Medical Care and Benefits

In recent years, the cost of health care has risen more rapidly than overall inflation. In Oregon's workers' compensation system, the cost of medical services has increased more than 38 percent since 2000. Payments for medical services account for approximately half of workers' compensation system costs in Oregon. There have been recent initiatives to contain medical costs; these are discussed later in this section.

Early cost-containment measures

In 1990, Senate Bill 1197 eliminated most palliative care after the worker becomes medically stationary, when no further improvement in the worker's condition is expected. Palliative care is treatment to relieve symptoms rather than to improve the worker's underlying condition. These restrictions had an immediate impact on workers who had been receiving ongoing palliative treatment. SAIF's medical payments for palliative care in the first six months after the medically stationary date dropped more than 30 percent following the implementation of SB 1197. In 1995, SB 369 restored a worker's right to request approval for a broader range of care after being declared medically stationary. Workers can now receive palliative care if they have a permanent total disability or a prosthetic device, when they need services to monitor prescription medicine, or when the attending physician believes the palliative care is necessary for continued employment.

SB 1197 also placed limits on who could be an attending physician. The attending physician acts as the gatekeeper for most treatment and indemnity benefits. Care must be provided by, or upon referral from, the attending physician. Under SB 1197, for example, a chiropractor outside of a managed care organization, could not be the worker's attending physician after 12 visits or 30 days from the first service date, whichever came first. Data from SAIF showed that the proportion of total payments received by chiropractors dropped from 16 percent before 1990 to 3 percent after 1990. In 2008, House Bill 2756 relaxed that limitation to 18 visits or 60 days from the first service date, whichever comes first. HB 2756 also changed limits for other provider types acting as attending physicians. These changes are discussed in more detail later in the report.

Medical benefits

Insurers and self-insured employers must pay the cost of medical services for compensable claims. During the period before claim acceptance or denial, however, there is uncertainty about who will be responsible for medical bills. This uncertainty may make some medical providers reluctant to treat injured workers, and some treatments may be delayed until after insurers' compensability decisions.

In 2001, SB 485 tried to address this concern in two ways. First, the bill reduced the time allowed for insurers to accept or deny a claim from 90 days to 60 days. Second, it amended the law regarding the payment of some medical services prior to the initial acceptance or denial of a claim. The law covers certain services: pain medicine, diagnostic services required to identify appropriate treatment or to prevent disability, and services required to stabilize the worker's condition and to prevent further disability. However, it excludes any services provided to workers enrolled in managed care organizations (MCOs). For denied claims, medical costs are paid as follows:

- If the insurer denies the claim more than 14 days after the employer knowledge date and the worker has health insurance, the health insurer pays for the services, subject to the limitations in its policy; the workers' compensation insurer pays any balance.
- If the insurer denies the claim within 14 days of the employer knowledge date and the worker has health insurance, the health insurer pays for the services, subject to the limitations in its policy; the worker pays any balance.
- If the insurer denies the claim and the worker has no health insurance, the worker pays the entire bill.

Fee schedules

The Workers' Compensation Division has had medical services fee schedules since 1982. Over time, new schedules have been added through administrative rules. Medical fee schedules exist for anesthesiology, surgery, radiology, laboratory and pathology services, medicine, physical medicine and rehabilitation, evaluation and management, multi-disciplinary services and other Oregon-specific service codes, durable medical equipment and medical supplies, and pharmacy services. Insurers must pay for medical services at the lesser of the providers' usual fees or according to the fee schedule. This rule also applies to claims enrolled in MCOs unless terms are otherwise dictated by the MCO contract.

The medical fee schedules establish the maximum allowable reimbursement for services. In 1997, the department also adopted the Federal Resource Based Relative Value Schedule, which is used to determine the ceiling for most medical services. For durable medical equipment and medical supplies, the ceiling is 85 percent of the manufacturer's suggested retail price or 140 percent of the actual cost, whichever is greater. In July 2008, a reduction in the pharmacy fee schedule took place. The maximum allowable fee for pharmaceuticals is now set at 83.5 percent of the Average Wholesale Price plus a $2.00 dispensing fee. Previously it was 88 percent of Average Wholesale Price and an $8.70 dispensing fee.

