

**Department of Consumer
and Business Services**

2005-2006 Medical Quality Initiative – Reporting Evaluation Phase
Final Report and Recommendations

Presented to
Oregon Department of Consumer and Business Services,
Workers' Compensation Division Administrator and Team Sponsors

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Prepared by:
The MQI-REP Committee

The Workers' Compensation Division Medical Quality Initiative – Reporting Evaluation Phase Committee was comprised of the following staff:

John Shilts, Administrator, Sponsor
Phil Jarvis, Operations Section Manager, Sponsor
Nancy Bieber, Project Coordinator
Win Lombardi, Administrative Assistant and Note taker

Team Members:

Barry Jones*
Bryan Skalberg
Debra Buchanan*
Donita White
Ed Lanssens
Gayle Parrish
Holly Mercer
Kim Duncan
Nanci Johnston
Nathan Johnson
Tracy O'Connor*

* members left or resigned prior to project completion.

Medical Quality Initiative – Reporting Evaluation Phase (MQI-REP)

Project Summary Report June 2006

The following is the final report of the MQI-REP team. It includes background information, reports on the three project tasks, and team recommendations to WCD Exec Team.

I. Background:

Introduction

The Medical Quality Initiative began as a way to address medical inflationary pressures while assuring that workers receive consistent, timely, high quality care. The Workers' Compensation Division (WCD) developed a proposal and identified three main recommendations:

- 1) The development or adoption of some type of treatment guidelines,
- 2) The development of a training and voluntary certification program for medical providers, and
- 3) A reduction and simplification of paperwork for medical providers and medical data reports in anticipation of and consistent with adoption of nationally standardized electronic billing and data interchange.

WCD chartered two committees to review these recommendations.

- The Treatment and Guidelines Committee addressed the first two recommendations and more clearly defined the MQI goals as follows:
 - Decrease overall claim costs
 - Assure consistent, high-quality care
 - Provide workers with timely treatment and access to medical care
 - Improve return-to-work outcomes
 - Improve partnerships among system stakeholders
 - Provide resources/guidance to medical providers.

(See attached "Treatment and Guidelines Committee Final Report")
- The MQI-REP team was charged with developing the third concept and established the following objectives:
 - Determine if the department is currently impeding the process for medical providers to move from a paper-based to an electronic reporting and record-keeping environment.
 - Determine the department's role in encouraging or enabling medical providers to move from a paper-based to an electronic reporting and record-keeping environment.
 - Evaluate current statutes, rules, and bulletins related to medical reporting and data requirements of insurers and medical providers to identify barriers and opportunities to streamline.

The MQI is the most recent development in an ongoing process of review and modification of medical services, billing and reporting, and also reflects current changes and trends within the greater healthcare system. In developing its recommendations, the MQI-REP team considered the following previous initiatives, national standards, and statutory framework:

The Paperwork Reduction Task Force

This task force was created in 1997 due to the long-standing dissatisfaction on the part of many medical providers with the administrative “hassles” of treating injured workers. The task force included stakeholders and WCD staff that met over several months and made 18 final recommendations to simplify the system. Some of these recommendations included:

- Reducing the length of time Oregon insurers have to accept or deny a claim from 90 to 60 days
- Consolidating existing medical reporting forms into one form (the 827)
- Publishing a “Physicians Guide for Reporting Oregon on the Job Injuries”
- Developing the capacity to accept coverage data via IAIABC Electronic Data Interchange (EDI)
- Developing the capacity to bill and report medical data via a standardized EDI format

A number of the recommendations of this task force were implemented, such as the consolidation of medical reporting forms, but others, such as electronic medical billing and reporting, are still pending.

HIPAA, the IAIABC, and Electronic Medical Billing/Reporting:

The MQI-REP project was also launched within the national context of developing standards for electronic billing of medical information as required by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires all but a few smaller medical providers to adopt electronic billing for Medicare. Many providers also electronically bill general healthcare, using the HIPAA standards.

