

Medical Quality Initiative

External Meeting Discussion

Portland (morning) – 11/16/05

There were a total of 25 stakeholders who attended this meeting. They included the following : medical providers, workers' compensation insurers, employers, MCO representatives, self-insured employers, representatives of injured workers, and an attorney.

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 should be presumptively correct – party wanting to go outside needs to show why. **Four (4) votes**

Having guidelines (ACOEM) would help in disputes (MRU) something “evidence” based as guide – instead of using AP treatments as basis. **Three (3) votes**

Now cumbersome process
Neutral treatment basis

What is driving cost? P.T., Imaging, IME, Meds. – What sectors? **Three (3) votes**

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

Many doctors need to follow guidelines.

Would give “us” (other than doctor) something to refer to, we could see if treatment is reasonable.

Guideline on what to put in chart notes would help.

Are there guidelines out there to use?

PT huge increase – should have guideline for this.

Who would review them/update them? Very expensive to monitor.

Nice for employer/self-insured to have statewide guidelines to check if treatment appropriate.

Guidelines would be another “redflag” barometer – then what do you do? Should be physician to physician discussions about “redflag” concerns.
Difficult issue, especially for physicians, telling patient they are “as good as they are going to get” and stop treating.
Instead of having another “treatment guideline” focus on what medical information you need and where do you need it from physician. It would save doctors time.
Doctors need structure in the process for dealing with workers comp. Otherwise they will be frustrated.
If things are easy and user friendly – will be used and of help to doctors.
Guidelines wouldn't / shouldn't be mandatory.
Doctor would need to provide reasonable, objective information to deviate from guideline.
Difficult for family physicians in under serviced areas to back off on treatment, don't want to offend – since they also treat rest of worker's family and friends.
In workers comp. system doctors get challenged – they don't like to be challenged.
Therefore, they don't make Y/N decisions.
Universal – apply to MCO's, but MCO has responsibility to enforce them with panelists.
Oregon medical providers should develop/adopt or appt. a panel.
Don't adopt Minnesota's.
Prefer medically developed versus bureaucratically developed guidelines.
Detailed/somewhat flexible.
MCO use and train their providers.
What about injury outside of guidelines?
How to enforce guidelines?
Guidelines can place more burden upon providers.
More burden may cause providers to leave.
Good idea, maybe the time isn't right.
Guidelines – common sense
State of Washington – Mandatory? Then it's rule not guidelines. MCO only? What if it is not MCO claim?
Keep them as guidelines – not rules.
Do you need guidelines for every injury/claim?
Keep it simple – limited areas – best practices.
Does the state have “teeth” – should guidelines?
Medical benefits constitute majority of claim cost.
Is that necessarily bad?
Might we be serving the customer better – healing them faster? Getting them back to work sooner.
But at a higher cost.
Are we getting?
Standards of care change.
Advancement of medical treatment change so fast that state guidelines would become obsolete.
Time is money – have guidelines in sync with other states.
What are we trying to manage?
Is physical therapy a big cost driver?

Expanding MCO's Discussion

Increase responsibility and power of MCO's to enforce standards/guidelines and move case appropriately—power over panel. Rules and statutes need to support this. **Five (5) votes**

Are they worth it? **Four (4) votes**

Should WCD eliminate provision that allows worker to continue to treat with non-panelist family doctor? **Four (4) votes**

MCO's more effective with solid guidelines and teeth. **Two (2) votes**

MCO's provides "tool" or intermediary between insurer/provider. **Two (2) votes**

Identify providers willing to provide care to injured workers. **One (1) vote**

Perhaps a tiered enrollment system. **One (1) vote**

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MCO should have "list" of doctors that they shouldn't use.

Increasing scope good – should be voluntary.

Questions: Only disabling claims? Everyone in certain category?

Should MCO's manage claims?

City of Portland has greater ability to co-ordinate workers comp./non-workers comp. care. Good experience.

Shouldn't be mandatory to have one.

Power over panel.

Hold MCO's responsible to director (not insurer/employer).

MCO's would help if Legislature expands field of providers.

Shouldn't be required to enroll all, but more would be enrolled in better/stronger MCO's.

MCO's may improve communications to/from providers.

Pre-certification – decisions made by medical people.

Help with RTW issues.

"Black holes" outside PDX area.

Enrollment upon injury

private insurance versus self-insured.

Pros: Discounted fee scheduled

Provider panels

Cons: Conclusive evidence of MCO advantage

Lower reimbursement to providers

Insurer managing care (Ex. Guidelines)

Insurer size effects ability to manage care.

Efficiency of MCO's for case management.

MCO is "middle-man" that manages care operates as third-party.

Why are MCO's being used? Difficult to provide evidence for and against.

MCO's lessen burden of managing the claims from the insurer.
Geographic distribution of willing providers.
MCO can intervene on behalf on insurer.
Advantage from using MCO's, although no evidence of increasing/decreasing medical costs.
Concerns about mandatory enrollment.
Control utilization of services versus cost of services.
Increase diagnostic provides networks – labs, path., and radiology.
MCO – effective? Yes – so are IPO (Liberty)
How does it effect cost of claim?
Patients in general are getting used to accept list of doctors/care.

