

**Department of Consumer
and Business Services**

2005 Medical Quality Initiative Report of Results

Presented to

Oregon Department of Consumer and Business Services,
Workers' Compensation Division Administrator and Executive Team

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Prepared by:

The MQI Internal Advisory Committee

The Workers Compensation Division's Medical Quality Initiative Committee was comprised of the following staff:

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Medical Quality Initiative Treatment and Guidelines Committee Assessment Report and Recommendations

Following is the final report of the WCD Treatment and Guidelines Internal Advisory Committee. It includes background information, a report of meetings with stakeholders around the state, a statistical report developed by the Information Management Division (IMD), and the committee's evaluation and recommendations for next steps in the Medical Quality Initiative.

BACKGROUND: In 2002-2003, a special external advisory committee met over several months to review and recommend revisions to the workers' compensation medical fee schedule. In addition to their original charge, this group, consisting primarily of doctors and insurers, unanimously recommended that WCD develop a program to provide for a higher rate of reimbursement to certain medical providers who demonstrated the highest level of care and success in treating injured workers. One member, on behalf of that committee, drafted the following recommendation:

Create a tiered medical fee schedule system that would encourage and compensate accordingly, those health care providers who undertake basic and ongoing instruction that would increase their understanding and competence in the area of occupational medicine, and increase the overall perception of value added to the care and administrative requirements of workers' compensation cases.

WCD reviewed the recommendation, and recognized that one problem in implementation would be determining what criteria to use to determine which providers would qualify for the upper tier. As a participant in a Robert Wood Johnson Foundation study, WCD staff were able to consult with health policy and workers' compensation leaders in the country to explore this issue.

While WCD was exploring the idea of implementing the advisory committee recommendation, the National Council on Compensation Insurance (NCCI) and the Information Management Division (IMD) of the Department of Consumer and Business Services (DCBS) independently reported that medical costs in Oregon's workers' compensation system are growing at rates significantly higher than the general inflation rate, and medical costs are representing an increasingly higher percentage of all claims costs in Oregon's workers' compensation system. After more than a decade of premium decreases and three years of no change, the continued growth in medical costs will almost inevitably lead to higher premium rates.

As a result of the concerns over higher costs, quality of care, consultations with policy leaders, review of initiatives undertaken by other jurisdictions, and research into the statistics and general trends in health care policy, WCD staff proposed a Medical Quality Initiative that was initially comprised of three primary components - a voluntary certification program for medical providers that would be tied to the Fee Schedule; adoption of some treatment guidelines; and simplification and streamlining of medical provider reporting and billing requirements. WCD completed a preliminary feasibility study of this proposal in December 2004.

After meeting with a variety of stakeholders to assess interest in and support for the Medical Quality Initiative, WCD determined it needed considerably more input from the stakeholder community to create a Medical Quality Initiative. Therefore, WCD convened two internal advisory committees to pursue this input. One was charged with reviewing reporting requirements, and this committee has been working separately and will make a separate report to the WCD Executive Team. The second committee was charged with developing a plan to gather input from stakeholders, not only about the

original concepts laid out in the feasibility study, but also to generate and gather other ideas and concepts consistent with the goals of the initiative.

However, the committee had concerns about the original goals of the project. The goal stated in the MQI feasibility study was: "To control medical costs in Oregon's workers' compensation system while minimizing disputes and litigation and assuring workers have adequate access to quality healthcare which results in a high return-to-work rate for Oregon's injured workers."

The committee felt there was an over-emphasis on medical costs which was not on target. The committee felt that it is quite possible that reducing medical costs could actually result in increased claims cost. The committee was also concerned that emphasizing costs could jeopardize other important aspects of delivering medical care to injured workers, such as quality and access. The group therefore revised the goals, which were presented to and endorsed by the sponsors. These goals were then incorporated into and guided the project team in completing the assignment. The goals adopted by the committee are:

- Decrease overall claim costs;
- Assure consistent, high quality care;
- Provide workers with timely treatment and access to medical care;
- Improve return-to-work outcomes;
- Improve partnerships among system stakeholders; and
- Provide resources/guidance to medical providers.

The committee reviewed the proposals for certification and guidelines and developed other possible ideas which were reviewed in the light of the goals of the project. They then devised a process for obtaining stakeholder feedback and input through a series of meetings with all the systems stakeholders – workers and labor groups, medical providers, insurers, employers and business groups, managed care organizations, the legal community and policy makers.

STAKEHOLDER MEETINGS: WCD held meetings in Medford, Eugene, Lincoln City, La Grande, Portland, Salem and Bend. While over one hundred stakeholders attended these meetings, WCD had hoped for more participation. Over 2000 letters were sent directly to stakeholders inviting them to the meetings. Information about the meetings was posted on the WCD website. The Oregon Medical Association, SAIF, a professional group representing human resource managers, and other trade and professional organizations assisted WCD's outreach by including information about the meetings in their newsletters or websites. WCD staff phoned stakeholders in several areas prior to the scheduled meetings to specifically invite them to attend. Even with this outreach, only 111 stakeholders participated in the meetings.