The International Association of Industrial Accident Boards and Commissions (IAIABC) is the organization responsible for the development of workers’ compensation specific standards for electronic reporting and electronic billing for jurisdictions.

Electronic billing and electronic reporting comprise two different, but connected, “pieces” of general electronic medical information sharing. **Electronic reporting** refers to the flow of data between a payer and a jurisdiction. The IAIABC has developed national standards for this reporting in order to provide consistency between jurisdictions, simplifying the development of reporting systems, especially for multi-state insurers. **Electronic billing** refers to the flow of electronic medical bills between a provider and a payer, and is heavily influenced by HIPAA requirements. The IAIABC has just launched the development of national standards for electronic billing.

Both electronic billing and electronic reporting are rapidly increasing in popularity and usage, chiefly due to two factors: HIPAA, and, within workers' compensation, state mandates for IAIABC-standard reporting.

Because of the first factor, HIPAA, Medicare requires electronic billing from most providers. When Medicare revised its standards to no longer require that chart notes be attached to every bill, this proved a crucial catalyst to the widespread and successful adoption of electronic billing for all non-workers' compensation medical claims, including general health care. Many Oregon providers already bill Medicare and general healthcare electronically, and would like to be able to extend electronic billing to their workers' compensation cases. However, there are obstacles to this that must be overcome. An example is the continued need to attach chart notes and other reports to medical bills. The Major Contributing Cause standard in Oregon (see below) appears to heavily influence this ongoing need.

The second factor encouraging EDI is recent state mandates for IAIABC medical bill data reporting (payer to jurisdiction) by California and Texas. Although HIPAA specifically excludes workers' compensation, market demand from providers has resulted in the involvement of the IAIABC to develop a standard for electronic reporting of workers' compensation medical bills. In response, these two populous states which account for a significant portion of all workers' compensation claims in the United States have mandated EDI. Florida and other states are now considering similar initiatives. California's and Texas' mandates will require most national insurers, self-insureds, third-party administrators, bill reviewers and software vendors to develop the capacity to report medical bills using the IAIABC (HIPAA-compliant) standard. Now that these entities have invested in a standard reporting system, it is more feasible for them to expand its use to other states instead of developing or maintaining single-state proprietary reporting schemes such as Oregon's Bulletin 220.

Major Contributing Cause:

Another "historical" component related to the issues of medical reporting and billing is the change in the standard for compensability of a workplace injury from a "material contributing cause" standard to a "major contributing cause" (MCC) standard. This change occurred with the passage of SB1197 in 1990, and was further clarified and modified in SB 369 in 1995. The MCC standard, as compared to the "material contributing cause" standard, requires a more complex medical analysis in order to determine the compensability of a claim. Rather than accepting injuries or conditions which are more broadly defined, e.g. back strain, the insurer requires information from the medical provider which specifically articulates the exact condition to be accepted and an opinion as to whether the injury was a major contributing cause of that condition.

II. The MQI-REP Project:

In order to understand the current situation regarding medical reporting and billing and to complete the goals of this project, the REP team completed analyses in three areas:

- 1) Current statutes and rules for medical reporting in order to identify what is required to be reported by medical providers and the industry, when, and to whom;
- 2) Internal business needs and capabilities in order to assess what the department's needs and uses are of the data DCBS receives, and what the

- department's capacities are to modify the current structure; and
- 3) External business needs and capabilities in order to assess the impact of the requirements and system on stakeholders and to obtain their input on what works and what changes would be desirable.

After completing these analyses (see the attached summary reports for more detailed information and supporting documentation), the team reviewed the findings and developed recommendations. Following are brief summaries of the analyses.

Current statutes and rules

Through its law and rule review, the team found that medical providers provide the majority of required medical information and send it to insurers, rather than to the division. The providers must meet multiple timelines to provide a wide range of reports in a variety of specific forms and/or formats. In addition to billing information, there are 38 possible reports required from providers.

