STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

In the Matter of the Amendment of:

OAR 436-009, Oregon Medical Fee and Payment
OAR 436-010, Medical Services
OAR 436-015, Managed Care Organizations

) SUMMARY OF
) TESTIMONY AND
) AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency's conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated Feb. 1, 2023. On Feb. 15, 2023, at 1 p.m., a public rulemaking hearing was held as announced, in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon, and by teleconference and videoconference. Fred Bruyns, from the Workers' Compensation Division, was the hearing officer. The record was held open for written comment through Feb. 21, 2023.

Testimony list:

Exhibit	Testifying
1	Connie Whelchel, k.p.d. insurance
2	Scott Colling, PT, Cascade Health
3	Elaine Schooler, SAIF Corporation
4	Hearing transcript: a) Scott Colling, PT, Cascade Health b) Richard Abraham, MD, Cascade Health
5	Steven Bennett, American Property Casualty Insurance Association

Testimony: OAR 436-009-0040 ***Exhibit 2, 4.a.***

Note: Exhibit 2 has extracted text from Mr. Colling's written testimony, which is consistent with Exhibit 4.a., the oral testimony Mr. Colling provided at the rulemaking hearing.

". . . . My clinic and my coworkers provide many occupational services for local businesses and injured workers. Our clinic provides pre-employment testing, fit for duty exams, ergonomic training, PCE's, work conditioning, as well as treating injured workers. As you are most likely aware the vast majority of work-related injuries are musculoskeletal in nature and thus are significantly helped by the therapies we provide. Providing therapies helps an injured worker regain function and contributes to either a quicker return to full duty at their place of

employment, or moving the claim along in a more expedited manner. Both of these benefits contribute to reducing overall costs of workers comp injuries, which in turn, helps businesses, workers, and insurance companies alike.

"Over the last 12 to 13 years the most commonly charged CPT codes for Workers Compensation have remained relatively flat and, in some cases, decreased in the amount of reimbursement. Moreover, most if not all of the frequently used CPT codes for treatment, such as therapeutic exercise, manual therapy, ultrasound, electrical stim, iontophoresis, and manual traction have decreased in reimbursement during this time. For example, in 2010 therapeutic exercise, one of the most commonly used codes in both physical and occupational therapy, had a reimbursement value of $53.12. As of January 1, 2023, the same code for reimbursement is now $51.70, a decrease in reimbursement of 3%. The table below provides illustration regarding this trend.

Code	***Service***	***2010***	***2023***	***% Increase/Decrease***
97140	Manual therapy	50.32	47.54	- 8%
97110	Ther. Exercise	53.72	51.70	- 3%
97033	Iontophoresis	48.33	34.47	-28%
97140	Manual Traction	50.32	45.54	-9%
97014	Unat E-Stim	25.84	21.99	-15%

"Simultaneously during this same 13-year period, the cost of doing business in our clinic as well as providing rehabilitation services in general have rose substantially. As with other sectors of the economy, this inflation increase has significantly spiked post Covid Pandemic. The conservative estimate of our wage cost increases are 39-65% over the same period. This does not factor in benefit cost increases or additional items like clinic supplies, vendor related charges or durable medical equipment, which have all increased as well by similar percentages.

"In April 2023 there is a proposed increase of approximately 1.2 to 1.5% per CPT code reimbursement for the treatments listed above. While this may help offset some of the costs associated with treating injured workers, we feel that the amount is contrary to an equitable increase. Therefore, we are proposing for an increase of 18% which is in alignment with the Physician Evaluation and Management (E & M), office code fees suggested earlier this year. I realize that this initial increase in reimbursement values is substantial, however when dividing this over the past 13 years it equates to less than a 1.3% increase, per year, during that time. The suggested increase is also under half of the increase in inflation over that same 13-year period.

"The current increasing gap between the cost to treat and the flat or decreasing reimbursement rate for therapy CPT codes commonly used for treating these workers is unsustainable. The rising cost of providing services to our clients, along with overhead, places increased pressure on a therapist's ability to remain viable in this market. Without a realistic increase in value for these codes, therapists will continue to find it increasingly difficult to treat injured workers effectively, which in turn would cause substantial increases in claim-costs for injuries. These higher costs will inevitably have to be absorbed by insurance companies, workers, and businesses…."

Response: Thank you for your testimony. Proposed rule and fee schedule changes are in large part based on discussions with stakeholders during the rules advisory committee meeting and follow-up advice we receive from stakeholders prior to the publication of the proposed rules and

fee schedules. For the medical fee and payment rules to be effective April 1, 2023, there was no discussion at the advisory committee meeting, and we did not receive any input from stakeholders regarding the fees for physical medicine and rehabilitation, and, therefore, we did not propose any change to the overall fees of this particular service category. However, we will add a proposed fee increase for physical medicine and rehabilitation services to the agenda of the rules advisory committee meeting for the April 1, 2024, medical fee and payment rules.

Testimony: OAR 436-009-0040 ***Exhibit 3***

"…. SAIF acknowledges the importance of reviewing the fee schedule on an annual basis and adjusting payments to maintain consistency with other fee schedules.

