Physicians Dedicated to the Health of North Dakota

NORTH DAKOTA MEDICAL ASSOCIATION

1622 East Interstate Avenue
Post Office Box 1198
Bismarck, North Dakota
58502-1198

(701) 223-9475
Fax (701) 223-9476

Robert A. Thompson, MD
Grand Forks
President

Kimberly T. Krohn, MD
Minot
Vice President
Council Chair

A. Michael Booth, MD
Bismarck
Secretary-Treasurer

Steven P. Strinden, MD
Fargo
Speaker of the House

Gaylord J. Kavlie, MD
Bismarck
AMA Delegate

Robert W. Beattie, MD
Grand Forks
AMA Alternate Delegate

Shari L. Orser, MD
Bismarck
Immediate Past President

Bruce Levi
Executive Director

David Peske
Director of
Governmental Relations

Leann Tschider
Director of Membership
Office Manager

Industry, Business, and Labor Committee
March 6, 2008

Chairman Berg and committee members, I'm Bruce Levi and I serve as the executive director and general counsel to the North Dakota Medical Association. The ND Medical Association is the professional membership organization for North Dakota's physicians, residents and medical students. Our organization was requested to provide a perspective on physician experience with Workforce Safety & Insurance.

We requested comments from our membership and did receive comments that I will share with you. First, I will provide the context for these comments as they relate to the patient-physician relationship. Second, I will provide an overview of the present venues established by WSI for addressing physician concerns and providing physician input into WSI policy decisions, as well as our experience with those venues. Then I will share the comments we received from physicians and which we intend to forward to WSI for their consideration.

The Patient-Physician Relationship Is Paramount

Our context for this perspective is the patient-physician relationship, as physicians recognize their responsibility to patients first and foremost. In that regard we interpret the request to NDMA as a consideration of the impact of WSI policy and practice on the patient-physician relationship that is established in the course of physicians providing medical care to injured workers in North Dakota.

Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount, above obligations to all others. This ethical obligation is no different when a physician treats an injured worker. Since successful medical care requires an ongoing collaborative effort between patients and physicians, patients also have responsibilities, including the responsibility to communicate openly with their physician, participate in decisions about the diagnostic and

treatment recommendations, and then to comply with the treatment program that is agreed upon with their physician.

Any practice or policy by a third party that interferes in the independent medical judgment of a physician is an intrusion in the patient-physician relationship, and certainly even a terse review of WSI statutes and regulations reveals an entanglement of the patient-physician relationship with provisions for managed care, prior authorization and preservice review, other utilization review and independent medical examinations that by any definition interferes in the patient-physician relationship. Whether this entanglement is a reasonable and appropriate way to manage medical care is the question that needs to be asked and addressed periodically with physician input.

From the standpoint of the Medical Association, we work to address issues that arise when, in our view, payors inappropriately interfere in the patient-physician relationship. WSI is not the only payor in North Dakota. We often have issues with other government and commercial payors in North Dakota. The key from a legislative standpoint is to protect patients by assessing what forums or venues the payor establishes, or is required by law to establish, to address these issues and to ensure appropriate input by physicians in payor policies that impact patient care.

The Larger Perspective: North Dakota is a "Poor Payor" State

We come with another perspective as well in our concern that the issue of most consequence to our state's health care system today is that we in North Dakota have become a "poor payor" state.

We have worked over the past sixteen months to improve the WSI physician fee schedule for 2008. We appreciate the opportunity we had to work with WSI staff and their hired consultant in discussing the development of the new physician fee schedule. However, it still falls short in our goal that the agency pay for medical services at the rate of the commercial market. At the same time, the commercial market through BCBSND pays for medical services at a level considerably less in North Dakota than by commercial insurers in other states in our region. You are well aware after our efforts over the past two legislative sessions that the Medicaid reimbursement for medical services does not even cover the actual cost of providing those medical services. At the federal level, Medicare payments for medical services in North Dakota are among the lowest in the nation. At NDMA, our physician leaders are very concerned that this continuing trend of poor payment does not bode well for the future of health care in North Dakota, and in time the access

and quality in health care we now enjoy will deteriorate rapidly as health care resources become increasingly scarce and health care workforce and capital needs are not met.

The concern that we have over payment disparity and inadequacy by all the payors in our state demands, in our view, at least the same if not greater level of concern and attention that is being brought to bear on the future of WSI.

