

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

In the Matter of the Amendment of OAR)	
436-009, Oregon Medical Fee and Payment Rules)	SUMMARY OF
436-010, Medical Services)	TESTIMONY AND
436-015, Managed Care Organizations)	AGENCY RESPONSES
436-030, Claim Closure and Reconsideration		

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency’s conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated Oct. 1, 2011. On Oct. 24, 2011, a public rulemaking hearing was held as announced at 10:00 a.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record was held open for written comment through Oct. 27, 2011.

Two people testified at the public rulemaking hearing, recorded below as exhibit 2. The public submitted four written documents as testimony.

Testimony list:

Exhibit	Rule divisions	Testifying
<u>1</u>	009	Mike McNickle, Workers’ Compensation Division
<u>2</u>	009	Transcript of hearing: a. Mike McNickle, Workers’ Compensation Division b. William Roberts, Advanced Prosthetics and Orthotics
<u>3</u>	009	Allison Morfitt, SAIF Corporation
<u>4</u>	009	Mercedes Rhodes, Mitchell International
<u>5</u>	009	Dave A. Janke, Columbia Prosthetics and Orthotics

Note: “DMEPOS” in these summaries means durable medical equipment, prosthetics, orthotics, and supplies.

Testimony: OAR 436-009-0080, Appendix E *Exhibit 1, 2a*

The maximum payment amounts listed in Appendix E of OAR 436-009, were based on a July release of the Centers for Medicare and Medicaid Services (CMS) DMEPOS fee schedule. CMS inadvertently discontinued to list payment amounts for HCPCS codes L3660, L3670, and L3675

in their July release. CMS subsequently clarified that these three codes will not be discontinued and published payment amounts. The director recommends adding these three codes to Appendix E and to set the maximum payments as follows:

L3660 - \$93.57; L3670 - \$107.01; L3675 - \$155.10

Response: The division has incorporated the above testimony into the permanent rules.

Testimony: OAR 436-009-0080, Appendix E

Exhibit 2b

The Medicare fee schedule will not bode well for injured workers, and work may be denied. Medicare is not a reasonable reimbursement rate. They are at least 30 to 200% behind our retail prices. 10% above Medicare is still well below our break even points in some regards. The rate should be at least 166% of Medicare. Workers' compensation paperwork requirements are even more onerous than Medicare requirements, in the sense that insurers require preauthorization, as well as all the documentation. A lowered reimbursement rate implies a lowered expectation for the functional requirements for the patients. Insurers are mandated to provide for the care of injured workers and to give them a reasonable expectation of returning to their workplaces and to their normal lives. I see no hope in being able to do that under these cost restraints.

Response: Thank you for your testimony. The agency projects that implementing the proposed DMEPOS fee schedule should not have a large impact on any of the affected providers and the overall payments for these services should remain approximately the same as under the current rule.

Testimony: OAR 436-009-0080, Appendix E

Exhibit 3

We support a fee schedule with maximum payment amounts based on 110 percent of 2011 Medicare DMEPOS rates. These rates are reasonable and widely accepted by DMEPOS suppliers. These rules will help ensure reimbursement consistency for similar DMEPOS items.

Response: Thank you for your testimony. We appreciate the recognition of our intent to adopt reasonable payment rates for DMEPOS.

Testimony: OAR 436-009-0080, Appendix E

Exhibit 3

The rule should specify that DMEPOS billers must include standard modifiers (NU, RR, UE) to ensure that items are identified correctly and rentals are not paid as purchased items.

Response: Thank you for your testimony. The division has incorporated above testimony into the permanent rules. *See* OAR 436-009-0080(5).

Testimony: OAR 436-009-0080, Appendix E

Exhibit 4

We are requesting clarification on the following:

- 1) Will you be indicating which procedure codes can be purchased new, purchased used or rented by providing modifiers to indicate new, rented or used?
- 2) From the Appendix E list of codes, "E" and "K" category codes have specific modifier usage listed for each code in the 2011 HCPCS Level II book (NU, RR or UE). If the answer to our question #1 is "NO," will you approve the use of the HCPCS Level II modifiers to distinguish code billing limitations such as rental only?
- 3) For rentals, is there a rental cap requirement? i.e. up to the purchase price?

