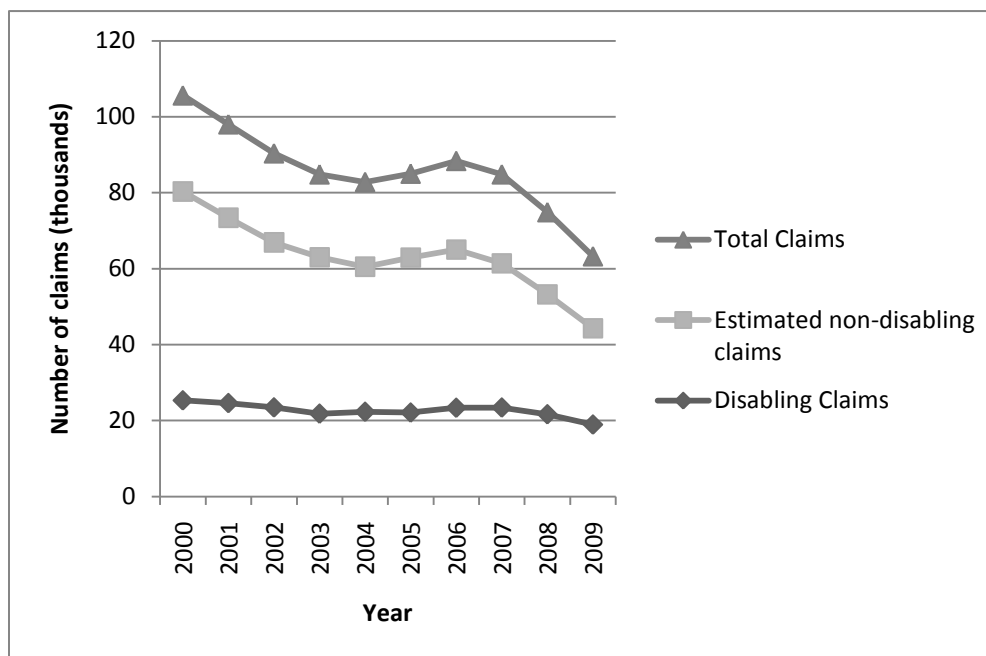


## Indemnity and Medical Payments

The number of claims has continued to decline. In 2009, the Information Management Division estimated that insurers accepted 44,300<sup>1</sup> non-disabling claims. In the same year, insurers accepted a total of 18,948 disabling claims. The estimated number of total accepted claims was 63,248. (See Figure 1A)

**Figure 1A** Accepted claims (2000-2009)



The total system payments for 2009 were estimated at \$627.7 million. Indemnity payments made up nearly 47 percent of the total costs. Medical payments made up the remaining 53 percent including both accepted disabling claims and the estimated number of accepted

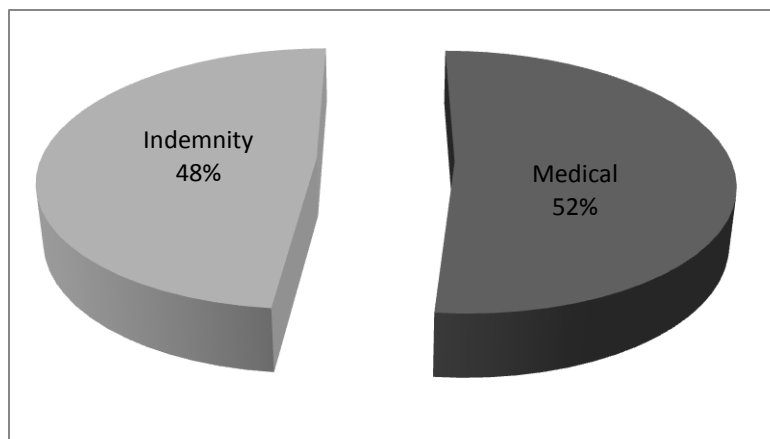
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<sup>1</sup> Estimates based on several sources. Data from 1994-present data have been revised due to changes in estimation methodology; estimates may change over time.

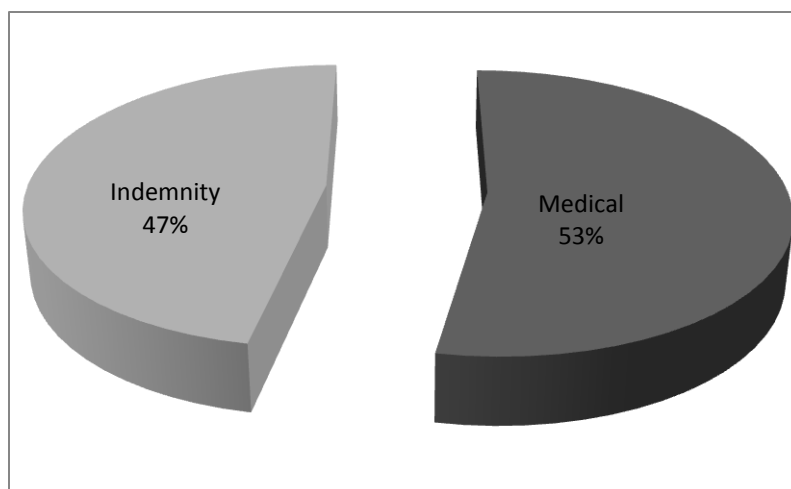
# Workers' compensation medical system costs and trends

non-disabling claims. The share of medical costs as a portion of total costs is only one percentage point higher in 2009 than in 2004. (See Figures 1B and 1C)

**Figure 1B** 2004 Total WC Payments



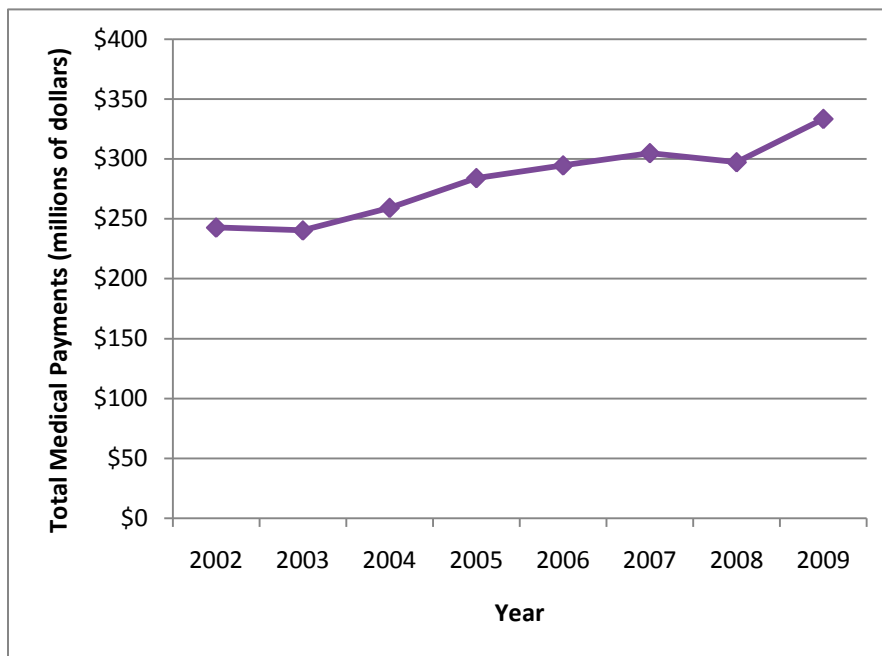
**Figure 1C** 2009 Total WC Payments



## Medical Payments

In 2009, total medical payments increased 12.2 percent to \$333.3 million. The increase follows a 2.5 percent decrease from 2007 to 2008. Considering the 2009 increase in payments, the medical system continues to have an annual growth rate of 4.4 percent, which remains consistent with the medical component of the Consumer Price Index as compiled by the US Bureau of Labor Statistics. (See Figure 1D)

