



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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Salem, OR 97309-0405
1-800-452-0288 or 503-947-7810
www.wcd.oregon.gov

April 17, 2008

Proposed Changes to Workers' Compensation Rules

The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436, affecting hearings before the director, medical services and fee schedules, managed care organizations, workers' compensation insurance coverage, insurers' record keeping and reporting, the Preferred Worker Program, and electronic data interchange of medical bill payment records.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** May 19, 2008, 9:00 a.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone - (503) 947-7717; Fax - (503) 947-7581

The closing date for written comments is May 22, 2008.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –
<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>
Or call (503) 947-7627 to get free paper copies

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
A Statement of Need and Fiscal Impact accompanies this form.

Department of Consumer and Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns^{FB}
Rules Coordinator

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Rules Coordinator

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RULE CAPTION

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Hearing date	Time	Location	Hearings Officer
May 19, 2008	9:00 a.m.*	Room 260 (2 nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns

***NOTE: The hearing will begin at 9:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through May 22, 2008.**

The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

ADOPT: OAR 436-050-0025

AMEND: OAR 436-001, 436-009, 436-010, 436-015, 436-050, 436-160 and 436-030-0003, 436-040-0003, 436-045-0003, 436-110-0320, 436-110-0330, 436-110-0240^{FB}

REPEAL: OAR 436-040-0100

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656

Stats. Implemented

RULE SUMMARY

General changes to OAR chapter 436: The agency proposes to correct typographical and citation errors, delete duplicate requirements, clarify or relocate some provisions, and streamline processes. To the extent that these changes may substantially affect the meaning of the rules, they are described below.

The agency proposes to amend OAR chapter 436, division 001, "Procedural Rules Governing Rulemaking and Hearings." These proposed rules address: The applicability of the rules; notice of rulemaking; distribution of exhibits; content of exceptions; stay of director review; time limits for attorneys to submit statements of services; and administrative law judge authority to approve settlements and dismiss cases.

The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules." These proposed rules address: Adoption of updated medical fee schedules and resources for the payment of health care providers; time frames for refunds of overpaid medical bills and related appeal rights; compensability of lumbar artificial disc replacements; electronic data interchange medical reporting requirements; adjustment of the conversion factors for evaluation/management (increase) and surgery (decrease); reduction of the maximum allowable fee for brand and generic drugs from 88% to 83.5% of the average wholesale price; and reduction of the dispensing fee from \$8.70 to \$2.00.

The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules address: Treatment and time-loss authority time limits applicable to several health care provider types; how the enrollment of a nonsubject worker in an MCO affects the worker's maximum number of choices of attending physician; contraindications to lumbar artificial disc replacement; and requirements for the worker's social security number on Form 827.

Notice of Proposed Rulemaking Hearing
Page 2

The agency proposes to amend OAR chapter 436, division 015, “Managed Care Organizations” (MCOs). These proposed rules address: MCO certification requirements relevant to the definition of the terms “group” (of medical service providers) and “non-qualifying employer”; requirements for MCOs to contract with multiple insurers; documentation requirements for prospective MCOs (applicants); MCO quarterly data reporting; wording of appeal rights notices that MCOs must provide to parties that may appeal an MCO's decision; appeal time frames; and the process for making complaints about rule violations.

The agency proposes to amend OAR chapter 436, division 030, “Claim Closure and Reconsideration,” division 040, “Workers with Disabilities Program,” and division 045, “Reopened Claims Program.” These proposed rules: Correct the applicability provisions in rules 030-0003, 040-0003, and 045-0003; and repeal OAR 436-040-0100, “Suspension and Revocation of Authorization to Issue Guaranty Contracts” (because this rule duplicates OAR 436-050-0015).

The agency proposes to amend OAR chapter 436, division 050, “Employer/Insurer Coverage Responsibility.” These proposed rules address: The definition of “complete records”; service of penalty orders; the definition of “owner of the private home” to include any person related by an Oregon registered domestic partnership; effect on a guaranty contract of an employer’s cancellation of coverage; in-state claims processing requirements and allowance for claims to be “dispatched” from any location, record-keeping, including record-keeping for supplemental disability benefits; elimination of the requirement to include workers’ social security numbers on lists of claims provided to the director when an insurer or self-insured employer transfers claims to a new processor/location; that excess insurance coverage may include a deductible endorsement acceptable to the director; time frames for a self-insured municipality to provide its annual report to the director; notice to the director when the self-insured employer changes its operation in a manner that affects its workers’ compensation claims liability; and in-state record-keeping, claims processing, auditing procedures, and required reporting of contact information specific to self-insured employers.

