

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

In the Matter of the Amendment of: )  
 )  
 436-009, Oregon Medical Fee and Payment Rules ) SUMMARY OF  
 ) TESTIMONY AND  
 ) AGENCY RESPONSES

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

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated February 1, 2006. On February 21, 2006, a public rulemaking hearing was held as announced at 10:00 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through February 24, 2006.

One person testified at the public rulemaking hearing. The transcript of the hearing is marked as Exhibit 5. In addition, eight written documents were submitted as testimony.

**Testimony list:**

<b>Exhibit</b>	<b>Testifying</b>	<b>Representing</b>
1	Carlene Hall	Brian E. Hayes, M.D.
2	Nicole Schneider	Liberty Northwest Insurance
3	Brian Allen	WorkingRX
4	Martha J. MacRitchie, MD et al	Rehabilitation Medicine Associates of Eugene- Springfield, PC
5	Joan Kapowich	SAIF Corporation
6	Joan Kapowich	SAIF Corporation
7	Karen McNamee	Providence MCO
8	J. David Hook, MD	Work Injury Management Program, Salem Hospital
9	John Di Paola, MD	Occupational Orthopedics

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**Testimony:** OAR 436-009 (General testimony) *Exhibit #5*

SAIF Corporation encourages the Workers' Compensation Department to expand their fee schedule to include guidelines for interpreter fees, dental services, hearing aid and supply services, and ambulance services.

**Response:** The division will consider fee schedules for the above in future rulemaking and as feasible considering available resources and data.

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**Testimony:** OAR 436-009 (General testimony) *Exhibit #8*

I have discussed with Dr. John DiPaola the issues on which he will be presenting testimony this afternoon and am in complete agreement with him. The changes he is proposing will improve our ability to care for Oregon's injured workers.

**Response:** Please see response below.

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**Testimony:** OAR 436-009 (General testimony) *Exhibit #9*

Regarding the term "Usual and Customary." I feel the agency is on course by "always intending that the term apply only to the specific providers' usual fees charged to the public."

Oregon physicians who exclusively treat injured workers primarily operate on the fee schedule enacted and approved by the Workers' Compensation Division. We also provide other services including IMEs, Arbitrator's exams, impairment examinations, and closing examinations. The occupational specialists understand the specific issues that need to be clearly related in the provision of these various services. The reimbursement for the services provided by occupational specialists is significantly higher than the typical reimbursement provided to community physicians whose "public" includes primarily Medicare, Oregon Health Plan, HMOs, PPOs, and a few commercial insurance products. Their services are highly discounted and their approach is purely clinical. They have no interest nor do they provide the information required by the workers' compensation stakeholders for the system to work at its highest level of efficiency. Therefore, it is my recommendation that the Division strongly support physicians with a majority commitment to the care of injured workers to sustain the value of their usual and customary fees.

**Response:** Consistent with this testimony, these permanent rules reflect the provider's usual fee, not a regional or demographically calculated usual fee.

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**Testimony:** OAR 436-009-0004 *Exhibit #7*

While it is an improvement to "allow" HCPCS [Healthcare Common Procedure Coding System] use, it would be a further improvement to require use of HCPCS. It is widely used by providers, and many providers and insurers have computer systems utilizing HCPCS. Allowing use of non-standard codes creates more work and expense in addition to increasing the likelihood that coding/payment errors will occur.

**Response:** Many providers are currently already doing this, and the director doesn't want to be more prescriptive than necessary in rulemaking. In addition, any new requirement must be carefully reviewed to assure that ORS 656.248(6) and ORS 656.012(2)(a) are followed. Sure, prompt and complete medical treatment for injured workers requires an adequate number of

providers in the system. The number of providers in the system can be adversely affected if there are too many reporting requirements. Therefore, the rules will not prescribe HCPS at this time.

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**Testimony:** OAR 436-009-0004

*Exhibits #5 & #6*

Changes in CPT codes and relative value units are implemented annually by commercial and public insurance carriers, including Medicare and Medicaid, nationwide on the 1<sup>st</sup> of January. WCD rules make the code changes effective on April 1<sup>st</sup>. This 3-month delay in implementation is another administrative burden for providers requiring them to bill Oregon Worker's Compensation carriers differently than other carriers. WCD should modify the timing on the adoption of codes to be in line with adoption of the annual CPT guidelines on January 1<sup>st</sup>.

