

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009**

OREGON MEDICAL FEE AND RELATIVE VALUE SCHEDULE

EFFECTIVE JUNE 1, 1996

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

[Ed. Note: These rules are renumbered from Oregon Administrative Rule 436, Division 10, Medical Services]

436-009-0001 Authority For Rules

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(3) and specific authority under ORS 656.248.

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

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(3)
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

These rules shall be applicable to all services rendered on or after the effective date of these rules.

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

436-009-0005 Definitions

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

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

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

436-009-0008 Fee Disputes, Administrative Review, And Contested Cases

Administrative review before the director:

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(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 Division 001 of the Chapter 436 rules.

(b) For purposes of these rules, "dispute resolution before the director" means any problem solving process authorized by statute, rule, or order, designed to resolve a dispute concerning the payment of medical services covered by these rules.

(c) The objective of the dispute resolution before the director is to resolve the dispute fairly and expeditiously, in a manner that encourages a nonadversarial environment. Toward this end, any party may request that the director provide voluntary mediation prior to or concurrent with the administrative review or contested case. When a dispute is resolved by agreement of the parties to the satisfaction of the director, the director may issue a Stipulated Letter of Agreement, or an Order of Dismissal if the party requesting review withdraws that request as a result of the agreement, or take other appropriate action.

[ED. NOTE: The following section (1)(d) and sections (2), (3), (4), and (5) of this rule have been renumbered from OAR 436-010-0110.]

(d) All issues pertaining to disagreement about medical fees or non-payment of bills within a Managed Care Organization (MCO) are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting administrative review of the matter by the director under section (2) of this rule. 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 in accordance with section (2) of this rule.

(2) The medical provider, the injured worker or the 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 compensable medical services. The request for review must be mailed to the division within 90 days of the dispute. For purposes of this rule, the day of the dispute shall be the date the party knew or should have known there was a dispute over either the amount of a fee or the non-payment of a bill. If the request for review is submitted by either the insurer or the medical provider, it shall be in the form and format as prescribed by the director and must:

(a) State specific code(s) and dates of service(s) in dispute;

(b) State the grounds for questioning the disputed amount;

(c) State the request for correction and relief; and

(d) Include sufficient documentation to support the review request, including but not limited to copies of original HCFA bills, chart notes, bill analysis, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute;

(e) Certify that the involved parties have been provided a copy of the request for review and attached supporting documentation;

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(f) Certify, if known, that there is no issue of causation or compensability of the underlying claim or condition.

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

(4) If additional information is necessary, the director shall so advise the parties. Upon receipt of a written request for additional information, the parties shall have 14 days to respond. If the parties do not provide the information requested by the director and/or when the investigation is complete, the director will issue an order resolving or dismissing the dispute based on available information. 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) Notwithstanding any other provision of this rule, when the director becomes aware that a dispute exists regarding either the amount of a fee or the non-payment of bills for compensable medical services, the director may resolve the dispute pursuant to ORS 656.248(13).

(6) Contested Cases Before the Director: Pursuant to 183.310 through 183.550, as modified by OAR 436-001 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 436-001. 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 must attach a copy of the order being appealed.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of action being appealed, unless the director determines that, in his or her discretion, there was good cause for delay.

(7) Contested Case Hearings of Sanction and Civil Penalties: The director may sanction a party or assess civil penalties due to a violation(s) of these rules. Under ORS 656.740, 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. The process for requesting a hearing is described in OAR 436-010-0008(14).

(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. For purposes of these rules, "administrative review" means any decision making process by the director, except as provided by ORS 183.310(2) and OAR 436-001. The aggrieved 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 ninety (90) days of the disputed action and must specify the

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grounds upon which the action is contested, unless the director determines that, in his or her discretion, there was good cause for delay or that substantial injustice may otherwise result.

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

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

Stat. Auth.: ORS 656.704, 656.726(3)

Stats. Implemented:

Hist: Renumbered from OAR 436-010-0110(1), (2), (3), (4), and (5) to OAR 436-009-0008(2), (3), (4), and (5);

From OAR 436-010-0110(6) to OAR 436-009-0008(1)(b); and

Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96

[ED. NOTE: Parts of the following rule have been renumbered from OAR 436-010-0040, 436-010-0047 and 436-010-0090]

436-009-0010 General Requirements For Medical Billings

(1) All billings shall be fully itemized, including ICD-9-CM codes, and services shall be identified by code numbers and descriptions found in the Oregon Relative Value Schedule (ORVS) or as otherwise provided in these rules. The definitions of commonality in the guidelines found in the Current Procedural Terminology (CPT) shall be used as guides governing the descriptions of services, except as otherwise provided in the ORVS or in these rules.

