall include the worker's full name, date of injury, the employer's name and, if available, the insurer's claim number.

(3)(a) All original medical provider billings shall be accompanied by legible chart notes documenting services which have been billed, and identifying the person performing the service and license number of person providing the service. Medical doctors are not required to provide their medical license number if they are already providing other identification such as tax identification, [NPI]**national provider identifier**, and social security numbers.

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) Codes listed in CPT® 200[3]**4** or Oregon Specific Codes (OSC) shall be used when billing medical services. All billings shall be fully itemized and include ICD-9-CM codes. Services shall be identified by the code numbers and descriptions provided in these rules. **A "zz" modifier shall be used when billing electronically for services that use the Oregon Specific Codes.**

(a) If there is no specific code for the medical service, the medical provider shall use the appropriate unlisted code at the end of each medical service section of CPT® 2003 and provide a description of the service provided.

(b) Any service not identifiable with a code number shall be adequately described by report.

(5) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings may be subject to discounts, not to exceed 10 percent for each 30 day period or fraction thereof, beyond 60 days, provided the medical provider has notice or knowledge of the responsible workers' compensation insurer or processing agent.

(6) Rebillings shall indicate that the charges have been previously billed.

(7) The medical provider shall bill their usual and customary fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law which require providers to bill other than their usual fee.

(8) Medical providers shall not submit false or fraudulent billings. As used in this section, "false or fraudulent" shall mean an intentional deception or misrepresentation issued with the

knowledge that the deception could result in unauthorized benefit to the provider or some other person. The medical provider shall not bill for services not provided.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but in no event later than 30 days following receipt of the request. Thereafter, worker copies shall be furnished during the regular billing cycle.

Stat. Auth.: ORS 656.245, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Renumbered from OAR 436-010-0010(5) and (6) to OAR 436-009-0010(1) and (2) ;
from 436-010-0040(3)(d) and (e) to 436-009-0010(3) and (4);
from 436-010-0040(7) and (9) to 436-009-0010(4) and (5);
from 436-010-0040(11) to 436-009-0010(11); and
Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff.7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 9/13/01 as WCD Admin. Order 01-058, eff. 9/17/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0015 Limitations on Medical Billings

(1) An injured worker shall not be liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer pursuant to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment that has not been prescribed by the attending physician **or authorized nurse practitioner,** or **a** specialist physician upon referral of the attending physician **or authorized nurse practitioner** . This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period **or by nurse practitioners in excess of the 90 day period,** as set forth in **ORS 656.245 (§3, ch. 811, OL 2003) and** OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director pursuant to OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental. [pursuant to OAR 436-010-

0300]

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3) of this rule.

(3) The preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service.

(4) No fee shall be paid for the completion of a work release form or completion of a PCE form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or the department or for a Worker Requested Medical Examination. Except as provided in OAR 436-009-0070 (10)(d), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider shall be paid at 50 percent of the examination or testing fee. A medical arbiter may also receive payment for a file review as determined by the director.

(6) Pursuant to ORS 656.245 (3), the director has excluded from compensability the following medical treatment. While these services may be provided, medical providers shall not be paid for the services or for treatment of side effects.

(a) DMSO, except for treatment of compensable interstitial cystitis,

(b) Intradiscal electrothermal therapy (IDET),

(c) Surface EMG **(electromylography)** tests,

(d) Rolfing,

(e) Prolotherapy, and

(f) Thermography.

(7) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician **or authorized nurse practitioner**: once near the beginning, once near the middle, and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient.

(9)(a) When a physician **or authorized nurse practitioner** provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's **or authorized nurse practitioner's** office, such services shall be identified by CPT® codes and paid according to the fee schedule.

(b) When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be

considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital fee schedule.

(10) Physician assistant or nurse practitioner fees shall be paid at the rate of 80 percent of a physician's allowable fee for a comparable service. The bills for services by these providers shall be marked with modifier "81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(11) Except as otherwise provided in OAR 436-009-0070, when a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT® Codes such as 99080. Refer to specific code definitions in the CPT® for other applicable codes. The billing should include the actual time spent reviewing the records or reports.

Stat. Auth.: ORS 656.245, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 9/13/01 as WCD Admin. Order 01-058, eff. 9/17/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0020 Hospital Fees

(1) Hospital inpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes. Unless otherwise provided for by a governing MCO contract, insurers shall pay hospitals for inpatient services using the current adjusted cost/charge ratio (see Bulletin 290). For purposes of this rule, hospital inpatient services include, but are not limited to, those bills coded "111" through "118" in space #4 on the UB92 billing form. The audited bill shall be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes, CPT® codes, HCPCS codes, and [NDC codes] **National Drug Codes (NDC)**, where applicable. Unless otherwise provided for by a governing MCO contract, insurers shall pay hospitals for outpatient services according to the following: the insurer shall first separate out and pay charges for services covered under the CPT® and RBRVS. These charges should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the non-facility total column. All other charges billed using both the hospital name and tax identification number will be paid as if provided by the hospital.

(3) Each hospital's HCFA/CMS 2552 form and financial statement shall be the basis for determining its adjusted cost/charge ratio. If a current 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost/charge ratio is determined from estimated data, the hospital will receive the lower ratio of (1) the hospital's last published cost/charge ratio or, (2) the hospital's cost/charge ratio based on estimated data.

(a) The basic cost/charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (b), by the total patient

revenues from Worksheet G-2.

