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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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, division: 009, Oregon Medical Fee and Payment Rules 010, Medical Services 070, Workers' Benefit Fund Assessment 085, Premium Assessment	)))))))	SUMMARY OF TESTIMONY AND AGENCY RESPONSES

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 February 1, 2005. On March 1, 2005, a public rulemaking hearing was held as announced at 2:00 p.m. in Room F 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 March 4, 2005.

NOTE: No oral or written testimony was submitted regarding OAR 436-070 or 436-085.

Subject Division	Exhibit #	Oral testimony received from:
010	21	Debra Buchanan, Workers' Compensation Division
009 & 010	22	Robert G. Petersen, PA-C, Oregon Society of Physician Assistants
009	23	E. Lloyd Hiebert, MD
009	24	David J. Silver, MD
009	25	Carl Balog, Providence Medical Center, Portland
009	26	Joseph H. Eusterman, M.D. Western Occupational/Environmental Medicine Services
009	27	Michael Karasek, MD, Northwest Spine Group

Subject Division	Exhibit #	Written testimony received from:
009 & 010	1	Nicole Schneider, Liberty Northwest Insurance
009 & 010	2	Diana E. Godwin, Attorney, on behalf of Oregon Physical Therapists in Independent Practice (OPTIP)
009	3	Karen McNamee, RN, MCO Program Manager, Providence MCO

009	4	Stacy Epsteen, RN, MS, ANP
009 & 010	5	Linda Olsen, SAIF Corporation
010	6	Debra Buchanan, Workers' Compensation Division
009	7	Joseph H. Eusterman, M.D. Western Occupational/Environmental Medicine Services
009 & 010	8	Robert G. Petersen, PA-C, Oregon Society of Physician Assistants
009	9	David J. Silver, MD
009	10	Michael Karasek, MD
009	11	Mark Greenburg, MD
009	12	David J. Silver, MD
009 & 010	13	William Bartel, Special Districts Association of Oregon & Public Risk Consultants
009	14	F. M. Prideaux, DC
009	15	Michael Karasek, MD
009	16	Robert G. Petersen, PA-C, Oregon Society of Physician Assistants
009	17	Andi Easton, Associate Director, Government Affairs, Oregon Medical Association
009 & 010	18	John Di Paola, MD, Occupational Orthopedics
009	19	Christopher A. Park, OTR, FABDA, Occupational Therapist
009	20	Joseph H. Eusterman, M.D. Western Occupational/Environmental Medicine Services
009	28	Susan King, Oregon Nurses Association

SUMMARY OF TESTIMONY AND AGENCY RESPONSES
Oregon Administrative Rules, Chapter 436 – public hearing March 1, 2005

The following is a summary of the testimony received and the agency's responses to that testimony.

OAR 436-009-0015(6)

Regarding the proposal to remove intradiscal electrothermal therapy (IDET) from the list of treatments excluded from compensability under ORS 656.245(3).

Testimony in support of the rule as proposed, or as proposed with the addition of criteria for when the procedure may be provided (and allowing reimbursement for IDET):
Exhibits: 1, 10, 11, 15, 23, 25, & 27

- IDET is not investigational or unproven. The FDA approved IDET in 1998.
- Over 40,000 IDET procedures have been performed 1998-2004.
- There have been approximately 20 observational trials with over 1,000 patients, most with one to two year follow-up.
- Literature indicates 50-60% of patients achieve a significant response, with reduced pain and increased activity. 10 to 20% may be essentially cured. The alternative for these patients is long-term narcotic intake, significant disability, and in many cases, spinal fusion.
- The alternative to IDET is long term narcotic care or spinal fusion.
- IDET is very safe – complication rate well below 1%.
- Personal experience with over 300 IDET patients – 54% good/excellent results with zero complications.
- In a randomized, controlled trial conducted by K. J. Pauza (award winning study), results clearly showed IDET superior to placebo.
- Of the surgical procedures now allowed for workers with spinal injuries, none are supported by a randomized, placebo controlled trial.
- The Oregon Workers' Compensation Medical Advisory Committee recommends removing IDET from the "unproven" list and recommends the patient selection criteria used by Pauza, criteria that conform to ISIS Guidelines for patient selection.
- IDET is cost effective when compared with fusion, as well as far less risky and debilitating.
- In properly selected patients, IDET offers a reasonably effective treatment and should be one of our treatment options.
- About 90 percent of my patients have pain that is related to the spine. Discogenic pain, or pain related to the disc, is probably the most misdiagnosed and under-treated spinal problem I've seen in my practice. This could be for three reasons. Firstly, many primary care providers have not been trained in the diagnosis of spinal pain or discogenic pain. Spine X-rays in young workers with discogenic pain are usually normal, and MRI scans only show an anular tear about 50 percent of the time. Until IDET came along, the only available treatment was a fusion. This is very expensive, and it permanently alters the functionality and the flexibility of the spine. With IDET I have a credible alternative to a fusion. It's done under a local anesthesia. It's very minimally invasive. It maintains the functionality of the spine, and it avoids the biomechanical stress that is caused by a fusion. I've had excellent success with the IDET procedure, because I've adhered to a very strict selection criteria.
- In Dr. Pauza's study, it emerged that IDET was significantly more effective than sham treatment in patients with poor physical function and high disability.

- (In response to other testimony) It is incorrect to state that there are “other equally convincing studies and articles that do not support this position.” There is no other randomized control trial that convincingly disputes the efficacy of IDET demonstrated in the Pauza trial. The Webster, *et al.* study cited is flawed because 68% of the patients were not selected by recommended criteria. The Davis, *et al.* Study is flawed by the absence of pretreatment pain data, because there is no way to know the degree of pain relief in the patients.
- (In response to other testimony) Regarding the concern that patient selection criteria will not be followed, this has nothing to do with the question of whether IDET is unproven. If there is a dispute, presumably the Workers’ Compensation Division would use the selection criteria in review of the appeal.
- (In response to other testimony) There is not a “lack of published evidence that IDET produces long-term benefits.” Numerous studies involved two-year follow-up.
- (In response to other testimony) Regarding the assertion that IDET is unproven in treating injured workers, IDET has been found to be successful in treating injured workers in a number of different studies at different centers {five studies cited}.
- (In response to other testimony) Regarding the assertion that findings of the K. J. Pauza randomized controlled trial were of modest efficacy for IDET, Dr. Bogduk stated “The improvements in pain and function achieved by the patients treated by IDET were significantly greater than those achieved by the sham group. * * *”
- (In response to other testimony) Regarding the assertion that IDET might have reduced efficacy in workers’ compensation cases, some involving litigation. IDET should subject to more strenuous requirements of proof that are not required for other interventions such as multidisciplinary rehabilitation, functional restoration, or spinal fusion. None of these treatments can be shown to be more effective than IDET for the relive of pain.
- (In response to other testimony) Regarding the suggestion to consult Drs. Deyo and Bigos, these physicians were probably selected because they champion the psychosocial model and oppose the medical model for low back pain (i.e., that there is an actual organic cause). Treatment based on the psychosocial model has proven ineffective at best. The majority of spine specialists are focusing on discogenic pain. If the Workers’ Compensation Division consults with Drs. Deyo and Bigos, it should also seek opinions from experts (Drs. Bogduk, Aprill, Wetzel, Derby, Anderson) who believe discogenic pain represents the most scientific approach to spine diagnosis.
- The Medical Advisory Committee made its recommendations regarding IDET based on research findings. The findings included criteria for when IDET should be used. We propose that criteria for when IDET is compensable be added to the rules, probably to OAR 436-010-0230.
- In the event DCBS decides to allow this procedure, we ask that strict criteria be met as outlined in the September 17, 2004 memo to Mr. Shilts (Workers’ Compensation Division Administrator) from the Medical Advisory Committee. The criteria should also include obesity as testified at hearing.
- IDET is a viable alternative to lumbar surgery. A large portion of my patients suffer from chronic back ailments, in many cases due to on-the-job injuries. When steroids have failed, and the only option available is surgery, patients feel trapped. Everyone knows of a friend or relative who has undergone a so-called corrective surgery and ended up worse. But with the prospect of either losing your income or taking a chance on surgery, workers would rather risk the surgery. I tell my patients that statistically the chances for a successful response in terms of pain reduction to either back fusion or an IDET are about the same. Given this choice, most reasonable people would choose the less invasive procedure, along with a shorter recovery time. They know that faster recovery means quicker return to work. And a savvy case manager, I believe, would also appreciate the cost savings.

