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Is There A Doctor in the House? *Provider Trends in Workers Compensation*

Dean Stiles and Brannon Transue

The doctor who made house calls is a nostalgic memory for some and the stuff of folklore for more recent generations. Things have changed since the days of the black doctor bag, and the role of the provider continues to evolve as all stakeholders address the rising costs of medical care. Today, some practices are closing their doors on workers compensation claims — to the detriment of both employers and injured workers. Fortunately, tools exist today that can help organizations give their injured workers access to timely, appropriate, and cost-effective care. And if health-care trends are any indication, although tomorrow may not bring a return of the doctor to your doorstep, all employees could someday benefit from a system that promotes high-quality, patient-centered care.

The Times They Are A-Changin'

Today, a number of issues affect the quality, cost, and availability of care in workers compensation claims. From a provider's perspective, costs and time pressures are rising and reimbursement is not. From an employer's perspective, access to network providers is becoming limited. From an injured employee's perspective, it's difficult to get quality care.

How did workers compensation get to this point? And where is it headed?

For decades, provider networks of various types have been widely used tools in both group health and workers compensation. Traditionally, a workers compensation provider network served as a means of identifying viable providers while achieving unit cost controls. Networks have typically concentrated on accessibility and discounts. According to traditional thinking, to provide easy accessibility, networks need to be as broad as possible, so they were often developed without taking into consideration the treatment patterns of the contracted providers.

Network reimbursement rates have historically been based on discounts below the fee schedule for a given state. Providers accept these discounts on the premise that participation in the network will drive traffic into the office, so they will be able to make up the discounts on volume. However, many states have not updated their fee schedules in a timely manner, essentially locking providers into yesterday's rates — despite increases in the cost of providing care. Discounts that made sense two or three years ago have been eaten up by inflation. This issue is especially acute with orthopedists and orthopedic surgeons — key specialists in the workers compensation arena. Orthopedists in key areas of Pennsylvania terminated their discounts with networks due to the high cost of medical malpractice insurance. In Florida, providers were reluctant to accept new workers compensation claimants because the fee schedule rates had not been increased in 20 years. In Massachusetts, which has a particularly low fee schedule for workers compensation, physicians bill more office visits at higher revenue Current Procedural Terminology (CPT) codes than do physicians in states with higher fee schedules.[1]

To make matters worse, many providers have begun to prenegotiate fees that are above fee schedule, particularly for complex services. Although 96 percent of radiological exams in Massachusetts are paid at the state fee schedule, more than 60 percent of surgical procedures such as arthroscopic ligament repair or cartilage debridement are paid above the state's fee schedule. Oregon will allow discounts only if the network/employer relationship is certified with the state. This certification helps ensure that

Exhibit 1

Comparison of Fee Schedule Amounts and Prices Actually Paid for Selected Common Medical Procedures Billed by Massachusetts Physicians

Service Code	Service Description	% Paid Below Fee Schedule	% Paid at Fee Schedule	% Paid Above Fee Schedule	Median Payment as Percent of Fee Schedule Amount
22851	Application of intervertebral biomechanical device	9	26	64	303%
23420	Reconstruction of complete shoulder	13	45	42	100%
29826	Arthroscopy, decompression of subacromial space	13	19	68	240%
29877	Arthroscopy, debridement/shaving of articular cartilage	12	20	68	247%
29881	Arthroscopy, with meniscectomy	10	28	62	238%
29888	Arthroscopically aided anterior cruciate ligament repair	10	28	62	202%
49505	Repair initial inguinal hernia, age 5 or over	21	63	16	100%
63030	Laminotomy with decompression of nerve roots, one interspace	9	33	58	287%
64721	Neuroplasty and/or transposition, median nerve at carpal tunnel	11	39	51	100%
69990	Microsurgical techniques	5	42	53	153%

Source: How Does the Massachusetts Medical Fee Schedule Compare to Prices Actually Paid in Workers' Compensation? (April 2006) Workers' Compensation Research Institute.