(b) The net expenses for allocation derived from Worksheet A shall be modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-Based physician adjustment;

(B) [Provider-Based physician adjustment - general services cost center;

(C) Telephone service;

(D) Television and radio service]**Patient expenses such as telephone, television, radio service and other expenses determined by the department to be patient-related expenses**; and

[(E)]**(C)** Expenses identified as for physician recruitment.

(c) The basic cost/charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost/charge ratio calculated in (3)(a) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate, and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's HCFA/CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(e) The factors resulting from subsections (3)(c) and (3)(d) of this rule will be added to the ratio calculated in subsection (3)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(f) The adjusted cost/charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as [prescribed] **described** by bulletin. Each hospital shall submit a copy of their HCFA/CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Management Division, Department of Consumer and Business Services. The adjusted cost/charge ratio schedule will be published by bulletin twice yearly, to be effective for the six-month period beginning April 1, and to be effective for the six-month period beginning October 1.

(g) For those newly formed or established hospitals for which no HCFA/CMS 2552 has been filed, or for those hospitals that do not file Worksheet G-2 with the submission of their HCFA/CMS 2552, the division shall determine an adjusted cost/charge ratio for the hospital based upon the adjusted cost/charge ratios of a group of hospitals of similar size and/or geographic location.

(h) If the financial circumstances of a hospital unexpectedly and/or dramatically change, the division may revise the hospital's adjusted cost/charge ratio to allow equitable payment.

(i) If audit of a hospital's HCFA/CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost/charge ratio to reflect the data developed subsequent to the initial calculation.

(j) Notwithstanding subsections (c) through (i) of this section, the cost/charge ratio shall be 1.000 for out-of-state hospitals, unless a lower rate is negotiated between the insurer and the hospital.

(k) Notwithstanding section (1) and (2) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost/charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index, as originally developed by Dr. William Cleverley. All rural hospitals having a financial flexibility index at or below the median for hospitals nationwide with a bond rating of BBB+, BBB, or BBB- will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost/charge ratio.

Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248; sec. 2, ch. 771, Oregon Laws 1991; 656.252; 656.256
Hist: Renumbered from OAR 436-010-0090(1) thru (4), (7) thru (32) to OAR 436-009-0020(1) thru (29), (32) and (33);
from OAR 436-010-0040(4)(b)(A) and (c) to OAR 436-009-0020(30) and (31);
from OAR 436-010-0047(6) and (7) to OAR 436-009-0020(34) thru (37), and;
filed 5/3/95 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4-21-97 as Admin. Order 97-053, eff. 7-1-97
Amended 7-9-97 as WCD Admin. Order 97-056, eff. 7-9-97 (Temp)
Amended 12-15-97 as WCD Admin. Order 97-056, eff. 12-15-97
Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff.7/1/99
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0022 Ambulatory Surgical Center Fees

(1) Bills from an ASC shall be submitted on HCFA/CMS 1500 form. The modifier "SG" shall be used to identify facility charges.

(2) Fees shall be paid at the usual and customary fee, or in accordance with the fee schedule, whichever is less. For all MCO enrolled claims, payment of fees shall be as provided by the MCO contract, at the provider's usual and customary fee, or according to the fee schedule, whichever is less.

(3) Payment shall be made using the Medicare ASC groups, except:

(a) Arthroscopies (CPT® codes 29819 through 29898 except 29888 and 29889) are paid as Group 6.

(b) Arthroscopies (CPT® codes 29888 and 29889) are paid as Group 7.

(c) Procedures not listed in the Medicare ASC groups shall be paid at the provider's usual and customary rate.

(4) The ASC fee schedule is:

Group 1	$ 853.28
Group 2	$ 1,143.88
Group 3	$ 1,307.68
Group 4	$ 1,616.75
Group 5	$ 1,838.68
Group 6	$ 2,108.00
Group 7	$ 2,551.95
Group 8	$2,485.78
Group 9	**$ 3,444.43**

(5) The ASC fee includes services, such as:

(a) Nursing, technical, and related services;

(b) Use of the facility where the surgical procedure is performed;

(c) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of the surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

(e) Administrative, record-keeping, and housekeeping items and services;

(f) Materials for anesthesia; and

(g) Supervision of the services of an anesthetist by the operating surgeon.

(6) The ASC fee does not include services, such as physicians' services, laboratory, x-ray or diagnostic procedures not directly related to the surgical procedure, prosthetic devices, orthotic devices, durable medical equipment, and anesthetists' services.

(7) When multiple procedures are performed, the highest payment group shall be paid at 100% of the maximum allowed fee. Each additional procedure shall be paid at 50% of the maximum allowed fee.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0025 Reimbursement of Related Services Costs

(1) The insurer shall notify the worker at the time of claim acceptance that actual and reasonable costs for travel, prescriptions and other claim-related services paid by the worker will be reimbursed by the insurer upon request. The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the worker's written request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable

injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed. On deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance and shall be paid within 14 days. If there is a claim for aggravation or a new medical condition on an accepted claim, reimbursement of related services is not due and payable until the aggravation or new medical condition is accepted. If the claim is denied, requests for reimbursement shall be returned to the worker within 14 days.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle reimbursed at the rate of reimbursement for State of Oregon classified employees, as published in Bulletin 112, complies with this section. Reimbursement may exceed these rates where special transportation or lodging is needed.

(3) Requests for reimbursement of related services costs must be received by the insurer within two years of the date the costs were incurred or within two years of the date the claim or medical condition is finally determined compensable, whichever date is later. The insurer may disapprove requests for reimbursement received beyond the two year period as being untimely requested.

