

BEFORE THE DIRECTOR OF THE  
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
OF THE STATE OF OREGON

In the Matter of the Amendment of: )  
 )  
 436-009, Oregon Medical Fee and Payment Rules ) SUMMARY OF  
 ) TESTIMONY AND  
 ) AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The agency has summarized and combined similar testimony; however, a given exhibit listed with the summary may not address all of the points in the summary. The public may obtain exact copies of the exhibits by contacting the Workers' Compensation Division, Fred Bruyns, E-mail: [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us), (503) 947-7717; fax (503) 947-7581, 350 Winter St. NE, Salem OR, 97301. The purpose of this summary is to provide the Director with a record of the agency's conclusions about the major issues raised.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated April 1, 2007. On April 23, 2007, a public rulemaking hearing was held as announced at 9:00 a.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through April 26, 2007.

Four people testified at the public rulemaking hearing. The transcript of the hearing is marked as Exhibits 25-A through 25-D. In addition, 33 written documents were submitted as testimony.

**Testimony list:**

<b>Exhibit</b>	<b>Testifying</b>	<b>Representing</b>
1	Tracy Hamaker, Vice President	DBS Health Information
2	Debbe Klaja, PT	Luke Klaja Physical Therapy
3	Thomas Bentley, PT	Luke Klaja Physical Therapy
4	Debbe Klaja and Luke Klaja PT, PC	Luke Klaja Physical Therapy
5	Joe Martinez, CBO Director	Concentra
6	Ben Bronicel, MD, President	Cascade Medical Associates
7	Richard Koller MD	NorthStar Neurology, LLC
8	Richard Abraham MD Thomas Thrall MD Eric Ackerman MD Charles Pederson MD	

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<b>Exhibit</b>	<b>Testifying</b>	<b>Representing</b>
9	Eric A. Spencer MD	
10	Larry Kroesing	Medical Section Resolution Team, Workers' Compensation Division
11	Alex Morley, MD	
12	Marc Schnapper, MD	
13	Richard Abraham MD	
14	Howard W. Tsang MD	Salem Occupational Health Clinic
15	Richard Abraham MD	
16	Mark L. Jewell, M.D.	Plastic Surgery Center
17	Raymond N. Englander, MD	Neurology Associates Of Eugene-Springfield, PC
18	Lee W. Davidson, MD	
19	Joan M. Takacs, DO	
20	Erik D. Stowell, MD Martha J. MacRitchie, MD Bryan L. Andresen, MD Victor K. Lin, MD K. Annette Weller, MD	Rehabilitation Medicine Associates
21	Kim Diehl, Director of Compliance	Third Party Solutions
22	John Di Paola, MD	Occupational Orthopedics
23	David J. Silver, MD	OMAWorkers' Compensation Advisory Committee
24	Klaus Martin, MD, PC	
25A	Debra Buchanan	Workers' Compensation Division
25B	Kim Diehl, Director of Compliance	Third Party Solutions
25C	John Braddock, MD Medical Director, CEO	Cascade Occupational Medicine
25D*	John Di Paola, MD	Occupational Orthopedics
26	Alana LaCombe Government Affairs Specialist	Third Party Solutions
27	Mark John Davison, LLC	Oregon Self-Insurers Association

<b>Exhibit</b>	<b>Testifying</b>	<b>Representing</b>
28	Richard J. Cantwell	The Gilroy Law Firm, PC
29	Matthew F. Denley	Cummins, Goodman, Fish, Denley & Vickers, PC
30	John Braddock, MD Medical Director, CEO	Cascade Occupational Medicine
31**	Robert J. Radler	Radler, Bohy, Replogle & Miller, LLP
32	Klaus Martin, MD	Oregon Medical Association
33	Joan M. Kapowich, Medical Services Manager	SAIF Corporation
34	Carol Homan, Sr. Administrative Assistant	Jackson County

\*Prior to testifying, Dr. DiPaola conferred with Dr. Ray Larsen, Dr. Nancy Borman, Dr. Gwynn Carver, Dr. Greg Henry, and Dr. Glen Stream, who staff the Concentra Medical clinics in the Portland area; Dr. J. David Hook, Medical Director of Salem Rehab Associates and the Salem Occupational Clinic; Dr. Howard Tsang, Salem Occupational Health Clinic; and Dr. William Ferguson, Corvallis Clinic Occupational Health

\*\* Mr. Radler’s testimony included the following statement: “I have reviewed and agree with the comments by Special Districts Association of Oregon and City County Insurance Services.” [This testimony was submitted as Exhibit 27, by Oregon Self-Insurers Association.]

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**Testimony: OAR 436-009 (general testimony) *Exhibit #21, 25-B, 26***

Globally, we propose removal of the words “medical provider” or “medical provider bill/billings.” By limiting the scope of the receipt of bills from a defined medical provider, the ability of others to submit invoices for reimbursement for valid workers’ compensation services and/or products rendered could be hindered. We do not feel that this is the intent of the Oregon Division of Workers’ Compensation.

**Response:** Currently there is litigation before the Court of Appeals regarding the status of entities that do not directly provide medical services to injured workers within the parameters of Oregon workers’ compensation law. The director will wait for direction from the Court before considering changes to the current scope of the Medical Fee and Payment Rules.