**Response:** The division has researched this and determined there are technical and legal difficulties. Adopting a resource prospectively in this way is currently prohibited by state law.

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**Testimony:** OAR 436-009-0004

*Exhibits #5 & #6*

In this section, WCD updated the date of a reference in the federal register. In addition, WCD should explicitly adopt national coding standard references for the medical billing industry. This would streamline work in providers' offices and decrease the number of billing questions about coding for services. (CPT Assistant, AMA Press, Practical Guide to Current Coding, CMS official National Correct Coding Initiative (NCCI)).

**Response:** The director is reviewing the adoption of CPT Assistant and this will be revisited next year. There are many resources available in a variety of venues. Different providers and payers have various preferences. If there are too many resources adopted with multiple changes in them regularly, it becomes very difficult to keep the rule current. Multiple rule revisions would need to be made yearly. This becomes very difficult to administer and it could be difficult for providers to keep current with which resource they should be using, and it may not be the one they are used to or prefer. It is our understanding that Medicare (MC) had the National Correct Coding Initiative (NCCI) created because of portions of the Social Security Act (1965), the Code of Federal Regulations, the requirements of the MC rules, and as a cost saving measure for them, as noted in their instruction manual. Some medical providers do not agree these should be adopted universally as it is a cost saving measure for insurers and could have an adverse effect on provider payments. NCCI was developed specifically to "*control improper coding, leading to inappropriate coding for Part B claims*". However, the American Medical Association (AMA) has not endorsed these initiatives or descriptions of appropriate coding, as noted in the NCCI Policy Manual, where a disclaimer states "*No endorsement by the American Medical Association is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any uses, non-use, or interpretation of information contained or not contained in this product.*"

The NCCI was developed for Medicare and a population routinely older than the workers' compensation (WC) population. Across the board application of a resource created for a very specific cost saving purpose to a completely different population seems questionable. NCCI "bundles" codes together and often this "bundling" effectively results in reduced payments to providers. The AMA and other providers do not endorse or adopt the medical correctness of the bundling of these codes. With the additional requirements of WC it seems reasonable that undue

reductions in payments to providers be avoided in order to assure access to quality care for injured workers. On the other hand, medical provides have a responsibility to bill and code appropriately. In addition, ORS 656.248(6) requires the director to create a fee schedule adequate to ensure at all times that injured workers receive and have access to the standard of medical services and care intended by Ch 656. Applying additional MC standards and MC fee schedules to the Oregon workers compensation system could create problems for injured workers in accessing quality, timely care. Lastly, the NCCI updates their publication quarterly and the Administrative Law manual prohibits adopting resources prospectively, the resource must be in existence at the time of rule promulgation.

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**Testimony:** OAR 436-009-0004

***Exhibit #7***

It is suggested that reference be made to use of the ASA, CPT and RBRVS pertinent to the current year, rather than annually changing the rules to indicate the current year. For example, specify the year of the CPT should match the year services were provided.

**Response:** Currently, the director must adopt resources that are in existence at the time of rule promulgation according to Administrative law.

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**Testimony:** OAR 436-009-0005

***Exhibit #3***

We request that the important role of third party providers utilized by health care providers and pharmacies be recognized by being included in the definitions. The rule should address the agent or assignee for the purpose of billing, claims processing, assignment of claims, processing and receiving payments, or filing required reports on behalf of the pharmacy or health care provider.

**Response:** Currently, third party providers for pharmacies are not considered medical service providers as defined by law. Case law on this issue is currently pending. Any future rule addressing this issue is dependent on the case law and statutory requirements.

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**Testimony:** OAR 436-009-0010

***Exhibit #3***

To help facilitate EDI Billings for pharmacies, we would propose that the electronic format must include all of the required information found on the most current NDCDP form but not necessarily have to be submitted in that exact format. This would facilitate a bulk transfer of claim information that the payer can more readily input into their electronic processing system.

**Response:** This was received too late to be considered in these rules, but will be considered next time the rules are opened for revision.

