

# MEMORANDUM

August 27, 2004

**To:** John Shilts, Administrator, WCD  
WCD Executive Team

**From:** Nancy Bieber, Manager, RDRS

**DRAFT**

**Subject:** Proposal to pursue a medical quality initiative including:

- Medical provider certification
- Development of treatment guidelines
- Contract with a Medical Advisor to WCD

**Background:** Medical service costs in workers' compensation are increasing at rates exceeding inflation in most jurisdictions throughout the United States. At the same time, and partially as a result, the percentage of workers' compensation costs attributable to medical services is increasing throughout the country. According to NCCI, in 1982, medical costs comprised 40% of all claims in NCCI states; by 2002, these costs comprised 53% of all claims. In Oregon, the percentage of medical costs is even greater, at 61.6% by 2002. NCCI reports that between 1993 and 2001, the average severity in an Oregon workers' compensation case increased at an annual rate of 8.7%, well in excess of wage growth over the same period of time.

In 2002-2003, a special external advisory group of insurers, doctors, and employer and worker representatives, reviewed physician fees governed by the Division 09 rules. Oregon fee schedules are among the highest in the nation (WCRI), but Oregon's medical costs per PPD case is lower than the regional average (NCCI). WCD presented the results of a survey of primary care and specialist physicians to the group. The survey showed that doctors believe there are more "hassle" factors involved in treating injured workers than other patients. Some doctors indicated they do not treat injured workers because these factors are too great, and others, especially the specialists, feel the current compensation rates do not compensate adequately for the "hassles." The members of the special advisory committee agreed to maintain the relatively high fees allowed in the Oregon fee schedule, while making some adjustments between fees for categories of services. The committee members stressed the importance of providing excellent medical care to Oregon injured workers, but emphasized results oriented medicine that results in return to work and optimal recovery for the worker. **The members of the special advisory committee unanimously agreed in principle to finding a way to identify and reward those providers who demonstrated the best understanding of the principles of workers' compensation and had the best results in returning injured workers to work.** This would also better compensate the doctors who best manage the "hassle" factors.

Over the same period of time, the Medical Advisory Committee (MAC) has reviewed a number of treatment modalities at the request of stakeholders. **MAC members have urged WCD to develop some guidelines to help Oregon providers, workers and insurers evaluate what the evidence is that supports certain treatment standards for conditions or specific modalities, as a means to assure consistent high quality service while reducing inappropriate, unnecessary, excessive or ineffective care.** MCOs and many states have developed mandatory or advisory guidelines to assure quality care to injured workers while controlling the costs that occur in providing less effective or equally effective but more costly treatment. Colorado is an example of a jurisdiction that has developed a certification program for its medical providers, and these include ten treatment guidelines. The Colorado guidelines are not mandatory, but they are presumptive in that treatment provided within the guidelines is generally considered compensable, while treatment outside the guidelines must be specifically approved by the insurer or state decision makers. According to Dr. Kathryn Mueller, Medical Director of Colorado's Division of Workers' Compensation, the guidelines significantly reduce disputes, assist workers in obtaining treatment supported by evidence and community standards, and allow flexibility to allow each worker to receive individualized medical care. While the motivating factor behind the development of the guidelines is not cost, the guidelines do help reduce excessive and unnecessary care and provide parameters for approval of certain modalities.

**Some resources are currently available to help defray some planning and development costs.** The state of Oregon was selected to participate in a grant through the University of Massachusetts Center for Health Policy and Research. This grant funded consultation with researchers at the University of Massachusetts, an extensive consultation with Dr. Mueller, and will provide funds to bring advisory groups together to assist WCD with these projects.

Finally, I believe **a gap was created when WCD eliminated the role of medical advisor.** Medical Advisory Committee members, WCD staff and volunteer medical experts have filled much of the gap, some well and some not quite so well. For example, it has taken up to four years to obtain necessary input and advice from volunteer experts to make adjustments to the disability standards, because the volunteers have had to work on our issues during their spare time. In addition to providing support to this proposal, I believe there are other important services a Medical Advisor could contribute to the WCD and to the workers' compensation community, which will be described more fully below. Based on prior experience, however, there does not appear to be sufficient need to recreate a full time Medical Advisor position.

