

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

In the Matter of the Amendment of	)	
436-001, Procedural Rules for Rulemaking and Hearings	)	
436-009, Oregon Medical Fee and Payment Rules	)	
436-010, Medical Services	)	
436-015, Managed Care Organizations	)	SUMMARY OF TESTIMONY AND AGENCY RESPONSES
436-030, Claim Closure and Reconsideration	)	
436-040, Workers with Disabilities Program	)	
436-045, Reopened Claims Program	)	
436-050, Employer/Insurer Coverage Responsibility	)	
436-110, Preferred Worker Program	)	
436-160, Electronic Data Interchange	)	
	)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The public may obtain exact copies of the exhibits by contacting the Workers' Compensation Division, Fred Bruyns, E-mail: [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us), 503-947-7717; fax 503-947-7581, 350 Winter St. NE, Salem OR, 97301. The purpose of this summary is to create a record of the agency's conclusions about the major issues raised.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated May 1, 2008. On May 19, 2008, a public rulemaking hearing was held as announced at 9:00 a.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. Business Support Services audio-recorded the hearing and created a written transcript – exhibit 66. The record was held open for written comment through May 22, 2008.

One person testified at the public rulemaking hearing. The public submitted 99 written documents as testimony.

**Testimony list:**

Exhibit	Rule divisions	Testifying
1	010	Susan Kelly, DePuy Spine, Inc.
2	160	Kelly Hansen, CS STARS
3	160	Colin Turner, Department of Consumer and Business Services
4	009	Thomas K Wuest, MD, Slocum Center for Orthopedics & Sports Medicine
5	009	John R. Bauman, Slocum Center for Orthopedics & Sports Medicine

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6	009	Gregory M. Phillips, MD, Slocum Center for Orthopedics & Sports Medicine
7	160	Kelly Hansen, CS STARS
8	009	Matthew Shapiro, MD, Oregon Association of Orthopaedists, Inc.
9	009	Lisa Pomranky, MD, Slocum Center for Orthopedics & Sports Medicine
10	009	Brick A. Lantz, MD, Slocum Center for Orthopedics & Sports Medicine
11	009	Brian A. Jewett, MD, Slocum Center for Orthopedics & Sports Medicine
12	009	Clyde Alan Farris, MD
13	009	Rolf Sohlberg, MD
14	009	John Durkan, MD
15	009	Marc Davidson, MD, Advantage Orthopedic + Sports Medicine
16	009	David J. Silver, MD, PC
17	009	Kevin Murphy, MD, Sports Medicine Oregon
18	009	John Di Paola, MD, Occupational Orthopedics
19	009, 010	Kathy Loretz, SAIF Corporation
20	010	Juerg Kunz, Department of Consumer and Business Services, on behalf of the Medical Advisory Committee
21	009	Courtnei Dresser, Oregon Medical Association
22	009	Ron Bowman, MD, Chairman, Medical Advisory Committee
23	009	Joan M Takacs, DO, John P. Takacs, DO, and Kevin Kane, DO
24	009	John R. Braddock, MD, Cascade Occupational Medicine
25	009	Robert A. Hart, MD, Oregon Health & Science University
26	009	Joel Moore, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
27	009	James Hall, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
28	009	Soma Lilly, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
29	009	Timothy Bollom, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
30	009	James D. Dowd, MD, Greentree Orthopedics, PC
31	009	Ben Bronicel, MD, FACEP
32	009	Robert Gessele, Pain Consultants of Oregon

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33	009	P. Evalyn Cole, Spine & Brain Center of Eugene
34	009	Royalle C. Lown, Pain Consultants of Oregon
35	009	Beth Anderson, Pain Consultants of Oregon
36	009	Brian Hall, MD
37	009	Terence Mitchell, Middle Fork Surgery Center, LLC
38	009	Joseph Mandiberg, MD
39	009	Eric Sandefur, DO
40	009	Greg Sarish, Northwest Urological Clinic
41	009	James MacKay, MD
42	009	Mark Yerby, MD
43	009	Richard Craft, MD
44	009	Wendy Warren, MD
45	009	Neil Olsen, MD
46	009	Michael Bespaly, MD
47	009	Richard McKim, Baker Clinic
48	009	Richard Smith, Pain Consultants of Oregon
49	009	James R. Morris, MD
50	009	Gorgon Banks, MD
51	009	Peter Bernardo, MD
52	009	Dan Montoya, PA-C, Bend Memorial Clinic
53	009	Jordi X. Kellogg, MD
54	009	Douglas Morrison, MD
55	009	Terry Burris, MD
56	009	Robert Wayne, MD
57	009	Nathan Kemalyan, MD
58	009	Bryan D. Miller, DO
59	009	Richard Abraham, MD
60	009	Timothy A Straub, MD
61	009	Anthony I. Colorito, MD
62	009	Subramaniam Seetharaman, MD
63	009	H. Daniel Zegzula, MD
64	009	Eric A. Spencer, MD
65	009	Ronald L. Teed, MD

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66	009	John Di Paola, MD, Occupational Orthopedics (transcript of oral testimony, public rulemaking hearing of 5/19/08)
67	009	Jeffrey Holmboe, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
68	009	Gary Sherwood, Administrator, Charles N. Versteeg, MD, Mark D. Peterson, MD, Steven E. Chamberlain, MD, Paul L. Sternenberg, MD, Heidi T. Bloom, MD, David L. Galt, MD, Omar Abdul-Hadi, MD, Yaser A. Metwally, MD Southern Oregon Orthopedics
69	009	Thomas P McWeeney, MD, Terrence A Sedgewick, MD, Bradford T Black, MD, James C Ballard, MD, David P Huberty, MD Oregon Orthopedic & Sports Medicine Clinic, LLP
70	009	Jennifer Flood, Ombudsman for Injured Workers, Department of Consumer and Business Services
71	009	Roy A. Slack, MD
72	009	Christina Flaxel, MD, Oregon Health & Science University
73	009	James Harris, MD, Northwest Occupational Health Associates
74	009	Cheryl Boyum, Cascade Health Solutions
75	009	Allen A. Goodwin, MD
76	009	Nick Eshraghi, MD
77	009	Kathie Oriet, Willamette Valley Clinics, LLC
78	009	Ira Weintraub, MD
79	009	Kathleen Daniels, Oregon Physician
80	009	Paul Puziss, MD
81	009	Barbara S. Mallett, MD
82	050, 110	Chris Davie, SAIF Corporation
83	009	Chance Steffey, LaPine Community Clinic, LLC
84	009	Richard E. Gellman MD, Summit Orthopaedics
85	009	Bradley J. Bergquist, MD
86	009	Lis Houchen, National Association of Chain Drug Stores
87	009	Maurice Collada Jr. MD, PC
88	009	Scott Jacobson, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
89	009	Jason Gilster, MD, The Oregon Clinic
90	009	Brian R. Allen, Fiserv® Workers' Comp Services
91	009	Linda Oldham, Pain Consultants of Oregon

92	009	Patty Bons, Medford Neurological & Spine Clinic
93	009	James R. Vanhorne, MD, Orthopedic Center for Joint Replacement & Sports Medicine
94	009	Robert T. Brents, MD, Orthopedic Center for Joint Replacement & Sports Medicine
95	009	James Verheyden, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
96	009	Knute Buehler, MD, THE CENTER Orthopedic & Neurosurgical Care & Research
97	009	Linda Clear, RN, Providence MCO
98	160	Tamara Mejias, Healthsystems
99	009	Richard S. Jany, MD, LLC
100	160	Kelly Hansen, CS Stars

**NOTES about the summaries of testimony:** Information enclosed in quotation marks has been extracted from written testimony. Unless information is enclosed in quotation marks, it has been paraphrased. Information enclosed in brackets has been paraphrased.

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**Testimony:** OAR 436-009-0008(2)(c)

*Exhibit 19*

“SAIF agrees with and appreciates the change in this rule. Restricting the time an insurer has to request an overpayment refund and adjusting the time an insurer has to request a review by the director strikes a fair balance.”

**Response:** Thank you for your testimony. Based on additional testimony, we increased the current 90 days time frame to 180 days.

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**Testimony:** OAR 436-009-0008(2)(c)

*Exhibit 21*

“The OMA realizes that overpayments may occur at no fault of the insurer or the physician, but the suggested quadrupling of the time frame appears to be excessive to us. It may be more reasonable to extend from three months to six months, \* \* \* most businesses \* \* \* should be able to reconcile their accounting in half of a year. Physicians have extensive experience with governmental retroactive payment adjustments that have been authorized by the insured who then look to the physician to bear the burden of errors that were of no fault of the medical practice.”

*Exhibit 16* includes related testimony, but suggests that if there are compelling reasons why insurers cannot review their payments within 90 days, perhaps 120 days would be adequate.

