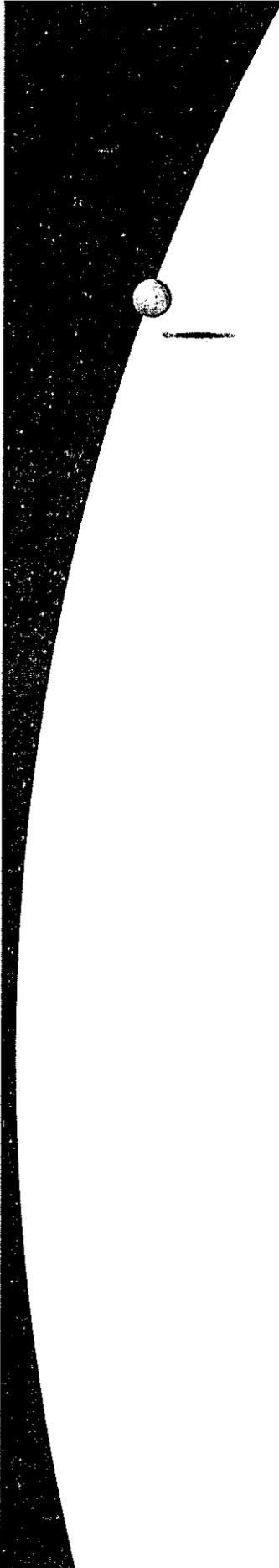


Speaker

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PUBLIC FORUM

HOSTED BY

OHIO BUREAU OF
WORKERS'
COMPENSATION

BOARD
OF
DIRECTORS

PRESENTED BY

MILLIE DROSTE
MMD CONSULTING, INC.

APRIL 24, 2008

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PUBLIC OPEN FORUM FOR THE WC BOARD

PRESENTED BY MILLIE DROSTE, PRESIDENT MMD CONSULTING, INC.
4/22/2008

Good Morning I am Millie Droste and I thank you for the opportunity to speak to the workers' compensation board.

As President and CEO of MMD Consulting, Inc I started my vocational rehabilitation company in 1998. Vocational rehabilitation is performed by degreed and certified professionals. A Voc Rehab counselor works with injured workers whose barriers have prevented them from returning to work and whose case is complicated necessitating a one on one meeting and coordination of services in a comprehensive rehab plan designed to return them to work.

I am here today to talk about reimbursement rates and the practice of referring case managers based on geography instead of focusing on the quality of vocational rehabilitation case managers. I would like to pose some questions to you as you listen to my testimony.

In Voc Rehab, we cannot limit our business to a small region and survive financially.

Could you limit your business to a small region? Most probably cannot.

Have you gone without raising your fees for 11 years?

Could your business survive if there was no way to raise your fees to cover ever growing expenses?

Those are the questions I ask you.

The answer has to be "no" unless you have a parent company who can survive the non existent profit margin and support you financially.

When I started this company in 1998 our reimbursement was \$65 per hour and travel was \$32.50 per hour or one half of the professional reimbursement rate. Mileage was at the rate of \$0.27. Some office procedures, such as sending a fax, were covered.

In 2003 the BWC increased the reimbursement rate for professional time to \$70 per hour which was a \$5 per hour increase. However, at the same time they instituted a policy in which only 2 hours round trip was paid. Therefore we actually took a cut in reimbursement because we travel the state to serve the injured workers and the clients who send cases to us. We cannot get enough cases in a one hour radius as the majority of injured workers live outside the one hour-one way "line".

This regionalization was to encourage MCOs to use case managers in the area of the injured worker. However some areas, such as southeast Ohio, have few to no case managers. We travel into these areas and eat the cost of travel and mileage. We do this because injured workers in this area need the help and we virtually never decline a case.

More importantly, regionalization penalizes injured workers. Injured workers now must rely on geography and not quality for their choice of case managers. MCOs are looking for the closest case manager to the injured worker and not necessarily the best one.

Geography should not be a factor in deciding quality of case management. If quality of treatment is the real goal and a case manager has shown quality in their practice, regardless of the area, then why is it necessary to restrict a case manager to only cases within a one hour radius? This has been proposed as a filter in the new referral system. There is no reasonable rationale for this filter other than elimination of competition.

Reimbursement

I have included a graph for your review containing reimbursement rates throughout many states including those adjacent to the state of Ohio and another monopolistic state – Washington. As you can see the average is over \$80 per hour and there are no states, that I saw, that cap travel to one hour one way. In Washington, the rates are reviewed each year and increased as necessary. Their rate is \$81.70. Mileage reimbursement is \$0.51 and increased every July 1.

West Virginia has increased their professional time to \$80 per hour and they re-evaluate annually.

National insurance companies, who have cases in Ohio, pay their national rate of at least \$80 per hour to over \$100 per hour. Travel and wait is paid at the same rate, it is not reduced.

Our Expenses:

Over the last 10 years health insurance has more than doubled, the market has dictated that case manager salaries have increased from \$35,000 per year to over \$50,000 per year. We are not allowed to bill for faxes, postage including

certified letters. Postage began \$0.32 in 1998 and is now at \$0.41. It is going to increase again in May.

We used to be able to send a single-page summary invoice for our services. In 2003 the BWC began requiring us to itemize each service. For this reason, our paper, toner, fax expenses nearly tripled.

Fuel prices have also tripled in the past 11 years. Energy costs and building overhead has increased greatly. Reimbursement has not.

The real result of low reimbursement of professional, travel and mileage is that injured workers are not being seen regularly and we have heard that some have not been seen in person at all because the reimbursement rate does not cover the travel expenses incurred. Case management companies are closing and excellent case managers are leaving the field. Examples are Gates, Comp Management and The Parman Group. We have lost 2 fine case managers in the past five months who left voc rehab altogether.

I would ask that you institute an increase to, at least, \$80 per hour and eliminate the one hour one way cap on travel. Do not reduce travel time to one half of professional time. Additionally, set up a system to re-evaluate the compensation rate annually and a mechanism to make change as needed.

Thank you for your time and consideration of these matters.

STATE	PROFESSIONAL	TRAVEL TIME	WAIT TIME	MILEAGE	NOTES
MICHIGAN	\$74.00	\$74.00	\$74.00		Provided by Janine Holloman . Michigan does not cap or set rates. Vendors choose rates (market dictated). The professional hourly rate listed is for a single case manager in Grand Rapids. She states Detroit commands higher hourly rates. She does not discount for travel time. She did not mention mileage reimbursement.
PENNSYLVANIA	\$68 - \$80				Provided by Linda Croushore. She states national companies charge the higher \$80 rate.
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RHODE ISLAND	\$80.00				Provided by Judith Drew
TENNESSEE	\$80.00				Provided by Certified Life Care Planner Kathy Smith, MS, CRC, CLCP
WEST VIRGINIA	\$80.00	\$40.00			West Virginia is now governed by Brickstreet insurance for workers' comp. They evaluate the vocational rehab rates each year. This information provided by RTW services department Ruth at 1866-452-7425 ext 5610.
WASHINGTON STATE	\$81.70	\$40.85	\$40.85	\$0.51	Provided by John Berg in Seattle, WA. Reference to Washington State's rates as published in the Medical Aide Rules for codes and costs for ancillary and medical providers. Mileage is increased every July 1.
ARIZONA	\$83.00	\$83.00	\$83.00		Provided by Patti Sinclair, CRC, case manager who works for Cascade, a National Company who also does business in Ohio. Patti used to live in Ohio and has provided services in Ohio.
MASSACHUSETTS	\$80 - \$90				Provided by Jan Nixon, RN, BSN, MA, CDMS, CRC, LRC, CCM, CLCP. She states the rates are "not mandated by the state insurance's department of industrial accidents".
OREGON	\$85 - \$90				Provided by Scott Stipe, MA, CRC, CDMS, LPS, DIABVE in Portland
FLORIDA	\$85.00	\$85.00	\$85.00		Provided by Bunch & Associates, based in Florida and also works in Ohio.
ARIZONA	\$86.00	\$86.00	\$86.00	\$0.50	Provided by Arizona Vocational Consulting company owner. She increases their rates every 5 three years. She has worked in Ohio (and is a Ohio BWC Provider). However, she has refused to do any work out of Ohio for the past three years "because of the ridiculousness (sic) of getting paid for my services....I found it wasn't worth my time to continue accepting referrals".
NORTH CAROLINA	\$78 - \$100+				Provided by Rehab Consultant, Barbara Armstrong, RN, CCM, CDMS, CLCP in Charlotte. The says most large national companies charge over \$100 per hour; however, many independents charge \$78-\$90 to remain competitive.
NATIONAL COMPANY					
MATRIX	\$80.00				Rate of pay was FOUR years ago. No reduction in travel or wait.
BUNCH AND ASSOC	\$85.00	\$85.00	\$85.00		Provided by Millie Droste, MMD Consulting, Inc.
CRAWFORD	\$98.00				Provided by Lisa Clapp, MA, CRC, CEA

MAJOR ISSUE: Reimbursement Rates

MMD Consulting began in January 1998. At that time we were paid:

Professional Time (per hour)	Travel (per hour)	Mileage (per mile)
\$65.00	\$32.50	\$0.26

- On July 1, 1998 the mileage rate was increased to \$0.27.
- On July 1, 1999 the mileage rate was increased to \$0.28.
- On July 1, 2000 the mileage rate was increased to \$0.30 and has not increased since that time seven years ago.
- Meanwhile, on 3/1/06 the BWC increased the mileage rate for injured workers to \$0.40 per mile. The BWC claims they were "not allowed to increase the provider's mileage reimbursement to \$0.40 on 3/1/06 due to the unresolved hospital lawsuit against the BWC". We were not provided an increase in fees because, they say, of the hospitals that already are paid a flat percentage of what they bill – regardless of the amount they bill.

FACT:

1. Vocational Rehab professional rates have increased only once time in ten years...by only \$5.00 per hour or 7%.
2. Travel reimbursement has increased only once in ten years by \$2.50 per hour or 7%.
3. Our mileage has increased by \$0.04 in ten years while the federal mileage rate has increased from \$0.325 in 1998 to more than \$0.485 today. This is an increase of \$0.16 in ten years...four times as much.
4. **BWC employees** and injured workers are both reimbursed at \$0.40 per mile which is \$0.10 more per mile than we are.

Policy Implementation restricting "Intern" pay:

An issue that also significantly affected our reimbursement was when the BWC implemented policy in 2004 that would pay voc rehab interns at 85% of the reimbursement rate. Our rate of pay was bad anyway and then the BWC took 15% away for an intern. An intern is considered to be a person who has the same education as a credentialed case manager but has not sat for their credentialing test but is scheduled to. They perform the exact same services as a credentialed case manager. The only distinction is that the intern must have all work verified by a credentialed case manager. With the average salary increasing every year we were forced to hire credentialed case managers for significantly higher salaries and forced to end intern employment.

SECONDARY ISSUES:

One-hour one-way payment for travel time.

Beginning 01/01/03 the BWC went from paying full travel and mileage to restricting payment to only paying one hour one-way for a vocational rehab person to travel to an appointment and paying a maximum of 130 miles round trip for mileage. This significantly affected our business as our CMs were now spending sometimes up to six hours on the road traveling and only being able to bill for two of those hours while losing hundreds of miles in non-reimbursable mileage.

This one hour one-way restriction was promoted significantly by the large MCOs that self-refer to their own vocational rehab companies. These large MCOs have employees working from their homes all over the state. As was their goal, this restriction had no significant impact on them but did, however, have a significant impact on smaller companies such as ours.

The MCOs are held responsible for the outcome of voc rehab referrals from return to work percentages to billing audits. The MCO has a portion of their payment from the BWC tied to these results. For this reason an MCO should be able to choose whichever vocational rehab company it feels can best help them in these areas and NOT because of where they are geographically located.

The result of this policy has hurt injured workers. We receive cases that have been previously closed and then reopened when appealed. When we see the injured worker we find that they have never been seen in person. We can only surmise that this is due to the cost of travel.

The travel and mileage restrictions should be eliminated as they hurt the injured worker.

Salaries: 1999 vs. 2007

Year	Average Salary
1999	\$28,000
2001	\$40,000
2004	\$46,000
2007	\$55,000

- The average salary paid to a vocational rehab case manager has nearly doubled in the past decade.

YEAR	TOTAL PAYROLL	# employees	AVG
1999	\$133,182	4.5	\$29,596
2000	\$211,249	6	\$35,208
2001	\$429,372	11	\$39,034
2002	\$598,498	14	\$42,750
2003	\$415,363	9.5	\$43,722
2004	\$407,321	9	\$45,258
2005	\$294,979	6	\$49,163
2006	\$325,721	6	\$54,287

Around 2003 - 2004 the BWC, who previously allowed MCOs to refer any injured worker for vocational rehabilitation if they felt it would benefit them, began requiring all voc referrals to be approved by the BWC before the referral could be made. This also helped significantly reduce the number of our referrals. The BWC began making the requirements for vocational rehab eligibility so stringent that many injured workers who may have benefited from our services were no longer considered "eligible".

Fuel Prices

Fuel cost \$1.20 per gallon in 1998. In 2007 it has more than tripled to almost \$4 per gallon.

Assuming 20 mpg per vehicle....

Postage

In 1998 the cost of a first-class stamp was \$0.32.

On May 2007 that cost increased to \$0.41.

This is a 22% increase in ten years!

Naturally, our postage costs have increased by at least that amount in the past ten years while our reimbursement has only increased 7%.

Additionally, prior to 2001 the BWC required an invoice be submitted with three codes with totals for: professional, travel and mileage. We were able to submit one invoice with supporting documentation. We were mailing in roughly 3 pages per invoice total.

As of 2001 we were required to itemize every single activity we billed for.

This significantly increased our postage as our 3 pages per invoices suddenly increased to roughly 12 per invoice. This added paper increased weights and subsequently increased our postage by 50%.

Office Supplies/Costs

- Directly relating to the new policy on submitting billing in detail, this increased our paper purchase by 40% in 2001 vs. 2000.
- The cost of general office supplies has increased by roughly 3% each year since 1998. For example, the cost of printing and fax toner, per-sheet price for faxing and printing, and all other office supplies.

Software design

The BWC consistently changes the criteria MCOs must meet to be awarded "incentive money". This incentive money used to be part of the basic fee paid to the MCO based on the premiums generated by their customers, the employers. Around 2003 the BWC instead began paying the MCO part of this fee but held back part as an "incentive" when they reached the goals the BWC set for them. These different criteria have ranged from successful return to work (RTW) percentages to billing accuracy. The MCO is forced to constantly monitor the number this criteria so they may be awarded their incentive money. In turn, we must be able to provide the MCOs with this information upon request. For this reason we've spent many thousands of dollars on software development and modifications over the years in order to generate reports for our clients, the MCOs, to prove we are doing the job they hired us to do. We spent thousands developing software to create reports that would help justify their incentive payment. Then, after only one year of these criteria, the BWC changed their incentive criteria. It rendered our newly designed and purchased software useless.

**Please see attached list of reports we developed

Billing

The current incentive for MCOs now include, in part, scrutinizing billing submitted by vocational rehabilitation companies. This has significantly increased the amount of time spent on managing incoming payments. We spend an extraordinary amount of time attempting to justify, for example, a \$7 or \$14 charge for a phone call placed to the injured worker. The MCOs are basically guessing at how long an activity will take. Because part of their paid incentive money is tied to billing accuracy, the MCO is now arbitrarily reducing the amounts we submit in an effort to do what the BWC would deem as appropriate and not necessarily what is fair and accurate.

In addition, despite the amount of time our case managers spend on an individual case, they are limited to a specified maximum amount of billing. This is unreasonable as each case is unique and the amount of

time needed to benefit the injured worker differs from case to case. Each case is as unique as the person we're attempting to help and time constraints significantly reduce our capabilities to assist them in returning to work successfully.

Summary

In the past decade, the cost of salaries, benefits, rent, cell phones, office supplies, utilities, etc. have increased while our reimbursement has not. Any other business may adjust their fees according to what it costs them to operate their business. MMD Consulting cannot do this as we are paid a fee that has not increased in almost a decade. While everything else has increased in cost our professional reimbursement has not. Our profit margin, which used to be 30%, has decreased to no profit margin. If no change is effected soon our company cannot continue to operate. We will surely become one of the dozens that have closed their doors because there are no funds to continue operating with. This will be extremely detrimental to the smaller MCOs who do not have "sister" voc rehab companies to self-refer to...and ultimately it will hurt the injured worker. Fewer choices mean fewer options. And less competition never increases service.

Millie Droste
President, CEO
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**ANALYSIS OF
VOCATIONAL REHABILITATION
for
THE OHIO BUREAU OF
WORKERS' COMPENSATION**

BY
MILLIE DROSTE
PRESIDENT/CEO
MMD CONSULTING, INC.

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DEFINING CASE MANAGEMENT AND THE PROCESS OF REFERRAL

In an attempt to define the nature of vocational rehabilitation as it applies to the State of Ohio Bureau of Worker's Compensation and the barriers encountered in providing this service I am hoping to reveal some difficulties in our current system and provide some answers to these issues.

My company, MMD Consulting, was formed 9 years ago. We have seven case managers who are all are certified and have worked in this field for no less than seven years. A lot has changed about the process of providing this service. Some of these areas may be unknown to the reader.

The definition of vocational rehabilitation is "to empower individuals with disabilities to achieve a greater quality of life by obtaining and maintaining employment." Employment contributes to a person's ability to live independently, and it is a case manager's belief that every person has the right to work.

Vocational rehabilitation is different than telephonic case management. Telephonic case management is provided by the Managed Care Organizations (MCOs) who are the agents for the bureau. It is done over the phone early in the case during the medically unstable phase of the claim. Vocational rehabilitation is provided when authorized by the MCO and the BWC. Participation is authorized when the injured worker meets the criteria determined by the BWC. After eligibility is determined then feasibility is decided. This part of the process can be subjectively determined by the BWC. The definitions are not always clear. Feasibility looks at the injured workers past history of compliance, determines if this person has failed vocational rehabilitation goals previously, is too impaired to be determined able to return to work, etc. There are times when case managers believe an injured worker should participate in vocational rehabilitation but is not referred because the MCO is reluctant to have their return to work percentages lowered by taking a chance. Last year the MCO contract money given for incentive work was partially awarded based on return to work statistics. This resulted in MCOs cherry picking the injured workers who were to get vocational assistance. If it was determined by the MCO that the injured worker may not be able to return to work quickly the case was not referred. As a result, I believe some injured workers were denied these services.

With creativity, the vocational case manager can often assist the worker to return to work through liaison work with all the potential members of the team including the physician of record, lawyer, physical therapist, family members, the BWC disability management coordinator, the MCO case manager and the injured worker. This is sometimes the only hope an injured worker may have. Injured workers can view the BWC as a daunting entity and they simply don't know where to start to help themselves. They don't understand the rules, how they get paid and what may be needed to get them back to work.

The vocational case manager meets with the injured worker within 5-10 days of receiving a referral. This initial interview provides the case manager information regarding perceived barriers by the worker, information regarding family and friend support, need for counseling, pain management, medical stability, and the worker's job duties, etc.

BARRIERS TO CASE MANAGEMENT

LOW REIMBURSEMENT FOR SERVICES RENDERED TRAVEL AND MILEAGE ONE HOUR ONE WAY

The BWC will only reimburse for only one hour one way of travel for case managers. When this is coupled with appointments that are more than one hour away there is a loss of revenue.

Beginning 01/01/03 the BWC went from paying full travel and mileage to restricting payment to only paying one hour one-way for a vocational rehab person to travel to an appointment and paying a maximum of 130 miles round trip for mileage. The rate for travel is one half of the professional rate, or \$35 per hour. Additionally, case managers are only paid one half of the professional hourly rate when waiting for appointments with the injured worker. This significantly affected our business as our case managers were now spending sometimes up to six hours on the road traveling and only being able to bill for two of those hours while losing hundreds of miles in non-reimbursable mileage.

This one hour one-way restriction was promoted significantly by the large MCOs that self-refer to their own vocational rehab companies. These large MCOs have employees working from their homes all over the state. As was their goal, this restriction had no significant impact on them but did, however, have a significant impact on smaller companies such as ours. It was their attempt to negatively financially impact the smaller companies, which it did.

The MCO is held responsible for the results of the vocational case managers but they are not free to choose a case manager that travels more than one hour one way unless the case manager is willing to take reduced reimbursement. The MCO is financially impacted if the case management company does not meet standard benchmarks. A large portion of their contract money is tied to meeting these benchmarks. That means if an MCO wants MMD to travel to Cleveland for a case we do so knowing we will be reimbursed only a fraction of our actual travel and mileage costs. Sometimes an MCO must use case managers that are not in their area because there are either few or no other case managers in the area or they are not quality providers.

GAS MILEAGE

Gas mileage has not increased during the eight and one half years I have been in business. It is still well below the national rate. Reimbursement continues at \$0.30 per mile.

- On July 1, 1998 the mileage rate was increased to \$0.27.
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- Meanwhile, on 3/1/06 the BWC increased the mileage rate for injured workers to \$0.40 per mile. The BWC claims they were "not allowed to increase the provider's mileage reimbursement to \$0.40 on 3/1/06 due to the unresolved hospital lawsuit against the BWC.

REIMBURSEMENT FOR PROFESSIONAL TIME

Eight years ago the professional reimbursement rate was \$70 per hour and that amount enabled us to have a reasonable margin of profit. That profit is no longer there and sustainability is doubtful if changes are not made. There have been many individual case managers and case management companies who have gotten out of the business because of this problem. Any profit has been significantly decreased by increases in the salaries paid to case managers, cost of health insurance (that has risen more than 100% in eight years), postage, rent, technology (computer programs and hardware) needed to meet the BWC expectations, and general increases in the cost of doing business.

THE FACTS

MMD Consulting began in January 1998. At that time we were paid:

Professional Time (per hour)	Travel (per hour)	Mileage (per mile)
\$65.00	\$32.50	\$0.26

In 2008, TEN years later, MMD Consulting is currently being reimbursed:

Professional Time (per hour)	Travel (per hour)	Mileage (per mile)
\$70.00	\$32.50	\$0.30

FACT:

1. Vocational Rehab professional rates have increased only one time in ten years, on 01/01/03 by only \$5.00 per hour or 7%. That's an average increase of only 0.7% per year.
2. Travel reimbursement has also increased only once in ten years (on 01/01/03) by \$2.50 per hour or 7%. Travel reimbursement has always been half of the professional time. Therefore, when the professional time reimbursement increased by \$5 per hour on 01/01/03 the travel time reimbursement increased by half that, or \$2.50 per hour.
3. Our mileage has increased by \$0.04 in ten years while the federal mileage rate has increased from \$0.325 in 1998 to \$0.485 today. This is an increase of \$0.16 in ten years...four times as much.
4. **BWC employees** and injured workers are both reimbursed at \$0.40 per mile which is \$0.10 more per mile than we are.

Ohio has one of the few workers' compensation systems governed by the state. This is a disadvantage for us when we see what other insurance-based workers' compensation systems in other states are reimbursing for services. The average reimbursement for professional time in those states ranges from \$80 - \$120 per hour including travel and wait time as well. Currently travel and wait time reimbursement is only \$35 per hour in Ohio. Ohio is well below the national average for case management reimbursement. There are services we perform that are not reimbursed by the BWC. Faxing, for example, is not a covered service. Faxing costs the case management company time and money in phone line charges and in productivity lost. There is no other fee-for-service company that I know of that is not reimbursed for this.

During the last eight years reimbursement MCOs and TPAs have increased their revenue when workers' compensation premiums increase. MCOs are paid a percentage

of premiums paid to the BWC. TPAs often base their reimbursement on percentage of premiums paid also. The only part of the workers' compensation delivery system to not get an increase is the vocational rehabilitation component.

CASE MANAGERS

In the definition of vocational rehabilitation, there is an implication that the person providing this service will be qualified to decide on a goal for the disabled person, define a plan unique to that disabled individual, implement the plan, assess the merits and success of the plan and evaluate and change any portion of the plan that is not achieving the goal.

Inherent in this are the qualified case managers that perform this task. These individuals are certified RNs that have attained board certification and subsequent training in vocational rehabilitation, degreed people who have obtained a certification in vocational rehabilitation, or people who have attained a Master's degree in vocational rehabilitation. In short, case managers are a highly qualified group of people who desire to help people with disabilities to attain a better quality of life. Good, qualified case managers are in short supply and their salaries are high to reflect this. In the past, we have looked at the OSU program for Certified Case Managers. However, this program has lost its funding and their class size has been decreasing to less than ten per year. This has not helped fill the void.

Eight years ago I started my company, MMD Consulting, Inc. At that time a case manager could be hired for \$30,000-\$35,000 per year plus benefits. Today that same individual demands a salary of \$50,000-\$60,000 dollars plus benefits.

Salaries: 1999 vs. 2007

Year	Average Salary
1999	\$28,000
2001	\$40,000
2004	\$46,000
2007	\$55,000

- The average salary paid to a vocational rehab case manager has nearly doubled in the past decade.

YEAR	TOTAL PAYROLL	# employees	AVG
1999	\$133,182	4.5	\$29,596
2000	\$211,249	6	\$35,208
2001	\$429,372	11	\$39,034
2002	\$598,498	14	\$42,750
2003	\$415,363	9.5	\$43,722
2004	\$407,321	9	\$45,258
2005	\$294,979	6	\$49,163
2006	\$360,710	7	\$51,530
2007	\$365,410	7	\$52,201

Vocational case managers are not job oriented. They are professionals and this is their career. My staff has done many things for clients that are not covered in billing. A couple of examples include:

Taking equipment to injured workers although the case had been closed and we could no longer bill for our time and service. We did this solely for the benefit of the injured worker as they had no other way to obtain the equipment. In one case, the injured worker was in Chillicothe- my case manager lived in Columbus. Our case manager spent half a day of non-reimbursable time to assist this injured worker.

Additionally, one of my case managers spent an afternoon with the wife of an injured worker who recently was killed in a car accident. This hispanic woman felt so close to our staff member that she called immediately after hearing the news. This was also not reimbursable time.

Vocational staff works for the joy of providing assistance and seeing a worker overcome barriers and return to work. As you can see from these examples, our case managers also provide assistance regardless of the amount they can be reimbursed.

POLICY IMPLEMENTATION RESTRICTING "INTERN" PAY

An issue that also significantly affected our reimbursement was when the BWC implemented policy in 2004 that would pay voc rehab interns at 85% of the reimbursement rate. Our rate of pay was bad anyway and then the BWC took 15% away for an intern. An intern is considered to be a person who has the same education as a credentialed case manager but has not sat for their credentialing test but is scheduled to. They perform the exact same services as a credentialed case manager. The only distinction is that the intern must have all work verified by a credentialed case manager.

We believe this policy was implemented because the larger voc companies were using a significant number of interns at a lower salary. Additionally, those interns did not the education to sit for any test in the near future. The BWC wanted to limit the amount of time an intern could be an intern before they're able to become credentialed. As usual, the bigger MCO/Voc Rehab company partnership was pushing the policies to their breaking point and all companies are subsequently punished. The reimbursement rate was pathetic to begin with and we could not afford to hire interns to train any longer because they would only be reimbursed 85% of the professional rate. With the average salary increasing every year we were forced to hire credentialed case managers for significantly higher salaries and forced to end intern employment.

HEALTH INSURANCE AND BENEFITS

Health insurance has doubled and tripled for companies since I began my company in 1998.

Rates have increased consistently roughly 20% each year. In 1998 we were able to offer group health insurance coverage and pay 80% of the monthly premium. Each year that percentage decreased. By 2006 we could no longer offer group health coverage. All our employees are covered under an individual health plan and MMD can now only cover a small percentage of their cost.

FUEL PRICES

Fuel cost \$1.20 per gallon in 1998. In 2007 it has TRIPLED to \$3.50 per gallon.

Assuming 20 mpg per vehicle....

A tank that holds 20 gallons at \$1.20 per gallon (in 1998) will cost \$24.00 to fill the tank.

Reimbursement then at \$0.26 per mile would equal roughly \$104.00 per tank of gas.

Subtract the cost of \$24.00 for that tank and \$80.00 is left for "car maintenance"

Today, that same tank at \$3.50 per gallon (in 2007) costs \$70.00 to fill up.

Reimbursement today at \$0.30 per mile would equal roughly \$120.00 per tank of gas.

Subtract the cost of \$70.00 for that tank and only \$50.00 is left for "car maintenance".

POSTAGE

In 1998 the cost of a first-class stamp was \$0.32.

On May 14, 2007 that cost increased to \$0.41. In May 2008 this rate will again increase to \$0.42 to mail a first class envelope. This is a 23% increase in ten years!

In addition, the new postal pricing guidelines make mailing a large envelope, which we do often, even more expensive because the USPS has restructured their fees to reflect thickness as well as size and weight. For example, a "flat" envelope (9x13) that used to cost \$0.63 to mail now costs at least \$1.14.

Naturally, our postage costs have increased by at least that amount in the past ten years while our reimbursement has only increased 7%.

Additionally, prior to 2001 the BWC required an invoice be submitted with three codes with totals for: professional, travel and mileage. We were able to submit one invoice with supporting documentation. We were mailing in roughly 3 pages per invoice total.

As of 2001 we were required to itemize every single activity we billed for. This significantly increased our postage as our 3 pages per invoices suddenly increased to roughly 12 per invoice. This added paper increased weights and subsequently increased our postage by 50%.