Managing Care Outside of MCO's Discussion

Have form for physician to use, fill out, for on-the-job injuries. **Six (6) votes**
Documentation for that patient's injury would be in same place, make it easier to review.

It would be nice if employers can direct/control, send worker to a physician initially!
Four (4) votes

Direct care – should we allow it? **Three (votes)**
Carve out bad apples immediately.

Don't want to drive providers out of the system. **Three (3) votes**

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

Convince doctor's office staff that specific documentation/forms will save them and the doctor time and money.

How chart is put together helps doctor focus on issue. Would be very helpful for workers comp. claims if necessary forms were in the chart.

Doctor needs to be informed, aware of "what the worker actually does at work" to help With treatments – to get them back to work.

It would be good if "you" knew that doctor treating worker knows workers comp. system And goals of workers comp. and documentation necessary for workers comp.

Arbiter panel should be broader to make it fair.

Employers want:

- Best care for worker
- Back to work quickly
- Close claim
- Keep costs down
- Consistency in care.

Care of worker needs to be managed.

Workers go to ER a lot (initially) – very costly:

ER physician shouldn't be allowed / authorized to approve time-off for injured worker.

Educate ER doctors on goals of workers comp. and the need to return to work quickly.
Keep three day wait
Educate workers on workers comp. and why it's better to go to physician rather than ER.
Good medical care expected service is required.
Utilization review/case management should be encouraged, but not required.
Pre-authorization:
 By insurer?
 By medical director?
 By pre-authorized entity? (like claim raters)
Improve communications – single point. contacts.
Timelines need to be better enforced.
Access issues in Oregon -- (might need to look at alternative providers?)
 Training
 Retirements
 Malpractice
Can pre-certification occur outside of MCO
Can utilization review occur outside of MCO (UR).
UR outside of MCO has no teeth.
Formal provider training versus informal training (as cases arise).
Limits on certain services (ex. PT, etc.)
Managing Care – Keep cost down.



Discussion Topic: Reimbursements

General Discussion Regarding Reimbursements

Figure out what you are paying for and what were gains/outcomes. **Three (3) votes**

Fees in workers comp. very good now, leave alone. Won't bring in doctors. **Two (2) votes**

Manage claim as opposed to changing fees. **One (1) vote**

Don't lower reimbursements but give incentives. **One (1) vote**

Reimbursing "certain" physicians at higher rate not a good path to go down. **One (1) vote**

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

Look at utilization, is it appropriate. Utilization, medical management and

reimbursement.

Workers need to be responsible for medical care under workers comp.

Physicians should get paid by worker, when worker doesn't show up for appointment.

Consider breaking 827 down to simpler forms (example – 828)

Don't provide incentive to rural/underserved areas – not necessary. Not the problem/solution would increase bureaucracy, too.

Problem is they just don't want to deal with the system.

Fee schedule –

Make changes long term – rapid/big changes are costly and difficult.

Currently div. 09 working fine.

PT increases in part due to increases in RBRVUs? Need to look at RBRVUs?

Don't change statute to pay for required forms (827). Don't pay for clarification either.

Concepts around single point of contact:

- Web-based information/contacts.
- Electronic records.
- Provide incentives to medical providers to set up electronic systems.
- Grant from WBF?
- Develop/incentive single points of contact with both insurance and providers.

Need to do a better job including the worker in bringing claim to closure, keeping worker informed.

Quality/timely contacts save money in the long run.

Should higher payment be allowed geographically? - Yes!

Treatment location (not physician)

They want WC doctor and family physician.

Pay would mirror hospital %'s in rural areas.

Create treatment guidelines

- stay within guideline-- reimburse
- go beyond – then stop reimbursement.

Pay for performance – No, who determines what is great versus good.

Treatment guidelines based, create financial consequence for going beyond guidelines unless documented and approved.

Who decides who is not following guidelines? Pay them less for not following.

Should the fee schedule provide incentive payments?

Yes – but payment offered is an expectation of services.

Should WCD provide grants from the workers benefit fund to further MQI goals?

Yes – grants should be pursued from others but perhaps go beyond WBF.

Give money to benefit worker. “This will increase quality of care” justify use of money.

Should we pay for certain forms and reports?

Yes – if it is mandatory to fill them out they should be paid.

Doctors won't think it through if not paid.

Should codes be added, allowing greater payment flexibility?

Yes--pay them flexible billing for mandatory form completion. Based on complexity.

Don't mess with fee schedule.

Why should employers have to pay more because of their geographic location?

If only one specialist in an area, fears of employer as to the direction of care.

Not thrilled about incentives for new proven tech.

By adding specific codes, more to keep track of.

Is there a benefit?