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**Testimony: OAR 436-009 (general testimony) *Exhibit #26***

Although the rules appear to be written with a primary focus on the physician, the inclusion of drugs by definition as medical services leads to the inclusion of pharmacy services in the rules. An alternative approach that could resolve these issues is to clarify with a clause such as “only drugs provided by a physician”. If this clause were to be added, the proposed wording changes would no longer be relevant.

**Response:** ORS 656.245(1)(b) defines drugs and medicine as compensable medical services. There is currently litigation pending before the Court of Appeals regarding services provided by entities not defined as medical providers and the director will wait for direction from the Court before making any change to the current Medical Fee and Payment Rules.

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**Testimony:** OAR 436-009-0004(1) *Exhibit #10, 25-A*

The Workers' Compensation Division proposes to clarify this subsection by amending the titles of adopted columns in the Centers for Medicare & Medicaid Services 2007 Medicare Resource-Based Relative Value Scale to specify the "Transitional" columns. This will not affect the projected fiscal impact.

**Response:** There are multiple columns in the 2007 Medicare Resource-Based Relative Value Scale and use of each results in a different value in determining the payment maximum allowed by these rules. The clarification of which columns the director is adopting helps ensure that any party applying the payment rules will receive the same answer regarding the payment maximum.

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**Testimony:** OAR 436-009-0004 *Exhibit #33*

We appreciate the adoption of the AMA's CPT Assistant. Clear coding guidelines foster accurate billings and prompt adjudication of bills.

**Response:** The director acknowledges the helpful information contained within the *CPT*<sup>®</sup> *Assistant* publications in furthering the understanding of the *CPT*<sup>®</sup> codes and the services each represents. The director still considers the *CPT*<sup>®</sup> manual the definitive source and will give it deference when there is a discrepancy between the *CPT*<sup>®</sup> manual and the *CPT*<sup>®</sup> *Assistant*.

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**Testimony:** OAR 436-009-0004(5) *Exhibit #5*

We support adoption of the CMS Healthcare Common Procedure Coding System (HCPCS) 2007, to be used when billing for services to identify products, supplies and services that are not sufficiently described by CPT codes, so long as insurers will accept use of HCPCS generic codes such as E1399 and A9999. Not every supply code, product, or DME matches up exactly to a HCPCS code. In addition, we ask that insurers accept charges billed with HCPCS under \$75.00 without asking for an invoice.

**Response:** The rules allow the use of an unlisted HCPCS code for those items that are not described by a specific code. See OAR 436-009-0010(4). The supplying of an invoice is only required with billings for durable medical goods to determine the cost to the provider and allow calculation of the appropriate reimbursement. A dollar cap was not included in the rule. The director will monitor this change and request feedback for the next rule revision.

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**Testimony:** OAR 436-009-0008(2)(c) *Exhibit #33*

Often a corrected bill is received or an overpayment is discovered more than 90 days after the original payment. The language should be changed to make it clear that the parties should first attempt to resolve the issue without the director's intervention. The request for review by the director should be made within 90 days of the date that the insurer determines that voluntary resolution is not possible.

**Response:** The director is moving cautiously into this area in an attempt to assess the level of the problem and to determine if there is a need to address it further. Balance should be maintained for stakeholders involved and to minimize the potential for increased administrative burdens

associated with this process.

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**Testimony:** OAR 436-009-0008(3)(d) *Exhibit #21, 25-B, 26*

Remove CMS reference, as it would be presumed that any bills that were in question for review would be required to be submitted, i.e. Dental. Please add “where applicable” within the provision for providing certain medical documentation, as not all entities have access to chart notes or operative reports, as detailed in this section.

**Response:** This section deals with requesting administrative review and lists the types of information necessary for the director to proceed with a review. If the information is not provided with the initial request for the director to review, it will need to be obtained before the director can complete review and issue an administrative order. No changes were proposed by the director, so this suggestion will be carried over to the next time the rules are open for revision.

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**Testimony:** OAR 436-009-0010(2) *Exhibit #33*

Language should be included requiring the rendering provider on all billings. This would facilitate accurate data gathering by insurers and WCD and be in line with WCD’s electronic data exchange initiative requirements.

**Response:** The current CMS 1500 form has a location to identify the rendering provider and the rule requires the completed form be submitted for billing purposes. This information will be available to the insurer and WCD.

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**Testimony:** OAR 436-009-0010(2)(b) *Exhibit #21, 25-B, 26*

We request the removal of the mandatory use of the NCPDP form for pharmacy billings. While this form is nationally recognized, it adds to pharmacy service costs because the form is proprietary, must be purchased at a cost to the pharmacy, and it cannot be reproduced in a computer-generated form. We instead recommend use of the CMS 1500 form as it contains all of the elements necessary to invoice for pharmacy services.

**Response:** The director does not agree that the CMS 1500 form contains all the necessary information for billing pharmacy services. The director would need to write a rule directing the pharmacy provider how to bill and provide the information contained on the NCPDP form without using that specific form. No change will be made in the rules.

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**Testimony:** OAR 436-009-0010(2)(c) *Exhibit #21, 25-B, 26*

Regarding electronic billing, please include the words “When not in conflict with laws governing proprietary reproduction, computer-generated reproductions of these forms may also be used.” (i.e. the NCPDP form). By definition, a computer-generated reproduction is not an “electronic bill” but an electronic process to reproduce a paper bill, so it may be more appropriate to remove “computer-generated reproduction” altogether.

