Healthcare Reform & Workers' Comp: *The System is Complicated*

by
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Illinois workers' compensation (WC) is complicated, fraught with problems, in a state of flux, but necessary. Those hopeful for change are anxious to have enacted reform measures actually start. Meanwhile, legislators continue to analyze, debate, argue and defend its merits and shortcomings leaving everyone wondering—"what's next?"

Industry and economic experts point to several influential possibilities. One is whether the Affordable Care Act (ACA) will have any impact on the WC program and how the choice of medical care for conditions other than a work injury could affect a patient's WC injury. Under ACA, every state is required to offer a health insurance exchange (HIX) to its residents—either state based, federally facilitated, or through a partnership with the federal government. It is too early to tell what affect ACA will have on workers' compensation claims and or administration.

According to Joe Paduda, principal of Health Strategy Associates and a nationally recognized expert and author on managed care in group health and workers' compensation, the Affordable Care Act is just one of perhaps many WC changes on the horizon. "Specialty care is growing in impact, popularity, valuation and attention, while case management and referral services are shrinking," Paduda explained.

Other changes Paduda suggests might occur include consolidation within the industry, a growing number of medical generalists squeezing out specialists, medical management layoffs and a reduced ability to monitor legislation. "Work comp medical management will be fundamentally changed within the next two years," Paduda said. "It remains to be seen if that is a good thing."

Steve Schmutz, noted workers' compensation expert and founder and CEO of *Claimwire.com*, an online resource dedicated to WC forms, content, tools and analysis, also believes the Affordable Care Act leaves a lot still unknown—especially its impact on the current workers' compensation system. "Supporters and detractors do agree on one thing–'Obamacare' is a huge step toward the federalization of workers' comp," Schmutz told a ***Forbes*** *reporter.*

The push for WC reform has been driven largely by rising healthcare costs. Some politicians and industry executives suggest the WC system should convert to a traditional "group insurance"

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model as a cost containment solution. However, third party administrators (TPAs) are in business to make a profit which is disregarded with that type of a change. TPAs do not provide clinical care, nor do they ensure outcomes, quality, or value. They are, nevertheless, intimately involved in patient care decisions. TPAs make money by negotiating a lower rate for the healthcare provider's services and reduce the frequency of visits (i.e., limits access to care) or types of services (e.g., diagnostic tests, a limitation of service) provided to the client.

However, in a workers' compensation situation, clinicians' fees are governed (reduced/ limited) by a state fee schedule. Therefore, the only other way to decrease costs is to limit access—not an easy task for TPAs—so their solution is to create a massive operational infrastructure. This infrastructure is expensive to operate so healthcare costs unintentionally go up not because of the healthcare provider, but ironically because of the charges from those managing the costs. For example, in the Canadian healthcare system, costs associated with services such as those noted above, account for one percent of their healthcare costs. In the United States, they account for 11 percent.

To counter this, healthcare providers sometimes receive promises for increased patient referral volume. Those that opt to be part of a network usually find the utilization review too cumbersome or frustrating and drop out leaving lesser quality healthcare providers. Joe Paduda contends, "Low fee schedules deter provider participation in workers' compensation thereby reducing access to care, or the inability of the regulatory process to keep pace with medical innovation, or bill review vendors charging some payers merely to reduce provider bills to an inordinately-low fee schedule."

Greg Krohm, renown workers' compensation consultant and former executive in WC administration believes "Payment rules, like fee schedules, are devoid of financial incentives for good medicine and good treatment outcomes, including early return to work. I can think of no reason for a clinician – other than professional and moral values – to put in the extra time it takes to counsel and manage patients on tricky issues like return to work, pain management, therapeutic programs, and the prevention of re-injury," he explained. "The payment is a flat rate per billing code without regard to quality or care given."

Fee schedules also do not control costs and they do not eliminate cost differential between

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workers' compensation and group health insurances. Workers' compensation patients typically have labor intensive jobs, so the "activities of daily living" also must be adjusted to account for the physically demanding nature of their daily activities. At best, fee schedules provide short-term relief as costs eventually rise due to network abuses.

In response to this, the next evolution was to apply managed care-styled approaches to contain costs. Generally, these have resulted in delaying access to care and degrading the subsequent quality of care. Ironically, such an approach ultimately increases backend costs because of increased indemnity awards. According to Judith Green-McKenzie, MD, MPH, associate professor and program director in occupational environmental medicine at the University of Pennsylvania Perelman School of Medicine, "Containing medical costs is not an end in itself. If the cost of containment adversely affects the quality of medical care, workers will be negatively impacted, and the cost to the employers and insurers will increase as indemnity benefits rise to compensate for the consequences of diminished care."

Managed care techniques were developed within group health plans to lower cost. However in WC cases, managed care must address a different objective—restoring a worker to health and productivity at the lowest cost. This fundamental difference makes the application of managed care techniques to workers' compensation plans contentious and sometimes inappropriate. For WC managed care to succeed, the process must discover through utilization review and outcome evaluation how to change provider practice patterns to deliver better care and healthy, productive workers at the lowest cost. It also will require evaluation of the quality and appropriateness of care, and a timely return to work by injured employees.

Calculating Future Medical Care Costs

Regardless what transpires with workers' compensation reform, healthcare reform, Medicare or Medicaid, it will not change the fact that many injured workers require future medical treatment (FMT). Given the unknowns with both workers' compensation and future medical care costs, determining what those costs might be can be daunting should the injured worker elect to accept a lump sum settlement rather than keep medical compensation open.

Traditionally, calculating future medical care expenses starts by examining available data which may or may not be readily available. Dr. Steven Chudik, board-certified orthopaedic surgeon, sports medicine physician and *US News & World Report* Top Doctor in Orthopaedics with the Steven Chudik MD Shoulder and Knee Injury Clinic provides attorneys with whom he works detailed treatment and care costs for orthopaedic injuries he typically sees. This includes everything from office visits, surgery, physical therapy and even assistive devices and braces.

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“Working the past 12 years as an orthopaedic expert in shoulder and knee work-related injuries, I am frequently asked to help determine future medical care expenses,” Dr. Chudik said. “Making certain an award or settlement is sufficient to cover the injured worker's medical costs is an important aspect of any case. Even with minimally-invasive surgery, each injury is different and carries some level of permanence and potential need for future care. An awareness of this need and a knowledge of current fees for medical visits, surgeries and physical therapy can help more accurately determine the amount needed to cover future care expenses,” he explained.

The following are typical future knee and shoulder treatment costs for post-traumatic arthritis following common work-related injuries.

Total Knee Replacement

Fee Source	Misc.	Recommended Treatment	Estimated Costs
Surgeon			$10,485.00
Anesthesia			$1,900.00
Hospital			$60,000.00
Therapy		4 months	$14,662.50
Work conditioning		4 weeks	$5,136.80
Physician visits, pre-op / post-op		6 visits	$900.00
Misc., brace, other, etc.	Knee Immobilizer		$145.00
TOTAL			**$93,229.30**

Total Shoulder Replacement

Fee Source	Misc.	Recommended Treatment	Estimated Costs
Surgeon			$11,881.00
Anesthesia			$2,800.00
Hospital			$65,000.00
Physical therapy		4 months	$14,662.50
Work conditioning		4 weeks	$5,136.80
Physician visits, pre-op / post-op		6 visits	$900.00
Misc., brace, other, etc.	Ultra Sling		$235.75
TOTAL			**$100,616.05**