

# **THE MEDICAL FEE SCHEDULE UNDER THE WORKERS' COMPENSATION LAW**

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Report No. 8, 1998

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## **FOREWORD**

This study was prepared in response to Senate Resolution No. 55, S.D. 2, adopted during the Regular Session of 1998. The Resolution requested the Legislative Reference Bureau to determine if the 110% ceiling on the workers' compensation medical fee schedule should be adjusted, whether the workers' compensation fee schedule has had a negative impact on the access to specialty care or diminished the quality of care, and what the conditions are for adjusting the fee schedule.

The Bureau extends its appreciation to the agencies and organizations who cooperated and assisted with the investigation, specifically, the Disability Compensation Division of the Department of Labor and Industrial Relations, the Licensing Division of the Department of Commerce and Consumer Affairs, the Workers' Compensation Committee of the Hawaii Medical Association and all the other organizations who provided information and support, without whose cooperation and assistance this report could not have been completed. Mahalo.

Wendell Kimura  
Acting Director

December 1998

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# Chapter 1

## INTRODUCTION

This report is the result of Senate Resolution No. 55, S.D. 2, entitled “Requesting the Legislative Reference Bureau to Conduct a Study of the Workers’ Compensation Fee Schedule” adopted during the Regular Session of 1998. A copy of the resolution is attached as Appendix A. The resolution specifically asks the Legislative Reference Bureau to make findings and recommendations with regard to the conditions and criteria of the medical fee schedule within the workers’ compensation law.

Workers’ compensation in Hawaii, as established under the Workers’ Compensation Law, Chapter 386, Hawaii Revised Statutes, has three major components. They are indemnity, lost time, and medical care. Each of these components has specific costs that are commonly associated with the phrase “the price of workers’ compensation.” “Indemnity” costs refer to the lump-sum payments workers receive for permanent damage incurred as a result of an injury at work. “Lost time” refers to payments made to injured workers in the form of temporary disability. Finally, the third component, and subject of this study is medical care. The medical care component encompasses the costs incurred for all medical care received by injured workers. The cost to the employer comes in the form of an insurance premium that will provide the employee the benefits required by law.<sup>1</sup> The premiums are broken down into temporary disability insurance (TDI) which covers only the “lost-time” wages and is regulated under chapter 388, Hawaii Revised Statutes, and workers’ compensation (WC) premiums. The WC premiums cover both the “indemnity” and “medical care” costs of the injured worker. Both indemnity and medical care are regulated under chapter 386, Hawaii Revised Statutes. The scope of this report includes only the fee schedule for payment of medical care costs as provided in section 386-21, Hawaii Revised Statutes.

### Background

During the 1980s the medical care portion of workers’ compensation costs amounted to approximately one-third of the costs<sup>2</sup> of workers’ compensation. By 1994, the medical care percentage had risen to forty-two percent of the cost of workers’ compensation. Hawaii’s experience with rising workers’ compensation costs in the 80s and early 90s was similar to many states across the country.<sup>3</sup> Employers were concerned that the increasing workers’ compensation insurance costs would drive them out of business. Hawaii’s Legislature addressed this situation by passing Act 234, Session Laws of Hawaii 1995. Act 234 made sweeping reforms to the Workers’ Compensation Law to address various issues. One of those reforms was to change the

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<sup>1</sup> Sections 386-21 through 386-57, Hawaii Revised Statutes (1993, 1998 Supp.).

<sup>2</sup> Interview with Gary Hamada, Administrator, Disability Compensation Division, Department of Labor and Industrial Relations, May 22, 1998.

<sup>3</sup> United States, General Accounting Office, Workers’ Compensation, Selected Comparisons of Federal and State Laws, USGAO, Washington, D.C., April 1996 p. 35. See also: Trolin, Brenda, “Workers’ Compensation – Managed Care”, *National Conference of State Legislatures Legisbrief*, April 1993, Volume 1, No. 15.

medical fee schedule from a schedule based on customary charges that was adjusted annually according to the Consumer Price Index<sup>4</sup> to one that was based on the Medicare Resource Based Relative Value Scale system (“Medicare-RBRVS”). The workers’ compensation law now limits payments for medical services to not more than 110 percent of Medicare-RBRVS. This change effectively reduced the payments to health care providers who provided care to injured employees and were subject to the medical fee schedule. Since the 1995 reform, workers’ compensation costs have decreased. Some lawmakers estimate that savings to employers equaled as much as \$100 million in 1996 and 1997,<sup>5</sup> but it is unclear whether the savings are due to the reduced rates of the medical fee schedule or other factors.<sup>6</sup> These savings have materialized in the form of a 37 percent decrease in costs for workers’ compensation.<sup>7</sup>

Unfortunately, the medical fee schedule has generated a new concern that was unintended, but hardly surprising. Health care providers claim they are forced to turn away workers’ compensation patients because the medical fee schedule doesn’t cover the cost of the care provided. This may affect an injured worker’s access to quality care. While estimates differ, private health insurance pays average fees that are comparable to 135 percent of the Medicare-RBRVS,<sup>8</sup> while payments to injured workers are capped at 110 percent.<sup>9</sup>

Health care providers claim the disparity in payments for similar treatments is driving health care providers away from accepting workers’ compensation patients and away from

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<sup>4</sup> Before Act 234, Session Laws of Hawaii 1995, Section 386-21(c) read:

“... (c) The liability of the employer for medical care, medical services, and medical supplies shall be limited to the charges computed as set forth in this section. The director shall make determinations of such charges and promulgate fee schedules based upon such determinations as set forth in this section. For the calendar year 1974 and for each succeeding calendar year thereafter the charges shall be limited to the amounts determined in applicable regulations of the department which became effective on August 13, 1971, and amendments thereto, adjusted to reflect increases or decreases in the Consumer Price Index for the Honolulu region prepared by the Bureau of Labor Statistics of the United States Department of Labor which have occurred in the last twelve months ending June 30 of the year preceding.

The adjustments in charges provided for in this section shall be computed annually and rounded to the next higher multiple of 10 cents in each case.

Notwithstanding the foregoing, the director shall review and if necessary revise the applicable regulations every three years, the review and revision to be conducted in accordance with section 91-3. The first review and revision shall be completed not later than December 1, 1974, to be effective January 1, 1975, and subsequent review or revisions shall be made at each three year interval thereafter. In making such reviews and revisions and adopting fee schedules pursuant thereto, the director shall establish reasonable fees for medical care, medical service, and medical supplies and may take into consideration in making such determination the charges made in the State for similar treatment of injuries which are not compensable under this chapter. The director may, at any time, in the foregoing manner, establish an additional fee schedule or schedules to cover charges for medical care, medical services, and medical supplies not previously regulated pursuant to this section.

The liability of the employer may exceed the amount set forth in such fee schedule or schedules only under conditions prescribed by the director.” (Emphasis added)

<sup>5</sup> Creamer, Beverly. “Doctors and patients grapple with fund cuts from legislative changes”. *The Honolulu Advertiser*, April 19, 1998, p. E1, E10.

<sup>6</sup> The Department of Labor and Industrial Relations attributes decreases in costs to lower employment levels, effective employer safety and prevention programs, and timely delivery of medical services to injured workers in addition to the medical fee schedule reform. The Workers’ Compensation Data Book 1996, Research and Statistics Office, Department of Labor and Industrial Relations, State of Hawaii, Honolulu, 1996, p.3.

<sup>7</sup> Creamer, Beverly. “Doctors and patients grapple with fund cuts from legislative changes”.

<sup>8</sup> Senate Resolution No. 55, S.D. 2 indicated that private health insurance payments were comparable to 135%, but in an interview with the author on June 16, 1998, Gary Chen, President of HMSA Works, commented that a closer analysis revealed that the figure is probably closer to 123% of Medicare-RBRVS.

<sup>9</sup> Creamer, Beverly. “Doctors and patients grapple with fund cuts from legislative changes”.

