

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICES

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EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10

EFFECTIVE AUGUST 7, 1990

436-10-003 Applicability of Rules

(1) These rules are effective to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.268(7), 656.325, 656.327 and 656.794, and govern all vendors of medical services licensed or authorized to provide a product or service which is chargeable as a claims cost.

(2) The provisions of OAR 436-10-090 shall be applicable to all services rendered subsequent to the effective date of these rules.

(3) These rules apply to all compensable claims existing or arising on or after July 1, 1990.

Hist: Fled 10/20/76, as Admin. Order 4-1976, eff. 11/1/76
Filed 6/5/78 as Admin. Order 7-1978, eff. 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80
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436-10-090 Charges And Fees

(1)(a) Hospital charges billed to insurers shall include appropriate ICD-9 diagnostic codes and the appropriate diagnostic related group (DRG) number. Insurers shall reimburse hospitals for inpatient hospital and outpatient surgical services rendered on or after January 1, 1991, using the current adjusted cost/charge ratio. Insurers shall audit each bill for inpatient services and outpatient surgical 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.

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(b) A hospital's HCFA form 2552 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 (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A shall be modified by adding the adjustments to expenses for both the "Malpractice Premiums and/or Self-Insurance Fund Contributions" shown on line 37 (less line 37-A) of Worksheet A-8, and the "Provider-Based Physician Adjustments" on lines 8 and 9 of Worksheet A-8.

(d) The basic cost/charge ratio shall be further modified to allow for a return on equity where applicable, and/or to cover any patient related services not otherwise included in the ratio calculated in subsection (b) above. The actual calculation will consist of multiplying the difference of 1.000 less the ratio calculated in subsection (b) above, by 15 percent. The resulting figure shall be added to the ratio calculated in (b) to obtain the adjusted cost/charge ratio.

(e) The adjusted cost/charge ratio schedule shall be revised annually. On or before October 1 of each year, each hospital shall submit a copy of their most recently filed HCFA form 2552 to the division. On or before December 20 of each year, the division shall publish by bulletin the revised adjusted cost/charge ratio schedule for hospitals, to be effective for the subsequent twelve-month period beginning January 1.

(f) For those newly formed or established hospitals for which no HCFA form 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.

(g) 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.

(h) If audit of a hospital's HCFA form 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.

(2) The insurer may not pay any more than the medical provider's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 75th percentile of the usual and customary fees as determined by the director, and as published and attached hereto as Appendix "A" or elsewhere in these rules. The medical provider shall not attempt to collect from the injured worker any amounts reduced by the insurer pursuant to this rule.

(3) The director shall review and update medical fees annually by bulletin using data from a statistically valid survey, the physician service component of the National Consumer Price Index, or from any state agency having access to usual and customary medical fee information.

(4) 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 issue an

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order to all parties establishing the fee in the particular case and shall apply the fee to all similar disputes which arise. The director shall incorporate the fee into the department's relative value scale at the next hearing on the medical service rules. 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.

(5) All billings shall be fully itemized and services identified by code numbers and descriptions found in the Current Procedural Terminology or as described in OAR 436-10-040(12)(a) through (j). Hospitals may bill for inpatient services and surgery using the International Classification of Diseases, 9th edition--with Clinical Manifestations (ICD9-CM). The definitions of commonality in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services.

(6) Beginning January 1, 1989, all medical providers shall submit bills for medical services on form UB82 or 1980 or 1984 form HCFA 1500, except for dental billings which shall be submitted on ADA dental claim forms. Billings shall include the claimant's full name, date of injury, the employer's name and, if available, the insurer's claim number. Billings not correctly filled out may be returned to the medical provider for correction and re-submission. All medical provider billings shall be accompanied by chart notes documenting services which have been billed.

(7) When a provider of medical services, including a hospital, submits a bill to an insurer for medical services, the medical provider shall submit a copy of such bill to the worker to whom the services were provided. The copy to the worker shall be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the worker.

(8) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The medical provider may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness.

(9) 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.

(10) 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.

(11) 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

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with the knowledge that the deception could result in unauthorized benefit to the provider or some other person.

(12) 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.

(13) 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.

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

(15) When services are provided in hospital emergency or outpatient departments which are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes and reimbursed at no more than the 75th percentile as shown in the department's relative value schedule. Such services include outpatient physical therapy, outpatient X-rays and emergency department treatment and physician's services.

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.

(16) Physician's assistants 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.

(17) 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.

(18) 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.

(19) Fees for surgical procedures shall be billed 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 Relative Value Schedule, 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 22550-22565 and/or CPT Codes 22730-22735.

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(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 in the RVS and the subsequent procedures paid at 10 percent of the value listed in the RVS.

(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 myelograms are not subject to the Relative Value Schedule. Physician's services for inpatient myelograms are subject to the Relative Value Schedule.

(20) 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 reimbursed at 60 percent of the maximum allowable fee and the professional component is reimbursed at 40 percent of the maximum allowable fee.

(21) Outpatient hospital service shall be reimbursed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the Relative Value Schedule, 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 Relative Value Schedule. 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 Relative Value Schedule.

(22) 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 Physical Therapy Relative Value Schedule.

(23) When ultrasound, diathermy, microwave, ultraviolet and hot packs are used in combinations of two or more during one treatment session, only one shall be reimbursed.

(24) 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.

(25) Effective January 1, 1991, treatment in a pain center program, physical rehabilitation program or a substance abuse program is not reimbursable unless the program is accredited for

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that purpose by the Commission on Accreditation of Rehabilitation Facilities (C.A.R.F.) or the Joint Commission on Accreditation of Healthcare Organizations (J.C.A.H.O.).

(26) Dimethylsulfoxide (DMSO) is not reimbursable except for treatment of compensable interstitial cystitis.

(27) When multiple areas are examined using Magnetic Resonance Imaging (MRI) 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 Relative Value Schedule.

(28) Mechanical muscle testing shall be reimbursable three times during a treatment program: 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 by the insurer prior to the testing. The fee for mechanical muscle testing includes an interpretation of the results and a report.

(29) 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.

(30) Fees for reports:

a. A medical provider may not charge any fee for completing a medical report form required by the director under this chapter.

b. Copies of office progress notes when requested by insurer - 25 cents a page

c. Brief Narrative - Summary of treatment to date and current status; answer to 3-5 specific questions - \$25

d. Complete narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary? - \$50

(31) Fee for a deposition (Includes preparation time):

a. First hour \$300

b. Each subsequent hour \$100

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