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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

WCD 5-2023
CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

FILED
12/26/2023 11:51 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Adoption of temporary changes to OAR 436-009, new medical billing codes for 2024

EFFECTIVE DATE: 01/01/2024 THROUGH 03/31/2024

AGENCY APPROVED DATE: 12/26/2023

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Filed By:
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NEED FOR THE RULE(S):

Temporary rules are needed to allow health care providers and workers' compensation insurers to use 2024 medical billing codes on and after Jan. 1, 2024.

JUSTIFICATION OF TEMPORARY FILING:

Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. Delay in adoption of up-to-date codes creates procedural friction in workers' compensation billing and payment. Adoption of 2024 codes will keep workers' compensation billing codes consistent with industry standards.

The agency finds that issuing temporary rules under ORS 183.335(5) is appropriate because it will avert administrative burdens to health care providers, workers' compensation insurers, and self-insured employers we would expect with delayed adoption of 2024 codes. Without these temporary rule changes: providers and payers would be required to use only 2023 codes until the agency can formally adopt new codes effective April 1, 2024 (projected); workers' compensation bills would have to be processed differently than bills for private health insurance, Medicare, etc.; providers using new codes would be subject to bill rejection; and insurers submitting data containing new codes to the agency would be subject to civil penalties. In addition, workers' access to quality health care is jeopardized if health care providers perceive workers' compensation care as too burdensome.

The agency finds that issuing permanent rules under ORS 183.335(2) and (3) is not appropriate because updated billing codes are not published by the Centers for Medicare and Medicaid Services and others in time for Oregon to adopt changes using standard (permanent) rulemaking procedures.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Rulemaking advisory committee records; this issue was discussed with the committee. These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Marie Loiseau, rules coordinator, 971-286-0316, WCD.Policy@dcbs.oregon.gov.

RULES:
436-009-0004, 436-009-0010, 436-009-0012, 436-009-0023, 436-009-0040, 436-009-0080

AMEND: 436-009-0004

RULE TITLE: Adoption of Standards (temporary rule)

RULE SUMMARY: Revised rule 0004 adopts, by reference, new medical billing codes for 2024 and related references:
- The American Medical Association (AMA) Current Procedural Terminology (CPT®2024);
- The AMA CPT® Assistant through Volume 32, Issue 12, 2023;
- The Healthcare Common Procedure Coding System (HCPCS2024); and
- The American Dental Association's CDT 2024 Dental Procedure Codes.

RULE TEXT:
(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2023 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2023, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumberg, IL 60173, 847-825-5586, or www.asahq.org.
(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2023 and CPT® 2024), Fourth Edition Revised, 2022 and 2023, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 2023 and and CPT® 2024 govern the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.
(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 32, Issue 12, 2023. If there is a conflict between CPT® 2023 or and CPT® 2024 and the CPT® Assistant, CPT® 2023 and and CPT® 2024 are the controlling resources.
(4) To get a copy of the CPT® 2023, and CPT® 2024, or the CPT® Assistant, contact the American Medical Association, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885, 312-464-4782, or www.ama-assn.org.
(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.
(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.
(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
(6) The director adopts, by reference, CDT 2023 and CDT 2024: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, 312-440-2500, or www.ada.org.
(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 11.0 7/23 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, or www.nucc.org.
(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2023 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606, 312-422-3000, or www.nubc.org.
(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 –5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or www.ncpdp.org.
(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2023, CPT® 2023, and CPT® 2024, CPT® Assistant, HCPCS 2023, HCPCS

2024, CDT 2023, CDT 2024, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.
(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem, OR 97301.

STATUTORY/OTHER AUTHORITY: ORS 656.248, ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248

AMEND: 436-009-0010

RULE TITLE: Medical Billing and Payment (temporary rule)

RULE SUMMARY: Revised rule 0010 specifies that billing codes and modifiers in Current Procedural Terminology (CPT®2024) may be used on billing forms.

RULE TEXT:

(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 workers' compensation claim. Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner. Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(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. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may 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 that 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.

