Medical Payments in the Oregon Workers' Compensation System, 2004

Department of Consumer & Business Services **September 2006**

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Medical Payments in the Oregon Workers' Compensation System is an annual statistical report published by the Information Management Division (IMD) of the Department of Consumer and Business Services (DCBS). The purpose of this report is to provide the reader with basic statistics regarding payments made by workers' compensation insurers for medical services provided to injured workers in 2004. The analysis is based on the medical service billing data reported to IMD according to Oregon Administrative Rule (OAR) 436-009-0030(10).

Data sources and methodology

Each year, DCBS develops information on total system workers' compensation benefit payments, including both medical and indemnity payments, in response to a survey by the National Academy of Social Insurance (NASI). The National Council on Compensation Insurance (NCCI) provides the payment data for private insurers and the State Accident Insurance Fund Corporation (SAIF) to DCBS. Since neither DCBS nor NCCI collects complete information on self-insurer benefit payments, DCBS estimates these payments using three data sources: SAIF and private insurer paid and incurred loss data from NCCI, simulated self-insurer premium from the DCBS Self-Insurer Assessment Reporting System, and historical estimated self-insurer loss information.[1]

Based on the estimates for the NASI survey, medical payments for treating injured workers in Oregon for calendar year 2004 amounted to $259,447,381.[2] Payments reported by insurers under Bulletin 220[3] (OAR 436-009-0030(10)), however, totaled $210,528,467, nearly $49 million less. The difference between the two reporting methods stems from the fact that all insurers are not required to report their medical billing data and that pharmacy payments are underrepresented in the Bulletin 220 data. According to OAR 436-009-0030(10), insurers with fewer than 100 accepted disabling claims in the prior calendar year are not required to report their medical billing data. Furthermore, insurers are not required to report reimbursements to injured workers for "out-of-pocket" expenses. Presumably, some of the "out-of-pocket" expenses are initial prescriptions paid by workers before their claim is accepted.

The analysis described in this report is based on Bulletin 220 data; however, in order to reflect the total system medical payments, the Bulletin 220 payments were benchmarked to match the NASI reported payments.[4]

The insurers reporting workers' compensation medical data belong to one of the following categories: state fund (SAIF), private, or self-insured.[5] Bulletin 220 medical payments for SAIF, private, and self-insured insurers represented 96.8 percent, 68.9 percent, and 58.9 percent of the respective NASI reported figures (Table 1). SAIF,

Table 1. Comparison of Bulletin 220 and NASI workers' compensation medical payments in 2004

	Insurer Type			
	SAIF	Private	Self-insurer	Total
Bulletin 220	$118,322,481	$78,569,607	$13,636,379	$210,528,467
NASI	$122,204,650	$114,094,727	$23,148,004	$259,447,381
Percent	96.8%	68.9%	58.9%	81.9%

Note: Total medical payments for SAIF and private insurers reported by NASI are based on the figures provided directly by the insurers. Total medical payments for self-insurers are estimated by the DCBS Information Management Division.

[1] For more details on estimation of self-insurers' paid medical losses, please contact Satenik Hackenbruck from Information Management Division, DCBS: satenik.r.hackenbruck@state.or.us.

[2] The noncomplying employers payments (provided by the Collections Unit of Fiscal and Business Services, DCBS) were added to the original NASI figures under private insurer category.

[3] Bulletin 220 data provides information on a medical service level, whereas the NASI report is based on aggregate figures.

[4] Bulletin 220 payments and service units were multiplied by the inflation factor equal to 1.23 ($259,447,381 divided by $210,528,467) to account for services that were not reported.

[5] For this analysis, noncomplying employers are treated as private insurers.

the largest workers' compensation insurer in Oregon, meets the reporting threshold criteria and has the highest percentage (96.8) of corresponding payments. Private insurers, mainly represented by large insurers, have the second highest matching percentage (68.9). The self-insured category, with the highest concentration of insurers below the reporting threshold level, has the lowest percentage of matching payments (58.9).

Bulletin 220 medical billing data had to meet the following criteria to be used for this analysis.

- *Adequate provider type distribution.* The distribution of medical payments by provider type for each insurer was not significantly different from the mean distribution for that insurer type.
- *Valid service codes.* The number of services with unknown codes was not in excess of 5 percent of the total number of services reported in Bulletin 220.
- *Valid values for charges and payments.* Each service must have only one entry to eliminate double counting.

The distribution of medical payments by provider type was analyzed for each insurer that reported medical payments under Bulletin 220 in 2004, to determine if the distribution was significantly different from the mean distribution of the corresponding insurer type (SAIF, private, or self-insurer). A few insurers showed significant deviations from the means, however, because these insurers had such a small proportion of total medical payments (mainly self-insurers with small payments), they were included in the analysis.