**Response:** The director agrees that electronic billing and computer-generated reproduction are not the same thing. The director will separate the two thoughts in the rule and leave use of a

computer-generated reproduction for billing purposes as an option a medical provider might use.

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**Testimony:** OAR 436-009-0010(3)(a) *Exhibit #21, 25-B, 26*

Please provide an exception to the requirement that medical services bills be accompanied by specific notes or types of documents. Pharmacists and their agents are not provided with chart or operative notes. It would be a burden on these entities to force them to accept and retain documents.

**Response:** Pharmacies receive prescriptions from medical providers, either written on paper or by electronic data. That is sufficient documentation from the pharmacy to include with a billing for services. It is the director's understanding that many pharmacies do not bill the workers' compensation insurer for services, but rather the worker. Further study and data would be needed before the director would consider removing documentation requirements on specific billings.

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**Testimony:** OAR 436-009-0010(3)(a) *Exhibit #26*

Instead of requiring that bills include a license number of the person providing the service, allow for a "national identification number of the provider of the service."

**Response:** The rule allows the option of providing the license number or a national identification number to identify the provider.

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**Testimony:** OAR 436-009-0010(4) *Exhibit #26*

Clarify selection of appropriate code, to include allowance for another "universally accepted code that accurately describes the service or product provided." Remove reference to HCPCS code in subsection (a).

**Response:** The director has adopted the nationally recognized coding systems that most medical providers will be familiar with and have references for as the standard for identifying services being billed. The director acknowledges that pharmacies use a National Drug Code (NDC) to identify drugs and biologicals. The director will include these codes in the acceptable codes at this time. The director will not remove the reference to HCPCS codes in the rule.

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**Testimony:** OAR 436-009-0010(4) *Exhibit #33*

Requiring the use of Health Care Procedure Code System (HCPCS) codes when appropriate will provide more accurate data gathering by insurers and WCD. The second to the last sentence in the first paragraph does not appear to be a complete sentence. Also, the last sentence of the first paragraph uses the word "may". This will lead providers of medical services to believe the use of HCPCS codes is optional.

**Response:** The paragraph was reviewed and edited for clarity.

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**Testimony:** OAR 436-009-0010(4) *Exhibit #21, 25-B, 26*

We suggest inserting a new subsection (d): "With the exception of pharmacy services, the bill shall include ICD-9-CM codes." Physicians do not provide these codes to pharmacists and

pharmacists are not licensed to identify a diagnosis or code a prescription based on a conversation with an injured worker. Tracking down the ICD-9 from a physician can take several days and delay the injured worker's receipt of medications. Texas and California specifically exclude the use of ICD-9 codes on pharmacy billing forms.

**Response:** The director amended the wording to allow billings without the ICD-9-CM code, if the billing form does not require such information.

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**Testimony: OAR 436-009-0010(5)**

*Exhibit #27, 28, 33, 34*

We urge WCD not to limit access to late filing adjustment. Prompt claim decisions, settlements, and timely provider payments should be supported in rule. The removal of the late filing penalty negates the incentive for submission of bills within 60 days. With this rule change, providers will have 365 days to submit bills without penalty.

To expedite processing, and adhere to the accept/deny timeframe, examiners will have to request chart notes. Providers then will bill for providing those chart notes. Late bills may require insurers to retrieve claim records from storage. Additional late billing will increase claims costs and be detrimental to injured workers.

We agree that if not billed within 12 months, the bill should be considered late and payment not due

**Response:** No data was supplied as to how many providers actually bill after the 60-day time frame. The director's understanding from medical providers is that the vast majority of them do bill within 60 days in order to expedite payment and limit their exposure to unnecessary re-billing, overhead and administrative costs. And they include their chart notes with their billing if they are following the rules. Their incentive is to get paid as quickly as possible. If more providers begin billing late than billing timely, that data could be supplied and reviewed the next time the rules are revised. There have been complaints from insurers in the past about the difficulty in administering the discount portion of the rule. In order to facilitate a streamlined process and reduce administrative burdens for both providers and insurers, the rule eliminates unnecessary paperwork and calculations, and matches private health in having no reductions prior to 12 months, as well as matching no payment after the 12 months. This way, stakeholders don't have to operate differently for workers' compensation claims as compared to private health.

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**Testimony: OAR 436-009-0010(8)**

*Exhibit #33*

The addition of the last sentence implies that requests for pre-payment can be false or fraudulent. The sentence should be deleted.

**Response:** The rule was revised for clarity.

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**Testimony: OAR 436-009-0025(1)(3)**

*Exhibit #27, 28*

We recommend decreasing the amount of time the worker is allowed to submit requests for

reimbursement so processing can be accomplished when the information is fresh. By allowing two years, there is the increase in files that will have to be ordered from storage facilities, which in turn increases costs to employers. If medical providers will be allowed one year to submit a billing, apply the same standard to worker reimbursements.

**Response:** This issue will be addressed in the next rules advisory committee process as it was not addressed this year.

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**Testimony: OAR 436-009-0025(2)(a) *Exhibit #33***

The language in paragraphs (A), (B) and (C) should be changed to “when overnight travel is required and/or an appointment requires absence from home or work...” to better clarify when meals are to be reimbursed.

**Response:** After further consideration, the rule was revised to be less prescriptive, which will allow for more judgment depending on the specific facts of a particular instance, while still allowing more structure and guidance than the rules did formerly.

