Department of Consumer and
Business Services

Workers' Compensation Care Provider Study

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Workers' Compensation
Management-Labor Advisory Committee
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Workers' Compensation Care Provider Study

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Appendices

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Executive Summary

Four types of care providers submitted bills during the 2005 legislative session to expand their authority as attending physicians in the workers' compensation system: chiropractors (CH), naturopaths (NA), podiatrists (PO), and physician assistants (PA). In response, Governor Kulongoski requested that the Department of Consumer and Business Services (DCBS), in conjunction with the Management Labor Advisory Committee (MLAC), review the role of chiropractors and "other providers as MLAC feels is appropriate," in the workers' compensation system. The Governor requested that the evaluation of care provider roles in Oregon's workers' compensation system focus on how to best meet the needs of workers and employers.

Thus, this study provides information about the delivery of compensable medical care for work-related injuries and illnesses in Oregon. The medical care delivery model is evaluated to determine if current regulations regarding who may treat workers and authorize disability benefits facilitates accessible, timely, efficient, and effective medical treatment, consistent with the goals of the workers' compensation system.

The study found that overall both injured workers and employers are satisfied with the care provided, although there are some areas of the system that could be improved. For example, better notification to workers about their options in selecting a treatment provider would be helpful in educating workers about the choices they do have within the system.

Oregon statute specifies attending and non-attending physician roles in workers' compensation. Currently, medical doctors (MD), doctors of osteopathy (DO), oral and maxillofacial surgeons , and chiropractors (for 30 days or 12 visits, whichever comes first) can function as attending physicians.

Non-attending physician providers cannot authorize the payment of temporary disability compensation (time loss) or make findings regarding the worker's impairment for the purpose of evaluating the worker's permanent disability. Of note, though a chiropractor may function as an attending physician for any 30-day or 12-visit period within the initial claims, once they meet these treatment limits they are considered a non-attending provider.

Most health care providers who are not designated by statute as an attending physician (for example, naturopaths, podiatrists, and physician assistants) may provide compensable medical services to an injured worker without the authorization of an attending physician for up to 30 days from the date of the occupational injury or illness or for 12 office visits, whichever comes first.

Managed care organizations (MCOs) have the authority to establish their own business rules regarding which providers can function as attending physicians and the number of services a care provider can deliver without receiving pre-authorization from the MCO. Most MCOs in Oregon developed rules similar to those specified in statute for non-MCO providers. It appears that within a managed care context, extending the limitation from 30 days or 12 visits to 60 days or 20 visits has not significantly affected chiropractor utilization and practice patterns.

Available literature regarding the role of chiropractors, naturopaths, podiatrists, or physician assistants as attending physicians in a workers' compensation system is scant and does not provide sufficient evidence to either support or oppose a change of Oregon's limitations on attending physician status.

Focus groups conducted throughout the state indicate that employers are generally satisfied with their employees' access to health care. Employers from the eastern part of the state, however, did note problems with timely access to health care in their area due to a lack of physicians.

A survey of injured workers found that the majority of workers are satisfied with their access to health care, the choice of health care providers available to them, the quality of care they received, and their ability to see a qualified health care provider.

The study also analyzed whether regulatory restrictions on care providers have affected the level of care they provide to injured workers. Podiatrists, naturopaths, and physician assistants provided a relatively small proportion of care.

Limitations on care do appear to have affected chiropractors. Since 1990, payments to chiropractors have accounted for a decreasing percent of medical payment dollars while the proportion of payments to physical therapists have increased slightly and payments to medical doctors have remained steady.

Workers' Compensation Care Provider Study
Background

At the request of Gov. Kulongoski, the Department of Consumer and Business Services (DCBS) and the Management-Labor Advisory Committee (MLAC) worked together to develop and conduct a study about the roles of various care providers within Oregon's workers' compensation system, as well as worker access to appropriate care for work-related injuries and illnesses. The study has been guided by the goals of Oregon's workers' compensation system as laid out in ORS 656.012 (2) and (3):

- To provide, regardless of fault, sure, prompt, and complete medical treatment for injured workers and fair, adequate, and reasonable income benefits to injured workers and their dependents;
- To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;
- To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable;
- To encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents; and
- To provide the sole and exclusive source and means by which subject workers, their beneficiaries, and anyone otherwise entitled to receive benefits on account of injuries or diseases arising out of and in the course of employment shall seek and qualify for remedies for such conditions.
- To benefit all citizens, through impartial and balanced interpretation of the law.

In conducting the study and making recommendations for changes, DCBS and MLAC considered the history of regulation of care providers in Oregon's workers' compensation system. Below is a brief overview.

Care Providers in Oregon Workers' Compensation System

Oregon workers who suffer compensable work-related injuries and illnesses have the right to choose their attending physician or nurse practitioner. An attending physician is defined as "a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury" (656.005(12)(b)(A)). Thus, a physician or nurse practitioner works with the injured worker to determine what care is needed, provides care that is within their scope of practice, and refers the worker to other care providers for treatment as necessary. Furthermore, the attending physician is responsible for managing the care the injured worker receives from all other care providers (ORS656.245 (2)(a)).

Oregon Revised Statute 656.005 (12)(a) clarifies that a "physician" is "a person duly licensed to practice one or more of the healing arts in any country or in any state, territory, or possession of the United States within the limits of the license of the licentiate." Thus, a broad range of providers

satisfy the definition of physician in the workers' compensation system. The specific authorities of an attending physician, what providers can exercise these authorities, and the length of time a provider can function as an attending physician have changed over time.

The law prior to 1990

Oregon law ORS 656.245 (3) provides workers with the choice of who serves as their initial attending physician. Prior to 1987, workers were allowed to change their attending physician up to four times during the course of treatment for their work-related injury or illness. In 1987, in response to concerns of "doctor shopping," the number of times a worker could change attending physicians was limited to an initial selection with two subsequent changes.

Changes in 1990

In 1990, there were concerns about the high overall costs of the workers' compensation system, rapidly rising medical costs, high utilization of medical services, increasing disability duration, and provider fraud and abuse. Senate Bills 1197 and 1198, negotiated by a labor-management committee appointed by the governor, were enacted in response to these concerns. The original draft bills limited the authority of an attending physician to only medical doctors and doctors of osteopathy "since the attending physician is the 'gatekeeper' for entry into the workers' compensation system and thus should be an individual possessing as comprehensive a license as possible."[1]

A legislative amendment (approved by the same labor-management committee and enacted in the final bill) extended attending physician authority to two additional groups: oral and maxillofacial surgeons and chiropractors (ORS 656.005 (12) (b)). The period of time a chiropractor was permitted to be an attending physician was limited to "a period of 30 days from the date of [the] first visit on the initial claim or for 12 visits, whichever first occurs."

Medical providers who were not qualified to be an attending physician were given the authority in ORS 656.245 (2)(b) to provide "compensable medical service to an injured worker for a period of 30 days from the date of injury or occupational disease or for 12 visits, whichever first occurs, without the authorization of an attending physician. Thereafter, medical service provided to an injured worker without the written authorization of an attending physician is not compensable." Furthermore, the law directed that these non-attending providers were not to "authorize the payment of temporary disability compensation" or "make findings regarding the worker's impairment for the purpose of evaluating the worker's disability" at claim closure.

Also in 1990, managed care organizations (MCOs) became a feature of the workers' compensation system. Upon being certified by the DCBS, these organizations could provide managed care for compensable work-related injuries and illnesses. Limitations on which providers could serve as an attending physician were modified for providers within MCOs. "Any medical service provider" could authorize temporary disability compensation and make findings of worker impairment if the MCO included these authorities in the provider's contract. This change was presented as being "consistent with the overall purpose of establishing incentives for all medical service providers to become members and actually participate in managed care organizations."[1]

[1] Report from The Governor's Workers' Compensation Labor Management Advisory Committee , May 1, 1990.

Other major changes enacted in 1990 further affected compensable medical care and providers' treatment patterns (see Summary of 1990 Reforms, Appendix A). Among them:

- Limitations in palliative care
- Requirements for "objective findings" to establish a compensable claim
- Revised medical dispute resolution processes
- Changes in aggravation standards
- Ability to terminate indemnity benefits with a Claim Disposition Agreement (CDA)

Changes in 2003

In 2003, HB 3669 expanded who could be attending physicians 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. 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 began a study to measure the effects of HB 3669 before its sunset on January 2, 2008. The department presented the study's findings to MLAC in late 2006[2]. The study provided the results of the review of the department's medical billing data, claims information provided by the State Accident and Insurance Fund (SAIF), and a survey of board-certified nurse practitioners. The findings were 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. This shows some expansion of workers' ability to continue treatment with providers with whom they had established relationships. As a result of these findings, the department has recommended the sunset be removed by the 2007 Legislature.

Proposals for change in 2005

In 2005, there were two bills submitted to expand the role of various care providers: SB 669 and HB 2588. Senate Bill 669 requested a study of the feasibility of extending physician privileges to personal physicians who do not qualify as attending physicians. The bill specifically mentioned naturopathic physicians and physician assistants. House Bill 2588, proposed by the Chiropractic Association of Oregon, requested a five-year study of the financial impact of allowing chiropractors to serve as full attending physicians. While the latter bill was passed in the legislature, MLAC did not support this bill and Governor Kulongoski vetoed it. In his veto letter, the Governor stated:

> "In my view, changes in the workers' compensation system should be driven by the needs of employers and workers, not the desires of those who provide services. I am not opposed to the idea of reexamining the role of chiropractors in the workers' compensation system. For this reason, I am asking the Department of Consumer and Business Services, in conjunction with MLAC, to review the role of chiropractors in the workers' compensation system and make recommendations to the next legislative session. This review may cover the role of other providers if MLAC feels it would be appropriate. Once this review is complete, we will have better information on which to base a discussion about whether changes to the workers' compensation system are needed." (full letter in Appendix B)

[2] The Nurse Practitioner Study is available at: http://www.oregon.gov/DCBS/MLAC/support.shtml.

Workers' Compensation Care Provider Study
Study Design

Study Purpose

1) Evaluate the accessibility and availability of quality health care necessary to treat the medical conditions of workers resulting from on-the-job injuries and illnesses.

2) Provide the Governor and Oregon Legislature with information as to whether the current system of regulating who may treat workers and authorize disability benefits facilitates accessible, timely, efficient, and effective medical treatment, consistent with the goals of the workers' compensation system as defined in ORS 656.012. If it is found that the current system does not facilitate treatment consistent with the public policy goals, describe why not.

Study Scope

The study will focus on the roles of the four types of care providers that submitted bills last session in order to expand their authority to provide care in the workers' compensation system: chiropractors, naturopaths, podiatrists, and physician assistants.

Study Objectives and Methodology

1. Determine if research literature exists to support or oppose a change in public policy regarding the role of various medical providers in the workers' compensation system.

    - Literature Review

2. Describe the accessibility and availability of quality health care as reported by workers with accepted disabling claims and employers regarding the current attending physician model, and explore other providers' (non-attending physicians) abilities to authorize disability benefits and provide treatment to injured workers. Include findings regarding workers' access to medical care, continuity of care, cost considerations, quality of care, and whether workers or employers desire a change in current policy. If workers or employers desire a change in policy, explore their recommendations and reasons for desiring change.

    - Development and implementation of mailed worker survey(s), followed by telephone surveys if the response rate isn't sufficient. The surveys will be designed to create a statistically valid sample group(s).
    - Review the relationship between the worker's condition and the care provider's background in order to determine the degree to which the worker accessed a care provider qualified to treat the worker's condition. Likely requires sampling, file review, and reviewer judgment.
    - Determine the preferred means of obtaining employers' input (interviews, focus groups, surveys) and implement this method. Consider variations in employer types when selecting a sample group.
    - Consider the impact of variations in geographic areas in review of results.

3. Describe the current requirements and responsibilities of an attending physician (AP), as currently defined in statute and rule.
    - Describe the responsibilities of the AP as defined by statute and rule.
    - Describe the status quo regarding current APs and their practices as they relate to the responsibilities of the AP.

4. Describe the preparation of the various providers to fulfill each of the attending physician responsibilities.
    - Interview medical providers, associations, and schools to fully describe their preparation and scope of practice in relation to current responsibilities of the attending physician.
    - Review the Scope of Practice for these medical provider groups.

5. Describe managed care organizations' (MCO) utilization of care providers, regardless of discipline.
    - Review provider panels to determine the representation and utilization of various provider groups.
    - Determine if injured workers have pre-existing patient-provider relationships with MCO panel care providers per ORS 656.245 (4-6).
    - Describe MCO protocols and experience allowing injured workers to "bring along" their primary provider when enrolled in an MCO.

6. Determine if any relevant cost or outcome data are available that could clarify the efficacy of using various provider types within the Oregon workers' compensation system.
    - Cost or outcome by diagnosis
    - Cost or outcome by attending physician or other provider
    - Comparable diagnosis/severity by provider
    - This data may be available through insurers, self-insured employers, the department, or others.

Note: The scope of this study was expanded in September 2006, at the request of MLAC members, to include analysis of any data available prior to the 1990 reforms that could provide additional information as to the impact of chiropractic care in the workers' compensation system prior and subsequent to the 1990 restrictions.

Workers' Compensation Care Provider Study
Committee Membership

MLAC Care Provider Subcommittee

Lon Holston-AFSCME (Labor)
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Workers' Compensation Care Provider Study
Literature Review

Policy issue

Determine if research literature exists to support or oppose a change in public policy regarding the role of various medical providers in the Workers' Compensation system of Oregon.

Background

Oregon's workers' compensation system has a number of features that define the roles of medical providers. These features, while not unique individually, together represent a structure which is unique nationally and internationally. Oregon is classified as an "Employee Choice of Physician" state; however, this choice is restricted in a number of significant ways:

- Only medical doctors, osteopaths, and oral and maxillofacial surgeons have full rights as an attending physician
- Chiropractors and nurse practitioners may be an AP, with certain restrictions (visit or duration limits)
- Other providers may only be an attending physician within a Managed Care Organization (MCO), under the MCO plan and contract
- MCO enrollment is discretionary on the part of the insurer/self-insured employer (which may effectively compel a change of attending physician)
- An employee, if enrolled in an MCO, chooses a provider from the MCO provider panel

States employ a wide variety of system features designed to contain workers' compensation medical costs. One recent (2005) discussion of a single feature, limits on chiropractic visits, notes that California became one of seven states with visit limits[3]. Unfortunately, we were unable to find a truly current compendium of all these features. The most recent such compendium is over four years old as of this writing, and was published by the Workers' Compensation Research Institute (WCRI): *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*.

This National Inventory classifies system features designed to contain workers' compensation medical costs into ten categories: The table below details these categories, whether Oregon was classed as using a particular feature, and the number of states using that feature (out of 51, including D.C.). Oregon uses five of the ten features listed, as detailed in Table 1 below.

While Oregon's use of any single feature is not unique, at the time of the study no other state used the same combination of cost-containment features. When evaluating the relevance of various studies to the Oregon workers' compensation system, it is important to consider the degree to which

[3] Dembe, Allard; Understanding Workers' Compensation Medical Care in California, The California Healthcare Foundation, June 2005

comparable system features exist. For example, a fundamental system feature is whether the worker or employer controls the choice of provider, and studies of other states should take this into account.

Table 1. System features designed to contain workers' compensation medical costs

Feature	Oregon uses?	# of states using
Limited Initial Provider Choice	No	25
Limited Initial Provider Choice (via MCO only)	Yes	12
Limited Provider Change	Yes	32
Limited Provider Change (via MCO only)	No	13
Provider Fee Schedule	Yes	42
Hospital Payment Regulation	Yes	37
Mandated Managed Care	No	4
Mandated Utilization Review	No	17
Mandated Bill Review	Yes	17
Treatment Guidelines	No	20

Source: Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002. WCRI 12/2001.

This National Inventory also describes each state's statutory definitions of provider types that may be treating providers (analogous to Attending Physician status in Oregon.) The Inventory notes that 11 states do not have any specific statutory provision for treating provider. The types of providers who can treat workers, among those states with such statutory provisions, can be seen in Table 2. Medical doctors have treating provider status in all 40 states listed; nearly all also grant treating provider status for Osteopaths (39), Dentists (38), and Chiropractors (38). Oregon and Virginia grant a more limited treating provider status to chiropractors than the other 36 states. Podiatrists (35) and Optometrists (27) also have treating provider status in a majority of the 40 states listed. Naturopaths' status was not summarized in the study.

Table 2. States with statutory authorization for treating providers by type of provider

Providers	Can be treating provider.	Must be referred by a treating provider.	Specifically not authorized for workers' compensation treatment.
Medical doctor	40	0	0
Osteopath	39	0	0
Dentist	38	0	0
Chiropractor	38	0	0
Podiatrist	35	1	1
Optometrist	27	6	6
Psychologist	16	17	17
Physical therapist	7	29	29
Occupational therapist	5	26	26
Registered nurse	4	20	20
Licensed practical nurse	4	19	19
Acupuncturist	2	5	5
Spiritual healer	5	1	1
Psychiatric social worker	1	21	21
Christian Science practitioner	2	1	1

Source: Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002. WCRI 12/2001.

Methodology

The following selection criteria were used in this literature search:

Relevance. An ideally relevant study would involve:

- Comparison of the relative effectiveness of medical care provided by chiropractors, naturopaths, podiatrists, and physical assistants with medical care provided by medical doctors
- Both workers' compensation medical care and case management
- A state system with workers' choice of medical provider
- A system with an "attending physician" or gatekeeper role

Quality. Another critical factor is the quality of the studies included in the literature review. The quality of a study is especially important in studies of back pain, where there is an absence of objective measures of severity. To be considered a quality study, one should:

- Utilize a quality data sample, large enough that findings can be statistically significant.
- Have appropriate case-mix and severity controls[4].
- Have appropriate cost measures (medical payments and indemnity costs).
- Have measures of outcome beyond cost (time-loss duration, return to work, satisfaction, etc.).
- Published by a highly credible organization, or in a peer-reviewed journal.
- Incorporate recent knowledge.

Because there are no studies available that meet all of these criteria, research with widely varying degrees of relevance to this very specific public policy question must be considered. To assist in evaluating the relevance of available research studies, we pose a hierarchy of increasingly relevant questions:

1. How effective is treatment by providers other than medical doctors and osteopaths?
2. How effective is chiropractic in regards to medical outcome for back pain (such as symptom relief, functional status, etc.)?
3. How cost-effective is chiropractic in general health care, i.e., manipulation for back pain?
4. How cost-effective is chiropractic for back pain in a workers' compensation context?
5. How cost-effective is chiropractic for back pain in a workers' compensation context, given limitations on choice, frequency, etc?

For the lower-level (less relevant) questions, the findings of large, high-quality literature reviews from highly credible organizations are evaluated. For the most relevant questions, individual studies and literature reviews are utilized.

What do we mean by effectiveness?

The term *effectiveness* has different meanings from different perspectives. From the injured worker's perspective, it may mean a return to functional status, relief from pain, a satisfying treatment experience, minimally invasive treatment, or restoration of economic status. From the employer/insurer perspective, it may mean minimizing cost (either medical or total), returning the worker to work promptly, returning the worker to full productivity, and minimizing risk of further flare-ups.

Most economic studies involving workers' compensation cases measure effectiveness primarily from the point of view of the payer, i.e. the employer/insurer. From a policy evaluation perspective, however, both perspectives need to be considered.

[4] Severity controls attempt to separate cases into groups of comparable injury severity, in an effort to assure that observed differences between treatments or providers are due primarily to the effectiveness of the treatments themselves, rather than differences in the initial characteristics of patients.

Results and Summary of Findings

There is not sufficient high-quality literature to answer the basic question of how the effectiveness of naturopathic, podiatric, or physician assistant treatment compares to medical doctor treatment. Chiropractic treatment versus physician (medical doctor) treatment is better documented, particularly for manipulation of the spine for low-back pain. Because of the large quantity of literature in this area, and its indirect applicability to the Oregon policy question, we rely on recent literature reviews conducted by impartial organizations.

Because there are no studies available that meet all of the quality and relevance criteria, research with widely varying degrees of relevance to this very specific public policy question (various care providers' status in the Oregon workers' compensation system) must be considered. To assist in evaluating the relevance of available research studies, we summarize our findings along a hierarchy of increasingly relevant questions below.

1. How effective is treatment by providers other than MDs and osteopaths?

There is not sufficient high-quality literature to answer the basic question of how effective naturopathic, podiatric, or physician assistant treatment compares to medical doctor or doctor of osteopathy treatment. Insufficient data exists to make any well-founded statement for providers other than chiropractic.

2. How effective is chiropractic in regards to medical outcome (such as symptom relief, functional status, etc.)?

Chiropractic treatment versus medical doctor treatment is better documented, particularly for manipulation of the spine. Because of the large quantity of literature in this area, and its indirect applicability to the Oregon policy question, we rely on recent literature reviews conducted by impartial organizations. Based on the findings of these literature reviews, chiropractic is about as effective as other medical treatments for back pain.

3. How cost-effective is chiropractic in general health care, i.e., manipulation for back pain?

Chiropractic is similar or better in terms of medical outcomes for back pain in a group health plan environment; the evidence is ambiguous or mixed on cost outcomes.

4. How cost-effective is chiropractic for back pain in a workers' compensation context?

Results are mixed in an unrestricted employee-choice environment, although patient satisfaction is generally better among chiropractic patients. The quality of severity controls is an important limiting factor in cost-effectiveness findings. As the authors of one paper put it, "*The unanswered question is the extent to which the differences in costs reflect differences between chiropractic and physician care, or differences in the characteristics of their patients*."

5. How cost-effective is chiropractic for back pain in a workers' compensation context, given limitations on choice, frequency, etc?

There is some evidence from studies of other states that limitations in an employee-choice context appear to improve chiropractic cost-effectiveness, although patient satisfaction with treatment may be reduced. There is not sufficient evidence to support or oppose a change in specific details of Oregon's limitations on attending physician status, such as visit or duration limits.

Summaries of the studies used in conjunction with the above findings are presented below.

General health care studies

1. ***Assendelft W.J.J., S.C. Morton, E. I. Yu, M.J. Suttorp, and P.G. Shekelle, "Spinal manipulative therapy for low-back pain," The Cochrane Database of Systematic Reviews, Issue 1. Art. No.: CD000447. DOI: 10.1002/14651858.CD000447.pub2, 2004.***

   The review is a publication of the Cochrane Collaboration, an international organization that evaluates medical research. Systematic reviews draw evidence-based conclusions about medical practice after considering both the content and quality of existing medical trials on a topic. The review of 39 randomized clinical trials by the Cochrane Back Review Group found that "There was little or no difference in pain reduction or the ability to perform everyday activities between people with low-back pain who received spinal manipulation and those who received other advocated therapies. Spinal manipulation was more effective in reducing pain and improving the ability to perform everyday activities than sham (fake) therapy and therapies already known to be unhelpful. However, it was no more or less effective than medication for pain, physical therapy, exercises, back school or the care given by a general practitioner."

2. ***California Health Benefits Review Program, "Analysis of Assembly Bill 1185: Chiropractic services," Report to California State Legislature, Oakland, CA, 2005: CHBRP 05-10.***

   The literature review study by California Health Benefits Review Program (2005) includes 280 references. In this review, meta-analyses and systematic reviews of randomized trials are given the greatest weight, followed by individual randomized trials, and then by observational studies and case reports. The analysis relies upon 23 meta-analyses and systematic reviews of randomized trials to assess the impact of chiropractic services for musculoskeletal disorders, supplemented by two case-control studies on serious adverse events and a recently-published randomized controlled trial on the cost of chiropractic care. Each article was reviewed by at least two persons.

   The main conclusions of this study are: (1) overall, the evidence indicates a pattern toward favorable outcomes for chiropractic services, with respect to symptom relief of musculoskeletal disorders, (2) chiropractic services have a pattern toward favorable effect on objective (measurable) signs, (3) the evidence indicates a pattern toward favorable effect of chiropractic services on a patient's performance of activities of daily living and their ability to return to work, (4) there is ambiguous or mixed evidence that chiropractic care results in lowered use of drugs, improved patient satisfaction, or lower costs than other treatments.

3. ***Brown A., D. Angus, S. Chen, Z. Tang, S. Milne, J. Pfaff, H. Li, and S. Mensinkai. "Costs and outcomes of chiropractic treatment for low back pain," [Technology report no 56]. Ottawa: Canadian Coordinating Office for Health Technology Assessment; July 2005.***

   The Canadian Coordinating Office for Health Technology Assessment (CCOHTA) published a high quality systematic, clinical and economic review of chiropractic care for low back pain (LBP). The review was conducted to shed light on the uncertainty of the clinical and cost effectiveness of chiropractic care compared with standard medical treatment or physical therapy in treating LBP (acute, sub acute and chronic). This is a comprehensive review, including the reimbursement practices of chiropractic care across Canada that attempts to

provide answers to decision-makers involved in the provision of chiropractic services across Canada. Major findings of this study include:

- There is no clear clinical advantage to chiropractic treatment for LBP versus standard medical care or physical therapy. Studies show that the three treatment methods have similar effects on pain relief and functional improvement. The higher quality reviews did not find significant differences in effectiveness.
- There is no clear cost advantage for any of the three methods studied. One of the included economic studies compared chiropractic care with physical therapy; and found costs to be similar. Cost results varied among the studies comparing chiropractic care with standard medical care. In terms of improving lost time from work, chiropractic care was similar to physical therapy and was as effective as or better than standard medical care.

In summary, chiropractic care for LBP is similar in effectiveness to that of standard medical care and physical therapy. The evidence from other countries is inconclusive about the costs for chiropractic treatment of LBP, relative to physical therapy or medical care. The authors suggest that a well-designed Canadian study that compares the cost-effectiveness of LBP care provided by chiropractors, physical therapists and primary care physicians, would be beneficial.

Workers' compensation studies

Workers' compensation is concerned with a larger set of factors than general health care. In workers' compensation the emphasis is on management of the total liability of a case, as opposed to provision of all the care that is necessary within the limits of the group health plan design. Claims management in the workers' compensation environment must be concerned not only with payment for medical treatment, but also with appropriateness of treatment, whether that treatment will improve the injured worker's health and functionality, the path and methods of returning workers to their jobs, and the cost of income replacement benefits.

Seven workers' compensation studies (the search included only studies published after 1990) were identified that were of decent quality. In addition, two literature review studies of decent quality (they included some but not all criteria for a quality study described in the methodology section of this report) were identified. Summaries of these studies are provided below.

1. ***Carey T.S., J. Garrett, A. Jackman, C. McLaughlin, J. Fryer, and D.R. Smucker, "The outcomes and costs of care for acute low back pain among patients seen by primary care practitioners, chiropractors, and orthopedic surgeons", N Engl. J Med, 1995, pp: 913-917.***

   This study examines the outcomes and charges of care provided to patients with acute low back pain from different primary care practitioners, such as medical doctors, chiropractors, and orthopedic surgeons in North Carolina. Using medical and chiropractic state-licensure files, the authors randomly selected primary care practitioners from six strata: urban medical doctors, rural medical doctors, urban chiropractors, rural chiropractors, orthopedic surgeons,[5] and medical doctors and a small number of nurse practitioners and physician's assistants at a group-model health maintenance organization (HMO). The authors did not include physical

[5] Because few orthopedic surgeons practice in rural areas, this group is not divided into rural and urban practitioners.

therapists as primary care providers for patients with acute back pain, because such patients rarely seek care from a physical therapist first.

The selected primary care practitioners (who agreed to participate) enrolled their patients in the study. The patients were selected based on the following criteria: (i) the patient has acute low back pain of less than 10 weeks, (ii) he or she did not receive previous care and has no history of back surgery or cancer, and (iii) if female, she was not pregnant at the time of initial visit. The sample included 1633 patients treated by 208 selected providers from June 1992 to March 1993. Workers' compensation was involved in 31 percent of the cases.

The data regarding medical outcomes and patient demographics were collected by interviewing patients at 2, 4, 8, 12, and 24 weeks or until the patients declared themselves "completely better". Data on the charges for outpatient services were based on average statewide charges assigned by a large health insurance carrier by specific specialty. Charges for medication were calculated as the average wholesale cost to the pharmacist plus 40 percent.

The results of the study suggest that among patients with acute low back pain, the outcomes are similar whether they receive care from medical doctors, chiropractors, or orthopedic surgeons. However, satisfaction is the greatest among chiropractic patients. Regarding costs of care, the authors' findings indicate that medical doctors provide the least expensive care for acute low back pain.

This study has one major flaw: the authors used average charges per service to estimate total costs. Medical charges are a biased measure of health-care costs, because payments for health-care services are typically discounted from the amount charged, and discounts vary among payers and providers (Baldwin et al., 2001). Furthermore, the average charges used were not based on the charges of participating patients, but were estimates based on average charges for services from a single insurer in North Carolina.

2. ***Cole N., "Comparing Costs of Chiropractor and Physician Treatments in Workers' Compensation Low Back Claims", East Carolina Economic Review, 1999.***

Cole used data provided by the Workers' Compensation Research Institute (WCRI), which consisted of 320,000 claims from three large insurance companies with injury dates between August 1995 and July 1997. The claims were from three states: Connecticut, California, and Texas. The author developed an econometric model that allowed the comparison of medical payments received by physicians and chiropractors for the treatment of similar workers' compensation cases. The model was based on the estimation of a cost function with age, gender, Mills ratio (this ratio reflects the probability of selecting physician or chiropractor by a patient), managed care enrollment, state (Connecticut, California, and Texas) and the type of service delivered (consultations, emergency room visit, laboratory or x-ray, MRI, physical therapy, real surgery, and surgical procedures) as the explanatory variables.

The results of this study indicate that chiropractors treated older patients than physicians. Females and people with a higher income were more likely to choose a chiropractor, and in the employee choice states of Texas and Connecticut, workers were more likely to see a chiropractor than in California, an employer choice[6] state. Cole found that physicians treat work-related back pain at the lowest cost. However, when confidence intervals were

[6] California workers, under certain circumstances, can choose their physician, although the employer generally makes the initial provider choice.

calculated, there was no significant difference in the costs of physician and chiropractic care. The main drawbacks of this study are: (i) the author did not include indemnity costs or duration of work absence in the cost comparison between chiropractic and medical treatments and (ii) severity control measures were not sufficient.

3. ***Jarvis K.B., R.B. Philips, E.I Morris, "Cost Per Case Comparison of Back Injury Claims of Chiropractic vs. Medical Management for Conditions with Identical Diagnostic Codes," Journal of Occupational Medicine, 1991, vol. 33: 847-852.***

   This study compares the total costs and outcomes of chiropractic treatment with those of physician (medical doctor) treatment for claims with identical ICD-9 diagnostic codes. The sample consists of 3062 claims (40.6% of the 7551 estimated back injury claims) with injury date in 1986, provided by the Workers' Compensation Fund of Utah. Surgical cases and cases treated by both medical doctors and chiropractors were excluded from the sample.

   The authors compare patient age, number of diagnoses after the primary diagnosis associated with each patient, number of visits, duration of the treatment, number of days the patient received compensation, compensation costs, and costs for care between chiropractic and medical cases. On average, chiropractic patients were about 3 years older than medical doctor patients. The number of diagnoses per claim was higher for the chiropractic patients. The number of visits per claim was almost 3 times higher for chiropractic patients compared to physician patients (13 versus 5 visits). The duration of care was about twice as long for chiropractic patients as for physician patients (55 versus 34 days). However, the number of days chiropractic patients received compensation was almost 10 times less than for physician patients (2 days versus 20). Accordingly, the average time loss compensation per claim was nearly one-tenth as much for chiropractic patients. The average medical costs were higher for the medical doctors' patients ($684 versus $527 for chiropractic claim).

   Overall, the findings of this paper indicate that total costs of chiropractic care are lower than medical care costs; however, the authors do not control for the severity level within comparison groups. The failure to separate indemnity from non-indemnity cases in the data analysis is another weakness of the study. The fact that the average number of days off work is 10 times greater for the medical doctors' patients may be indicative of more severe cases in this comparison group.

4. ***Johnson W. G., M. Baldwin, and R. J. Butler, "The Costs and Outcomes of Chiropractic and Physician Care for Workers' Compensation back Claims," The Journal of Risk and Insurance, 1999, Vol. 66, No. 2: 185-205.***

   This article analyzes differences in costs, patterns of care, and return to work outcomes between workers treated by either a chiropractor or a physician for an episode of back pain. The authors use data from Zenith, a national workers' compensation insurer, to compare the sum of health care and indemnity costs. The data refer to approximately 850 closed claims that began and ended between 1991 and 1993. The comparison groups are (1) cases treated by a physician but not by a chiropractor and (2) cases treated by a chiropractor but not a physician.

   This paper is of very high quality. It addresses all of the quality issues previously identified (see background and methodology sections of this report). The authors compare pricing, service mix, and service utilization to determine how each contributed to the differences between the average health-care costs of physicians and chiropractors for various claim types (medical only, temporary disability only, and permanent partial disability). The study results

imply that chiropractors and physicians are equally effective in treating back pain and that neither group offers a clear advantage in terms of the costs of care or the total costs of a workers' compensation back claim. In effect, chiropractors and physicians are close substitutes as care givers for non-surgical cases of work-related back pain.

5. ***Nyiendo J. and L. Lamm, "Disabling Low Back Oregon Workers' Compensation Claims", Journal of Manipulative Physiological Therapeutics, 1991***

   Part I: Methodology and Clinical Categorization of Chiropractic and Medical Cases, 14 (3): 177-184

   Part II: Time Loss, 14 (4): 231-239

   Part III: Diagnostic and treatment procedures and associated costs, 14 (5): 287-297

   This case-controlled study by Nyiendo and Lamm attempts to evaluate the differences between chiropractic and medical care of workers' compensation disabling low-back injuries, based on a sample of 201 randomly selected claims with a date of injury between June 3, 1985 and December 31, 1985 provided by SAIF Corporation. The importance of this paper is that it reviews the pre-law-change era for chiropractic care in Oregon (the statutory changes that imposed restrictions on chiropractic care were enacted in 1990). The methods of analysis used by the authors received a very high evaluation by other researchers (for example, Baldwin et al, 2001). The principal drawback of this study is the small sample size, which significantly impaired the results. The authors generally do not clearly identify which of their findings were statistically significant.

   To control for claim severity, a classification scheme based on documented clinical signs and symptoms was used to divide claims from two provider groups (chiropractors and medical doctors) into three categories of clinical presentation. Cases classified as category 1 were typically those that involved injury to soft tissue structures, category 2 cases generally presented as a transient localized compromise of one or more nerve roots, and category 3 cases presented as a non-transient compromise of one or more nerve roots.

   The main findings of the first part of the paper, dedicated to the description of methodology and categorization of chiropractic and medical claims, suggest that there is a greater level of chronicity among chiropractic claimants. Chiropractic claimants are less likely than medical claimants to have an initial treatment in the emergency room, more likely to have a history of chronic, recurrent low back pain, and are more likely to have exacerbation episodes.

   In the second part of the paper, the authors analyzed the differences between time-loss days and time-loss compensation between chiropractic and medical physician patients with comparable clinical presentations (severity). The analysis showed that chiropractic claimants had a higher frequency of return to work with one week or less of time loss. The median time loss days for cases with comparable clinical presentation were lower for chiropractic patients (9 versus 11.5 for medical doctor cases). However, the mean time-loss days were lower for medical doctor patients (39 versus 41 for chiropractor cases). The authors also looked at the differences between chiropractic and medical cases with a documented history of low-back pain. It is suggested that chiropractors are better able to manage injured workers with a history of chronic low-back problems and to return them more quickly to productive employment. Nevertheless, the authors note that they found no significant difference between the chiropractic and medical doctor subgroups in either time-loss days or compensation.

In the third part of their paper, the authors found that chiropractic claimants have more treatments over a longer duration and at greater cost than claimants who treated with medical physicians (statistical significance was not specified for this finding). However, the authors caution that these outcomes might be affected by many other uncontrolled variables, such as differences in age and gender of chiropractic and medical claimants, the differences in methods used by these providers, and other factors. The authors concluded that more research is required in this area.

6. ***Victor R.A., and D. Wang, "Patterns and Costs of Physical Medicine: Comparison of Chiropractic and Physician-Directed Care," Workers' Compensation Research Institute, WC-02-07, December 2002.***

   This study compares the costs of chiropractic and physician-directed care of similar cases in five states (California, Connecticut, Florida, Massachusetts, and Texas) and focuses on a single outcome – the duration of temporary disability. The study analyzed a set of back pain cases with back strains, sprains, and nonspecific back pain, excluding cases with disc conditions and significant complicating conditions. Case selection was designed to maximize the similarity of the sample and reduce the likelihood that comparisons across different provider types would be distorted by differences in the conditions treated by those providers. Data was provided by five nationwide insurance companies for claims with injury dates in 1997 and longitudinal claim data available through mid-1999.

