Secretary of State
Certificate and Order for Filing

TEMPORARY ADMINISTRATIVE RULES

A Statement of Need and Justification accompanies this form.

I certify that the attached copies are true, full and correct copies of the TEMPORARY Rule(s) adopted on Upon filing. by the

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	(503) 947-7717
Rules Coordinator	Telephone
PO Box 14480, Salem, OR 97309-0405	
Address	

To become effective 04/15/2014 through 10/11/2014.

RULE CAPTION

Repeal of requirement to use International Classification of Disease Tenth Revision (ICD-10) codes

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
436-009-0010, 436-009-0020

SUSPEND:

Statutory Authority:
656.252, 656.254, 656.726(4)

Other Authority:

Statutes Implemented:
656.252, 656.254

RULE SUMMARY

These temporary rules repeal the requirement that medical providers use ICD-10 codes on billings for services provided on or after Oct. 1, 2014. The current ICD-9 requirements will remain in place.

Fred Bruyns	fred.h.bruyns@state.or.us
Rules Coordinator Name	Email Address

FILED
4-15-14 2:45 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Secretary of State

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Department of Consumer and Business Services, Workers' Compensation Division | 436

Agency and Division | Administrative Rules Chapter Number

Repeal of requirement to use International Classification of Disease Tenth Revision (ICD-10) codes

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

Amendment of OAR 436-009, Oregon Medical Fee and Payment Rules

Statutory Authority:

656.252, 656.254, 656.726(4)

Other Authority:

Statutes Implemented:

656.252, 656.254

Need for the Temporary Rule(s):

Current rules require providers to use ICD-10 codes on billings for services delivered on or after Oct. 1, 2014. Due to passage of HR 4302 by the United States Congress, adoption of ICD-10 codes by the Centers for Medicare & Medicaid Services (CMS) has been delayed for at least one year. In order to remain consistent with billing standards common to medical providers, the Oregon Workers' Compensation Division will repeal its requirements for use of ICD-10 codes.

Documents Relied Upon, and where they are available:

H.R. 4302, Protecting Access to Medicare Act of 2014. This document is available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday.

Justification of Temporary Rule(s):

Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. Adoption of ICD-10 codes by CMS has been delayed by at least one year, but OAR 436-009 requires medical providers to use the ICD-10 codes on billings for services provided on and after Oct. 1, 2014. This inconsistency will create uncertainty among medical providers regarding whether Oregon will impose the ICD-10 requirement, and this uncertainty has the potential to affect providers' willingness to provide care for injured workers. Repeal of the ICD-10 requirement by this temporary rule will remove the uncertainty until the ICD-10 requirement can be repealed through permanent rulemaking.

Fred Bruyns | fred.h.bruyns@state.or.us

Printed Name | Email Address

FILED

4-15-14 2:45 PM

ARCHIVES DIVISION

SECRETARY OF STATE

Authorization Page

Generated on April 11, 2014 2:40PM

TEMPORARY ADMINISTRATIVE RULES

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	fred.h.bruyns@state.or.us
Rules Coordinator	Email Address
PO Box 14480, Salem, OR 97309-0405	503-947-7717
Address	Telephone
Upon filing.	
Adopted on	
04/15/2014 thru 10/11/2014	
Effective dates	

RULE CAPTION

Repeal of requirement to use International Classification of Disease Tenth Revision (ICD-10) codes

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 436-009-0010,436-009-0020

SUSPEND:

Stat. Auth.: 656.252, 656.254, 656.726(4)

Other Auth.:

Stats. Implemented: 656.252, 656.254

RULE SUMMARY

These temporary rules repeal the requirement that medical providers use ICD-10 codes on billings for services provided on or after Oct. 1, 2014. The current ICD-9 requirements will remain in place.

STATEMENT OF NEED AND JUSTIFICATION

Amendment of OAR 436-009, Oregon Medical Fee and Payment Rules

In the Matter of

H.R. 4302, Protecting Access to Medicare Act of 2014. This document is available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday.

Documents Relied Upon, and where they are available

Current rules require providers to use ICD-10 codes on billings for services delivered on or after Oct. 1, 2014. Due to passage of HR 4302 by the United States Congress, adoption of ICD-10 codes by the Centers for Medicare & Medicaid Services (CMS) has been delayed for at least one year. In order to remain consistent with billing standards common to medical providers, the Oregon Workers' Compensation Division will repeal its requirements for use of ICD-10 codes.