Hawaii as well. In 1997, The Honolulu Advertiser reported a declining number of providers are available for workers' compensation injuries, including orthopedic surgeons and physical therapists.<sup>10</sup> This decline in providers is attributed to two things: (1) the reduced medical fee schedule; and (2) the review of the provider's billings to the insurance companies.<sup>11</sup> The insurance companies screen health care provider's invoices for proper coding and documentation before payment. This review often results in a reduced payment. The review process is commonly referred to as "down-coding". In addition to down-coding, doctors complain that approval for medical treatment is being made by adjusters with little or no medical training.<sup>12</sup> This study concerns itself with these important developments behind the workers' compensations medical fee schedule.

### **Focus and Organization**

The focus of this study is to improve the statutory framework of the reimbursement for medical services for workers' compensation injuries. By improving that framework, the Bureau hopes to provide a method for effective and efficient treatment to workers and reasonable rates to health care providers that are based on criteria that can be reviewed and revised with relative ease over the years as required.

The resolution requests the Bureau to make findings and recommendations to three questions as follows:

- (1) Whether the existing ceiling of 110 percent of Medicare Resource Based Relative Value scale system as set forth in section 386-21(c), Hawaii Revised Statutes, should be adjusted.
- (2) Whether the fee schedule has had a negative impact on access to specialty care by injured workers or has diminished the number and quality of providers who treat workers' compensation injuries; and
- (3) What are the conditions and criteria the Legislature may consider in making an adjustment to the ceiling?

The approach of the study logically called for addressing the second and third directives as preliminary matters, so that the principles derived could be applied to answer the first question. Therefore, Chapter 2 addresses the impact of the new fee schedule on the access and

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<sup>10</sup> The Department of Commerce and Consumer Affairs does not require physicians and surgeons to register their specialty but orthopedic surgeons claim that 11% of the orthopedic surgeons have left practices in Hawaii since the 1995 workers' compensation reforms. *See Creamer, Ibid.*

<sup>11</sup> *Ibid.*

<sup>12</sup> *Ibid.*

quality of medical care available to workers' compensation patients. It analyzes data that was collected from surveys of participants in the workers' compensation arena. Chapter 3 examines the conditions and criteria for the workers' compensation medical fee schedule in Hawaii and other states. Finally, Chapter 4 addresses the first directive, whether the fee schedule ceiling should be raised. The findings and recommendations of the report are also included in Chapter 4.

## Chapter 2

### THE EFFECTS OF THE MEDICAL FEE SCHEDULE

Medical services rendered for injuries covered under the workers' compensation law are compensated according to a medical fee schedule as directed by section 386-21(c), Hawaii Revised Statutes. The current medical fee schedule based on the Medicare system has been in place for approximately three years. Over the course of the three years, much anecdotal information has been reported about the impact of the fee schedule.<sup>1</sup> The implications are that fewer health care providers are willing to accept workers' compensation patients and, therefore, access to care and the quality of care has been diminished. The Legislature asked this office to determine whether the fee schedule as presently formulated has had a negative impact on access to specialty care by injured workers or has diminished the number and quality of providers who treat workers' compensation injuries. This chapter discusses regularly recorded statistics and data, and information obtained by the Bureau through a survey addressing the quality of care and access issues.

#### Measurements

The law requires that all health care providers rendering health care under the workers' compensation law be qualified by the Director of Labor and Industrial Relations.<sup>2</sup> The administration of the workers' compensation law is handled through the Disability Compensation Division ("DCD") of the Department of Labor and Industrial Relations ("DLIR"). The DCD could not confirm the stories reporting diminished access to quality health care providers because administrators had not received any significant complaints from injured employees claiming they were unable to find medical treatment for their injuries. The DCD reports that there are no specific qualifications beyond the requisite licensure of professions through the Department of Commerce and Consumer Affairs ("DCCA"), so all health care providers are eligible to participate. The Bureau went to the DCCA to determine if there had been a drop in the number of health care providers in the State of Hawaii. The DCCA reported the information set out in Table 2-1 concerning the numbers of health care providers that are licensed acupuncturists, chiropractors, doctors of medicine, doctors of naturopathy, doctors of osteopathy, and physical therapists.

The DCCA figures show an increase in the total number of active current licenses in every category except chiropractors. This may be slightly misleading because the figures represent only the number of presently issued licenses and do not indicate whether these health care providers are actually providing services in Hawaii. A breakdown by location of the largest category, Doctors of Medicine, reveals that in 1998 there are almost as many licensed doctors

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<sup>1</sup> See Creamer, Beverly. "Doctors and patients grapple with fund cuts from legislative changes", *The Honolulu Advertiser*, April 19, 1998, p. E1, E10.

<sup>2</sup> §386-27, Hawaii Revised Statutes (1993, 1998 Supp.)

PROVIDER	1998	1994
Acupuncturists	382	301
Chiropractors	443	479
Doctors of Medicine	5576	5243
Doctors of Naturopathy	59	48
Doctors of Osteopathy	360	334
Physical Therapists	769	681

**Table 2-1.** Number of current, active licenses in selected health care provider occupations in the State of Hawaii during August 1998 compared with August 1994.

with out-of-state mailing addresses as on Oahu.<sup>3</sup> Compared to 1994 figures, the relationship of licenses with Hawaii addresses versus out-of-state licensees has been static. In order to obtain more information to evaluate whether access to health care or quality of care has been impaired, the Bureau contacted each organization<sup>4</sup> named in the Resolution to ask what kind of data or records were available. Unfortunately, the Bureau was unable to obtain any data that could be considered in an unbiased analysis of the

problem. Measuring the effects of the medical fee schedule on the access to health care and quality of provider presented a unique challenge to the Bureau in light of the lack of statistics throughout the industry that directly addressed the issue. The Bureau determined that the only way to obtain a reasonable assessment of the situation was to survey the populations involved. Two surveys were designed, one for health care providers, and the other for the employee/employer community.

The health care provider survey was designed to assess the health care providers' attitudes toward treating workers' compensation patients and to obtain their perspectives on the effects of the current medical fee schedule. The Workers' Compensation Committee of the Hawaii Medical Association was consulted regarding the content and wording of the questions. The health care provider survey is included in this report in Appendix B. The survey was mailed to more than 2,400 physicians, and 300 chiropractors, and appeared in the newsletter of the Hawaii Chapter of Physical Therapists and the Hawaii Acupuncture Association.

A similar survey was designed for the business community of employers and employees. In order to reach this population, the Bureau contacted Small Business Hawaii, the National Federation of Independent Business, and the Chamber of Commerce of Hawaii. Both Small Business Hawaii and the National Federation of Independent Business reported that they had no opportunity to present the survey to their members. The Chamber of Commerce of Hawaii did

<sup>3</sup> The Division of Professional and Vocational Licensing at the Department of Commerce and Consumer Affairs reported the following statistics in their lastest printout dated March 3, 1998, of doctors of medicine arranged by island: 2339-Oahu; 244-Big Island; 216-Maui; 99-Kauai; 6-Molokai; 1-Lanai; and 2295 not in the State.

<sup>4</sup> Small Business Hawaii; National Federation of Independent Businesses; Chamber of Commerce of Hawaii; Hawaii Medical Services Association; Hawaii Medical Association; Hawaii State Chiropractic Association; American Physical Therapy Association-Hawaii Chapter; Haku Alliance; Kaiser Permanente Medical Care Program; Hawaii Orthopedic Association.

include the survey in their October newsletter, although no completed surveys were received by the Bureau from the business community.

## **Results of the Survey**

Eight hundred sixty-nine health care providers returned the survey. The cumulative responses appear in Appendix C. Initial analysis was completed based on responses from 710 physicians, 65 chiropractors, 14 osteopaths, 2 physical therapists, 2 administrators, a podiatrist, optometrist, naturopath, nurse and workers' compensation biller. The number of final responses included an additional 24 physicians, 35 physical therapists and 9 acupuncturists.