Attendees included representatives of all the stakeholder groups listed above, but the representation at each meeting varied. Attachment 1 shows the specific representation at each meeting. Overall, the representation of labor and other worker representatives was low. While there were a number of medical providers and staff, there was only one physical therapist and no pharmacists at any of the meetings. (As will be noted below, some of the suggestions endorsed at the meetings involved physical therapy services and drug reimbursements.) In the smaller meetings (Lincoln City, Eugene, Bend and La Grande), all the attendees discussed the issues as a single group. In the larger meetings (Medford, Portland morning, Portland afternoon, and Salem), attendees discussed the issues in small groups, and then the groups shared their ideas with each other. In all the meetings, participants were given the opportunity to cast votes for those concepts and ideas they thought were the most important or most worthy of further exploration.

In reviewing the summaries of responses from all eight meetings, five general concepts and ideas emerge which were common to all the meetings and received strong endorsement from the participants. They are:

- 1) Oregon's workers' compensation system is basically sound, especially when compared to other jurisdictions. Participants cautioned WCD about making any significant changes without careful thought and planning, to avoid any chance of making changes that would make the system worse rather than better.
- 2) There was a lot of concern about "outliers," which participants define as those providers who provide treatment that is significantly more costly, takes longer or has poorer outcomes than for the vast majority of the providers. Most of the participants noted experiences in working with these "outliers," and thought the system may have, or needs, tools to either control or exclude them.
- 3) There was little support for taking actions that would expand the use of MCOs without more evidence that MCO's improve outcomes or control costs.
- 4) There was a lot of interest in modifying the pharmacy rules to encourage the use of effective, lower cost drugs in lieu of the more costly brand names.
- 5) Finally, participants requested additional and more reliable data to better understand what is driving cost increases, to clarify the areas most impacted, and to support the general contention that rising costs are truly an issue.

WCD requested specific feedback on a number of topics, which will be discussed in detail. In each meeting, WCD requested input and feedback on the following general areas:

Managing Care

- Treatment guidelines?
- Expanding MCOs?
- Managing care outside MCOs?
- Other ideas?

Reimbursements

- Developing alternative reimbursement methods?
- Modify fee schedules?
- Managing pharmacy costs?
- Other ideas?

Certification/Education

- Certification of providers?
- Education and outreach for all participants?
- Other ideas?

Managing Care – Developing treatment guidelines: Initially, there was not a great deal of enthusiasm for the idea of developing guidelines. Most participants were adamant that inflexible guidelines or a system like Washington's would not be appropriate for Oregon. However, as discussion continued in most of the groups, many participants felt there could be a benefit to develop certain flexible guidelines. There was interest in developing some sort of very broad guidelines to help control outliers. There was agreement that some guidelines could improve the focus on outcomes and returning injured workers to appropriate work.

In general, participants agreed that if any guidelines are adopted by WCD they should:

- * Be developed by Oregon's medical community, or adopted from existing guidelines by Oregon's medical community.
- * Be flexible and allow latitude for individual provider judgment.
- * Be very limited and address only the most costly or common treatment areas.
- * Be based on evidence-based data.

Concepts endorsed by a number of participants include:

- * Focus on "process" guidelines as opposed to prescriptive treatment guidelines. For example, the guideline might require a review of treatment at various points in time. If the treatment is yielding improvement, it would be appropriate to continue, but otherwise, it is time to terminate it and possibly consider another approach.
- * Provide guidelines for pain management, including appropriate drug therapies.
- * Provide guidelines on physical medicine.
- * Develop drug formularies and encourage or require both generic and therapeutic substitutions.

Some other ideas suggested by participants include:

- * Consider limiting or periodically reviewing care provided by primary care providers, or, if certification is adopted, by non-certified providers.
- * Recognize the impact of the aging of the baby-boomers in developing guidelines, because this creates a new medical challenge as well as complications in determining the compensability of combined conditions.
- * Provide guidance to make chart notes more standard, or even to make the medical file more standard to assure the file includes necessary forms and documentation.
- * Provide guidance on when and what diagnostic procedures to use, given the legal as well as medical issues involved in workers' compensation injuries.
- * Provide medically sound guidance on new technologies and techniques.

There was some consensus around the idea that the Medical Review Unit (MRU) has or needs tools to control outliers. While some participants felt that the tools already exist, others agreed that adopting some general guidelines would provide some standards against which MRU could measure an individual provider's treatment of injured workers.

Many participants noted that there are a lot of guidelines currently available. A few participants familiar with the American Council on Occupational and Environmental Medicine "Occupational Medicine Practice Guidelines" (the ACOEM Guidelines) felt these guidelines appropriately address workers' compensation issues.

Many participants questioned the practicality of adopting guidelines and keeping them current, but agreed that good guidelines could help providers in the decision making process.

Managing Care – Expanding MCOs: There was little enthusiasm for this idea, especially outside the Portland-Salem area. In all the meetings, participants felt that the evidence is insufficient to demonstrate that MCOs do what they are supposed to – provide quality care while controlling costs, and they were unwilling to endorse any expansion without clearer evidence that they work. There was mixed support for MCOs as they currently operate within the system.

Especially at the Salem and Portland meetings, which included more than half of the participants throughout the state, many of the participants felt MCOs added value by holding physicians accountable, by encouraging return-to-work and by providing an intermediary between the insurer

and provider. Participants saw some value in strengthening the current MCO system, including encouraging greater and earlier enrollment and encouraging expansion to less populated areas. A number of participants supported giving MCOs more “teeth” to enforce their rules and guidelines, and some felt the system would be strengthened by not allowing workers to continue to treat with their primary care physicians following enrollment.