Response: Thank you for your testimony.

- 1) Historically, the rules have not addressed whether items could be purchased new, purchased used, or rented. Stakeholders have not raised this as an issue and the rules do not contain any provision regarding what items may be purchased new, purchased used, or rented.
- 2) The revised rule now requires providers to use the modifiers -NU, -UE, and -RR. *See* OAR 436-009-0080(5).
- 3) The rental amount is capped at 130 percent of the purchase price. *See* OAR 436-009-0080(6) and (7)(a).

Testimony: OAR 436-009-0080, Appendix E

Exhibit 5

Apparently this proposal is based on current Medicare fee schedules plus ten percent. I am very concerned for Oregon's injured workers if this is implemented.

Please refer to the attached spread sheet that shows the complete history of changes to Medicare fees compared to the changes to the CPI since the inception of our current coding system. When comparing the two most current indices of 210.8 and 144.9 it results in a difference of about 45%. This means that if Oregon's fees for our types of services for injured workers had been maintained equivalent over the years, and flat Medicare allowable amounts were considered acceptable, current reimbursement would be current Medicare rates plus 45%. While relative Medicare rates have decreased during this time, our labor, operating expenses and cost of materials have maintained their increase. With the difference of 35% in this scenario we all should be concerned about shrinking numbers of providers, as some cannot provide quality service at these rates.

Many of the Medicare profile amounts set for procedure codes were skewed by non-prosthetic and orthotic providers, i.e. physicians and physical therapists. When these providers bill using O&P codes, they are also allowed to bill separately for the office visits and fitting fees. Our profession includes items and the entire service element. When considering these inaccuracies, it would be less erroneous to base reimbursement on a prosthetic and orthotic provider's customary fee schedule and consider a percentage discount from that.

Response: Thank you for your testimony. The agency projects that implementing the proposed DMEPOS fee schedule should not have a large impact on any of the affected providers and the overall payments for these services should remain approximately the same as under the current rule.

Testimony: OAR 436-009-0080(5) and (6)

Exhibit 3

The rule should specify that rental payments be applied to the purchase price of the equipment. Often the equipment is rented for less than 13 months. In addition, WCD should modify the rental rates so that rental payments do not exceed the purchase price as would happen with rates of 10 percent of the purchase price per month for 13 months. Medicare has a 13-month rental period, however the rental rate declines from 10 percent to 7.5 percent in months 4 through 13. For ease of administration, we suggest that rentals be paid at 10 percent of the purchase price per month for 10 months to be considered purchased.

Response: Thank you for your testimony. The division has revised the proposed rule and now provides for a credit of 75 percent of the rental paid going towards the purchase. *See* OAR 436-

009-0080(7)(b). The division disagrees with your recommendation for a rental cap of 100% of the purchase price. The rule will implement a rental cap of 130 percent of the purchase price.

Testimony: OAR 436-009-0080(8)(c)

Exhibit 1, 2a

The rule as proposed is not clear whether hearing aids should be paid according to the payment table under OAR 436-009-0080(5). Accordingly, the division recommends to change OAR 436-009-0080(8)(c) to:

(c) Payment for hearing aids is determined under section (5) of this rule. However, without approval from the insurer or director, the payment for hearing aids may not exceed \$5000 for a pair of hearing aids, or \$2500 for a single hearing aid.

Response: The division has incorporated the above testimony into the permanent rules.

Dated this 16th day of November, 2011.

Workers' Compensation
Medical Fee and Payment Rules

Exhibit
“1”

October 19, 2011

Testimony of
Mike McNickle, Medical Section Manager
Workers' Compensation Division
Department of Consumer and Business Services

For the record, my name is Mike McNickle. I am the Medical Section Manager of the Workers' Compensation Division of the Department of Consumer and Business Services. I am providing testimony on two separate issues that were identified after the proposed rules were filed with the Oregon Secretary of State.