"As part of SAIF's review to determine the potential impact of the proposed changes, an initial fiscal review showed an estimated increase in medical fees that was not proportionate to the estimated fiscal impact provided by WCD. For example, SAIF estimated that an 18 percent increase to the E&M codes alone results in an additional $4.3 million per year in medical fee expenses. With approximately 50 percent of the market share, SAIF's estimated fiscal impact is at odds with WCD's estimated fiscal impact of $6.22 million per year for the same increase to the E&M codes. Additionally, WCD's initial expected fiscal impact estimated that every 1 percent increase in the E&M codes would increase the medical fee expenses by $400,331. See WCD's October 18, 2022 Issues Document. For E&M office visits alone, the expected fiscal impact would be approximately $7.2 million (18 percent increase x $400,331) per year. Based on the different estimated fiscal impacts provided by WCD and compared to SAIF's analysis, it is unclear how WCD arrived at its estimated system-wide impact for the proposed increases. SAIF would appreciate further clarification from WCD as the different estimates are significant.

"SAIF has also reviewed the proposed increases and remains unsure as to the methodology used by WCD to arrive at the specific fee increases. Additional explanation would allow for meaningful feedback from SAIF regarding the proposed changes. SAIF requests that WCD provide further guidance regarding its methodology prior to adopting permanent rules, which allows stakeholders to offer constructive feedback.

"In addition, WCD's January 24, 2023 notice addresses the cost of compliance effect on small businesses, focusing on insurers, self-insured employers and health care providers. The notice does not address the impact on small businesses in general whose insurance costs may be affected by the proposed rule changes. SAIF requests that WCD's impact analysis consider the cost of compliance for all small businesses as part of its analysis…."

Response: Thank you for your testimony.

The department uses the following methodology to calculate the impact of a fee increase:

- The department calculates the amount, in dollars and cents, that the fee schedule would change in response to a 1 percent increase for each affected service code;
- The department then applies that to the department's estimate of the utilization for the year of the increase and sum across each service category (e.g., E&M – Office Visits);
- The department then multiplies that by the size of the proposed increase (e.g., 18%); and

- Lastly, the department adjusts by the proportion of the change that's expected to be realized in terms of payments. (See also NCCI's Research Brief "The Impact of Fee Schedule Updates on Physician Payments.")

Amending rules and fee schedules is a rather lengthy process, and final numbers may not be available yet when WCD holds the rules advisory committee meeting. The department updates the projected fiscal impacts based on updated data available when publishing proposed rules. Based on the most up-to-date data available, the department projects the implementation of the updated fee schedules, effective April 1, 2023, will have the following fiscal impacts:

- 18 percent increase in fee schedule for E&M office visits: $6.63 million (1.8 percent of total medical costs);
- 14 percent increase in fee schedule for major surgery: $2.63 million (0.7 percent of total medical costs);
- 10 percent increase in fee schedule for chiropractic manipulation treatment: $0.25 million (0.1 percent of total medical costs);
- Increase in fee schedule for selected arbiter services: $0.26 million (0.1 percent of total medical costs); and
- 8.7 percent increase of the DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) fee schedule: $1.12 million (0.3 percent of total medical costs).

Proposed rule and fee schedule changes are in large part based on discussions with stakeholders during the rules advisory committee meeting and follow-up advice we receive from stakeholders prior to the publication of the proposed rules and fee schedules. Multiple providers stated that many providers are dropping out of providing care for injured workers, there are record inflation levels, supply chain disruptions, steeply increasing commercial property costs, and drastically increasing skilled medical workforce wages and salaries. Based on the above, providers reasoned that a substantial increase in fees was needed. One provider explained that "when I crunch all the numbers, for me to be at where I was at in 2021 – just flat – I came up with an 18.16% increase that was necessary."

The department also analyzed the all payers all claims (APAC)[1] data and found that over the last few years, the E&M fee schedules were close to or below the fee schedules of private health plans. Providers have noted that the time consuming nature and additional overhead and labor costs managing workers' compensation patients results in significantly higher costs compared to caring for non-workers' compensation patients. Therefore, it is justified to have higher workers' compensation fee schedules than private health fee schedules. When comparing the workers' compensation fee schedules for chiropractic manipulation treatment and major surgery to private health, the department noted that the difference between private health and workers' compensation has been getting smaller over the last four to five years.

[1] The APAC database is jointly administered by the Oregon Health Authority (OHA) and DCBS. The OHA has a data-sharing agreement with DCBS' Division of Financial Regulation (DFR). The APAC database has service-level billing data for medical services paid by commercial insurers, Medicare and Medicaid. Our analysis included only data from commercial insurers. More about the APAC database can be found here.

Developments in the cost of covering workers' compensation claims are reflected in the pure premium rates employers pay for coverage. Pure premium rates represent the anticipated cost per $100 of payroll to cover an employer's claims, without any allowance for the insurer's overhead expenses and profit. Pure premium rates are calculated each year by the National Council on Compensation Insurance (NCCI) and submitted to the Director for review and approval.

Medical costs are one of the factors that impact pure premium rates, but they are also impacted by other factors that affect claim costs, such as changes to how claims are adjudicated and trends in claim frequency and severity. Oregon's average pure premium rate has generally declined over the past ten years even as medical costs have risen.

Because medical costs are only one of the many factors that impact pure premium rates, we are not able to estimate how the proposed rules will impact small businesses.