Comment: Massachusetts has one of the lowest fee schedules for workers compensation, but higher fees are often negotiated, particularly for major surgery. In addition, Massachusetts bills more office visits at higher-revenue CPT codes.

contract discounts are applied fairly. A few states have proposed allowing discounts below the fee schedule for certain types of providers, although no jurisdiction has enacted this. Louisiana, on the other hand, enacted legislation that disallowed any discounts below fee schedule. This legislation led to signification litigation between contracted providers and the networks doing business in the state.

Another issue affecting providers in connection with workers compensation claims is the administrative costs in addition to the normal costs of providing health-care services. Network reimbursement at procedure-level rates doesn't account for the additional time required for workers compensation cases. If a network reimburses $50 for an office visit, it does so regardless of whether the provider completes one form or ten. Network reimbursements also fail to take into account the time the provider might need to spend generating reports, coordinating with the employer, or dealing with litigation. These administrative costs are rising, too. No wonder workers compensation cases are becoming increasingly unattractive to providers — even if they don't accept a discounted network rate.

Cost Controls Are Closing Doors

As states become more aggressive at controlling unit costs through fee schedules, the payment to the provider has decreased based on the contracts with the network. Providers may decide to remain in the network, but may stop accepting new workers compensation cases, essentially eliminating access to these providers. This trend has a snowball effect. With fewer in-network providers available to treat new claimants, the providers that are still accepting patients may find that they cannot treat the claimants as timely as necessary due to the increased case load.

With limited provider choice in some jurisdictions, the challenge now becomes getting the injured worker into the right specialty in a timely manner. The insurer and adjuster are more willing to consider a non-network provider if this provider is a mechanism to obtain treatment — but while these negotiations are carried out, both treatment and return to work may be delayed. Such delays may have a negative impact on both clinical and return-to-work outcomes.

Paying to Save More

The solution would seem to be to identify quality providers and pay them appropriately so that they have incentive to remain in the workers compensation game. This is happening in some jurisdictions, as the concept of the Exclusive Provider Organization (EPO) gains a stronger foothold in

workers compensation. The EPO represents a return to the original concept of the network as a certifier of clinical quality. Under an EPO, the list of providers is pared down to those who demonstrate positive treatment patterns as gauged by timely return to work, high patient satisfaction, appropriate medical costs, and other metrics. Care is continually monitored in order to maintain optimal outcomes.

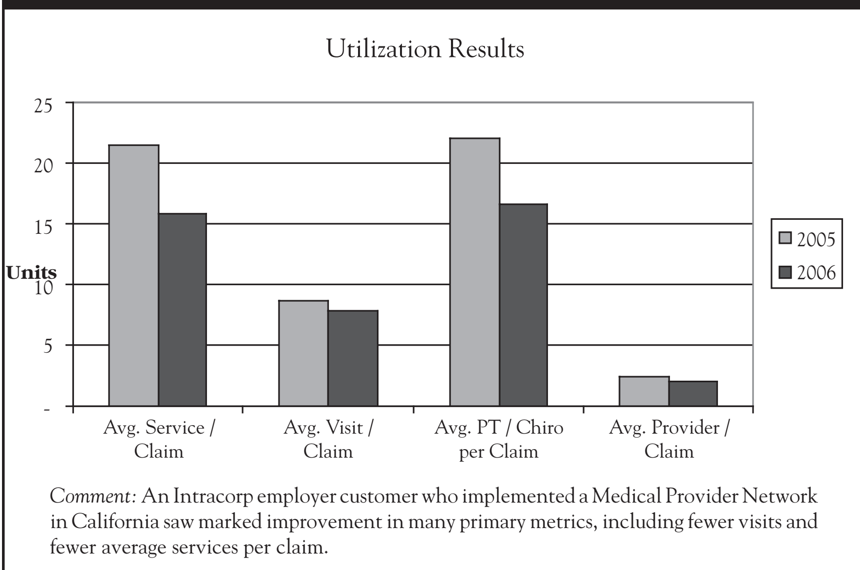
Where appropriate, EPOs can be part of a certified plan. With a certified EPO, the network reimburses only for care provided in-network. In this way, it differs from a preferred provider organization (PPO). Some EPOs have been in place for many years, particularly in states that have allowed "hard channeling" of injured workers to network providers. Recent legislation has made EPOs available to more employers in different jurisdictions, and some states have embraced such programs aggressively. In California, where the cost of workers compensation was causing businesses to leave the state, the state's Medical Provider Network (MPN) legislation helped create an environment that enables execution of an EPO. Injured workers there are now required to use a provider from within their employer's or insurer's MPN, which is certified with the state workers compensation regulators.