Need for the Temporary Rule(s)

Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. Adoption of ICD-10 codes by CMS has been delayed by at least one year, but OAR 436-009 requires medical providers to use the ICD-10 codes on billings for services provided on and after Oct. 1, 2014. This inconsistency will create uncertainty among medical providers regarding whether Oregon will impose the ICD-10 requirement, and this uncertainty has the potential to affect providers' willingness to provide care for injured workers. Repeal of the ICD-10 requirement by this temporary rule will remove the uncertainty until the ICD-10 requirement can be repealed through permanent rulemaking.

Justification of Temporary Rules

Authorized Signer	Printed Name	Date
	John L. Shilts	4/15/14

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

OREGON MEDICAL FEE AND PAYMENT RULES

436-009-0010
Medical Billing and Payment

(1) General.
(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a worker's compensation claim.
(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number.
(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law which require providers to bill other than their usual fee.
(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.
(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.
(f) When rebilling, medical providers must indicate that the charges have been previously billed.
(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.
(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)
(a) Medical providers must bill within:
(A) 60 days of the date of service;
(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or
(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.
(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.
(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.
(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.
(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.
(3) Billing Forms.
(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization.
(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or
CMS 1500 form (Versions 08/05 or 02/12 for dates of service prior to Oct. 1, 2014; Version 02/12 for dates of service Oct. 1, 2014 or after) except for:
(A) Dental billings, which must be submitted on American Dental Association dental claim forms;
(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or
(C) Electronic billing transmissions of medical bills.
(c) Medical providers may use computer-generated reproductions of the appropriate forms.
(d) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	Use ICD-9-CM codes
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2014; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2014 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" to identify their services.
24I (shaded area)	See under box 24J shaded area.
24J (non-shaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the non-shaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.

(4) Billing Codes.
(a) When billing for medical services, a medical provider must use codes listed in CPT® 2014 or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service. If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service. If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2014 or the appropriate unlisted HCPCS code, and provide a description of the service provided. A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.
(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.
(5) Modifiers.
(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2014, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.
(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10 or 90 days listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:
(A) Unusually lengthy procedure;
(B) Excessive blood loss during the procedure;
(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);
(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

(E) Other pathologies, tumors, malformations (genetic, traumatic, surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or
(F) The services rendered are significantly more complex than described for the submitted CPT.
(6) Physician Assistants and Nurse Practitioners.
Physician assistants and nurse practitioners must bill using modifier "81" and document in the chart notes that they provided the medical service.
(7) Chart Notes.
(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.
(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.
(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.
(8) Challenging the Provider's Bill. For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, and any extenuating circumstances.
(9) Billing the Patient/Patient Liability.
(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. However, the patient may be liable, and the provider may bill the patient:
(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;
(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;
(C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;
(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or
(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.
(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.
(10) Disputed Claim Settlement (DCS). The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.
(11) Payment Limitations.
(a) Insurers do not have to pay providers for the following:
(A) Completing forms 827 and 4909;
(B) Providing chart notes with the original bill;
(C) Preparing a written treatment plan;
(D) Supplying progress notes that document the services billed;
(E) Completing a work release form or completion of a PCE form, when no tests are performed;
(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or
(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing.
(12) Excluded Treatment. The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:
(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
(b) Intradiscal electrothermal therapy (IDET);
(c) Surface EMG (electromyography) tests;
(d) Rolfing;
(e) Prolotherapy;
(f) Thermography;
(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:
(A) The single level artificial disc replacement is between L3 and S1;
(B) The patient is 16 to 60 years old;
(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and
(D) The procedure is not found inappropriate under OAR 436-010-0230(15) or (16); and
(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:
(A) The single level artificial disc replacement is between C3 and C7;
(B) The patient is 16 to 60 years old;
(C) The patient underwent unsuccessful conservative treatment;
(D) There is intraoperative visualization of the surgical implant level; and
(E) The procedure is not found inappropriate under OAR 436-010-0230(17) or (18).
(13) Missed Appointment (No Show). In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.
Stat. Auth.: ORS 656.245, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.252, 656.254

436-009-0020
Hospitals
(1) Inpatient.
(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.
(b) Hospital inpatient bills must include:
(A) ICD-9-CM codes;
(B) When applicable, procedural codes;
(C) The hospital's NPI; and
(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.
(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost to charge ratio (See Bulletin 290). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.
(2) Outpatient.
(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.
(b) Hospital outpatient bills must, when applicable, include the following:
(A) Revenue codes;
(B) ICD-9-CM codes;
(C) CPT® codes and HCPCS codes; and
(D) The hospital's NPI.
(c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows:

Revenue Code	Pay Amount:	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or
		The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or
		The amount billed
All other revenue codes	• For hospitals listed in Bulletin 290, the amount billed multiplied by the cost to charge ratio. • For in-state hospitals not listed in Bulletin 290, 80% of the amount billed.	