The agency proposes to amend OAR chapter 436-110, “Preferred Worker Program.” These proposed rules address: Issuance of Preferred Worker cards to workers determined eligible before claim closure; and time frames for insurers to request claim cost reimbursement from the Workers’ Benefit Fund.

The agency proposes to amend OAR chapter 436-160, “Electronic Data Interchange.” These proposed rules address: Requirements for trading partner agreements; address reporting requirements; adding and deleting coverage for non-subject workers; time frames for notice to the director of guaranty contract terminations (correction to ten days from seven days to be consistent with requirements in OAR 436-050); elimination of the requirement that insurers submit cancellations of medical bills before resubmitting; and EDI medical reporting requirements.

Request for public comment: The Workers’ Compensation Division requests public comment on whether other options should be considered for achieving the rules’ substantive goals while reducing the negative economic impact of the rules on business.

Address questions to:

Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us

Proposed rules are available on the Workers’ Compensation Division’s Web site:

<http://wcd.oregon.gov/policy/rules/rules.html#proprules>

or from WCD Publications, 503-947-7627 or fax 503-947-7630.

May 22, 2008
Last Day for Public Comment

/s/ John L. Shilts 4/10/08
Authorized Signer and Date

John L. Shilts, Administrator, Workers’ Compensation Division
Printed name

*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Consumer and Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

In the Matter of)
The Amendment of OAR:)
436-001, Procedural Rules Governing Rulemaking and Hearings)
436-009, Oregon Medical Fee and Payment Rules)
436-010, Medical Services)
436-015, Managed Care Organizations)
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)

Rule Caption:

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656

Need for the Rule(s): The agency is proposing changes: to update the medical fee schedules as required by ORS 656.248; to implement House Bill 2007 affecting domestic partners; to begin to implement Senate Bill 559 affecting how insurers report proof of workers' compensation insurance coverage to the agency; to establish standards for electronic data interchange of medical and coverage data; to ensure insurers and self-insured employers keep sufficient records in Oregon for agency audits; to streamline certain procedures affecting the Preferred Worker Program; and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

Documents Relied Upon, and where they are available: "Issues" documents presented to stakeholder advisory committees; advisory committee meeting minutes; written advice from advisory committee members and other interested parties. These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 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. Please call (503) 947-7717 to request copies.

Fiscal and Economic Impact, including Statement of Cost of Compliance: Unless stated otherwise, references to "insurers" (below) include "self-insured employers." The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by OAR chapter 436:

OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules"

- Adoption by reference of Centers for Medicare & Medicaid Services (CMS) 2008 Medicare Resource-Based Relative Value Scale (RBRVS), Addendum B and Addendum C, 72 Federal Register No. 227, Nov. 27, 2007, as the fee schedule for payment of medical service providers, except as otherwise provided in the rules

The agency projects, due to some changes in the CMS relative value units for 2008, that adoption of the RBRVS would decrease overall medical payments that are subject to the RBRVS by approximately \$350,000, or -0.18%.

- Increasing the conversion factor for the service category "Evaluation/Management" (E&M) from \$59.79 to \$64.79 and decreasing the conversion factor for Surgery from \$93.66 to \$86.44

The agency projects an annual increase in E&M reimbursements of approximately \$2 million and a decrease in Surgery reimbursements of approximately \$2 million. Data available to the agency shows payments for E&M services average 9% above the maximums allowed during calendar year 2007, while payments for surgery average 26% below the maximums allowed. The purpose of these changes is to better align these components of the fee schedule with reimbursement generally received for the services provided, as required under ORS 656.248(1); in addition, access to high quality E&M services is critical in promoting early, effective treatment, improving long-term outcomes, and promoting early return to work.

- Maintaining the other conversion factors at 2007 levels

Overall, the agency projects that keeping the conversion factors at 2007 levels will result in reduced net income for some medical providers, because providers' business costs are rising. Between 2006 and 2007, the Physicians' Services Component of the Consumer Price Index increased by 4.04%. Relative to increasing the conversion factors by the 2006-2007 CPI increase, 4.04% is the approximate, potential, maximum effect on Oregon medical providers as a whole; effects on individual providers may be more or less depending on the types of services provided. However, available medical billing data shows that average payments in the following service categories are below the maximums allowed during calendar year 2007: Surgery, Radiology, Lab & Pathology, Medicine, Physical Medicine and Rehabilitation, and Multidisciplinary/Other Oregon-Specific Codes. For those medical providers that bill below the maximums, maintaining the 2007 levels will have no direct fiscal impact.

