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New Strategies To Contain Workers' Comp Medical Costs: Targeting Issues In Diagnostic Testing

Summary/Description:

Issues with Diagnostic Testing

A myriad of research regarding the overly aggressive care generally in the medical care system, more specifically in the workers' compensation system, exists. Several of those studies sited below build a picture of why we are addressing this issue today.

To begin painting the picture, an article published by The American College of Occupational and Environmental Medicine (ACOEM) noted a troublesome trend in which people who were treated in the workers' compensation system fare worse than those who receive care for similar types of injuries in other medical care systems. Some of the causes point to misaligned incentives, a physician shortage and significant variability in quality care.

This impact on overly aggressive care is demonstrated by data from NCCI, in which thirty-five years ago indemnity benefits represented the majority (57%) of the workers' compensation benefit dollar. Medical costs now represent almost 60% of total benefit costs. In addition to the increase in medical costs, it is noted that treatment across state lines varies.

To combat overly aggressive costly care, evidence -based medicine (EBM) continues to grow as an important set of tools in the Workers' Compensation industry. Evidence-based medicine can assist in ensuring that the appropriate and timely care for the condition results in the best patient outcomes.

A part of the problem in driving overly aggressive care is the use of Magnetic Resonance Imaging (MRI) as well as other high-end radiology services which has increased significantly over the years in Workers' Compensation. This increase in utilization may be a result of deep fee schedule reductions which have made the cost per unit less expensive. Another potential increase in the requests may simply be a result of providers being pressured by the injured

worker to order these tests or potentially it is an attempt to reassure the injured worker that there is nothing wrong. Regardless of the reason for the increase, early use or unnecessary use of MRI's, despite established guidelines, causes increased medical and disability costs.

In an article published by Washington State Workers' Compensation[1], it was determined that early MRI use may lead to greater subsequent interventions, potentially poorer outcomes, and an increase in health care costs. NCCI has reported that there has been an increase in more costly diagnostics over the course of the last several years

In an article published by Lockton[2] in 2015, they indicated that "Red Herrings" and medical over diagnosis drive large-loss workers' compensation claims. A red herring is a diagnosis made based on poor science or inaccurate criteria. They went on to state that the medical literature suggests that in more than 90 percent of most common injuries, a diagnosis based on MRI 'abnormalities' represents medical over-diagnosis.

In a study conducted in 2011 by neurosurgeon Nancy Epstein and published in the Surgical Neurology International Journal[3], she saw 274 patients who had been told they needed spinal surgery. The surgeon found that 47 of the patients or 17.2% were scheduled for unnecessary surgery. Consistent with this finding, a review of in-depth studies and data generated by both government and academic sources cited in a 2013 USA Today article[4], unnecessary surgeries might account for 10% to 20% of all operations in some specialties, including a wide range of cardiac procedures as well as many spinal surgeries. Knee replacements, hysterectomies, and cesarean sections were among other surgical procedures which were performed more often than needed.

The gateway to an unnecessary surgery can be diagnostic tests done too early that are poorly correlated with the patient's symptoms. Numerous studies have been conducted over the last two decades on the result of performing an unnecessary or premature MRI test and the negative result it has on patient outcomes and overall claim costs. A study published in the 2010 Journal Occupational and Environmental Medicine by Webster, Cifuentes, Choi, Bauer and Pransky[5] suggested that the iatrogenic effects of early MRI testing in a no "red flag" situation

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[1] Spine (Phila Pa 1976). 2012 Sep 1;37(19):1708-18.

[2] Red herrings and Medical Overdiagnosis, Drive Large-Loss Workers' Compensation Claims, February 2015.

[3] Surg Neurol Int. 2011; 2: 83. ;Published online 2011 Jun 21. doi: 10.4103/2152-7806.82249

[4] Doctors perform thousands of unnecessary surgeries, USA Today 2013

[5] J Occup Environ Med. 2010 Sep;52(9):900-7. doi: 10.1097/JOM.0b013e3181ef7e53.

resulted in a “cascade of diagnostic and therapeutic services (including surgery)”, driving up the overall medical costs and subjecting the patient to a treatment or surgery that was unrelated to their actual pain. The researchers believed that the treatment was related to the MRI results and not to pain.

Another issue we face is that of inaccurate interpretation of results. When an MRI test is done and the MRI results show a finding, which is poorly correlated with the symptoms, they can often still lead to unnecessary treatment. Research (Boden et al, 1990)[6] found that a prevalence of MRI abnormalities with no back pain occurred in about 20% of patients under 60, and over the age of 60 the number increased to 36%. This demonstrated the importance of radiology sub-specialization to ensure accurate readings.