   The results of the analysis showed that medical costs per claim in physician-directed cases were about 25 percent lower to achieve the same duration of temporary disability as chiropractor-treated cases (in California, Connecticut, and Texas), after case-mix adjusting. Indemnity costs per indemnity claim were about 20 percent lower in physician-directed cases in Connecticut and Texas but not in the other states. In Florida, chiropractor-treated cases achieved the same duration of temporary disability with lower medical costs and similar indemnity costs compared with physician-directed cases. The fact that the chiropractors in Florida were able to achieve the same outcome (duration of disability) at a lower cost than physicians was attributed to Florida's workers' compensation regulations that imposed a restriction on the number of chiropractic visits (18 visits in 1997) or duration of treatment (eight weeks), whereas the other four states did not.

   One of the main critiques of this study is that the authors examine only one outcome – duration of disability. This study does not address important outcomes such as clinical efficacy, recovery of health and functioning, speed of return to work, and satisfaction with care.

7. ***Victor R.A., P.S. Barth, and, D. Neumark, "The Impact of Provider Choice on Workers' Compensation Costs and Outcomes," joint publication of the Workers' Compensation Research Institute and the Public Policy Institute of California, 2005.***

   This study was designed to evaluate how costs and outcomes differ depending on whether the employer or employee chose the provider. This study analyzed not only costs but also time-loss days, perceived completeness of recovery, and satisfaction with the care received. This is the only study to look at how costs and outcomes differ depending uponwhether workers chose their prior providers (providers who had treated them before their injury) or new providers. The data was collected from employee interviews conducted in California, Massachusetts, Pennsylvania, and Texas in 2002 and 2003.

The authors found that, in general, when employers choose the workers' compensation health care provider, costs are lower, employees return to work sooner, and the degree of recovery is the same as when employees choose their provider, although workers are less satisfied with their overall care. The comparison of costs and outcomes of care when the employee selects a prior provider, versus when the employee chooses a new provider, shows that the worker treated by a new provider was less likely to return to work, returned to work more slowly if he or she did return, had a lower level of satisfaction with overall care, and experienced no better physical recovery. Medical costs were similar in both cases, but indemnity costs per claim were higher for a worker treated by a new provider. The authors conclude that provisions of a recently passed California law, which affect provider choice[7], are conducive to cutting costs without impairing outcomes other than satisfaction, although the study is not a direct test of the impact of the changes.

Workers' Compensation Literature Review Studies

1. ***Assendelft W.J.J, Bouter L.M., "Does the goose really lay golden eggs? A methodological review of workmen's compensation studies," Journal of Manipulative and Physiological Therapeutics 1993, vol.16 (3): 161-8***

   The objective of this study was to assess the value of workers' compensation studies to determine the effectiveness of chiropractic care. The authors summarized the results of older workers' compensation studies (before 1980) separately from the results of more recent studies with better methodological quality. The older studies were in favor of chiropractic treatment, whereas the more recent studies that the authors examined (up until 1990) challenged chiropractic effectiveness. However, the studies reviewed by the authors contained methodological limitations, providing insufficient evidence to make any valid conclusions about the effectiveness of chiropractic treatment.

2. ***Baldwin M.L., Cote P., Frank J.W., and Johnson W.G., "Cost-effectiveness studies of medical and chiropractic care for occupational low back pain: a critical review of the literature", The Spine Journal, 2001 vol. 1, pp: 138-147***

   The purpose of this study was to critically appraise and synthesize recent literature (1990-1999) on the cost-effectiveness of medical and chiropractic care for occupational low back pain (OLBP), and to propose a cost-effectiveness methodology that integrates epidemiologic and economic methods for future studies. This review suggested that chiropractors and physicians provide equally effective care for OLBP, but that chiropractic patients were more satisfied with their care. Evidence on the relative costs of medical and chiropractic care was conflicting. Several methodological deficiencies limited the validity of the reviewed studies. No studies combined high-quality cost data with adequate sample sizes and controls for confounding factors.

[7] Recent California legislative changes further limited worker choice of provider, with an exception when there is a preexisting provider relationship; expanded use of medical provider networks; and placed limits on chiropractic and physical medicine visits as part of larger pieces of legislation.

Workers' Compensation Care Provider Study

Chiropractic, Naturopathic, Podiatric, and Physician Assistant Care Providers' Scope of Practice in Oregon

Workers seeking treatment for work-related injuries and illnesses in Oregon are presented with a wide range of options for types of treatment and care providers. Each provider type has unique educational and licensing requirements, clinical competencies, and practice parameters as prescribed by Oregon Revised Statute and Oregon Administrative Rules.

When licensed, chiropractors, naturopaths, and podiatrists may practice as independent care providers. Physician assistants are health care professionals licensed to practice medicine with physician supervision. A brief description of care providers and their scope of practice are provided in Table 3. Medical doctor and osteopathic physician information is provided for comparison. (Refer to Appendix D for tables with greater detail)

Table 3. Providers' Scope of Practice in Oregon

Care Provider	Brief Definition and Scope of Practice Information
Chiropractic Physician (CH)	Focus on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, pain in the joints of the arms or legs, and headaches. The most common therapeutic procedure performed by doctors of chiropractic is known as "spinal manipulation." Manipulation, or adjustment of the affected joint and tissues, restores mobility, thereby alleviating pain and muscle tightness and allowing tissues to heal.
Naturopathic Physician (NA)	Focus on diagnosing and treating the human body and maintaining or restoring it to a state of normal health. Concentrate on the whole-patient wellness, centers around the patient and emphasizes prevention and self-care. Naturopathic medicine attempts to find and correct the underlying cause of the patient's condition. Therapies may include clinical nutrition, ayurvedic medicine, botanical medicine, colon therapy, counseling, diagnosis, homeopathic medicine, physical medicine, and/or prescription medications.
Podiatric Physician (PO)	Focus on preventing, diagnosing, and treating conditions associated with the foot and ankle. To treat these problems, podiatrists prescribe drugs, order physical therapy, set fractures, and perform surgery. They also fit corrective inserts called orthotics, design plaster casts and strappings to correct deformities, and design custom-made shoes.
Physician Assistant (PA)	Within the physician - physician assistant relationship, physician assistants exercise autonomy in medical decision-making and provide a broad range of diagnostic and therapeutic services. Physician assistants may conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, write prescriptions, and order or carry out therapies.
Medical Doctor (MD) and Osteopathic Physician (DO)	Diagnose illnesses and prescribe and administer treatment for people suffering from injury or disease. Physicians examine patients, obtain medical histories, and order, perform, and interpret diagnostic tests. They counsel patients on diet, hygiene, and preventive health care. While both medical doctors and osteopaths may use all accepted methods of treatment, including drugs and surgery, osteopaths place special emphasis on the body's musculoskeletal system, preventive medicine, and holistic patient care.

Educational programs for these care provider disciplines have fairly consistent entrance requirements. All programs require at least two years of college liberal arts and science studies. Some physician assistant and medical schools, as well as all naturopathic programs, require a bachelor's degree prior to admission.

Graduation requirements for these disciplines exhibit greater variation, though all require both classroom and clinical practice components. Physician assistants are required to complete a bachelor's or master's level degree, depending on the program. Chiropractic physicians must complete at least four to five years of classroom, laboratory, and clinical experience. Naturopathic physicians are required to complete a four-year graduate degree. To become a doctor of podiatric medicine, candidates must graduate from an approved podiatric school and complete a two-year podiatric residency. After graduating from a school of medicine, medical doctors are required to complete three- to seven-year residency training in an area of specialty and an additional one to three years of a fellowship for subspecialty training. Osteopathic physicians follow an education pathway similar to medical doctors, but may elect to end their formal education after the first year (internship) of their residency.

All of the professions have licensing requirements administered by their governing licensing board, which include a standardized examination and review of the licensing application by their respective professional board. Once licensed, all care providers are statutorily required to complete seven hours of pain management continuing education. Each corresponding licensing board regulates other continuing education (CE) requirements (Table 4).

Table 4. Provider Continuing Education Requirements

Care Provider	Licensing Board	CE Requirements
Chiropractic Physician	Board of Chiropractic Examiners	20 hours, including four hours of over-the-counter nonprescriptive substances education every 12 months
Naturopathic Physician	Board of Naturopathic Examiners	25 hours, including five hours of prescriptive substances education every 12 months
Podiatric Physician	Board of Medical Examiners	50 hours every two years
Physician Assistant	Board of Medical Examiners	100 hours every two years, and successful passage of a recertification examination every six years
Medical Doctors and Osteopathic Physician	Board of Medical Examiners	There is no CE requirement for MDs or DOs in Oregon outside of the seven hours of pain management continuing education.

In addition to professional requirements and limitations, providers must comply with workers' compensation laws and rules that specify the length of time a provider may treat a worker, and the extent to which a type of provider may direct the worker's care. Though a worker may treat with any or all of these providers, the role of the provider may differ. Oregon statute prescribes which provider types can function in what capacity, including who can function as an attending physician.

Workers' Compensation Care Provider Study

Current Non-MCO Care Provider Roles, Oregon Workers' Compensation

In the Oregon workers' compensation system, an attending physician is a care provider who is primarily responsible for the treatment of a worker's compensable injury per ORS 656.005(12)(b)(A). Attending physician authority can be classified into five primary areas:

1) Providing compensable medical services for initial injury or illness without authorization from another care provider.
2) Authorizing payment for time loss (temporary disability).
3) Establishing impairment findings (permanent disability).
4) Releasing workers back to work.
5) Providing compensable medical services for aggravation of injury or illness without authorization from another care provider.

A more detailed listing of AP authorities and responsibilities is available in Appendix E.

In 1990, Oregon statute was revised to specify, for the first time, who could function as an attending physician for workers' compensation care. Aside from providers functioning under an MCO contract (where the MCO contract may allow authority that extends beyond the statute), the revised statute clarified that an attending physician must be:

> "a medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States."

As part of this same reform, chiropractors licensed by the Oregon Board of Chiropractic Examiners were permitted to practice as attending physicians for a period of 30 days from the date of their first visit on an initial claim or for 12 visits, whichever comes first (ORS 656.005(12)(b)(B)). In other words, chiropractors were permitted to exercise all attending physician authorities noted above for any 30-day period within an initial claim. Provision of medical services for the aggravation of an injury or illness cannot be authorized by a chiropractor, but must be authorized by an medical doctor, osteopath, or dental surgeon.

Most health care providers who are not designated by statute as an attending physician (including naturopaths, podiatrists, and physician assistants) may provide compensable medical services to an injured worker without the authorization of an attending physician for up to 30 days from the date of the occupational injury or illness or for 12 visits, whichever comes first (ORS 656.245(2)(b)(A)(B)). These non-attending providers cannot authorize the payment of temporary disability compensation (time loss) or make findings regarding the worker's impairment for the purpose of evaluating the worker's permanent disability[8,9].

[8] There is an exception for nurse practitioners (NP) (ORS 656.245(2)(C)), which allows NPs to provide 90 days of compensable treatment and authorize up to 60 days of time loss starting from the date of the first visit on the initial claim.

Thirty days after the worker's injury, medical services provided without the written authorization of an attending physician are not compensable and will not be reimbursed by the insurance carrier. If an attending physician authorizes continued treatment, the non-attending physician may continue to deliver compensable medical care. However, the worker must be referred back to the attending physician for authorization of time loss, establishment of impairment findings, and release to work (Appendices F and G).

All medical services to treat the aggravation of a compensable work-related injury or illness must be authorized by an attending physician who is a medical doctor, osteopath, or dental surgeon.

[9] There is an exception for physician assistants (ORS 656.245 (5)) who practice in areas served by Type A, B, or C rural hospitals. They may authorize temporary disability for a period of up to 30 days from the date of the first visit on an initial claim.

Workers' Compensation Care Provider Study
Care Provider Roles in Managed Care Organizations (MCOs)

MCO Background

As part of the 1990 reforms (SB 1197), workers' compensation insurers were given the option of contracting with MCOs, certified by DCBS, to provide compensable medical services. MCOs are required "to provide services that meet quality, continuity and other treatment standards reviewed and approved by the director and will provide all medical and health care services that may be required by this chapter in a manner that is timely, effective and convenient for the worker." (ORS 656.260(4)(a)).

Thus, all managed care organizations must offer:

- A panel of providers that satisfies access and coverage requirements;
- A quality assurance program for monitoring the medical care provided by the panel;
- Appropriate financial incentives to reduce service costs and utilization without sacrificing quality of service;
- A program to promote early return-to-work for injured workers; and
- A workplace safety and health consultation program for employers.

MCOs must have a panel of medical service providers of sufficient size and diversity to ensure quality care to injured workers in Oregon. The Workers' Compensation Division (WCD) monitors MCO compliance in two areas: access and coverage.

Access

"Adequate access" is defined as ensuring that workers governed by the MCO can "access an MCO provider panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan." The worker must also be able to "access providers, including attending physicians, within a reasonable distance [30 miles one way in urban areas and 60 miles one way in rural areas] from the worker's employment" (OAR 436-015-0030).

Workers may receive compensable medical treatment from a primary care physician who is **not** a member of the MCO (ORS 656.260 (4)(g), OAR 436-015-0030 and OAR 436-015-0070), if the physician or nurse practitioner meets all of the following requirements:

- Has a documented history of providing primary care services to that worker prior to the date of injury.
- Qualifies as an attending physician (state-licensed medical doctor, doctor of osteopathy, dental or maxillofacial surgeon) and is a general practitioner, a family practitioner, or an internist.
- Maintains the worker's medical records.
- Agrees to comply with all terms and conditions regarding services governed by the MCO.
- Agrees to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require.

- Practices closer to the worker's residence than an MCO provider of the same category and agrees to the terms and conditions of the MCO.

In addition, if an injured worker has selected a primary care physician through a private health plan prior to the date of injury, this primary care physician may qualify. If the primary care physician does not meet the above conditions, the worker may continue to treat with a nonqualified provider for a maximum of seven days after receiving notice of enrollment in the MCO. Thereafter, an MCO panel provider must treat the worker.

Coverage

"Adequate coverage" means that workers have a choice of at least three medical service providers within each of eight categories and three ancillary service providers, including, but not limited to, physical therapists and psychologists. To be certified in a geographic service area[10] (GSA), the MCO must have a panel of providers in the GSA that includes at least three providers within each of the following categories: acupuncturist, chiropractor, dentist, medical doctor, naturopath, optometrist, osteopath, and podiatrist[11] unless the MCO provides evidence that the minimum number of providers are not available within the GSA (OAR 436-015-0030).

The MCO may "not discriminate against or exclude … any category of medical service providers and [must] include an adequate number of each category…to give the workers adequate flexibility to choose medical service providers from among…providers…under the plan" (ORS 656.260(2)(b)). Each MCO must develop credentialing standards for providers, and can deny an applicant provider who does not meet their credentialing standards. In addition, if a provider does not agree to comply with all terms and conditions regarding services governed by the MCO (treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services), the MCO may decide not to contract with that provider.

Per administrative rule 436-015-0035, WCD can authorize MCOs that do not meet the minimum categories of required medical service providers in a GSA, as long as the MCO provides evidence of recruiting attempts, and establishes that there are not an adequate number of providers in a given category "able or willing" to become members of the MCO. If the MCO has fewer than three providers in a category, the MCO must allow a worker to treat with a provider in that category who is not a member of the MCO. In addition, if a worker requires specialized medical services that the MCO is not otherwise able to provide, a provider who is not a member of the MCO may treat the worker, if the provider agrees to comply with all terms and conditions regarding services governed by the MCO.

MCO Service Utilization

Business rules that specify the times, places, and manner of providing services under the plan are submitted for approval of the Director of the Department of Consumer and Business Services as a requirement of MCO certification (ORS 656.260 (2)). MCO contracts with providers further specify which provider types can function as an attending physician, as well as how long a provider (attending or non-attending) can deliver treatment without receiving pre-certification from the MCO (656.260 (13)).

[10] GSAs or Geographic Service Areas are established to ensure that MCO-governed workers will have reasonable and convenient access to medical care (Bulletin 248-Appendix I); there are 15 GSAs in Oregon.

[11] Note that physician assistants currently are not a required medical service provider category.

MCO Analysis—Provider Panels

Currently, Oregon has four certified MCOs that, for the most part, meet the required panel composition in their most populated authorized GSAs (Appendix H):

1. Kaiser On-the-Job MCO
2. Managed Healthcare Northwest (MHN/CareMark Comp MCO)
3. Oregon Health Systems Inc. (OHS MCO)
4. Providence MCO

However, there are several GSAs where, despite recruitment efforts, panels do not meet the minimal number of providers (3) for the specified provider types. Physician assistants (PAs) are included in this analysis because they are of interest, though they are not specified provider types with minimal panel requirements.

Most of the GSAs that do not have adequate provider representation have fewer than 10 providers who practice within that geographic area, making recruitment difficult (Table 5). Multiple recruitment efforts have been made for chiropractors in GSA 15, but only one has joined the MCO. Of note, however, there are geographic areas (GSA 9 and 11) where 10 or more naturopaths practice, but there are fewer than three represented on all MCO panels. Of the two MCOs servicing these areas, one reports considerable recruitment efforts and one contracts with an agency to bolster recruitment (but does not report recruitment numbers for that agency).

Table 5. Provider Representation on MCO Panels

GSA[12]	CH	NA	PO	PT	PS	PA
1 North Coast	-	↓*	↓*	-	↓*	↓*
2 Central Coast	-	↓*	↓*	-	↓*	-*
3 South Coast	-	↓*	↓*	-	↓*	↓*
4 Portland Metro	-	-	-	-	-	-
5 Salem	-	-	-	-	-	-
6 Linn-Benton	-	↓*	↓*	-	-	-
7 Eugene	-	-	-*	-	-	-
8 Roseburg	-	↓*	↓*	-	↓*	↓
9 Jackson/Josephine	-	↓	-	-	-	-
10 The Dalles	-	↓*	-*	-	-	↓
11 Bend	-	↓	↓*	-	↓	-
12 Klamath Falls	-	↓*	↓*	↓	↓*	-
13 Pendleton	-	↓*	-*	-	↓*	↓
14 LaGrande	-	↓*	-*	-	↓*	↓*
15 Burns/Ontario	↓*	↓*	↓*	↓	↓*	-

- At least one MCO meets the minimal provider panel representation
↓ All MCOs have fewer than three providers on their panel
*Fewer than 10 providers are available

CH-Chiropractic Physician, NA-Naturopathic Physician, PO-Podiatric Physician, PT-Physical Therapist, PS-Psychologist, PA-Physician Assistant.

[12] Bulletin 248 specifies current GSAs (see Appendix I.)

MCO information indicates one recruitment effort for a physical therapist within GSA 12 and no efforts in GSA 15. Well over 10 physical therapists practice within each of these areas. There are many reports of recruitment for psychologists within GSA 11, but none have joined an MCO panel. Ten or more PAs practice in GSAs 8, 10, and 13, and MCOs report no recruitment efforts for PAs in these areas. Again, neither statute nor rule mandates that MCOs have three or more PAs on their provider panels.

Challenges in Provider Panel Recruitment

Generally, medical providers are most interested in becoming an MCO panel member when the provider practices in a competitive health care business environment, such as the Portland metropolitan area, where there are an abundance of providers competing for a limited number of patients. In a competitive health care business environment, providers have incentive to comply with MCO pre-certification requirements and discounted reimbursement schedules because their membership in the MCO brings them patients who would otherwise go to their competitors.

However, outside a competitive health care environment, in more rural areas of the state where there are no or few practicing providers in some categories, there is little provider incentive to contract with MCOs because providers have more patients seeking their services than they can fit into their schedules. In these situations, there is excess demand for service and essentially no provider competition for patients. Therefore, the advantage of having MCO patients referred to them is not worth the resources required to comply with MCO contractual obligations.

In addition to provider availability, MCOs report additional issues that can affect recruitment:

- Groups of providers may band together and refuse to contract with any MCO in some rural areas.
- Dentists may be reluctant to become an MCO panel member because of lower reimbursement rates and the amount of malpractice insurance required.
- Psychologists and psychiatrists may be reluctant to become panel members because insurers often deny psychiatric conditions and do not reimburse these providers.
- Providers may be unwilling to drive long distances to admit patients to distant hospitals.
- Providers may only have medical staff privileges at their local hospital.

Business Rules

MCO business rules outline which providers can provide attending physician services, as well as any limitations on service utilization by specific provider types (Appendices J-K3). However, MCO business rules cannot impose limitations to provider authority currently allowed under statute.

- Consistent with non-MCO chiropractic regulations, all MCOs allow a chiropractor to function as an attending physician at any point during the claim. Three MCOs require chiropractors to get authorization to treat beyond 30 days or 12 visits, and one MCO requires chiropractors to get authorization to treat beyond 60 days or 20 visits.
- One MCO permits a naturopath to be an attending physician at any point during the claim; the other MCOs require referral. In addition, most MCOs have limits on the number of manipulations and visits that can be performed without pre-certification.

- No MCOs authorize a physician assistant to be an attending physician. PAs can treat by referral and often have limits on the number of visits. Per statute, a physician assistant may authorize time loss for up to 30 days in rural areas.
- Podiatrists treat by referral only in the MCOs; no MCOs authorize them as attending physicians.

MCO Provider Utilization and Practice Patterns

OHS, MHN, and Kaiser allow chiropractic treatment at any point during an initial claim, but require authorization for chiropractic treatment beyond 30 days or 12 visits, whichever comes sooner. Providence, however, requires authorization after 60 days or 20 visits. Accepted claims, both disabling and non-disabling, with dates of injury from 2000 to 2004 were examined to compare chiropractor treatment patterns between MCOs with differing treatment limitations (OHS, MHN, and Kaiser vs. Providence). The number of chiropractor visits and the time between first and last chiropractor visit for these two groups are nearly identical. Thus, it appears that within a managed care context, extending the limitation from 30 days or 12 visits to 60 days and 20 visits has not significantly affected chiropractor utilization and practice patterns. Chiropractor practice patterns outside the MCO environment are added for comparison (Table 6 and Appendix L).

Table 6. Chiropractor Practice Patterns MCO v. Non-MCO

Type of Claim MCO	Claims	Number of CH visits		Time between first and last CH visit	
	Number	Mean	Median	Mean	Median
All Accepted Claims					
Providence	1,164	9.3	7	50.0	25
Other MCOs	7,459	9.6	7	53.6	25
Non MCO	6,402	10.2	7	54.2	27
ADCs					
Providence	573	11.3	9	62.8	28
Other MCOs	3,600	11.6	9	67.8	28
Non MCO	2,389	12.7	9	71.2	28
ANCs					
Providence	591	7.4	6	37.5	22
Other MCOs	3,859	7.8	6	40.5	21
Non MCO	4,013	8.7	7	44.1	25

MCO-Managed Care Organization, CH-Chiropractic Physician, ADC-Accepted Disabling Claim, ANC-Accepted Non-disabling Claim

MCO Data Sources

The following information was requested by WCD and provided by each MCO for the purpose of this analysis. Information was provided for chiropractors, naturopaths, podiatrists, physician assistants, physical therapists, and psychologists. This information is summarized in (Appendix M through O).

- The availability of specific care provider categories in each geographic service area
- The recruiting efforts, in those categories, by Oregon's certified MCOs
- Current panel membership, of these categories, on Oregon MCOs' panels

To determine available providers in each of the geographic service areas, publicly available provider information was used to group providers by their ZIP codes. Then, these ZIP codes were divided into the respective GSAs per Bulletin 248 (Appendix I) and counted. This method does not account for providers who may have practices in multiple GSAs.

Utilization and practice pattern data were available via the DCBS claims data system and Bulletin 220 data system. Full descriptions of these systems can be found on page 45 of this report.

Workers' Compensation Care Provider Study
Employer Focus Groups

Focus Group Purpose

DCBS conducted employer focus groups to solicit employer feedback regarding the accessibility and availability of quality health care within the current care delivery model and solicit recommendations for desired change. Employers were encouraged to provide information about workers' access to medical care, continuity of care, cost considerations, quality of care, and whether workers or employers desire a change to current workers' compensation medical provider policies. The focus groups also explored the idea of expanding the time frame during which non-physicians can provide compensable medical care and expanding providers' abilities to authorize disability benefits for injured workers.

Focus Group Findings

Employers are generally satisfied with their employees' access to health care and indicate that workers experience little or no difficulty accessing any providers, including chiropractors, podiatrists, physician assistants, and naturopaths. Employers from the eastern part of the state do note problems with timely access to health care in their area due to a lack of physicians.

Employers feel that access to health care providers is better in workers' compensation than in general health care, because some general health care plans provide fewer provider options in their networks than are available to injured workers under the current workers' compensation system.

Employers said occupational health clinics and occupational health specialists are underrepresented in the current system, and that orthopedic surgeons are overrepresented. Employers have not heard employees complain about difficulty accessing care with specific types of providers. However, they did report hearing occasional concerns from workers who wished to see a specifically named care provider.

When asked how the continuity of care was affected when the worker changed medical providers, approximately one quarter of the employers felt that the new provider wanted to start over and repeat much of what was done by the previous provider.

Employers cite several reasons why workers change health care providers:

- Workers treated at urgent care facilities or emergency rooms are referred to a new provider for follow-up care.
- Some workers search for a provider who will authorize time loss.
- If workers are not getting better, they may want to try another provider.
- Workers may need a specialist because the injury is more serious than originally thought, or there have been complications that require a specialist.
- Workers may feel they need a particular type of treatment and search for a provider who will deliver that specific treatment.
- Workers who experience a personality conflict with their provider may request a change.

When asked about extending the role of chiropractors, podiatrists, physician assistants, and naturopaths, employers who had worked with a podiatrist (18 percent) had no problems with the prospect of expanding the role of podiatrists and questioned the current restrictions. Only three of the employers had worked with a naturopathic physician, and those who had experience indicated that naturopaths are focused on holistic care and take too long to get workers back to work, thus they did not favor expanding the role of the naturopath. The majority (86 percent) of the employers did not have experience working with a naturopath.

Overall, employers in urban and rural areas do not favor changing the role of physician assistants. Employers in these areas felt that the workers treated by physician assistants experienced delays due to a lack of oversight by a physician. The claim would go on too long before a physician reviewed it, causing a postponed return to work. One employer cited an example when a worker was out of work for six months under treatment of a physician's assistant with no oversight by an medical doctor.

Chiropractors generated the most discussion among employers. The general consensus was that the current system is working well, and there is no need to change the role of the chiropractor. Employers expressed strong feelings against expanding the attending physician role of the chiropractor. Their reasons included:

- Workers treated by chiropractors have a large amount of time loss.
- Workers treated by chiropractors frequently have permanent disability.
- Workers treated by chiropractors generate high legal costs.

One employer claimed that defense costs were astronomically high when chiropractors were allowed to be attending physicians, while another cited examples where chiropractors encouraged injured workers to hire attorneys.

Employers also felt that workers would not receive quality care if chiropractors could be unrestricted attending physicians, citing that:

- Without statutory limitations, the unknowledgeable worker might be taken advantage of by the chiropractor, believing that they were getting better as their condition actually worsened.

  > "Manipulation goes on and on and the checks keep flowing, but the worker doesn't get better."

- Chiropractors provide maintenance, not curative care, so the "real" care of a worker does not begin until chiropractic treatment ends and the worker is seen by a medical doctor.
- Workers with severe injuries, i.e., herniated disc, should not be treating with a chiropractor, because the chiropractor can actually make the condition worse.
- Chiropractic care is based on subjective findings, so there are not objective measures (diagnostics) for determining what treatment is needed.

Other employers advocated for chiropractic care, arguing that workers choose chiropractic care so they can get active treatment for their injury rather than bed rest and medication that a medical doctor might prescribe.

Eastern Oregon employers were less critical of chiropractors and physician assistants. While they did not feel the role of the chiropractor should be expanded, they did not want to lose access to chiropractors. Employers in this part of the state report that it is much easier and quicker to get an appointment with a chiropractor or physician's assistant than a medical doctor. They indicate that

there is a lack of physicians in eastern Oregon, so physicians carry heavy caseloads and have limited availability.

Focus Group Methodology

DCBS formulated focus group questions to solicit employer opinions about the accessibility and availability of quality health care for injured workers as well as the impact of changing care providers during the course of treatment. The employers were also asked to compare the care provided by the workers' compensation system with that of general health care. Finally, the employers were asked their thoughts about expanding the role of workers' compensation care providers, such as chiropractors, podiatrists, naturopaths, and physician's assistants. (Focus group recruitment letters and questions can be found in Appendices P & Q)

Five focus groups were held in four Oregon cities: Salem, Portland (2), Eugene, and Pendleton. DCBS used letters and phone calls to invite 390 employers chosen through listings in the Yellow Pages, Internet searches, chamber of commerce records, and DCBS' employer database. The department selected employers to represent a variety of industries, company sizes, and workers' compensation insurers. Of the 390 employers invited, 24 individuals representing 22 employers (about 5 percent of invited employers) participated in the focus groups. Each employer accounted for one attendee, with the exception of the Salem group where one employer brought two colleagues (Table 7).

Table 7. Focus Group Recruitment and Attendance

Location	Date	Employers contacted	Employers represented	Industries represented at focus group	Insurance types represented at focus groups
Salem	July 6, 2006	32	8	Electrician services; Health club; Trucking company; Vineyard; Sand & gravel company; Food processing; Retirement home management; Not-for-profit (working with disabled)	2 SAIF; 2 Self-insured; Hartford Underwriters; Liberty Northwest; Travelers Property Casualty; Liberty Insurance Corp
Portland	July 13, 2006	123	3	Roofing company; Water treatment facility; Nonprofit training center for disabled adults	2 SAIF; 1 Self-insured
Eugene	July 20, 2006	100	4	Fire district; School district; Construction; Veterinary services	2 SAIF; 2 Self-insured
Pendleton	July 27, 2006	34	6	Meat packing; Retail furniture; Grain mill; Beverage distributor; Chiropractor; County government	3 SAIF; Commerce & Industry Insurance Co.; WAUSAU Underwriters Insurance; Self-insured
Portland	August 23, 2006	101	1	City government	Self-insured

The focus groups were held in hotel conference rooms and were facilitated by Workers' Compensation Division staff members with group facilitation experience. Groups were recorded on audiotape with permission from the attendees. The last Portland group, scheduled in the evening with the hope of drawing a larger attendance, had one attendee and was not recorded.

Workers' Compensation Care Provider Study

Injured Worker Perspectives

Provider Type Utilization and Treatment Patterns

Introduction

This data analysis describes the utilization of selected provider types within the workers' compensation system, comparing their treatment patterns and associated costs. Providers of interest to this study include chiropractors, physician assistants, podiatrists, and naturopaths. Other provider types are included for comparison.

The first section of the analysis describes practice patterns: how soon workers are seen, what providers see them, the number of times they are seen, and the length of time between their first and last visits with these specific providers. This analysis uses a subset of accepted workers' compensation claims with dates of injury in 2002[13] or 2000 though 2004[14].

The second part of the analysis compares the utilization and costs of chiropractic treatment with the utilization and costs of medical doctors and physical therapist treatment for workers with back injuries.

Findings

Analysis of podiatric treatment patterns showed that the current regulatory restrictions are not consistent with treatment patterns. While the statute states that podiatrists can deliver compensable care for the first 30 days of a claim without the authorization of an attending physician, this seldom occurs, because podiatrists usually begin treating injured workers well beyond this 30-day post-injury mark.

There is no evidence that regulatory restrictions have significantly affected treatment of injured workers by physician assistants, who usually see workers one time under the supervision of a medical doctor.

The number of workers receiving naturopathic care during the time period studied (119 claims) is insufficient to draw any valid conclusions.

The statutory limitations on chiropractors, as well as other changes to the workers' compensation system, have affected the length and intensity of the treatment they deliver. Subsequent to the 1990 regulatory reform, payments to chiropractors have accounted for a decreasing percent of medical payment dollars. The proportion of payments to physical therapists has increased slightly, while remaining fairly consistent for medical doctors.

The median treatment duration and number of chiropractic visits come close to the statutory limitation, indicating high utilization of allowable treatment. Workers do, in some cases, receive authorization to receive chiropractic treatment beyond the statutory limits.

[13] Claims with dates of injury in 2002 were chosen because they have a higher likelihood of having closure costs (time-loss costs, permanent disability awards, etc.) and medical data available for analysis than claims with more recent dates of injury.

[14] The broader time frame was used to get a more adequate sample size of claims that had treatment with certain provider types (podiatrists - PO, naturopaths - NA, and physician assistants - PA).

Within the current environment of statutory limitations on chiropractic treatment, workers treated by chiropractors (and not medical doctors or physical therapists) for back injuries have lower claim costs and fewer time loss days. Claims receiving treatment from multiple practitioners are the most costly and evidence the most time loss.

Provider Type Utilization and Treatment Patterns: Days to First Visit

To better understand treatment patterns, the number of days between a worker's injury and his or her first visit were calculated. Accepted disabling claim (ADC) and accepted non-disabling claim (ANC) information is given separately because injury severity may influence treatment patterns. Overall, workers with ANCs are seen earlier in their claims than workers with ADCs.

Workers with accepted claims, both disabling and non-disabling, often receive treatment from more than one care provider. For example, a medical doctor may refer a patient to a specialist for treatment, and may see the worker again later to authorize further treatment or authorize release to work. Furthermore, an injured worker may be seen in an emergency room on the day of his or her injury and be referred to a medical doctor or other provider for outpatient follow-up treatment.

Workers with ADCs are generally seen by other providers prior to their first visit with any of the provider types in this analysis. About half of all workers with ADCs seen by a medical doctor had visits prior to the first medical doctor visit, most typically by a hospital outpatient provider. Similarly, half of all workers with ADCs seen by a chiropractor and three-quarters of workers with ADCs seen by PAs had visits with a medical doctor or a hospital outpatient provider (HO) prior to their first visit. Workers with ADCs seen by naturopaths were typically seen by a chiropractor or hospital outpatient provider prior to the naturopath.

Provider patterns for ADCs and ANCs were similar with the exception that more workers with ANCs seen by naturopaths were previously seen by medical doctors or chiropractors. Of note, the number of workers with either type of claims seen by naturopaths is small.

Physical therapists (PTs) are seldom the first provider because their services require a referral.

Table 8. Claims Treated by Medical Doctors, Physical Therapists, and Chiropractors ADC and ANC Days to First Visit, Injury Year 2002

Provider type and claim type	Number of claims	Days to first visit by provider type		Percent of claims where the provider type was the first provider
		Mean	Median	
Medical Doctor	**42,742**	**16**	**1**	
ADC	13,680	23	3	53%
ANC	29,062	13	1	67%
Physical Therapist	**7,309**	**83**	**33**	
ADC	4,323	100	42	6%
ANC	2,986	59	24	18%
Chiropractor	**3,803**	**37**	**6**	
ADC	1,576	48	7	47%
ANC	2,227	28	5	67%

Table 9. Claims Treated by Physician Assistants, Podiatrists, and Naturopaths ADC and ANC Days to First Visit, Injury Years 2000-2004

Provider type and claim type	Number of claims	Days to first visit by provider type		Percent of claims where the provider type was the first provider
		Mean	Median	
Physician Assistant	**1,940**	**90**	**7**	
ADC	858	146	57	22%
ANC	1,082	44	2	63%
Podiatrist	**902**	**133**	**51**	
ADC	489	157	59	14%
ANC	413	413	105	33%
Naturopath	**119**	**42**	**9**	
ADC	50	50	59	34%
ANC	69	69	31	48%

Podiatrists, naturopaths, and physician assistants often provide treatment to workers beginning one to three months following the worker's initial injury of illness. These providers cannot function as attending physicians and must receive approval from an attending physician to deliver care beyond the first 30 days or 12 visits following the injury or illness. Thus, they must have received authorization from an attending physician to see many of these injured workers.

Provider Type Utilization and Treatment: Number of Visits and Duration of Treatment

For all provider types in the analysis, injured workers were seen more often and for a longer period of time (duration) when their claim status was disabling rather than non-disabling. (Tables 10 & 11).

Currently, chiropractors may function as an attending physician for up to 12 visits or for any 30-day period within a worker's claim, whichever comes first. The median treatment duration (27 days) and number of visits (eight visits) are close to the statutory limitation. Upon reaching these limits, the chiropractor is no longer the attending physician and may no longer provide compensable care without the authorization of the worker's new attending physician (presumably an medical doctor, osteopath, or doctor of dental surgery). The mean, or average, number of visits and duration of treatment indicate that chiropractors do receive authorization from these non-chiropractor attending physicians to continue chiropractic treatment beyond the statutory limits.

