



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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August 20, 2007

Proposed Changes to Workers' Compensation Rules

The 2007 Oregon Legislature passed a number of bills affecting workers' compensation laws. The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436 to make these rules consistent with the revised laws. In addition, the department proposes changes to make the rules easier to understand, to streamline regulations, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** September 24, 2007, 2:00 p.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone - (503) 947-7717; Fax - (503) 947-7581

The closing date for written comments is September 27, 2007.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>

Or call (503) 947-7627 to get free paper copies

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services (DCBS),
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns	PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879	(503) 947- 7717 Fax (503) 947-7581
Rules Coordinator	Address	Telephone

RULE CAPTION

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

September 24, 2007	2:00 p.m.*	Room 260 (2 nd Floor, 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 September 27, 2007.**

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

RULEMAKING ACTION

ADOPT: OAR 436-105-0511; 436-105-0512; 436-160-0400; 436-160-0410; 436-160-0420; 436-160-0430

AMEND: OAR 436-040; 436-105; 436-110; 436-120; and

436-009-0005	436-015-0005	436-030-0175	436-050-0100	436-060-0008	436-160-0004
436-009-0010	436-015-0030	436-030-0185	436-050-0175	436-060-0010	436-160-0005
436-009-0020	436-015-0040	436-035-0005	436-050-0200	436-060-0015	436-160-0006
436-009-0030	436-015-0120	436-035-0110	436-050-0400	436-060-0018	436-160-0010
436-009-0040	436-030-0007	436-035-0350	436-050-0410	436-060-0055	436-160-0020
436-010-0005	436-030-0020	436-035-0390	436-050-0420	436-060-0060	436-160-0030
436-010-0210	436-030-0035	436-035-0420	436-050-0440	436-060-0140	436-160-0040
436-010-0220	436-030-0115	436-035-0500	436-050-0450	436-060-0147	436-160-0050
436-010-0230	436-030-0135	436-045-0008	436-050-0455	436-060-0150	436-160-0060
436-010-0240	436-030-0145	436-045-0030	436-050-0460	436-160-0001	436-160-0070
436-010-0265	436-030-0155	436-050-0003	436-050-0470	436-160-0002	436-160-0080
436-010-0280	436-030-0165	436-050-0005	436-050-0480	436-160-0003	436-160-0090

REPEAL: 436-030-0440; 436-030-0450; 436-030-0460; 436-030-0550; 436-030-0570;
436-110-0326; 436-110-0327; 436-110-0380; 436-120-0730

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Stats. Implemented

RULE SUMMARY

Amendments to implement changes in the Workers' Compensation Law, including:

- Replacing the term "Handicapped Workers" with "Workers with Disabilities" (SB 83);
- Updating name of Board of Medical Examiners for the State of Oregon to "Oregon Medical Board" (SB 147);

- Including “administrative law judge” as a person who may approve or disapprove a claims disposition agreement (SB 253);
- Describing restrictions affecting emergency room physicians’ rights to be attending physicians and authorize temporary disability benefits (SB 504);
- Deleting requirement that managed care organizations send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval; deleting related definitions (SB 563);
- Explaining how DCBS will publish the maximum reimbursable amount for medical services for non-disabling claims (SB 762);
- Amending penalty provisions affecting managed care organizations; deleting procedures for temporary rule promulgation to address disability in individual claims (when medical conditions are not addressed by current standards), and addressing such conditions in the director’s order on reconsideration, and providing that penalties will not be assessed if an increase in compensation results from such an order; describing how insurers must process requests for a lump sum payments of permanent partial disability awards (HB 2218);
- Describing the authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians (HB 2756);
- Referring to ORS 656.427 regarding time frames for termination of guaranty contracts; defining “premium” (HB 2783);
- Adopting standards of professional conduct for health care providers who perform independent medical examinations, which apply if the provider’s professional regulatory board has not adopted standards for performing such examinations (HB 2943);

General amendments to OAR chapter 436, including:

- Using plain language to add clarity to a number of rules;
- Shortening some rules by removing unnecessary descriptions of DCBS procedures;

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI), to improve the quality of medical billing data for use by DCBS and its customers, including:

- Requiring hospitals and other health care providers to include sufficient data on their billings so insurers and DCBS can identify the providers;
- Requiring insurers to report medical billing data to DCBS using standards for electronic data interchange adopted by the International Association of Industrial Accident Boards and Commissions;
- Listing the data elements reportable to DCBS; testing procedures for EDI; phase-in dates for EDI and when insurers and self-insured employers are subject; procedures for requesting deferral of EDI reporting;

Amendment to OAR 436-010, “Medical Services,” to remove obsolete medical utilization guideline:

- Regarding frequency of treatment in OAR 436-010-0230;

Amendments to OAR 436-030, “Claim Closure and Reconsideration,” to eliminate conflicts between statute and rules, streamline processing, delete obsolete rules, and reduce litigation, including:

- Restricting reconsideration of claim closure to issues raised by the parties plus requirements under ORS 656.268(1);
- Requiring insurers to submit documents related to reconsideration of claim closure in chronological order;
- Removing the limitation on attorney fees from OAR 436-030-0175(4);
- Deleting obsolete rules OAR 436-030-0440, 0450; 0460, 0550, and 0570; the relevant subject matter from these rules has been addressed in other rules in OAR 436-030 and 436-035 (since approximately 1988), but the rules have remained in the Oregon Administrative Rules published by the Secretary of State;

Amendments to OAR 436-035, “Disability Rating Standards,” to clarify or correct certain provisions, and to provide for rating disability for a medical condition not currently addressed by the standards, including:

- Clarifying the definition of “direct medical sequela”;
- Correcting the description of impairment involving angulation or malalignment of the humerus;
- Clarifying how to rate impairment for surgery involving one or more discs or vertebrae;
- Eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed;