Therefore, WCD publishes the physician fee schedule (Appendix B) as proposed.

Testimony: OAR 436-009-0040 ***Exhibit 4.b.***

"…. I was looking at our commercial contracts that we have in place, that I would use for comparative purposes. And, I think that with what was done in the E&M codes, even though I understand that it's a substantial increase over one year, it kind of gets us to where we probably should have been at least two or three years ago. And, so whether that happens in one year, over two years, I think what's been done has been great. But, I think that, and honestly, [audio unclear] to catch up. That said, I think that the discrepancies I see that I'm kind of surprised a bit are the surgical codes. And, you know, I want to be a little careful here, but I feel like, to me, when I look at all of our other contracts, the surgical codes and the E&M codes are all paid at the same rate. We don't have any contracts, at least that I've ever seen where they're paid differently. So, you know, if we were to take money from somewhere, perhaps from the surgical code increase – and we use both codes in our practice. We use both surgical codes and E&M codes, and particularly in our emergency medicine practice seeing injured workers. But, to me, if you were to pull some money from somewhere, perhaps it should come from the increase in surgical codes.

"That's just a suggestion, you know, trying to hear both sides of the story in talking to my contacts at SAIF, [connection lost temporarily] … and employers, I know that are [audio unclear] I know there's concern that the rates are going up so much in one year. And, I would say that I understand that and empathize with that, but had we had annual escalators in place, like most – at least like all of our commercial contracts do, we wouldn't have ever been put in this situation. And, I would suggest that going forward honestly, because this is a huge process to go every year and very time consuming with people that are very busy doing their jobs in a day. And, I think having an annual escalator of two and a half or three percent every year would make sense.

"…. But, you know, with these proposed increases the surgical codes are going to be, I think, over $100, which is - it would just be pretty substantial. I don't want to get any scalpels thrown at me, but I feel like that is something to possibly look at as far as redistributing some of the dollars, or taking some dollars out to kind of save some money overall, as far as the overall annual impacts for this year on insurers and employers.

"So, I just think that – the other contracts, the commercial contracts we have also [audio unclear] nurse prac [audio unclear] pay mid-level the same as they pay the physicians, because of the pay parity. We don't see any where there's a 15 percent reduction either. So, that's the other area that's different, is normally the surgical codes and E&M codes are the same conversion factor, and the mid-levels are paid at the same level as physicians are paid, with the pay parity laws.

"So, that's just something else to consider, but I don't know what the spend is annually, between surgical codes and E&M codes. I'm assuming it's more skewed to E&M codes, but I'm not sure. Does anybody have that data, in terms of how much – what the dollar amount is of the proposed 14 percent increase for surgical codes, versus 18 percent in E&M codes – what the actual dollar amount, overall dollar amount be? …. Are the E&M codes higher? …. [Agency staff provided estimated dollar amounts from the rulemaking notice.] …. Okay, yes, that's helpful. But, I think this proposed increase would take surgical codes over $100, which is pretty unheard of. Just trying to look at all sides here. And, so if we were to, you know, rob Peter to pay Paul so to speak, that might be the place to consider doing it. …. And, but I do feel like, at least on the E&M side, it does catch up to where we should be, not including kind of a differential over the last, you know, five or ten years that's been lost. But, I know it is a significant impact, and I recognize that…."

Response: Thank you for your testimony. Based on the discussions at the advisory committee meeting in November, and analysis of the all payer all claims (APAC) data, the division believes that an 18% increase in E&M fees and a 14% increase in major surgical fees is reasonable and justified. Even with the 14% increase in major surgical fees, the conversion factor for major surgery is $86.84, well below the $100 you are suggesting. The conversion factor for E&M office visits will be $77.77, i.e., $9.07 below the major surgical conversion factor. Going back ten years, we find that from 2013 through 2022, the average conversion factor for E&M was $10.62 lower than the surgical conversion factor. This means, even with the implemented fee increases, the difference of the conversion factors of these two categories is less than the historical, ten year average.

There was no discussion at the advisory committee meeting regarding payment levels of nurse practitioners and other mid-level providers and, therefore, WCD did not propose a change in how nurse practitioners and physician assistants are being paid. If you would like this topic discussed at the advisory committee meeting for the April 1, 2024, Medical Fee and Payment Rules, please complete "How to submit a rule change recommendation - form: PDF or Word," which can be found under "Oregon Administrative Rules" on this website: Oregon Workers' Compensation Division : Laws and rules resources : Laws and rules : State of Oregon

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Testimony: OAR 436-010-0240 ***Exhibit 1***

"It is heartening to see the amended 436-010-0240 rule that encourages medical providers to discuss work duties/restrictions with employers. The communication between providers and the employers-at-injury is not only reasonable, but ideal as employers are constantly yearning for work releases ASAP so they can create/offer modified work accordingly. When employers don't receive work releases timely, it can needlessly extend workers' disabilities and claims (i.e., Time Loss) costs. And when the employers must rely on their insurers to get work releases, using a middle person (i.e., the insurer) can unnecessarily extend the disability time and claims costs, too. Eventually, I'd like to see an additional rule(s) that provides medical providers with clear

timelines regarding when they need to provide work release information to employers, especially following their exams of injured workers. (Maybe for the next rule-making session.) Even though employers will enact policies for their workers to provide them with copies of their work releases, workers don't always comply with these, or they are not timely providing their work releases to their employers. Consequently, there are claims that go disabling that could have stayed non-disabling if only the providers sent the work release information directly to the employer vs. relying on the insurer or worker to be the go-between. It is, after all, the employer who is responsible for creating/offering the modified work…."