By providing a service, all the reports and forms are included in the service reimbursement.
Direct incentive towards returning to work. Managing the claim towards closure.
By focus on forms/reports; cost may increase because over use of the codes.
Will using codes for services reduce fee disputes?
With different injury severities, how to follow more severe without overlooking less severe claims.
How to differentiate between non-compensable services and compensable.
Direct incentive towards reducing hassles for providers to manage the claim.
Reward timely submission of paperwork.
What is considered timely?
Who monitors the timeliness of submissions?
Yes – use the worker benefit fund to help provide better services to workers.
The medical fee schedule does need to be reviewed on a regular basis.
What is the criteria for increasing the fee schedule.
Because of litigation, provider may use diagnostic tests, x-rays and MRIs to protect themselves.
Difficult to measure utilization and effectiveness.
Don't break down fees by this piece of paper or that form.
If we are reimbursing at higher rate in worker's comp. why aren't we attracting more physicians?
Paperwork
Litigation
Challenge to get physicians in worker's comp.
What is the measure?
What would it drive in the medical community.
Are our reimbursement rates fair or overly generous?
Maybe – don't increase for a period of time

Managing Pharmacy Costs Discussion

PBM are cost saver – workers should be required to use PBM. **Five (5) votes**

Bulk purchasing? **Three (3) votes**

Will it work? If yes, why not buy from Canada?

Group purchasing. **One (1) vote**

- who?

Create pharmacy formularies. **One (1) vote**

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

Doctors would have option to prescribe name brand if specific need is documented.

Use networks to obtain generic medical.

Use generic drugs whenever possible/appropriate.

Network (PBM) of pharmacy(s) would be a good thing to reduce pharmaceutical costs.

Issue – how fast can drugs get on/off formulary. - Need fast reaction time.

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Unless physicians prescribes “name brand” based on need, reimburse at generic price if worker wants name brand they pay difference.

Formularies:

- Need updates

- Need management

- Use established one – continue reinvention

- Needs to be appeal-able to an expert, can be challenged by all parties.

- Guidelines specific to pharmacy.

Generic prescriptions should be mandatory

Create pharmacy fee schedule

Pharmacy huge cost factor even outside WCD

Create pharmacy guidelines – what you prescribe for what injuries.

Workers are being over-medicated

Delays getting them back to work.

Pharmacy is a “chemical soup” and very hard to create guidelines for.

Look at Washington’s guidelines – some great ideas.

Workers pay difference between generic and name brand IF they are equivalent.



Discussion Topic: Education/Certification

General Discussion Regarding Education/Certification

Giving certified physician more money doesn’t fix the problem. **Two (2) votes**

Continuing education for physicians, on workers comp. **One (1) vote**

Education of physician good thing – how system works, return to work process of workers comp. **One (1) vote**

Recruit Spanish speakers to the industry. **One (1) vote**

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Educate doctors on workers comp.

May help – may not shouldn’t pay provider more for having it.

OMA partner with WCD to provide education for physicians.

Outreach (not written forms) to workers and employers.

Who provides the outreach

- OIW

- Insurer

Training for adjusters in dealing with injured workers.

Focus on Hispanic community –

How? Who?
35% of OIW calls are Hispanic.
Translation services with medical providers.
Educate provider about compensable service for accepted injuries.
without education providers can be overwhelmed.
Claims adjuster shouldn't be the those that educate.
How much training – 2 hours, 4 hours?
How to provide education without driving doctors out of the system.
Can we educate the staff of doctors?
It is the staff that fill the forms and field the phone calls.
How to measure effectiveness of education?
Link effectiveness to higher reimbursement.
Focus on office staff for education.
If education not required, who will come to education.
Sell the education to providers office staff, key to the success of education.
Office staff need free and easy access to education.
Collaboration with existing licensing board for workers comp. education.

Certification:

Would doctors participate?
Who would establish implementation?
Penalize non-certified providers versus additional money for certified.
Who tracks?
Who would be certified?
How about NP's?
Good idea, but lots to work out.
If enough certified providers in a geographic area, workers would have to choose
from certified list.
Any proof it would work?
Would certification duplicate MCO's?
Don't make it mandatory but create monetary incentives.
Is it MCO to MCO – or statewide standard?
Yes – create statewide – but not mandatory program.
If you are certified – you receive bonus %.
WCD should be in charge of it.
Who does the training? Online training? Interactive with trainer physicians.
Keep it always up to-date.
Criteria – TBD
someone with expertise create training
ask WC doctors to create.
Make it convenient for providers.
Require a minimal level of workers comp. training for certification with continuing
education to maintain certification.
Tiered certification general health versus occupational medicine specialties.
Can there be a "grandfather clause" for those with much workers comp.
experience?
Certification will not improve care; will improve compliance with rules and forms.
If you can treat without certification; why become certified?

Discussion Topic: Other Ideas

Other Ideas Discussion

Don't rush into changes without knowing what is driving cost. **Ten (10) votes**
Be specific!

Outliers are the problem – most are doing the right thing. **One (1) vote**