Information required by WCD comes from the industry (insurers, self-insured employers and third party administrators), either through required forms and reports or through the Bulletin 220 requirements. While the medical information they report comes to them from the providers, they do not report the bulk of the information they receive. They are required to send more extensive medical information only on a case-by-case basis, such as when there is a dispute. The majority of reporting requirements fall on medical providers who report to the insurers during the life of the claim.

Internal business needs and capabilities

In its analysis, the team found that most WCD programs use some or all of the medical information contained in insurer-submitted 801, 827, and 1502 reports, such as part of body injured, nature of injury, and permanent impairment body part which is found in the Claims Information System (CIS). Additionally many of WCD program areas use the WCD claim file to compare or verify previously reported claim information. However, most of the medical information required for dispute resolution is not found in the claim file, but rather requested from insurers and/or providers on a case-by-case basis outside of the claim reporting process.

Currently the medical bill data collected by the department is utilized and is necessary but somewhat limited. Existing bill data collected via Bulletin 220 is in a proprietary electronic format, specific only to Oregon, reported quarterly. The existing data elements were developed many years ago and may not reflect today's business needs.

The department uses a limited amount of the collected medical bill data in day-to-day work processes. However, the department uses this information extensively for research and analysis and provides this information to department policy makers, the legislature, MLAC, and other external stakeholders. Given the increasing importance of the analysis of medical costs and other medical information, the MQI-REP team reviewed the Bulletin 220 data and concluded that the current data needs have out-paced the current reporting standards.

External business needs and capabilities

Medical Providers and Their Staff

Medical providers are required by statute to provide reports as frequently as every 15 days. Insurers may require reports “on demand,” and providers may be sanctioned if they fail to meet the varying reporting requirements. The team met with several providers and their staff and then surveyed a larger population of each (providers and staff) to gain a better understanding of the providers’ concerns in treating injured workers. Many providers complained that it is not so much the reporting requirements themselves that are a “hassle,” as it is the frequency and the redundancy of the reporting. They complain that sometimes they must submit the same information over and over. The necessity of attaching chart notes or reports to every bill is also reported to be a “hassle” as well as an impediment to electronic billing. To underscore this point, providers stated that in the past Medicare required chart notes for all Medicare claims. However, due to the newly implemented Medicare electronic billing, Medicare now only requests chart notes on a case-by-case basis, and this is the exception rather than the rule. Providers indicated that electronic billing would have been much more difficult if Medicare had not dropped the requirement to attach the chart notes. Nevertheless, many providers reported that even with the chart-note requirement, electronic billing would be an improvement to the current system.

Providers and staff responding to the survey listed the following as the top three issues they’d like the department to address:

- 1) billing;
- 2) diagnosis versus accepted condition; and
- 3) payment pre-authorization.

They also listed the following top three training choices:

- 1) billing and treatment disputes;
- 2) claim acceptance/denial; and
- 3) coding, billing, and payment.

Insurers, Self-insured employers and Third Party Administrators

The team surveyed Oregon industry representatives - claims reporting entities that included insurers, self-insurers, and third-party administrators. Ninety-one percent of industry representatives responded to the survey and said they need specific medical information in order to determine compensability as well as to determine if the injury was the major contributing cause to the claimed condition and need for treatment. This is the only way they can decide appropriate payments for time loss benefits and medical bills. About half of them reported the need to contact providers regarding complex injuries, time loss approvals, and return to work releases. In order to meet their statutory requirements, representatives said they need timely and readable medical information.

Industry representatives reported three major issues with information sent to them from providers:

- 1) inadequate or unreadable chart notes;
- 2) incomplete or inappropriate information, i.e., the provider’s response didn’t

- answer the insurer's question; and
3) lack of necessary information on the medical billings.

In addition, many industry representatives said that providers don't know the rules or industry's processes for handling worker's compensation claims. The team concluded that this lack of knowledge might be the main contributor to the communication and payment issues raised by providers.