(4) Requests for reimbursement denied as unreasonable or not related to the accepted compensable injury or disease shall be returned to the worker within 30 days of the date of receipt by the insurer. The insurer shall provide the worker an explanation of the reason for nonpayment and advise the worker of the right to appeal the insurer's decision by requesting administrative review before the [administrator]**director**, pursuant to [ORS 656.245(6)] **OAR 436-009-0008.**

(5) Pursuant to ORS 656.325(1)(c) and OAR 436-060-0095(5)(f), the insurer shall reimburse the worker for costs related to the worker's attendance at an insurer medical examination regardless of the acceptance, deferral, or denial of the claim.

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended and renumbered from OAR 436-060-0070, 12/17/01, as WCD Admin. Order 01-064, eff. 1/1/02
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0030 Insurer's Duties and Responsibilities

(1) The insurer shall pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(2) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0070(1). If the evaluation of the records must be conducted on-site, the provider shall furnish a reasonable work-site for the records to be reviewed at no cost. These records shall be provided or made available for review within 14 days of a request.

(3) Insurers shall date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly

shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form must be returned or a request for chart notes on EDI billings must be made, to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer shall retain a copy of each medical provider's bill received by the insurer or shall be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, **date the insurer received the bill,** type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2) and insurer action, for any fee reduction other than a fee schedule reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(b) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided.

(c) When a medical provider renders a bill via EDI, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(5) Failure to pay for medical services timely may render insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(6) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer shall, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code. Resolution of billing disputes shall be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(7) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(8) The insurer shall establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit shall be continuous and shall include no fewer than 10 percent of medical bills. The insurer shall provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation shall include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(9) Insurers that ha**d**[ve] at least 100 accepted disabling claims in [a]**the previous** calendar year, as determined by the director, are required to [transmit]**submit** detailed medical service [and

]billing data to the Information Management Division of the Department of Consumer and Business Services **at 350 Winter St NE, PO Box 14480, Salem OR 97309-0405**. Once an insurer has [been determined to have]**reached** the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. [In such circumstances, t]**T**he insurer may apply for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will [publish a bulletin identifying]**notify** the affected insurers **when they reach the minimum.** [and advising the insurers of t]**T**he **transmission** data and format requirements [for data transmission]**are included in Appendix A**;

(b) The data shall include all payments made during each calendar quarter for medical services **that are covered by the department's fee schedules.**[which are covered by the department's fee schedules. These fee schedules include anesthesiology, surgery, radiology, laboratory and pathology, medicine, physical medicine and rehabilitation, evaluation and management services, multidisciplinary and other Oregon-specific codes, all hospital services, pharmacy, and durable medical equipment;] **The following apply:**

(A) Hospital Inpatient: Each hospital inpatient stay should be reported as one record summarizing all services related to the inpatient stay using provider type "HI." Report ICD-9-CM procedure code in the service code field.

(B) Hospital Outpatient: Report at the individual service-code level using provider type "HO." A service code, whether CPT, HCPCS, hospital revenue code, or other code, is required on all "HO" records in addition to the ICD-9-CM procedure code.

(C) Adjustments to payments must be associated with specific services.

(c) The affected insurers shall submit the medical data within 45 days of the end of each calendar quarter. [However, a]**A** grace period of two calendar quarters may be granted for revised requirements and also for insurers which are newly affected by these requirements. **The calendar quarter due dates are as outlined in the table below**[.]**:**

QUARTERLY DUE DATES Table

QUARTER	MONTH OF PAYMENT	DUE NEXT
First	January, February & March	May 15th
Second	April, May & June	August 14th
Third	July, August & September	November 14th
Fourth	October, November & December	February 14th

(d) **Technical Requirements: Data for each quarter calendar year must be transmitted as an individual file. Only insurers transmitting data for more than one insurer may batch multiple insurer data in one file. Data must be transmitted in electronic text files either on a 3.5 inch diskette, CD, or by file transfer protocol (FTP). Contact the Information Management Division (IMD) to arrange submission by FTP files or other electronic transmission methods. The record length must be fixed, 129 bytes, no packed fields, and in conformance with the records layout in Appendix A. Diskettes must be ASCII format, high density. Diskettes and CDs must have a physical label that indicates "Medical Data", the name of the group submitting, the quarter reported, and the date the file was created. Include a cover letter in the same package with each diskette or CD. Contact IMD**

for e-mail cover letter instructions. The cover letter must include the label information and the following: a list of all insurance companies' data included in the transmission; number of records; a contact person's name, address, and telephone number; and any known problems with the data.

(e) Data Quality: The director will conduct electronic edits for blank or invalid data. [Listed]**Affected** insurers are responsible for pre-screening the data they submit to check that all the required information is reported. Files which have more than five percent missing or invalid data in any field, based on initial computerized edits, will be returned to the insurer for correction and must be resubmitted within three weeks (21 days) from the date it was returned by the department.

[(e)] **(f)** Audit Quality: The director may also conduct field audits of actual payments reported for individual claims. When an audit occurs, in order to be in compliance with this rule and OAR 436-[010-0275(10)]**009-0025**, audited data must have no more than 15 percent inaccurate data in any field.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-801, eff. 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff. 2/1/95
Renumbered from OAR 436-010-0100(8) thru (15), (27) and (28) to OAR 436-009-0030 and
Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4-21-97 as Admin. Order 97-053, eff. 7-1-97
Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0035 Interim Medical Benefits

(1) Interim medical benefits are not due on claims:

(a) When the worker is enrolled in an MCO prior to claim acceptance pursuant to ORS 656.245(4)(b)(B).