The following proposal is designed to address:

- Increasing medical costs,
- The perceived need provide incentives to medical providers to attend to the special needs of workers' compensation patients and insurers, and
- The need for a part-time medical advisor, while
  - Helping to assure quality medical care for Oregon's injured workers,
  - Promoting functional outcomes, including return-to-work, and
  - Reducing and simplifying medical disputes.

**Business Benefit Analysis.** This case examines the costs and benefits of pursuing this comprehensive Medical Quality Initiative. It recommends contracting with a medical doctor to fill gaps created by the elimination of a full time Medical Advisor which cannot be adequately filled by volunteer advisors; developing a few medical treatment guidelines, and the developing a medical provider certification program to train, identify and reward those providers who understand and agree to comply with the special needs of the workers' compensation system. It recommends using the current Medical Advisory Committee (MAC) and the WCD Executive Team to determine the scope and boundaries of the Medical Advisor position and using MAC, WCD staff and special task forces of volunteers to develop treatment guidelines and a certification program.

The purpose of this business case is to help the director, administrator and executive team determine whether or not to expend Premium Assessment Operating Account (PAOA) funds to contract with a Medical Director, and if so, to develop a plan to determine how much to allot and how much benefit to demand from/expect from the position. Based on the data presented below, it is my recommendation that WCD approve the concept of contracting with a medical doctor to serve as a part-time Medical Director. Ultimately to the extent determined appropriate by the director and administrator, based on the recommendations of the Medical Advisory Committee (MAC) and the WCD Executive Team, the Medical Director would support special medically related projects including medical provider certification and the development of treatment guidelines; support standing MAC and the Management Labor Advisory Committee (MLAC); provide medical expertise to the director and the division; assist in recruiting and retaining medical arbiters and volunteers to advisory groups and MAC; and provide any other services determined appropriate by MAC and the WCD Executive Team. The purpose is also to examine the costs and benefits of pursuing certification and the development of treatment guidelines.

In order to control the acceleration of medical costs and assist in holding down the costs of workers' compensation in Oregon, the following is proposed:

**Proposal specifics:**

- I. Proposal:
  - A. Development a certification program for primary medical care
  - B. Develop some advisory treatment guidelines
  - C. Contract a part-time Medical Consultant to facilitate A & B and provide other services to WCD.
  - D. Develop an implementation plan for the above.
  
- II. Components
  - A. Certification: *Develop via consensus of stakeholders a program to certify medical providers as providers who understand the workers' compensation system and agree to facilitate the goal of "restoring the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent possible." Certified providers would agree to support this goal by providing*

***prompt and adequate treatment focused on functional improvement, assisting in claim management by understanding the basic principles of the medical/legal system and providing adequate and timely information, and assisting in returning workers to the workplace as quickly as possible. Components need to include training materials and methods, certification process, criteria for maintaining, renewing, restricting or revoking certification, and modifications to the fee schedule to support the program.*** Questions and issues include:

1. Certification as a
    - WC specialist?
    - Disability Management specialist?
  2. Certification of
    - Doctors?
    - Chiropractors?
    - Authorized Nurse Practitioners?
  3. Possible benefits to providers:
    - Training/competency in disability management?
    - Higher pay?
    - More referrals?
    - Special pay (i.e., “time” billing under E&M for disability management activities)?
    - CME credits?
    - Enhanced credibility?
  4. Benefits to others if providers are trained in disability management:
    - Faster return-to-work times benefit everyone in the system.
    - Focus on functional recovery and patient participation yields more positive outcomes.
  5. Considerations:
    - Who develops the materials (Oregon providers, OMA, MAC, WCD?)
    - How is it presented? (Seminars, home study, on-line?)
    - How are providers certified (Testing, self-certification, completing training?)
    - What are the FTE needs within WCD to provide training and certification?
      - Could the program self-support through charges to providers?
- B. Treatment Guidelines: Develop ***or adopt treatment guidelines for a few key conditions or selected procedures to facilitate appropriate treatment of injured workers, consistent with research findings and community standards; that promote an emphasis on functional results, including return to work and activities of daily living; and reduce disputes and litigation by developing a set of guidelines generally supported by all stakeholder groups. These guidelines would become part of the body of knowledge required for certification. The guidelines could also create presumptions about the appropriateness of treatment to reduce and simplify medical disputes.*** Questions and issues include:
1. Do we have the statutory authority to develop some?
    - Advisory guidelines – probably so