(2) All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on current form UB92 or form HCFA 1500, except for dental billings which shall be submitted on ADA dental claim forms. 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. All original medical provider billings shall be accompanied by chart notes documenting services which have been billed.

(3) Outpatient occupational therapy is compensable only when provided under a written treatment plan as described in OAR 436-010-0230. CPT codes 97900 and 97901 in the ORVS denote occupational therapy and shall be used only for services provided by a licensed occupational therapist. In addition, CPT Code 97902 shall be used to denote the initial visit for evaluation and establishment of the treatment program.

(4) The preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service. No additional fee shall be paid except a reasonable amount for copies or summaries of the records of treatment as provided in accordance with OAR 436-009-0020(29).

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

(6) The descriptions of medical services for CPT numbers itemized in (a) through (j) shall be the basis for determining the appropriate level of service.

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(a) 95831 - Muscle Testing, Manual, Separate Procedure, Extremity, with Report (also includes 95832, 95833, 95834) - Detailed individual testing of multiple muscles of a patient with a severe neuropathic or myelopathic disorder. It does not apply to general or specific muscle testing done during a regular physical examination.

(b) 97110 - Therapeutic Exercises - Instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a physician or therapist present and supervising would not be covered.

(c) 97112 - Neuromuscular Reeducation - The provision of direct services to a patient who has had muscle paralysis and is undergoing recovery or regeneration. Examples would be severe trauma to nervous system, cerebral vascular accident and systemic neurological disease. The code does not apply to massaging or exercising relatively normal muscles or treatment of minor disuse atrophy, e.g. following cast removal.

(d) 97114 - Functional Activities - The development and instruction in specific activities for persons who are severely handicapped or debilitated. The code does not apply to routine exercises for relatively normal individuals.

(e) 97116 - Gait Training - Teaching individuals with severe neurological or muscular-skeletal disorders to ambulate in the face of their handicap or to ambulate with an assistive device. This code does not apply to simple instructions given relatively normal individuals with minor or transient abnormalities of gait who do not require an assistive device.

(f) 97220 - Hubbard Tank - This service involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals.

(g) 97240 - Pool Therapy with Therapeutic Exercises - This service is provided individually, in a pool, to severely debilitated or neurologically impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.

(h) 97540 - Activities of Daily Living - Services provided in an office or clinic to severely impaired individuals, e.g. how to get in and out of a tub; how to make a bed; how to prepare meals in a kitchen. It does not apply to simple instructions or counseling in body mechanics given briefly to a patient.

(i) 97720 - Extremity Testing for Strength, Dexterity, or Stamina - Detailed testing of a patient with a generalized neurological or debilitating disease. It does not apply to routine physical examinations of relatively unimpaired individuals.

(j) 97530 - Kinetic Activities - When there are major impairments or disabilities which preclude the patient performing the activities and exercises that are ordinarily prescribed. Considerable time is spent developing specific, individualized therapeutic exercises and instructing the patient in how to perform them. This code does not apply to instructions in routine exercises.

(7) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review [the efficacy of treatment, frequency and necessity of care, and] accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0020(29). If the evaluation of the records must be conducted on-

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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. Failure to provide the records in a timely manner may result in a sanction or penalty as provided in OAR 436-009-0100.

Stat Auth.: ORS 656.245, 656.252, 656.254
 Stats. Implemented: ORS 656.245, 656.252, 656.254
 Hist: Renumbered from OAR 436-010-0010(5) and (6) to OAR 436-009-0010(1) and (2);
 From 436-010-0040(3)(d) and (e) to 436-009-0010(3) and (4);
 From 436-010-0040(7) and (9) to 436-009-0010(4) and (5);
 From 436-010-0040(11) to 436-009-0010(11); and
 Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96

[ED. NOTE: Parts of the following rule have been renumbered from 436-010-0040, 436-010-0047 and 436-010-0090]

436-009-0020 Charges And Fees

(1)[(a)] Inpatient and outpatient hospital charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes and, additionally, inpatient hospital charges shall include the diagnostic related group (DRG) number. Unless otherwise provided for by a governing MCO contract, insurers shall reimburse hospitals for inpatient hospital services using the current adjusted cost/charge ratio. For purposes of this rule, inpatient hospital service bills include, but may not be limited to, those bills coded "111" through "118" in space #4 on the UB92 billing form. Insurers shall audit each bill for inpatient services for mathematical accuracy and compensability. The resulting sum shall be multiplied by a hospital's adjusted cost/charge ratio to determine the allowable payment. When the insurer is auditing bills for outpatient hospital services, including emergency room services, the insurer shall first separate out and pay charges which have CPT codes and are subject to the ORVS, pursuant to OAR 436-009-0010(1) and (14)(a). The amount billed for services that are subject to the ORVS should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance.