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**Testimony:** OAR 436-009-0010(8)

***Exhibit #2***

We request that language be added to the rule clarifying that an insurer would not be asked to and shall not be required to prepay any services. We recognize the inconvenience to medical providers associated with scheduling time away from patient care only to have conferences and or depositions cancelled on short notice. Liberty agrees that if representatives for injured workers or insurers are engaging in this practice, it is inappropriate. Demanding prepayment as a

condition of access to a medical provider, however, allows the medical provider to hold the party requesting access hostage over the access. It places the party requesting access in the position of having to pay any charge demanded, whether reasonable or entirely unreasonable, in order to obtain that access. Liberty has no objection to a rule that would require a party that cancels on short notice or neglects to attend a conference or deposition a reasonable fee for the medical provider's time. Allowing a medical provider to demand prepayment, however, places the party requesting access to the provider in an unreasonable position without meaningful recourse and allows medical providers to circumvent requirements that charges for services be reasonable.

**Response:** This concept requires further study before any revision. The concept will be considered next opening of the rules.

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**Testimony:** OAR 436-009-0010

*Exhibits #5 & #6*

In the requirements for medical billings section, the WCD proposed new language states, "Providers *may* use the appropriate HCPCS code in the description." The use of the HCPCS standard national codes here is permissive rather than mandated. The "Requirements for medical billings" should include requirements, not suggestions. If a provider may use a code, this does not serve to standardize billing practice. Billing confusion will persist unnecessarily with this language. We believe the language should read, "Providers *shall* use the appropriate HCPCS code in the description."

**Response:** Many providers are currently already doing this, and the director doesn't want to be more prescriptive than necessary in rulemaking. In addition, any new requirement must be carefully reviewed to assure that ORS 656.248(6) and ORS 656.012(2)(a) are followed. Sure, prompt and complete medical treatment for injured workers requires an adequate number of providers in the system. The number of providers in the system can be adversely affected if there are too many reporting requirements. Therefore, the rules will not prescribe HCPCS codes at this time.

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**Testimony:** OAR 436-009-0010

*Exhibits #5 & #6*

WCD modified the language for late billings. Unlike other insurance carriers and other state Workers' Compensation regulators, WCD has not included parameters on late billings. Most carriers have periods of time in which providers may file late billings. They customarily range from 12 -18 months after the date of service. There are usually provisions for providers to file later than those dates under special circumstances. We encourage WCD to adopt a time-based deadline for late billings. This makes business sense and serves to streamline the administration of the late filing formula.

**Response:** This concept will be reviewed further and revisited next year.

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**Testimony:** OAR 436-009-0010

*Exhibits #5 & #6*

The prohibition on prepayment for services should be more explicit.

**Response:** Prepayment is a complex issue with many dynamics in play. Provider and payers have different perspectives on this issue. Further study is needed and this issue will be revisited

next year.

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**Testimony:** OAR 436-009-0015(10)

*Exhibits #5 & #6*

We support the proposed rule modification on physician assistant (PA) and nurse practitioner (NP) modifiers.

**Response:** Due to difficulties in application for stakeholders, the proposed rule was removed and the prior permanent rule remains in effect. The PA modifier would have been an Oregon specific codes, and the NP is a current CPT code. The difficulty in mixing the two would have been problematic.

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**Testimony:** OAR 436-009-0015(10)

*Exhibit # 5, 6*

WCD did not include the following suggestions for hardware changes in hospitals or for out-of-state hospital fees. We encourage the adoption of rule revisions to bring payments in line with services -- in alignment with other medical service fees paid in Oregon under Workers' Compensation rules.

**Response:** Because payments to hospitals are done via a cost/charge ratio (Bull. 290), based on the hospitals financial health, it seems that it would be too complex and cumbersome for hospitals to break out a specific type of service in a hospital billing and treat it differently and for special payment considerations. However, if simple streamlined approaches can be found the issue may be revisited.

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**Testimony:** OAR 436-009-0020(3)(j)

*Exhibit #6*

We suggest, putting a limit on reimbursements to out-of-state hospitals by limiting payment to their state fee schedule, or their usual and customary rate. The insurer would reimburse at the lesser of these charges, unless a lower rate is negotiated between the insurer and the hospital.

This would serve to bring out of state hospital fees in line with those of in state hospitals and end the cost shifts from out of state hospitals to Oregon employers.