OFFICE SUPPLIES/COST

- Directly relating to the new policy on submitting billing in detail, this increased our paper purchase by 40% in 2001 vs. 2000.
- The cost of general office supplies has increased by roughly 3% each year since 1998. For example, the cost of printing and fax toner, per-sheet price for faxing and printing, and all other office supplies.

SOFTWARE DESIGN

The BWC consistently changes the criteria MCOs must meet to be awarded "incentive money". This incentive money used to be part of the basic fee paid to the MCO based on the premiums generated by their customers, the employers. Around 2003 the BWC instead began paying the MCO part of this fee but held back part as an "incentive" when they reached the goals the BWC set for them. These different criteria have ranged from successful return to work (RTW) percentages to billing accuracy. The MCO is forced to constantly monitor the number this criteria so they may be awarded their incentive money. In turn, we must be able to provide the MCOs with this information upon request. For this reason we've spent many thousands of dollars on software development and modifications over the years in order to generate reports for our clients, the MCOs, to prove we are doing the job

they hired us to do. We spent thousands developing software to create reports that would help justify their incentive payment. Then, after only one year of these criteria, the BWC changed their incentive criteria. It rendered our newly designed and purchased software useless.

BILLING

The current incentive for MCOs now include, in part, scrutinizing billing submitted by vocational rehabilitation companies. This has significantly increased the amount of time spent on managing incoming payments. We spend an extraordinary amount of time attempting to justify, for example, a \$7 or \$14 charge for a phone call placed to the injured worker. The MCOs are basically guessing at how long an activity will take. Because part of their paid incentive money is tied to billing accuracy, the MCO is now arbitrarily reducing the amounts we submit in an effort to do what the BWC would deem as appropriate and not necessarily what is fair and accurate. In addition, despite the amount of time our case managers spend on an individual case, they are limited to a specified maximum amount of billing. This is unreasonable as each case is unique and the amount of time needed to benefit the injured worker differs from case to case. Each case is as unique as the person we're attempting to help and time constraints significantly reduce our capabilities to assist them in returning to work successfully.

SUBJECTIVE REDUCTION OF BILLS BY THE MCO

MCOs have the ability to reduce charges submitted without explanation. An example is a phone call placed by one of our case managers to an injured worker. The call was billed at a 0.2 unit which means it was between 7 - 11 minutes long. The MCO arbitrarily reduced the payment to a 0.1 unit. Despite our appeal, we were not provided a reasonable explanation and no adjustment was made. We were simply told that they did not "think" the phone call would have taken that long. This is despite the detailed activity entry submitted outlining the conversation. This happens regularly since the MCOs are now scrutinized for their billing procedures as part of their contract incentives. The case management company is not able to get their invoices paid in full. For the MCO, it is not about paying what is fair but about paying what will benefit their numbers and get them the most incentive money.

CASE SETTLEMENT

Finally, and most disturbing, are cases that are settled can result in vocational rehabilitation not being reimbursed. We have had five cases this year alone in which we were not informed of settlement and therefore provided services that were not paid. Sometimes we received the notice of settlement after the fact and therefore as of the date of settlement no further payments can be made. In one case we were assured by the MCO that we would get payment and to please continue the case. We continued services and payment was denied. There is very little communication between the MCO and the case management company regarding settlements. The MCO wants services to continue so occasionally we are not informed of these potential settlements. There is no company out there who wishes to work for free. Like everyone else, we expect payment for services we were requested to provide.

LACK OF BWC INFORMATION

Vocational case management companies that are owned by MCOs are given access to the BWC's case notes system called V3. They are able to access this through the MCO computer system. Those of us who are independent do not have that access. This information alerts case managers to legal aspects and helps avoid providing service after settlement. It also gives important information regarding the claim and therefore provides a clearer picture. I believe all those who are parties to the claim (actively providing services to an injured worker) should have access to this information. Clearly, those who have access to ALL information are at an advantage.

Likewise, large MCOs have direct access to the administrators of the BWC and have helped write the contracts for the MCOs. Smaller companies, like MMD Consulting, have limited access and virtually no access to the administrator. Access and influence can be directly proportional to the size of the company.

MCO contract specifications or changes in expectations regarding vocational rehabilitation are not provided to the vocational case managers. We must rely on the MCOs to provide that information to us. We should be part of this information system so we can provide the service that is needed and expected.

INJURED WORKERS

By definition, case management should begin early in the claim to allow for the best result. When cases are managed shortly after the injury, injured workers often return to work quicker and feel less anxiety because they are more knowledgeable about the system and their options. The BWC does not allow for early intervention unless the claim is a catastrophic claim. This is a mistake. Early intervention has been shown to reduce overall costs.

Unfortunately, task assignments are not allowed. A task assignment is an intervention in which the case manager would perform one or two tasks such as assessment to see how the injured worker is doing, going to a doctor's appointment to clarify the job requirements and if the employer has a position that can accommodate restrictions. It does not require a treatment plan or prolonged case management; however, it can assist the injured worker in directing them early on, inform the employer of any potential barriers in the future, and provide information to the provider so he or she can correctly assess the need for continued time off work. Many self-insured employers are using this now with great success. Task assignments can reduce the cost of prolonged case management down the road.

PUNISHMENT OF ALL FOR THE MISTAKES OF A FEW

The BWC levees rules on all case management companies when a few, usually larger companies, make mistakes or are fraudulent. This is harmful to us all. Six years ago we were given only six hours to put an injured worker in to a vocational rehabilitation plan. Any time needed after that was not reimbursed. This was the result of some companies charging exorbitant amounts for pre-plan time (the time requirement to meet, assess, and develop a plan). We were not one of those companies. Our company provided the service to the injured worker regardless of the time it took if we thought the injured worker was feasible and just needed a little more help. This hurt us financially but left us with knowing we did the right thing by the injured worker. Because of this rule some injured workers suffered. At the magic number of six hours their case was closed. We received some of those cases and worked with them regardless of reimbursement if we felt the injured worker could benefit.

It is only right to deal directly with those offenders rather than implement changes that negatively affect the rest of us.

SUMMARY

Case management is a much needed tool for some cases. It provides the liaison and creative work necessary to assist the injured worker to get the services they need. Case managers are in short supply and can demand salaries that are 60% higher than eight years ago. The cost of doing business has escalated but reimbursement has not changed in over eight years. The profit margin has dwindled to nothing forcing many companies out of the industry. The vocational rehabilitation companies and individual case managers are not included in the information system of the BWC and are not informed by the BWC of bureau expectations. Large case management companies are owned by the MCOs which seems to be a conflict of interest and certainly not in the best interest of the injured worker. These large companies command a presence in the BWC and are given access that smaller companies are not.

In short, the future is dismal for the case management industry unless changes are forthcoming.

Speaker

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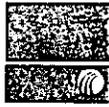
Julie Zalar
Supervisor, Work F.O.R.C.E
Upper Valley Medical Center

Not only am I concerned about the decreased referrals to WC and WH that my program is experiencing, I also have concerns regarding the client absenteeism and no shows from the clients in my Industrial Rehab Program. If a client does not show up for treatment how can the facility demonstrate the outcomes expected by the MCO and BWC? I have discussed this concern with case managers, and other program managers. I have been told that it would be a bookkeeping nightmare to make it a financial consequence for the client if they do not show up. But it seems to me that thousands of dollars are being lost by paying TT and LM to clients that continually no show for treatment.

WKF keeps meticulous records for a client's attendance and if they do not attend the case manager is notified immediately. We also have a policy that states if a client misses more than 3 (three) days during his/her program they will be dismissed.

Herein lies the problem. Most of the time the client is not dismissed because, first, we need the revenues and also, as I have been informed, if dismissed the client will usually complain to the Industrial Commission and the decision to dismiss will be overturned, the case reopened, and all the paperwork will need to be redone. It doesn't appear to make a difference that as the supervisor, I have scheduled therapists to cover a certain number of clients, and provide evaluations, and treatments and this drives my operating expenses up.

Maybe, BWC would like to initiate a new policy that would allow programs such as mine to charge for the visit if the client does not show up; much like physicians do for missed appointments not cancelled within 24 hours. In January of 2008, Work Force had 24 client absences and this was with a census of 7 clients. This is an average of approx 3.42 per person and equated to several thousand dollars of lost revenues and incurred personnel expenses that could have been adjusted. With the decreases in referrals to WC and WH every little bit helps keep the door open. Is there anything that can be done?



UVMC

To: BWC Board of Directors
From: Julie V. Zalar, MOT, OTR/L
Supervisor, Work F.O.R.C.E.
Date: April 24, 2008

RE: Decreased Occupational Rehabilitation Referrals:

I am here today to report to BWC that I am concerned about small CARF accredited facilities such as Work FORCE. I am afraid we will not be around in another two years. Since 2005, Work FORCE has seen a drop in Occupational Rehabilitation (OR) visits by 34% while Work Conditioning visits have increased by 55%. While the increase in WC visits is welcomed, the revenues hardly replace what is being lost by the decreased referrals to the OR program.

In the past a client who was not job ready was referred to OR for a more intensive work simulation component and increased hours. However, it appears that instead of utilizing this program progression, a number of clients are being referred to Active Physical Therapy first and then WC, eliminating OR all together. Active Physical Therapy is extremely expensive and cannot usually be provided in facilities that provide OR and WC. The reason being, Active Physical Therapy is a Physical Therapy code and is charged as such. As a physical therapy CPT code, it is defined as an individual one-to-one treatment and can not, per PT scope of practice, be provided in a group setting. Clients usually attend for 3 times per week at 2 hours per visit. They are charged with CPT codes and if modalities are used a 2 hour treatment can cost over \$500 per hour. That would be approximately \$3,000 per week for 6 hours of therapy. Beside the cost, the other obvious concern is what type of work simulation is being done in these active PT programs? Is walking on a treadmill considered work simulation because the client must walk from one end of the factory to another? I would submit this is not the definition of work simulation.

Regarding the increased referrals to WC and why these revenues have not off set the decreased OR referrals. Chapter 4 states clients can attend WC for 3-5 days per week. Some clients initially attend 3 days per week and progress to 5 after several weeks but many clients attend only 3 days because they cannot tolerate more days than that. They have either not had any previous therapy or the therapy they have completed did not ready them for the WC program. Therefore the concern remains, if a client attends 8 weeks of WC for 3 days per week, they have participated for only 24 days. What outcomes can be expected in 24 days, especially when the average number of days from injury to referral to the WC program for WKF in 2007 was 756 days. Where do these

clients go after WC? Are they expected to be job ready at the completion of the WC program?

My question is this: What does the future hold for (OR) and programs such as Work Force and if OR programs are discontinued, what will take their place?

I have learned that when you voice a concern you should offer a solution. My suggestion to the above stated concern would be to reinstate a WO code for (supervised) reconditioning. This would allow clients to begin their rehabilitation in industrial rehab centers which are designed to provide the work simulation that is being requested. The client could attend 2 – 3 times per week, increasing time as tolerated and in some programs be allowed to participate in aqua therapy along with the WC and OR program clients. If modalities are needed, CPT codes could be charged for these but only provided with physician order and approved C-9. The treatment options would be limitless and when the client was ready, the transition into WC would be seamless. No new evaluation, no waiting to be included in the census. RTW goals would already be set and clients could progress faster, without wasted time and money.

The case manager would have more treatment options, the client would have a more positive outcome, and programs such as WKF would have another source of revenue.

My final question is this; if referrals and revenues continue to decline and reimbursement continues to decrease, programs such as WKF will have no choice but to close their doors. Where will the clients go for treatment then, what options will they have? They can probably go to the library for their FCE, or maybe even do an FCE in their home. They can complete WC at a room in a strip mall, or even the back of a truck, lifting boxes and some free weights and call it work simulation. Sure they can do this, but is it really what they need or what BWC wants to pay for?

RE: Client Absenteeism:

In January of 2008, WKF documented 24 client absences and this was with a census of 7 clients. This is not unusual as it has been a problem for many years. I am concerned about the lack of consequences to clients that continually no show for treatment. They are told at the beginning of the program they are allowed 3 absences and sign an agreement not to miss more than that. But, many clients continue to call in "sick" and miss many more days than allowed. When asked to bring a physician's excuse to prove they are ill, client's most often state they cannot afford to go to the doctor. My hands are tied.

I have discussed this concern with case managers and other program managers and have been told that it would be a bookkeeping nightmare to make it a financial consequence for the client if they do not show up. And that if the client is discharged because of non-compliance they usually complain to the Industrial Commission and the decision to dismiss will be overturned, the case reopened, and all the paperwork will need to be redone. It does not seem to make a difference that as the manager, I have scheduled

therapists to cover a certain number of clients, and provide evaluations and treatments. I am certainly not allowed to charge for missed visits and this becomes a financial consequence for my program.

I would like to request that BWC put into place a policy for attendance and enforce it when clients take advantage of sick days and other excuses that appear to be inappropriate. If BWC were to withhold TT or LM to clients for missed days it would save thousands of dollars and would most certainly make clients think twice before missing a day if they were really not ill or just not showing up because they do not want to attend.

Speaker

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To Whom it May Concern:

RE: Those who wish to speak may also send the following information to PublicForum@bwc.state.oh.us or fax it to (614) 621-9412

Registration information:

- ☒ Name: Julie Keil
- ☒ Title: Exec Director
- ☒ Company/association representing: Ohio Assn of Rehab Facilities
- ☒ Mailing address: 17 S High St, Ste 280, Columbus, OH 43215
- ☒ E-mail address: oarf@sbcglobal.net
- ☒ Phone number: 614/461-OARF
- ☒ Summary of your presentation :

Medical services within an injured workers vocational rehab plan of care; BWC Vocational Rehab Redesign proposal; medical voc rehab services with the Health Partnership Plan

Thanks

Julie A Keil, MPA
Ohio Association of Rehabilitation Facilities
17 S. High Street, Suite 280
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Ohio Association of Rehabilitation Facilities

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April 24, 2008

Chairman Lhota and Members of the Board:

Thank you for the opportunity to provide testimony today. My name is Julie Keil, and I am the executive director of the Ohio Association of Rehabilitation Facilities. Our members are BWC vendors that provide medical rehab and vocational rehab services to IWs.

We are here today in response to your call for testimony to:

- Identify barriers that keep quality providers from participating in BWC's program that, if removed, would enhance the delivery of quality, cost-effective medical treatment;
- Identify strategies BWC could implement to enhance provider performance for the delivery of quality, cost-effective health care and return-to-work services.

We think both these objectives can be best achieved by eliminating conflicts of interest within BWC's Health Partnership Program in the delivery of medical services, particularly in the Vocational Rehabilitation Program.

These conflicts of interest have begun to create a monopolistic¹ environment that effectively excludes many quality providers.

The situation to which I refer is one in which some Managed Care Organizations (MCOs) decide **what** services an IW is to receive, **provides** those services through "sister" companies, and **control referrals** to those services, both directly and through their sister companies.

I ask you to consider Blacks Law Dictionary definition of "conflict of interest" which reads in part:

"...a clash between **public interest** and the private pecuniary interest of the ... individuals concerned; a conflict of interest arises when a person's personal or financial interest conflicts or appears to conflict with his official responsibility."²

This is the situation we have today among MCOs and their sister companies in the HPP.

I emphasize **public interest** here because BWC is not a private insurance company or health care provider; it is a public agency, with a public purpose, authorized by the People in Ohio's Constitution at Article 2.35.

The public --employers and injured workers-- place their trust and confidence in someone to act in their best interests, but in this situation those interests compete with the pecuniary interests of the MCOs and their sister companies.

Other health care systems operating in the public interest in this country, namely Medicare and Medicaid, do not permit conflicts of interests. Beginning in 1992 the federal "Stark Law"³ prohibited this activity.

BWC's own Vocational Rehabilitation Internal Audit of August 2007 recommended that:

"BWC should take steps to eliminate the potential conflict of interest created by MCOs that refer vocational rehabilitation cases to their sister companies."

We would add to this that BWC should also take steps to eliminate the additional conflict of interest that exists when the sister companies make referrals to *themselves* to provide services.

Interestingly, the Ohio Revised Code and Ohio Administrative Code *already* infer prohibitions against these arrangements in defining the role of the MCO to the exclusion of being a service provider, but these have been largely ignored by BWC under previous administrations.

We would draw your attention to ORC 4121.44 (B)(1) wherein the BWC is to certify

"... 'managed care organizations' to provide **medical management and cost containment services** in the health partnership program..."

Moreover, OAC 4123-6-01 (C) further clarifies that:

"...a managed care organization is not a health care provider."

OAC 4123-6-01 (G) defines "Health care provider" or "provider" as those that:

"...provide particular medical services or supplies including, but not limited to: a hospital, qualified rehabilitation provider, pharmacists, or durable medical equipment supplier."

It is our contention that the existence of a financial relationship between MCOs and their "sister" companies has the effect of making the MCO and the "sister" one and the same, regardless of their organizational tax status or structure. Thus, in delivering BWC health care and vocational rehab services, MCOs operate in fact as a "health care provider" beyond their statutorily prescribed purpose, and in violation of statute and rule.

Finally, we would bring to your attention to governor Strickland's Executive Order 2007-01S--his very first executive order in which he spoke on the matter of ethics in government and ordered compliance with Ohio Ethics Laws:

3. **Vendor and Grantee Ethics.** Those who have contracts with the State or who get grants from the State should also play a role in making sure that State officers and employees follow the law and this order. Accordingly:
 - a. My Chief Legal Counsel, in consultation with the Ohio Ethics Commission and the Chief Ethics Officers at the various agencies, will, over the next 60 days, develop a program which requires those doing business with the State of Ohio or receiving grant funds from the State of Ohio to certify, before they can receive any money from the State, that they know and understand Ohio's ethics and conflict of interest laws, are aware of this order, and that they will not do anything inconsistent with those laws or this order.

I submit to you that the conflict of interest of which I have spoken is also in violation of Ohio's ethics and conflict of interest laws, and therefore in violation of the executive order.

To remedy this situation, and consistent with the BWC Internal Audit finding, the Ohio Revised Code, the Ohio Administrative Code and Executive Order 2007-01S, we urge you to act to eliminate the conflict of interests

We recommend this be achieved by amending the Ohio Administrative Code to include new language that we propose that would eliminate the act of self referrals by MCOs and their sister companies.

Our amendment would have the effect of clarifying *existing* state statute and Administrative Code, and conform to Ohio ethics law and the governor's Executive Order by eliminating the conflict of interest within the system.

We urge you to consider our proposed amendment, and to act swiftly to move the proposal through JCARR as necessary to amend the Code. A copy of our proposed amendment is included in our written testimony.

Thank you again for the opportunity to testify.

End Notes

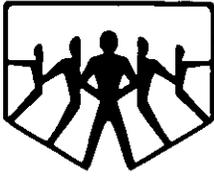
¹ **Monopoly:** A privilege or peculiar advantage vested in one or more persons or companies, consisting in the exclusive right (or power) to carry on a particular business or trade, manufacture a particular article, or control the sale of the whole supply of a particular commodity. A form of market structure in which one or only a few firms dominate the total sales of a product or service; the two main elements of the Sherman Antitrust Act are: possession of monopoly power and willful acquisition or maintenance of that power, as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.

Monopoly Power: That which must exist to establish a violation of the Sherman Anti-Trust Act. The power to fix prices, to exclude competitors, or to control the market in the geographical area in question.

Monopolization: It is monopolization for persons to combine or conspire to acquire or maintain power to exclude competitors from any part of trade or commerce, provided they also have such power that they are able, as group, to exclude actual or potential competition, and provided they have intent and purpose to exercise that power. Blacks Law Dictionary, 6th Edition.

² Blacks Law Dictionary, 6th Edition.

³ 42 U.S.C.S. §1395nn which is §1877 of the Social Security Act. Additionally, the regulations are at [42 C.F.R. §411.350 through §411.389.



Ohio Association of Rehabilitation Facilities

17 South High Street, Suite 280 • Columbus, OH 43215 • 614/461-6273

RECOMMENDATION TO RESOLVE CONFLICTS OF INTEREST IN THE BWC HEALTH PARTNERSHIP PROGRAM & BWC VOCATIONAL REHABILITATION PROGRAM REDESIGN PLAN

PROPOSED RULE

No managed care organization and no organization or person having a financial relationship with a managed care organization shall make a referral to themselves or to an organization or person with whom they or the managed care organization has a financial relationship for the provision of the treatment or other goods and services rendered to the injured worker

A managed care organization or organization or person having a financial relationship with a managed care organization that violates this rule may be subject to decertification or disciplinary sanctions pursuant to the rules of XXX chapter of the Administrative Code.

If any person believes that this rule has been violated, the person may file a complaint with the administrator. Upon receipt of the complaint, the administrator shall forward the complaint to the inspector general who shall investigate the complaint. If after investigating the complaint the inspector general determines reasonable evidence exists that this rule has been violated, the administrator shall decertify the organization or person that is the subject of the complaint.

Voc Rehab Services Trending

CY	# Claims		% Claims		LWR-Referral Avg Log		Voc Rehab Med Cost		Avg Med Cost/Claim		Total Comp Amt Post Rehab		Avg Comp Amt Post Rehab	
	Successful RTW	Unsuccessful RTW	Successful RTW	Unsuccessful RTW	Successful RTW	Unsuccessful RTW	Successful RTW	Unsuccessful RTW	Successful RTW	Unsuccessful RTW	Successful RTW	Unsuccessful RTW	Successful RTW	Unsuccessful RTW
2005	1,785	2,247	40.5%	51.0%	224	322	\$9,244,673	\$7,779,411	\$5,179	\$3,462	\$9,042,099	\$22,649,864	\$5,066	\$10,080
2004	1,913	2,095	44.8%	48.8%	200	282	\$10,006,655	\$7,688,589	\$5,231	\$3,670	\$13,459,185	\$26,738,339	\$7,036	\$12,763
2003	1,987	2,632	40.6%	53.8%	165	225	\$10,131,944	\$9,758,530	\$5,099	\$3,708	\$15,493,808	\$37,639,405	\$7,798	\$14,301
2002	3,268	4,157	42.4%	53.9%	124	189	\$15,274,511	\$15,116,242	\$4,674	\$3,638	\$24,585,671	\$73,726,686	\$7,526	\$17,736
2001	3,679	4,630	42.8%	53.9%	123	190	\$15,153,617	\$16,617,259	\$4,119	\$3,589	\$28,282,165	\$89,238,150	\$7,969	\$19,274

CY	Successful RTW		% of Claims
	PC 11 (Closed)	PC 18 (Closed)	
2005	36%	49%	86%
2004	39%	48%	87%
2003	45%	42%	87%
2002	48%	38%	86%
2001	50%	37%	87%

Successful RTW: Claims having closure code PC 11-15, P11-15, J11-12, NE16
 Unsuccessful RTW: Claims having all other closure code other than the above
 Does not include Claims in 'Open' Status. 'Open' means that the closure text is blank, as such, unable to determine success or non-success.
 Voc-Rehab Med Cost: Medical cost accumulated during first year from First Voc Rehab Service Date of first paid Voc Rehab services.
 Comp Amounts Post Rehab: Comp cost paid after Voc Rehab Case Closed date through 7/21/07.
 Duration: lag between Referral Date and Case Closed Dates (includes only those claims with Referral & Closure Dates).

Speaker

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4

James Anthony
Medical Director
Mercy Hospital of Tiffin
Occupational Health Services

One of the most effective strategies to make the system work more efficiently is to assure that accurate, physician-derived, diagnoses are present as the approved diagnoses in the claim. Even if the final approved diagnoses take longer to formally "attach" to the claim, the result will be a system that has a fighting chance to work as intended. As currently applied, the approved diagnoses come from either the initial diagnoses listed on the FROI or a BWC coders interpretation of the description provided by the injured worker when the FROI was written. As a full-time occupational medicine physician, I have found case after case where the approved diagnoses are not found on any medical record and definitely not on my medical record, even though I am the physician of record. Most often, however, the inaccurate approved diagnoses are found on the FROI and in the medical record, but only the medical record of the Emergency Room where the initial injury treatment occurred. In their defense, most emergency room physicians have no formal occupational medicine training, do not focus on causality and mechanism of injury, and have the least information at their disposal to provide a final diagnosis. They do the best they can to stabilize the condition as it appears to them until the injured worker can follow-up with another physician. At the time of the follow-up visit or a later visit, the POR is in a better position to finalize the most accurate diagnoses. Those diagnoses should be listed as the approved diagnoses and the MCO will now be able to apply guidelines and approvals appropriately. As it currently stands, many claims are managed by the "garbage in and garbage out" principle such that the initial inaccurate diagnoses are used to incorrectly decide what treatment should or should not be approved.

If accurate diagnoses are approved in the claim, then a "community-based" program where the providers that see worker injuries are experienced and interested, the businesses and MCOs communicate with the providers such that providers understand their concerns, the providers communicate with the businesses and MCOs such that they understand the clinical complexities, transitional work is correctly applied, and rapid return-to-work is supported by all will work and costs will plummet. It is far better to spend, if necessary and appropriate, more medical dollars on a claim for correct diagnoses while, at the same time, lowering indemnity costs by all parties working together to support rapid and safe return-to-work. All parties, including the injured worker, are best served by accurate diagnoses allowances, proper treatment, and rapid return-to-work. Teach us, work with us, engage us, but let us do our jobs as we are trained. The result will be a more efficient and lower cost system.

Providers treating Ohio's injured workers - Why Not?

James M. Anthony, M.D.
Medical Director
Mercy Hospital of Tiffin
Occupational Health Services

First of all, I would like to thank the Ohio Bureau of Worker's Compensation Board of Directors for allowing me to address some of the key issues surrounding why providers might not decide to provide care for our injured workers. I have been a full-time occupational medicine physician for the past 10 years and have provided injured worker care for over 24 years. Having cared for our workers through the transition from open to managed care and providing care full-time in our current managed system for 10 years, I do think I can offer some reasonable insight into the decision to become a provider under the Ohio BWC system.

As background to my thoughts I wish to remind this fine Board that physicians and other providers still pride themselves on being healers and helpers. Yes, medicine is a business, but most physicians would like the business to take second place to the practice of medicine and healing. I will freely admit that some of my colleagues do focus on financial gain, but it is never in the physician's best interest to place the business of medicine over the practice of medicine. The first item in the Code of Ethical Conduct of the American College of Occupational and Environmental Medicine states: "accord the highest priority to the health and safety of individuals in both the workplace and the environment." These generalizations are quite consistent with providers and the ethical standards of good medical care being top priority are clear.

Because of this, I feel that the bias among physicians (and likely other providers) is to say "Yes" when asked to take care of the injured workers in Ohio. Except for complaints from my surgical colleagues about reimbursement rates from the BWC, I do not hear many comments about reimbursement rates being a reason not to take care of injured workers. I do not believe that this means providers feel the reimbursement rates are necessarily good, but they do not feel the fee schedule presents an adequate reason to say "No". Again, therefore, there is a positive bias toward saying "Yes" and signing up as a BWC provider.

Despite this positive bias, more and more physicians are refusing to sign up to provide care under the BWC system. In my small town of Tiffin, there are numerous primary care and specialty physicians who refuse to sign up as a BWC provider. Some specialty physicians who were personal friends of mine refused to sign up as a BWC provider even after I pleaded with them to consider this so I had a local referral source. I guess I should be appreciative of this sad fact, because these physicians all refer their injured worker cases to my occupational health program. However, I recognize the bigger picture that the inability to attract quality providers is a major problem for the State of Ohio and, therefore, the Board to whom I am addressing these comments.

Since there is a positive bias to say "Yes" and more and more physicians are saying "No", we must acknowledge that there are other factors to be considered beyond reimbursement and the ethical desire to care for an injured person. We all know these other factors exist and the Board has defined them as "barriers" and asked that we all help identify them.

Although I have many of my own thoughts, I turned to my excellent occupational health services nursing and clerical staff for some key bullet points. You should all know that these were expressed within seconds and almost no thought was needed to identify them. My staff was clear and concise. The staff identified the following barriers for physicians to sign up as providers under the Ohio BWC system:

- 1) Too complicated
- 2) Too much "red tape"
- 3) Too much paperwork
- 4) Too much time to get responses to our requests
- 5) Too much duplication of paperwork
- 6) The injured workers do not understand the system and ask us to explain it all to them
- 7) Too time consuming
- 8) Very costly because staff needs to be increased to assist with paperwork, case management and billing
- 9) The Employer, injured worker, MCO, and BWC all seem to have different and sometimes incompatible agendas. It is a constant battle to understand what each party needs and when.
- 10) We waste huge amounts of time following up on unanswered C-9s and providing the documentation for them

There were other even less kind comments, but I think these will suffice to make my point. If these were the comments that were rattled off in seconds by a staff dedicated to the Ohio BWC system, you can imagine what other physicians hear from their staffs when they decide to become a BWC provider. Their staffs are expected to juggle the needs of numerous insurance products and soon find that it takes unique and special expertise to work under the Ohio BWC system. This creates enormous inefficiencies in physician's office and is very costly in both economic and human capital.

However, despite the significant cost and complaints from their staff, I still think the Ohio BWC could attract nearly all providers to its system because of the positive bias from physicians to care for an injured person. If I am right, then we still need to explore further the question of "Why Not?"