## **Access**

Determining whether access to health care had been diminished was accomplished through a series of questions concerning the health care provider's personal practices regarding workers' compensation injuries. First, the Bureau asked health care providers to compare the number of workers' compensation patients they had before and after the new medical fee schedule was instituted. The Bureau also asked health care providers if they believed access to appropriate health care providers had changed since the current medical fee schedule was in effect. The second approach to determining whether access to health care had been diminished was to have health care workers state their policy on accepting workers' compensation patients both before and after the current medical fee schedule was enacted. The survey also asked health care providers to designate their experience based on a time scale relative to the length of time the present fee schedule has been in place, approximately three years. The three categories of experience were those who could not make a comparison identified as being in practice only for three years, those who had equal experience with both the present and past fee schedules being in practice between three and six years, and those who had more experience with previous fee schedules, being in practice for more than six years.

Survey responses indicated that, generally, health care providers are now treating fewer workers' compensation patients than before the new medical fee schedule was instituted. Health care providers also indicated they believe the decrease in the number of workers' compensation patients treated, is due to changes in the fee schedule level of reimbursement. Specifically, seventy-five percent of medical doctors who indicated a decrease from 1990-1995 in the number of workers' compensation patients they treated attributed the medical fee schedule as a reason for this change. Figure 2-1 indicates how these figures break down. The table in Figure 2-1 compares the qualities of the doctors that showed a decrease in the number of workers' compensation patients with those that showed no decrease. Those doctors who showed a decrease are mostly in individual practice. These doctors also showed a greater range of decreases in their workers' compensation. Members of group practices were less likely to have experienced a substantial decrease in workers' compensation patient load and stayed in the 1-25 percent brackets both before and after 1995.



Decreases in the workers' compensation patient load could be reflective of the decrease in the number of workers' compensation injuries reported in the last few years. The Department of Labor and Industrial Relations calculated a 10.3 percent drop in reported workers' compensation injuries in the year 1996,<sup>5</sup> compared to 1995.

The majority of health care providers responding to the survey believe that injured workers' access to appropriate health care providers has decreased because of changes in the workers' compensation law since 1995. Analyzing these responses in more detail, sixty-three percent of the health care providers practicing in Hawaii before 1995 and who had at least some experience with previous workers' compensation fee schedules believed that injured workers' access had diminished. Sixteen percent believed access had stayed the same and nineteen percent stated they didn't know. Only two percent of the responses indicated that injured employees' access to appropriate health care had increased.

Health care providers also indicated a policy shift with regard to accepting workers' compensation patients. Survey data indicated that before 1995, eighty-three percent of health care providers who treated workers' compensation patients accepted all workers' compensation patients. Today, only fifty percent of health care providers who previously treated all workers' compensation patients accept all workers' compensation patients. Focusing on the health care providers' length of time in practice in Hawaii, approximately fifty-eight percent of those practicing longer than six years in Hawaii and who previously accepted all workers' compensation patients are not taking any new patients and treating only current patients with workers' compensation injuries. Eight percent of those health care providers do not take any workers' compensation patients at all. Almost sixty-five percent of physicians practicing longer than six years are not accepting new workers' compensation patients.

A number of health care providers commented that although they currently accept all workers' compensation patients, they were finding it difficult to continue the policy. Other comments in this area focused on avoiding, reluctantly accepting, and turning away new workers' compensation patients--especially chronic injuries. Some health care providers indicated that they prefer to screen their workers' compensation patients for complexity of injury, or availability of alternate health insurance in case payment was not received under workers' compensation. Comments on the survey responses included:

“Currently, pre-authorization is required (in writing) prior to scheduling to guarantee compensation..” *Neurologist, Survey ID #425*

“Currently, try to minimize number of workers' compensation patients seen.” *Neurologist, Survey ID #806*

“Currently, will treat patients already in my practice but no new patients. Have decided recently to refer nearly all patients to other

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<sup>5</sup> Workers' Compensation Data Book 1996, State of Hawaii, Department of Labor and Industrial Relations, Research and Statistics Office, Honolulu, Hawaii, 1996, p.2.

MD's willing to deal with workers' compensation." *M.D. Internal Medicine, Survey ID #676*

This reluctance to accept new workers' compensation patients may be a warning sign that the trend in policy shifting identified above will continue. If health care providers do not accept workers' compensation injuries for treatment, then logically an injured employee's access to care will be diminished.

The most frequent, number-one, reason cited by health care providers for the change in their policy on accepting workers' compensation patients was the change in the medical fee schedule level of reimbursement. A significant amount of the group that had previously had the policy of accepting all workers' compensation patients noted that controverted claims, processing paperwork and delays in prior approval for treatment were also reasons that caused a change in their policy of accepting all workers' compensation patients.

## Quality

The quality of the care an injured employee receives is an essential element that will determine that employee's effective return to employment. Recall that the DLIR does not have any additional requirements beyond state professional licensing requirements for doctors and other health care providers administered by the respective licensing authorities and the DCCA. This policy allows a range of expertise from adequate to excellent within a profession to qualify to treat workers' compensation cases. Under private insurance agreements, insurance companies will often screen health care providers before authorizing the health care provider to serve as a "provider" under a certain health care program. This screening process would also be carried out with health maintenance organizations (HMOs). The screening process that exists in the private health care industry provides a level of assurance to the patient that the quality of the health care provider meets a standard accepted by the insurance agency or HMO. On the other hand, the state's workers' compensation law as administered by DLIR does not have this type of quality of care screening.

In addressing the issues of access, this report identified a trend in patient acceptance policies of health care providers. The trend of shifting away from accepting *all* workers' compensation patients operates to limit access to appropriate health care. Limited access to all possible health care providers may diminish access to a quality provider and, therefore, diminish the quality of care received. If every specialist is available to every injured employee, it is a logical assumption that those injured employees would likely be provided a higher quality of care because the employees could shop around until a suitable health care provider and treatment to their liking could be found. The decrease in the number of health care providers accepting *all* workers' compensation patients may signal that injured employees are not getting the quality of care they may need. This quality of care relates to whether or not injured employees have access to the specialty care provided by various health care providers. A closer look at doctors of medicine, osteopaths, and podiatrists and the policy shift away from accepting all workers' compensation cases indicates that access to some specialty areas may already be in jeopardy. The selected health care providers and their stated specialties appear in Table 2-2.

CONDITIONS AND CRITERIA

Table 2-2 reveals that fewer health care providers are willing to accept all workers' compensation patients when compared to a time period under the old medical fee schedule,

M.D.s, Osteopaths, & Podiatrists	Total Responses to Survey	Pre-1995 Accept All WC Patients	Currently Accept All WC Patients	% Decrease Pre-'95 to Present
Allergy	10	7	3	57%
Anesthesiologists	28	25	18	28%
Cardiology, cardiovascular	18	11	8	27%
Dermatology	11	8	4	50%
Ear, nose, & throat	15	7	1	86%
Emergency medicine	10	8	8	0%
Endocrinology	6	2	0	100%
Family practice; general	85	61	33	46%
Gastroenterology	9	3	2	33%
Geriatrics	3	0	0	0%
Infectious diseases	2	2	2	0%
Internal medicine	119	74	28	62%
Medicine	2	2	1	50%
Medical administration	1	1	1	0%
Musculoskeletal injuries	1	1	0	100%
Neonatology (newborns)	3	0	0	0%
Nephrology (kidney)	4	0	0	0%
Neurology & neurosurgery	24	15	7	53%
Nuclear medicine	1	1	1	0%
Obstetrics & gynecology	47	3	2	33%
Occupational medicine	16	15	8	47%
Oncology	4	0	0	0%
Ophthalmology	28	22	21	5%
Orthopedics	33	28	7	75%
Pathology	4	3	2	33%
Pediatrics	56	17	13	24%
Physical medicine & rehab.	16	13	3	77%
Plastic & reconstructive surgery	13	10	7	30%
Preventive medicine	2	1	0	100%
Psychiatry	68	34	7	79%
Podiatric surgery	1	1	0	100%
Pulmonary (lung)	7	6	6	0%
Radiology	14	9	7	22%
Rheumatology	3	1	0	100%
Sports medicine	2	2	0	100%
Surgery, general	26	20	14	30%
Tuberculosis	1	0	0	0%
Urology	11	6	4	33%

**Table 2-2.** Comparison of Current and Pre-1995 workers' compensation acceptance policies of Doctors of Medicine, Osteopaths, and Podiatrists indicating a specialty in response to the Bureau Survey.

previous to 1995. Note that, currently, only 7 orthopedists accept *all* workers' compensation patients, down from 28 before 1995. Quality of care is related to whether or not injured employees have access to certain specialists and if specialists are turning workers' compensation patients away, then the quality of care they receive may suffer. The Bureau asked health care providers to compare the quality of care that employees receive under the workers' compensation system to the care a patient would receive under private insurance. Generally, of those health care providers that responded to the question, half believed that the quality of care was about the same as private insurance; forty-four percent believed the quality of care was worse; and only five percent believed the quality of care in the workers' compensation system

was better than with private insurance. Further analysis of this data reflected these percentages when considering length of time practicing or type of practice, whether individual or group setting.