Table 10. Claims Treated by Medical Doctors, Physical Therapists, and Chiropractors ADC and ANC Overview, Injury Year 2002

Provider Type and Claim Type	Number of claims seen one or more times	Number of visits		Duration	
		Mean	Median	Mean	Median
All Accepted Claims	**60,072**				
ADC	15,505				
ANC	44,567				
Medical Doctor	**42,742**	**5**	**2**	**101**	**13**
ADC	13,680	9	6	230	120
ANC	29,062	3	2	40	2
Physical Therapist	**7,309**	**12**	**7**	**96**	**31**
ADC	4,323	16	10	129	51
ANC	2,986	7	5	49	20
Chiropractor	**3,803**	**10**	**8**	**60**	**27**
ADC	1,576	12	9	76	28
ANC	2,227	9	7	48	25

Table 11. Claims Treated by Physician Assistants, Podiatrists, and Naturopaths ADC and ANC Overview, Injury Year 2000-2004

Provider Type and Claim Type	Number of claims seen one or more times	Number of visits		Duration	
		Mean	Median	Mean	Median
All Accepted Claims	**314,419**				
ADC	78,946				
ANC	235,473				
Physician Assistant	**1,940**	**2**	**1**	**22**	**0**
ADC	858	3	1	35	0
ANC	1,082	1	1	11	0
Podiatrist	**902**	**4**	**2**	**109**	**31**
ADC	489	5	3	136	44
ANC	413	3	2	77	21
Naturopath	**119**	**5**	**3**	**42**	**11**
ADC	50	6	3	63	12
ANC	69	4	3	27	11

Comparing Costs and Outcomes of Medical Doctor, Chiropractor, and Physical Therapy Treatments for Back Sprain, Strain, or Tear Injuries

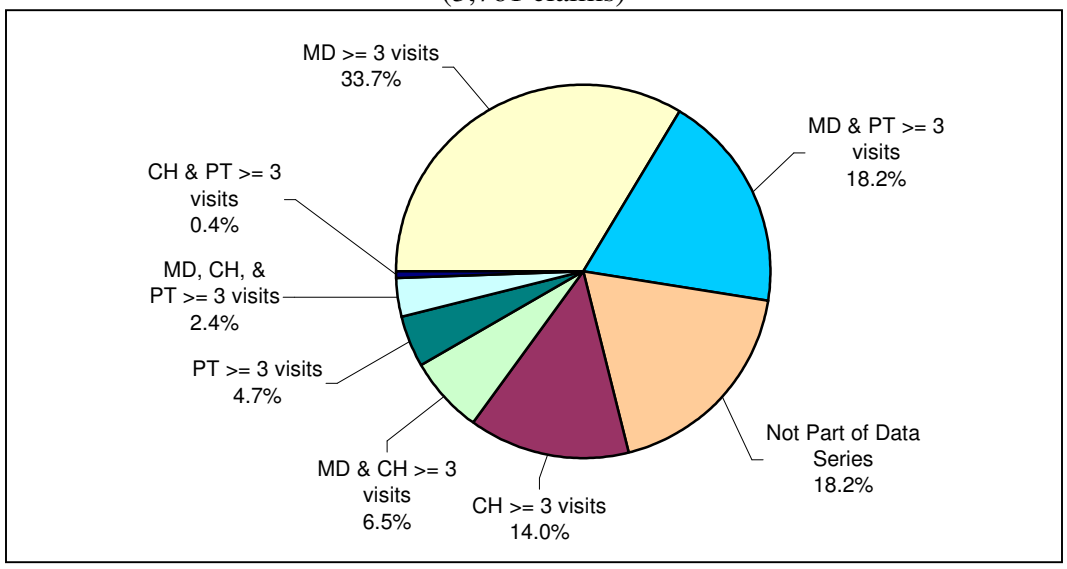
Back injures are the largest category of ADCs treated by chiropractors and were used to compare the costs and outcomes of chiropractic treatment with those of medical doctors and physical therapists. A subset of 5,421 claims with back sprain, strain, or tear constituted the sample (Occupational Injury and Illness Classification System codes: nature = 02 and part = 23.) .

Since chiropractors typically do not perform surgeries and are limited in treatment duration, claims with surgical interventions and permanent partial or total disability were excluded. To further control for differences among claims, the sample was limited to the four most frequent ICD-9 diagnostic codes: lumbar sprain or strain, sacroiliac sprain or strain, lumbago, and thoracic sprain or strain. The final data set included 3,761 in-state disabling claims with the initial injury between 2000 and 2002. Only closed claims with medical billing data were used.

To distinguish between providers who treated a worker for a significant period of time from those who did not, provider types who saw workers three or more times during the course of their claim were considered to have significant impact on the workers' treatment. Thus, the claims were grouped into categories based on whether a medical doctor, physical therapy, or chiropractor saw workers three or more times during the course of their claim.

Of the 3,761 claims in the sample, workers in 3,056 claims (81 percent) were seen by a medical doctor, physical therapy, or chiropractor three or more times. Worker groups (note that they are mutually exclusive) and the distribution of claim counts are shown in Figure 1.

Figure 1. Distribution of Claims by Provider Groups, Injury Years 2000-2002
(3,761 claims)



Workers were seen three or more times by an medical doctor in 60.8 percent of these claims; 23.3 percent were seen three or more times by a chiropractor; and 25.7 percent were seen three or more times by a physical therapy. PTs worked in combination with a medical doctor on 20.6 percent of cases; CHs worked in combination with a medical doctor on 8.9 percent of cases. For 2.4 percent of claims (a total of 90 claims), the worker saw all of these providers three or more times.

In Table 12, the demographic information for the 3,761 claimants is presented by primary treatment provider categories. The similarity of demographic variables among categories suggests that treatment choices among provider types are not generally affected by the geography, gender, age, or insurer type.

Table 12. Claim Demographics by Treatment Cohorts
Lumbar Sprain or Strain, Sacroiliac Sprain or Strain, Lumbago,
or Thoracic Sprain or Strain Injury Years 2000 - 2002

		Urban/Rural		Gender			Workers' Compensation Insurer		
Provider Type	**Number of Claims**	**Urban%**	**Rural %**	**M %**	**F %**	**Median Age At Injury**	**SAIF**	**Private**	**Self-Insured**
All Providers	3,761	62%	38%	65%	35%	37	58%	34%	8%
MD ≥ 3 visits	1,269	64%	36%	65%	35%	38	65%	28%	6%
MD & PT ≥3	701	58%	42%	62%	38%	37	57%	34%	9%
CH ≥ 3	525	58%	42%	69%	31%	39	56%	38%	6%
MD & CH ≥ 3	244	61%	39%	65%	35%	38	63%	31%	7%
PT ≥ 3	175	58%	42%	66%	34%	39	41%	46%	13%
MD, CH, & PT ≥ 3	126	60%	40%	56%	44%	38	58%	36%	6%
CH & PT ≥ 3	16	88%	13%	69%	31%	39	44%	56%	0%

The following analysis focuses on groups with significant counts of claims (more than 150 claims). Mean and median statistics for days before initial visit, number of visits, and duration of treatment for groups with more than 150 claims are presented in Table 13.

Table 13. Comparison of Duration and Visit Counts
Injury Years 2000-2002

Provider type	Number of claims	Percent of like claims	Days to first visit		Number of visits		Duration	
			Mean	Median	Mean	Median	Mean	Median
All providers	3,761	100.0%						
MD ≥ 3 visits	1,269	33.7%	9	2	7	5	133	57
MD & PT ≥ 3 visits	701	18.6%	7	3	19	16	222	118
CH ≥ 3 visits	525	14.0%	6	2	10	10	52	31
MD & CH ≥ 3 visits	244	6.5%	6	2	24	22	315	184
PT ≥ 3 visits	175	4.7%	27	12	8	6	65	37

* Lumbar sprain or strain, sacroiliac sprain or strain, lumbago, or thoracic sprain or strain in-state ADCs with no surgical intervention, no PPD or PTD.

The median days to first visit was about two to three days for all groups except physical therapy only (physical therapy ≥ 3 visits, without medical doctor or chiropractor ≥ 3 visits), who saw the worker for the first time about 12 days after injury. The median number of visits as well as duration of treatment was the highest for groups with multiple providers. Of the groups with one provider, chiropractors had the highest number of visits and medical doctors had the longest duration. For a more detailed comparison of treatment patterns between these various provider categories, diagrams with number of visits and duration of treatment were constructed.

Figure 2. Percentage of Claims by Number of Visits
Back Injuries, 2000-2002

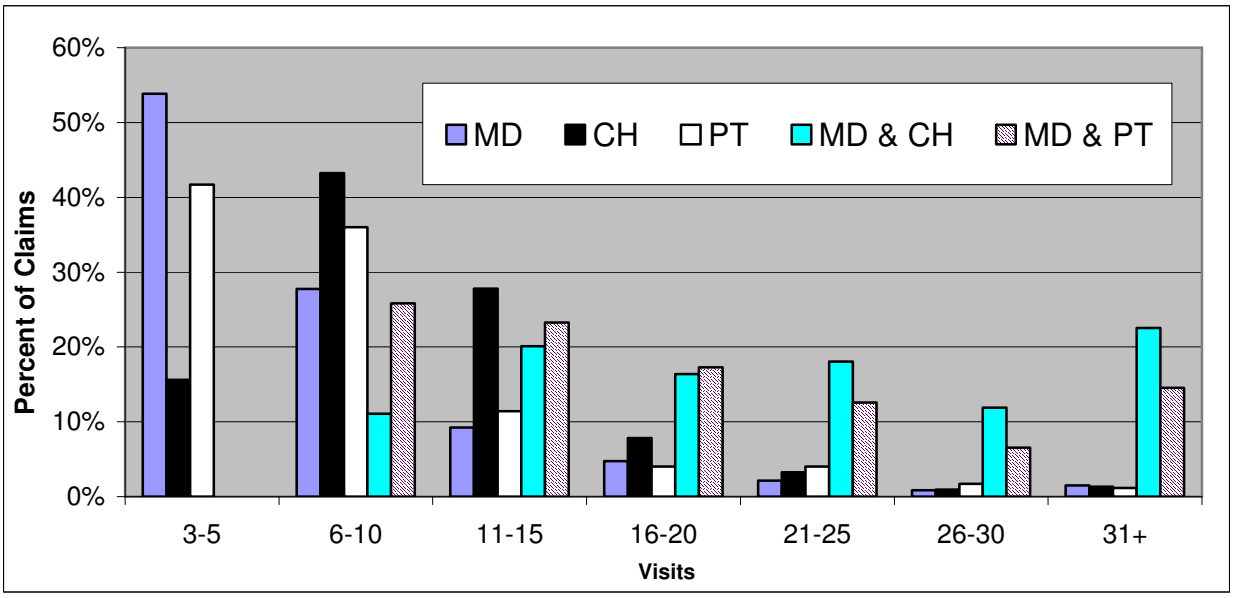


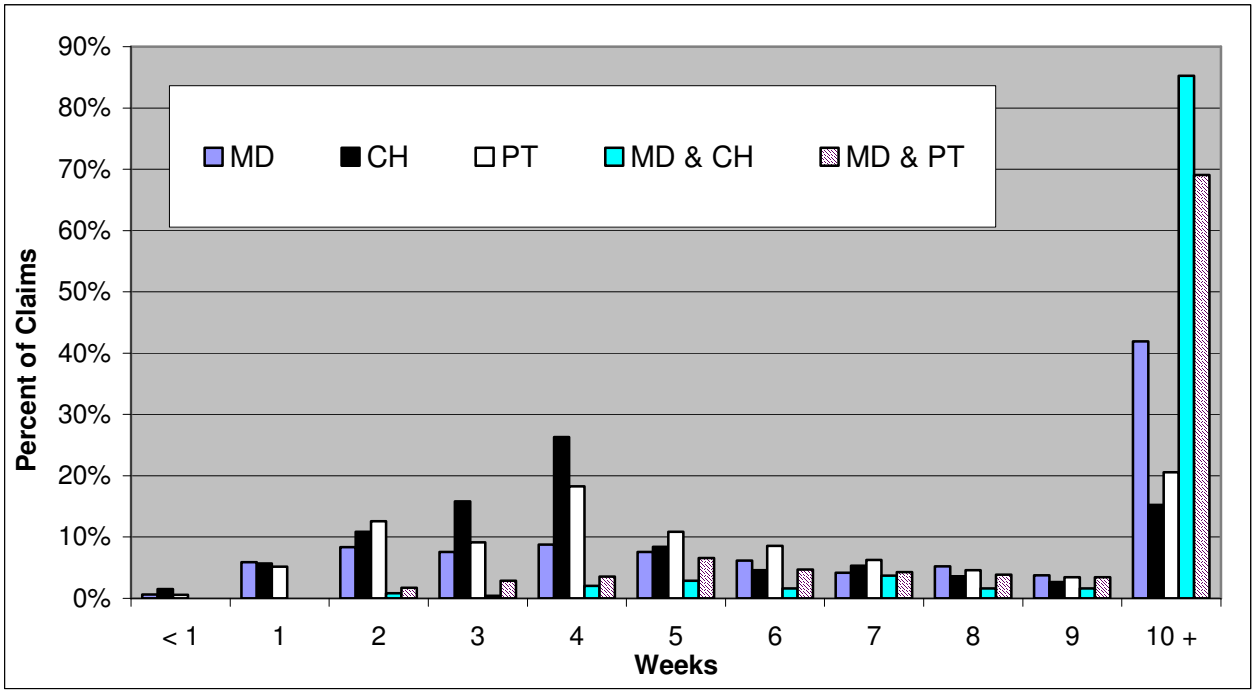
Figure 2 shows the percentage of claims by number of visits. Half of the workers with claims seen only by medical doctors are seen three to five times. The remaining portion of claims shows a steadily decreasing percentage as the number of visits increases.

About 15 percent of chiropractor-only claims receive five or fewer visits. The largest portion of workers with chiropractor-only claims (more than 40 percent) receive between six and 10 visits for their back injury, followed by nearly 30 percent who receive 11 to 15 visits. Subsequently, the percentage of claims decreases steadily as the visits increase.

Physical therapy-only claims drop off steadily after an initial peak, with more than 70 percent of workers with claims being seen for 10 or fewer visits. For the medical doctor and chiropractor treatment group, there is a small spike in the 11 to 15 visit groups. Visit counts in the medical doctor and physical therapy treatment group peak at the six to 10 visit group, and then decline smoothly. Both of these multiple provider groups contain a relatively high portion of claims with more than 31 visits.

Figure 3 illustrates the proportion of claims by duration of treatment, or the time elapsing between the first and last visit on the claim.

Figure 3. Percentage of Claims by Visit Duration
Back Injuries, 2000-2002



The portion of medical doctor-only claims hovers slightly under 10 percent for durations of two to five weeks, after which it steadily decreases over time. Almost 42 percent of medical doctor claims have a duration of 10 weeks or longer.

Physical therapists and chiropractors have similar treatment duration distributions, spiking at about four weeks then dropping off substantially. More physical therapy-only claims extend beyond 10 weeks period (20.6 percent versus 15.2 for chiropractors).

Claims with two providers (medical doctor and physical therapy $\geq$ 3 visits; medical doctor and chiropractor $\geq$ 3 visit) have longer treatment durations than those with single providers.

Important outcomes of treatment, such as number of time-loss days, time-loss costs, medical costs, total costs, and days until closure are presented in Table 14. The median time-loss days for the chiropractor-only group is about half that of the medical doctor-only and physical therapy-only groups. Accordingly, the cost of time loss is about half as much for chiropractor-only claims compared to medical doctor-only and physical therapy-only groups. Medical costs are lowest for the chiropractor-only group, followed by the medical doctor-only and physical therapy-only groups.

Table 14. Comparison of Time Loss Days and Total Costs, Back Injuries, 2000-2002

Provider type	Number of claims	Time-loss days	Time-loss costs	Medical costs	Sum of costs	Days to closure
		Median	Mean	Mean	Mean	Median
All providers	3,761					
MD ≥ 3 visits	1,269	11	$1,346	$1,612	$2,958	104
MD & PT ≥ 3 visits	701	23	$2,027	$2,992	$5,019	140
CH ≥ 3 visits	525	6	$517	$1,021	$1,538	95
MD & CH ≥ 3 visits	244	25	$1,970	$3,364	$5,334	164
PT ≥ 3 visits	175	13	$1,118	$1,850	$2,968	107

* Lumbar sprain or strain, sacroiliac sprain or strain, lumbago, or thoracic sprain or strain in-state ADCs with no surgical intervention, no PPD or PTD.

Care involving multiple providers is the most expensive in terms of time-loss days, time-loss costs, and total costs.

Data Sources

Claims data system contains information regarding accepted disabling claims, reported to DCBS by each insurer at the time of injury, upon claim acceptance, and when the claim is closed. Claims reporting includes data describing time loss, return to work, claim costs, and claim characteristics. Reported claims information is stored in the Claims Information System at DCBS.

Bulletin 220, first issued in 1990, requires insurers with 100 or more accepted disabling claims per year to submit medical billing information to DCBS. Data reported through the Bulletin 220 process accounts for about 75 percent of all accepted disabling claims. In general, insurers required to submit medical billing data for ADCs also submit medical data for ANCs. Medical billing data is available for 70 percent of all estimated ANCs. Reported data include the claim number, date of injury, medical services provided, service date, service units, type of provider, worker diagnosis, billing charges and payments to providers, payment date, and other information.

Pre- and Post-1990 Reform Trends

To obtain detailed pre-reform medical billing data, the department contacted several insurers, self-insurers, and third-party administrators (SAIF, Liberty NW, Safeway, NORPAC, City of Portland, Sedgwick CMS, and Crawford & Company). SAIF, NORPAC, and Crawford & Co. were able to provide some pre-1990 data to the department, but the data provided was incomplete and did not support a valid analysis.

SAIF medical payment data previously provided to the department show aggregate provider type payment distributions. The provider type breakouts are similar to those currently used in Bulletin 220, which began in September 1990.

Data shows that prior to 1991, chiropractors received between 11.2 percent (1987) and 16.2 percent (1989) of SAIF dollars paid to medical providers. Following 1990, there was a drop to 3.5 percent (1991), with 1992 and 1993 showing chiropractors receiving less than 3 percent of payments. Physical therapists show an increase in their portion of payments during this same time span, from 4.4 percent in 1990 to 5.9 percent in 1993. Data for 2005 attribute 2.0 percent of medical payment dollars to chiropractors and 6.7 percent to physical therapists. The portion of payments to medical doctors remained relatively constant (around 30 percent) throughout the entire period.

Table 15. SAIF medical payment distributions, 1987 - 1993

Provider Types	1987	1988	1989	1990	1991	1992	1993
Chiropractor	11.2%	15.6%	16.2%	13.6%	3.5%	2.8%	2.8%
Dentist	0.2%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%
Hospital Inpatient	N/A	N/A	N/A	23.3%	26.1%	25.9%	17.7%
Hospital Outpatient	N/A	N/A	N/A	13.4%	13.0%	12.8%	19.7%
All Hospital *	34.3%	35.9%	34.4%	36.7%	39.1%	38.7%	37.4%
Laboratory	0.3%	N/A	0.1%	0.2%	0.2%	0.2%	0.2%
Medical Doctor	31.0%	24.5%	28.5%	24.6%	29.4%	29.5%	31.3%
Medical Supplies	0.8%	1.9%	1.9%	2.1%	2.7%	3.1%	2.9%
Naturopath	0.0%	0.2%	0.3%	0.2%	0.1%	0.0%	0.0%
Nurse Practitioner	0.4%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
Other Medical Provider	17.1%	12.2%	5.3%	9.2%	9.3%	10.4%	9.7%
Osteopath	0.5%	1.2%	1.0%	1.1%	1.2%	1.1%	1.2%
Occupational Therapist	N/A	N/A	0.2%	0.1%	0.3%	0.4%	0.4%
Physician Assistant	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Pharmacy	0.2%	N/A	2.8%	3.2%	4.3%	3.9%	3.7%
Podiatrist	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%
Physical Therapist	3.9%	4.4%	4.6%	4.4%	5.2%	5.3%	5.9%
Radiologist	N/A	3.5%	4.0%	3.9%	4.2%	3.9%	3.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* From 1987 through 1989, inpatient and outpatient hospital payments were reported collectively; from 1990 onward they were reported separately.

Worker's Compensation Care Provider Study
Injured Worker Perspectives
Worker Survey

Introduction and Findings

The primary objective of the injured worker survey was to measure the accessibility and availability of quality health care for injured workers. Also of interest were the injured workers' continuity of care, choice of health care providers, and general satisfaction with the delivery of health care within the workers' compensation system.

Specifically, the survey was designed to solicit the following information from the sample of injured workers:

- **The extent of general health care insurance coverage.**

  Most injured workers (84 percent) reported having general health care insurance at the time of their work-related injury or illness.

- **The existence of an established relationship with a primary health care provider (PCP) prior to the work-related injury or illness.**

  Nearly two-thirds (64 percent) of injured workers had an established relationship with a PCP before their work-related injury or illness.

- **If the workers continued treatment with their established PCP, the importance of being able to do so, and reasons they did not continue with their PCP.**

  About one-third (37 percent) of injured workers indicated that they continued with their PCP for the treatment of the work-related injury or illness. Almost all of the workers (92 percent) who continued with their PCP indicated that it was important to do so.

  Of those who did not continue with their PCP, much fewer (39 percent) indicated that it was important to stay with their PCP.

  The most common reason given for not continuing treatment with their PCP was that the treatment requirements were beyond what the PCP could provide (49 percent). Nearly one-third (29 percent) of those who did not continue with their PCP indicated that they were required to see another provider.

- **If the injured workers saw a new health care provider for their work-related injury or illness, how that person came to be their provider.**

  One-fourth (25 percent) of injured workers who did not see their PCP for treatment indicated that they located their workers' compensation health care provider (WCHCP) through their employer or workers' compensation insurer. An equal amount (25 percent) indicated that their PCP referred them.

- **The type of health care provider that served as the PCP (pre-injury provider) and the WCHCP (post-injury provider).**

  The overwhelming majority (84 percent) of injured workers were seeing a medical doctor for their pre-injury health care; most workers (79 percent) report having a medical doctor as their post-injury WCHCP.

- **If the workers felt they had a choice of who became their workers' compensation health care provider and the importance of having that choice.**

  Nearly half (45 percent) of all injured workers who saw a new provider for post-injury care indicated they had a choice of who became their WCHCP; nearly all (92 percent) of this group indicated that having this choice was important.

  Nearly half (45 percent) of all injured workers who saw a new provider for post-injury care indicated they did not have a choice of who became their WCHCP; only two-thirds (64 percent) of this group indicated that having a choice was important.

- **Important factors in choosing a workers' compensation health care provider.**

  Injured workers who chose their WCHCP identified the provider's experience and training (44 percent), as well as ease of access (speed and location) (26 percent) as the most important factors.

- **If the workers were required to change providers during their treatment and the reasons for this change.**

  Most workers (81 percent) indicated that they were not required to change providers during their treatment.

  Of those who indicated that they were required to change (13 percent), about one-third (36 percent) indicated that the change was required because they needed to see a specialist. Another one-third (34 percent) indicated that the change was required because they were enrolled in an MCO where their WCHCP was not on the provider panel.

- **If the worker was enrolled in a managed care organization and, if so, if they continued treating with the same health care provider as before enrollment and the importance of being able to do so.**

  A small portion of injured workers (15 percent) indicated they were enrolled in a managed care organization at some point in the treatment for their workplace illness or injury.

  Of the injured workers who indicated they were enrolled in an MCO, most (78 percent) were able to continue seeing the same WCHCP after enrollment and they felt it was much more important to continue with the same provider than those who were required to change providers.

  Nearly one-third (29 percent) of injured workers did not know or did not remember if they were enrolled in an MCO.

- **Satisfaction with the choice of workers' compensation health care providers available, the quality of care received, and the ability to see a workers' compensation health care provider qualified to treat the condition.**

  Responses revealed that workers are generally satisfied (greater than 80 percent satisfied) with the choice of workers' compensation health care providers available, the quality of care received, and the ability to see a workers' compensation health care provider qualified to treat the condition.

The sample survey and a summary of survey responses can be found in Appendix X and Appendix Y, respectively.

About the Worker Survey

The Department of Consumer and Business Services sent the injured worker survey to a random sample of 2,500 workers out of 10,944 claimants with an accepted disabling claim and a date of injury falling between April 1, 2005 and September 30, 2005. At the time of the survey mailing (June 9, 2006), this group of workers had received treatment for up to 14 months, depending on the date of their injury. DCBS surveyed workers with fairly recent injuries so that the workers would still remember details about their treatment and have been exposed to the workers' compensation system for an adequate amount of time.

It is unknown if workers with a longer claim duration would offer different survey responses than the current sample, but the current sampling strategy ensures that surveyed workers have a recent experience about which they can comment. Though this sample does not include workers with claims exceeding 14 months of duration, the sample does include workers at various points in the development of their claim.

Of the 2,500 mailed surveys, 233 were undeliverable due to relocation or bad addresses. Of the remaining 2,267 delivered surveys, 616 were returned to the department. Five surveys did not contain usable information, leaving 611 usable survey responses. That calculates to a response rate of 27 percent, which is high compared to previous injured worker surveys the department has conducted.

Given the number of usable responses and the size of the defined population, the survey results are statistically significant at the 95 percent confidence level with a +/- 3.85 point confidence interval. Thus, if all 611 respondents answer a question, we can be 95 percent sure that the answers provided by them are within 3.85 percentage points (plus or minus) of the answers we would receive if we surveyed all 10,944 workers in the defined population.

Although the survey response rate meets a generally accepted level of statistical significance, it is possible that the survey results contain a significant level of response bias. For example, those who responded to the survey may be more or less satisfied with their medical treatment than the population as a whole, or the demographic makeup of the response group may differ substantially from the sample population, resulting in non-representative results. Confidence intervals (at a 95 percent confidence level) for the survey responses as presented in the report can be found in Appendix Y.

Interestingly, only 357 of the 611 survey respondents (58 percent) had closed claims as of June 9, 2006, while 1,727 (69 percent) of the survey sample had closed claims at that time. The fact that survey respondents were more likely to have longer claims than those in the survey sample may somewhat mitigate any claim duration impact.

Table 16 presents some demographic detail regarding injured workers within the population, survey sample, and survey respondents. The rural designation is determined by using the definitions developed by the Oregon Office of Rural Health at Oregon Health and Sciences University (http://www.ohsu.edu/oregonruralhealth/what_is_rural.html) as it applies to the injured workers' residential ZIP codes reported to DCBS. The Workers' Compensation Insurer column presents the distribution of injured workers based on the type of insurer that is liable for each claim.

Table 16. Survey population, sample, and response demographics

	Urban/Rural %[1]		Gender M/F %	Median Age at injury	Workers' Compensation Insurer[1]	
Population	Urban:	56 %	M: 68 %	40	SAIF:	47 %
	Rural:	37 %	F: 32 %		Private:	35 %
10,944	Out-of-state:	7 %			Self-Insured:	18 %
Sample	Urban:	55 %	M: 68 %	40	SAIF:	48 %
	Rural:	38 %	F: 32 %		Private:	34 %
2,500	Out-of-state:	7 %			Self-Insured:	18 %
Responses	Urban:	54 %	M: 62 %	47	SAIF:	48 %
	Rural:	42 %	F: 38 %		Private:	32 %
578[2]	Out-of-state:	5 %			Self-Insured:	20 %

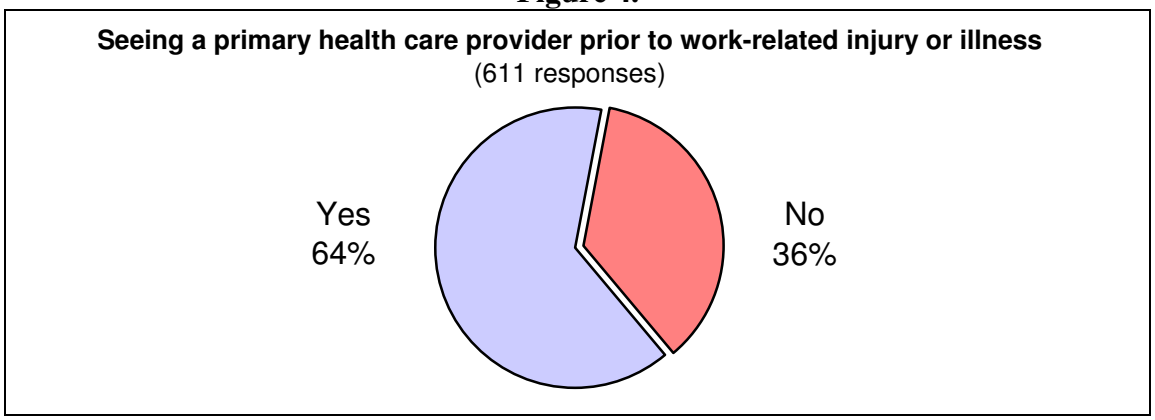
1. Percentages may not sum to 100 percent due to rounding.
2. 33 respondents did not include their survey ID and thus could not be linked to the Claims Information System.

The demographic variables of the response group are fairly similar to the demographic variables of the sample group and population, thus survey responses should be generally reflective of the responses anticipated if all 10,944 workers were surveyed. A summary of the survey responses follows.

Workers with Primary Care Providers

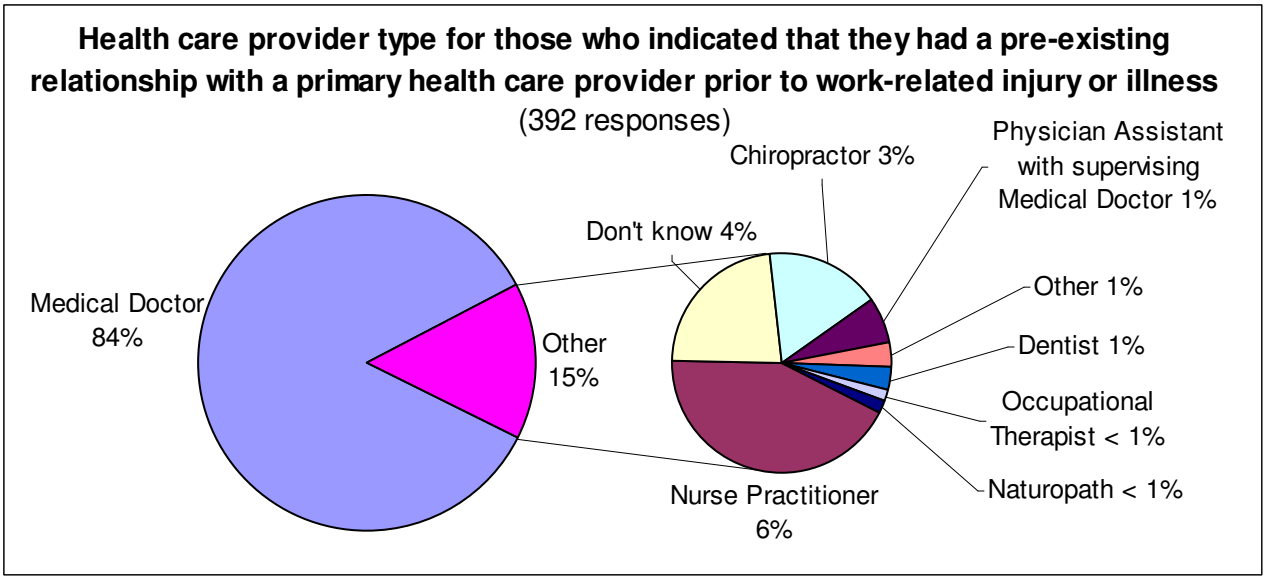
Most workers (84 percent) reported having general health insurance coverage prior to their work-related injury or illness. Furthermore, nearly two-thirds (64 percent) of survey respondents indicated that they had an established relationship with a primary care provider prior to their work-related injury or illness (Figure 4). A primary health care provider is defined as a doctor, nurse, or other care provider that they would have visited most often for regular health care.

Figure 4.



For the 392 injured workers who said they were seeing a primary health care provider prior to their work-related injury or illness, the overwhelming majority were seeing a medical doctor for their general health care (Figure 5). Nurse practitioners and chiropractors were a distant second and third, respectively.

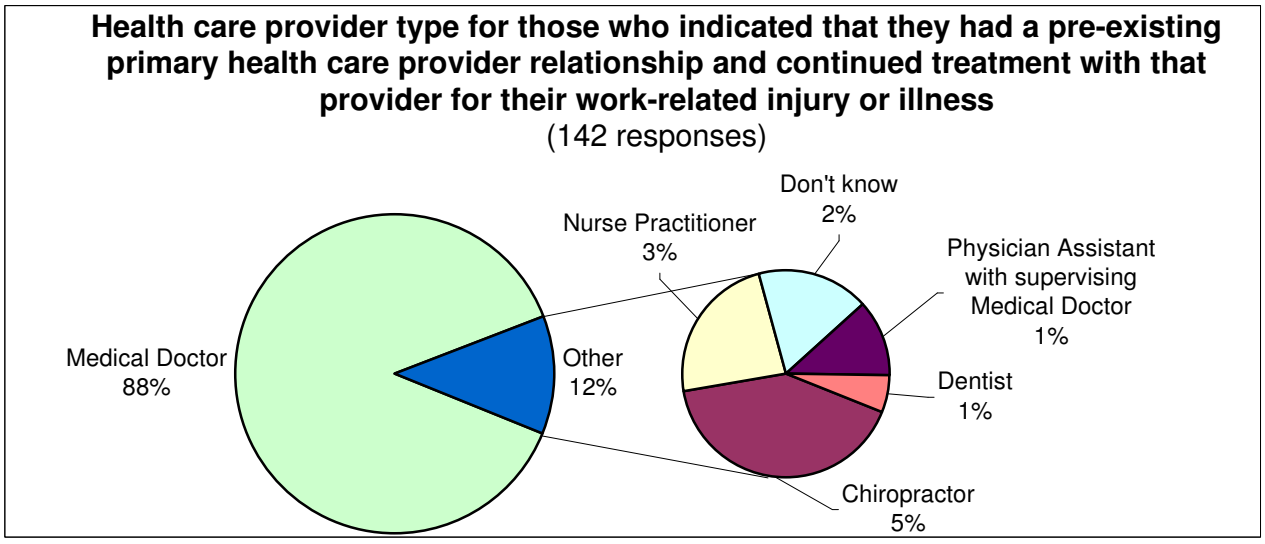
Figure 5.



Of those injured workers who identified a pre-existing relationship with a primary health care provider, about one-third received treatment for their work-related injury or illness from that primary health care provider. The remaining two-thirds received treatment from someone other than their pre-injury PCP. The distribution of PCPs who continued to treat post-injury is shown in Figure 6.

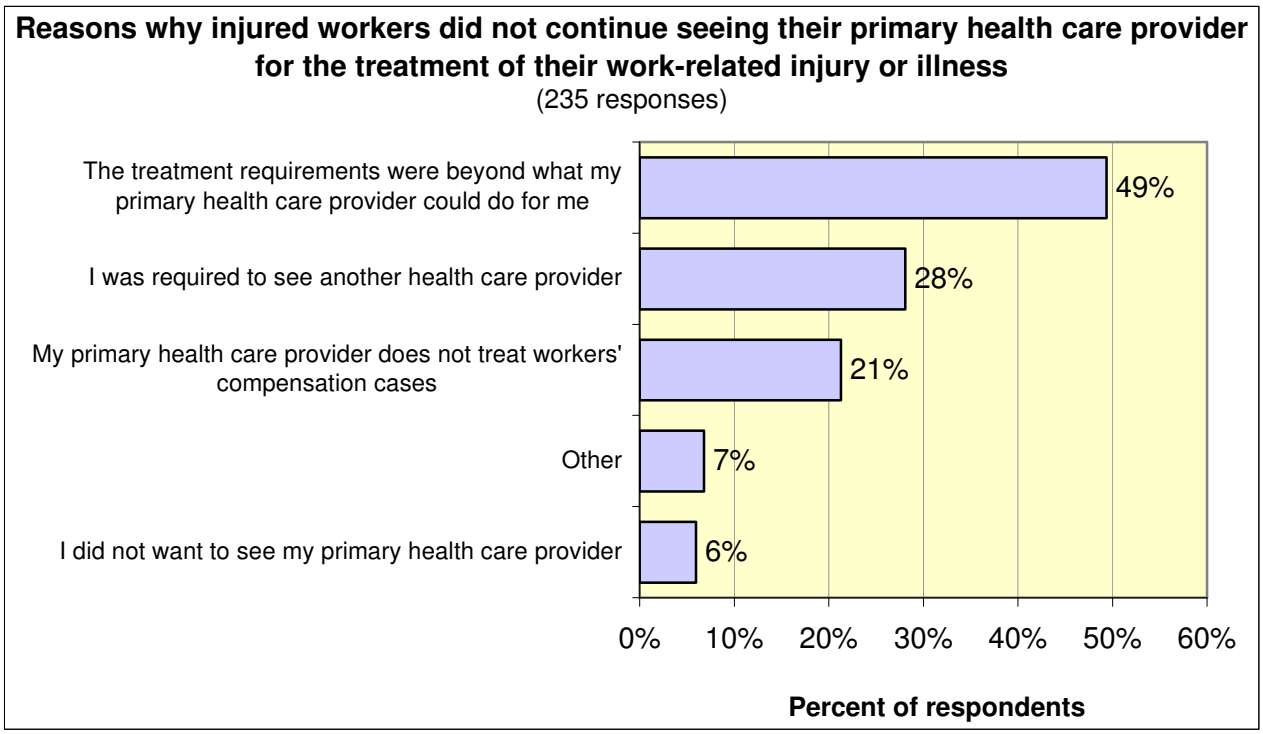
Comparing Figure 6 to Figure 5, it is apparent that workers are more likely to continue with their primary health care provider after injury if that provider is a medical doctor or chiropractor. These workers consistently reported that it is important for them to continue seeing their primary health care provider for their work-related injury or illness. (See Appendix Y for more detail.)