Radiology is an outlier in the U.S. medical system in its low level of clinical sub-specialization. Research (Pinto, Antonio et al 2010)[7] dating back over 50 years has shown that the average error rate among radiologists is around 30%. Inaccurate interpretation of results can be attributed to the use of general radiologists instead of fellowship trained sub-specialized radiologists.

Radiology sub-specialization began amid the development of new imaging modalities and a focus on efficiency and reduced error rates. If a radiologist looks at a mixture of images of bones, then brain, and then breasts they are less likely to get the kind of detailed experience that looking at just one of those areas gives them.

Overall, once a patient and physician believe they have a significant MRI finding, the resulting behavior on both parts can result in iatrogenesis. To begin with, the patient hears he has a herniated disc and thus he believes the only solution to this is to have surgical intervention, thus, any treatment short of the surgery will often not satisfy them. The physicians themselves, even if the MRI findings are not consistent with symptomology, have a desire to find a treatable condition to help the patient find relief from pain and disability. As a result, more aggressive and more costly treatment ensues. This ultimately impacts recovery, disability, and medical costs. However, most importantly, it impacts the injured worker and their ability to return to their standards of living.

How to address the issue: Early Intervention is key

<u>Pre-diagnostic Physician Review Services</u>

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[6] SD Boden, DO Davis, TS Dina, NJ Patronas and SW Wiesel, J. Bone Joint Surg. Am. 72:403-408, 1990

[7] World J Radiol. 2010 Oct 28; 2(10): 377-383.

In a standard workers' compensation workflow, treating providers send their requests to the claims adjuster and/or nurse. A request is then made of the treating provider to provide all the medical records that would validate the need for the request. The request is then managed by utilization review nurses who review the request to standards of care. If not certified, the provider may request an appeal. The appeal is then sent to a peer review provider. If there is no utilization review in place, the request may be approved at the adjuster level or if available a telephonic case manager. Sometimes, the peer review provider does not have an expertise or background in Evidence Based Medicine and may approve the request. This could also lead to a poorly supported denial leading to claim controversy.

We consider it a best practice that all MRI requests be reviewed by a provider who is in active practice with the same/similar specialty, background and experience. The provider will provide recommendations on medical necessity for the request based on Evidence Based Guidelines, standards of care and experience. This will stand up well and hold value on the issue of necessity and prevent premature diagnostics from being performed. By going directly to a peer provider of like specialty, utilization review costs will also be decreased.

Fellowship Trained Radiologist

Once an MRI request has been deemed appropriate the test will be scheduled with a facility that has fellowship trained subspecialty radiologists. With the advances in medical imaging, have come unprecedented levels of complexity and as a result it is necessary to be certain you have the right level of expertise in radiology in the specific anatomy and technology required. Fellowship trained radiologists have that expertise.

Provider Management

A key activity that must occur if we are going to effect changes in working with the providers, who are making these unneeded requests, is to manage a provider log and track requests, results of each requests, and reasons for denial or approval. If there is an established pattern of increased frequency without the use of conservative care, we must communicate this concern with the provider immediately. Contact the provider via approved channels or engage the PPO network, if the provider is a participating provider. It is incumbent on the network to educate the provider on the issue and manage participation.

If there is no requirement around utilization review, consider a peer to peer conversation with the treating provider to discuss plan of action and factors that were taken into consideration for making the request for the test. Most providers will welcome the opportunity.

Injured Worker Support

It is truly in the injured workers best interest not to be led into an overly aggressive treatment plan which could have life changing consequences for them. In addition, early requests for MRIs or frequent requests for MRIs, may be masking other issues regarding an injured workers' health.. There may be underlying psycho-social issues that are impacting recovery or are

effecting perception of illness. It's important to identify these claims sooner rather than later so that the proper resources may be engaged to expedite the best possible outcome for the injured worker. Also, better engagement in these requests can help identify when it may be necessary to consider transferring care to specialty provider.

Surgical Peer Review

If the diagnostic work has already been completed, and surgery is being requested, rather than sending the case directly to a Utilization Review, the case should be reviewed by a like specialty orthopedic surgeon with the diagnostic being reviewed by a sub-specialized radiologist. This will provide a more thorough review to ensure the procedure is necessary and that the proper procedure is being recommended.

Retrospective Review

In addition to performing prediagnostic review and/or a surgical peer review, a retrospective review process on a block of claims is beneficial to help determine if the performance of your network providers is appropriate as it relates to diagnostic requests. This will also help identify opportunities regarding utilization management escalation, testing interpretation, surgical recommendations, and peer review quality. Retrospective reviews will also provide insight on provider specific work product reviews and potentially uncover equipment issues regarding quality with a facility.

Challenges

In states where utilization review is required, there must be a state approved utilization review program in place that is compliant with all state rules. Also, you need to ensure that the decisions are based on medical necessity.