(3) Specific Circumstances. When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital inpatient fee schedule.
(4) Out-of-State Hospitals.
(a) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.
(b) Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative.
(c) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.
(d) If the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.
(5) Calculation of Cost to Charge Ratio Published in Bulletin 290.
(a) Each hospital's CMS 2552 form and financial statement shall be the basis for determining its adjusted cost to charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost to charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost to charge ratio or the hospital's cost to charge ratio based on estimated data.
(b) The basic cost to charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.
(c) The net expenses for allocation derived from Worksheet A shall be modified by adding, from Worksheet A-8, the expenses for:
(A) Provider-based physician adjustment;
(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and
(C) Expenses identified as for physician recruitment.
(d) The basic cost to charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost to charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.
(e) The basic cost to charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule will be added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost to charge ratio. In no event will the adjusted cost to charge ratio exceed 1.00.
(g) The adjusted cost to charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of their CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost to charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.
(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division shall determine an adjusted cost to charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.
(i) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost to charge ratio to allow equitable payment.
(j) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost to charge ratio to reflect the data developed subsequent to the initial calculation.
(k) Notwithstanding sections (1)(c), (2)(b), and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost to charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost to charge ratio.
Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248; 656.252; 656.256

Appendix A
Oregon hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills under OAR 436-009-0020

	HOSPITAL NAME	NPI	ALT NPI	SECOND ALT NPI
1	Adventist Medical Center	1801887658		
2	Ashland Community Hospital*	1386644029	.	.
3	Bay Area Hospital – Coos Bay	1225016561	.	.
4	Good Samaritan Regional Medical Center - Corvallis	1962453134	.	.
5	Holy Rosary Medical Center – Ontario*	1891891792	.	.
6	Kaiser Sunnyside Medical Center	1124182902	.	.
7	Kaiser Westside	1891048807		
8	Legacy Emanuel Hospital & Health Center	1831112358	1295756898	.
9	Legacy Good Samaritan Hospital & Medical Center	1780608216	.	.
10	Legacy Meridian Park Hospital	1184647620	.	.
11	Legacy Mt. Hood Medical Center	1255354700	.	.
12	McKenzie-Willamette Medical Center – Springfield	1568413573	1528006301	.
13	Mercy Medical Center – Roseburg*	1477590198	1134161391	.
14	Mid Columbia Medical Center – The Dalles*	1306842752	.	.
15	Oregon Health & Science University Hospital	1609824010	1376873570	1548272511
16	Providence Medford Medical Center	1689755670	.	.
17	Providence Milwaukie Hospital	1366536963	.	.

18	Providence Newberg Hospital*	1952482275	.	.
19	Providence Portland Medical Center	1003991845	.	.
20	Providence St. Vincent Medical Center	1114015971	1083866933	.
21	Rogue Valley Medical Center – Medford	1770587107	1427277086	.
22	Sacred Heart Medical Center Riverbend – Springfield	1083888515	1881928067	.
23	Sacred Heart Medical Center University Dist. – Springfield	1346237971	1164595617	.
24	Salem Hospital	1265431829	1114197894	.
25	Samaritan Albany General Hospital	1154372340	.	.
26	Santiam Memorial Hospital – Stayton*	1154302214	.	.
27	Silverton Hospital	1669424354	.	.
28	Sky Lakes Medical Center – Klamath Falls	1811130149	1659340370	.
29	St. Charles Medical Center – Bend	1982621447	1598839789	.
30	St. Charles Medical Center – Redmond*	1225056146	.	.
31	Three Rivers Community Hospital – Grants Pass*	1801891809	1598895690	.
32	Tuality Community Hospital – Hillsboro	1275591984	1336228659	.
33	Willamette Falls Hospital – Oregon City	1639108434	.	.
34	Willamette Valley Medical Center – McMinnville *	1346269982	.	.
**Denotes hospital as rural. All of the 25 OR Critical Access Hospitals are intentionally excluded from this list.*				