January 2004

workers' compensation

medical costs

in minnesota

A summary of the Minnesota Department of Labor and Industry's Medical Costs Task-force activities and recommendations

The Minnesota Department of Labor and Industry convened a Workers' Compensation Medical Costs Task-force that met seven times between Aug. 26 and Dec. 2, 2003. Twelve representatives from the labor, business, health care, insurance, hospital and pharmacy industries considered the nature and scope of medical costs in the Minnesota workers' compensation system (see Appendix A). The department provided briefings of available information and data about medical costs in Minnesota workers' compensation, other Minnesota health care systems and other state's workers' compensation systems. The department also presented a series of recommendations to serve as a starting point and focus for the task-force's discussions and considerations.

An overview of the department's recommendations:

Pharmacy costs

1. Set maximum allowable fee for medications at:
   - maximum allowable charge + $3.65; or
   - 86 percent average wholesale price + $3.65, if no maximum allowable charge price is available.
2. Allow an employer/insurer to contract with and negotiate rates with, a pharmacy network from which the injured employee must select a pharmacy to fill prescriptions. Mileage parameters would be included to ensure reasonable access.
3. Require pharmacy benefit managers to disclose to employers and insurers any rebates or discounts received from drug manufacturers or pharmacists.
4. Amend the workers' compensation treatment parameters to provide:
   - rules for use of specific classes of drugs (such as use of narcotics for musculoskeletal pain); and
   - time and quantity parameters for the use of selected drugs for specific conditions (such as nonsteroidal anti-inflammatories for initial treatment of musculoskeletal injuries).

Hospital costs

1. For all services not covered by the medical fee schedule, pay noncritical-access hospitals at the most recent average overall payment-to-charge ratio for all hospitals plus 15 percent (53 percent + 15 percent = 68 percent). Adjust this reimbursement rate annually with updated data from Department of Health.
2. Identify critical-access hospitals for increased reimbursement. Pay in-patient services at critical-access hospitals at 100 percent of usual and customary (U and C) rate. Pay all other services at the medical fee schedule rate *plus* 15 percent, if it applies, or at the average payment-to-charge ratio for all hospitals *plus* 30 percent, if it does not apply.

Summary of department's recommendations continued ...

Medical fees

1. The appropriate inflator for the conversion factor is the producers price index for physicians (PPI-P). Re-adjust the Minnesota workers' compensation medical fee schedule conversion factor to what it would have been had the PPI-P been used for annual adjustments since 1993 — $62.86 — and in the future adjust by PPI-P.

2. Pay nonhospital services not covered by the fee schedule at 68 percent of the providers U and C costs.

Utilization control

1. Amend the statute to limit physical medicine modalities and procedures to 24 visits per injury.

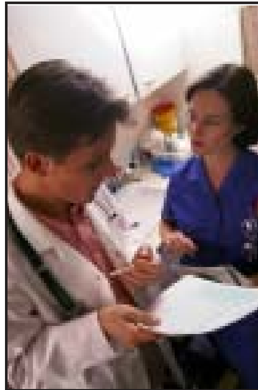
2. Amend the statute to define any technology not approved by the FDA prior to the date of enactment as "not reasonably required" unless approved for use by the Department of Labor and Industry commissioner in consultation with the Medical Services Review Board (MSRB).

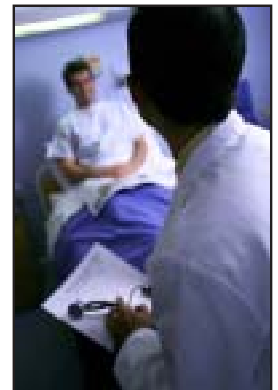
Treatment parameters

1. Add to the statutory definition of "reasonably required treatment":
   - "as defined by any applicable treatment parameter;"
   - treatment exceeding a parameter is presumed to be "not reasonably required;" and,
   - presumption is rebuttable by clear and convincing medical evidence that a reason for departure exists.

2. Require judges and payors to apply the parameters:
   - payors must cite parameters in denials of "unreasonable" treatment;
   - fact finders must make decisions based on parameters; and
   - if parameter was not used in adjudicating a claim, the fact finder must explain why it was not used.

3. Authorize the department to use "expedited" rule-making to update and extend parameters with legal standard that parameter must reflect evidence-based medical practice and be developed in consultation with MSRB.





Managed care

1. Certified managed care plans be allowed to negotiate fees with participating providers.

2. Make peer review, utilization review, case management and dispute resolution optional features of certified managed care.