To deepen our exploration, let's look at some barriers a physician might see that have little or nothing to do with their staff or any financial considerations. These items are again in bullet point form and do not necessarily reflect reality but the perception of reality from a providers viewpoint. Remember, the physician's perception is what they will use to make a decision on signing up as a BWC provider. I have heard many of these

comments from my colleagues. Many physicians perceive the following about caring for patients under the BWC system:

- 1) I am not allowed to practice medicine the way I have been trained. I make an initial assessment and then test my diagnostic belief in subsequent visits. If I obtain new or more compelling information, I adjust my diagnosis and treatment to fit the current active diagnosis. Under the BWC system, if I did not make the complete diagnosis the first time, my patient might need to fight for months to get the updated diagnosis added to the claim and, in the meantime, I am unable to adjust my treatment to match the diagnosis. My patient suffers and I can do nothing to help them. This is just too painful for me to provide care under these conditions. I want out.
- 2) My patients do not understand the system and neither do I. They come in to see me angry about the attitude of their employer and "worker's compensation". It is very hard for me to get my patient well when they are angry all the time. It just doesn't seem worth it.
- 3) The injured workers just don't want to get well. I do the same things for them that I do for all my patients. My treatment seems to work so much better for my patients that were not hurt at work. It is frustrating to hear my patient come in over and over complaining of the same things and never seeming to improve. I want to help people get better not watch them stay sick. Why should I keep doing this?
- 4) It wouldn't be so bad if it weren't for the lawyers and the legal battles. I just can't understand it. If I were allowed to provide the treatment I have been trained to give, my patient would be better and working. As it is, they are angry, in pain, not working and my treatment is denied. It won't be allowed until it is approved in a hearing and the employer still gets two weeks to appeal. I am not used to practicing medicine by a sundial. I think I will refer him to a specialist. Maybe he can talk some sense into them.
- 5) The employer is always calling me and asking why I can't get my patient well enough to return-to-work. I keep explaining how complex all of this is, but they just don't understand. I know they want their worker back, but, if I send him back too soon, he is likely to get hurt again. This time it might be even worse. Then I will need to deal with my patient's lawyer in a very different way, as a defendant in a malpractice case. I just can't afford to do that to my other patients by taking time to explain myself to a third party over and over. I think I will withdraw as a BWC provider. They can't pay me enough to do this.

I think the board realizes that I could go on with these vignettes, but further examples will only water down the message.

It is the undeniable juxtaposition of two powerful themes that drives providers, especially physicians, away from the BWC system.

- 1) The administrative nightmare imposed by multiple forms, duplication of information, many parties-to-the-claim, tracking approvals, incompatible agendas, and a patient's lack of understanding of the system.
- 2) The perception by the physician that they are immersed in a legal and not medical system that impairs their ability to treat their patient as they were trained while, at the same time, indirectly incentivizing their patient to stay hurt. This is then combined with another customer, the employer, who has trouble understanding why the physician just can't get the job done faster.

I do not suggest by any of my comments that this issue is either simplistic or easily rectified. I wish I was able to spend the time to develop solid solutions for these vexing problems. As of this time, I have not identified any timely, cost-effective, and practical solutions to resolve the concerns most physicians have about providing care under the Ohio BWC system. I do know that, together, we must find a solution or our injured workers will not be able to find the competent and understanding care they truly deserve.

I trust that this great Board will find some answers so that we can move forward. I honestly believe that there are ways to remove many of these barriers and allow more physicians to say "Yes". I also believe that if you find a way to remove or reduce these barriers, you will have also found an answer to your second concern today about strategies to enhance provider performance. We must engage providers and energize them about the importance of excellent quality care that is cost-effective and embraces the critical importance of early, safe return-to-work.

I thank you for your valuable time.

Speaker

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Shawn Roll
Program Coordinator
Fairfield Medical Center - WorkLife

A copy of my comments:

WorkLife at Fairfield Medical Center in Lancaster, Ohio has been providing BWC rehabilitation services for nearly 2 decades. Services provided by our program have been highly praised by case managers, clients, employers, as well as with the local BWC DMC and other BWC personnel. Our rehabilitation services have received high marks through accreditation reviews and we provide a comprehensive menu of clinic-based and on-site rehabilitation services. Furthermore, as the coordinator of the program, I currently hold a peer reviewed certification for completing functional capacity evaluations and am continually increasing my clinical abilities through further education. It therefore, can no doubt be said that services provided at our facility are nothing but the pinnacle of quality with annual program return to work rates between greater than 80%, exceeding statewide averages.

However, within the past 5 to 6 years our facility has suffered financially due to a marked drop in referrals for program services. Between 2001 and 2006 referrals to clinical based referrals for services decreased by up to 78% (Work Conditioning: 54/year vs. 12/year; Work Hardening: 15/year vs. 9/year). While we have been informed by BWC that services are trending on-site, we have also seen a drop in our on site referrals from 17/year in 2003 to having NO on-site referrals since 2004. It has been reported that the number of injured workers has declined in the past 5-6 years. The vocational rehabilitation fee schedule has not increased in more than a decade, yet costs in the system have risen or, at best, remained stable.

With less injured workers and less referrals to independent rehabilitation providers in a system with a stable fee schedule, there is a disconnect in logic for overall costs to have increased in the past 5-6 years. It is no coincidence that during this same time period, companies providing case management and rehabilitation services with apparent direct ties to managed care organizations became increasingly prevalent, and reported referrals and billable revenues in the hundreds of thousands and even millions of dollars. With direct access to approval of medical/rehabilitation requests and means of referral to providers, a conflict of interest between MCOs and companies aligned with them to provide services does exist and Fair Market Access for independent and facility based providers has been compromised.

Ethical violations of the client's autonomy and right to chose providers are often breached due to this referral practice. I can't begin to count the number of times that a Fairfield Medical Center client own has been informed that he or she must go to a different provider for a follow-up service because the MCO has mandated this in the approval, even though the client prefers to receive the service from our facility. Additionally, referral to follow-up services with other providers requires another review of all

background information and re-collection of data and measurements leading to additional time and costs to the system.

Due to the transient nature of providers with these rehabilitation companies, no clinic based services can be provided. As a result, inappropriate referrals and changes to physician requests have been frequently noted. I can recall one injured worker with a severe crush injury of his foot. As reported by the frustrated injured work, the client's physician requested physical therapy and the client was informed by the MCO that he was required to have his physical therapy completed on-site followed by transitional work instead of honoring his request for clinical services. After 6 months and 2 failed attempts at spending merely 30 minutes doing his own work in a transitional work program, the client recalled that he was informed by the therapist and MCO that he would have to remain on light duty or find other work. Furthermore, he was told he would be dropped from the system due to the inability to be rehabilitated any further and no other rehabilitation services were available to him.

A year following his injury the client's deficits had become chronic and the client was facing termination by his employer. Becoming frustrated enough with his situation the client researched on his own and discovered numerous clinic-based services that could meet his needs and demanded to be approved for these services. With participation in clinic-based services the client was rehabilitated to a point at which he could tolerate working at his job part-time. Unfortunately due to the inappropriate use of on-site services during his acute injury and significantly long delay in being referred to clinic-based rehabilitation services, the client was unable to achieve significant gains to meet the full-duty responsibilities of his job. Due to the nature of his injury, I am fairly confident that had the client received appropriate progression through the continuum of clinic based services during the acute and sub-acute phases of his rehabilitation followed by on-site and transitional work services, that his outcomes would have been different. Instead the client now faces a life-long disability due to the chronic nature of his injury.

This self-referral process has had numerous notable detrimental impacts, not only to high quality statewide independent rehabilitation providers such as our facility, but it has compromised the ethical and constitutional rights of injured workers in Ohio. The primary statutory responsibility of the MCOs is one of fiduciary matters and is not of service provision. As mandated by statute and directed by the Governor, it is the responsibility of the Ohio BWC to ensure that these ethical conflicts are not occurring and these barriers to fair market access must be removed. In order to ensure all providers are receiving equal opportunities and to be certain that the Ohio taxpayer funds are being used to provide appropriate, high quality, cost-effective services the BWC must regain control of this snowballing situation.



Fairfield Medical Center

April 24, 2008

Chairman Lhota and Members of the Board,

I would like thank you for the opportunity to provide testimony. My name is Shawn Roll and I have been providing industrial rehabilitation services as an Occupational Therapist for 5 ½ years. I have been asked to speak not only on behalf of my employer, but also on behalf of the Ohio Occupational Therapy Association. As a representative of these two organizations I will speak to the ethical, quality, and financial issues related to referral for services within the current rehabilitation system.

The comprehensive menu of services provided by WorkLife at Fairfield Medical Center have received high marks from accreditation reviews, and have been highly praised by case managers, clients, employers, and the local BWC DMC for nearly 2 decades. As the coordinator of the program, I hold a peer-reviewed certification and I continuously further my education. The services provided at our facility are nothing but the pinnacle of quality with annual program return to work rates greater than 80%, exceeding statewide averages.

However, within the past 5 to 6 years our facility has suffered financially due to a marked drop in referrals by up to 78%, with Work Conditioning referrals dropping from 54/year to 12/year, Work Hardening from 15/year to 9/year, and on site referrals from 17/year in 2003 to having NO on-site referrals since 2004. At the same time, companies providing rehabilitation services with direct ties to MCOs reported billable revenues in the hundreds of thousands to millions of dollars. Overall, the number of injured workers has declined in the past 5-6 years; however, the vocational rehabilitation fee schedule has not increased in more than a decade, and costs in the system have risen or, at best, remained stable.

With less injured workers and less referrals to independent providers in a system with a stable fee schedule, there is no reason for overall costs to have increased, aside from the rise of a self-referral system. The direct access to requests and means of referral to providers creates a conflict of interest between MCOs and rehabilitation companies aligned with them and Fair Market Access for other providers has been compromised.

In uncountable instances, my clients have been mandated by the MCO to see a different provider for a follow-up service, even though the client prefers to receive the service from our facility, breaching autonomy and right to choose providers. This guiding practice also compromises the autonomy and beneficence of therapy practitioners and referral to follow-up services with other providers leads to additional time and costs to the system. Furthermore, the inability of these companies to provide clinic-based services frequently leads to inappropriate referrals and modifications of physician requests, impacting quality.



Fairfield Medical Center

I can recall an injured worker with a severe crush injury of his foot. As reported by the frustrated client, the MCO required him to complete on-site treatment instead of honoring his request for clinic-based services. After 6 months and 2 failed attempts at spending merely 30 minutes in transitional work, the therapist and MCO informed him he would be dropped from the rehabilitation system due to the inability to progress and that there were no other services available to help him.

A year later, facing termination by his employer, the client independently discovered numerous clinic-based services and demanded to be approved and referred. Participation in our work hardening program increased the client's tolerances to return to his regular duties part time; however, due to the significant delay in being referred to clinic-based services, the client was unable to achieve significant gains to tolerate a full-time return. I am fairly confident that his outcomes would have been different had the client received appropriate progression through the continuum of clinic based services during the acute and sub-acute phases of his injury, followed by on-site services. Instead, the client now faces unemployment and a permanent, life-long disability due to the chronic nature of his injury.

Increased inappropriate referrals leading to increased costs and poor quality have resulted in financial hardships for high quality statewide independent rehabilitation providers, and the process has compromised the ethical and constitutional rights of both the injured workers in Ohio and individual rehabilitation providers. The primary statutory responsibility of the MCOs is one of fiduciary matters and not service provision. As mandated by statute and directed by the Governor, it is the responsibility of the Ohio BWC to ensure that ethical conflicts are not occurring and barriers to fair market access must be removed. In order to ensure all providers are receiving equal opportunities and to be certain that the Ohio taxpayer funds are being used to provide appropriate, high quality, cost-effective services BWC must regain control of this snowballing situation.

Thank you for your time.

Shawn C. Roll, MS, OTR/L, CWCE
WorkLife Program Coordinator

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Speaker

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David Kessler
Medical Director
CompManagement Health Systems, Inc

In the initial days of MCO medical director meetings, there was recommendation to provide financial incentives for providers demonstrating ability to meet various benchmarks. Consideration to federal government programs used in general non-occupational medicine maybe a reference tool. Consolidation and standardization of forms may reduce provider's work and allow greater efficiency. Auto-population of demographic data and having drop down boxes upon accessing online screens for providers or staff to complete may assist in the process. Finally, defined consequences for non-compliance of providers leading to non-renewal of an annual or 2-year contract with BWC allows ability to tier providers based on benchmarks being met.

Speaker

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Ken Keifer
District 4 WC Representative
Ohio Association of Professional Firefighters

Comment will pertain to the barriers that keep faulty providers from participating as BWC certified providers: 1. Complications with an allowed condition vs. unallowed conditions; 2. Complications of an active claim vs. inactive claim; 3. Complications result from multiple reviewing entities - employer, MCO, BWC and the need to constantly defend the access to treatment.

PUBLIC FORUM APRIL 24, 2008
PART 1: MEDICAL ISSUES

My name is Ken Kiefer and I am a Workers Compensation representative for the Ohio Association of Professional Fire Fighters. I would like to thank the Board of Directors for allowing me to address the issue of complications with medical treatment that discourages Providers from being involved in the Workers Compensation system. Obviously my experience is limited to claims for Professional Fire Fighters. However, after working 17 years as a representative, I believe that I have a broad base of claims experience.

On the participation form, I indicated there were three areas that create barriers for quality Providers from becoming certified BWC Providers. After further consideration, I feel there is one primary reason that discourages quality Providers and the other three issues are just complicating factors that can complicate the BWC system.

The primary issue is ECONOMICS.

A Providers' fee schedule is preset at a fixed reimbursement based on the treatment rendered and the associated CPT code. There is no negotiating additional payment if the treatment is more complicated or difficult due to non allowed medical conditions. One fee fits all is the practice with the BWC. The Provider must have an office, staff, equipment, malpractice insurance and all expenses associated with operating a business. In addition, the Provider usually needs a staff person that has special training in handling the extra paperwork associated with BWC claims.

A Peer Reviewer for an MCO negotiates a separate contract for fees for a certain period of time. If the individual review is more difficult, the Reviewer can negotiate with the MCO for added reimbursement. The Peer Reviewer does not need to have an office with staff, malpractice insurance or specialized equipment for treating patients.

A File review done by a BWC Specialist can designate how many 'Units' of time are needed to complete the review. Each unit is 15 minutes and the current rate is \$20 per unit. A single 1 ½ hr. review nets the Reviewer \$120. Some of these Physicians are retired and thus don't have standard office expenses.

IME Physicians can negotiate their fees for the single exam. Again, they can have minimal expenses to operate their practice and can be paid \$300 to \$500 for the IME.

So the mere negative economics can influence a quality Provider to not participate. Then add in the following complicating factors.

First is the complications resulting from multiple levels of reviewing entities that can contest access to medical care. All treatment must be pre-approved by the MCO who is hired by the Claimant's Employer. A Nurse reviewer at the MCO can object to a treatment requested by a Physician and state merely that the treatment requested does not meet one of many treatment guidelines, Official Disability Guidelines, Milliman & Robinson 7th ed., the Mercy Guidelines or Miller criteria. This denial puts a stop to any treatment needed by the Injured Worker until the denial is resolved by the Alternative Dispute Resolution process. The ADR process requires a Level 1 Peer Review by a like Provider who is paid by the MCO. This review nearly always supports the denial. The Level 2 Appeal is done by a BWC Nurse Reviewer who always agrees with the MCO decision. Finally the Appeal is heard by the Industrial Commission.

During this time, the Provider has only a few choices.

1. Refuse to treat the Injured Worker so that they do not have to be concerned with non reimbursement. During this time the Injured Workers medical condition can decline.
2. Treat the Injured Worker and hope the ADR Appeal will eventually be resolved in their favor.
3. Attempt to obtain approval from the Injured Workers regular health care provider.

In the case of Injured Worker D.W., injury date 10-17-1996, the ADR process took 7 months for a single C-9 request for 16 chiropractic treatments. The C-9 was dated 8-10-2007 and the IC Hearing was 3-10-08. The Provider chose to treat the Injured Worker and hoped to file a retro bill. The bills for this treatment have still not been paid as of this date.

Second is the complication of 'Active' claim vs an 'Inactive' claim. All claims have a statute of limitations based on the type of claim, date of injury and payments of compensation or medical payments in the claim. When the BWC Rule 4123-3-15 was created, a claim would become 'Inactive' if the Injured Worker did not receive treatment every 12 months. So the Provider had a choice to make.

1. Schedule regular yearly visits to keep the claim 'Active' in case the injured Worker should develop a complication in the future.
2. Only treat the Injured Worker when they have a complication and allow the claim to become 'Inactive'. When the claim is 'Inactive' the Physician must submit

a C-9 with office notes and treatment request to the MCO. However, the MCO cannot reactive the claim. This request must be referred to the BWC Claim Specialist for review. A file review can be requested by the BWC CSS and a BWC Physician will review the claim. If the reactivation is denied, the claim will have a hearing in the Industrial Commission.

Again treatment is stopped or the Physician can continue to treat and hope to be paid in the future.

Lastly, allowed conditions vs un-allowed conditions. An allowed condition can lead to another flow-thru condition but the Provider cannot treat the new sequelae until it is recognized as an allowed medical condition in the claim. The request for the additional condition can take months and faces File reviews and/or IME exams that are usually negative. It usually is decided in the Industrial Commission. The Treating Physician must defend the Injured Workers access to needed medical treatment. During the process, treatment is stopped or filed with private insurance.

Solution:

1. Get rid of MCO's and return medical management to the BWC staff. This will eliminate redundancy and place claims management in one entity.
2. Require All Peer Reviewers, IME Physicians and BWC File review Physicians to be BWC certified Providers with active practices. They will then have an awareness of the complications faced by other Treating BWC certified Providers.
3. Reduce the number of guidelines used to review treatment requests. Streamline the process.

Speaker

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TESTIMONY BEFORE THE OHIO BUREAU OF WORKERS' COMPENSATION BOARD

Woody Woodward
Executive Director
April 24, 2007

Thank you Mr. Chairman and members of the Board. I am Woody Woodward, Executive Director of the Ohio State Chiropractic Association and I am pleased to be with you this morning to briefly discuss the care which our nearly 1,000 member doctors provide to Ohio's injured workers and to address some of the barriers to care which injured workers face when seeking chiropractic care in the system.

Chiropractic physicians throughout Ohio provide safe, conservative, cost effective treatment to tens of thousands of injured workers. In many of these cases, chiropractic care alone effectively addresses the workers injuries. This care often renders riskier and higher cost treatment protocols including surgery, spinal injections and prescription drugs unnecessary. Numerous published studies suggest that spinal manipulation performed by chiropractic physicians is at least as effective for eliminating low back pain as prescription drugs, injections or surgery. Still, Ohio injured workers face some barriers when seeking chiropractic treatment for their work-related injuries.

First, the OSCA is concerned about the steering of injured workers away from chiropractic physicians. Not a week goes by when we are not made aware of injured workers who make it in to see a chiropractic physician only after being discouraged from doing so by an employer, or worse yet, an MCO. During the last few years, we have collected a number of employee notices which suggest that an injured worker seek treatment at a company approved occupational medical center. We believe strongly that injured workers are being steered by some employers toward facilities which have the best interests of the employer in mind. This steering at least makes it difficult for injured workers to choose their own doctor—a fundamental element of HPP. We would appreciate the opportunity to work with the Bureau and the employer community to devise a plan which helps to educate injured workers and employers relative to injured worker rights in seeking medical treatment.

Second, the peer review system for claims is in need to reform. Constant reviews, file reviews and hearings cost the system money and inconvenience injured workers. In most cases, care is ultimately authorized, however it is only authorized after a number of exams, file reviews and hearings. I am aware of one claim—which is less than two years old—that has been the subject of no fewer than sixteen BWC reviews and four Industrial Commission hearings *on the issue of chiropractic care alone*. After repeated denials in BWC or MCO reviews, all questions were ultimately settled in favor of the claimant at the IC—the sixteen reviews simply representing an unnecessary expense of time and money. The review industry has become a subset of the chiropractic profession in Ohio. It is a self-perpetuating industry where more reviews and more denials equal more compensation for the reviewer, more cost to the system, more hassle for the

injured worker and delayed income for the provider. The BWC is urged to look closely at the claims review system and follow the lead of other states by requiring reviewers to spend a reasonable amount of time (50%) in actual clinical practice and establishing quality assurance and accountability programs for claims reviewers. Our members deserve to know that their claims for payment are truly being reviewed by their peers, rather than by doctors who have essentially gone to work for MCOs and no longer treat patients.

Third, I have stated in numerous conversations with the previous medical director over the past two and a half years our desire to do whatever it takes to work with the Bureau to address any concerns or barriers that prevent the system from having full confidence in the chiropractic profession treating Ohio's injured workers. This could include educating the BWC and MCOs on standard chiropractic treatment protocols, establishing guidelines for supportive care and working to address issues of doctors who practice outside of the protocols or are gaming the system. The HPP will work when all interested parties work together to provide high quality, proper and cost effective care to the injured workers of Ohio.

Again, I appreciate the opportunity to be with you this morning. Chiropractic care provides low cost, high quality, drug free and non-invasive care to the injured workers of Ohio. The Ohio State Chiropractic Association is committed to doing all that we can to insure that those injured workers receive the quality care they need and are able to return to the workforce as quickly as possible. We look forward to continuing to work with you and BWC staff to address the barriers which we believe exist to those objectives and to striving together as we move closer to them.

Speaker

#

9

H. Owen Ward PH
Clinical Psychologist
Ohio State Chiropractic

I am representing the organization Justice for Ohio Employees. I will present a paper outlining suggestions for the reform that will be useful for the Board's consideration. I would appreciate an opportunity to introduce J.O.E. and handout a brochure to those who are present.

Speaker

#

10

Alan Marco
President
Ohio Society of Anesthesiologists (OSA)

We will address the questions listed in the forum announcement about what is working well and what can be improved in both billing for anesthesia and pain management, challenges that come with anesthesia billing, barriers to care, and efficiencies that could be implemented.

Speaker

#

11

Ohio Bureau of Workers Compensation
Board of Directors
Public Forum
April 24, 2008

My position is that the Employer in the State of Ohio, by default, is held to the most stringent provisions of the OAC and actually ends up paying for all the financial and actuarial consequences that arise when a BWC Certified Physician (BWCCP) does not comply with the OAC.

Having stated my position, I must also note that it appears that Bob Coury and his staff have undertaken with great energy and earnest the effort of trying to rectify some of these improprieties and infractions. Therefore, I encourage you to give them all of the support you can with their effort.

However, their task is daunting because of years of bad habits and misconduct. During these years of incompetence, bureaucratic laziness, and low morale the BWC developed the institutional bad habit of letting certain physicians ignore the conditions of their contract with the BWC.

I support my position with the following documentation:

1. A BWCCP assigned and submitted Medical Reports (a C-84 and a Medcol4) without ever examining the claimant. The claimant simply called into the BWCCP and requested that certain conditions be assigned to his claim status. * Ohio Bureau of Workers' Compensation Special Investigation Department. Case Name: Thomas J. McDonough. January 5, 2005.
2. Delinquent reporting by numerous BWCCP cost my company \$30,000 out of pocket expenses in the years 2003-2004. * Claims # 03-430942, 03-459484, 03-425259, 03-403573, 02-379774

The \$30,000 and other consequences of all this Late Reporting by numerous BWCCP?

Unnecessary Lost Work Days costs had to be absorbed by my company.

Unnecessary Continuous Salary payments had to be absorbed by my company.

If my company had chosen not to absorb the unnecessary costs of this claim, our EMR would have gone up unnecessarily. Ultimately, my company would have been eliminated from their Group Rating Discount. In addition, because my company is in the Construction Business we would have been prohibited from even conducting our normal business operations; because the majority of our customers require that to submit a bid for a project an employer must have an EMR of below 1.00.

3. So in instances as those just described, why doesn't the Employer become "pro-active" as they are taught by the BWC?

When the Employer or the MCO are forced to call the BWCCP and asks them to submit their delinquent medical reports, this action often creates dissension with the physician and or, the

physician's staff. In retaliation, and because of this dissension, the BWCCP often extends certain conditions assigned to the claim; such as, Return to Full Duty and Physical Therapy.

* BWCCP: "I will sign the Medco 14 when I get back from vacation". Claim # 02-379774

4. These next considerations are from a claim which is still under adjudication. Therefore, I am choosing not to reveal the claim number at this time. However, I would hope that once this claim is settled, the BWC would investigate the following events:

A BWCCP initiated and then provided medical treatment for other than an allowed condition. Even though the District Hearing Officer stated "this claim is specifically denied for a herniated disc"; the BWCCP blatantly disregarded that order and treated for a herniated disc anyway and received payment from the BWC for the medical services associated with a herniated disc.

A BWCCP had been treating a claimant for some earlier established claim. On October 2, 2008 the BWC sent notice to the BWCCP that payment for those particular treatments and services were denied.

It then appears that someone instructed the IW to simply file a new claim for a Lumbar Sprain (847.2) which the IW did on October 5, 2008. The alleged date of this Lumbar Sprain was August 29, 2007. Ironically, the treatment and services for this new claim align perfectly with the previously denied medical services.

The previously denied medical treatment and services were then simply resubmitted for the new claim. The BWC then paid the previously denied medical treatments and services because they were now allowed as approved treatment of the new claim.

The questions now become:

With what specificity could the BWCCP have diagnosed a simple back sprain and assign its cause to a particular incident 37 days later?

Was an injury conjured up to fit the previously denied medical treatments and services?

Reference the "Official Disability Guidelines" used by the BWC.

Finally, a question to the Board: Can a claimant's attorney, invoking "Attorney and Client Privilege", prohibit the MCO from contacting the claimant?

If your answer is yes; why should the BWC pay the MCO for a service that by definition, the MCO cannot provide, and then charge the Employer's Premium for that service?

All these issues of noncompliance, improprieties, inefficiencies, and ineffectiveness lead to increased costs to the Employer, increased costs to the BWC and ultimately to higher and unnecessary costs of doing business in the State of Ohio.

Bruce De Marco
Safety Director
Norris Brothers Co., Inc.

Representative for BWC Affairs
Construction Employers Association (CEA)

Speaker

#

12

Jim Hammonds
Chief Admin. Officer
Orthopedic Neurological Consultants Inc

1) Concerning "Barriers", Ortho Neuro very much enjoys it's work with BWC and the patients sent us by BWC. The Announcement last year that if any of our physician would have 3 retroactive certification requests during the year then they would be removed from BWC participation - came across as HARSH. We do make every effort to comply with BWC rules and needs. We comply because we want to work with you there threat was not needed. 2. As you seek new strategies to: Enhance Provider performance: I would ask that the BWC Board of Directors not make the claims from any more complicated by requiring additional data - because it's already a struggle to comply with the varied and numerous claims data requirements of all the carriers and plans in Ohio.

Speaker

#

13

Melven Nehleber
President, CEO
Access On Time

Discuss transportation / logistics issues related to servicing Ohio injured workers. Key issue is directed to the current Ohio BWC fee schedule, liability issues associated with the service, coordination and tracking of the service, and insurances that are necessary to provide the responsible financial liability coverages for the injured workers, the payors, employers, TPAs, MCOs and the Ohio BWC should an incident occur during the transport. The impact of the current fee schedule on the delivery of transportation services in the state of Ohio for workers' compensation claimants.

Ohio Bureau of Workers' Compensation Board of Directors
Public Forum; Thursday, April 24, 2008
William Green Building
30 W. Spring Street
Columbus, Ohio

Chairman William Lhota
Board of Director Members
Guests

Good morning and thank you for the opportunity to speak before this forum. My name is Melven Nehleber. I am the President of a company, AccessOnTime, that provides transportation, travel and language services nationwide and currently on a very limited basis in Ohio. My company has been in business providing these services since 1998. Our experience in working with the workers' compensation industry is extensive. In 2007, we performed more than 174,000 transport legs for injured worker claimants and 21,000 language services. Again, these services were performed throughout the United States with all the transportation services in the workers' compensation industry.

The inability of a claimant to provide their own transportation to comply with their plan of care only lengthens the disability period and extends costs. It may even impact the rehabilitation process.

Today I wish to address transportation services and why my company elects to provide limited transportation services in Ohio resulting from the impact of the Ohio fee schedule instituted in 2005. There is no intent on my part to discredit the services of other providers, but rather to inform the Bureau why a company such as ours that specializes in servicing the workers' compensation marketplace elect not to offer our services in the State.

Please note that even though during 2004 we performed almost 3,700 trip legs in Ohio, we were not contacted or consulted concerning feedback on the proposed and subsequently implemented fee schedule. For the record, we are a provider for the Ohio BWC.

Today, due to financial issues with the fee schedule, we perform limited services in Ohio and only to assist certain of our national clients that service injured workers' in Ohio. This resulted in approximately 190 trip legs in Ohio for 2007 versus the 3,700 mentioned previously. The differences in rates may not look to be significant on the surface, but ours is a business of pennies. Your fee schedule and our costs are to say it simply, not aligned.



Why more than 800 clients comprised of insurance companies, third party administrators, managed care providers, self-insured, federal and state organizations and the like utilize our services and those of our competitors are:

- AccessOnTime specializes in the workers' compensation sector.
- AccessOnTime does not provide the services directly. Rather we coordinate the services to enhance the successful execution of them. On average for each order we perform 7 to 10 points of touch to monitor and manage the transport.
- We utilize credentialed independent providers. We have an extensive network of providers that we manage through our vendor relations department.
- We provide all modes of transportation services. All by contacting one organization.
- Liability. We have a sophisticated insurance program to ensure that there is \$5 million of coverage while we are transporting an injured worker. The key word here is injured, they already are to some extent. What are the ramifications should an incident occur while being transported? It protects our company, our clients and the injured worker.
- We have a sophisticated information technology system that allow us to document in an indelible format, all contacts and notes associated with the services rendered. It very much is a mini-medical/documentation record.
- Our IT systems also allow us to do extensive data mining and reporting for our clients.
- Orders can be place in multiple ways from the traditional phone call, fax, email, our real-time online portal or through various integrations.