(a) Each hospital's HCFA Form 2552 and audited financial statement shall be the basis for determining its adjusted cost/charge ratio. 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 (d), 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) Malpractice Premiums and/or Self-Insurance Fund Contributions, less the Administrative portion of malpractice premiums and/or Self-Insurance Fund Contributions;

(B) Provider-Based physician adjustment;

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

(D) Telephone service;

(E) Television and radio service; and

(F) Expenses identified as for physician recruitment.

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(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: Use the audited financial statement and 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 (1)(c) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow for 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 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 figures resulting from (1)(c) and (1)(d) of this rule will be added to the ratio calculated in (1)(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 shall be revised annually, at a time based on their fiscal year, as prescribed by bulletin. Each hospital shall submit a copy of their HCFA 2552 and audited financial statements each year within 120 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 shall be published by bulletin twice yearly, on or before February 20 of each year to be effective for the subsequent six-month period beginning March 1, and on or before August 20 of each year to be effective for the subsequent six-month period beginning September 1.

(g) For those newly formed or established hospitals for which no HCFA 2552 has been filed, or for those hospitals that do not file Worksheet G-2 with the submission of their HCFA form 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 2552 by the Health Care Financing Administration 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) Hospitals which provide inpatient hospital and outpatient surgical services to injured workers who are governed by a MCO may be granted exemption or partial exemption from the cost/charge ratio in accordance with ORS 656.248(12).

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(2) Notwithstanding subsection (1) of this rule, the director may exclude rural hospitals defined in ORS 442.470 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 Flexibility Index as calculated by the Oregon Health Sciences University, Office of Rural Health. Fee schedule exemption will be granted to all hospitals which are more than three standard deviations below the Index's zero point.

(3) The insurer shall notify the medical provider in writing at the time of payment of the reasons for any reduction in payment of the medical provider's billings. The medical provider shall not attempt to collect from the injured worker any amounts reduced by the insurer pursuant to this rule.

(4) The director shall review and update medical fee schedules annually as prescribed in ORS 656.248.

(5) When there is a dispute about a fee for a medical service for which no CPT code or relative value has been established, the director shall determine and promulgate a reasonable fee for the services, which shall be the same for all medical providers. The director shall periodically issue a bulletin to all parties establishing the fee that shall apply to all similar disputes which arise. The director shall incorporate the fee into the ORVS. When determining such a fee the director shall consider:

- (a) The relative difficulty of the service;
- (b) The fee for like or similar services; and
- (c) The skill, time, risk and investment of the medical provider and other medical providers in delivering the service.

(6) Workers may make a written request to a medical provider to receive copies of medical billings. Providers receiving a request may issue the worker a copy during the next billing cycle, but not later than 30 days following receipt of the request. Thereafter, worker copies are to be issued during the regular billing cycle.

(7) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker shall not be liable for payment for any services for the treatment of that injury or illness and a medical provider shall not attempt to collect from an injured worker for services, with the following exceptions:

- (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 worker's attending physician. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period as set forth in 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 436-010-0041, 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 436-010-0270; or

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(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental pursuant to OAR 436-010-0300.

(8) The medical provider shall bill the medical provider's 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.

(9) The medical provider shall not bill for services not provided to the worker, nor shall the medical provider bill multiple charges for the same service. Rebillings shall indicate that the charges have been previously billed.

(10) 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.

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

(12) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings will be subject to discounts, not to exceed 10 percent for each 30 day period or fraction thereof, beyond 60 days.

(13) Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

(14)(a) When services are provided in hospital emergency or outpatient departments and are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes or Oregon specific codes and reimbursed at no more than the 75th percentile as shown in the ORVS. Such services include, but are not limited to, outpatient physical therapy, outpatient X-rays, and physician's services.

(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 or outpatient surgical services shall be considered part of the hospital services subject to the hospital fee schedule.

