



# Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
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Aug. 12, 2010

## **Proposed Changes to Workers' Compensation Rules**

The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436, division 009, rule 0030.

The proposed rule changes are not substantive, and we anticipate no economic impacts on any person or business. The changes address the completion of the transition from quarterly reporting (also known as Bulletin 220 reporting) to the ANSI X12 837 medical bill reporting requirements described in OAR 436-160, to be effective Jan. 1, 2011.

Please review the attached documents for more information about proposed changes.

**The department welcomes written comment on proposed rule changes.**

**How can I make a comment?** 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](mailto:fred.h.bruyns@state.or.us)  
Fax: 503-947-7514

**The closing date for written comments is Sept. 21, 2010.**

**How can I get copies of the proposed rules?**

On the Workers' Compensation Division's website –

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

Or call 503-947-7717 to get free paper copies.

**Questions?**

Contact Fred Bruyns, 503-947-7717.

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

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	503-947-7717
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350 Winter St. NE, Salem, OR 97301-3879 <a href="mailto:fred.h.bruyns@state.or.us">fred.h.bruyns@state.or.us</a>	

**RULE CAPTION**

**Workers' compensation medical bill data reporting**

**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 (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing

**AMEND:** OAR 436-009-0030

Stat. Auth.: ORS 656.726(4)

Other Auth.:

Stats. Implemented: ORS 656.252, 656.254, 656.264

**RULE SUMMARY**

**The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules,"** by removing medical bill data reporting procedures from rule 0030, "Insurer's Duties and Responsibilities." For the past two years, the agency provided two medical bill reporting formats, quarterly reporting (also known as Bulletin 220 reporting) and ANSI X12 837 reporting. These proposed rule changes are not substantive, and simply reflect the completion of the transition to the ANSI X12 837 medical bill reporting requirements described in OAR 436-160, to be effective Jan. 1, 2011.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

Address questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7514; e-mail [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us)  
Proposed rules are available on the Workers' Compensation Division's website:

<http://wcd.oregon.gov/policy/rules/rules.html#proprules> or telephone 503-947-7717 or fax 503-947-7514.

Sept. 21, 2010

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

/s/ *John L. Shilts*

Signature

John L. Shilts

Printed name

Aug. 10, 2010

Date

\*Rulemaking Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. A public rulemaking hearing may be requested in writing by 10 or more people, or by an association with 10 or more members, within 21 days following the publication of the Rulemaking Notice in the Oregon Bulletin or 28 days from the date Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.  
ARC 923-2005

Distribution: WCD-ID, S0, S1, S4, S7, S, U, AT, CE, EG, LU, NM, CI, MR, TT, DC, DO, GR, MD, ND, OT, PY, M1, M2; Agency e-mail lists

**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	436
Agency and Division	Administrative Rules
Chapter Number	

**Workers' compensation medical bill data reporting**

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

**In the Matter of:** The Amendment of OAR 436-009, Oregon Medical Fee and Payment Rules

**Statutory Authority:** ORS 656.726(4)

**Other Authority:**

**Stats. Implemented:** ORS 656.252, 656.254, 656.264

**Need for the Rule(s):** These changes are needed to remove medical bill data reporting procedures from OAR 436-009, including the removal of the Bulletin 220 reporting format. OAR 436-160, Electronic Data Interchange; Medical Bill Data," includes all relevant requirements and procedures for medical bill data reporting.

**Documents Relied Upon, and where they are available:** Advisory committee meeting records.

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:** The agency projects that these proposed changes will have no economic effect on any party. Estimated fiscal impacts of proposed changes to the ANSI X12 837 reporting were included in a statement filed (in July) with proposed amendments to OAR 436-160.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): **None**.
2. Cost of compliance effect on small business (ORS 183.336):
  - a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:  
**No small businesses will be affected by this rule change.**
  - b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: **None**
  - c. Equipment, supplies, labor and increased administration required for compliance: **None**

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

The agency did not consult small businesses about the proposed removal of medical data reporting procedures from these rules – small businesses will not be affected by this change.

Administrative Rule Advisory Committee consulted?: Yes. June 21, 2010

If not, why?:

<i>/s/ John L. Shilts</i>	John L. Shilts	Aug. 10, 2010
Signature	Printed name	Date



*Proposed*  
**Oregon Medical Fee and Payment Rules**  
**Oregon Administrative Rules**  
**Chapter 436, Division 009, Rule 0030**

NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in

~~Deleted~~

Added text is bold and underlined, as in

**Added**

**436-009-0030 Insurer's Duties and Responsibilities**

(1) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(2) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0070(1). If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(3) Insurers must date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was not paid or what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(b) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided.