There are certain states where ex-parte communication may be an issue regarding peer to peer discussions. Other avenues may need to be considered when communicating peer recommendations.

Proven Results

Client A

Client A was concerned about the high rate of surgical interventions in the State of Oklahoma in upper extremity injury claims and asked our group to work with their current third-party administrator to ensure their workers' compensation claims were being properly diagnosed and an appropriate treatment plan was formed based on the diagnosis.

We worked with the third-party administrator and 98 cases were identified for a retrospective review. After filtering the cases based on specific criteria, 77 cases were analyzed. The approach of the review was twofold:

1. Review for accuracy of the diagnostic read.

2. Review for the necessity of the request for the exam.

The clinicians performing the second opinion diagnostic review did not receive or review the original diagnostic report. They only provided their own opinion on the findings. Our Orthopedic Surgeon was then provided with the first and second reviews along with any pertinent medical records. The Surgeon would then do the comparison of the first and second readings to determine if any discrepancies existed between the readings. The Surgeon would also provide recommendations on ODG (Official Disability Guidelines) standard application for the request.

There were two facilities in the review, and while the overall error rate was 23%, Facility 1 which used general radiologists had a 35% error rate, while Facility 2 which used sub-specialized radiologists showed a 5% error rate. Using the (ODG) as the benchmark, 79% of the upper extremity cases that were reviewed were deemed to have used diagnostic tests prematurely or unnecessarily. Of the surgeries that were preformed, 69% were found to be overly aggressive in that they lacked diagnostic indicators or were premature based on ODG guidelines.

An additional review was done on 36 surgical cases and of the 36 cases, 18 were identified for further peer review. The results of the peer review showed that in 39% (7) of cases the surgery was indicated, but in the remaining 61% (11) of cases the reviewers found that the surgeries were overly aggressive. They found that nonsurgical alternatives were not fully explored (premature) or diagnostic indicators were lacking.

In addition to the overall findings, providers were identified who had more claims in which they were overly aggressive and one provider had particularly good results, thus informing the client about network choices.

After the study in Oklahoma, Client A decided to utilize our group for a review of potential leakage on back claims in the southern part of Florida. 68 of the 249 claims reviewed were identified as having had 80 MRI's performed on them. The same approach was followed as in Oklahoma.

As it relates to the performance of tests, the findings of the Florida study showed a very low error rate of 9%; however a facility which had performed 3 studies, was shown to have image quality issues in all three.. Regarding the need for testing, our review was consistent with the Oklahoma study. 69% of the claims reviewed did not support the need for diagnostic imaging.

Out of the 68 claims, 26 had surgery, and while our group was not contracted to evaluate the surgical rates, utilizing the ODG guidelines as a benchmark and after reviewing available information, the information showed 4 surgeries were likely indicated, 19 appeared to be not

indicated, and 3 of the surgeries could not be classified into either category based on available information.

Client B

Our group has been preforming pre-diagnostic services in California for Client B. We conducted a recent analysis of almost 700 cases which demonstrated the following results:

Of the diagnostic requests that are submitted for review, 72% were deemed "not indicated" by an orthopedic surgeon, 27% were deemed necessary and timely by an orthopedic surgeon, 1% were unable to be completely analyzed due to lack of documentation submitted by the treating physician, and 2% could not be reviewed because they had already been approved by the adjuster or nurse case manager.

Our Orthopedic Medical Panel advised that requests that fell in the "non-indicated" category were not appropriate for one of the following reasons: in 67% of the cases the diagnostic was premature, as the Evidence Based Guidelines reported that the patient required continued conservative care at that time; in 9% of the cases the physicians had conducted an inadequate physical exam, and it was not clear whether or not the patient's condition warranted a diagnostic procedure; in 4% of the cases the physicians reported a normal physical examination of the patient; in 3% of cases the patients were showing improvement in symptoms; 3% of the cases had no red flags at all warranting the diagnostic procedure; and in 1% of the cases, the diagnostics should have been ordered by a specialist, if appropriate, and that could have impacted the course of treatment.

Claims Team Feedback

The feedback we have received from the claims team has been very positive. The examiners see this as another tool to control unnecessary treatment, improve injured worker outcomes, and reduce claim costs.

The process is easy to use and the centralization of the entire request cycle streamlines the workload. The review of necessity of the request as well as the coordination of the exam, results in an appropriate and efficient execution of the testing request.

In states where utilization review is not required or does not have regulatory weight, the claims team finds it useful to utilize the prediagnostic report to discuss opportunities with providers and to push them to utilize conservative care longer in accordance with accepted medical guidelines.

The identification of providers with overly frequent requests has also been received very positively and has caused our clients to engage with their network to address this issue.