WSI Physician Venues

North Dakota physicians have a long history of involvement in workers compensation. Over the years we have had a good amount of dialogue with WSI staff on issues that concern physicians, throughout all the various leadership changes experienced by the agency. Over that course of time we have impressed upon WSI leadership the need to recognize the importance of their partner physicians, clinics and hospitals in ensuring continued access to quality medical care for injured workers. We have also encouraged WSI to work with our organization at the very early stage in the development of regulations, programs or initiatives relating to medical care so that we are able to effectively solicit physician perspectives and share our input to assist in resolving issues.

There will always be issues. As all payors become more aggressive in their efforts to control costs, physicians will assert that those payors interfere in their independent medical judgment. From a legislative perspective, you need to ask: Are the venues available from WSI to North Dakota physicians adequate to address their ongoing concerns as well as ensure appropriate input by physicians in policy development that impacts patient care?

Prior to 2003, the physicians of North Dakota did not have a voting voice on the WSI Board of Directors. Physicians now have a single vote on the Board. The statute requires that one Board member is to be a physician, selected by the Governor from a list of three candidates submitted by NDMA. The Legislative Assembly, in formalizing the physician position on the Board, recognized the importance of the medical profession as an equal partner with the worker/patient, their employer, and WSI in the goal of facilitating the provision of quality medical care and the patient's return to work in as timely and safe a manner as possible.

Physicians also provide input to the agency in an advisory capacity, under formal consultant agreements, serving on two internal WSI groups. One is the Medical Guidance Council, consisting of seven physicians in various specialties and one chiropractor, who address care and treatment issues brought to them for review by WSI staff members, and who may also raise issues of concern to them as providers. Specifically, the Council is charged in its advisory capacity to review guidelines for treatment and return to work protocols, provide recommendations on experimental or new procedures, provide input on education efforts, and review standards of care and provide recommendations on outcome-based profiles. The Council has met 2-3 times each year since its formation in 2006. Topics considered by the Council to date have included quality improvement initiatives, prior authorization guidelines, disability guidelines and procedures, mental health of injured workers, surgical therapies, improvements to reporting forms, and provider reimbursement updates. The response we have received from physicians participating in that venue has been mixed. One physician told us that he left the Council in frustration that the Council "is nothing more than a mini think tank to solve WSI problems," rather than an advisory group for improvement of WSI processes.

The second consultant body is the Pharmacy and Therapeutics Committee, on which two physicians, one pharmacist, and a pharmacy educator serve with the agency's Director of Pharmacy to create a formulary listing of drugs, and their indications or limitations, which may be prescribed for use in the treatment of WSI patients.

Both of these consulting bodies are relatively new, but if used appropriately by WSI could become a very effective means of involving physicians in the development of WSI policy. Time will tell. We expressed a view to the agency last year that both groups should be set up by administrative rule to ensure appropriate accountability as well as flexibility for ongoing improvement in how those groups operate, but WSI expressed a contrasting view. Establishing these consulting bodies in a more formal manner through administrative rule may be a consideration for this committee. Aside from the formation of these consulting groups, we did take WSI to task in 2006 on a prescription drug issue ("Dispense As Written" prescriptions), taking the matter to the Legislative Council's Administrative Rules Committee which sided with

WSI on an 8-7 vote. We would have appreciated in that case to have resolved our differences informally.

In addition, WSI has enlisted NDMA assistance over the years to help arrange technical and educational sessions across the state for medical providers and their staff, and has sought our input in discussing potential revisions to agency statutes, rules, or medical fee schedules.

WSI Physician Fee Schedule

Within the venues made available to us, NDMA has taken an active interest in the operation and policies of WSI, seeking to gain a positive relationship with the agency management and staff and creating opportunities to discuss our viewpoints and suggested policy and procedure improvements. As mentioned previously, our most recent focus addressed appropriate payment levels for the medical services provided by physicians, as well as asking WSI to recognize the importance of their partner physicians, clinics and hospitals in ensuring continued access to quality medical care for injured workers.