III. Conclusions:

In response to the questions outlined in the introduction, the team reached the following conclusions:

- Determine if the department is currently impeding the process for medical providers to move from a paper-based to an electronic reporting and record-keeping environment:
 - The team found no evidence that any of the laws, rules or policies of the department impede the process for medical providers to move toward electronic record-keeping, the records and chart notes the providers keep on their patients. We do note that there is an accelerating trend in the Oregon medical community to this type of environment, and it is used non-selectively for all patients within a practice. To the extent that "reporting" includes billing, however, the current system does impede electronic billing (see below).
- Determine the department's role in encouraging or enabling medical providers to move from a paper-based to an electronic reporting and record-keeping environment:
 - The trend toward electronic medical record-keeping is ongoing without intervention from the Department. In fact, the governor recently reported that Oregon will be participating in a grant program to help move this process forward even faster. However, WCD does have a role in promoting electronic billing, and will need to lead the community in adopting standards and solving issues that impede this process.
- Evaluate current statutes, rules, and bulletins related to medical reporting and data requirements of insurers and medical providers to identify barriers and opportunities to streamline.
 - The bulk of the team's work concerned this final objective. The team concluded that stakeholders need to work together (with department assistance) to reduce barriers and adopt opportunities to streamline reporting by providers to payers. We also concluded that communications and training gaps add to the confusion and difficulties that providers experience. Payer-to-jurisdiction reporting can be streamlined through adoption of standardized EDI. See the recommendations below for greater detail.

IV. Recommendations:

After analysis of the data and feedback received from all stakeholders contacted during the MQI-REP study, the team offers the following recommendations and asks WCD Executive Team to approve their adoption:

1) Appoint a team to plan a transition to adopt the HIPAA- and IAIABC-compliant EDI (Electronic Data Interchange) medical reporting standard in place of the current proprietary Bulletin 220 reporting. Since the Data Committee forming in response to the Treatment and Guidelines Committee recommendations will be reviewing medical data and the department's statistical reporting, we recommend that the EDI planning team be incorporated as part of that group.

Rationale:

- **Streamlining:** Sixty-eight percent of insurers surveyed agreed that medical EDI reporting was desired and/or possible. Especially for industry members who operate in multiple jurisdictions, reporting via a standardized format may be ultimately more efficient and less costly than having to adapt to a variety of proprietary systems.
- **Benchmarking:** IAIABC-standard medical bill data would provide more complete information for use in policy decisions, would answer the shortcomings of current Bulletin 220 data, and would allow comparison with other states' data on medical costs and related high-interest topics. IAIABC has adopted a "menu" of data elements that incorporate all the current Bulletin 220 requirements, but tie them more clearly to the nationally standardized billing forms Oregon requires providers to use and provide greater flexibility and detail.
- **System Analysis:** Since the IAIABC EDI "modules" are designed as part of a coordinated approach to data capture and analysis, use of the IAIABC medical standard along with the IAIABC claims standard would allow direct matching of medical bills to both disabling and nondisabling claims; thereby providing data for the entire workers' compensation system.

Implementation Guidelines:

- Develop a plan to migrate from the Bulletin 220 reporting to IAIABC-format medical bill reporting. The plan should include stakeholders and consider both their concerns and the system's business information needs. The plan should provide a phased implementation to allow partners sufficient time to reprogram, while still continuing to report Bulletin 220 data until changeover. (This will prevent major breaks in medical bill data needed for DCBS policy makers, MAC, MLAC, and other stakeholders.)
- Together with reporters, develop a schedule for a "soft mandate" of IAIABC medical bill data, an assigned implementation schedule, and a variance request process to allow for potential unforeseen delays in programming.
- The planning team should consider the costs and benefits of outsourcing a new medical bill database in the Oracle environment, as well as EDI file programming and data mapping. Since DCBS' existing database of medical bill data is not being migrated to Oracle and a new Oracle database will have to be developed to capture

IAIABC standard data, it may be a better use of internal resources to concentrate on EDI claims programming and allow experienced outside vendors to develop an EDI medical bill system.

2) Concurrently with Recommendation #1, provide staff support to the IAIABC EDI Medical Committee for development of the provider-to-payer HIPAA standard.