Response: Thank you for your testimony. We will add the issue of "an additional rule(s) that provides medical providers with clear timelines regarding when they need to provide work release information to employers" to the agenda of the rules advisory committee meeting later this fall for the Medical Services rules to be effective April 1, 2024.

Testimony: OAR 436-010-0240(4)(g) ***Exhibit 5***

"…. APCIA in general supports the proposed amendments and thanks the Workers' Compensation Division on their efforts in updating the rules. APCIA does, however, have some concerns regarding proposed new section 436-010-0240(4)(g). This new section states: "A medical provider is encouraged to discuss potential modified work duties with employers. However, a medical provider may not discuss medical treatment or diagnoses with employers or release medical records to employers."

"APCIA is concerned that the new language could be interpreted to interfere with a workers' compensation insurer's or self-insured employer's need for medical information to properly administer the claim. Any prohibition or delays in communicating medical information to the carrier or to the self-insured employer would disrupt and delay the administration of the claim and could prevent the claimant from receiving timely and appropriate medical care. It is essential that insurers and self-insureds may communicate with the medical provider and receive the claimant's medical information.

"APCIA has been advised that the intent of the new language is not to interfere in any way with the communication and distribution of medical information to the carrier or self-insurer to efficiently administer the claim. We also understand that the new language is not intended to interfere with the right of the carrier to discuss with its policyholder case management and appropriate treatment. We believe the intent of the proposed new section is only to limit communications between the medical provider and the employer when the employer is not self-insured.

"APCIA notes that other sections of the rule preserve the right of the carrier and the self-insurer to the claimant's medical information. Section 436-010-0240(4)(a) provides that "Health Insurance Portability and Accountability Act rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services." Section 436-010-0240(4)(b) states "When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records….The authorization is for the life of the claim and cannot be revoked by the patient or the patient's representative."

"New proposed section 436-010-0240(4)(g)'s prohibition of communications between the medical provider and the employer creates at least the possibility of some confusion and ambiguity regarding the release of medical records of the provider to carriers and self-insured employers. To alleviate the potential for any ambiguity, APCIA recommends that the Division insert additional language to proposed new section 436-010-0240(4)(g) to clarify that notwithstanding the new language, insurers and self-insureds may continue to obtain medical information from the medical provider and the insurer remains free to discuss case management and treatment plans with its policyholder.…"

Response: Thank you for your testimony. WCD added additional language to OAR 436-010-0240(4)(g) to alleviate the potential for any ambiguity.

Dated this 10th day of March, 2023.

Exhibit "1"

BRUYNS Fred H * DCBS

From: Connie Whelchel <Conniew@kpdinsurance.com>
Sent: Monday, January 30, 2023 3:58 PM
To: BRUYNS Fred H * DCBS
Cc: KUNZ Juerg * DCBS
Subject: RE: Proposed rules published: OAR 436-009, 010, and 015

Hi Fred,

Thank you for the explanation. In that case, here's what I'd like to submit for written testimony:

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It is heartening to see the amended 436-010-0240 rule that encourages medical providers to discuss work duties/restrictions with employers. The communication between providers and the employers-at-injury is not only reasonable, but ideal as employers are constantly yearning for work releases ASAP so they can create/offer modified work accordingly. When employers don't receive work releases timely, it can needlessly extend workers' disabilities and claims (i.e., Time Loss) costs. And when the employers must rely on their insurers to get work releases, using a middle person (i.e., the insurer) can unnecessarily extend the disability time and claims costs, too. Eventually, I'd like to see an additional rule(s) that provides medical providers with clear timelines regarding when they need to provide work release information to employers, especially following their exams of injured workers. (Maybe for the next rule-making session.) Even though employers will enact policies for their workers to provide them with copies of their work releases, workers don't always comply with these, or they are not timely providing their work releases to their employers. Consequently, there are claims that go disabling that could have stayed non-disabling if only the providers sent the work release information directly to the employer vs. relying on the insurer or worker to be the go-between. It is, after all, the employer who is responsible for creating/offering the modified work.
==========

Please let me know if there's anything else I need to do.

Thank you for your guidance!
Connie

CONNIE WHELCHEL MBA | NPN #6243330
WORKERS' COMP CLAIMS RISK ADVISOR
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k.p.d. Insurance LLC CA #6005451

Exhibit "2"

Good afternoon:

My name is Scott Colling, and I am a Physical therapist in Eugene, Oregon who treats injured workers for Cascade Health physical and occupational therapy. The purpose of my attendance in this hearing today is regarding the real value of rehabilitation for treating injured workers vs the low CPT code reimbursement for Workmen's Compensation.

My clinic and my coworkers provide many occupational services for local businesses and injured workers. Our clinic provides pre-employment testing, fit for duty exams, ergonomic training, PCE's, work conditioning, as well as treating injured workers. As you are most likely aware the vast majority of work-related injuries are musculoskeletal in nature and thus are significantly helped by the therapies we provide. Providing therapies helps an injured worker regain function and contributes to either a quicker return to full duty at their place of employment, or moving the claim along in a more expedited manner. Both of these benefits contribute to reducing overall costs of workers comp injuries, which in turn, helps businesses, workers, and insurance companies alike.