1. The maximum payment amounts listed in Appendix E of chapter 436, division 009, were based on a July release of the Centers for Medicare and Medicaid Services (CMS) DMEPOS fee schedule. CMS inadvertently discontinued to list payment amounts for HCPCS codes L3660, L3670, and L3675 in their July release. CMS subsequently clarified that these three codes will not be discontinued and published payment amounts for L3660, L3670, and L3675. *See* MLN Matters® Number: MM7300 *or at* <http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp> .

Accordingly, the director recommends adding these three codes to Appendix E and to set the maximum payments as follows:

Code	Maximum Payment
L3660	\$93.57
L3670	\$107.01
L3675	\$155.10

2. It has come to our attention that the rule as proposed is not clear whether hearing aids should be paid according to the payment table under OAR 436-009-0080(5). Accordingly, the division recommends to change OAR 436-009-0080(8)(c) to:

(c) Payment for hearing aids is determined under section (5) of this rule. However, without approval from the insurer or

**director, the payment for hearing aids may not exceed \$5000
for a pair of hearing aids, or \$2500 for a single hearing aid.**

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

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR:)	TRANSCRIPT OF TESTIMONY
436-009, Oregon Medical Fee and Payment Rules)	
436-010, Medical Services)	
436-015, Managed Care Organizations)	
436-030, Claim Closure and Reconsideration)	

The proposed amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated Oct. 1, 2011. On Oct. 24, 2011, a public rulemaking hearing was held as announced at 10:00 a.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record will be held open for written comment through Oct. 27, 2011.

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TRANSCRIPT OF PROCEEDINGS

Fred Bruyns: Good morning and welcome. This is a public rulemaking hearing. My name is Fred Bruyns and I’ll be the presiding officer for the hearing. The time is now 10:01 a.m., on Monday, October 24, 2011. We’re in Room 260 of the Labor & Industries Building, 350 Winter St. NE, in Salem, Oregon. If you wish to present oral testimony today, please sign in on the testimony sign-in sheet on the table by the entrance. For anyone on the phone with us, just let me know and I will actually put you on our list. I’ll call for testimony in just a couple of minutes.

First, the Department of Consumer & Business Services, Workers’ Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically:

- Division 009, Oregon Medical Fee and Payment Rules,
- Division 010, Medical Services,
- Division 015, Managed Care Organizations,
- Division 030, Claim Closure and Reconsideration.

The department has summarized the proposed rule changes in the *Notice of Proposed Rulemaking Hearing*. This hearing notice, a *Statement of Need and Fiscal Impact*, and full text of the proposed rules with marked changes, are on the table by the entrance. Also on that table are copies of written testimony received to date. To date, we’ve only received one exhibit.

Transcript of public rulemaking hearing
Oct. 24, 2011

The Workers' Compensation Division:

Filed the *Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact* with the Oregon Secretary of State on Sept. 15, 2011;
We mailed the Notice and Statement to its postal and electronic mailing lists;
Notified Oregon Legislators as required by ORS chapter 183; and
Posted public notice and the proposed rules to the division's website.

The Oregon Secretary of State:

Published the hearing notice in its October 1, 2011 *Oregon Bulletin*.

This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including Thursday, October 27, and will make no decisions until all the testimony is considered. We have created a new webpage where we will post written testimony as soon as possible after it arrives. Information about this webpage is on the table by entrance.

We are ready to receive testimony. If you are reading from written testimony and give the agency a copy of that testimony, we will add it to the rulemaking record. Would someone from the division be so kind as to bring the testimony sign-in sheet up to me?

Mike – you get to stay. Mike McNickle, from the Oregon Workers' Compensation Division. You're on.

Mike McNickle: For the record, my name is Mike McNickle. I'm Medical Section Manager of the Workers' Compensation Division for the Department of Consumer and Business Services. I'm providing testimony on two separate issues that we identified after proposed rules were filed with the Oregon Secretary of State.

Number one: The maximum payment amounts listed in Appendix E of chapter 436, division 009, were based on a July release of the Centers for Medicare and Medicaid Services, also known as CMS, DMEPOS fee schedule. CMS inadvertently discontinued to list payment amounts for HCPCS codes L3660, L3670, and L3675 in their July release. CMS subsequently clarified that these three codes will not be discontinued and published payment amounts for L3660, L3670, and L3675. See MLN Matters Number MM7300 or at www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp. Accordingly, the director recommends adding these three codes to Appendix E and to set the maximum payment as follows: For code L3660, the maximum payment would be \$93.57. For code L370, uh L3670, the maximum payment would be \$107.01, and for code L3675, \$155.10.