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**Testimony: OAR 436-009-0030(3)(c) *Exhibit #26***

Require that the party submitting a bill apply an electronic date stamp.

**Response:** This issue will be added to the advisory committee process for the next revision as it was not addressed this year.

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**Testimony: OAR 436-009-0030(6) *Exhibit #26***

Require that insurers provide reasons for non-payment or payment reductions “in writing.”

**Response:** That requirement is in 0030(3)(a).

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**Testimony: OAR 436-009-0040(4) *Exhibit #23***

Maintaining the total medical costs constant during the next twelve months fails to account for increases in overhead costs that occur as a result of inflation. WCD should consider this reality in its deliberations.

**Response:** Inflation, overhead costs, etc., were considered, however, rising medical costs also is an urgent issue that must be addressed. WCD will continue to work with and to have dialogue with the medical community to find ways of streamlining administrative processes for providers so that they can continue to provide the important medical care of injured workers.

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**Testimony: OAR 436-009-0040(4) *Exhibit 2, 3, 4***

An increase in the conversion factor for physical therapy is needed to offset increased costs for staffing, utilities, liability insurance, and health insurance premiums. The relative value units for physical therapy have dropped over the years and your conversion factor has not increased in many, many years. Your net fees have not increased in seven years, and in fact have decreased due to changes in relative value units. Our costs have doubled in that time.

Please consider increasing reimbursement to keep up with cost increases and to keep qualified individuals employed in physical therapy.

**Response:** As noted in the proposed rule fiscal impact statement, providers system wide should receive essentially the same payments, depending on their individual practice. Inflation, overhead costs, etc., were considered, however, rising medical costs also is an urgent issue that must be addressed. While the conversion factor will go down for Evaluation and Management, the relative value units, overall for workers' compensation codes, have gone up. The director has determined that payments system wide will remain essentially revenue neutral while individual providers may see some increase or decrease depending on the particular codes they utilize in their practice.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #25-C, 30*

I urge you to reconsider your proposed downward revision of the evaluation & management conversion factor. This is projected to be revenue neutral, but this is not the case for us. As applied to our 2006 services, this change would have resulted in a net loss to our organization of approximately \$80,000. This loss, on top of the fact that we haven't had a cost of living increase for seven years, does represent a significant loss of revenue for us.

We have a very good record of managing claims, working with employers, and provide services such as on-site evaluations to make the workplace safe. You have only to look to the north to see a system that is failing. They cannot attract physicians to treat injured workers because of poor reimbursement. Currently it is difficult to recruit physicians in the northwest, which now ranks second lowest in reimbursement after Puerto Rico for workers' compensation physicians. We have only been able to recruit good physicians because of lifestyle issues. If reimbursement continues to be frozen or decline, we'll have to select from the bottom of the barrel, and that is not fair to injured workers.

**Response:** As noted in the proposed rule fiscal impact statement, providers system wide should receive essentially the same payments, depending on their individual practice. Inflation, overhead costs, etc., were considered, however, rising medical costs also is an urgent issue that must be addressed. While the conversion factor will go down for Evaluation and Management, the relative value units, overall for workers' compensation codes, have gone up. The director has determined that payments system wide will remain essentially revenue neutral while individual providers may see some increase or decrease depending on the particular codes they utilize in their practice.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #6, 8, 9, 11, 12, 14, 15, 18, 19, 20, 32*

The reimbursement for evaluation & management (E&M) codes has not changed since 2003 and in fact were reduced in 2005, a fact not mentioned in the division's letter describing the changes. Reimbursements for new patient and some established patient services would actually decrease. Costs for staffing, building, utilities, and supplies have increased substantially. We understand there is a slight increase in a few of the established visit E&M codes, however feel strongly that a similar increase in the new patient visit E&M codes would be appropriate. The increases proposed for 99213 and 99214 still lag the cumulative CPI over the last few years, substantially

so with the proposed decrease for E&M. Commercial carriers have raised their reimbursement rates each year.

**Response:** As noted in the proposed rule fiscal impact statement, providers system wide should receive essentially the same payments, depending on their individual practice. The conversion factor for workers' compensation for E&M was increased in 2003 and 2004. If there was reduction in reimbursement to individual providers in 2005 it would have to be due to changes in the RVUs relative to the specific provider's services. Inflation, overhead costs, etc., were considered, however, rising medical costs also is an urgent issue that must be addressed. While the conversion factor will go down for Evaluation and Management, the relative value units overall for E&M codes utilized in workers' compensation have gone up. The director has determined that payments system wide will remain essentially revenue neutral while individual providers may see some increase or decrease depending on the particular codes they utilize in their practice.

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**Testimony: OAR 436-009-0040(4) Exhibit #6, 7, 8, 9, 11, 12, 14, 16, 17, 18, 19, 20, 24, 32**  
Decreasing reimbursement for cognitive evaluation and management (E&M) codes devalues our work and would only exacerbate the shortage of qualified physicians willing to see workers' compensation patients, and in the long run, would lead to much higher costs. Highly trained physicians in occupational medicine would choose consulting rather than injury care and, therefore, the overall cost of medical care would increase significantly. In addition to limiting the number of workers' compensation patients, practices would be less inclined to take over attending physician responsibilities in complex cases. If access to care becomes more limited, secondary effects would include longer delays in treatment and additional time loss costs. Given that workers' compensation services require additional paperwork, time, and staff resources, and are generally more stressful compared to similar patients in a non-work related setting, physicians are underpaid for the services that they provide in the state of Oregon.