Over the last 12 to 13 years the most commonly charged CPT codes for Workers Compensation have remained relatively flat and, in some cases, decreased in the amount of reimbursement. Moreover, most if not all of the frequently used CPT codes for treatment, such as therapeutic exercise, manual therapy, ultrasound, electrical stim, iontophoresis, and manual traction have decreased in reimbursement during this time. For example, in 2010 therapeutic exercise, one of the most commonly used codes in both physical and occupational therapy, had a reimbursement value of $53.12. As of January 1, 2023, the same code for reimbursement is now $51.70, a decrease in reimbursement of 3%.

The table below provides illustration regarding this trend.

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97014	Unat E-Stim	25.84	21.99	-15%

Simultaneously during this same 13-year period, the cost of doing business in our clinic as well as providing rehabilitation services in general have rose substantially. As with other sectors of the economy, this inflation increase has significantly spiked post Covid Pandemic. The conservative estimate of our wage cost increases are 39-65% over the same period. This does not factor in benefit cost increases or additional items like clinic supplies, vendor related charges or durable medical equipment, which have all increased as well by similar percentages.

In April 2023 there is a proposed increase of approximately 1.2 to 1.5% per CPT code reimbursement for the treatments listed above. While this may help offset some of the costs associated with treating injured workers, we feel that the amount is contrary to an equitable increase. Therefore, we are proposing for an increase of 18% which is in alignment with the Physician Evaluation and Management (E & M), office code fees suggested earlier this year. I realize that this initial increase in reimbursement values is substantial, however when dividing this over the past 13 years it equates to less than a 1.3%

increase, per year, during that time. The suggested increase is also under half of the increase in inflation over that same 13-year period.

The current increasing gap between the cost to treat and the flat or decreasing reimbursement rate for therapy CPT codes commonly used for treating these workers is unsustainable. The rising cost of providing services to our clients, along with overhead, places increased pressure on a therapist's ability to remain viable in this market. Without a realistic increase in value for these codes, therapists will continue to find it increasingly difficult to treat injured workers effectively, which in turn would cause substantial increases in claim-costs for injuries. These higher costs will inevitably have to be absorbed by insurance companies, workers, and businesses.

I want to thank you for giving me the opportunity to speak on behalf of my profession.

Sincerely,

Scott Colling, PT

Cascade Health Physical and Occupational Therapy

2650 Suzanne Way

Eugene, OR 97408

(541)-228-3130

Exhibit "3"

saif Work. Life. Oregon.

February 15, 2023

FRED BRUYNS, RULES COORDINATOR
WORKERS' COMPENSATION DIVISION
PO BOX 14480
SALEM, OR 97309

Re: Proposed permanent rules for medical fee schedules, payments, and related procedures under OAR 436-009

Dear Fred,

SAIF Corporation (SAIF) has considered the Workers' Compensation Division's (WCD) proposed permanent amendments to OAR 436-009. SAIF, as always, appreciates the opportunity to provide input on the proposed rule changes and urges WCD to reassess the projected fiscal impact of the proposed changes.

WCD's proposed permanent rule increases the physician fee schedule for the maximum payment for Evaluation and Management (E&M) office codes, major surgery, chiropractic manipulation, medical arbiter exams, and durable medical equipment. SAIF acknowledges the importance of reviewing the fee schedule on an annual basis and adjusting payments to maintain consistency with other fee schedules.

As part of SAIF's review to determine the potential impact of the proposed changes, an initial fiscal review showed an estimated increase in medical fees that was not proportionate to the estimated fiscal impact provided by WCD. For example, SAIF estimated that an 18 percent increase to the E&M codes alone results in an additional $4.3 million per year in medical fee expenses. With approximately 50 percent of the market share, SAIF's estimated fiscal impact is at odds with WCD's estimated fiscal impact of $6.22 million per year for the same increase to the E&M codes. Additionally, WCD's initial expected fiscal impact estimated that every 1 percent increase in the E&M codes would increase the medical fee expenses by $400,331. See WCD's October 18, 2022 Issues Document. For E&M office visits alone, the expected fiscal impact would be approximately $7.2 million (18 percent increase x $400,331) per year. Based on the different estimated fiscal impacts provided by WCD and compared to SAIF's analysis, it is unclear how WCD arrived at its estimated system-wide impact for the proposed increases. SAIF would appreciate further clarification from WCD as the different estimates are significant.

SAIF has also reviewed the proposed increases and remains unsure as to the methodology used by WCD to arrive at the specific fee increases. Additional explanation would allow for meaningful feedback from SAIF regarding the proposed changes. SAIF requests that WCD provide further guidance regarding its methodology prior to adopting permanent rules, which allows stakeholders to offer constructive feedback.

400 High Street SE
Salem, OR 97312
P: 800.285.8525
F: 503.373.8020

In addition, WCD's January 24, 2023 notice addresses the cost of compliance effect on small businesses, focusing on insurers, self-insured employers and health care providers. The notice does not address the impact on small businesses in general whose insurance costs may be affected by the proposed rule changes. SAIF requests that WCD's impact analysis consider the cost of compliance for all small businesses as part of its analysis.