**Response:** The State of Oregon does not have jurisdiction to limit what an out-of-state provider should bill, only what Oregon payers are required to pay. If the hospitals do not receive adequate payment there is a higher risk of injured workers being billed for the remaining balance, which is not in line with statutory policy. Thus, any revisions to the current payment structure should carefully consider the needs of all the stakeholders. This issue will be studied by the Workers' Compensation Division, using medical payment data and other information provided by stakeholders, and by surveying other jurisdictions.

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**Testimony:** OAR 436-009-0022

*Exhibits #5 and #6*

We suggest WCD adopt rules regarding physician office based surgery centers where surgery centers should be subject to the ASC rules. Professional fees for services provided in a physician office based surgery center should be reimbursed as though provided in an ASC.

**Response:** This issue needs further study and will be revisited during the next opening of these

rules.

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**Testimony:** OAR 436-009-0025

***Exhibit #2***

Exhibit #2: At the advisory committee meeting, we heard suggested criteria for travel of 60 miles from home for 1 meal and 120 miles from home for 2 meals, as well as adoption of Oregon Accounting Method (OAM) guidelines for reimbursement. Liberty requests development of guidelines for reimbursement of related service costs. Some of these guidelines include allowance of payment for breakfast only when employees are on travel two or more hours before a scheduled shift, no lunch reimbursement for non-overnight travel, etc. Clear guidelines would benefit the worker, by giving them a clear understanding of when they can receive reimbursement and for the insurer, in processing these benefits.

Exhibit #6: SAIF recommends the adoption of guidelines for meal reimbursement. The rules could include a guideline based on reimbursement policy for State of Oregon employees. The Oregon Accounting Manual (OAM) allows payment for breakfast only when employees are on travel status 2 or more hours before their scheduled shift. No lunch reimbursements are made for non-overnight travel and payment for dinner is made only when the worker is traveling more than 2 hours after the end of their workday. Breakfast, lunch and dinner for injured workers more than 2 hours or 75 miles away from their home would be reimbursed. The rules should describe when a worker would qualify to have a meal paid for by the insurer. A worker would know when to expect reimbursement.

**Response:** This issue was reviewed, and more data is needed on the scope of the problem. Currently the rule allows for insurers to deny payment to workers if they feel the fee is not appropriate. If there is disagreement, the parties can come to the director for review. Under OAR 436-0010-0270(7)(d), the director will settle the dispute based on principles of reasonableness and fairness based on specific case facts and the intent of the law. Thus, the parties currently have a remedy for disagreements. There is also a question as to whether the Oregon Accounting Manual (OAM) is the best resource to apply to visits by injured workers to medical appointments, etc., because of the use of work schedules as a criterion. While a simple and fair option has not yet been clearly identified, stakeholders are encouraged to bring streamlined options to the rulemaking process next year for consideration. In addition, the director will also review this further.

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**Testimony:** OAR 436-009-0040

***Exhibit #4***

Given the multi-factorial needs of this patient population (factors beyond the specific medical diagnoses – including but not limited to return to work issues, psycho-social factors and legal complications), we feel that reimbursement needs to be increased to reflect the actual work involved.

We believe there is a shortage of physicians in Lane County willing to provide care to Oregon Injured Workers. This is most likely due to the fact that reimbursement is low and the amount of paperwork and professional frustration associated with frequent denials of recommended diagnostic tests or treatments is high.

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We will soon have to evaluate the volume of Oregon Injured Workers our practice can schedule due to the lack of increase in reimbursement over the next year. Workers Comp Conversion Factors have not been increased since 4-1-2004, and show in the proposed rules that they will not be changing again in the next year. Meanwhile our commercial insurance contracting rates (conversion factors) have had an increase of between 11-12% over the same period of time in which the Workers Comp rates have not changed. Workers Comp Evaluation and Management Codes Conversion Factor of \$68.40 has been behind our commercial contracting rates since it became effective and the Workers Comp Medicine Codes Conversion Factor of \$75.04 is currently behind our commercial contracting rates for all codes in 2006.

**Response:** This issue was not received in time for discussion and review this year. However, it will be reviewed next year.

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**Testimony:** OAR 436-009-0050(3)

***Exhibit #9***

Regarding pre-surgical office visits and inclusion in the global value of the surgical procedure, I would agree that the preoperative visit need not be immediate to be included in the global value. However, oftentimes patients are indicated for surgery and because of the unique requirements of the Workers' Compensation System, their surgeries are not approved for many months. Therefore, I would recommend only including the visit immediately prior to surgery for inclusion in the global service fee.

