Medical Dispute Activity, Oregon, Fiscal Year 2002

Research & Analysis Section
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Introduction

Under Oregon workers' compensation law, injured workers, insurers, and medical providers may request resolution of medical disputes by the director of the Department of Consumer & Business Services. These disputes may involve medical services and treatments, palliative care, fees, changes of attending physician, and requests for additional insurer medical exams. Statutory authority to resolve medical disputes is given to the director under Oregon Revised Statutes 656.245, 656.247, 656.248, 656.260, 656.325, 656.327, and 656.704. Oregon Administrative Rules Chapter 436, Divisions 9 and 10, provide the guidelines for administering the delivery of and payment for medical services and for resolving disputes.

The Medical Review Unit, formed during a 1992 Workers' Compensation Division reorganization, is responsible for handling the majority of medical disputes. Effective October 23, 1999, Senate Bill 728 gave responsibility for disputes in which the compensability of the underlying medical condition is at issue to the Workers' Compensation Board Hearings Division.

This report presents information about medical dispute activity during fiscal year 2002. The data include disputes received and resolved, disputes involving managed care organizations, the time required to process requests, and appeals of the orders. Additional information is available from the department's Research & Analysis Section.

Highlights of the report

In FY 2002, the department received 1,157 medical dispute requests (see Table 1). Thirty-eight percent of these were medical service disputes, 23 percent were fee disputes, 15 percent were compensability disputes, 11 percent were treatment disputes, and 13 percent were other types of disputes.

In FY 2002, 1,145 medical disputes were resolved. Fifty-six percent of the disputes were approved, 14 percent were disapproved, 5 percent of the treatments were partially approved, 8 percent were approved with stipulations, and 14 percent were dismissed or withdrawn.

In FY 2002, 13 percent of the orders resolved disputes for injured workers enrolled in managed care organizations. Of these, 66 percent involved disputes with the MCO itself.

In FY 2002, the average number of calendar days from the receipt of a dispute to its resolution was 82 days (see Table 3). There is great variability in the resolution time of different issues. Treatment disputes averaged 88 days to resolve, while Independent Medical Examinations disputes averaged 32 days. Compensability issues took 235 days to resolve. MCO disputes averaged 87 days to resolve. Fifty-six percent of the treatment disputes that were not dismissed required the use of outside physician reviewers. Physician reviews added an average of 28 days to the processing time of reviewed orders.

In FY 2002, nine percent of the orders issued were appealed to contested case hearings.

Legislative history

Most legislative sessions since 1987 have produced changes in the medical dispute resolution process. In 1987, House Bill 2900 allowed the director to establish a medical review panel to review, upon request of any of the parties, the medical treatment of an injured worker. This review process was seldom used. HB 2900 also limited IMEs to three per claim opening, unless the director authorized more.

The administrative dispute resolution process became mandatory for medical disputes when Senate Bill 1197 took effect July 1, 1990. In part, the intent of SB 1197 was to reduce litigation by placing the responsibility for medical decisions on the department's medical personnel. SB 1197 also eliminated most palliative care after the worker becomes medically stationary; this eliminated many potential disputes.

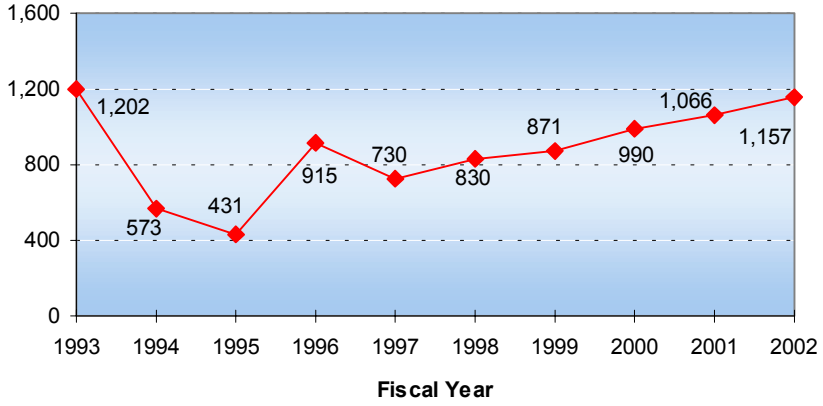
Following the Court of Appeal's decision in Meyers v. Darigold in October 1993, the director lost jurisdiction over disputes involving proposed medical treatment. The resulting decline in the number of disputes can be seen in Figure 1. SB 369, effective June 7, 1995, restored this jurisdiction. SB 369 also allowed a worker (not just the worker's attending physician) to request approval for palliative care when the insurer denies the care. Also, SB 369 took jurisdiction for appeals of medical dispute orders, other than orders concerning additional IMEs, from the

Workers' Compensation Board Hearings Division. These disputes are now heard as "contested cases."

