

Medical Quality Initiative External Meeting Discussion Salem – 11/18/05

There were a total of 24 stakeholders who attended this meeting. They included the following: medical providers, pharmacy representative, workers' compensation insurers, employers, MCO representatives, self-insured employer, representatives for injured workers, chamber of commerce, 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

Focus on outliers. **Fifteen (15) votes**

Pick 3-4 top drivers – PT, high drug cost (treat pain with oxycontin) **Eleven (11) votes**
-- Guidelines not enough
– look at diagnoses, procedures.

Limits (30, 60, 90 day) for Primary Care Provide. **Eight (8) votes**
– it's difficult to manage care for PCP.

Don't mirror Washington's Rules. **Four (4) votes**

ACOEM guidelines are created with WC in mind. **Three (3) votes**

Benchmarks evidence based data. **Two (2) votes**

We need standard to refer to Evidence Based Medicine. There is a place for evidence based medicine. **One (1) vote**

Visit limits on non-certified providers. **One (1) vote**

PT visit limitations (in rule?) review of referrals. **One (1) vote**

Cooperation, education of all providers. **One (1) vote**

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

Make sure guidelines are flexible and meaningful.
Do MCO's have guidelines?
Physicians would be open to guidelines – not mandatory.
Is there really a problem?
More analysis of cost drivers.
Over utilization of MRI's?
Community-created guidelines are slow and troublesome.
Need pathways to resolve care outside of guidelines.
Diagnostics to address malpractice.
Expand 30/12 limits to get more opinions.
Basic guidelines to treatment . (e.g. Other opinion after 6 months)
Guidelines- Need way of monitoring
 – otherwise accomplish nothing
 -- bureaucratic nightmare.
Guidelines--Need to be taught, based on national standards – ODG, ACOEM, MDA (lesser known)
Enforce through education, seminars.
Train physicians on guidelines, certification.
Need to be accepted.
Evidence-based medicine.
Guidelines alone – need more education high-volume and community.
Provide incentives for following/using.
Two groups of physicians – not much workers' comp. - primarily worker's comp.
We are the leaders no need to follow other states.
Include all providers, not just physicians.
Work with PT to reduce costs.
Geographic differences.
Guidelines on extremes with appeals. (e.g. limit to 30 visits.)
Guidelines: Framework, function, and enforcement.
Improve provider-to-provider communication.
Peer Review.
Don't fix what's not broken.

Expanding MCO's Discussion

Don't push MCO's as a solution, without any evidence that there is cost savings. **Three (3) votes**

Need MCO's in low population areas. **One (1) vote**

Strengthen MCO system –
 Encourage enrollment **One (1) vote**
 Enroll sooner **One (1) vote**

Educate physicians
Hold physicians accountable
Encourage RTW

MCO's resource for workers who can't get treatment. **One (1) vote**

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MCO – insurer partnership.

There is no clear evidence that MCO's are cost effective not cost effective overall.

Evidence inconclusive.

Some MCO's force physicians into limited situations, limited equipment, inaccessible providers.

MCO's vary greatly.

No big effort to recruit new members into MCO's.

Need analysis to make intelligent decision. Is there evidence from other jurisdictions?

Managing Care Outside of MCO's Discussion

Outliers – Questions regarding enforcement issues. **Six (6) votes**

Outside of MCO's who can control/remove them?

Create universal case management for conditions. Do not have insurers required to provide it. **Two (2) votes**

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Review must be given by peers within same specialty(s).

Lack of objective treatment standard creates opportunities for conflict. If we could reduce conduct/ we would reduce cost.

Preauthorization is O.K. as long as it doesn't slow down the process of helping the patients.

How can we ensure that AP's make decisions that lead towards medical improvement.

Can we have medical arbiters be expanded the review AP's medical decisions.

Arbiters are practicing and credentialed physicians.

Allows for review outside of MCO's.

Getting back to work.

Workers have rights and responsibilities.

Physician case managers – need to recognize good ones.

Provide incentives – professional, financial (no pay cut).

Identify the 20% group of workers who have continuous treatments.

Most money is being spent on the small group of people.

Recommend doctors required to send record to PT if feasible. At least advised of specific treatment.

Discussion Topic: Reimbursements

General Discussion Regarding Reimbursements

Proper utilization of pain management. **Seven (7) votes**

- pain management guidelines
- do not reduce medical fee schedule.

The preferred provider must meet X number of CE credit in WC. **Four (4) votes**

Don't pay extra for paperwork – reduce paperwork. **Four (4) votes**

Require use of HCPCS for medical supplies no longer use CPT for general supplies.
Three (3) votes

Reimbursement rates must stay where they are. **Three (3) votes**
If dropped – recruitment will be an additional issue.

Provide means for MCO's to reward good/best practices. **Two (2) votes**

Financial incentives should not influence treatment decisions. **Two (2) votes**

Markups on devices outrageous – doesn't seem to be any science to it. **One (1) vote**

Manage DME and drugs. **One (1) vote**

Use some sort of sanction. **One (1) vote**

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Dollar amounts okay / hassles are excessive.