(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 (MCO).
(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 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 (see OAR 436-008).
(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.
(d) Medical providers may use computer-generated reproductions of the appropriate forms.
(e) 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. [See attached table.]
(4) Billing Codes.
(a) When billing for medical services, a medical provider must use codes listed in CPT® 2023, CPT® 2024, 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® 2023, CPT® 2024, 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® 2023, CPT® 2024, 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 as 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, or 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 document in the chart notes that they provided the medical service. If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."
(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, or any extenuating circumstances.
(9) Billing the Patient and 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, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:
(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 nonattending 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 they are 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.
(c) A provider may bill a patient for a missed appointment under section (13) of this rule.
(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 may be paid for only when authorized in writing by the insurer prior to the testing.
(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.
(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 electromyography (EMG) 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;
(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and
(i) Platelet rich plasma (PRP) injections.
(13) Missed Appointment (No Show).
(a) 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.
(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:
(A) The provider has a written missed-appointment policy that applies not only to workers’ compensation patients, but to all patients;
(B) The provider routinely notifies all patients of the missed-appointment policy;
(C) The provider’s written missed-appointment policy shows the cost to the patient; and
(D) The patient has signed the missed-appointment policy.
(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider’s policy.

STATUTORY/OTHER AUTHORITY: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

436-009-0010 Medical Billing and Payment

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(3) Billing Forms. ***

(e) 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	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-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® 2023 or CPT® 2024; • 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® 2023, CPT® 2024 (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" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the nonshaded 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.
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

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AMEND: 436-009-0012

RULE TITLE: Telehealth (temporary rule)

RULE SUMMARY: Revised rule 0012 – has been amended to include the reference to CPT® 2024. The revised rule explains that notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2023 or CPT® 2024.

RULE TEXT:

(1) Definitions.

(a) For the purpose of this rule, "telehealth" means providing healthcare remotely by means of telecommunications technology, including but not limited to telemedicine and telephonic or online digital services.

(b) For the purpose of this rule, "telemedicine" means synchronous medical services provided via a real-time interactive audio and video telecommunications system between a patient at an originating site and a provider at a distant site.

(c) "Distant site" means the place where the provider providing medical services to a patient through telehealth is located.

(d) "Originating site" means the place where the patient receiving medical services through telehealth is located.

(2) Scope of services.

(a) All services must be appropriate, and the form of communication must be appropriate for the service provided.

(b) Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2023 or CPT® 2024.

(3) Distant site provider billing.

(a) When billing for telemedicine services, the distant site provider must:

(A) Use the place of service (POS) code "02" (Telehealth Provided Other than in Patient's Home) or "10" (Telehealth Provided in Patient's Home); and

(B) Use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.

(b) When billing for telehealth services other than telemedicine services, the distant site provider:

(A) Must use the POS code "02" (Telehealth Provided Other than in Patient's Home) or "10" (Telehealth Provided in Patient's Home); and

(B) May not use modifier 95.

(4) Originating site billing. When billing for telehealth services, the originating site may charge a facility fee using HCPCS code Q3014, if the site is:

(a) The office of a physician or practitioner; or

(b) A health care facility including but not limited to a hospital, rural health clinic, skilled nursing facility, or community mental health center.

(5) Payment.

(a) Insurers must pay distant site providers at the non-facility rate.

(b) Equipment or supplies at the distant site are not separately payable.

(c) The payment amount for code Q3014 is $35.70 per unit or the provider's usual fee, whichever is lower. In calculating the units of time, 15 minutes, or any portion of 15 minutes, equals one unit.

(d) Professional fees of supporting providers at the originating site are not separately payable.

(e) Insurers are not required to pay a telehealth transmission fee (HCPCS code T1014).

STATUTORY/OTHER AUTHORITY: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

AMEND: 436-009-0023

RULE TITLE: Ambulatory Surgery Center (ASC) (temporary rule)

RULE SUMMARY: Revised rule 0023 includes associated fee schedules in Appendices C and D that list codes and maximum allowable payments for ambulatory surgery center services. Appendices C and D have been amended to include new medical billing codes for 2024. Maximum payment amounts for new codes have been set using 2023 multipliers if the Centers for Medicare & Medicaid Services has published Outpatient Prospective Payment System amounts. Otherwise, the maximum payment is set at 80% of the amount billed.

RULE TEXT:

(1) Billing Form.

(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.

(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.

(2) ASC Facility Fee.

(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:

(A) Nursing, technical, and related services;

(B) Use of the facility where the surgical procedure is performed;

(C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;

(D) Radiology services designated as packaged in Appendix D;

(E) Administrative, record-keeping, and housekeeping items and services;

(F) Materials for anesthesia;

(G) Supervision of the services of an anesthetist by the operating surgeon; and

(H) Packaged services identified in Appendix C or D.