The merits of having alternative therapy, which bridges the gap between conservative care and surgical intervention should be self-evident.

Testimony in opposition to the rule as proposed (and retaining the exclusion of IDET from compensability):
Exhibits: 3, 7, 9, 12, 13, 14, 20, 24, & 26

- The IDET is not a "proven" procedure. It appears the Medical Advisory Committee reviewed the SPINE 4 (2004) article and found it convincing that IDET yielded significantly greater improvement than a placebo. However, there are equally convincing studies and articles that do not support this position.
- No study documents lasting improvement beyond 24 months.
- The exact effect of IDET on the disc is still being researched. Until the mechanism of action is understood, the long term effects cannot be fully understood. Some investigators have raised the possibility that IDET may destabilize the disc, with destructive results over the long term.
- Barbara S.Webster, BSPT, PA-C, Santosh Verma, MD, MPH, and Glenn Pransky, MD, MoocH, (SPINE, Volume 29(4), February 15, 2004. 435-441), concluded that IDET appeared to be much less effective when performed by a variety of providers in workers' compensation populations; narcotic use before IDET and having discography and IDET performed by the same provider were associated with poor results in all outcomes measured; negative prognostic factors for improved work status included provider self-referral, male gender, litigation, narcotic use 3 months before IDET, and older age.
- Timothy T. Davis, MD, Rick Delamarter, MD, Parveen Sra, MHP, and Theodore Goldstein, MD (SPINE, Volume 29(7). April 1, 2004.752-756) concluded that at 1 year post-IDET, half of the patients studied were dissatisfied with their outcome and the percentage of patients on disability remained the same. Nearly all continued to report pain 1 year post IDET. It was estimated that 15% of patients would undergo fusion at 1 year and 30% would undergo fusion at 2 years post IDET.
- There are currently no published randomized, controlled studies evaluating IDET.
- The criteria established by the Medical Advisory Committee regarding when to allow IDET at one or two levels is conservative. However, there is no mechanism within the state system to validate that the criteria will be followed by practitioners. If an MCO or Insurer does not authorize IDET as being medically indicated or reimbursable, will the Medical Review Unit (of the Workers' Compensation Division) be required to utilize these criteria in review of the appeal? Will the Medical Review Unit provide this criteria to physician arbiters to follow when workers are examined during the appeals process? Will DCBS require evidence that providers are properly trained and experienced in this procedure since there is a direct correlation between the practitioner's skill level and outcomes?
- Regarding the Pauza study, pain relief in the treated group went down by 2.4 on the visual analog scale. For a worker who has intense, dreadful, horrible pain that is reduced to distressing, miserable pain, the change won't necessarily benefit the person, or make that person more productive or able to go back to work.
- In 1995 an orthopedist named Rhyne did a study of patients who had what was called discogenic pain. 68 percent of the patients improved without any further treatment. IDET is not the only alternative to spinal fusion. If one carefully evaluates patients with chronic back pain, many would advise no surgery in a large group of patients.
- Payment for IDET in injured workers will not significantly decrease worker disability or

significantly increase return to work. It will increase the medical costs of workers' compensation, and will produce some increased disability costs by increasing time loss associated with the procedure, and the recovery from it. Disability costs will increase because some workers will be worse after the procedure, and a few will have complications which will increase both disability and medical costs.

- Nearly 50 percent of patients who have the IDET procedure do not improve at all.
- An international back pain authority, Richard A. Deyo, M.D., MPH does not support the still very controversial concept of discogenic pain, the basis for IDET, and thus, the procedure itself.
- The MAYO Clinic considers IDET still to be "experimental."
- Obesity is not included among the deselection factors by the proponents and those factors are only vaguely addressed.
- Many in low back pain management would question the thoroughness of the assessment of possible psychosocial factors being eliminated in candidate selection only a score less than 20 on the Beck depression scale.
- The appearance of possible conflict of interest by the proponents has been a concern throughout the last four years of consideration by the Medical Advisory Committee members.
- The Medical Advisory Committee considered IDET experimental in 2001. What has changed?
- A new concern is the apparent diagnosing of small annular tears by unenhanced lumbar MRI, a skill thought possible only through the use of CT/discography. Is this another way to legitimize discogenic pain and use of IDET?
- Back-injured workers are very vulnerable to iatrogenic disability.
- The Workers' Compensation Division should invite the opinions of two highly qualified nearby experts, Richard A. Deyo, M.D. and Stan Bigos, M.D.
- In 2004, K. J. Pauza *et al.* published a randomized, prospective, placebo-controlled study of IDET. This carefully done study provides scientific evidence for a modest favorable effect for relieving back pain in a carefully selected group of patients. However, injured workers were excluded from the study "in order to avoid potentially confounding effects of litigation or motivation." This exclusion leads to the conclusion that there is no convincing scientific evidence that IDET will benefit injured workers.
- IDET studies have produced conflicting data. Dr. Michael Karasek achieved pain reduction of 5 on the Visual Analog Scale (VAS), a truly remarkable improvement. However, other published series have not achieved these gains. The Pauza study reported a modest mean reduction of 2.4 in the treated group. Two other studies reported reductions of 2.9 and 1.8. Dr. James Dunn found that no injured workers among his IDET patients had obtained pain relief. This contrasts with Dr. Bogduk's and Dr. Karasek's more recent report that compensation status (workers' compensation and auto liability) did not affect outcome.
- Workers' compensation insurer representatives have not reported good results with IDET. In a study of IDET involving 142 workers treated by 97 providers in 23 states, 27 were working before EDT and 55 were working afterward, but the data was insufficient to attribute the increase to IDET. 6% of patient who were working before IDET were not working after IDET.
- The Webster study found that 68% of the claimants who received IDET did not meet published criteria for having it done. IDET was designed to treat a small number of patients with internal disc disruption, involving minimal disc degeneration. If IDET is compensated, one can predict that the treatment will be applied to patients who have significant degenerative disc disease.
- IDET has a powerful placebo effect. In Pauza's study, 38% of treated patients achieved 50% relief from pain, but 33% of patients with sham treatment also achieved 50% pain relief.