Figure 6.



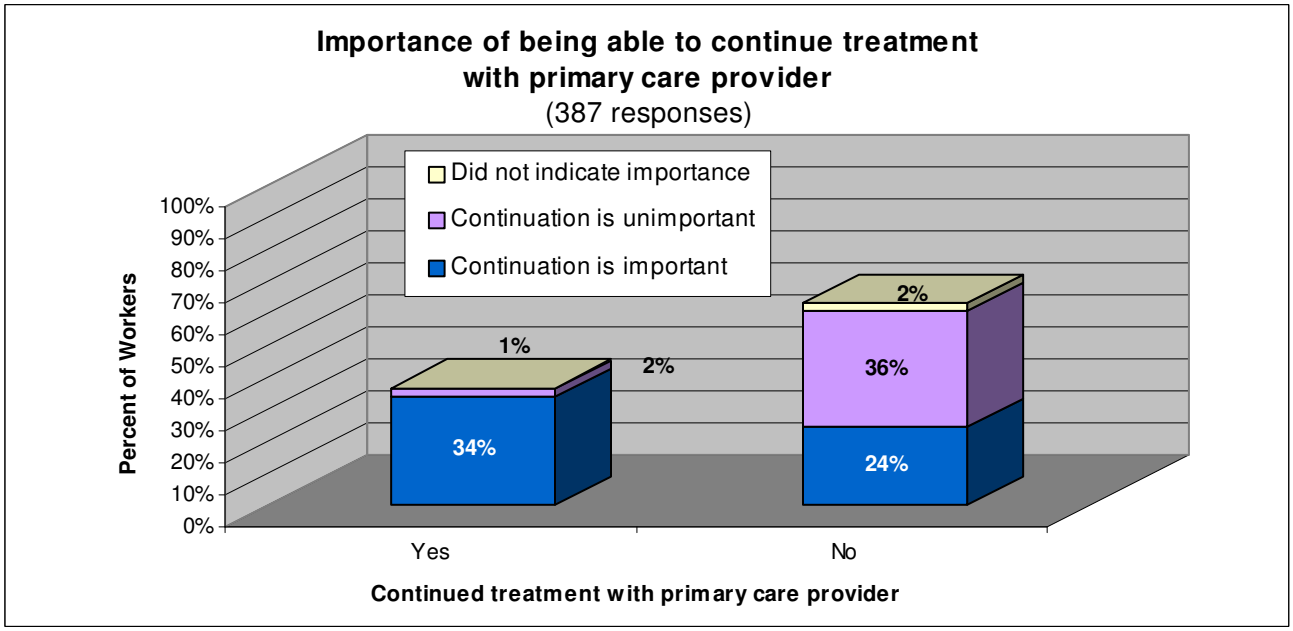
Nearly half (49 percent) of workers who did not continue with their PCP changed providers because their treatment requirements were beyond what their primary health care provider could provide (Figure 7). While almost all of the workers who continued treatment with their PCP indicated that it was important to them to do so, the majority of workers who did not continue with their PCP did not feel it was important for them to see their PCP for post-injury care (Figure 8).

Figure 7.



Workers were able to choose multiple reasons; therefore, the percentages will sum to more than 100 percent.

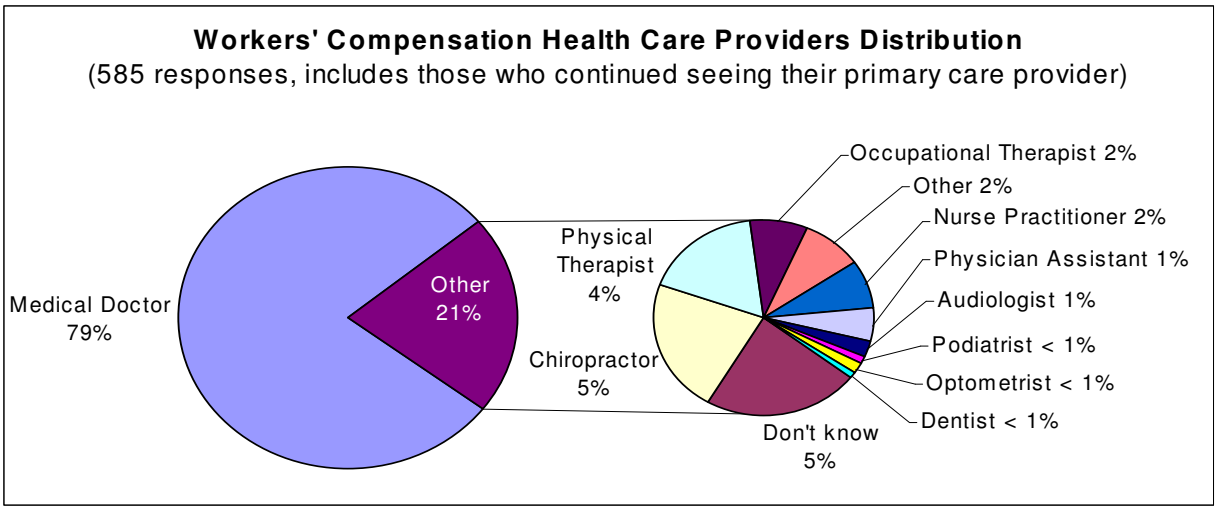
Figure 8.



Workers' Compensation Health Care Providers

Most workers reported having a medical doctor as their workers' compensation health care provider (WCHCP). A WCHCP is defined as the health care provider who was most responsible for the treatment of the worker's work-related injury or illness. The distribution of WCHCPs in Figure 9 combines responses of workers who continued with their existing primary health care provider as well as those who saw someone new.

Figure 9.



It is important to note that a few of the provider types indicated in Figure 9, such as physical therapist and occupational therapist, can only be seen through referral from an attending physician and would therefore not be the provider most responsible for a worker's treatment. However, workers may have identified these providers as their WCHCP because they provided the bulk of their treatment.

A higher percentage of rural workers indicated having a medical doctor or nurse practitioner as a WCHCP than urban workers (Table 17). Urban workers more frequently indicated treating with a physical therapist or occupational therapist. One reason for this difference may be a greater availability of diverse provider types in urban settings.

Table 17.
Workers' Compensation Health Care Providers with Urban/Rural Split

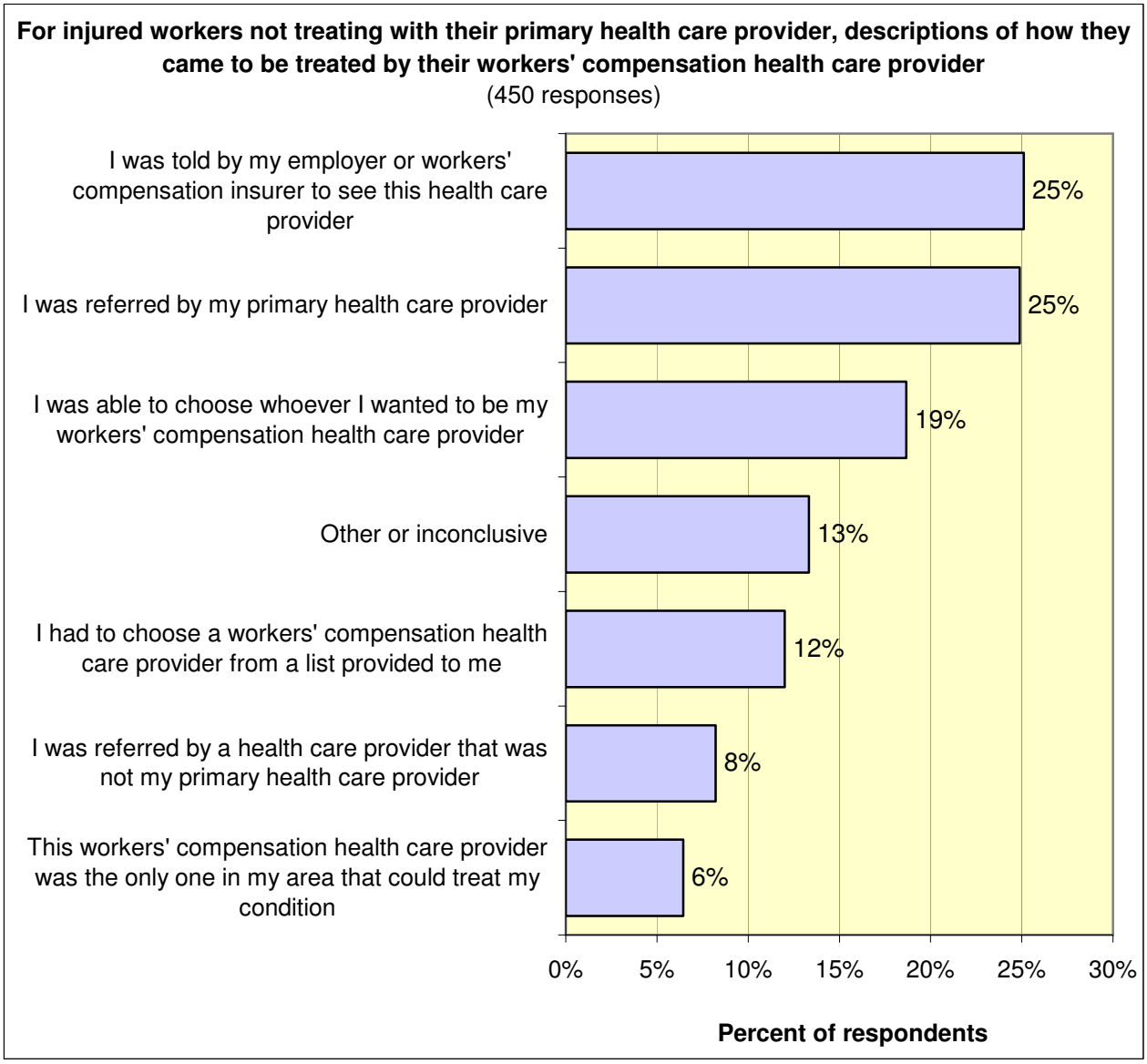
Provider Type	Urban %	Rural %
Medical Doctor	76%	82%
Don't know	5%	4%
Chiropractor	5%	5%
Physical Therapist	5%	2%
Occupational Therapist	3%	1%
Other	2%	2%
Nurse Practitioner	1%	2%
Physician Assistant	1%	1%
Audiologist	< 1%	1%
Dentist	1%	--
Podiatrist	--	1%
Optometrist	< 1%	--

Of the 585 who identified their workers' compensation health care provider, 554 provided their survey ID number allowing for geographic identification. 527 in-state responses were used. Responses that are indicated as < 1% would have rounded to zero.

Choice of Workers' Compensation Health Care Providers

Twenty-five percent of workers who saw a new provider for post-injury care indicated that they located their WCHCP through their employer or workers' compensation insurer. Another 25 percent indicated that they were referred by their PCP (Figure 10).

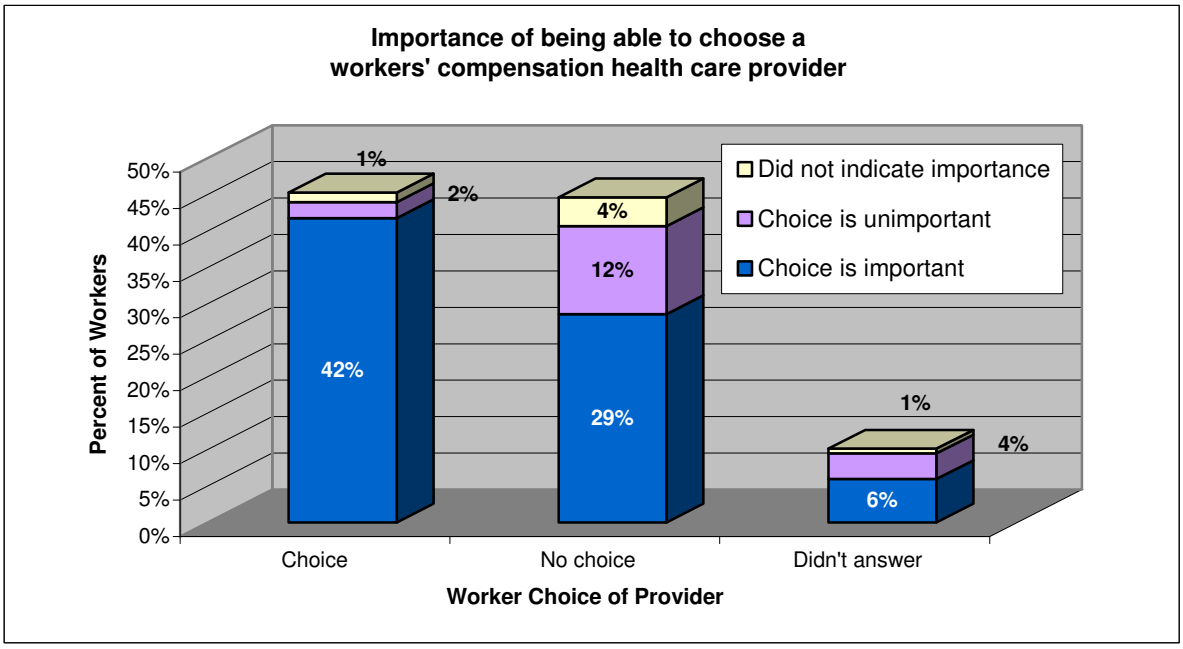
Figure 10.



Workers were able to choose multiple descriptions; therefore, the percentages will sum to more than 100 percent.

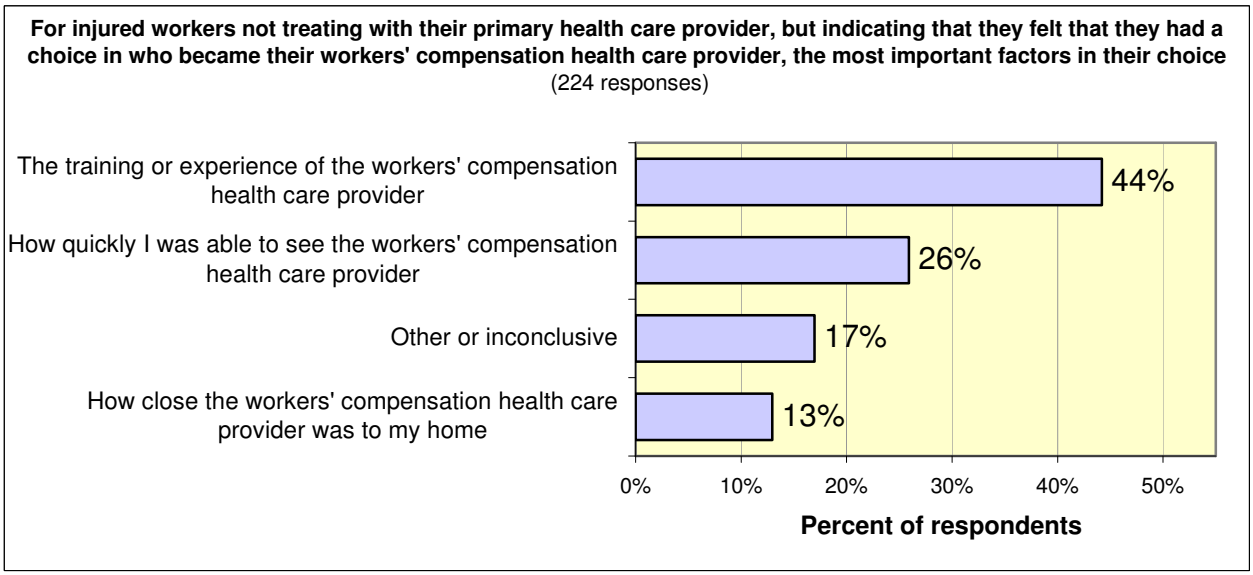
Nearly half (45 percent) of all workers who saw a new provider for post-injury care indicated they had choice of who became their WCHCP, while an equal proportion indicated they didn't have a choice. Of those who felt they had a choice, almost all indicated that having this choice was important; fewer of those who felt they didn't have a choice indicated that having this choice was important to them (Figure 11).

Figure 11.



Workers who indicated having a choice of who became their WCPCP or could not remember if they had a choice (56 percent of respondents who did not treat with their PCP, or columns one and three from figure 11) said the provider's experience and training as well as ease of access (speed and location) are the most important factors to consider when choosing a WCHCP (Figure 12).

Figure 12.



Satisfaction levels were evaluated separately for workers who felt they had a choice in who became their WCHCP and for those who felt they did not have a choice (Figures 13 and 14). Included in Figure 13 are those who continued with their PCP under the assumption that they did so by choice. Those workers who indicated that they don't know or don't remember if they had a choice in their WCHCP were excluded from figures 13 and 14.

Nearly nine out of 10 workers who claimed to have a choice of their WCHCP indicated that they were satisfied with the choice of health care providers available, the quality of care received, and the ability to

see a qualified health care provider (Figure 13). Comparing the satisfaction levels of the workers who claimed to have a choice to those who claimed to have no choice, it is clear that choice led to significantly higher levels of satisfaction.

Although one-third of all workers who completed the survey indicated that they felt that they did not have a choice in their WCHCP, more than two-thirds (68 percent, Figure 14) of this group indicated that they were generally satisfied with the choice of health care providers available. This finding suggests that, although they did not have a choice of providers, they were not displeased with who they did see for treatment. Even higher proportions of the "no choice" group indicated that they were satisfied with the quality of care received and their ability to see a qualified health care provider (74 percent and 80 percent, respectively).

Figure 13.

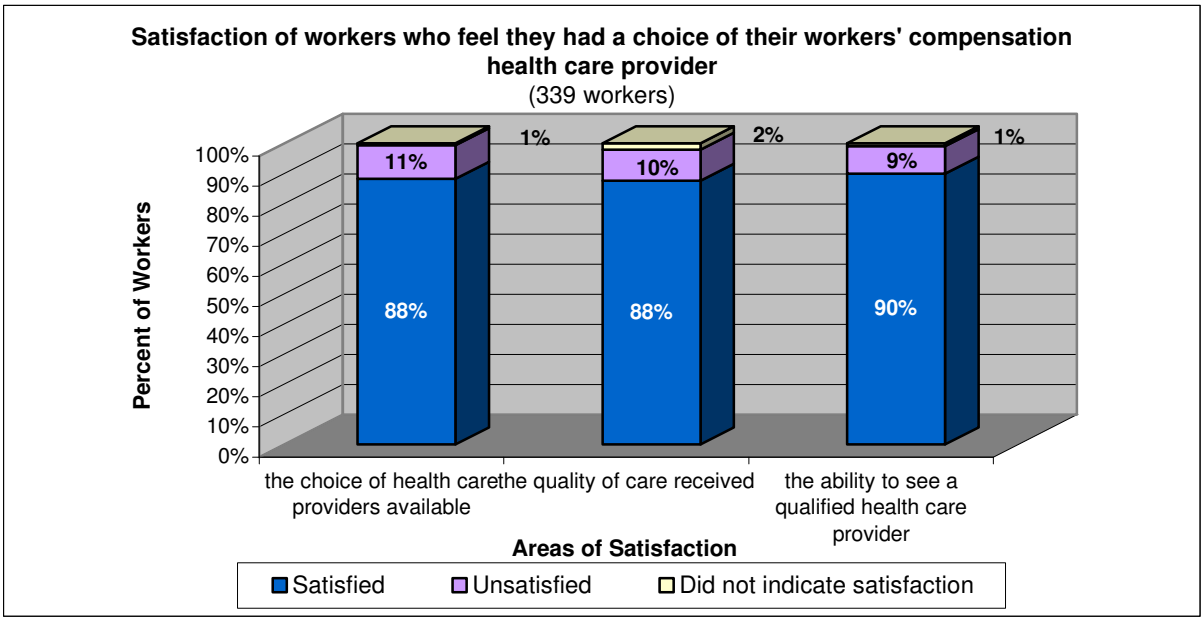
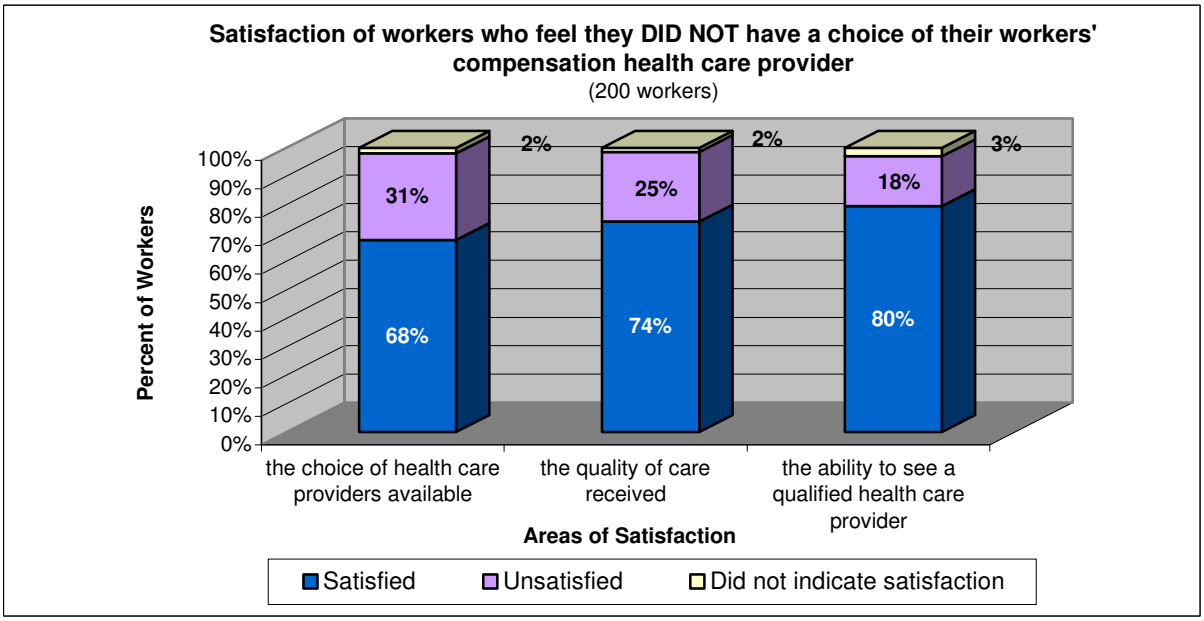


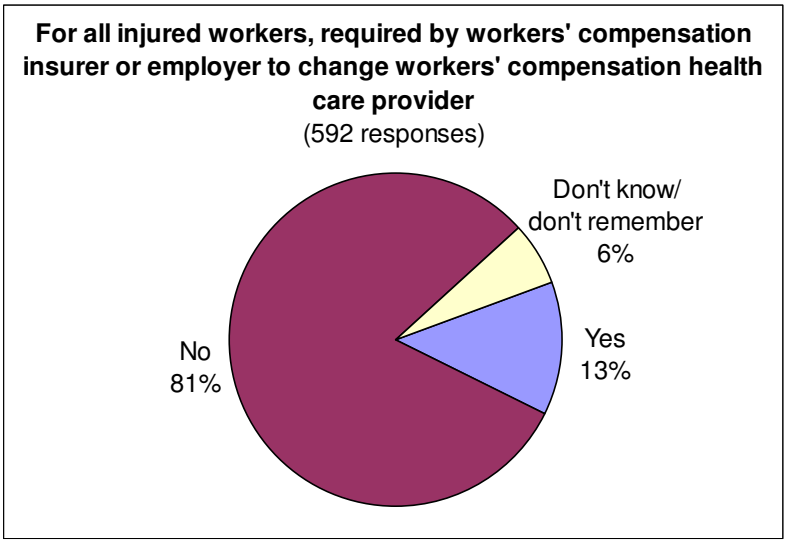
Figure 14.



Changing Workers' Compensation Health Care Providers

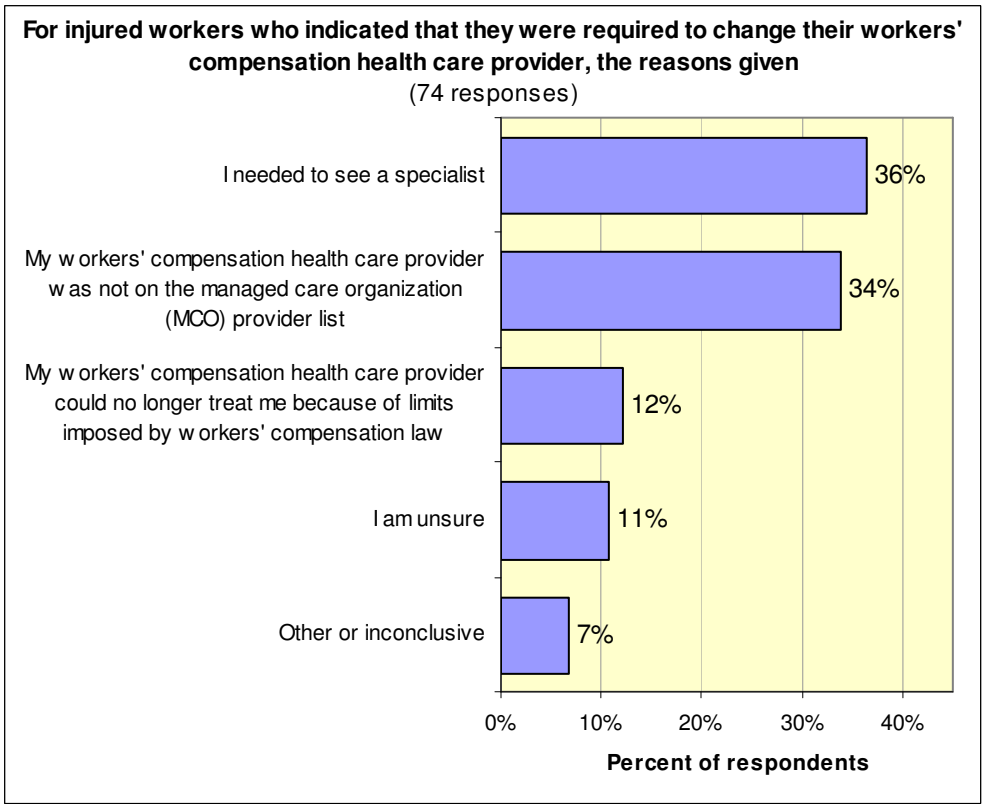
Most survey respondents indicated that they continued with the same WCHCP throughout their post-injury treatment (Figure 15).

Figure 15.



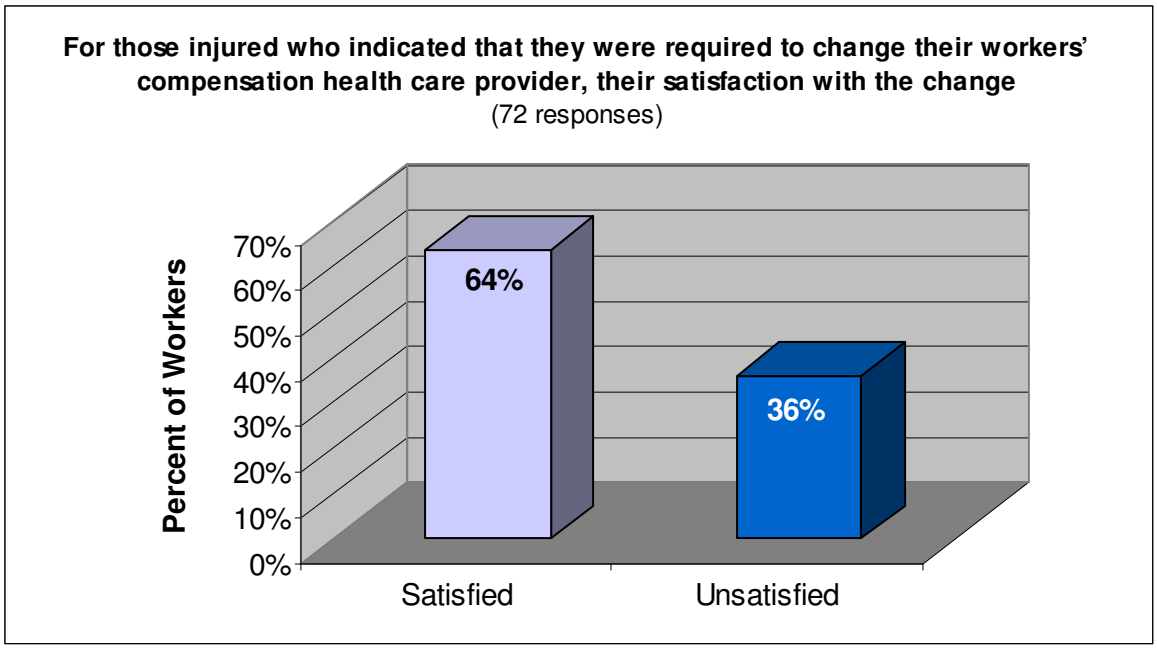
Most of the injured workers who were required to change their workers' compensation health care provider changed providers so they could see a specialist or because they were enrolled in an MCO where their WCHCP was not on the provider panel (Figure 16 – note the small number of responses).

Figure 16.



Nearly two-thirds of workers who indicated that they were required to change their WCHCP were satisfied with the change (Figure 17). For those who were unsatisfied with the change, the common reason for the change was that their WCHCP was not on the MCO panel. However, only 11 workers fell into this category.

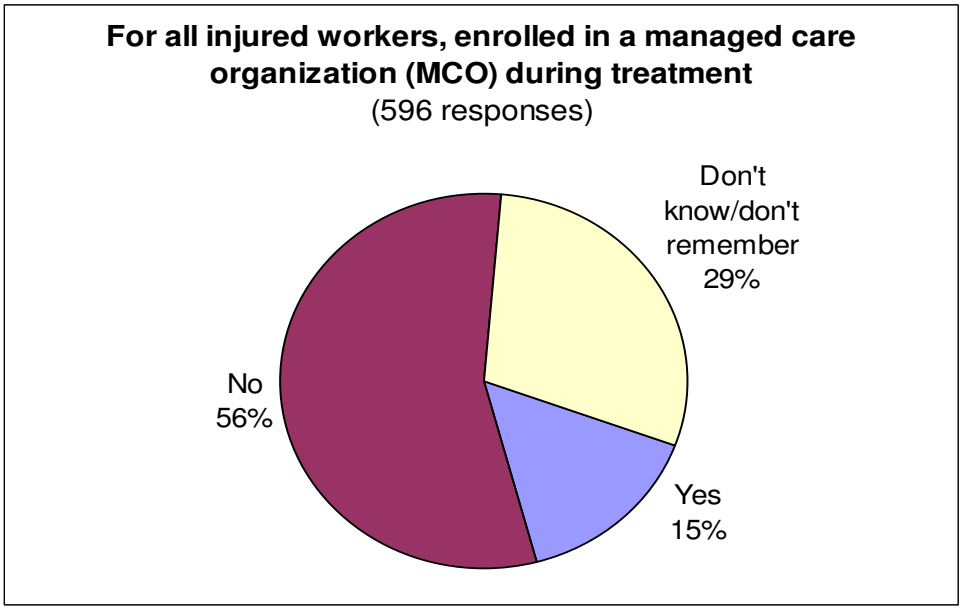
Figure 17.



Managed Care

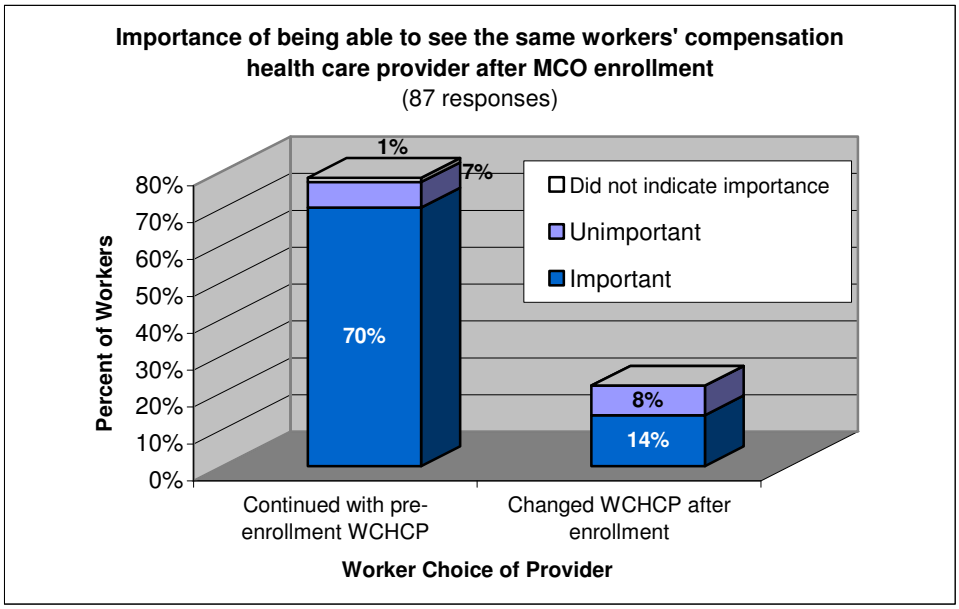
Fifteen percent of survey respondents indicated they were enrolled in a managed care organization at some point in the treatment for their workplace illness or injury. More than one-half of injured workers (56 percent) indicated that they were not enrolled. Interestingly, nearly one-third of all injured workers were unsure if they were enrolled in an MCO (Figure 18).

Figure 18.



Of the injured workers who indicated they were enrolled in a MCO, 78 percent were able to continue seeing the same workers' compensation health care provider after enrollment who they were seeing before enrollment. Those who did continue seeing the same provider felt it was much more important to continue with the same provider than those who were required to change providers (Figure 19).

Figure 19.



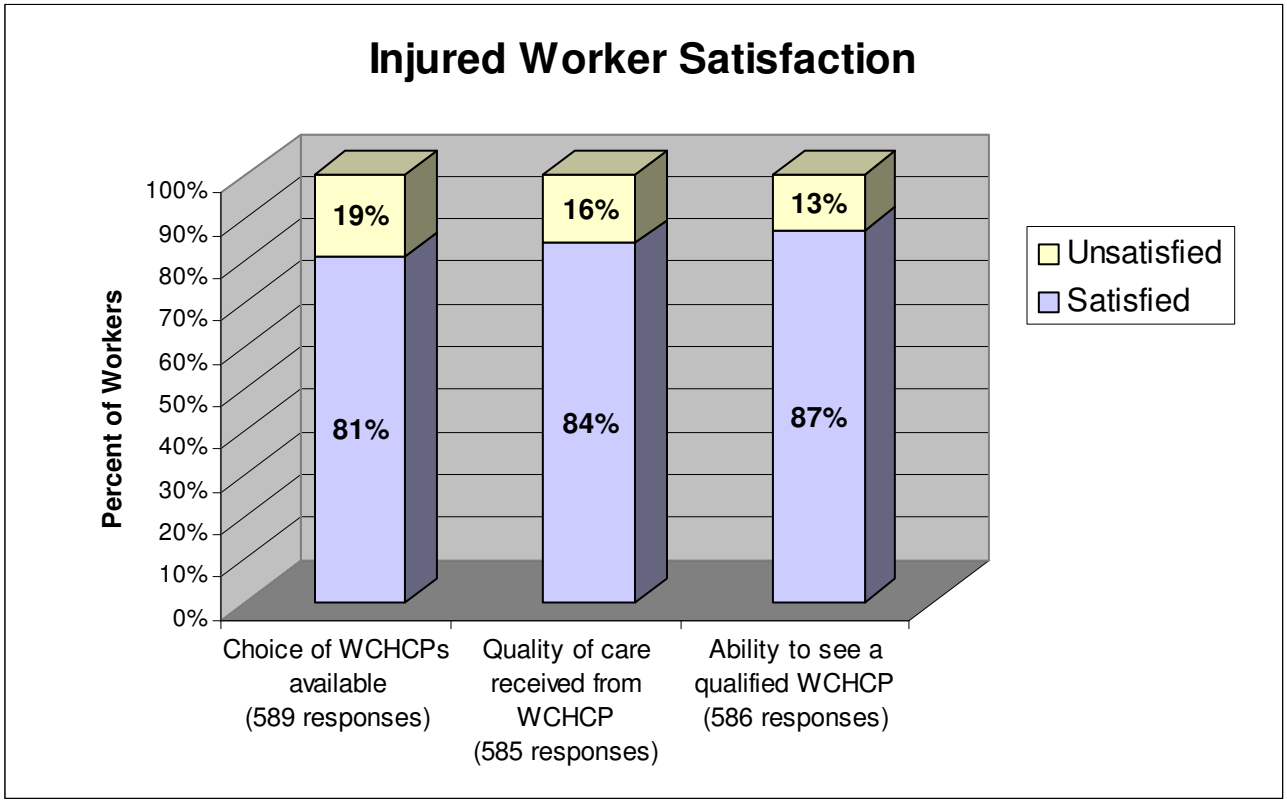
General Satisfaction

All surveyed workers were asked to rate their level of satisfaction with:

- The choice of workers' compensation health care providers available to them
- The quality of care they received from their workers' compensation health care provider
- Their ability to see a workers' compensation health care provider qualified to treat their condition.