Issue number two: It has come to our attention that the rule as proposed is not clear whether hearing aids should be paid according to the payment table under OAR 436-009-0080, sub (5). Accordingly, the division recommends to change OAR 436-009-0080, subsection (8)(c) to new section, little (c): Payment for hearing aids is determined under section (5) of this rule. However, without approval from the insurer or director, the payment for hearing aids may not exceed \$5000 for a pair of hearing aids, or \$2500 for a single hearing aid.

Thank you very much.

Fred Bruyns: Ok, thank you very much Mike. Would anyone else like to testify this morning?

William Roberts: Anyone else from O and P want to get up before me?

Fred Bruyns: Have you signed in?

William Roberts: No I haven't.

Fred Bruyns: Or can we – we'll just have you sign in right here. Excellent. Thank you.

William Roberts: My name is William Roberts from Advanced Prosthetics here in Salem, and this is the third meeting that we've had to try to straighten out and discuss this fee schedule for Medicare. I'm not reading – I have just a few notes, so I'm going to try to wing this. I thought it would be important to bring the perspective for the cause needed to change the prices by workman's compensation for the services we provide. I'd like to bring one fact to mind at this point, that in 2010, the Medicare expenditures for O and P was less than 1% of their total expenditures. Yet it's been proven that we provide a 30% hidden return on other cost savings associated with wearing a prosthesis, versus not wearing a prosthesis or orthosis. Another fact is that Medicare is primarily for retirees over 65, and other individuals with proven long-term disability. With these individuals, the functional requirements are usually minimal, and we're really not mandated to provide services above or beyond the functional capacity of the patient.

Now that SAIF has decided that they want to change their fee schedule in line with Medicare, it raises several issues about why this is done as none of this has been disclosed. Most of us were under the impression that SAIF would – almost had too much money; they were sitting on \$100,000,000. And if that's the case, they were shifting to this plan maybe to lower their costs and their liability. This other scenario is they don't have hardly any money at all and they're scrambling for ways to try to save money any way they can. We in our profession can fight this two ways. We can fight for more reimbursement by at least requiring 166% or above and continue to negotiate for a better price. Or, if this is truly the case that you don't have any money, then maybe the profession can turn around their – their plan and swim with you in regards to saving money. There are several ways that we as an industry can work with you to reduce costs. A few would be to eliminate all high technology, revert back to old past technology which basically was minimal and required office visits once or twice a week to take care of pressure problems. We should also then assume that you want to lower your functional requirements for these patients, as in fact your 10% increase, and your paperwork requirements, are even more onerous than Medicare requirements, in the sense that you require preauthorization, as well as all the documentation. You're not making our job any easier with your approach. So, in determining which way we go, either fight against you to get the reimbursement we need – we've got to remember that as orthotists and prosthetists – clients have required more than minimal expertise in order to return them to work, which is our basic mandate – is to provide a complex enough appliance, with all the properties, to return them to a functional working ability. If we're stuck with Medicare allowables, or just slightly above, then obviously the mandate to lower the functional requirements is also going to follow suit. So in a

