

Orientation to Issues Involved in:

The Accessibility, Costs, and Quality of Workers' Compensation Medical Care

This self guided learning session is designed to provide participants with a broad introduction to the issues of accessibility, costs, and quality in the provision of medical care to occupationally ill and injured workers. The specific learning objectives are to:

- 1) Provide participants with an overview of key concepts and issues related to the accessibility, costs, and quality of workers' compensation medical care
- 2) Provide specific examples of efforts to improve and measure the accessibility, costs, and quality of workers' compensation medical care
- 3) Provide additional resources and opportunities for further study.

The session content will draw from the experiences and lessons of the Robert Wood Johnson Foundation Workers' Compensation Health Initiative (WCHI), as well as other relevant projects, publications and programs.

Orientation Module Outline:

- I. Introduction to Workers' Compensation Medical Care**
- II. The Access, Costs and Quality Connection**
- III. Access to Care for Workers:**
 - Primary Access Issues:
 - Insurance Coverage and the Uninsured
 - Establishing Causation
 - Claim Denials
 - Under-Reporting of Injuries and Claim Filing
 - Secondary Access Issues:
 - Restrictions on Provider Choice
 - Authorization and Utilization Review
 - Out of Pocket Expenses
 - Geography
 - Providers Unwilling to Treat
 - Tertiary Access Issues
 - Socio-cultural
 - Education and Awareness of Rights and Responsibilities
- IV. Cost and Utilization of Care for Occupational Injuries:**
 - Cost of Care Varies Tremendously by State and Within States
 - Utilization of Services Varies by State
 - Cost Containment Strategies Used by States
- V. Defining Quality of Care:**
 - Evidence of Quality Problems in WC
 - The Workers' Perspective

VI. Measuring Quality Care:

Examples of Quality Measures:

URAC MCO Performance Measures

Rhode Island Technical Resource Center Surveys

WCRI Workers' Survey:

Texas School of Public Health "WINS" Survey

The Role of Clinical Practice Guidelines

Evaluating the Minnesota Workers' Compensation Practice Guidelines

ACOEM Treatment Guidelines

Efforts to Simplify Reporting

VII. Return to Work Assistance and Outcomes:

Communication and Coordination

MidAmerican Collaboration

North Country On The Job Network

Training Case Managers

Georgetown/FECA RTS Training

VIII. Improving Quality Care:

A Summary

I. Introduction to Workers' Compensation Medical Care

The payment for medical care needed as a result of an occupational injury or disease is regulated by each separate state workers' compensation statute. In addition, Federal workers are covered under a Federal Employees Compensation Act and there are a few laws enacted by the Federal Government to cover workers who work on or adjacent to navigable waters (Jones Act and the Long shore and Harbor Workers Act) in addition to a few unique laws that cover specific exposures (Black Lung and Bilibrium are examples). Each state legislature decides the level of benefits available to injured workers in their state and provides the authority to state agencies who over see the administration of the law in each state to enact rules to ensure prompt medical treatment to ensure the worker can recover and return to work as soon as possible.

The payment of medical care under the workers' compensation laws differs from general health in a number of ways:

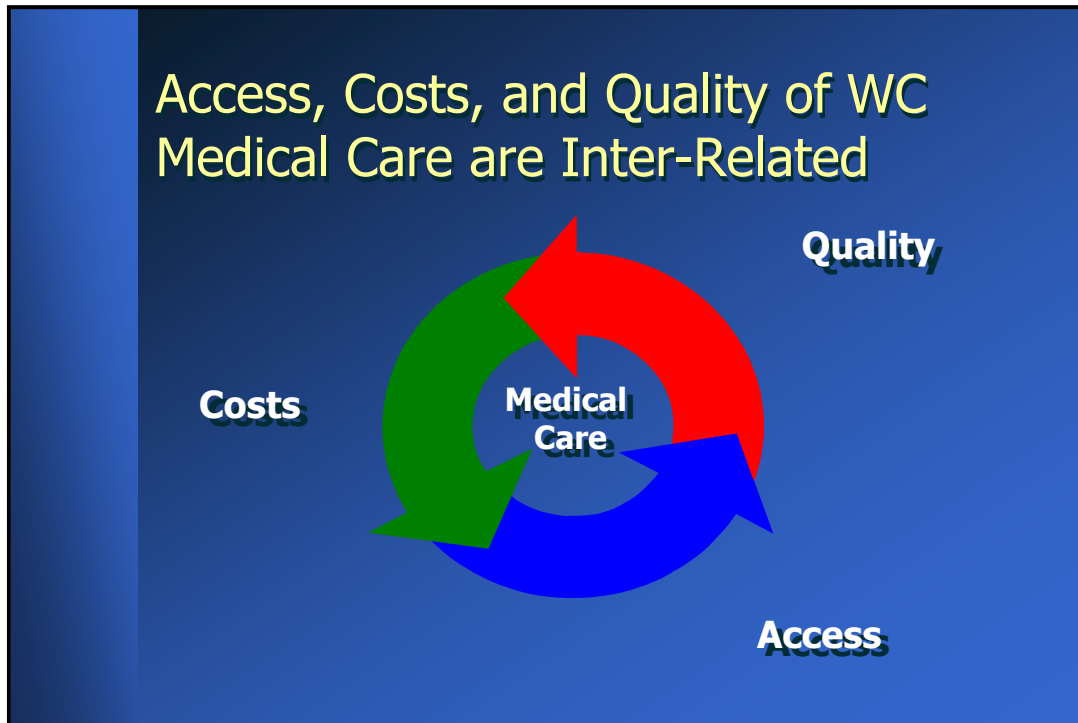
- ❑ Medical benefits for treatment of work related injuries in all states but Washington are financed through insurance premiums paid 100% by employers and not by the injured worker
- ❑ There are no deductibles or co-payments by the injured worker but the worker may be responsible for payment of non-covered or non-authorized treatment
- ❑ Care is delivered primarily on a fee-for-service basis and many states have enacted maximum fees that are payable for specific services, although managed care plans and other cost containment tools have been adopted
- ❑ Workers' compensation insurance generally pays for all medically necessary benefits and services, as well as current and future wage loss so return to work assessments often necessitates the need for qualified occupational health physicians, clinicians, and medical case managers
- ❑ Medical care needs to be closely coordinated with return to work efforts for the benefit of the employee's healthy recovery and to minimize the cost of lost wages to the employer.
- ❑ Entry into the workers' compensation system (and therefore access to medical care) is impacted by state workers' compensation laws and regulations governing coverage, eligibility, and compensability

II. The Access, Costs and Quality Connection

Health service systems are often examined or analyzed from the perspectives of the access, costs, and quality of care. This is certainly true in the general health care system and to a lesser extent has been true in the workers' compensation system. A theme that was underscored in many, if not all, of the WCHI grant-funded projects is the need to be aware of and consider the inter-relationships between costs, access, and quality.

In other words, policy decisions focused in one area are likely to have consequences in another – for example, implementation of a fee schedule to help address cost concerns may have an impact on access to care if providers perceive fees for certain procedures to be too low. Issues related to accessing appropriate care may impact treatment provided and subsequent recovery and return to work – key considerations in the area of quality.

Policymakers should be mindful of the interconnection of these factors that affect provision of medical care when enacting new policies. All three areas should be measured and monitored in order to ensure that policies enacted to contain costs do not negatively influence access or quality of care, or efforts to increase the access to care does not negatively impact costs or quality of care; or efforts to improve quality outcomes such as return to work and reduction of physical permanent impairments do not negatively influence other quality outcomes like satisfaction with medical care. There is likely a delicate balance between all these interconnected aspects of medical care delivery.



III. Access to Care for Workers

Understanding how system features impact who enters the workers' compensation system is an important first-step in understanding the medical care provided to injured workers. In this section we draw on access to care models developed in the general health care field. If we apply one such model developed by Arlene Bierman and colleagues that was used to examine care provided to older adults (*See Bierman, A. et al. 1998. "Assessing access as a first step towards improving quality of care for very old adults." [Journal of Ambulatory Care Management 21\(3\):17-26](#)), we can categorize primary, secondary, and tertiary access barriers for people with work related injuries and diseases.

Primary access issues involve who might not be able to access the workers compensation system at all because they are not considered employees, were working for an uninsured employer, have a condition not covered under the state act, have a condition that the payor deems not to be work related or not related to the injury, or for some reason the condition is not reported and handled as a work related injury.