- Provide standards for rating impairment for vaginal prolapse;

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility,” to clarify certain provisions and ensure appropriate oversight of worker leasing company licensing and practices, including:

- Clarifying time frames and process for cancellation of self-insurance;
- Revising regulations affecting worker leasing companies, including:
 - Relevant definitions;
 - The application and license renewal process;
 - Reporting and record-keeping;
 - Grounds for disqualification, suspension of license, and revocation of license by the director;
 - Appeal rights for persons refused approval or renewal of a worker leasing license;
 - Reapplication following disqualification for, or revocation of, license;
 - Continuation of a disqualification, suspension, or revocation of a worker leasing license applicable to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person or controlling person;
 - Penalties under ORS 656.990;

Amendments to OAR 436-060, “Claims Administration,” to eliminate inconsistencies in DCBS rules and clarify or streamline certain provisions, including:

- Revising time frame for employers’ first aid record-keeping (to be consistent with Oregon OSHA requirements);
- Reducing the documentation a worker must submit when appealing an insurer’s refusal to reclassify a claim;
- Clarifying conditions under which the insurer must notify health care providers when a workers’ compensation claim is denied or partially denied;

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP), to promote increased use of the EAIP and therefore earlier return to work of injured workers with their employers at injury, by streamlining program administration, setting an appropriate fee payable to insurers for administration of the program, and expanding some incentives, including:

- Providing that a medical release remains in effect until another medical release is issued by the worker’s medical service provider;
- Providing that a worker is eligible for EAIP services while the claim is “deferred” (prior to acceptance or denial);
- Providing insurers greater discretion to determine appropriate EAIP worksite modifications and EAIP purchases;
- Providing insurers greater discretion to determine what is appropriate training; eliminating the requirement that EAIP purchases for training are limited to “accredited” or “licensed” training or courses;
- Increasing maximum reimbursable amount for EAIP purchases for tools and equipment;
- Allowing insurers to submit more than one reimbursement request per EAIP;
- Stating the administrative fee payable to the insurer for its administration of EAIP services (formerly not prescribed by rule);

Amendments to OAR 436-110, “Preferred Worker Program” (PWP) to promote increased use of the PWP and therefore facilitate the return to work of injured workers and improve return-to-work outcomes (wages, tenure, etc.), by streamlining program administration, creating new PWP incentives, and expanding some existing incentives, including:

- Redefining and simplifying “date of hire” and “reimbursable wages”;
- Shortening and simplifying the wording that must appear on notices to workers about potential PWP benefits;
- Issuing PWP identification cards with no expiration date - workers could offer the initial and any subsequent employers three full years of premium exemption and claim cost reimbursement;
- Eliminating the requirement that a modification of regular work be “substantial” in order for a worker to be eligible for PWP benefits other than Worksite Modification;
- Removing the restriction that Wage Subsidies may not be combined with subsidies from other sources, with the exception of subsidies under OAR 436-120;
- Revising the name of “Obtained Employment Purchases” to “Employment Purchases”;
- Allowing Employment Purchases while a worker is receiving vocational assistance under OAR 436-120;

- Allowing replacement of Employment Purchases;
- Increasing the maximum expenditure for an Employment Purchase for tools and equipment;
- Providing Employment Purchases needed to create a new worksite;
- Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment;
- Allowing a second use of Wage Subsidy and a second use of each category of Employment Purchase for a different job with the same employer (formerly two wage subsidies could not be used with the same employer);
- Eliminating forms currently required for Worksite Modifications costing \$2,500 or less;
- Eliminating the general requirement for competitive bids for Worksite Modification;

Amendments to OAR 436-120, “Vocational Assistance to Injured Workers,” to improve sufficiency of certain notices, clarify time frames for submitting information to DCBS, streamline return-to-work plan development process, clarify or define certain provisions, and delete obsolete provisions, including:

- Describing how the Workers’ Compensation Division will determine the timeliness of any document that must be sent to the division in vocational matters;
- Requiring that notices of eligibility for vocational assistance, training, or direct employment services explain the rights of the worker to request a return-to-work plan conference;
- Requiring that notice must be in writing when an insurer notifies a worker that an eligibility determination is postponed while awaiting information about permanent restrictions;
- Requiring that if an insurer ends a worker’s eligibility because lack of suitable employment is not due to the limitations caused by the injury, the insurer must have obtained new information that did not exist or that the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility;
- Including among the reasons a worker would be ineligible for vocational assistance or for which eligibility would end, that the worker is unavailable for vocational assistance due to short-term incarceration;
- Eliminating all time frames related to return-to-work plan development except that a plan must be approved within 45 days (direct employment) or 90 days (training) under OAR 436-120-0500(1) & (2);
- Updating the vocational fee schedule (consistent with changes in state average weekly wage and Bulletin 124);
- Eliminating the requirement that insurers request administrative approval for vocational services when the insurer is entitled to claims cost reimbursement under OAR 436-110;
- Repealing the rule: “Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries”; and
- Defining “show-cause hearing” for the purposes of OAR 436-120-0915(3).

Request for public comment: The Workers’ Compensation Division 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#proprules>

or from WCD Publications, 503-947-7627 or fax 503-947-7630.

September 27, 2007
Last Day for Public Comment

John L. Shilts
Authorized Signer and Date

8-14-07

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.