Code 99213 pays for the attending physician to communicate with the worker, the nurse case manager, and at times the employer in facilitating early return to work. Codes 99203 and 99204 involve taking more detailed histories to document common soft tissue sprain/strain injuries as well as negotiations and paper work outlined above. Lowering reimbursement for these codes will likely create negative incentives towards being an attending physician.

The agency should implement a long overdue increase in reimbursement for all E&M codes to at least mirror the medical CPI since the last increase in 2003.

**Response:** Inflation, overhead costs, etc., were considered, however, rising medical costs also is an urgent issue that must be addressed. While the conversion factor will go down for Evaluation and Management, the relative value units, overall for workers' compensation codes, have gone up. The director has determined that payments system wide will remain essentially revenue neutral while individual providers may see some increase or decrease depending on the particular codes they utilize in their practice. The director also considered and is concerned with workers having access to prompt, quality medical treatment.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #8, 23, 32*

Some MCOs discount WCD-approved fees. The evaluation & management reimbursement situation is exacerbated even further due to discounts paid by providers to participate in MCOs.

**Response:** Providers choose whether or not to enter into contract with a managed-care organization, and should consider this aspect as well.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #7, 17, 22, 25-D, 32*

We understand the difficult position that the Workers' Compensation Division is in due to the potential for a \$4.5 million increase in medical costs per year brought on by the change the Centers for Medicare and Medicaid Services made in relative value units (RVU's) for evaluation and management (E&M) codes. However difficult that position is, the burden of making up those costs should not be placed on physicians and other health care providers. The proposed reduction to the conversion factor for (E&M) from \$68.40 to \$59.79 is apparently designed to hold steady the amount providers are paid for seeing workers' compensation patients for E&M services. This proposed decrease directly thwarts the reason for the RVU increase i.e. to reward cognitive physicians and to reduce the imbalance between what cognitive physicians and proceduralists are paid. The changes are designed to better reflect the work and time required of a cognitive physician to provide a service to the patient. The change in RVU's is a result of a lengthy review by the Relative Value Update Committee of the American Medical Association. They are endorsed and accepted by the Centers for Medicare & Medicaid Services and are in use in the Medicare Fee schedule for 2007. The increases are especially important in injured worker care. Compensatory decreases occurred in procedure codes for surgery, radiology, and electrodiagnostic medicine (EMG, EEG). I strongly urge you to reconsider the reduction.

The proposed reduction in the E&M conversion factor will result in lower payments for both cognitive E&M work in addition to procedures. While this may save money for the workers' compensation carriers, it does not accurately reflect the findings of the AMA and CMS.

**Response:** As noted in the proposed rule fiscal impact statement, providers system wide should receive essentially the same payments, depending on their individual practice. The workers compensation (WC) system is a separate and different population than the population of CMS, which is primarily for older people, many with chronic diseases. While the AMA worked with CMS for the Medicare system, this is not the same as the Oregon WC system. The RVUs are not changing in the rules, only the conversion factor. There are many policies and philosophies of CMS that are not adopted by the Oregon WC administrative rules, for the very reason that the systems and populations are different and have different needs. This year, the rise in the E&M RVUs would have added an unacceptable increase to the workers' compensation system medical costs.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #14, 22, 24, 25-D*

Treating physicians account for less than one-third of workers' compensation medical costs. Occupational medicine is a specialty where there is good communication not only with the patient but also with the employer and the insurance company. This type of global management leads to better outcomes and has a positive economic impact on the care of injured workers, but

avoiding the pitfalls such as over-utilization, increased administrative costs, higher rates of disability and impairment, higher rates of litigation, and overall increased medical costs. Look at the findings of the California Workers' Compensation Institute's 2003 report, "Provider Experience and Volume-Based Outcomes in California Workers' Compensation." The medical costs of claims treated by the highest volume workers' compensation providers are less than half that of their peers who treat the fewest workers' compensation cases. I hope that you recognize this in establishing the upcoming fee schedules and implement a long overdue increase in reimbursement for all evaluation and management codes to at least mirror the medical CPI increase since 2003.

Calling the employer and coordinating return to modified work takes considerable additional time that is not compensated by the current E&M codes. The workers' compensation rules should encourage more face-to-face interaction between the injured worker and the physician. This would help to facilitate early return to work and reduce time loss. By reducing the conversion factor, the physicians who see the most injured workers and produce the most benefits to the system in the form of cost savings and best outcomes will be the providers most negatively impacted. Another impact of reducing reimbursement would be reduced availability of specialists that we rely on when we need help with injured workers' care, already a significant problem at the current fee schedule. Discounted fee schedules have never been proven to reduce the overall medical costs of a workers' compensation claim.