The support for MCOs was less enthusiastic outside the Portland-Salem metropolitan areas. In Bend, the three participants did not discuss the option of expanding MCOs, but one participant remarked that MCOs turn away doctors. In Eugene, the group was concerned that MCOs do not have enough panel providers, or enough willing to take new patients, to assure workers adequate access to care. One stakeholder remarked, however, that in areas without MCO coverage, costs are higher and workers aren’t treated fairly or appropriately. Several felt that MCOs haven’t demonstrated value statistically, and need to before the system should consider expanding the MCO role. In La Grande, the attendees felt the MCO just added another layer of bureaucracy, and workers are more likely to be denied treatment. The La Grande group also felt that MCOs do not pay adequately. The Lincoln City participants echoed the idea that the MCOs add another layer of bureaucracy. Some participants also expressed the idea that MCOs are biased, unresponsive and slow, and that it would be better to “fix” MCOs within the law.

In summary, the one area of general agreement on the question of expanding MCOs is that more study is needed to assess the success of MCOs before expansion should be considered an option.

Managing Care – Outside of MCOs and Other: There was a broad range of ideas for managing care better outside the MCO system. Some employers, insurers and self-insureds expressed an interest in Preferred Provider Organizations, which would provide panelists who would treat workers quickly, effectively and appropriately. They expressed an interest in being able to manage workers’ care more directly, conduct utilization reviews, and have the authority to pre-authorize certain services, such as physical therapy. The most dominant themes on this topic were:

- * Control outliers better
- * Don’t do anything that will drive providers away from treating injured workers.

Other ideas suggested by various participants included the following:

- * Pre-authorization: There was interest expressed at a lot of meetings about allowing or requiring limited pre-authorization. Many participants felt that it should be optional and at the request of the physician and/or limited to specific treatments or modalities over a certain dollar amount.
- * Consider allowing employers to direct workers to the initial provider.
- * Place a limit on primary care providers similar to the current limit on chiropractors, for example 60 or 90 days. At that time, the worker might be referred to a specialist, or at least there would be a mandatory review of treatment.
- * Require providers to provide adequate records to physical therapists
- * Improve forms or develop a template that providers are required to complete.
- * Develop a “functionality test” for workers to assess when they can come back to work and if they can do their job.

Reimbursements – Developing alternative methods: There was a general agreement that the current method of reimbursements is appropriate and there was not much interest in ideas designed to change the system. Most groups felt that the solution to dissatisfaction with fees is to reduce

hassles for providers rather than to change the fee structure. The only areas that got more than one or two "votes" were:

- * Simplify billing-
 - o Allow/encourage electronic billing
 - o Stop requiring chart notes with every bill. Currently Medicare requires them only on a case specific basis.
 - o Consider grants to providers, especially rural providers, to purchase computers and software.
- * Revise the pharmacy fee schedule (which will be discussed further below)
- * Expand the use of Oregon Specific Codes to cover reports (with detail to help determine what constitutes a simple, moderate, complex or very complex report); WRMEs or legal/medical activities such as depositions and IMEs.

Reimbursements - Modify fee schedules: There was a strong consensus that the current fee schedule is adequate and appropriate and should not be changed. There was concern about the concept of adopting a tiered schedule. Most providers noted that the fee schedule in workers' compensation was higher than in general health

Reimbursements – Pharmacy fees: Modifying the pharmacy fee schedule was possibly the most endorsed concept throughout the meetings. Recommendations that received a lot of support included the following:

- * Require generic substitution and do not reimburse for brand names, even if the worker makes the purchase up front (unless the doctor prohibits generic substitution.)
- * Develop or adopt a formulary.
- * Require therapeutic substitution (substituting one drug for another that has been determined to be therapeutically equivalent – often as part of a formulary.)

Other ideas introduced included:

- * Developing an education program to educate doctors about the top prescribed drugs, costs and problems.
- * Develop a step therapy protocol (delineating when it is appropriate to try particular drugs)
- * Require pharmacy benefit managers (PBMs) for all workers.
- * Consider bulk purchasing for drugs to be used by injured workers. (This raises the question of who would purchase and how would drugs get to workers)
- * Set up a statewide "prescription gatekeeper" that could monitor the drugs workers are getting and identify any workers receiving multiple narcotics.

Reimbursements – other ideas: Some other ideas suggested by participants included:

- * Allow a broader range of diagnosis codes when reviewing billing – some insurers are overly "picky" and deny bills even though they are obviously intended for the accepted condition.
- * Modify the rules that allow insurers to discount late bills from providers. This creates a great deal of trouble for the provider who often doesn't know what provider to bill at first, or the insurer returns (or throws out) early bills because they don't yet have an accepted claim. Then they claim the provider failed to timely bill.
- * Consider employer co-pays, to keep experience rates down.
- * Consider worker co-pays, to give workers an interest in controlling costs.
- * Require carriers to have a website where providers could check claim status and provider information about billing and reporting requirements.
- * Allow MCOs to deviate from fee schedule to reward best practices.

- * Manage DME costs better – mark-ups on some devices are outrageous.