(b) When the insurer denies the claim within 14 days of the employer's notice.

(c) With dates of injury prior to January 1, 2002.

(2) Interim medical benefits include:

(a) Diagnostic services required to identify appropriate treatment or prevent disability.

(b) Medication required to alleviate pain.

(c) Services required to stabilize the worker's claimed condition and to prevent further disability. Examples of such services may include, but are not limited to: antibiotic or anti-inflammatory medication; physical therapy and other conservative therapies; and necessary surgical procedures.

(3) If the medical service provider has knowledge that the worker filed a work related claim, the medical service provider shall not collect health benefit plan co-payment from the worker.

(4) The medical service provider shall submit a copy of the bill to the workers' compensation insurer in accordance with OAR 436-009-0010, and the health benefit plan(s) in accordance with the plan's requirements.

(5) The insurer shall notify the medical service provider when an initial claim is denied.

(6) When the claim is denied, the medical service provider shall first bill the health benefit plan(s) with a copy of the workers' compensation denial letter.

(7) After payment is received from the health benefit plan(s), the medical service provider may bill the workers' compensation insurer, pursuant to OAR 436-009-0010, for any remaining balance. The provider shall include a copy of the health benefit plan(s)' explanation of benefits with the bill. If the worker has no health benefit plan, the workers' compensation insurer is not required to pay for interim medical benefits.

(8) The workers' compensation insurer shall pay in accordance with the Oregon fee rules, any amount not reimbursed by the health benefit plan within 45 days of receipt of the bill with the health plan's explanation of benefits, in accordance with OAR 436-009-0030 (6).

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.247
Hist: Filed 1/1/02 as Admin. Order 01-064 eff. 1/1/02

436-009-0040 Calculating Medical Provider Fees

(1) Medical fees shall be paid at the provider's usual and customary fee or in accordance with the fee schedule whichever is less. For all MCO enrolled claims, payment of medical fees shall be at the provider's usual and customary fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract.

(2)(a) When using RBRVS, the RVU is determined by reference to the appropriate CPT® code. Where the procedure is performed inside the medical service provider's office, use Year 200[3]**4** non-facility total column. Where the procedure is performed outside the medical service provider's office, use Year 200[3]**4** facility total column. Use the global column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Year 200[3]**4** non-facility total column. No other column applies.

(b) When an Oregon Specific Code is assigned, the RVU for multidisciplinary program services is found in OAR 436-009-0060(5), or for other services in OAR 436-009-0070 (13).

(c) When using the ASA Relative Value Guide, a basic unit value is determined by reference to the appropriate Anesthesia code. The basic unit value includes unit value, time units,

and modifying units.

(3) Payment according to the fee schedule shall be determined by multiplying the assigned RVU or basic unit value by the applicable conversion factor. Where the code is designated by an RVU of "0.00" or IC (individual consideration) for Anesthesia codes, it shall be paid at the provider's usual and customary rate. **An insurer may challenge the reasonableness of a provider's billing on a case by case basis by asking the director to review the billing under OAR 436-009-0008. If the director determines the fee is unreasonable, the director may establish a different fee based on: reasonableness, the usual and customary fees of similar providers, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances.**

(4) The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical professionals.

Service Categories	Conversion Factors
Evaluation / Management	[$ 66.84]**$68.40**
Anesthesiology	[$ 52.23]**$53.45**
Surgery	[$ 91.53]**$93.66**
Radiology	[$ 66.45]**$68.00**
Lab & Pathology	[$ 58.63]**$60.00**
Medicine	[$ 73.33]**$75.04**
Physical Medicine and Rehabilitation	[$ 64.29]**$65.79**
Multidisciplinary and Other Oregon-Specific Codes	[$58.63]**$60.00**

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0050 CPT® Sections

Each CPT® section has its own schedule of relative values, completely independent of and unrelated to any of the other sections. The definitions, descriptions, and guidelines found in CPT® shall be used as guides governing the descriptions of services, except as otherwise provided in these rules. The following provisions are in addition to those provided in each section of CPT®.

(1) Evaluation and Management services.

(2) Anesthesia services.

(a) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(b) Anesthesia basic unit values are to be used only when the anesthesia is personally

administered by either a licensed physician or nurse anesthetist who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

(c) When a regional anesthesia is administered by the attending surgeon, the value shall be the "basic" anesthesia value only without added value for time.

(d) When the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the modifier "NT" (no time) shall be noted on the bill.

(e) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the relative value unit for the surgical procedure.

(3) Surgery services.

(a) When a worker is scheduled for elective surgery, the immediate pre-operative visit, in the hospital or elsewhere, necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed global value of the surgical procedure. If the procedure is not elective, the physician is entitled to payment for the initial evaluation of the worker in addition to the global fee for the surgical procedure(s) performed.

(b) When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

(c) Multiple surgical procedures performed at the same session shall be paid as follows:

(A) When multiple surgical procedures are performed by one surgeon, the principal procedure is paid at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures are paid at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid accordingly.

(B) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures paid at 50 percent of the value listed.

(C) When more than one surgeon performs surgery, each procedure shall be billed separately. The maximum allowable fee for each procedure, as listed in these rules, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation, each is entitled to an additional fee of 20 percent of the other surgeon's allowable fee as an assistant's fee. When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' allowable fees.

(D) When a surgeon performs surgery following severe trauma that requires considerable time, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. Such a request must be accompanied by written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(E) When a surgical procedure is performed bilaterally, the modifier "-50" shall be noted on the bill for the second side, and paid at 50% of the fee allowed for the first side.