WCD implemented a hospital payment system using adjusted cost-to-charge ratios (CCR) in 1991. In July 1992, the department began publishing revised CCRs semi-annually for all general, acute-care hospitals in the state. The CCR is the percentage of the hospital bill that insurers reimburse Oregon hospitals for treating injured workers. The computation of the CCR uses data from each hospital's audited financial statement and Medicare cost report. The CCR allows all hospitals to recover the cost of providing facility-related services to injured workers, a reasonable rate of return on their capital assets, and an allowance for losses due to bad debt and charity care. The CCR is revised annually based on the hospital's fiscal year and is published twice yearly.

Oregon hospitals designated as rural hospitals by the Office of Rural Health may be excluded from imposition of the CCR. This exclusion is based on designation as a critical-access hospital under the Medicare Rural Hospital Flexibility Program, or on economic necessity as determined from financial reports. Currently, 25 of the 58 general, acute-care hospitals in Oregon are designated as critical-access hospitals, thereby qualifying for an exclusion from the hospital fee schedule. Five additional rural hospitals qualify for the exclusion based on their financial condition.

In 2007, 88 percent of medical payments reported to the department were for services subject to fee schedules other than the hospital CCR. On average, these payments were 29 percent lower than the charged amounts. Reimbursements for hospital charges subject to the CCR averaged 47 percent less than the charged amounts.

Managed care organizations

The 1990 reforms introduced managed care into the Oregon workers' compensation system. SB 1197 allowed workers' compensation insurers to contract with department-certified managed care organizations and it set the rules under which covered workers must obtain treatment within MCOs. Each MCO contracts with medical providers who agree to the MCO's terms and conditions. In return, these providers have the opportunity to treat the covered workers. The terms and conditions differ by MCO, but they must include treatment and utilization standards and peer review. Each panel of providers must include eight types of medical service providers: chiropractors, naturopaths, acupuncturists, osteopaths, dentists, optometrists, podiatrists, and physicians.

Insurers have the option to enroll injured workers covered by MCO contracts in managed care. When this happens, the insurer notifies the injured worker that he or she must seek any future treatment from providers who are on the MCO's panel. Since 1995, insurers are allowed to require that injured workers receive medical treatment in the MCO before the determination of claim acceptance or denial. However, if the insurer denies the claim it must pay the medical costs until the worker

receives notice of the denial or until three days after the denial notice is mailed. Insurers that do not enroll workers in an MCO are not required to pay medical services if the claim is eventually denied.

In 2005, SB 670 made minor revisions to the statute (ORS 656.260) regarding managed care organizations. The bill clarified that in order for an MCO to become certified, the quality, continuity, and treatment standards contained in its plan must be reviewed and approved by the director. The bill also provided that the managed care plan cannot prohibit an injured worker's attending physician from advocating for medical services and temporary disability benefits supported by the medical record. This provision addressed concerns that some managed care contracts contained provisions limiting the attending physician's role.

As of Dec. 31, 2007, four certified MCOs had 69 active contracts with workers' compensation insurers and self-insured employers. Contracts in effect on Oct. 31, 2007, covered 58,684 Oregon employers, or 64 percent of Oregon workers' compensation covered employers. The percent of Oregon workers covered by managed care has increased from 64 percent in October 2005 to 65 percent in October 2007. In October 2007, an estimated 1,144,700 Oregon workers were covered by a managed care contract.

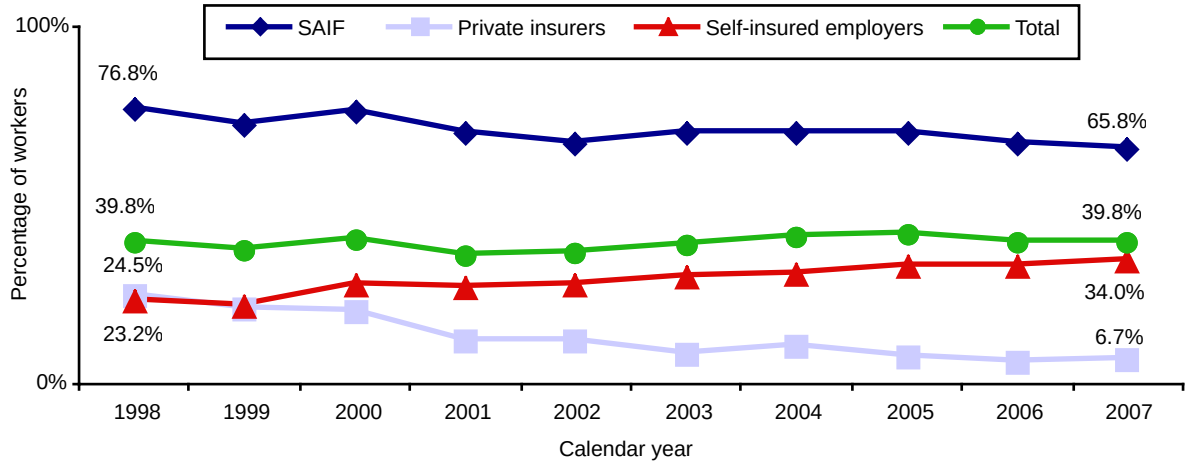
The percentage of workers with accepted disabling claims who were enrolled in MCOs has ranged from 36 percent to 42 percent since 1998. In 2007, it was 40 percent. SAIF insured 79 percent of those enrolled. Self-insured employers enrolled 34 percent of accepted disabling claims. The percentage of workers with accepted disabling claims enrolled by private insurers has dropped more than 16 percent since 1998, reaching a low of 7 percent in 2007.