One way to define quality of care is to relate it to experience. Health care providers would appear more likely to provide a higher quality of care with increased experience. The survey data of health care providers who have been in practice for more than six years and had some prior experience with workers' compensation patients shows that more than half of those doctors who used to treat any type of workers' compensation patient, have either decided not to accept workers' compensation patients, do not accept new patients, or screen and give low priority to injured employees. The shift away from workers' compensation patients by more experienced health care providers may indicate loss of access to quality of provider.

### **Summary and Evaluation**

The investigation of the Bureau as to whether or not the workers' compensation medical fee schedule has had a negative impact on access to specialty care by injured workers or has diminished the number and quality of providers who treat workers' compensation injuries has led to the following observations:

- (1) State records at the Department of Labor and Industrial Relations do not indicate an influx of complaints from patients who are unable to get treatment for their work-related injuries over the last three years the Medicare-based medical fee schedule has been in existence.
- (2) State records indicate a rise in the number of health care providers licensed in the State.

While these facts may superficially indicate that the medical fee schedule has not had a negative impact on employees' access to specialty care, they are not convincing. Although the number of health care providers has increased since the inception of the current workers' compensation medical fee schedule, that, in and of itself, does not indicate an increase in access to specialty care. After analyzing data from a survey of health care providers, the Bureau determined that health care providers' decisions to turn away patients with workers' compensation injuries has more bearing on the issues related to access to specialty care and quality of provider and care. If health care providers are choosing not to treat workers' compensation patients, then injured employees cannot continue to have the same level of access to the specialty care they once had.

The quality of health care providers in the workers' compensation arena is difficult to determine because there are no additional requirements enforced beyond the standard state licensing issued through the various licensing authorities and the Department of Commerce and Consumer Affairs. Limited access to specialty care must be factored into the equation when computing the quality of the provider. A reduction or loss of access to those providers with experience and expertise in certain fields reduces the chance of receiving a high quality of care.

The Bureau's survey results indicate that experienced health care providers are demonstrating an unwillingness to accept patients with work-related injuries.

The Bureau identified a significant trend in health care providers that is shifting away from accepting *all* patients with workers' compensation injuries and moving towards policies that limit or totally reject prospective patients with work-related injuries covered under the workers' compensation law. The most common reason given for this trend is the change to the medical fee schedule level of reimbursement. Other reasons cited for this change in policy shift include controverted claims, paperwork processing and delays in prior approvals required for treatment.

The Bureau concludes that the decrease in the number of reported workers' compensation cases in the last two years does not fully explain the shift in health care providers' policies regarding accepting new injured workers into their practice. While the impact of the change in the medical fee schedule may not have reached overwhelming proportions, it appears to have affected the treatment of injuries in workers' compensation cases. Health care providers are struggling with a duty to heal, while juggling fiscal responsibilities that will afford them to stay in business to continue to practice medicine. This trend of turning away workers' compensation patients should be given attention before it becomes critical. The medical fee schedule definitely appears to have had a negative impact on an injured employee's access to specialty care and diminished access to more experienced health care providers. This unproductive trend should be discouraged.

## Chapter 3

### CONDITIONS AND CRITERIA

The essence of this study is identifying the conditions and criteria for the workers' compensation medical fee schedule. This chapter briefly reviews the conditions and criteria for the medical fee schedules set to date, examines the conditions and criteria other states have adopted, and considers suggestions from participants in the workers' compensation system.

#### Historical Conditions and Criteria

The workers' compensation system was first designed more than 85 years ago in 1911.<sup>1</sup> In Hawaii, workers' compensation benefits have been required by law since 1915. Medical costs that were the responsibility of the employer were originally limited to those incurred in the first fourteen days after injury, but not to exceed fifty dollars. The liability of employers was limited to "such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for the injured person."<sup>2</sup> Two years later, the Territorial Legislature removed the fourteen-day limitation, and increased the employer's liability to not more than one hundred fifty dollars.<sup>3</sup> By 1923, all specific dollar limitations were removed and the only remaining limit on the pecuniary liability of employers was the "charges as prevail in the same community for similar treatment of injured persons of a like standard of living, when such treatment is paid for by the individual."<sup>4</sup>

The law relating to medical costs in workers' compensation injuries was finally codified in the Revised Laws of 1925<sup>5</sup> and was unchanged<sup>6</sup> until 1939, when the Department of Labor and Industrial Relations replaced the authority of the Industrial Accident Board.<sup>7</sup> While the specific section of law that is the subject of this study did undergo some modifications,<sup>8</sup> it was not until 1961 before the promulgation of a medical fee schedule appeared in the statutes<sup>9</sup>.

Act 152, Session Laws of Hawaii 1961, qualified the employers' liability that was previously limited to the standards of "charges as prevail in the community...of a like standard

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<sup>1</sup> Trolin, Brenda, "Workable Workers' Comp", *State Legislatures*, June 1993, pp.38-43.

<sup>2</sup> Section 12, Act 221, Laws of the Territory of Hawaii, Regular Session 1915.

<sup>3</sup> Section 3, Act 227, Laws of the Territory of Hawaii, Regular Session 1917.

<sup>4</sup> Section 2, Act 249, Laws of the Territory of Hawaii, Regular Session 1923.

<sup>5</sup> Section 3615, Revised Laws of Hawaii, 1925.

<sup>6</sup>Section 7491, Revised Laws of Hawaii, 1935.

<sup>7</sup> Act 237, Laws of the Territory of Hawaii, Regular Session 1939.

<sup>8</sup> Act 253, Laws of the Territory of Hawaii, Regular Session, 1941, gave the authority to the director to suspend weekly compensation to employees who refused medical treatment, and Act 14, Laws of the Territory of Hawaii, Regular Session, 1955, provided the employee the right to select the physician of their choice. The Revised Laws of Hawaii 1955 re-codified the relevant section at §97-22, Revised Laws of Hawaii, 1955.

<sup>9</sup> Act 152, Session Laws of Hawaii 1961.

of living”. The 1961 statutory change required the Director, “from time to time to make determinations of such charges in accordance with the foregoing [charges as prevail in the community...of a like standard of living] and promulgate fee schedules reflecting such determinations.”<sup>10</sup> This change in the law appeared to be the first instance of a medical fee schedule for workers’ compensation, but both Senate and House Standing Committee Reports clearly state that the change would only provide legal status and sanction to a procedure that had been in effect for over thirty-five years.<sup>11</sup> Act 152 also gave the Director authority to allow the employer’s liability to exceed amounts in the fee schedule, but only under conditions prescribed by the Director.<sup>12</sup> Although dealing with a regular common practice, the passage of this measure was not as smooth as might be expected. Clearly there is evidence of unresolved concerns in the five times the measure was deferred on the House calendar, and the failed attempt of legislators to recommit the issue to the Finance Committee before the final passage in the House.<sup>13</sup> Newspaper accounts indicated that the method for adjusting the fee schedule was a controverted issue at the time.<sup>14</sup>

The 1961 fee schedule was based on what was in use at the time, the prevailing rates in the community of the doctor’s practice for the treatment of the injured persons of a like standard of living when the payment was made by the patient. In other words, the fee schedule considered (1) the community of the treatment; (2) the injured person’s standard of living; and (3) the prevailing cost of the treatment if the injury had not been covered under the workers’ compensation law. Act 16, Session Laws of Hawaii 1967, modified the determination for the fee schedules by removing the consideration for the injured person’s standard of living and set a broader scope of community to include the entire State. The employer’s liability for medical charges and elements for determination of the medical fee schedule was now pared down to “the charges that prevail in the State for similar treatment of injuries which are not compensable under this chapter.”<sup>15</sup>

Six years later, in 1973, the issue was once again before the Legislature. This time the Legislature provided a more specific adjustment process by requiring that the fee schedule adopted by the Director, and presently in use, be adjusted annually by the percentage increase of the Consumer Price Index (CPI) as determined for the Hawaii Region by the United States Department of Labor.<sup>16</sup> The Legislature called for the change because the old method of determining the fee schedules based on prevailing costs was “unadministrable”.<sup>17</sup> The Legislature still required that the fee schedules be reviewed by the Director of Labor and Industrial Relations every three years. Upon review, the fee schedules could be revised as

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<sup>10</sup> §97-22, Revised Laws of Hawaii, 1955 (1961 Supplement)

<sup>11</sup> Senate Standing Committee Report 730, Committee on Labor, Senate Journal 1961, p. 931, and House Standing Committee Report 902, Committee on Labor, House Journal 1961, p. 1018.