In both 2006 and 2007, the NDMA House of Delegates adopted resolutions (attached) urging WSI to recognize this partnership and to develop a payment system that equitably reimburses providers in a manner consistent with the commercial insurance market, including the use of WSI surplus reserves to support a more equitable physician payment system. NDMA and the ND Medical Group Management Association submitted comments on the WSI proposed physician fee schedule which converted the previous fee schedule to the Resource Based Relative Value Scale (RBRVS), with a $56.50 conversion factor for six of the eight major medical service types. WSI responded to the comments by increasing the baseline conversion factor to $60, which became effective January 1, 2008. WSI asserts that this updated conversion factor provided an "increase in payments to physicians of 27.3 percent for 2008."

In earlier comments, NDMA and NDMGMA noted that while the medical community embraces the notion of converting to the RBRVS as a more widely accepted payment methodology, "the current WSI proposal falls short in not creating an appropriate 2008 baseline conversion factor that reflects the cost of providing medical care to injured workers, as well as recognizing the

higher administrative costs and time required to care for injured workers." We encouraged WSI "to use this transition as an opportunity to implement a policy that recognizes the need for a physician payment system that equitably pays for medical services to injured workers in a manner consistent with, or better than, the commercial insurance market in our region." We believe this consideration of payment policy should be a topic of ongoing review by the WSI Board of Directors, as reimbursement issues continue to be cited by physicians as a major concern and consideration in their decision to participate in workers compensation cases.

Additional Physician Comments

In February, knowing that this Committee was scheduling meetings to receive input on WSI, we sent a general request for comments on WSI issues to our NDMA membership. The response was fairly immediate, with both primary care and specialty physicians offering diverse perspectives on their experience with WSI in treating injured workers. Not all comments were negative. Some physicians report positive relationships and experience with WSI (particularly physicians practicing occupational health in large health systems who see large numbers of injured workers and are administratively "geared" to the WSI processes), noting that physicians need to be aware of WSI limitations and procedures and conform their practice to those norms.

Whether positive or negative in their general tone, the physicians who participated in providing comments identified a number of areas of concern. It is our hope that the following issues identified below can be brought to WSI venues, including the Medical Guidance Council and Board of Directors, for review with appropriate physician input and consideration of solutions.

<u>Patient Reluctance to Admit Work-Related Injuries</u>

-Some physicians confirm that patients express a desire not to be seen as a WSI case or hesitate to admit their injuries are work related due to worker perceptions of being treated unfairly by WSI. Physicians indicate they are proactive in having the C3 (Doctor's Report of Injury) form available to start the process and encourage patients to be forthright in disclosing the source of their injury.

Physician Reluctance to See Injured Workers

-Some physicians will not see WSI patients for varying reasons and those reasons included low reimbursement, instances of perceived interference in their medical decisionmaking and paperwork or other "hassles;" others expressed the importance of treating injured workers. A concern was expressed by a primary care physician that it is frustrating to be told by a potential consulting physician that they are not willing to see WSI patients on his referral for injuries. Other physicians reported not seeing WSI patients due to refusal of WSI to allow certain procedures desired by the physician to timely treat patients.

-One of the major frustrations is that the physician not only has to deal with the patient but they have additional relationship and communication requirements with the patients' employer and WSI, but receive no additional reimbursement for the additional relationships that are necessary to treat these patients.

-Low WSI reimbursement and burdensome paperwork are clearly a concern to many physicians. However, some physicians indicate the paperwork hassles are no greater than that required by other payors.

Prior Authorization and Preservice Review

-Several physicians indicated concern over WSI delay in approving specialized care such as MRIs and treatments. A surgeon noted that "access to surgical specialists who are willing to see WSI patients is limited and WSI should be more accepting of the physician's treatment determination and not keep physicians guessing which only delays treatment." He cited an example that "although WSI may cover the surgery and the surgeon's work they may not cover the implant or prosthetic product that the surgeon used to treat the injury." He also noted that there is a lot of uncertainty related to the treatment of WSI patients and suggested that WSI could prior authorize certain treatments, or even certain "profiled" physicians who are possibly treating outside usual parameters. "At least a non-prior authorized treatment could then proceed speedily so that the injured worker could receive treatment and return to work in an expeditious manner."

Determinations of Work-Related Injury / Case Adjusters

-Concern was expressed over the time delay in WSI determinations of whether an injury is work related.

-Physicians report that patients complain that they do not get an early response to their queries from case adjusters which is important because their wages and livelihood depend on these determinations. Patients also complain about long delays in claims processing from the time of injury until patients begin receiving payments.