(c) When a medical provider submits a bill electronically, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) With each payment, the insurer or its representative must provide the medical

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provider a written explanation identifying the service(s) being paid. If the insurer or its representative denies or reduces payment, the insurer or its representative must provide the medical provider a written explanation that includes the specific reason(s) for non-payment, reduced payment, or discounted payment for each service billed by the medical provider. The written explanation must also include:

(a) An Oregon or toll-free contact phone number for the insurer for billing inquiries from medical providers;

(b) A notice of right to administrative review as follows: **“If you disagree with this decision about this payment, contact {insurer’s name and an Oregon or toll-free contact phone number}. If you are unable to reach an agreement with {insurer’s name}, you may request administrative review by the director of the Department of Consumer and Business Services. Your request for review by the director must be made within 90 days of the mailing date of this explanation. To request review, sign and date this document in the space provided, indicate which decisions you disagree with, and mail this document with supporting documentation to the Workers’ Compensation Division, Medical Section, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-934-6050. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records.”**

(c) Space for the medical provider’s signature and the date.

(5) An insurer must answer a medical provider’s inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the medical provider’s inquiry.

(6) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(7) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(8) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code. Resolution of billing disputes, including possible overpayment disputes, must be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(9) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240, must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(10) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit shall be continuous and shall include no fewer than 10 percent of medical bills. The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

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(11) 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 disputed claim settlement (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.

(12) **Once the director has determined that an insurer's average accepted disabling claim count is 100 or higher per calendar year the insurer must report medical bill payment data to the department in subsequent years. If the insurer's claim count drops below an average of 50 accepted disabling claims, the insurer may apply to the director for exemption from the reporting requirement. See OAR 436-160 Electronic Data Interchange Medical Bill Data rules for reporting requirements.** Insurers that had at least 100 accepted disabling claims in the previous calendar year, as determined by the director, are required to submit detailed medical bill payment data to the Information Management Division of the Department of Consumer and Business Services at 350 Winter St NE, Room 300, PO Box 14480, Salem OR 97309-0405. Once an insurer has reached the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. The director will notify the affected insurers when they reach the minimum. If the insurer drops below the 100 disabling claim level or encounters other significant hardships, the insurer may apply to the director for exemption from the reporting requirement. The reporting requirements are as follows:

(a) ~~The transmission data and format requirements are included in Appendix A of these rules and Appendix B of OAR 436-160. OAR 436-160 explains the IAIABC ANSI 837 medical bill reporting requirements. To determine which appendix applies to required reporting insurers, see below.~~

(b) ~~Each insurer must continue to report according to Appendix A until successfully completing IAIABC ANSI 837 testing under OAR 436-160. Once successfully completing testing, the insurer may only report via IAIABC ANSI 837.~~

(c) ~~Group 1 is all required reporting insurers who are currently reporting data via IAIABC ANSI 837 in another jurisdiction. Each insurer in Group 1 must begin testing on July 1, 2008.~~

(d) ~~Group 2 is the State Accident Insurance Fund Corporation. Group 2 must begin testing on April 1, 2009.~~

(e) ~~Group 3 is all other required reporting insurers. Each insurer in Group 3 must begin testing on October 1, 2009.~~

(13) ~~An insurer may request, in writing, additional time to report the requested data elements according to OAR 436-160. The insurer must demonstrate that the date to begin testing creates an undue hardship. The request must include a plan to begin testing within 12 months of the group's testing date, and may not extend beyond January 1, 2010.~~

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~~(14) Undue hardship is demonstrated by providing the total required expenses to begin testing; the reporting cost per bill if transmitted directly by the insurer; and the total cost per bill if reported by a vendor.~~

~~(15) If the director allows additional time, the insurer must continue to report all medical billing data under Appendix A during the testing.~~

~~(16) The director may audit an insurer's actual payments reported for individual claims. An insurer is subject to a civil penalty if an audit determines that the insurer's error rate is 15 percent or higher in any field.~~

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264  
Hist: Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10

**ORDER NO. 10-XXX**

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**Appendix A — 436-009-0030**

Insurers are required to report medical bill payment data on all payments made during each quarter for medical services as defined in OAR 436-010-0005. Insurers must submit medical bill payment data no later than 45 days after the end of each quarter, as shown below.

QUARTER	MONTH OF PAYMENT	DUE NEXT
First	January, February & March	May 15th
Second	April, May & June	August 14th
Third	July, August & September	November 14th
Fourth	October, November & December	February 14th

**Technical Requirements:** Medical bill payment data for each quarter calendar year must be transmitted as an individual file. Insurers transmitting data for more than one insurer may batch multiple insurer data files in one transmission. Data must be transmitted in electronic text files by secure file transfer protocol (SFTP) using the secure shell (also known as SSH) protocol. Contact the Information Management Division (IMD) to arrange submission of files by SFTP. The record length must be fixed, 129 bytes, no packed fields, and in conformance with the records layout requirements described in this appendix. Contact IMD for e-mail cover letter instructions. The cover letter must include the following: a list of all insurance companies' data included in the transmission; number of records; a contact person's name, address, and telephone number; the quarter being reported, and any known problems with the data.