Certification/Education – certifying providers: In most of the groups, there was little enthusiasm in general for the idea of certifying providers, but considerable interest in providing appropriate training for providers and provider staff. There was some consensus that providers would more likely participate if there were an obvious benefit for them to do so. If doctors did become certified, there was a lot of disagreement over whether certified providers should be reimbursed at a higher rate than non-certified providers. Other benefits might be that certified providers could be exempt from some documentation, pre-authorization requirements, etc. One group suggested developing a “test” that most providers could easily pass, to identify the providers who were in greatest need of training in order to provide services to injured workers. There was interest in certifying the office staff of providers. Following were some of the topics participants thought should be included in any curriculum:

- * Educate providers that return-to-work is a critical component of recovery.
- * Educate providers about the principles of workers’ compensation, including “major contributing cause” and the legal implications of previously existing conditions.
- * Educate providers on workers’ compensation rules.
- * Training to providers should include physical therapists.
- * Provide and train on standard chart-noting, templates, forms etc.
- * Educate providers and staff on the specifics of Oregon’s system. (Workers’ compensation is not the same from state to state. Some providers won’t treat Oregon workers because they dislike Washington or California’s systems)
- * Educate office staff on billing and paper work requirements (and the purpose they serve)

Education/Certification – Education and outreach for all participants:

- * Educate employers about completing 801s (First Report of Injury form) correctly.
- * Educate workers about workers’ compensation BEFORE they are injured.

Miscellaneous suggestions: Following is list of some of the other ideas to meet the goals of the MQI suggested by participants at the meetings:

- * Create a standard form for physical therapists to give good, objective information to the PCP.
- * Provide grants to new physicians to pay off student loans if they treat workers in underserved areas.
- * Increase the limit on chiropractic visits – chiropractic treatment can be an effective alternative to return workers to work quickly.
- * Have a standardized return-to-work form that is complete and used across the state. (Note: WCD does provide a standard form. Many providers report that insurers and employers require them to use other forms, and some users complain that the state form is not detailed enough.)
- * Video tape the worker’s job and light duty alternatives so the doctor can better determine what the worker is required to do on the job.

Data Analysis Summary:

One of the stated goals of the Medical Quality Initiative is to decrease overall claim costs. To support this goal, the Medical Team of the Information Management Division, Research and Analysis Section, has conducted an analysis of claim costs, specifically focusing on medical costs and its various components. The purpose of the analysis is to describe the current composition of medical costs within the workers’ compensation system and to identify drivers of medical cost

growth so that the advisory committee can formulate recommendations for external and internal review and adequately respond to questions and concerns directly related to medical cost data.

The following summary identifies key findings from the data analysis. Each statement is supported by an attachment, which includes either descriptive charts or data tables. Questions or comments concerning the analysis can be directed to Bryan Skalberg or Nathan Johnson of IMD.

General claim costs overview:

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| <p>Total claim counts are decreasing by more than 5% per year.</p> | <p>Based on a review of Accepted Disabling Claims (ADCs) and Accepted Non-disabling Claims (ANCs) by injury year for 1999 to 2003, total claim counts are falling at an annual rate of 5.4%. More specifically, non-disabling claim counts are falling at a faster rate than disabling claims. From 1999 to 2003, non-disabling claim counts fell at an annual rate of 5.6% while disabling claim counts fell at an annual rate of 4.9%. (Non-disabling claims represented 77% of all claims and 29% of all first-year payments in 2003.) <i>See Attachment 1.</i></p> |
| <p>Total medical payments are increasing by nearly 4% per year.</p> | <p>While claim counts are decreasing, total medical payments continue to increase. Analysis of claims with injury years from 1999 to 2003 shows a 3.9% annual growth rate in total medical payments during the first year after date of injury. <i>See Attachment 1.</i></p> |
| <p>Average medical payments per claim are increasing by more than 9% per year.</p> | <p>A decreasing trend in claim counts and an increasing trend in aggregate medical payments equate to a substantial increase in average medical payments per claim. Analysis of claims with injury years of 1999 to 2003 shows that average medical payments per claim within the first year after injury are increasing at an annual rate of 9.4%. Average medical payments within the first year after injury for non-disabling claims increased at an annual rate of 9.9%. Average medical payments within the first year after injury for disabling claims increased at an annual rate of 8.8%. (These figures are not adjusted for inflation. From 1999 to 2003, the Medical Services component of the Consumer Price Index increased at an annual rate of 4.6%. Inflation-adjusted growth rates can be calculated by subtracting the inflation rate from the nominal rate.) <i>See Attachment 1.</i></p> |
| <p>Claims with lower medical costs are declining faster than claims with higher medical costs.</p> | <p>From 1999 to 2003, the count of all claims by year of injury has decreased at a rate of 5.4% per year (non-disabling -5.6%; disabling -4.9%). Analysis of medical payments per claim shows that the median (mid-point) payment per claim is increasing faster than the average (mean) payment per claim for both non-disabling and disabling claims. These observations suggest that lower-cost claims are declining more rapidly than higher-cost claims in both the disabling and non-disabling groups of claims. <i>See attachment 2.</i></p> |
| <p>Average number of visits per claim and average number of services per visit are increasing. Increases in average visits per claim are driving the growth in average services per claim.</p> | <p>Analysis of claims with injury year from 1999 to 2003 and services provided within one year of injury shows the average number of visits per claim has increased from 6.0 in 1999 to 7.3 in 2003, an annual growth rate of 5.0%. Similarly, the average number of services provided per visit has increased from 3.1 in 1999 to 3.4 in 2003, an annual growth rate of 2.2%. The combination of these data equates to a 7.4% annual growth in the average number of services per claim. During this time, the average payment per service has increased at an annual rate of 4.8%, consistent with the Consumer Price Index for Medical Services, which has had an annual growth rate of 4.6%. <i>See Attachment 3.</i></p> |
| <p>Compared to the WCRI published 12-state median, Oregon has a slightly lower average medical cost per claim.</p> | <p>In an analysis of medical costs for claims with injury dates between October 1, 2000 and September 31, 2001 and with services evaluated through March 31, 2002, Oregon had an average medical cost per claim of \$1,582 compared to the WCRI published 12-state median average medical cost per claim of \$1,750. Utilization levels were comparable. <i>See attachment 4.</i></p> |
| <p>Medical payments are</p> | <p>Average costs at closure for Accepted Disabling Claims (ADCs) at notice of closure</p> |