(d) Physician assistants or nurse practitioners shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The bills for services by these providers shall be marked with a modifier "-81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The operation report shall document who assisted.

(4) Radiology services.

(a) In order to be paid, x-ray films must be of diagnostic quality. Billings for 14" x 36" lateral views shall not be paid. Billings for X-rays shall not be paid without a report of the findings.

(b) When multiple areas are examined by **computerized axial tomography (**CAT**)** scan**,** **magnetic resonance angiography (MRA)** or **magnetic resonance imaging (**MRI**)**, the first area examined shall be paid at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent of these rules.

(5) Pathology and Laboratory services.

(a) The laboratory and pathology conversion factor applies only when there is direct physician involvement.

(b) Laboratory fees shall be billed in accordance with ORS 676.310. If any physician submits a bill for laboratory services that were performed in an independent laboratory, the bill shall show the amount charged by the laboratory and any service fee that the physician charges.

(6) Medicine services.

(7) Physical Medicine and Rehabilitation services.

(a) Increments of time for a time-based CPT® code shall not be prorated.

(b) Payment for modalities and therapeutic procedures shall be limited to a total of three separate CPT®-coded services per day. CPT® codes 97001, 97002, 97003, or 97004 are not subject to this limit. An additional unit of time (15 minute increment) for the same CPT® code is not counted as a separate code.

(c) All modality codes requiring constant attendance (97032, 97033, 97034, 97035, 97036, and 97039) are time-based. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day.

(d) CPT® codes 97010 through 97028 shall not be paid unless they are performed in conjunction with other procedures or modalities which require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by a machine, device or table there shall be a notation on the bill that treatments were provided simultaneously by a machine, device or table and there shall be one charge.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248
Hist: Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0060 Oregon Specific Code, Multidisciplinary Services

(1) Services provided by multidisciplinary programs not otherwise described by CPT® codes shall be billed under Oregon-Specific Codes. **Electronic billings shall include a "zz" modifier as provided in OAR 436-009-0010.**

(2) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program shall not be paid unless the program is accredited for that purpose by the CARF or the JCAHO.

(a) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to 6 months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(b) Notwithstanding OAR 436-009-0010(4), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(c) All job site visits and ergonomic consultations must be preauthorized by the insurer.

(3) When an attending physician **or authorized nurse practioner** approves a multidisciplinary treatment program for an injured worker, [the attending physician] **he or she** must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Billings using the multidisciplinary codes must include copies of the treatment record which specifies the type of service rendered, the medical provider who provided the service, whether treatment was individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(5) The table below lists the **Oregon Specific Codes for Multidisciplinary Services**.

Codes	Relative Value	Description
97642	0.91	Physical conditioning - group - 1 hour Conditioning exercises and activities, graded and progressive
97643	0.46	Each additional 30 minutes
97644	1.45	Physical conditioning – individual 1 hour Conditioning exercises and activities, graded and progressive

97645	0.73	Each additional 30 minutes
97646	0.91	Work simulation - group 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors
97647	0.46	Each additional 30 minutes
97648	1.50	Work simulation - individual 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors
97649	0.75	Each additional 30 minutes
97650	0.81	Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals
97651	0.41	Each additional 15 minutes
97652	0.54	Therapeutic education - group 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals
97653	0.28	Each additional 15 minutes
97654	0.41	Professional Case Management – Individual 15 minutes Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician)
97655	0.39	Brief Interdisciplinary Rehabilitation Conference - 10 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits
97656	0.78	Intermediate Interdisciplinary Rehabilitation Conferences - 20 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits
97657	1.35	Complex Interdisciplinary Rehabilitation Conferences – 30 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits
97658	0.68	Each additional 15 minutes Complex conference-up to 1 hour maximum
97659	1.72	Job site visit - 1 hour (includes travel) - must be preauthorized by insurer A work site visit to identify characteristics and physical demands of specific jobs
97660	0.86	Each additional 30 minutes

97661	2.32	Ergonomic consultation - 1 hour (includes travel) - must be preauthorized by insurer Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications
97662	0.94	Vocational evaluation - 30 minutes Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options
97663	0.47	Each additional 15 minutes
97664	1.27	Nursing evaluation - 30 minutes Nursing assessment of medical status and needs in relationship to rehabilitation
97665	0.63	Each additional 15 minutes
97666	1.02	Nutrition evaluation - 30 minutes Evaluation of eating habits, weight and required modifications in relationship to rehabilitation
97667	0.52	Each additional 15 minutes
97668	1.07	Social worker evaluation - 30 minutes Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome
97669	0.54	Each additional 15 minutes
97670	6.70	Initial Multidisciplinary conference - up to 30 minutes
97671	7.56	Initial Complex Multidisciplinary conference - up to 60 minutes

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 5/26/99 as Admin. Order 99-057, eff. 7/1/99
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0070 Oregon Specific Code, Other Services

(1) Copies of requested medical records shall be paid under OSC-R0001.

(2) A brief narrative [by the attending physician], including a summary of treatment to date and current status, and, if requested, brief answers to one to five specific questions related to the [attending physician's] current or proposed treatment, shall be paid under OSC-N0001.

(3) A complex narrative [by the attending physician], may include past history, history of present illness, [attending physician's]treatment to date, current status, impairment, prognosis, and medically stationary information, shall be paid under OSC-N0002.