<sup>12</sup> Act 152, Session Laws of Hawaii 1961.

<sup>13</sup> House Journal 1961, History of Senate Bill 1056, pp. 574, 578, 580, 584, 587 and 595.

<sup>14</sup> “Case Heard to Increase Medical Fees,” Honolulu Star-Bulletin, December 15, 1960, p.10.

<sup>15</sup> Act 16, Session Laws of Hawaii 1967.

<sup>16</sup> Act 78, Session Laws of Hawaii 1973.

<sup>17</sup> Senate Standing Committee Report No. 349, Senate Committee on Human Resources, Senate Journal 1973, p. 792; See also House Standing Committee Report No. 880, House Committee on Labor and Employment, House Journal 1973, p. 1180.

necessary to establish reasonable fees, taking into consideration the charges made in the State for similar treatment of injuries which are not compensable under the workers' compensation law. From 1973, the fee schedules were adjusted annually according to the CPI, but the Director made no further adjustments. For the next twenty years, no further substantive changes in the law were made to the medical fee schedules.<sup>18</sup>

Act 274, Session Laws of Hawaii 1995, made sweeping reforms to many aspects of the workers' compensation law. One of those changes replaced the State of Hawaii medical fee schedule with a medical fee schedule based on the Medicare Resource-Based Relative Value Scale (Medicare-RBRVS). All payments to health care providers were limited to 110 percent of the Medicare-RBRVS. The fee schedule would be updated annually, through recognition of the changing Medicare-RBRVS schedule or by an independent survey of the prevailing rates. This annual review was changed to every three years in 1996.<sup>19</sup> Currently, the Department of Labor and Industrial Relations is involved in surveying the insurance community on the prevailing rates and a report is expected out before the adjournment of the 1999 Regular Session.<sup>20</sup>

Figure 3-1 summarizes the progression of conditions and criteria for medical costs in the Hawaii's workers' compensation law, including the emergence of a legally sanctioned medical fee schedule.

### **Conditions that Led to this Report**

The medical fee schedule that evolved over time as a result of the 1973 reform that allowed annual adjustment, according to the CPI, became a lucrative piece of the medical industry pie. Although authorized to review and adjust the fee schedule every three years, as increased by the CPI, the State never chose to exercise that authority. In the twenty years that the CPI was used to adjust the fee schedule, the Director never reviewed the fee schedule and it was never adjusted through the review process. It was estimated that the fee schedule was approximately 40 percent higher than the average customary fees paid for the same services for an injury not covered under the workers' compensation law.<sup>21</sup> Act 234, Session Laws of Hawaii 1995, was an effort to contain unchecked costs. Although the limit of fees using the Medicare-RBRVS was originally proposed at 120 percent,<sup>22</sup> the Legislature settled on 110 percent in conference. There is no documentation as to why the limitation of 110 percent of Medicare was selected.

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<sup>18</sup> Act 132, Session Laws of 1979 and Act 120, Session Laws of 1988 adjusted dates in the computation of the CPI; Act 296, Session Laws of Hawaii provided for a deductible amount on the liability for medical care services, equipment and supplies.

<sup>19</sup> Act 260, Session Laws of Hawaii 1996.

<sup>20</sup> This survey has been difficult to conduct because while insurers are required by law to submit to the Department of Labor and Industrial Relations the fees paid by them to providers for medical services, compliance has not been forthcoming. The absence of authority to enforce compliance severely restricts the Department's ability to demand compliance from the insurance companies. (Telephone interview with Eleanor Yoshida, Department of Labor and Industrial Relations, Office of Disability Compensation Division, September 24, 1998.)

<sup>21</sup> Botticelli, Ann. "Workers' Comp ready for final vote," *The Honolulu Advertiser*, April 29, 1995, p. A3.

<sup>22</sup> See H.B. 1572, Regular Session 1995 and H.B. 2133, S.D. 1, Regular Session 1995.

*CONDITIONS AND CRITERIA*

## Current Conditions and Criteria

The current fee schedule based on the Medicare Resource Base Value Scale is a formula that the federal government has derived for the Medicare program that assigns each medical procedure a specific code and a value that takes into account three different factors. The three factors are: (1) the relative value for the service; (2) the geographic adjustment factor for the service area; and (3) the conversion factor.<sup>23</sup> The Medicare formula can also be expressed as follows:

$$\text{Payment} = [(RVU_{\text{work}} \times GPCI_{\text{work}}) + (RVU_{\text{practice}} \times GPCI_{\text{practice}}) + (RVU_{\text{malpractice}} \times GPCI_{\text{malpractice}}) \times CF]$$

Where RVU equals Relative Value Unit; GPCI equals Geographical Practice Cost Index; and CF equals Conversion Factor.

These three criteria that determine the rates are derived through collected data as well as review by peer groups. One problematic area is that the formula is derived from a different population that has different requirements from injured employees. Medicare is a system that serves the elderly.<sup>24</sup> Treatment of the elderly is different from the treatment of injured workers. The physicians' activities related to the treatment will be different, and the extent of the paperwork required will be different. These differences are more apparent in examining the details of the formula.

The first factor, the relative value for physicians' services, defines the specific procedure code by addressing the actual service that is performed. This is where the terminology "relative value" system is derived. Each procedure is assigned a value. The values are established by evaluating the procedures in relation to each other within an area of medical practice. For example, procedure code 71020 is for two views of a chest x-ray and procedure code 99211 is for a brief office visit for an established patient. Each procedure code contains a bundle of services that includes pre- and post-services related to the direct service, for example, reviewing the history and charting the visit after the exam. Figuring the relative value for physicians' services requires examination of three different components: (1) the "work component"; (2) the "practice expense component"; and (3) the "malpractice component". The values assigned to each of these components are published in the Federal Register in years of adjustment.

The "work component" reflects the physician's time and intensity in furnishing the service and includes activities before and after direct patient contact.<sup>25</sup> This includes the paperwork required. Here is one place where the formula may be adjusted to reflect the different procedures required for Medicare as opposed to workers' compensation. Results of the Legislative Reference Bureau's survey indicated the following results with regards to time involved and paperwork concerns of health care providers.

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<sup>23</sup> 42 U.S.C.A. 1395w-4(b), (Supplementary Pamphlet 1998)

<sup>24</sup> The Health Care Financing Agency of the United States Department of Health and Human Services maintains extensive data. Generally see <http://www.hcfa.gov>.

<sup>25</sup> Specifically defined surgical procedures to reflect a global definition of pre- and post-operative physicians' services are also included.

The Bureau asked health care providers to estimate the difference in the time spent on workers' compensation injuries as compared to a similar injury not covered under the workers' compensation law. Thirty-four percent of health care providers who responded to that question stated that it took at least 25 percent more time for workers' compensation injuries. An additional twenty-two percent of health care providers believed that workers' compensation injuries took 50 percent more time. One quarter of the respondents stated the time involved was about the same. Health care providers reiterated their concern with the amount of paperwork and length of time required treating workers' compensation patients in declaring "paperwork processing" and "controverted claims" in the top three reasons health care providers attributed to the change in the number of workers' compensation injuries they treat.