Responses revealed that workers are generally satisfied with the care they receive in Oregon's workers' compensation system. There is little variation in the levels of satisfaction of urban and rural workers (see Appendix Y for further rural and urban detail).

Figure 20.

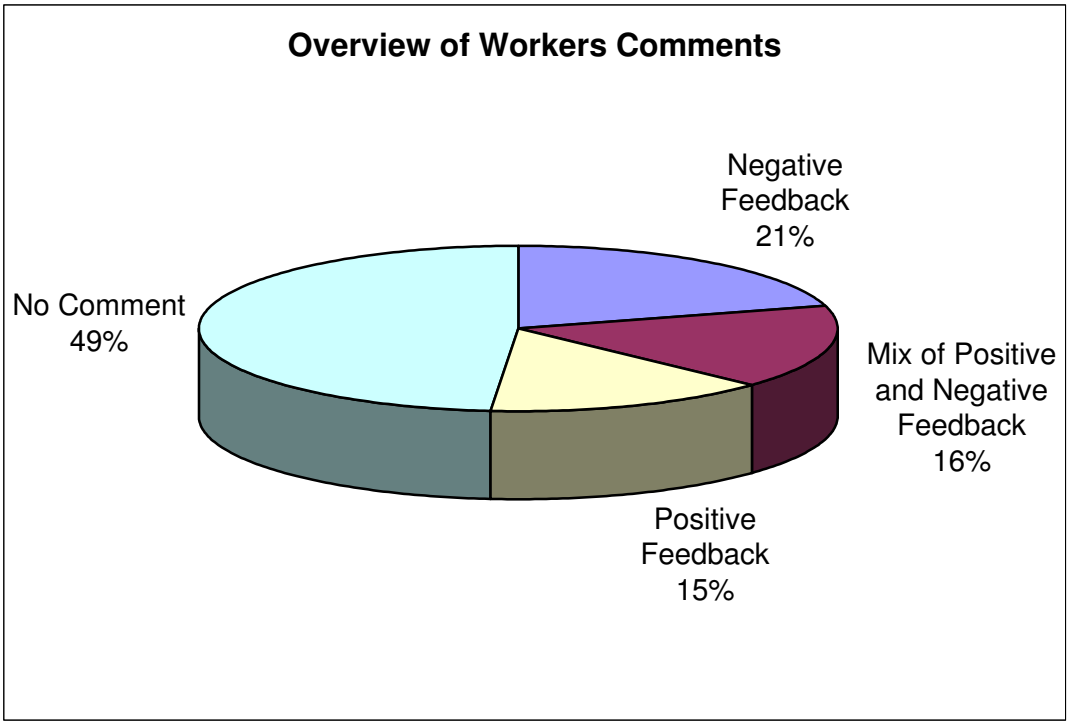


Survey Respondent Comments

Workers were given several opportunities to write comments about their satisfaction with the choice of providers, the quality of providers, the qualifications of providers, and their overall experience receiving care for their work-related injury or illness.

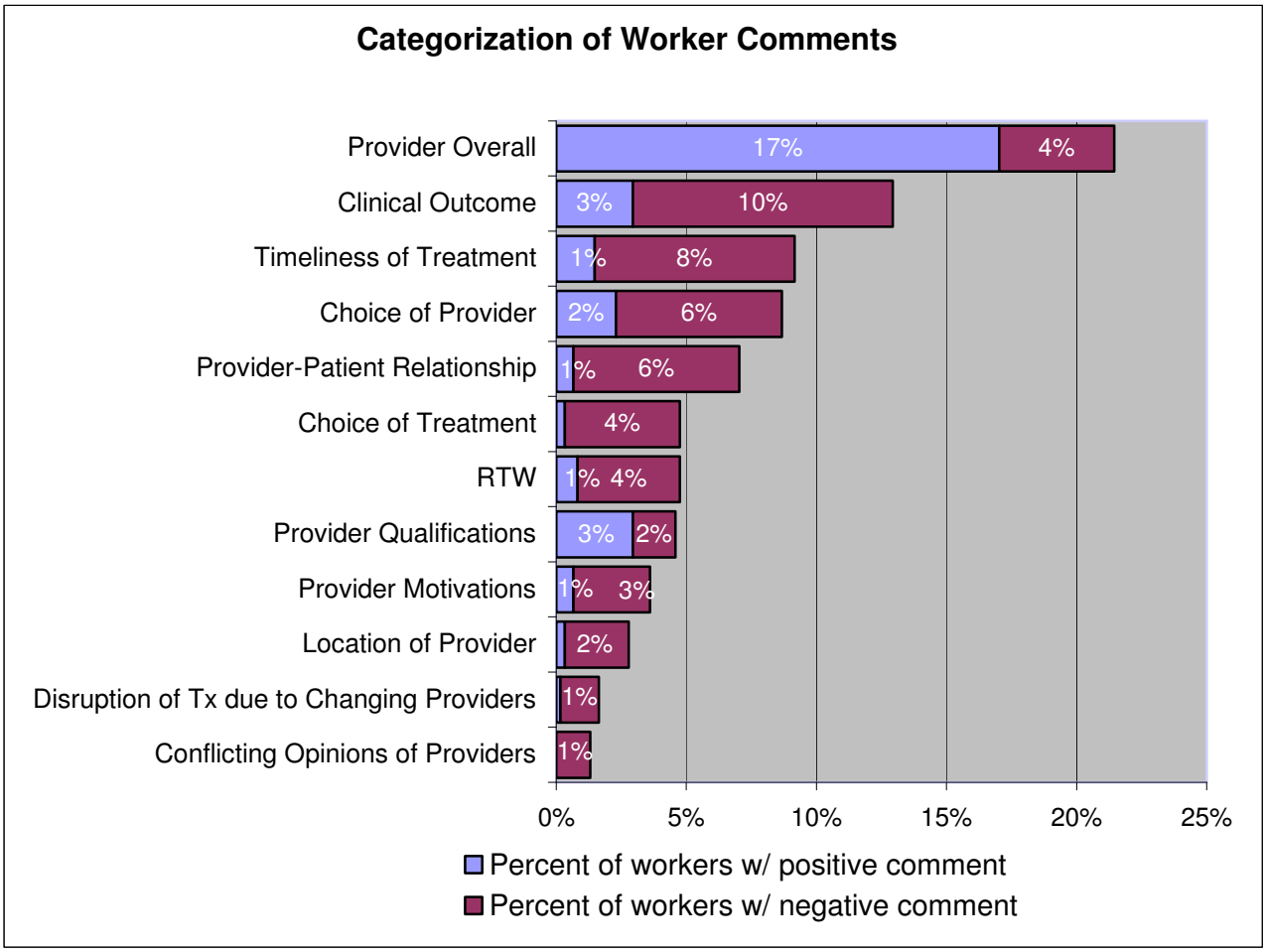
Of the respondents, 314 workers, or 51 percent, offered at least one comment. Each worker's comments were rated as generally positive, negative, or a mixture of positive and negative. Comments were almost evenly divided among the three groups, with negative comments being the largest group and positive comments being the smallest group (Figure 21). However, the disproportionate number of negative responses, when considering the generally high satisfaction of all survey respondents, suggest that the comment section is negatively biased.

Figure 21.



Worker comments were further sorted into topical categories. Many comments included more than one topic and counted in multiple categories. For example, if someone expressed great confidence in his or her WCHCP, but said seeing the provider necessitated a two-hour drive, the comment would be categorized in two areas: (1) provider overall positive and (2) location of provider negative. Positive comments outnumbered negative comments regarding overall satisfaction with providers and satisfaction with provider qualifications. Negative comments outnumbered positive comments in all other areas.

Figure 22.



When percentage is not indicated, it is less than 1%. Percentages represent percentage of all respondents to the survey.

Because negative comments may provide further clarification of worker concerns, samples of common themes are included below.

Ten workers (1.6 percent of respondents) commented that they had no choice of whom they saw for their work-related injury or illness. Two of them said they had no knowledge that they could have a choice (0.3 percent of respondents).

Eight workers (1.3 percent of respondents) stated they would have preferred to continue with their pre-injury care providers for treatment of their work-related injury or illness. Six had treated with MDs; two had treated with chiropractors.

Seven workers (1.2 percent of respondents) felt they were restricted from seeing appropriate specialists for their condition.

Four workers (0.7 percent) expressed dissatisfaction with restrictions on the care providers who could see them within an MCO. The prior provider of one of these workers was a chiropractor.

Two workers (0.3 percent of respondents) commented that they would have liked to have seen a chiropractor, but did not specify why they had not.

Two workers (0.3 percent of respondents) expressed dissatisfaction with having to discontinue treatment with their chiropractor due to the 30-day limit.

Worker's Compensation Care Provider Study
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Workers' Compensation Care Provider Study
Glossary

Accepted disabling claim (ADC)
A claim that includes compensable time loss, a permanent partial disability award, or an in-patient hospital admission.

Accepted non-disabling claim (ANC)
A claim that does nor include compensable time loss, a permanent partial disability award, or an in-patient hospital admission.

Back Sprain, Strain, or Tear
Determined by the Occupational Injury/Illness Classification System (OIICS) code included on the notice of claim.

B220 data
Medical billing data reported by insurers and self-insured employers with at least 100 accepted disabling claims in the previous year. Includes approximately 75 percent of all accepted disabling claims (ADCs); 70 percent of all estimated accepted non-disabling claims (ANCs).

Bureau of Labor Statistics (BLS)
Federal agency responsible for the collection of labor-related economic statistics. Notably, BLS administers the Injuries, Illnesses, and Fatalities (IIF) program which provides data on illnesses and injuries on the job and data on worker fatalities.

CH
Chiropractic Physician or Chiropractor. Focus on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, pain in the joints of the arms or legs, and headaches. The most common therapeutic procedure performed by doctors of chiropractic is known as "spinal manipulation." Manipulation, or adjustment of the affected joint and tissues, restores mobility, thereby alleviating pain and muscle tightness and allowing tissues to heal.

Claim Disposition Agreement (CDA)
An agreement that permits parties to a workers' compensation claim to dispose of all matters regarding the accepted claim (e.g., rights to compensation, attorney fees, expenses) except medical benefits.

Claims Data
Data reported by employers, insurers, and care providers as specified in statute and rule.

Closed claim

A claim that has been officially closed by the insurer. A claim may be closed when the worker is found to be medically stationary or the worker is no longer seeking medical treatment.

Confidence Interval

The plus-or-minus figure usually reported with survey results. For example, if you use a confidence interval of 4 and 47 percent of your sample picks an answer, you can be "sure" that if you had asked the question of the entire relevant population, between 43 percent (47-4) and 51 percent (47+4) would have picked that answer.

Confidence Level

Tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95 percent confidence level means you can be 95 percent certain; the 99 percent confidence level means you can be 99 percent certain. Most researchers use the 95 percent confidence level.

Days to closure

The number of days between the date of injury and the notice of claim closure.

DO

Osteopathic Physician or Osteopath. Diagnose illnesses and prescribe and administer treatment for people suffering from injury or disease. Examine patients, obtain medical histories, and order, perform, and interpret diagnostic tests. They counsel patients on diet, hygiene, and preventive health care. While both medical doctors and osteopaths may use all accepted methods of treatment, including drugs and surgery, osteopaths place special emphasis on the body's musculoskeletal system, preventive medicine, and holistic patient care.

Duration

The number of days between the first and last visit to a particular medical provider.

Injury year

Calendar year in which the injury occurred.

In State

A worker whose residence is within Oregon, as currently listed on the Claims Information System.

Managed Care Organization (MCO)

A health management organization with which an insurer can contract to provide medical services to injured workers.

Management-Labor Advisory Committee (MLAC)

An advisory committee created by the Oregon legislature as part of the reform of the workers' compensation system in 1990 to study issues affecting the workers' compensation system and report its findings and recommendations to the Oregon legislature. MLAC

consists of five representatives from business and five from labor, appointed by the governor and confirmed by the senate.

Mean

Commonly known as the "average," the mean is calculated by summing all observations and then dividing by the total number of observations. As a measure of central tendency, outliers can skew the mean.

Median

The midpoint in a sorted series of values; half of the values are below the median and half are above. The median is generally preferred to the mean when substantial outliers exist.

MD

Medical Doctor. Diagnose illnesses and prescribe and administer treatment for people suffering from injury or disease. Doctors examine patients, obtain medical histories, and order, perform, and interpret diagnostic tests. They counsel patients on diet, hygiene, and preventive health care. Medical doctors may use all accepted methods of treatment, including drugs and surgery.

NA

Naturopathic Physician. Focus on diagnosing and treating the human body and maintaining or restoring it to a state of normal health. Concentrate on the whole-patient wellness, centers around the patient and emphasizes prevention and self-care. Naturopathic medicine attempts to find and correct the underlying cause of the patient's condition. Therapies may include clinical nutrition, ayurvedic medicine, botanical medicine, colon therapy, counseling, diagnosis, homeopathic medicine, physical medicine, and/or prescription medications.

Occupational Injury and Illness Classification System (OIICS)

A standard coding system developed by the Bureau of Labor Statistics to record facts relating to an occupational injury or illness. The OIICS code contains five characteristics: nature of the injury or illness, part of the body affected, source of affliction (object or substance), event, and a secondary source.

PA

Physician Assistant. Under the authority and supervision of a physician, physician assistants exercise autonomy in medical decision-making and provide a broad range of diagnostic and therapeutic services. Physician assistants may conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, write prescriptions, and order or carry out therapies.

PO

Podiatric Physician or Podiatrist. Focus on preventing, diagnosing, and treating conditions associated with the foot and ankle. To treat these problems, podiatrists prescribe drugs, order physical therapy, set fractures, and perform surgery. They also fit corrective inserts called orthotics, design plaster casts and strappings to correct deformities, and design custom-made shoes.

PS

Psychologist. Provide mental health care. May provide psychotherapy through interviews or diagnostic testing. Although they are not permitted to prescribe medication, psychologists may work with physicians or psychiatrists to develop a treatment plan. Psychologists may apply psychological principles and research methods to the workplace in the interest of improving productivity and the quality of worklife.

PT

Physical Therapist. Provide services that help restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease. Treatment options includes exercise, electrical stimulation, hot packs or cold compresses, and ultrasound to relieve pain and reduce swelling. They may use traction or deep-tissue massage to relieve pain. Therapists also teach patients to use assistive and adaptive devices, such as crutches, prostheses, and wheelchairs. They also may show patients exercises to do at home to expedite their recovery.

Primary Care Provider (PCP)

As used in this study, the PCP is the doctor, nurse, or other health care provider that the worker would have visited most often for their regular health care.

Rural

A worker is considered rural if his or her residence ZIP code (as currently listed on the Claims Information System) is rural as defined by the Oregon Office of Rural Health at the Oregon Health Sciences University (OHSU).

Surgical Intervention

A claim includes a surgical intervention if the medical billing data, as reported through Bulletin 220, includes any surgery-related CPT codes.

Urban

A worker is considered urban if his or her residence ZIP code (as currently listed on the Claims Information System) is urban as defined by the Oregon Office of Rural Health at the Oregon Health Sciences University (OHSU).

Workers' Compensation Health Care Provider (WCHCP)

As used in this study, the WCHCP is the health care provider who was most responsible for the treatment of a worker's work-related injury or illness.

Appendices

Appendix A

Summary of 1990 Reforms to the Workers' Compensation Law

In December 1989, Governor Neil Goldschmidt asked seven employee representatives and seven employer representatives to join him to form a Workers' Compensation Labor Management Advisory Committee. The committee, often referred to as the "Mahonia Hall" committee, negotiated a strategy to control the costs of Oregon's workers' compensation system. The committee's report to Governor Goldshmidt in April 1990 formed the basis for legislative action: Senate Bills 1197 and 1198, enacted by the 1990 Special Session of the Oregon Legislature, made major changes to Oregon workers' compensation laws.

In June 1990, the Workers' Compensation Division issued a bulletin (#214) to insurers, workers' compensation attorneys, labor unions, and other interested parties describing the changes to the workers' compensation laws. Major changes included:

Managed care organizations (MCOs)
For the first time in Oregon, insurers may contract with MCOs to provide medical services to the employees of those they insure. MCOs are to be certified by the department after meeting specific standards and conditions.

Attending physicians and nonattending physicians
Nonattending physicians who are not members of an MCO may provide medical services for up to 30 days or 12 visits (first to occur). Nurse practitioners and physician assistants who practice in rural areas served by Type A, B, or C rural hospitals will be allowed by rule to authorize the payment of temporary disability for up to 30 days from the first visit on the claim. Otherwise, only attending physicians may authorize temporary disability compensation or rate impairment. An attending physician must be a medical doctor, doctor of osteopathy, board-certified oral surgeon; or for a period of 30 days from the first office visit or 12 visits (first to occur), a doctor of chiropractic.

Prior to the reforms, any licensed medical provider could be an attending physician.

Medical fees
The director must resolve medical fee disputes using an administrative process; formerly, the appeal route for an aggrieved party would be to the Hearings Division of the Workers' Compensation Board. In addition, the director may exclude MCOs from medical fee schedules and may exclude certain hospitals from the hospital fee schedule based on economic necessity.

Palliative care
Payment for palliative care is limited to three situations: (1) when provided to workers determined to be permanently and totally disabled; (2) when necessary to monitor prescription medications required to keep the worker's condition stable; or (3) to monitor the status of a prosthetic device. However, if the attending physician believes that palliative care is needed to enable the worker to continue current employment, the physician may ask the insurer to approve treatment. If the insurer does not approve palliative care, the physician may request approval from the director.

Prior to the reforms, the law did not limit palliative care, provided such care was related to the compensable injury.

Dispensing of generic drugs
Pharmacists or dispensing physicians are required to dispense generic drugs to the worker. Formerly, the workers' compensation law provided no direction regarding the dispensing of generic drugs.

Acceptance and denial of claims
The insurer must accept or deny a claim within 90 days (formerly 60 days; returned to 60 days again 1/1/2002) of the employer's knowledge. The insurer may revoke acceptance and deny a claim within two years of acceptance if the insurer obtains evidence that the claim is not compensable or the insurer is not responsible for the claim. Formerly, the workers' compensation law did not provide for denial after the claim had been accepted.

Objective findings and major contributing cause as thresholds for claim compensability
In order for an initial claim or an aggravation (worsening) claim to be compensable, the injury or illness must be established by written medical evidence

supported by "objective findings" (this term is defined in the new law); if a compensable injury contributes to another injury, the resulting condition is only compensable if the compensable injury is the major contributing cause of the consequential condition; and, if the compensable condition combines with a preexisting medical condition, the combined condition is compensable only to the extent that the compensable injury remains the major contributing cause of the disability or need for treatment.

Formerly, the law did not include the objective-findings or major-contributing-cause standards in its definition of "compensable injury."

Compromise and Release (Claims Disposition Agreements)
Except for medical services, all issues relating to a worker's claim may be resolved by agreement of the worker and insurer, with the approval of the Workers' Compensation Board. Formerly, ORS 656.236 stated that "No release by a worker or beneficiary of any rights under ORS 656.001 to 656.794 is valid."

Penalties payable to workers
If the insurer unreasonably delays acceptance or denial of a claim or unreasonably delays or refuses to pay compensation, the director may order the insurer to pay penalties directly to the worker. Formerly, jurisdiction over this penalty process resided with the Workers' Compensation Board.

Stays of compensation
Except for temporary disability and permanent total disability benefits, compensation is stayed when an insurer requests a hearing on a reconsideration order, requests a board review, or appeals a board review order. Formerly, under ORS 656.313, such benefits continued to be payable during the appeal process.

Suspension of temporary disability compensation and medical benefits
Temporary disability is not due when the attending physician cannot verify the worker's inability to work. When the insurer requests but the attending physician does not provide such verification, medical services are not compensable until the verification is received. In addition, the insurer may suspend payment of temporary disability if the worker fails to attend an appointment with the attending physician and then fails to attend a rescheduled appointment.

Prior to the reforms, unless the attending physician released the worker for work, temporary disability was assumed payable based on the last available authorization. In addition, the law had no established process for suspension of temporary disability when the worker failed to attend medical appointments.

Permanent partial disability (PPD) awards
The value of a degree for scheduled disability is increased from $145 to $305 per degree for claims with dates of injury on or after May 7, 1990.

Mandatory reconsideration
Any party dissatisfied with an insurer's Notice of Closure or the department's Determination Order must request reconsideration by a special appellate unit of the department. Formerly, all appeals went to the Hearings Division of the Workers' Compensation Board.

Handicapped Workers' Reserve phase-out
Requests for relief from the Handicapped Workers' Reserve will only be processed on applications received by the department on or before April 30, 1990.

Preferred Worker Program Expansion
For the first time, the department will issue Preferred Worker Identity Cards to permanently disabled workers who cannot return to their regular work. Employers who hire Preferred Workers will not pay insurance premiums or premium assessments for the worker for three years from the date of hire. If the worker has a new injury during the three-year period, insurer claim costs are reimbursed from the Reemployment Assistance Reserve [now part of the Workers' Benefit Fund]. Formerly, employers could be reimbursed for the premium they paid for Preferred Workers for two years from the date of hire, but the insurer did not receive reimbursement of claims costs in the event of new injuries during that period. In addition, the insurer could not recoup its costs through charge-backs to the employer via ratemaking or dividend calculation.

THEODORE R. KULONGOSKI
Governor

September 2, 2005

The Honorable Bill Bradbury
Secretary of State
900 Court Street NE – Room 136
Salem OR 97301

Dear Secretary Bradbury:

I am returning House Bill 2588 unsigned and disapproved.

This bill would allow chiropractors to serve as attending physicians for some injured workers while the impact is studied, with the study cost of nearly $1 million to be paid out of the Workers Benefit Fund.

The Workers Benefit Fund comes from employer and worker payments of a few cents for every hour worked. It was set up as a dedicated fund, specifically for the purposes of providing supplemental benefits for injured workers and helping them return to work. This special-purpose fund should not be used by the legislature to pay for studies or projects like that proposed by HB 2588.

It is particularly inappropriate to use funds from the workers' compensation system to pay for a proposal that is not supported by employers and workers. HB 2588 has not received the support of the Management-Labor Advisory Committee (MLAC), consisting of representatives of management and labor; instead, it was promoted by chiropractors seeking greater authority to treat injured workers. In my view, changes in the workers' compensation system should be driven by the needs of employers and workers, not the desires of those who provide services.

Proponents of the bill have argued that chiropractic care can be a preferable and more cost-effective approach to treating some conditions such as back injuries. However, the bill is not limited to treatment of back injuries or other areas where chiropractic care may be appropriate. It would give chiropractors unlimited authority to serve as attending physicians regardless of the nature of the worker's injury, including responsibility for all treatment of the injured worker, establishment of treatment plans, authorization of time loss, releasing the worker to return to work, deciding when the worker is medically stationary, evaluation of permanent impairment, authorization of physical therapy, allowing the worker to decline light duty due to the commuting distance, and perhaps even approval of palliative (pain control) care needed to remain at work.

The role of chiropractors in workers' compensation was intentionally limited as part of the Mahonia Hall reforms. Thus far, I have not seen any evidence that access to chiropractic care under these limits is insufficient. Neither workers nor employers have said that the current limits cause problems. However, I am not opposed to the idea of re-examining the role of chiropractors in the workers' compensation system. For this reason, I am asking the Department of Consumer and Business Services, in conjunction with MLAC, to review the role of chiropractors in the workers' compensation system and make recommendations to the next legislative session. This review may cover the role of other providers if MLAC feels it would be appropriate. Once this review is complete, we will have better information on which to base a discussion about whether changes to the workers' compensation system are needed.

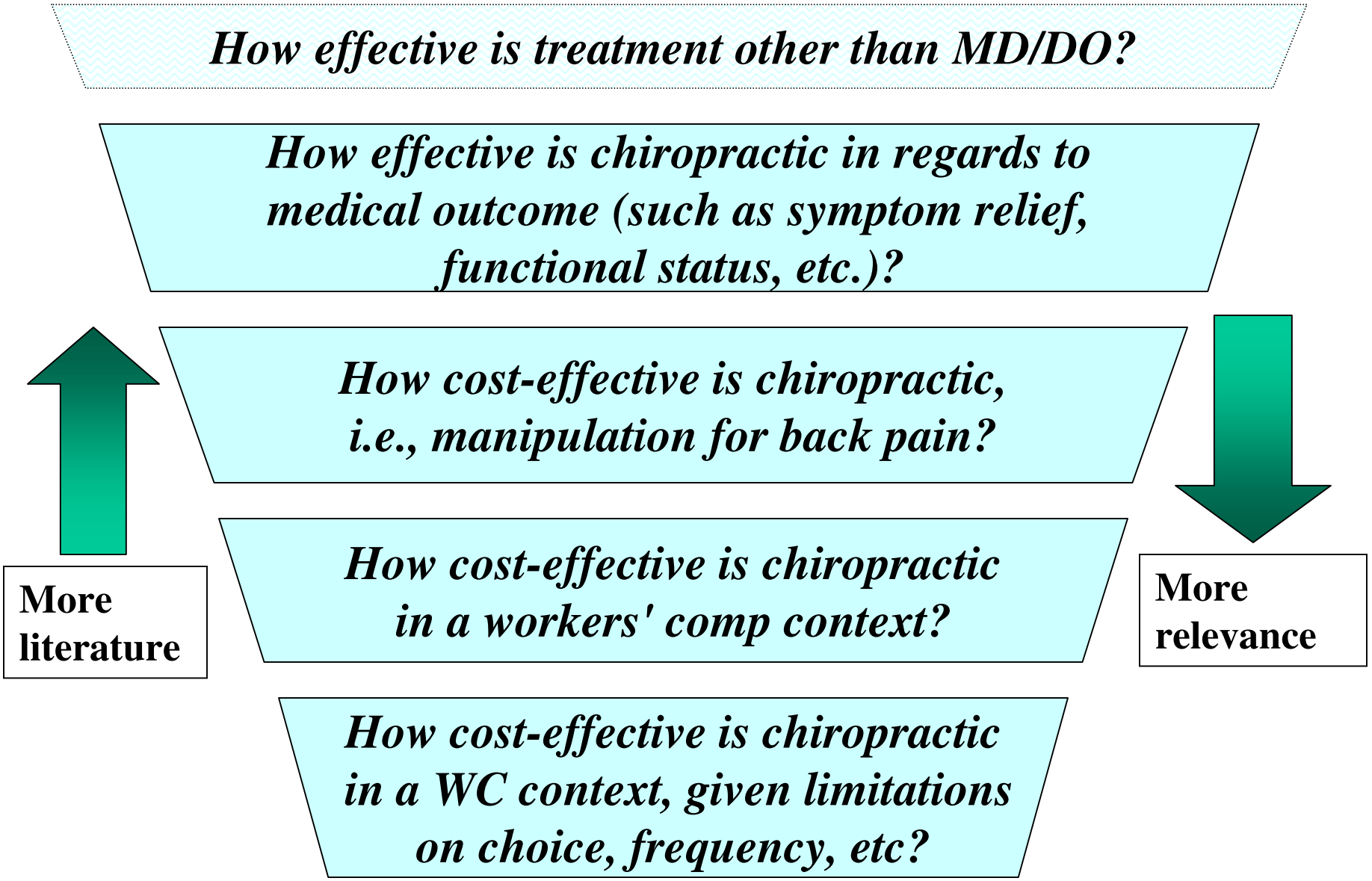
Sincerely,

THEODORE R. KULONGOSKI
Governor

TRK:DCR:lmh

Appendix C

Relevance Questions for Literature Review



Appendix D

State Board of Chiropractic Examiners

ORS Chapter 684 -Statutes Regulating Chiropractors
http://www.leg.state.or.us/ors/684.html

Rules of Procedure…..OAR 811-001-0001
http://arcweb.sos.state.or.us/rules/OARS_800/OAR_811/811_tofc.html

Board of Chiroproactic Examiners
http://oregon.gov/OBCE/index.shtml

Board of Medical Examiners – Physician's Assistant

ORS Chapter 677 -Statutes Regulating the Physician Assistants
http://www.leg.state.or.us/ors/677.html

Rules of Procedure…….OAR 847-050-0005
http://arcweb.sos.state.or.us/rules/OARS_800/OAR_847/847_tofc.html

Association of Physician Assistant Programs
http://www.apap.org/apapdirectory/app2_pa_program.htm

National Commission for the Certification of Physician Assistants
http://www.nccpa.net/

Board of Medical Examiners
http://egov.oregon.gov/BME/index.shtml

Board of Medical Examiners – Podiatrists

Rules of Procedure….OAR 847-080-0001
http://arcweb.sos.state.or.us/rules/OARS_800/OAR_847/847_tofc.html

ORS Chapter 677 -Statutes Regulating the Practice of Podiatry
http://www.leg.state.or.us/ors/677.html

Board of Medical Examiners
http://egov.oregon.gov/BME/index.shtml

Board of Medical Examiners – MD/DO

Rules of Procedure….OAR 847-080-0001
http://arcweb.sos.state.or.us/rules/OARS_800/OAR_847/847_tofc.html

ORS
http://www.leg.state.or.us/ors/677.html

Board of Medical Examiners
http://egov.oregon.gov/BME/index.shtml

Board of Naturopathic Examiners

Rules of Procedure……..OAR 850-001-0000
http://arcweb.sos.state.or.us/rules/OARS_800/OAR_850/850_tofc.html

ORS Chapter 685 — Statutes Regulating Naturopaths
http://www.leg.state.or.us/ors/685.html

Oregon Board of Naturopathic Examiners
http://www.obne.state.or.us/

Oregon Association of Naturopathic Physicians
http://www.oanp.org/

Appendix E

Attending Physician Definition per 656.005 (12)(b)(A-B)

A doctor or physician who is primarily responsible for the treatment of a worker's compensable injury and who is:

A medical doctor or doctor of osteopathy
Licensed by the Board of Medical Examiners for the State of OR per ORS 677.100 to 677.228

Or an oral and maxillofacial surgeon
Licensed by the Oregon Board of Dentistry

A chiropractor (for 30 days from the date of first visit on the initial claim or for 12 visits, whichever comes first)
Licensed by the Oregon Board of Chiropractic Examiners

Authorities and Responsibilities	Citation
Provide compensable medical services for an initial injury or illness without authorization from another care provider.	
First report to insurer or self-insured employer within 72 hours after first service rendered.	656.252 (1)(a)
Required to submit follow-up reports within specified time limits or upon request	656.252 (1)(b)
Whenever an injured worker changes APs, the new one shall notify the insurer within 5 days of the date of the change or first treatment. Every AP who refers a worker to a consulting physician shall notify the responsible insurer of the referral.	656.252 (5)
When an AP continues to provide care for an injured worker who is enrolled in a MCO (but the AP is not) more than 7 days after a notice was mailed by the insurer, this can result in suspension of compensation payment to worker.	656.262 (4)(i)

Authorities and Responsibilities	Citation
Authorize payment of temporary disability compensation. (NP can for 60 days)	**656.245(2)(B); C(i)&ii**
An AP who has authorized temporary disability benefits can release a worker to return to regular employment. An AP must advise the worker and document, in writing, this release. Temporary total disability benefits are discontinued at this time.	656.268 (4)(b)
Except when previously indicated that temporary disability will not exceed 14 days, shall forward medical reports to the insurer every 15 days if they are requested.	656.252 (2)(b)
Can cease to authorize, or for a period of time not authorize temporary disability. This will halt temporary disability compensation. Can retroactively authorize temporary disability compensation up to and including 14 days.	656.262 (4)(g)
May reauthorize payment of temporary disability benefits to the worker upon the expiration of a period of temporary disability.	656.262 (4)(h)
An offer of modified employment may be refused by a worker, if the AP has stated that a commute is beyond the physical capacity of the worker. This will not terminate temporary disability benefits to the worker.	656.268 (4)(c)(A)

Authorities and Responsibilities	Citation
Performs physical capacity evaluation, or refers worker to someone who can, or advises insurer that worker is not able to participate in a physical capacity evaluation within 20 days of notification by insurer. This evaluation is for determination of eligibility for vocational assistance.	**656.340(3)**
Prescribes palliative care needed for worker's continued employment or vocational training program	656.245(J)

Authorities and Responsibilities	Citation
An AP can authorize that a worker is released to return to modified employment. This decision must be documented in writing.	**656.268 (4)(c)**
Cooperate to expedite diagnostic and treatment procedures and with efforts to return injured workers to appropriate work	656.252 (2)(a)
Advise insurance of the anticipated date for release of the injured worker to return to employment, the anticipated date that the worker will be medically stationary, and the next appointment date.	656.252 (2)(b)
Advise insurer or employer within 5 days of the date the injured worker is released to return to work and notify the worker at the same time.	656.252 (2)(c)

Authorities and Responsibilities	Citation
A claim for aggravation must be in writing and be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury.	**656.273(3)**
If a claim has been closed and treatment is resumed or reopening of a claim is recommended, must notify insurer or self-insured employer within 5 days.	656.252 (2)(d)
An AP may authorize curative treatment when there has been a worsening of the compensable injury. In these cases an AP may authorize temporary disability compensation until the worker's condition becomes medically stationary.	656.278(1)(a)
An AP may authorize curative treatment when there has been a new or omitted medical condition. In these cases an AP may authorize temporary disability compensation until the worker's condition becomes medically stationary.	656.278(1)(b)

Appendix F

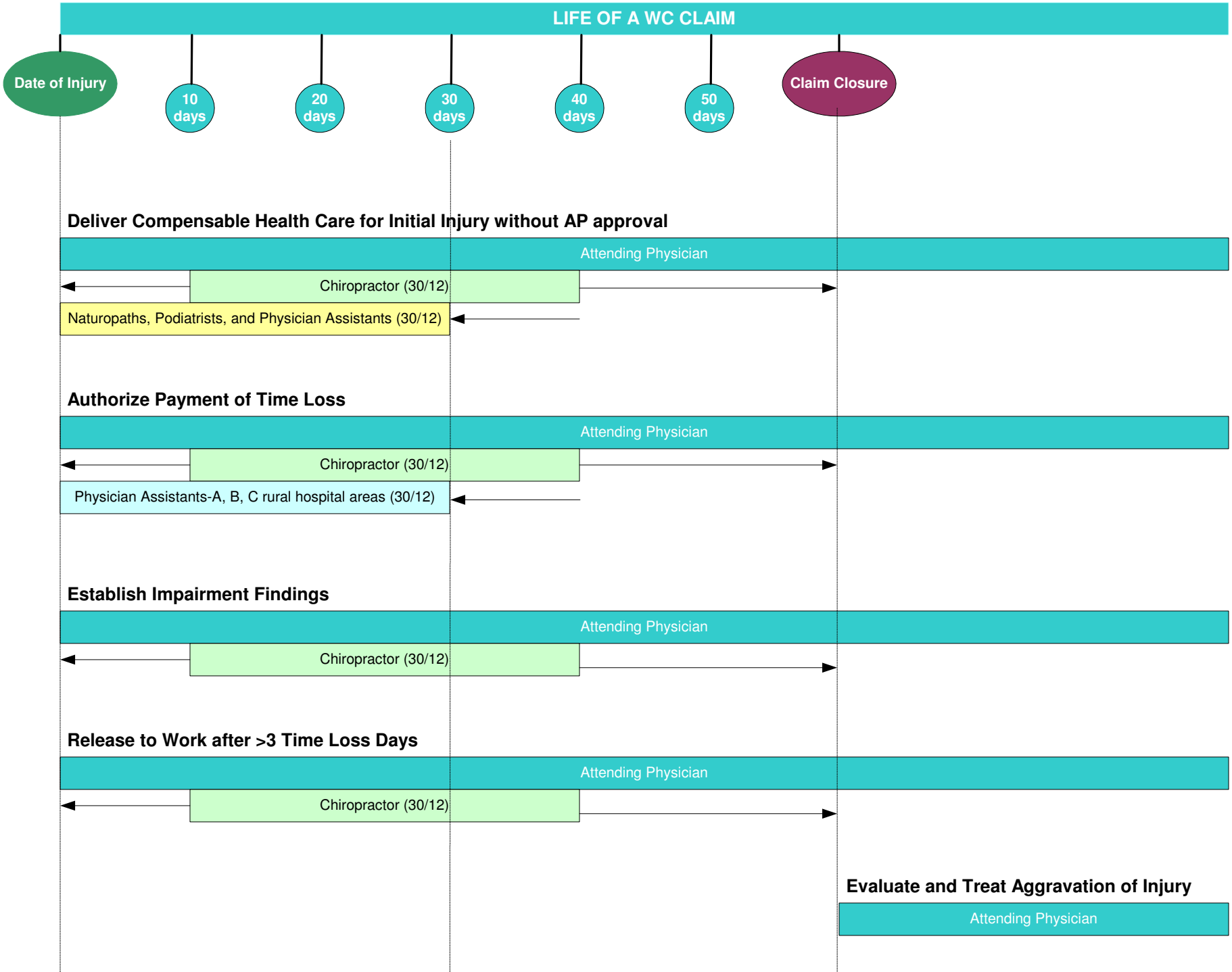
Selected Care Providers and Their Independent Authority to Treat Injured Workers
Non-MCO Enrolled Workers

Authority	Chiropractor		Naturopath Podiatrist		Physician Assistant	
Provide compensable medical services for initial injury or illness without authorization from an Attending Physician	Yes	ORS 656.005(12)(b)(B) May serve as an attending physician for a period of 30 days or 12 visits, whichever comes first, from the date of the initial chiropractor visit for the initial claim. Initial chiropractor visit can occur at any point within the claim. When the attending physician period ends, OAR 436-010-0230(4)(a)(c) applies: Ancillary or medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a occupational therapist, physical therapist, chiropractor, naturopath, acupuncturist, or podiatrist will be carried out under a treatment plan prepared and sent prior to the commencement of treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration.	Yes	ORS 656.245(2)(b)(A) For 30 days from the **date of injury** or 12 visits, whichever occurs first. After this time, they must obtain written authorization from the Attending Physician. OAR 436-010-0230(4)(a)(c)Ancillary or medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a occupational therapist, physical therapist, chiropractor, naturopath, acupuncturist, or podiatrist will be carried out under a treatment plan prepared and sent prior to the commencement of treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration.	Yes	ORS 656.245(2)(b)(A) For 30 days from the **date of injury** or 12 visits, whichever occurs first. After this time, they must obtain written authorization from the Attending Physician. OAR 436-010-0210 (5) Physician assistants working within the scope of their liscense and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(4)(a), nor under the direct control and supervision of the attending physician.
Authorize the payment of time loss (temporary disability)	Yes	If within the specified 30 day or 12 visit attending physician status period noted above.	No	ORS 656.245(2)(B) A medical service provider who is not an attending physician or authorized nurse practitioner cannot authorize the payment of temporary disability compensation.	No	ORS 656.245(2)(B) A medical service provider who is not an attending physician or authorized nurse practitioner cannot authorize the payment of temporary disability compensation. OAR 436-010-0210 Those physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim.
Establish impairment findings (permanent disability)	Yes	If within the specified 30 day or 12 visit attending physician status period noted above.	No	ORS 436-030-0020(2)(a) An authorized nurse practitioner's or attending physician's written statement regarding impairment is required.	No	ORS 436-030-0020(2)(a) An authorized nurse practitioner's or attending physician's written statement regarding impairment is required.
Release to work after 3 days of time loss	Yes	If within the specified 30 day or 12 visit attending physician status period noted above.	No	ORS 626.252(2)(c) The attending physician or authorized nurse practitioner will advise the insurer of the anticipated date of release to employment and the anticipated medically stationary date.	No	ORS 626.252(2)(c) The attending physician or authorized nurse practitioner will advise the insurer of the anticipated date of release to employment and the anticipated medically stationary date.
Provide compensable medical services for aggravation of injury or illness without authorization from an Attending Physician	No	Except when referred by an attending physician. Requires a treatment plan approved by the attending physician.	No	Except when referred by an attending physician. Requires a treatment plan approved by the attending physician.	No	Except when referred by an attending physician. Requires a treatment plan approved by the attending physician.