Medical payments

In 1991, the Workers' Compensation Division began requiring that insurers with 100 or more accepted disabling claims report their medical payment data under Bulletin 220. In 2007, more than 83 percent of total medical payments were reported. Department research analysts developed a model that adjusts reported payments to account for payments that are not reported in Bulletin 220. Using this model, the estimated total medical payments in 2007 were $319.4 million.

In 2007, insurers paid about $92 million for medical doctor services which accounted for 29 percent of all medical payments. This was followed by hospital outpatient services at 22 percent, hospital inpatient services at 12 percent, "other medical" providers at 10 percent, and physical therapy services at 8 percent. These five provider types accounted for 81 percent of all medical payments. A substantial number of the payments classified under the "other medical" provider type were for independent medical exams and ambulance services. Six percent of medical payments went to pharmacies. Radiologists received 3 percent of total payments,

Figure 11. Percentages of workers with accepted disabling claims enrolled in MCOs, by insurer type, 1998-2007



mostly for providing magnetic resonance imaging, computed tomography, and X-ray services. Chiropractors received 2 percent of payments for providing chiropractic manipulative treatments and other therapeutic services.

Physical medicine and rehabilitation services, evaluation and management services (such as office visits, emergency visits, etc.), and surgery are the top three service categories in terms of payments. Physical medicine and rehabilitation services accounted for 15 percent of total 2007 medical payments, nearly $47 million. Evaluation and management accounted for 14 percent of total medical payments, or about $46 million, and surgical services accounted for 13 percent of 2007 total medical payments, approximately $42 million.

Independent medical exams also generated a large percentage of the payments. IME services, grouped together to include basic exams, reports, and specialized IME services (panel exams and exams by specialists), accounted for 3.2 percent of total medical payments.

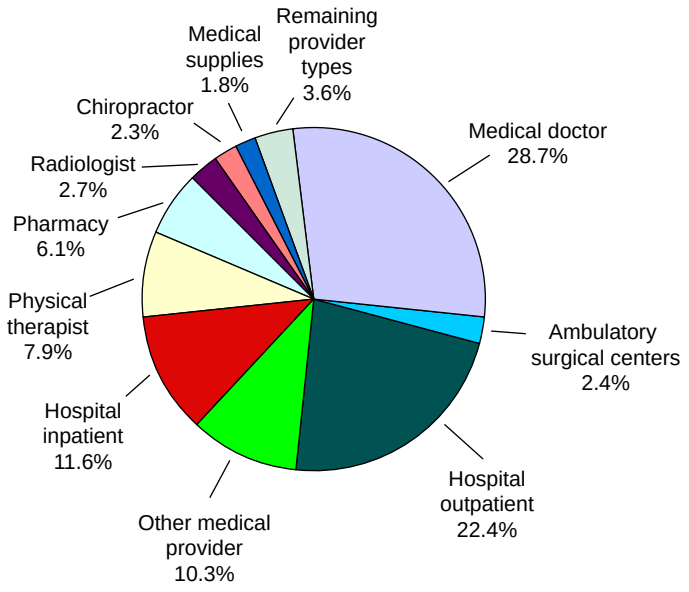
Reported pharmacy data shows that narcotic analgesics (pain relievers) ranked as the top category of drugs prescribed to injured workers and accounted for 37 percent of total pharmacy payments in 2007, followed by anti-convulsants (anti-seizure medications) at 11 percent, and anti-arthritics (anti-inflammatories) at 8 percent. Some of the widely used narcotic analgesics in workers' compensation are Hydrocodone/Acetaminophen, Oxycodone HCL, Fentanyl, Oxycodone/Acetaminophen, and Morphine Sulfate. There is evidence of higher use of generic drugs in workers' compensation than in the general health care system. In 2007, generic drugs made up about 79 percent of the prescriptions dispensed to injured workers and 49 percent of pharmacy payments.