(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable payment shall be as follows:

(a) FIRST LEVEL PCE: This is a limited evaluation to measure [the functional performance testing] **primarily musculoskeletal components** of a specific body part. **These components include**

such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level requires not less than 45 minutes of actual patient contact. A first level PCE shall be paid under OSC-99196 which includes the evaluation and report. Additional 15-minute increments may be added [for each additional] **if multiple** body part**s** [to establish endurance (e.g. cardiovascular), or to project tolerances (e.g. repetitive motion)] **are reviewed and time exceeds 45 minutes**. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(b) SECOND LEVEL PCE: This is a PCE [requested by the insurer, or attending physician]to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level requires not less than two hours of actual patient contact. The second level PCE shall be paid under OSC-99197 which includes the evaluation and report. Additional 15 minute increments [(per additional body part) may be necessary to establish endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion)]**may be added to measure additional body parts, to establish endurance and to project tolerances**. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(c) WCE: This is a residual functional capacity evaluation, with special emphasis on**:**

(A) the ability to perform essential physical functions of the job based on **a** specific job analysis **as related to the accepted condition**.

(B) the ability to sustain activity over time; and

(C) the reliability of the evaluation findings.

The evaluation may also include a musculoskeletal evaluation for a single body part. This level requires not less than [6] **4** hours of actual patient contact. [The primary purpose of this evaluation is to establish if a worker can return to work at a specific job(s).] A WCE shall be paid under OSC-99198 which includes the evaluation and report. **Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.**

[(d) In addition, if requested, a musculoskeletal evaluation (e.g., ROM, strength, sensory, etc.) with up to 30 minutes of actual patient contact for the first body part may be added to a first level PCE, second level PCE or WCE. An additional 15 minutes may be requested for each additional body part tested. Musculoskeletal evaluation and each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.]

(5) When an attorney requires a consultation with a medical provider, the medical provider shall bill under OSC-D0001.

(6) The fee for a deposition shall be billed under OSC-D0002. This code should include time for preparation, travel and deposition. Payment of the hourly rate may be limited to a customary fee charged by similar providers.

(7) When an insurer obtains an Insurer Medical Examination (IME), the medical service provider shall bill under OSC-D0003. This code shall be used for a report, file review or examination.

(8) The fee for interpretive services shall be billed under OSC-D0004.

(9) Fees for all arbiters and panel of arbiters used for director reviews pursuant to OAR 436-030-0165 shall be established by the director. This fee determination will be based on the complexity of the examination, the report requirements and the extent of the record review. The level of each category is determined by the director based on the individual complexities of each case as compared to the universe of claims in the medical arbiter process. When the examination is scheduled, the director shall notify the medical arbiter and the parties of the authorized fee for that medical arbiter review based on a combination of separate components.

(a) Level 1 OSC-A0001 Exam
Level 2 OSC-A0002 Exam
Level 3 OSC-A0003 Exam
Limited OSC-A0004 Exam

As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors. A limited exam generally involves a newly accepted condition, or some other partial exam.

(b) Level 1 OSC-A0011 Report
Level 2 OSC-A0012 Report
Level 3 OSC-A0013 Report

As determined by the director, a level 1 report generally includes standard questions. A level 2 report generally includes questions regarding complicating factors. A level 3 report generally includes questions regarding multiple complicating factors.

(c) Level 1 OSC-A0021 File Review
Level 2 OSC-A0022 File Review
Level 3 OSC-A0023 File Review
Level 4 OSC-A0024 File Review
Level 5 OSC-A0025 File Review

As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of a large record or disability evaluation without an exam. A level 4 file review generally includes an extensive record. A level 5 file review generally includes an extensive record with unique factors.

(d) The director shall notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review.

(e) If the director determines that a supplemental medical arbiter report is necessary to clarify information or address additional issues, an additional report fee may be established. The fee is based on the complexity of the supplemental report as determined by the director. The additional fees are established as follows:

Limited OSC-A0031

Complex OSC-A0032

(f) Prior to completion of the reconsideration process, the medical arbiter may request the director to redetermine the authorized fee by providing the director with rationale explaining why the physician believes the fee should be different than authorized.

(g) The director may authorize testing which shall be paid according to OAR 436-009.

(h) Should an advance of costs be necessary for the worker to attend a medical arbiter exam, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(10) A single physician selected pursuant to ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under OSC-P0001 for the examination and under OSC-P0003 for the report.

(b) Physicians selected pursuant to OAR 436-010-0008, to serve on a panel of physicians shall each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. Each physician shall bill for the record review and panel examination under OSC-P0002. The panel member who prepares and submits the panel report shall receive an additional payment under OSC-P0003.

(c) The director may in a complex case requiring extensive review by a physician pre-authorize an additional fee. Complex case review shall be billed under OSC-P0004.

(d) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician shall bill under OSC-P0005.

(e) Should an advance of costs be necessary for the worker to attend an exam under ORS 656.327 or 656.260, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(11) The fee for a Worker Requested Medical Examination shall be billed under OSC-W0001. This code shall be used for a report, file review, or examination.

(12) The table below lists the **Oregon Specific Codes for Other Services**.