Appendix G

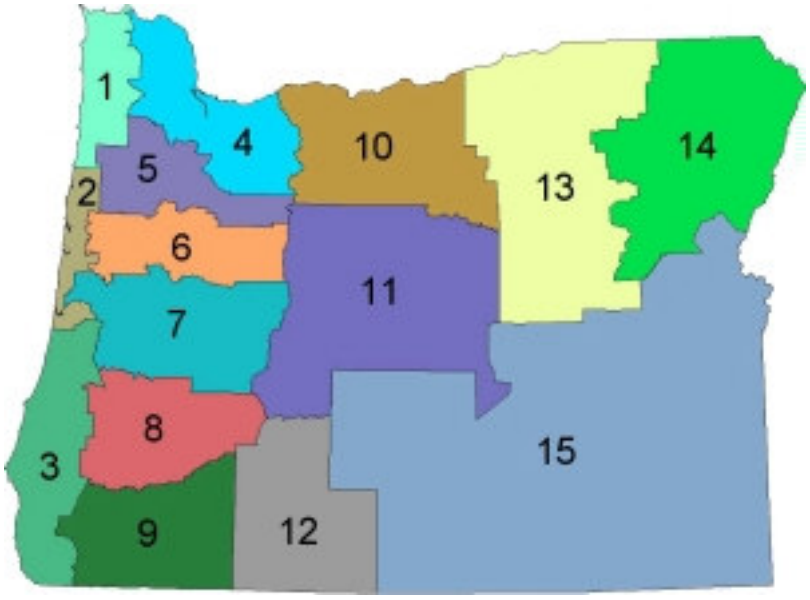
Statute and Rule Review

Selected Care Providers and Their Independent Authority to Treat Injured Workers--Non-MCO Enrolled Workers



Appendix H

MCO Geographic Service Area Map



1 North Coast
2 Central Coast
3 South Coast
4 Portland Metro
5 Salem
6 Linn-Benton
7 Eugene
8 Roseburg
9 Jackson- Josephine
10 The Dalles
11 Bend
12 Klamath Falls
13 Pendleton
14 LaGrande
15 Burns-Ontario

Appendix I

Oregon

Theodore R. Kulongoski, Governor

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Workers' Compensation Division
350 Winter St. NE
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1-800-452-0288, (503) 947-7810
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BULLETIN NO. 248 (Revised)
November 17, 2004

TO: Certified managed care organizations (MCOs), Oregon workers' compensation insurers, self-insured employers, and other interested parties

SUBJECT: MCO geographical service areas (GSAs)

The purpose of this bulletin is to notify all interested parties of the current MCO GSAs. This bulletin has been revised to delete four ZIP Codes that no longer exist (97460 in GSA 3 and 97821, 97831, and 97872 in GSA 13) in Exhibit A. No other substantive changes have been made. This bulletin supersedes Bulletin 248 issued January 10, 2003.

MCO GSAs

The Workers' Compensation Division has established 15 GSAs statewide. These service areas are established to ensure that MCO-governed workers will have reasonable and convenient access to medical care. Reasonable distance is defined in OAR 436-015-0030(3)(g) to be within 30 miles (one way) in urban areas and 60 miles (one way) in rural areas, considering normal patterns of travel. Each of the GSAs identified below is comprised of multiple postal zip codes which are specified on the attached listings in Exhibit A.

GSA	DESCRIPTION	GSA	DESCRIPTION
1	North Coast	9	Jackson/Josephine
2	Central Coast	10	The Dalles
3	South Coast	11	Bend
4	Portland Metro	12	Klamath Falls
5	Salem	13	Pendleton
6	Linn-Benton	14	LaGrande
7	Eugene	15	Burns/Ontario
8	Roseburg		

Authorization of MCO GSAs

In accordance with OAR 436-015-0035(2), the director shall designate an MCO's initial GSA and approve any expansions to the MCO's service area. An MCO's authorized service area will consist of all GSAs approved for that MCO. The GSAs for each MCO and all updates will be reflected in the division's listing of certified MCOs. This listing is available upon request. The division keeps this list and current GSA details on its Web site: www.wcd.oregon.gov/compliance/ioac/mco/mcoweb.html.

Please contact the Workers' Compensation Division at (503) 947-7821 with any questions regarding this bulletin or with requests for the MCO listing.

/s/ John L. Shilts
John L. Shilts, Administrator
Workers' Compensation Division

Attachments: Oregon map — Geographic Service Areas; Exhibit A — ZIP Codes for associated GSAs

Distribution: ID, S0, S4, S7, MC, ME, LY

EXHIBIT A

GSA	Associated ZIP Codes
1)	97102 97103 97107 97108 97110 97112 97118 97121 97122 97130 97131 97134 97135 97136 97138 97141 97143 97145 97146 97147 97149
2)	97341 97357 97364 97365 97366 97367 97368 97369 97372 97376 97380 97388 97390 97391 97394 97439 97453 97493 97498
3)	97406 97407 97411 97414 97415 97420 97423 97441 97444 97449 97450 97458 97459 ~~97460~~ 97464 97465 97466 97467 97473 97476 97491
4)	97004 97005 97006 97007 97008 97009 97010 97011 97013 97015 97016 97017 97018 97019 97022 97023 97024 97027 97028 97030 97034 97035 97036 97038 97042 97045 97048 97049 97051 97053 97054 97055 97056 97060 97062 97064 97067 97068 97070 97075 97076 97077 97078 97080 97106 97109 97113 97115 97116 97117 97119 97123 97124 97125 97132 97133 97140 97144 97201 97202 97203 97204 97205 97206 97207 97208 97209 97210 97211 97212 97213 97214 97215 97216 97217 97218 97219 97220 97221 97222 97223 97224 97225 97227 97228 97229 97230 97231 97232 97233 97236 97238 97239 97240 97242 97251 97253 97254 97255 97256 97258 97259 97266 97267 97268 97269 97271 97272 97280 97281 97282 97283 97286 97290 97291 97292 97293 97294 97296 97298 97299
5)	97002 97020 97026 97032 97071 97101 97111 97114 97127 97128 97137 97148 97301 97302 97303 97304 97305 97306 97307 97308 97309 97310 97311 97312 97313 97314 97325 97338 97342 97344 97346 97347 97350 97351 97358 97360 97361 97362 97371 97373 97375 97378 97381 97383 97384 97385 97392 97396
6)	97321 97322 97324 97326 97327 97329 97330 97331 97333 97335 97336 97339 97343 97345 97348 97352 97355 97359 97370 97374 97377 97386 97389 97456
7)	97401 97402 97403 97404 97405 97408 97409 97412 97413 97419 97424 97426 97427 97428 97430 97431 97434 97435 97436 97437 97438 97440 97446 97448 97451 97452 97454 97455 97461 97463 97472 97477 97478 97480 97482 97487 97488 97489 97490 97492 97499
8)	97410 97416 97417 97429 97432 97442 97443 97447 97457 97462 97469 97470 97479 97481 97484 97486 97494 97495 97496

GSA	Associated ZIP Codes								
9)	97497	97501	97502	97503	97504	97520	97522	97523	97524
	97525	97526	97527	97528	97530	97531	97532	97533	97534
	97535	97536	97537	97538	97539	97540	97541	97543	97544
10)	97001	97014	97021	97029	97031	97033	97037	97039	97040
	97041	97044	97050	97057	97058	97063	97065	97812	97823
	97830	97861	97874						
11)	97425	97701	97702	97707	97708	97709	97711	97712	97730
	97733	97734	97737	97739	97741	97750	97751	97752	97753
	97754	97756	97759	97760	97761				
12)	97601	97602	97603	97604	97621	97622	97623	97624	97625
	97626	97627	97632	97633	97634	97639	97731		
13)	97801	97810	97813	97817	97818	97820	~~97821~~	97825	97826
	~~97831~~	97835	97836	97838	97839	97843	97844	97845	97848
	97856	97859	97862	97864	97865	97868	97869	~~97872~~	97873
	97875	97880	97882	97886					
14)	97814	97819	97824	97827	97828	97833	97834	97837	97840
	97841	97842	97846	97850	97857	97867	97870	97876	97877
	97883	97884	97885	97905					
15)	97620	97630	97635	97636	97637	97638	97640	97641	97710
	97720	97721	97722	97732	97735	97736	97738	97758	97901
	97902	97903	97904	97906	97907	97908	97909	97910	97911
	97913	97914	97917	97918	97920				

Appendix J

MCO Summary

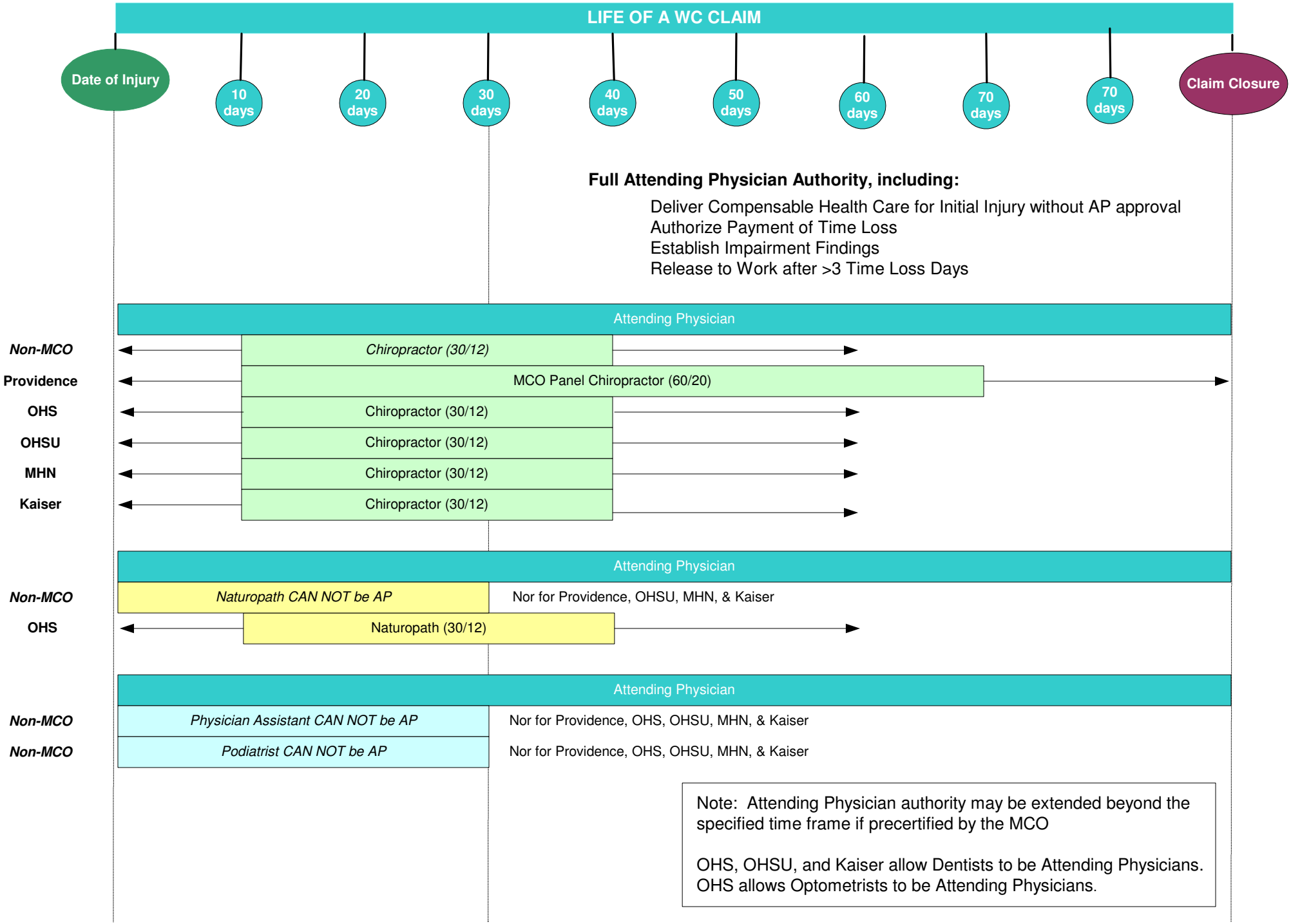
MCO business rules regarding Attending Physician (AP) status and utilization by select medical provider types.
Information concerning MCO rules were obtained from their plans as submitted to WCD and through direct contact..

	Chiropractors	Naturopaths	Physician Assistants	Podiatrists	Other notes
Non-MCO model	Can be AP for 30 days from first visit or 12 visits (whichever comes first). Can treat beyond limits by referral from AP.	Cannot be AP. Can treat for 1st 30 days after injury or 12 visits or by referral from AP.	Cannot be AP. Can treat for 1st 30 days or 12 visits or by referral from AP.	Cannot be AP. Can treat for 1st 30 days or 12 visits or by referral from AP.	
Providence	Can be AP. Tx beyond 60 days or 20 visits must be precertified.	Cannot be AP. Can treat, however, tx beyond 60 days or 20 visits must be precertified.	Cannot be AP. May treat 30/12. May authorize time loss (30 days) in rural areas only. No impairment ratings. No referrals or tx plans. Notes cosigned by AP.	Cannot be AP. Cannot authorize time loss. Tx by referral only.	APs can only be MD, DO, or MCO-panel CH.
OHS	Can be AP. Manipulations beyond 30/12 require precertification.	Can be AP. Manipulations beyond 30/12 require precertification.	Cannot be AP. May treat 30/12. May authorize time loss (30 days) in rural areas only.	No mention in plan.	Dentists and Optometrists can be AP with approval.
OHSU	Can be AP for 30 days from first visit or 12 visits. Can treat beyond limits by precertified referral from AP	Cannot be AP. Can treat by precertified referral from AP.	No mention in plan (app states cannot be AP)	Cannot be AP. Can treat by precertified referral from AP.	Dentists can be AP.
MHN – CareMark	Can be AP for 30 days from first visit or 12 visits. Allows extended AP status under individual payer contracts. Manipulations beyond 30 days require precertification.	Cannot be AP. Can treat by referral.	Cannot be AP. May treat 30/12. May authorize time loss (30 days) in rural areas only. Notes cosigned by AP.	No mention in plan.	
Kaiser	Can be AP for 30 days from first visit or 12 visits. Can treat beyond limits by referral from AP.	Cannot be AP. Can treat by referral.	Cannot be AP. Can treat by referral.	Cannot be AP. Can treat by referral.	Dentists can be AP.

Abbreviation Key: 30/12 – 30 days or 12 visits; AP – Attending Physician; CH – Chiropractor; DO – Doctor of Osteopathy; MCO – Managed Care Organization; MD – Medical Doctor; Tx - Treatment

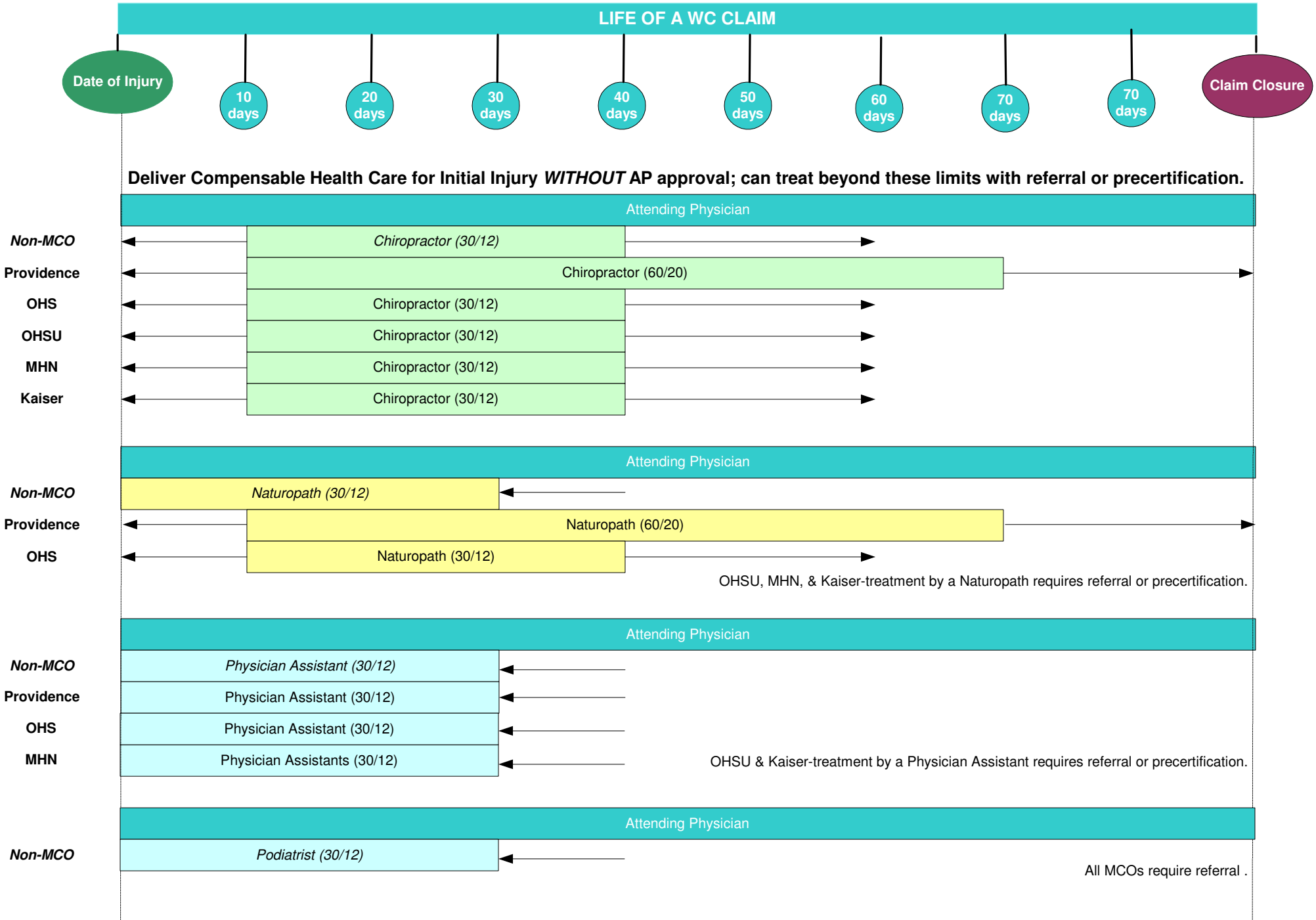
Appendix K1

Selected Care Providers and Their Independent Authority to Treat Injured Workers
MCO Enrolled Workers



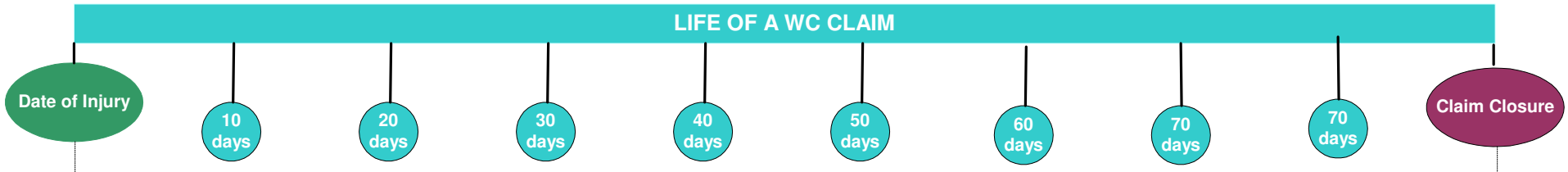
Appendix K2

Selected Care Providers and Their Independent Authority to Treat Injured Workers
MCO Enrolled Workers



Appendix K3

Selected Care Providers and Their Independent Authority to Treat Injured Workers
MCO Enrolled Workers



Authorize Payment of Time Loss

	Attending Physician
Non-MCO	*Physician Assistants-A, B, C rural hospital areas (30)*
Providence	Physician Assistants-A, B, C rural hospital areas (30)
OHS	Physician Assistants-A, B, C rural hospital areas (30)
OHSU	Physician Assistants-A, B, C rural hospital areas (30)
MHN	Physician Assistants-A, B, C rural hospital areas (30)
Kaiser	Physician Assistants-A, B, C rural hospital areas (30)

Chiropractors, Naturopaths, and Podiatrists when NOT functioning as an AP are NOT permitted to authorize time loss.

All PAs are able to Authorize payment of time loss for the first 30 days of the claim in A, B, C rural hospital areas. OAR 436-010-0210(4)

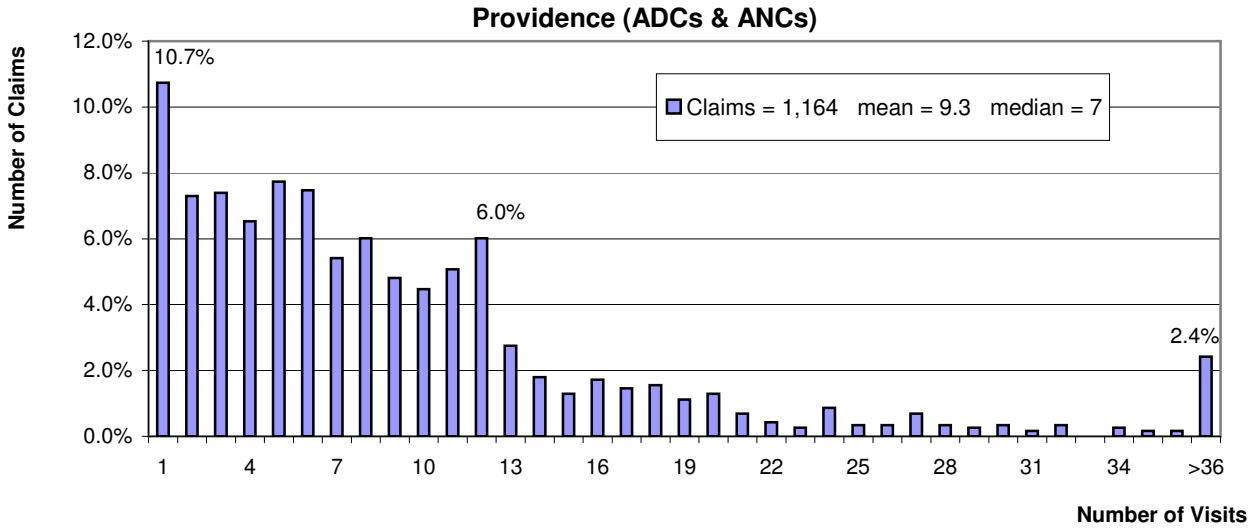
Type A rural hospitals - small & remote, have less than 50 beds, and more than 30 miles from the nearest hospital

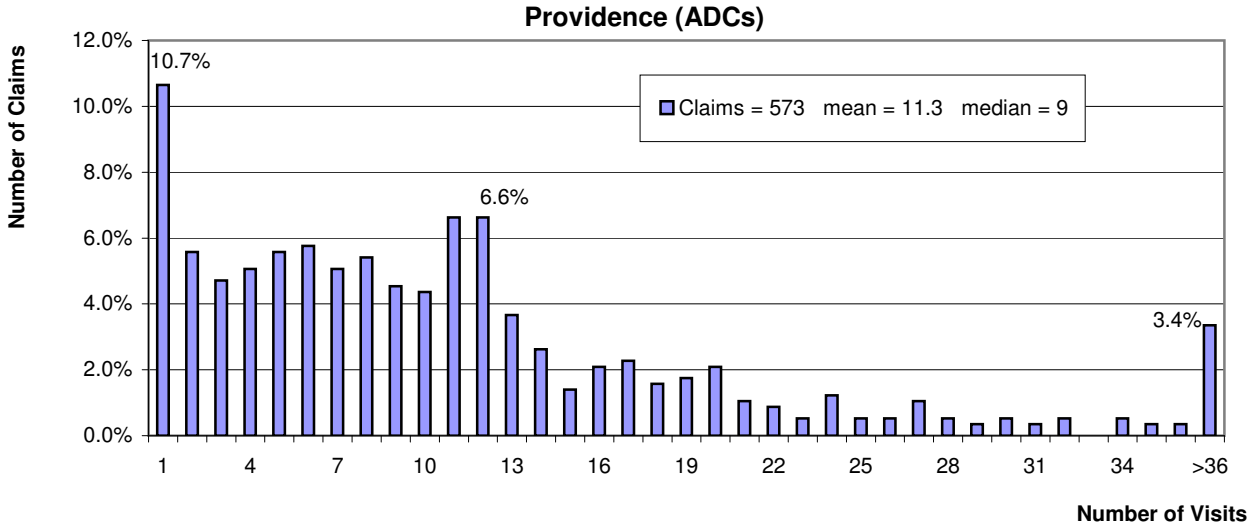
Type B rural hospitals - small & rural, have less than 50 beds, and 30 miles or less from the nearest hospital

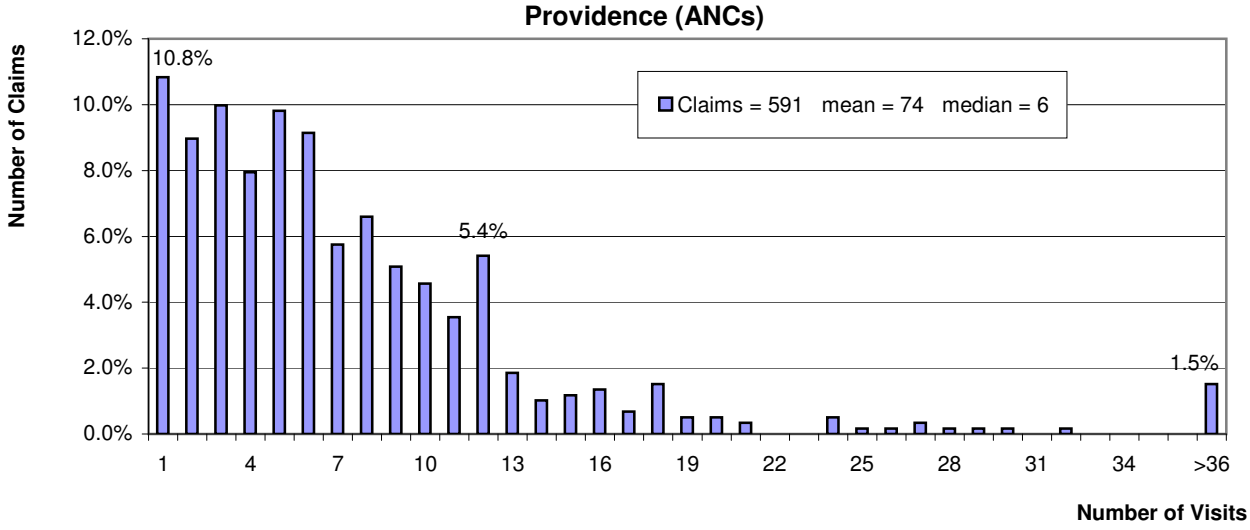
Type C rural hospitals - considered rural and have 50 or more beds

Appendix L1

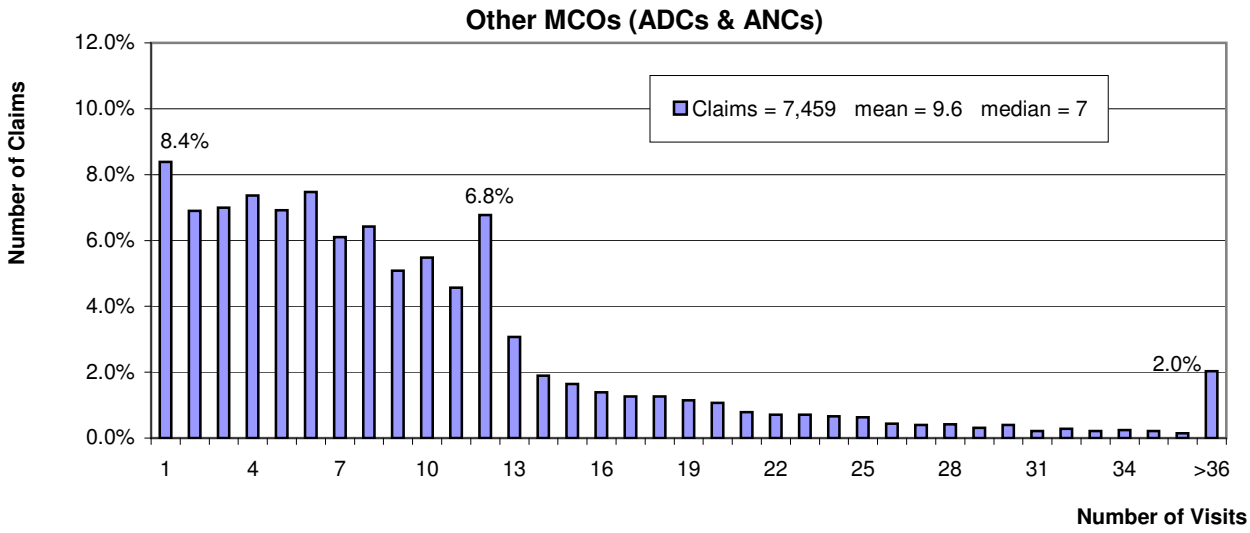
Care Provider study: Frequency of Visits by Claims, Chiropractors