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

OAD CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

In the Matter of)
The Amendment of OAR:)
436-009, Oregon Medical Fee and Payment Rules)
436-010, Medical Services)
436-015, Managed Care Organizations)
436-030, Claim Closure and Reconsideration)
436-035, Disability Rating Standards)
436-040, Workers with Disabilities Program)
436-045, Reopened Claims Program)
436-050, Employer/Insurer Coverage Responsibility)
436-060, Claims Administration)
436-105, Employer-at-Injury Program)
436-110, Preferred Worker Program)
436-120, Vocational Assistance to Injured Workers)
436-160, Electronic Data Interchange)

Rule Caption:

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Need for the Rule(s): Chapter 436 must be amended to be consistent with the Workers' Compensation Law, as amended by legislation passed by the 2007 Oregon Legislature. Some of that legislation required the director to make rules to implement revised laws. The department is proposing additional changes to make the rules easier to understand, to streamline regulations affecting stakeholders, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Documents Relied Upon, and where they are available: "Issues" documents as presented to advisory committees; advisory committee meeting minutes; written advice from advisory committee members.

These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 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) 947-7717 to request copies.

Fiscal and Economic Impact, including Statement of Cost of Compliance: The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by proposed rule amendments:

Amendments to implement changes in the Workers' Compensation Law

- Senate Bill 504 restricts emergency room physicians' rights to be attending physicians and authorize temporary disability benefits. Overall emergency-room treatment charges can be substantially higher than charges for visits to primary care physicians. In addition, early referral to primary care physicians should improve insurers' ability to keep track of authorization of temporary disability benefits and to promote return-to-work. The agency estimates that these changes should result in a small reduction in insurers' claims costs.

- Senate Bill 563 eliminates the requirement that managed care organizations (MCOs) send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval. In the “Statement of Need and Fiscal Impact” filed with the Secretary of State on 8/14/06, DCBS estimated reporting costs for such reporting based on advice from MCOs. The low-high range of estimated reporting costs was then \$100 per year to \$50,000 per year per MCO, potentially \$400/year to \$200,000/year for the four active MCOs. The agency projects elimination of these reporting costs for MCOs.
- House Bill 2756 provides authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians. Because we cannot project how many injured workers will choose these providers as their attending physicians, we cannot now project the fiscal impacts. However, DCBS will monitor the effects of HB 2756 to identify impacts over time.
- House Bill 2783 requires insurers to notify the employer of termination of a guaranty contract 45 days in advance instead of the 30 days currently required. In addition, HB 2783 allows for a shorter notice requirement of only 10 days if the termination is based on nonpayment of premium. The agency projects some reductions in costs for insurers, because they can shorten their liability under the 10-day notice provision. The agency projects that these savings will be greater than any increased costs due to the 45-day notice provision, because insurers can adjust notice procedures in order to end liability, in most cases, by a date certain. The agency projects a small positive impact for employers subject to the 45-day notice, as it will give them more time to shop for cost-effective workers’ compensation insurance coverage.

In addition to changes to implement changes in the Workers’ Compensation Law:

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI)

- The agency projects that proposed rule changes will not have a significant fiscal impact on Oregon health care providers, as providers already send sufficient data to insurers on standard billing forms. The agency projects some fiscal impacts for insurers and self-insured employers, smaller for those companies already using EDI in other states and greater for Oregon-only reporters. The advisory committee did not express concerns about implementation costs. However, the agency projects significant costs for some insurers and self-insured employers in order to prepare for EDI, and also projects that these costs will eventually be exceeded by savings due to efficiencies inherent in electronic communication.

Amendments to OAR 436-035, “Disability Rating Standards”

- The agency projects that eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed, will have a positive economic impact on affected workers and an equal increased cost to affected insurers. However, this combination of medical conditions is very rare and the impact is not expected to be significant overall.

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility”

- The agency projects that proposed rules affecting worker leasing companies will add a small cost to submit additional information with the application for initial license or renewal of license.
- Conversely, the purpose of these rule changes is to create a level playing field for leasing companies by preventing or removing unfair competition by companies that cannot or will not comply with worker leasing laws and rules. Successfully preventing unfair competition would have a positive economic effect on leasing companies that do comply with the laws and rules. Relative to taking no action, the agency projects a small positive economic impact on worker leasing companies.

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP) and OAR 436-110, “Preferred Worker Program” (PWP)

- The agency projects that expanded benefits and administrative fees for the EAIP will cost the Workers’ Benefit Fund (maximum/annual):
 - Reimbursement of EAIP costs before the claim is accepted or denied (if ultimately denied)..... \$700,000.00
 - Increased reimbursable amount for EAIP purchases for tools and equipment \$300,000.00
 - Proposed fee payable to insurers for administration of the EAIP \$480,000.00
 - Total \$1,480,000.00

- The agency projects that expanded benefits for the PWP will cost the Workers' Benefit Fund (maximum/annual):
 - Providing Employment Purchases needed to create a new worksite..... \$100,000.00
 - Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment \$100,000.00
 - Total \$200,000.00
- The agency projects that issuing PWP identification cards with no expiration date will increase use of premium exemption and thus increase costs to the Workers' Benefit Fund. However, the impact would be very minor in the near term and increase gradually over time. The agency does not have a basis to project how many workers will use their cards for future employment, but will monitor this closely.
- Additional proposed changes that expand access to reemployment incentives will have lesser impacts on the Workers' Benefit Fund; however, the agency does not have a basis to project how extensively these incentives will be used.
- All moneys paid out of the Workers' Benefit Fund would have a positive economic impact on Oregon employers and insurers. In addition to the direct dollar transfer, by promoting early return to work, the proposed rules may reduce claims costs. In addition, the proposed changes should positively affect injured workers by promoting early return to work, which produces better long-term employment outcomes.
- The Workers' Benefit Fund has adequate reserves to cover any increased costs resulting from proposed rule changes.

Regarding: Additional proposed changes:

- The agency estimates that additional changes will not have any significant negative economic impacts on any persons or businesses, including small businesses. Because a number of the proposed rule changes streamline processes, the agency projects a small overall positive economic impact of proposed rule changes not otherwise described.