In summary, if my attendance at this forum has any impact, I would like to see the opportunity for myself and others to be more a part of the process of designing a fee schedule that makes sense and offers the Ohio Workers' Compensation program the most alternatives prior to formalizing and incorporating it into law. We have quite a bit of experience and would like to be included in the process. It is truly my belief that you may obtain and locate the service for your clients but I assure you that the experience, quality and liability coverages will not be the same.

In closing, thank you for allowing me to make this presentation.

Respectfully,



Melven R. Nehleber
President and CEO

Speaker

#

14

BWC Forum April 24, 2008

Thank you for having this forum. Our office needs your help in understanding the process with Independent Medical Exams that are done every 90 days. The patient is sent for an IME to determine if the patient is medically max improved for the allowed conditions in the claim. There are times when the patient may have pending allowances that needs to be added to the claim.

The IME provider exams the patient based on the allowed conditions in the claim only. Although 9 times out of 10 the patient is found to be MMI. The IME provider has never treated the patient before and we understand the examiner may need to have a bias opinion. But if there are diagnostic test which were approved by the MCO, and those results reveals additional conditions that should be added to the claim. Why waste the time and the money on an IME. Maybe before a patient is sent for an IME the BWC should communicate with the Physician to see if there are any pending allowances that may need to be considered before an IME is performed.

The above process impedes on the continuity of care for these individuals. Could some practices be given the opportunity to skip these processes and communicate with the BWC to collaborate on when the IME will be performed, a simple phone call or a letter to assess the injured worker to see if the patient is even feasible for the exam?

IME's are costly to the BWC, if a practice displays the ability to properly take care of patients and has established (with history) to the BWC that they have the BWC and the patient's best interest in mind then allow them to manage the patient to the closure of the case. We all know that returning the patient to their prior duties as quickly as possible is the goal of the BWC and the Physician. The faster the patient returns to work the fewer costs are uncured and the patient feels better about themselves.

Speaker

#

15

Judy Vincent
Director of Operations
Workers Choice Health Service

BARRIERS FOR WORKSITE THERAPY

There are key barriers that are keeping quality Physical Therapy and Occupational Therapy providers from delivering therapy at the worksite to enable the Injured Worker to remain at work and progress safely to full duty

It continues to be difficult for the physician of referral to understand when and what to request for appropriate onsite intervention. The confusion over the semantics between Onsite Therapy/Billed Using CPT codes and TWT/Using WC637 code is an ongoing problem. Because the POR orders frequently state "PT", the therapist is locked into using CPT codes for services. The onsite provider is unable to progress the injured worker at the worksite. The therapist is also not able to observe job tasks and use those tasks to progress to full duty. The therapist is locked into the restrictions that the IW has in place until the terminology is clarified. On average at least two weeks has elapsed before any changes are made to the C9 that allows for the TWT to proceed and:

1. Injured Worker is unable to be progressed in job duties
2. Physician must be re-contacted for a new C-9
3. MCO must go through the process for changing the initial C-9 to a new C-9
4. Employer is not served timely

To change the CPT codes to the appropriate TWT code, thereby getting the correct authorization and script, takes a great deal of time. Sometimes the POR never responds to this request. Time is wasted and quality therapy is hindered and at times paralyzed.

RECOMMENDATIONS/SOLUTIONS

We would suggest that the BWC implement and empower the MCO to change the billing/code to TWT if the IW is at the worksite and has established worksite restrictions.

Speaker

#

16

Jerry Bower
Risk Manager
Franklin County Commissioners

I am a certified workers' compensation specialist and also possess the ARM designation. I have over 20 years of experience and involvement in the Ohio Workers' Compensation Industry.

I want to discuss and highlight some problems with the evaluation of permanent partial disability awards. I just have a few questions and comments that will take a maximum of 10 minutes. Thank you.

Speaker

#

17

Dean Rallof
Outpatient Program Mgr
St. Rita's Medical Center

1. Elimination of conflict of interest in the HPP. 2. Absence of fee schedule increases in past 10 years/move. 3. Accessibility of appropriate services for injured Ohio workers. 4 Incentives for healthcare providers.

**Ohio Bureau of Workers' Compensation
Board of Directors
Public Forum April 24, 2008**

Chairman Lhota and Members of the Board:

Thank you for the opportunity to provide testimony today. My name is Dean Rallof and I am here to speak on behalf of the members of the Ohio Association of Rehabilitation Facilities (OARF). I have 18 years of experience working with persons who have work related injuries as a counselor and as a program manager of CARF (Commission for the Accreditation of Rehabilitation Facilities) accredited Comprehensive Pain Management Programs, CARF accredited Comprehensive Occupational Rehabilitation Programs and Work Conditioning Programs. Presently I am also the Chair Person of the Industrial Division of OARF. As a representative of OARF I wish to address issues related to barriers for health care providers and incentives for providing cost effective services.

Member facilities of the OARF Industrial Division including my own employer provide Work Conditioning, Comprehensive Occupational Rehabilitation (Work Hardening), Comprehensive Pain Management and other industrial rehabilitation services to Ohio's injured workers. We are providers who hold ourselves to the highest standards in the industry including staff who receive certifications in industrial rehabilitation and obtaining special accreditations for our programs as a commitment to providing excellent care. As a facility based organization we track the outcomes of our member facilities and our members show consistently high return to work rates for injured workers as high as a 100% in a quarter across all these various services. Yet over the past seven years all of our members have seen significant declines in referrals and programs have been closed because of lack of support. In our own organization we have closed our Comprehensive Occupational Rehabilitation Program better known as Work Hardening because of the absence of referrals and we have experienced an 80% reduction in BWC referrals for pain management services.

The closure of these programs by our members also comes when Rehabilitation Providers associated with BWC MCO's have demonstrated growth when work injuries have been reported to be on the decrease. It is our position that their growth in this environment is a result of a conflict of interest between BWC MCO's and sister companies which provide rehabilitation services. In my own healthcare facility as well as other members of OARF we have had injured workers referred for services to have a case manager associated with the employer's MCO contact the facility, cancel the injured workers appointments and transfer their services to their preferred provider, a company associated with the MCO. Not only do these activities reflect a conflict of interest but also interfere with the injured worker's right to choose their health care provider.

This conflict of interest is a barrier for healthcare providers to compete fairly and is prohibited by other payers such as the Centers for Medicare and Medicaid services through the Stark Laws and recently the American Hospital Association has encouraged

our Congress to place more restrictions on self referral practices. The reasons these conflicts of interest are prohibited are because time and again these relationships lead to over utilization of services and higher health care expenses as reported in such journals as the New England Journal of Medicine. It is our belief the Ohio BWC and the Ohio Injured Worker can benefit from actions to prohibit conflicts of interest.

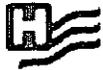
An additional barrier to providing services to the injured worker under Vocational Rehabilitation is that there has not been a fee schedule increase for Comprehensive Occupational Rehabilitation or Work Conditioning in more than 10 years. The cost of maintaining a quality rehabilitation service with highly trained staff continues to increase and the level of reimbursement is a major consideration on whether providers will continue to provide these services.

Access to services has been limited as well by changing reimbursement availability. Approximately 3 years ago pain management services were removed as a vocational rehabilitation service and referrals of these services have decreased by 80% in my facilities program and has resulted in the closing of 3 programs of which this speaker is aware and threatening the viability of others. I wish I could believe that the need for pain management has decreased for our injured workers but statistics show that across the nation the prominence of chronic pain disorders continues to increase and Comprehensive Pain Management Programs have been empirically demonstrated to be the most cost effective care for these patients (Gatchel & Okifuji, 2006).

Efforts to improve services by health care providers should focus on incentives for providers who develop programs that earn specialty accreditations which monitor the quality and outcomes of industrial rehabilitation services and maintain staff with appropriate licensure and certifications to provide this care. Incentives for desired outcomes which lead to return to work and efficient case closure for injured workers would encourage health care providers to improve services. Outcomes are always difficult to define across a diverse group of patients but it can be done.

Thank you for your time.

Dean Rallof, M.A.
Ohio Association of Rehabilitation Facilities (OARF)
Chair Person Industrial Division



American Hospital
Association

Press Releases & Statements

Statement: Congress Should Include the Physician Self-Referral in the Farm Bill...

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Elizabeth Lietz - (202) 626-2284

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Washington D.C. (Friday, April 18th 2008)

STATEMENT: CONGRESS SHOULD INCLUDE THE PHYSICIAN SELF-REFERRAL IN THE FARM BILL FOR PATIENTS AND COMMUNITIES

Congress has long been concerned about physician self-referral and the conflict of interest it creates between a patient and a physician's financial interests. In fact, over the last year, the House of Representatives has twice passed a ban on physician self-referral at hospitals in which a physician has an ownership interest. Clearly Congress is openly and strongly committed to address self-referral as possible.

The provision being considered in the Farm Bill would not close physician-owned hospitals. It would simply stop physician self-referral at facilities. Studies have shown that many physician-owned facilities treat far fewer patients who are sicker or poor and need emergency and trauma care. Research also reveals that when physician-owned facilities enter a community, it results in higher rates. Studies also have shown that physician-owned hospitals, as a whole, do not deliver the promised benefits of high quality care at a lower cost. These include studies in peer-reviewed journals such as *The New England Journal of Medicine* and *The Journal of the American Medical Association* as well as reports by government agencies and advisory groups such as the Medicare Payment Advisory Commission and the Government Accountability Office. The government's own Congressional Budget Office found that banning self-referral would reduce Medicare spending by \$2.4 billion over ten years, so taxpayers will win. In short, these facilities siphon off the Medicare dollars that hospitals need to provide the range of services needed in everyday emergencies as well as in times of community crisis.

Including a provision in the farm bill - or any bill - to ban self-referral would protect patient access to vital health care and ensure fair competition in health care. That's why Congress must act on their commitment and end the practice of self-referral.

Editor's note: For a listing of research addressing self-referral, see attachment.

About AHA

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the their communities. The AHA is the national advocate for its members, which includes 5,000 hospitals, health care systems, providers of care and 37,000 individual members. Founded in 1898, the AHA provides education for health care leaders information on health care issues and trends. For more information, visit the Web site at www.aha.org.

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FOCUS ARTICLE

Evidence-Based Scientific Data Documenting the Treatment and Cost-Effectiveness of Comprehensive Pain Programs for Chronic Nonmalignant Pain

Robert J. Gatchel* and Akiko Okifuji[†]

*Department of Psychology, College of Science, The University of Texas at Arlington, Arlington, Texas.

[†]Pain Research Center, Department of Anesthesiology, University of Utah, Salt Lake City, Utah.

Written for the American Pain Society Task Force on Comprehensive Pain Rehabilitation, Glenview, Illinois.

Abstract: Chronic pain is one of the most prevalent and costly problems in the United States today. Traditional medical treatments for it, though, have not been consistently efficacious or cost-effective. In contrast, more recent comprehensive pain programs (CPPs) have been shown to be both therapeutically efficacious and cost-effective. The present study reviews available evidence demonstrating the therapeutic efficacy and cost-effectiveness of CPPs, relative to conventional medical treatment. Searches of the chronic pain treatment literature during the past decade were conducted for this purpose, using MEDLINE and PSYCHLIT. Studies reporting treatment outcome results for patients with chronic pain were selected, and data on the major outcome variables of self-reported pain, function, healthcare utilization and cost, medication use, work factors, and insurance claims were evaluated. When available, conventional medical treatments were used as the benchmark against which CPPs were evaluated. This review clearly demonstrates that CPPs offer the most efficacious and cost-effective, evidence-based treatment for persons with chronic pain. Unfortunately, such programs are not being taken advantage of because of short-sighted cost-containment policies of third-party payers.

Perspective: A comprehensive review was conducted of all studies in the scientific literature reporting treatment outcomes for patients with chronic pain. This review clearly revealed that CPPs offer the most efficacious and cost-effective treatment for persons with chronic pain, relative to a host of widely used conventional medical treatment.

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Key words: Chronic pain, comprehensive pain programs, biopsychosocial, interdisciplinary treatment, cost-effectiveness, treatment efficacy.

Specialized pain clinics are relatively new. Earlier pain clinics were basically simple, treating pain with local anesthetics and neural blockades. In the past few decades, however, various clinical services for treat-

ing pain have proliferated. In 2001, approximately 3,800 pain programs, clinics, centers, and solo practices in the United States provided care for 8 million persons with pain.⁶⁶ Some of these clinics are modality specific (eg, nerve block clinics, massage, biofeedback); some are diagnosis specific (eg, headache clinic, pelvic pain clinic); and some are specialized pain centers in which clinicians with expertise in various pain-related disciplines (eg, physicians, physical therapists, psychologists) work as a team to provide comprehensive pain care. As will be reviewed, these latter comprehensive pain programs (CPPs) have been the only ones that have been consis-

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tently documented to be both therapeutically efficacious and cost-effective for treating chronic pain. Unfortunately, however, many third-party payers refuse to reimburse such programs because of their misunderstanding of them and misguided attempts at cost containment. This has created a major crisis and conundrum in the field of chronic pain management: Even though there is now more evidence-based research documenting their effectiveness relative to any other medical treatment approach, many such programs are being closed because of the refusal of third-party payers to utilize them. In response to this "clear and present danger" of depriving patients with chronic pain of the most effective treatment currently available, the President of the American Pain Society (Dennis Turk, PhD) convened a Task Force on Comprehensive Pain Rehabilitation, chaired by Robert J. Gatchel, PhD, ABPP.⁵² The charge of this Task Force was to develop a report of published results that support the clinical and cost-effectiveness of comprehensive pain programs. The present article presents these results.

Chronic pain, one of the most prevalent physical complaints, is loosely defined as prolonged pain of at least 3 months' duration. Epidemiological research has shown that the prevalence of chronic pain varies on the basis of how the questions are asked and how chronic pain is defined. However, researchers estimated that 10% to 20% of adults in the general population experience persistent pain of at least 3 months' duration.^{11,54,119} In a large-scale epidemiological study, Von Korff et al¹²¹ estimated a 19% prevalence for chronic spinal pain (neck and back) in the United States in the previous year and a 29% lifetime rate. The American Academy of Pain Management³ stated that more than half of all Americans (approximately 57%) reported experiencing recurrent or chronic pain in the past year. About 62% of those individuals had been in pain for more than 1 year, and 40% reported that they are constantly in pain. Congress has also passed a provision into law declaring this decade the "Decade of Pain Control and Research."

Chronic pain is not only prevalent but also costly, with the total estimated healthcare costs to Americans of more than \$70 billion per year.³ In addition, earlier estimates indicated that pain is responsible for a half million lost workdays and costs more than \$150 billion annually in healthcare, disability, and related expenses in the United States alone.^{72,115} Musculoskeletal conditions have a significant effect on the U.S. population and the healthcare system, with the costs for healthcare increasing 70% between 1988 and 1995.² The high costs of chronic pain reflect the complexity of the disorder. Chronic pain is typically compounded with other physical and functional syndromes. More than 87% of persons with chronic spinal pain in the United States, for example, present at least one other comorbid pain disorder (69%), functional disorder (55%), or psychiatric disorder.¹²¹ Clearly, the interaction of these problems determines the socioeconomic effect of pain. For example, not all patients with chronic pain incur elevated healthcare

utilization. Blyth et al¹¹ found that it is the significant functional disability that drives medical costs upward.

The trends discussed above are not isolated only to the United States. In the United Kingdom, more than 50% of patients going to general practitioners complain of chronic pain; however, less than one-third of these individuals take analgesics or seek treatment. "Severe pain" with apparent significant functional limitation was reported by 6% of patients, and 61% of those were not working, relative to 1.3% of individuals with no pain and 13% of individuals with pain without severe functional limitation.¹⁵ Thus, chronic pain is not only a pain disorder but also a disorder of functional illness that encompasses pain, function, work, healthcare utilization, and indemnity issues.

Similarly, such high prevalences and costs are being experienced worldwide. For example, Ekman et al³⁷ reported that one type of chronic pain—low back pain—represented 11% of the total costs for short-term sick leave in Sweden, as well as about 13% of all early retirement pensions that were granted. There has now been careful documentation of such high costs of various types of chronic pain from other countries, such as The Netherlands,^{6,13} New Zealand,⁹² Australia,¹² Denmark,³⁹ Canada,¹¹⁷ Spain,²⁵ and Italy.²⁴ Thus, there is a clear chronic pain crisis worldwide, in terms of both human suffering and economic costs.

Healthcare expenditures make up only about 10% of the costs of chronic pain in the United States, yet the total costs are massive. For example, pain medications contribute substantially to healthcare costs for those experiencing pain. More than 312 million prescriptions for analgesics (137 million for opioids) are written each year (Merck Pharmaceutical, 2002, personal communication with Mark Williams). As the upper limits of annual costs for medication nears \$21,500 (\$19,823 in 2002, with the annual inflation rate of 3%⁹⁹), the total could be as high as \$62.5 billion annually. Moreover, the costs of medications used to treat pain increased by an average of 27% from fiscal year 2000 through fiscal year 2001.⁷⁴

Another common treatment for chronic pain is surgery. In a meta-analysis of interdisciplinary pain rehabilitation programs, Flor et al⁴³ discovered that more than 54% of patients referred to these facilities had had at least one prior surgery to treat their pain, and the average patient had 1.76 surgeries. Arguably, the most frequent class of patients with chronic pain treated surgically is spinal disorders. More than 317,000 lumbar surgeries are performed each year—primarily for pain⁸⁰—at an average cost of \$15,000.⁴⁵ Thus, the total cost for back surgery alone is in excess of \$4.7 billion annually. Between 1985 and 1995, the number of spinal surgeries increased by 55%.³²

The Biopsychosocial Model of Pain and Disability

The biopsychosocial approach to pain and disability is widely accepted as the most heuristic perspective to the understanding and treatment of chronic pain disorders and has replaced the outdated biomedical reductionistic

approach (eg,^{51,109,111}). The biopsychosocial approach views pain and disability as a complex and dynamic interaction among physiologic, psychologic, and social factors that perpetuates—and may even worsen—the clinical presentation. In stark contrast, the traditional biomedical approach assumes that symptoms have specific physical causes, and attempts are made to eradicate the cause by rectifying the physical pathology or by cutting or blocking the pain pathways pharmacologically or surgically. The biomedical approach traditionally has promised a cure or, barring that, elimination of a significant amount of pain. Currently, though, there are no definitive cures for the most prevalent chronic pain syndromes such as back pain, upper extremity pain disability, peripheral neuropathies, and so on. Holding out the promise for an elusive cure adversely affects people with musculoskeletal pain because none currently exists, thereby driving up healthcare costs. Rehabilitation rather than cure is the most appropriate therapeutic option.

Indeed, chronic pain can rarely be understood by the linear, nociceptive mechanisms. Healthcare providers often are unable to identify specific pathophysiological mechanisms underlying persistent pain complaints. The absence of the documentable isomorphic relation between pathology and pain is frequently confused as a psychiatric condition. Although certain psychopathology can be expressed as a medical complaint (eg, hallucination, malingering, factitious disorder), most chronic pain does not present psychopathology as a sole cause. Pain and disability are most appropriately viewed as major stressors in a person's life that trigger a certain degree of emotional distress, such as fear, anxiety, depression, or uncertainty. Such psychosocial responses, in attempting to understand and manage the pain and disability, are to be expected as a concomitant of the actual pain event.

Comprehensive Pain Programs: An Overview

With the above biopsychosocial perspective in mind, the emphasis on dealing with psychosocial factors in achieving optimal rehabilitation outcomes in CPPs does not assume that a "cure" of major psychopathology will be an important component of the treatment process. Rather, everyday psychosocial reactions to the stress of pain are to be expected. Therefore, healthcare providers need to be sensitive to individuals' emotional concerns about what the pain or disability may mean in terms of healing time and prognosis (eg, fear of the unknown), whether this will affect their ability to return to work and to maintain their expected income level (eg, uncertainty and, sometimes, depressed mood), as well as issues concerning obstacles that they may encounter in "working through" the healthcare system (eg, distress, anger, hopelessness). The comprehensive interventions reviewed in this paper are meant to help manage these normal emotional reactions to a major stressor such as pain. Intervention techniques are developed to help manage the pain and the accompanying psychosocial concomitants—and not to cure any major psychopathology.



Figure 1. Outcomes as a function of the various stake holders involved in pain management.

An overview of potential pain mechanisms is beyond the scope of this paper. Pain is a perceptual experience, centrally modulated through internal physiologic and psychologic events, as well as external, environmental factors. Pain is not a simple sensory experience. Such complexity is incorporated in the formal definition of pain, "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."⁵⁸ No single medication, procedure, or therapy can address all the aspects involved in a complex case of chronic pain.

What complicates the already complex picture of pain management is the fact that therapy outcomes for chronic pain require multidimensional assessment because (a) chronic pain affects multiple domains of life; (b) different parties involved in the care of persons with chronic pain are interested in different outcomes; and (c) those outcomes are not necessarily correlated with one another.^{75,104,122,125} The first point is self-explanatory. Those who are afflicted by chronic pain report significant decreases in quality of life. Patients and their families may be interested in symptom reduction and improvement in the quality of life; however, third-party payers may be more interested in identifying the treatment that will reduce the future needs for healthcare. Workers compensation board members, on the other hand, may be interested in returning their workers back to gainful employment and closing the claims. Indeed, as highlighted by Schultz and Gatchel,⁹⁰ the multiple stakeholders involved in the healthcare process add a political dimension to pain assessment and the treatment process. A number of variables can be assessed to evaluate treatment outcome studies, such as self-reported pain, function (activities of daily living), healthcare utilization, return-to-work factors, medication use, and insurance case closure. The importance of each outcome varies depending on who is asked—patients, healthcare providers, managed care organizations, workers compensation carriers, or other third-party payers (see Fig 1).

At the time this paper was written, the only treatment approach that scientifically pursued the various outcomes was a rehabilitation program that incorporated multiple therapy modalities. Such CPPs proliferated in

the 1980s, which stimulated a great deal of outcome research in pain medicine. The criticism levied against CPPs is that they are expensive but offer only limited clinical benefits. Available pain literature, however, cannot be construed to support this erroneous claim. The primary purpose of this paper is to present the available evidence that demonstrates the efficaciousness and cost-effectiveness where activating, rehabilitative therapies have been provided by a multidisciplinary treatment team. When available, conventional medical treatments were used as the benchmark against which CPP treatments were evaluated; however, direct comparisons are difficult because of the large variability in the patient characteristics. CPP patients exhibit higher degrees of pain, disability, and mood dysfunction than patients who have just begun to undergo medical and interventional treatments.²⁷ In practice, patients are tried on medical treatment or surgical repair of pathology (eg, spinal abnormality), and if they do not respond to that treatment, they are sent to a CPP. The effectiveness of CPPs is generally assessed, therefore, on recalcitrant patients.

Studies/Reviews of CPPs for Pain Management

This section is a review of the most methodologically sound studies and evidence-based data evaluating CPPs. Searches of the chronic pain treatment literature during the past decade were conducted for this purpose, using MEDLINE and PSYCHLIT. Among the studies selected were systematic reviews and meta-analysis studies in peer-reviewed journals; randomized, controlled trials in which at least two treatment approaches were compared; and relevant unrandomized trials in which at least two treatment approaches were compared. It should also be noted that as reviewed by Gatchel and McGeary,⁴⁹ randomized, controlled trials are not the only experimental designs that should be relied on to produce trustworthy cause-effect treatment relations. There are a host of other experimental designs, including unrandomized trials, that may be appropriately used to yield important scientific data to help in delineating cause-effect relations. Some may even have greater internal or external validity than certain randomized, controlled trials and often yield a reasonable comparable effect size when compared with randomized designs. Therefore, in the present review, we have included such appropriate uncontrolled trials. Finally, in addition to the aforementioned criteria, only those studies reporting treatment outcomes that were systematically collected on all subjects were included. These outcomes could include data on self-reported pain, function, healthcare utilization and cost, medication use, work factors, and insurance claims. Whenever available, conventional medical treatments were used as a benchmark against which comprehensive pain programs were evaluated.

Functional Restoration

One type of CPP for low back pain, first introduced by Mayer and Gatchel,⁷¹ is functional restoration. Functional restoration is an intensive treatment approach in-

tended for patients experiencing the effects of significant physical deconditioning and chronic disability. The critical elements of a CPP, such as functional restoration, involve the following:

- Formal, repeated quantification of physical deficits to guide, individualize, and monitor physical training progress.
- Psychosocial and socioeconomic assessment to guide, individualize, and monitor disability behavior-oriented interventions and outcomes.
- Multimodal disability management programs using cognitive-behavioral approaches.
- Psychopharmacological interventions for detoxification and psychological management.
- Interdisciplinary, medically directed team approach with formal staffings and frequent team conferences.
- Ongoing outcome assessment using standardized objective outcome criteria.

Initial research showed that a CPP focused on functional restoration, when fully implemented, is associated with substantive improvement in various important socioeconomic outcome measures (eg, return to work and resolution of outstanding legal and medical issues) in chronically disabled patients with spinal disorders in both 1-year follow-up studies^{56,67,68} as well as a 2-year follow-up study.⁶⁹ For example, in the 2-year follow-up study by Mayer et al,⁶⁹ 87% of the functional restoration treatment group was actively working at 2 years, compared with only 41% of a non-treatment comparison group. About twice as many of the comparison group of participants had both additional spine surgery and unsettled workers compensation litigation relative to the treatment group. The comparison group continued with approximately a five-times-higher rate of patient visits to healthcare professionals and had higher rates of recurrence or re-injury. Thus, the results demonstrate the striking effect of a functional restoration program on these important outcome measures in a chronic group consisting primarily of workers compensation cases (traditionally the most difficult cases to treat successfully).

The effectiveness of this original functional restoration program has been independently replicated by Hazard et al⁵⁶ and Patrick et al⁸³ in the United States. Randomized, controlled trials demonstrating positive outcomes include Bendix et al⁸ and Bendix and Bendix⁹ in Denmark; Hildebrandt et al⁵⁷ in Germany; Corey et al²⁶ in Canada; Jousset et al⁵⁹ in France; and Shirado et al⁹³ in Japan. The fact that different clinical treatment teams, functioning in different states and different countries, with markedly different economic and social conditions and workers compensation systems, produced comparable positive outcome results speaks highly for the robustness of the research findings and utility, as well as the fidelity, of this approach to pain management in occupational settings. This functional restoration approach has also been found to be effective with chronic upper extremity disorders.⁴⁰ This type of approach has also been found to be an effective early intervention treat-

ment for preventing chronic disability. For example, in a randomized, controlled study, patients with acute low back pain who were identified as "high risk" for developing chronic back pain disability were randomly assigned to an early functional restoration group or a treatment-as-usual group.⁵⁰ The functional restoration group displayed significantly fewer indexes of chronic pain disability at 1-year follow-up on a wide range of work, healthcare utilization, medication use, and self-reported pain variables. For example, the functional restoration group was less likely to be taking narcotic analgesics (odds ratio = 0.44) and also less likely to be taking psychotropic medications (odds ratio = 0.24). Moreover, the treatment-as-usual group was less likely to have returned to work (odds ratio = 0.55). The cost-comparison savings data from this study were also quite impressive: The treatment-as-usual group cost twice as much as the functional restoration group over a 1-year period.

CPPs in General

There have been other studies demonstrating the effectiveness of CPPs in general—and not just functional restoration—in successfully treating chronic low back pain. For example, van Tulder et al¹⁸ found "strong evidence" for such a CPP approach by using the Cochrane Collaboration's high methodology and analysis standards. In a recent review of different treatment modalities for persistent low back pain published in *The New England Journal of Medicine*, Carragee²⁰ concluded that CPPs that focus on functional improvements produce the best outcomes. Finally, three new prospective, randomized, controlled trials also demonstrated the long-term effectiveness of CPPs. Friedrich et al⁴⁴ conducted a study in which 93 patients with chronic and recurrent low back pain were randomly assigned to either a control group (a standard exercise program) or a CPP. Follow-up assessments at 3.5 weeks, 4 months, 12 months, and 5 years demonstrated the greater long-term efficacy (up to 5 years) of the CPP group in terms of decreased disability and pain intensity scores, as well as increased working ability.

Fairbank et al⁴¹ compared spinal fusion against a CPP with patients with chronic low back pain in a multicenter, randomized, controlled study of 349 patients who had chronic low back pain for at least 1 year. A 24-month follow-up was conducted by using a disability scale (the Oswestry) and the short form (SF)-36. Both groups improved, and there was no evidence that surgery produced better relief than the CPP. Using this same cohort of patients, Rivero-Arias et al⁸⁵ conducted a cost-utility analysis of these data. At the 2-year follow-up, even though there were no significant differences in treatment effectiveness between the two groups, the average cost of surgery was £7,830 (approximately \$14,400), compared with only £4,526 (approximately \$8,323) for the CPP. Thus, these investigators concluded that "A policy in which patients receive spinal fusion surgery as first-line therapy for their chronic low back

pain seems not to be a cost-effective use of healthcare resources at 2-year follow-up."