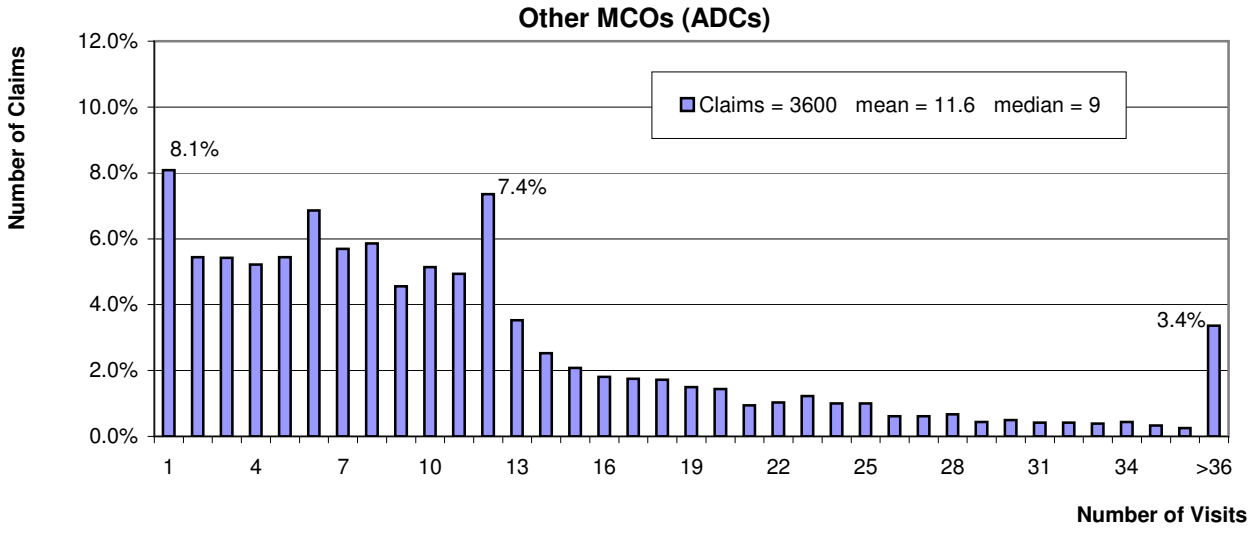


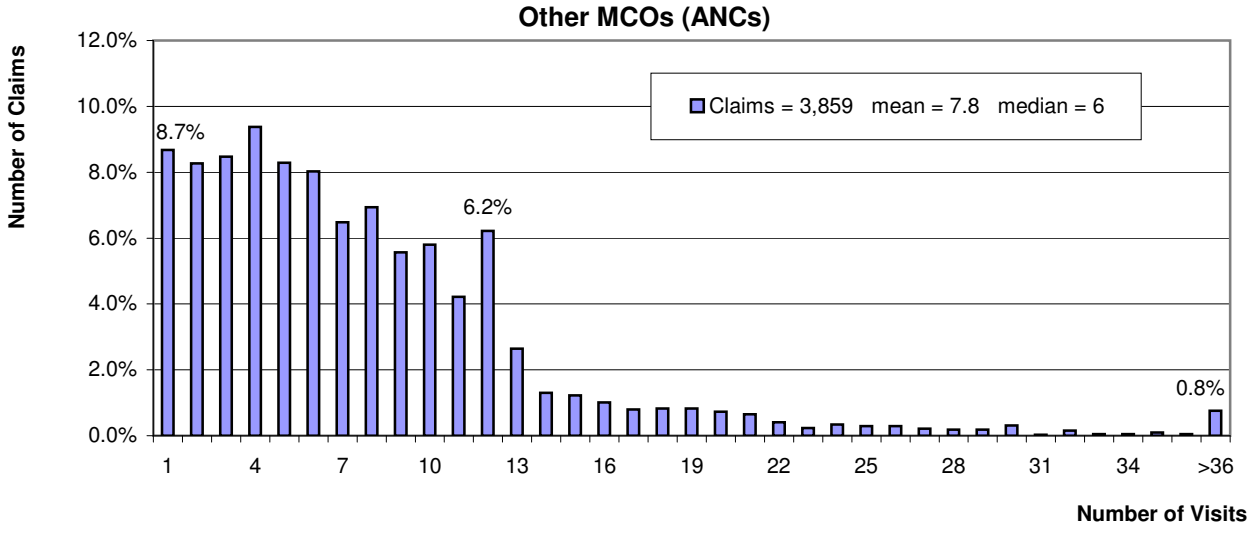




Care Provider study: Frequency of Visits by Claims, Chiropractors

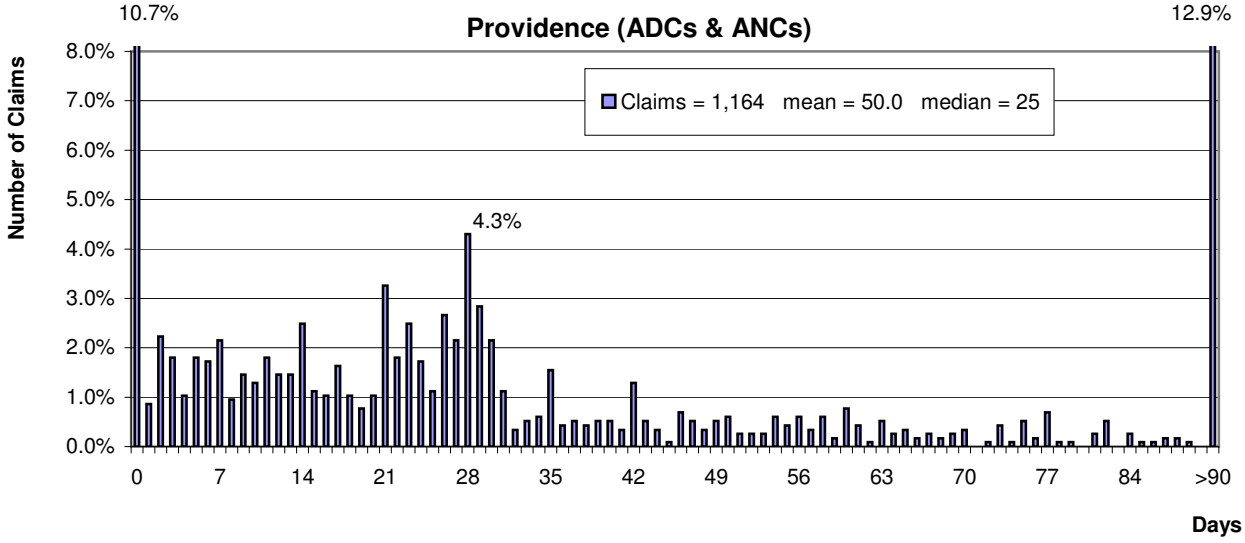


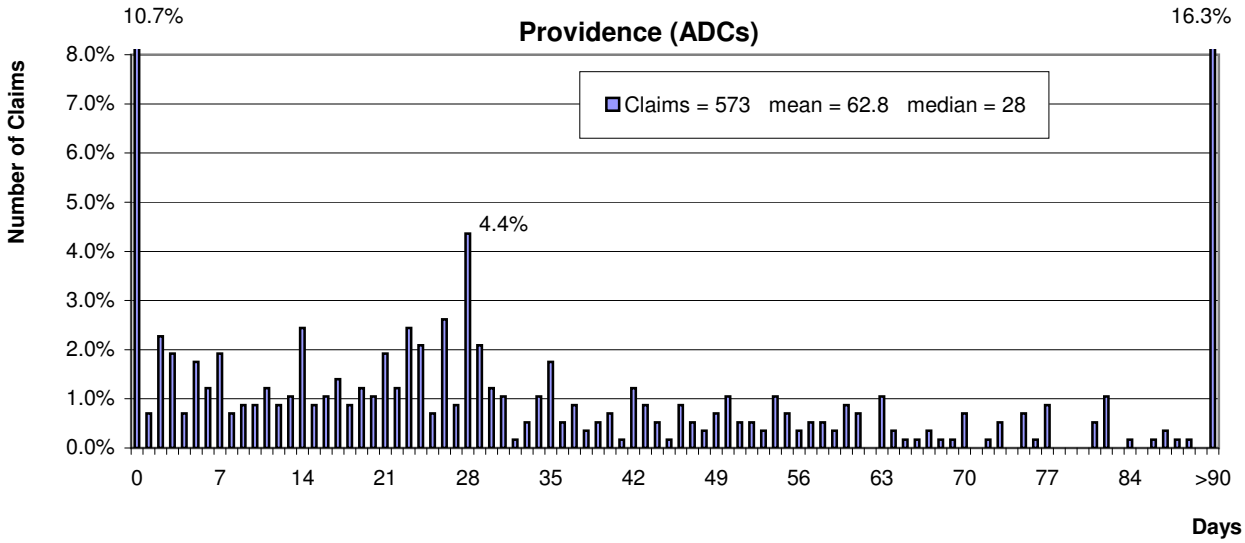


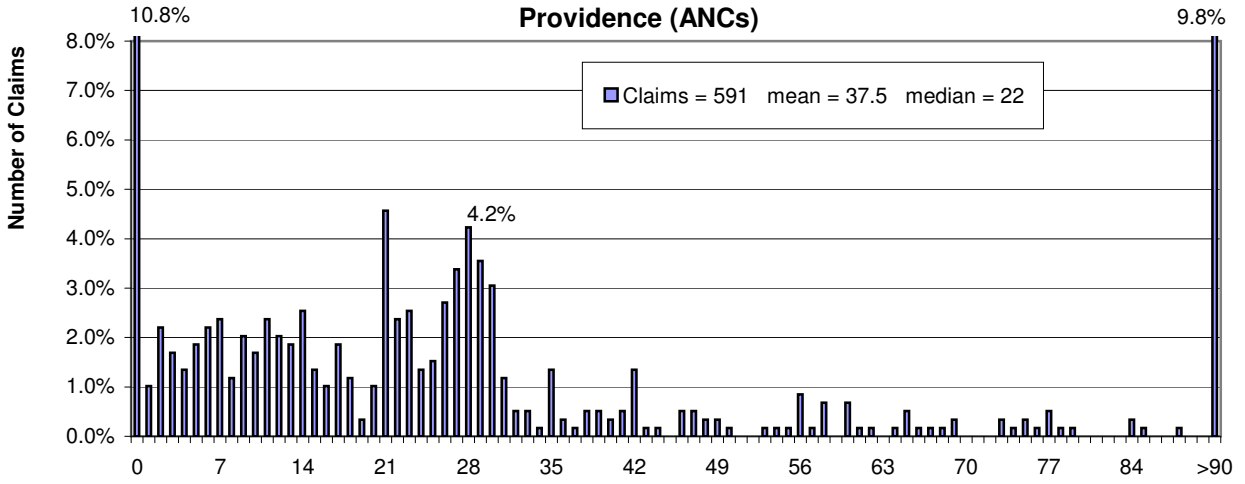


Appendix L2

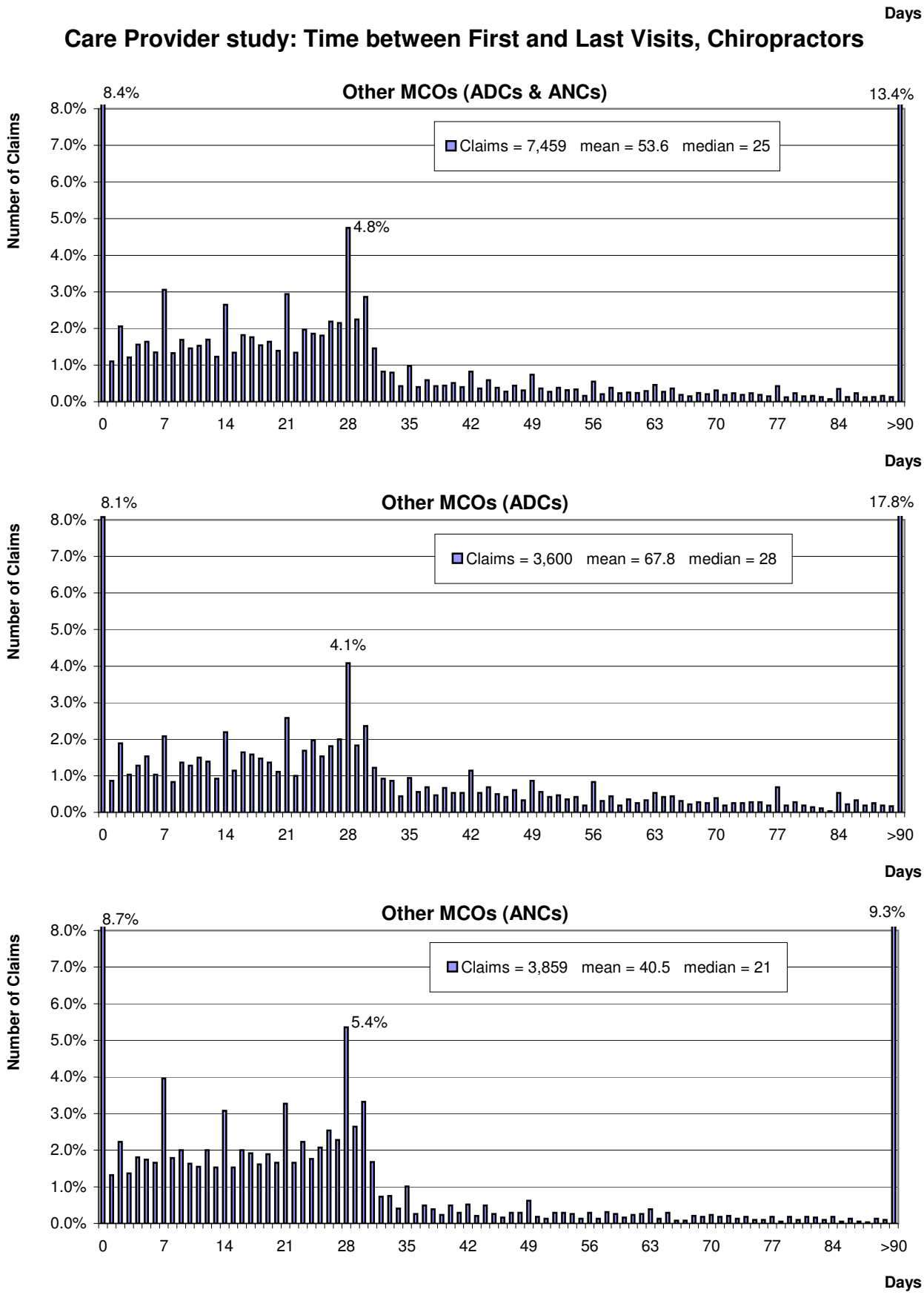
Care Provider study: Time between First and Last Visits, Chiropractors







Care Provider study: Time between First and Last Visits, Chiropractors



Appendix M

2006 - Provider Availability In Oregon Geographic Service Areas (GSAs) with Current MCO Provider Panels

These charts reflect the number of each care provider type, as provided by medical licensing boards, that is located in each GSA.
We have separated each type of provider, to show the provider availability in each GSA.

GSAs	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	***
Chiropractors	**16**	**14**	**21**	**633**	**84**	**145**	**71**	**19**	**90**	**12**	**77**	**11**	**15**	**10**	**8**	**-**
Kaiser	-	-	-	*152*	*22*	-	-	-	-	-	-	-	-	-	-	-
MHNW	*0*	-	-	*55*	*5*	-	-	-	-	*4*	-	-	-	-	-	*1*
OHS	*1*	*3*	*3*	*10*	*5*	*11*	*5*	*6*	*9*	*4*	*5*	*5*	*9*	*4*	*1*	*1*
Providence	*3*	*3*	-	*52*	*10*	*6*	*9*	-	*15*	*3*	-	-	*1*	-	-	*1*
Naturopaths	**5**	**4**	**2**	**399**	**17**	**5**	**23**	**1**	**20**	**7**	**16**	**1**	**2**	**2**	**0**	**-**
Kaiser	-	-	-	*35*	*6*	-	-	-	-	-	-	-	-	-	-	-
MHNW	*0*	-	-	*2*	*1*	-	-	-	-	*0*	-	-	-	-	-	*0*
OHS	*0*	*0*	*0*	*1*	*2*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Providence	*0*	*0*	-	*8*	*2*	*0*	*3*	-	*2*	*1*	-	-	*0*	-	-	*0*
Podiatrists	**2**	**2**	**4**	**68**	**16**	**4**	**7**	**3**	**13**	**3**	**6**	**2**	**3**	**3**	**2**	**-**
Kaiser	-	-	-	*10*	*4*	-	-	-	-	-	-	-	-	-	-	-
MHNW	*1*	-	-	*30*	*4*	-	-	-	-	*1*	-	-	-	-	-	*3*
OHS	*0*	*1*	*1*	*2*	*6*	*2*	*2*	*0*	*5*	*1*	*0*	*1*	*3*	*3*	*0*	*3*
Providence	*2*	*2*	-	*9*	*5*	*2*	*3*	-	*4*	*4*	-	-	*3*	-	-	*0*
Physician Assistants*	**4**	**9**	**5**	**389**	**61**	**26**	**45**	**14**	**55**	**10**	**58**	**10**	**12**	**3**	**18**	**-**
Kaiser	-	-	-	*61*	*13*	-	-	-	-	-	-	-	-	-	-	-
MHNW	*2*	-	-	*36*	*2*	-	-	-	-	*1*	-	-	-	-	-	*6*
OHS	*1*	*4*	*0*	*4*	*8*	*16*	*8*	*1*	*6*	*0*	*11*	*5*	*1*	*0*	*3*	*3*
Providence	*1*	*0*	-	*19*	*8*	*3*	*11*	-	*11*	*1*	-	-	*1*	-	-	*23*
Physical Therapists	**24**	**50**	**47**	**1582**	**246**	**98**	**311**	**38**	**244**	**39**	**204**	**39**	**26**	**21**	**17**	**-**
Kaiser	-	-	-	*64*	*14*	-	-	-	-	-	-	-	-	-	-	-
MHNW	*2*	-	-	*183*	*35*	-	-	-	-	*13*	-	-	-	-	-	*12*
OHS	*3*	*8*	*12*	*135*	*53*	*17*	*80*	*18*	*28*	*4*	*64*	*1*	*13*	*9*	*0*	*0*
Providence	*0*	*1*	-	*30*	*52*	*18*	*34*	-	*11*	*9*	-	-	*3*	-	-	*3*
Psychologists	**4**	**8**	**7**	**674**	**83**	**46**	**152**	**9**	**44**	**11**	**40**	**4**	**4**	**7**	**2**	**-**
Kaiser	-	-	-	*15*	*3*	-	-	-	-	-	-	-	-	-	-	-
MHNW	*0*	-	-	*21*	*1*	-	-	-	-	*0*	-	-	-	-	-	*2*
OHS	*0*	*1*	*1*	*12*	*4*	*7*	*8*	*2*	*3*	*0*	*0*	*0*	*0*	*0*	*0*	*3*
Providence	*1*	*1*	-	*19*	*5*	*4*	*7*	-	*5*	*3*	-	-	*0*	-	-	*0*

***Out of the providers listed above, all are required categories, except the Physician Assistants.**

***** GSA outside of Oregon and were recruited to assist workers in locating a provider closer to the worker's home residence.**

Appendix N

Care Provider Study

Providers per Geographic Service Area (GSA), First Quarter 2006 and 2004-2005 Recruitment Efforts

MCO Name: Kaiser On-The-Job

Current Number of Panel Providers

Provider Number/GSA	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total
04	152	35	10	61	64	15	337
05	22	6	4	13	14	3	62

MCO Recruitment Efforts 2004-2005

GSA Recruitment Efforts	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total Number of These Provider Types Recruited in Each GSA
04	0	0	0	0	0	0	0
05	0	0	0	0	0	0	0

Note: Kaiser on-the-job has full panel provider composition in both GSAs (4 & 5), and is not required to recruit additional providers
Note: GSAs *99, **98, & ***97 are not Oregon GSAs. MCOs are not authorized in these areas, but recruit these out-of-state providers to assist workers in locating a provider closer to the worker's home residence.

MCO Name: Managed Healthcare Northwest, Inc; CareMark Comp

Current Number of Panel Providers

Provider Number/GSA	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total
01	0	0	1	2	2	0	5
04	55	2	30	36	183	21	327
05	5	1	4	2	35	1	48
10	4	0	1	1	13	0	19
99*	1	0	3	6	12	2	24

MCO Recruitment Efforts 2004-2005

GSA Recruitment Efforts	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total Number of These Provider Types Recruited in Each GSA
01	10	0	3	0	0	0	13
04	0	0	0	0	0	0	0
05	0	9	0	0	0	0	9
10	0	12	3	0	0	16	31

Note: GSAs *99, **98, & ***97 are not Oregon GSAs. MCOs are not authorized in these areas, but recruit these out-of-state providers to assist workers in locating a provider closer to the worker's home residence.

Appendix N

Care Provider Study

Providers per Geographic Service Area (GSA), First Quarter 2006 and 2004-2005 Recruitment Efforts

MCO Name: Oregon Health Systems, Inc.

Current Number of Panel Providers

Provider Number/GSA	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total
01	1	0	0	1	3	0	5
02	3	0	1	4	8	1	16
03	3	0	1	0	12	1	17
04	10	1	2	4	135	12	164
05	5	2	6	8	53	4	78
06	11	0	2	16	17	7	53
07	5	0	2	8	80	8	103
08	6	0	0	1	18	2	27
09	9	1	5	6	28	3	52
10	4	0	1	0	4	0	9
11	5	0	0	11	64	0	80
12	5	0	1	5	1	0	12
13	9	0	3	1	13	0	26
14	4	0	3	0	9	0	16
15	1	0	0	3	0	0	4
98**	0	0	0	0	0	0	0
99*	0	0	1	0	0	0	0

MCO Recruitment Efforts 2004-2005

GSA Recruitment Efforts	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total Number of These Provider Types Recruited in Each GSA
01	15	7	4	1	0	3	30
02	11	5	4	1	4	3	28
03	8	2	1	4	0	3	18
04	0	5	10	3	3	1	22
05	0	5	0	2	2	0	9
06	0	6	5	0	0	0	11
07	0	10	3	0	0	1	14
08	0	4	3	0	1	4	12
09	0	11	0	1	0	6	18
10	0	1	7	0	0	11	19
11	0	10	3	0	0	21	34
12	0	1	2	0	1	1	5
13	0	4	0	0	0	3	7
14	0	1	0	1	0	3	5
15	3	0	0	0	0	0	3
15	3	0	0	0	0	0	3

Note: GSAs *99, **98, & ***97 are not Oregon GSAs. MCOs are not authorized in these areas, but recruit these out-of-state providers to assist workers in locating a provider closer to the worker's home residence.

Appendix N

Care Provider Study

Providers per Geographic Service Area (GSA), First Quarter 2006 and 2004-2005 Recruitment Efforts

MCO Name: Providence MCO

Current Number of Panel Providers

Provider Number/GSA	Chiropractor	Naturopath	Podiatrist	Physician Assistant	Physical Therapist	Psychologist	Total
01	3	0	2	1	`0	1	7
02	3	0	2	0	`1	1	7
04	52	8	9	19	30	19	137
05	10	2	5	8	52	5	82
06	6	0	2	3	18	4	33
07	9	3	3	11	34	7	67
09	15	2	4	11	11	5	48
10	3	1	4	1	9	3	21
13	1	0	3	1	3	0	8
99*	1	0	0	23	3	0	27

MCO Recruitment Efforts 2004-2005

GSA Recruitment Efforts	Chiropractor#	Naturopath#	Podiatrist	Physician Assistant	Physical Therapist##	Psychologist	Total Number of These Provider Types Recruited in Each GSA
01	2	2	2	0	0	2	8
02	0	2	3	0	0	2	7
04	0	0	0	0	0	0	0
05	0	0	0	1	1	0	2
06	0	4	3	0	0	0	7
07	0	0	0	0	0	0	0
09	0	0	0	0	0	0	0
10	0	3	3	0	0	0	6
13	0	0	1	0	0	0	1

#Providence contracts with Complementary Healthcare for these provider types (see summary) and has asked them to recruit.

##Providence MCO contracts with physical therapists at a facility level, "because hospitals are not required to submit staff rosters", the MCO is "not privy to how many therapists are employed by them." However, Providence is able to report individual therapists contracted through private facilities.

Note: Providence MCO recruited several provider types in GSA's 11 & 99. Providence recruited many nurse practitioners in 2004.

Note: GSAs *99, **98, & ***97 are not Oregon GSAs. MCOs are not authorized in these areas, but recruit these out-of-state providers to assist workers in locating a provider closer to the worker's home residence.

Appendix O

2004/2005 - MCO Panel Provider Terminations

Kaiser On-the-job:

Kaiser does not keep records regarding provider terminations, or why those terminations occurred. Kaiser does recall terminating two chiropractors from its panel in the past few years, one for billing injured workers for costs above the fee schedule and for referring off-panel, the other for questionable billing practices. Since 1991, Kaiser has had very few requests (10 or less) from providers wanting to become a contracted panel provider, and of those few, none were from a naturopathic provider. As Kaiser On-the-job MCO is part of the larger Kaiser Permanente group, it integrates its MCO recruitment efforts with the Kaiser Permanente HMO recruitment process.

Managed Healthcare Northwest (MHN MCO/CareMark Comp):

MHN MCO provided the following provider termination information, for terminations **in 2004 and 2005**:

Reason	Provider Types	Number of Providers
Involuntary Termination (Terminated by the MCO)	No Providers were terminated by MHN MCO	0
Voluntary Terminations (Providers choosing to terminate their participation with MHN MCO) as follows:		
In 2004-		
Provider Deceased	Chiropractor	1
	Naturopath	1
Left Practice	Chiropractor	1
	Physician Assistants	4
	Physical Therapists	16
Retired	Podiatrist	1
	Psychologists	2
Moved Outside of GSA	Podiatrist	1
	Psychologist	1
	Physical Therapist	1
Provider Choice	Psychologist	1

In 2005-		
Left Practice (Provider no longer works for the medical/clinical practice)	Naturopath	1
	Physician Assistants	3
	Psychologist	1
	Physical Therapists	18
Closed Practice	Podiatrist	1
Long-term Leave of Absence	Chiropractor	1
Moved Outside GSA	Physical Therapist	1
Changed Practice Type	Psychologist	1
Provider Choice	Chiropractor	1
	Podiatrist	1

MHN MCO said some providers do not give a reason for terminating their agreement. The MHN MCO Participating Provider Agreement allows contracted providers to terminate the agreement without supplying a reason, if the provider gives a 60-day notice of this termination. MHN MCO says that when these providers are asked why they want to terminate, the usual response is that no CareMark Comp enrolled workers have sought treatment, and therefore is no reason to continue their participation.

Oregon Health Systems, Inc. (OHS MCO):

OHS MCO provided records regarding the termination of providers. These providers may be terminated by the MCO, or they may wish to no longer contract with the MCO. The MCO provided these details **for 2005**:

Reason	Provider Types	Number of Providers
No Reason Provided	Physical/Occupational Therapist	1
	Podiatrist	1
	Psychologist	1
This data is when the provider decided to terminate and did not provide OHS with a reason for terminating. Six physicians and two osteopaths also terminated their contracts in 2005.		
OHS Termination	Nurse Practitioner/Physician Assistant	1
	Physicians	4

Provider Disagreed with OHS Rules Terms and Conditions:	Acupuncturist	1
	Chiropractors	2
Provider Deceased:	Naturopath	1
Provider No Longer Using *TIN:	Nurse Practitioner/Physician Assistant	5
	Optometrist	1
	Physical Therapist	1
	Psychologist	3
Provider Using Another *TIN:	Chiropractor	1
	Physical/Occupational Therapist	4
	Psychologist	1
Provider Relocated:	Acupuncturist	1
	Chiropractor	1
	Naturopath	2
Provider Retired	Physical/Occupational Therapist	3
	Podiatrist	1
Provider Termed from IPA**	Physical/Occupational Therapist	53

* TIN is the identification number used by clinics that employ these providers
* * IPA Means an Independent Physician Association

Providence MCO:

Providence provides its provider terminations information annually, as part of its annual reports. **For 2005**, Providence MCO's annual report lists one provider termination, initiated by the MCO.

Because of this study, Providence has also supplied this additional information:

- Regarding providers who have initiated a termination, Providence MCO does not keep records of these issues, and cannot provide us with this information. Providence MCO does not require these providers to supply a reason for termination, only that they provide adequate notification to the MCO. The MCO mentions that provider-initiated terminations are usually related to the provider moving out of the area, retiring, or not liking the workers' compensation reimbursement rate.

- Providence also mentions that physician assistants and physical therapists usually terminate because they leave a panel provider's practice or a contracted clinic.

- In the past five years, Providence MCO terminated two chiropractors in the Portland area. Providence MCO terminated one chiropractor because he refused to comply with contract requirements; and terminated the other one because she took a medical leave and never came back.

- Providence MCO recently terminated a podiatrist from Corvallis. It terminated this provider because the provider would not renew his board certification. The provider had not been board certified since 1997. He told the MCO several times that he would renew his certification, but never completed the renewal, Providence MCO decided against re-credentialing this provider.

Appendix P

June 12, 2006

Workers' Compensation Manager
«Company»
«Address»
«City» «State» «Zip»

Dear Employer,

The Governor has asked the Department of Consumer & Business Services, in conjunction with the Management-Labor Advisory Committee, to study the role of chiropractors and other care providers in the workers' compensation system. An important component of this study is to determine employer concerns regarding access to and delivery of workers' compensation health care. Some of the issues the study will address are:

- The accessibility of quality medical care for injured workers.
- Employer views regarding the need to change current workers' compensation practices, laws, or rules that address the provision of health care to injured workers.
- Adequacy of the process for selecting providers to deliver health care to injured workers.

The Department will be holding focus groups throughout the state to gather employers' perspectives on the above issues. We would like to know your perspective on the potential benefits and detriments to expanding the role of selected provider types in workers' compensation treatment. The information gathered from these focus groups will be presented in a report to the Governor and Legislators in the 2007 Legislative Session. The focus group meetings will last approximately 1 1/2 hours and will be made up of 10-15 people. There is a meeting scheduled in Salem on July 6 from 2:00 p.m. – 4:00 p.m. at the Labor and Industries Building, 350 Winter St, NE. Please consider joining us for this important meeting.

A representative from the Workers' Compensation Division will be calling you within the next two weeks to confirm attendance. If you have a colleague that you feel could provide valuable input regarding this subject, please let us know. For questions or more information, please contact Kara Olsen, (503) 947-7515 or kara.r.olsen@state.or.us. Thank you in advance for your consideration. We look forward to talking with you soon.

Sincerely,

John L. Shilts

John Shilts, Administrator
Workers' Compensation Division

Appendix Q

Care Provider Study

Employer Focus Group Questions

When an on-the-job injury or illness occurs at your place of business…

What has been your (Company's, Risk Mgr's) experience regarding your employee's access to and selection of Workers' Compensation Health Care Providers for the treatment of work related injuries and illnesses?

- Is the employee able to make a choice of health care provider without restriction?
- Describe any factors that might restrict your employee's ability to choose the health care provider they prefer?

What has been your (Company's, Risk Mgr's) experience with regard to employees changing Workers' Compensation Health Care Providers during the course of their treatment?

- What is your understanding of why employees decide to change Workers' Compensation Health Care Providers?
- If employees change Workers' Compensation Health Care Providers, how does this impact the continuity of their treatment and how does it influence their treatment outcomes?

Have you or your employees experienced a difference in your ability to access the care of any health care providers for workers' compensation care versus general health care? If so, how does the access differ?

- How do these differences influence the worker's treatment and treatment outcomes?
- Are there health care disciplines that are under-represented or over-represented in the Workers' Compensation treatment of your employee(s)? Which ones?
- Are employees concerned about access to specific types of health care providers for work related injuries and illnesses? What are their concerns?

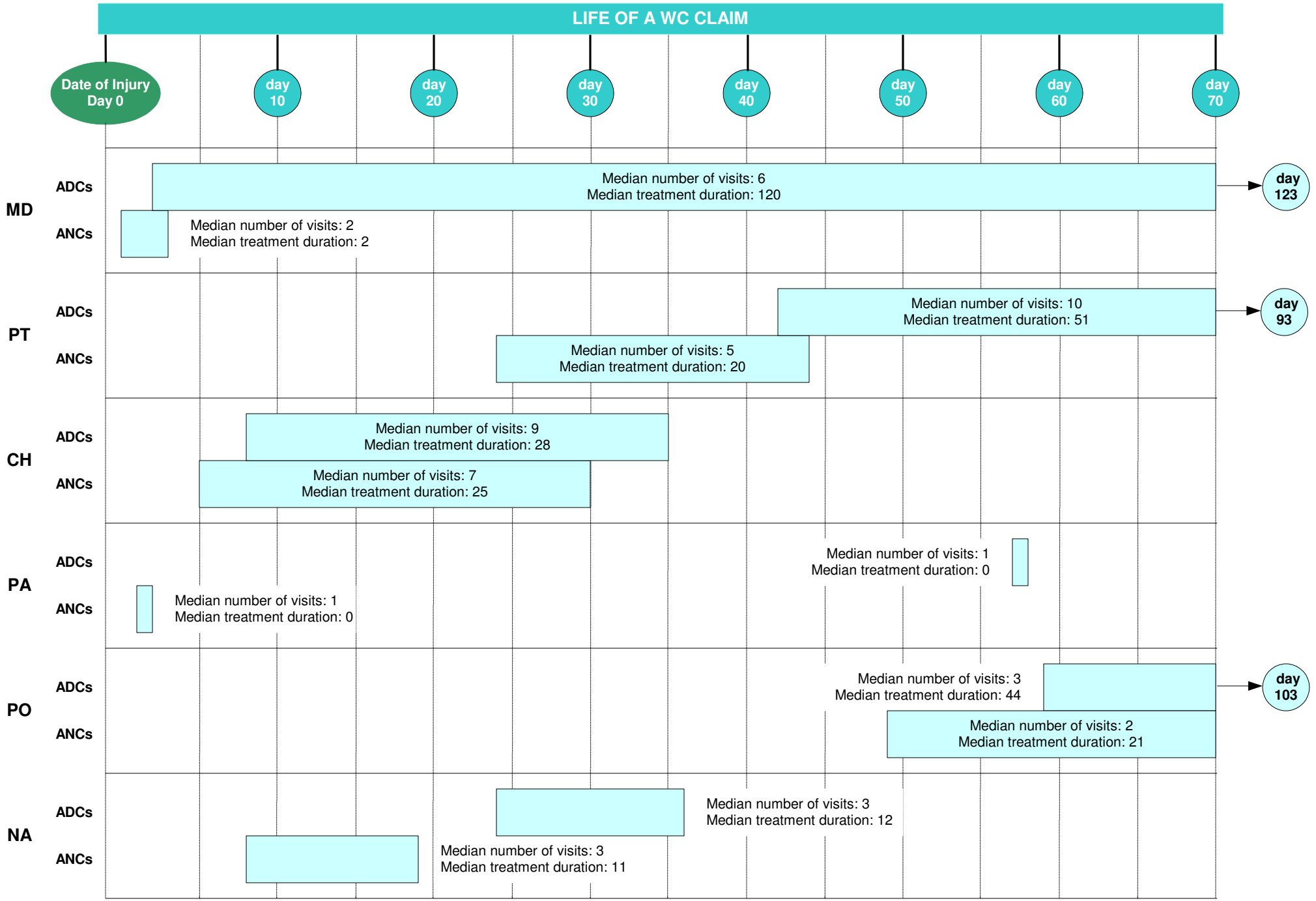
A ***workers' compensation attending physician*** is the health care provider who is most often responsible for the treatment of your employee's work-related injury or illness. Attending physicians deliver compensable health care, authorize payment of time loss, establish impairment findings (disability), and release workers back to work after time loss.

What are your (Company's, Risk Mgr's) thoughts about the impact (positive/negative) of expanding the range of workers' compensation health care providers who are able to function as attending physicians to include chiropractors, podiatrists, naturopaths, and physician's assistants, etc?

Appendix R

Treatment Patterns of Selected Care Providers - Oregon Workers' Compensation

MD, PT, CH - injury year 2002 -- PA, PO, NA - injury years 2000-2004



Appendix S

March 14, 2006

«first_name» «last_name» «addl_name»
«address1»
«address2»
«city» «state» «zip»

Dear «First_Name_Proper»:

We need your valuable input! The Department of Consumer & Business Services is planning to survey injured workers to determine and understand the choices they have in who provides medical treatment, how important these choices are, and how satisfied workers are with the experience.

We need your help determining if our survey is written in a way that provides us the information we're looking for. We would appreciate you taking the survey either on-line through the Internet at **https://www4.cbs.state.or.us/exs/imd/survey/intrv/iwhealthcaretest/index.cfm** or by filling out the attached copy and returning it to us in the envelope provided.

Additional questions have been added at the end of the survey specifically for those who are taking this "test" survey.

Please complete the survey by **March 29, 2006**. Your response will help us find out if this survey provides us the information we need to help injured workers and employers. If you have any questions, please contact Kara Olsen, (503) 947-7515 or kara.r.olsen@state.or.us.

Sincerely,

John Shilts, Administration
Workers' Compensation Division

Workers' compensation health care survey

Introduction

This survey is about the care you received for your work-related injury or illness. Your answers will help improve the care of injured workers.

We would like to know about the doctors and others who provided your treatment and what choices you had in selecting them. We'd also like to know how important these choices were to you, and how happy you were with your treatment.

The survey should take less than 10 minutes to complete.

Instructions

Before you answer, please read each question carefully. Some questions are about your care before your work-related injury or illness. Other questions are about the care you received for your work-related injury or illness.

There are at least a dozen different kinds of doctors and nurses who provide care for injured workers. These include doctors, nurse practitioners, chiropractors, dentists, and others.

This survey asks about your "primary health care provider," which is your doctor, nurse, dentist, or other care provider whom you visit for regular care.

The survey also asks about your "workers' compensation health care provider," which is the care provider who treated your work-related injury.

Please take care to note which of these each question is about. Your primary health care provider may also have served as your workers' compensation health care provider.

Some questions are about how important different choices were to you. Please check the box that best describes how you felt about the choice.

When you have completed the survey, please place it in the enclosed postage-paid envelope and mail to:

Oregon Department of Consumer and Business Services
Workers' Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

Thank you.

DEPARTMENT OF CONSUMER & BUSINESS SERVICES
440-3933 (3/06/COM)

Continued

Please enter the survey identification number from your cover letter: _____

For Question 1, think about the health care you received *before* your work-related injury or illness.

Question 1

What type of general health care insurance did you have at the time of your work-related injury or illness?

- ☐ Health care insurance purchased by you, your employer, your union, or through your spouse's employer or union
- ☐ Public health insurance (Medicare, Oregon Health Plan, etc.)
- ☐ I had no general health care insurance

Were you receiving services from a ***primary health care provider*** *before* your work-related injury or illness? (Your ***primary health care provider*** is the doctor, nurse, or other care provider you visited most often for regular health care *before* your work-related injury or illness.)

☐ Yes ☐ No

If you checked "No," skip to Question 2.

If you checked "Yes," please write the name of the ***primary health care provider*** you were seeing *before* your work-related injury or illness here:

_____

What type of health care provider is he or she? If you aren't sure, check "Don't know." **Please choose only one.**

- ☐ Medical doctor – includes physicians (M.D.) and osteopaths (D.O.)
- ☐ Nurse practitioner
- ☐ Chiropractor
- ☐ Naturopath
- ☐ Physician assistant with supervising medical doctor
- ☐ Physical therapist
- ☐ Optometrist
- ☐ Occupational therapist
- ☐ Radiologist
- ☐ Psychologist
- ☐ Dentist
- ☐ Podiatrist
- ☐ Acupuncturist
- ☐ Other: _____
- ☐ Don't know

Were you able to continue seeing this **same *primary health care provider*** for the treatment of your work-related injury or illness?

☐ Yes ☐ No ☐ Don't know/don't remember

How important was it to continue seeing your ***primary health care provider?***

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

Continued

For Question 2, think about the health care you received *after* your work-related injury or illness.

Question 2

A ***workers' compensation health care provider*** is the health care provider who was most often responsible for the treatment of your work-related injury or illness.

Write the name of the ***workers' compensation health care provider*** you saw here:

_____

What type of health care provider is he or she? If you aren't sure, check "Don't know." **Please choose only one.**

- ☐ Medical doctor – includes physicians (M.D.) and osteopaths (D.O.)
- ☐ Nurse practitioner
- ☐ Chiropractor
- ☐ Naturopath
- ☐ Physician assistant with supervising medical doctor
- ☐ Physical therapist
- ☐ Optometrist
- ☐ Occupational therapist
- ☐ Radiologist
- ☐ Psychologist
- ☐ Dentist
- ☐ Podiatrist
- ☐ Acupuncturist
- ☐ Other: _____
- ☐ Don't know

For the treatment of your work-related injury or illness, were you able to choose your ***workers' compensation health care provider***?