- IDET is an invasive procedure. While injuries are rare, there has been one case of cauda equina injury due to a misplaced electrode, and once can expect there will be discitis, osteomyelitis, and nerve root injury from IDET.
- (In response to other testimony) It has been pointed out that many surgical procedures have not been subjected to the rigorous evaluation required of IDET. However, there is no ethical way to perform a perspective randomized placebo-controlled study of spinal surgery. Surgery probably does have a placebo effect, but neither the placebo effect of surgery nor the limitations of surgery constitute an argument for IDET. The value of IDET must rest on demonstrated effectiveness.
- I am aware of no MCO in Oregon that approves spinal fusion for discogenic back pain, as the concept of discogenic back pain remains disputed, and there is no general agreement that spine fusion is useful treatment for discogenic back pain, particularly in injured workers.
- Injured workers represent a substantially more difficult group than patients who suffer back pain from non-traumatic degenerative lumbar disc disease. The Pauza study included only patients with non-traumatic mild degenerative disease. Therefore, it seems inappropriate to compensate a procedure that has not demonstrated effectiveness in a randomized prospective group of injured workers.
- Regarding the Pauza study: In general, a result is considered statistically significant if there is less than a 1 in 20 or 0.05 chance that the result obtained would have occurred by chance alone. The statistical calculation for the Pauza study was 0.045, which is valid at the lowest accepted level of statistical significance.
- IDET has been available for seven years, but is not widely supported by neurosurgeons, orthopedists and physiatrists who care for patients with back pain. If IDET were as effective as claimed, these specialists would add IDET to their armamentarium. Because IDET has produced substantial improvement in less than 50% of patients, its use will diminish and become a procedure of historical interest rather than one used in common practice.
- We are all aware that injured workers are unique as compared to patients without work related injuries. Overall, it does not appear that it would be cost effective to treat injured workers as the larger percentage would still require additional procedures in addition to IDET.
- The Medical Advisory Committee apparently did not have a Quorum when it voted on IDET. I am concerned the Committee has been packed with IDET proponents.
- I have never found a post-IDET in vivo study with discograms showing clear objective evidence of alleged sealing of disc tears/fissures, a much more desirable result proof than the very crude, subjective, assessment using the visual analog scale.
- An international back pain authority, Dr. Richard A. Dale, does not support the still very controversial concept of discogenic pain, the basis of the IDET procedure, and thus, he does not support the IDET procedure itself.

Response: There are many issues to consider regarding IDET, most of which has been discussed. The division has carefully considered all of the discussion and concerns. The division received input from the Medical Advisory Committee that some members wanted to revisit the issue. The administrator would like to allow the MAC to review the issue further. Thus, at this time it is best to wait for the MAC's recommendation before deciding whether to change the rule.

OAR 436-009-0015(10) ***Exhibit #4***
Testimony: Nurse Practitioners in this state provide competent, compassionate care to the workers of Oregon and their remuneration should reflect that care. I urge you to set fees in a fair and equitable

manner that is consistent with the payments made to physicians. It would be unfortunate if this segment of clinical care providers would withdraw from providing this care based upon the disparity of compensation.

Response: We agree that Nurse Practitioners provide very valuable services for injured workers. The 80% rate of reimbursement has been in effect since at least 1986. Originally, it was based, in part, on the Medicare reimbursement rate, which is one of the statutory requirements, in ORS 656.248(1), that the division must consider in setting the rates. There was much discussion in the advisory committee regarding this rate. There was not agreement the rate should be raised. The Medicare reimbursement rate is currently at 85%. In this time of economic challenge we must consider whether it would be wise to make a large jump in reimbursement rates to any group of medical providers. However, after considering all of the input and testimony, as well as the Medicare rate, the division believes that the payment rate in Oregon can be raised to 85% without adverse affect to injured workers, employers or the WC system here in Oregon. Thus, the rate has been raised to 85%.

OAR 436-009-0015(10) ***Exhibit #28***

Testimony: It is our understanding that the Medicare provisions were used as guidance for establishing reimbursement to NPs at 80% of the physician rate. There is much question about the basis on which CMS establishes reimbursement. Nurse Practitioners are independent providers whose office staff, supplies, occupancy and other expenses are no different than those of physicians. Additionally, for the services they provide within their scope of practice, the knowledge and time to provide that service are no different than physicians. It is unclear why the Division chose to use a questionable federal standard and why the use of that standard was not decided by the Division in an open meeting. The Oregon Nurses Association respectfully requests that the issue of NP reimbursement be reconsidered by the Division in an open discussion with stakeholders as soon as possible and that the proposed rules referenced above not be implemented.

Response: Nurse Practitioners provide very valuable services for injured workers. There was much discussion in the advisory committee which included representation from Nurse Practitioners, regarding this rate. There was not agreement that Nurse Practitioners provide exactly the same service, nor that the rate should be raised. The division practices open communication with the stakeholders through many processes, including the administrative rules process. This includes seeking and receiving input on rules throughout the year as well as at the time of advisory meetings where issues are discussed at length. Also, as part of the rules process, testimony is taken at the Rules Hearing, and the division's response is available through the testimony and response document. The division always strives to operate with an open, clear, and collaborative process to the greatest extent practicable. The WCD 80% rate of reimbursement for physician assistants and nurse practitioners had been in effect since at least 1986. Originally, it was based, in part, on the Medicare reimbursement rate, which is one of the criteria that statute requires, in ORS 656.248(1), that the division consider in setting the rates. In this time of economic challenge we must consider whether it would be wise to make a large jump in reimbursement rates to any group of medical providers. The Medicare reimbursement rate is currently at 85%. After considering all of the input and testimony, as well as the Medicare rate, the division believes that the payment rate in Oregon could be raised to 85% without adverse affect to injured workers, employers or the rest of the WC system here in Oregon. Thus, the rate has been raised to 85%. The division is very open to reviewing new and ongoing data on other systems and rates. Any specific data submitted regarding reimbursement rates in other sectors, e.g., private health reimbursement rates, etc. would be valuable information in next years' rule review process.

OAR 436-009-0015(10) ***Exhibit #5***
Testimony: This rule increases the rate of reimbursement for physician assistants and authorized nurse practitioners from 80% to 85% of a physician's allowable fee. The increase is not warranted, because there is a very distinct difference between the medical education and expertise of physicians and nurse practitioners. It has been approximately one year since nurse practitioners obtained limited attending physician status. It has been less than 6 months since they were required to obtain their certification to become authorized nurse practitioners. It would seem more appropriate to wait to consider increasing their rate of reimbursement until this group of providers has demonstrated that they see patients quicker, release patients back to work faster and close claims sooner than physicians.

We also propose a change in the rule to provide more clarity around the issue of out of state nurse practitioners:

"Physician assistant, authorized nurse practitioners or *out of state nurse practitioner* fees shall be paid at the rate of 80 percent of [a]the physician's allowable fee for a comparable service. The fees for services by these providers [shall] must be marked with modifier "81"."