Finally, Rasmussen et al⁸⁴ evaluated the rates of lower back pain in a geographical region of Denmark, before and after implementation of two multidisciplinary non-surgical spine clinics (in 1997), and compared these rates with those for the rest of Denmark during the same time periods. Results revealed that the annual rate of low back pain surgeries for patients in this region decreased from about 60 to 80 per 100,000 before 1997 to 40 per 100,000 in 2001. Moreover, the rates of elective, first-time disc surgeries decreased by approximately two thirds. In striking contrast, the annual rates of lumbar disc surgeries for patients in the rest of Denmark remained unchanged during the same time period. Thus, when there is an option for this type of treatment in a community, nonsurgical CPPs can reduce the rates of more costly spine surgery.

A plethora of other studies have demonstrated the effectiveness of CPPs in successfully treating various other prevalent chronic pain syndromes. For example, the American Academy of Orofacial Pain¹ estimates that 75% of the U.S. population experiences temporomandibular joint (TMJ) disorder symptoms during their lifetimes and that 5% to 10% of those require professional treatment. Research also estimates that within a 6- to 12-month period, more than 5.3 million people in the United States seek treatment for TMJ, which can result in a conservative cost estimate of \$2 billion for direct costs of treatment alone.³³ Extrapolating from these figures would bring the total cost of TMJ to more than \$4 billion per year, assuming that the indirect costs probably would exceed direct costs.⁵³

As Gatchel et al⁵³ have reviewed, traditional treatments for TMJ have included interocclusal appliances, nocturnal alarms when clenching, physical therapy, surgery, and occlusal calibration/equilibrium. However, these techniques have not been shown to be very effective. In contrast, CPPs (many of which include a strong cognitive-behavioral intervention) have proven to be effective by independent research teams led by Dworkin,^{34,35} Turk,^{87,103,105} and Gatchel.^{46,53,77} Most recently, Turner et al¹¹⁴ and Gatchel et al⁵³ have reported randomized, controlled trials that demonstrated the short- and long-term efficacy of such programs. Moreover, the study by Gatchel et al⁵³ also found that CPP patients had significantly fewer visits to dental healthcare providers during the year following their treatment, thus suggesting greater cost savings.

Such CPPs have also been shown to be the best treatment of choice for a variety of other chronic pain disorders, such as fibromyalgia, headache, whiplash and neck pain, repetitive strain disorders, and various other musculoskeletal disorders (cf⁸⁹). CPPs including a cognitive-behavioral treatment component also appear to be effective regardless of medical diagnosis. For example, a double-blind, randomized, controlled trial for the treatment of chronic insomnia, which often is seen in a variety of chronic pain syndromes, has been shown to be efficacious.³⁸

Table 1. Studies Demonstrating the Efficacy of Comprehensive Pain Programs

AUTHORS/DATE OF PUBLICATION	STUDY SUMMARY
Turk, 2002	A review of representative published studies evaluating clinical effectiveness of pharmacological treatments, conservative (standard) care, surgery, spinal cord stimulators, implantable drug delivery systems, and CPPs. CPPs were found to provide significantly better outcomes for medication use, healthcare utilization, functional activities, return to work, and closure of disability claims, and with substantially fewer iatrogenic consequences and adverse events (relative to other treatment modalities). Such programs are significantly more cost-effective.
Okifuji, 2003 Lang et al, 2003	A review of the effectiveness of interdisciplinary CPPs. A comparison of the outcome of a multidisciplinary CPP that was organized with cooperation from local healthcare providers and independent physicians who provide usual care for patients with chronic low back pain. Evaluated 6 months after rehabilitation, the multidisciplinary rehabilitation program was found to be significantly better than usual care in improving physical and mental health domains of the SF-36, reducing days off work, and creating higher overall patient appraisal of successful outcome.
Becker et al, 2000	A randomized, controlled study evaluating the effect of outpatient multidisciplinary pain center treatment to treatment by a general practitioner after initial supervision by a pain specialist and to a group of patients who waited 6 months for treatment. Patients receiving outpatient multidisciplinary pain management experienced reduced pain intensity, improved psychological general well-being, and improvements in most of the subscales of the SF-36, relative to the other two groups. After 6 months, these multidisciplinary pain center-treated patients still reported statistically significant less pain and higher general psychological well-being than patients in the other two groups.
Skouen et al, 2002	Study included 195 patients with chronic low back pain who were on an average sick-listed for 3 months. Patients randomly assigned to a light multidisciplinary treatment program, an extensive multidisciplinary treatment program, or treatment as usual by their primary physician. Light multidisciplinary treatment patients demonstrated significantly better results for full return to work than treatment-as-usual patients, but no differences were found between extensive multidisciplinary treatment patients and treatment-as-usual patients. Productivity gains for society from light multidisciplinary treatment versus treatment as usual of 57 patients with low back pain would, during the first 2 years, accumulate to U.S. \$852,000.
Guzman et al, 2001	A systematic literature review of randomized, controlled trials assessing the effectiveness of multidisciplinary biopsychosocial rehabilitation on clinically relevant outcomes in patients with chronic low back pain. There was strong evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improves function when compared with inpatient or outpatient nonmultidisciplinary treatments. There was also moderate evidence that intensive multidisciplinary rehabilitation reduces pain when compared with outpatient, nonmultidisciplinary rehabilitation, or usual care. The reviewed trials are evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration reduces pain and improves function in patients with chronic low back pain. Less intensive interventions did not show improvements in clinically relevant outcomes.
Flor et al, 1992	After treatment at multidisciplinary pain management centers, patients required one-third the number of surgical interventions and hospitalizations compared with patients treated with alternative medical and surgical care.
Robbins et al, 2003	An evaluation of the therapeutic effectiveness of an interdisciplinary pain management program on a heterogeneous group of chronic pain patients. Successful completion of the program produced significant improvement on a wide range of biopsychosocial and socioeconomic outcomes at 1-year follow-up. Insurance carrier policies of contracting treatment "carve outs" significantly compromised the effectiveness of this evidence-based, best standard of medical care interdisciplinary treatment.
Linton et al, 2005	A randomized controlled trial, acute low back pain patients seen in a primary care setting were randomly assigned to either a standardized, guideline-based treatment as usual or cognitive behavioral treatment and physical therapy. The treatment-as-usual group had a greater number of days off work for back pain during the 12-month follow-up than the other two groups. Risk for developing long-term sick disability leave was more than 5-fold higher in the treatment-as-usual group than the other two groups.

Abbreviation: CPP, comprehensive pain program.

Besides the above, there have been a great number of other investigations demonstrating the effectiveness of CPPs in treating chronic pain syndromes. Many of the early studies were reviewed by Lande and Kulich.⁶³ Subsequently, in a systematic review of studies comparing CPPs to unimodal treatment or no-treatment control patients, which involved a total of 3,089 participants, Mc-

Cracken and Turk⁷³ reported the following outcomes comparisons: return to work, 68% CPP versus 32% unimodal or no treatment; pain reduction, 37% versus 4%; medication reduction, 63% versus 21%; and increases in activity, 53% versus 13%, respectively. Table 1 lists brief summaries of other studies demonstrating the effectiveness of CPPs in general. Other general reviews of the

treatment- and cost-effectiveness of CPPs are as follows: Deschner and Polatin,³⁰ Feuerstein and Zostowny,⁴² Gatchel and Turk,⁴⁷ Okifuji et al,⁸¹ Turk and Burwinkle,¹¹³ Turk and Gatchel,¹⁰⁷ and Wright and Gatchel.¹²⁴ Sanders et al⁸⁸ have also delineated evidence-based clinical guidelines for the interdisciplinary management of chronic pain.

Cognitive-Behavioral Treatment

In a very influential early study, Morley et al⁷⁹ reported the results of their systematic review and meta-analysis of the existing randomized trials of cognitive-behavioral therapy as well as behavioral therapy for chronic pain. Their findings concluded that such treatment is effective for a variety of chronic pain conditions. The major goals of such treatment are to replace maladaptive patient cognitions and behaviors with more adaptive ones. Most recently, Linton and Nordin⁶⁴ reported a 5-year follow-up of a randomized, controlled trial of early cognitive-behavioral intervention for back pain. Results demonstrated that this intervention resulted in significantly less pain, produced more active and better quality of life, and resulted in better general health, relative to the comparison group. There were also significantly greater economic benefits associated with the cognitive-behavioral intervention group.

Besides the above studies, there have been numerous other well-conducted studies demonstrating the therapeutic effectiveness of behavioral and cognitive-behavioral treatment techniques (a key component in most CPPs) for treating chronic pain. For example, a study by Brox et al¹⁶ was an exceptional randomized, controlled trial that compared the relative efficacy of lumbar spinal fusion versus CPP (cognitive behavioral therapy plus exercise) for patients with back pain who had documented underlying pathophysiology. A total of 64 participants were randomly assigned into one of these two treatments. At the 1-year follow-up, the "difference between the groups given lumbar instrumental fusion and cognitive intervention and exercise was neither clinically important nor significant" (p. 1920). Both groups displayed significant clinical improvement in a wide range of measures. These findings were similar to those of Fairbank et al,⁴¹ who reported outcomes at 2 years. Even more recently, Brox et al¹⁷ conducted an randomized, controlled trial demonstrating the effectiveness of CPP with lumbar instrumental fusion in patients with chronic low back pain and who also had a previous surgery for disc herniation. Again, no differences in treatment efficacy were found.

Finally, it should be noted that these cognitive-behavioral perspectives proceed from the view that an individual's interpretation, evaluation, and beliefs about his or her health condition and coping repertoire, with respect to pain and disability, will affect the degree of emotional and physical disability associated with the pain condition.¹⁰⁰ Also, usage of the phrase cognitive-behavioral intervention varies widely and may include self-instructions (eg, distraction, imagery, motivational self-talk), re-

laxation or biofeedback, development of coping strategies (eg, distraction, increasing assertiveness, minimizing of negative or self-defeating thoughts), changing maladaptive beliefs about pain, and goal setting. An individual referred for cognitive-behavioral intervention may be exposed to varying selections of these strategies. A more detailed summary of some of these studies is listed in Table 2. The following are a number of other studies documenting the efficacy of cognitive-behavioral therapy: Astin et al,⁴ Keefe and Caldwell,⁶¹ Bradley,¹⁴ Burns et al,¹⁸ Chen et al,²³ Cutler et al,²⁸ Eccleston et al,³⁶ Spinhoven et al,⁹⁶ and Weydert et al.¹²³

A More Detailed Look at Outcomes

Pain and Quality of Life

As noted earlier, better pain management and restoration of functionality are of primary concern for persons with pain and their families. Published reports indicate that CPPs result in varying degrees of pain reduction, from 14%⁷⁸ to 60%¹⁰¹, to an average of 20% to 30%.⁴³ These figures are comparable to the most conventional medical management of chronic pain with opioids, which yields an average pain reduction of 30%.¹¹⁰

Functional restoration is a primary driving philosophy for many CPPs; even if treatment does not totally eliminate pain, restoring function provides persons with an opportunity to resume productive lives, thereby improving quality of life. Unfortunately, research evaluating pharmacological treatments for chronic pain rarely measures functional ability as a clinical outcome, and, when it does, the results are not very encouraging.⁵ The comparison of the functional outcomes thus has to rely on the results from the meta-analysis⁴³ evaluating CPPs in relation to unimodal, conventional medical care. CPPs clearly excel: Approximately a 65% increase in physical activity is observed following CPP treatments. In contrast, only a 35% increase is reported in patients receiving conventional medical care.

Another important functional outcome is return to work (RTW). Resumption of gainful employment is a major concern in the care of individuals with chronic pain, especially those whose pain began after a work-related injury. CPPs have consistently shown RTW results superior to those of conventional medical therapies. Table 3 presents the results from the past studies assessing RTW following the completion of CPPs, as compared with control patients (generally continuing medical management therapies). RTW rates following CPP range from 29% to 86%, with a mean of 66%, whereas conventional medical treatments consistently yielded lower rates, from 0% to 42%, with a mean rate of 27%. The meta-analysis⁴³ has shown comparable figures for patients with the average of 7-year history of chronic pain.

Although RTW is an "objective" and nonambiguous outcome criterion, it is not a pure clinical variable. A number of socioeconomic factors interact with it, such as regional variation in the job market, availability of job accommodations, marketability of the patient's skills, extent of wage replacement, and financial incentives. Also,

Table 2. Studies Demonstrating the Therapeutic Efficacy of Behavioral and Cognitive-Behavioral Techniques for Treatment of Chronic Pain

AUTHOR/DATE OF PUBLICATION	STUDY SUMMARY
Morley et al, 1999	A literature review of 33 papers from which 25 trials suitable for meta-analysis were identified. The effectiveness of cognitive-behavioral treatment was compared with the waiting list control to alternative treatment control conditions. The cognitive behavioral treatments produced significantly greater changes for pain experience, cognitive coping and appraisal (ie, positive coping measures), and reduced behavioral expression of pain. Active psychological treatments based on the principle of cognitive behavioral therapy are effective.
McCracken & Turk, 2002	Numerous controlled clinical trials of behavioral treatment and cognitive behavioral treatment for chronic pain, alone or more commonly in multidisciplinary treatment contexts, suggest that these treatments are effective. Results of published studies in the scientific literature showed that overall behavioral and cognitive behavioral treatments for chronic pain reduce the patient's pain, distress, and pain behavior and improve daily functioning.
Pincus et al, 2002	A systematic review of prospective cohort studies of low back pain to evaluate evidence implicating psychological factors in the development of chronicity in low back pain. The biopsychosocial model is gaining acceptance as a treatment for low back pain and has provided a basis for guidelines and interventions. Purpose was to evaluate the unique contributions of psychosocial factors in the transition from an acute presentation to chronicity. Results showed that psychosocial factors (especially distress, depressive mood, and somatization) are significantly implicated in the transition to chronic low back pain. Psychosocial factors (which are considered in biopsychosocial interdisciplinary pain management programs) are important in chronic pain patients.
Vlaeyen & Morley, 2005	The lead article of a special topic series on cognitive behavioral treatment for chronic pain: "...cognitive behavioral treatment interventions for chronic pain have expanded considerably. It is now well established that these interventions are effective in reducing the enormous suffering that patients with chronic pain have to bear. In addition, these interventions have potential economic benefits in that they appear to be cost-effective, as well" (p.1).
McGrath & Holahan, 2003	A review of data and studies that demonstrate treatment effectiveness of psychological interventions such as cognitive behavioral treatment in reducing chronic pain in children and adolescents.

not only are some patients older than they were at the onset of their pain problems, but years of unemployment might have resulted in considerable mismatch between the patient's job skills and the skills that are required.

Table 3. Return-to-Work Rates

STUDY	COMPREHENSIVE PAIN PROGRAM	
	PROGRAM	CONTROL
Bendix et al, 1996	64	29
Deardorff et al, 1991	48	0
Duckro et al, 1985	71	33
Feuerstein et al, 1993	74	40
Finlayson et al, 1986	65	44
Guck et al, 1985	75	25
Hazard et al, 1989	81	29
Hildebrandt et al, 1997	62	N/A
Mayer et al, 1987a	87	41
Pfingsten et al, 1997	63	N/A
Roberts & Reinhardt, 1980	77	5
Sachs et al, 1990	63	42
Sturgis et al, 1984	29	14
Tollison et al, 1989	56	27
Tollison, 1991	57	20
Tyre et al, 1994	86	N/A
Vendrig et al, 2000	65	N/A
Average	66	27

Healthcare Utilization

The cost of health care continues to rise. Healthcare utilization data from CPP trials generally yield favorable results. For example, researchers found a more than 33% reduction in pain-related clinic visits in the HMO setting in the year following the completion of CPPs with the strong cognitive behavioral orientation.²¹ Several reports^{19,91,101} indicated that 60% to 90% of CPP patients do not seek any additional therapy for pain within 1 year following the treatment. Another study⁷⁰ reported a substantial 50% decline in pain-related clinic visits following a comprehensive rehabilitative treatment.

Earlier reviews^{81,106} reported striking reductions in the subsequent hospitalization and surgical intervention following CPPs. Approximately 16% and 17% of CPP-treated patients receive subsequent surgical therapy and hospitalization, respectively. In contrast, almost half of the conventionally treated patients undergo surgery or would be hospitalized.⁹⁴ Overall, it has been estimated that annual medical costs following a CPP are reduced by 68%.⁹⁴ In the randomized, controlled trial reported by Rivero-Arias et al,⁸⁵ even when compared with traditional interventions such as spine surgery, the long-term treatment outcome results at a 2-year follow-up were comparable but with a significantly reduced economic cost associated with CPPs.

Many patients with chronic pain experience various comorbid disorders. Thus, it should not be surprising to

see polypharmacy issues associated with chronic pain. Annual pharmaceutical costs per patient with chronic pain are not known at this time, but it is not difficult to assume that there is substantial consumption. Medication costs for back pain alone have been estimated to range from \$5,000 to \$10,250 per patient.^{29,99} According to a recent estimate, the sales of analgesics in the United States approximated \$8 billion in 2000, and the value is expected to grow by 10% annually.⁶⁶ It should also be noted that although there have been a number of randomized, double-blind, controlled trials and meta-analyses demonstrating the treatment efficacy of various medications with pain conditions such as neuropathic pain (eg, Cepeda and Farrar²²), these were not direct comparisons with CPPs. Therefore, their relative efficacy cannot be determined. Moreover, in a recent review of clinical trials of opioid analgesics for the treatment of chronic pain, Katz⁶⁰ has highlighted the fact that most of these trials were associated with methodological problems that compromised their integrity and produced conflicting results.

Research considering reduction in medication use has traditionally focused on the use of opioid analgesics. The use of opioids for noncancer chronic pain patients remains a controversial issue. The nature of the debate is beyond the scope of this paper. However, reduction or elimination of opioid medications has frequently been considered an important part of clinical outcome for research investigating the effectiveness of CPPs. Approximately one half of patients take opioid analgesics at the time of an initial evaluation at CPPs.⁴³ Following CPP treatments, more than 65% of these patients discontinued their opioid medications for at least 1 year.¹⁰¹ Subsequently, Tollison¹⁰² reported the striking results from the comparisons of opioid use among individuals who completed a CPP and individuals who were not able to participate in the program because of denial from their third-party payers. The former group showed significant reduction in opioid use, from 69% at the admission to 22% at 1-year follow-up, whereas in the latter group, opioid use remained relatively unchanged, decreasing from 81% to 75%. Thus, there is also a significant cost offset produced by CPPs; cost offset refers to decreases in other healthcare utilization as the result of a particular treatment.

These figures are presented not to dispute the appropriateness of the use of opioid analgesics for patients with noncancer chronic pain. However, the results are rather telling when they are accompanied by significant pain reduction and improvement in functions. From the healthcare economy perspective, helping patients become more efficient in self-management of their pain and disabilities should decrease their reliance on the healthcare system.

Disability Claims

Inability to maintain gainful employment is common in chronic pain. Pain patients whose pain onset began

with work-related injury almost always file for workers compensation benefits. Administrative policies vary by state across the United States, so it is difficult to generalize the trend nationwide. As an example, the Department of Labor and Industry in the state of Minnesota¹⁰ reported a general decline of indemnity per claim cost from 1990 to 1998 and then an upward trend from 1998 to present. As of 2001, it was estimated that the average indemnity cost per claim was \$12,900, and medical benefits per claim were \$11,500. Another report⁴⁵ estimated that up to \$43 billion is spent annually in the United States for disability compensation for back pain alone. Similar to the RTW criterion and healthcare utilization, whether CPP treatment leads to the closure of disability claims has become an important outcome because of the socioeconomic implications of reduced productivity, wage loss, and disability payments.

A substantial number of CPP-treated patients seem to close disability claims after completing the treatment. Painter et al⁸² found that the proportion of the patients receiving disability significantly declined (70% to 45%). For example, approximately 75% of the cases were recommended for closure,⁹¹ and the majority of litigation was settled within 1 year.⁶⁷ The clinical effects of the conventional and surgical interventions on closing disability claims, unfortunately, have not been studied and are thus unknown.

The decision as to whether a claim should be closed is essentially administrative, not clinical. In an ideal situation, the decision should be based on signs and symptoms that are objectively measured. However, claim closure for patients with chronic pain must depend on the patient's self-reports of pain and disabilities, given the subjective nature of the syndrome. The complex nature of chronic pain disorders inevitably makes claim adjusters very important. Of course, case workers and insurers also often seek outside medical opinions as to whether a claimant has reached "maximum medical improvement" as a basis of case closure. Nonetheless, very little is known about the reliability of decision making by case managers on closing disability claims. In addition, societal and organizational pressures to promote closures may also become relevant as financial resources become more constricted. Therefore, careful interpretation is needed to understand the disability closures as a treatment outcome in pain therapy.

Cost-Effectiveness Evaluation

Costs for CPP treatment vary, depending on the settings and level of intensity. Because of the reimbursement pressures, many CPPs have cut back their programs or closed their organized programs. This is quite paradoxical in the light of findings such as those of Rivero-Arias et al⁸⁵ that surgical treatment for chronic low back pain costs more than twice that of a CPP, even though treatment outcomes are comparable at a 2-year follow-

up. The average cost for outpatient CPP has also shown a significant decline. It is estimated that an average outpatient multidisciplinary rehabilitation program cost \$5,075 in 2001.⁶⁶ The data on which this discussion is based were gathered several years ago when CPPs offered more intensive treatment and were thus more costly. The following analysis is based on the (\$8,100) cost estimated in 1995,⁶⁵ which is a more appropriate representation for our analyses.

Healthcare Costs

Annual medical therapy costs, including medications for back pain, are estimated to be \$12,900 to \$19,823.^{7,29,98} As noted earlier, annual medical costs following a CPP are reduced by 68%.⁹⁴ With the assumption of age 45 as the average age at CPP⁴³ and life-expectancy age of 77,⁷⁶ the lifetime healthcare cost per patient can be calculated as follows:

$$\text{CPP: } \$8,100 + (\$12,900 - \$19,823) \times (100\% - 68\%) \times 32 \text{ years} = \$140,190 - \$211,087$$

CPP cost range of annual healthcare cost not reduced

$$\text{Conventional: } (\$12,900 - \$19,823) \times 32 \text{ years} = \$412,800 - \$634,366$$

$$\text{Lifetime saving} = \text{Conventional} - \text{CPP} = \$272,610 - \$423,279$$

This estimate does not account for any increase in healthcare costs. The figures are consistent with previous reports^{81,108,110} that estimated the healthcare saving of \$8,500 to \$8,772 per patient per year following CPP treatment.

Disability

In 2004, a total of 6.2 million disabled workers received \$5.5 billion in Social Security disability bene-

fits (\$10,728 per person⁹⁵). The average age of patients referred to CPPs is 45 years.⁴³ Assuming a retirement age of 65 years, a time-unadjusted total of \$214,560 over 20 years of disability will be incurred per patient. From the literature, 66% of CPP-treated and 27% of conventionally treated patients return to work. Thus, the lifetime disability cost for each treatment per patient is calculated as follows:

$$\text{CPP: } 34\% \times \$10,728 \times 20 \text{ years} = \$72,950$$

$$\text{Conventional: } 73\% \times \$10,728 \times 20 \text{ years} = \$156,628$$

The summary (using the lower-cost figures for the healthcare costs) is shown in Fig 2. Altogether, CPP saves \$356,288 per person over the course of a lifetime for healthcare and disability compared with conventional medical therapy for chronic pain. The savings is, however, the tip of a large iceberg. Numerous other costs have not been included here, such as tax revenue, lost productivity, and sick leaves. Lost productivity in the U.S. workforce is estimated at \$61.2 billion per year.⁹⁷ Need-

less to say, there are also the unmeasurable emotional costs of pain and suffering for patients and their families.

Finally, Hatten et al⁵⁵ recently analyzed the cost-utility (expressed in Cost/Quality - Adjusted Life Years or QALYs) of interdisciplinary treatment for chronic spinal pain. The calculation of QALYs involve the costs of a specific intervention, relative to the desired improvement in health (in this case, increased functioning and decreased pain). Results of this study revealed that rela-

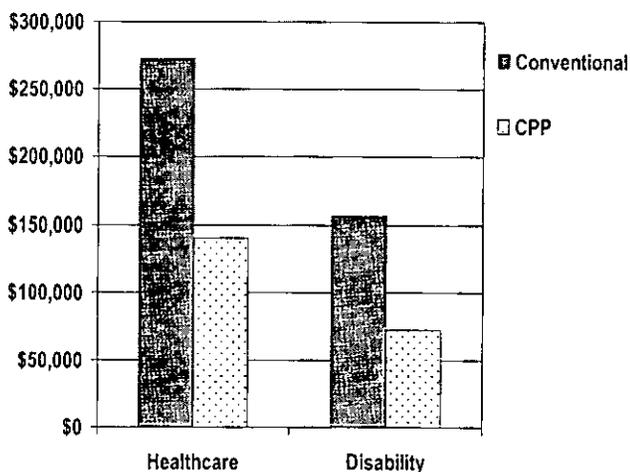


Figure 2. Lifetime healthcare and disability costs following treatment (comprehensive pain program versus medical treatment).

tive to medication treatment with or without anesthetic procedures, the interdisciplinary treatment was associated with a better QALY. Such cost-utility findings indicate that the CPP was both less costly and more effective than the other treatments.

Concluding Comments

Chronic pain is a ubiquitous medical condition. Traditionally, pain has been conceptualized as a symptom reflecting an underlying pathology. Many chronic pain cases, however, fail to fit into such a category, rather manifesting as multisystem illnesses that significantly compromise major parts of the patient's functional life. For these cases, the standard medical approach or medication management does not seem to provide much relief. The only therapeutic approach that has shown efficacy and cost-effectiveness is a CPP, with functional restoration as a primary goal. Indeed, based on the growing number of randomized, controlled trials from different clinical research centers in the United States and other countries, there is unequivocal evidence for the effectiveness of CPPs. There is now more evidence-based research documenting this effectiveness than for any other medical treatment approach.

Given what the scientific literature indicates, the assumption that CPPs are too costly and have no good clinical benefit is quite puzzling. Because CPPs involve multiple professionals in a time-intensive manner, the initial cost for this approach may be higher than that for the conventional medical management approach. However, despite clear evidence of the significant long-term clinical and cost benefits of CPPs and the growing acknowledgment of the central role of outcomes in evidence-based medicine, third-party payers continue to resist reimbursement for the expenses of these rehabilitation programs. The randomized, controlled trial by Rivero-Arias et al⁸⁵ found that even

when compared with a traditional medical intervention such as spine surgery, the long-term treatment outcome results at 2-year follow-up are comparable, but CPPs demonstrated significantly reduced economic cost. This is even more startling because many have questioned the need for spinal fusion surgery.³¹ Furthermore, managed care organizations have been "carving out" portions of comprehensive, integrated programs (ie, sending patients to different providers for their various needs outside of the CPPs), thus diluting the proven successful outcomes of such integrated programs in an effort to cut costs.^{48,62,86} In the long run, however, the program that can help patients resume productive lives is much more cost-effective from the perspectives of healthcare, tax, legal, and general economic factors.

Indeed, a major obstacle to effective CPPs is the lack of understanding of third-party payers who refuse to cover such programs, even though CPPs are known to be beneficial in significantly reducing pain and disability. Efforts of third-party payers to contain costs have paradoxically steered patients away from treatments that demonstrably reduce healthcare utilization and toward more expensive therapies with poorer outcomes. As noted by Turk,¹¹² "Greater collaboration is required among professional groups, consumers of healthcare services, governmental agencies, and third-party payers to ensure that the most clinically effective and cost-effective treatments are provided to all likely to benefit from them" (p. 13). This will be especially important in the immediate future with the "graying" of America. Indeed, persons 50 years and older are twice as likely to have been diagnosed with chronic pain. Epidemiologic projections suggest a chronic pain prevalence of at least 2% of the adult population.¹²⁰ By the year 2030, the U.S. Census Bureau¹¹⁶ projected that about 20% of the population will be 65 years or older. Thus, the survival and continued growth of CPPs will be an important investment for the future health care of senior citizens in the United States.

The misunderstanding of the cost-effectiveness of CPPs often leaves physicians in an impossible situation. Because of the multidimensional, multisystem presentation of chronic pain, they are compelled to become a comprehensive, multidisciplinary pain team by themselves. However, it is unrealistic that a single physician be expected to have a detailed understanding of psychology, physical therapy, occupational therapy, and nursing at the levels sufficient to complete comprehensive assessment and treatment of chronic pain. Nor is it likely to be a cost-effective practice. Consequently, inadequate treatment of persons with pain has been acknowledged to be an epidemic by several important organizations in the United States, resulting in the development of new standards for the evaluation and treatment of pain. The U.S. Department of Veterans Affairs and the Joint Commission on Accreditation of Healthcare Organizations now require that pain be documented as the 5th vital sign (added to the other four of pulse, blood pressure, core temperature, and

respiration). These organizations assert that patients have "a right" to have their pain adequately managed. In 2001, Congress passed and President Clinton signed into law a bill designating the period January 1, 2001, to December 30, 2010, as the "Decade of Pain Control and Research." At this juncture in the decade, great advances have been made in pain management, especially in response to the cry by government and managed care officials to provide them with evidence-based data documenting the outcomes of pain management efficacy.

In conclusion, the available literature documents that CPPs offer the most efficacious treatment for persons with chronic pain. Furthermore, CPPs have been shown to be more cost-effective than conventional medical interventions. These results are particularly impressive, given that many patients have undergone

other treatments without achieving satisfactory outcomes and have come to CPPs as the last resort. If those patients could be referred early or undergo preventive programs, the clinical effectiveness and cost-effectiveness of CPPs probably would yield more improvement. Indeed, the early intervention program conducted by Gatchel et al⁵⁰ clearly demonstrated striking therapeutic effect and cost-effectiveness outcomes for patients with low back pain treated at the acute phase (i.e., less than 3 months since pain onset). A reasonable conclusion, therefore, is that CPPs offer a vital clinical option for persons with chronic, disabling pain problems.