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| representing an ever-increasing portion of total claim costs. | from 1997 to 2004 has increased at an annual rate of 6.3%. The medical component of total costs has increased at an annual rate of 7.4%. In 1997, medical payments represented 50% of total ADC costs. By 2004, this percentage had increased to 55%. <i>See attachment 5.</i> |
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Medical Cost Drivers:

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| Medical services by provider types medical doctors, physical therapists, radiologists, and pharmacy are contributing to medical cost growth. | Analysis of the growth in total medical payments by provider types from 1999 to 2003 identifies specific provider types that are either increasing or decreasing their contribution to medical payment growth. Those with an increasing contribution were medical doctor, physical therapist, radiologist, and pharmacy. Those with a decreasing contribution to medical payment growth were hospital outpatient, hospital inpatient, and chiropractors. Other provider types had a very small impact on growth. <i>See Attachment 6.</i> |
| Evaluation and management¹ services are the leading cost drivers in the growth of medical doctor payments. | For medical doctors, the service category with the largest share of fee schedule payments in 2003 was evaluation and management, representing 36.7% of all fee schedule payments to medical doctors. A close second was surgery, representing 36.1% of 2003 fee schedule payments to medical doctors. Evaluation and management is the leading cost driver in the growth of medical doctor payments, representing 49.3% of total growth from 1999 to 2003 ¹ . <i>See Attachment 6.</i> |
| The service categories of physical medicine and evaluation and management are the largest contributors to the growth in fee schedule payments. | Analysis of the growth in total medical payments by fee schedule service categories from 1999 to 2003 identify specific service categories that are either increasing or decreasing their contribution to medical payment growth. Those with an increasing contribution were physical medicine, evaluation and management ¹ , radiology, and surgery. Those with a decreasing contribution to medical payment growth were those related to Oregon Specific Codes, anesthesia, medicine, and laboratory and pathology. <i>See Attachment 7.</i> |
| Physical medicine billed as hospital outpatient is taking an increasing share of physical medicine cost growth. | While physical therapists accounted for the largest share of physical medicine payments in 2003 (42.9%) by provider type, hospital outpatient accounted for the largest share (36.0%) of the total growth in physical medicine payments from 1999 to 2003. Hospital outpatient is the only provider type that is increasing its share of physical medicine payments. Hospital outpatient physical medicine payments represented 24.6% of total physical medicine payments in 2003. <i>See Attachment 7.</i> |
| Review of medical costs related to the use of Managed Care Organizations (MCOs) is inconclusive. | A comparative analysis of claims that were enrolled in MCOs and claims that were not enrolled indicate that MCO-enrolled claims are increasingly more costly. This may be attributable to an insurer's tendency to enroll only the more complicated or severe claims. We are not able to effectively account for differences in claim severities. Therefore, our analysis of the impact of managed care on medical costs is inconclusive. <i>See Attachment 8.</i> |

¹. A portion of the increase in Evaluation and Management payments may be attributable to a 20% increase in the fee schedule conversion factor in July 2003. *See attachment 9.*

². Average annual growth rates were calculated over the time period specified and reflect the slope of the least squares line through the natural log of the annual data points.

Notes on the data used for the analysis:

Figures for the number of accepted disabling claims (ADCs) and estimated accepted non-disabling claims (ANCs) are from department publications and include all insurers (SAIF, private, and self-insured) in Oregon's workers' compensation system. ANCs are not reported to the department. They

are estimated by creating estimates of the ratios of ANCs to ADCs. This is done using data from four sources. Medical billing data reported to the department are combined with the department's claim information system (CIS) to provide estimates for SAIF and some private insurers and self-insurers. National Council on Compensation Insurance (NCCI) data provides ratios of indemnity cases to medical cases for SAIF and private insurers. Also, on occasion SAIF has provided counts of claims with and without payments. The figures for ANCs are subject to revision.

A quality sample of data was selected from medical billing data to determine figures for average medical payment, median medical payment, average number of visits (number of individual days a service was provided), and the average number of services. The number of services per visit (number of services/number of visits), payments per visit (total payments/number of visits), and the payments per service (total payments/number of services) are also determined from the sample. The sample is comprised of insurers (notably SAIF and the Liberty Mutual group, along with other private insurers and self-insurers) that have reported billing data, which has a high degree of correlation to the CIS. These insurers have reported billing data that matches 90 percent or more of the ADCs listed on the CIS as accepted by the insurers and have consistently reported valid medical service and payment data. The injury year in the sample consists of claims with injuries between January 1st of the injury year through December 31st. All services provided within one year (365 days) of the injury are used in the analysis. This time frame was chosen for analysis because a significant portion of services on a claim is provided over a uniform time frame. Furthermore, a one-year time frame allows for the use of the most recent data available. An exception are the figures on attachment 5 which are determined from total ADC costs for medical, time loss, and net PPD (permanent partial disability) as reported to the department at notice of closure. These total costs are the sum of the payments in each category. Total ADC costs are the sum of total medical, total time loss, and total net PPD costs.

