

Connecticut Workers' Compensation Commission

Testimony presented at March 8, 2007 Public Hearing

Before the Labor Committee

By Chairman John A. Mastropietro

Re: Senate Bill No. 1378 An Act Concerning the Workers' Compensation Medical Practitioners Fee Schedule.

Good morning Senator Prague, Representative Ryan, and Members of the Labor Committee.

Thank you for the opportunity to discuss the Commission's proposed legislation, Senate Bill No. 1378 An Act Concerning the Workers' Compensation Medical Practitioners Fee Schedule.

- This proposed legislation concerns a simple issue that appears to be more complex than it really is. What we are seeking is to amend the methodology for the computation of the Workers' Compensation medical fee schedule. We believe SB 1378 provides us with the authority we need in order to make our medical fee schedule consistent with current medical payment practices.
- Attached is an outline of reasons explaining why the statutory provisions enacted in 1993 regarding Workers' Compensation medical fee schedules are no longer applicable. I believe the attached outline will give you all the information necessary to understand the nature of our technical request to amend the Workers' Compensation Act.

A. Objective of the Workers' Compensation Act

Provide Medical Care to Injured Workers

When the legislature enacted the Workers' Compensation Act 94 years ago, one of its objectives was to provide medical care to injured workers. Subsumed within the objective was the promise that an injured worker would receive quality medical care so as to enable them to return, as much as the advancement of our medical arts permitted, to the physical capacity he or she enjoyed prior to the injury and ultimately a return to work.

Connecticut's Act has a proud history of being able to provide injured workers with an assurance that their injuries will be treated with the same skill and attention that would attend to anyone sustaining a similar injury.

B. Brief History of Medical Fees

1. Before 1993

Through most of the Act's history the medical fee to which a physician was entitled was "limited to the charges that prevail in the same community or similar communities for similar treatment of injured persons of a like standard of living when the similar treatment is paid for by the injured person." Understand that at the time of the Act's inception doctors were paid directly by a patient or through charity. Former Chairman John Arcudi summarized the Act's authorization of fees as the following "Sec. 31-294 limits the employer's pecuniary liability for such services to a community standard and not to the measure a grateful Midas might employ in rewarding his healer." Bowen v. Stanadyne, Inc., 232 CRD-1-83 (June 19, 1984)(emphasis ours)

2. 1993 Workers' Compensation Reform

As you may recall in the late 80's and early 90's on a national level we faced the growing escalating costs of medical care which put a serious drain on our economy. Attempts were made at a total reformation of our nation's health care and overhauling the amounts and methods by which physicians were paid. The health insurance industry and the physicians came to accept that a doctor could no longer expect to charge a fee and be paid without some justification of how the fee amount was determined. By 1993 medical fee schedules were being incorporated into the world of group health insurance as a means of controlling costs and providing physicians with acceptable fees.

By 1993 the medical fee structure, or lack thereof, which existed under the Workers' Compensation Act did not reflect the real world of medical economics and was a contributor to escalating Workers' Compensation costs. Thus, in 1993, our legislature empowered the Chairman of the Workers' Compensation Commission to

develop a fee schedule. As you can imagine the proposal of a medical fee schedule for care provided to injured workers was a significant change from the former methods employed to determine fees.

The medical fee schedule that was enacted was based on the state of medical economics in 1993, in which doctors still might expect payment on a pro rata portion of the fee charged. Since 1993, in the vast majority of cases doctors are paid on the basis of an established relative value system. The major player in medical economics is Medicare. At almost the same time that we were adopting our present fee schedule, Medicare changed its payment structure to a **RELATIVE VALUE SYSTEM**. Under that system the fee paid to a doctor is based on the relative value of the procedure itself taking into account the time and skill necessary for the particular medical treatment as well as the expense associated with a medical practice i.e., administrative overhead and legal liability.

C. Where we are today

Outmoded data collection and methodology

In short, we need to update the methodology by which we calculate our medical fee schedule. Currently our medical fee schedule requires us to calculate the fee schedule on the basis of amounts charged by physicians. Basing a medical fee schedule on such data is now outmoded and archaic. Utilization of charge data to determine medical fees does not reflect current medical payment standards. Thus, it is our hope that by changing the methodology to calculate the fee schedule we can lessen the costs associated with its annual production.

Using a fee schedule methodology which is consistent with that used on a larger scale will also help us to see how we compare with other states and thereby allow us to remain competitive and maintain Connecticut as a good place to work and do business.

D. Fee Schedule Methodology

1. Current methodology for establishing fees

CGS §31-280 and administrative regulation §31-280-3(b) set forth the methodology to be used by the Chairman of the WCC to establish a fee schedule for payment to medical providers for services rendered to injured employees. The current methodology relies on there being a data base consisting of current charge data (that being the amount a physician charges for a particular service or procedure). The fee schedule is established at the 74th percentile level of those statewide charges. Due to changes over the last decade as to the manner in which health care services are billed and paid, most significantly due to the implementation of preferred provider networks and managed care contracts, charge data is no longer a reliable basis on which to calculate medical fees. As we have outlined above our current methodology is no longer workable. Because of this we are seeking a

change in subdivision (11) of subsection (b) of section 31-280 to allow the Workers' Compensation Chairman to utilize the Medicare methodology to calculate fees paid to Workers' Compensation medical providers. Such a change in methodology will allow us to develop a fee schedule that is based on the largest and most accepted relative value system, i.e., the Medicare system

2. Proposed Methodology set out in Senate Bill No. 1378

As noted above, the Medicare value system is a relative value system. For those who would enjoy some greater detail, the Medicare value system is more correctly identified as a Resource-Based Relative Value Scale (RBRVS) in which medical services are ranked according to the relative cost of resources to produce the service. Medicare uses three components to calculate resource costs and therefore the relative value (RVU) of each medical service: 1) physician work (55%); 2) practice expense (42%); and 3) professional liability insurance (3%). The Medicare fee is determined by multiplying the total relative value unit (RVU) of a particular medical service by a conversion factor. The RBRVS methodology is familiar to and accepted by all physician practices due to Medicare being the largest payer of medical services in the nation.

In transitioning to this new methodology it is our intent to not only remain revenue neutral presently, but to establish conversion factors that will allow us to maintain fees at a level which reflects the unique circumstances inherent in the delivery of medical care to the injured worker. The task of determining appropriate fees for new procedures and for those procedures that have changed to reflect current technology will be accomplished more equitably and efficiently by relying on the methodology already established by Medicare.

II. Conclusion

A. Enactment of SB 1378 will:

1. Allow the Workers' Compensation Commission to establish a medical fee schedule that more closely approximates the methods used in the current medical marketplace to determine the appropriate level of compensation to physicians.
2. Assure that physicians are fairly compensated thereby keeping the experienced doctors in the system and providing injured workers with access to an established quality level of medical care
3. Control costs and maintain Connecticut as a good place to work and do business.
4. Allow for the production of a medical fee schedule less expensively and to have a basis of comparison with other jurisdictions.