3. Redefine when there is a prior treating relationship.

4. Require the employee to use the certified managed care plan's designated provider for the first 14 days of treatment.

5. Even when the employer does not have a managed care plan, allow employer to select initial health care provider for the first 14 days of treatment.

Summary of medical task-force's recommendations

The labor representatives were universally opposed to any changes in the status quo, consistent with their opinion that there was no medical cost problem and their concern that the proposed changes would all have negative impacts on the injured workers' access to health care services.

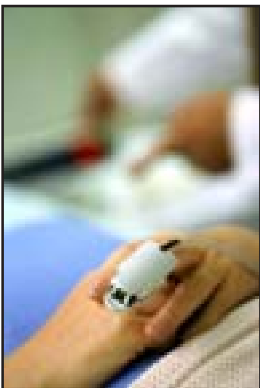
The pharmacy representative also opposed any changes to the current system.

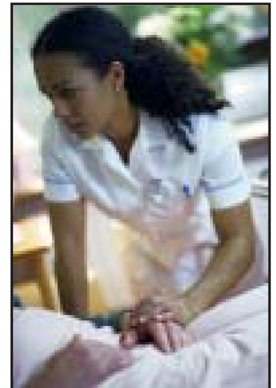
The health care provider representatives unanimously opposed any reductions in payments for services, but frequently endorsed recommendations aimed at controlling inappropriate utilization and strengthening the treatment parameters.

Only two of the health care provider representatives offered any comments about the department's managed care recommendations.They both opposed any changes – especially allowing managed care plans to negotiate rates of payment with participating providers.

A majority of the employer representatives generally endorsed the department's recommendations or offered no comment.

Note: The task-forces agendas, testimonials and minutes can be found online at www.doli.state.mn.us/medcost.html.





Background about workers' compensation medical costs

The cost of medical care in workers' compensation has been a recurrent concern both in Minnesota and around the country. Workers' compensation insurers pay for any "reasonable and necessary" treatment for the "cure or relief" of the work injury.

Unlike almost all other medical payment systems, there are no limits placed on the types of services covered, the types of health care providers that can render treatment or the duration of liability. Moreover, a number of cost-control techniques used in general medical insurance are not compatible with the workers' compensation system: deductibles, co-pays and co-insurance paid by the claimant or lifetime limits on liability.

In May 1988, the Minnesota Legislature provided funding to the Department of Labor and Industry for the first comprehensive study of medical costs in workers' compensation in the United States. The study[1], released in March 1990, found that:

- medical costs were increasing faster in workers' compensation than in general health care;
- the rate of inflation was getting larger (9.3 percent in 1965-1970; 14.7 percent in 1980-1985);
- workers' compensation insurers paid twice as much as general medical insurers for comparable injuries.

Since then, these findings have been extended and reproduced in studies in other states[2].

As a result of these findings, in 1992 the Minnesota Legislature enacted a number of workers' compensation reforms designed to control medical costs. These included:

- a 15 percent reduction in maximum fees paid to health care providers, imposition of the Medicare resource-based relative value system (RBRVS) and limitation of future fee inflation to no more than the change in the statewide average weekly wage (SAWW)[3];
- Introduction of certified managed care and mandatory treatment parameters to reduce inappropriate health services utilization[4].

Footnotes

[1] Research and Education Division "Report to the Legislature on Health Care Costs and Cost Containment in Minnesota Workers' Compensation" St. Paul, Minn.; Minnesota Department of Labor and Industry; 1990 W.G. Johnson, J.F. Burton, L. Thornquist, B. Zaidman, "Why Does Workers' Compensation Pay More for Health Care" Benefits Quarterly 1993; 9(4): 22-3.

[2] Johnson W.G., Baldwin M.L., Burton J.F., "Why is treatment of work related injuries costly? New evidence from California" Inquiry 1996; 33: 53-65.

[3] Minnesota Statutes section 176.136; available at: www.revisor.leg.state.mn.us/stats/176/.

[4] Minnesota Statutes sections 176.1351 and 176.83 subd. 5; available at: www.revisor.leg.state.mn.us/stats/176/.

Recent increases in workers' compensation premiums have again raised concerns about medical costs in workers' compensation. While the average medical cost per claim grew 3 to 7 percent a year from 1995 to1998, increases in the cost of medical care per claim reached double digits beginning in 1999: 16 percent in 1999, 12 percent in 2000, and 15 percent in 2001, the most recent year for which data is available[5].