sense you're telling your workers, well we're going to cover your work but we're not really going to pay for the work that you need. In my 40 years of doing this profession, I've worked on a lot of SAIF patients and continue to work on them. When I tell them that SAIF can no longer afford my work, then it's going to raise other questions. I can't work and be drained of every bit of every profit. And so far SAIF was the only and the remaining entity that would pay a retail price. You provided the butter to our bread, whereas all other insurance companies have just given us the bread. And now that's what you're asking us to take is just the bread. If this action follows through, it's going to change the nature of the profession in this state, forcing mergers and acquisitions. And probably in three years you'll be dealing with one payer – or one provider who'll set the price. And they won't under the competition to play with the price – so be prepared for that. I'm not sure what we're going to end up with here, but we're a long ways away from any decision that is workable. And, I – I'm not quite sure where we should go with this information. If this law stands, then we as a profession will have to revise our mandate, we will have to see what problems evolve after that mandate is put in place. So hopefully we can work this out and we can come to a reasonable reimbursement. Medicare is not a reasonable reimbursement. They are at least 30 to 200% behind our retail prices. Medicare fee schedule will not bode well for your workers, and the fact that work may be denied – I can't afford your price, so maybe I'm going to be resigned to having to receive payment from the patient and have them turn their receipts over to you for reimbursement. If that's how I have to make my living I'll do it that way, and I will leave it up to my client and their attorneys to recapture the amounts that they've had to spend. At this point I've already shut off all new work to SAIF. I will not initiate any new work. I may accept your price on some supplies, but as far as all manufactured items go, I will stop it right now. I don't know what my colleagues are going to do about this situation, but hopefully we can work out a situation where we can all get paid a fair price, we can mandate policies to put your patients back to work, by providing more appropriate technology, which will require a little more payment beyond the Medicare allowable, or 10% above it, which is still well below even our break even points in some regards. So, this problem remains, SAIF has just – has not worked out any discussion groups other than these groups to try to tell us what your plan is. There's been no working groups set up to try to work out an appropriate scenario. So, we as a profession will knee-jerk to your reactions, and then we will see what happens down the road. In the mean time, you'd better be prepared for the fights that are going to happen. My clients are certainly not going to sit for this. You were mandated to provide for their care and to give them a reasonable expectation of returning them to their workplace and to their normal lives. I see no hope in being able to do that under these current cost restraints. So, that will be one of the situations that comes up in the future, as to how these patients are treated, and my colleagues will have to work that out for themselves. Thank you very much.

Fred Bruyns: William, do you have just a moment? Sometimes people confuse us, confuse us with SAIF Corporation, and you may know the distinction, but we're the regulatory body, so the State Accident Insurance Fund and all insurers would be subject to the same fee schedule, and it's just a proposed schedule at this point – it's 110% of what CMS pays. And, so, and not wanting to put words in your mouth, but basically, you're testifying that the 110% is not adequate?

William Roberts: Absolutely.

Transcript of public rulemaking hearing
Oct. 24, 2011

Fred Bruyns: OK

William Roberts: Absolutely.

Fred Bruyns: OK. Thank you for your testimony.

Is there anyone else who'd like to testify, either in person or over the phone this morning?

OK. Uh, it's our policy to keep these hearings open for one-half hour, although I'll go into recess in just a moment. But I wanted to remind you again that the record remains open for written testimony through Thursday, October 27, and you may submit testimony in any written form, whether hard copy or electronic. On the table by the entrance are business cards that include my fax number, postal mailing address, and e-mail address. I encourage you to use e-mail, as that allows you to acknowledge your testimony very quickly. Regardless of how you send it, however, I will acknowledge all testimony received.

This hearing is recessed at 10:17 a.m.

This hearing is resumed at 10:30 a.m., and since there's – there's no one else here who wishes to testify, I'm thinking. OK, that's true.

The time is still 10:30 a.m. This hearing is adjourned. Thank you very much for coming.

Transcribed from a digital audio file – Fred Bruyns, Oct. 24, 2011.



Exhibit "3"

October 27, 2011

Fred Bruyns
Workers' Compensation Division
350 Winter St NE
Salem, OR 97301

Re: Proposed amendments to OAR Chapter 436, Division 9

Dear Mr. Bruyns:

SAIF Corporation appreciates the opportunity to provide input on the proposed changes to the Oregon Administrative Rules.

436-009-0080 We support the amended language to implement a fee schedule with maximum payment amounts based on 110 percent of 2011 Medicare rates for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These rates are reasonable and widely accepted by DMEPOS suppliers. These rules will help ensure reimbursement consistency for similar DMEPOS items.

The rule should specify that rental payments be applied to the purchase price of the equipment. Often the equipment is rented for less than 13 months and the amount paid in rental charges should be applied to the purchase price. In addition, we ask WCD to modify the rental rates so that rental payments do not exceed the purchase price as would happen with rates of 10 percent of the purchase price per month for 13 months. Medicare has a 13-month rental period, however the rental rate declines from 10 percent to 7.5 percent in months 4 through 13. For ease of administration, we suggest that rentals be paid at 10 percent of the purchase price per month for 10 months to be considered purchased.