Insurance Coverage and the Uninsured

Numerous state workers' compensation laws do not require small employers (those with less than 4 employees for example) to have workers' compensation coverage. Additionally, some states have tremendous challenges in ensuring that all employers that are required by law to carry workers compensation insurance actually do. For example, a grand jury in Florida found that more than 13 percent of Florida employers did not comply with coverage laws (AFL-CIO 2000). Also a Lucas and Sanford (1998) study found that frequent users of emergency care in an urban university hospital were less likely to have WC coverage than expected. Lastly, a study by Dembe (2001) found that as many as 11% of patients at a free clinic in central MA were receiving care for work-related conditions that should have been covered under WC.

Establishing Causation

Even when an employee has workers' compensation coverage, the treatment for which they are incurring medical expenses is not always accepted by the payor. Unlike general health policies, workers' compensation coverage is "per occurrence" coverage that pays only for medical treatment and supplies necessary to "cure and relieve" the effects of that particular injury, incident or occurrence. Medical treatment needed for conditions that require treatment at the same time as treatment for the work related injury or treatment that might or might not be causally related to the work related "occurrence" reported will likely not be paid voluntarily by the employer or insurance company. This can happen when there are conflicting facts on how the injury or illness came about and if it was related or "caused" by a person's work activities or when some treatment is accepted and being paid for but other treatment rendered at the same time is deemed not to be related to the worker related incident.

Claim Denials

The denial of workers' compensation claims causes particular access problems for patients. General health plans and auto insurance policies have exclusions for treatment resulting from an occupational injury or disease. Policymakers often assume if a workers' compensation claim has been denied, a patient should be able to show that denial to their health carrier and have access to medical treatment under their health policy. Unfortunately, this often does not occur, resulting in the patient being denied care for lack of the ability to pay for it or substantial loss of the patient's savings while the insurance companies fight over who should pay for the treatment. One particular WCHI was funded to design a process to resolve this for a group of workers in New York. (see [UNITE: Expanding Access to Workers' Compensation Medical Care for Low-Wage Immigrant Workers](#)) State regulations requiring coverage by group health during controversy may be stronger option than "payment without prejudice." However, only a few states currently require this.

Under-Reporting of Injuries and Claim Filing

Workers may be reluctant to report injuries due to fear of reprisals, lack of management support, safety programs, or personal tolerance for pain (Roberts 1997). Rates of underreporting are not well documented. Data from a Michigan surveillance system indicated that only 45% diagnosed occupational disease patients filed for benefits (Biddle 1998). Another study in CT estimated that only 10.6% with work-related upper extremity pain filed a claim for workers' compensation benefits. Lastly, a Harvard study of a large HMO found that physicians were failing to diagnose and report occupational asthma because detailed work histories were not conducted.

Secondary access issues affect the worker who is already covered under the workers' compensation statute and usually involves some access limitation caused by state laws, rules or regulations. These include restrictions on provider choice, delays or disagreements over authorization for treatment or utilization review requirements that result in opinions that some treatment is not reasonable and/or necessary; out of pocket expenses the worker may incur; access problems caused by remote geographical areas; and providers who may be unwilling to treat due to limits on fees or the requirements for pre-authorization, reporting or disputes.

Restrictions on Provider Choice

Employer or insurer limits on choice or change of provider: 37 states limit initial choice and 32 limit change. There is some evidence that limits may diminish worker satisfaction with care (WCRI National Inventory; Dembe 1998; Kyes et al. 1998)

Authorization and Utilization Review

Twenty eight (28) states mandate utilization review by MCOs and private payers. The impact on care and access of this type of regulation is still uncertain.

Out of Pocket Expenses

Additional secondary access issues might involve out-of-pocket costs for drugs that may be incurred up-front by a worker. These costs are reimbursed, but the worker is still required to pay up front. A study in Connecticut found that workers with work-related musculoskeletal disorders paid on average \$489 in out of pocket expenses annually.

Geography

Geography may also impact convenient access to specialty care including occupational medicine specialists in areas where these resources are lacking as providers may not be conveniently located near workers' homes and job sites. One of the WCHI involving a community-based coalition in rural Clinton County, New York, sought to provide appropriate and timely care in an area of scarce medical resources at a time when business was leaving the area. (see [North County On The Job Network: A Rural Coalition Accessing Medical Management for Injured Workers](#))

Scarce medical resources with expertise in occupational medicine resulted in the use of independent nurse case managers employed by a local hospital to enhance communication with employers and workers and assist with critical task assessment, work restrictions, patient tracking, and problem solving. This project resulted in improved and timely access when parties follow a care management plan which was collaboratively designed and service providers are perceived as neutral.