Rationale:

- **Organizational Support:** The IAIABC, as a volunteer organization, has limited resources to develop EDI products. The EDI Medical Committee has focused its attention on developing the “payer-to-state” standard for reporting medical bills, which has recently been completed and is being adopted by California, Texas, and others. The “provider-to-payer” standard is the next task for the Medical Committee. By serving on this committee, we can assure that Oregon’s concerns and issues are fully considered as well as develop an in-depth understanding of the standard.
- **Software/Vendor Support for Providers:** EDI achieves maximum efficiency and value as an integrated part of a complete system of data sharing. The development of the provider/payer standard will be an important incentive to both providers and payers to adopt and fully realize the potential of EDI medical bill reporting, since commercial software and support will be made available as soon as the standard is ready.
- **Reporting Streamlining:** Development of the provider/payer standard will ease the reporting burden on insurers, bill reviewers, and other submitters of medical bill data by allowing providers to create the medical bill “data stream” so that payers can add their own payment data to the originating data before passing it on to the state. For existing Bulletin 220 reporting, payers must create the entire data record “from scratch” before submission to DCBS.

Implementation Guidelines:

- Assign one or more staff (suggest one IMD and one WCD) to participate in the IAIABC EDI Medical Committee as working members to expedite the development of the provider/payer medical bill standard. This participation will involve participation in monthly teleconferences, completion of interim assignments and reviews, and attendance, if possible, at two out-of-state meetings per year.
- In return for staff participation in the EDI Medical Committee, WCD and IMD will gain an in-depth understanding of the national standard that will allow a more effective, efficient and smoother implementation of medical data reporting and analysis.
- Begin internal analysis of requirements for a new IAIABC-compliant database and EDI programming, contact vendors for rough cost estimates of a new system, include in budgets, develop a Request for Proposal (RFP), and work with a chosen vendor(s) to implement the new system.

3) Create a stakeholder taskforce to seek and develop opportunities to streamline and simplify current medical reporting – the information flow from medical providers to payers (industry including insurers, self-insured employers and TPAs). This task force could be combined with a taskforce reviewing similar issues that have arisen as part of WCD’s function review activities.

Rationale:

- **Bridging the communication gap:** Medical providers operating within the workers’ compensation system are required to provide a myriad of reports and information to the industry. In fact, the MQI-REP team identified 38 possible reporting requirements for medical providers. As previously discussed, many of these reporting requirements and informational requests relate to compensability issues surrounding the major contributing cause (MCC) standard. Claims adjusters are often unable to determine compensability of the claim until they have clear, readable, and responsive reports from the medical provider.

Based on responses to the MQI-REP industry survey, when asked to identify the three most common issues with providers, the respondents listed the following:

- 1) Providers failed to send needed information on billings;
- 2) Providers did not reply timely to requested information by the insurer; and
- 3) Providers call the insurer for payment prior to the insurer’s acceptance or denial of a claim.

When respondents were asked to identify the most common issues with attending physicians, nearly 40 percent replied that the attending physician’s charts notes were unclear, incomplete, or unreadable. One third of the respondents replied that the information provided by the attending physician is inappropriate or incomplete. This data clearly suggests that gaps exist between the information/reporting needs of the industry and the medical providers’ understanding of those needs.

On the other hand, many respondents to the provider survey were critical of the repeated demands for information from the industry representatives. Historically, multiple information requests are consistently identified as a primary reason that some providers will not treat injured workers. Providers feel that insurer demands are not reasonable and insurers do not appreciate the impact these repeated requests have on their limited time.

Better communications and understanding seem to improve the situation for both sides. A few providers who have mastered a greater understanding of the workers’ compensation system and insurer needs report they receive fewer demands for reports and forms. Similarly, insurers who best understand the concerns of providers are able to obtain the information they need more successfully. As an example, a few years ago, a large provider group in southern Oregon met with SAIF and Liberty representatives to discuss their concerns. SAIF and Liberty agreed to provide a “single point of contact,” and arranged for other parties (such as vocational consultants) to obtain necessary medical information directly from the insurer, decreasing the repeated requests for more information from the medical

providers. The members of the provider group gained an appreciation of the importance of the forms and reports they were asked to provide, and were able to better provide the information the insurers needed.