How were small businesses involved in the development of this rule?

Representatives from small businesses participated in the stakeholder advisory committees.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

One managed care organization. (Of the four managed care organizations certified and active in the Oregon workers' compensation system, one managed care organization meets the definition of a small business under ORS 183.310.)

Identify the types of businesses and industries with small businesses subject to the proposed rule:

The proposed rule amendments will affect managed care organizations.

Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:

Reporting: Proposed rule changes would require less reporting by managed care organizations, who will no longer have to send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval.

Record-keeping: Proposed rule changes may substantially reduce record keeping by a managed care organization only if organization keeps a running record of updated treatment standards, protocols, and guidelines for the purpose of reporting the updates to the director.

Other administrative activities and costs of professional services: For managed care organizations that contract with companies that specialize in provision of guidelines and protocols, there is the potential for reduced professional services costs.

Extent of economic impact: The agency projects a substantial reduction in reporting costs for MCOs.

Identify equipment, supplies, labor and increased administration required for compliance with the proposed rule:

Equipment: The proposed rule changes do not require the purchase of equipment to achieve compliance.

Supplies: The proposed rule changes do not require the purchase of supplies to achieve compliance.

Labor: The proposed rule changes do not require increased labor costs to achieve compliance.

Administration: The proposed rule changes do not require increased administrative costs to achieve compliance.

Extent of economic impact: No increased costs for these categories.

Administrative Rule Advisory Committee consulted:

Yes. Advisory committees met on 6/21/07, 7/10/07, 7/16/07, 7/17/07, 7/19/07, 7/20/07, 7/23/07, 7/26/07, 7/31/07

The agency asked the advisory committee for advice on the impact of the discussed changes on costs, including any significant adverse impacts on small businesses.

John L. Shilts 8-14-07

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Oregon Medical Fee and Payment Rules
Proposed Oregon Administrative Rules
Chapter 436, Division 009

Summer/Fall 2007

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Revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~

Added text is bold and underlined, as in **Added**

HISTORY LINES: These rules include only the most recent "History" lines. The history line shows when the rule was last revised (or "filed" if the rule has never been revised) and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: http://www.wcd.oregon.gov/policy/rules/full_set.html

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed Rules **OREGON MEDICAL FEE AND PAYMENT RULES**

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

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.

(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) **ANSI means the American National Standards Institute.**

(b) **CMS** means Centers for Medicare & Medicaid Services.

(~~b~~)(c) **CPT**[®] means Current Procedural Terminology published by the American Medical Association.

(d) **DME means Durable Medical Equipment.**

(e) **DRG means diagnosis related group.**

(~~e~~)(f) **EDI** means electronic data interchange.

(~~d~~)(g) **HCPCS** means Healthcare Common Procedure Coding System published by CMS.

(~~e~~)(h) **IAIABC means International Association of Industrial Accident Boards and Commissions.**

(i) **ICD-9-CM** means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(~~f~~)(j) **MCO** means managed care organization.

(k) **NPI means National Provider Identifier.**

(~~g~~)(l) **OSC** means Oregon specific code.

(~~h~~)(m) **PCE** means physical capacity evaluation.

(~~i~~)(n) **RBRVS** means Medicare Resource-Based Relative Value Scale published by CMS.

(~~j~~)(o) **RVU** means relative value unit.

(~~k~~)(p) **WCE** means work capacity evaluation.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.726(4)

Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

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) Billings ~~shall~~ **must** include the worker's full name and date of injury, the employer's

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed Rules OREGON MEDICAL FEE AND PAYMENT RULES

name and, if available, the insurer's claim number; **and the provider's NPI. If the NPI is not available, then provider must provide the license number and FEIN.** All medical providers **must** submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a completed current UB-04 (CMS 1450) or CMS 1500 form, except for:

(a) Dental billings, which ~~shall~~ **must** be submitted on American Dental Association dental claim forms;

(b) Pharmacy billings, which ~~shall~~ **must** be submitted on the most current National Council for Prescription Drug Programs (NCPDP) form; and

(c) EDI transmissions of medical bills under OAR 436-009-0030(3)(c).

(d) Computer-generated reproductions of forms referenced in subsections (2)(a) and (b) may also be used.

(3)(a) All original medical provider billings ~~shall~~ **must** be accompanied by legible chart notes documenting services which have been billed and identifying the person performing the service and license number of the person providing the service. Medical providers are not required to provide their license number if they are already providing a national identification number.

(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) When billing for medical services, a medical service provider must use codes listed in CPT[®] 2007 or Oregon Specific Codes (OSC) that accurately describe the service. If there is no specific CPT[®] code or OSC, a medical service provider must use the appropriate HCPCS code, if available, to identify the medical supply or service. Pharmacy billings ~~shall~~ **must** use the National Drug Code (NDC) to identify the drug or biological billed. A "zz" ~~qualifier~~ **modifier** ~~shall~~ **must** be used when billing electronically for services that use an OSC.

(a) If there is no specific code for the medical service, the medical service provider shall use the appropriate unlisted code from HCPCS or the unlisted code at the end of each medical service section of CPT[®] 2007 and provide a description of the service provided.

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

(5) Medical providers must submit billings for medical services in accordance with this section.

(a) Bills must be submitted within:

(A) 60 days of the date of service.

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

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(b) A medical service billing submitted later than the time frames in subsection(a) of this section may be payable in full if the provider establishes good cause for submitting the bill late. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(c) A bill rendered over twelve months after the date of service is not payable, except when a provision of subsection (a) of this section is the reason the billing was rendered after twelve months.

(6) When rebilling, medical providers ~~shall~~ **must** indicate that the charges have been previously billed.