To satisfy the second criterion, all service codes reported in Bulletin 220 for 2004 were analyzed. Unknown service codes accounted for only 1.5 percent of all service codes, which was 3.8 percent of total medical payments. Because these unknown service codes represented such a small portion of all services, the services with unidentified codes and their respective payments were included in the analysis.

And, lastly, to meet the third criterion, services with multiple entries were combined into one entry. For these entries, payment amounts were adjusted to reflect any reported refunds or MCO adjustments.

Medical payments by provider type

The distribution of medical payments by provider type regardless of insurer type is shown in Table 2.

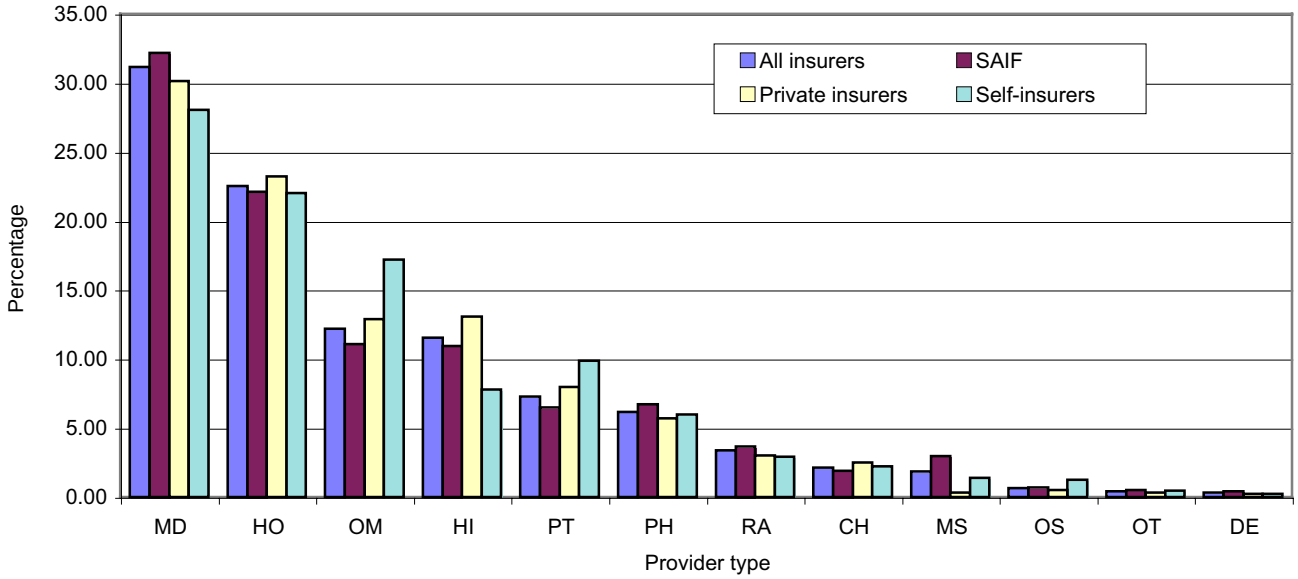
Medical doctor (MD) services represented 31.1 percent of total medical payments, followed by hospital outpatient (HO) services at 22.5 percent. "Other medical" (OM) providers were ranked third (12.2 percent), representing more than $31.5 million in payments. A substantial number of payments classified under OM provider were for insurer medical exams, home health care, ambulance services, and nursing home care. The four provider types with the highest medical payments – MD, hospital inpatient (HI), HO, and OM – accounted for 77.3 percent of total medical payments in 2004.

Considerable portions of medical payments also went to physical therapists (PT) and pharmacies (PH), 7.3 percent and 6.2 percent of the total medical payments

Table 2. Workers' compensation medical payments by provider type, 2004

Provider type	Total payments	Percent of total payments
Medical doctor (MD)	$80,758,971	31.13%
Hospital outpatient (HO)	$58,414,728	22.52%
Other medical provider (OM)	$31,558,276	12.16%
Hospital inpatient (HI)	$29,888,856	11.52%
Physical therapist (PT)	$18,824,839	7.26%
Pharmacy (PH)	$16,055,352	6.19%
Radiologist (RA)	$8,763,458	3.38%
Chiropractor (CH)	$5,572,942	2.15%
Medical supplies (MS)	$4,807,698	1.85%
Osteopath (OS)	$1,737,140	0.67%
Occupational therapist (OT)	$1,122,595	0.43%
Dentist (DE)	$862,654	0.33%
Physician's assistant (PA)	$242,689	0.09%
Laboratory (LA)	$223,835	0.09%
Podiatrist (PO)	$186,647	0.07%
Optometrist (OP)	$168,046	0.06%
Registered nurse practitioner (NP)	$152,352	0.06%
Acupuncturist (AC)	$84,816	0.03%
Naturopath (NA)	$21,485	0.01%
Total	$259,447,381	100%