**Figure 1D** Total Medical Payments (2002 – 2009)



Private insurers and self-insured employers saw the biggest percentage increase in medical payments in 2009 at 16.3 percent and 35.2 percent, respectively. SAIF Corporation had the lowest percentage increase. While the increases appear alarming, self-insurers also had the biggest increase in market share on the premium side. Since self-insurers tend to be large companies whereas SAIF covers many small businesses, recent economic conditions may have driven some of these changes.

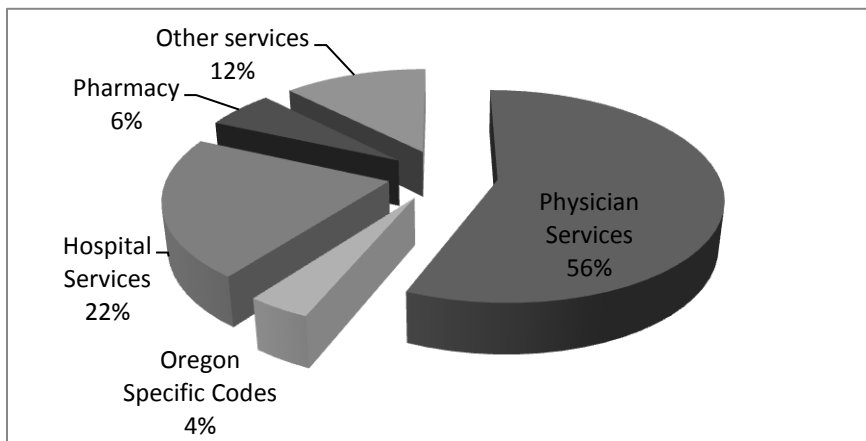
# Workers' compensation medical system costs and trends

Only insurers and self-insured employers with 100 or more accepted disabling claims were required to report payment data. IMD used a model to estimate payments on claims not reported.

Beginning in 2009, the Workers' Compensation Division received most of its medical payment data through Electronic Data Interchange (EDI). The data collected through EDI provides the department a more complete and accurate picture of medical payments. Since implementing medical payment EDI reporting, third-party administrators and other vendors regularly report medical data on workers' compensation claims for clients that have less than 100 claims who do not have to report. As a result, the payment data is more accurate and complete. It is likely that the shift toward private insurers and self-insured employers is in part due to the change in how the medical data is reported.

Overall payments for 2009 are sorted into service categories. Service categories are broad collections of different provider types and procedures. For example, the physician services category includes medical doctors, anesthesiologists, physical therapists, chiropractors, nurse practitioners, and others. Of the total medical payments made in 2009, the physician services category accounts for 56 percent; hospital services accounts for 22 percent; other services account for 12 percent, pharmacy accounts for 6 percent, and the Oregon specific codes category accounts for 4 percent. (See Figure 1E)

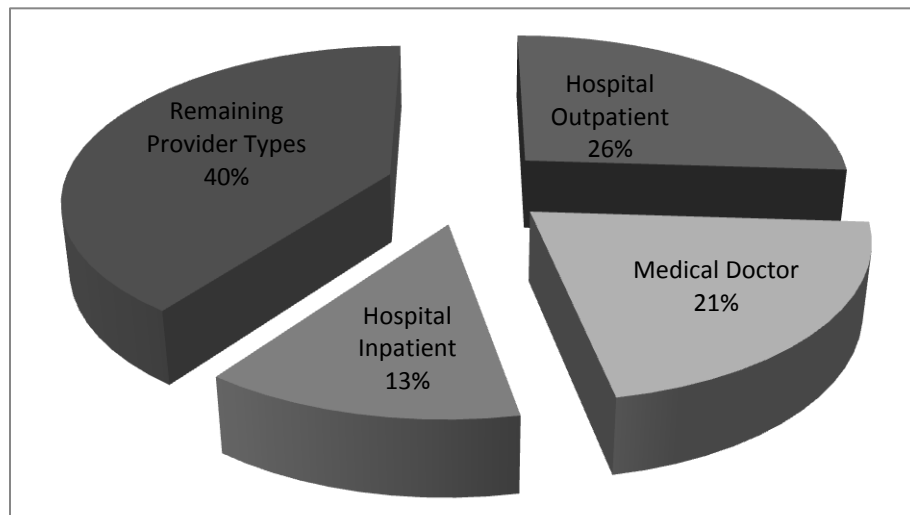
**Figure 1E** Breakdown of medical payments by service categories (2009)



# Workers' compensation medical system costs and trends

The data is also broken down by provider type. In 2009, total medical payments were approximately \$333.3 million. Of that amount, 26 percent was paid to hospitals for outpatient services, and 21 percent was paid to medical doctors. This is the first year that hospital outpatient exceeded payments to medical doctors. Hospital inpatient payments were the third highest costs at nearly 13 percent. The top three make up nearly 60 percent of total medical payments. This is due, in part, to improvements in the classification methodology resulting from the switch to EDI reporting. EDI payments are classified according to the Health Care Provider Taxonomy Code system which provides greater specificity in classification and relies less on the judgment of the reporter. Analysis of the two types of data (EDI and Bulletin 220) separately indicates that the ascendancy of the hospital outpatient category is not due to the changes in reporting. (See Figure 1F)