-An orthopaedic surgeon from the eastern part of the state suggested the WSI consider Minnesota Workers' Compensation use of a patient care ombudsman (qualified rehabilitation consultant or QRC) that has been successful. An injured worker can call upon the QRC to assist in preparation and execution of a rehabilitation plan for retraining.

Re-Injuries

-If there has been a previous injury, the claim for a re-injury is often denied initially. Physicians express their view that an exacerbation of a previous injury, if the re-injury occurred in the course of employment, should be compensated as a new injury.

Pain Management

-Several physicians expressed concerns over WSI denial of pain management (SI joint injections, spinal injections, etc.) for chronic injuries even if recommended by pain specialists.

-Concern was expressed over the use of clinical guidelines by WSI, including by one physician who participated in the development of those guidelines. While these guidelines help physicians guide treatment toward the most useful modalities for their patients in the physician's clinical judgment, WSI treats those guidelines as criteria for what services should be reimbursable. So, while WSI uses its Medical Guidance Council to develop these guidelines, it turns around and uses those guidelines inappropriately in a manner that ignores or substitutes the judgment of the physician who sees the patient face to face. For example, while the guidelines for the treatment of

chronic pain are based on the best available evidence, they are not nearly as precise in direction as are guidelines for the treatment of conditions such as diabetes, cancer, or hypertension.

Medical Directors

-There is concern that WSI needs to more appropriately define the role and qualifications of its medical director, particularly as it relates to the weight given the opinion of the medical director versus the treating physician. The American Medical Association Code of Medical Ethics includes an ethical opinion (8.021) on the obligations of medical directors.

Independent Medical Examinations / Case Management

-Several physicians identified specific cases involving their patients who they believe were treated unfairly by WSI, including cases involving independent medical examinations and unreasonable fraud claims against injured workers. WSI should consider implementing recommendations of the Independent Medical Examination Audit Report of DA Dronen Consulting, February 2007. It is our understanding that WSI staff is working to address the IME audit recommendations.

-One physician stated: "They send patients to us for evaluations and direct us not to make ANY recommendations," otherwise it makes it more difficult for WSI to deny appropriate services. "The patients view us as agents of WSI who are there to stonewall them, so a therapeutic relationship with the patient can never (or rarely) be formed."

-Another physician complained that WSI sends their case managers into the exam room with his patients, which he believes is an intrusion upon the patient-physician relationship.

"Compartmentalized" Care

-There is a general concern over the "compartmentalization" of medical care as physicians often see injured workers for other medical care not related to the work injury. This causes difficulty and confusion and focuses away from patient-centered care, yet is inherent in whenever two payors are involved in coverage for a patient's medical care.

-Another concern was expressed over WSI refusal to pay for uninsured complications that occur as a result of treatment for a work-related injury. One example included refusal of WSI to pay for heart surgery that resulted when the otherwise uninsured patient suffered a heart attack during a WSI-approved hernia repair. With no other insurance, there was no reimbursement for the heart surgery.

Appeals

-Some concern was expressed regarding appeals generally. North Dakota law [NDCC Section 65-02-20] does give WSI authority to establish a managed care program, which allows for a narrow avenue for appeals as interpreted in WSI administrative rules. Prior to 2004, NDMA sought consideration for a second level appeals process under which a physician who is initially denied approval for treatment or payment for services could request that a physician in the same or similar specialty then review the case.

Claims Processing

-A large health system reports that WSI has "lost or misplaced" nine batches of claims submitted over the past two months. The same system reports that WSI will request a refund years after they have paid and that there should be some limit on the timeframe for recoupment such as one year. Otherwise it is difficult to submit the stale claim to another insurer and typically results in a write off of the charge.

Again, these comments will be brought forward to WSI.

We appreciate the opportunity to provide these comments on behalf of North Dakota physicians.

Resolution

Introduced By: **NDMA Council**
Subject: **Workforce Safety & Insurance Medical Fee Schedule**

A resolution urging Workforce Safety & Insurance to fully recognize the importance of their partner physicians, clinics and hospitals in ensuring continued access to quality medical care for injured workers, to develop a physician payment system that equitably pays for medical services to injured workers in a manner consistent with the commercial insurance market, and to consider the use of WSI surplus reserves to support a more equitable physician payment system.