(7) The medical provider ~~shall~~ **must** bill their usual 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, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, costs ~~shall~~ **must** 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 no later than 30 days following receipt of the request. Thereafter, worker copies ~~shall~~ **must** be furnished during the regular billing cycle.

Stat. Auth.: ORS 656.245, 656.252, 656.254

Stats. Implemented: ORS 656.245, 656.252, 656.254

Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

436-009-0020 Hospital Fees

(1) Hospital inpatient charges billed to insurers **must** include ICD-9-CM diagnostic and procedural codes. **Hospitals must include their NPI on all bills.** Unless otherwise provided for by a governing MCO contract, insurers ~~shall~~ **must** 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 UB-04 billing form. The audited bill ~~shall~~ **must** be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers ~~shall~~ **must** include revenue codes, ICD-

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9-CM diagnostic and procedural codes, CPT[®] codes, HCPCS codes, and National Drug Codes (NDC), where applicable. **Hospitals must include their NPI on all bills.** Unless otherwise provided for by a governing MCO contract, insurers ~~shall~~ **must** pay hospitals for outpatient services according to the following: the insurer ~~shall~~ **must** first separate out and pay charges for services by physicians and other licensed medical service providers assigned a code under the CPT[®] and assigned a value in RBRVS for physician fees as identified by the revenue codes indicating professional services. These charges must be subtracted from the total bill and the adjusted cost/charge ratio applied only to the balance. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Year 2007 transitional 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 CMS 2552 form and financial statement shall be the basis for determining its adjusted cost/charge ratio. If a current form 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 either the hospital's last published cost/charge ratio or 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 subsection (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 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

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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~~ **must** submit a copy of their 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, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(g) For newly formed or established hospitals for which no 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 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 or geographic location.

(h) If the financial circumstances of a hospital unexpectedly 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 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 payment to out-of-state hospitals, may be negotiated between the insurer and the hospital.

(A) Any agreement for payment less than the billed amount must be in writing and signed by a hospital and insurer representative.

(B) The agreement must include language that the hospital will not bill the worker any remaining balance and that the negotiated amount is considered payment in full.

(C) If the insurer and the hospital are unable to reach agreement within 60 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(k) Notwithstanding sections (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: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

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436-009-0030 Insurer's Duties and Responsibilities

(1) The insurer ~~shall~~**must** 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~~**must** furnish a reasonable work-site for the records to be reviewed at no cost. These records ~~shall~~**must** be provided or made available for review within 14 days of a request.

(3) Insurers ~~shall~~**must** 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 to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was not paid or what needs to be corrected. 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~~**must** retain a copy of each medical provider's bill received by the insurer or ~~shall~~**must** 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 non-payment or 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. The insurer must provide the specific reason(s) for non-payment or reduced payment of the billing, in writing, to the submitting medical provider.

(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 submits a bill electronically, 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 the 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~~**must**, 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.

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Resolution of billing disputes, including possible overpayment disputes, ~~shall~~ **must** 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 ~~shall~~ **must** be paid for within 45 days of receipt by the insurer even if the claim is denied.

(8) The insurer ~~shall~~ **must** 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~~ **must** provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation ~~shall~~ **must** 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 on or before 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.

(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 ~~bill payment~~ **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. **The director will notify the affected insurers when they reach the minimum.** If the insurer drops below the 100 disabling claim level or encounters other significant hardships, 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 Appendices A; **and B, which the director adopts by reference. To determine which appendix applies to required reporting insurers, see below.**

(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.~~

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~~(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.~~

~~(e) 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 by secure file transfer protocol (SFTP). Contact the Information Management Division (IMD) to arrange submission by secure FTP files. The record length must be fixed, 129 bytes, no packed fields, and in conformance with the records layout in Appendix A. Contact IMD for e-mail cover letter instructions. The cover letter must include 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.~~

(b) Each insurer must continue to report according to Appendix A until successfully completing IAIABC ANSI 837 testing. Once successfully completing testing, the insurer may only report via IAIABC ANSI 837.

(c) Group 1 is all required reporting insurers who are currently report data via IAIABC ANSI 837 in another jurisdiction. Each insurer in Group 1 must begin testing on July 1, 2008.

(d) Group 2 is the State Accident Insurance Fund Corporation. Group 2 must begin testing on April 1, 2009.

(e) Group 3 is all other required reporting insurers. Each insurer in Group 3 must

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begin testing on October 1, 2009.

(11) An insurer may ask, in writing, for additional time to report the requested data elements according to Appendix B. The insurer must demonstrate that the date to begin testing creates an undue hardship. The request must include a plan to begin testing within 12 months of the group's testing date, and may not extend beyond January 1, 2010.

(12) Undue hardship is demonstrated by providing the total required expenses to begin testing; the reporting cost per bill if transmitted directly by the insurer; and the total cost per bill if reported by a vendor.

(13) If the director allows additional time, the insurer must continue to report all medical billing data under Appendix A during the testing.

~~(14) Audit Quality:~~ The director may also conduct field audits of audit an insurer's actual payments reported for individual claims. **An insurer is subject to a civil penalty if an audit determines that the insurer's error rate is 15 percent or higher in any field.** ~~When an audit occurs, in order to be in compliance with this rule 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: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

436-009-0040 Calculating Medical Provider Fees

(1) The insurer ~~shall~~**must** pay for medical services at the provider's usual fee or in accordance with the fee schedule whichever is less. Insurers ~~shall~~**must** pay for medical services that have no fee schedule at the provider's usual fee. For all MCO enrolled claims, the insurer ~~shall~~**must** pay for medical services at the provider's usual 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 of, but not limited to, the following: reasonableness, the usual 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 2007 **transitional** non-facility total column. Where the procedure is performed outside the medical service provider's office, use Year 2007 **transitional** 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 2007 **transitional** 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 (12).