**Response:** Thank you for your testimony. The department agrees with the OMA that a six months time frame for insurers to request a refund is reasonable.

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**Testimony:** OAR 436-009-0008(2)(c)

*Exhibit 23*

“It should not take the insurer a year in order to audit the bill and decide if the payment was appropriate. We are not permitted with an active workmen's compensation case to bill the

individual privately or use their private insurance. We, therefore, take a good faith chance in providing this care. We are careful to bill only the accepted conditions. If the insurer opts against paying the bill, we need to make other financial arrangements with the patient. If they decide a year after the fact not to accept the bill, we have incurred many office visits by then, as have our other colleagues in Oregon, and are highly unlikely to recoup any of the money from the patient when the bill is that far past the actual office visit. It appears to us that less primary care physicians are willing to accept workmen's compensation patients as the system is already quite burdensome with paperwork, etc. \* \* \* Waiting up to a year to make a refund decision is essentially stealing medical care from providers, because it is too late to bill regular health insurance and patients don't want to pay.”

*Exhibits 31, 32, 34-40, 42, 43, 44, 46-52, 55-59, 61-63, 71, 72, 76, 78-81, 85, 87, 89, 91* include related testimony.

*Exhibit 21* includes related testimony, but adds that it may be more reasonable to extend the time frame from three months to six months.

**Response:** Thank you for your testimony. The agency agrees that 12 months, as was proposed, is too long of a period for insurers to request a refund. Insurers will have 180 days to request a refund. Further, we have clarified that insurers may only request refunds on compensable medical services.

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**Testimony:** OAR 436-009-0008(2)(c)

*Exhibit 70*

“Would the rule only apply to 'overpaid' medical bills? The medical bill was compensable, just not paid correctly.... double payments; payment exceeded the fee schedule/PPO contract; etc. My concern is if the proposed rule applies to medical bills that were paid and then determined to be non-compensable. In this situation, the medical provider may not have billed private health insurance and if it's beyond the timeframe for billing the private health -- the worker may be stuck with the liability, due to the WC insurer 'error'. \* \* \* I ask that WCD consider the impact on ability for private health to pick-up the liability and minimize the 'surprise' impact on the worker. Also, please make it clear as to what situations the rule applies to -- if it's not all inclusive.”

**Response:** Because we have clarified that insurers may only request refunds for compensable medical services, a worker should not be stuck with the liability due to an insurer requesting a refund.

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**Testimony:** OAR 436-009-0015(6)(g)

*Exhibit 19*

“Adding specific language regarding the exclusion of lumbar artificial disc replacement except under certain circumstances clarifies this rule. The reference to the guidelines outlined by the Medical Advisory Committee in OAR 436-010-0230(13) further outlines when this procedure is appropriate.”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

**Testimony: OAR 436-009-0015(6)(g)**

**Exhibit 16**

“\* \* \* I believe it in the best interest of workers that WCD make no rule at this time. \* \* \*. The lack of a rule does not mean that a worker cannot receive a lumbar artificial disc should that be considered medically appropriate. \* \* \* the rule as presently written, is insufficiently restrictive and will tend to create a ‘right’ to a technology for which there is *no* scientific evidence demonstrating effectiveness in treating back pain in *injured workers*. \* \* \* There are substantial differences in the outcomes of injured workers with back pain and the population treated outside of workers' compensation. \* \* \* The rule, as proposed, is likely to increase legal costs in workers' compensation. The worker has to prove that an injury caused disabling low back pain. As there is no scientific support for this position, and there is evidence to the contrary, I foresee potentially large numbers of workers asserting a ‘right’ to a technology not proven to help them. \* \* \* Insurers and MCO's will respond with IME's to refute these claims \* \* \* in my opinion, the restrictions outlined in the proposed rule change are insufficiently restrictive because they do not take into account common issues such as disputed compensation claims, somatic focus, presence of other non-lumbar pain, job dissatisfaction and psychometric profile \* \* \*. If the Division decides that lumbar artificial disc replacement should be placed in the rules, I would strongly recommend that the Division establish a registry for these patients and a mechanism to follow them for a minimum of five years after the procedure. \* \* \* By establishing a registry, the Division would acquire data to judge the benefit of this procedure.”

**Response:** Thank you for your testimony. The rule will be revised as proposed. This rule does not create a “right” to a lumbar artificial disc replacement. On the contrary, the rule specifically excludes artificial disc replacement from compensability with only very limited exceptions. The department proposed this rule based on advice from the Medical Advisory Committee, which reviewed a large amount of scientific literature before making the recommendation to the director.

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

**Exhibit 59**

“\* \* \* the fee schedule should not discount physician extenders (FNP's and PA's) as they do require physician oversight. No other commercial carriers discount physician extenders.”

*Exhibit 83* includes related testimony and notes that in rural areas, mid-level providers are treated as primary care providers and are required to have essentially the same responsibilities as physicians.

**Response:** The matter subject to the testimony was not considered by the External Advisory Committee. The division will take the issue under advisement for possible future action.

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**Testimony: OAR 436-009-0030 (Appendix A)**

**Exhibit 19**

“WCD is proposing to make the gathering of worker social security numbers optional under OAR 436-010-0240. WCD should consider making the transfer of worker social security number optional in Appendix A as well. If capturing the social security number from the worker is not required, it should not be required for the insurer to report it to WCD.”

**Response:** The main reason for allowing the social security number (SSN) to be optional on Form 827 is to be consistent with Form 801. The intent is to allow a worker to file a legitimate workers compensation claim whether or not the worker has an SSN.

In addition, currently the division's claims system requires the worker's SSN. While insurers generally rely on their claim numbering system to identify claims, the division receives claims from all Oregon insurers and the SSN is the only unique number to distinguish one claimant from another.

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

***Exhibit 19***

“SAIF agrees with the proposed Conversion Factor changes in this rule. The financial impact will be negligible to insurers while redistributing the payment in a more equitable fashion among primary care and surgery providers.”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 77***

“The proposed increase in the conversion factor for E & M codes is warranted due to ever increasing expenses in every medical practice. These cost increases are across the board, to every specialty, including primary care.”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 5***

“\* \* \* I wholeheartedly support the argument that Evaluation and Management fees need to be increased. The current reimbursement rate in the Oregon Fee Schedule has fallen behind rates paid by commercial health insurers who make significantly fewer demands on physicians. \* \* \*”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 18, 66***

“It is reasonable to increase the evaluation and management conversion factor since it is critical to promote early effective treatment to improve long-term outcomes and early return to work.”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 73***

“I appreciate the proposed increase in reimbursement to Evaluation / Management codes, as this reflects an appreciation for the cognitive skills and coordination of care than physicians provide for injured workers. It has been my experience that injured workers require extra care and attention in coordinating their care and communicating with insurers and employers. Some of these activities, such as reviewing an IME, is covered under a separate charge, but often discussions with employers / supervisors / claims adjusters is not specifically covered. I hope the increased in fees will allow physicians to take more time with their patients and provide excellent communication to workers and all involved parties.”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 24***

“\* \* \* I am very pleased you have proposed increasing the conversion factor for E&M fees by \$5.00. This move clearly has the most positive effect on most physicians and it is greatly appreciated. Raising reimbursement keeps us ‘in the ball game’ when trying to attract Occupational Medicine physicians to Oregon. In addition, it encourages those physicians practicing Occupational Medicine to continue that practice.”

*Exhibit 45* includes related testimony.

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 59***

“I do applaud the long overdue increase in the E&M codes, but there should be an overall increase in the fee schedule to match medical inflation. The fee schedule has dropped twice since 2003 while medical inflation and the cost of providing care to our patients has sky rocketed. The overhead, especially associated labor costs, and administrative burden to provide care to injured workers is also higher than a primary care practice. Commercial insurance reimbursements have on average increased over 20% in the same time frame and now far exceed workers compensation rates.”

**Response:** Thank you for your testimony. The rule will be revised as proposed. Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 24***

“I am somewhat disappointed that balancing the increasing fees for the E&M requires you to decrease the fees for surgical care. While this move effects a lesser number of physicians, this change, unfortunately pits one group of physicians against another, yet both groups are trying their best to provide optimal patient care in the worker's comp arena even as their own expenses increase dramatically. \* \* \* In conclusion, Cascade Occupational Medicine supports the proposed rules changes regarding physician compensation.”

**Response:** Thank you for your testimony. The rule will be revised as proposed. The department does not intend to pit one group of physicians against another. The conversion factors are used as one of the tools to meet the department’s goal in ensuring workers access to quality care while maintaining a positive business climate by controlling system costs.