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Speaker

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18

Tim Grabenstetter
HR Director / Risk Manager
Sandusky County

Good morning, I am a public sector employer. The significant financial strain four years of claims experience has on any employer can be very detrimental. My past experience with costly and unmanageable claims prompted an in-depth discussion with my TPA, BWC Representatives and our Group Plan Administrators. Collectively, the professionals from these organizations established some possible changes in the system we felt would be beneficial to employers, and the BWC as well as the injured worked. We presented these changes at a round table which took place on August 30, 2007, and was attended by representatives, Todd Spence, Laura Abu-Absi, and Christina Madriguera, of the BWC. Thus far, I have not received any follow up on this meeting. Once these issues are reviewed by this Board, I believe these issues would assist both employers and injured workers.

- Issue one – POR Accountability
- Issue two – Treatment and scheduling
- Issue three – Time line for exams and MMI decisions
- Issue four – Communication and decision-making



Sandusky County Human Resources

* Personnel Administration - Risk Management *

* Workers' Compensation - Life - Health Insurance *

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COPY

Good morning, I am a public sector employer. My past experience with costly and unmanageable claims prompted an in-depth discussion with my TPA, BWC Representatives and our Group Plan Administrators. Collectively, the professionals from these organizations established some possible changes in the system we felt would be beneficial to employers, B.W.C., as well as the injured worker. Once this Board reviews these issues, I believe these suggestions would assist both employers and injured workers.

We are currently at risk of losing our credit rating due to circumstances completely out of our control, as I have no control over treatment plans, ongoing examinations or undetermined prognosis. I have three claims which I would like to use as examples:

Example three: Claim 05-889316

Example one: Claim 07-339934

Example two: Claim 07-803808

Issue #1: POR Accountability

- An EOR along with their TPA or MCO needs to have some control over an injured worker's treatment plan, and scheduling of specialty exams for consultative purposes, to enhance treatment and functional ability. If any of these parties feel a treatment plan is not reasonable and other options may improve an outcome compatible with evidence based medicine recommendations or benchmarks, then having the ability to change direction of the said treatment is logical.
- An EOR should have the ability to accommodate light duty, staying within changing restrictions passed along by the POR.
- The POR should provide clinical evidence to support his opinion that the objective testing via FCE is not valid or reliable.
- An uncooperative or disengaged POR should have appropriate counseling by BWC or duty to provide reasonable clinical data, and be informed of a defined consequence for failure to meet the minimum communication, to ensure an appropriate treatment plan is in place.
- Allowed conditions that exceed natural history for resolution shall have adequate explanation in the clinical records, and offer insight as to the mitigating circumstances.

Issue #2: Treatment and exam scheduling

- While on compensation, (wage continuation or TT) office visits or examinations should be required every 2-4 weeks with a progress report or copies of notes outlining current and future courses of action and consideration for transitional work program.
- An EOR should be kept up to date of the activity the injured worker is involved in while being paid for a work related injury. The injured worker should be required to log his or her daily activity and turn this into BWC monthly. POR should be following state-mandated references such as ODG (Official Disability Guidelines) unless proof or reasoning for another form of care or prolonged disability is given from another reference such as ACOEM's Occupational Medicine Practice Guidelines.
- BWC should make it mandatory, while receiving compensation, that the injured worker has a monthly follow-up assessment with POR and furthermore the BWC should be responsible for monitoring the POR's monthly assessment of injured worker.
- Injured worker must have continuity of care or an assessment by treating provider and/or POR. The injured worker should not have to wait longer than 3 weeks for treatment or an exam from a certified BWC provider and should be seen by their POR within a month between visits, with some type of therapy, treatment or an assessment being performed between visits.
- Injured worker's POR should be the primary physician treating the injury. If this physician is a specialist, the injured worker was referred to, then this specialist may be considered to have similar authority as the POR and have the ability to diagnose the injured worker, certify disability or release to full or transitional duty.

Issue #3: Timelines for exams and MMI decisions

- The BWC Claims Manager; a BWC Nurse; MCO Health Nurse or Doctor; TPA; the Industrial Commission or a separate review board with medical authority, should be allowed to make reasonable recommendations to the injured worker's POR after reviewing reports from various exams (e.g. IME's, 90 day exams and physical therapy notes, etc.). The BWC and employers are spending good money on these exams to have the results ignored by the POR. *(The responsibility in making the unfavorable decision to move forward must be assigned.)* There is a need to initiate a medical review board with the authority to override the POR when decisions have not been within compliance of ODG or inline with other medical reports.
- An IME report must have an opinion on a reasonable time to achieve MMI, or what care would be appropriate prior to declaring MMI. Any DEP or other BWC certified provider that does not provide this data should be counseled for the correct reporting format.
- BWC should have a periodic Quality Assurance (QA) review of the DEP providers to ensure quality remains at the forefront of the IME process. Reports that are sub-standard should have corrective action and possible consequence of removal from the DEP panel.
- The definition of MMI needs to be specified as to whether the employee will be able to return to work at his current job, performing all the essential functions of the position, within a "reasonable" period of treatment and time off.

Issue #4: Communication and decision making

- BWC needs to remove the exposure of liability from the medical profession when making the decision to return an injured worker to full duty or light duty rather than allowing an injured worker to remain at home stagnant collecting TT or remain in a long term transitional duty program with no progression of the claim. This behavior may encourage the status of deconditioning, potentially causing more medical issues which are being additionally allowed with the original injury.
- If an attorney does not want their injured worker talking to their nurse case manager then the attorney or their representative should be involved in a conference call with all involved parties, within 24 hours, in order to promote an optimal outcome. There should not be a delay in communication, as this is not in the best interest of the involved parties.
- The MCO provides managed care with medical professionals on hand such as Nurses and Doctors. They should be given some type of authority on making a decision as such. If the BWC or the Industrial Commission does not want to extend this authority to the MCO, I personally believe an unbiased committee, outside the BWC and the Industrial Commission, made up of individuals such as the responsible parties I carbon copied on Governor Strickland's letter (collectively working towards the same goal), should be allowed to review all documentation in a claim and be afforded the final decision on an injured workers ability to RTW or when they have reached MMI.

I believe collectively the professionals from organizations, such as BWC, Comp Management and the CCAO, can establish some possible changes in the system that would be beneficial to the employer, B.W.C, as well as the injured worker.

Speaker

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19

James B Hoover, MD
RehabMed Associates

There are instances of delays in approval of treatment, that make timely, effective management of the injured workers very difficult. This most commonly occurs in State Funded claims when a non allowed condition that is due to the injury, but not yet added is encountered. Additionally, the self-insured injuries are a whole problem in and of themselves. They do NOT follow the same rules as the state funded ones. They often just deny almost everything, and only when the IW gets an attorney, is anything approved, and this is certainly not timely. The best thing BWC could do, is make self insureds follow exactly the same rules as the state funded claims.

Rick Wickstrom
Physical Therapist / Ergonomist
Ohio Physical Therapy Association

Self-dealing/conflict of interest practices that negatively impact cost-effectiveness of industrial therapy services BWC's vocational redesign proposal only partly addresses the problem of self-dealing/conflict of interest by eliminating MCO case management referrals to affiliated sister companies. These self-dealing conflicts of interest extend deeper into the BWC system, because many physicians and MCO sister companies that provide medical management are also providing industrial therapy services. These practices should be closely monitored for over utilization trends or delays that limit return to work. Minimally, C-9 requests or vocational plans submitted should require disclosure notice to BWC when a self-dealing conflict of interest exists. These providers should also be required to describe how they intend to ensure cost-effective care and inform claimants of their right to treat with alternative providers. C-9 requests semantics confusion that delays services Ancillary service providers such as physical therapists should have the latitude to submit their own C-9 service or equipment requests to limit unnecessary semantics confusion that results in unnecessary delays or interruptions. Functional Job Analysis as an early intervention tool. If the employer of record is unable to supply an adequate report of physical job demands, then a functional job analysis should be authorized under presumptive preauthorization without need for a physician prescription if lost-time results or the IW reports an aggravation of symptoms in response to modified duty assignment. The functional job analysis process should invite participation by the IW and supervisor to facilitate identification of suitable transitional work option to prevent needless work disability or work restrictions.

Ohio Bureau of Workers' Compensation

Board of Directors

Public Forum on Thursday, April 24



American Physical Therapy Association
OHIO COMPONENT

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Summary of Testimony by

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My name is Rick Wickstrom, PT, CPE, CDMS, and I am testifying on behalf of the Ohio Physical Therapy Association (OPTA). The OPTA is a professional association representing over 2400 physical therapists (PTs) and physical therapist assistants (PTAs) who are licensed in the state of Ohio, and physical therapy students.

I am a Licensed Physical Therapist, a Certified Professional Ergonomist, and Certified Disability Management Specialist. In my capacity as President and owner of Workability Systems and Workability Network, I have served as a consultant in occupational health and ergonomics for over twenty-five years. This includes development, training and quality assurance related to worker assessment and job analysis protocols and reporting software to support Workability Network's industrial therapy providers. I have gained additional perspectives on early intervention during my experience as a BWC-accredited transitional work program developer and from my recent volunteer service as a member of the steering committee and facilitator at the multi-stakeholder summit to Prevent Needless Work Disability of Ohioans.

The purpose of my brief testimony before you is to discuss and provide constructive suggestions to help address three important barriers that contribute to needless work disability and poor medical management of work-related injuries. Those barriers are:

- o Semantics confusion in C-9 requests that delays appropriate services
- o Self-dealing/conflict of interest practices that negatively impact cost-effectiveness of industrial therapy services
- o Roadblocks to provision of functional job analysis (W0645) and ergonomic study (W0644) as early intervention tools

Semantics confusion in C-9 requests delays appropriate services

There is unnecessary semantics confusion in the process for C-9 requests by physicians for physical or occupational therapy services. This limits our ability to delivery industrial therapy services in a timely and cost-effective manner. I would like to illustrate my point with a simple, but all too common example from my company, WorkAbility Network. Most of our therapy professionals that provide industrial therapy services at the work-site only do so within a limited coverage area because travel time and expense is not compensated. We recently received a request from an MCO to provide on-site therapy to a 3rd shift work on a C-9 that specified "physical therapy 3 times per week for 4 weeks". The diagnosis was an upper extremity cumulative trauma condition, lateral epicondylitis that is commonly treated by a physical or occupational therapist. For this service request, the most convenient and qualified industrial therapist happened to be an occupational therapist located only 5 minutes from the company location. Because the wording of the C-9 request stipulated physical therapy, there was a delay in start of services because we had to first educate the physician to submit another C-9 request to change the semantics language to "Transitional Work Services to 12 visits" and then wait for the MCO to authorize the new C-9 request revision.

Many physicians request "evaluate and treat" in their referrals for physical and occupational therapy services because they understand that it is quite common for physical therapists and occupational therapists to have to modify the type, frequency or duration of services appropriate for patients based on initial and follow-up examinations and professional judgment of the physical therapist.

The simplest solution to eliminate these types of semantics problems would be to allow the physical therapist or occupational therapist the latitude to submit their own C-9 requests directly to the managed care entities or self-insured companies. This would be more consistent with how independent physical therapists submit and revise authorization requests to non-occupational payers such as group health insurers. This solution would help eliminate treatment access barriers created by semantics confusion and relieve the administration burden on attending physicians and industrial therapy providers.

Allowing physical and occupational therapists to directly submit their own C-9 requests is also consistent with the scope of practice for licensed physical therapists and licensed occupational therapists in Ohio. In fact, much of the justification for removing the physician prescription or referral requirement for physical therapy services with passage of Senate Bill 35 in 2005 was based on consideration that direct access physical therapy services have been shown in multiple studies to be more cost-effective than physician-referred services. Allowing physical and occupational therapists the latitude to submit their own C-9 requests would limit unnecessary semantics confusion and foster an environment of early intervention that supports companies with transitional work programs.

The expected outcomes allowing physical and occupational therapist to submit their own C-9 requests and clarification plan would be a reduction in unnecessary treatment delays or interruptions to can lead to development of more serious health conditions, unnecessary medical interventions, or needless work disability.

Self-dealing/conflict of interest practices that negatively impact cost-effectiveness of industrial therapy services

It is the position of the Ohio Physical Therapy Association that BWC's vocational redesign proposal only addresses part of the problem of self-dealing/conflict of interest by eliminating MCO case management referrals to affiliated sister companies. These self-dealing conflicts of interest extend deeper into the BWC system, because many physicians and MCO sister companies that provide direction of medical management are also providing industrial therapy services.

These types of self-dealing practices may involve several real and potential effects on consumers. Once a physical therapist is employed by a physician or vocational rehab provider that is responsible for medical management, a conflict of interest exists, in which the best interests of the injured worker or employer may be compromised for financial gain of the physician or vocational rehab company owners. Having a financial interest in other services for which a physician or case manager refers a patient may cloud their judgment regarding the need for referral or length of treatment required. Similarly, the physical therapist employed in these situations may face pressure to evaluate and treat all injured workers referred without regard to their needs. The consumer is not likely to be aware of any conflict of interest when the service is provided under the umbrella of the physician or vocational rehab company that is directing their medical management.

Physician associations have argued that self-referral to a physician-employed physical therapist is not a conflict of interest by labeling physical therapy as an "ancillary service provided incident to physician practice. However, the suggestion that physical therapy is not a separate profession is clearly wrong. For example, the Office of the Inspector General of Medicare issued a report in 2006 that found that 91 percent of physical therapy billed by physicians in the first 6 months of 2002 failed to meet program requirements, resulting in improper Medicare payments of \$136 million dollars for that period of time alone. In addition to inherent conflicts of interest, these self-dealing relationships limit the injured worker's and employer's right to choose a qualified industrial therapist that has the expertise to prevent needless lost-time and restricted duty.

The consumer may not recognize this loss of choice, as no other options is offered. I have seen a number of examples where the injured worker is expected to travel longer distances to a self-dealing provider, rather than being informed of a more convenient physical therapist who is located close by.

Given the magnitude of problems created by self-dealing arrangements, the Ohio Physical Therapy Association believes that Ohio BWC should take immediate action to limit these self-dealing arrangements. At a minimum, these practices should be closely monitored for over utilization trends or delays that limit return to work.

OPTA would suggest that BWC implement a tracking mechanism for all C-9 requests or vocational plans submitted to require disclosure notice to BWC when a self-dealing conflict of interest exists. These providers should also be required to describe how they intend to manage such conflicts of interest to ensure cost-effective care and inform claimants of their right to treat with alternative providers.

Roadblocks to provision of Functional Job Analysis and Ergonomic studies as early intervention tools.

One of the greatest contributors to needless work disability in the Ohio Workers Compensation system is that the attending physician is often put in a position where they are asked to make a guesstimate about a worker's functional abilities or rely on erroneous information about job demands or availability of accommodation options. When an injured worker is released to return to work in a job that exceeds their safe workabilities, a re-injury or aggravation of the condition may occur. When job demands are misrepresented as too high or the physician sets work restrictions that are excessive, needless work disability and lost productivity may occur. In an ideal world, a high quality functional job analysis would be in place and immediately available to disseminate to all parties involved in treatment or medical management. Unfortunately, most state fund employers don't have the expertise or resources develop and maintain quality functional job analysis in advance of an injury claim. Time is the enemy, and getting a good job analysis done is especially appropriate when the employer of record is unable to supply adequate information to support job placement decisions or the physician has rendered the worker temporarily and totally disabled. It is unlikely and unrealistic to expect attending physicians who certify needless disability leave to request job analysis information early in the claims process. After all, getting more objective information about job demands might result in a denial for inappropriate work-related injury claims.

The current version of Chapter 4 Guidelines for Vocational Rehab contains an unnecessary and burdensome requirement that a functional job analysis or ergonomic study be prescribed by a physician. It is our suggestion that language requiring a physician prescription or referral be removed not only from Chapter 4 Guidelines, but also from any other MCO authorization policies that relate to provision of industrial therapy services and job accommodation equipment. Furthermore, early intervention would be improved if a functional job analysis (W0645) and ergonomic study (W0644) services were included under the list of services allowed under presumptive preauthorization. Making these services more readily available under presumptive preauthorization would provide an early intervention tool that can help reduce needless work disability.

I would like you to consider the following case scenario: A worker injures his back and seeks treatment with Dr. Quack. No information about job demands or accommodation options, so the doctor has to rely solely on the injured worker report that no modified duty is available. The physician certifies disability leave, and doesn't even consider transitional work as a therapeutic option. He prescribes medicines or physical therapy in an outpatient clinic that separates the worker from employment. The focus of the treatment is diagnosis-specific, rather than job-specific. This scenario usually results in unnecessary treatment. Usually the worker is not released by the physician back to regular duties until the worker asks for a full release. One lost time claim like this can be the straw that gets the employer kicked out of a group rating as a result of becoming penalty-rated.

Now consider the same case and opportunity under a new environment that permits functional job analysis and ergonomic study by BWC under presumptive preauthorization. The injured worker would receive a WE CARE contact by the employer to invite him or her to attend a work-site visit and actively participate in a return to work planning process facilitated by an industrial therapist. This visit would allow feedback from both the injured worker and supervisor in a manner that objectively clarifies the physical job demands and identifies musculoskeletal risks and accommodation options. Active participation by the injured worker in the job analysis process would lead to buy-in from the worker and treating physician that is necessary to implement a cost-effective and individualized transitional return to work plan. Another benefit is that job analysis services early on in the claims process would help guard against fraudulent or inappropriate claims. In this scenario, the claim may remain medical-only due to improved communications.

In summary, implementation of properly structured industrial therapy services with consideration to the suggestions made in my testimony would shorten the recovery from work-related injuries and protect the health of workers and businesses in Ohio.

This is why our Ohio Physical Therapy Association is advocating for responsible changes within Ohio BWC to:

- o Eliminate semantics confusion in C-9 requests that delays appropriate services,
- o Guard against self-dealing/conflict of interest practices that negatively impact cost-effectiveness of industrial therapy services, and
- o Remove roadblocks to provision of functional job analysis (W0645) or ergonomic study (W0644) as early intervention tools

I would be happy to respond to any questions you might have.



Rick Wickstrom, PT, CPE, CDMS

Stephen E Mindzak
Attorney
Stephen E Mindzak Law Offices / Various Medical Practices

Several issues of concern to injured workers, such as approval of treatment, concerns over BWC examining physicians; opinions which are in direct opposition to State of Ohio Medical Board's Opinions, Cessation of prescriptions to PTD patients, etc. More specific details will be clearly set forth in my written remarks which I will submit at the meeting. Several issues of concern to IW medical providers, such as, delay of payment for services rendered, downcoding, prior authorization requests when none should be needed (i.e. for normal office visits), etc. Specific details will also be set forth in my written materials which I will submit at the meeting.

TESTIMONY BEFORE BWC BOARD OF DIRECTORS ON APRIL 24, 2008

Mr. Chairman, Members of the Committee, my name is Steve Mindzak and I am an attorney who has been working within the BWC System for about 20 years. During that time, I have had the opportunity to represent injured workers, medical providers, and employers within the BWC System. First of all, let me thank this Board, the new Administrator, and all of those responsible for having this open forum. It shows the forward-thinking nature of this group. It finally gives the practitioners who work in the system a chance to give input about a system that we work in everyday.

Given the time constraints, I have chosen only a few topics to speak about today. When looking at the BWC, I don't think anyone would argue with the point that the underlying medical issues are a driving force in this system. After all, treatment for injured workers is what this system is all about. Having said that, Let me get into the areas that seems to come up most frequently in my practice.

The first area concerns workers that have been declared permanently and totally disabled as a result of their workplace injuries. These are persons that are granted weekly benefits for the rest of their lives due to the serious nature of the injuries they sustained while at work. At the outset, remember that any worker being paid PTD benefits has had to go through a detailed hearing at the Industrial Commission before the benefits are granted. I don't think anyone would ever contend that persons with minor injuries would be granted PTD benefits. In fact, it is only the most severely injured workers that are ever even granted PTD benefits. Basically, it says that the person will never be able to do any kind of work for the rest of their lives based on the injuries they

sustained at work. Thus, it should be readily apparent that the PTD recipients suffer from extremely debilitating medical problems brought on by their workplace injury. As such, it is also reasonable to conclude that these medical conditions will need continued treatment for the person's lifetime. Surely we would not contend that a medical condition(s) is / are so severe as to disable someone from work forever and would somehow not require treatment. Yet in the last several years, an increasing amount of PTD recipients have had their continued medical treatment questioned by the BWC. When I say questioned, I mean that the BWC has a medical review performed by a physician of its choice to opine on the necessity of the injured workers' need for continued medical treatment. As noted, the very nature of the benefits should mandate that continued treatment will be necessary.

I am not talking about treating unrelated conditions. I am only speaking about ongoing treatment in the nature of office visits required for ongoing medications. Many of the PTD recipients have undergone one or more surgical procedures and the only treatment left is the medical management of their symptoms by ongoing medications. The medications are not designed to "fix" their condition(s), only to make the remainder of their lives tolerable – given the ongoing pain that they are forced to live with for the rest of their lives.

While there are many examples, I will only speak about one example of a recent case that I was involved with to illustrate this. I did not include his name, but I would be more than glad to do so should this Board request the same. The gentleman involved sustained a work injury and was granted PTD benefits over 10 years ago. Over the last 5 years, this gentleman's medical file was reviewed by four (4) different physicians on the

BWC's behalf on four (4) separate occasions approximately one (1) year apart. On each of those occasions, the physicians chosen by the BWC opined that the treatment that he was receiving was necessary and appropriate. The treatment that he was receiving was in the nature of routine office visits to have his medications re-filled and the required follow-up to obtain these medications. At the beginning of this year, this man's file was reviewed for the fifth time by another BWC physician who opined that no further treatment was necessary inasmuch as the treatment being offered was only palliative in nature. This occasioned a hearing to be scheduled that was set to terminate this man's treatment. At that hearing, the hearing officer decided to continue the medical benefits.

The obvious question must be asked – why was this man's treatment even questioned? While continued medical treatment for PTD recipients may be a large cost to the system, so are the weekly benefits that were awarded to him for life. However, this doesn't mean that the system should tell him that his treatment will no longer be paid for because it cannot have the effect of making him better. If he were able to be made better, PTD benefits would not have been granted in the first place.

How much money was spent in obtaining the medical reviews, the subsequent hearing, and all of the work leading up to that? This is especially disturbing given the fact that four (4) previous doctors agreed that his treatment was necessary.

The next area of concern is the practice of down-coding by the MCO's. This is where the MCO's, on their own, determine that a physician is not entitled to be paid the full amount for the service that he / she rendered. In essence, it is saying, "We don't believe that you performed the services that you said you did." Medical services are based on CPT (Current Procedural Terminology) guidelines. These guidelines are

published by the American Medical Association. An MCO should not be permitted to substitute a lower code (for a lesser service to be paid at a lower rate) simply because it believes that it has the right to do so. If the physician can demonstrate, based on proper CPT Coding Requirements, that he / she has fulfilled the criteria for a certain service level, then the bill(s) should be paid. No additional requirements should be able to be superimposed by an MCO.

This is only one example of billing problems that physicians who treat workers' compensation patients encounter. One other area is that MCO's are requiring that a physician submit office notes each and every time before payment will be made for regularly scheduled, routine office visits (i.e., medication re-fills and required follow-up). No other insurance company in Ohio requires this. The various other insurance providers such as Medicare, Medicaid, United Healthcare, Aetna, Anthem, Humana, Cigna, and Medical Mutual of Ohio to name just a few – do not require the submission of office notes before payment can be made for routine office visits. While every company does periodic audits of physicians, the routine requirement of submitting office notes is not needed by the other companies before payment is issued. Why is the additional time and cost necessary? An increasing number of physicians are refusing to accept workers' compensation patients due to the problems with increased paperwork and lack of prompt payment for services rendered.

Another issue of concern is the use of narcotic medication in soft tissue injury cases. In a position paper from the State Medical Board of Ohio, it was specifically noted that long term use of narcotic medication was appropriate and acceptable in cases where treating intractable chronic benign pain (soft tissue injuries). This paper is somewhat

lengthy and I would be more than happy to provide the Board with copies should they request it. The whole point of this is: How can the governing body of physicians (State Medical Board) in Ohio take a specific position on a form of treatment and the BWC reviewing physicians not be required to follow the same? Yet, it is routine to see medical reviews by BWC physicians that state, "Long term use of narcotic medication in soft tissue case is not appropriate. Soft tissue injuries are self-limiting and usually resolve in 6-8 weeks." While some case may resolve, it should be used to deny benefits in cases where the injured workers continue to have problems.

Once again I would like to thank this Board for the opportunity to express my concerns today. I would be glad to answer any questions that you may have.

Speaker

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Karen Conrad-Ball
President – Elect
Ohio Chapter of IARP

Short intro of membership role in provider community, codes and standards of practice relative to the need for rehab redesign as proposed by the BWC to the LMG board in August-present. Comments will reinforce support for the proposed redesign involving feasibility and assignment and other recommendations within the BWC proposal currently on the table. We realize the BWC Board of Directors has not been formally presented with the redesign proposal and understand the forum will be educational as well as provide a conduit for additional data gathering , pertinent to the current problems plaguing the system.

Will present capsulized examples / concerns about current process , fallout for providers , employers, consumers relating to feasibility process. Talking points will be specific line items submitted by our membership and other medical providers with short recommendations provided in a handout (to be submitted Tuesday COB)

We request 10-15 minutes if this is possible . Handout will be submitted Tuesday . Thank you for your consideration and we look forward to assisting the BWC and the provider community in the delivery of better practice standards, service delivery, process efficiencies.

Karen Conrad
614 309-0499



IARP - Ohio

International Association Of
Rehabilitation Professionals

**Presentation
To
BWC Board of Directors
April 24, 2008**

**Public Forum
Medical Issues Part I: Providers
Barriers and Strategies**

Presented by

**International Association of Rehabilitation Professionals
OHIO Chapter**

Presenter: Karen Conrad President –Elect
Ohio-IARP
kconradball@comcast.net
(614) 309-0499

Introduction IARP purpose, role, codes:

- On behalf of the Ohio Chapter of the International Assoc of Rehab Professionals thank you for the opportunity to present our concerns and recommendations supporting the need for reform within both the state fund and self insured /self administered vocational rehabilitation programs.

1. For those of you unfamiliar with our membership and role within rehab community, our

PURPOSE is to:

- Improve and Advance the delivery of vocational rehabilitation services by way of:
 - Promoting Highest Ethical Practices
 - Undertake activities to stimulate service effectiveness in our communities
 - Conduct continuing education programs
 -

ROLE: is one of Advocacy for both consumer and Ohio's Employers.

MEMBERSHIP:

- Consists of persons or organizations having an interest in the provision of rehabilitation services in the private sector

Highlights from IARP

PROFESSIONAL CODE OF ETHICS :

Regarding:

- **Conflicts of Interest**
Respect the integrity and protect the welfare of the individuals or groups to whom their work pertains.

Detrimental or Exploitive Relationships

Professionals should disclose to their clients, professional boundaries, particularly if those involved multiple services where there exists a high potential for ethical conflict

- **Objectivity** -defined as providing evaluation without bias , as well as applying objective use of all available services and resources.

Talking Points

What is driving good vocational rehab providers out what could encourage them to stay??

Voc Rehab services should benefit both IW and employers. Over the last 4-5 years policies and procedures have resulted in a system that is not in line with the original intent of the revised code or the spirit of vocational rehabilitation as recognized in national practice standards.

Program oversight is not allowing medical or vocational rehab providers to own best practice outcomes. Decisions and overriding of professional recommendations are frequent and less than optimal for the two most important parties, the consumer of the service and the instant employer.

- a. There is a critical need to eliminate multi-layer bureaucracy of duplication, delays
- b. **Current Program encourages conflicts of interest** , Personality driven referral process, service approvals
- c. **Individuals with little to no competency in arena of voc rehab, are making critical decisions in the lives of IWs and employers....** Specifically , IWs with no job to return to are being denied referral for a basic feasibility assessment by a trained professional.
- d. Excessive Overriding of a treating physician's request for professional vocational assessment.
- e. Too much comfort in labeling providers as "bad" without regard for the potential damage to the provider and without any qualifying data to support the "label".
- f. Many IWs are being deemed MMI without the benefit of any work readiness program. **IMEs for 90 day exams and MMI evaluations should be postponed until an assessment for rehab has been done and certainly halted when the IW is already engaged in services. Current practice is not cost efficient or reasonable. The Soc Sec Adm in their "ticket to work" program structures rehab in this way .**
- g. **In the current process, case complexity invites bias for who gets referred and who does not.**
- h.. There is critical need to establish formal levels of complexity in claims, **not just at the point of a rehab closure**, as is currently the practice.
- i We Recommend a Shared Report Card for Performance Outcomes with Individual performance standards built in. We support score cards and performance standards across all disciplines.

Summary

In August 2007 , the BWC submitted a proposal for “rehab redesign” to the LMG Advisory Counsel. The proposal currently sits in the hands of a recently formed LMG stakeholder workgroup on Vocational Rehab . Notes are available from BWC Rehab Policy Unit.

Our own informal polling of members supports reform. We are currently undertaking a formal poll and would be delighted to share the results with the board at the next meeting.