(c) When using the *American Society of Anesthesiologists Relative Value Guide*, a basic

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unit value is determined by reference to the appropriate Anesthesia code. The anesthesia value includes the basic unit value, time units, and modifying units.

(3) Payment according to the fee schedule ~~shall~~**must** 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, the insurer ~~shall~~**must** pay at the provider's usual rate.

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

Service Categories	Conversion Factors
Evaluation / Management	\$59.79
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

Stat. Auth.: ORS 656.726(4)
 Stats. Implemented: ORS 656.248
 Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

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Appendix A 436-009-0030

Insurers are required to report medical bill payment data on all payments made during each quarter for medical services as defined in OAR 436-010-0005. Insurers must submit medical bill payment data no later than 45 days after the end of each quarter, as shown below.

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

Technical Requirements: Medical bill payment 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 by secure file transfer protocol (SFTP) using the secure shell (also known as SSH) protocol. Contact the Information Management Division (IMD) to arrange submission of files by SFTP. The record length must be fixed, 129 bytes, no packed fields, and in conformance with the records layout in Appendix B. Contact IMD for e-mail cover letter instructions. The cover letter must include 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; the quarter being reported, and any known problems with the data.

Data Quality: The director will conduct electronic edits for blank or invalid data. Required reporting insurers are responsible for pre-screening the data 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 for correction and must be resubmitted within three weeks (21 days) from the date it was returned by the department.

Special Requirements

The medical bill payment data must include all payments made during each calendar quarter for medical services. The following apply:

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.

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.

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UPIN: The unique provider identifier number (UPIN), is a six-position alphanumeric identifier that is assigned to all Medicare physicians, medical groups, and non-physician practitioners. Left justify the UPIN and follow with blanks.

ICD-9-CM Diagnosis Codes: The International Classification of Diseases (ICD-9-CM) diagnosis code(s) must appear on all records where the provider type is chiropractor, hospital inpatient, hospital outpatient, medical doctor, osteopath, physician's assistant, or registered nurse practitioner. The primary code must be supplied first and, if available, the secondary code should be supplied.

Service, Drug, or Procedure Codes: Report the Physicians' Current Procedural Terminology (CPT®) code or other applicable code from the Oregon Medical Fee and Relative Value Schedule (OMFARVS): for example, "99201". On payments for durable medical equipment, report the appropriate HCPCS code: for example, "E0110". On payments for pharmaceuticals, report the eleven-digit National Drug Code (NDC): for example, "61392054230". On hospital inpatient services, report the ICD-9-CM procedure code: for example, "81.97". If reporting a hospital outpatient service, you may report the appropriate hospital revenue code: for example, "450". All codes must be left-justified and followed with blanks, as necessary, to comply with the required record layout format.

Modifier Codes: All adjustments to payments need to be associated with specific services.

- **Use modifier 'SG' to identify ambulatory surgical center facility charges.**
- **Use modifier 'NT' (no time) on bills from a surgeon or attending physician administering a local or regional block for anesthesia during a procedure.**
- **Use modifier '50' when a surgical procedure is performed bilaterally for the second side.**
- **Use modifier '81' on bills for services by a physician assistant or nurse practitioner.**
- **Use a "zz" modifier when billing electronically for services that use Oregon Specific Codes.**
- **For a refund payment, repeat the record exactly as originally reported but enter payment and charge amounts as negatives (put minuses in the sign fields) and put "RF" (for refund) in the modifier code field.**
- **Adjustments that result in a partial refund or additional payment for a service that has already been paid should be coded with "DC" in the modifier code field.**

Number of units or services: Report the number of time units paid on each time-based service such as anesthesiology and therapeutic procedures. For example, where base time unit equals 15 minutes (anesthesia, CPT® 97110, 97530, etc.), one hour of service equals "04" units. Where base time unit equals one hour (CPT® 97546), two hours of service equals "02" units. Also report the number of services if multiple, identical services to a patient are bundled into one record. For example, three whirlpool treatments (CPT® 97022) equals "03".

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Appendix A 436-009-0030**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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Appendix A 436-009-0030**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
Ambulatory Surgical Center	AS
Chiropractor	CH ₁
Dentist	DE
Home Health Care	HH
Hospital Inpatient	HI ₁
Hospital Outpatient	HO ₁
Laboratory	LA
Medical Doctor	MD ₁
Medical Supplies	MS
Naturopath	NA
Nursing Home	NH
Occupational Therapist	OT
Optometrist	OP
Osteopath	OS ₁
Pharmacy	PH
Physical Therapist	PT
Physician's Assistant	PA ₁
Podiatrist	PO
Psychologist	PS
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
Radiologist	RAD
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.

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IAIABC ANSI 837 Medical Bill Reporting Requirements

1) Event Reporting Requirements:

- * **Original Medical Bills: Report within 90 days of date paid.**
- * **Cancellations: Report immediately, as soon as payer knows that an original medical bill was previously sent in error. Report prior to replacement of an original bill with a revised bill (Replacement transaction).**
- * **Replacement: Report within 30 days of: a) payer knowledge of change in claim administrator, location of service, or provider type; b) payer action of paying an additional amount on a previously-reported bill; or c) payer receipt of an overpayment from a medical provider on a previously-reported bill.**

2) Data Reporting Requirements:

The following data must be reported to the Department: (NOTE: M = mandatory; C = conditional element which becomes mandatory under the stated trigger; O = optional)