- Reducing the maximum allowable fee for brand and generic drugs from 88% to 83.5% of the average wholesale price (AWP); reducing the dispensing fee from \$8.70 to \$2.00

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

- Restricting compensability of lumbar artificial disc replacements

Under ORS 656.245(3), the director may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded, or experimental. Based on the advice of the Medical Advisory Committee, the director proposes to exclude artificial disc replacements from compensability unless the devices and the patients meet specific conditions – with the goal to improve patient outcomes. Improved patient outcomes should lower overall medical costs paid by insurers. Restrictions affecting artificial disc replacement could have a slight negative fiscal impact on surgeons who perform disc replacements, though surgeons may perform other procedures on patients that do not meet the criteria for disc replacement. Artificial disc replacement is not a commonly used procedure, so the overall fiscal impact should be small.

OAR chapter 436, division 010, “Medical Services”

- Contraindications to lumbar artificial disc replacement

See analysis under OAR 436-009 regarding “Restricting compensability of lumbar artificial disc replacements”

OAR chapter 436, division 015, “Managed Care Organizations” (MCOs)

- Reduced documentation requirements for prospective MCOs (applicants)

The agency projects a small savings for applicant MCOs.

OAR chapter 436, division 050, “Employer/Insurer Coverage Responsibility”

- Required record-keeping for supplemental disability benefits (SDB)

The agency projects that insurers that have elected to process SDB will incur small initial costs to establish record-keeping procedures, plus some on-going costs to track eligibility and payments. The

majority of insurers have elected to refer affected claims to the agency's contracted agent for processing; for these companies there would be no fiscal impact. The few companies that process their own SDB claims are reimbursed by the agency for SDB claims costs from the Workers' Benefit Fund. Included in these reimbursements is an administrative cost factor, most recently 17.15%, which is intended to cover the costs to process claims, including associated record-keeping.

OAR chapter 436-110, "Preferred Worker Program"

- Issuance of Preferred Worker cards to workers determined eligible before claim closure
The agency projects a small positive fiscal impact on affected workers - those who can receive Preferred Worker cards earlier and use them to obtain employment.
 - Expanded time frames for insurers to request claim cost reimbursement from the Workers' Benefit Fund
The agency projects a small positive fiscal impact on employers whose insurers can obtain reimbursement of claims costs even if the insurer is informed about eligibility late – after existing deadlines for requesting reimbursement would have expired. Affected insurers would reimburse their insured employers for any premiums and premium assessments paid during the premium exemption period.
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Regarding additional proposed changes to chapter 436, including amendments to OAR 436-001, 030, 040, 045, and 160

The agency estimates that additional changes will not have a significant economic impact on any persons or businesses, including small businesses.

How were small businesses involved in the development of this rule?

Representatives of small businesses participated in the stakeholder advisory committee. Small businesses affected by these rules are primarily medical providers and pharmacies.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

Based on available data, we estimate approximately 12,000 medical providers and 110 pharmacies are small businesses, as defined in ORS 183.310(10).

Identify the types of businesses and industries with small businesses subject to the proposed rule:

Oregon medical providers
Oregon pharmacies

Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:

Reporting: The proposed changes do not require increased reporting for small businesses.

Record-keeping: The proposed changes do not require increased record-keeping for small businesses.

Other administrative activities and costs of professional services:

The agency projects that, due to some changes in the Centers for Medicare & Medicaid Services (CMS) relative value units for 2008, adoption of the CMS schedule would decrease overall medical payments that are subject to the schedule by approximately \$350,000, or -0.18%.

The agency projects that increasing the conversion factor for the service category Evaluation/Management (E&M) from \$59.79 to \$64.79 will increase reimbursements for E&M services by approximately \$2 million.

The agency projects that decreasing the conversion factor for Surgery from \$93.66 to \$86.44 will decrease reimbursements for surgical services by approximately \$2 million.

Overall, the agency projects that keeping the remaining conversion factors at 2007 levels will result in reduced net income for some medical providers, because providers' business costs are rising. Between 2006 and 2007, the Physicians' Services Component of the Consumer Price Index increased by 4.04%. Relative to increasing the conversion factors by the 2006-2007 CPI increase, 4.04% is the approximate, potential, maximum effect on Oregon medical providers as a whole; effects on individual providers may be more or less depending on the

Statement of Need and Fiscal Impact
Page 4

types of services provided. However, available medical billing data shows that average payments in the following service categories are below the maximums allowed during calendar year 2007: Surgery, Radiology, Lab & Pathology, Medicine, Physical Medicine and Rehabilitation, and Multidisciplinary/Other Oregon-Specific Codes. For those medical providers that bill below the maximums, maintaining the 2007 levels will have no direct fiscal impact.