**Data Quality:** The director will conduct electronic edits for blank or invalid data. Required reporting insurers are responsible for pre-screening the data to check that all the required information is reported. Files which have more than five percent missing or invalid data in any field, based on initial computerized edits, will be returned for correction and must be resubmitted within three weeks (21 days) from the date it was returned by the department.

**Special Requirements**

The medical bill payment data must include all payments made during each calendar quarter for medical services. The following apply:

**Hospital Inpatient:** Each hospital inpatient stay should be reported as one record summarizing all services related to the inpatient stay using provider type "HI." Report ICD-9-CM procedure code in the service code field.

**Hospital Outpatient:** Report at the individual service code level using provider type "HO." A service code, whether CPT®, HCPCS or other, is required on all "HO" records in addition to the ICD-9-CM diagnostic code.

**UPIN:** The unique provider identifier number (UPIN), is a six position alphanumeric identifier that is assigned to all Medicare physicians, medical groups, and non-physician practitioners. Left justify the UPIN and follow with blanks.

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~~ICD-9-CM Diagnosis Codes: The International Classification of Diseases (ICD-9-CM) diagnosis code(s) must appear on all records where the provider type is chiropractor, hospital inpatient, hospital outpatient, medical doctor, osteopath, physician's assistant, or registered nurse practitioner. The primary code must be supplied first and, if available, the secondary code should be supplied.~~

~~Service, Drug, or Procedure Codes: Report the Physicians' Current Procedural Terminology (CPT®) code or other applicable code from the Oregon Medical Fee and Payment Rules: for example, "99201". On payments for durable medical equipment, report the appropriate HCPCS code: for example, "E0110". On payments for pharmaceuticals, report the eleven digit National Drug Code (NDC): for example, "61392054230". On hospital inpatient services, report the ICD-9-CM procedure code: for example, "81.97". If reporting a hospital outpatient service, you may report the appropriate hospital revenue code: for example, "450". All codes must be left justified and followed with blanks, as necessary, to comply with the required record layout format.~~

~~Modifier Codes: All adjustments to payments need to be associated with specific services.~~

- ~~• Use modifier 'SG' to identify ambulatory surgical center facility charges.~~
- ~~• Use modifier 'NT' (no time) on bills from a surgeon or attending physician administering a local or regional block for anesthesia during a procedure.~~
- ~~• Use modifier '50' when a surgical procedure is performed bilaterally for the second side.~~
- ~~• Use modifier '81' on bills for services by a physician assistant or nurse practitioner.~~
- ~~• For a refund payment, repeat the record exactly as originally reported but enter payment and charge amounts as negatives (put minuses in the sign fields) and put "RF" (for refund) in the modifier code field.~~
- ~~• Adjustments that result in a partial refund or additional payment for a service that has already been paid should be coded with "DC" in the modifier code field.~~

~~Number of units or services: Report the number of time units paid on each time-based service such as anesthesiology and therapeutic procedures. For example, where base time unit equals 15 minutes (anesthesia, CPT® 97110, 97530, etc.), one hour of service equals "04" units. Where base time unit equals one hour (CPT® 97546), two hours of service equals "02" units. Also report the number of services if multiple, identical services to a patient are bundled into one record. For example, three whirlpool treatments (CPT® 97022) equals "03".~~

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**Appendix A — 436-009-0030**

**RECORD LAYOUT FOR ELECTRONIC DATA TRANSMISSION**

<b>DESCRIPTION</b>	<b>ALPHA NUMERIC</b>	<b>POSITION</b>	<b>LENGTH</b>	<b>REQUIREMENT</b>
Insurer's WCD number	9	1	4	Required
Insurer's claim number	X	5	20	Required
Claimant's SSN	9	25	9	Required
Date of injury (YYYYMMDD)	9	34	8	Required
Medical only or disabling (M or D)	X	42	1	Optional
Medical provider type	X	43	2	Required
Medical provider specialty	X	45	3	Required
Medical provider FEIN	X	48	10	Required
Medical provider other Federal Tax Reporting ID number or UPIN	X	58	9	Optional
MCO number	X	67	6	Required
ICD-9-CM diagnosis code	X	73	6	Required
Secondary ICD-9-CM diagnosis code	X	79	6	Optional
Service, drug, or procedure code	X	85	11	Required
Modifier code	X	96	2	Required
Date of service (YYYYMMDD)	9	98	8	Required
Date of payment (YYYYMMDD)	9	106	8	Required
Charge amount sign	X	114	1	Required
Charge amount	9	115	6	Required
Payment amount sign	X	121	1	Required
Payment amount	9	122	6	Required
Number of units or services	9	128	2	Required