Internal Advisory Committee Evaluation and Recommendations:

The committee's recommendations listed below are framed in light of the strong concern expressed by stakeholders that because we have a system that works well, changes should be made only with careful thought and planning. Because of this admonition, most of the recommendations below recommend the creation of task forces to study further and make further recommendations in the areas, which generated the most interest from the stakeholders.

We were disappointed by the small turnout of participants compared to the outreach efforts involved. While we gained valuable assistance and insight, we did not hear equally from all constituent groups. Rather than continue the initial process of trying to obtain their general input, we urge that extra efforts be made when creating the committees recommended below to be certain that impacted stakeholders are appropriately represented on them.

We also assume that these recommendations will be reviewed with the Management Labor Advisory Committee (MLAC), the Medical Advisory Committee (MAC), other policy makers and decision makers as the executive team finds appropriate, so that we can continue to assess the support and concerns of our stakeholders.

Based on the input from the stakeholders, the statistical data compiled by IMD, and the assessment and evaluation of the internal advisory committee, we offer the following recommendations. We note that the internal advisory committee was not asked to prioritize these recommendations and we have made no attempt to do so. The order of presentation of these recommendations is random.

1. **Appoint a special advisory committee of WCD staff and stakeholders to review the pharmacy schedule to consider additional pharmaceutical price-control mechanisms.**

DISCUSSION: This was an area of interest at all of the meetings. While pharmacy costs only comprise an estimated 6% of medical costs in Oregon's system, it is one of the fastest growing areas. There are also just a small number of drugs that make up a disproportionately large share of the pharmacy costs. The small number of these cost drivers may make it easier to target a few strategies that could have a significant impact on reducing or slowing cost increases in this area. Ideas suggested at the meetings included developing or adopting formularies for certain classes of drugs, allowing or requiring therapeutic substitution of drugs, and increasing the use of generics.

PROS: This is an area that was of interest to a majority of those attending the meetings. Following up on the recommendations to do something in this area will be responsive to those who provided their input. It is also, comparatively speaking, a "small bite," a more focused and directed project than is likely in some of the other areas.

CONS: Because pharmacy costs only make up an estimated 6% of medical costs, even significant gains in controlling these costs will not have a large effect on overall medical costs. The efforts at reform in this area might not be worth the savings gained.

2. Appoint a special advisory committee of WCD staff and stakeholders to review the Oregon Specific Codes to determine if expanding these codes is desirable to provide clarity for billing and paying for activities not specifically addressed by current codes.

DISCUSSION: Both medical providers and insurers and other claims administrators reported that they have problems with billings for activities which are not clearly addressed by the CPT or Oregon Specific Codes. For example, doctors reported that bills for reports seemed to be paid inconsistently for the effort required. Insurers reported that bills for reports, depositions, and other activities currently billed "by report" have sometimes been significantly out of proportion to the effort required or similar bills from other providers. One participant suggested that if there was a well defined schedule to follow for reports or return-to-work activities, such as that provided in the Oregon Specific Codes for arbiter examinations, file reviews and reports, it would be much easier to determine an appropriate bill for these activities. It would provide clarity and consistency both for the providers and for the insurers. This committee could also consider whether the statute should be amended to allow doctors to receive payment for filling out statutorily required forms, and make appropriate recommendations to the administrator. It should be noted that the second MQI committee looking at reporting requirements has also uncovered many of these same issues, and likely will make recommendations in this area. These recommendations should be combined for a single project.

PROS: This is again a relatively "small bite" that could have a positive impact and reduce friction and disputes between providers and insurers. If new codes are adopted, it would help resolve disputes if they arose, since there would be a clearer guidance on an appropriate fee for a specific service. It would make providers more satisfied that they were fairly compensated, which would have a beneficial impact on access to care. It would also allow the division, with input from all impacted stakeholders, to have greater influence over the costs of these services.

CONS: Although the anticipated problems with conforming to HIPAA standards have largely been resolved in using non-standard codes such as the Oregon Specific Codes, adding more non-standard codes could create confusion and difficulties, especially if the workers' compensation system moves toward electronic billing. The review would need to consider impacts on electronic billing and restrictions created by HIPAA. Also, adopting new codes might add clarity and reduce friction, but may not have a significant impact on medical costs.

3. Appoint a special advisory committee of WCD staff and stakeholders to develop an education program for medical providers and office staff in general workers' compensation law and principles, return-to-work, reporting and billing.

DISCUSSION: While there was little enthusiasm for certification of medical providers or mandatory training, the medical providers and staff who attended the meetings almost universally described a need for training to better work with a workers' compensation population. Training needs expressed by providers ranged from gaining better knowledge of the workers' compensation law to billing and administrative requirements. Other participants, such as insurers, also stated there was a need to provide training to medical providers and staff. Providers who understand the system have less frustration, and both insurers and providers report that when the provider understands the type of information and decisions that need to be made, it makes it easier to process the claim appropriately. The advisory committee will need to determine what training is required and to whom the training should be oriented (medical providers and/or office staff). It will also be critical to develop the type and methods of training that providers will consider worth their time, or they may not participate in spite of their need. This should include updating the Physician's Guide, WEB pages and other resource materials. As one doctor who urged training put it, medical providers are very protective of the little free time they have, and they will need to see a pay-off for taking time for training. To aid this recommendation, a survey of providers that will be conducted by the MQI-REP committee will include questions about what topics for training are seen as needed by the medical providers, and what methods of providing/receiving training are most desirable.

PROS: Providers who believe they have a good understanding of workers' compensation state that it makes their work much easier and less frustrating than it was before they gained that understanding and than it is currently for their less-trained peers. A training plan will help more providers improve their level of knowledge and understanding of the system, its purpose, and requirements.

CONS: Unless WCD is able to develop a compelling training program that is seen as valuable and worth the time required of providers, it may not pay dividends consistent with the investment required. One team member notes that if the turnout at the stakeholder meetings is a measure, turnout for training might be very low.

4. Request that the Medical Advisory Committee (MAC) evaluate and make recommendations to manage stakeholder concerns with inconsistent or inappropriate treatment of chronic pain, use of physical medicine, and use of drug therapies.

DISCUSSION: There was very little support among the stakeholders for prescriptive guidelines. On the other hand, there was interest in setting standards or providing limited guidance in particular areas, especially those listed in the above recommendation. There was more support among insurers and employers than among medical providers. For example, some participants expressed concern that physical therapy is overused, and they felt it could be helpful if process guidelines recommended review of the efficacy of on-going therapy at particular times before prescribing additional sessions. Other participants noted a lack of consistency in treating pain. Others suggested that it would be helpful to adopt "step-therapies" for helping providers determine when to try particular drugs. A number of participants stated that if there were some type of best-practice standards, it would be easier to identify and control "outliers." (See recommendation #5)

Recommending treatment guidelines created some controversy within the internal advisory committee, with two members strongly dissenting, stating that this concept should not be pursued at all. Their comments are included primarily in the "Con" section of this recommendation.

We recognize the need for strong medical community support and involvement if any type of standard is to be developed and accepted by them. Therefore, we recommend forwarding this concept to the Medical Advisory Committee for further development, evaluation and recommendations. The MAC should be advised that most stakeholders agreed that if any standards or guidelines are developed or adopted, they should be flexible, more process than prescriptive in nature, and evidence based to the extent possible.

One alternative suggested by a team member is that perhaps MAC could develop education, regulation (limiting prescriptions of certain drugs) and resources in these areas in lieu of guidelines.

PROS: Some standards or guidance could improve management of care for workers not treated within MCOs, and if they applied to MCOs, could increase consistency of the care enrolled workers receive. Providing guidance could help reduce disputes over medical treatment by clarifying expectations.

Many stakeholders, both within and outside of the stakeholder meetings, have expressed concern about controlling “outliers” in order to improve the quality of care injured workers receive and to avoid unnecessary costs for inappropriate or excessive treatment. Some felt that normative standards would help. We believe that controlling “outliers” is not feasible unless there are standards recognized by the division against which to measure the treatments provided by these “outliers” and take appropriate action.

CONS: Those opposed to recommending treatment guidelines disagree that there was support for the concept by a significant number of participants at the stakeholder meetings, and contend that they would not be supported by the medical community no matter what they are called or how they are presented. They would add an unnecessary burden to the providers without providing a useful benefit. Furthermore, the administrator, in testifying on the MCO bill last session, specifically stated that WCD should not and cannot develop treatment guidelines. Pursuing this now could appear to be a contradiction to those statements. Developing guidelines would also duplicate the work already being performed by MCOs, and MCOs are in a better position to react rapidly to new developments and findings in medical treatment. There is already a process in place (dispute resolution through MRU) to allow parties to challenge care they believe is inappropriate or excessive. Adopting guidelines could increase rather than decrease disputes because parties will contend that other parties aren't following them. Finally, any kind of standard or guideline cannot be voluntary and flexible and still be enforceable. These members also expressed concern that the MAC, comprised primarily of specialists with a lot of interest in workers' compensation issues, is not representative of the medical community at large. Therefore, even if the MAC members endorse the concept of developing some type of best practice standards, the medical community at large may well be opposed.

5. Request that MAC evaluate and make recommendations regarding “outliers.” Specifically, MAC should provide behavioral criteria that define when a medical provider is an “outlier”; develop criteria to determine when action is necessary to intervene with an “outlier”; and determine what the range of effective actions should be in “outlier” intervention.

DISCUSSION: One of the most dominant themes in all the stakeholder meetings was the issue of “outliers.” Participants felt that a small number of providers typically provide inappropriate or excessive treatment, fail to support return-to-work goals, and perpetuate, rather than mitigate, the workers disability. Many stakeholders remarked “and we all know who they are.” However, WCD, at

least from a legal perspective, does not know who they are. The Director has the statutory responsibility to deal with providers who demonstrate a pattern of inappropriate or excessive treatment. There is a process in place (designed jointly by MRU and Compliance section) designed to detect them, but it is too cumbersome and inefficient to identify and deal with them. It requires multiple MRU orders finding the provider's treatment to be inappropriate or excessive in order to establish a pattern that would then be turned over to the Sanctions Unit for appropriate investigation and action. There simply is not the volume of orders from the MRU to reasonably establish such a pattern. Therefore, if WCD is to address the issue of "outliers," we need at least the system's medical advisors to develop a consensus on what defines an "outlier" as a starting point in order to pursue a program to identify, educate and/or sanction these providers.

PROS: Having a clear and accepted approach of dealing with "outliers" would allow WCD to better meet its statutory responsibilities. Being responsive to this request could improve relations between insurers and the medical community while improving medical treatment for injured workers.

CONS: There is concern that the task cannot be accomplished, that there is not enough consensus about who these "outliers" are.

6. Appoint an internal advisory committee of IMD and WCD staff to evaluate the current data available to DCBS about medical treatment and costs in Oregon's workers compensation system, and to recommend what data would be most useful in furthering the goals of the MQI initiative. Determine the cost/benefits of increasing the available data and reports. Solicit feedback about the perceived costs and benefits from the stakeholder community.

DISCUSSION: Most stakeholders were frustrated with the lack of data and of more specific data used to support the Medical Quality Initiative. They expressed interest in knowing more specifically what areas and services are most responsible for driving costs. We recognize that stakeholders are the source of much of this data, and may be unable or unwilling to provide any more than they do. It may also be possible to develop other reports with existing data that would meet the expressed need. This committee will be asked to determine the cost/benefits of increasing the available data and reports and to determine the impact on and support of the stakeholder community on increasing the data and reporting.

Some of these issues (medical treatment and costs) should be combined with similar recommendations from the MQI-REP committee. The recommendations of the IAC and REP should be combined for a single project. The Claims Redesign project will address similar issues (claims costs and outcomes) as well. The MQI and Redesign efforts need to be combined or coordinated.

PROS: Knowledge is power. The more information that is available, the better are the decisions that can be made.

CONS: While many would like more information, it might prove to be very expensive and intrusive to provide it.

7. Appoint an internal advisory committee of IMD and WCD staff to investigate the need and feasibility of conducting a study to analyze MCO outcomes that will allow a comparison in MCO outcomes and costs.

DISCUSSION: Again, nearly all stakeholders complained about the lack of data available to evaluate the value that MCOs provide, particularly in terms of improving outcomes or lowering costs. Currently

available data is inconclusive about the value of the MCOs. A 1999 study compared outcomes between MCO covered and non-MCO covered claims. The new study should also compare enrolled and non-enrolled claims along with changes in MCO enrollment patterns. This committee should seek feedback about the perceived costs and benefits of performing the study from the stakeholder community.

PROS: If an MCO study was completed and clearly demonstrated whether or not MCOs provide value, policy makers could determine the future of MCOs, including whether to expand their role in the system, based on knowledge and evidence. If the study was conducted by MCOs, they could introduce actual or perceived bias.

CONS: A study like this would cost money as well as use staff resources. Some have argued that since MCOs would be the primary beneficiary of a study that demonstrates they add value, MCOs should conduct and fund such a study. If they are not willing or able to do so, their value remains inconclusive.

8. Recommend that the Regulatory Redesign teams reviewing return-to-work consider the feedback from the stakeholder meetings regarding return-to-work issues, specifically including medical provider input as part of their review.

DISCUSSION: Although there wasn't a "section" on return-to-work, many stakeholders in the meetings expressed their concerns about the lack of coordination on return-to-work activities. Providers complained about:

- * The forms they are required to use.
- * The lack of adequate information they often receive.
- * The difficulties in working with employers to facilitate return to work.
- * That some employers seem to have little understanding of the need to provide suitable light work while the worker is recovering and still partially disabled.

Insurers and employers complained about:

- * Providers' lack of understanding about the benefits of returning workers to meaningful work as quickly as possible.
- * That some doctors are very resistive and think they are best serving their patients by "protecting" them from return-to-work options.
- * Doctors' lack of understanding of job descriptions and inadequate reporting to help make appropriate return-to-work options available to the workers.

It should be noted that the second MQI committee looking at reporting requirements has also uncovered many of these same issues.

PROS: The redesign team will be able to use the information already gathered.

CONS: Could be beyond the scope of the regulatory redesign process.

Stakeholder Meeting Demographics

There were a total of 111 stakeholders at the meetings:

| Meeting Location | # | Med Prov | Attorney | MCO s | Insurer | Employer/Org | Worker /labor | Other |
|--------------------|----------------------|------------------|---------------------|----------------|---------|--------------|---------------|-------|
| Medford | 19 | 4 | 1 (clmt) | 1 | 3 | 5 | 1 | 4 |
| La Grandee | 5 | 5 ¹ | | | | | | |
| Lincoln City | 4 | 1 | 1 (clmt) 1 (ins) | | 1 | | | |
| Eugene | 12 | 1 | 1 (clmt) | 2 | 4 | 2 | | 2 |
| Salem ³ | 24 | 6 ² | 1 (unk) | 2 | 3 | 5 | 3 | 4 |
| Portland | 44 | 6 | 1 (clmt) | 9 ⁴ | 12 | 9 | 1 | 6 |
| Bend | 3 | 1 | | | 1 | 1 | | |
| Totals | 111 | 24 | 6 | 14 | 24 | 22 | 5 | 16 |
| Percent | 100% ⁶ | 22% ⁵ | 5% | 13% | 22% | 20% | 5% | 14% |

NOTES: ¹ One attendee had a son who is an injured worker and also represented his interests. A second attendee had experience as an employer, and represented employer interests.

² Includes one representative of a Pharmacy Benefit Management organization and one physical therapist.

³ One insurer rep and one MCO rep are also medical providers.

⁴ Five MCO reps are also medical providers.

⁵ There were at least six other medical providers listed in other categories.

⁶ Total exceeds 100% because of rounding.