- Guidelines that bind or create presumptions - ?
  - 2. Broad (systems, broad categories of treatment) or Narrow (e.g., IDET)?
  - 3. Evidence based, consensus based, combination?
  - 4. How much can we borrow from what already exists (Wash, Colo, and other states)?
  - 5. Process issues:
    - role of MAC
    - role of medical providers
    - role of other stakeholders
    - role of WCD staff
  - 6. Scope
    - How many guidelines?
    - How quickly developed?
    - How often reviewed?
  - 7. Considerations
    - Can we get sufficient community support to
      - Buy in?
      - Help develop and deliver training, guidelines?
    - Include training in guidelines in certification training
    - WCD FTE/staffing issues
      - Paid/contracted medical director to chair development of standards and guidelines.
      - Can we get sufficient volunteer assistance from the medical community?
      - Project management/support staff within WCD.
- C. Hire a contract Medical Director: ***Hire (through a personal services contract), a part-time Medical Director for the Oregon Workers' Compensation Division to provide rapid medical advice to the Director, Administrator, and division staff; support the Medical Advisory Committee; and serve as a project coordinator for medically related projects.*** Advantages and risks include:
1. Advantages
    - Increase medical expertise within WCD
    - Speed the development of new rules and standards by faster, in-house response to medical questions.
    - Increase credibility for WCD medical policies and decisions with medical community and other stakeholders
    - Improved satisfaction and participation of volunteer medical advisors, medical arbiters and physician reviewers
    - Increased stakeholder satisfaction.
    - Better control of medical costs.
  2. Costs & risks
    - Can we find a consultant who is seen as unbiased and credible?
    - \$25,000 to \$50,000 per year for pay, travel, office space, etc.?
    - Can we find a consultant who understands the needs of the WC community?

- A consultant might pursue his/her own agenda.

### III. Implementation (Dates are **very** tentative)

#### A. Assess and develop medical community buy-in:

1. August – October: Build alliances with professional medical groups and other stakeholders:
  - Make presentations at professional groups, starting with OMA.
    - Contact groups, schedule presentations or opportunities to dialogue.
    - Conduct meetings & dialogues.
  - Give a presentation to MLAC to advise them and seek their endorsement for this project.
  - Recruit a full Medical Advisory Committee, seeking opinion leaders to serve on the committee.
    - Identify and recruit two new doctors who will provide credibility and energy to the committee.
  - Obtain MAC commitment to:
    - Endorse the proposals to develop a certification program and treatment guidelines.
    - Advise the administrator on what areas to begin with to develop guidelines.
    - Assist in choosing and recruiting medical providers to serve on task forces to develop guidelines and assist in developing a certification program.
    - Agree to review task force recommendations on a regular basis.
2. By January 1<sup>st</sup>, hire a Medical Advisor: This step will be viewed positively by the medical community as an indication WCD seeks and values medical expertise.
  - Determine what qualifications, background, job duties etc. are appropriate for this position: MAC and WCD Exec. Staff
  - Submit a RFP.
  - Identify/recruit any doctors seen as good fits for this position.
  - Select and “hire” a Medical Advisor.

#### B. Develop certification program:

1. October, 2004 to June, 2005: Utilizing a multidisciplinary advisory panel, plan and develop a certification program, including training materials, and a plan for renewing certification, continuing education requirements and provisions to discipline. (Grant monies will help defray advisory group expenses.)
2. June to December 2005: Develop rules to implement certification, provide for revocation and other disciplinary actions.
3. 2006 and onward:
  - Certify medical providers.
  - Provide continuing education materials/programs.
  - Review disciplinary questions/issues.
  - Periodically review and revise program if and as necessary.

C. Develop treatment guidelines:

1. October to December 2004:
  - Develop procedure for promulgating treatment guidelines.
  - Determine scope of guidelines (broad versus specific treatment; broad versus specific diagnosis, many versus few, etc.)
  - Develop other parameters for promulgating guidelines, such as adoption of guidelines produced by other jurisdictions.
2. November 2004 – January 2005: MAC selects first condition for development of treatment guideline and helps WCD select members of task force to develop guideline.
3. February 2005 – July 2005: Task force creates first treatment guideline. Guideline is incorporated into training for certification.
4. July 2005 – September 2005: MAC and WCD develop schedule for future development of treatment guidelines.
5. October 2005 and onward: Continued development and revision of treatment guidelines.

**Costs:**

The costs of this proposal are:

\$25,000 to 50,000 per year for the actual cost of the contract to hire a medical advisor.