**Figure 1F** Breakdown of medical payments by provider type (2009)



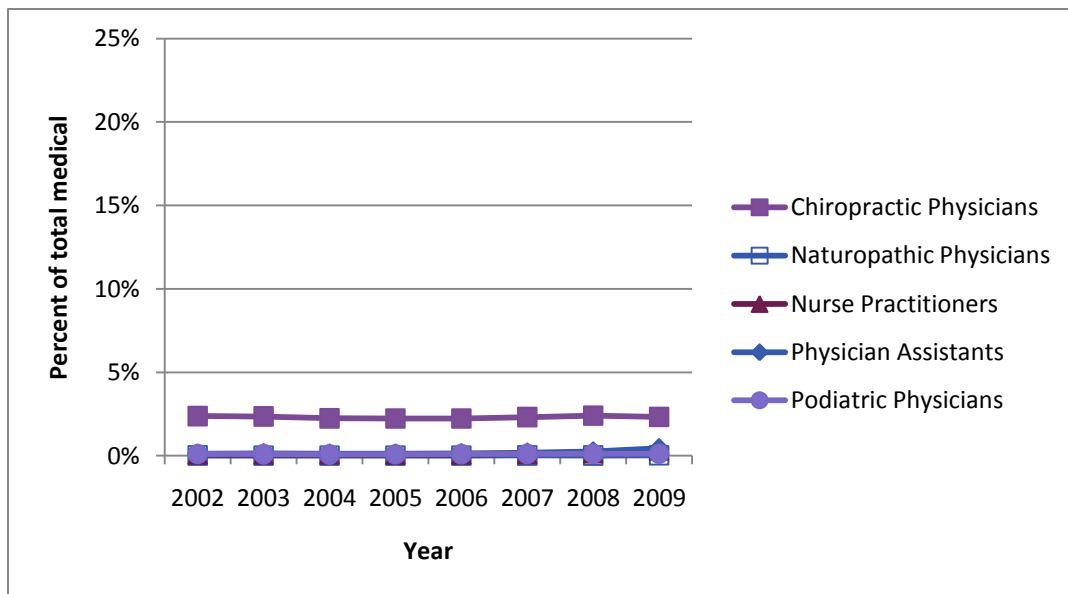
## Impact of Expanded Attending Physician Status on Medical Payments

In 2003, the Oregon Legislature allowed Nurse Practitioners to authorize temporary disability for up to 60 days and provide attending physician services for 90 days (HB 3669). In 2007, the Legislature allowed Physician Assistants, Naturopathic Physicians, and Podiatric Physicians to serve as attending physicians. The provisions allowed those providers, as well as Chiropractic Physicians, to be attending physicians and authorize temporary disability with specific limitations. (HB 2756)

# Workers' compensation medical system costs and trends

The Management-Labor Advisory Committee asked the department to provide impact data on those changes. Because for many claims the attending physician may change over the course of the workers recovery, neither the department nor the insurers are able to consistently demonstrate the role of a provider as an attending physician versus a provider serving in another capacity. Therefore, we can not provide specific data regarding the types of physicians serving in this role. However, we can provide system impact data to compare the percentage of payments to each of the provider types over a period of time. (See Figure 1G)

**Figure 1G** Payments by provider type as a percent of total medical payments (2002-2009)



Since 2007, payments to Nurse Practitioners and Physician Assistants have increased slightly more than the other provider types in review. However, those payments remain below .5 percent of total medical payments. Payments to Chiropractic Physicians have remained stable since 2002. Payments to Naturopathic Physicians and Podiatric Physicians remain low at .03 percent and .12 percent, respectively. Some payments were classified as medical doctor under Bulletin 220 because they were billed by the doctor's office, but under EDI are classified appropriately because there are separate fields for rendering providers and billing providers. The department will continue to monitor payments to the provider types.

## July 1, 2010, Fee Schedule Changes

New medical fee schedule provisions went into effect on July 1, 2010. The most significant issues addressed in the rules related to increasing payments for the Evaluation and Management service category, creating a two-tiered fee schedule for the Surgery service category, achieving greater equality among conversion factors for specific service categories, and implementing a fee schedule for interpretive services.

## Public policy incentives and parity issues

Ideally, the new fee schedules will help achieve public policy goals. In 2008, the department established a public policy to promote better and more complete evaluation and management of workers' compensation patients as well as promoting early return to work. However, the conversion factor for Evaluation and Management remained lower than the Medicine, Physical Medicine and Rehabilitation, and Surgery categories. The cost factors for each service category are included in relative value units developed by the federal Centers for Medicare and Medicaid Services. By setting other service categories higher than Evaluation and Management, the former fee schedule in theory focused providers on the delivery of services rather than promoting upfront and continued management of workers' medical treatment.

**Table 2A**      *Conversion factors comparison*

<b>Service Categories</b>	<b>2009 Conversion Factors</b>	<b>2010 Conversion Factors</b>
Evaluation and Management	\$64.79	\$75.00
Anesthesiology	\$53.45	\$58.00
Radiology	\$68.00	\$69.00
Lab & Pathology	\$60.00	\$60.00
Medicine	\$75.04	\$71.00
Physical Medicine and Rehabilitation	\$65.79	\$68.00
Oregon Specific Codes and Multidisciplinary	\$60.00	\$68.00

Table 2A demonstrates the disparity between the different service categories before July 1, 2010. The department could not find any documented or even anecdotal evidence that the differences were driven by public policy decisions to achieve desired outcomes. The department recommended moving to a consistent conversion factor for Physical Medicine, Radiology, Medicine, Laboratory, Multidisciplinary and Oregon Specific Codes. Because the Anesthesiology Category is calculated differently, its conversion factor would need to be reviewed separately.

The increase in the Evaluation and Management is designed to promote earlier return to work opportunities, to set patient treatment and recovery expectations, and generally promote better medical management of workers' compensation patients. The incentive is directed at all health care providers.

While the adopted conversion factors do not achieve absolute parity, the factors do represent a significant movement toward parity. Economic projection models indicate that reducing the conversion factor for the Medicine category even more might lead doctors delivering these services to refuse to treat workers. As a result, the director decided that ensuring workers have access to medical providers was paramount to gaining absolute parity.

## **Two-tiered Surgery conversion factor**

Services with a surgery CPT<sup>®</sup> code not only include services that are commonly referred to as "surgery" and are performed in an operating room (e.g., carpal tunnel, shoulder, knee, or spine surgeries), but also includes services that are commonly performed in a physician's office, an urgent care clinic, or a hospital emergency room (e.g., stitching up a small cut, cleaning skin/tissue, etc).

The payment for the surgery includes follow-up visits during the postoperative period of the surgery. These visits are related to the recovery from the surgery and occur during what is called the "global period," which is the typical time needed for post-operative follow-up care. A physician does not receive additional payment for follow-up visits during the global

# Workers' compensation medical system costs and trends

period. According to surgeons, procedures with a 90-day global period include more follow-up visits than those with a shorter global period. In 2007, approximately two-thirds of all payments in the surgery category were for services with a global period less than 90 days.

The department adopted a two-tiered payment model for the Surgery category. Those surgery CPT® codes that include a 90-day global period will be paid at a higher rate, and those that include a global period of less than 90 days will be paid at a lower rate. (See Table 2B)

**Table 2B**      *Conversion factor comparison for Surgery service categories*

<b>Service Categories</b>	<b>2009 Conversion Factors</b>	<b>2010 Conversion Factors</b>
Surgery with global period of 90 days	\$86.44	\$89.00
Surgery with global period of less than 90 days		\$84.50

## Interpreter Fee Schedule

The Management-Labor Advisory Committee formed a subcommittee to address the issue of establishing a fee schedule for interpreter services. The chair of the subcommittee stated the purpose was to ensure people who do not speak English, or speak limited English, have access to an interpreter in a cost effective way and can understand the process.

Interpretive services are the set of necessary services that allow workers to communicate effectively with a medical service provider. Better communication between medical providers and patients can improve outcomes for workers, both medically and financially. Better outcomes are also beneficial for employers by reducing workers' compensation and related costs.

The recommendation was presented to the full committee at the December 16, 2009 meeting. The full committee made it clear that a worker has a right to interpretive services when receiving medical services in the workers' compensation system. The committee's intent with these recommendations is to provide a process and mechanism for professional

# Workers' compensation medical system costs and trends

interpreters to receive payment. The department implemented the committee's recommendation as follows:

- Requiring insurers and self-insured employers to pay for the services of a professional interpreter as needed by the worker to get medical services;
- Establishing a fee schedule for interpreter services;
- Limiting application of rules to interpreter services provided in conjunction with the delivery of medical benefits;
- Providing that only professional interpreters may be paid a fee for interpretive services; neither the worker's family and friends, nor the staff of the medical provider may be paid; and
- Payments are only due and payable once a claim is accepted.

## Independent Medical Examination (SB 311) Update

In 2005, the Oregon Legislature passed Senate Bill 311, which addressed many aspects of independent medical examinations. After passage of SB 311, the Management-Labor Advisory Committee asked the department to survey workers regarding their IME experiences.

Between July 1, 2006, and December 31, 2007, an estimated 12,500 to 14,000 IMEs were conducted. The department received complaints about less than 1 percent of the total IMEs performed. Less than one percent resulted in a complaint about an exam. The number of workers complaining is actually less because one exam could result in more than one complaint.

Most of the workers (81 percent) who responded to the department's survey stated that they were satisfied with their overall IME experience. Only 36 percent of the workers provided written comments about their overall experience. One quarter of those found the IME experience beneficial, while the rest expressed some dissatisfaction. The most often cited dissatisfaction was that the provider was uncommunicative, rude or unprofessional.

The 2005 amendments require the director to adopt rules relating to professional-licensing training requirements and educational materials for providers performing independent medical exams at the request of insurers or workers. The administrative rules adopted to implement the statutory requirements require providers to be in good standing with their respective licensing boards, and complete a director-approved, three-hour training class.

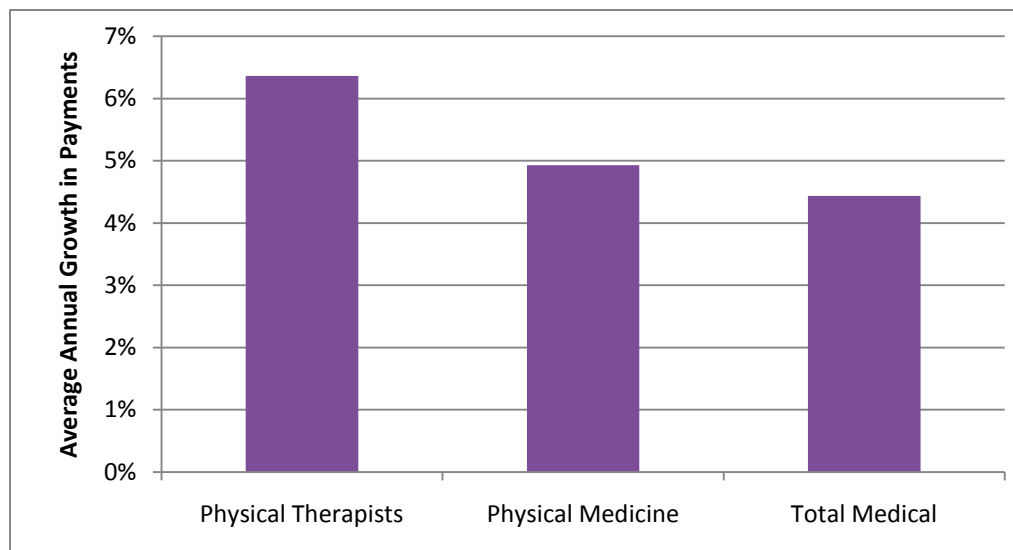
Although most provider classifications have a sufficient number of providers on the list who have complied with the educational requirements, there are some specialty providers such as neurologists, oncologists, and cardiologists that are not well represented on the list, if at all. The department has found it difficult to recruit these specialty physicians because of the three-hour education requirement.

## Medical Initiatives

### *Physical Therapy Utilization*

The annual growth of payments to physical therapists has grown at a faster pace than overall medical payments. Payments made under the Physical Medicine service category have also outpaced overall payment growth. (See *Figure 1H*) Several stakeholders have asked the department to look at physical therapy utilization.

**Figure 1H** Comparison of average annual growth 2002 - 2009



In response, the medical section has developed a project to look at the efficacy and utilization of physical therapy in workers' compensation. The Information Management Division reviewed other studies conducted as a starting point. We will review those studies to establish the scope of the project. Stakeholders have asked to be involved in establishing the scope. We will roughly define the project's scope, and then hold an advisory committee to review the scope and provide input. The project began on September 1, 2010.

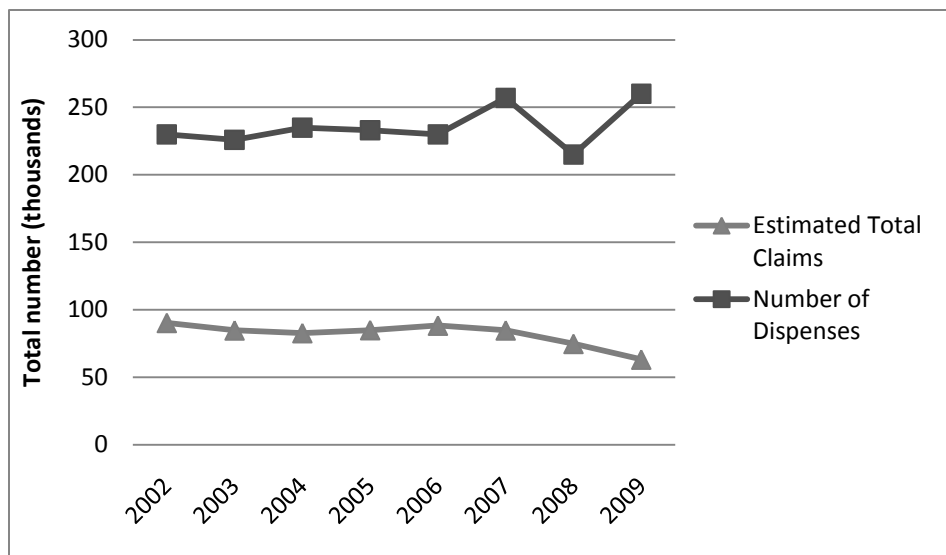
## Pharmacy Cost and Utilization

The department has adopted the Average Wholesale Price as the basis for the pharmacy fee schedule. The AWP has been under scrutiny the past few years, and may even go out of publication. The project is currently focusing on whether a better, more appropriate model is available as a basis for developing a fee schedule.

Even though the number of claims has continued to decline over the past seven years, the number of pharmaceuticals dispensed has not followed the trend. (See Figure 1) The number of dispenses means the number of prescriptions filled; it does not include the pill count included when filled. The difference may be explained by a number of contributing factors, such as reduced supplies being filled more often.

The average number of temporary disability days has also increased slightly over the past decade. We are interested in understanding whether the type of pharmaceuticals being dispensed is related to the increase of temporary disability. Moving forward, EDI data should provide us with greater information about the number and strength of pills dispensed.

**Figure 11** *Number of claims compared to the number of pharmaceuticals dispensed (2002-2009)*



## Physician's Role in Return to Work/Stay at Work

Many factors determine a worker's financial and medical outcomes following a workers' compensation claim. The program team began with several assumptions about return to work and outcomes:

- ❑ Many of the world's medical associations state that staying at work, or returning to work at the earliest possible time, helps injured workers improve their performance, regain functionality, and enhance their quality of life;
- ❑ Unemployment is a risk factor for poor health;
- ❑ A worker who receives 60 or more days of temporary disability with no permanent disability has the worst financial outcomes of all other workers who are not permanently and totally disabled;
- ❑ Other data suggests that at 60 days after a filing a claim, psychosocial factors are a significant barrier in workers returning to work; and
- ❑ A worker's relationship with an immediate supervisor or employer may also be a significant factor.

Physicians and other providers play a significant role in preventing temporary disability that will negatively impact workers medical and financial outcomes. Safely returning workers to work at the earliest point in a claim may help reduce employers' costs for premiums, improve workers' medical and financial outcomes, and can reduce the costs passed on to consumers.

Each barrier identified becomes an opportunity to improve workers' medical and financial outcomes after being injured at work. Our goal is to develop a plan to overcome the barriers, educate providers in their role, and improve the delivery and affordability of medical services.

## Division 009 administrative rule reorganization and redrafting

A number of complaints the Medical Section receives are from customers who can not find something in the rules. The Medical Section answers many questions about the meaning of a rule. Based on input from end-users, our goal for this project is to:

- Minimize the time it takes to find the applicable rule;
- Minimize the need to look in different places for all relevant rules;
- Minimize the time needed to become a proficient user of the rules;
- Maximize the ability to understand what a rule means on first reading; and
- Maximize the ability to know if a rule applies to a factual situation on first reading.

The Interpreter Fee Schedule was our first published attempt at achieving the metrics end-users of the rules said were important. The rules look and work very differently from the traditional method of writing rules. We did receive some questions at the rules hearing about why the fee schedule rules looked different, and even some suggestions to restore the old method of writing rules. Because the fee schedule was effective on July 1, 2010, we do not have enough data to evaluate whether the rules have substantially achieved the end-user metrics.

## Physician Hassle Factor

One reason physicians and other medical service providers give for expecting higher reimbursement from workers' compensation claims is the added administrative burdens they associate with these claims. These administrative burdens are commonly referred to as the "hassle factor".

The *2004 Physician Workforce Survey* conducted by the Office of Medical Assistance Programs<sup>2</sup> shows that only 65 percent of the physicians responding accepted patients with

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<sup>2</sup> Oregon Department of Human Services

# Workers' compensation medical system costs and trends

workers' compensation claims. Thirty-four percent either restrict their practice from accepting new patients with claims or were not willing to treat patients with workers' compensation claims. The report states that 72 percent of the physicians restricting workers' compensation from their practice cite administrative requirements as the primary reason.

The *2006 Physician Workforce Survey* reported that only 50 percent of responding physicians will accept workers' compensation patients without restriction. General surgery and other surgical specialties were the most likely to have no restrictions. Family practice and internal medicine are most likely to place restrictions on workers' compensation patients. Administrative requirements were reported as the primary factor by 73.5 percent of those physicians restricting their practice.

**Table 2C** 2004/2006 Comparison

Category	2004	2006
Physician's practice open to accepting workers' compensation patients	65 %	50 %
Limit practice or not willing to treat	34 %	50 %
Administrative requirements "very important" factor in decision to restrict practice	72 %	73.5 %

For those physicians that restrict their practice, the amount of reimbursement is not a primary factor in their decision to limit or not treat workers' compensation patients, it is the administrative hassle. For those physicians that don't restrict their practice, the amount of reimbursement in relation to the hassle factors associated with workers' compensation is most often cited for the need to increase the fee schedule's conversion factors.

The federal health care reforms may also significantly impact workers compensation. Under the federal law, more Oregonians will have health insurance. If physicians continue to view workers' compensation as entailing unnecessary administrative burdens, workers' compensation could experience more physicians restricting their practices. The theory is that as competition for physician services increases, access to quality medical care for workers' compensation patients could be threatened unless the hassle factors are reduced.

## **Provider e-Billing/e-Payment**

Input from providers suggests that electronic billing in workers' compensation would reduce administrative hassles created by the current paper process. The department currently allows e-billing in the rules, but it is rarely used. The department will work with stakeholders to facilitate increased use of electronic communication and data exchange, including e-billing and e-payment.

The department actively participates with the International Association of Industrial Accident Boards and Commissions' EDI committees. The association's ProPay committee is working on national standards for electronic billing. While the Centers for Medicare and Medicaid Services (CMS) currently mandate electronic billing, its reporting standards do not easily accommodate billing for workers' compensation. The association is attempting to establish standards that are as consistent as possible with CMS and private health standards, while accommodating the few differences identified for workers' compensation, such as submitting electronic chart notes with every bill.

## **Improving training and outreach to providers and other stakeholders**

Recently, the department has expanded the types of media and opportunities it uses to provide information and training to the public. The medical section is currently working to identify the scope of training needs within the workers' compensation community. The project will result in more accessible and targeted material that is understandable and easy to access. Several professional associations have offered to partner with us to provide training and support to their members. The project began in August and will continue through most of the next year.

## **Dispute Resolution of Medical Issues**

The Medical Section's Resolution Team's procedures and resources have significantly changed over the past decade. In 2000, the department had 11 reviewers and 4.5 administrative support staff allocated to resolving disputes. In 2010, the department has six medical review positions and 3.5 administrative support positions allocated. Despite the

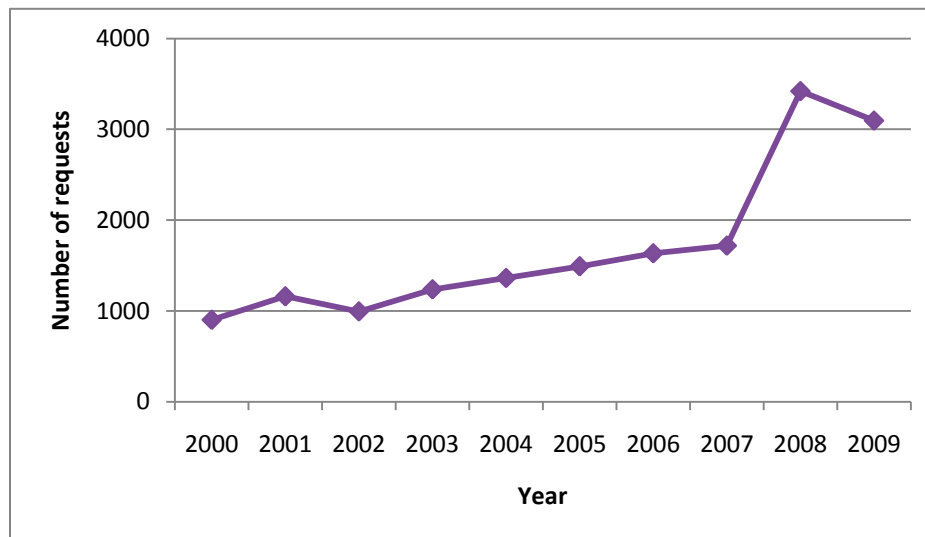
# Workers' compensation medical system costs and trends

planned staff reduction, the Medical Section's Resolution Team significantly improved its performance.

More recently, the department has responded to decreased revenues through staff and other expenditure reductions. Current vacancies in the Resolution Team will not be filled within the foreseeable future. As a result, it is likely the staff reductions will be reflected in the data demonstrating the team's overall performance.

While the number of workers' compensation claims continues to decrease, the department has experienced an increase in the number of requests for administrative review involving medical issues. Figure 1J demonstrates the increase from 2000 through 2009.

**Figure 1J** *Number of Requests for Administrative Review (2000-2009)*

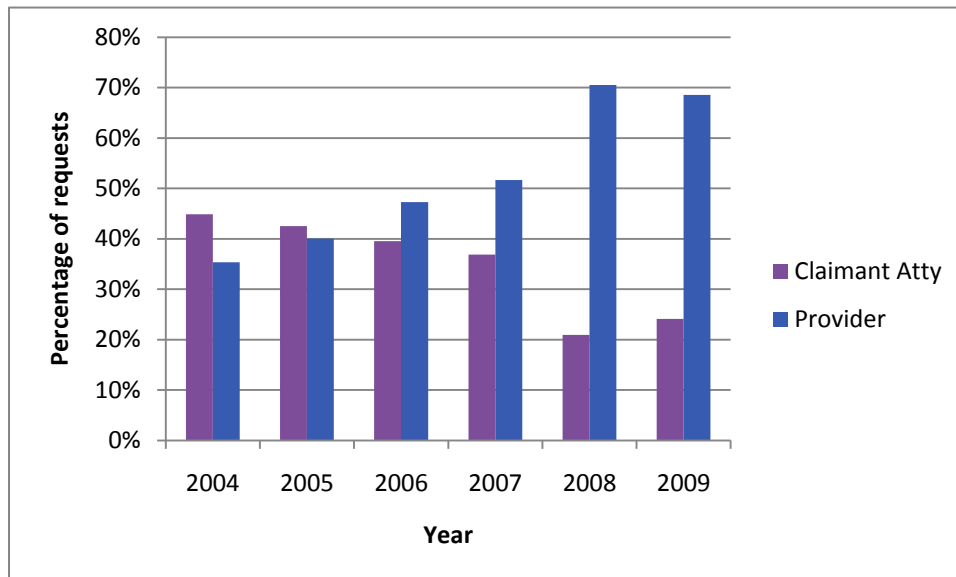


The number of requests was highest in 2008 when the department received 3,506. The dramatic increase was largely driven by preferred-provider discounts being applied to physician's payments. The issues that lead providers to file disputes regarding PPO discounts have largely been resolved. However, the number of requests has not declined once the cases attributed to PPO discounts were resolved. The department received nearly 2,000 requests during the first six months of 2010. If this trend continues, 2010 will exceed the 2008 figure.

# Workers' compensation medical system costs and trends

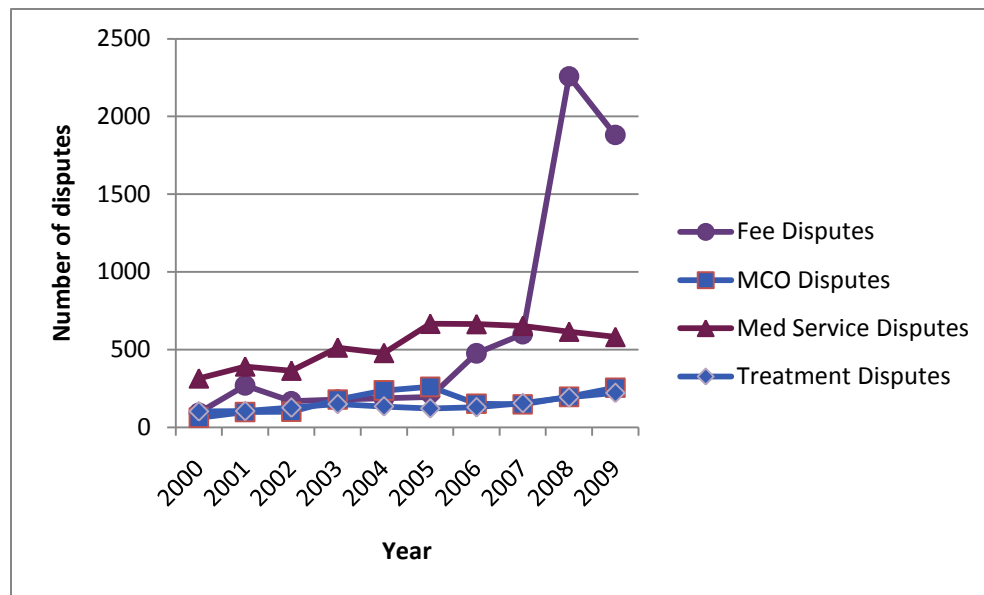
Since 2004, workers' attorneys and medical providers have made up 82 percent to 92 percent of total requests for administrative review. Since 2006, providers have requested administrative review more often than any other group, which usually involve disputes over medical fees. Figure 1K shows the growth in requests received by providers to total requests, and the decline in requests received by workers' attorneys. Figure 1L demonstrates the number of dispute types. The number of fee disputes is related to the number of disputes received from medical providers.

**Figure 1K** *Percentage of requests received from workers' attorneys and providers (2004-2009)*



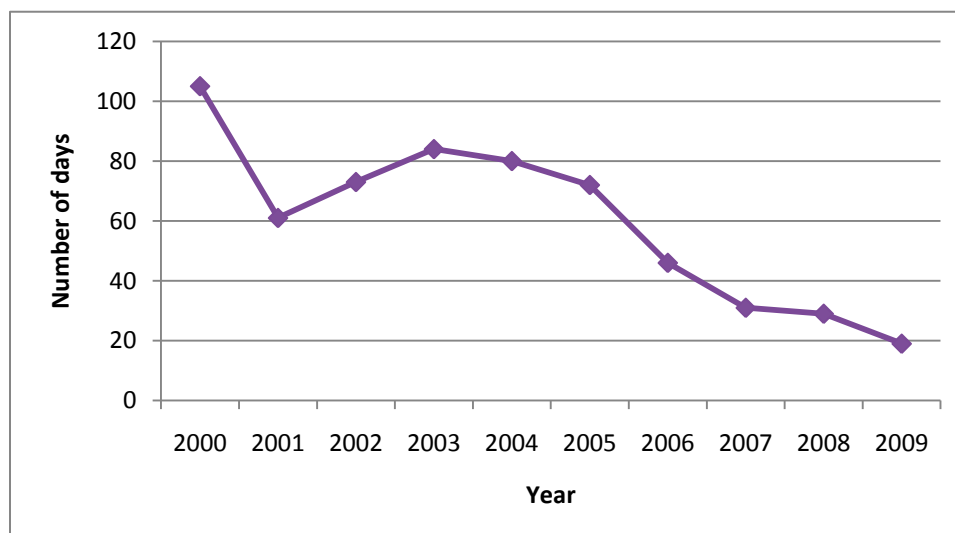
# Workers' compensation medical system costs and trends

**Figure 1L** Number of requests by dispute types (2000-2009)



Since 2000, the average number of days it takes the team to resolve disputes has decreased (See Figure 1M). By evaluating its functions, redesigning processes, and expanding the use of Alternative Dispute Resolution (ADR), the team was able to reduce the average number of days to resolve a dispute by nearly 85 percent over the past decade. In 2000, the team averaged 105 days to resolve a dispute. In 2009, the average number of days is 19.

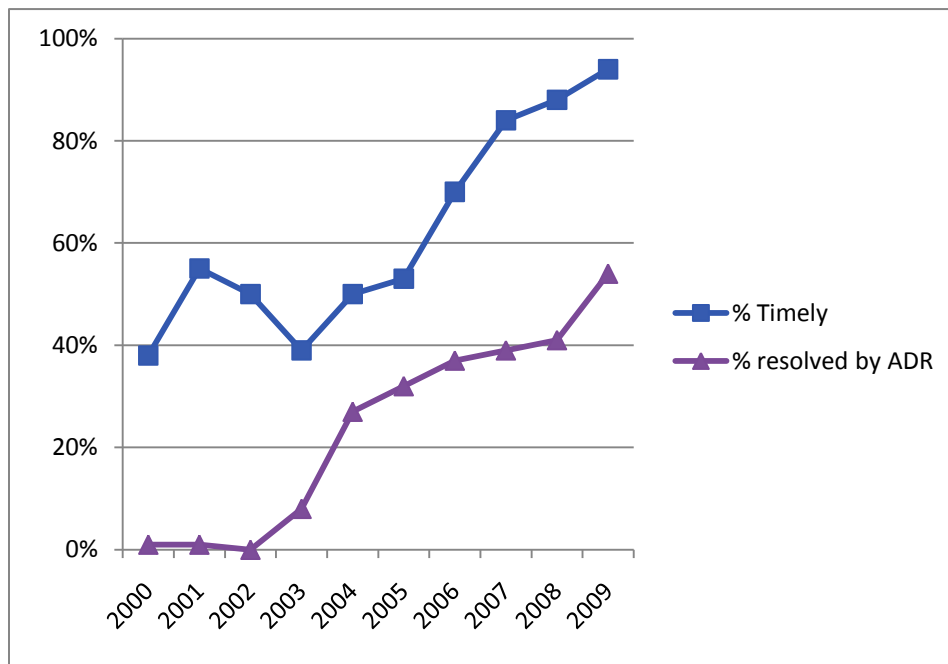
**Figure 1M** Average number of days to resolve a medical dispute (2000-2009)



# Workers' compensation medical system costs and trends

Figure 1N below demonstrates the significant impact the use of ADR has had on improving the team's performance. There is a clear relationship between the increase of the percentage of disputes resolved timely and the percentage of disputes resolved by ADR. The team's performance for 2010 is at 96 percent timely.<sup>3</sup>

**Figure 1N** *Percentage of disputes resolved timely and by ADR (2000-2009)*

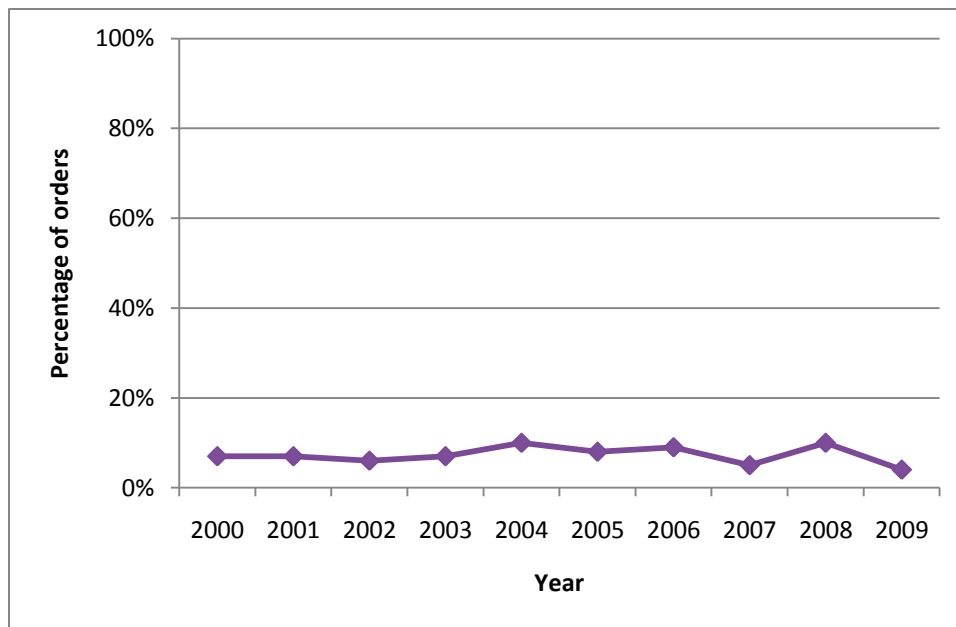


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<sup>3</sup> The team uses a 60-day standard to measure performance. The Key Measure System for the agency and reported to the Oregon Legislature uses a 120-day standard. Under the KMS 120-day standard, the Resolution Team has been at 99 percent - 100 percent for the past few years.

The share of administrative orders that are appealed to the Workers' Compensation Board for a contested case hearing continues to remain low. Since 2000, the number of orders appealed has been at 10 percent or less. (See Figure 10)

**Figure 10** *Percentage of orders appealed to the Workers' Compensation Board (2000-2009)*



## **Medical Advisory Committee Update**

The committee continues to work on medical policy issues facing the workers' compensation community. The committee is currently working on three major reviews:

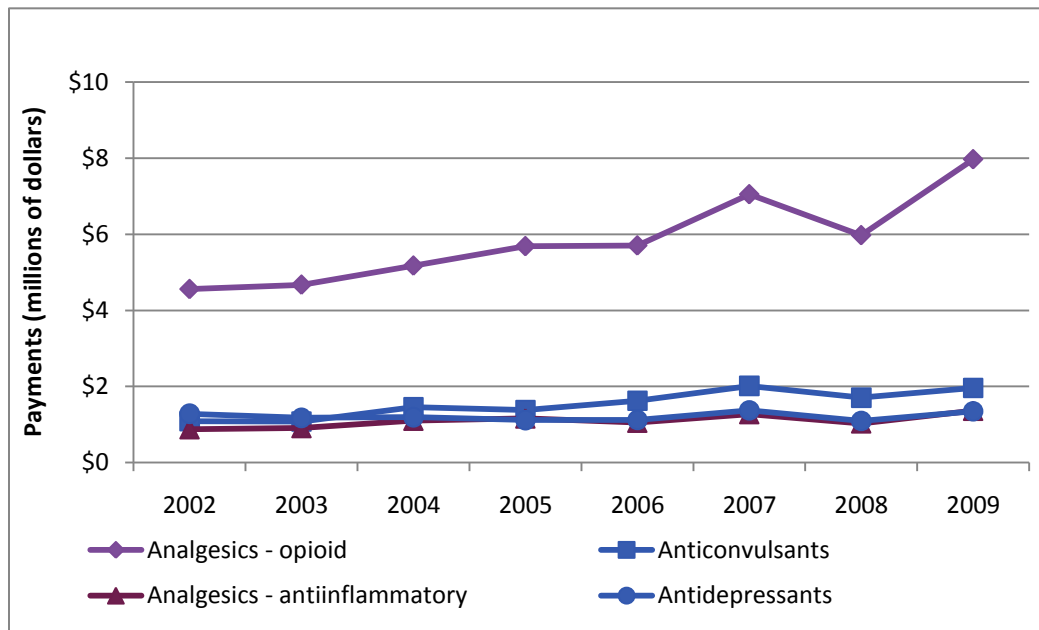
### ***Chronic Opioid Therapy***

In the late 1980s, opioids became a more acceptable form of treatment for chronic non-cancer and acute pain. While the use of opioids has become more acceptable, very little is known about the long-term impact on outcomes for acute pain treated with opioids. Opioid analgesics, such as OxyContin, continue to be the most costly and dispensed pharmaceuticals in workers' compensation. From 2002 to 2009, the payments for opioid

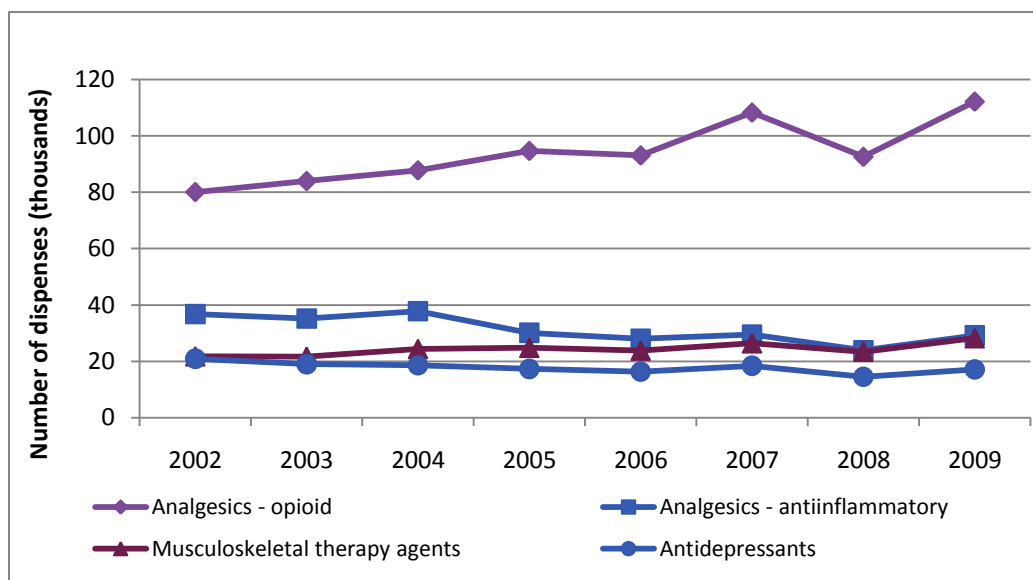
# Workers' compensation medical system costs and trends

analgesics increase nearly 74 percent, from \$4.6 million to \$8 million. (See Figure 1P) For the same time frame, the number of dispenses has increased over 40 percent from 80,100 to 112,000. (See Figure 1Q)

**Figure 1P** Top 4 drug classes by payments (2002 – 2009)



**Figure 1Q** Top 4 drug classes by dispenses (2002 – 2009)



Opioids produce side effects that may impact a patient's ability to drive or work safely. The drugs may cause drowsiness, clouded mental activity, decreased concentration, and slower reflexes. These effects may be more pronounced when first taking the drugs, increasing doses, or taking opioids with other drugs that affect the central nervous system. The effects may place a worker at a higher risk of re-injury or of a new injury. However, we are not aware of any studies that evaluate the impact of patients' ability to safely return to work. At a prior meeting, the committee discussed that some workers may never be weaned from opioids, and may never return to work.

A 2006 study found a strong correlation between states with high accidental drug poisoning rates, and high consumption of opioid analgesics. The highest correlation was with oxycodone and methadone. The study cautioned against using the data as a basis to make broad policy decisions regarding opioids, but did encourage careful consideration between the mortality rates and opioids. While Oregon was on the higher end of the spectrum for total sales (grams per 100,000 population), the state's mortality rate from accidental drug poisoning is near the middle.

The committee has developed educational guidelines for physicians to use when using opioid therapy to manage pain. The committee has been careful to consider the transition from acute to chronic pain management and the impact of continue any opioids through the chronic phase. The department anticipates the committee will complete its work on this topic by early 2011.

### ***Lumbar Fusions***

As part of an ongoing process to review high-cost, high-occurrence injuries, the committee is reviewing lumbar fusions to determine when the surgery is appropriate to treat back injuries. In 2008, the Information Management Division looked at the number of lumbar fusions in relation to a specific diagnosis code. The data showed that only 31 percent of workers who undergo a lumbar fusion ever return to work. The goal of the project is to review the treatment to identify when patients may benefit from the surgery and when patients are not likely to have positive outcomes. The department anticipates the committee will work on the review throughout 2011.

## ***New Technologies***

The administrative rules exclude some treatments from compensability. Many of these treatments have been on the exclusion list for a number of years. The committee determined that new technologies were constantly evolving as well. In response, the committee has established a process and a sub-committee to review new technologies and the exclusion list on a regular basis to identify when a review is necessary. The committee believes that in some cases new technologies are being called other names, but are essentially the same treatment as excluded under the list. In addition, new technologies that are closely related to an item on the list may actually be supported by studies to show positive outcomes. The committee is currently reviewing prolotherapy.

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September 20, 2010