Although EPO networks may pay a higher rate for services in exchange for increased treatment time by the provider, the investment in quality care appears to have value. Employers who have pared down their provider lists are starting to see better outcomes. As a result, injured employees are less likely to switch providers — an indicator that they are satisfied with the quality of care they are receiving. Overall, injured workers with access to an EPO require less medical care, and the workers compensation process is less adversarial.

One national employer that instituted the Medical Provider Network in 2005, along with the overall claim management model for California, has experienced positive medical and indemnity results. Although average cost per service increased slightly (7 percent), analysis of claim financial data for a 17-month period saw significant positive changes, including a 27 percent reduction in average services per claim, a 24 percent reduction in average physical service per claim, and a 17 percent decrease in the average number of providers per claim. The average treatment duration and number of visits per claim also were reduced, by 10 percent and 9 percent, respectively. In addition, lost-time claims decreased by 23 percent and average disability durations were cut by 18 percent.[2]

The Maryland workers compensation system is another good example of how the quality of care can drive costs down more than discounts alone

EXHIBIT 2



Comment: An Intracorp employer customer who implemented a Medical Provider Network in California saw marked improvement in many primary metrics, including fewer visits and fewer average services per claim.

can. In September 2004, Maryland increased fees for physical medicine and evaluation and for management services, and it decreased fees for surgical services. Workers Compensation Research Institute (WCRI) conducted interviews and compared outcomes data for injured workers in 10 states. In Maryland, employers pay more for medical care, yet the study found that "the average medical cost per claim with more than seven days of lost time was 31 percent lower than the average medical cost for the median of the 10 states studied."[3] WCRI also reported that Maryland had among the lowest percentage of workers who wanted to change their initial or primary provider due to dissatisfaction with care, and only a very small percentage indicated having problems accessing the initial or primary provider they wanted. Recovery of physical health and functioning and return-to-work outcomes for the state were typical of the other study states. Since the time of the survey, Maryland has made additional changes, including increasing the fee schedule for neurological and orthopedic surgeries.

A successful EPO requires more than just giving an orthopedic surgeon more money. The provider list should be developed based on solid outcomes data. A successful outcome requires reasonable access and the right providers who have a record of positive outcomes and who are willing to work with the employer on return to work. It also requires ongoing monitoring to ensure continuing quality. An EPO that meets these requirements will

save money and improve outcomes. However, even the best network will not drive return to work on its own. The network should be one piece of a total managed care program. When providers work in tandem with case managers and return-to-work specialists, we move from a system where medical management professionals act as watchdogs to a true partnership between providers and medical management professionals. This ultimately leads to clinically focused outcomes and improved results.

Bringing It All Back Home

An evolving provider trend that is likely to affect the network environment is the concept of the "medical home," where a provider acts as a personal physician, coordinating comprehensive, patient-centered medical care. The idea is gaining traction among physicians' organizations. The Association of American Medical Colleges, which supports the concept, defines a medical home as "a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for a patient's cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services."[4] In a November 2008 editorial, the president of the American Medical Association stated that the AMA "is among a growing number of health care stakeholders that are beginning to embrace the medical home model."[5]

Employers, medical organizations, and major health plans are forming coalitions intended to standardize the medical home model. For instance, four medical organizations (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association), a number of health plans (CIGNA, Aetna, Wellpoint, Blue Cross and Blue Shield Association, et al.), and a handful of employers have formed the Patient-Centered Primary Care Collaborative (PCPCC), chartered to achieve some standardization between physicians and payors around what constitutes a medical home model and to move to a multipayor pilot project.[6]

The medical home model offers potentially significant advantages in terms of getting the right care in the right place at the right time. The medical home serves as a gatekeeper or a coach, ensuring that the individual gets to the right resource in the continuum of care. The medical home would address both occupational and nonoccupational issues, seeing the "big picture." For example, if a worker has a knee injury today, he or she sees a specialist who just treats the injury, without having any context and without addressing any influencing factors — and that's all the insurer reimburses

for. Under the medical home model, the physician would also take into consideration chronic conditions such as the injured worker's obesity or diabetes, the fact that he or she cares for an aging parent at home, and any other factors that might affect the outcome or influence the treatment decision. The medical home would then coordinate with the other providers on the treatment plan. On the flip side, an employee whose physician is already addressing issues such as obesity may be less likely to wind up with musculoskeletal problems.