The second component in computing the relative value for physicians' services is the "practice component." Medicare adjusts each regional fee schedule to accommodate the portion of resources used in furnishing the service that reflects the general categories of expenses, such as office rent, and wages of personnel, but not including malpractice.<sup>26</sup> This component is not likely to differ between Medicare and workers' compensation cases and therefore, not a good indicator of conditions and criteria to adjust the fee schedule.

The third component, the "malpractice component", reflects the expenses in furnishing the service. Malpractice fees are directly related to the risk of the activity involved. Medical risk is evaluated by many factors that include the experience of a doctor and the type of medicine the doctor practices. Again, there are some significant differences between the Medicare and workers' compensation populations that affect this component of the fee schedule. Beyond the fact that workers' compensation system has more contested cases than Medicare,<sup>27</sup> the majority of Medicare patients are retired, while injured workers may have many years of earning potential ahead of them. This factor translates into dollars when determining the value of a lawsuit. The increased value of injured workers' potential earnings increases the risk, which increases the malpractice component for workers' compensation as compared to Medicare.

The second factor in the formula is the geographic adjustment factor. Each one of the relative value unit components, work, practice expense, and malpractice, is multiplied by a geographic adjustment factor that reflects the region's cost-of-living. This adjustment factor is reviewed every three years<sup>28</sup> and printed in the Federal Register when changed. This factor is important when adopting any federal guidelines to accommodate the economic situation of the State, but it is not likely that this factor is a condition and criteria for evaluation when considering adjustment to the medical fee schedule.

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<sup>26</sup> One doctor in response to the LRB Survey estimated the average overhead in Hawaii for physicians is approximately \$100 per hour, including office salaries for two workers, rent at \$3 per sq. ft., telephone, electricity, water, maintenance fees, and parking.

<sup>27</sup> Using the Westlaw system, a search of case law going back ten years brings up five times as many cases when using the terms "workers' compensation and medical malpractice" compared to a search using the terms "medicare and medical malpractice".

<sup>28</sup> 42 U.S.C.A. 1395w-4(e)(1)(C) (Supplementary Pamphlet 1998).

The third and final part of the formula is the conversion factor. This is the part of the formula that converts the relative values into a dollar figure. It is updated every year and incorporates the Medicare Economic Index (“MEI”).<sup>29</sup> The MEI is a measure of the direct labor components for physicians.<sup>30</sup> The Medicare-RBRVS conversion factor also takes into account the adjustments required under the Balanced Budget Act of 1997<sup>31</sup> (“BBA 1997”). The BBA 1997 adjustments reflect requirements that measure allowed expenses versus actual past and projected expenses. A BBA 1997 adjustment is made when Congress cuts the Medicare budget and, therefore, lowers the payments on each procedure. While the MEI is a reasonable basis for adjustment related to Hawaii, adjustments to the conversion factor based on the BBA 1997 do not reflect the current workers’ compensation situation in Hawaii. Therefore, the conversion factor may be a criteria to be evaluated when considering an adjustment to the fee schedule.

### Other State Approaches

Forty-one other states use some form of a medical fee schedule to determine criteria for reasonable and customary medical charges for workers’ compensation.<sup>32</sup> There is a wide range of methodologies used for developing reimbursement levels, coding schemes to identify procedures, the services covered, and the frequency of fee schedule updates. The fee schedules are either expressed in dollar amounts or in relative unit values with dollar conversion factors.<sup>33</sup> Hawaii, as well as thirty other states, uses relative unit values. Ten other states base their relative units on the Medicare relative unit values. Those states are Maine, Massachusetts, Michigan, Minnesota, Ohio, Oregon, Pennsylvania, South Carolina, Washington, and West Virginia.

The National Conference of State Legislatures reviewed medical fee schedule payments for selected workers’ compensation procedures and compared them. A comparison of Hawaii versus the national average and the other ten states using a Medicare relative unit value system is set forth in Table 3-1.

It is easy to see from the table that despite the fact that many states use the Medicare-RBRVS system, every state does not pay the same amount for the same services. This is because while a state may use the basic elements of the Medicare-RBRVS system, that is the relative values for the procedure codes, many states adapt the system to the needs of the community. Pennsylvania is the only state that sets a specific limit for payments. The Pennsylvania limit is not “in excess of one hundred thirteen per centum.”<sup>34</sup>

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<sup>29</sup> 42 U.S.C.A. 1395w-4(d) (Supplementary Pamphlet 1998).

<sup>30</sup> A full explanation of its calculation can be found in Title 42, Section 405.504, Code of Federal Regulations.

<sup>31</sup> Balanced Budget Act of 1997, Public Law 105-33.

<sup>32</sup> United States, General Accounting Office, “Workers’ Compensation, Selected Comparisons of Federal and State Laws”, USGAO, Washington, D.C., April 1996 p. 35.

<sup>33</sup> United States General Accounting Office, Workers’ Compensation, Selected Comparisons of Federal and State Laws, USGAO, Washington, D.C., April 1996 p. 36.

<sup>34</sup> Section 306(f.1)(iii)(3)(i) Pennsylvania Laws.

CONDITIONS AND CRITERIA

Several state laws allow the director to select the schedule used, including Minnesota and Oregon. Minnesota allows the director to adopt the Medicare-RBRVS fee schedule, or some other relative value fee schedule, but further requires that the conversion factor be updated annually.<sup>35</sup> This update is accomplished by the Commissioner of Workers' Compensation.

State	29881 Arthroscopy	49505 Inguinal Hernia Repair Unilateral	63005 Laminectomy Lumbar	71020 Chest X-ray Two Views	72131 CAT Scan, Lumber without Contrast	99205 Office visit, New Patient, Comprehen- sive Exam	99213 Office Visit, established patient, intermediate exam
Oregon	\$1,723	\$1,064	\$3,107	\$75	\$605	\$179	\$53
West Virginia	\$1,500	\$713	\$1,800	\$52	\$398	\$102	\$38
Ohio	\$1,445	\$897	\$2,633	\$52	\$416	\$157	\$47
<b>Median all States</b>	<b>\$1,387</b>	<b>\$816</b>	<b>\$2,449</b>	<b>\$57</b>	<b>\$464</b>	<b>\$144</b>	<b>\$47</b>
Michigan	\$1,328	\$768	\$1,977	\$51	\$488	\$118	\$43
Maine	\$1,130	\$697	\$2,037	\$58	\$464	\$193	\$58
Minnesota	\$1,018	\$634	\$1,840	\$52	\$421	\$179	\$54
South Carolina	\$1,011	\$624	\$1,824	\$52	\$416	\$173	\$52
Pennsylvania	\$991	\$598	\$1,802	\$42	\$346	\$155	\$47
<b>Hawaii</b>	<b>\$908</b>	<b>\$542</b>	<b>\$1,654</b>	<b>\$41</b>	<b>\$334</b>	<b>\$140</b>	<b>\$43</b>
Washington	\$823	\$509	\$1,488	\$42	\$343	\$143	\$43
Mass.	\$779	\$410	\$1,418	\$25	\$163	\$72	\$37

**Table 3-1. Comparison of state workers' compensation payments for selected specific procedure codes.**

<sup>35</sup> Section 176.136, Minnesota Statutes 1997. (see <http://www.revisor.leg.state.mn.us>)

Oregon authorizes the Director of the Department of Consumer and Business Services to develop fee schedules based on all or part of an assorted list of options including the Medicare-RBRVS system, average rates of the Oregon health insurance industry, or the actual costs of providing services. The law also requires the Director to update the schedule annually to ensure the schedules “represent the reimbursement generally received for the services provided”.<sup>36</sup>

Some states that use the Medicare-RBRVS system are not required at all by law to adopt it. There is no mention in the law of the specific code only that the schedule adopted “ensure appropriate limitations”,<sup>37</sup> or be “reasonable amounts”.<sup>38</sup>

The State of Michigan authorizes the bureau of workers' compensation to promulgate the fee schedule in rules with the assistance of an advisory committee to aid and assist them.<sup>39</sup> While Michigan uses the Medicare-RBRVS system as the base of their schedule, they have adopted extensive evaluation and management codes that allow flexibility to the standard relative value procedure codes.<sup>40</sup>

While many states have adopted some form of Medicare-RBRVS system, many states have modified the system, or included an update process that includes elements that provide for the needs of the local communities.