1. Refer to Bulletin 220 for additional special field reporting instructions.

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**Appendix A—436-009-0030****RECORD LAYOUT SPECIAL FIELD REQUIREMENTS**

<b>DESCRIPTION</b>	<b>Special Field Requirements</b>
Alpha Numeric (Table Column)	X = Character or alphanumeric data: No lower case letters; fill empty spaces with blanks and left justify. 9 = Numeric data; right justify numbers including leading zeros; fill empty spaces with zeros.
Length (Table Column)	No compressed or packed fields.
Insurer's WCD number	Workers' Compensation Division insurer number National Association of Insurance Commissioners (NAIC) number, where applicable, is included for reference.
Date of injury (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Medical provider type	Use code from list of provider type codes in this appendix.
Medical provider specialty	Use code from list of provider specialty codes in this appendix.
Medical provider FEIN	Use the federal employer identification number that is used for federal tax reporting purposes.
Medical provider other Federal Tax Reporting ID number or UPIN	Report the nine digit other federal tax reporting identification number that is used for federal tax reporting purposes, or the Unique Provider Identification Number of the individual providing the medical service.
MCO number	See instructions in Bulletin 220.
ICD-9-CM diagnosis code	See instructions in Bulletin 220.
Secondary ICD-9-CM diagnosis code	See instructions in Bulletin 220.
Service, drug, or procedure code	See instructions in Bulletin 220.
Modifier code	Optional CPT <sup>®</sup> or HCPCS modifier codes are required when needed to report a modified service. Do not report physical status modifiers for anesthesia services. See instructions in Bulletin 220 for usage of adjustment modifiers "RF" and "DC" for adjustments. See instructions in Bulletin 220 for usage of modifiers "SG", "NT", "81", "50".
Date of service (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Date of payment (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Charge amount sign	If this is a refund or other negative amount, put a minus sign in this field, otherwise fill with a blank.
Charge amount	Rounded to the nearest whole dollar, for example, a \$300.05 payment would be shown as "000300."
Payment amount sign	If this is a refund or other negative amount, put a minus sign in this field, otherwise fill with a blank.
Payment amount	Rounded to the nearest whole dollar, for example, a \$300.05 payment would be shown as "000300."
Number of units or services	See instructions in Bulletin 220.

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**Appendix A—436-009-0030**

**Data and Format Requirements:**

**PROVIDER TYPES:** Use the following codes to describe the type of medical provider:

<b>TABLE OF MEDICAL PROVIDER-TYPE CODES</b>	
<b>PROVIDER DESCRIPTION</b>	<b>CODE</b>
Acupuncturist	AC
Ambulatory Surgical Center	AS
Chiropractor	CH <sub>1</sub>
Dentist	DE
Home Health Care	HH
Hospital Inpatient	HI <sub>1</sub>
Hospital Outpatient	HO <sub>1</sub>
Laboratory	LA
Medical Doctor	MD <sub>1</sub>
Medical Supplies	MS
Naturopath	NA
Nursing Home	NH
Occupational Therapist	OT
Optometrist	OP
Osteopath	OS <sub>1</sub>
Pharmacy	PH
Physical Therapist	PT
Physician's Assistant	PA <sub>1</sub>
Podiatrist	PO
Psychologist	PS
Radiologist	RA
Registered Nurse Practitioner	NP <sub>1</sub>
Other Medical Provider	OM

1. ICD 9 CM diagnosis codes are required on records with these types.

**PROVIDER SPECIALTY:** If the medical provider-type is "MD", use the following codes to designate the medical provider specialty:

<b>TABLE OF MEDICAL PROVIDER SPECIALTY CODES</b>	
<b>PROVIDER SPECIALTY</b>	<b>CODE</b>
Anesthesiologist	ANE
Dermatologist	DER
Emergency Medicine	EMM
Family Practice	FPR
General Practice	GPR
General Surgeon	GSU
Internist <sub>3</sub>	INT
Neurologist	NEU
Neurosurgeon	NSU
Occupational Medicine	OCC
Ophthalmologist	OPH
Oral Surgeon	OSU
Orthopedist/Orthosurgeon	ORS
Otolaryngologist	OTO
Pathologist	PTH
Physiatrist	PMR
Plastic Surgeon	PSU
Psychiatrist	PSY
Radiologist	RAD
Urologist	URO
Other Surgical/non-Surgical Specialists <sub>1</sub>	OTH
Unknown Specialist <sub>2</sub>	UNK

1. Indicates provider specialty does not fit any of the above categories.

2. Indicates provider specialty cannot be determined.

3. All internal medicine specialties.

NOTE: ANSI 837 Medical Bill Reporting Requirements are described in OAR 436-160