(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.

(3) ASC Billing.

(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says "packaged" in Appendices C or D.

(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.

(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC's cost for an implant is $100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.

(4) ASC Payment.

(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.

(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:

(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or

(B) The ASC's usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly. The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.

(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this

case do not use Appendix C to calculate payment, use the rates listed below instead. [See attached table.]
(e) When the ASC's cost of an implant is $100 or more, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.
(f) When the ASC's cost of an implant is less than $100, insurers are not required to pay separately for the implant. An implant may consist of several separately billable components, some of which may cost less than $100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.
(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:
(A) The ASC is not a contracted facility for the MCO;
(B) The MCO has not pre-certified the service provided; or
(C) The surgeon is not an MCO panel provider.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252

436-009-0023 Ambulatory Surgery Center (ASC)

* * * *

(4) **ASC Payment.**

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(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.

CPT® Code	Maximum Payment Amount		CPT® Code	Maximum Payment Amount
23350	$235.12		36410	$19.94
25246	$220.99		36416	80% of billed
27093	$304.90		36620	80% of billed
27648	$274.16		62284	$282.47
36000	$39.05		62290	$417.89

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AMEND: 436-009-0040

RULE TITLE: Fee Schedule (temporary rule)

RULE SUMMARY: Revised rule 0040 includes an associated Appendix B, “Physician Fee Schedule,” that lists codes and maximum allowable payments for numerous medical services. Appendix B has been amended to include new medical billing codes for 2024. Maximum payment amounts for new codes have been set using 2023 conversion factors if the Centers for Medicare & Medicaid Services has published relative value units. Otherwise, the maximum payment is set at 80% of the amount billed.

RULE TEXT:

(1) Fee Schedule Table.

(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table: [See attached table.]

(b) The global period is listed in the column ‘Global Days’ of Appendix B.

(2) Anesthesia.

(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.

(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.

(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier ‘NT’ (no time) must be on the bill.

(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.

(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $60.93. Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

(A) The maximum allowable payment amount for anesthesia codes; or

(B) The provider’s usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.

(3) Surgery. Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:

(a) One surgeon [See attached table.]

(b) Two or more surgeons [See attached table.]

(c) Assistant surgeons [See attached table.]

(d) Nurse practitioners or physician assistants [See attached table.]

(e) Self-employed surgical assistants who work under the direct control and supervision of a physician [See attached table.]

(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(g) If the surgery is nonelective, the physician is entitled to payment for the initial evaluation of the patient in addition to

the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.
(4) Radiology Services.
(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.
(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component. The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.
(5) Pathology and Laboratory Services.
(a) The payment amounts in Appendix B apply only when there is direct physician involvement.
(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.
(6) Physical Medicine and Rehabilitation Services.
(a) Time-based CPT® codes must be billed and paid per code according to this table: [See attached table.]
(b) Except for CPT® codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code. When a provider bills for more than three separate CPT®-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.
(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.
(d) CPT® codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.
(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.
(7) Reports.
(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT® codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.
(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.
(8) Nurse Practitioners and Physician Assistants. Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248

AMEND: 436-009-0080

RULE TITLE: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (temporary rule)

RULE SUMMARY: Revised rule 0080 includes an associated Appendix E, that lists codes and maximum allowable payments for durable medical equipment, prosthetics, orthotics, and supplies. Appendix E has been amended to include new medical billing codes for 2024. Maximum payment amounts for new codes have been set using 2023 multipliers applied to payment amounts published by the Centers for Medicare & Medicaid Services.

RULE TEXT:

(1) Durable medical equipment (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:

(a) Is primarily and customarily used to serve a medical purpose,

(b) Can withstand repeated use,

(c) Could normally be rented and used by successive patients,

(d) Is appropriate for use in the home, and

(e) Is not generally useful to a person in the absence of an illness or injury.

(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An orthotic is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.

(4) Supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

(a) NU for purchased, new equipment;

(b) UE for purchased, used equipment; and

(c) RR for rented equipment

(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table: [See attached table.]

(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes): [See attached table.]

(8) For items rented, unless otherwise provided by contract:

(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.

(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:

(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or

(b) The provider may offer a service agreement at an additional cost.

(10) Hearing aids must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner. Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $7000 for a pair of hearing aids, or $3500 for a single hearing aid. If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.
(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for vision services billed with HCPCS codes V0000 through V2999.
(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.
(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.
(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248