Providers Unwilling to Treat

In some states, providers may not be willing to treat patients for the fees allowed under the workers compensation statute. Other challenges result from what providers may consider burdensome rules and regulations for reporting and complying with utilization review criteria or time consuming legal depositions when there are disagreements over treatment or charges. Research on this issue has not determined the scope of this barrier to quality treatment.

Tertiary access barriers involve cultural and language barriers as well as knowledge of workers' rights for access to care under each state's workers' compensation system.

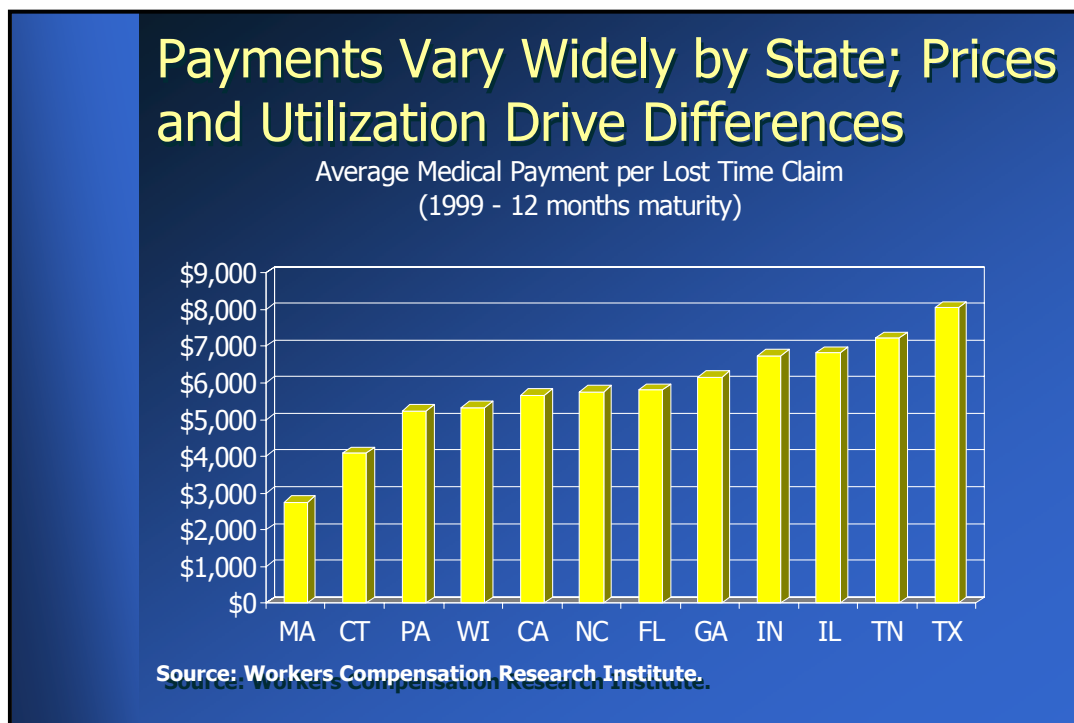
Not having access to providers that speak your language and understand your culture and traditions may affect other outcomes involving health recovery and return to work. A recent workers' survey in Texas found that workers who preferred to be interviewed in Spanish had longer periods of disability and poorer outcomes regarding return to work than did other workers in the study.

Fewer than 50% of the states as of the end of the 1990s disseminated materials about workers' rights and responsibilities under the statutes in Spanish or other languages.

IV. Cost and Utilization of Care for Occupational Injuries

The overall cost of workers' compensation medical care tends to make headlines and drive policy debates in workers' compensation. According to the National Academy of Social Insurance (see [National Academy of Social Insurance, 2002. Benefits, Coverage, and Costs 2000: New Estimates](#)). Washington, DC), Employers paid \$56 billion in premiums for workers' compensation insurance in 2000. Of this amount, \$20 billion paid for medical care expenses. Even though this is only about 1.4% of total general health care costs, workers' compensation costs directly affects the costs of an employer's goods and services and their competitive advantages against like employers in other states or in the global economy, thereby attracting state legislatures attention regularly.