IARP can play a pivotal role in the BWC redesign currently in motion and we encourage this new Board of Directors utilize IARP’s collective expertise, our experiences, and our wisdom gained over the last decade of working within the HPP

We are putting our trust in **this board** to ensure this BWC Administration is educated in the application of the laws and ethics that govern medical and vocational services .

Ohio Providers are depending on the BWC to:

- Promote and adopt rules that support the delivery of ethical and objective medical and vocational services that can benefit both consumers and employers.
- Protect the spirit of the practice of rehabilitation in both *state funded* and *self administered* programs

4121.61 Aiding Rehabilitation of Injured Workers.

- “The Administrator of workers compensation, with the advise and consent of the workers’ compensation oversight commission, shall adopt rules, take measures, and make expenditures as it deems necessary to aid claimants who have sustained compensable injuries or incurred compensable occupational diseases pursuant to Chapter 4123., 4127., or 4131. of the Revised Code, to return to work OR to assist in lessening or removing any resulting handicap.”

Ohio-IARP members can provide many examples supporting the concerns and information relayed here today. Please contact Karen Conrad at 614 309-0499 to request information .

Additional exhibits and “ rehab redesign” related materials will be respectfully submitted to The BWC Board of Directors prior to June 1st, 2008 for ongoing reference and consideration.

Memorandum

To: LMG Council
From: Robert Coury, Chief, Medical Services and Compliance
Date: November 27, 2007
Cc: Marsha Ryan, BWC Administrator
MCO League

COPY

Subject: MCO League Position on the Ohio BWC Vocational Rehabilitation Redesign Project Report and Proposal

Prior to the LMG Meeting of October 2, 2007, the MCO League released a position paper to members of the LMG Council which expressed the opinions of the League as well as a number of statements intended to support those opinions. BWC has reviewed the MCO League position and is making a conscious effort to alleviate the concerns it has raised by providing additional information and/or clarification so that the issues can be fairly and completely examined. To that end, the following response to the MCO League Position Paper has been developed for LMG members. Discussion is presented in the same order as the MCO League Position Paper for ease of reference. MCO League statements are italicized.

It should be kept in mind that the objective of the BWC Workgroup was to identify opportunities for improvement in a benefit program intended to reduce the duration of disability occurring as a result of a worksite injury. To meet that objective, the BWC Vocational Rehabilitation Redesign Workgroup conducted a comprehensive study of the processes and outcomes of the program. Metrics and study samples were carefully drawn in order to support the analytical questions. Data analysis was planned using only those variables which could be validated in order to assure that the conclusions were, in fact, sound. In addition, detailed process mapping was done in order to identify inefficient, duplicative practices which reduce the effectiveness of service through unnecessary delays and increase the administrative costs of operations. The identification of such convoluted processes was, in fact, a major demonstration of the study and they are, in and of themselves, compelling reasons for process changes.

MCO League Position Statement #1. MCOs have effectively managed vocational rehabilitation.

- *MCO voc. rehab. audit scores average 93%.*

BWC response: The assertion that a 93% audit score based on compliance with technical process elements equates with performance excellence is the equivalent of claiming the success of a perfectly executed surgery for the wrong diagnosis. The audit measures utilized in the MCO audits referenced by the MCO statement were limited to compliance with technical procedural requirements such as billing appropriateness (50% of the audit score), correct attribution of costs to the correct fund (State Fund vs. Surplus), compliance with the return to work hierarchy, and remain at work service documentation.

Although procedural compliance is certainly a positive, it does not reflect a higher level case management performance evaluation and is not a measurement of service effectiveness, appropriateness, impact or outcome. Compliance with basic process requirements in a program plagued by procedural inefficiencies is not an outstanding achievement. As stated in the BWC proposal, appropriateness of services and utilization review criteria should be the indicators of quality measures.

The MCO League concludes that the audit score achievement and the absence of monetary penalties is indicative of sound program performance. That conclusion is contested by the fact that MCO and vocational rehabilitation providers who participated in study focus groups consistently stated that role ambiguity and absence of clear authority has been a basic problem of the program leading to duplication of effort and redundancy.

The League commentary makes reference to “independent analysis by the MCO League” which shows “that MCOs who have affiliations or preferred provider relationships with vocational rehabilitation vendors, have the same or better outcomes...at a significantly reduced cost.” Whether this observation is germane to the discussion at hand is questionable. However, BWC welcomes any body of comparative data from these MCOs which include claim numbers so that the analyses can be validated and compared to other MCO and vendor experiences.

- *Rehab costs are down 30% since 2001*

BWC Response: The study done by BWC consisted of a study sample over the years of 2001 through 2005 as shown in the following table:

YEAR	Total Cost	Total Claims	Av/S Successful	Av \$ / Unsuccessful
2001	\$31770876	8309	\$4119	\$3589
2005	\$17024084 (Down 46.5%)	4032 (Down 51.5%)	\$5179 (Up 25.8%)	\$3462 (Down 3.6%)

Although total costs have decreased by 46.5% that finding must be taken in the context of a declining claim population. The total number of claims over the period shown above has decreased by 51.5%. However, the average cost per successful claim has **increased**

by 25.8% over the same period. (1) It is patently disingenuous to claim that the declining costs of vocational rehabilitation are due to better service rather than to a decrease in the number of total claims served, particularly when the average cost per claim has increased.

- *Return-to-work is at all-time high per BWC's MCO Report Card.*
BWC Response: The current measurement used by BWC for the MCO report card consists of those cases from a restricted sample of only 266 ICD-9 diagnosis codes with a true return to work as well as a physician release for return to work (not an actual return) . Any case with a lost time duration over fifteen months is dropped from the calculation so that the overall outcome based on the study population is further adjusted. Although used for contract benchmark purposes, the figure is not a true reflection of improved actual results and, is not in any way a measure of vocational rehabilitation service outcome.

In addition, it should be noted that the proportion of lost time claims referred to vocational rehabilitation varies from between 2.8% to 5% of total lost time claims on a rolling twelve month basis. This proportion, then, would make up only between 0.5% to 0.75% of the DoDM population. This would present a negligible impact on the DoDM scores and would hardly be an indicator of successful vocational rehabilitation outcomes.

(1) *Whether this increased cost is due to inappropriate services or increased complexity remains a question.*

MCO League Position Statement #2. Statistics in the proposal are flawed.

- *Return-to-work is not accurately reported for reopened cases.*
BWC reponse: The analysis presented in the workgroup proposal was based on a defined population, which was fully explained in the proposal report. The study population was carefully drawn in order to control for any confounding variable(s) which would distort findings. Re-referrals were included in the summary tables and were identified as follows: 63%-1 referral, 22%-2 referrals, 8%-3 referrals.

The MCO League contends that inherent barriers, hurdles or complexities of the vocational rehabilitation service in support of return to work “skew” the outcome measures and unfairly undermine the roles of MCO medical case managers and vocational case managers. BWC acknowledges that the return to work effort is beset by such challenges. The essence of the redesign model fully supports the central role of the MCO in the core process of medical case management and in fact, do not recommend any change to those responsibilities which include development of treatment plans and identification of return to work barriers. The MCO medical case manager is expected to continue to be an important part of the team effort to assemble the appropriate services to be delivered in a timely way.

It is puzzling to note that the League position statement reports that it was the role of the MCOs to work with the employer to develop transitional work programs “until January 2007,” a point in time which coincides with the termination of the BWC Transitional Work Grant Program. Presumably, the role of the MCO should continue to support the best practice of encouraging and assisting employers in this development regardless of special grant incentives.

Although it is comforting to learn that the MCO League considers that the current “joint MCO/BWC program” contains “excellent checks and balances,” this finding is not supported by the recent BWC internal audit which identified serious shortcomings in the internal controls and program integrity measures. Those audit recommendations are cornerstones of the redesign proposal and intended to assure that program features are sound, carefully monitored and controlled and that accountability is established.

- *BWC DMC decisions negatively impact return-to-work in some cases.*
BWC reponse: This is a purely subjective statement that cannot be addressed.

MCO League Position Statement #3.: BWC is not Prepared to Oversee Vocational Rehabilitation

- *BWC Ombuds Report shows serious service issues at BWC. BWC complaint rate is 2000% higher than MCO rate.*

BWC Response: It is regrettable that serious consideration of this important program change is diverted by irrelevant statements. The findings of the Ombuds Report did not include ANY

elements related to BWC vocational rehabilitation services. That report categorized the complaints by type as follows:

Compensation: 25.93%	Processing delay: 15.20%
IC Hearing: 9.10%	Employer Policy Issues: 7.56%
General status of claim: 7.52%	BWC: 6.68%
Employer delay: 4.89%	Santos: 3.84%
Auth of medical Rx: 3.84%	Forms required: 3.55%
Medical bills: 2.96%	Injured worker; 2.84%
Remaining (<2% each) : Attorney delay, Managed Care Organization (1.42%) Medical Provider, PBM (1.25%) Lost file, Claim destroyed in error)	

The MCO League statement is a misguided attempt to besmirch the BWC agency as a whole as a means of undermining the capacity of the operations to provide vocational rehabilitation services. The complaints summarized above relate to a myriad of issues with only a small proportion relating to operational service matters.

- *BWC has 91 material or significant operational weaknesses according to its own audit.*
BWC Response: Findings in the BWC Annual Audit published on the BWC website did not include any vocational rehabilitation dimensions. The Medical Services Division of BWC did request that Internal Audit conduct a specific audit of vocational rehabilitation program and services in early 2007. Preliminary recommendations of that audit were included as Attachment III in the Vocational Redesign Proposal in the spirit of open communication and transparency. The fact that the BWC turned to internal audit as an additional information source for completing the vocational rehabilitation program study is something of which we are proud to report. As stated above, the findings and recommendations will be incorporated into the new program design. It should be noted that such attention would be required irrespective of service delivery model changes.

The assertions of the MCO League that the “stated goal of the report, ‘to flatten and simplify the operational model’ appears to be more of an attempt to better utilize highly paid employees as a way to justify their salary” is ludicrous. BWC is required by O.R.C. 4121.69 to retain professional employees to “fulfill the duties placed upon the bureau of workers’ compensation pursuant to sections 4121.61 to 4121.69 of the Revised Code.” Accordingly, the BWC employs highly qualified professionals in order to meet this statutory responsibility and to provide stewardship of the funds administered in behalf of the Workers’ Compensation program. The recent analysis of process workflows supports the business need to reduce duplication and ambiguity of roles which was identified as a program weakness by all internal and external focus groups.

The statement of the MCO League that comparisons to other states or rehabilitation services is inappropriate is difficult to understand. While there are obvious differences in benefit plan designs and service criteria, there are basic elements of service quality and cost-benefits that are useful considerations. For example, the state of Washington Department of Labor and Industries is charged by statute with the requirement to establish criteria of quality and effectiveness in the vocational rehabilitation program, to monitor individuals who are providing services, and to make referrals based on the

above. Many of the Ohio BWC internal audit recommendations for vocational rehabilitation internal controls address these same issues. It would be foolish to fail to take advantage of the work, study and experience of another state, or another Ohio agency in evaluating the program and services of the BWC vocational rehabilitation service.

MCO League Position Statement #4: The claim that the redesign is budget neutral is misleading.

- *System changes are required, but cost estimates have not been developed.*
- *Billing and reimbursement changes are necessary, but cost estimates have not been developed.*

BWC Response: It is the operational responsibility of BWC to continually assess and improve ALL services which includes system upgrades as well as process changes. This is the point of all program evaluation efforts and is ongoing across all operations activities. Elements of the redesign plan have emphasized improvements that would be required with or without the realignment of DMC responsibilities. (Ref: Internal Audit recommendations for internal control improvements.) Accordingly, five out of six of the recommendations of the plan redesign relate to those basic program requirements and would be necessary under any circumstances as a function of program improvement as identified by internal audit.

One of the most significant driving factors for change is the necessity to reduce present administrative costs apparent in today's world. It is the responsibility of BWC to continually assess current processes and apply continuous improvement criteria to reduce costs to the employers and to facilitate a safe, permanent return to work for their injured workers.

MCO League Position Statement #5: The proposal is not consistent with the Ohio Revised Code.

- *O.R.C. 4121.44 B(1) states external vendors will provide medical management services.*
- *O.A.C. 4123-18091 states that medical management includes vocational rehabilitation.*

BWC response:

The redesign proposal clearly acknowledges that Rule changes will be required in order for implementation of the changes proposed. It should be noted that O.R.C. 4121.62 (A)(1) states: "The authority granted to the administrator of workers' compensation pursuant to sections 4121.61 and 4121.69 of the Revised Code includes the authority to do all of the following:

- (1) Contract with any public or private person for the rendition of rehabilitation services."

Conclusion:

The BWC vocational rehabilitation redesign recommendations were the result of a comprehensive review of the benefit plan as well as the service model. The workgroup, which was multidisciplinary (operations, legal, policy, internal audit, vocational rehabilitation professionals) conducted a thorough analysis with carefully defined deliverables that could be summarized by increasing accountabilities, streamlining services and improving program outcomes. All elements of the study have been presented to the LMG and have been openly discussed.

Streamlining service delivery and eliminating multiple hand-offs is a well-known and respected business practice for achieving these objectives. Simply put, the BWC is fulfilling its statutory mandate to provide effective vocational rehabilitation services in the most efficient manner possible to the benefit of the employers of the state of Ohio and their workforce population. This is a singular duty which rests with the Administrator of BWC and, as such, places the onus for benefit plan design and execution within the bureau.

Speaker

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23

Marilyn Orr & James Hammond
Executive Director
Beacon Orthopedics and Ortho Neuro

Possible Barriers for Physicians Becoming a BWC Provider (info gleaned from 5 ortho practices in Ohio)

1. Overwhelming amount of paperwork:

Examples: C9 (authorization), C84 (paid time off though BWC), FROI (first report of injury), MEDCO 14 (paid time off though MCO), C86 (Motion)

2. BWC Lack of knowledge:

If a new case worker is assigned, my staff states the new case worker does not review the patient's chart. Instead, the case worker expects the medical office staff to start from the beginning in educating the case worker. Frequently Case Managers will call or fax our staff the day of a scheduled appointment or the day after to receive an update that will be sent to them within 7-10 business after the transcription has been processed. Requesting special handling frequently only disrupts our office further. In the situation where the caseworker is dealing with non-compliant patients we understand but this should be the exception and not the rule.

The rules of BWC can be challenging at times and the physicians may find BWC guidelines difficult to understand. Education to medical office staff should be offered and/or a website of "how to" and FAQ's should be provided to streamline and/or answer routine handling questions.

3. The quality of care to the patient may be compromised due to BWC Policies. The patient would strongly benefit from an overview from the case worker as to the purposes of the various forms. Example of impact of policy: Time delay for additional allowances, only being able to treat a patient for the specific diagnosis allowed under their claim until the additional diagnosis is allowed..

4. The timing of care and BWC responsiveness

There is supposed to be a 10 day turn around from the time the medical office staff provides information to the case worker. The turn around time is much longer requiring multiple follow up efforts on our staff's part on behalf of the patient.

5. Becoming POR (Physician of Record) when a physician does not want to be.

If a physician submits the FROI, or if the physician is the first to treat the patient under the claim, they will become POR.

6. Documentation/Medical Challenges

The Medical office staff is required to provide responses to duplicate requests for information as the employer and case worker do not communicate effectively. There needs to be a way to share the information so it only has to disseminated once. The time

involved in processing the same information numerous times becomes a barrier for the practice providing the patient's care.

The Bureau can be very particular about the physicians medical.

Example: A patient is seen under consultation for an allowed diagnosis such as degenerative disc disease. The physicians dictation mentions the condition of arthritis, the bill can be denied due treatment for a non allowed condition.

7. Appeal treatment process is very involved and can be confusing whereas an attorney may need to be involved. Viscal injection medications (synvisc, hyalgan, orthovisc) are not getting paid without fighting for it even though we have authorizations.

8. Split surgeries:

Actual medical attached showing a physicians point of view and frustration.

Below outlines an actual summary of a patient's BWC case, we have removed all names and personal information.

Diagnostic arthroscopy only is approved in this case but the physician requested arthroscopy with possible synovectomy and debridement to be allowed. The Bureau felt the diagnostic arthroscopy should be performed. Then a 2nd surgery would be considered at a later date if the arthroscopy supported the conditions above.

We have received word from BWC that ultimately, they are not allowing a wrist arthroscopy with possible synovectomy and debridement to be allowed. However, I would like to argue and state that this should be allowed. They want me to move forward simply with diagnostic wrist arthroscopy. This is possible, however, if there is synovitis or debris within the joint, it would be at that time that it should be taken care of. I do not believe that it should be taken care of with a separate surgical procedure. If there is a frank ligament tear that needs to be addressed with a different procedure, then that is something that would have to be done at a staged position, but when we do synovectomies or debridement of the joint, we do this through wrist arthroscopy. I do not think it would be in the patient's best interest to have two separate surgical procedures that are almost the same thing. They are done through the same approach. This would require two separate anesthesia as well as separate admissions. Again, I would like to submit that she undergo right wrist diagnostic arthroscopy with the possibility, if I find synovitis or debris in the joint, that I move forward and take care of it then, instead of moving forward with a second, repeat procedure.

They were also stating that this was not allowed under the code 842.00. This is coded as a sprain. A sprain, as you and all people in medicine know, includes injury to soft tissue which can include synovitis and inflammation, tearing of the triangular fibrocartilage, and tearing of ligaments that are in the wrist.

Unacceptable time-frame for payment remittance. BWC percentage of business is significantly less than the BWC percentage of outstanding Accounts Receivable. In addition, the personnel required to monitor and process BWC is significantly higher than those needs for other lines of business.

Workers Comp - REAL DATA

Month A/R Balance Avg. Charges Days Revenue O/S

Jan 07 \$	311,019 \$	2,478	125.51
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Speaker

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24

Angelyn Atha
Regional Account Manager

Home Health What are the specific credentials a home health agency needs to meet to become certified with the BWC (an agency can be enrolled, but not certified, and no payment will be issued without certification)? We are concerned that we have to only use certified agencies, but the reimbursement rate is too low for certified agencies and individuals to do business. Transportation Our network of transportation providers willing to accept the low BWC reimbursement rates is very minimal. Those that will accept the low rates are not as dependable as those belonging to our network prior to the cut in BWC reimbursement rates, therefore we have ceased providing transportation in Ohio. This leaves our clients to do the work themselves. It can take hours of contacting vendors to find one willing to provide the service within the BWC reimbursement rates. This is affecting our service, the client, and the injured worker. We provide all of our services nationwide. Ohio is the only state we are unable to assist our clients with transportation. Coding We receive a lot of requests for Rollabouts prescribed by the Injured worker's physicians. The MCOs advise us that the BWC will only reimburse them under code E0118 (crutch substitute) which the allowable amount is \$200. We contacted 5 vendors and none of them offered a Rollabout below \$400. We understand that eventually the BWC will realize this and make an adjustment, but there should be a temporary solution for these types of situations so we don't have to leave the injured worker without the item they desperately need.

As a provider Modern Medical offers various products & services to Self Insured employers and MCOs such as medical equipment, orthotics and prosthetics, language and transportation assistance, and Home Health. **We** have been in business for over 20 years and have always focused on providing a level of service above and beyond the injured workers expectations.

Transportation

According to Consumer Reports since 2004 gas prices have increased over 68%. **In** 2004 the BWC reduced the fee schedule reimbursement for transportation. **At** this time Modern Medical had to scramble to reconstruct our network searching for new providers who would agree to provide transportation and meet the fee schedule. **We** wanted to continue uninterrupted service to our clients so often we paid our vendors more than we were able to bill our clients at fee schedule and we absorbed the difference.

Unfortunately the companies we were forced to use to transport injured workers were not reliable, resulting in **27 less than standard occurrences** last year. **These** occurrences include not arriving on time resulting in injured workers missing IME examinations, which we in turn paid the missed appointment fees, not arriving for pick up at all and drivers unable to locate correct addresses. **We** found it difficult to meet the fee schedule, provide quality service and maintain our valued reputation for superior service, so last year we chose to discontinue this service in Ohio. **We** are able to provide this service in all states and maintain state fee schedules and UCRs, except OHIO! **So** with the 68% increase in fuel charges, of course transportation companies are forced to increase their prices, yet the BWC remains at their reduced 2004 rates. Please consider increasing the transportation fee schedule reimbursement to reflect the real life cost of fuel.

Home Health

We have been experiencing some of the same issues with the Home Health Service reimbursement, however, slightly different from transportation. **We** are having trouble finding home health agencies to provide the service at a rate that will honor the fee schedule, however the issue here lies more with the certification requirements. **The** process is considered extensive and tedious. Once the paperwork is filled out the home health agency can wait as long as 8 weeks to receive an answer on their status, meanwhile an injured worker is in need of assistance. **To** be certified, (which is the only way to meet the BWC requirements for reimbursement); an agency needs to have certain expensive licensing credentials and certifications, but the BWC is not offering adequate reimbursement to off set this cost. **Some** patients only need domestic assistance, which may consist of light housework or preparation of meals. **The** BWC is requiring that we use one of these agencies licensed to administer medication and provide medical attention for simple domestic assistance. **There** are less expensive agencies more suited for domestic assistance work, yet the certification requirement is keeping us from utilizing them and their more reasonable rates. **Please** consider increasing the Home Health reimbursement rates for certified providers who do administer medical attention, as well as permitting non certified providers enrolled in the BWC network to provide domestic assistance at their reduced rates.

We sincerely thank you for the opportunity to express our interests in improving your provider program.

Speaker

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25

OHIO BUREAU OF WORKERS' COMPENSATION
BOARD OF DIRECTORS
PUBLIC FORUM APRIL 24, 2008

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As an employer who places great value on our employees' health and welfare and considers them our greatest asset, we urge the OBWC to enact more stringent standards and increased accountability of BWC certified Medical Providers.

Our injured workers should not be subject to Medical Providers whose treatment and return-to-work stats consistently fall outside the DoDM guidelines and whose offices consistently fail to communicate and partner with the employer and MCO to develop successful return-to-work strategies. We do not want our employees to have to settle for mediocre and sub-standard results – we want our employees to be given the best possible care.

The vehicle to drive greater accountability is already in place with the OBWC certified Managed Care Organizations. MCO's can easily track response times for the timely submission of appropriate medical documentation, and, even more importantly, DoDM results.

This data can then be used to evaluate medical providers in much the same way as the MCO's are annually evaluated for the standards they must meet to remain an OBWC certified Managed Care Organization.

Being an Ohio Bureau of Workers' Compensation certified medical provider should be a coveted title. I challenge the OBWC to raise the bar for medical providers treating our injured workers as we continue to strive as employers to prevent injury through accident prevention measures.

Speaker

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OHIO BUREAU OF WORKERS' COMPENSATION
BOARD OF DIRECTORS
PUBLIC FORUM APRIL 24, 2008

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As a concerned employer, we encourage the OBWC to take steps to improve the oversight of prescription medications.

Medications are often unnecessarily prescribed for the allowed conditions in the claim. Pharmacists have no way (and little motivation) to ensure the prescription being submitted is appropriate under the workers' compensation number provided.

We strongly encourage the OBWC to allow the MCO to monitor and manage prescription medication and to improve the system to automatically forward for pre-certification certain formularies.

- 1) I am encouraging incentives for those public employers who have an identified safety budget.
- 2) Workers Comp is the #1 expense in most school districts or the one of the top 5.
- 3) Medical Providers Keeping educators totally disabled. We have clerical and student monitoring functions available.

On Site
Registration
Speakers

Speaker

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April 24, 2008

Dear Members of the Board of Directors,

Thank you for taking some of your valuable time to consider the ways in which the Ohio Bureau of Workman's Compensation can improve the services delivered to injured workers to assist them to get back to work as soon as possible. The public forum today represents, in my opinion, the beginning of a process of inquiry about how the current system is failing to achieve the goal of minimizing the time, suffering, and money lost to injured workers and reducing the ability of employers to operate and build their business.

**Six Improvements to Reduce Return to Work Time of Injured Workers by
Improving Treatment Outcomes Which Reduce Costs For Businesses**

We all agree that the fundamental goal of BWC is to help injured workers return to work after an injury as soon as possible. As I have worked with more seriously injured workers over the past ten years, providing psychological services, I see the need for improvement in **six main areas** in order for the goal of reducing the time needed return the injured worker to work and reducing costs to be realized:

1. improving initial diagnosis of the true nature of the injury which does not minimize or exaggerate the nature of the actual injury;
2. improving access to less invasive medical treatments (especially in the areas of injuries to discs in the back and any injury which produces chronic pain);
3. improving access to medical care generally to streamline and reduce requirements

of paperwork as a part of a broader strategy to encourage former physician providers in specialties of high need to return to being BWC providers. Also, initiating new methods of documenting treatment to create a best practices database for all providers to improve their methods and help researchers determine which types of care are most efficient for specific types of injuries and complications of those injuries might interest new providers and/or help retain new physicians;

4. improving the method of reimbursement for treatment that will make treating injured workers more cost-effective for medical service providers;
5. improving access to rehabilitation and adaptive services to assist employers to get their work done and to assist workers to get back to work or get retraining in case they cannot return to their former job;
6. improving the accuracy of the initial diagnosis of the injury, the rapid access to treatment by the appropriate treatment professional using the best practices model of treatment, and the availability of rehabilitation and adaptive services when needed will significantly reduce the need for and expense of attorneys to argue in the Industrial Commission for diagnoses, treatments, and benefits that should have been allowed in the beginning of the process—the savings of time, money, and wear and tear on workers and employers would be very significant.

Prevention As a Part of the Improvement Plan

Many of the patients that I have seen for diagnosis or treatment of mental health disorders resulting from injuries at work have described unsafe work conditions that might have been modified by the employers or their managers to reduce the risk in the workplace. While I see signs in many businesses where I have consulted that recognize the value of safety in the workplace, there appears to be no way for workers who are concerned about the safety of their workplaces to report their concerns in an anonymous way which leads to some sort of positive and proactive action to assist businesses to either reduce unsafe conditions or modify practices.

Both state and federal agencies charged with the responsibility to monitor and improve their effectiveness seem to have a long way to go to continue to reduce accidents

and risk to employees and their employers. We cannot afford unsafe working conditions—the costs of injury are great!

Problems With Initial Diagnosis Lead to False Expectations

Many injured workers with whom I work describe feeling upset when they are told that they have been diagnosed with a soft tissue injury (i.e., muscle strain) that should heal within six to eight weeks and yet they are experiencing severe pain, loss of stamina, and weakness years after the injury. Are these people simply magnifying or exaggerating their symptoms, extending their time off work at 50-60% of their salaries (putting great financial stress on themselves and their families, themselves into bankruptcy, or even losing their homes)? Alternatively, are these workers accurately reporting symptoms of a more serious injury that was misdiagnosed within a very short time of the injury when initial swelling obscures the nature of the real damage?

I am not a specialist in this area, but I have observed many clients who were reportedly informed by orthopedic specialists later in their recovery that the actual damage was more extensive than originally thought—thus many legal battles ensue that cause in some cases significant delays in accessing treatment which lead to degeneration and exacerbation of the conditions and extend the recovery time of the injury, and loss of trust between workers who feel insulted by lawyers and independent medical examiners (based on 5-15 minute reviews of cases and in some cases never actually talk to the injured worker) who accuse them of malingering and employers who feel that injured workers are simply milking a system for unnecessary benefits. I can site specific examples, if needed.

Invasive Treatments Are Also the Most Expensive Treatments

Many injured workers describe the disappointment of being told that their back surgery would help them or might help them, only to find that they are worse off after surgery. These unfortunates also describe meeting other people that they meet along the way in their healing process who have had similar disappointing results—they are much worse off after surgery.

I felt frustrated that there did not appear to be much that could be done to help these people with ruptured discs in their back. When I learned about disc decompression therapy (i.e., discs are revived through being stretched infused with natural fluids from tissues surrounding the discs) and saw how it worked I was immediately impressed by how much quicker, less expensive (i.e., \$5,000), and less invasive decompression was compared to surgery for spinal fusion (i.e., \$50,000 to \$100,000). The first patient that I actually saw receiving the decompression therapy was a physician who wanted to avoid back surgery if possible—he said to me that he thought that the treatment was helping him to feel better. The use of spinal decompression is not a cure all, but I think that decompression and other non-invasive treatments should be considered much more often.

In addition, I have seen several patients' reacting to invasive shots for chronic pain—sometimes the shots really appear to help, but other times the clients report to me that they feel worse from the shots. In another example, last summer I saw a machine that provided a type of biofeedback that gave significantly greater pain relief than anything that I have seen before that time. The machine, known as the myoscope for muscle and tendon pain relief and accuscope to help other dysfunctional cells to improve their functioning, promises to greatly increase the potential for non-drug relief of chronic pain.

This biofeedback modality needs additional testing perhaps by a group of Ohio university health research centers specializing in the treatment of chronic pain to improve the chances of Ohio's injured workers to return to the most healthy life possible after a serious injury. Non-invasive treatments should become the new standard of first line care when effective treatments are found.

Wanted: More Physicians to Replace the Providers Who Have Dropped BWC

I have seen a trend of physicians telling my patients that they are retiring or ending their participation in the BWC panel. As I have called these physicians to find out why they are no longer willing to provide services to BWC injured workers, most have replied that they are sick and tired of having to write up multiple requests for treatment authorizations, being denied the right to direct care of their patients by managed care organizations who rarely demonstrate any rationale for denials other than to say that they do not see the need for the treatment.