Bridging the communications gaps will help both payers and providers understand and be understood, improving relationships as well as data flow. Simpler forms and requirements typically result in higher compliance and greater satisfaction for both reporters and receivers.

Implementation Guidelines:

- **Phase I: Create a joint taskforce that includes medical providers and staff, industry representatives, and department staff to:**
 - Discuss concerns, issues and needs of insurers and providers as well as “system” needs for data and information.
 - Review reporting requirements for medical providers, assess the importance and usefulness of the current requirements, and recommend modification or elimination of requirements that are not necessary or useful.
 - Create a liaison with the EDI/Data Review Committee (see Recommendation #1) to assure that the recommended medical reporting requirement modifications are consistent with the system data needs.
 - Review and recommend modification of forms so they are “user friendly” and effective in providing the necessary information.
- **Phase II: Create a WCD workgroup to:**
 - Determine and pursue rule and statute changes required to implement the taskforce recommendations.
 - Develop or modify forms as recommended by the taskforce.
 - Report back to the taskforce to review rule, statute and form changes.
 - Create a liaison with the Outreach Committee (See Recommendation #4) to provide a feedback loop so that any recommended changes are included in future outreach and training activities.

4) Develop outreach programs and provide navigation tools to assist medical providers in efficiently participating in the workers’ compensation system. This recommendation is consistent with a recommendation from the Treatment & Guidelines Committee to develop training and outreach, and the charges included in this recommendation should be given to the committee implementing those recommendations. The team notes that this project overlaps with many recommendations that have arisen from WCD’s function review activities. The outreach and training project can be approached comprehensively, or, alternatively, in a planned series of small increments.

Rationale:

- **Bridging training gaps:** As discussed earlier, the complexity of the MCC standard, coupled with the requirement that it is incumbent upon workers to file a

claim for a new or omitted condition, often creates a knowledge/understanding gap for medical providers.

- According to the MQI-REP Insurer Survey, when insurers were asked to describe “other” issues with providers, 45 percent replied that a medical provider “contact” person was needed for complex conditions, time loss and/or return to work issues.
- One third of the respondents replied that providers need increased knowledge of the workers’ compensation system, increased information regarding insurers’ needs, and more knowledge regarding major contributing cause.
- As referenced earlier in this report, the gravity of this issue was captured in the MQI-REP team’s “pulse” survey of medical providers where 95 percent of medical providers indicated that when the provider’s diagnosis doesn’t match the insurer’s accepted condition, this creates a barrier to effective and prompt medical treatment of injured workers.”

Oregon Workers’ Compensation Educational Conference: In addition to the foregoing external surveys, the MQI-REP team received additional feedback during the 2006 “Oregon Workers’ Compensation Educational Conference” held in Salem on May 15 and May 16, 2006. Out of the total number of 375 conference attendees, a quarter identified themselves as medical providers. Attendees of the conference conveyed the following interests and concerns: delays in the processing and payment of medical bills, issues surrounding the communication of the “accepted” condition to a physician and/or specialist, the circumstances under which a provider would be required to complete Form 827, and the process requirements and differences between palliative care and curative care.

These questions and concerns, not only reinforce the information received from the MQI-REP surveys, reflecting providers frustration with the billing and reporting process, but they also provide guidance in identifying stakeholders’ focus areas during the development of outreach/educational material for the MQI – Provider Outreach Project (see below).

- **Providing Navigation Tools:** Medical Providers engaged in the workers’ compensation system, not only are required by the system to timely and accurately submit reports, but they are also requested by insurers and numerous WCD programs to provide additional clarifying information on a case-by-case basis. The complexity of the system clearly impacts the limited time and resources of the medical community, which subsequently impacts the willingness of medical providers to continue to participate in the workers’ compensation system. Although the Workers’ Compensation Division currently provides training through its Benefits Consultation Unit (BCU) and Medical Review Unit (MRU), this training is usually offered on request due to the “issue-specific” topics in dispute. On a limited basis, BCU and MRU provide more comprehensive “rules” training, but due to limited resources, the education/outreach is again based on requests from providers, rather than being comprehensively “marketed” to those providers. The MQI-REP team therefore recommends that WCD develop a comprehensive Provider Outreach

Project with the goals of assisting medical providers in navigating through the system and which achieves the values/goals of the Medical Quality Initiative.