- Treatment plans.
- MCO's require sign off before treatment can begin.
- Delays starts off care and AP knows what's going on.
- PT doesn't always get enough medical information/record.

Review DME fee schedule; vendor must provide proof of safety and efficacious.

Reduce hassles for physicians.

Permit payments above fee schedule to providers that exhibit good outcomes (RTW, lower severity, etc.)

Identify and limit outliers.

What about cherry-picking easy/less severe claim? Consider a deposition(?) fee schedule.

How to reward the good doctors?

Require consult after X number of days/visits.

- maybe 60 days because of claims acceptance process.

Unlimited choice for first 60 days, then limited provider choice. Then be referred to

physician with good track record.
Allow travel over 60 miles for consults.
Flexibility on travel rules for different geographical areas.
Focus of medical necessity of travel vs. the possible inconvenience.
Reduce the paperwork (the multiple reports of the same information.)
 By reducing paperwork; more physicians will provide care.
Streamlining the process of paperwork to bring in new provider.
Focus on the key elements of information required to move the claim forward.
Allow for reimbursement of advice/counseling.
Do not reduce rates without offsetting benefits.
Current levels are good.
Perform comprehensive comparison analysis.
 Across systems (Medicare etc.)
MCO designs own fee schedule.
Incentive programs:
 Financial incentives to workers for preferred providers.
 Higher rates to certified providers.
Fee schedule for forms/reports.
Any incentives should be very clear to avoid conflict.
Study RUU differences between Medicare and WC.
Ambulatory surgical center fees – high.
 Not big problem in Oregon yet but could be.
 Theoretically should be more efficient.
Cost of IME's huge.
No fee schedule for WRME's.
Independent technology assessment.
Use arbiter panels.
Don't want to cut fees, but do need to review to ensure parity – these are complex cases.
Need to accept condition is one of the drivers
 – hassle factor
 -- what makes clinical/medical sense doesn't always work in the system (not for the accepted condition, even though physician believes it is.)
Worker, not physician, needs to request.
Let AP start process if evident related to injury.
Go back and revisit reimbursement, to reduce it will create many problems.
Should incentives be given to small town doctors?
 No – it doesn't help to pay extra to poor doctors.
Pay providers extra for “hassle factors” – key functions they provide.
Try electronic billing – dramatically reduce hassle factor.
Paper is a hassle – but is it a relative hassle?
 Where are complaints coming from?
Scanning items into electronic world, proves to be problematic.
Focus on sorting of communication and hassles; don't change the fee schedule.

Managing Pharmacy Costs Discussion

Formularies – MAC role in developing and managing. **Three (3) votes**

Dept. provide direction to create and use formularies (reg. the use of.) **Two (2) votes**

Create formulary or borrow/steal. **Two (2) votes**

Keep moving to generics. **Two (2) votes**

Review off-label prescriptions/ reg. using std. Rx therapy first. **One (1) vote**

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Require the use of generics.

Generic substitution vs. therapeutic equiv.

Bulk purchasing.

Discussion Topic: Education/Certification

General Discussion Regarding Education/Certification

Require that certified providers are educated on WC system/rules. **Four (4) votes**

Education helps you navigate thru the system. **Four (4) votes**

It will not necessarily make any better physicians.

Provide help to providers understanding “major contributing cause” and pre-existing conditions? Provider education/certification. **Three (3) votes**

Certification could provide PCP’s an “out” from WC if they don’t want to do WC. **Two (2) votes**

Pay more for certified. **Two (2) votes**

Patient education issues. **Two (2) votes**

Review of clinical options with workers.

Provide light-duty descriptions to workers.

If certified, waive pre-authorization. **Two (2) votes**

-- streamline, fast-track

– less documentation, burden.

-- no need to justify brand name.

Physicians not trained in system. **One (1) vote**

Worker comp. boot camp. **One (1) vote**

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Education of worker demographics (education levels, etc.)
Education of the provider community on the WC system and occupational medicine in general. Clarification of med-stat to AP's review the AP role and decision-making; especially regarding WC decisions.
Educate provider of methods to improve communication with workers.
Acknowledge different cultures within Oregon.
Need something between MCO and certification.
Administrative requirements, not clinical competency, for providers and managers.
Certification--Incentives for example fee schedule + 5%
Certifications should not waste doctor's time or the money of taxpayers.
Certification must be taught peer to peer.
How do you force individuals to participate?
MCO made education – mandatory.
More education on the WC system.
Could trainings be sent out on CD-ROM/paper?
Is there enough time in a day to watch/read them?
Effective, but not onerous.
Hard to be selective.
Would increase efficiency, not manage behavior.

Discussion Topic: Other Ideas

Other Ideas Discussion

Is the M.A.C. effective.
Let insurers weigh in on M.A.C. decisions.
Does M.A.C. feel their role is as effective as they want?