The 1999 legislative session produced two changes. HB 2525, effective August 1, 1999, moved the contested cases hearings officers from the department to the Oregon Employment Department. Effective October 23, 1999, SB 728 gave responsibility to the Hearings Division when the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service is disputed.

The 2001 legislative session produced SB 485, which amended the law regarding the payment of medical services provided prior to the claim's initial acceptance or denial. The amendment applies to injuries since January 1, 2002. Disputes about this amendment are a new category of medical dispute.

Figure 1. Medical dispute resolution requests received, FY 1993-2002



Note: This figure does not include reconsiderations or general issues.

Medical disputes received

In fiscal year 2002, the department received 1,157 requests for medical dispute resolution (see Table 1). This was a nine percent increase from the number received in FY 2001, largely due to disputes involving provider fees. Fifty-six percent of the requests were from workers or their attorneys, 39 percent were from medical providers, and 4 percent were from insurers. The percentage of requests from medical providers increased more than eight percent from FY 2001. This increase is related to the increase in the number of fee disputes.

The most common medical dispute is over medical services. These disputes are about the services, other than palliative care, to which a worker is entitled. In FY 2002, 38 percent of the disputes fell into this category. This category was created in December 1996 when the coding system was revised to better match the medical service sections of the statute. (Compensable medical services are defined in ORS 656.245.) Many issues formerly defined as palliative care or fee disputes are now classified as medical service disputes. Palliative care disputes arise when a worker or the worker's attending physician requests that the insurer approve palliative care to enable the worker to continue current employment after the worker has become medically stationary. Claimants and providers bring these disputes to the department. In FY 2002, palliative care accounted for three percent of the disputes.

Fee disputes are between an insurer and medical provider regarding the amount of a medical fee. Most fee dispute resolution requests come from providers who are seeking reimbursement on a reduced bill. In FY 2002, these fee disputes accounted for 23 percent of the disputes.

Treatment disputes are another common category of dispute. Treatment disputes are those in which a worker or an insurer claims that the medical provider's treatment is inappropriate, excessive, ineffectual, or in violation of the administrative rules. Eleven percent of the disputes received in FY 2002 were treatment disputes. Fifty-seven percent of the insurer requests involved treatment issues. As will be shown later, treatment disputes are the most contentious and difficult to resolve.

In October 1999, MRU created a new category for classifying disputes: MCO disputes. These are disputes about managed care organization actions as defined in ORS 656.260(14). Prior to October 1999, most of these disputes were defined as treatment disputes. When this code was created, it was assigned to some existing disputes; therefore, some of these disputes appear in Table 1 as FY 1999 disputes. These disputes accounted for eight percent of the FY 2002 disputes.

Table 1. Medical dispute activity, FY 1998-2002

	Disputed issues										Reconsid-erations of issues	General issues
	Fee dispute	Interim Benefits	Palliative care	Medical services	Treat-ment	MCO	Change of physician	Additional IME	Compen-sability	Total		
Received												
FY 1998	139	-	32	423	188	-	35	13	-	830	19	141
FY 1999	34	-	41	540	201	2	33	11	9	871	21	166
FY 2000	72	-	64	426	117	51	23	26	211	990	8	113
FY 2001	160	-	47	484	104	58	24	8	181	1,066	13	138
FY 2002	264	1	37	445	124	93	13	10	170	1,157	14	137
FY 2002 %	22.8%	0.1%	3.2%	38.5%	10.7%	8.0%	1.1%	0.9%	14.7%	100%		
Resolved												
FY 1998	202	-	24	357	165	-	33	13	-	794	20	131
FY 1999	35	-	36	482	227	-	34	9	-	823	19	156
FY 2000	56	-	46	430	138	16	28	29	95	838	11	133
FY 2001	131	-	69	495	123	73	24	7	163	1,085	14	133
FY 2002	297	1	31	441	98	95	12	9	161	1,145	12	152
FY 2002 %	25.9%	0.1%	2.7%	38.5%	8.6%	8.3%	1.1%	0.8%	14.1%	100%		

Notes: "MCO" was defined as a separate category in October 1999.
Compensability issues became a WCB responsibility in October 1999. Some existing disputes were transferred to WCB at that time.
"Interim Benefits" was defined as a separate category in October 2002.

Change of physician disputes occur when a worker requests an additional change of attending physician beyond the two changes allowed by statute. Insurer medical exam disputes arise when an insurer requests that a worker undergo an additional medical exam beyond the three allowed in statute. These two categories accounted for two percent of the FY 2002 disputes.