Implementation Guidelines (These guidelines can be adapted for a comprehensive or incremental approach) – MQI Provider Outreach Project:

- **Phase I:**

Identify Current Practice/Best Practice The Medical Provider Outreach Project will commence in June 2006, with the preparation of a Charter Statement and timeline. The initial phase of the project will include the organization of an internal WCD workgroup to identify current training resources, review stakeholders concerns/needs as set forth in the MQI-REP interim summary reports, and identify stakeholders for an external advisory group. During the initial phase, the workgroup will identify external stakeholders who have established “best practices” in their clinics/offices. “Best Practices” will be defined as those processes that exemplify efficient and cost-effective procedures, which reflect the MQI goals (as stated above). The WCD workgroup will consult with “Best Practice” groups in developing the outreach training material. In addition, the project team will research and identify continuing education requirements for medical office providers and staff and identify conferences in which the Provider Outreach Project may participate.

Integrate with External Health Policy Committee/Groups It is important that the Provider Outreach Project be developed with input from key stakeholder groups such as the Oregon Health Policy Commission and the recently formed Governor’s Task Force relating to the installation of electronic health records. These groups are currently addressing electronic health records and interoperability in Oregon. From a health care “system” standpoint, it is imperative that the Provider Outreach Project, in its development of consultation/training material, be responsive to these other health policy initiatives.

- **Phase II:**

Develop Training Modules The second phase of the project will focus on the development of training modules. These modules will provide training material based on training needs as defined in the MQI-REP Provider Survey.

- The three topics of most interest to providers were:
 - 1) billing in relation to treatment disputes;
 - 2) claim acceptance/denial; and
 - 3) billing in relation to coding issues.

Based on this feedback, the project team will develop training modules that address these issues. The training modules will be developed to include a variety of training methods, including in-person training, Web-based training, and conference presentations.

- **Phase III:**

“Beta Test” the Training Modules The third phase of the project will “beta-test” the training modules with external stakeholders. In this phase, training teams will identify methods to “beta test” not only the training methods, but also the training/outreach material. After the “beta tests,” the project team will revise the training/outreach methods and material and prepare an initial timeline for implementation.

- **Phase IV:**

Implement Methods and Material The fourth phase of the project involves the implementation of training/outreach methods and materials. The project team will develop a one-year Provider Outreach training plan, which identifies outreach opportunities through in-person training, conference participation, and Web-based material. Additionally, the project team will determine the need for cross-program training within WCD. If cross-program training is determined to be beneficial, the project team will develop a cross-program training and implementation plan.

- **Phase V:**

Evaluate Project The fifth phase will evaluate the project by contacting each of the participating providers to determine if the outreach methods and material assisted the providers in navigating the system. The evaluation criteria will focus primarily on the goals of improving partnerships among system stakeholders and providing resources/guidance to medical providers.

IV. Summary

The MQI-REP team appreciates the opportunity to work on this exciting project. We welcome questions and comments on the findings of our study, and look forward to its further development. We ask that WCD Executive Team approve the adoption of our four recommendations:

- 1) Plan a transition to adopt the HIPAA- and IAIABC-compliant EDI (Electronic Data Interchange) medical reporting standard in place of the current proprietary Bulletin 220 reporting;
- 2) Concurrently with Recommendation #1, provide staff support to the IAIABC EDI Medical Committee for development of the provider-to-payer HIPAA standard;
- 3) With stakeholders, seek and develop opportunities to streamline the current medical reporting system; and
- 4) Develop outreach programs and provide navigation tools to assist medical providers in efficiently participating in the workers’ compensation system.