<u>OREGON MEDICAL DATA ELEMENT REQUIREMENT TABLE</u>					
<i>NOTE: This table is also published in OAR 436-160.</i>					
<u>Bill Reason Submission Codes</u>					
		<u>Original</u>	<u>Cancellation</u>	<u>Replace</u>	
<u>DN</u>	<u>Data Element Name</u>	<u>00</u>	<u>01</u>	<u>05</u>	<u>Mandatory Trigger</u>
<u>513</u>	<u>Admission Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and patient has been admitted</u>
<u>535</u>	<u>Admitting Diagnosis Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code is "A" and patient has been admitted</u>
<u>564</u>	<u>Basis of Cost Determination Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
<u>545</u>	<u>Bill Adjustment Amount</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If paid amount is not equal to billed amount</u>
<u>543</u>	<u>Bill Adjustment Group Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If paid amount is not equal to billed amount</u>
<u>544</u>	<u>Bill Adjustment Reason Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If paid amount is not equal to billed amount</u>
<u>546</u>	<u>Bill Adjustment Units</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If paid amount is not equal to billed amount</u>
<u>508</u>	<u>Bill Submission Reason Code</u>	<u>M</u>	<u>M</u>	<u>M</u>	
<u>503</u>	<u>Billing Format Code</u>	<u>M</u>	<u>M</u>	<u>O</u>	
<u>629</u>	<u>Billing Provider FEIN</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
<u>528</u>	<u>Billing Provider Last/Group Name</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Rend. Bill Provider Last/Group Name</u>

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<u>537</u>	<u>Billing Provider Primary Specialty Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
<u>630</u>	<u>Billing Provider State License Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
<u>523</u>	<u>Billing Provider Unique Bill Identification Number</u>	<u>O</u>	<u>O</u>	<u>O</u>	
<u>634</u>	<u>Billing Provider National Provider ID</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has an NPI, it must be reported; otherwise, report the provider FEIN</u>
<u>502</u>	<u>Billing Type Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "B" and prescriptions or durable medical equipment are billed</u>
<u>015</u>	<u>Claim Administrator Claim Number</u>	<u>M</u>	<u>M</u>	<u>M</u>	
<u>187</u>	<u>Claim Administrator FEIN</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If the Claim Administrator FEIN is different than Insurer FEIN</u>
<u>188</u>	<u>Claim Administrator Name</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If the Claim Administrator name is different than Insurer name</u>
<u>512</u>	<u>Date Insurer Paid Bill</u>	<u>M</u>	<u>O</u>	<u>O</u>	
<u>511</u>	<u>Date Insurer Received Bill</u>	<u>M</u>	<u>O</u>	<u>O</u>	
<u>31</u>	<u>Date of Injury</u>	<u>M</u>	<u>O</u>	<u>O</u>	
<u>554</u>	<u>Days/Units Billed</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Jurisdiction Procedure Billed Code or HCPCS Line Procedure Billed Code are present or Billing Type Code = DM, or a drug is dispensed by a physician during an office visit.</u>
<u>553</u>	<u>Days/Units Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Jurisdiction Procedure Billed Code or HCPCS Line Procedure Billed Code are present or Billing Type Code = DM or a drug is dispensed by a physician during an office visit.</u>
<u>557</u>	<u>Diagnosis Pointer</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "B" and Jurisdiction Procedure Billed Code or HCPCS Line Procedure Billed Code is present or a drug is dispensed by a physician during an office visit.</u>
<u>514</u>	<u>Discharge Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and patient has been discharged</u>
<u>562</u>	<u>Dispense As Written Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
<u>567</u>	<u>DME Billing Frequency Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code = DM and Total Chg. per Line - Rental is present</u>
<u>518</u>	<u>DRG Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A"</u>
<u>563</u>	<u>Drug Name</u>	<u>O</u>	<u>O</u>	<u>O</u>	
<u>572</u>	<u>Drugs/Supplies Billed Amount</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code, value is "RX" or "MO".</u>
<u>579</u>	<u>Drugs/Supplies Dispensing Fee</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
<u>571</u>	<u>Drugs/Supplies Number of Days</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code, value is "RX" or "MO".</u>
<u>570</u>	<u>Drugs/Supplies Quantity Dispensed</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code, value is "RX" or "MO".</u>
<u>152</u>	<u>Employee Employment Visa</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security number or Employee Green Card number is not available.</u>

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44	<u>Employee First Name</u>	<u>M</u>	<u>O</u>	<u>O</u>	
153	<u>Employee Green Card</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security number is not available.</u>
154	<u>Employee ID Assigned by Jurisdiction</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security, Employee Green Card, Employee Employment Visa or Employee Passport Number not available.</u>
43	<u>Employee Last Name</u>	<u>M</u>	<u>O</u>	<u>O</u>	
156	<u>Employee Passport Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Employee Social Security, Employee Green Card, or Employee Employment Visa not available.</u>
42	<u>Employee Social Security Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>Employee SSN is preferred ID number. If none, see Employee Green Card. If injured worker is not a United States citizen and has no other identification, call WCD to receive Jurisdiction Assigned ID Number for reporting purposes</u>
504	<u>Facility Code</u>	<u>C</u>	<u>C</u>	<u>O</u>	<u>If Billing Format Code equals "A"</u>
678	<u>Facility Name</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If service performed in a licensed facility</u>
682	<u>Facility National Provider ID</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If service performed in a licensed facility</u>
737	<u>HCPCS Bill Procedure Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If HCPCS Prin. Procedure Billed Code is present and more than one procedure is performed</u>
714	<u>HCPCS Line Procedure Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Type Code not equal RX or MO, and if Jurisdiction Procedure Billed Code or NDC Billed Code not present</u>
726	<u>HCPCS Line Procedure Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than HCPCS Line Procedure Billed Code</u>
717	<u>HCPCS Modifier Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If HCPCS Line Procedure Billed Code is modified</u>
727	<u>HCPCS Modifier Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If HCPCS Line Procedure Paid Code is modified</u>
626	<u>HCPCS Principal Procedure Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code is "A" and the code value is not an ICD-9 code. For surgical bills only.</u>
736	<u>ICD-9 CM Procedure Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If ICD-9 CM Prin. Procedure Code is present and more than one procedure is performed</u>
522	<u>ICD-9 CM Diagnosis Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Principle Diagnosis Code is present and more than one diagnosis occurs or if Billing Format Code = B and HCPCS Line Procedure Billed Code or Jurisdiction Procedure Billed Code or a drug is dispensed by a physician during an office visit.</u>
525	<u>ICD-9 CM Principal Procedure Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code is "A" and the code value is not a HCPCS code. For surgical bills only.</u>
6	<u>Insurer FEIN</u>	<u>M</u>	<u>M</u>	<u>M</u>	
5	<u>Jurisdictional Claim Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If the first report of injury has been filed and a jurisdictional claim number is available.</u>
718	<u>Jurisdictional Modifier Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Jurisdiction Procedure Billed Code is modified</u>
730	<u>Jurisdictional Modifier Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Jurisdiction Modified Billed Code</u>
715	<u>Jurisdictional Procedure Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If the procedure is included as an Oregon-specific code in the Oregon Medical Fee Schedule</u>

