

July 15, 2005

Medical Advisory Committee Meeting

Present:

Ronald Bowman, M.D.; Timothy Keenen, M.D.; Hans Carlson, M.D.; Brad Lorber, M.D.; Linda Jefferson, City of Portland; Tom Williams, P.T.; Maria Carraher, Worker Rep.; Linda Olsen, SAIF; Kevin Willingham, WCD; Debra Buchanan, WCD.

Absent:

Frank Prideaux, D.C.; Pam DeVisser, FNP; Gary Rischitelli, M.D.; Franklin Wong, M.D.

Minutes: May 20, 2005 minutes approved.

Medical Quality Initiative: Update by Barry Jones (WCD). He and Nancy Bieber (WCD) are going out to all the stakeholders and discussing this initiative. He reports that overall the response is positive. Everyone is interested in controlling climbing costs while maintaining or improving quality and access to care.

Barry noted some of the concerns expressed by stakeholders:

Worker Attorneys- whatever we do don't drive physicians out of the system, and don't reduce quality of care for workers.

Self Insured Employers: treatment guidelines haven't saved money in other states. If the treatment guideline says "12 PT visits", and the worker only needs 5, the worker still expects 12. It becomes an entitlement issue.

There are three parameters that have been developed for the upcoming statewide stakeholder meetings:

- 1) status quo is not an option
- 2) we must maintain or improve quality of care for injured workers
- 3) we are open to all ideas from everyone.

How do we compare with other states? Our rates are lower than California, Washington, and Idaho. However their overall systems have problems. We are competitive now but considering medical inflation we want to maintain that for the next 10 years.

Dr Lorber has heard from some colleagues of his down in California. They have reduced physician reimbursements and it's a fiasco down there. His colleague's business had to split up and each physician try to figure out how to be solvent on their own.

Do we have any information on best practices from other states? Each state does things a little differently, and we are not aware of any one model that works well. Everyone is watching California and Texas to see how it comes out in the long run.

Linda: Texas adopted a lot of what we do in Oregon, even to the names of things. It will be interesting to see what happens in Texas and California. .

Kevin: Oregon has been a leader in the past: Tennessee, Minnesota, etc. have adopted Oregon concepts. We need to take a methodical approach and achieve balance in the system.

Dr. Bowman: What is the expected end result? Barry: We will have to see what the stakeholders and process brings and figure it out as we go along. There is no predetermined outcome.

Dr. Bowman: What do you want the committee's role to be? Barry: We would like to keep you apprised and bring issues to you for input.

Dr. Bowman: Where will this go? The legislature? Barry: Not necessarily- depends on what we wind up with as resolutions. It depends.

Kevin: Right now we are in the information gathering stage. We will bring ideas to this committee for input. But WCD may narrow the number of ideas if need be. If legislation is needed it will need to go to the Management Labor Advisory Committee first. If legislation is needed it's a long process.

Public Policy: WCD would like to develop a public policy regarding medical services and treatment within the workers' compensation system that provides the director flexibility to affect the impact of medical inflation on claim costs. We would like MAC to help develop the policy. Should we have a preference for evidence based medicine and therapeutic equivalency? The Medical Quality Initiative (Barry's group) is the "how" piece of this, and we need to discuss the "target". What is the target? What are we aiming at? However, we would like this committee to address this policy. We realize we have put the horse (MQI) before the cart (public policy target) in that regard.

Kevin: Costs of the workers' compensation system affect all consumers and business. We can attempt system controls as one method. Employers are responsible for costs related to the accepted condition. That is one policy statement. There are four major benefit areas in Oregon WC: 1) wage replacement or time loss 2) Permanent disability 3) Return to work assistance and 4) Medical benefits. Want to discuss medical benefits today. As we have discussed, we have already started considering treatment guidelines but the division is still struggling with what we will do with them. MAC acts in a group free to make decisions with less political affects than other committees. Some ideas from this group may result in legislative concepts WCD's legislative concepts are due in February of 2006. Maria: what is your understanding of what the public policy is right now? Kevin: (see page 4 of hand out)- Access, Quality; Costs. Discussed the handout. Kevin: what I'm trying to say is, if I'm in Texas and trying to get to Pittsburg, there are many options in *how* to get there, e.g., plane, car, train, etc.. In this project, I', asking this committee to help us identify our target. We don't know if we *are* going to Pittsburg yet, that's what we input on. The MQI is the "how" to get there. Usually we adopt the public policy first.....so that's how our cart is before our horse.