Codes	Relative Value	Description
R0001		Copies of medical records when requested shall be paid at $10.00 for the first page and $.50 for each page thereafter and identified on billings
N0001	1.71	Brief narrative [by the attending physician]
N0002	3.41	Complex narrative
99196	2.73	First Level PCE
99197	4.87	Second Level PCE
99198	10.28	WCE
99193	0.70	Additional 15 minutes
D0001	0.00	Attorney consultation time
D0002	0.00	Deposition time
D0003	0.00	Insurer Medical Examination and report
D0004	0.00	Interpretive services
A0001	5.12	Level 1 arbiter exam
A0002	6.82	Level 2 arbiter exam
A0003	8.53	Level 3 arbiter exam
A0004	2.56	Level 4 arbiter exam
A0011	0.88	Level 1 arbiter report
A0012	1.32	Level 2 arbiter report
A0013	1.77	Level 3 arbiter report
A0021	0.88	Level 1 arbiter file review
A0022	2.21	Level 2 arbiter file review
A0023	5.30	Level 3 arbiter file review
A0024	10.23	Level 4 arbiter file review
A0025	13.65	Level 5 arbiter file review
A0031	0.88	Limited arbiter report
A0032	1.77	Complex arbiter report
P0001	4.27	Director single medical review/exam
P0002	4.27	Director panel medical review/exam
P0003	2.17	Director single medical review/report
P0004	5.12	Director complex case review/exam
P0005	2.17	Failure to appear director required examination
W0001	0.00	Worker Requested Medical Examination and report

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 7/1/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0080 Durable Medical Equipment and Medical Supplies

(1) Fees for durable medical equipment shall be paid as follows:

(a) The insurer shall pay for the purchase of all compensable DME and other devices that are ordered and approved by the physician, at 85% of the manufacturer's suggested retail price (MSR).

(b) The DME provider shall be entitled to payment for any labor and reasonable expenses directly related to any subsequent modifications other than those performed at the time of purchase, or repairs. A subsequent modification is one done other than as a part of the initial set-up at the time of purchase. Labor shall be paid at the provider's usual and customary rate.

(c) The provider may offer a service agreement at an additional cost.

(d) Rental of all compensable DME and other devices shall be billed at the provider's usual and customary rate. Within 90 days of the beginning of the rental, the insurer shall be entitled to purchase the DME or device at the fee provided in this rule, with a credit for rental paid up to 2 months.

(2) Fees for all prosthetics as defined in OAR 436-010-0230 (12), orthotics, and other medical supplies shall be listed as 0.00.

(a) Testing for hearing aids must be done by a licensed audiologist or an otolaryngologist.

(b) Based on current technology, the preferred types of hearing aids for most workers are programmable BTE, ITE, and CIC multi channel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician **or authorized nurse practitioner**.

(c) Without approval from the insurer or director, hearing aids should not exceed $5000.00 for a pair of hearing aids, or $2500.00 for a single hearing aid.

(3) The worker shall have the right to select the service provider, except for claims enrolled in a managed care organization (MCO) where service providers are specified by the MCO contract.

(4) Except as provided in subsection (2)(c) of this rule, this rule shall not apply to a worker's direct purchase of DME and medical supplies, and shall not limit a worker's right to reimbursement for actual out-of-pocket expenses pursuant to OAR 436-009-0025.

(5) DME, medical supplies and other devices dispensed by a hospital (inpatient or outpatient) shall be billed pursuant to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: (See Rule 0999, Admin. Order 99-053 (Temp), eff 3/31/99)
Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02

436-009-0090 Pharmacy Fees

(1) **Except as otherwise provided in this subsection,** [P]**p**harmacy fees shall be paid at [95]**85**% of the Average Wholesale Price (AWP) + $[6.70] **10.00** (dispensing fee) for both brand name and generic, effective on the day the drug was dispensed except for in-patient hospital charges. Payment will be the lower of either the provider's usual and customary charge or **the fee established by this rule.**[95% of the AWP + dispensing fee .] **However, brand name drugs that have a generic equivalent will be paid at the lesser of 85% of the AWP for the brand name or 85% of the average AWP for generically equivalent drugs, plus dispensing fee, unless the prescribing medical provider writes "Do not substitute" or similar notation on the prescription.** All providers who are licensed to dispense medications in accordance with their practice must be**,** paid similarly regardless of profession.

(2) All prescription medications are required medical services and do not require prior approval under the palliative care provisions of OAR 436-010-0290.

(3) Under ORS 689.515(2) licensed providers may dispense generic drugs to injured workers.

(4) **Payment for Oxycontin, Vioxx, Celebrex and Neurontin is limited to an initial five day supply unless the prescribing medical provider writes a clinical justification for prescribing that drug rather than a less costly drug with a similar therapeutic effect. The justification may accompany the prescription and be submitted by the pharmacist or may be given directly to the insurer by the medical provider.**

(5) Insurers shall use the prescription pricing guide published by First DataBank Inc, Thomson Healthcare, Inc., or Facts & Comparisons (a Wolters Kluwer Health, Inc., Company) for calculating payments to the licensed provider. Insurers must update their source at least monthly.

[(5)] **(6)** The worker shall have the right to select the pharmacy, except for claims enrolled in a managed care organization (MCO) where pharmacy service providers are specified by the MCO contract.

[(6)] **(7)** **Except for sections 2 through 4 of this rule, t** [T]his rule shall not apply to a worker's direct purchase of prescription medications, and shall not limit a worker's right to reimbursement for actual out-of-pocket expenses pursuant to OAR 436-009-0025.

[(7)] **(8)** The insurer shall be required to pay the retail-based fee for over-the-counter medications.

[(8)] **(9)** Drugs dispensed by a hospital (inpatient or outpatient) shall to be billed pursuant to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 3/8/01 as Admin. Order 01-051, eff. 4/1/01
Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-009-0100 Sanctions and Civil Penalties

The director may impose sanctions upon a medical provider or insurer for violation of OAR 436-009 in accordance with OAR 436-010-0340.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff. 04/01/00

To access **Diskette Order Form # 440-3039**, select a hyperlink to one of the formats below:

MS Word 97 fill in form **Adobe PDF printable form**

Forms are also available on line at
http://www.cbs.state.or.us/external/wcd/policy/forms/formsbyno.html.