I have never received one offer from a managed care organization to help me develop a treatment plan for one injured worker—all I have heard is statements such as, "we want more documentation..., we had our independent consultant review the case file and found that the injured worker is MMI (when in fact the reviewers rarely have the complete sets of my notes and reports)...we see no evidence that the described condition relates directly to the allowed injury condition (when some new problem is uncovered upon more thorough examination)."

I have worked with two injured workers who were told that there was no MRI evidence that the severe pain in their shoulders was any real physical injury, but when the

surgeon did an exploratory surgery, in both cases damage was found and repaired—in one case BWC finally paid for the surgery, while in the other case the injured worker had to use private insurance. In both cases, surgery which was delayed for more than three years proved that initial diagnoses were incorrect and the doctors handling the direct patient care proved to know what was wrong and what to do to help their patients.

Unfortunately, delaying surgery for several years causes exacerbation of the injury and extends the time need to recover from surgery. In both cases, the employers fought the treatments vigorously in the Industrial commission and then never said, “I’m sorry that my experts were wrong that your suffering was increased.”

The fact that MCO’s believe that they do not have to reveal details of their arrangements with independent medical examiners, do not reveal the credentials of their experts, do not have to reveal what kinds of public money they are spending on their medical consultants, and that they seem to be able to put many of the senior medical consultants on their payroll, thereby reducing the pool of independent examiners. Often my clients have a hard time finding someone to examiner their cases because most of the examiners in town are already bought up by the MCO’s—this seems very unfair.

Improving the Speed of Reimbursement Might Allow for Some Reduction in Fee Schedules

Just as interfering with treatment authorization causes great frustration among physicians and other medical providers, delaying reimbursement also causes great consternation among providers. In some cases C-9’s (a document required to request authorization to treat a patient) are being lost, or “allowed C-9’s” (authorized treatment documents) are not being faxed. This requires that extra calls are being made to confirm

that the authorizations have been approved. My billing manager works with a number of psychologists and has experienced numerous problems, trying to bill and collect from BWC; she has also related to me some positive experiences with some companies—her statement of observations is included in the addendum #1 of this presentation. Self-insured companies seem to be the worst at paying their bills—it seems like they really think that they don't need to pay their bills. Speeding up the reimbursement payments might allow for a reduction of fee schedules, as most of us providers have been forced to experience fee reductions by Medicare in the midst of the great financial problems experienced by Medicare.

**Access to Adaptive Work Programs and Rehabilitation Services Is a Vital Link
In the Process of Getting Severely Injured Workers Back to Work More Quickly**

I have worked with several injured workers who were given assistance to get back to working a modified light duty job, but the "light duty" was neither light nor was it related to any form of work that was adapted to the worker's ability to make a contribution to their work team. In some cases injured workers are called names by their co-workers—this should not be allowed to happen without some expert assistance to the worker and the employer. In some cases injured workers are terminated due to their inability to do the job.

I have also worked with injured workers who were pursuing new careers by getting higher education and doing well in their studies on their way to making more money and higher taxes, but their programs were terminated because they were found as MMI due to their improvements—this was not really true that they were MMI because they were capable of making even more progress, but the Industrial Commission magistrates (in

many cases in a matter of minutes considering these cases), terminated all benefits. These clients have been unable to finance their educations and are either unemployed or under employed—this is a shame on our system.

The infamous case of the injured worker who appeared at the BWC building with a shot gun, threatening to shoot someone at BWC was reported to have been another one of the cases where the worker was trying to improve his functioning and career options when his educational benefits were terminated suddenly. The prospect of an injured worker coming out of the process being better off than before the injury by getting vocation rehabilitation benefits could make a huge impression on discouraged workers. Blogs and other internet resources could help injured worker in various stages of recovery communicate with one another and encourage one another—at no cost once the system was set up!

The True Cost of the Legal Battles Within BWC

The BWC system was originally set up as a way to reduce the strain on the legal system which was seen as at risk for battle between injured workers and their attorneys against miners and manufacturers and their attorneys. Get the injured worker the help he or she needs and get on with the business of business. However, a very large number of my clients must go into court several times per year (to their great exhaustion and increase of stress which often exacerbates their mental health recovery) in order to get initially superficial medical diagnoses to be allowed for more serious injuries, to get more extensive benefits and extension of those benefits because medical services are denied and their recovery processes are complicated. Many clients are given very superficial independent medical examinations (5-15 minutes) which they are often

not given a basic physical examination (while the examiners are paid very handsomely for their minimal efforts) and then the Industrial Commission may rule in such a way that one party or the other will appeal and the system drags on while the expenses rise.

In another case, one of my clients felt forced to seek heroine for pain control (having originally gotten on heroine while serving in Viet Nam), and broke a nine year recovery from drug addiction because his physician of record refused to prescribe adequate pain medications after given him morphine post-surgery and then stepping him down on a very mild pain medication. He was eventually arrested, spent time and jail and was forced to agree to not seek pain medications (in spite of the fact that he had seven surgeries for his injury), and is now being threatened to be considered MMI if he doesn't get on anti-depressant medication (which will have to be approved by his probation officer). Think about the cost of federal investigation, prosecution, legal defense, incarceration, and probationary follow-up for an injured worker who was supposed to be receiving adequate care to help him return to work. By the way, he really does want to return to work because he (as well as every other person with whom I work) knows that he cannot live on BWC benefits and/or the SSI benefits (which take an average of 2-3 years to be approved) are even worse! **Who wins in this system—not the businesses or the injured workers.**

Conclusion

I am sure that many of the less seriously injured workers are doing fine within the current system. Managed Care manages cases, injured workers receive their needed care, and they return to work within a few weeks or a month and life returns more or less to normal and business goes on trying to compete, slightly the worse for wear. The seriously

injured workers, those requiring six or more months of care and services (often stretching out to years in my experience) are a very different matter. Losing homes, careers, families, and all hope of ever getting back on track—yes, some of these workers commit suicide. My colleagues and I in the mental health field have experienced the loss of our patients who make the ultimate statement of desperation--we deserve better than this. You members of the BWC board and the senior leaders of BWC have the authority to investigate, redesign, evaluate, and modify programs, policies, and procedures. Ohio has great research institutions and world class leaders in healthcare who could be recruited to help BWC improve from its current position to a national leader in policies and programs that have strong empirical support.

There are few really successful programs in the whole world—we could begin a new generation of technological and methodological improvements for the benefit of our business community and workers who all need help to reduce costs and suffering. Let's "Git 'Er Done!" in the immortal words of Larry the Cable Guy. After all, you never know when you might be the next person to experience a serious injury—you will want the best help possible then. Thank You for the opportunity to share these observations and thoughts. Thank you for sponsoring this forum on your watch.

Speaker

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Ohio Council for Home Care

The Voice of Home Care and Hospice

COMMENTS BY BETH FOSTER, RN, BA, CPHQ

Regulatory Specialist, Ohio Council for Home Care

RE: Barriers That Keep Quality Providers from Participating in BWC's Program

April 24, 2008

Good morning. My name is Beth Foster and I am the Regulatory Specialist for the Ohio Council for Home Care (OCHC) -- an association of home care and hospice providers with more than 363 members across the state of Ohio. The Council was created 43 years ago with a major goal in mind -- to assist our members in safely and efficiently providing home care and hospice services to thousands of Ohioans every day.

I wish to thank the Ohio Bureau of Workers' Compensation (BWC) Board of Directors for the opportunity to publicly comment on enhancing BWC's medical provider network.

There are three major barriers that affect home health agencies, as follows:

- 1) Initially the greatest barrier to provide home care services is getting the C- 9 form signed by the physician and/or obtaining the correct C-9 diagnosis information to accurately document in the medical record and on the claims form. Home Health Agencies (HHA) also cannot request visit authorization from the Managed Care Organizations (MCOs) without this necessary information. This initial administrative process is very time consuming and costly. While the home health agency is waiting for the diagnosis and the authorization, patient care is delayed therefore increasing the time it takes to rehabilitate the patient. Ohio Council suggests that the MCOs improve the physician process in completing the C-9 and returning this form to the MCOs in a timely manner.
- 2) Many home health agencies have major issues with the Managed Care Organizations (MCOs) after the claims have been submitted. It is not unusual for an agency to resubmit claims and visit notes several times only to have the claim continuously denied. When the MCO's customer service has been contacted a typical answer is that the claim should not have been denied so the agency is directed to resubmit again. Needless to say, this causes the accounts receivable time to increase to over 151+ days which places a great strain on the agency's cash flow. Ohio Council recommends that the BWC increase their support to HHAs by interceding with prompt pay issues.
- 3) Taking into consideration not only extra administrative time and mileage costs, but also the fact that skilled nursing and therapy per visit reimbursement rates are below the Medicare rate, some agencies cannot accept BWC patients and stay in business. (see rate attachment)

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OCHC Recommended BWC Reimbursement Rates Based on Medicare/Medicaid Rates

Code	Description	Current BWC Rates since 2005(?)	Association Rec. Fee 2008*	Amount Differential	Differential
W0100	Home Health Agency Registered Nurse Per Hour	\$46.00	\$80.00	(\$34.00)	-42.5%
W0101	Outcome, assessment, information set/documentation to MCO	\$15.00	\$70.00	(\$55.00)	-78.6%
W0105	Home Health Agency Skilled RN or LPN Visit	\$94.00	\$110.32	(\$16.32)	-14.8%
W0110	Home Health Agency LPN Per Hour	\$34.50	\$67.00	(\$32.50)	-48.5%
W0120	Home Health Agency Nurse's Aide Per Hour	\$20.50	\$46.59	(\$26.09)	-56.0%
W2703	Social worker service per home health visit	\$94.00	\$164.90	(\$70.90)	-43.0%
W0678	Physical Therapist service per home health visit	BR	\$112.48		
W0678	Occupational Therapist service per home health visit	BR	\$113.24		
92506	Speech-Language Pathologist service per home health visit	BR	\$122.13		
W2704	Home health agency worker providing direct care, mileage per mile	\$0.30	\$0.51	(\$0.21)	-40.6%
W2705	Travel time, home health agency professional worker ea 6 min.	\$3.50	\$3.50		
W2706	Travel time, home health agency non-professional worker ea 6 min.	\$2.00	\$2.00		

***Based on Medicare/Medicaid Rates**

"By Report." No fee is associated with the procedure or service; therefore, a report is necessary to consider reimbursement. Reimbursement is at the discretion of the party responsible for payment of the bill (i.e., BWC, Managed Care Organization, and Self-Insuring Employer).

BR

Amy Shuman
Manager, Human Capital
Ohio Dept. of Youth Services

I would like for the BWC to explore ways in which Providers can become more involved in the injured worker's return to work. Specifically, recognizing the programs employers offer such as Transitional Work Programs that provide work through the final stages of recovery.

I would also like to learn more about whether BWC could provide incentives, such as higher reimbursement rates, to Providers who return injured workers to work within widely accepted duration of disability guidelines. Conversely, providers whose patients remain off significantly longer than average could face a financial disincentive.

Michelle Rippley
Safety & Loss Control Coordinator
Portage County

I would like to make the Ohio Bureau of Workers' Compensation Board of Directors aware of an issue that I experienced with a local physician. I feel it is very important that the B.O.D. address the credential/contract requirements of the physicians. The lack of cooperation on behalf of a treating physician can have serious consequences for a workers' compensation claim. Failure to respond appropriately (meaning in a timely manner) sets the tone for the entire claim. Please review the following issue.

(Physician) of Newton Falls refused to allow (Jill T. of University Comp Care) to fax an approval for an MRI and physical therapy. He insisted that all medical authorizations must be received via the U.S. mail. An employee off work since December 3rd, 2007 claim #07-400781, did not have an MRI scheduled until 1-9-07, only after the MCO overnight expressed the authorization. The initial Emergency Room diagnosis, Lumbar sprain- strain, remained the same at the conclusion of the MRI. This employee is still off work and now seeking additional allowances due to a fall that he experienced outside of his rehabilitation appointment.

Initial receipt of the C-9 on 12-13-07 (via fax) she approved MRI and physical therapy on 12-17-07 (via fax). The physician refused to accept the authorization via electronic transmission. He demanded the request mailed via the U.S. mail. He held up the process until January. This refusal to cooperate, in my opinion, created a chain reaction to a whole string of events.

I would appreciate a review of the credentialing process.

Thank you for your time and consideration.

April 23, 2008

Provider Public Forum:
Medical Provider Issues
In the Ohio BWC System

It is not without significant deliberation that I respond to the request to provide information for the Provider Public Forum. Unfortunately, due to my patient care commitments I am unable to attend the Forum; so I am submitting these written considerations regarding provider quality and delivery of services. As a member of the BWC Quality Assurance Advisory Committee I have been an advocate for integrating high quality providers into the workers' compensation system for many years. In an attempt to reflect not only my opinions, but those opinions of other physicians and their office staff who care for injured workers, I surveyed approximately 10 BWC certified physicians as well as my office staff and other providers (nurses, PAs, therapists) of over 40 individuals who work with the workers' compensation system on a daily basis. Below is a compilation of their reflections, which I have filtered in order to deliver this in a presentable format. Not all of these comments reflect my opinions, but I did feel compelled to pass along thoughtful commentary which had merit.

Please understand that the framework for these observations is based on this premise: Most quality physicians who treat injured workers in the Ohio BWC system do so because they enjoy treating these individuals and seeing them return to work in a healthy, safe, and productive manner; while at the same time being able to favorably assist businesses in the community; that same community in which the physician lives and works.

1. Our Biggest Issue

The most overwhelming issue that confronts providers, I have distilled down to this: The workers' compensation system in Ohio is becoming quite unfriendly to medical providers; and more so every year. With the advent of HPP in 1997 there was a real hope among medical providers that this would lead to a better system of providing care to injured workers. Most physicians who experienced the "pre-HPP" BWC agreed that initially things improved dramatically. Now, the feeling of these physicians is that we are being increasingly driven to cut corners and lower standards. Physicians feel squeezed between caring for the patient and the needs of the employer, MCO, BWC, attorneys, etc. This potential conflict has always been present in the system, but it appears that this has become more pronounced at this time. There are pressures for a quick return of the employee to work; and this is real and probably good; but sometimes unrealistic and not in the patient's best interest. OSHA recording, while not a concern to the BWC certainly does exacerbate these issues.

Indeed, much of the above is intrinsic in the system of workers' compensation; but one aspect has changed immensely, and it is making physicians feeling quite uncomfortable. Physicians, who treat work-related injuries are being scrutinized to a degree that has never occurred in the past. This scrutiny occurs to an extent that is

present in nearly no other medical system. Within 48-72 hours of treatment, the physician's detailed progress notes, recommendations, forms, etc., are all available for review by the employer, MCO, BWC and employee on the BWC website. With this "openness" all of the physician's comments, diagnosis, recommendations, etc. are critically, and many times incorrectly, critiqued by individuals who have never laid eyes or hands on the patient/injured worker. With the BWC website now available to injured workers, it is becoming a more frequent occurrence for a patient to return on the second or third visit and make mention or complain about a detail of their care, or the phraseology that the physician used, when he/she saw their report on the website the previous evening. While sunshine can be good, it certainly compromises the position of the physician in this circumstance, especially given some of the other issues which I have outlined below.

And finally, what compounds the above is that the fact is driven into us that we are not a "party" to the claim; so many times it feels like we are trying to perform surgery from outside of a house through an open window, with the patient on the inside. We are being held responsible for providing quality care; but not infrequently, we are not allowed to use the tools we have available for healing. If you can get a feel for all the facets of the issues contained in the above paragraphs, then, you get a sense for a large part of what keeps good providers out of the BWC system.

2. Major Issue #2 - Self Insureds

The "Self Insureds" were consistently viewed as the single source of most readily identifiable problems in the entire BWC system. On the whole, SIs were viewed negatively, although it was acknowledged that a very small minority of SIs did a very good job of providing high quality care to their employees (most of these, it was felt, followed HPP-like standards). All individuals, (physicians, physician assistants, and office staff) agreed that the care provided to employees of this large majority of SIs is substandard and much inferior to what would be considered "good quality" care. It is felt that the SIs meet the bare minimum standard that is required by Ohio law to provide treatment to their employees. Delays and denials are standard fare in the SI world. SIs are frequently downright hostile to providers. Their view of the workers' compensation system is that it is one of inherent conflict and antagonism. This view is initiated, fostered and propagated by their hired TPAs and attorneys for purposes of their self perpetuation. The BWC has hidden its head in the sand long enough; cowering to the powerful SIs. If the BWC is at all serious about improving the quality of care to injured workers in Ohio, then it must tackle this ugly problem. Hands are waived, excuses are made; but, you can not exclude this large segment of the working population in Ohio and say you have a quality system. The BWC must take charge of this; by rule or law if necessary.

3. Managing the Care -- Uncompensated Costs

The physicians and office staff at many occupational health centers in Ohio assume a large portion of the burden of managing the care of an injured worker: This includes, but is not limited to the following: Educating injured workers on the workers compensation process; evaluation and treatment; assisting workers in obtaining

prescribed testing, treatment protocols, therapies, supplies, medications; communication with the work place and employer; scheduling of appointments for most all services provided to the injured worker by any provider; coordinating care with specialists; taking responsibility to obtain approval for all treatments; responding to and working with the injured worker's attorney; communicating with the MCO; assisting the injured worker with follow-up pathways or appeals for treatment denials; faxing information to the BWC; etc. This burden is frequently unrecognized, under-appreciated, and certainly (except for the evaluation and treatment by the physician) not reimbursed to a measurable extent. Quality medical practices deserve the recognition and reimbursement needed to continue providing these services.

Assuming the role of Physician of Record (POR) in the current BWC system is also a taxing role. Frequently, the only way in which we can get specialist or sub-specialist to see a patient is to promise that they need not become POR; that we will assist with all necessary paperwork; and, once they have completed their procedure/intervention/surgery/evaluation/consultation the injured worker will return to us to continue managing his/her care.

Treating work-related injuries in Ohio requires an office staff that is adept at all of the nuances of the BWC system. It is difficult to integrate workers' compensation treatment with other reimbursement or insurance plans. For this reason, when HPP was rolled out in 1997, most of the primary care physicians in our community opted not to become BWC certified.

Finally, the MCOs who are compensated for the task of "managing care" readily acknowledge that their job is impossible without the cooperation of interested providers. Several providers expressed a belief that it is they who are really managing the care; and the MCOs simply observe, document & obstruct at inopportune times. On the other hand, good, individual case managers were viewed as a tremendous asset for complex cases.

4. Reimbursement Issues

Physicians in general feel that the reimbursement for treating work-related injuries is not worth all the headaches, hassles, required forms, coordination of care and required communication. One physician simply stated, "Any BWC surplus should be shared with providers by increasing reimbursement rates." It is interesting to note that office staff who have worked in other medical offices and other systems have mentioned that the reimbursement rates appear low with respect to all the work that is required to provide medical care in the Ohio worker's compensation system. (It is understood that within the past few years the BWC has thoughtfully evaluated the issue of reimbursement, particularly in comparison to other states, and determined that the Ohio BWC rates are adequate. My point is not to initiate a dispute about what is fair and reasonable with respect to reimbursement rates in the Ohio BWC; but rather, to relay perceptions presented to me from multiple individuals who work in the system on a day-to-day basis.)

Office staff and managers consistently commented on the issues of "No-shows" in a workers compensation practice, and the manner with which they are able to be addressed. "No-shows" in a workers compensation practice seemed to be tolerated

because the recourse of the medical provider is seriously limited. The options available to providers outside the workers compensation system are greater.

5. Delivery of Care - "Centers for Excellence"

Due to the nature of many of the above comments, a concern was expressed by several individuals that more and more mid-level providers (PAs and NPs) would be providing care for injured workers in Ohio in lieu of physicians. They extended this thought to assert the following: their feeling was that within 10 years mid-level providers would treat the overwhelming majority of injured workers in Ohio.

Following up on the above, one manager and two physicians expressed concern about a potential disturbing trend. Reimbursement concerns coupled with the administrative hassles of the system call into question the viability of many Occupational Medicine Centers in Ohio. Everyone in this group [bias noted] felt that an Occupational Medicine Center with staff dedicated to the treatment of work related injuries, along with oversight of expert, trained and experienced physicians, is a preferred system to deliver care to workers in Ohio. In order to survive, many of these clinics are considering shifting to a model that is becoming prevalent nationwide: combining Occupational Medicine with the urgent care center. In this growing trend, urgent care centers become the predominant provider of injured worker treatment. This seriously deviates from the Occupational Medicine Center model. The BWC has never before tried to structure a delivery system for the treatment of injured workers in Ohio. It may now be time to re-look at that. The BWC has the ability to force a preferred model based upon reimbursement structure. If the BWC agrees that the Occupational Medicine Center model is a preferable one for employees and employers in Ohio, it can move towards this model by developing "Centers for Excellence" that follow this model. These Centers may be required to meet more stringent requirements than an urgent care center, and could possibly be separately certified by the BWC; yet, be reimbursed at higher levels by the BWC. This is definitely a paradigm shift for the BWC; but following such a path could certainly preserve and possibly propel the quality of treatment provided to injured workers in Ohio.

6. Miscellaneous

The physicians and staff expressed frustration with the need to provide initial injury care to workers when a claim is alleged, pending or being investigated. There is a 28 day period, that can be extended even longer, in which the treating medical provider in good-faith provide services; yet, can get no guarantee of payment should the claim ultimately be denied. There are some "work-arounds" to this issue, but the physician and staff are frequently balancing the provision of care with non-reimbursement and a potential pending denial. Some physicians have suggested some sort of "no-fault" coverage that allows the injured worker to obtain treatment when alleging a work-related injury, and payment can be made to the provider when services are provided in good-faith if the claim is ultimately denied. This situation appears to be a moderate impediment to good, quality care in the first few days after an injury. There are many components to this issue that would take too long to elaborate.

Simplify and streamline the BWC paperwork process: This has improved over the years, but it should get even better. There are too many forms for the physician to complete which require faxing of information by office staff, and rarely is any of this process reimbursable.

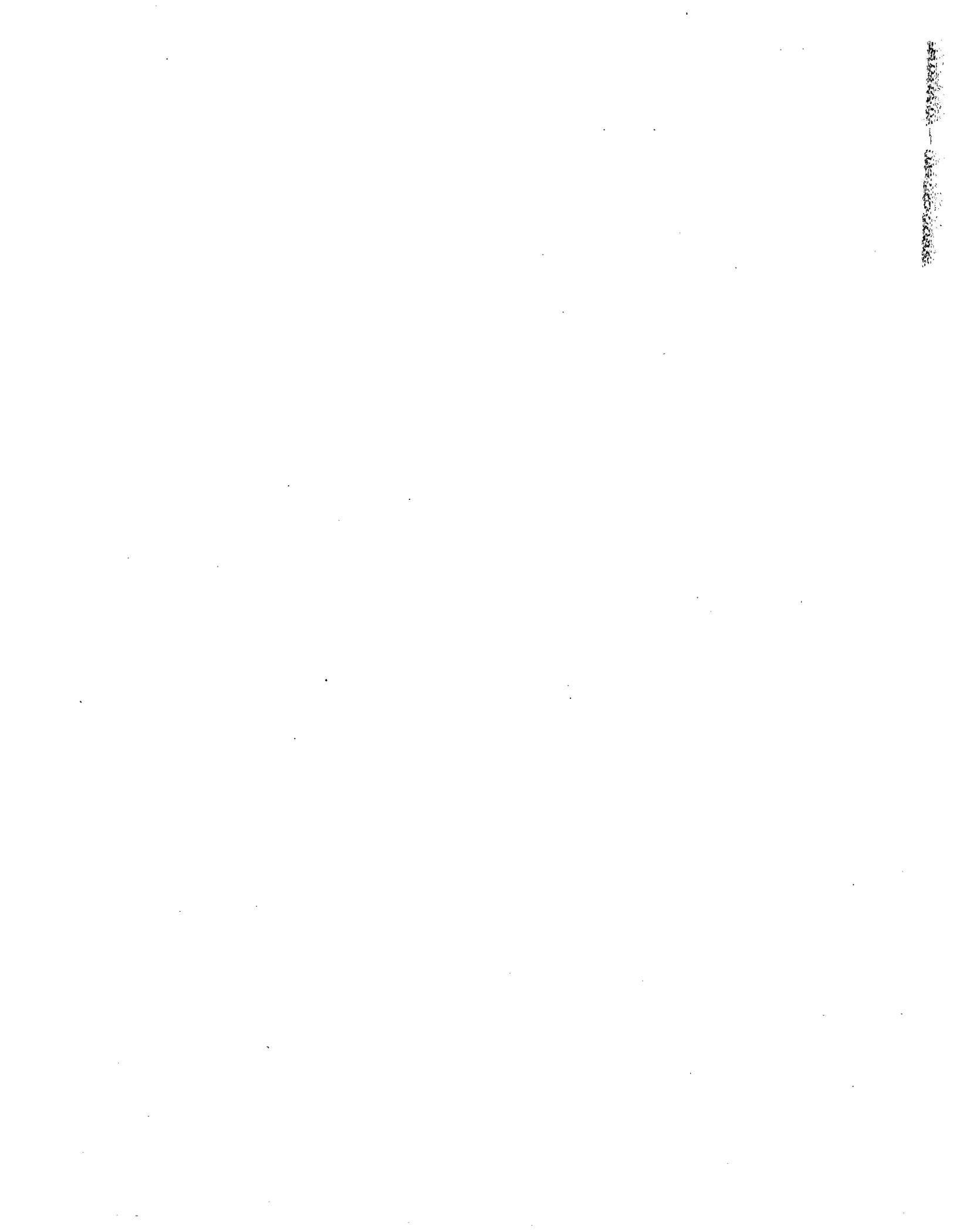
The "Presumptive Authorization" process, which was initiated by the BWC, was viewed as very favorable. This process should be expanded to 90 days and encompass additional treatments.

Several providers expressed dismay with the manner in which medications are handled by the BWC and the pharmacies. There appears to be many inconsistencies in what is allowed, disallowed and, when something can be obtained by review or prior authorization. An Internet available formulary outlining all medications and their status would be preferred.

Thank you for the opportunity to provide input to the Provider Form. Should you desire clarification on any of these issues, please do not hesitate to contact me.

Sincerely,

E. Dean Imbrogno, M.D., M.P.H.
Medical Director, MedWork Occupational Health Care
Dayton, Ohio



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April 10, 2008

Ohio Bureau of Workers' Compensation

RE: The upcoming public forum by the BWC Board of Directors on Medical Service Improvements.

To Whom it May Concern:

Unfortunately I will be unable to attend the forum on April 24, 2008 and on June 26, 2008.

I have been a practicing orthopedic surgeon for over 30 years. I have taken care of Workers' Compensation patients and I have done medical evaluations in the context of Workers' Compensation programs of Colorado and Ohio throughout this time. While practicing in Colorado from 1980 to 1996, I was a "Level II" provider. I was very impressed by the Workers' Compensation program as it was structured in Colorado in terms of providing medical services but also in terms of treatment guidelines, the monitoring of the medical treatment as the patient "moved through the system" and the overall fairness of this program. To provide good medical care which is cost-effective and "evidence-based," I have the following suggestions to make:

To assure superior care for BWC patients, a group of medical providers should be identified as "preferred providers." This identification would rest on professional qualifications but also, after some time, review of "performance" (for instance, how many patients return to work or require less pain medication after lumbar spinal fusions by a specific surgeon?).

To attract the best providers in each specialty, there should be an appropriate financial inducement.

Identifying a specific group of providers also would make it easier to familiarize them with the Workers' Compensation system, the bureaucratic requirements and the medical treatment guidelines. It is a reasonable expectation that providers who are familiar with the bureaucratic pathways of the Workers' Compensation system would be less likely to consider it as an onerous

imposition on their practice (which, in my opinion, is one of the main reason why medical providers do not participate).

The "preferred provider status" should also extend to radiologists and EMG/NCV interpreters. MRIs should only be done at up-to-date scanners and be interpreted by experienced radiologists. For instance, MRIs of the lumbar spine or the knee should be evaluated by specific protocols to make sure that all of the issues which are generally of importance in the context of an injury are addressed (for instance, the presence or absence of evidence for a soft tissue contusion outside the knee joint; the presence or absence of an effusion; the presence and the degree of possible chondromalacia which can only be seen on high quality scanners). These issues are frequently not addressed in the reports that I see. There is a wide difference in quality of the x-ray and MRI reports between individual interpreters.

It appears to me that the present system allows for relative non-specialized providers such as occupational medicine physicians, family physicians, and "sports medicine" physicians and chiropractors to treat injuries for a prolonged period of time with ineffective means beyond the time when recovery is to be expected. Specialist referral, in my opinion, in many cases occurs late, delaying a determination of maximum medical improvement or possibly more effective treatment.

An "in house" quality review should make it possible to identify providers but also examiners who practice outside of the framework of evidence-based medicine or cannot consistently reasonably apply the standards of the AMA Guides to evaluate impairment. It seems to me, for instance, that physical therapy has been in most cases prescribed in a nonspecific and vague manner such as "evaluate and treat." (No one would think of sending a patient to a pharmacist to "evaluate and treat.") Physical therapy should be specifically prescribed as to the type of therapy to be administered, the frequency, the duration and the expected results in every case.

Again, I apologize that I will not be able to attend the meetings. There are many other issues that come to mind. The above is only a short list of issues that in my practice come up frequently and are of some importance to me.

Sincerely,

Rudolf A. Hofmann, M.D.
Board Certified Orthopaedic Surgery
Certified Independent Medical Examiner – C.I.M.E.

RH/ad

