

Medical Quality Initiative External Meeting Discussion Portland (afternoon) – 11/16/05

There were a total of 19 stakeholders who attended this meeting. They included the following: medical providers, workers' compensation insurers, employers, MCO representatives, and self-insured employers.

The meeting opened with a brief presentation on some background information about the initiative. The attendees then broke into four 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 that were determined as most important are listed at the beginning of each discussion.

Discussion Topic: Managing Care

Guideline Discussion

Guidelines on pain management and pharmacy. **Four (4) votes**

15% of our injured workers create 80% of our costs. **Three (3) votes**

Should be easier to get person treated first and figure out if it's WC or general health care—one should pay back the other easier. **Three (3) votes**

Guideline on new technology would be helpful. **Two (2) votes**

Guidelines would be difficult/limited value—some broad guidelines could help. **One (1) vote**

Guidelines should focus on high cost/growth areas like DME's. **Two (2) votes**

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

Any should be flexible

Washington guidelines and approvals discourage access and stalls care.

How do they work in other states?

Any statistics from other states?

Kaiser has MCO guidelines-

Who manages them?

Who creates them?
MCO's have guidelines—adopting another set is problematic.
Use to manage reimbursements or to manage care?
If it is difficult for MCO's to enforce, who would enforce outside of MCO's?
Disputes only?
Guidelines cannot equal rules. If used as rules, need to keep them broad.
Outliers?
Surgery
How do you judge appropriateness?
Costs are up but so is impairment.
There is value in the cost increase.
The assumption is that Managed Care has a positive impact.
Create profile/screening process to identify problematic cases.
Where are the outcomes of the study group?
Observing knees/ergo outcomes research study—ever published?
Guidelines differ from MCO to MCO.
Should state have standard for everyone—No.
Pay people to do reasonable work.
Claims processors love guidelines, nurses don't like them.
As physician, I would like workers moved along and get the treatment they need.
Guidelines could help move the process.
If certain criteria are met for worker, then they get moved through the process and treatment.
Insurer delaying treatments, approving surgery.
Insurer (adjusters) having IME's done, questioning medical treatment plan of MCO's.
Does this really save insurer money?
Guidelines could help to provide early treatment for workers. This would be good.
Patient should get treatment whether or not it's compensable.
Make it easier to coordinate care between attending physician and consulting physician.
Specialist physicians say there is too much paperwork in WC system and don't want to be Attending physician. You end up with two physicians, twice the costs.
Attending physician (AP) delegate AP responsibilities to the specialist.
Need better flexibility with AP and other providers, to get service for workers. Worker doesn't have to change AP.
Don't want Oregon to be like Washington with guidelines.
Don't have guidelines for everything, only for certain issues/treatments.

Expanding MCO's Discussion

Recommend a study to better determine if there is a benefit with MCO's **Six (6) votes**
MCO—Doing well overall. Excellent: **Two (2) votes**
Partnership
Communication
Time is money and MCO give answers quickly.

MCO expansion should be market driven. **One (1) vote**

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

MCO's may reduce disability, indemnity costs.

Should we encourage people to speak directly to MCO's?

Should they still contact Insurance adjusters due to agendas?

No mechanism for managing consistency in MCO's

No requirement to enroll in MCO at claims acceptance

MCO doctors are well versed in WC, in general. Physicians outside MCO aren't familiar with WC.

Outside of metro area physicians don't want to be in MCO.

Do any statistics show effectiveness?

Insurers tend to enroll the difficult claims.

Managing Care Outside of MCO's Discussion

Sometimes need to direct workers care. We should be able to direct worker to appropriate care-System doesn't allow. **One (1) vote**

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

Insurers do provide case management.



Discussion Topic: Reimbursements

General Discussion Regarding Reimbursements

What would it take for physicians to be willing to do second opinions? OSC's? **Four (4) votes**

What's driving increases? **Two (2) votes**

Pharmacy

Lifetime medical

Use of questionable devices/techniques

Electronic submission of billing and report for WC would really help. **One (1) vote**

Law requires attaching paper documents—costly to do.

DME schedule needs to be reviewed and fixed. **One (1) vote**

Too loose

New technology/devices pushed by sellers—need information/answers about any new technology.

Reduced paperwork is money in the pocket. **One (1) vote**

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

System provides no incentive/role for workers to be concerned about medical costs.
Close claim entirely when claim closes (no lifetime medical—include in settlement) At least clarify better.

Requiring treatment plans has helped control costs.
Should there be an incentive in underserved areas?

They don't want to take on additional WC patients.