Even after adjusting for annual growth in wages to correct for general inflation, the rate of growth in costs has been substantial: 10 percent in 1999, 7 percent in 2000, and 12 percent in 2001.

Likewise the cost of workers' compensation, which had fallen by almost half from 1994 to 2000, rose 5 percent relative to payroll in 2001, with another 12 percent increase in cost in 2002, to $1.58 per $100 of payroll[6]. This increase has occurred despite the fact that the number of occupational injuries continues to decline – 22.9 percent since 1995, 14.6 percent since 2000[7].

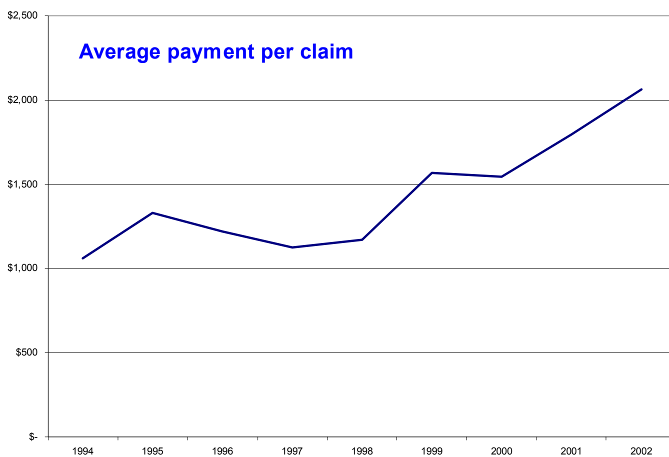
Large increases in workers' compensation medical costs have not been unique to Minnesota, but have occurred in other jurisdictions as well, many of which have recently begun to address these issues[8]. In 2003, the Minnesota Legislature directed the Department of Labor and Industry to convene a "working group" with members representing labor, employers and health care providers to study medical costs in the state's workers' compensation system[9].

The working group was directed to identify cost drivers, determine if costs were excessive and consider whether injured workers have adequate access to health care. In particular the group was asked to examine the growth of medical costs in workers' compensation in comparison to overall medical costs and medical costs that might be unique to the workers' compensation system. The working group was required to make a report of its findings and any recommendations it may have to the Workers' Compensation Advisory Council (WCAC) by Jan. 9, 2004. In turn, the WCAC must report to the Legislature by Feb. 15, 2004.

Medical costs in Minnesota workers' compensation since 1993

Department presentation: After a 13.7 percent decline between 1993 and 1994 due to the cost containment measures implemented after the 1992 legislative reforms, the average medical payment per claim has nearly doubled:

Figure 1



Research and Statistics,
Minnesota Department of Labor and Industry, 2003

While the medical cost per case has risen most dramatically for those claims with lost work time, they have also increased for claims without lost time.

Of course, some of this increase is explained by the statutory provision that allows the maximum fees paid to providers to increase each year by no more than the change in the SAWW.

But this is not the entire explanation; the increase in the average payment per claim is greater than the increase in maximum fees due to the annual increase in the medical fee schedule's conversion factor.

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[5] Research and Statistics, Minnesota Department of Labor and Industry, 2003.

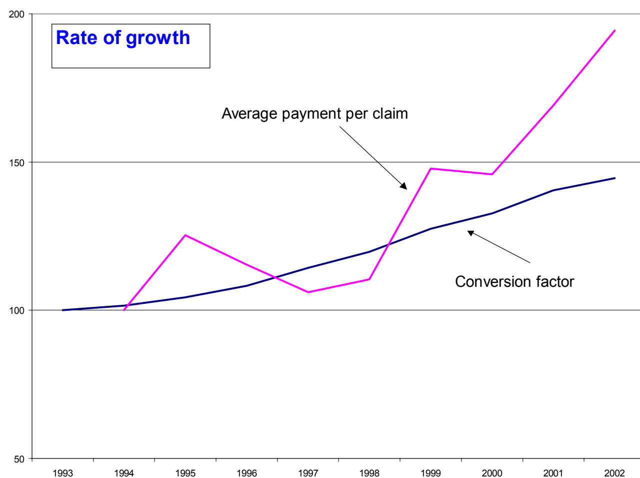
[6] Ibid. The 2002 estimate is based on preliminary data from the Minnesota Workers' Compensation Insurers Association.

[7] Ibid.

[8] J.B. Treaster "Cost of Insurance for Work Injuries Soars Across U.S." The New York Times June 23, 2003; reprint available at: www.wcrinet.org/article_ny_times_6.26.03.html.