WHEREAS, ND Workforce Safety & Insurance (WSI) is a state government insurer of work-related injuries, reliant upon the willing participation of physicians, hospitals, and other healthcare professionals in providing services and access to care to injured workers; and

WHEREAS, WSI currently uses the procedure codes and descriptions of the AMA's physicians CPT and payments are calculated using the Relative Values for Physicians (RVP) published by St. Anthony's Publishing Inc. with eight different variable conversion factors used to determine payments; and

WHEREAS, the NDMA House of Delegates adopted a resolution in 2006 urging WSI to develop a physician payment system that equitably pays for medical services to injured workers in a manner consistent with the commercial insurance market, citing the fact that a major health system in North Dakota had recently compared WSI reimbursement for physician services to reimbursement received from BlueCross BlueShield of North Dakota, concluding that *WSI reimbursement is 22% less than that provided by BCBSND* for physician services at 2005 levels; and

WHEREAS, WSI is in the process of updating its physician fee schedule, announcing an increase in the E&M code conversion factor this past summer, and is planning to convert its reimbursement framework from the current St. Anthony's Values to a broader RBRVS schedule by early in 2008, with the intent to maintain budget neutrality in the conversion which is likely to create both increases for some physician specialties and decreases for others; and

WHEREAS, WSI is under a legislative mandate to reduce its surplus reserve funds in 2007; and

WHEREAS, the WSI Board of Directors recently approved a premium dividend credit for 2007-08, estimated to reduce WSI reserve funds by $69 million, while the recent E&M changes in the proposed fees for physicians will amount to reimbursement increases statewide of less than $1 million; and

WHEREAS, WSI has approved more than $150 million in premium dividend credits to employers over the last three years while physician, clinic and hospital costs in providing medical services to injured workers continue to increase; and

WHEREAS, while WSI boasts over $1.2 billion in assets and the nation's lowest premiums for employers, this robust financial health has come at the expense of equitable reimbursement for North Dakota physicians and hospitals; and

WHEREAS, North Dakota's health care system suffers from the systematic underfunding of medical and hospital services by government payors;

THEREFORE, BE IT RESOLVED BY THE 2007 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION that Workforce Safety & Insurance is urged to fully recognize the importance of their partner physicians, clinics and hospitals in ensuring continued access to quality medical care for injured workers, to develop a physician payment system that equitably pays for medical services to injured workers in a manner consistent with the commercial insurance market, and to consider the use of WSI surplus reserves to support a more equitable physician payment system; and

BE IT FURTHER RESOLVED that WSI consider the use of WSI surplus reserves to support a more equitable physician payment system.

Adopted September 21, 2007

A. Michael Booth, MD, Speaker of the House
North Dakota Medical Association

Resolution

Introduced By: **NDMA Council**

Subject: **Workforce Safety & Insurance Medical Fee Schedule**

A resolution urging Workforce Safety & Insurance to develop a physician reimbursement system that equitably pays for medical services to injured workers in a manner consistent with the commercial insurance market.

WHEREAS, ND Workforce Safety & Insurance (WSI) currently uses the procedure codes and descriptions of the AMA's physicians CPT and fees are calculated using the Relative Values for Physicians (RVP) published by St. Anthony's Publishing Inc. with eight different variable conversion factors used to determine fees; and

WHEREAS, a major health system in North Dakota has recently compared WSI reimbursement for physician services to reimbursement received from BlueCross BlueShield of North Dakota, concluding that *WSI reimbursement is 22% less than that provided by BCBSND* for physician services at 2005 levels; and

WHEREAS, while North Dakota employers are enjoying the benefits of an estimated $46 million in premium dividend credits from WSI for the 2005-06 premium year and while WSI boasts over $1 billion in assets and the nation's lowest premiums for employers, this robust financial health has come at the expense of equitable reimbursement for North Dakota physicians and hospitals; and

WHEREAS, North Dakota's health system suffers from the systematic underfunding of medical and hospital services by government payors; and

WHEREAS, WSI recently hired a consultant to assist with the analysis, development and maintenance of WSI medical and hospital fee schedules;

THEREFORE, BE IT RESOLVED BY THE 2006 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION that Workforce Safety & Insurance is urged to develop a physician reimbursement system that equitably pays for medical and hospital services to injured workers in a manner consistent with the commercial insurance market.

Adopted September 15, 2006

Kimberly T. Krohn, MD, Speaker of the House
North Dakota Medical Association