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 31 percent since 2002. In 2013, payments for medical services accounted for 54 percent of workers' compensation system costs in Oregon.

Early cost-containment measures

In 1990, Senate Bill 1197 eliminated most palliative care for medically stationary injured workers. Palliative care is treatment to relieve symptoms rather than to improve the worker's underlying condition. These restrictions had an immediate effect on workers who had been receiving palliative treatment. SAIF Corporation'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 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 must provide or prescribe care. Under SB 1197, for example, a chiropractor outside of a managed care organization could not continue to be a worker's attending physician beyond 12 visits or 30 days after the first service date. Data from SAIF showed that the proportion of payments to chiropractors dropped from 16 percent before 1990 to 3 percent after 1990. House Bill 2756 (enacted in 2007) relaxed the limitation to 18 visits or 60 days from the first service date. 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 a claim is accepted or denied, however, there is uncertainty about who will be responsible for medical bills. This uncertainty may lead some medical providers to delay treatment until after insurers make compensability decisions or make them reluctant to treat injured workers at all.

In 2001, the Legislature addressed this problem in two ways. First, SB 485 reduced the time allowed for insurers to accept or deny a claim from 90 days to 60 days. Second, it amended the law to require payment for some services performed before acceptance or denial. Included among these services are pain medicine, some diagnostic services, and services to stabilize the worker's condition and prevent further disability. However, the law excludes services provided to workers enrolled in managed care organizations.

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 first fee schedules for medical services in Oregon were implemented in 1982. Fee schedules now exist for nine physician service categories: pharmacy services; ambulatory surgery centers; durable medical equipment, prosthetics, orthotics, and medical supplies; transportation; interpreter services; dental services; multi-disciplinary services; and other Oregon-specific

service codes. Insurers pay for medical services at the lesser of the fee schedule or the billed amounts. Currently, nearly all payments for medical services to injured workers are subject to a fee schedule. The department is currently looking at new fee schedules for other service areas.

In 1997, the department adopted the Federal Resource-Based Relative Value Schedule (RBRVS) method for determining the maximum payment for the physician service categories. Since then, enhancements improved the usability of the physician fee schedule. A maximum allowable payment (MAP) for each service is published annually in OAR 436-009 according to its Current Procedural Terminology (CPT) code.

A new fee schedule methodology was adopted July 1, 2011, for durable medical equipment, prosthetics, orthotics, and medical supplies. The maximum is 110 percent of the Centers for Medicare and Medicaid Services (CMS) MAP or 80 percent of the billed amount for most products not covered by CMS. Hearing aids, however, are paid at 100 percent of charges.

Also on July 1, 2011, the department implemented a fee schedule based on the CMS Ambulatory Payment Classification (APC) system for payment of services performed in ambulatory surgery centers. The department publishes the MAPs according to the services' Healthcare Common Procedure Coding System (HCPCS) codes. Medical implants are paid at 110 percent of the APC's actual cost for the implant. Facility services that are not covered by CMS (and therefore not part of the APC system) are paid at 80 percent of the billed amount.

Before Jan. 1, 2011, all services that did not fall under one of the currently applicable fee schedules were to be paid as billed, that is, 100 percent of the amount charged. New rules took effect on that date requiring a maximum payment of 80 percent of the amount charged. Subsequently, fee schedules have been adopted in several categories to replace the 80 percent rule. Dental services are now paid at 90 percent of charges. Seven services relating to transportation (ambulance services) are paid at 100 percent of charges.

The maximum allowable fee for pharmaceuticals is 83.5 percent of the Average Wholesale Price, plus a $2 dispensing fee.

The interpreter services fee schedule was first implemented in April 2011 covering the interpreters' services, as well as travel to and from appointments.

The Workers' Compensation Division implemented a hospital payment system using adjusted cost-to-charge ratios (CCR) in 1991. Since July 1992, the department has published revised CCRs semi-annually for all general, acute-care hospitals in the state. The CCR is the proportion of the hospital bill that insurers reimburse Oregon hospitals for treating injured workers. The CCR calculation is based on information from hospitals' audited financial statements and Medicare cost reports. The CCR allows 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.

Rural hospitals 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 need as determined from financial reports. Currently, 25 of the 58 hospitals in Oregon are designated as critical-access hospitals. Three additional rural hospitals qualify for the exclusion based on their financial conditions. Exempt hospitals are paid 100 percent of charges.

Managed care organizations

SB 1197 (1990) established regulations regarding workers' compensation insurers' contracts with department-certified managed care organizations (MCOs), and it set the rules under which covered workers must obtain treatment within MCOs. MCOs contract with medical providers and, in return, MCO-covered workers are directed to those providers for treatment. 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.

In 2005, SB 670 made revisions to the statute regarding MCOs. The bill clarified that in order for an MCO to become certified, the DCBS director must review and approve the standards contained in the MCO's plan. 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 2013, four certified MCOs had 114 active contracts with workers' compensation insurers and self-insured employers. Forty-five percent of workers with accepted disabling claims were enrolled in MCOs. SAIF has used MCOs more than most other insurers. In 2013, SAIF enrolled 67 percent of its claimants with accepted disabling claims. For comparison, self-insured employers enrolled 43 percent of their claimants with accepted disabling claims, and private insurers enrolled 7 percent of their claimants.

Medical payments

The Workers' Compensation Division requires that insurers with a three-year average of 100 or more accepted disabling claims report their medical payment data. In 2013, approximately 85 percent of total medical payments were reported under the administrative rules. Total medical payments in 2013 are estimated to be $317.3 million.

Physician services made up the largest category of medical services in the WC system. Nearly 60 percent of the medical dollars spent went to physician services. Physical medicine, which includes physical therapy, wound care management, and osteopathic manipulation, was the largest sub-category, in terms of dollars, within physician services. Facility services made up the second largest service category at 23 percent of total payments.

Among physician services, therapeutic exercises were 10 percent of costs. Four of the top 15 physician services were physical medicine services. Narcotic analgesics (pain relievers) ranked as the top category of drugs prescribed to injured workers; 39 percent of drug costs were for this class of drugs. Anti-convulsants (anti-seizure medications, 12 percent) and anti-depressants (7.5 percent) round out the top three classes. The use of generic drugs increased in 2013 to 82 percent of dispenses and 45 percent of payments.

Independent medical exams account for a significant portion of medical payments. IME services, grouped together to include basic exams, reports, and specialized IME services (panel exams and exams by specialists), totaled 2.6 percent of total medical 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 the claim, authorize the payment of temporary disability benefits for 60 days, and release workers to their jobs.

In 2005, the department studied 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 that there were 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 (MLAC), completed a study of care providers. The department and MLAC focused on chiropractors, naturopaths, podiatrists, and physician assistants. The study tried to determine if rules regarding who may treat workers and authorize disability benefits facilitated 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 maxillofacial surgery can act as attending physician.