The disputes rising from SB 728 are the medical disputes heard by the Hearings Division. These are disputes for which the issue is the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service. These disputes are resolved by a hearing order before any other disputed medical issues are resolved. This change took effect October 23, 1999. A number of these disputes had been received by the department prior to the effective date of this change. These disputes were transferred to the Hearings Division for resolution. Their original request dates were retained; therefore, Table 1 shows some of these disputes in FY 1999. These disputes accounted for 15 percent of the FY 2002 disputes. Most of the requests were from claimants or their attorneys.

In addition to these disputes, there are also reconsiderations and general issues. These are cases in which the department reconsiders its own order. The parties may request the reconsideration of an order within 30 days if they believe the order contains errors or misapplications of the law or if they have new evidence that could not reasonably have been discovered or produced during the review. There were 14 reconsideration requests in FY 2002.

General issues requests are requests of a general nature. They are not considered disputes, and do not require a director's order to resolve. Rather, informational letters are sent in response to these requests. In FY 2002, 137 of these general requests were received.

Dispute orders

During FY 2002, 1,145 disputes were resolved. Of these orders, 14 percent were orders of dismissal (see Table 2). A dismissal may occur for a variety of reasons, such as the inappropriate, incomplete, or untimely submission of the request or because the request was withdrawn. Twenty-nine percent of the compensability disputes were dismissed.

Excluding the compensability cases, 65 percent of the FY 2002 orders were orders of approval, 17 percent were disapproval orders, 5 percent were partial approvals, and less than 1 percent were stipulations. Approval orders direct payment to providers, approve palliative care, approve all of the medical provider's treatment, or approve the additional change of attending physician or additional IME. Disapproval orders deny these items. Partial approval orders approve part, but not all, of the request for additional reimbursement, palliative care, or treatment. Stipulations are written agreements between the parties that are reached through mediation. They were the most common outcome of compensability disputes. Transfer orders are MRU orders that transfer responsibility to the Hearings Division.

Most of the compensability cases were dismissed or resolved with stipulations. Thirty cases were resolved with orders. In 17 cases, the decision was that the underlying medical

Table 2. Medical dispute orders by issue, FY 2002

	Fee dispute	Interim benefits	Palliative care	Medical services	Treat-ment	MCO	Change of physician	Additional IME	Compen-sability	Total Orders	Total Percent
Approved	248	0	7	290	47	29	7	8	-	636	55.5%
Allowed	-	-	-	-	-	-	1	-	-	1	0.1%
Disapproved	19	1	8	64	20	50	2	1	-	165	14.4%
Partial Approval	13	0	2	22	8	9	0	0	-	54	4.7%
Stipulation	0	0	0	6	1	1	0	0	84	92	8.0%
Transfer	0	0	0	1	2	0	-	-	-	3	0.3%
Causally related	-	-	-	-	-	-	-	-	17	17	1.5%
Causally unrelated	-	-	-	-	-	-	-	-	13	13	1.1%
Dismissed	17	0	14	58	20	6	2	0	47	164	14.3%
Total	297	1	31	441	98	95	12	9	161	1,145	100%
% of orders	25.9%	0.1%	2.7%	38.5%	8.6%	8.3%	1.0%	0.8%	14.1%	100%	

Notes: In this table "-" indicates combinations of issues and orders that are not used.
"Allowed" is an order type used only for change of physician issues.
When an additional IME is allowed, it is counted under "Approved."
Transfer orders are used by MRU to transfer issues to WCB for compensability decisions.
"Causally related" and "Causally unrelated" are used by WCB for hearing order outcomes.

condition was compensable or that the accepted condition caused the need for the medical treatment. In 13 cases, the condition was found non-compensable or the accepted condition was determined not to be the cause of the need for treatment.

In the following discussion, dismissed cases are excluded. Of the disputed medical services, 76 percent were approved, 17 percent were disapproved, and 7 percent were settled with a partial acceptance or a stipulation. Of the disputed treatments, 60 percent were approved, and 26 percent were disapproved. Of the palliative care requests, 41 percent were approved, and 47 percent were disapproved.

Medical providers were usually successful when they requested dispute resolution. Excluding the dismissals, 90 percent of the medical services for which providers requested approval were granted. Payment of disputed bills was approved in 89 percent of the fee disputes.

The department reconsidered 12 orders. Of the 7 reconsiderations that were not denied, 3 upheld the earlier order, 2 reversed the earlier order, 1 modified the earlier order, and 1 had a stipulation amended to the earlier order.

Disputes involving managed care organizations

Thirteen percent of the FY 2002 orders resolved disputes for injured workers enrolled in managed care organizations. Of these, 66 percent involved disputes with the MCO itself. The remainder of the disputes were not related to the MCO. MCOs must have internal dispute resolution processes, although they may choose to have the department resolve certain types of issues. Therefore, medical disputes come to the department either because the MCO does not have a resolution process for a particular type of issue or because the MCO's decision is being appealed. About 36 percent of the workers with accepted disabling claims are enrolled in MCOs. The small number of MCO disputes received by the department indicates that the MCOs resolved many medical disputes themselves.