The rule should also specify that DMEPOS billers must include standard modifiers (NU, RR, UE) to ensure that items are identified correctly and rentals are not paid as purchased items.

Thank you for your consideration of our testimony. Please let us know if you have any questions.

Sincerely,

Allison Morfitt, Medical Audit Supervisor
440 Church Street SE
Salem, Oregon 97312
P: 503.315.3232 or 800.285.8525
F: 503.945.3232
allmor@saif.com

Bruyns Fred H

From: Mercedes Rhodes [Mercedes.Rhodes@mitchell.com]
Sent: Thursday, October 27, 2011 8:49 AM
To: 'Bruyns Fred H'; 'Wadsworth Amy D'; 'MedicalQuestions WCD'
Cc: Karen Ritchie; Miriam Encarnacion; Mercedes Rhodes
Subject: RE: Questions - Proposed Rules - 436-009 Effective 1/1/2012

Exhibit
“4”

Hello Mr. Bruyns:

In response to your email, Mitchell is requesting that the Workers' Compensation Division process our **REVISED** questions (See below) as testimony.

Thank you,

MERCEDES RHODES | Data Analyst 2
Mitchell | (o) 858.368.7042 | (f) 858.408.7290 | mercedes.rhodes@mitchell.com | www.mitchell.com



From: Bruyns Fred H [<mailto:fred.h.bruyns@state.or.us>]
Sent: Thursday, October 27, 2011 8:43 AM
To: Wadsworth Amy D; Bruyns Fred H; Mercedes Rhodes; MedicalQuestions WCD
Cc: Karen Ritchie; Miriam Encarnacion
Subject: RE: Questions - Proposed Rules - 436-009 Effective 1/1/2012

To: Mercedes Rhodes
Mitchell

Good morning Mercedes:

Thank you for contacting me. I am forwarding your questions to our Medical Section, and someone will contact you shortly.

We talked briefly this morning and agreed that the Workers' Compensation Division will not process your questions as testimony unless you get back to us and ask us to do so. You also have the option to submit related written testimony and are aware that today is the closing date for testimony.

Sincerely,

Fred Bruyns, policy analyst/rules coordinator
Department of Consumer and Business Services
Workers' Compensation Division
503-947-7717; fax 503-947-7514
Email: fred.h.bruyns@state.or.us

From: Mercedes Rhodes [<mailto:Mercedes.Rhodes@mitchell.com>]
Sent: Wednesday, October 26, 2011 3:33 PM
To: Bruyns Fred H
Cc: Karen Ritchie; Miriam Encarnacion; Mercedes Rhodes
Subject: Questions - Proposed Rules - 436-009 Effective 1/1/2012

Hello Mr. Bruyns:

(**REVISED** set of questions)

In regard to the proposed Oregon Medical Rules 436-009-0080 (DMEPOS) – We are requesting clarification on the following:

- 1) Will you be indicating which procedure codes can be purchased new, purchased used or rented by providing modifiers to indicate new, rented or used?
- 2) From the Appendix E list of codes, we identified "E" and "K" category codes to have specific modifier usage listed for each code in the 2011 HCPCS Level II book (NU, RR or UE). If the answer to our question #1 is "NO"... Will you approve the use of the HCPCS Level II modifiers to distinguish code billing limitations such as rental only?
- 3) For rentals, is there a rental cap requirement? i.e. up to the purchase price?

Your assistance is greatly appreciated!

MERCEDES RHODES | Data Analyst 2

Mitchell | (o) 858.368.7042 | (f) 858.408.7290 | mercedes.rhodes@mitchell.com | www.mitchell.com



COLUMBIA PROSTHETICS AND ORTHOTICS

173 N.E. 102nd Avenue
Portland, OR 97220-4169

TELEPHONE 503-252-5100
FACSIMILE 503-253-8086

October 27, 2011

Fred Bruyns, Rules Coordinator
Workers' Compensation Division
350 Winter Street NE
Salem OR 97309-0405

Exhibit
"5"

Via Email: fred.h.bruyns@state.or.us

Mr. Bruyns,

I am writing to you regarding the proposed changes to fee and payment rules that effect reimbursement for prosthetics and orthotics. Apparently the proposal is based on current Medicare fee schedules plus ten percent. I am very concerned for Oregon's injured workers if this is implemented.