Figure 1. Distribution of medical payments by provider type and insurer type, CY 2004



respectively. Radiologists (RA) received 3.4 percent of the total payments, mostly for providing magnetic resonance image (MRI), computed tomography (CT), and X-ray services. Chiropractors (CH) received 2.1 percent of payments for providing chiropractic manipulative treatments and other therapeutic services.

The distributions of the medical payments by provider type for SAIF, private insurers, self-insurers, and "all insurers" are compared in Figure 1. In general, the distributions of payments for all three insurer types are similar. The correlation between SAIF and private insurers' distributions is 0.99, between SAIF and self-insurers' is 0.96, and between private and self-insurers' is 0.97. These correlation coefficients are significant on a 99 percent confidence level.

Medical payments by service

Oregon's medical fee schedule is based on the Resource Based Relative Value System (RBRVS) established by the federal government. Payments are determined by the cost of the resources needed to provide each service. RBRVS cost components include medical provider services, practice expenses, and professional liability insurance costs. In the current system there are two Relative Value Units (RVUs) values for determining practice expenses: facility and nonfacility practice values.

Facility practice values are applied to services furnished to patients in a hospital, skilled nursing facility, community mental health center, or Ambulatory Surgical Center (ASC) for procedures on the approved procedures list.[6] Nonfacility practice values are applied to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, or any facility or institution other than the ones specified under facility practice. The nonfacility practice RVUs for a particular code may not be greater than the facility RVUs.[7]

DCBS calculates Oregon's workers' compensation medical fee payment ceilings by multiplying the combined costs of a service (facility or nonfacility RVUs) by a conversion factor determined by DCBS. Providers

[6] The ASC approved procedure list can be obtained from Centers for Medicare and Medicaid Services at http://www.cms.hhs.gov.

[7] Code of Federal Regulation, Title 42, Volume 2, Section 414.22, A

Table 3. Top 25 workers' compensation medical services in descending order by total payments, 2004

Rank	Service	Description	Total units	Total medical payments	Percent of total medical payments	Average medical payment	Medical fee schedule ceiling		
							Average	Facility	Non-facility
1	97110	Therapeutic exercises	362,764	$15,752,580	6.1%	$43	$51	$51	$51
2	99213	Office/outpatient visit (established patient, 15 min)	146,312	$12,140,121	4.7%	$83	$81	$97	$64
3	D0003	Insurance medical exam (IME)	14,211	$8,996,754	3.5%	$633	-	-	-
4	97140	Manual therapy	192,667	$7,910,695	3.0%	$41	$47	$47	$47
5	360	Operating room services	7,513	$7,333,148	2.8%	$976	-	-	-
6	450	Emergency room	37,193	$5,063,841	2.0%	$136	-	-	-
7	N/A	Ambulatory surgical center (ASC) facility fees	644	$4,544,512	1.8%	$7,055	-	-	-
8	99214	Office/outpatient visit (established patient, 25 min)	30,899	$3,900,987	1.5%	$126	$128	$150	$105
9	99203	Office/outpatient visit (new patient, 30 min)	26,744	$3,861,186	1.5%	$144	$154	$176	$131
10	72148	Magnetic image (MRI); lumbar and spine w/o dye	6,098	$3,567,098	1.4%	$1,021	$1,021	$1,021	$1,021
11	73721	MRI; joint of lower extremity w/o dye	5,499	$2,897,675	1.1%	$903	$906	$906	$906
12	99283	Emergency department visit	24,497	$2,632,594	1.0%	$107	$112	$112	$112
13	97530	Therapeutic activities	57,065	$2,560,805	1.0%	$45	$51	$51	$51
14	97001	Physical therapy evaluation	23,021	$2,530,826	1.0%	$110	$122	$131	$113
15	73221	MRI; joint upper extremity w/o dye	4,348	$2,288,224	0.9%	$904	$906	$906	$906
16	99212	Office/outpatient visit (established patient, 10 min)	40,121	$2,251,092	0.9%	$56	$57	$70	$43
17	99906	Outpatient hospital disallow	21,882	$2,066,642	0.8%	$94	-	-	-
18	31.1	Temporary tracheotomy	14	$1,904,949	0.7%	$140,794	-	-	-
19	97035	Ultrasound therapy	96,958	$1,861,263	0.7%	$19	$22	$22	$22
20	270	Medical/surgical supplies & devices	16,970	$1,711,224	0.7%	$101	-	-	-
21	72158	MRI; lumbar and spine w/o & w/dye	1,597	$1,689,977	0.7%	$1,886	$1,989	$1,989	$1,989
22	99204	Office/outpatient visit (new patient, 45 min)	7,866	$1,625,893	0.6%	$207	$221	$250	$193
23	29881	Knee arthroscopy/surgery	1,526	$1,591,392	0.6%	$1,043	$1,491	$1,491	$1,491
24	80.51	Excision intervert disc	264	$1,512,243	0.6%	$5,718	-	-	-
25	72141	MRI; neck spine w/o dye	2,879	$1,500,118	0.6%	$939	$946	$946	$946
Total of top 25 services:				**$103,695,839**	**40.0%[8]**				
Total workers' compensation medical payments, 2004:				**$259,447,381**	**100.0%**				