### **Comments from the Bureau's Survey<sup>41</sup>**

A popular proposal, suggested by respondents to the Bureau's Survey, was to combine the private-pay system with the workers' compensation system and have only one health care system. This proposal is also known as twenty-four-hour coverage. Twenty-four-hour coverage merges general health insurance with the medical care portion of workers' compensation insurance. Although there are many barriers, both legal and policy based, to adopting the concept, the twenty-four-hour coverage proposal has gained popularity because it would rid the system of duplication. The largest legal barrier is running afoul of the broad preemption provision of the Employment Retirement Income Security Act of 1974 (“ERISA”). While a full discussion of this issue is beyond the scope of this study, Hawaii has a unique relationship to ERISA because of Hawaii's Pre-paid Health Care Act that mandates employers to provide health insurance that incorporates issues that may not be of concern in other states.

One policy barrier to the adoption of a twenty-four-hour coverage program becomes apparent when examining how the two separate systems are operated. Under the pre-paid Health

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<sup>36</sup> Section 656.248, 1997 Oregon Revised Statutes. .

<sup>37</sup> Section 209, Maine Revised Statutes Annotated (1997 Cumulative Pocket Part).

<sup>38</sup> Section 23-4-3, West Virginia Code Annotated (1998 Supplement).

<sup>39</sup>Section 418.315 Michigan Compiled Laws 1985 (1998 Cumulative Pocket Part).

<sup>40</sup> Section 418.105, Michigan Administrative Rules.

<sup>41</sup> See Chapter 2 of this Report.

Care Act, an employee who works more than twenty hours a week is entitled to health insurance paid for in part by the employer. The health insurance that the employee chooses can allow a deductible, a maximum amount out-of-pocket expenses, or some other form of co-payment. This would require employees to contribute to the treatment of work-related injuries. The workers' compensation law, on the contrary, requires that workers' compensation injuries be paid entirely by the employer or the insurance agency, and that the employee have no out-of-pocket expenses.

Other respondents suggested exploring alternative fee schedules such as the Fee-for-Service National Payor Reimbursement system. The scope of this report, however, is focused on determining conditions and criteria for evaluating the current Medicare-based fee schedule.

### **Summary, Analysis, and Conclusions**

The legislative history of the medical fee schedule within the workers' compensation law can be summarized by pointing out that the system has always used some form of a medical fee schedule. That schedule was to ensure that injured employees get the medical care they need without putting the employers out of business and provided a fair payment to the health care providers. The conditions and criteria of the fee schedule have changed little over the long history of the law, until Act 234, Session Laws of Hawaii 1995. During the majority of the time, the fee schedules have been conditioned upon the prevailing rates of care for similar injuries and adjusted upon review by the Director of Labor and Industrial Relations, or as guided by the Consumer Price Index (CPI). For the last two years, the fee schedule has been based on the Medicare system. Believing the pendulum had swung too far with the annual CPI adjustments to the fee schedule, as provided by law from 1973 to 1995, the Legislature reset the balance by adjusting the medical fee schedule to the opposite end of the pendulum's arc. This action may have been avoided if the State had monitored the fee schedule more closely, making adjustments downward as needed over that twenty-year period. Although review and evaluation of the fee schedule was required by law, this type of review is difficult and described as unadministrable.

The Medicare-RBRVS fee schedule, that our system currently uses, is structured to operate fairly across the United States. Factors of the formula evaluate essential expenses to physicians according to their regions. Two factors have been identified as potential conditions and criteria for adjustment. The first factor determining the relative value of the physicians' service has two components that would be helpful criteria in evaluation. The "work component" includes the before and after periods of direct contact with the patient, and naturally, must reflect an adequate allowance for the difference in the paperwork requirements between Medicare and workers' compensation cases. The majority of survey responses indicated that difference between the time required for Medicare populations and the workers' compensation populations may be twenty-five to fifty percent greater for the workers' compensation cases. The same principle is true of the second component, which is the "malpractice component". Although this study was unable to quantify it, if the malpractice risk is greater in caring for workers' compensation patients, an adjustment should be made to this component.

The other factor, the conversion factor, is an additional criterion that can be used for evaluation. The conversion factor can be reviewed and adjusted to reflect only the adjustments

that affect the Hawaii situation. This adjustment could be made based on the annual publication in the Federal Register of its calculation.

Currently, Hawaii's medical fee schedule is capped at 110 percent of Medicare-RBRVS. If any adjustments were to be made, ideally, each procedure code could be adjusted to reflect the differences in the two identified factors and components above. Alternatively, an estimate of the differences between the two systems could be made and quantified in terms of a percentage. When quantifying the differences in the systems, it is essential to examine the policy of the programs.

The Medicare system is a health plan for the elderly and disabled that requires contribution from the Medicare patient. It sets a limit to the amount Medicare will pay for a procedure, but is less restrictive on the amount a patient may pay. The workers' compensation system, on the other hand, provides injured workers the necessary treatment required as a result of an injury on the job without out-of-pocket expenses. When choosing to adopt a fee schedule that allows a co-payment from the patient, consideration for the difference in payment to the health care provider becomes a concern. If payment for the services in treating similar injuries is different simply because one is work-related and one is not, a policy is set that declares one injury more valuable than the other.

The Medicare system allows Medicare patients a range of options that dictate the amount of out-of-pocket expenses the patient will incur. In addition, a health care provider under Medicare can obtain payment from the patient, a practice prohibited under the workers' compensation law. It could be interpreted that the 10 percent in the 110 percent limit on payments, is the estimate of out-of-pocket expenses that would cover a Medicare patient's portion of fees<sup>42</sup> that are not allowed under the Workers' Compensation Law, although this is a low estimate to ensure health care providers will obtain the full payment for services. Using the fee schedule with a percentage cap has simplified the administration of the fee schedule. Unfortunately, the current fee schedule does not provide the compensation health care providers receive for their services when treating uncompensable injuries. Using specific factors that define the differences in the populations to which the schedule is applied may strike a good balance for the participants in the workers' compensation arena.

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<sup>42</sup> In 1998, Medicare benefits were \$43.80 per month, plus additional expenses depending on the particular plan you choose. The basic plan provides that the patient pays twenty percent of most costs. Some plans have additional monthly charges, others pay only a per-visit fee or a percentage of the total amount due, and may require supplemental insurance premiums.

## Chapter 4

### ADJUSTING THE SCALE: FINDINGS AND RECOMMENDATIONS

The ultimate question for this report is whether the existing ceiling of 110 percent of the Medicare Resource Based Relative Value Scale (“Medicare-RBRVS”) system as set forth in section 386-21(c), Hawaii Revised Statutes, should be adjusted. The short answer is yes, the ceiling should be increased. A longer answer is needed, however, to decide how much it should be increased.

In Chapter 3 of this report, the Bureau identified the components of the Medicare-RBRVS, and pointed out that the Medicare system allows payments to be made to health care providers by patients. The Bureau also noted that having the employee contribute any part of the payment is contrary to the current policy of workers’ compensation. The Bureau finds that an additional ten percent of the Medicare-RBRVS system, does not allow many health care providers to obtain full payment due for their services. A range of an additional ten to twenty percent would provide for inclusion of the additional payment a health care provider could obtain from a patient under the Medicare program.

One criterion that was identified and evaluated was the population that the Medicare-RBRVS system serves in comparison to the workers’ compensation population. An accommodation should be made to compensate for these differences. The Bureau finds that the malpractice component of the relative values formula does not reflect the same level of risk from the Medicare population that would apply to the population of injured employees.

Similarly situated, is the work component of the relative value formula, as it relates to the amount of paperwork and other tasks or services that are performed by the health care provider in addition to the direct contact with the patient. These bundled services are typically more involved and take more time with workers’ compensation patients than similar services for a Medicare patient.