Please refer to the attached spread sheet that shows the complete history of changes to Medicare fees compared to the changes to the CPI since the inception of our current coding system. As I understand, Medicare's original intent was to follow the rules that state that a current year's reimbursement rates are changed by the same percentage as that of the previous year's CPI. From the attached table you can determine that only on occasion was this the case. History shows us several years of "zero percent increase" and other years when those amounts arbitrarily established were far below the CPI.

When comparing the two most current indices of 210.8 and 144.9 it results in a difference of about 45%. This means that if Oregon's fees for our types of services for injured workers had been maintained equivalent over the years, and flat Medicare allowable amounts were considered acceptable, current reimbursement would be current Medicare rates plus 45%. While relative Medicare rates have decreased during this time, our labor, operating expenses and cost of materials have maintained their increase.

With the difference of 35% in this scenario we all should be concerned about shrinking numbers of providers as some cannot provide quality service at these rates. Also, the optimum care that injured workers deserve might be converted to adequate care by those providers that are left with no choice except to leave out some of the quality aspect of the service. Our profession is much more than dispensing "expensive" hardware to our patients.

This attached table shows only one of the many problems when considering Medicare rates to be accurate and fair. Many of the profile amounts that were established for each procedure code early on were skewed by non-prosthetic and orthotic providers, i.e.: physicians and physical therapists. When these providers bill using O&P codes, they are also allowed to bill separately for the office visits and fitting fees. Our profession includes items and the entire service element in one billed amount. This usually includes initial evaluations, measurements, impressions, fabrication, fitting and follow-up.

When considering these inaccuracies, It would be less erroneous to base reimbursement on a prosthetic and orthotic provider's customary fee schedule and consider a percentage discount from that.

Sincerely,



Dave A. Janke, CPO
Owner

Relative annual increases to Medicare allowable amounts for orthotics and prosthetics compared to the national Consumer Price Index

Year	O&P Index	CPI-U Index	MC O&P %Change	CPI-U %Change
1984	100.0	100.0	-----	-----
1985	100.0	103.8	0.0%	3.8%
1986	100.0	105.7	0.0%	1.8%
1987	101.4	109.6	1.4%	3.7%
1988	101.1	114.0	-0.3%	4.0%
1989	102.9	119.9	1.8%	5.2%
1990	101.8	125.5	-1.1%	4.7%
1991	103.4	131.4	1.6%	4.7%
1992	108.3	135.5	4.7%	3.1%
1993	111.6	139.6	3.1%	3.0%
1994	111.6	143.0	0.0%	2.5%
1995	111.6	147.3	0.0%	3.0%
1996	115.0	151.5	3.0%	2.8%
1997	118.2	155.0	2.8%	2.3%
1998	119.4	157.6	1.0%	1.7%
1999	120.6	160.7	1.0%	2.0%
2000	121.8	166.7	1.0%	3.7%
2001	126.3	172.0	3.7%	3.2%
2002	127.5	173.9	1.0%	1.1%
2003	129.0	177.6	1.1%	2.1%
2004	129.0	183.4	0.0%	3.3%
2005	129.0	188.0	0.0%	2.5%
2006	129.0	196.1	0.0%	4.3%
2007	134.5	201.4	4.3%	2.7%
2008	138.1	211.5	2.7%	5.0%
2009	145.0	208.5	5.0%	-1.4%
2010	145.0	210.8	0.0%	1.1%
2011	144.9		-0.1%	

2010 Productivity Adjustment = -1.2%

Year Span	% Change—Medicare O&P Fee Schedule Allowables
1984-2010	45.0%

Year Span	% Change—CPI-U
1984-2010	110.8%

Year Span	% Medicare Shortfall
1984-2010	65.8%

This data was made available from the American Orthotic and Prosthetic Association.