**Response:** All testimony was considered. As noted in the proposed rule fiscal impact statement, providers system wide should receive essentially the same payments, depending on their individual practice. The director also considered and is concerned with workers having access to prompt, quality medical treatment

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**Testimony:** OAR 436-009-0040(4) *Exhibit #6, 7, 11, 12, & 13, 17, 18, 19, 20, 23, 32*  
The new conversion factor for evaluation & management will drop workers' compensation from one of the top payers for services in Oregon to the lowest with the exception of Medicare and Oregon Medicaid. Average reimbursement for commercial carriers, including BlueCross, Providence, PacificSource, Pacificare, Lifewise, ODS, HealthNet, United and LIPA have gone up annually, resulting in cumulative increases of between 16% and 21.5% since 2003. In the same time frame the workers' compensation fee schedule has dropped approximately 1%. Even Medicare has gone up approximately 7% in that time frame. The workers compensation fee schedule is lagging significantly the commercial sector in keeping up with inflation.

A December 2004 article in the Journal of Bone and Joint Surgery indicated that the administrative costs of workers' compensation claims for medical providers was higher than for any other insurance category.

**Response:** Private health care rates were considered. Inflation, overhead costs, etc., were also considered. While the conversion factor will go down for Evaluation and Management, the relative value units, overall for workers' compensation codes in E&M, have gone up. Only the E&M category conversion factor will be adjusted to neutralize the increase in costs, keeping payments overall essentially revenue neutral.

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**Testimony:** OAR 436-009-0040(4) *Exhibits #20, 23, 32*

The notion of reducing only certain services is flawed. It is unwise to pit physicians against one another if you want to maintain a balanced and fair system. Instead of the reduction to evaluation & management only, WCD should reduce fees proportionately in all service categories. A 4% reduction in the expected costs for each service category would spread the reduction fairly and produce the least impact on each practice. This calculation will need to account for the 2007 changes to major relative value units that contribute to cost in each service category, as there are likely to be decreases for some of the surgical codes that enabled CMS to increase the E&M codes.

Instead of the reduction to evaluation & management only, WCD should reduce fees proportionately in all service categories, with the exception of Lab and Pathology, which comprises a minute proportion of the \$104.5 million cost

If across the board cuts are made instead of a reduction in only the evaluation & management service category, it may be tempting to reduce surgical codes more because its conversion factor is higher than the other service areas. The reason for not doing that is that the surgeons are also attending physicians and have the same burden as family physicians, internists, and physiatrists in managing the total care for this frequently difficult group of patients. Furthermore, surgical fees include 90 days of postoperative care, meaning “free” office visits that would ordinarily generate 99213 fees. In my practice, a patient on whom I perform a carpal tunnel release or a lumbar discectomy commonly requires a single post-operative visit. An injured worker with these conditions commonly requires four post-operative visits in the 90-day “free” post-operative period. Neurosurgeons and orthopedic surgeons who do spine surgery are frequently not paid for months or years after surgery because carriers do not have to pay for denied claims until the claim has been adjudicated. Finally, many workers who present with problems they believe to be work-related and requiring surgery lack health insurance, which leads either to delay in treatment or treatment for which the surgeon will most probably not be paid.

**Response:** This option was considered. However, the director believes that specifically addressing the issue that would have caused the \$4.5 million increase is the better option. Only the E&M category conversion factor will be adjusted to neutralize the increase in costs, keeping payments overall essentially revenue neutral.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #24*

The Resource Based Relative Value Scale (RBRVS) was designed to put all services on an equal footing. The evaluation & management (E&M) services always had been undervalued. The surgical fee conversion factor was based on historic fees and not on the cost of actually providing medical services. Historically, surgical services have been paid 37% higher than E&M services. If WCD believes the RBRVS should be applied as designed, then all service categories should have the same dollar conversion factor. When the federal government adjusts the RBRVS, it uses a budget neutral approach, and has in effect frozen physician’s fees for the last two years. A ten percent reduction in fees is projected for the calendar year 2008 for Medicare. Medicare patients are unable to find physicians who are willing to see them. The proposed reduction in E&M will

create the same difficulty for injured workers. The motor vehicle accident-related injuries also use the workers' compensation fee schedule, so this group of patients also will not be able to get timely and appropriate medical care.

**Response:** The director believes that specifically addressing the issue in the E&M RVUs that would have caused the 4.5 million dollar increase is the better option. As noted in the proposed rule fiscal impact statement, providers system wide should receive essentially the same payments, depending on their individual practice. The director is aware of how the RBRVS is designed and its budget neutrality requirement. The workers compensation (WC) system is a separate and different population than the population of CMS, which is primarily for an older population, many with chronic diseases. While some portions of the CMS system are useful in determining payments for workers compensation, not all aspects are. There are many policies and philosophies of CMS that do not fit well and are not adopted by the Oregon WC administrative rules, for the very reason that the systems and populations are different and have different needs. This year, the rise in the E&M RVUs would have added an unacceptable increase to the workers' compensation system medical costs. Thus, only the E&M conversion factor will be adjusted to neutralize that increase, keeping payments to providers essentially revenue neutral, depending on the individual providers practice. The director also considered and is concerned with workers having access to prompt, quality medical treatment.

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**Testimony:** OAR 436-009-0040(4) *Exhibit #26*

Instead of saying: "The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical providers." say "\* \* \* rendered by specific medical providers."

**Response:** After consideration, the rule will not be changed to this wording as medical provider is an intentionally broader term.

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**Testimony:** OAR 436-009-0050 *Exhibit #4*

You already cut our physical therapy fees by allowing only 3 codes when 4 is standard for our office. If you can't increase conversion factors across the board, allow us to bill a fourth code. Your fees also affect what we are reimbursed by auto insurers now, but auto insurers allow the extra code.