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

***Exhibit 41***

“As an Oregon Physician who did E and Ms I very much agree with these changes. The surgery conversion factor is far too high and needs to be reduced”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 50***

“I support the increase in the E&M conversion factor and the decrease in the surgical conversion factor, although you will have to be careful you don't make it so surgeons refuse to see your patients. Procedures have been overreimbursed and evaluation and management underreimbursed for many years.”

**Response:** Thank you for your testimony. The rule will be revised as proposed.

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

***Exhibit 58***

“\* \* \* You will not fix a cumbersome, grossly litigious system where 30 cents of every premium dollar goes to legal contest/administration by reducing provider remuneration!! I do agree that surgical specialists are disproportionately paid for their services, as no other insurer pays a different rate for E&M care vs surgical specialist (that has already been accounted for in RVU units assigned per CPT code). I think a budget neutral single rate for all physicians is appropriate, and let the RVU's for services provided make the difference for specialists. If you look at any of the MCO provider lists, there are many, many more surgeons signed up than there are primary care providers partially because of this tiered payment. If I have calculated the numbers correctly based on your budget neutral \$5.00 conversion factor increase for E&M care vs \$7.22 decrease for surgery, then the 'happy medium' would be at approximately \$77.50 for every provider. Then index it for inflation and never have to deal with it again. This would go a long way toward recruiting more providers to work with workers compensation (which most providers consider a major hassle)”

**Response:** The goal of the department is to ensure workers receive access to quality care at the lowest cost to employers. The conversion factors are one tool to strive towards that goal. The department is also starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize three areas within this initiative: (1) decreasing the administrative burdens to providers; (2) increasing incentives for providers to provide timely evaluation of injured workers, and (3) increasing incentives for providers to actively participate in managing the care of injured workers, and focusing on the ultimate goal of returning to work.

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

***Exhibit 83***

“\* \* \* As a primary care provider I would support the proposed rule changes. Addressing the issue of reimbursement and the conversion factors for E/M and Surgical codes, personally I would prefer that the conversion factor be the same. The RVRBS tables were developed to address the relative value of every procedure code, why would surgery codes be so much higher than E/M codes, when the RVU for these procedures are already higher. It appears that you are trying to correct this inequality. My opinion is that in order to promote access to these patients that the conversion factors must be competitive for all providers and that reimbursements are done in a timely manner. In order to pay our bills we need the money we have earned within at least a 30 day time frame. My highest insurance conversion factor is \$72. I'm sure that other providers, especially in urban areas have higher conversion factors for their commercial insurance, but this might give you a reference for future adjustments.”

**Response:** The goal of the department is to ensure workers receive access to quality care at the lowest cost to employers. The conversion factors are one tool to strive towards that goal. The department is also starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize three areas within this initiative: (1) decreasing the administrative burdens to providers; (2) increasing incentives for providers to provide timely evaluation of injured workers, and (3) increasing incentives for providers to actively participate in managing the care of injured workers, and focusing on the ultimate goal of returning to work.

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

***Exhibit 4***

“I write with a serious concern over any proposed fee schedule decreases for the treatment of injured workers in the state of Oregon. \* \* \* As you may be aware, there have been similar proposals enacted in a number of other states, e.g. Hawaii, Texas, and others. Following those fee cuts, there has been a precipitous and predictable reduction in the number of providers willing to continue to provide care to the injured worker. In some states the level of participating providers willing to see workers' compensation patients has plummeted from the high 70 - 80% range down to the low 20% range. I would hope that you seriously consider that ramification for the citizens of Oregon as I and my associates all decide that taking care of the injured worker no longer makes professional or practical sense. \* \* \* If there is a decrease in the fee schedule, I am certain that the number of participating physicians will drop accordingly. I urge you \* \* \* to maintain or increase the compensation levels in treating the injured worker.”

*Exhibits 5, 6, 8, 9, 10, 11, 13, 17, 21, 22, 25, 31-40, 42, 43, 44, 46-49, 51, 52, 53, 55-63, 65, 69, 74, 75, 76, 77, 78-81, 84, 85, 87-89, 91, 93, 94, 99* include related testimony regarding physician participation/worker access.

*Exhibits 8, 22* include data about specialists' participation from other states that have cut reimbursement rates.

**Response:** There is not an across the board decrease of the Oregon fee schedule. Most conversion factors stay at the current levels and we are increasing the Evaluation & Management conversion factor. Only the Surgery conversion factor is being reduced, from \$93.66 to \$86.44. Even with this reduction, the Surgery conversion factor is nearly \$23.00 higher than the average health insurance Surgery conversion factor. Therefore, we do not foresee a participating provider decrease from 70% to 20%.

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

***Exhibit 18, 66***

“The failure of our workers' compensation system to attract additional specialists is producing a much higher negative impact due to increased indemnity costs resulting from delays in treatment, inappropriate causation decisions, and apportionment statements by physicians who are not motivated to learn more about the skills required to provide truly effective injured worker care which would improve outcomes substantially.”

*Exhibits 74, 84, 97* include related testimony.

**Response:** The department attempts to emphasize the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. Surgical

specialists continue to have the highest conversion factor. Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

*Exhibit 18, 66*

“To continue its' success the Workers' Compensation System needs the skills, talents, and abilities of Occupational Specialists \* \* \* who have historically been key players in developing the system and who hold the promise of magnifying the accomplishments of Oregon as a national leader in Workers' Compensation. \* \* \* I served on a WCD fee schedule committee a few years back and was openly frustrated by the perceptions of the stakeholders present that doctors were a big part of the problem with rising medical costs particularly as it related to brand name medicine use and rising physical therapy utilization. The solution offered .... cut reimbursements to physicians. My point to the committee was that if the physicians were engaged to solve problems they would prove to be an asset to the system. I set out to reduce physical therapy utilization in my practice by one third over two years. I accomplished this by establishing physical therapy protocols, using exercise kits, and spending a great deal of time educating therapists and my patients. The results were that PT utilization in my practice has been reduced by OVER HALF, saving carriers on average \$700 for each post operative knee patient and \$1500 for each past operative shoulder patient. \* \* \* I implemented and perfected a minimally invasive technique for the surgical treatment of lateral epicondylitis (tennis elbow), a condition associated with poor surgical outcomes and high utilization of medical and indemnity resources in injured workers. These procedures can be performed in the office instead of a hospital (saving the carrier \$1500-\$4000/patient) and rarely require post operative physical therapy (a savings of \$600-\$1000/patient). Traditional surgical treatment is associated with a 25-50% failure rate resulting in need for vocational redirection and PPD awards after lengthy treatment. Our minimally invasive office procedure has been successful in returning 90% of our patients to full duty in their job at injury within 6-12 months. \* \* \* Conclusion: We all do our best work when we feel appreciated. The greatest accomplishments in history were made by groups of talented and willing people who seized an opportunity to do a great work for the public good. It is the basic nature of those people who seek a career in Medicine and Surgery to be willing to seize such opportunities. \* \* \* But they have become weary of ‘playing the shell game’ for reimbursement and being viewed only as a ‘problem’ and a ‘line item expense.’ They wonder how we can ever attract other talented physicians who would be willing to dedicate themselves to our cause, stand with us, and pick up the fight when we are through. The risk management and occupational medicine literature indicates clearly that those physicians who perform the highest volume of injured worker care produce the best outcomes with dramatically less medical and indemnity costs.”

**Response:** Occupational specialists use Evaluation & Management services to a large degree and will benefit from the increased Evaluation & Management conversion factor. Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 18, 66***

“One of the biggest challenges urgent care and occupational physicians face is the difficulty in obtaining specialty care for patients who did not recover completely from conservative therapies. The flow of a workers' care often ‘stalls out’ because of their inability to obtain timely access to specialty care.”

*Exhibit 73* includes related testimony.

**Response:** Surgical specialists continue to have the highest conversion factor. The Surgery conversion factor will be nearly \$23.00 higher than the average health insurance surgery conversion factor. The department is also starting an initiative to ensure workers access to quality care, at the lowest cost to employers and, at the same time, to address the concerns raised by the physicians. The department will be focusing on incentives for providers to provide timely evaluation of injured workers, increasing incentives for providers to actively participate in managing the care of injured workers, focusing on the ultimate goal of returning to work, decreasing the administrative burden to providers, and maintaining a positive business climate by controlling system costs.

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

***Exhibit 18, 66***

“The proposed rules would have a negative impact on specific key specialties which are in greatest need to obtain the best outcomes in injured worker care: Surgery, Medicine, Physical Medicine and Rehabilitation. Rapid access to these key specialists is hampered by the relatively few doctors who are willing to be involved in the care of injured workers.”