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729	<u>Jurisdictional Procedure Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Jurisdiction Procedure Billed Code</u>
547	<u>Line Number</u>	<u>M</u>	<u>O</u>	<u>O</u>	
208	<u>Managed Care Organization Identification Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If worker enrolled at time of service.</u>
721	<u>NDC Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.</u>
728	<u>NDC Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than NDC Billed Code</u>
555	<u>Place of Service Bill Code</u>	<u>C</u>	<u>C</u>	<u>O</u>	<u>If Billing Format Code equals "B"</u>
600	<u>Place of Service Line Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Place of Service Billed Code and not a pharmacy bill</u>
527	<u>Prescription Bill Date</u>	<u>O</u>	<u>O</u>	<u>O</u>	
604	<u>Prescription Line Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
561	<u>Prescription Line Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a pharmacy bill submitted on universal claim form/NCPDP format</u>
521	<u>Principal Diagnosis Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A"</u>
550	<u>Principal Procedure Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and if ICD-9 CM Principle Procedure Code or HCPCS Principle Procedure Billed Code is present</u>
524	<u>Procedure Date</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Billing Format Code equals "A" and more than one surgical procedure was performed</u>
507	<u>Provider Agreement Code</u>	<u>M</u>	<u>O</u>	<u>O</u>	<u>Enter the value "P" if the injured worker is enrolled in a Managed Care Organization at time of service</u>
642	<u>Rendering Bill Provider FEIN</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
638	<u>Rendering Bill Provider Last/Group Name</u>	<u>M</u>	<u>O</u>	<u>O</u>	
647	<u>Rendering Bill Provider National Provider ID</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has an NPI, it must be reported; otherwise, report the provider FEIN</u>
651	<u>Rendering Bill Provider Primary Specialty Code</u>	<u>M</u>	<u>O</u>	<u>O</u>	
643	<u>Rendering Bill Provider State License Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
586	<u>Rendering Line Provider FEIN</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
592	<u>Rendering Line Provider National ID</u>	<u>C</u>	<u>O</u>	<u>C</u>	<u>If provider has an NPI, it must be reported; otherwise, report the provider FEIN</u>
595	<u>Rendering Line Provider Primary Specialty Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Rendering Bill Provider Primary Specialty Code</u>
599	<u>Rendering Line Provider State License Number</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If provider has no NPI, report FEIN plus State License Number</u>
615	<u>Reporting Period</u>	<u>M</u>	<u>M</u>	<u>M</u>	
559	<u>Revenue Billed Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If a value for Facility Code with 1st digit equal to 1</u>

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576	<u>Revenue Paid Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Revenue Billed Code</u>
733	<u>Service Adjustment Amount</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
731	<u>Service Adjustment Group Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
732	<u>Service Adjustment Reason Code</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If applicable.</u>
509	<u>Service Bill Date(s) Range</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Svc. Lines Date Range</u>
605	<u>Service Line Date(s) Range</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If not a pharmacy bill submitted on universal claim form/NCPDP format</u>
516	<u>Total Amount Paid Per Bill</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If different than Total Charge per Bill</u>
574	<u>Total Amount Paid Per Line</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If paid amount is not equal to billed amount</u>
501	<u>Total Charge Per Bill</u>	<u>M</u>	<u>M</u>	<u>M</u>	
552	<u>Total Charge Per Line</u>	<u>O</u>	<u>O</u>	<u>O</u>	
566	<u>Total Charge Per Line – Purchase</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Durable Medical Equipment is purchased</u>
565	<u>Total Charge Per Line – Rental</u>	<u>C</u>	<u>O</u>	<u>O</u>	<u>If Durable Medical Equipment is rented</u>
266	<u>Transaction Tracking Number</u>	<u>M</u>	<u>M</u>	<u>M</u>	
500	<u>Unique Bill ID Number</u>	<u>M</u>	<u>M</u>	<u>M</u>	<u>Cancel & Replace. Transactions must match previous submitted Original Unique Bill ID No.</u>

- 3) The data must include all payments made during the previous 90 days for medical services.
- 4) Technical Requirements: See Division 160, EDI Filing Rule and the Oregon EDI Medical Bill Implementation Guide for specifications on the Secure File Transfer Protocol (SFTP) requirements.
- 5) 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, and is formatted correctly. See 436-160-0090, Acknowledgements, for a description of the acceptance/rejection protocol for all reported medical bills. The insurer is responsible for correcting and resubmitting all rejected transactions for which law or rule require filing, reporting, or notice to the director.