(15) Physician assistant or nurse practitioner fees will be paid at the rate of 80 percent of a physician's fee for a comparable service except that assisting in surgery shall be paid at the rate of 10 percent of the surgeon's reimbursable fee. The bills for services by these providers shall be

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marked with modifier 81. Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(16) 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.

(17) Reimbursement to physicians shall not exceed 20 percent above the physician's costs for braces, supports and other medical devices. Invoices for devices with a unit price greater than \$25 shall be provided on request of insurer. Invoices for devices with a unit price under \$25 shall be provided upon request of the director.

(18) When more than one surgeon performs surgery, the process for billing shall be as follows:

(a) When two surgeons operate and one performs a discectomy and one performs an arthrodesis, each procedure is to be billed separately. The maximum allowable fee for each procedure, as listed in the ORVS, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation each may bill an additional fee of 20 percent of the other surgeon's 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' fees.

(b) When one surgeon performs a discectomy and arthrodesis the procedure shall be billed under CPT codes 22550 through 22585 as specified in the ORVS.

(c) When multiple surgical procedures are performed, the principal procedure is reimbursed at 100 percent of the maximum allowable fee, the secondary procedure is reimbursed at 50 percent of the maximum allowable fee and all subsequent procedures are reimbursed at 25 percent of the maximum allowable fee.

(d) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in the ORVS and the subsequent procedures paid at 10 percent of the value listed.

(e) Surgery following severe trauma, for which several procedures are required and which take considerable time, and for which the surgeon feels his or her fees should not be reduced, can receive special consideration by the insurer. Such a request must be accompanied by written documentation and justification.

(f) Hospital charges for inpatient myelography are not subject to the ORVS. Physician's services for inpatient myelography are subject to the ORVS.

(19)(a) When two bills are submitted for an X-ray, one by the person taking the X-ray (technical component to be designated by modifier 27) and one by the radiologist who interprets the X-ray (professional component to be designated by modifier 26), the maximum allowable fee is to be divided between them. The technical component is to be reimbursed at 60 percent of the maximum allowable fee and the professional component is to be reimbursed at 40 percent of the maximum allowable fee.

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(b) Physicians, other than the radiologist, who inject air, contrast materials or isotopes as part of a radiologic study, shall bill for this service using CPT codes from the surgery section. For example, CPT code 62284 shall be used for the injection for myelography. This fee for the injection will be reimbursed in addition to the value of the complete procedure. The complete procedure fee shall be reimbursed based on 60 percent for the technical component and 40 percent for the professional component.

(20) Outpatient hospital services shall be reimbursed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the ORVS, are to be applied to hospital bills only for outpatient services.

(b) CAT scans, when performed as an outpatient service, are subject to the limitations of the ORVS. When multiple areas are examined by CAT scan, the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the ORVS.

(21) A physical medicine modality or manipulation, when applied to two or more areas at one visit, shall be reimbursed at 100 percent of the maximum allowable fee for the first area treated, 50 percent for the second area treated, and 25 percent for all subsequent areas treated. This rule does not apply when a physical therapist uses CPT codes 97200 and 97201 from the ORVS for physical therapy.

(22) When ultrasound, diathermy, microwave, infrared and hot packs are used in combinations of two or more during one treatment session, only one shall be reimbursed, unless two separate effects are demonstrated.

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

(24)(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program is not reimbursable unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive reimbursement for multi-disciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multi-disciplinary 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.

(c) Billings for medical services provided within a CARF or JCAHO accredited multi-disciplinary program which do not have established CPT codes shall be billed based upon the Oregon specific codes identified in the ORVS for multi-disciplinary programs. Billings using the multi-disciplinary 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

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individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(d) When an attending physician approves a multi-disciplinary treatment program for an injured worker, the attending physician must provide the insurer with a copy of the approved treatment program within seven days of the beginning of the treatment program.

(e) Notwithstanding section (5) of this rule, program fees for services within a multi-disciplinary 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.

(25) Dimethylsulfoxide (DMSO) is not reimbursable except for treatment of compensable interstitial cystitis. Additionally, surface EMG tests, rolfing, prolotherapy, and thermography are not reimbursable. These non-reimbursable services may be administered; however, medical providers shall not receive additional reimbursement for providing such services.

(26) When multiple areas are examined using Magnetic Resonance Imaging (MRI), the first area examined shall be reimbursed at 100 percent, ORVS the second area at 50 percent, and the third and all subsequent areas at 25 percent.