**Response:** The conversion factors for Medicine, and for Physical Medicine and Rehabilitation are not changing.

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

***Exhibit 18, 66***

“Reducing the fee schedule has the severest negative financial impact on the physicians that see the highest volume of injured workers and who are providing the best outcomes. Adding the CPI of 4.04% plus the reduction in the surgery conversion factor of 7.7% will result in an 11.74% negative impact on those specialist providers the system benefits from the most.”

**Response:** Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 18, 66***

“Insurance carriers, MCOs, and the WCD need to develop a system to educate physicians and their staffs proactively to succeed in the delivery of healthcare to Oregon's' workers. Identifying providers who are currently delivering care to workers and offering assistance to learn and understand the unique needs of the system would help them to see this as a desirable area of their practice to enhance and develop. The financial incentives are built into the current fee schedule and need only to be understood by those willing to participate so they feel comfortable that they are being compensated correctly. There are currently no educational forums for physicians in our state to learn the basic principles of causation and medical evidenced based practice that are widely known or attended. We will not remain a leader in the field if our physicians are not

educated to sustain our position. A dedicated effort needs to be made by the system to attract and retain experienced providers who are willing to see high volumes of injured workers. This would result in improved outcomes for all stakeholders and contribute to Oregon's continued position as the national leader in Workers Compensation.”

**Response:** The matters subject to the testimony were not considered by the External Advisory Committee. The division will take the issues under advisement for possible future action.

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

*Exhibit 18, 66*

“Most community specialists begrudgingly accept injured workers into their practice as a ‘fact of life’ in providing service to their primary referral base of family practice and internal medicine providers. They view injured worker care as a loss leader that is necessary to attract what they consider to be more desirable business from commercial carriers such as Blue Cross/Blue Shield, etc.”

**Response:** Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

*Exhibit 4*

“Musculoskeletal injuries account for over 75% of worksite injuries - - you can ill afford to have numerous orthopedic surgeons unwilling to care for the injured workers in our communities and across the state. \* \* \*”

*Exhibit 8, 10, 11, 15, 17, 25, 26, 27, 28, 29, 67, 95, 96, 99* include related testimony about orthopedists’ willingness to continue their involvement in the Oregon workers’ compensation system.

*Exhibit 15* adds that effects of lowered reimbursements are reflected in non-participation in Washington’s workers’ compensation plan.

**Response:** Surgical specialists continue to have the highest conversion factor. Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

*Exhibit 14*

“I am an Orthopedic surgeon in Hood River. I see a number of worker's compensation patients and often, their conditions involve surgery. I am one of only 2 Orthopedists in the entire north central Oregon region that accepts WC patients. This is more for convenience and support of our patients. There is a proposal to limit reimbursement for surgical procedures. If this is done, my partner and I may have to discontinue serving the Worker Compensation patients. These individuals will have to travel by private car or ambulance to Portland for their surgery, at a very expensive cost to your system. Please reconsider your actions to limit our ability to serve these patients.”

*Exhibit 6, 22, 30, 47, 93, 94* include related testimony about access to care in rural communities.

**Response:** Surgical specialists continue to have the highest conversion factor. Data available to

the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 22***

“Last year the MAC supported \* \* \* the decrease in the E&Ms as it was predicted to have a neutral effect on providers' revenue when utilized with the Medicare adjustments. Instead revenue decreased, and the impact depended upon the proportion of Work Comp patients within an individual practice. Particularly hard-hit were the Occupational Medicine clinics that exclusively treat Worker's Compensation patients and have no options to adjust their office's patient profile. Ironically the Occupational Medicine clinics have the potential for efficiency by excluding other payers and may be helpful for developing a best practice model for the system.”

**Response:** Thank you for your testimony. The rule will be revised as proposed, with the Evaluation & Management conversion factor being raised by \$5.00.

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

***Exhibit 4***

“The documentation requirements, multiple letters, questions, coordination of care and restrictions, etc. all present a significant increased burden for the physician and staff in the delivery of their care. We cannot continue to shoulder that burden if the compensation level drops.”

*Exhibits 6, 8, 17, 18, 21, 22, 25, 26, 27, 28, 29, 30-40 42-44 46-51, 54-60, 62, 63, 65-68, 71, 72, 73, 76, 78-81, 85, 87-89, 91-97 include related testimony.*

*Exhibits 8, 13, 26, 27, 28, 29, 67, 87, 95, 96 add that depositions and legal conferences take time away from patient care and are not adequately compensated.*

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. Decreasing the administrative burdens to providers is an area the department will be focusing on within this initiative.

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

***Exhibit 12***

“ ‘work comp’ patients are much more difficult to deal with than other patients. The paperwork burden is significant with these patients and in many cases the recovery and resultant follow up are much more prolonged than average. In some cases the patients are not motivated to return to work and the physician gets caught in a tug of war between the patient and the employer/industrial carrier. This all results in more stress and alot of wasted time. \* \* \* Some of these patients are a pleasure to care for but a large percentage have hidden agendas and secondary gain issues that greatly complicate their treatment. If re-imburement is lowered very much the incentive to keep participating in the program would certainly diminish.”

*Exhibit 13, 15, 16, 18, 21, 60, 66, 93, 94, 97 include related testimony.*

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize two areas

within this initiative: (1) increasing incentives for providers to provide timely evaluation of injured workers and (2) increasing incentives for providers to actively participate in managing the care of injured workers, focusing on the ultimate goal of returning to work.

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

***Exhibit 16***

“I am enclosing a copy of a medical bill analysis from May 18, 1995 for a unilateral lumbar discectomy. Payment at that time was \$2,993.76. Current payment in 2008, thirteen years later, is \$2,298.42. WCD proposes to reduce the conversion factor additionally in order to ‘better align the fee schedule with reimbursement generally received for the service provided’. \* \* \* the care of an injured worker involves much more work than the care of a person covered by health insurance. That situation has not changed. \* \* \* surgical fees include 90 days of postoperative care, meaning ‘free’ office visits that would ordinarily generate 99213 fees. In my practice, a patient on whom I perform a carpal tunnel release or a lumbar discectomy commonly requires a single post-operative visit. An injured worker with either of these conditions commonly requires four post-operative visits in the 90-day ‘free’ post-operative period.”

*Exhibits 51, 57, 60, 93, 94* include related testimony.

**Response:** While the proposed change in the conversion factor for surgery results in an approximate 3.6 percent projected decrease in surgery payments, the Oregon WC fee schedule still offers nearly \$23.00 more per relative value unit (RVU) than the average Oregon general health insurance fee schedule. The difference more than allows for a reasonable markup for the additional services required within Surgery’s global fees in relation to workers’ compensation.

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

***Exhibit 18, 66***

“\* \* \*Despite the higher fee schedule the extra time, administrative costs, and communication demands placed on the practitioner prove too frustrating for most specialists to sustain any interest in ‘getting good at worker's comp care.’ They are also frustrated by the complex issues and demands of the claims that they have no training or preparation to address. Patients' expectations are not managed appropriately, outcomes are disappointing, and the doctor's feel vulnerable legally and professionally. Obstacles to reimbursement make them feel it is a poor business decision to become involved any more than is absolutely necessary. Cutting the fee schedule will send a negative message to those physicians who show a willingness to assist the State of Oregon to continue its' record of improvement in the effectiveness of its' Workers Compensation System.”

**Response:** Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery. The department is also starting an initiative to ensure workers access to quality care, at the lowest cost to employers and, at the same time, to address the concerns raised by the physicians. The department will be focusing on incentives for providers to provide timely evaluation of injured workers, increasing incentives for providers to actively participate in managing the care of injured workers, focusing on the ultimate goal of returning to work, decreasing the administrative burden to providers, and maintaining a positive business climate by controlling system costs.

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

***Exhibit 22***

“The [Medical Advisory] committee is sensitive to budget issues. Oregon competes against other states for new business and the cost of Workers' Compensation insurance is a major consideration for industries considering a move. Attracting new business has obvious positive impact for Oregon's economy. Oregon currently ranks in the middle of the states for cost of insuring workers. The primary care and specialty medical providers are the true gatekeepers of the system and should be properly motivated and compensated to maintain or increase quality while decreasing the overall costs through proper medical management of the injured worker. We began to look at this concern with the Medical Quality Initiative a couple years ago. 25% of the overall costs for non-Workers' Compensation insurance is administrative, and for Workers' Compensation the figure is estimated to be 35-50%. \* \* \* We are interested in pursuing decreases in overall costs to the system while maintaining quality of and workers' access to medical care by open discussion and analysis of the data \* \* \*.”

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. Decreasing the administrative burdens to providers is an area the department will be focusing on within this initiative.