Response: Nurse Practitioners provide very valuable services for injured workers. The 80% rate of reimbursement has been in effect since at least 1986. Originally, it was based, in part, on the Medicare reimbursement rate, which is one of the statutory requirements, in ORS 656.248(1), that the division must consider in setting the rates. The Medicare reimbursement rate is currently at 85%. After considering all of the input and testimony, as well as the Medicare rate, the division believes that the payment rate in Oregon for Nurse Practitioners could be raised to 85% without adverse affect to injured workers, employers or the WC system here in Oregon. Thus, the rate has been raised to 85%.

The out-of-state nurse practitioner issue has been clarified in the rules.

OAR 436-009-0015(10) ***Exhibits #8, 16, & 22***
Testimony: Physician Assistants (PAs) are dependent medical practitioners that work as part of the physician's team. Because physicians services provided by PA's are in conjunction with the physical practice and overhead of the physician's practice, the practice incurs the same costs, whether or not the PA is involved. In an era of frivolous lawsuits, increasing overhead, and declining revenues for physicians, physicians are finding it harder to provide access and care. Reimbursement needs to be adjusted to meet the real expenses of providing physician services.

Currently, over 50% of states reimburse physician services provided by a PA at 100% of the physician fee schedule. Neighboring western states – Alaska, Washington, Idaho, California, Montana, and Wyoming have pay at 100%. Medicare pays 100% when there is on-site physician presence. Medicare pays at 85% when the physician is not directly on site when the service is delivered. Currently most private insurance carriers reimburse for physician services provided by PAs at 100 percent of the allowable physician's fee schedule. Regardless of the situation, in all cases Oregon laws and rules and regulation require physician involvement and therefore reflects physician's cost and quality assurance incurred in the delivery of physician services delivered by PA's.

Response: Physician Assistants provide very valuable services for injured workers. There was, however, not much discussion in the WCD advisory committee on this issue regarding Physician Assistants as we

had not had any input from Physician Assistants prior to the proposed rules. The division actively practices open communication with the stakeholders through many processes, including the administrative rules process. This includes seeking and receiving input on rules throughout the year as well as at the time of advisory meetings where issues are discussed at length. Also, as part of the rules process, testimony is taken at the Rules Hearing, and the divisions response is available through the testimony and response document. The 80% rate of reimbursement for Physician Assistants has been in effect since at least 1986. Originally, it was based, in part, on the Medicare reimbursement rate, which is one of the criteria statute requires, in ORS 656.248(1), the division consider in setting the rates. In this time of economic challenge we must consider whether it would be wise to make a large jump in reimbursement rates to any group or groups of medical providers. The Medicare reimbursement rate is currently at 85%. After considering all of the input and testimony, as well as the Medicare rate, the division believes that the payment rate in Oregon could be raised to 85% without adverse affect to injured workers, employers or the rest of the WC system here in Oregon. Thus, the rate has been raised to 85%. The division is very open to reviewing new and ongoing data on other systems and rates. Any specific data submitted regarding reimbursement rates in other sectors, e.g., private health reimbursement rates, etc. would be valuable information in next years' rule review process.

OAR 436-009-0020 ***Exhibit #8***
Testimony: The Oregon Medical Fee and Payment Rules currently provide for payment of Physician Assistants (PAs) at 10% of the surgeon's allowable fee for surgical procedures. Medicare reimburses at 17%. Many private carriers pay at 20%.

Response: Physician Assistants provide very valuable services for injured workers. There was, however, not any discussion in the WCD advisory committee meetings on this issue regarding Physician Assistants and surgical fees as that issue was not raised prior to the proposed rules and hearing. The division actively practices open communication with the stakeholders through many processes, including the administrative rules process. This includes seeking and receiving input on rules throughout the year as well as at the time of advisory meetings where issues are discussed at length. The division is very open to reviewing new and ongoing data on other systems and rates. Any specific data submitted regarding reimbursement rates in other sectors, e.g., private health reimbursement rates, etc. would be valuable information in next years' rule review process. The issue could be reviewed in depth and a decision made for the 2006 rules.

OAR 436-009-0030(9) ***Exhibit #2***
Testimony: We support the change to section (9) to require an insurer to pay a medical provider for bills the insurer received on or before the date of a disputed claim settlement. A number of physical therapy clinics I represent have submitted bills to the insurer during the time the claim is in deferred status (as opposed to accepted or denied). Subsequently the claim is settled and the money disbursed to the worker. When the clinic objects that its bills were not paid (at the 50% rate) as part of the DCS, the insurer responds that the clinic needs to seek payment from the worker. This defeats the purpose of ORS 656.313(4)(c) and (d). The new language gives the director a rule to enforce 656.313(4).

We have one suggestion for a language change. In the second line of new subsection (9), replace "prior to" with "on or before," to conform to the language in 656.313(4)(c). The statute pertains to bills that are received on the day of the settlement.

Response: Agree, rule revised.

OAR 436-009-0030(9) ***Exhibit #5***
Testimony: It appears this rule was modified to address bills submitted prior to claim settlement that are either not included or not reimbursed at the time of settlement. We propose a slight change in wording to add clarity, as both parties should have the right to dispute whether the bill qualifies for reimbursement:

"The insurer must pay a medical provider for any bill otherwise **reimbursable under the department's rules that is** related to the claimed condition received by the insurer prior to the date the terms of a disputed claims settlement (DCS) were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS even if the DCS payment has already been made. **Nothing in this rule prohibits either the provider or the insurer from raising a dispute before the director as to whether or not the bills were reimbursable under the department's rules and/or received by the insurer prior to the date of the terms of the disputed claims settlement.** Payments **not in dispute** must be made within 45 days of the insurer's knowledge of the outstanding bill."

Response: Adding the "reimbursable" requirement seems somewhat contrary to the intent of the rule. And, since the rule is in the division 009 rules, OAR 436-009-0008 allows for the parties to come to the director to resolve disputes about payment/non-payment for medical services. Another specific reference does not appear to be necessary at this time. Since this is a new rule, it is reasonable to wait and see how it is applied in the system to identify any revisions needed. It is anticipated that discussion will occur at the next WCD advisory meetings for the 2006 review of the rules. In that time, the stakeholders are encouraged to gather information and data regarding this rule and any suggested revisions needed.

OAR 436-009-0040 ***Exhibit #17***
Testimony: Physician reimbursement rates have not been changed in over a decade to reflect the ever increasing cost of medical inflation. We believe the Workers' Compensation Division has historically shifted the values of certain procedures and or diagnoses around within a zero sum balance. The OMA would rather see the Division look into adjusting the reimbursement rates at a rate that is comparable to that of the current medical inflation rate.

Response: WCD received written input from the OMA at the Advisory Meetings. In those meetings the present fee schedule was deemed satisfactory by the OMA representative. Other parties requested the surgical fee schedule value be reduced. After considering all of the input and testimony, the economic impact to the system and to Oregon, the division believes that the payment rate in Oregon should remain unchanged this year. The division is very open to reviewing new and ongoing data on other systems and rates. Along with the CPI, any specific data submitted regarding reimbursement rates in other sectors, e.g., private health reimbursement rates, etc. would be valuable information in next years' rule review process.