**Response:** Consistent with this testimony, the permanent rule eliminates the word "immediate".

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**Testimony:** OAR 436-009-0070

***Exhibits #5 & #6***

We recommend OSC-D0005 be changed to D0019. SAIF contractually uses D0005 for a two-panel IME. In addition, we recommend adding *x-rays* to the rule for when copies are requested and will be paid at \$10.00 for the first page and \$.50 for each additional page thereafter and identified on billings.

**Response:** The OSC was modified as requested. The copy rule pertains to paper copies and does not translate well to X-rays. That rule was not revised.

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**Testimony:** OAR 436-009-0070(1)

***Exhibit #2***

Many providers are requiring prepayment for chart notes. This often results in a delay in the determination of benefits, if the information is being gathered to evaluate compensability. In addition, providers are not billing as specified under this rule as they are charging a generic fee. It is Liberty's request that the following statement be added to the end of this rule: "A provider cannot require prepayment for chart notes."

**Response:** Please see prior response to the pre-payment issue. 009-0010(8) Ex. 2.

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**Testimony:** OAR 436-009-0080

***Exhibits #5 & #6***

We suggest if no MSRP is available the insurer shall pay the provider 125% of the applicable manufacturer's invoice.

**Response:** As discussed by the external advisory committee, the concept of a percent above actual cost was included in the permanent rule.

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**Testimony:** OAR 436-009-0080

*Exhibit #7*

Regarding DME payment. It was noted that the suggested payment amounts were not based on specific data. Is the suggested payment of 85% of MSRP a reasonable payment and reflective of payments made by large insurers? Medicare and Medicaid have low reimbursement for these items. Many private insurers negotiate contracts with suppliers to obtain discounts on DME. It is also believed that many items of durable medical equipment are overpriced. We've noted that calls to manufacturers of prosthetics often indicate a much lower price should be paid than that being suggested by the supplier. We suggest no required payment amount be set until full data have been reviewed to determine appropriate pricing. In the meantime, it seems inappropriate to require payment at a specific level without allowing insurers to develop discounts.

**Response:** As discussed by the external advisory committee, the concept of a percent above actual cost was included in the permanent rule.

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**Testimony:** OAR 436-009-0080

*Exhibit #1*

Over the past year we have had problems with durable medical equipment charges from work comp insurance companies. Sometimes we will bill (the same company) and we will be paid in full, sometimes a minimal fee.

Example 1: The insurer refused to pay for a post operative ankle brace unless we supplied an invoice. We supplied the invoice showing what we paid for the brace along with shipping and handling. The insurer reimbursed us 85% of our cost of the brace. I was told that if I could not supply them with a "retail" price, this was the best they could do.

Example 2: Same problem as above. In addition, there is question as to whether ankle splints, knee braces, etc fall under orthotics or durable medical equipment. Medicare considers anything that the patient takes out of the office, unless we have to place it on, such as a cast or splint, as durable medical equipment.

It would be nice to have a rule that was straight forward so that everyone can understand it. The 140% rule appears to do that. It would probably cut down on expenses from the work comp companies. I also think addressing what falls under the durable medical equipment description would be helpful.

**Response:** As discussed by the external advisory committee, the concept of a percent above actual cost was included in the permanent rule. Definitions of durable medical equipment, prosthetics, etc., have been included in the rule.

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**Testimony:** OAR 436-009-0080

*Exhibit #2*

Proposed language was added to OAR 436-009-0080 (1) (a) to state if the MSRP is not available the insurer shall pay the provider 140% of the applicable invoice. The proposed language is confusing and Liberty has concerns this could cause unnecessary disputes.

**Response:** The proposed language was modified in the permanent rule to clarify that the percent above cost refers to the provider's actual cost for the item as documented on a receipt of sale.

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**Testimony:** OAR 436-009-0080

*Exhibits #5 & #6*

(1) The DME list should include crutches, wheelchairs and scooters. These are defined as DME in every other national coding reference. In addition, they meet the definition of DME cited in the rule.

(2) We recommend the removal of crutches, wheelchair and scooter from the list of [prosthetics] supplies as these are DME items.

