

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
OREGON MEDICAL FEE AND RELATIVE VALUE SCHEDULE

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Only adopted, amended, and repealed rules are included in this document:

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436-009-0010 General Requirements for Medical Billings

(1) Only treatment that falls within the scope and field of the practitioner's license to practice will be paid under a worker's compensation claim.

(2) All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on current form UB92 or form HCFA 1500, except for:

- (a) dental billings which shall be submitted on ADA dental claim forms;
- (b) pharmacy billings, which shall be submitted on the most current NCPDP form;
- (c) EDI transmissions of medical bills pursuant to OAR 436-009-0030(3)(c).

Computer-generated reproductions of these forms may also be used. Billings shall include the worker's full name, date of injury, the employer's name and, if available, the insurer's claim number.

(3)(a) All original medical provider billings shall be accompanied by legible chart notes documenting services which have been billed, and identifying the person performing the service and license number of person providing the service. Medical doctors are not required to provide their medical license number if they are already providing other identification such as tax identification, National Practitioner Identification Number (NPIN), and social security numbers.

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) Codes listed in CPT™ 2001 or Oregon Specific Codes (OSC) shall be used when

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billing medical services. All billings shall be fully itemized and include ICD-9-CM codes. Services shall be identified by the code numbers and descriptions provided in these rules.

(a) If there is no specific code for the medical service, the medical provider shall use the appropriate unlisted code at the end of each medical service section of CPT™ 2001 and provide a description of the service provided.

(b) Any service not identifiable with a code number shall be adequately described by report.

(5) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings may be subject to discounts, not to exceed 10 percent for each 30 day period or fraction thereof, beyond 60 days, **provided the medical provider has notice or knowledge of the responsible workers' compensation insurer or processing agent.**

(6) Rebillings shall indicate that the charges have been previously billed.

(7) The medical provider shall bill their usual and customary 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.

(8) Medical providers shall not submit false or fraudulent billings. As used in this section, "false or fraudulent" shall mean an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. The medical provider shall not bill for services not provided.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but in no event later than 30 days following receipt of the request. Thereafter, worker copies shall be furnished during the regular billing cycle.

Stat. Auth.: ORS 656.245, 656.252, 656.254

Stats. Implemented: ORS 656.245, 656.252, 656.254

Hist: Renumbered from OAR 436-010-0010(5) and (6) to OAR 436-009-0010(1) and (2) ;
from 436-010-0040(3)(d) and (e) to 436-009-0010(3) and (4);
from 436-010-0040(7) and (9) to 436-009-0010(4) and (5);
from 436-010-0040(11) to 436-009-0010(11); and
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Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98
Amended 5/27/99 as Admin. Order 99-057, eff. 7/1/99
Amended 03/15/00 as Admin. Order 00-051, eff. 04/01/00
Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 9/13/01 as WCD Admin. Order 01-058, eff. 9/17/01

436-009-0015 Limitations on Medical Billings

(1) An injured worker shall not be liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer pursuant to OAR Chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment that has not been prescribed by the attending physician or specialist physician upon referral of the attending physician. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period as set forth in OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director pursuant to OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental pursuant to OAR 436-010-0300.

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3) of this rule.

(3) The preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service.

(4) No fee shall be paid for the completion of a work release form or completion of a physical capacity evaluation form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or the department. Except as provided in OAR 436-009-0070 (10)(d), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider shall be paid at 50 percent of the examination or testing fee. A medical arbiter may also receive payment for a file review as determined by the director.

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(6) Payment shall not be made for DMSO except for treatment of compensable interstitial cystitis. Additionally, payment shall not be made for **intradiscal electrothermal therapy (IDET)**, surface EMG tests, rolfing, prolotherapy, and thermography. While these services may be provided, medical providers shall not be paid for such services or for treatment of side effects.

(7) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician: once near the beginning, once near the middle and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for 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.

(9)(a) When a physician provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's office, such services shall be identified by CPT™ codes and paid according to the fee schedule.

(b) When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital fee schedule.

(10) Physician assistant or nurse practitioner fees shall be paid at the rate of 80 percent of a physician's fee for a comparable service. The bills for services by these providers shall be marked with modifier "81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(11) When a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT™ Codes such as 99080. Refer to specific code definitions in the CPT™ for other applicable codes. These CPT™ codes shall be used for prolonged physician service without direct patient (face-to-face) contact that will require the physician to review complex, detailed medical records transferred from previous physicians and/or to complete a comprehensive treatment plan. They may also be used to review subsequent reports on patient status, to include communication with other health care professionals involved in the patient's care. The billing should include the actual time spent reviewing the records or reports.

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