(27) Mechanical muscle testing shall be reimbursable a maximum of three times during a treatment program when prescribed and approved by the attending physician: once near the beginning, once near the middle and once near the end of the treatment program. Additional mechanical muscle testing is reimbursable 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, and a written interpretation of the results.

(28) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, the costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer. Modifiers from the CPT shall be used to indicate reduced billing.

(29) Fees and codes for records and reports requested by an insurer, worker, employer, or their representative shall be as follows:

(a) 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(2) of this rule.

(b) Copies of medical records when requested shall be reimbursed at \$3.50 for the first page and 25 cents for each page thereafter and identified on billings by Oregon specific code R0001.

(c) Brief Narrative by the Attending Physician - Summary of treatment to date and current status; - if requested, brief answers to 3-5 specific questions which are related to the current or proposed treatment shall be reimbursed, using the conversion factor for "Medicine", at a RVU of 6.66 and identified on billings by Oregon specific code N0001.

(d) Complete Narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary information shall be reimbursed, using the

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conversion factor for "Medicine," at a RVU of 13.32 and identified on billings by Oregon specific code N0002.

(e) When a medical provider is asked to provide opinions regarding alternative treatments or to review records or reports prepared by another medical provider, the medical provider should bill for their review of the records utilizing CPT Code 99080. The billing should include the actual time spent reviewing the records or reports and should list the medical provider's normal hourly rate for such review. This would include, but not be limited to, insurer medical examination reports.

(30) Fees for a physical capacity evaluation (PCE) and a work capacity evaluation (WCE) shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable reimbursement shall be as follows:

(a) **FIRST LEVEL PCE:** This is a general evaluation to establish early return-to-work capability or a specific evaluation requested to measure the physical capacity of a specific body part. This level requires not less than 45 minutes of actual claimant contact. Using the conversion factor for "Medicine," the RVU for this PCE is 13.32, which includes the evaluation and report. A first level PCE should be billed using Oregon specific code 99196.

(b) **SECOND LEVEL PCE:** This is a PCE requested by the insurer, or attending physician, to measure general residual functional capacity to perform work or provide other general evaluation information. This level requires not less than one hour and 45 minutes of actual claimant contact. Using the conversion factor for "Medicine," the RVU for this PCE is 29.96, which includes the evaluation and report. A second level PCE should be billed using Oregon specific code 99197.

(c) **WORK CAPACITY EVALUATION:** This is a residual functional capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. This level requires not less than 6 hours of actual claimant contact. Using the conversion factor for "Medicine," the RVU for this WCE is 63.25, which includes the evaluation and report. A work capacity evaluation should be billed using Oregon specific code 99198.

(31) No fee shall be paid for the completion of a work release form or completion of a physical capacity evaluation form where no tests are performed.

(32) Fee and codes for a deposition (includes preparation time):

(a) First hour of deposition (including preparation time) RVU of 39.95; using the conversion factor for "Medicine (Oregon specific code D0001)

(b) Each subsequent hour or portion thereof RVU of 13.32; using the conversion factor for "Medicine" (Oregon specific code D0002)

(33) The CPT codes included in Appendix "A" attached hereto are included in and made a part of the ORVS.

(34) All arbiters, panels of arbiters, physicians and panels of physicians used for director's reviews shall be paid as follows:

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(a) A single medical arbiter appointed pursuant to OAR 436-030-0050, shall bill under Oregon specific code A0001. Using the conversion factor for "Medicine," the relative value unit (RVU) for this service is 26.63. In addition, the arbiter shall bill under Oregon specific code A0003 for the report to the director. Using the same conversion factor, the RVU for this report is 6.66. These fees apply to all single arbiter evaluations.

(b) Physicians selected to a panel of arbiters pursuant to OAR 436-030-0050, shall each receive payment for record review and the examination. The physician who prepares and submits the report shall receive an additional payment amount. Billings by each arbiter selected to a panel shall be billed under Oregon specific code A0002. Using the conversion factor for "Medicine," the RVU for this service is 33.29. Billing for the panel report shall be billed under Oregon specific code A0003. Using the same conversion factor, the RVU for this report is 6.66.

(c) A single physician selected pursuant to OAR 436-010-0310, 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. In addition, the physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under Oregon specific code P0001 for the examination and Oregon specific code P0003 for the report. Using the conversion factor for "Medicine," the RVU for services billed under code P0001 is 19.97. Using the same conversion factor, the relative value for the report billed under code P0003 is 13.32.