**Response:** This issue will be added to the issues for the advisory committee next revision as it was not discussed this year.

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**Testimony:** OAR 436-009-0070(1)(6) *Exhibit #33*

By placing the prohibition on pre-payment requests in a section on medical records, the department is implying that pre-payment requests for other services are allowed. We suggest the addition of a new subsection to OAR 436-009-0015 that bars medical providers from billing for services before they are rendered. If an insurer has consistently failed to pay medical providers in a timely manner, the provider may be permitted to request prepayment only when the director issues a specific order authorizing pre-payment.

This concern applies also to the provision for pre-payment for depositions.

**Response:** Due to concerns by most stakeholders who commented on this rule, the essential components of the proposed rule were deleted, and returned to the former rule. The issue of pre-payment has and continues to be a difficult and complex issue to adequately address the needs of all stakeholders. This issue can be reviewed again in the next rules revision advisory committee.

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**Testimony:** OAR 436-009-0070(1)(6) *Exhibit #28*

We believe there needs to be a better definition of “payment difficulties”. Non-payment may occur due to lack of understanding at the provider’s billing office and is open to interpretation. For example, a bill could be reduced per the fee schedule and a provider could take non-payment of the reduction as a payment difficulty situation. We recommend payment difficulties be defined as insurers or self-insured employers who receive repeated penalties assessed by the department for non-payment, inappropriately reduced payment, or payment delayed beyond 45 days of billing. There is already a process in place where a medical provider can request the Medical Director review when dealing with non-payment, inappropriately reduced payment, or payment delayed beyond 45 days of billing.

**Response:** Due to concerns by most stakeholders who commented on this rule, the essential components of the proposed rule were deleted, and returned to the former rule. The issue of pre-payment has and continues to be a difficult and complex issue to adequately address the needs of all stakeholders. This issue can be reviewed again in the next rules revision advisory committee.

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**Testimony:** OAR 436-009-0070(6) *Exhibit #27, 28, 29, 31, 34*

Depositions of physicians are based upon medical reports that have been submitted as proposed hearing exhibits. If an employer’s attorney submits as a proposed exhibit a medical report, the injured worker’s attorney often times automatically will request a deposition of the author in order to comply with OAR 438-006-0081(2). The employer’s attorney could withdraw the medical report and cancel the deposition but most of the time the employer’s attorney will want the report as evidence in the hearing. Thus, most often the injured worker’s attorney is the one who controls whether to withdraw the request to depose the physician and cancellation of the deposition.

Without exception, the cost of a deposition is paid for by the employer regardless of whether it is the claimant or the employer who requests cross-examination. See OAR 438-007-005(3). Cancellations or reschedules of depositions are most often done by the plaintiff's attorney, often with short notice. We believe an employer should not be penalized and get 'stuck' with a cancellation or a reschedule fee when the employer’s actions did not cause the cancellation or rescheduling. There is the potential for legal maneuvering to increase the costs in order to get employers to pay more in a claims settlement. We request that the party responsible for making the cancellation notice or reschedule request be the one responsible for these proposed costs. Should this concept not be acceptable, then we would recommend that if the claimant or plaintiff attorney is responsible for the cancellation, the insurer and self-insured employer be allowed to take this cancellation or reschedule fee as an overpayment on the workers claim, similar to that

of the IME process.

The cancellation time frames are too long.

To the extent the division wants to regulate this, we recommend the advance notice of cancellation to percent of fee paid be:

48 hours - 100%

72 hours - 75%

less than 5 days - 50%

6 days or more - no cancellation fee

We are in favor of a deposition fee schedule.

**Response:** Due to concerns by most stakeholders who commented on this rule, the essential components of the proposed rule were deleted, and returned to the former rule. The issue of pre-payment has and continues to be a difficult and complex issue to adequately address the needs of all stakeholders. This issue can be reviewed again in the next rules revision advisory committee.

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**Testimony: OAR 436-009-0070(6) *Exhibit #29***

Currently, medical providers charge their “usual” deposition fee and if the employer objects, the director may limit payment to the fee charged by similar providers, based on a survey of physicians in the geographic area. Rather than determining an average deposition charge, the Workers’ Compensation Division essentially determines the highest fee charged by a similar provider, and limits the doctors to that amount. This type of review process is more charade than substantive. The Division is invited to seriously consider instituting a deposition fee schedule before attempting to regulate the cancellation or rescheduling of depositions.

**Response:** Due to concerns by most stakeholders who commented on this rule, the essential components of the proposed rule were deleted, and returned to the former rule. The issue of pre-payment has and continues to be a difficult and complex issue to adequately address the needs of all stakeholders. This issue can be reviewed again in the next rules revision advisory committee.

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**Testimony: OAR 436-009-0070(6) *Exhibit #27, 28,33***

The legislature and the Management/Labor Advisory Committee have recently heard testimony that some medical providers are charging enormous fees for providing testimony in litigated cases, such as \$500 for a 15-minute telephone conference. Unfortunately, the lack of a department fee schedule for depositions or litigation reports has given a few physicians license to charge whatever they wish without regulation and without having to be concerned about what the market will bear. We urge the department to establish a reasonable fee schedule without further delay.

We recommend that you do not rush these rules into place but that there be further review and discussions by a workgroup to address how to compensate the deposed provider (commonly doctors) for their time, while not penalizing the employer or the worker.