OAR 436-009-0070(12) ***Exhibit #2***
Testimony: We support the increase in the relative values for a First or Second Level PCE and for a WCE. The reimbursement for these procedures has not been increased for some time. We also support the increase in the relative value for each additional 15 minutes of a PCE or WCE.

Response: Agree. Rule remains as proposed.

OAR 436-009-0070(12) ***Exhibit #5***
Testimony: The current 5-digit Oregon Specific Codes used for arbiter examinations present problems in reimbursement because they match the national CPT codes for ambulance reimbursements. We propose a slight modification to the arbiter codes that would be easy for those physicians who perform arbiter examinations to incorporate into their billing:

Current Code	New Code
A0001	**AR001**
A0002	**AR002**
A0003	**AR003**
A0004	**AR004**
A0011	**AR011**
A0012	**AR012**
A0013	**AR013**
A0021	**AR021**
A0022	**AR022**
A0023	**AR023**
A0024	**AR024**
A0025	**AR025**
A0031	**AR031**
A0032	**AR032**

Response: This suggestion came in too late in the process for adequate review and discussion with the stakeholders. WCD will include this suggestion in next years review and advisory meetings.

OAR 436-009-0070(12) ***Exhibit #19***
Testimony: I support the proposed 10% increase in the relative value units for physical capacity evaluations and work capacity evaluations. In more 14 years of practice, there has been very little, if any, increase in the fee for these services, while the need for our services has increased. Recent changes in the workers' compensation law (Senate Bill 757) will likely increase the need for these types of evaluations. The amount of patient time, medical record review and report writing is often so great that a reasonable fee is not returned. The proposed 10% increase would be greatly appreciated.

Response: The rule will remain as proposed.

OAR 436-009-0080 ***Exhibit #18***
Testimony: The provision of durable medical equipment has been problematic in our practice in maintaining efficient and effective treatment for our workers. One of the key problems is coordinating the schedules of the product representatives who deliver these devices with our clinic and operating schedules. It is not infrequent that a patient will have an appointment arranged in the clinic for the fitting or application of a brace, only to have it postponed or cancelled due to the unpredictable schedules of the product representatives.

Because of the ineffectiveness of the medical community to deliver these services in a timely and predictable manner, we have instituted a system of providing these devices ourselves for clinic and operating room environments. However, we have been denied payment from some carriers based upon OAR 436-009-0080(1)(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)." The problem is that we have attempted for over one year to obtain from our DME suppliers a manufacturers suggested retail price. We have been unable to obtain this information from any of our vendors and have been told that it is not available.

The MSRP is duplicative and confusing. Since the MSRP does not exist, it creates an opportunity for the non-uniform application of the guidelines outlined by OAR 436-009. The statement, "85 percent of the manufacturer's suggested retail price (MSRP)" should be removed from the rules. The rules should require that DME reimbursement be based on the prevailing and customary range of charges for similar devices in the geographic region where services are provided. This will have no negative financial impact on the delivery of care to injured workers as long as DME providers are reimbursed in the same manner as they are now. It would have a positive impact on the safe and timely treatment of injured workers by reducing morbidity and complications.

Response: This suggestion came in too late in the process for adequate review and discussion with the stakeholders. WCD will include this suggestion in next years review and advisory meetings.

OAR 436-010-0230(6) ***Exhibit #18***

Testimony: This rule section includes the one contradictory statement in all the rules and regulations relating to the provision of medications to injured workers:

> **"…….**Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the provisions of this rule and OAR 436-009-0090."

This statement not only contradicts every other reference and rule regulating dispensing medications to injured workers, it is in direct contradiction to the usual and customary medical practices followed throughout Oregon and the U.S. Typically, an emergency room patient will be provided a small supply (seven to ten days) of medications to treat his or her condition. Later, the treating physician will determine whether to continue those medications. Dispensing practices of physicians throughout the U.S. are largely geared towards providing medications in 30-day increments. This is consistent with physician-monitoring practices to oversee the utilization of pharmaceuticals. The contradictory statement in OAR 436-010-0230(6) is used as a basis to deny payment for medical services.

This rule creates an adverse financial impact by requiring a subset of Oregon workers to seek prescription medications at other sources despite the availability of those medications within some providers' offices. The outcome is that workers often do not obtain the medicines prescribed, either because they lack the means of transportation to go to a participating pharmacy or the funds to be able to pay for the medications up front. When they return to the doctor, they are embarrassed to tell the doctor they did not have the funds for medication and they may well not inform the doctor that they in fact have

not been treated. This places them at risk of their doctor recommending more aggressive and invasive types of treatment because they are under the impression that conservative measures have failed.

I believe the removal of the contradictory statement from OAR 436-010-0230(6) will have a very positive impact on reducing the costs to the workers' compensation system.

Response: This issue has been reviewed previously, but was not raised this year until the end of the rules process, where there is no time for discussion with other stakeholders. WCD will include this suggestion in next years review and advisory meetings.

OAR 436-010-0240(1)(c) ***Exhibit #6***

Testimony: In response to inquiries from the public, I propose that subsection (c) be amended to include the federal citation, as has been done in subsection (a):

"\. . . . The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, this authorization does not authorize the release of information regarding:
(a) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, . . . or
(b) The release of HIV related information otherwise protected by ORS 433.045(3) . . .
(c)Mental health records which may only be obtained in compliance with federal regulations.

Response: After further consideration and investigation of the issue, WCD has determined that the subsection is not necessary, and it has been deleted.

OAR 436-010-0240(12) ***Exhibit #1***

Testimony: This rule section requires the authorized nurse practitioner to follow the requirements of OAR 436-010-0280 regarding determination and report of permanent impairment. The proposed language is confusing. Here are two alternatives:
1) "follow the requirements of OAR 5436-010-0280 regarding **closing examinations** and the determination and reporting of permanent impairment," or,
2) "follow the requirements of OAR 436-010-0280 regarding the determination and reporting of permanent impairment **and** closing examination**s**."

Response: The proposed rule was modified to add clarity.

OAR 436-010-0275(11) & (12) ***Exhibit #2***

Testimony: We support the addition of these two paragraphs to require insurers to notify medical providers when a worker is disenrolled from an MCO or an MCO contract is ending.

Response: The rule will remain as proposed.

OAR 436-010-0280(1) ***Exhibit #1***

Testimony: To be consistent with the rest of the changes, we propose "shall" be replaced with "must" in (1) as follows: "An authorized nurse practitioner **must** refer the worker to a . . ."

Response: The proposed rule has been revised.