As always, SAIF appreciates WCD's engagement and commitment to the rulemaking process as well as its collaborative approach.

Sincerely,

/s/ Elaine Schooler
Attorney
P: 503.534.5944
F: 503.584.9576
elasch@saif.com

Exhibit "4"

BEFORE THE DIRECTOR OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES OF THE STATE OF OREGON

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR: 436-009, Oregon Medical Fee and Payment 436-010, Medical Services 436-015, Managed Care Organizations	)))))	TRANSCRIPT OF TESTIMONY

The proposed amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated Feb. 1, 2023. On Feb. 15, 2023, a public rulemaking hearing was held as announced at 1 p.m. in Room F and via teleconference from the Labor & Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns from the Workers' Compensation Division, was the hearing officer. The record will be held open for written comment through Feb. 21, 2023.

INDEX OF WITNESSES

Witnesses **Page**

TRANSCRIPT OF PROCEEDINGS

Fred Bruyns:

Good morning and welcome. This is a public rulemaking hearing. My name is Fred Bruyns, and I'll be the presiding officer for the hearing.

The time is now 1 p.m. on Wednesday, Feb. 15, 2023. We are conducting this hearing from Conference Room F in the Labor & Industries Building in Salem, Oregon. However, we are also doing so virtually, by video and telephone conferencing. We are making an audio recording of the hearing and a video recording.

The Workers' Compensation Division of the Department of Consumer and Business Services proposes to amend chapter 436 of the Oregon Administrative Rules, specifically:

- OAR 436-009, Oregon Medical Fee and Payment,
- OAR 436-010, Medical Services, and
- OAR 436-015, Managed Care Organizations.

The department has: summarized the proposed rule changes and prepared estimates of fiscal and economic impacts in the notice of proposed rulemaking filed with the Oregon

Secretary of State; published rulemaking notice to its postal and electronic mailing lists; notified Oregon legislators as required by ORS chapter 183; and posted public notice and the proposed rules to its website. I'll add that we also have some testimony posted to our website, so I would encourage anyone who is interested to go and have a look at that.

The Oregon Secretary of State published the hearing notice in its *Oregon Bulletin* dated Feb. 1, 2022.

This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including Feb. 21, 2023, and will make no decisions until all of the testimony is considered.

We are ready to receive public testimony. I going to ask Scott Colling, with Cascade Health to go ahead and testify.

Scott Colling, PT:

Good afternoon. My name is Scott Colling, and I am a physical therapist in Eugene, Oregon, who treats injured workers for Cascade Health Physical and Occupational Therapy. The purpose of my attendance at this hearing today is to bring to light the real value of rehabilitation for treating injured workers versus the CPT code reimbursement for workers' compensation.

My clinic and my co-workers provide many occupational services for local businesses and for injured workers. Our clinic provides pre-employment testing, fit for duty exams, ergonomic training, PCE's, work conditioning, as well as treating injured workers. As you are most likely aware the vast majority of work-related injuries are musculoskeletal in nature and thus are significantly helped by the therapies we provide. Providing therapies helps an injured worker regain function and contributes to a quicker return to their place of work, or helps the claim move on in a more expedited manner. Both of these benefits contribute to reducing overall costs of workers, their injuries, and in turn helps businesses, workers, and insurance companies alike.

Over the past 12 to 13 years the most commonly charged CPT codes for Workers' Compensation have remained relatively flat and, in some cases, decreased in the amount of reimbursement. Moreover, most if not all of the frequently used codes for treatment, such as therapeutic exercise, manual therapy, ultrasound, electrical stim, iontophoresis, and manual traction have decreased in reimbursement during this time. For example, in 2010, therapeutic exercise, one of the most commonly used for both physical and occupational therapy, had a reimbursement value of $53.12. As of Jan. 1, 2023, that same code for reimbursement is now $51.70, a decrease of reimbursement of 3%.

The table below provides an illustration regarding this trend, and I'll summarize. Manual therapy has decreased in reimbursement by 8 percent. Iontophoresis decreased by 28 percent. Manual traction, a decrease in 9 percent. And, ultrasound and e-stim a decrease of 15 percent.

Simultaneously during the same 13-year period, the cost of doing business in our clinic, as well providing rehabilitation services in general, have rose substantially. As with other sectors of our economy, this inflation increase has significantly spiked post-COVID pandemic. The conservative estimate of our wage cost increases are 39 to 65 percent over that same period. And, this does not factor in the benefit cost increases or additional items like clinic supplies, vendor related charges or durable medical equipment, which have all increased as well by similar percentages.

In April 2023, there is a proposed increase of approximately 1.2 to 1.5 percent per CPT code reimbursement for the treatments listed above. While this may help offset some of the costs associated with treating injured workers, we feel this amount is contrary to an equitable increase. Therefore, we are proposing an increase of 18 percent, which is in alignment with the Physician Evaluation and Management, or E&M office code fees suggested earlier this year. I realize that this initial increase for reimbursement values is substantial. However, when dividing this over the past 13 years it equates to approximately 1.3% increase per year during that time. The suggested increase is also under half of the increase of inflation during that same 13-year period.