**Response:** A deposition fee schedule has been an issue for some years, but difficult to adequately address and balance the needs of all stakeholders. Due to concerns by most stakeholders who commented on this rule, the essential components of the proposed rule were deleted, and returned to the former rule. The issue of pre-payment has and continues to be a difficult and complex issue to adequately address the needs of all stakeholders. These issues can be reviewed again in the next rules revision advisory committee.

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**Testimony:** OAR 436-009-0070(6) *Exhibit #22*

I strongly favor the requirement that physicians be paid for deposition preparation time at their usual and customary rate. There have been times when a payer has refused to pay for a last minute cancellation including preparation. It should require that at least three weeks notice be given so that the physician has ample time to optimally rebook his or her schedule. Depositions scheduled less than three weeks in advance should require non-refundable payment in full. This requirement would reduce the number of frivolous deposition requests and produce an overall savings to the carriers. There should be only one all-or-nothing deadline without a sliding scale. Sliding-scale systems are difficult to administer due to their complexity, and in our experience have led to disputes over when notification was actually given, in what form, and what rate should be paid.

**Response:** Due to concerns by most stakeholders who commented on this rule, the essential components of the proposed rule were deleted, and returned to the former rule. The issue of pre-payment has and continues to be a difficult and complex issue to adequately address the needs of all stakeholders. This issue can be reviewed again in the next rules revision advisory committee.

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**Testimony:** OAR 436-009-0070(8) *Exhibit #33*

An interpreter's service is not a medical service and should not be regulated under department rules on medical fees. However, if the department determines that regulation is necessary, interpreter fees should be treated like other professional services, and we should not pay interpreters who lack the necessary credentials. We recommend that the department set a maximum rate of \$50 per hour for time spent actually interpreting. In addition, the rules should require (in addition to proposed data) that any billing include the health care provider's name and address (where interpreter's service provided) and the name of the interpreter. The rules should also state that no reimbursement will be made for travel time and that mileage will be reimbursed based on the maximum allowed for State of Oregon Classified Employees; mileage billing must include the starting and ending addresses.

**Response:** The rule was proposed because in the recent past stakeholders raised the issue and wanted it addressed. However, more work needs to be done with stakeholders. This issue can be reviewed in the next rules revision advisory committee.

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**Testimony:** OAR 436-009-0070(9)(10) *Exhibit #28*

We recommend that we agree to pay the no-show fee for an arbiter or director-required examination but that if the worker is the party that no shows, there should be a penalty against the worker just like in the IME process.

**Response:** This issue can be reviewed in the next rules revision advisory committee because it wasn't discussed this year.

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**Testimony: OAR 436-009-0070(12)                      *Exhibit #1***

The fee for copying medical records under Oregon specific code R0001 should be increased, at a minimum, to keep up with changes in the consumer price index. The fee has not increased in more than four years. The age of the electronic record has made the process more costly.

**Response:** This issue can be reviewed in the next rules revision advisory committee because it wasn't discussed this year.

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**Testimony: OAR 436-009-0080(2)                      *Exhibit #26***

Remove crutches, wheelchairs, and scooters from the list of prosthetics, as these are considered durable medical equipment under CMS guidelines.

**Response:** The workers compensation (WC) system is a separate and different population than the population of CMS, which is primarily for an older population, many with chronic diseases. While some portions of the CMS system are useful in determining payments for workers compensation, not all aspects are. There are many policies and philosophies of CMS that do not fit well and are not adopted by the Oregon WC administrative rules, for the very reason that the systems and populations are different and have different needs. In Oregon, these have been determined as prosthetics because they aid a natural function. However, the issue can be added to the advisory committee discussions for next revision.

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**Testimony: OAR 436-009-0080(2)(3)(4)                      *Exhibit #26***

Change "usual" fee to that which is normally charged for the specific prosthetic device, orthotic product, or medical supplies.

**Response:** This issue can be reviewed in the next rules revision advisory committee because it wasn't discussed this year.

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**Testimony: OAR 436-009-0090                                      *Exhibit #33***

We understand that Third Party Solutions has proposed a rule amendment to allow medical providers to assign receivables to third parties. Third party billers have billed insurers at pharmacy rates that are often significantly higher than the fee that would have been paid if it had been billed directly by the service provider. This is an issue that is currently being considered by the Oregon Court of Appeals, and we urge the department to take no action while this issue is still in litigation.

**Response:** The director may review this issue further and work with stakeholders while waiting for the litigation to finalize.

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**Testimony: OAR 436-009-0090(1)                                      *Exhibit #26***

This rule requires that the usual fee be charged for the service, not only for pharmacy services but also for all other services. It stands to reason that the amount charged is the "usual" charge

and should therefore be taken into consideration by the payer when making reimbursement.

**Response:** The term usual has had some differing interpretations and so the current language is specific to the providers usual rate. No change is necessary.

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**Testimony:** OAR 436-009-0090(4)(a) *Exhibit #26*

Provide that a clinical justification may be submitted to the insurer by an agent of the pharmacist.

**Response:** This issue can be reviewed in the next rules revision advisory committee because it wasn't discussed this year.

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Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 4<sup>th</sup> day of June 2007.

WORKERS' COMPENSATION DIVISION

*Fred Bruyns*

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Fred Bruyns,  
Hearings Officer

*Debra Buchanan*

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Debra Buchanan,  
Medical Resolution Team Manager