OAR 436-010-0280(1), (2)(a), (b) & (3)(a), (b) ***Exhibit #5***

Testimony: The changes in this section of the rules help clarify that a determination for claim closure must be done under OAR 436-030-0020(2) and that an authorized nurse practitioner must refer a worker to an attending physician if there's a reasonable expectation of permanent impairment. However, section (2)(b) indicates the nurse practitioner must arrange or request that the insurer arrange for a closing exam within 5 days from the medically stationary date. The wording of (2)(b) will present considerable problems for insurers, providers and workers. If not changed, it would also take away a worker's right to choose his or her own attending physician. We would strongly recommend that the authorized nurse practitioner confer with the injured worker to select an attending physician of the injured worker's choice to conduct the closing examination and that the insurer be kept out of this process unless specifically asked by the worker for assistance. Suggested wording:

"(b) The authorized nurse practitioner refers the worker for a closing examination, in which case he or she in partnership with the worker must arrange for the worker to be examined for a closing examination under section (1) of this rule within five days of the examination in which the worker is declared medically stationary."

Response: Subsection (b) of this rule is a mirror of the process in subsection (a) that has been in place since 1999 for attending physicians. Insurers have been required to be a part of the process in order to assist the worker and the physician in obtaining the required closing examination and findings regarding permanent impairment. The rule does not take away the worker's right to choose an attending physician but simply outlines what must be done in accordance with statutory requirements for authorized nurse practitioners regarding closing exams. We are not aware of any worker complaining of an insurer choosing their attending physician for them since it has been in place (1999). The claim closure rules, OAR 436-0030, then come into play in the requirements for claim closure. Insurers, workers, physicians and nurse practitioners are not prohibited by the rule in working out a collaborative solution. There are some challenges with the nurse practitioner piece as they cannot sign off on the closing exam if there is permanent impairment. However, we believe that nurse practitioners can and do have professional connections to physicians capable of performing or concurring with the closing examination. The time frames have not been a problem thus far. After implementing the rule, if there are difficulties in meeting the time frame, the issue can be reviewed with stakeholders at the next rule revision advisory meetings.

OAR 436-010-0280(3)(b) ***Exhibit #1***

Testimony: The language is confusing. The sentence ends with "provide a written statement." Do you mean, "provide a written statement **of no impairment**"? If so, we recommend this sentence be changed.

Response: The written statement is specifically addressed in OAR 436-030-0020(2). It is imperative to read that rule in conjunction with this rule for this to make complete sense. However, the rule was

rearranged to clarify the need to read 030-0020(2) in conjunction with this rule. There are many requirements of the written statement in 030-0020(2), and in order not to unnecessarily lengthen these rules we just referenced the appropriate rule. This is primarily a claim closure issue.

OAR 436-009 & 010 General recommendation ***Exhibit #18***
Testimony: A comprehensive review of our complete practice shows the median education level among U.S. citizens is a GED or High School Diploma, with about 1/3 of patients having taken vocational or college level courses but not attaining a degree. Only 5% had college degrees. Among non-citizens, the median education level is 6th – 9th grade.

We reviewed the reading age and level of difficulty of information received by injured workers, using a method called the **Flesch Formula.** The documents reviewed show a mismatch between the communication to the workers informing them of their rights and their ability to comprehend it. Workers are unable to get a clear understanding of their rights from carriers and MCOs. If their attending physician is not clear on these issues to appropriately counsel their patients and provide timely treatment, the outcome of care is in jeopardy.

Document examples provided show a reading grade level of age 13 through undergraduate level.

Response: The division has been actively trying to simplify language in rules and all communication with the public for the last several years. Our goal is to help the public better understand the law and options available. We want to do this to the greatest extent that we can while still having the rules adequate in a legal sense. Specific suggestions on materials that could be improved are always welcome.

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 14th day of April, 2005.

WORKERS' COMPENSATION DIVISION

Fred Bruyns
Fred Bruyns, Rules Coordinator
Policy Section
Workers' Compensation Division

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

March 1, 2005	2:00 p.m..	Room F (basement, Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	**Time**	**Location**	**Hearings Officer**

NOTE: The hearing will begin at 2:00 p.m. and end when all present who wish to testify have done so. Written testimony will be accepted through March 4, 2005.

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

AMEND: OAR chapter 436, divisions 009, 010, 070, and 085

REPEAL: OAR 436-070-0060, 436-085-0006, 436-085-0020, 436-085-0065, 436-085-0070

ORS 656.726(4), 656.704
Stat. Auth.

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

ORS chapter 656; sections 005, 245, 248, 250, 252, 254, 256, 260, 264, 268, 273, 313, 325, 327, 331, 506, 612, 614, 704, 735, 740, 745, 794; ORS chapter 183, sections 310 through 690; ORS chapter 293, section 445
Stats. Implemented

RULE SUMMARY

The agency proposes to amend OAR chapter 436-009. These proposed rules:

- Adopt by reference updated medical resources:
  - Centers for Medicare & Medicaid Services 2005 Medicare Resource-Based Relative Value Scale Addendum B "Relative Value Units (RVUs) and Related Information" except the "status indicators," and Addendum C "Codes with Interim RVUs," 69 Federal Register No. 219, November 15, 2004 as the fee schedule for payment of medical service providers except as otherwise provided in the rules;
  - *American Society of Anesthesiologists (ASA), Relative Value Guide 2005* as a supplementary fee schedule for payment of anesthesia service providers except as otherwise provided in the rules for anesthesia codes not found in the Federal Register; and
  - *The Physicians' Current Procedural Terminology (CPT® 2005)*, Fourth Edition Revised, 2004 for billing by medical providers;
- Provide that if a party submits a request for administrative review without the required information, the review may not begin until the information is submitted;
- Remove intradiscal electrothermal therapy from the list of non-compensable services;
- Provide for the determination of an adjusted cost/charge ratio for a newly established hospital based on the ratios of similar hospitals, when there is insufficient data available specific to the new hospital;
- Increase maximum fees paid to physician assistants and nurse practitioners from 80 to 85% of a physician's allowable fee for a comparable service;
- Require insurers to pay medical providers for bills they have received prior to a DCS, but which were not included in the DCS or were not paid according to the terms of the DCS. Payment must be made within 45 days of the insurer's knowledge of the unpaid bill;
- Modify "no show" notice from 24 to 48 hours for medical arbiter examinations;
- Increase by 10% the relative value units for physical capacity examinations and work capacity evaluations; and
- Replace references to Vioxx®, Celebrex®, and Bextra® with "COX-2 inhibitors" as being limited to a five-day initial supply without clinical justification.

The agency proposes to amend OAR chapter 436-010. These proposed rules:

- Provide that if a party submits a request for administrative review without the required information, the review may not begin until the information is submitted.
- Provide that, for the purpose of determining attorney fees, the threshold of extraordinary circumstances is not met by merely exceeding 8 hours or exceeding a benefit amount of $6000.

- Clarify that, in order to provide compensable medical services under ORS 656, a nurse practitioner must be licensed in Oregon and must be assigned an authorized nurse practitioner number by the director;
- Provide that signed workers' compensation release statements do not authorize release of mental health records covered by federal regulations;
- Clarify communication and notification requirements regarding elective surgery;
- Require insurers to give written notice, with specified time frames, of when a worker is no longer subject to a managed care organization (MCO), to the worker, the worker's representative, all medical service providers, and the MCO, and that such notice advise the worker how the worker may receive medical services for compensable injuries after the worker is no longer enrolled; and
- Clarify that authorized nurse practitioners must refer workers for closing examinations to medical providers who are eligible to be attending physicians only if there is a reasonable expectation of permanent impairment, and if the referral is made, that the referral must occur within five days of the examination in which the worker is declared medically stationary.