Another aspect is MCOs, and enrolled and not enrolled workers. Non-enrolled is somewhat limited in choice for workers regarding choice of physician, etc. Under the MCO, you have an attending physician, but the worker's choices are restricted, the physicians choices are restricted, and the treatment is very structured.

In WC and medical care there are cost drivers and Nathan and Bryan from IMD are here today to discuss some. (handouts) Bryan- In this data, we compared Accepted Disabling Claims (ADC) by year of closure and costs. Break out by medical costs, disability payments and time loss costs. Rising medical costs are driving overall claim costs to rise. Maria- there should be some correlations between the return-to-work (RTW) changes and the medical care. Because the medical care goes on even if workers are back to work. Just looking at disabling claims only may not be the right thing to look at. Linda J: the majority of claims are non- disabling and we should be looking at those. We might even see a sharper "v" on a graph of those. We have been having the same conversation in the private general health care side too. Nathan: we feel that the WC medical ADC portion is rising faster than general health care considering Cost Price Index.....which is 4.6 between 1999 and 2003. Oregon is at 8.7.

Contested Case and Disputed Claim Settlement costs are not included in these figures.

Linda O: We are seeing the “aging population” affect costs as well. MAC should also look at these types of factors....which we might not have control over.

Nathan: How are Oregon costs compared to other states? The Workers’ Compensation Research Institute (WCRI) has some data on this....but the data is not readily available from other states. We had to compare other states 7 days of TL with Oregon’s 3 days because most of the other states studied had 7 days to differentiate a disabling claim. We made the assumption that care is very similar in the initial stages of a claim regardless of non-disabling or disabling status. This chart shows that Oregon is not that different. (Medical Cost and Utilization Trends)

Average cost per claim, average number of visits and average number of services per visit all increased.

The last document (in the bigger packet) Data from Bulletin 220. There are 19 provider types in the whole data, but only 8 are shown here. The remaining 11 make up less than 1 percent. The sample was 65% of all ADCs. Dr Keenen: do you eliminate outliers.....say a horrendous claim with incredible costs? Nathan: we are looking at averages and the costs are spread over all provider types. These costs are specific to utilization. Discussion of handouts. These figures are not inflation adjusted.

Under the Surgery page- the Service Description is only physician costs, not all medical costs. From the Current Procedural Terminology (CPT) book.

We are trying to look at like claims, which is really difficult considering similar cohorts, conditions, treatment, original vs aggravation claims and severity.

Linda J: some of the costs may be shifting to private health because a back surgery may not be found compensable. If there was a way for us to get data from the group health side for different types of services it might be beneficial for the committee to review considering cost shifting. Can we get some of that info? Overlay cost of inflation of health care and how it is impacting WC in Oregon. They may be willing to share that with us.

Nathan: California’s methodology is interesting. We have to be careful of what we call ICD- 9 creep.....differing evolving diagnoses. Which one do we use: the initial one, the last one, the one with the highest cost, or ?? We are trying to create models. Dr. Keenen- a lumbar strain is a diagnosis that insurers may be motivated to keep because of costs. As the claim and diagnosis evolves and it becomes apparent that the diagnosis should be a herniated disc, it becomes a hot topic. Linda: However, after 60 days when it is determined that the disc is really what it should be, insurers don’t have the ability to change that. Dr. Keene- and physicians also don’t have much ability to change that. Dr. Bowman- this is a big issue all across differing diagnoses. This needs to be cleaned up in the system. Currently we write medical jargon on a piece of paper for them to give to their claims adjuster. It doesn’t work well. Dr. Keenen- my guess is that the cost of a low back claim is related to RTW time frames rather than diagnosis. A better look at data for lumbar strain would be 6 months rather than 3 months.. Dr. Bowman- this would be similar for shoulder surgery. Can we break this down to similar dollars for comparison? Nathan: yes and we’ll email it to you and also put it on the web..