The agency projects that reducing the maximum allowable fee for drugs from 88% to 83.5% of the average wholesale price, and reducing the dispensing fee from \$8.70 to \$2.00 would reduce annual drug payments by approximately \$3.6 million, or 21.8% of total pharmacy payments.

Extent of economic impact: The proposed changes to the conversion factors and pharmacy fees for brand name drugs would better align the medical fee schedules with reimbursement generally received for the services provided, as required under ORS 656.248(1). The proposed changes to pharmacy fees for generic drugs continue to provide a significantly higher reimbursement than some widely accepted pharmacy benefit plans. There is no basis to say that economic impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

Identify equipment, supplies, labor and increased administration required for compliance with the proposed rule:

Equipment: The proposed changes do not require the purchase of equipment to achieve compliance.

Supplies: The proposed changes do not require the purchase of supplies to achieve compliance.

Labor: The proposed changes do not require that small businesses hire additional staff to achieve compliance.

Administration: The proposed changes do not require increased administration to achieve compliance.

Extent of economic impact: There is no basis to say that any impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

Administrative Rule Advisory Committee consulted:

Yes, advisory committees met on Jan. 25, Feb 11, and Feb. 25, 2008.

The agency asked the committees for advice on the economic impacts of the discussed changes, including impacts on small businesses.

/s/ John L. Shilts

4/10/08

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

ORDER NO. XX-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed WORKERS WITH DISABILITIES PROGRAM *RULES*

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 040, RULES 0003 & 0100

Revisions are marked as follows:

Deleted text has a "strike-through" style, as in	Deleted
Added text is bold and underlined, as in	<u>Added</u>

436-040-0003 Applicability of Rules

(1) These rules are effective ~~December 26, 1990~~**July 1, 2008**, and apply to all applications for relief submitted prior to May 1, 1990 and all requests for reimbursement from the Workers with Disabilities Program filed with the director on or after ~~December 26, 1990~~**July 1, 2008** for injuries occurring on or after November 1, 1981.

(2) These rules carry out the provisions of ORS 656.628.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628 (§286, ch. 70, OL 2007)
Hist: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

436-040-0100 Suspension and Revocation of Authorization to Issue Guaranty Contracts
(Repealed)

~~(1) Pursuant to ORS 656.447, the director may suspend or revoke the insurer's authority to issue guaranty contracts upon a determination that the insurer has failed to comply with its obligations under such contract or that it has failed to comply with the rules or orders of the director.~~

~~(2) For the purpose of this rule:~~

~~(a) "Suspension" and its variations means a stopping by the director of the insurer's authority to issue new guaranty contracts for a specified period of time.~~

~~(b) "Revocation" and its variations means a permanent revocation by the director of an insurer's authority to issue guaranty contracts.~~

~~(c) "Show cause hearing" means an informal meeting with the director or designee in which the insurer shall be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke an insurer's authority to issue guaranty contracts.~~

~~(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show cause hearing before the director and "show cause" why it should be permitted to continue to issue guaranty contracts.~~

~~(4) A show cause hearing may be held at any time the director finds that an insurer has failed to comply with its obligations under a guaranty contract or that it failed to comply with rules or orders of the director.~~

~~(5) Following a show cause hearing, the director may rescind the proposed order if the~~

ORDER NO. XX-XXX

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* WORKERS WITH DISABILITIES PROGRAM RULES**

insurer establishes to the director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

~~(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy lapses or is canceled during the period of suspension.~~

~~(7) After 12 months of the suspension has elapsed, the division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the director revoke the insurer's authority to issue guaranty contracts.~~

~~(8) When an insurer's authority to issue guaranty contracts has been revoked, the insurer may serve an existing account only until the policy lapses, is canceled or until the next renewal date, whichever first occurs.~~

~~(9) After a revocation of an insurer's authority to issue guaranty contracts has been in effect for five (5) years or longer, it may petition the director to restore its authority by submitting a plan in the form prescribed by the director, demonstrating its ability and commitment to comply with the workers' compensation law, these rules and orders of the director.~~

~~(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-040-0008.~~

~~(11) Any order of suspension or revocation issued by a referee or other person pursuant to ORS 656.447 and this rule is a preliminary order subject to revision by the director.~~

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.628

Hist: Amended 11/1/07 as WCD Admin. Order 07-061, eff. 1/1/08

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx