Medical Quality Initiative
External Meeting Discussion
Medford – 10/26/05

There were a total of 19 stakeholders who attended this meeting. They included the following : nurses, a physical therapist, union representative, workers' compensation insurers, employers, an MCO representative, self-insured employer, and an attorney.

The meeting opened with a brief presentation on some background information about the initiative. The attendees then broke into three groups to facilitate the discussion process. The initial subject for discussion was on managing care. All of the ideas from each of the groups were captured and then presented to everyone for discussion. Then the attendees voted on what they thought were the most important issues, concerns or suggestions; before moving on to the next discussion subjects, reimbursements and training/certification.

All of the ideas, suggestions and concerns identified in the discussions are captured here. The items captured are what was written by the groups. The items that were determined as most important are listed at the beginning of each discussion.

Discussion Topic: Managing Care

Guideline Discussion

Costs should be apportionment between Workers Comp injury and pre-existing conditions. Seven (7) votes

10% doctors are the outliers? System punishes 90% to fix 10%? Seven (7) votes

Tools for physicians and workers to improve. Six (6) votes

Any solution must focus on <u>Outliers.</u> Five (5) votes

Reduce paperwork burden for medical providers. Five (5) votes

Need data from other states who have implemented guidelines. Five (5) votes

We don't want to create more work for physicians by having guidelines. Four (4) votes

Continuing education on guidelines for physicians and why important. Four (4) votes

Self-insured have more input on who treats worker. Four (4) votes

> Sometimes the provider the worker want to see can't for 3 months which increases time off.

Need more physicians in workers' comp system? Don't want to drive out physicians. Three (3) votes

Explore new, more cost effective technologies. Three (3) votes

ERs as treatment. Two (2) votes

Process for self-insured to apply to state: to allow them to manage care. One (1) vote

The following were suggestions from the groups, but did not receive any votes in the prioritizing phase of the meeting.

Ultra-sound vs. MRIs, e.g. on rotator cuff injuries.
Employees tired of waiting – want MRI, etc. NOW!
Insurers will not pay until they are sure treatment is needed.
Guidelines for treatment – physicians will not treat injured workers – too much paper work, e.g. specialists
Make agreements with doctors regarding priority treatment.
Barriers to treatment – physicians
    Reimbursement – deferred claims
    Authorization – Variety of treatment options
        - Shortage of doctors
    Not getting approved
    Not accepting recommendations
    Misc. paper work
Provide <u>treatment protocols.</u>
Insurers no longer require MRIs.
Need consistent mechanism for making decisions, e.g. MRIs.
No incentive <u>for doctors not</u> to make claims Workers Comp claims ↑ $ - 93%.
Clinics argue with workers to push Workers Comp claim.
Administration costs for doctors are off the chart.
HIPPA issues.
Are guidelines an answer?
    Hard to come up with.
    Hard to administer.
    Hard to enforce.
Employer selection of doctors would poison the well?
Rogue Valley Manor directs workers to a particular practice – usually works – some workers leave.
Study other states and report back – e.g. UR in California.
    We know some "outliers" are leaving.
Guidelines for ER usage.
Pre-authorization.
Employers have interest in workers getting best possible care.
Where would guidelines come from?
How do you account for pre-existing conditions?
Some guidelines for physicians would be good.
    Must be flexible.
    Tool for physicians.
    Should only be for areas of care that would lead to positive outcomes.
    Could outline diagnostics.
Physician group/provider should develop any guideline.

List of preferred providers
Doctors who do a good job and treat worker quickly, effectively and appropriately.
Have option under rules to allow self-insured to send worker to one of preferred providers, not have it count as IME.
Communication around treatment plans.
For employers:
Need to know what worker restrictions are.
The need to provide medical provider the worker P.D.
Be part of discussion with physician.
Educate employers, workers and physicians on light duty and goals of light duty:
Need to be worthwhile light duty.

Expanding MCO's Discussion

Until MCOs demonstrate results – don't expand.
Specialists? Enough
Need to put more pressure on doctors to respond to employers.
Concept makes sense.
MCOs not controlling doctors who aren't providing appropriate care. How do we control?
Guidelines don't work if there are no controls or accountability. MCOs not doing enough.
Need more consistency from one MCO to another.

Discussion Topic: Reimbursements

General Discussion Regarding Reimbursements

Standardize chart notes? Four (4) votes
Could reduce need for report – (like the So. Oregon Ortho Dictation Guide.)

Allow MCO provider participants to have higher max. Three (3) votes

Revisit interim medical services. Three (3) votes

Explore co pay idea. One (1) vote
Get workers invested in their health care.
Workers get paid back if claim accepted

Exploring uninsured impact on Workers' Comp. One (1) vote
Consider permitting therapeutic equivalent. One (1) vote

The following were suggestions from the groups, but did not receive any votes in the prioritizing phase of the meeting.