Kevin: Now that you’ve seen some of the cost drivers, we need your expertise to help us develop new targets. We need to look at where we’ve been and where we need to go regarding whether treatment is outmoded, unscientific, experimental, etc. I’d like to hear from you if you think this policy project will support the work the committee is doing. Especially when we are looking at new technology and new treatments. How big is this? Any thoughts?

Dr. Keenen discussed an experience he had regarding treatment guidelines from when he got to Oregon in 1988 and said yes to something he didn't really understand: the Oregon Health plan and data on utilization. Considering pure scientific analysis, the only thing I'm aware of that reduces pain based on real scientific data, is Tylenol. As you move to other things it becomes based on data analysis. When you get into guidelines you'll only get so far with scientific information, and then you'll get into your own biases. Look at IDET You're going to go with your own biases. Kevin- if you had a standard or guide, would it help make the decision? Dr. Keenen- yes, but virtually everything has "yes it works" and "no it doesn't work" literature so it's difficult to just take one study. It is a valuable process to have guidelines, but, the process will end up like negotiating a budget. Kevin- I don't want to focus this on guidelines but I don't know what the target is. Dr. Keene- sounds like it's controlling costs. The physician's pen is the most potent component of that. That's where the guidelines and certification part comes in. What and why are physicians prescribing what they are. Physicians need to understand how the system works. Then determining what is acceptable....not doing PT for 16 months....eliminate the outliers.

Maria- what I heard you say is reduce the costs.....you want Kevin to walk to Pittsburg?

Dr. Bowman- what is the definition of Quality? We are mixing cost and quality and they should be different.

Kevin- that's what I'm asking you to look at. Quality- in general health care we are trying to get people back to health, in WC the focus is on getting them back to work.

Linda J. didn't this discussion start in the fee schedule group from a few years ago? And there was a recommendation that there be an initiative that physicians that understood and partnered with the stakeholders and were responsive would get a higher level of reimbursement than those that did not. RTW is the very best thing. Another quality consideration is access to care. Especially in rural areas. Quality won't mean a thing if there are no services available. Maybe we can think about in the future how we can alleviate concerns, hassles that providers have in WC.

Kevin- also a hassle factor in WC that can be considered in this- reporting is regulated. Are the hassle factors consistent with business principles? Can we move them to regulating vs operating in a business. We have no umbrella that tells us where we are going, or a superhighway. That's what I was looking for. Are there other ways that we can affect the impact of medical inflation on claims costs? Can we build some flexibility in the system to get there? I thought this group could establish that. We don't want to lose doctors.

Linda O- do we have any data from the Paperwork Reduction Taskforce from years ago? Kevin- one outcome was that we eliminated several forms and got down to one form with multiple purposes. Maria- it is an improvement. Dr. Bowman- you want a best practice. Kevin- yes, not just guidelines. Are those same constructs that were in effect then still in effect today? Linda J- It would be beneficial to have input and ideas from medical providers on how to get the information insurers need with minimal impact and hassle to physicians. This is a good opportunity to have an exchange about that. Maybe we could just do it by rule.

Maria- would it be good to look at again what unproven, experimental, unscientific, etc., means? There should be a better way to cut these conversations short. (IDET, etc)

Kevin- any policy needs to address the broad perspective, 80/20 rule.

Dr. Carlson- guidelines don't have much effect. What would be interesting to him would be how to identify the outliers. What is excessive and address that first. Eliminate that and see if it affects cost. Tom W.- agrees with identifying the outliers first and not spending time on guidelines. I could give you 3 or 4 right now that would be good for outliers. You won't need evidence based information to address the outliers.

Dr. Keenan- The phys who keeps them on TL and PT excessively, the providers whose pen is doing this. Outliers will be easy to identify with data.

Kevin- how do we get to the public policy?

Dr. Lorber – the problem is that it's an insurer that is making the call. Individual cases have so many variables that the excessive component will be harder to identify.

Kevin- public policy- if you have a preference for evidence based medicine what do you do with case specific cases.? I want to be careful with getting too specific....the more specific you get the farther you get from the umbrella policy.

Dr. Bowman- it would be helpful to look at avoidable and unavoidable costs and prioritizing them. Looking at data on that would be helpful.

Kevin- I will develop questions to try to help lead us through the discussion on the public policy.

Next meeting is 3rd Friday in Sept.

Adjourn