The agency proposes to amend (and repeal in part) OAR chapter 436-070. These proposed rules:

- Clarify that employers that elect to provide workers' compensation coverage for otherwise non-subject workers are then subject to Workers' Benefit Fund assessments;
- Establish a process for the department to notify employers that filings are late or inaccurate, and to estimate assessments due under specific conditions;
- Provide that employers or the director may initiate resolution of reporting errors, omissions, or discrepancies for a period not to exceed the current calendar year plus three prior calendar years, however, no time limitation applies to cases involving fraud;
- Require employers to maintain payroll and employment records that reflect the total hours worked by all employees for the current calendar year plus three prior calendar years;
- Provide that for an overpayment of less than $20, the director will refund the overpayment only upon written request; and
- Repeal 436-070-0060, "Issuance/Service of Penalty Orders," because service of orders is sufficiently described in the Oregon Rules of Civil Procedure.

The agency proposes to amend (and repeal in part) OAR chapter 436-085. These proposed rules:

- Provide that the director may allow an insurer to report and remit premium assessments annually when the annual premium assessment is less than $1,000;
- Provide that the director may waive an insurer's reporting liability after confirming that the insurer has no earned premium for at least four consecutive quarters;
- Provide that the director may waive a self-insured employer's reporting liability after confirming that the employer has had no Oregon payroll for four consecutive quarters;
- Provide that the self-insurer's premium reporting method remains in effect until the employer timely elects to change the method;
- Provide for the assessment of civil penalties up to the statutory maximum of $2,000 rather than the $1,000 maximum stated in the current rule;
- Repeal 436-085-0020, "Premium Assessment Rates; Method and Manner of Determining," because rates are now established under OAR 440-045;
- Repeal 436-085-0065, "Issuance/Service of Penalty Orders," because service of orders is sufficiently described in the Oregon Rules of Civil Procedure; and
- Repeal 436-085-0070, "Suspension and Revocation of Authorization to Issue Guaranty Contracts," because this rule duplicates provisions in OAR 436-050-0015;

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://wcd.oregon.gov/policy/rules/rules.html **or from WCD Publications at 503-947-7627 or fax 503-947-7630.**

March 4, 2005	/s/ John L. Shilts 1/14/2005
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	)	Statutory Authority,
The Amendment of:	)	Statutes Implemented,
OAR 436-009, Oregon Medical Fee and Payment Rules	)	Statement of Need,
OAR 436-010, Medical Services	)	Principal Documents Relied Upon,
OAR 436-070, Workers' Benefit Fund	)	Statement of Fiscal Impact
OAR 436-085, Premium Assessment	)	

Statutory Authority: ORS 656.704, 656.726(4)

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

Statutes Implemented: ORS chapter 656; sections 005, 245, 248, 250, 252, 254, 256, 260, 264, 268, 273, 313, 325, 327, 331, 506, 612, 614, 704, 735, 740, 745, 794; ORS chapter 183, sections 310 through 690; ORS chapter 293, section 445

Need for the Rule(s):
Rule amendments are needed to:

- Carry out the director's duties to publish and update medical fee schedules under ORS 656.248;
- Update the list of non-compensable medical procedures;
- Clarify medical rule requirements affecting authorized nurse practitioners, elective surgery, administrative review, and attorney fees;
- Establish time-frames for record-keeping and account resolution affecting Workers' Benefit Fund assessments;
- Reduce reporting requirements for insurers and self-insured employers who have little or no earned premium or payroll;
- Eliminate the annual requirement for self-insured employers that use retrospective rating methods to re-elect the method annually in order to avoid reverting to "normal" rating methods;
- Simplify the refund process for small overpayments of Workers' Benefit Fund assessments; and
- Repeal duplicative administrative rules.

Documents Relied Upon: Advisory committee meeting records; issues documents, and medical cost analyses. These documents are 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 to request copies.

Fiscal and Economic Impact:
Increased reimbursements to nurse practitioners and physician assistants (from 80% to 85% of a physician's allowable fee for a comparable service) should have a minimal to negligible impact on insurers' and self-insured employers' costs, in part because these services represent a very small fraction of medical services, and also because some reimbursements are currently above 85%. However, some nurse practitioners and physician assistants will derive an economic benefit from this change.

Maximum reimbursements for physical capacity examinations and work capacity evaluations are proposed to be increased by 10%. Because many providers do not bill at the maximum allowable rate, we estimate the net result will be a 4.2% increase in reimbursement for these services, to be paid by insurers and self-insured employers. The system-wide cost should not exceed $20,000. Medical providers who perform these services should derive an economic benefit from this change.
Reductions in premium assessment reporting and payment requirements should result in savings for the affected insurers and self-insured employers; and

Other rule amendments should have either no significant fiscal impact or produce slight savings due to simplification of record-keeping and account resolution, primarily affecting administration of and payments to the Workers' Benefit Fund.

Administrative Rule Advisory Committee consulted: Yes

November 16, 2004, November 22, 2004, November 23, 2004

/s/ John L. Shilts 1/14/2005

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.

PROPOSED
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 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
Amended 3/4/04 as Admin. Order 04-054, eff. 4/1/04

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the Centers for Medicare & Medicaid Services (CMS) 200[4]**5** 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," [68]**69** Federal Register No. [216]**219**, November [7]**15**, 200[3]**4** 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]***5** 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 ***The Physicians'*** *Current Procedural Terminology (CPT® 200[4]***5)**, Fourth Edition Revised, 200[3]**4** 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]**69** Federal Register No. [216]**219**,

November [7]**15**, 2003, ASA Relative Value Guide 200[4]**5**, or CPT® 200[4]**5**.

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 3/4/04 as WCD Admin. Order 04-054, 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) ASA means American Society of Anesthesiologists

(b) ASC means ambulatory surgical center

(c) CARF means Commission on Accreditation of Rehabilitation Facilities

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

(e) CPT® means Current Procedural Terminology

(f) DME means Durable Medical Equipment

(g) DMSO means Dimethyl sulfoxide

(h) EDI means Electronic Data Interchange

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

(j) HCPCS means Healthcare Common Procedure Coding System

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

(l) JCAHO means Joint Commission on Accreditation of Healthcare Organizations

(m) MCO means Managed Care Organization

(n) NCPDP means National Council for Prescription Drug Programs

(o) OSC means Oregon specific code

(p) PCE means physical capacity evaluation

(q) RBRVS means Medicare Resource-Based Relative Value Scale

(r) RVU means relative value unit

(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 3/4/04 as WCD Admin. Order 04-054, 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 and Contested Cases

Administrative review before the director:

(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. If the dispute does not resolve through mediation, a director's order shall be issued.

(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]**must** submit requests for administrative review to the director in the form and format prescribed by the director. **When an insurer or the worker's representative submits a request without the required information, at the director's discretion the administrative review may not be initiated until the information is submitted. Unrepresented workers may contact the director for help in meeting the filing requirements.** The requesting party [shall]**must** 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 **or services**.

(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) A party fails 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 (6) of this rule, within 30 days of the administrative order, any party may appeal to a contested case before the director.