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

***Exhibit 97***

“It is increasingly difficult to find physicians who will agree to see patients who have been injured on the job. Providence MCO's Physician Advisory Board has stated it is because of the low payment. \* \* \* We believe reduction of the surgery conversion factor will make it even more difficult to find surgeons who will see WC patients. They are increasingly reluctant to act as attending physicians, due to paperwork and questions from other parties asking about return-to-work and impairment (they want to assume the role of consulting physician only). \* \* \*”

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize three areas within this initiative: (1) decreasing the administrative burdens to providers; (2) increasing incentives for providers to provide timely evaluation of injured workers, and (3) increasing incentives for providers to actively participate in managing the care of injured workers, and focusing on the ultimate goal of returning to work.

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

***Exhibit 13***

“The point is not that w/c is going to go away, but that IT IS DIFFICULT and fewer and fewer physicians (especially surgeons) are willing to take on these cases. It is simply NOT FAIR to those of us hardworking docs who are trying to serve this population to decrease the surgical reimbursement. \* \* \* Please reconsider this egregious proposal, and, if there is any justice left in the system, consider increasing the surgical fees for those of us who continue to do this difficult, often thankless task!”

*Exhibits 25, 60* include related testimony.

**Response:** Surgical specialists continue to have the highest conversion factors. Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than

the average health insurance industry conversion factors with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 74***

“I would like to request that that these changes not be accepted and that instead, the workers' compensation fee schedules be increased to a competitive rate with commercial fee schedules for the same services. Since 2003, the Workers' Compensation fee schedules have actually been reduced on two separate occasions. In addition to decreased reimbursement, we continue to pay MCO fees. During this same time period, we have been obligated to honor our labor contracts which have increased salary and benefits by an average of 5% or more each year. \* \* \*”

*Exhibits 15, 64, 65* include related testimony.

*Exhibit 75* includes related testimony, including data on general health care versus workers' compensation payments, with workers' comp averaging \$38.12 less per visit and \$188.46 less per patient – for a mixture of Surgical services and E&M.

**Response:** Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 24***

“It would be nice to find other ways to encourage those physicians who dedicate their practices to worker's compensation and the care of the worker to continue that practice besides adjusting the fees each year. One possibility would be to set the fees and then increase them annually but the increase would be tied to the CPI or some other recognizable inflation index. This would alleviate the annual battle over fees while at the same time recognize that you cannot continue to buy a silk purse for the price of a pig's ear. One could also consider a preferred provider panel, encouraging workers and employers to use those physicians who demonstrate an ability to efficiently and effectively care for the injured worker while also being mindful of the costs. However, these debates are best saved for another day.”

**Response:** The matters subject to the testimony were not considered by the External Advisory Committee. The division will take the issues under advisement for possible future action.

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

***Exhibit 54***

“I have been treating injured workers in Oregon for more than 25 years and providing, I believe, good care at reasonable cost. The administrative burdens of providing that care have increased over the years but I have accepted that as part of our increasingly complex society. Because I believe that I provide good care with timely response to questions from your Division I believe that I should be fairly compensated for that service. My costs continue to escalate with no end in sight so a decrease in reimbursement puts the future of my practice at risk. I would ask that cuts in reimbursement not be approved.”

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize three areas within this initiative: (1) decreasing the administrative burdens to providers; (2) increasing

incentives for providers to provide timely evaluation of injured workers, and (3) increasing incentives for providers to actively participate in managing the care of injured workers, and focusing on the ultimate goal of returning to work.

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

***Exhibit 5***

“\* \* \* I suggest that reimbursement for Evaluation and Management Services should be increased without a concomitant decrease in Surgical Services reimbursement in order to adequately compensate physicians who provide E&M services, without jeopardizing injured worker's access to surgical services in Oregon.”

*Exhibits 45, 49, 52, 59, 68, 92* include related testimony.

**Response:** Surgical specialists continue to have the highest conversion factors. Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 5***

“Is Revenue Neutrality Necessary? I can appreciate that insurers and employers are concerned about the cost of workers compensation insurance. However, \* \* \* the cost of providing such coverage for employers has been decreasing over the past several years, a result of a number of reforms to the workers compensation regulations in Oregon. Despite these positive trends, physician reimbursement has not been updated regularly to reflect the costs faced by physicians in caring for injured workers. The system has certainly not been ‘revenue neutral’ for physicians, but rather been eroded by inflation and the operating costs of providing professional services to injured workers.”

*Exhibits 31-40, 43, 46, 47, 48, 49, 54-59, 61-63, 71, 72, 76, 78-81, 85, 87, 89, 91* include related testimony.

*Exhibit 97* includes related testimony that questioned the agency's “Statement of Need and Fiscal Impact,” and projects that the proposed reduction in the surgery conversion factor will increase costs.

**Response:** As medical costs in Oregon continue to rise, the department's goal is to reduce costs while providing workers access to quality health care. The increase in the Evaluation & Management conversion factor will help promote stronger evaluation and management of workers' injuries, which should result in better outcomes. The decrease in the Surgery conversion factor will offset that increase, while staying competitive with conversion factors in the health insurance industry. Surgical specialists continue to have the highest conversion factors. Data available to the agency shows that all Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 21***

“\* \* \* the Division has consistently used ‘budget neutrality’ to reduce or maintain a declining reimbursement rate. The OMA would appreciate the Division identifying the statutory or regulatory authority for that policy position \* \* \*”

**Response:** Budget neutrality is not a goal of the workers' compensation system. There is no statutory or regulatory authority to maintain medical costs at a specific level as method of containing medical costs in workers' compensation. Medical costs are now 65% of all claims costs.

Our statutory charge is to establish a fee schedule that represents the reimbursement generally received for the services provided. In reviewing the fee schedule, the director considered many factors. We surveyed private health carriers and found that in the Evaluation & Management category, the conversion factor was less than the average conversion factor for the Oregon health insurance industry; on the other hand, the surgery conversion factor was \$30.00 above the average private health care rate. To contain cost, we shifted reimbursement levels from surgery to Evaluation & Management to meet the statutory requirements.

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

***Exhibit 65***

"I believe we should be debating the percentage increase for E&M and Surgical code reimbursements, not how to move reimbursement around to maintain the status quo!"

**Response:** Conversion factors are but one facet of the multifaceted workers' compensation system. In our efforts to meet department's goal in ensuring workers access to quality health care, at the lowest cost to employers and, at the same time, to address the concerns raised by the physicians, the department will be focusing on four areas:

- 1) Increasing incentives for providers to provide timely evaluation of injured workers,
- 2) Increasing incentives for providers to actively participate in managing the care of injured workers, focusing on the ultimate goal of returning to work,
- 3) Decreasing the administrative burdens to providers, and
- 4) Maintaining a positive business climate by controlling system costs.

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

***Exhibit 68***

"This devaluation [in the surgery conversion factor] also comes at the same time as other reductions in the Medicare RBRVS values proposed to be used. This represents a double hit in many cases."

*Exhibit 92* includes related testimony.

**Response:** From 2000 through 2006, payments for surgical services have increased approximately 8% per year. For 2008, the department predicts payments for surgical services to increase approximately 9.3% with no changes to the RVUs or the conversion factors. The department projects that, if no changes were made to the conversion factor, 2008 payment increases for surgical services would be reduced by 0.7% due to changes in the Medicare RVUs. In other words, the total payments for surgical services would increase by 8.6% (9.3%-0.7%) in 2008 rather than 9.3%.

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

***Exhibit 87***

"One of the reasons many using CMS formulas are making errors in reimbursing surgical specialists is that they are not allowing for all the overhead costs of surgical specialists while

doing surgery. I fear that you are underestimating the impact this has on our practices, and the backlog it could create in caring for the surgical needs of the workers' comp patients.”

**Response:** We have been adopting part of CMS’ RBRVS for several years and use the Relative Value Units (RVUs) to calculate payments to providers. The matter subject to the testimony regarding errors in CMS’ formulas and whether the department should address that was not considered by the External Advisory Committee. The division will take the issue under advisement for possible future action.

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

***Exhibit 68***

“Clearly, all categories of services deserve an increase in value given the increased costs of caring for the Oregon Workers’ compensation clients and the significant amount of added paperwork demanded of providers by the Division and insurers for these patients.”

*Exhibit 92* includes related testimony.

*Exhibit 77* includes related testimony, including a specific request that the conversion factor for anesthesia be increased.

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize three areas within this initiative: (1) decreasing the administrative burdens to providers; (2) increasing incentives for providers to provide timely evaluation of injured workers, and (3) increasing incentives for providers to actively participate in managing the care of injured workers, and focusing on the ultimate goal of returning to work. Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 68***

“\* \* \* if there is no other choice but to reduce conversion factors to balance budgetary expectations, then all provider groups must share the burden.”

*Exhibit 92* includes related testimony.

