

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
OREGON MEDICAL FEE AND RELATIVE VALUE SCHEDULE

REVISION-MARKED COPY

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EFFECTIVE JANUARY 1, 2002

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Only adopted, amended, and repealed rules are included in this document:

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436-009-0015 Limitations on Medical Billings

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

- (a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;
- (b) When the injured worker seeks treatment that has not been prescribed by the attending physician or specialist physician upon referral of the 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 436-010-0290, after the worker has been provided notice that the worker is medically stationary;
- (d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or
- (e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental pursuant to OAR 436-010-0300.

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

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

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

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

(6) Payment shall not be made for DMSO except for treatment of compensable interstitial cystitis. Additionally, payment shall not be made for intradiscal electrothermal therapy (IDET), surface EMG tests, rolfing, prolotherapy, and thermography. While these services may be provided, medical providers shall not be paid for such services or for treatment of side effects.

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

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

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

(b) When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital fee schedule.

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

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provided by a physician assistant or nurse practitioner.

(11) When a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT™ Codes such as 99080. Refer to specific code definitions in the CPT™ for other applicable codes. These CPT™ codes shall be used for prolonged physician service without direct patient (face-to-face) contact that will require the physician to review complex, detailed medical records transferred from previous physicians and/or to complete a comprehensive treatment plan. They may also be used to review subsequent reports on patient status, to include communication with other health care professionals involved in the patient's care. The billing should include the actual time spent reviewing the records or reports.

Stat. Auth.: ORS 656.245, 656.252, 656.254

Stats. Implemented: ORS 656.245, 656.252, 656.254

Hist: Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 9/13/01 as WCD Admin. Order 01-058, eff. 9/17/01
Amended 12/17/01 as WCD Admin. Order 01-064, eff. 1/1/02

436-009-0025 Reimbursement of Related Services Costs

(1) The insurer shall notify the worker at the time of claim acceptance that actual and reasonable costs for travel, prescriptions, and other claim-related services paid by the worker will be reimbursed by the insurer upon request. The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the worker's written request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed. On deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance and shall be paid within 14 days. If there is a claim for aggravation or a new medical condition on an accepted claim, reimbursement of related services is not due and payable until the aggravation or new medical condition is accepted. If the claim is denied, requests for reimbursement shall be returned to the worker within 14 days.

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

(3) Requests for reimbursement of related services costs must be received by the insurer within two years of the date the costs were incurred or within two years of the date the claim or medical condition is finally determined compensable, whichever date is later.

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The insurer may disapprove requests for reimbursement received beyond the two year period as being untimely requested.

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

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

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)

Stat. Implemented: ORS 656.245, 656.704, and 656.726(4)

Hist: Amended and renumbered from OAR 436-060-0070, 12/17/01, as WCD Admin. Order 01-064, eff. 1/1/02

436-009-0035 Interim Medical Benefits

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

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

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

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

(2) Interim medical benefits include:

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

(b) Medication required to alleviate pain.

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

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

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

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

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

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

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

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: Section 14, chapter 865, Oregon Laws 2001

Hist: Adopted 12/17/01 as WCD Admin. Order 01-064, eff. 1/1/02

436-009-0070 Oregon Specific Code, Other Services

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

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

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

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

(a) FIRST LEVEL PCE: This is a limited evaluation to measure the functional performance testing of a specific body part. This level requires not less than 45 minutes of actual patient contact. A first level PCE shall be paid under OSC-99196 which includes the evaluation and report. Additional 15-minute increments may be added for each additional body part to establish endurance (e.g. cardiovascular), or to project tolerances (e.g. repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

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

(c) WORK CAPACITY EVALUATION: This is a residual functional capacity evaluation with special emphasis on the ability to perform essential physical functions of the job based on specific job analysis. This level requires not less than 6 hours of actual patient contact. The primary purpose of this evaluation is to establish if a worker can return to work at a specific job(s). A WCE shall be paid under OSC-99198 which includes the evaluation and report.

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

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

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

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

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

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

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

As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors.

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

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

- (c) Level 1 OSC-A0021 File Review
- Level 2 OSC-A0022 File Review
- Level 3 OSC-A0023 File Review

As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of an extensive record.

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

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

Limited OSC-A0031
Complex OSC-A0032

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

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

(10) A single physician selected pursuant to ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report

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to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

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

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

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

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

(11) The fee for a worker requested medical examination shall be billed under OSC-W0001. This code shall be used for a report, file review, or examination.

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

<u>Codes</u>	<u>Relative Value</u>	<u>Description</u>
R0001		Copies of medical records when requested shall be paid at \$10.00 for the first page and \$.50 for each page thereafter and identified on billings
N0001	10.50	Brief narrative by the attending physician
N0002	21.00	Complete narrative
99196	16.79	First Level PCE
99197	29.96	Second Level PCE
99198	63.25	Work Capacity Evaluation
99193	4.28	Additional 15 minutes
D0001	0.00	Attorney consultation time
D0002	0.00	Deposition time
D0003	0.00	Insurer Medical Examination and report
D0004	0.00	Interpretive services
A0001	31.48	Level 1 exam
A0002	41.98	Level 2 exam
A0003	52.47	Level 3 exam
A0011	5.43	Level 1 report
A0012	8.15	Level 2 report
A0013	10.86	Level 3 report
A0021	5.43	Level 1 file review
A0022	13.58	Level 2 file review

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A0023	32.58	Level 3 file review
A0031	3.15	Limited report
A0032	7.35	Complex report
P0001	26.24	Single medical reviewer
P0002	26.24	Panel of medical reviewers
P0003	13.32	Single medical reviewer report
P0004	31.48	Complex case review
P0005	13.32	Failure to appear required examination

W0001 **0.00** **Worker requested medical examination and report**

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.248

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