Payments for medical care comprise about 45% of total workers' compensation benefits paid in 2000 (55% were paid for lost wages). But this can vary tremendously by state. According to the [Workers' Compensation Research Institute, WCRI's CompScope™ research summary](#) average medical payments per claim for states they studied varied from an average of \$2762 per claim in Massachusetts for 1999 dates of injury as of 12 months average of payments to \$8048 average per claim in Texas. These differences were driven in part by differences in provider treatment practices, prices and utilization. This of course is affected by the cost containment strategies each state implements. For a complete listing of cost containment strategies by state, (see [WCRI's National Inventory of Managed Care and Cost Containment](#)).



Most states have implemented some form of medical cost containment (fee schedules, network restrictions, treatment guidelines, payment regulations, managed care) and there is some evidence that these approaches can control costs, but less evidence of impact on access or quality. Some WCHI projects looked at patient outcomes such as workers' satisfaction with care, health and functioning and return to work. (see [Washington State Workers' Compensation Managed Care Pilot Evaluation](#)). The evaluation of the Washington state managed care project found costs 22% lower in the cases where managed care was used than standard care case provision. Additionally, there was a lower incidence of disability and shorter disability duration with no difference in the workers' functional outcomes. But workers were less satisfied with care provided.

Results of this project underscore the potential trade-offs between costs and other outcomes. It also suggests that policymakers need to assess the impact access and quality when evaluating policies or new approaches to containing medical costs as costs will continue to dominate policy debates, but awareness of these tradeoffs is important.

V. Defining Quality of Care

The Institute of Medicine (1990) defines quality of medical care as “...*the degree to which health services for individuals and populations increase the likelihood of desired health outcomes that are consistent with current professional knowledge.*” For the purposes of workers' compensation we would probably add to traditional health outcomes those of return to work and recovery of health and functioning.

Assessing quality

A quality chasm exists and has been described in general health care and by implication, workers' compensation medical care. However, through measurement, progress can and is being made in the general health care field. Measuring quality in workers' compensation is also moving forward in spite of historical challenges such as a lack of adopted quality standards, numerous barriers to measuring quality of care and a lack of a workers' perspective on satisfaction and quality.

IV. Measuring Quality Care

The Health Plan Employer Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that purchasers and consumers in general health plans have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance.

<u>HEDIS Effectiveness of Care Measure</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>
Childhood Immunization Status – Chicken Pox	64	70	75
Adolescent Immunization Status	24	28	34
Cervical Cancer Screening	72	78	80
Controlling High Blood Pressure	39	52	55
Beta-Blocker Treatment After Heart Attack	85	89	92
Cholesterol Management – Screening	69	74	77
Cholesterol Management – Control	37	53	59
Comprehensive Diabetes Care – Eye Exams	45	48	52
Comprehensive Diabetes Care – Lipid Profile	69	76	81
Comprehensive Diabetes Care – Lipid Control	37	44	50
Asthma Medication Use – All Ages Combined	58	63	66
Checkups After Delivery	72	74	77
Mean	56	62	66

In every single one of these areas improvements are documented. Why shouldn't we expect the same for workers' compensation medical care?

Examples of Quality Measures Developing in Workers' Compensation:

The WCHI generated tremendous interest in developing measures of quality medical care in the workers' compensation field. Among the contributions to this effort were the following projects: the development of a set of performance measures for managed care organizations; creation of a state technical resource center to define quality of care and begin to measure it; and a multistate effort to develop a workers' survey that would result in data that would assist in evaluating the quality of care nationally.

The **URAC performance measures** were developed to monitor and compare the quality of workers' compensation medical care within managed care organizations being used by workers' compensation payors. In a process involving representatives from all interested groups, broad categories of measures such as appropriateness of care, access to care, satisfaction, utilization, costs, coordination, return to work, communication, and prevention were developed. The project also developed multiple data collection strategies involving surveys of injured workers, medical record review and administrative data analysis. All this information is publicly available. (see [Development of a Performance Measurement Set for Workers' Compensation Managed Care Organizations](#)).