**Response:** As medical costs in Oregon continue to rise, the department’s goal is to reduce costs while providing workers access to quality health care. The increase in the Evaluation and Management conversion factor will help promote stronger evaluation and management of workers’ injuries, which should result in better outcomes. The decrease in the Surgery conversion factor will offset that increase, while staying competitive with conversion factors in the health insurance industry. Surgical specialists continue to have the highest conversion factor. Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

*Exhibit 68*

“\* \* \* we support the proposed increase in the conversion factor for E&M services. We do not support any decrease in the conversion factor for surgery services and advocate that conversion factor remain the same as in 2007. Frankly, we deserve a cost of living increase too. The division and insurer’s have an important tool to manage use of surgery services and that is the requirement of prior authorization for surgery services. This is an important tool in the appropriate utilization of surgery services.”

*Exhibit 92* includes related testimony.

**Response:** Surgical specialists continue to have the highest conversion factors. Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery. The department does not consider conversion factors a tool for the appropriate utilization of medical services.

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

*Exhibit 5*

“\* \* \* Given the positive cost trends in Oregon for the cost of workers compensation insurance, I would argue that reimbursement rates for E&M services can be raised without jeopardizing access to specialty surgical services for injured workers and without placing an undue financial burden on insurers and employers.”

**Response:** As medical costs in Oregon continue to rise, the department’s goal is to reduce costs while providing workers access to quality health care. The increase in the Evaluation & Management conversion factor will help promote stronger evaluation and management of workers’ injuries, which should result in better outcomes. The decrease in the Surgery conversion factor will offset that increase, while staying competitive with conversion factors in the health insurance industry. Surgical specialists continue to have the highest conversion factors. Data available to the agency shows that all Oregon workers’ compensation conversion factors will be higher than the average health insurance industry conversion factors, with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

*Exhibit 5*

“A number of the [workers’ compensation regulatory] \* \* \* reforms increased the administrative burden on physicians, requiring physicians to enter into conflicts between insurers and injured workers regarding the relative contribution of specific injuries and underlying chronic conditions (such as Osseo-arthritis) with regard to disability following an injury. These changes resulted in significant savings to insurers and employers, but increased costs for physicians. It seems to me that the beneficiaries of these reforms have effectively shifted the costs to providers.”

**Response:** The department is starting an initiative focused on improved outcomes for injured workers by emphasizing the need for timely evaluation and comprehensive management of medical care following a work place injury or illness. The department will emphasize three areas within this initiative: (1) decreasing the administrative burdens to providers; (2) increasing incentives for providers to provide timely evaluation of injured workers, and (3) increasing incentives for providers to actively participate in managing the care of injured workers, and focusing on the ultimate goal of returning to work. Data available to the agency shows that all

Oregon workers' compensation conversion factors will be higher than the average health insurance industry conversion factors with differences ranging from \$1.27 for Evaluation & Management to nearly \$23.00 for Surgery.

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

***Exhibit 5***

“[Regarding] The Validity of the Revenue-Neutral Analysis. \* \* \* I'm concerned that the analysis underlying the current proposal is simply inadequate. A simple reduction in surgical conversion factors by the same percentage as an increase in Evaluation and Management conversion factors is unlikely to result in a 'budget-neutral' result. Based on the testimony in the advisory committee meeting that I attended, there was a lack of understanding of the actual distribution of the various CPT codes that must underlie such an analysis. The approach seems overly simplistic. Do you now have confidence in your analysis?”

**Response:** We did not increase the Evaluation & Management conversion factor by a certain percentage and then turn around and use that percentage to reduce the Surgical conversion factor. Increasing the Evaluation & Management conversion factor is estimated to increase medical costs by \$1,986,561. To offset the increase in medical payments due to the increase of Evaluation & Management conversion factor, the department is decreasing the Surgery conversion factor by \$7.22, from \$93.66 to \$86.44, which will result in decrease of total medical payments by estimated \$1,986,174. The similar percentage is coincidental.

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

***Exhibit 16***

“Data provided to the WCD indicating that payments for E&M services averaged 9% above the allowed maximum in 2007 and payments to Surgery averaged 26% below the maximum do not agree with what we see in our medical practice. Payments for medical service are not guided by provider charges, but by prices fixed by the workers' compensation fee schedule, or by contractual arrangements with payers and MC0's. I cannot explain data that show E&M services average 9% above allowed maximums, since payers routinely analyze each medical bill and pay fees according to the fee schedule or to the fee schedule minus a contracted discount. If by accident a payer were to pay above the fee schedule, the payer would demand a refund.”

“Payments for surgery averaging 26% below the maximum allowed may, in part, reflect failure to take into account multiple procedure discounts that are applied to a bill when a surgeon does more than one procedure at a single session. As the statement of need and fiscal impact point out, the CPI index between 2006 and 2007 increased by 4.04%. It is true that medical providers that bill below the maximum will have no direct fiscal impact by the changes proposed. However, I would challenge WCD to find those practitioners, since it is not in the interest of a medical provider to bill below what the market pays for a service, particularly in a time of managed care.”

*Exhibit 97* includes related testimony.

**Response:** We validated your concerns raised regarding the accuracy of the absolute numbers and, therefore, we did not use those numbers to come to a final decision.

Following the 2007 adjustment to the Evaluation & Management (E&M) conversion factor, we received continued input from physicians across the state that the E&M conversion factor was too low. The feedback we received from physicians was that the E&M conversion factor was

now lower than private health. At the same time, we also heard that the Surgery conversion factor was higher than private health. Physicians advised us that if we needed to cut something in order to raise the E&M conversion factor then we should cut the Surgery conversion factor. We were looking for ways to accommodate what we were hearing from the public, in particular from physicians, and still contain cost to the system.

We also looked at the inflation factor and how that factors into medical costs. When we looked at total medical costs over time, even though the conversion factors had not changed significantly and we had maintained costs within the system, the total medical costs were still rising. This signifies that there is some inflation inherent in the system regardless of what our conversion factor is.

Given that information and our goal to emphasize evaluation and management, we had settled on the recommendation of increasing the E&M and decreasing the Surgery conversion factors. We looked at different levels of increasing E&M and what impact that would have on the surgical factor. In doing that we arrived at the \$5.00 increase in the E&M conversion factor over the current 2007 level, but that would mean a \$7.22 reduction in the surgical category.

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

***Exhibit 21***

“\* \* \* the OMA has several concerns on the data being used to rationalize the changes proposed to the fee schedule. The OMA's Workers' Compensation Committee could not identify from their own practice any insurer who was paying Evaluation and Management Fees (E&M) above the statutory fee schedule. In fact, the law provides that payments may not exceed the statutory rate. Similarly, we could not identify surgical practices that are discounted by approximately 26% of the fee schedule. The Division's own data shows that since 2000 the total payments for both surgical and E&M services have consistently declined. This would suggest that the proposed reduction for surgical services to slightly increase the rate for E&M services is illogical and not a reflection of either the consumer price index, the Medicare Economic Index nor the actual practice costs of physicians.”

**Response:** We validated your concerns raised regarding the accuracy of the absolute numbers and, therefore, we did not use those numbers to come to a final decision.

Following the 2007 adjustment to the Evaluation & Management (E&M) conversion factor, we received continued input from physician across the state that the E&M conversion factor was too low. The feedback we received from physicians was that the E&M conversion factor was now lower than private health. At the same time, we also heard that the Surgery conversion factor was higher than private health. Physicians advised us that if we needed to cut something in order to raise the E&M conversion factor then we should cut the Surgery conversion factor. We were looking for ways to accommodate what we were hearing from the public, in particular from physicians, and still contain cost to the system.

We also looked at the inflation factor and how that factors into medical costs. When we looked at total medical costs over time, even though the conversion factors had not changed significantly and we had maintained cost within the system, the total medical costs were still rising. This signifies that there is some inflation inherent in the system regardless of what our conversion factor is.

Given that information and our goal to emphasize evaluation and management, we had settled on

the recommendation of increasing the E&M and decreasing the Surgery conversion factors. We looked at different levels of increasing E&M and what impact that would have on the surgical factor. In doing that we arrived at the \$5.00 increase in the E&M conversion factor over the current 2007 level, but that would mean a \$7.22 reduction in the surgical category.

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

***Exhibit 22***

“[Regarding] the fee schedule change proposals. These were based upon data provided to the WC Division by the insurers as required in Appendix A 436-009-0030. The conclusions were based upon a free market model that does not appear appropriate for our system. OAR 436-009-0050 section 3 A describes payment of surgical services which requires payment at 100% of the maximum allowable fee with 50% discounts for secondary and all subsequent procedures. I reviewed the raw data in which there were 47,620 records and 52,622 procedures showing that overall payments include discounted multiple procedures, and the derived figure may actually represent 100% or more of the allowable payments. The data from the current reporting requirements do not allow for an in-depth analysis.”