The cost of recruiting (RFP)

The incidental costs which the incumbent will incur (travel, per diem, etc.)

The costs of providing a work area, if a work area is provided.

WCD staff to manage and staff task forces to development guidelines and a certification program.

Costs incidental to task force meetings, such as transportation, copies of documents, etc. *Note that some of these costs will be offset by grant funds.*

**Benefits:**

The benefits derived from these expenditures may not yield direct cash benefits or savings to the PAOA, but will provide:

- Increased stakeholder satisfaction;
- Encouragement to doctors to obtain training on occupational, outcome based medicine;
- Improved partnerships between medical providers, insurers and employers in helping injured workers return to work;
- Enhanced overall management of claims;
- Reduced need for IMEs because of increased clarity of standards of care and the increased ability of attending physicians to respond to insurer requests for information;
- Improved medical services to injured workers;
- Better control of medical costs;
- Fewer and simpler disputes and lower litigation costs;

- Prompter development of new rules and standards because an internal expert medical opinion could be very helpful in making policy and rule decisions. (WCD has taken a number of issues to MAC and volunteer doctors. However, because we must work with volunteers on an “as available” basis, it has taken literally years to complete some fairly simple changes to the medical rules and disability standards);
- Improved satisfaction and participation of volunteer medical advisors, medical arbiters and physician reviewers. (There is a tendency for a medical doctor to have a higher level of credibility and persuasiveness with another medical provider than a lay person might have);
- Increased credibility for WCD medical policies and positions;
- Assistance to WCD staff in making medical determinations; and
- Expert medical training for the division and stakeholders

**Assumptions:**

1. A medical doctor has specialized knowledge, skills and expertise.
2. A medical doctor will have greater credibility than WCD staff with both other medical providers and with the lay population on medical matters.
3. We can find a medical doctor who is willing and able to provide part-time assistance to the division at an affordable cost.
4. We can find a medical doctor with excellent “people” skills, communications skills and an ability to work collaboratively with WCD staff, stakeholders and policy makers, as well as with the medical community at large.
5. A Medical Advisor to WCD must not only understand medical issues but also the legal and political climate.
6. In order not to create the appearance of bias, the medical advisor probably should not perform (or continue to perform) insurer medical examinations within the workers’ compensation system.
7. A Medical Advisor to WCD needs to be able to manage projects, timelines and workloads effectively.
8. A part-time Medical Advisor would advise, but not be a part of, the WCD Executive Team.
9. The need for medical expertise will increase over time because of projects that support our strategic plan:
  - possible development of a drug advisory council
  - pressures to increase (and decrease) medical fees

**Scope and Boundaries of this Proposal:**

1. Initially, the scope in terms of responsibility for this position would be solely with the Workers’ Compensation Division. However, the scope could be expanded over time to provide advice to the Director’s office or other divisions within the department.

2. This proposal is for an on-going, long-term contractual arrangement and two initiatives (physician certification and the development of treatment guidelines) that will become long-term operational activities.

**Conclusions:**

Medical costs to the workers' compensation system are accelerating at rates far greater than the general rate of inflation. Quality medical care is an essential attribute to the Oregon workers' compensation system, as is returning injured workers as quickly and completely as possible to pre-injury status, both medically and economically. Oregon needs to take action now in order to assure continuing quality while controlling system cost growth.

Obtaining a medical advisor, developing a physician certification program and developing advisory treatment guidelines will keep Oregon in the forefront of workers' compensation reform, help control accelerating medical costs, and assure high quality, effective medical treatment.

The medical advisor will provide credibility and expertise to underlie the certification and treatment guideline initiatives.

The guidelines will provide guidance both to medical providers, WCD decision-makers, insurers and other stakeholders. Done right, the guidelines will be based on the latest evidence based medicine and/or reflect the consensus of Oregon medical providers as to what constitutes the best practices to treat certain conditions. Guidelines will reduce the number and complexity of medical treatment disputes and can also be used to make clear which party has the burden of proving treatment is compensable within or outside of the guidelines.

Certification will allow medical providers to learn the basics of workers' compensation principles and goals, and allow doctors to demonstrate their knowledge and understanding of those and of the treatment guidelines. It will encourage the best practices by rewarding those providers who know, understand and agree to follow the basic principles of functional based medicine, return-to-work issues and the needs the system has to work optimally.

**Recommendation:**

Approve and adopt as proposed or modified.