Appendix A 436-009-0030

Data and Format Requirements:

RECORD LAYOUT FOR ELECTRONIC DATA-TRANSMISSION

DESCRIPTION	ALPHA NUMERIC	POSITION	LENGTH	REQUIREMENT
Insurer's WCD number	9	1	4	Required
Insurer's claim number	X	5	20	Required
Claimant's SSN	9	25	9	Required
Date of injury (YYYYMMDD)	9	34	8	Required
Medical-only or disabling (M or D)	X	42	1	Optional
Medical provider-type	X	43	2	Required
Medical provider specialty	X	45	3	Required
Medical provider FEIN	X	48	10	Required
Medical provider other federal reporting ID number or PIN	X	58	9	Optional
MCO number	X	67	6	Required
ICD-9-CM diagnosis code	X	73	6	Required
Secondary ICD-9-CM diagnosis code	X	79	6	Optional
Service, drug, or procedure code	X	85	11	Required
Modifier code	X	96	2	Required
Date of service (YYYYMMDD)	9	98	8	Required
Date of payment (YYYYMMDD)	9	106	8	Required
Charge amount sign	X	114	1	Required
Charge amount	9	115	6	Required
Payment amount sign	X	121	1	Required
Payment amount	9	122	6	Required
Number of units or services	9	128	2	Required

1. Refer to the Bulletin 220 for additional special field reporting instructions.

SPECIAL FIELD REQUIREMENTS FOR RECORD LAYOUT

DESCRIPTION	Special Field Requirements
Alpha Numeric (Table Column)	X = Character or alphanumeric data: No lower-case letters; fill empty spaces with blanks and left justify. 9 = Numeric data; right justify numbers including leading zeros; fill empty spaces with zeros.
Length (Table Column)	No compressed or packed fields.
Insurer's WCD number	Workers' Compensation Division insurer number. National Association of Insurance Commissioners (NAIC) number, where applicable, is included for reference.
Date of injury (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Medical provider-type	Use code from list of provider-type codes in this appendix.
Medical provider specialty	Use code from list of provider specialty codes in this appendix.
Medical provider FEIN	"FEIN" means the federal employer identification number used by the medical provider for federal tax reporting purposes.
Medical provider other federal reporting ID number or PIN	If available, report the nine-digit other federal reporting number that is used for federal tax reporting purposes, or the unique personal identification number of the individual providing the medical service.
MCO number	See instructions in Bulletin 220.
ICD-9-CM diagnosis code	See instructions in Bulletin 220.
Secondary ICD-9-CM diagnosis code	See instructions in Bulletin 220.
Service, drug, or procedure code	See instructions in Bulletin 220.
Modifier code	Optional CPT or HCPCS modifier codes are required when needed to report a modified service. Do not report physical status modifiers for anesthesia services. Do not report physical status modifiers for anesthesia services. See instructions in the Bulletin 220 for usage of adjustment modifiers "RF" and "DC" for adjustments. See instructions in the Bulletin 220 for usage of modifiers "SG", "NT", "81" and "50".
Date of service (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Date of payment (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Charge amount sign	If this is a refund or other negative amount, put a minus-sign in this field, otherwise fill with a blank.
Charge amount	Rounded to the nearest whole dollar, for example, a $300.05 payment would be shown as "000300."
Payment amount sign	If this is a refund or other negative amount, put a minus-sign in this field, otherwise fill with a blank.
Payment amount	Rounded to the nearest whole dollar, for example, a $300.05 payment would be shown as "000300."
Number of units or services	See instructions in Bulletin 220.

PROVIDER TYPES: Use the following codes to describe the type of medical provider:

TABLE OF MEDICAL PROVIDER-TYPE CODES	
PROVIDER DESCRIPTION	**CODE**
Acupuncturist	AC
Chiropractor	CH[1]
Dentist	DE
Hospital Inpatient	HI[1]
Hospital Outpatient	HO[1]
Laboratory	LA
Medical Doctor	MD[1]
Medical Supplies	MS
Naturopath	NA
Occupational Therapist	OT
Optometrist	OP
Osteopath	OS[1]
Pharmacy	PH
Physical Therapist	PT
Physician's Assistant	PA[1]
Podiatrist	PO
Radiologist	RA
Registered Nurse Practitioner	NP[1]
Other Medical Provider	OM

1. ICD-9-CM diagnosis codes are required on records with these types.

PROVIDER SPECIALTY: If the medical provider-type is "MD", use the following codes to designate the medical provider specialty:

TABLE OF MEDICAL PROVIDER SPECIALTY CODES	
PROVIDER SPECIALTY	**CODE**
Anesthesiologist	ANE
Dermatologist	DER
Emergency Medicine	EMM
Family Practice	FPR
General Practice	GPR
General Surgeon	GSU
Internist[3]	INT
Neurologist	NEU
Neurosurgeon	NSU
Occupational Medicine	OCC
Ophthalmologist	OPH
Oral Surgeon	OSU
Orthopedist/Orthopedic Surgeon	ORS
Otolaryngologist	OTO
Pathologist	PTH
Physiatrist	PMR
Plastic Surgeon	PSU
Psychiatrist	PSY
Urologist	URO
Other Surgical/non-Surgical Specialists[1]	OTH
Unknown Specialist[2]	UNK

1. Indicates provider specialty does not fit any of the above categories.

2. Indicates provider specialty cannot be determined.

3. All internal medicine specialties.