Quantifying the difference in these two areas can be handled in several ways. The formula for arriving at the relative values can be dissected and the malpractice and work components can be re-computed. While isolating these factors within the relative value formulas may not be difficult,<sup>1</sup> it may be cumbersome to recalculate each procedure code’s malpractice and work component. Alternately, the difference between populations can be quantified in terms of an estimated percentage that will be closer to the real malpractice risk of worker’s compensation patients versus Medicare patients. The same could be done for the work component. It should be noted that any percentage applied to a portion of the formula would have a diminished effect on the overall scale. For example, the Bureau’s survey results indicated that the majority of respondents believed that it took twenty-five to fifty percent more time treating workers’ compensation patients versus Medicare patients. Making a twenty-five percent adjustment to the work component will bring different results for different procedure codes. If a

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<sup>1</sup> The relative values for procedure codes are published regularly in the Federal Register. See November 2, 1998, October 31, 1997,

particular procedure code has a work RVU of 1.66, a practice expense RVU of 20.04, a malpractice RVU of 1.32, for a total RVU of 23.02, a twenty-five percent adjustment to the work component would be 2.074. This would change the total RVU for the procedure from 23.02 to 23.434, only a two percent change. On the other hand, a procedure code that has a work RVU of 12, a practice expense RVU of 13.20, and a malpractice RVU of 1.22, the change would amount to almost a ten percent increase in the total RVU. These types of adjustments could be made with the advice of a specially created council, to assist the Department of Labor and Industrial Relations ("DLIR") with these technical aspects.

Another criteria, and the most critical, is the present Medicare-RBRVS formula for the conversion factor. As discussed in Chapter 3, the conversion factor is the part of the formula that turns the relative value units into a dollar figure. This process includes an annual calculation of the Medicare Economic Index (MEI). The MEI is then adjusted according to the Balanced Budget Act of 1997. This means that the conversion factor reflects the federal statutory limits of expenditures for Medicare. This conversion factor is based on information that has little to do with workers' compensation costs in Hawaii. The Bureau finds that using this conversion factor is not an accurate measure of the workers' compensation system or the economic situation in Hawaii.

The conversion factor is the critical number that determines the amount that health care providers are paid for their services. The Bureau finds that computing an appropriate conversion factor is essential to establishing reasonable rates under a workers' compensation medical fee schedule that is based upon the Medicare-RBRVS. Comparing the Medicare conversion factors for 1998 and 1999, which are respectively, \$36.68735<sup>2</sup> and \$34.7315,<sup>3</sup> indicates a five percent drop. Under the current law this means that health care providers paid under the workers' compensation fee schedule will be paid five percent less for their services in 1999, than in 1998. If the State is to maintain at least the current 1998 schedule, it must increase the ceiling an additional five percentage for 1999.

## Findings

1. The medical fee schedule set at 110 percent of the Medicare-RBRVS appears to have had a negative impact on access to specialty care by injured workers and has diminished the number and quality of providers who treat patients in workers' compensation cases.

A survey of health care providers providing services to injured workers indicates a trend in which health care providers are moving away from accepting new workers' compensation patients into their practices for treatment. The most common reason attributed to this trend is the current workers' compensation medical fee schedule. The survey also indicated this trend has contributed to a significant decrease in the number of physicians designating specialty care. The quality of care is likely to be diminished if fewer health care providers are available to treat injured workers.

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<sup>2</sup> Federal Register, Vol. 62, No. 211, Friday, October 31, 1997, p.59102.

<sup>3</sup> Federal Register, Vol. 63, No. 211, Monday, November 2, 1998, p. 58891.

2. The formula for the Medicare-RBRVS system fee schedule does not take into account the differences in the populations of injured workers and Medicare-eligible patients. The medical fee schedule should reflect current conditions and criteria as they apply to the care and treatment of injured workers' in Hawaii. This means that certain conditions and criteria of Medicare must be reviewed on a regular basis to ensure that adequate fees are paid to health care providers to ensure, at all times, the standard of services and care intended.

3. Participants in the workers' compensation system should be allowed to assist, provide comments, and advise during the process of evaluation. The differences should be reviewed, evaluated, and quantified by an advisory review board.

4. In the course of the study, the Bureau identified some related issues that are beyond the scope of this study, but should be noted so that they can be handled in other venues.

- (a) Although section 386-27, Hawaii Revised Statutes, authorizes the DLIR to qualify health care providers to treat patients under the workers' compensation law, no further qualifications other than state licensure are required to become eligible to treat workers' compensation patients. Imposing a minimum quality standard that includes regular review and education requirements on procedures for health care providers may provide an increased quality of care and communication between the DLIR and health care providers.
- (b) Section 386-21.5, Hawaii Revised Statutes, requires pre-paid health care plan contractors to provide information that will allow the DLIR to accurately adjust the fee schedule. The DLIR does not have the ability to enforce the provisions of the law that require it to review and update the schedules, because there are no penalties for the failure to comply with their requests. The ability to enforce the requests should be balanced with protection for proprietary interests. The DLIR should be able to impose penalties for failure to comply. Civil penalties in the form of fines that are administered at the Department level would be appropriate.
- (c) A problem exists with third party billing companies that is beyond the scope of this study. Further investigation of these issues would be an appropriate task assignment to an advisory board, or a topic of further study.

## **Recommendations**

1. The ceiling of the workers' compensation medical fee schedule should be increased as soon as is practicable, considering the identified criteria, the Bureau recommends that the ceiling be raised to not less than 125 percent but not more than 130 percent of Medicare-RBRVS.

2. There should be a regular adjustment of the workers' compensation medical fee schedule that does not blindly accept the federal standards of Medicare. Medicare adjusts the medical fee schedule annually. This is a condition that should not pass by without notice. The computations are published in the Federal Register, annually, in November. As long as there is an annual update by Medicare to their fee schedule, the DLIR with or without the assistance

from an advisory board should actively accept or deny the modifications similar to the relationship between the Hawaii Income Tax Law and the Internal Revenue Code.<sup>4</sup> These recommendations can be accomplished several ways.

- (a) An advisory board consisting of participants in the workers' compensation system should be established. The board should include representatives from health care providers, the insurance industry, the business community, and the Department of Labor and Industrial Relations. The board's duties should include reviewing updates and adjustments to the Medicare schedule, to decide whether or not the adjustments apply to Hawaii, and whether or not to accept or modify those adjustments. The advisory board should be responsible to annually review the Medicare-RBRVS formula, to adjust the identified criteria in this report, including the separate components and bundling of particular procedure codes, and other factors that the board may determine to have an impact. Based on this annual review, the board should make recommendations to the DLIR on adjustments to the fee schedule that will improve the workers' compensation program in Hawaii.
- (b) Alternatively, the fee schedule could use the Medicare-RBRVS relative values, but develop its own conversion factor. This could be accomplished by the DLIR or by an appointed advisory board. The conversion factor calculation can be reviewed to determine its relation to Hawaii and adjusted as appropriate.
- (c) Another option for keeping the medical fee schedule in line with community standards, is to have the medical fee schedule adjusted annually according to the Medicare Economic Index ("MEI"), as printed in the Federal Register without regard to other adjustments. From 1992, the MEI has averaged 2.3%, with a 1992 high of 3.7% and 1996 low of 2.0%.<sup>5</sup> This type of update could be accomplished through the DLIR without the need of an advisory board.

All of these options are feasible. Draft legislation is attached in Appendix D. What is important, is that the workers' compensation medical fee schedule provide adequate fees "to ensure at all times the standard of services and care intended by [the Workers' Compensation Law]".<sup>6</sup>

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<sup>4</sup> Section 235-2.3, Hawaii Revised Statutes (1993, 1998 Supp.) is amended annually to conform the Hawaii Income Tax Law to the provisions of the Internal Revenue Code.

<sup>5</sup> Federal Register, Vol. 62, No. 227, November 22, 1996, p. 59722.

<sup>6</sup> Section 386-21(c), Hawaii Revised Statutes (1993, 1998 Supp.).