Pay providers for filling out certain required forms
Lengthy forms
Not paying to finish out objective findings
Not all forms
Look at segments of fee schedule
No across the board, up or down
If providers are not doing RTW, etc pay less.
Co-pays for inappropriate treatment choice.
Co-pays?
Co-pays prior to claim acceptance?
Would co-pays discourage workers from seeking appropriate treatment?
Tie payment to actually getting necessary information especially ERs – Urgent care
Explore impact of aging workers on Workers' Comp.
Selective incentives?
Geographic
Reports
OSCs with descriptions to guide reimbursement for reports
Reimburse for forms to encourage response.
Use Worker Benefit Fund money to provide education and training of providers in Workers' Comp.
Balance between amount of reimbursement and incentive/disincentive to bill Workers Comp vs. general health insurance, needs to be maintained.
No overall change.
Cost-effective malpractice insurance in rural areas.
Guidelines for services in rural areas.
Need for equitable distribution of reimbursement rates.
Fewer documentation/forms for "doctors we like." (Doctors who are providing good care)
Some paper work is not required by WCD.
How to justify differing requirements for better doctors.
WCD provide performance guidelines. Reimbursement contingent on compliance.
Reward doctors for compliance.
Reimbursement should be higher if physician is doing appropriate work.
Sanctions for physicians who are outliers.
Withhold initial payment?
Provide grants for educational, incentive activities, e.g. alternatives to MRIs.
Fee schedule – revisit apart from Medicare guidelines.

Managing Pharmacy Costs Discussion

Certain drugs will not be approved without justification by physician. (Tiered Formulary)
Five (5) votes

Co pay for all drugs on Workers' Comp claims. One (1) vote
Especially generic drugs or throughout the claim or 30 days then revisit

Pharmacy Benefits Manager / Educator
Appropriate Rx. One (1) vote

The following were suggestions from the groups, but did not receive any votes in the prioritizing phase of the meeting.

Guidelines for pharmaceuticals.
Change law to limit reimbursement to generic drug level, unless "Dispense as Written"
Allow/explore group purchasing for drugs.
Develop evidence based drug formulary.
Pharmaceuticals – driving costs – How much?
Input from health insurance companies. Needed.
WCD should do cost/benefit analysis of creating a "Drug Formulary"
System only allows generic drugs
WCD pharmacy benefit manager or insurers do this…
    Pharmacy Benefits Manager / Educator
        Generic Drugs
        Limited amounts
        Cost containment
Drug seekers impact on system?

Discussion Topic: Education/Certification

General Discussion Regarding Education/Certification

Education for medical provider staff – office managers etc. al. Four (4) votes

Communication and educations between providers and payers. Three (3) votes

NO!!! Certification for Physicians. Three (3) votes

36 medical data items required of doctors – all necessary? Revisit annually. Three (3) votes

Encourage providers to receive education, by making it a chance for a two way exchange. Two (2) votes

Certify office staff. Certified office staff could give worker information about workers' comp. system/claim. Two (2) votes

Include in training information about how claims are processed/decided – especially pre-existing conditions. One (1) vote

Provide education to providers – WCD/TEAM/Insurers? One (1) vote

Require all providers to accept workers'comp. One (1) vote

Focus Ed. Requirements on problem areas. One (1) vote

The following were suggestions from the groups, but did not receive any votes in the prioritizing phase of the meeting.

Joint education for insurers, MCOs, self-insured on their process and what information is needed of physicians.
Conferences on roles of the players in workers comp. system.
Continuing education seminar or online education or?
Incentives for continuing education in workers comp. Maybe other than money. Less paperwork, pre-authorization.
Need to measure impact of continuing education.
Educate employers – treatment options – required forms.
System certification.
Medical and medical business are different –
How medical decisions affect business decision and vies versus.
Higher reimbursement for medical providers who employ certified office managers.
Include information about RTW benefit to worker's overall recovery.
Allow compensation for certified office staff "counseling." Person could also be a liaison to employers.

Discussion Topic: Other Ideas

Other Ideas Discussion

Can the number of calls physicians receive about treatment be streamlined or standardized? All asking for the same information.

Receive calls from: Insurers
Employee
MCO

Enrollment process in MCOs is cumbersome, can it be modified?

Letter sent to worker very confusing. Have it make sense.

One group had a general discussion of the WCD and MQI goals and the questions posed in the handouts.

Discussion Topic: WCD Goals and General Discussion

General Discussion

Why are medical costs going up? Seven (7) votes

WCD Overall Goals
Encourage and reward employees for doing the "right thing."
Reduce paper work for physicians.

MQI GOALS:
Reduce claims costs.
Maintain quality of care.
Medical cost 64% of claim.
    Medical costs rising at 7.4%
    Over-all costs rising 4.6%

QUESTIONS:
Should Oregon adopt treatment guidelines?
Should Oregon expand use of MCOs?
Other ways to contain costs?
Manage pharmacy costs?
More education-certification for medical providers?
Medical Fee Schedule – required by ORS
    Subject to modification – conversion factors
$60-$93 for surgery for workers comp.
Medical costs/claim about U.S. average.

CONSISTENCY ISSUES:
In or out of MCO
Panel vs. no panel.
Rules changing.
Most are in an MCO – few doctors.
Have to use some outliers.
Rural vs. urban providers.
Shortage of physicians – too busy.
Inconsistent information from doctors. → Doctors lack of knowledge regarding workers comp. System/ procedures.

RECOMMENDATIONS:
[Outliers are the main problem]
    Education
    Mandates
    Sanctions
        Based on what guidelines?
        By WCD?