**Response:** We validated your concerns raised regarding the accuracy of the absolute numbers and, therefore, we did not use those numbers to come to a final decision.

Following the 2007 adjustment to the Evaluation & Management (E&M) conversion factor, we received continued input from physician across the state that the E&M conversion factor was too low. The feedback we received from physicians was that the E&M conversion factor was now lower than private health. At the same time, we also heard that the Surgery conversion factor was higher than private health. Physicians advised us that if we needed to cut something in order to raise the E&M conversion factor then we should cut the Surgery conversion factor. We were looking for ways to accommodate what we were hearing from the public, in particular from physicians, and still contain cost to the system.

We also looked at the inflation factor and how that factors into medical costs. When we looked at total medical costs over time, even though the conversion factors had not changed significantly and we had maintained cost within the system, the total medical costs were still rising. This signifies that there is some inflation inherent in the system regardless of what our conversion factor is.

Given that information and our goal to emphasize evaluation and management, we had settled on the recommendation of increasing the E&M and decreasing the Surgery conversion factors. We looked at different levels of increasing E&M and what impact that would have on the surgical factor. In doing that we arrived at the \$5.00 increase in the E&M conversion factor over the current 2007 level, but that would mean a \$7.22 reduction in the surgical category.

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**Testimony: OAR 436-009-0070(5)**

***Exhibit 19***

“SAIF recommends using a separate code from the one used for attorney consultations. We suggest using a code from the range D0033 – D0039 since these codes are currently not in use. This will allow for better data gathering and analysis. SAIF also requests a payment schedule be assigned to the new code with payment allowed in 15 minute increments.”

**Response:** OAR 436-009-0070(5) and (12) already have addressed attorney consultations. The department agrees with SAIF to have a separate code (D0030) for insurer consultations. The

division will take the issues of a payment schedule with 15 minutes increments under advisement for possible future action.

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**Testimony: OAR 436-009-0090(1)**

*Exhibit 19*

“SAIF agrees with and appreciates the change in the maximum allowable fee for prescription medications. SAIF recommends adding additional language clarifying that when a worker requests a brand name medication but the prescriber has not prohibited generic substitution, the worker would be responsible for the cost difference \* \* \*.”

**Response:** This suggestion was not raised at the External Advisory Committee. The division will take this matter under advisement for possible future action.

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**Testimony: OAR 436-009-0090(1)**

*Exhibit 19*

“It would also be helpful to have the terms GEAP and AAWP more fully defined.”

**Response:** The division has removed these two terms from this rule.

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**Testimony: OAR 436-009-0090(1)**

*Exhibit 86*

“On behalf of the members of the National Association of Chain Drug Stores (NACDS) operating in Oregon, \* \* \* we strongly oppose the proposed changes in reimbursement for prescription drugs. The members of NACDS operating in Oregon include Costco, Haggens/Top Food and Drugs, Hi-School Pharmacy, Fred Meyer (Kroger), Medicine Shoppe, Pharmaca Integrative, Rite Aid, Kmart (Sears Holding Company), Shopko, Albertsons (Supervalu), Target, Walgreen and Wal-Mart. \* \* \* The proposal to take pharmacies from the current reimbursement rate of Average Wholesale Price (AWP) minus 12% plus an \$8.70 dispensing fee down to AWP minus 16.5% plus a \$2.00 dispensing fee is potentially placing pharmacies in a position of being unable to serve this client base. In a recent study conducted by Grant Thornton, the average cost of filling a prescription in Oregon ranges from \$11.61 to \$9.87. In addition, a study conducted by the Oregon State University School of Pharmacy found the average dispensing fee in Multnomah County to be right around \$10.00. Workers who are injured on the job have a right to expect to be taken care of immediately upon injury without the hassle of any red tape. Our members have been willing to provide that service by dispensing prescription drugs on the day of injury, even before the department has made a determination on the claim. With this severe of a cut to the reimbursement for prescription drugs, pharmacies may be economically unable to continue to provide this level of service. We strongly encourage the Division to reevaluate this deep cut in reimbursement rates to community pharmacies to ensure that injured workers will continue to have access to needed pharmacy services. \* \* \*”

**Response:** Under ORS 656.248(1), the director must adopt fee schedules that “\* \* \* represent the reimbursement generally received for the services provided.” The proposed rates are more consistent with rates paid for brand name drugs in the general health care system, while generic drug fees would remain above fees paid under some widely accepted benefit plans. The division projects the proposed rules changes would reduce workers compensation annual drug payments by approximately \$3.6 million or 21.8% of total pharmacy payments.

The division reviewed other pharmacy fee schedules including the current Oregon Prescription Drug Plan fee schedule and found those rates are widely accepted by Oregon pharmacies. The

proposed rates more closely reflect the pharmacy rates paid in general health and will help to ensure that workers receive appropriate pharmacy benefits at the most affordable rates.

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**Testimony: OAR 436-009-0090(1)**

***Exhibit 90***

“Fiserv is very concerned about the significant reduction in both the depth of the discount from AWP and the 75% reduction in the dispensing fee. In a time when labor costs, delivery costs and general operating costs are on the rise, the proposed cuts in the reimbursement will have a significant detrimental impact on providers who offer pharmacy services to workers’ compensation patients. The additional administrative burden \* \* \* and the additional financial risk to the pharmacy are not adequately addressed or economically covered \* \* \*. Unlike group health, the establishment of a workers’ compensation claim requires multiple phone calls to employers and carriers. It can sometimes take days to determine who the carrier is and where to send a bill. Adding to that burden, the required paperwork for processing and billing the claim is outside the normal flow of claims processing in a pharmacy creating exponentially higher administrative costs as compared to other types of pharmacy claims. Recent studies have concluded that the additional costs for processing a workers’ compensation claim can run between \$9.00 to \$21.00 per prescription depending on how automated the process is and how quickly employers and carriers respond to inquiries from providers. There is also a much greater risk of financial loss to the pharmacy provider. In nearly 10% of first fill claims, the pharmacy does not receive payment for dispensed medications because the claim was not deemed compensable or work-related. It should also be noted that the proposed reimbursement level at 83.5% of AWP is lower than the actual acquisition costs of the medication for some pharmacies. The proposed reduction will create a disincentive for providers to remain in the workers’ compensation system and may reduce the quality of pharmacy care available to injured workers. \* \* \* the savings realized to the overall system by cutting the reimbursement to pharmacies is negligible when compared to the significant negative financial impact the proposed cuts will have on individual pharmacies in Oregon. With no proposed changes to mitigate the processing and administrative costs in the system and no recognition of the actual acquisition costs of the medications paid by the pharmacy, we would urge the Oregon Workers’ Compensation Division to maintain its current level of reimbursement and dispensing fee. Pharmacists should not be required to work for free or at a loss to provide services to injured workers.”

**Response:** Under ORS 656.248(1), the director must adopt fee schedules that “\* \* \* represent the reimbursement generally received for the services provided.” The proposed rates are more consistent with rates paid for brand name drugs in the general health care system, while generic drug fees would remain above fees paid under some widely accepted benefit plans. The division projects the proposed rules changes would reduce workers compensation annual drug payments by approximately \$3.6 million or 21.8% of total pharmacy payments.

The division reviewed other pharmacy fee schedules including the current Oregon Prescription Drug Plan fee schedule and found those rates are widely accepted by Oregon pharmacies. The proposed rates more closely reflect the pharmacy rates paid in general health and will help to ensure that workers receive appropriate pharmacy benefits at the most affordable rates.

**Testimony: OAR 436-010-0220(3)(g)**

***Exhibit 19***

“SAIF agrees that a change of attending physician due to disenrollment from a MCO should not count as a worker change request.”

**Response:** Thank you for your testimony.

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**Testimony: OAR 436-010-0230**

***Exhibit 19***

“SAIF appreciates the inclusion of lumbar artificial disc replacement protocols in the rule.”

**Response:** Thank you for your testimony.

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**Testimony: OAR 436-010-0230(13)**

***Exhibit 1***

Recommendation: “Remove laminectomy from the absolute contraindications list. This recommendation is based on the FDA exclusion criteria for the CHARITÉ Artificial Disc as well as the \* \* \* 2008 manuscript by Geisler et al[\*], demonstrating that patients with prior surgery (i.e.; discectomy, laminotomy, laminectomy, without accompanying facetectomy or nucleolysis at the same level to be treated) experienced similar benefit from arthroplasty as patients without prior surgery.”

\*Geisler, F.H. et al. Effect of previous surgery on clinical outcome following 1-level lumbar arthroplasty. J Neurosurg Spine 8, 108-114 (2008).