Recent initiatives and studies

Nurse practitioners

In 2003, HB 3669 relaxed restrictions regarding who can be an attending physician by allowing nurse practitioners to perform some of these functions. The bill requires nurse practitioners to become authorized by the department to provide any compensable medical services as attending physicians. It allows authorized nurse practitioners to give expanded treatment in three significant ways. They may provide compensable medical services for 90 days from the date of the first visit on

Figure 12. Top 10 medical payments by provider type, 2007



Note: "Other medical provider" payments are chiefly for independent medical exams and ambulance services. The "Remaining provider types" are acupunturist, dentist, home health care, laboratory, naturopath, nursing home care, occupational therapist, optometrist, osteopath, physician assistant, podiatrist, psychologist, and registered nurse practitioner.

the claim, to authorize the payment of temporary disability benefits for 60 days, and to release workers to their jobs.

In 2005, the department began a study to measure the effects of HB 3669. The study provided the results of a review of the department's medical billing data, claims information provided by SAIF, and a survey of board-certified nurse practitioners. The results found no system cost increases related to the expanded authority for nurse practitioners. In the survey, nurse practitioners reported providing more services to injured workers after the bill went into effect.

Care providers

In 2006, the department, at the request of the Governor and in conjunction with the Management- Labor Advisory Committee, completed a study of care providers. The department and MLAC focused on chiropractors, naturopaths, podiatrists, and physician assistants. The study tried to determine if current rules regarding who may treat workers and authorize disability benefits facilitates accessible, timely, efficient, and effective medical treatment. The study included a literature review; an analysis of chiropractic, naturopathic, podiatric, and physician assistant care providers in Oregon's workers' compensation system; employer focus groups; and an injured worker survey.

The literature review found little data about the role of chiropractors, naturopaths, podiatrists, and physician assistants within the workers' compensation system. The available data did not provide sufficient evidence to either support or oppose a change in Oregon's limitations on who can treat workers.

Employers and injured workers indicated that they were generally satisfied with access to quality health care, the choice of available health care providers, and the quality of care received. Both groups requested that additional restrictions not be added to the current system.

The 2007 Legislature passed HB 2756, which expanded the roles and responsibilities of certain provider types. The new law increased the role of chiropractors, nurse practitioners, podiatrists, naturopaths, and physician assistants to act as attending physician. The new time limit for these providers to act as attending physician was established at 18 visits or 60 days from the first date of service, whichever comes first. These providers were also allowed to authorize temporary disability for up to 30 days from the first service date.

The new law also allowed a medical provider who did not qualify to be an attending physician to provide compensable services for the first 30 days or up to 12 visits, whichever comes first. Beyond the 60 days or 18 visits for chiropractors, nurse practitioners, podiatrists, naturopaths, and physician assistants, and 30 days or 12 visits for providers not authorized to be attending physicians, only a doctor of medicine, osteopathy, or maxillo-facial surgery can act as attending.

Independent medical examinations

SB 311 (2005) introduced changes to how independent medical examinations may be conducted. Much of the bill was based on findings from a study of IMEs the department completed at the request of the Management-Labor Advisory Committee. The study was designed to acquire information about Oregon's IME system, especially in areas where there were concerns regarding:

- Bias of IME physicians toward insurers
- Rude and rough behavior by IME doctors with injured-worker patients
- IME physicians not receiving actual diagnostic studies for review at the exam
- The distance injured workers had to travel for an IME
- The lack of information given an injured worker about what to expect at an IME
- The use of leading questions in letters from insurers to IME physicians prior to an exam

SB 311 required that IMEs be conducted by physicians who insurers select from a list developed by the Workers' Compensation Division, and that WCD develop the training requirements and educational materials necessary for qualification. Physicians must agree to abide by a standard of professional conduct for performing these exams. The bill also included a requirement to establish a process for the removal of a physician from the list and a process for investigating complaints about exams. In addition to physician training, the bill charged the department with approving specific training for claims examiners regarding communications with physicians conducting IMEs.

Other changes the bill made to the existing IME process included provisions for injured workers to challenge the location of an exam, imposing penalties against workers who fail to attend an exam without prior notification or justification, and imposing penalties against medical service providers who unreasonably fail to provide diagnostic records for an exam in a timely manner.