(35) 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. The panel member who prepares and submits the panel report shall receive an additional payment. Billings by each physician selected to a panel shall be billed under Oregon specific code P0002. Billings for the panel report shall be billed under Oregon specific code P0003. Using the conversion factor for "Medicine," the RVU for services billed under code P0002 is 19.97. Using the same conversion factor, the relative value for the report billed under code P0003 is 13.32.

(36) The director may in a complex case requiring extensive review pre-authorize an additional fee based on a RVU up to 26.63 above the units specified in this rule. Billings for such additional units shall be billed under Oregon specific code A0004 using the conversion factor for "Medicine".

(37) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each selected physician shall bill under Oregon specific code A0005. Using the conversion factor for "Medicine," the RVU for this service is 13.32.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.248, Sect. 2, Chpt. 771, OR Laws 1991, 656.252, 656.256

Hist: Renumbered from OAR 436-010-0090(1) thru (4), (7) thru (32) to OAR 436-009-0020(1) thru (29), (32) and (33);

From OAR 436-010-0040(4)(b)(A) and (c) to OAR 436-009-0020(30) and (31);

From OAR 436-010-0047(6) and (7) to OAR 436-009-0020(34) thru (37); and

Filed 5/3/96 as Admin. Order 96-059, eff: 6/1/96

[ED. NOTE: Parts of the following rule have been renumbered from OAR 436-010-0100]

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436-009-0030 Insurer's Duties And Responsibilities

(1) The insurer shall pay for compensable medical services relating to a compensable injury claim, except as provided by OAR 436-060-0055. Compensable medical services include but are not limited to medical, surgical, hospital, nursing, ambulance and other related services, drugs, medicine, crutches, prosthetic appliances, braces, supports, and where necessary physical rehabilitation.

(2) Insurers shall date stamp medical bills and reports upon receipt and shall 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(1) and (2) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form may be returned to the medical provider for correction and resubmission. If an insurer returns such billings, it must be documented and done within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing to the provider and the date the insurer receives the corrected billing, shall not apply toward the 45 days within which the insurer is required to make payment.

(3) Payment of medical bills in the following situations is required within 14 days of the action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later:

(a) When an order designating a paying agent pursuant to ORS 656.307 and OAR 436-60-180 has been issued;

(b) When an insurer voluntarily rescinds a claim denial;

(c) When there is a Stipulated Agreement which rescinds a claim denial;

(d) When there is an Opinion and Order or Order on Review that has become final which overturns a claim denial;

(e) When medical benefits become due upon claim acceptance following a claim denial;
and

(f) When medical benefits become due upon claim acceptance following a claim deferral period.

(4) Failure to pay for medical services timely may:

(a) Result in civil penalties pursuant to OAR 436-009-0100;

(5) When there is a dispute over the amount of a bill or the necessity 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 and OAR 436-015.

(6) The insurer shall establish an audit program for bills for all medical services to determine that services are billed as 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

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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.

(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 436-0010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(8) Insurers, insurer groups and self-insurers that have at least 100 accepted disabling claims in a calendar year, as determined by the Department of Consumer and Business Services, are required to transmit detailed medical service and billing data to the Information Management Division of the Department of Consumer and Business Services. Once an insurer has been determined to have the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. In such circumstances, the insurer may apply for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will publish a bulletin identifying the affected insurers and advising the insurers of the data and format requirements for data transmission;

(b) The data shall include all payments made during each calendar quarter for medical services which are covered by the department's fee schedules. These fee schedules include anesthesiology, medicine, evaluation and management services, physical therapy, surgery, radiology, multi-disciplinary, and hospital inpatient services and hospital outpatient surgical services;

(c) The affected insurers shall submit the medical data within 45 days of the end of each calendar quarter. However, a grace period of two calendar quarters may be granted for revised requirements and also for insurers which are newly affected by these requirements; and

(d) There must be no more than fifteen percent inaccurate data in any field. Listed insurers are responsible for pre-screening the data they submit to check that all required information is reported. Reports 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.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82

Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84

Renumbered from OAR 436-69-801, 5/1/85

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Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88

Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)

Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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Renumbered from OAR 436-010-0100(8) thru (15), (27) and (28) to OAR 436-009-0030; and

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436-009-0100 Sanctions And Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established pursuant to ORS 656.252 and 656.254(1) as found in OAR 436-009-0010, 436-009-0020, and 436-009-0030 of these rules, the director may impose sanctions in accordance with OAR 436-010-0340 and 436-010-0350.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

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