The creation of a **Rhode Island Technical Resource Center** with an objective to improve access to credible information and data about medical care and quality also created a model process for states wanting to start an agency resource center. Among their activities was a feasibility study to facilitate creation of a national research database and the establishment a health care quality monitoring process for Rhode Island. Part of the Center's role was to assess, interpret, and disseminate information relating to access and quality of care. Documentation of their needs-assessment and specification of quality measures is contained at (see [Development of a Model State Technical Resource Center for the Improvement of Workers Compensation Medical Care](#)).

The **Worker Injury National Survey (WINS)** resulted from the realization that the most salient predictors of cost and health outcomes can only be obtained from workers themselves. This was a multistate effort to develop and test a survey which would be used to determine the feasibility of creating an interstate research effort for studying workers' compensation medical care from the workers' perspective. The survey was designed to obtain information on an injured worker's physical and mental health outcomes; economic outcomes; demographics and background of both the worker and employer; their satisfaction with their interactions with providers and claims handlers; and learn more about worksite retribution and employment insecurity. No learn more about this effort visit their website at (see [Worker Injury National Survey \(WINS\)](#)). There is also a current effort by the Workers' Compensation Research Institute to repeat a **workers' survey** originally developed and tested in Texas in multiple states and match it with administrative and claims outcome data. Those interested in that effort should visit them at www.wcrinet.org.

The Role of Clinical Practice Guidelines

Most workers' compensation systems strive to provide quality medical care to occupationally injured or ill workers at a reasonable cost to the employers subject to the statutory act. According to the publication [Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002](#) by Tanabe, Ramona P., Murray, Susan M. (Workers Compensation Research Institute, December 2001), treatment guidelines generally attempt to define treatment standards and ranges for specific injuries and/or disabilities.

It is generally believed that treatment guidelines are an effective tool with which to help accomplish the above public policy objective. Treatment guidelines can be state specific guidelines adopted by a state workers' compensation agency, or they can be proprietary and used by the private sector to identify cases that may need additional attention, or they can be developed and utilized by physicians themselves. Not all state workers compensation agencies have adopted treatment guidelines, and even when they do, the condition for which they provide guidance and the level of enforcement vary. Of the twenty five or so that have developed them or were in the process of developing them in 2001, few have guidelines for more than the most common occupational injuries. The most common treatment guidelines in workers compensation are for conditions involving the low back, upper extremities, lower extremities, and specific carpal tunnel injuries.

As a part of the Robert Wood Johnson Foundation Workers' Compensation Health Initiative, there were three projects relating to treatment guidelines. These were designed to widely disseminate treatment guidelines and to determine whether or not the use of the treatment guidelines helped to achieve the public policy objective above:

1. **Stratis Health's- [Minnesota Workers' Compensation Program: Mandatory Treatment Parameters Evaluation](#)** was designed to determine how the Minnesota state-based WC treatment parameters for low back pain affect the cost, quality and outcome of health care. Major findings of this study were:
 - a. Patients whose care conformed to the treatment parameters had less time away from work, and had similar outcomes regarding pain relief, physical functioning, and satisfaction with care as patients whose care was not in conformance with the guidelines.
 - b. The project demonstrated that a process combining administrative, medical utilization, and patient reported data could be successfully implemented to evaluate the overall effects of a complex "episode of care" treatment guideline that integrates recommendations on diagnosis, treatment, and follow up of cases over time
 - c. A significant accomplishment of the project was the development of a weighted scoring process to measure overall adherence to the guidelines.
 - d. 70.8% of the workers studied were provided treatment that complied with the guidelines
2. **ACOEM- [Dissemination and Implementation of ACOEM Medical Practice Guidelines](#)**. This project disseminated the treatment guidelines recently developed by the American College of Occupational and Environmental Medicine for the neck, back, upper and lower extremities. California is one of the states considering formal

adoption of these guidelines for use in their workers' compensation system. Copies of these guidelines and how to use them effectively can be ordered from [OEM press](#).

3. **University of Colorado's- [Development and Testing of a Data Collection System for Assessing Clinician's Compliance with Occupational Treatment Guidelines](#)**. This project's goal was to collect reliable data at the clinical level to assess provider compliance with ACOEM guidelines and evaluate the association between practices and patient outcomes. A data-scan able clinical assessment tool was developed as a part of this project.

VII. Return to Work Assistance and Outcomes

In a number of states, employers are required to continue to pay lost wage benefits to workers until they are physically able to return to work. In the last ten years, workers' compensation administrators have recognized the importance of assisting the employee and employer in the communication necessary to safely return a worker to productivity without adverse results.