**Response:** The department agrees and has changed the rule to clarify that laminectomy by itself is not an absolute contraindication, but that only laminectomy that involves any part of the facet joint is an absolute contraindication

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**Testimony: OAR 436-010-0230(13)**

***Exhibit 20***

“The Medical Advisory Committee had the opportunity to study testimony from DePuy Spine regarding an absolute contraindication for lumbar artificial disc replacement (ADR). Proposed OAR 436-010-0230(13)(i) lists the following as absolute contraindications for lumbar ADR: Prior fusion, laminectomy, or facetectomy at the same level as proposed surgery. \* \* \* the MAC [Medical Advisory Committee] concluded that the proposed rule language should be clarified and modified as follows:

“OAR 436-010-0230(13)(i) Prior fusion, laminectomy **that involves any part of the facet joint**, or facetectomy at the same level as the proposed surgery.”

**Response:** Thank you for your testimony. The department agrees and will modify the rule as recommended by MAC.

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**Testimony: OAR 436-010-0240**

***Exhibit 19***

“SAIF agrees that submission of worker social security numbers should be optional to better protect the worker information. WCD should consider making the transfer of the social security number under OAR 436-009-0030 Appendix A optional as well to better match these two rules. If capturing the social security number from the worker is not required, it should not be required for the insurer to report it to WCD.”

**Response:** The main reason for allowing the social security number (SSN) to be optional on Form 827 is to be consistent with Form 801. The intent is to allow a worker to file a legitimate

workers compensation claim whether or not the worker has an SSN.

In addition, the division's claims system requires the worker's SSN. While insurers generally rely on their claim numbering system to identify claims, the division receives claims from all Oregon insurers and the SSN is the only unique number to distinguish one claimant from another.

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**Testimony: OAR 436-050-0110**

***Exhibit 82***

“Current business practices use a variety of employment relationships \* \* \* facilitated by technological advances that enable employees to perform work remotely. \* \* \* these employees are able to perform all the functions they can perform from their office. This arrangement is entirely transparent to the injured worker. Correspondence and checks are mailed from the office, telephone calls are made to the office, and emails are sent to the corporate email address. Claim documents are imaged and stored electronically, and they can be viewed and processed from any location. The rules should reflect the realities of the modern workplace. Therefore, we propose that this rule should be amended to include a new subsection as follows:

“(x) Upon the request of an insurer, the director may authorize an Oregon certified claims examiner to make compensability and claim management decisions by accessing electronic records while working remotely from a residence outside the state of Oregon, under the following conditions:

“(a) The insurer must maintain the claim records at a location within the state of Oregon and comply with all other rules governing claim management and insurer responsibility;

“(b) Injured workers and other parties to the claim must be able to make telephone contact with the examiner at a cost no greater than the cost of an instate call; and

“(c) Injured workers and other parties to the claim must be able to meet with a person with authority to make decisions in the claim, at an Oregon claims processing location during normal business hours, with reasonable advance notice.”

**Response:** The testimony points out technological advances that could create a seamless environment when employees telework remotely. The suggestion for amending the rule to “reflect the realities of the modern workplace” is an important issue affecting many stakeholders. The department wants to take time to examine this issue in more depth with input from various stakeholder groups. The department commits to looking into this issue prior to the next reopening of the rule.

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**Testimony: OAR 436-050-0110(1)**

***Exhibit 82***

“The proposed new sentence regarding ‘dispatching’ claims is unclear. Anyone reading this rule without knowing the background for why this was proposed will not know what it means. We suggest either defining the term or substituting a fuller explanation.”

**Response:** The testimony provided points out that technological advances in today's workplace should “reflect the realities of the modern workplace.” The last sentence under OAR 436-050-0110(1) [regarding “dispatching” claims] was added with at least some technology advances in mind; however, the proposal may not go deep enough as pointed out in testimony. The added sentence as proposed is dropped for later consideration when all out of state processing issues

can be more fully addressed.

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**Testimony: OAR 436-110-0330(1)(d)**

*Exhibit 82*

“We understand that the department has ruled that the administrative cost for a Premium Exemption claim will not be paid if the claim also qualifies for reimbursement under a different program, such as Own Motion. As the insurer has received no premium to cover the cost of administering the claim, the insurer should continue to receive its administrative cost regardless of whether the claim costs are being paid from another program of the Worker Benefit Fund. The rule should be amended accordingly.”

**Response:** This was not discussed during this rule making process. It will be considered during the next opening of the rules.

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**Testimony: OAR 436-110-0330(2)**

*Exhibit 82*

“The addition of the proposed language will inadvertently reduce the time allowed for the insurer to request reimbursement. By including the time period of six months from the date of notification, regardless of the date payment was made, the rule would require some requests to be made earlier than the current rule allows. For example, if a payment was made on May 1, 2007, the insurer would have until June 30, 2008 to request reimbursement. However, if notification was received on August 1, 2007, the reimbursement request must be made by February 1, 2008. We do not believe that was the intended result. We recommend replacing the words ‘regardless of the date payment was made’ with ‘whichever is later’.”

**Response:** We agree with this and have changed the rules accordingly.

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**Testimony: OAR 436-110-0330(2)**

*Exhibit 82*

“\* \* \* we would like the department to confirm by rule that the insurer will continue to be reimbursed for settlements that occurred before notification of preferred worker status. Without prior knowledge of preferred worker status, it would be impossible to secure approval of the settlement before it is signed.”

**Response:** This was not discussed during this rule making process, however, it will be added to the list of issues for the next opening of the rules.

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**Testimony: OAR 436-160-0410**

*Exhibit 2*

“If the State of Oregon expects to receive dental bill data from the ADA billing form, DN 719 ADA Procedure Billed Code must be added to the Data Element Requirement Table so this data can be reported in the SV3 segment. \* \* \* DN722 (ADA procedure paid code) will also be necessary in order to capture dental data.”

**Response:** We have added DN719 ADA Procedure Billed Code and DN722 ADA Procedure Paid Code to the Element Requirements for dental bills only.

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**Testimony: OAR 436-160-0410**

*Exhibit 7*

“In order to be in compliance with the IAIABC implementation guide for loop 2310 B, DN639 (Rendering Bill Provider First Name) should be added to the Oregon Data Element Requirement

Table. \* \* \* the IAIABC implementation guide indicates the Rendering Bill Provider must be a person (entity type qualifier = 1). \* \* \* further clarification would be beneficial in regards to how the Rendering Bill Provider loop is reported as it pertains to each bill type. Specifically, on the CMS 1500, the Rendering Bill Provider first and last name (DN638/639) would be reported from box 31. The other data elements in the 2310B loop (DN642 - Rendering Bill Provider FEIN, DN647 - Rendering Bill Provider NPI, DN651 - Rendering Bill Provider Primary Specialty Code, and DN643 - Rendering Bill Provider State License Number) would not be applicable on the CMS 1500 reporting since the rendering provider information is reported in loop 2420 for the Rendering Line Provider. Please also consider if any changes to the requirements for the Rendering Bill Provider loop are required for pharmacy bills submitted on the NCPDP billing form.”

**Response:** We have added DN639 Rendering Bill Provider First Name to the Element Requirements.

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**Testimony: OAR 436-160-0410**

***Exhibit 3***

“I just found something while I was checking a test file. I got an error of missing the total charge per line. Right now, DN552 (Total Charge Per Line) is required without notes. \* \* \* I think the table needs to be changed to say that DN552 is required for professional and institutional service lines (SV1, SV2, SV3).”

**Response:** We have changed the Trigger/Notes information of the Appendix for DN552 to indicate that the data element is required only for SV1-SV3. In addition, we have made the data element conditional instead of mandatory.

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**Testimony: OAR 436-160-0410**

***Exhibit 98***

“There is a requirement to report compounds ~ since there is not a generic compound drug NDC, can a default value of ‘99999’ be utilized as the NDC for state reporting?”

**Response:** We have added language to the Trigger/Notes column of the Appendix to specify use of the default value of “99999” for compound drugs NDC.

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**Testimony: OAR 436-160-0410**

***Exhibit 100***

“Rendering/Billing Provider segments moving target needs stability.”

**Response:** For the Billing Provider, Oregon will require the reporting of the Billing Providers FEIN (DN 629), Last/Group Name(DN528). For the Billing Provider, the state will also require either the NPI If the provider has an NPI (DN634) or State License Number if NPI is blank (DN630). If the provider is not licensed by the state, the trading partner will use "99999". For the Rendering Bill Provider the state will only require the Rendering Provider’s First Name (DN639) and Rendering Provider’s Last Name (DN 638). The state will add DN 639 to its required element table. It is also going to change DN 647 and DN 643 from conditional to optional.

<b>Dated this 12<sup>th</sup> day of June, 2008.</b>
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