☐ Yes ☐ No ☐ Don't know/don't remember

If you checked "No" or "Don't know/don't remember," please tell us why you did *not* have a choice about which ***workers' compensation health care provider*** you could see for the treatment of your work-related injury or illness. **Please check all that apply**:

- ☐ The ***primary health care provider*** I saw *before* my injury does not treat workers' compensation cases.
- ☐ The treatment requirements were beyond what my ***primary health care provider*** could do for me.
- ☐ I was treated by my employer's on-site ***workers' compensation health care provider***.
- ☐ I had to choose a ***workers' compensation health care provide***r from a list provided to me.
- ☐ I was originally treated by the ***workers' compensation health care provider*** of my choice, but he or she referred me to a different provider.
- ☐ Other: _____

How important was it to be able to choose your ***workers' compensation health care provider***?

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

Continued

If you checked "Yes," when choosing the ***workers' compensation health care provider*** for your work-related injury or illness, what was most important to you in making your choice? **Please choose only one answer.**

- ☐ The training or experience of the ***workers' compensation health care provider***.
- ☐ He or she was my ***primary health care provider*** prior to my work-related injury or illness.
- ☐ How close the ***workers' compensation health care provider*** was to my home.
- ☐ How close the ***workers' compensation health care provider*** was to my work.
- ☐ How quickly I was able to see the ***workers' compensation health care provider***.
- ☐ Other: _____

How important was it to be able to choose your ***workers' compensation health care provider***?

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

For Question 3, think about the health care you received *after* your work-related injury or illness.

Question 3

After beginning treatment for your work-related injury or illness, were you required by the workers' compensation insurer or your employer to change your ***workers' compensation health care provider***? (A ***workers' compensation health care provider*** is the health care provider who was most often responsible for the treatment of your work-related injury or illness.)

☐ Yes ☐ No ☐ Don't know/don't remember

If you checked "No," or "Don't know/don't remember," skip to Question 4.

If you checked "Yes," please indicate the reason you were required to change your ***workers' compensation health care provider***. **Please choose only one.**

- ☐ My ***workers' compensation health care provider*** could no longer treat me because of limits imposed by workers' compensation law.
- ☐ My ***workers' compensation health care provider*** was not on the managed care organization (MCO) provider list.
- ☐ I needed to see a specialist.
- ☐ I am unsure.
- ☐ Other: _____

Please tell us how satisfied you were with the required change:

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Continued

Question 4

During treatment of your work-related injury or illness, were you enrolled in a managed care organization (MCO)?

☐ Yes ☐ No ☐ Not sure

If you checked "No" or "Not sure," skip to Question 5.

If you checked "Yes," were you able to continue seeing **the same *workers' compensation health care provider*** *after* enrollment as you had seen before enrollment?

☐ Yes ☐ No

How important was it to continue seeing the same ***workers' compensation health care provider?***

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

Question 5

Please tell us about your level of satisfaction with the following:

a. How satisfied were you with the choice of ***workers' compensation health care providers*** available to you?

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Comment: _____

b. How satisfied were you with the quality of care you received from the ***workers' compensation health care provider*** you saw?

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Comment: _____

c. How satisfied were you with your ability to see a ***workers' compensation health care provider*** qualified to treat your condition?

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Comments: _____

_____

_____

_____

Continued

Question 6

Please share any additional comments or suggestions you may have about the care you received for your work-related injury or illness:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this survey about the care you received for your work-related injury or illness. Your answers will help us improve the care of injured workers.

Oregon Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
(503) 378-8254
Web site: wcd.oregon.gov

Appendix U

Questions about the Worker Care Provider Survey

1. Was the purpose of the survey clearly explained in the cover letter? ❑Yes ❑No
2. Was the cover letter: ❑Too long ❑Too short ❑Just right
3. Were the instructions clear as to how to fill out the survey? ❑Yes ❑No
4. Were the instructions for each question clear? ❑Yes ❑No
    a. If **no**, what was unclear?
5. Were the questions written clearly? ❑Yes ❑No
    a. If **no**, please tell us which questions were difficult to understand?
6. Is the appearance of the survey too crowded? ❑Yes ❑No
7. Is the question format easy to follow? ❑Yes ❑No
    a. If **no**, please tell us what made the format difficult to follow?
8. Are the questions meaningful to you as an injured worker? ❑Yes ❑No
    a. If **no**, what would have made the questions more meaningful to you?
9. If you were not a part of this test group and you received this survey in the mail, would you have filled it out? ❑Yes ❑No
    a. If **no**, what would convince you to complete the survey?
10. What didn't we ask that you think is relevant?
11. Do you have any suggested changes to this survey?

Thank you again for your help in our survey development.

Appendix V

Oregon
Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE, Room 27
PO Box 14480
Salem, OR 97309-0405
1-800-452-0288, (503) 947-7810
TTY (503) 947-7993
www.wcd.oregon.gov

June 5, 2006

«FIRST» «LAST» «SUF»
«ADDRESS_1»
«ADDRESS_2»
«CITY» «STATE» «ZIP»

Dear «First_Name_Proper»:

A few days from now, you will receive in the mail a request to fill out a brief questionnaire for an important study being conducted by the State of Oregon, Department of Consumer & Business Services.

It concerns the health care you received before and during the treatment of your work-related injury or illness. We want to better understand:

- The choices you had in who provided your health care treatment
- How important these choices were to you
- How satisfied you were with the experience

I am writing in advance because we have found many people like to know ahead of time that they will be contacted. The study is important in that it will look for ways to improve the health care of injured workers.

Thank you for your time and consideration. It's only with the generous help of people like you that our study can be successful.

Sincerely,

John L. Shilts

John Shilts, Administrator
Workers' Compensation Division

Appendix W

Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE, Room 27
PO Box 14480
Salem, OR 97309-0405
1-800-452-0288, (503) 947-7810
TTY (503) 947-7993
www.wcd.oregon.gov

June 9, 2006

«FIRST» «LAST» «SUF»
«ADDRESS_1»
«ADDRESS_2»
«CITY» «STATE» «ZIP»

Identification number: «ID»

Dear «First_Name_Proper»,

Workers, we need your input! The Department of Consumer and Business Services is conducting a survey of workers to find out about the medical care they received before and during the treatment of their work-related injury or illness. We want to better understand the choices that you had in:

- Who provided your medical treatment
- How important these choices were to you
- How satisfied you were with the experience

Your responses will be used to help legislators make decisions about the medical care of injured workers. The identification number at the top of the page will be used to follow-up on unreturned surveys. Your responses will be kept **strictly confidential** and will not affect any current or future workers' compensation benefits. The results will be reported only in summary form and not as individual responses.

The survey should take less than 10 minutes to complete. You may take the survey on line through the Internet at **http://www.wcd.oregon.gov/injured_wkr/healthcare.html** or you may complete this paper version and return it in the envelope provided.

Please complete the survey by **June 29, 2006**.

Thank you for your valuable time in completing this survey. Your input is important to us. If you have any questions, please contact the Benefit Consultation Unit at 800-452-0288 or workcomp.questions@state.or.us.

Sincerely,

John Shilts
Workers' Compensation Division Administrator

Si necesita asistencia en español para completa esta encuesta, comuníquese con Mary Lou Garcia al (503) 947-7533, Matt West al (503) 947-7655, o con Vio Rubiani al (503) 947-7560.

Если вы нуждаетесь в помощи при заполнении обозрения, пожалуйста позвоните Вере Гришиной по телефону: (503) 947-7639.

Workers' compensation health care survey

Introduction

This survey is about the care you received for your work-related injury or illness. Your answers will help improve the care of injured workers.

We would like to know about the doctors and others who provided your treatment and what choices you had in selecting them. We'd also like to know how important these choices were to you, and how happy you were with your treatment.

The survey should take less than 10 minutes to complete.

Instructions

Before you answer, please read each question carefully. Some questions are about your care before your work-related injury or illness. Other questions are about the care you received for your work-related injury or illness.

There are at least a dozen different kinds of doctors and nurses who provide care for injured workers. These include doctors, nurse practitioners, chiropractors, dentists, and others.

This survey asks about your "primary health care provider," which is your doctor, nurse, dentist, or other care provider whom you visit for regular care.

The survey also asks about your "workers' compensation health care provider," which is the care provider who treated your work-related injury.

Please take care to note which health care provider each question is about. Your primary health care provider may also have served as your workers' compensation health care provider.

Some questions are about how important different choices were to you. Please check the box that best describes how you felt about the choice.

When you have completed the survey, please place it in the enclosed postage-paid envelope and mail to:

Oregon Department of Consumer and Business Services
Workers' Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

Thank you.

Please enter the survey identification number from your cover letter:

ID _____

For Questions 1 through 6, think about the health care you received** before **your work-related injury or illness.

1. What type of general health care insurance did you have at the time of your work-related injury or illness?

- ☐ Health care insurance purchased by you, your employer, your union, or through your spouse's employer or union
- ☐ Public health insurance (Medicare, Oregon Health Plan, etc.)
- ☐ I had no general health care insurance

2. Were you receiving services from a ***primary health care provider*** *before* your work-related injury or illness? (Your ***primary health care provider*** is the doctor, nurse, or other care provider you visited most often for regular health care *before* your work-related injury or illness.)

☐ Yes ☐ No

If you checked "No," skip to Question 7 on page 3.

3. What type of health care provider is your ***primary health care provider***? If you aren't sure, check "Don't know." **Please choose only one.**

- ☐ Medical doctor – includes physicians (M.D.) and osteopaths (D.O.)
- ☐ Nurse practitioner
- ☐ Chiropractor
- ☐ Naturopath
- ☐ Physician assistant with supervising medical doctor
- ☐ Physical therapist
- ☐ Optometrist
- ☐ Occupational therapist
- ☐ Radiologist
- ☐ Psychologist
- ☐ Dentist
- ☐ Podiatrist
- ☐ Acupuncturist
- ☐ Other: _____
- ☐ Don't know

4. How important was it to continue seeing your ***primary health care provider*** for the treatment of your work-related injury or illness?

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

5. Did you continue seeing your ***primary health care provider*** for the treatment of your work-related injury or illness?

☐ Yes ☐ No

If you checked "Yes," skip to Question 12 on page 4.

Continued

6. **If you checked "No"** on Question 5, please tell us why you did not continue seeing your ***primary health care provider*** for the treatment of your work-related injury or illness? **Please check all that apply.**

- ☐ I did not want to see my ***primary health care provider***.
- ☐ My ***primary health care provider*** does not treat workers' compensation cases.
- ☐ The treatment requirements were beyond what my ***primary health care provider*** could do for me.
- ☐ I was required to see another health care provider.
- ☐ Other: _____

Now, think about the health care you received after *your work-related injury or illness.*

7. What type of ***workers' compensation health care provider*** did you see for the treatment of your work-related injury or illness? (A ***workers' compensation health care provider*** is the health care provider who was most often responsible for the treatment of your work-related injury or illness.) If you aren't sure, check "Don't know." **Please choose only one.**

- ☐ Medical doctor – includes physicians (M.D.) and osteopaths (D.O.)
- ☐ Nurse practitioner
- ☐ Chiropractor
- ☐ Naturopath
- ☐ Physician assistant with supervising medical doctor
- ☐ Physical therapist
- ☐ Optometrist
- ☐ Occupational therapist
- ☐ Radiologist
- ☐ Psychologist
- ☐ Dentist
- ☐ Podiatrist
- ☐ Acupuncturist
- ☐ Other: _____
- ☐ Don't know

8. Please tell us how the individual you identified in Question 7 became your ***workers' compensation health care provider***. **Please check all that apply.**

- ☐ I was referred by my ***primary health care provider.***
- ☐ I was told by my employer or workers' compensation insurer to see this health care provider.
- ☐ I had to choose a ***workers' compensation health care provider*** from a list provided to me.
- ☐ I was able to choose whoever I wanted to be my ***workers' compensation health care provider***; my choices were not limited.
- ☐ This ***workers' compensation health care provider*** was the only one in my area that could treat my condition.
- ☐ Other: _____

Continued

9. For the treatment of your work-related injury or illness, did you feel that you had a choice in who became your ***workers' compensation health care provider***?

☐ Yes ☐ No ☐ Don't know/don't remember

If you checked "No," skip to Question 11 on this page.

10. When choosing the ***workers' compensation health care provider*** for your work-related injury or illness, what was most important to you in making your choice? **Please choose only one.**

☐ The training or experience of the ***workers' compensation health care provider***.

☐ How close the ***workers' compensation health care provider*** was to my home.

☐ How close the ***workers' compensation health care provider*** was to my work.

☐ How quickly I was able to see the ***workers' compensation health care provider***.

☐ Other: _____

11. How important was it to be able to choose your ***workers' compensation health care provider***?

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

12. After beginning treatment for your work-related injury or illness, were you required by the workers' compensation insurer or your employer to change your ***workers' compensation health care provider***? (A ***workers' compensation health care provider*** is the health care provider who was most often responsible for the treatment of your work-related injury or illness.)

☐ Yes ☐ No ☐ Don't know/don't remember

If you checked "No" or "Don't know/don't remember," skip to Question 15 on page 5.

13. If you checked "Yes" on Question 12, please indicate the reason you were required to change your ***workers' compensation health care provider***. **Please choose only one.**

☐ My ***workers' compensation health care provider*** could no longer treat me because of limits imposed by workers' compensation law.

☐ My ***workers' compensation health care provider*** was not on the managed care organization (MCO) provider list. (A workers' compensation insurer may contract with an MCO to provide medical services. The MCO typically provides a list of health care providers from which the worker can choose).

☐ I needed to see a specialist.

☐ I am unsure.

☐ Other: _____

Continued

14. Please tell us how satisfied you were with the required change:

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

15. During treatment of your work-related injury or illness, were you enrolled in a managed care organization (MCO)? (A workers' compensation insurer may contract with an MCO to provide medical services. The MCO typically provides a list of health care providers from which the worker can choose).

☐ Yes ☐ No ☐ Don't know/don't remember

If you checked "No" or "Don't know/don't remember," skip to Question 18 on this page.

16. If you checked "Yes" on Question 15, were you able to continue seeing **the same *workers' compensation health care provider*** after enrollment in the MCO as you had seen before enrollment?

☐ Yes ☐ No

17. How important was it to continue seeing the same ***workers' compensation health care provider?***

☐ Very important ☐ Fairly important ☐ Fairly unimportant ☐ Unimportant

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For Question 18, think about your overall experience receiving care for your work-related injury or illness.

18. Please tell us about your level of satisfaction with the following:

a. How satisfied were you with the choice of ***workers' compensation health care providers*** available to you?

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Comment:_____

b. How satisfied were you with the quality of care you received from the ***workers' compensation health care provider*** you saw?

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Comment:_____

c. How satisfied were you with your ability to see a ***workers' compensation health care provider*** qualified to treat your condition?

☐ Satisfied ☐ Fairly satisfied ☐ Fairly unsatisfied ☐ Unsatisfied

Comments: _____

_____

_____

Continued

19. Please share any additional comments or suggestions you may have about the care you received for your work-related injury or illness:

Please remember to enter your survey identification number on page 1.

Thank you for completing this survey about the care you received for your work-related injury or illness. Your answers will help improve the care of injured workers.

Oregon Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
(503) 947-7810 or toll-free in Oregon (800) 452-0288
Web site: wcd.oregon.gov

Appendix Y

Injured worker survey responses and confidence intervals

Survey responses, cross tabulations, and confidence intervals by survey question

(Note: For all confidence intervals, a confidence level of 95 percent was used.)

Shaded cells indicate that the confidence interval (margin of error) is greater or equal to 100% of the value or values have been collapsed into other variables.

1. What type of general health care insurance did you have at the time of your work-related injury or illness?

Responses	Percentage	Confidence Interval +/-
Private - Health care insurance purchased by you, your employer, your union, or through your spouse's employer or union	80%	3.1
None - I had no general health care insurance	16%	2.8
Public - Public health insurance (Medicare, Oregon Health Plan, etc.)	4%	1.5

605 responses or 99 percent of sample; 99 percent of population used for confidence calculation = 10,837

2. Were you receiving services from a primary health care provider before your work-related injury or illness? **(Figure 1)**

Responses	Percentage	Confidence Interval +/-
Yes	64%	3.7
No	36%	3.7

611 responses or 100 percent of sample; 100 percent of population used for confidence calculation = 10,944

For 'Yes' responses to number 2.

3. What type of health care provider is your primary health care provider? **(Figure 2)**

Responses	Percentage	Confidence Interval +/-
Medical Doctor	85%	3.4
Nurse Practitioner	6%	2.4
Don't know	4%	1.8
Chiropractor	3%	1.5
Dentist	1%	0.7
Other	1%	0.7
Physician Assistant with supervising Medical Doctor	1%	1.0
Naturopath	< 1%	0.5
Occupational Therapist	< 1%	0.5

392 responses or 64 percent of sample; 64 percent of population used for confidence calculation = 7,021
Responses indicated as < 1% round to zero.

4. How important was it to continue seeing your primary health care provider for the treatment of your work-related injury or illness?

Responses	Percentage	Confidence Interval +/-
Very Important	46%	4.9
Fairly Important	14%	3.4
Fairly Unimportant	11%	3.8
Unimportant	29%	4.5

377 responses or 62 percent of sample; 62 percent of population used for confidence calculation = 6,753

5. Did you continue seeing your primary health care provider for the treatment of your work-related injury or illness?

Responses	Percentage	Confidence Interval +/-
Yes	37%	4.7
No	63%	4.7

387 responses or 63 percent of sample; 63 percent of population used for confidence calculation = 6,932

Cross tabulation - Questions 4 and 5 (Figure 5)

	Continued seeing primary care provider?		
Importance of continuing to see primary care provider	Yes	No	Total
Important (sum of very important and fairly important)	**34% +/- 4.6**	**24% +/- 4.2**	**58% +/- 4.8**
Very Important	29% +/- 4.4	16% +/- 3.6	45% +/- 4.8
Fairly Important	5% +/- 2.1	8% +/- 2.6	13% +/- 3.3
Unimportant (sum of fairly unimportant and unimportant)	**2% +/- 1.5**	**36% +/-4.7**	**39% +/- 4.7**
Fairly Unimportant	1% +/- 1.0	9% +/- 2.8	11% +/- 3.1
Unimportant	1% +/- 1.0	27% +/- 4.3	28% +/- 4.4
Did not indicate importance	**1% +/- 1.0**	**2% +/- 1.4**	**3% +/- 1.7**
Total	37% +/- 4.7	63% +/- 4.7	100%

387 responses or 63 percent of sample; 63 percent of population used for confidence calculation = 6,932

Health care provider type for those who indicated that they had a pre-existing primary health care provider relationship and continued treatment with that provider for their work-related injury or illness. **(Figure 3)**

Responses	Percentage	Confidence Interval +/-
Medical Doctor	88%	5.2
Chiropractor	5%	3.5
Nurse Practitioner	3%	2.6
Don't know	2%	2.3
Physician Assistant with supervising Medical Doctor	1%	1.9
Dentist	1%	1.3

142 responses or 23 percent of sample; 23 percent of population used for confidence calculation = 2,543

For 'No' responses to number 5.

6. If you checked "No" on Question 5, please tell us why you did not continue seeing your primary health care provider for the treatment of your work-related injury or illness? **(Figure 4)**

Responses	Percentage	Confidence Interval +/-
The treatment requirements were beyond what my primary health care provider could do for me.	49%	6.2
I was required to see another health care provider	28%	5.6
My primary health care provider does not treat workers' compensation cases	21%	5.1
Other (sum of those listed below with asterisks)	7%	3.1
I did not want to see my primary health care provider	6%	2.9
*I saw urgent care only**	*4%*	*2.4*
*Other**	*2%*	*1.8*
*My primary health care provider was unavailable at the time of injury**	*1%*	*1.1*

235 responses or 38 percent of sample; 38 percent of population used for confidence calculation = 4,209
Workers were able to choose multiple reasons; therefore, the percentages will sum to more than 100 percent.
* These categories were summed into “Other” for Figure 4.

7. What type of workers' compensation health care provider did you see for the treatment of your work-related injury or illness? **(Figure 6)**

Responses	**Percentage**	**Confidence Interval +/-**
Medical Doctor	79%	3.2
Don't know	5%	1.7
Chiropractor	5%	1.7
Physical Therapist	4%	1.5
Other	2%	1.8
Occupational Therapist	2%	1.8
Nurse Practitioner	2%	1.0
Physician Assistant	1%	0.9
Audiologist	1%	0.6
Dentist	< 1%	0.5
Podiatrist	< 1%	0.5
Optometrist	< 1%	0.3

585 responses or 96 percent of sample; 96 percent of population used for confidence calculation = 10, 478
Includes those who indicated that they continued seeing their primary health care provider.
Responses indicated as < 1% round to zero.

Workers Compensation Health Care Providers with Urban/Rural worker split. **(Table 2)**

Workers' Compensation Health Care Providers	Urban	Rural
Medical Doctor	76% +/- 4.7	82% +/- 4.8
Don't know	5% +/- 2.4	4% +/- 2.4
Chiropractor	5% +/- 2.5	5% +/- 2.6
Physical Therapist	5% +/- 2.4	2% +/- 1.8
Occupational Therapist	3% +/- 1.8	1% +/- 1.4
Other	2% +/- 1.6	2% +/- 1.6
Nurse Practitioner	1% +/- 1.3	2% +/- 1.8
Physician Assistant	1% +/- 1.3	1% +/- 1.1
Audiologist	< 1% +/- 0.7	1% +/- 1.1
Dentist	1% +/- 0.9	0% +/- 0.0
Podiatrist	0% +/- 0.0	1% +/- 0.1
Optometrist	< 1% +/- 0.7	0% +/- 0.0

293 responses for urban; urban injured worker population used for confidence calculation = 6,167
234 responses for rural; rural injured worker population used for confidence calculation = 4,009
Responses indicated as < 1% round to zero.

8. Please tell us how the individual you identified in Question 7 became your workers' compensation health care provider? **(Figure 7)**

Responses	Percentage	Confidence Interval +/-
I was told by my employer or workers' compensation insurer to see this health care provider	25%	3.9
I was referred by my primary health care provider	25%	3.9
I was able to choose whoever I wanted to be my workers' compensation health care provider	19%	3.5
Other or inconclusive (sum of those listed below with asterisks)	13%	3.1
I had to choose a workers' compensation health care provider from a list provided to me	12%	2.9
I was referred by a health care provider that was not my primary health care provider	8%	2.5
This workers' compensation health care provider was the only one in my area that could treat my condition	6%	2.2
*Other or inconclusive**	*5%*	*1.9*
*I saw urgent care only**	*4%*	*1.7*
*I had previous experience with this health care provider**	*3%*	*1.5*
*Other referral**	*1%*	*0.9*
*I was referred by my employer**	*0%*	*0.6*
*I was referred by my workers' compensation insurer**	*0%*	*0.6*

450 responses or 74 percent of sample; 74 percent of population used for confidence calculation = 8,060
Workers were able to choose multiple reasons; therefore, the percentages will sum to more than 100 percent.
* These categories were summed into "Other or inclusive" for Figure 7.

9. For the treatment of your work-related injury or illness, did you feel that you had a choice in who became your workers' compensation health care insurer?

Responses	Percentage	Confidence Interval +/-
Yes	45%	4.4
No	45%	4.4
Don't know/don't remember	10%	2.7

455 responses or 74 percent of sample; 74 percent of population used for confidence calculation = 8,150

Cross tabulation – Questions 9 and 18.

For "Yes" responses to number 5 and number 9. (Figure 10)

Satisfaction of those who had a choice in WCHCP	Area of Satisfaction		
	The choice of health care provider available	The quality of care received	The ability to see a qualified health care provider
Satisfied	**88% +/- 3.3**	**88% +/- 3.4**	**90% +/- 3.1**
Very Satisfied	71% +/- 4.7	72% +/- 4.7	74% +/- 4.5
Fairly Satisfied	17% +/- 3.9	16% +/- 3.8	16% +/- 3.4
Unsatisfied	**11% +/- 3.3**	**10% +/- 3.2**	**9% +/- 3.0**
Fairly Unsatisfied	2% +/- 1.5	3% +/-1.7	4% +/- 2.0
Unsatisfied	9% +/- 3.0	8% +/- 2.8	5% +/- 2.3
No indication	**1% +/- 0.8**	**2% +/- 1.5**	**1% +/- 1.0**

339 responses or 55 percent of sample; 55 percent of population used for confidence calculation = 6,072
"Very Satisfied" and "Fairly Satisfied" were summed to "Satisfied" for Figure 10.
"Fairly Unsatisfied" and "Unsatisfied" were summed to "Unsatisfied" for Figure 10.

For "No" responses to number 9. (Figure 11)

Satisfaction of those who did not have a choice in WCHCP	Area of Satisfaction		
	The choice of health care provider available	The quality of care received	The ability to see a qualified health care provider
Satisfied	**68% +/- 6.3**	**74% +/- 5.9**	**80% +/- 5.4**
Very Satisfied	40% +/- 6.6	47% +/- 6.7	47% +/- 6.7
Fairly Satisfied	28% +/- 6.0	28% +/- 6.0	33% +/- 6.3
Unsatisfied	**31% +/- 6.2**	**25% +/- 5.8**	**18% +/- 5.1**
Fairly Unsatisfied	13% +/- 4.5	9% +/- 3.9	6% +/- 3.2
Unsatisfied	18% +/- 5.1	16% +/- 4.9	12% +/- 4.3
No indication	**2% +/- 1.9**	**2% +/- 1.6**	**3% +/- 2.3**

200 responses or 33 percent of sample; 33 percent of population used for confidence calculation = 3,582
"Very Satisfied" and "Fairly Satisfied" were summed to "Satisfied" for Figure 11.
"Fairly Unsatisfied" and "Unsatisfied" were summed to "Unsatisfied" for Figure 11.

10. When choosing the workers' compensation health care provider for your work-related injury or illness, what was most important to you in making your choice? **(Figure 9)**

Responses	Percentage	Confidence Interval +/-
The training or experience of the workers' compensation health care provider	44%	6.3
How quickly I was able to see the workers' compensation health care provider	26%	5.6
Other or inconclusive (sum of those below with asterisks)	17%	4.8
How close the workers' compensation health care provider was to my home	13%	4.3
Other or inconclusive*	5%	2.9
How close the workers' compensation health care provider was to my work*	4%	2.6
I had previous experience with the health care provider*	4%	2.6
I was referred or they were recommended*	2%	1.7
I saw urgent care only*	1%	1.2

224 responses or 37 percent of sample; 37 percent of population used for confidence calculation = 4,012

* These categories were summed into "Other or inclusive" for Figure 9.

11. How important was it to be able to choose your workers' compensation health care provider?

Responses	Percentage	Confidence Interval +/-
Very Important	56%	4.6
Fairly Important	25%	4.0
Fairly Unimportant	10%	2.8
Unimportant	9%	2.6

428 responses or 70 percent of sample; 70 percent of population used for confidence calculation = 7,666

Cross tabulation- Questions 9 and 11. (Figure 8)

Importance of choice in who became workers' compensation health care provider	Choice in who became workers' compensation health care provider			
	Yes	No	Don't know/don't remember	Total
Important (sum of Very Important and Fairly Important)	**42% +/- 4.4**	**29% +/- 4.0**	**6% +/- 2.1**	**76% +/- 3.8**
Very Important	33% +/- 4.2	17% +/- 3.3	3% +/- 1.5	53% +/- 4.5
Fairly Important	9% +/- 2.6	12% +/- 2.9	3% +/- 1.5	24% +/- 3.8
Unimportant (sum of Fairly Unimportant and Unimportant)	**2% +/- 1.3**	**12% +/- 2.9**	**4% +/- 1.6**	**18% +/- 3.4**
Fairly Unimportant	2% +/- 1.1	7% +/- 2.2	1% +/- 1.0	9% +/-2.6
Unimportant	1% +/- 0.7	5% +/- 2.0	2% +/- 1.3	8% +/- 2.5
Did not indicate importance	**1% +/- 1.0**	**4% +/- 1.7**	**1% +/- 0.7**	**6% +/- 2.1**
Total	45% +/- 4.4	45% +/- 4.4	10% +/- 2.7	100%

455 responses or 74 percent of sample; 74 percent of population used for confidence calculation = 8,150
"Very Important" and "Fairly Important" were summed to "Important" for Figure 8.
"Fairly Unimportant" and "Unimportant" were summed to "Unimportant" for Figure 8.

12. After beginning treatment for your work-related injury or illness, were you required by the workers' compensation insurer or your employer to change your workers' compensation health care provider? (Figure 12)

Responses	Percentage	Confidence Interval +/-
Yes	13%	2.6
No	81%	3.1
Don't know/don't remember	6%	1.9

592 responses or 97 percent of sample; 97 percent of population used for confidence calculation = 10,604

For 'Yes' responses to number 12.

13. Please indicate the reason you were required to change your workers' compensation health care provider? (Figure 13)

Responses	Percentage	Confidence Interval +/-
I needed to see a specialist	36%	10.7
My workers' compensation health care provider was not on the managed care organization (MCO) provider list	34%	10.5
My workers' compensation health care provider could no longer treat me because of limits imposed by workers' compensation law	12%	7.2
I am unsure	11%	6.9
Other or inconclusive (sum of those below with asterisks)	7%	5.6
*I was directed to change by employer**	*3%*	*3.6*
*My health care provider retired or resigned**	*3%*	*3.6*
*Other or inconclusive**	*1%*	*2.6*

74 responses or 12 percent of sample; 12 percent of population used for confidence calculation = 1,325
* These categories were summed into "Other or inclusive" for Figure 13.

For 'Yes' responses to number 12.

14. Please tell us how satisfied you were with the required change? **(Figure 14)**

Responses	Percentage	Confidence Interval +/-
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**64%**	**10.8**
Satisfied	35%	10.7
Fairly Satisfied	29%	10.2
Unsatisfied (sum of Fairly Unsatisfied and Unsatisfied)	**36%**	**10.8**
Fairly Unsatisfied	7%	5.7
Unsatisfied	29%	10.2

72 responses or 12 percent of sample; 12 percent of population used for confidence calculation = 1,290
"Very Satisfied" and "Fairly Satisfied" were summed to "Satisfied" for Figure 14.
"Fairly Unsatisfied" and "Unsatisfied" were summed to "Unsatisfied" for Figure 14.

15. During the treatment of your work-related injury or illness, were you enrolled in a managed care organization (MCO)? (Figure 15)

Responses	Percentage	Confidence Interval +/-
Yes	15%	2.8
No	56%	3.9
Don't know/don't remember	29%	3.6

596 responses or 98 percent of sample; 98 percent of population used for confidence calculation = 10,675

For 'Yes' responses to number 15.

16. Were you able to continue seeing the same workers' compensation health care provider after enrollment as you had seen before enrollment?

Responses	Percentage	Confidence Interval +/-
Yes	78%	8.4
No	22%	8.4

87 responses or 14 percent of sample; 14 percent of population used for confidence calculation = 1,558

17. How important was it to continue seeing the same workers' compensation health care provider?

Responses	Percentage	Confidence Interval +/-
Very Important	69%	9.5
Fairly Important	16%	7.6
Fairly Unimportant	9%	6.0
Unimportant	6%	4.8

86 responses or 14 percent of sample; 14 percent of population used for confidence calculation = 1,540

Cross tabulation - Questions 16 and 17. (Figure 16)

	Continued with same WCHCP after MCO enrollment?		
Importance of continuing to see same WCHCP after MCO enrollment	Yes	No	Total
Important (sum of Very Important and Fairly Important)	**70% +/- 9.4**	**14% +/- 7.0**	**84% +/- 7.5**
Very Important	60% +/- 10.0	8% +/- 5.6	68% +/- 9.5
Fairly Important	10% +/- 6.2	6% +/- 4.8	16% +/- 7.5
Unimportant (sum of Fairly unimportant and Unimportant)	**7% +/- 5.2**	**8% +/- 5.6**	**15% +/- 7.3**
Fairly Unimportant	6% +/- 4.8	3% +/- 3.8	9% +/- 5.9
Unimportant	1% +/- 2.2	5% +/- 4.3	6% +/- 4.8
Did not indicate importance	**1% +/- 2.2**	**0% +/- 0.0**	**1% +/- 2.2**
Total	78% +/- 8.4	22% +/- 8.4	100%

87 responses or 14 percent of sample; 14 percent of population used for confidence calculation = 1,558
"Very Important" and "Fairly Important" were summed to "Important" for Figure 16.
"Fairly Unimportant" and "Unimportant" were summed to "Unimportant" for Figure 16.

18. Please tell us about your level of satisfaction with the following? **(Figure 17)**

a. How satisfied were you with the choice of workers' compensation health care providers available to you?

Responses	**Percentage**	**Confidence Interval +/-**
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**81%**	**3.1**
Satisfied	59%	3.9
Fairly Satisfied	22%	3.2
Unsatisfied (sum of Fairly unsatisfied and Unsatisfied)	**19%**	**3.1**
Fairly Unsatisfied	7%	2.0
Unsatisfied	12%	2.6

589 responses or 96 percent of sample; 96 percent of population used for confidence calculation = 10,550
"Very Satisfied" and "Fairly Satisfied" were summed to "Satisfied" for Figure 17.
"Fairly Unsatisfied" and "Unsatisfied" were summed to "Unsatisfied" for Figure 17.

Urban/Rural Splits for 18a.

Responses	Urban	Rural
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**82% +/- 4.3**	**80% +/- 4.9**
Satisfied	59% +/- 5.5	60% +/- 6.0
Fairly Satisfied	23% +/- 4.7	20% +/- 4.9
Unsatisfied (sum of Fairly unsatisfied and Unsatisfied)	**18% +/- 4.3**	**20% +/- 4.9**
Fairly Unsatisfied	8% +/- 3.0	6% +/- 2.9
Unsatisfied	10% +/- 3.4	14% +/- 4.3

For urban, 292 responses; urban worker population = 6,167
For rural, 238 responses; rural worker population = 4,009

18 b. How satisfied were you with the quality of care you received from the workers' compensation health care provider you saw?

Responses	Percentage	Confidence Interval +/-
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**84%**	**2.8**
Satisfied	63%	3.8
Fairly Satisfied	21%	3.2
Unsatisfied (sum of Fairly unsatisfied and Unsatisfied)	**16%**	**2.9**
Fairly Unsatisfied	5%	1.7
Unsatisfied	11%	2.4

585 responses or 96 percent of sample; 96 percent of population used for confidence calculation = 10,478
"Very Satisfied" and "Fairly Satisfied" were summed to "Satisfied" for Figure 17.
"Fairly Unsatisfied" and "Unsatisfied" were summed to "Unsatisfied" for Figure 17.

Urban/Rural Splits for 18b

Responses	Urban	Rural
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**85% +/- 4.0**	**84% +/- 4.6**
Satisfied	65% +/- 5.3	63% +/- 6.0
Fairly Satisfied	20% +/- 4.5	22% +/- 5.1
Unsatisfied (sum of Fairly unsatisfied and Unsatisfied)	**15% +/- 4.0**	**16% +/- 4.6**
Fairly Unsatisfied	6% +/- 2.7	5% +/- 2.7
Unsatisfied	9% +/- 3.2	11% +/- 3.9

For urban, 292 responses; urban worker population = 6,167
For rural, 235 responses; rural worker population = 4,009

18 c. How satisfied were you with your ability to see a workers' compensation health care provider qualified to treat your condition?

Responses	Percentage	Confidence Interval +/-
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**87%**	**2.6**
Satisfied	65%	3.8
Fairly Satisfied	22%	3.3
Unsatisfied (sum of Fairly unsatisfied and Unsatisfied)	**13%**	**2.6**
Fairly Unsatisfied	5%	1.7
Unsatisfied	8%	2.1

586 responses or 96 percent of sample; 96 percent of population used for confidence calculation = 10,496
"Very Satisfied" and "Fairly Satisfied" were summed to "Satisfied" for Figure 17.
"Fairly Unsatisfied" and "Unsatisfied" were summed to "Unsatisfied" for Figure 17.

Urban/Rural Splits for 18c

Responses	Urban	Rural
Satisfied (sum of Very Satisfied and Fairly Satisfied)	**89% +/- 3.5**	**85% +/- 4.4**
Satisfied	65% +/- 5.3	65% +/- 5.9
Fairly Satisfied	24% +/- 4.7	20% +/- 4.9
Unsatisfied (sum of Fairly unsatisfied and Unsatisfied)	**11% +/- 3.5**	**15% +/- 4.4**
Fairly Unsatisfied	4% +/- 2.2	7% +/- 3.1
Unsatisfied	8% +/- 3.0	8% +/- 3.4

For urban, 289 responses; urban worker population = 6,167
For rural, 237 responses; rural worker population = 4,009