The medical home model fits conceptually into the issue of integration across benefit lines, as employers begin to take a person-centric view as opposed to a benefit-line view of employee health and wellness. Yet despite the support from provider-side organizations, it will take time before the model becomes viable for health care or workers compensation. Adoption of the medical home model faces a number of challenges. For the model to work at its best, the patient and provider can't be caught in the middle of a debate over who pays for what treatment. To reap the advantages of the medical home model in the workers compensation environment, insurers, third party administrators (TPAs), and employers need to accept that the payment mechanisms will need to change. And although it makes sense that a holistic approach will result in better outcomes, it may take time before employers know what kind of cost savings they can expect.

Adoption of the medical home concept faces other, more basic challenges as well. According to projections from the Deloitte Center for Health Solutions, the move to the medical home model will require that provider practices invest in infrastructure — including information technology — that could cost each practice $80,000 to $120,000, and spend more on staffing to see a smaller number of patients.[7] Physicians will need to be trained to implement the model, and the health-care profession will need to address the shortage of primary care providers. In the meantime, the concept is moving forward. In 2006, Congress mandated that the Centers for Medicare & Medicaid Services study the model. The three-year Medicare Medical Home Demonstration project is slated to start in 2009. It will run in rural, urban, and underserved areas in up to eight states.

If the medical home represents the evolution of the managed care gatekeeper, the next step may be the concierge model, which is already in place today in health care. Concierge practices are provider groups that have set up services to support all of a patient's potential needs. Patients pay the practice an annual retainer fee for guaranteed access to care, including such services as 24/7 availability and home visits. (Fees can range widely, depending on what services are included.) Such practices are becoming particularly popular

in areas where access to primary care is difficult. Concierge practices care for fewer patients, but give patients more time. There are regulatory issues concerning what services a concierge practice may offer if the providers are part of a Medicare program or a network. Still, the concept of having workers compensation specialists on retainer might be worth exploring in an environment where availability is becoming limited.

Making It Happen

Traditional networks focus primarily on discounts and leave much room for improvement from the perspective of providers, employers, and injured workers. Access to providers is becoming more difficult and, in the long run, medical costs may be higher. Nontraditional networks, such as EPOs, are already showing that it is possible to reduce medical costs without compromising care.

As the provider's role continues to evolve, perhaps shifting to a 21st century version of the family doctor on the doorstep, workers compensation will need to keep up with the changes. The trend toward integrated benefits is in sync with the medical home model. Someday the medical home model may extend the promise of patient-centric care across an organization's entire work force by helping reduce the influence of chronic conditions on both occupational and nonoccupational claims. The success of both EPOs and medical homes depends on including the right providers. Selecting them requires more than measuring return-to-work outcomes — it requires the ability to judge providers across all product lines. Doing this successfully requires experience and resources in both health care and workers compensation.

Integrating health-care provider management into the workers compensation space shifts the emphasis from financial risk management to better employee health and safety. The concept sounds simple, but achieving it will be a challenge, as employers and payers sort out who gets paid for what from which bucket. It will take time for payers to adjust their paying habits to cover conditions that have not traditionally been associated with workers compensation. In this new, nontraditional provider environment, organizations with both health-care and workers compensation expertise are in the best position to meet the needs of employers and their employees.

Improving the health-care system in the United States is a critical issue, and it is likely that any changes to provider roles and reimbursement models will eventually affect the way that workers compensation medical care is delivered and paid for. Although it will take time before nontraditional models become the new paradigm, savvy organizations will recognize that

the winds of change are blowing. In order to prepare for the future, they'll need to shift their energies away from the long-held love affair with discount unit costs and focus instead on what keeps costs down in the long run: quality care and improved outcomes.

Endnotes

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