You are not going to get value out of paying them more.

Worker benefit fund too flush—return to those who paid in.

About \$60 million a year to injured workers—there is about \$140 million in fund currently.

Do not give incentives to those trying new technologies.

Ease up on paper required to get paid.

Look at things done by other states, any successful reimbursements.

Things agreed to by Oregon stakeholders.

Maybe we could adopt what they did.

Fee codes to promote managing care.

Reimburse physicians to manage care.

Interpreter fees.

Physicians asked frequently for supplemental report—paper hassle for the providers.

Why do we need to do this?

Simplify—start from scratch

Outside WC, providers are not paid to for reports. At least there is pay for that in WC.

Should there be a mechanism to reward excellence?

Allow greater flexibility.

Second opinions are not attractive to providers (consulting physicians).

Encourage/allow single points of contact—improved direct contact of provider to insurer.

Allow reasonable fee for dialogue.

Modify Fee Schedule Discussion

Fee schedule for special procedures like closing exams and reports. Need to set standards. **Three (3) votes**

Look at total costs to establish value of rising medical costs. **One (1) vote**

Is the Fee Schedule market driven? **Ones (1) vote**

Current Fee Schedule is very good. **One (1) vote**

Don't reduce the levels. **One (1) vote**

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

Managing Pharmacy Costs Discussion

Sharing cost information on drugs with providers. Also cost of equipment and devices.
Two (2) votes

Reactivate Pharmacy Committee to look at pharmacy fee schedule—only pay at generic rate. **One (1) vote.**

Formulary for drugs. **One (1) vote**
Who determines what gets on/off (quickly)?

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

Worker pay difference from generic and “name” brand drugs, name drugs very costly.
Allow therapeutic equivalent drugs, if appropriate.
Generic equivalents—Should patient get brand names if there is no evidence to base it
On.

Create statewide formulary process.

Prescribe drugs that are cheaper/similar/equally effective, to trade name drugs.

Patient should pay difference out of pocket for name brand vs. generic.

Should patient pay for medicine from non-compensatory claims?

Pay at generic level. If worker wants name brand, they pay the difference. Unless
physician shows need for name brand drug.

Limit money to generic.

Allow therapeutic equivalent or require.

Formulary. YES

Sharing savings with providers who avoid high cost drugs, DME’s etc. (Bonus) or

Cutting costs overall leads to higher fees.

Discussion Topic: Education/Certification

General Discussion Regarding Education/Certification

Certification would have more physicians opt out. **One (1) vote**

Focus on voluntary education. **One (1) vote**

Tradeoff—will improve your efficiency.

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

Certification—Bad Idea.

If a physician is not doing something they should:

mandatory training

then, if still no change, they cannot do WC.

Training for physicians on rules and other WC issues.

Offering training on WC, the law, WC system, good idea.

Method to address physicians who are;

doing inappropriate treatment.

not providing good services.

Education for physicians on the WC system, goals of the WC system, and how to navigate in the system.

Tough to get physicians to treat WC patients. Certification would drive more out of WC.

Can Oregon do study on certification like Washington did?

Show benefit of certification.

Smoother process is benefit for physician.

Show physicians trends in system—information bulletins.

State should push for continuing education for doctors.

Keep state out of training doctors on WC issues.

Give doctors incentives based on continuing education credits.

How do you certify them?

MCO rules could capture continuing education credits.

State of Oregon should look at capitated rate program.

State of Oregon should look at integrated disability study.

Share information by bulleted newsletter.

One on one training

Certify/train office staff person—who could bill for related activity.

Isn't this adjuster or RTW person's responsibility?



Discussion Topic: Other Ideas

Other Ideas Discussion

Too many rules, too much bureaucracy in WC. **Four (4) votes**

Coordination of benefits with general health care and WC. Key issue is that bills are paid and when decided if WC claim easy to get reimbursed and reverse. **Three (3) votes.**

System too rigid, too many rules, Doesn't allow for innovation/flexibility. **Two (2) votes**

Use pilot to test—before you make major change in system. **One (1) vote**

827 should ask if physician thinks that the injury is work related. **One (1) vote.**

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

Other states wish they had Oregon's WC.

Consulting physicians role in Oregon difficult. Can't say what treatment "will be", can
Only recommend to AP. Delaying treatment. Relying on AP so much is causing
problems.

Too many rules in WC—hard to navigate through system.

Uninsured!

Why don't physicians want to do WC:

Depositions?

Answering questions?

Different/difficult to bill? Oregon specific codes difficult.