(5) 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 mailed to the director before the administrative order becomes final.

(6) 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 mailed within 30 days of the mailing date of the order or notice of action being appealed.

(7) 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(15).

(8) 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 (7) 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 (6) 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,
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Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03
Amended 12/12/03 as WCD Admin. Order 03-068, eff. 1/1/04 (Temporary)
Amended 3/4/04 as WCD Admin. Order 04-054, 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 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 a federal tax reporting identification number, or Unique Provider Identification Number (UPIN).

(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® 2004 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 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® 2004 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 (§3, ch. 811, OL 2003), 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
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Amended 9/13/01 as WCD Admin. Order 01-058, eff. 9/17/01
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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.

(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 (9)(d) and** 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)]**(b)**Surface EMG (electromylography) tests,

[(d)]**(c)** Rolfing,

[(e)]**(d)** Prolotherapy, and

[(f)]**(e)** 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**, including authorized nurse practitioner,** fees shall be paid at the rate of 8[0]**5** 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
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Amended 3/4/04 as WCD Admin. Order 04-054, 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 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) Patient expenses such as telephone, television, radio service and other expenses determined by the department to be patient-related expenses; and

(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 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 which there is insufficient data**, 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) through (4), (7) through (32) to OAR 436-009-0020(1) through (29), (32) and (33);
from OAR 436-010-0040(4)(b)(A) and (c) to OAR 436-009-0020(30) and (31);
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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
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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 director, pursuant to 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)
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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) **The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer prior to the date the terms of a disputed claim settlement (DCS) were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.**

[(9)]**(10)** Insurers that had at least 100 accepted disabling claims in the previous calendar year, as determined by the director, are required to submit detailed medical service billing data to the Information Management Division of the Department of Consumer and Business Services at 350 Winter St NE, Room 300, PO Box 14480, Salem OR 97309-0405. Once an insurer has 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. **If the insurer drops below the 100 disabling claim level or encounters other significant hardships,** [T]**the** insurer may apply **to the director** for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will notify the affected insurers when they reach the minimum. The transmission data and format requirements 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. 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 or other, is required on all "HO" records in addition to the ICD-9-CM diagnostic 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. 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. Insurers transmitting data for more than one insurer may batch multiple insurer data files in one transmission. 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. 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.

(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 436-009-0025, 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
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Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
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Amended 3/4/04 as WCD Admin. Order 04-054, 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. Where there is no maximum payment established by the fee schedule, 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 amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one, but not limited to, the following: 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.

(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 2004 non-facility total column. Where the procedure is performed outside the medical service provider's office, use Year 2004 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 2004 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]**anesthesia** value includes **the basic** 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.

(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	$68.40
Anesthesiology	$53.45
Surgery	$93.66
Radiology	$68.00
Lab & Pathology	$60.00
Medicine	$75.04
Physical Medicine and Rehabilitation	$65.79
Multidisciplinary and Other Oregon-Specific Codes	$60.00

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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.

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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 practitioner approves a multidisciplinary treatment program for an injured worker, 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)
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Amended 3/4/04 as WCD Admin. Order 04-054, 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 or authorized nurse practitioner, 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 or authorized nurse practitioner's current or proposed treatment, shall be paid under OSC-N0001.

(3) A complex narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, attending physician's or authorized nurse practitioner'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 primarily to measure 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 if multiple body parts 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 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 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 which requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. 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. Special emphasis should be given to:

(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.

(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. **<u>If a worker fails to appear for a medical arbiter examination without giving the medical provider at least 48 hours notice, each 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.</u>**

(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 or authorized nurse practitioner
N0002	3.41	Complex narrative by the attending physician or authorized nurse practitioner

99196	[2.73]**3.00**	First Level PCE
99197	[4.87]**5.36**	Second Level PCE
99198	[10.28]**11.31**	WCE
99193	[0.70]**0.77**	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 12/12/03 as WCD Admin. Order 03-068, eff. 1/1/04 (Temporary)
Amended 3/4/04 as WCD Admin. Order 04-054, 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 **and paid** 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
Amended 12/12/03 as WCD Admin. Order 03-068, eff. 1/1/04 (Temporary)
Amended 3/4/04 as WCD Admin. Order 04-054, eff. 4/1/04

436-009-0090 Pharmacy Fees

(1) Except for in-patient hospital charges, pharmacy fees shall be paid at the provider's usual and customary rate or the maximum allowable fee established by this rule, whichever is the lower.

(a) The Average Wholesale Price (AWP) effective on the day the drug was dispensed shall be used to determine the maximum allowable fee.

(b) The maximum allowable fee is determined as follows:

(A) For generic drugs and for brand name drugs without a generic equivalent, 88% of the AWP for the dispensed drug plus $8.70 dispensing fee.

(B) For brand name drugs with a generic equivalent, if the prescribing medical service provider writes "Do not substitute" or a similar notation on the prescription, 88% of the AWP for the dispensed drug plus $8.70 dispensing fee.

(C) For brand name drugs with a generic equivalent, if the prescribing medical service provider did not write "Do not substitute" or a similar notation on the prescription, the lower of 88% of the AWP for the dispensed drug plus $8.70 dispensing fee, or 88% of the average AWP for the class of generic drugs plus $8.70 dispensing fee, or, in the event that the pricing guides have not established an average AWP, 88% of the calculated average AWP of the generic drugs listed in the pricing guide plus $8.70 dispensing fee.

(c) 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 Bextra]**and COX-2 inhibitors** is limited to an initial five-day supply unless the prescribing medical service provider writes a clinical justification for prescribing that drug rather than a less costly drug with a similar therapeutic effect.

(a) The clinical justification may accompany the prescription and be submitted by the pharmacist or may be given directly to the insurer by the medical provider.

(b) Clinical justification means a written document from the medical service provider stating the reason he or she believes the drug ordered is the one the patient should have. The justification may be included on the prescription itself and may simply be a brief statement. Insurers and self-insured employers cannot challenge the adequacy of the clinical justification. However, they can challenge whether or not the medication is excessive, inappropriate, or ineffectual in accordance with ORS 656.327.

(c) An additional clinical justification is not necessary for refills of that medication.

(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.

(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.

(7) Except for sections 2, 3, 4 and 6 of this rule, this 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.

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

(9) Drugs dispensed by a hospital (inpatient or outpatient) shall to be billed **and paid** 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 3/4/04 as WCD Admin. Order 04-054, 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

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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 Tax Reporting ID number or UPIN	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 Bulletin 220 for additional special field reporting instructions.

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RECORD LAYOUT SPECIAL FIELD REQUIREMENTS

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	Use the federal employer identification number that is used for federal tax reporting purposes.
Medical provider other Federal Tax Reporting ID number or UPIN	Report the nine-digit other federal tax reporting identification number that is used for federal tax reporting purposes, or the Unique Provider 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. See instructions in Bulletin 220 for usage of adjustment modifiers “RF” and “DC” for adjustments. See instructions in Bulletin 220 for usage of modifiers “SG”, “NT”, “81” , “50”, and “zz”.
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.

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Data and Format Requirements:

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/Orthosurgeon	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.