charge insurers the usual and customary charge for the rendered service and are reimbursed at the charged rate as long as it does not exceed the medical fee payment ceiling. Charges in excess of the medical fee payment ceiling are reimbursed at the ceiling payment amount, unless a higher payment is approved by the insurer.

The medical billing data reported by insurers to DCBS does not identify whether services are provided in a facility or nonfacility setting. For this reason in Table 3, the average medical payments per service are compared with the average of facility and nonfacility fee schedule ceilings. The table also includes total medical payments, total service units, and percentage of contribution to 2004 medical payments for the top 25 services.

This comparison shows that among the top 25 services with available fee schedule data, the average payment per service was always lower than the respective average fee schedule ceiling (except for the CPT 99213 office/outpatient visit, where the average payment was higher than the average fee schedule ceiling).

Three groups of services appeared most frequently among top 25 services: physical medicine and rehabilitation services, office or other outpatient services, and magnetic resonance image (MRI) services.[9]

[8] The percentages may not sum to the exact number due to the rounding to the nearest decimal.

[9] Physical Medicine and Rehabilitation Services, CPT codes: 97001-97546 and 97703-97799; Office or Other Outpatient Services, CPT codes: 99201-99215; MRI Services, CPT codes: 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 76093-76094, and 76400.

Table 4. Distribution and average payments by provider type for physical medicine services, 2004

Service	Description	Total payments	Fee schedule	Average payment	PT	HO	MD	OM	CH	OT
97110	Therapeutic exercises	$15,752,580	**$51**	**$43**	$42	$45	$47	$46	$36	$47
		6.1%		99.7%	50.2%	30.1%	9.8%	5.8%	1.3%	2.6%
97140	Manual therapy	$7,910,695	**$47**	**$41**	$42	$44	$42	$41	$30	$45
		3.0%		99.5%	55.2%	23.9%	7.6%	3.9%	7.0%	1.9%
97530	Therapeutic activities	$2,560,805	**$51**	**$45**	$44	$49	$45	$47	$35	$47
		1.0%		99.7%	56.0%	13.2%	6.7%	16.4%	1.3%	6.2%
97001	Physical therapy evaluation	$2,530,826	**$122**	**$110**	$107	$109	$121	$118	$71	$123
		1.0%		99.7%	48.7%	28.6%	15.9%	6.1%	0.1%	0.3%
97035	Ultrasound therapy	$1,861,263	**$22**	**$19**	$19	$21	$20	$19	$18	$21
		0.7%		99.5%	46.5%	25.9%	9.1%	4.7%	10.6%	2.8%
Remaining physical medicine services:		$6,760,846								
		2.6%								
Total of physical medicine services:		**$37,377,015**		**Weighted**	**$46**	**$49**	**$50**	**$49**	**$36**	**$51**
Percentage of total 2004 payments:		**14.4%**		**Average**	**51.6%**	**26.7%**	**9.4%**	**6.2%**	**3.2%**	**2.5%**

Note: In Tables 4-6, the percentage shown below the total payments for each service reflects the percentage of the total 2004 payments for that service and the percentage below each provider type's average payment reflects the percentage of total payments for the respective service.