For the non-compensability disputes involving MCOs, 39 percent of the orders were approval orders and 41 percent were disapproval orders. This contrasts with the disputes that did not involve MCOs; in this group, 69 percent were approval orders and 13 percent were disapproval orders.

Processing times

The average number of calendar days from the initial receipt of a dispute to its resolution was 82 days for FY 2002 orders (see Table 3). This compares to 105 days in FY 2001. Compensability disputes took the longest to resolve, at 235 days. Treatment disputes averaged 88 days for resolution. MCO disputes averaged 87 days to resolve. Medical services disputes averaged 64 days. IME disputes were resolved the quickest, averaging 32 days.

A portion of this processing time can be attributed to the involvement of outside physician reviewers. These reviewers or panels of reviewers may be appointed by the department to review the disputed treatments, medical services, or palliative care. The length of time between the date of the department's letter establishing the outside review and the date that the physician's report was received averaged 28 days. Fifty-six percent of the treatment orders that were not dismissed (45 percent of all treatment orders) used outside physician review.

Table 3. Average processing days for orders, FY 2002

Orders	Number	Average days	Number with a physician review	Percent with a physician review	Average days
Fee dispute	297	54.6	-	0.0%	-
Interim Benefits	1	62.0	-	0.0%	-
Palliative care	31	74.7	3	9.7%	22
Medical services	441	63.6	2	0.5%	8
Treatment	98	87.7	44	44.9%	28
MCO	95	87.4	32	33.7%	29
Change of physician	12	59.3	-	0.0%	-
Additional IME	9	32.0	-	0.0%	-
Compensability	161	234.6	-	0.0%	-
All disputed issues	1,145	82.0	81	7.1%	28
Reconsiderations	12	32.2	-	0.0%	-
General requests	152	34.0	-	0.0%	-

Note: Processing time is calculated using calendar days, not work days.
Weighted average calculated for "All disputed issues."

Appeals of orders

Orders from disputed and reconsidered issues other than IMEs and compensability can be appealed through the contested case hearing process within WCD. (IME orders and compensability orders are appealed to the Hearings Division.) Prior to August 1, 1999, these hearings officers were under the director's jurisdiction. They have become part of a centralized hearings panel in the Oregon Employment Department. The parties have 30 days to appeal a medical dispute order.

Of the 987 orders issued in FY 2002, 9 percent were appealed. In FY 2001, 7 percent of the 929 orders were appealed. Because many of the FY 2002 appealed orders did not have resolutions at the time of this report, the outcomes of appealed FY 2001 orders are provided in the following discussion (see Tables 4 and 5). Fifteen percent of the treatment dispute orders, 15 percent of MCO orders, and 6 percent of the medical service orders were appealed. Forty-two percent of the appeals were affirmed, while thirty-seven percent of the appeals were dismissed or withdrawn. The majority of the other resolutions were reversals, partial affirmations of the earlier orders, stipulated agreements, or remands to the Workers' Compensation Division for further action.

Table 4. Appeals of FY 2002 orders

Orders	Fee dispute	Palliative care	Medical services	Treatment dispute	MCO	Change of physician	Interim benefits	Total
Orders	299	34	444	101	96	12	1	987
Number appealed	23	6	28	17	15	-	-	89
% appealed	7.7%	17.6%	6.3%	16.8%	15.6%	0.0%	0.0%	9.0%

Order counts include reconsiderations.

Table 5. Appeals of FY 2001 orders, and outcomes

Orders	Fee dispute	Palliative care	Medical services	Treatment dispute	MCO	Change of physician	Interim benefits	Total	
Orders	131	69	500	129	76	24	-	929	
Number appealed	3	6	30	19	11	-	-	69	
% appealed	2.3%	8.7%	6.0%	14.7%	14.5%	0.0%	0.0%	7.4%	
Outcome of appeals									Percentage of resolutions
Affirmed	-	2	14	9	3	-	-	28	41.8%
Reversed	3	-	2	5	-	-	-	10	14.9%
Partial	-	-	2	-	-	-	-	2	3.0%
Stipulation	-	-	-	1	-	-	-	1	1.5%
Remand/other	-	-	-	-	1	-	-	1	1.5%
Dismissed/withdrawn	-	4	11	4	6	-	-	25	37.3%
							-		100%
Pending	-	-	-	-	1	-	-	1	
Other*	-	-	1	-	-	-	-	1	
Total	3	6	30	19	11	-	-	69	

Notes: In this table, reconsidered issues are included with the original disputed issue.
Few general issue orders are appealed, so they are not included.
Appeals of IME orders and compensability orders are not appealed to contested case hearings.
*One Medical Services case under consideration for appeal.

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