The current increasing gap between the cost to treat and the flat or decreasing reimbursement rate for therapy CPT codes commonly used for treating injured workers is unsustainable. The rising cost of providing services to our clients, along with overhead, places increased pressure on a therapist's ability to remain viable in this market. Without a realistic increase in value for these codes, therapists will continue to find it increasingly difficult to treat injured workers effectively, which in turn would cause substantial increases in claim costs for injuries. These higher costs will inevitably have to be absorbed by insurance companies, workers, and businesses.

I want to thank you for giving me the opportunity to speak on behalf of my profession.

Fred Bruyns:

Thank you very much, Scott. I appreciate it. Is there anyone else who would like to testify at this time?

Richard Abraham, MD:

Fred, can you hear me?

Fred Bruyns:

Yes, I can. Are you Dr. Abraham?

Richard Abraham, MD:

It's Dr. Abraham. Yeah, it's Dr. Abraham.

Fred Bruyns:

Go ahead, doctor.

Richard Abraham, MD:

I didn't know if there is anybody else who is scheduled to testify.

Fred Bruyns:

Not at this time, so go ahead.

Richard Abraham, MD:

Okay, so you know I appreciate the work the division did on the codes, and I think that I would just like to make a couple of comments. So, as I look at everything, and I apologize, I've got laryngitis now. I've lost my voice a bit. Hopefully, everybody can hear me okay. Can you hear me okay?

Fred Bruyns:

Yes, we can. It's coming through quite clearly. Thank you, doctor.

Richard Abraham, MD:

Okay, thank you. So, I was looking at our commercial contracts that we have in place, that I would use for comparative purposes. And, I think that with what was done in the E&M codes, even though I understand that it's a substantial increase over one year, it kind of gets us to where we probably should have been at least two or three years ago. And, so whether that happens in one year, over two years, I think what's been done has been great. But, I think that, and honestly, [audio unclear] to catch up. That said, I think that the discrepancies I see that I'm kind of surprised a bit are the surgical codes. And, you know, I want to be a little careful here, but I feel like, to me, when I look at all of our other contracts, the surgical codes and the E&M codes are all paid at the same rate. We don't have any contracts, at least that I've ever seen where they're paid differently. So, you know, if we were to take money from somewhere, perhaps from the surgical code increase – and we use both codes in our practice. We use both surgical codes and E&M codes, and particularly in our emergency medicine practice seeing injured workers. But, to me, if you were to pull some money from somewhere, perhaps it should come from the increase in surgical codes. That's just a suggestion, you know, trying to hear both sides of the story in talking to my contacts at SAIF, …. [connection lost]

Fred Bruyns:

Is that it Dr. Abraham? Are you still there, doctor? We may have lost the connection. Can anyone else hear me? Is anyone else on to make sure we haven't lost all connections. [Several attendees replied that they could hear Fred.] Okay, well hopefully Dr. Abraham will either be back, or that concluded his testimony, but I suspect we were cut off. Is there anyone else who would like to testify at this time? Sounded like someone was coming in. Okay, perhaps not.

Richard Abraham, MD:

Can you hear me now?

Fred Bruyns:

Yes I can, Doctor. Go ahead. You were cut off somehow.

Richard Abraham, MD:

Okay, so our building here does not have the best cell service. So, when we just – can you hear me now?

Fred Bruyns:

Yes we can. Go ahead.

Richard Abraham, MD:

Okay, where did I finish off, before I was talking to myself?

Fred Bruyns:

You just mentioned something about contacting SAIF Corporation – your contacts at SAIF.

Richard Abraham, MD:

Yeah, just my contacts at SAIF and employers, I know that are [audio unclear] I know there's concern that the rates are going up so much in one year. And, I would say that I understand that and empathize with that, but had we had annual escalators in place, like most – at least like all of our commercial contracts do, we wouldn't have ever been put in this situation. And, I would suggest that going forward honestly, because this is a huge process to go every year and very time consuming with people that are very busy doing their jobs in a day. And, I think having an annual escalator of two and a half or three percent every year would make sense. That said, I think that – I can't remember if this recorded or not earlier, but I think the big discrepancy I see in our contracts is the difference between the surgical codes and the E&M codes. And, in all of our other contracts, E&M and the surgical codes are paid the same rate. And, our practice does –

uses both codes, both our emergency medicine practice and our occ health practices use both surgical codes and E&M codes. But, you know, with these proposed increases the surgical codes are going to be, I think, over $100, which is - it would just be pretty substantial. I don't want to get any scalpels thrown at me, but I feel like that is something to possibly look at as far as redistributing some of the dollars, or taking some dollars out to kind of save some money overall, as far as the overall annual impacts for this year on insurers and employers. So, I just think that – the other contracts, the commercial contracts we have also [audio unclear] nurse prac [audio unclear] pay mid-level the same as they pay the physicians, because of the pay parity. We don't see any where there's a 15 percent reduction either. So, that's the other area that's different, is normally the surgical codes and E&M codes are the same conversion factor, and the mid-levels are paid at the same level as physicians are paid, with the pay parity laws. So, that's just something else to consider, but I don't know what the spend is annually, between surgical codes and E&M codes. I'm assuming it's more skewed to E&M codes, but I'm not sure. Does anybody have that data, in terms of how much – what the dollar amount is of the proposed 14 percent increase for surgical codes, versus 18 percent in E&M codes – what the actual dollar amount, overall dollar amount be?