**Response:** The items listed could be considered durable medical equipment (DME). However, the more specific application for Oregon workers' compensation, and in conformance with the rule, these items aid in the performance of a natural function and are therefore best categorized as prostheses. The permanent rule was modified to include a clearer definition of prosthetics, etc. Oregon workers' compensation has a specific charge to create a fee schedule that is sufficient to affect the medical care for injured workers intended by the statute. Different providers and payers have various preferences and references. Matching the Medicare (MC) resource may not be the best for the Oregon workers' compensation system because of the primary focus on cost saving measures. Medical providers and injured workers could be adversely affected because of this. (See testimony from a medical provider Ex. #9 below.) Accurately implementing the law and, where appropriate, achieving balance between benefits for employers and injured workers is optimum. In addition, the MC resource specifically referring to wheelchairs would exclude from compensability many standard wheelchairs commonly used by injured workers, and would require that wheelchairs were compensable only if the worker was bed or chair confined; which is a more stringent criterion than what injured workers have been subject to historically and currently. (See CMS Coverage Issues Manual (CIM) Appendix A, pg. 193.) More information and analysis would be needed before any change was made. Other resources developed by Medicare are primarily for a population generally older than the workers' compensation population. Application of a resource created for a very specific cost saving purpose to a completely different population (i.e., injured workers) must be viewed cautiously.

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**Testimony:** OAR 436-009-0080

*Exhibit #9*

Regarding defining "(for purpose of clarification) "prosthetic," "orthosis," and "medical supplies" (436-009-0080)." I strongly endorse clarifying the current definitions offered by the Workers' Compensation Division for DME orthotics, and supplies.

"Durable Medical Equipment" has been misapplied liberally by certain carriers resulting in the nonpayment or extreme discounted payment of services below the providers' cost of delivering those services. I have previously submitted EOBs showing that we have been flatly denied ANY

reimbursement for providing medically necessary and reasonable surgical supplies and orthoses which resulted in writing off over \$60,000 in charges.

The term "Durable Medical Equipment" actually applies to a very narrow group of equipment products. I believe that the definition and the examples provided by the WCD are accurate.

Finally, I would note that most specialists' overhead is 50 percent or more. To provide services at 40 percent above invoice would be a loss leader and have a negative impact on the providers.

All of the definitions provided by the WCD from universally accepted texts for orthotics indicate that all braces, splints, and supports provided for the treatment of injuries should be considered orthotics. These should not be reclassified as DME merely because they are capable of more than a single use (as compared to a Band-Aid or dressing). They are intended for use by a single patient and their life span is measured in weeks or months. Although laundering the device may provide some extension of it's use by a single user, extended need requires replacement.

The ability of occupational specialists to obtain, store, and provide orthoses along with the counseling and instruction by the physician or staff required for their safe and effective use distinguishes these items from other categories of supplies. These are particularly critical to the ability to return injured workers to the work place promptly. Office space and staff time are needed for inventory control and storage. Specific features must be shopped for including durability, comfort, and wear ability for use in the work place. An investment of time is required to evaluate new products and improved devices that are tailored to the specific needs of injured workers. This also precludes the need for more complicated services such as serial casting or custom fitted and fabricated products. There needs to be a distinct category for these products, which, although they can be used repetitively by a single patient, are not suitable for use by multiple patients.

Finally, the reimbursement environment must consistent with the WCD's policy on usual and customary reimbursement levels for these non-DME products, that has been consistently applied by the majority of carriers in the state over the past several years.

If the WCD decides to group all of the above devices as DME instead of orthoses, it would have a tremendously negative impact on small businesses consisting of the suppliers, vendors, and medical practices that handle these devices. While it may be appropriate to apply an invoice plus system to true DME, it is not appropriate to change the definitions, regroup the products and services, to support a level of reimbursement that falls below the usual and customary rates that have been in place for the past several years and is supported by the reimbursements provided by the majority of carriers in the state.

**Response:** The definitions were kept essentially the same as in the proposed rules, but with clarification of some wording.

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there is ongoing litigation between SAIF and third party billers, who have attempted to collect pharmacy bills at rates higher than the pharmacy's usual and customary fee. We do not support any rule change that could be construed to permit the practices that the Department has determined to be in violation of the rules.

**Response:** The rules were not changed in this regard, pending outcome of case law.

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

Dated this 13th day of October, 2006.

WORKERS' COMPENSATION DIVISION

*Fred Bruyns*

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Fred Bruyns, Hearings Officer