Without effective communication between the physician and patient, the patient and employer and the employer and health care providers, recovery and return to work can be delayed or worse, a worker may suffer reoccurrence of disabling symptoms if not properly prepared for the resumption of physical activities after a period of inactivity.

Three of the WCHI projects dealt with this issue in some form:

1. [Mid-America Coalition on Health Care](#) developed employer benchmarks for use by employers interested in monitoring and improving the care given to their injured workers by their chosen health care providers. Employers interested in protecting their human and financial resources from the effects of occupational injuries and diseases are hungry for information that will help them study and improve their processes of injury prevention, medical and disability management and successful return to work for their occupationally injured workers. As a part of the Robert Wood Johnson's Workers' Compensation Health Initiative, 30 major regional and national employers headquartered in Kansas City worked collaboratively with leading medical providers, occupational health service workers and the medical society to improve workers' compensation medical management and facilitate early return to work in Kansas City, Missouri. As a part of this initiative, they designed the [Uniform Workability Form](#). In addition to being a valuable communication form from the physician to the employee, employer and others that may need disability information, it provides a basis for the collection of important information that can help employers improve outcomes of their workers' compensation programs.

2. [The North Country on the Job Network \(NCOJN\)](#) was a voluntary, community-based coalition that began in Clinton County, New York adjacent to the Canadian border. The program grew from concerns of the business community and the local Chamber of Commerce following the closure of the Air Force Base in Plattsburgh, the county seat in 1995. The resulting loss of jobs in the area occurred in conjunction with the devaluation of the Canadian dollar and increasing concerns among the local business community about rising workers compensation costs. The initial project was funded by the Champlain Valley Physicians Hospital (CVPH) Medical Center as a community service with assistance from the Plattsburgh-North Country Chamber of Commerce. This project involved the continued development, evaluation and replication of this unique health care delivery model for management of injured workers in a rural upstate New York community. Major findings of the study included:
 - a) Improved and timely access to care is possible when all constituents in a small community are communicating and following the process for injury management which was collaboratively designed
 - b) The nurse case management model developed through this project is unique. Unlike in most workers' compensation cases, these case managers were not chosen or paid by the insurance carrier or employer and were perceived as being independent from their control. Instead they were employees of the local hospital.
 - c) The case coordination process appears to be crucially beneficial in areas such as critical task assessment, work restriction communication, patient tracking, liaison between care providers-patients-employers, and problem solving of issues which were not strictly medical
 - d) This project demonstrated that having a source of funding for case managers independent of the employer or insurer was well received by workers.
 - e) Few companies were utilizing or had an understanding of the benefits of transitional duty and few network companies were receiving any of the project provided statistics from their insurance companies

- f) Replicating this project in other areas will require a better understanding of the local politics and stronger coalition building activities.
3. [Maximizing Outcomes in the Federal WC System \(FECA\) Through Integrated Case Management](#) was achieved through a project designed by Georgetown University. This project examined the effects of an integrated case management approach that addressed multiple factors affecting health and disability outcomes in a workers' compensation system. This was compared to the case management model in place in the Federal Workers' Compensation System. This proposal represents the first controlled investigation of case management within a workers' compensation system. Major findings of the study included:
- a) Case management practices can be enhanced by a new integrative approach taught in a relatively brief training program developed by Georgetown University.
 - b) Case managers with this training were more likely to make recommendations for modifications in the worksite (such as improvements in seating posture, modification of workspace, use of accessories or lifting/carrying aids, etc.) than were case managers who had not had this training.
 - c) A tool developed by this study, "the Self-reported Measure of Ergonomic Exposure", was positively correlated with the number of accommodations recommended and implemented. This suggests that the use of this brief assessment tool may serve to prompt case managers of the presence of ergonomic stressors as perceived by the worker.
 - d) Those receiving the new case management programs reported higher levels of patient satisfaction.

VIII. Improving Quality Care

Improvements in the quality of care for workers occupationally injured or ill can result if public policymakers are aware of the connection between access, costs and quality; if continued attention is paid to the measurement and reporting of quality issues in workers' compensation; if workers' input is continued to be incorporated in the evaluation of the access, costs and quality; and if the tools and resources that are available through this website and other references are used.

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