Table 5. Distribution and average payments by provider type for office/outpatient visits, 2004

Service	Description	Total payments	Fee schedule	Average payment	MD	OM	HO	OS	CH	Others
99213	Office/outpatient visit	$12,140,121	**$81**	**$83**	$84	$86	$63	$81	$64	$76
	(established patient, 15 min)	4.7%		100.0%	77.2%	12.2%	3.9%	4.2%	0.9%	1.6%
99214	Office/outpatient visit	$3,900,987	**$128**	**$126**	$128	$129	$101	$120	$89	$118
	(established patient, 25 min)	1.5%		100.0%	80.0%	12.2%	1.8%	3.3%	1.1%	1.6%
99203	Office/outpatient visit	$3,861,186	**$154**	**$144**	$153	$151	$120	$147	$97	$129
	(new patient, 30 min)	1.5%		100.0%	71.5%	9.7%	9.9%	2.3%	4.4%	2.1%
99212	Office/outpatient visit	$2,251,092	**$57**	**$56**	$59	$59	$41	$55	$38	$50
	(established patient, 10 min)	0.9%		100.0%	76.6%	9.2%	5.5%	2.7%	3.1%	2.8%
99204	Office/outpatient visit	$1,625,893	**$221**	**$207**	$214	$216	$165	$180	$140	$196
	(new patient, 45 min)	0.6%		100.0%	75.7%	13.2%	2.3%	3.0%	4.2%	1.6%
Remaining office/outpatient visits:		$2,124,194								
		0.8%								
Total of office/outpatient visits:		**$25,903,473**		**Weighted**	**$109**	**$110**	**$83**	**$102**	**$76**	**$97**
Percentage of total 2004 payments:		**10.0%**		**Average**	**76.6%**	**11.6%**	**4.6%**	**3.5%**	**1.9%**	**1.8%**

Physical medicine and rehabilitation services accounted for 14.5 percent of the total 2004 medical payments, about $37.4 million. Physical therapists received about 51.6 percent of total physical medicine payments, followed by hospital outpatient providers with 26.7 percent, and medical doctors with 9.4 percent (Table 4). On average, physical therapists received $46 for a physical medicine service, hospital outpatient providers received $49, and medical doctors received $50.

Office or other outpatient services accounted for 10 percent of total medical payments, approximately $25.9 million (Table 5). Medical doctors received about 76.6 percent of the total payments for office/outpatient visits, followed by "other medical" providers and hospital outpatient providers, with 11.6 percent and 4.6 percent respectively. On average, medical doctors received $109 for an office/outpatient visit, "other medical" providers received $110, and hospital outpatient providers received $83.

MRI services accounted for 5.4 percent of 2004 total medical payments, approximately $13.8 million (Table 6). Radiologists received about 47.8 percent of payments for MRI services, followed by hospital outpatient providers with 33.8 percent, and medical doctors with 12 percent. On average, radiologists received $1,071 for an MRI service, hospital outpatient providers received $1,087, and medical doctors received $1,147.

Table 6. Distribution and average payments by provider type for MRI services, 2004

Service	Description	Total payments	Fee schedule	Average payment	RA	HO	MD	OM
72148	MRI; lumbar spine w/o dye	$3,567,098	**$1,021**	**$1,021**	$998	$1,033	$1,079	$954
		1.4%		99.6%	48.7%	35.3%	10.1%	5.5%
73721	MRI; joint of lower extremity w/o dye	$2,897,675	**$906**	**$903**	$904	$896	$961	$894
		1.1%		99.3%	45.2%	32.8%	15.0%	6.3%
73221	MRI; joint upper extremity w/o dye	$2,288,224	**$906**	**$904**	$870	$913	$969	$906
		0.9%		99.7%	45.3%	32.8%	14.8%	6.7%
72158	MRI; lumbar spine w/o & w/ dye	$1,689,977	**$1,989**	**$1,886**	$1,916	$1,880	$1,984	$1,739
		0.7%		99.3%	51.9%	34.3%	8.1%	4.9%
72141	MRI; neck spine w/o dye	$1,500,118	**$946**	**$939**	$921	$958	$995	$871
		0.6%		99.5%	49.1%	32.9%	10.9%	6.7%
Remaining MRI services:		$1,816,246						
		0.7%						
Total of MRI services:		**$13,759,338**		**Weighted**	**$1,071**	**$1,087**	**$1,147**	**$1,031**
Percentage of total 2004 payments:		**5.4%**		**Average**	**47.8%**	**33.8%**	**12.0%**	**6.0%**

Note: The average payment for an MRI service is estimated as the sum of the average payments for technical and professional components of the service, reported separately under "TC" and "26" modifiers (reported in Bulletin 220 under "Modifier code" field) respectively.

Summary

•Workers' compensation medical payments for 2004 totaled $259,447,381.

•Medical doctors, hospital inpatient, hospital outpatient, and "other medical" providers together accounted for 77.3 percent of total medical payments in 2004.

•On average, medical payments for services were below the respective fee schedule ceilings.

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