Fred Bruyns:

We did estimate the dollar amounts, and it's on the notice of proposed rulemaking, the dollar impacts of surgery and E&M changes. Go ahead doctor.

Richard Abraham, MD:

Are the E&M codes higher? I'm sorry, I don't have that at my fingertips. And, I probably didn't notice it.

Don Gallogly (Information Technology & Research):

Yes, E&M codes are higher. I don't have the dollar figures in front of me. This is Don Gallogly. I'm a research analyst on medical benefits. E&M codes indeed are higher by – they're about double generally, but I don't have the actual dollars in front of me.

Richard Abraham, MD:

Okay, no worries.

Fred Bruyns:

Doctor, there's a $6.22 million impact of the E&M – estimated impact of the E&M changes, and a $2.46 million per year impact of the major surgery category increase.

Richard Abraham, MD:

Okay, yes, that's helpful. But, I think this proposed increase would take surgical codes over $100, which is pretty unheard of. Just trying to look at all sides here. And, so if we were to, you know, rob Peter to pay Paul so to speak, that might be the place to consider doing it. Anyway, thanks for listening. I thought I'd at least say something, so that we know in hearing all sides, and try to consider where everybody fits and try to be, you know, to sit in someone else's chair in looking at this and not just from my side. And, but I do feel like, at least on the E&M side, it does catch up to where we should be, not including kind of a differential over the last, you know, five or ten years that's been lost. But, I know it is a significant impact, and I recognize that.

Fred Bruyns:

Thank you very much, Dr. Abraham for all of your input.

Richard Abraham, MD:

My pleasure.

Fred Bruyns:

Thank you. Is there anyone else who would like to testify at this time? Hearing no one, in a moment I will recess the hearing, but we will resume for additional testimony if anyone wishes to testify before 2 p.m.

Again, the record remains open for written testimony through and including Feb. 21. You may submit testimony in any written form. I encourage you to submit your testimony by email or as attachments to email. However, you may also use US mail. I will acknowledge all testimony received.

This hearing is recessed at 1:17 p.m.

Okay, this is Fred again. I'm checking back with you to see if there is anyone who would like to testify at this time. Hearing no one, the time is 1:59 p.m.

Thank you for coming. This hearing is adjourned. Good day.

Transcribed from a digital audio recording by Fred Bruyns, Feb. 15, 2023.

Exhibit "5"

February 21, 2023

Mr. Fred Bruyns
Rules Coordinator
Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
Salem, OR 97309-0405

Via Electronic Mail: WCD.Policy@dcbs.oregon.gov

Re: Proposed Amendments to Medical Service Rules

Dear Mr. Bruyns:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the Workers' Compensation Division's proposed amendments to the workers' compensation rules relating to medical fees and payments, medical services, and managed care organizations.

APCIA represents nearly 70 percent of the U.S. property casualty insurance market and the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, protecting families, communities, and businesses in the U.S. and across the globe. APCIA advocates for a healthy and stable state workers' compensation system that provides prompt indemnity benefits and high-quality medical care to injured workers at a fair and reasonable cost to employers.

APCIA in general supports the proposed amendments and thanks the Workers' Compensation Division on their efforts in updating the rules. APCIA does, however, have some concerns regarding proposed new section 436-010-0240(4)(g). This new section states: "A medical provider is encouraged to discuss potential modified work duties with employers. However, a medical provider may not discuss medical treatment or diagnoses with employers or release medical records to employers."

APCIA is concerned that the new language could be interpreted to interfere with a workers' compensation insurer's or self-insured employer's need for medical information to properly administer the claim. Any prohibition or delays in communicating medical information to the carrier or to the self-insured employer would disrupt and delay the administration of the claim and could prevent the claimant from receiving timely and appropriate medical care. It is essential that insurers and self-insureds may communicate with the medical provider and receive the claimant's medical information.

APCIA has been advised that the intent of the new language is not to interfere in any way with the communication and distribution of medical information to the carrier or self-insurer to efficiently administer the claim. We also understand that the new language is not intended to interfere with the

right of the carrier to discuss with its policyholder case management and appropriate treatment. We believe the intent of the proposed new section is only to limit communications between the medical provider and the employer when the employer is not self-insured.

APCIA notes that other sections of the rule preserve the right of the carrier and the self-insurer to the claimant's medical information. Section 436-010-0240(4)(a) provides that "Health Insurance Portability and Accountability Act rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services." Section 436-010-0240(4)(b) states "When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records….The authorization is for the life of the claim and cannot be revoked by the patient or the patient's representative."

New proposed section 436-010-0240(4)(g)'s prohibition of communications between the medical provider and the employer creates at least the possibility of some confusion and ambiguity regarding the release of medical records of the provider to carriers and self-insured employers. To alleviate the potential for any ambiguity, APCIA recommends that the Division insert additional language to proposed new section 436-010-0240(4)(g) to clarify that notwithstanding the new language, insurers and self-insureds may continue to obtain medical information from the medical provider and the insurer remains free to discuss case management and treatment plans with its policyholder.

APCIA thanks you for your consideration of these issues.

Sincerely,

Steven A. Bennett
Vice President, Workers Compensation Programs & Counsel
American Property Casualty Insurance Association