[9] 2003 Laws of Minnesota, Chapter 128, Article 11, Section 12.

Figure 2



Research and Statistics,
Minnesota Department of Labor and Industry, 2003

Underlying these increases are a number of trends[10]:

- There have been changes in the distribution of payments among providers. More payments are being made to hospitals and pharmacies now than prior to 1993.

- There have been large differences in the rate of growth in charges among providers. While physician and chiropractor charges per claim have increased by 230 percent and 172 percent respectively, hospital costs per claim have increased 247percent to 256 percent and pharmacy costs have grown by 829 percent.

- There have been changes in the distribution of payments by service category. While office visits accounted for almost 25 percent of costs prior to 1993, they now represent less than 10 percent of the charges. On the other hand, surgical services have increased from 8.8 percent of charges to 13.3 percent and radiology services from 7.2 percent to 9.8 percent.

- There have been large differences in the rate of growth in charges among service categories. While office visit costs per claim have increased a little more than 200 percen,t radiology and surgery costs per claim have gone up 270 percent and 280 percent, respectively.

In short, there has been a shift to providers that are not subject to the medical fee schedule and to services with the highest rate of growth in charges.

Medical cost increases are generally attributed to one or more of three mechanisms: an increase in the cost of services; an increase in the number of services provided; or a change in the type of services provided. There is evidence of all three phenomena in the Minnesota workers' compensation system[11].

The cost for services covered by the Minnesota fee schedule has increased more than 44 percent since 1993. This is substantially higher than the consumer price index and other measures of inflation. Only the increase in the CPI-M, a measure of inflation for medical services paid directly by consumers (as opposed to insurers), is comparable. Likewise, there has been an increase in the number of services per claim, especially for services not covered by the treatment parameters or services paid outside the medical fee schedule.

The change in the types of services provided is really a result of three different situations: substitution of more expensive services for less expensive options; introduction of new technologies; and addition of new types of therapy.

In the first instance, OxyContin™ is prescribed instead of Vicodin™, or Celebrex™ ($2.88/pill) is prescribed instead of naproxen ($0.29/pill).

An example of a new technology is intradiscal electrotherapy (IDET), which costs $8,000 per disc. The use of services from a massage therapist in treatment regimens already including chiropractic and physical therapy modalities is an example of the addition of new types of therapy.

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[10] Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: www.doli.state.mn.us/pdf/medtaskforce08_26_03.pdf.
[11] Ibid.

Charge to the task force

Pursuant to the legislative mandate, the commissioner of the Department of Labor and Industry empanelled the Workers' Compensation Medical Costs Task-force (see Appendix A for a list of members) to review data about medical costs and cost drivers in the workers' compensation system. As part of its charge the task force was asked to specifically consider four components of overall costs: pharmacy costs, payments to hospitals, medical fees and service utilization.

The task force also reviewed the efficacy of cost control mechanisms available in certified managed care, treatment parameters and the medical fee schedule (see Appendix B for list of meetings, agendas and testimony).

Pharmacy costs

Department presentation: Since 1993, retail drug expenditures have grown from about $50 billion a year to more than $100 billion a year[12]. Except for 1993 and 1994, the growth in prescription drug spending in general health care has been more than 10 percent per year[13].

Costs have increased so rapidly, because more drugs are being prescribed. More prescriptions are being written for newer and, thus, more expensive drugs. And generic drug costs have also increased.

While retail drug expenditures have gone up about 100 percent since 1993, drug costs per claim in Minnesota workers' compensation have gone up from $60.13 to $161.63, almost 270 percent since 1996[14].

There is good evidence the same factors underlie the increase in drug costs in workers' compensation as explain the growth in drug costs in general medical care: more injured employees are being prescribed medications, more pills are being dispensed when medications are being prescribed, the cost per pill has increased and newer, more expensive brand-name medications are being substituted for older medications available in generic formulations[15].

The department reviewed a variety of cost control options to address pharmacy costs in Minnesota workers' compensation.

It had convened an earlier informational meeting in November 2002, of members of the WCAC and the MSRB, along with other interested parties and open to the public, to explore the applicability to the workers' compensation system of the wide variety of pharmacy cost controls used in general health care.

Based on those discussions, three cost control mechanisms were presented to the task force:

- fee schedules;
- pharmacy networks;
- treatment parameters for selected medications.

In Minnesota, workers' compensation pays more than other systems for which reimbursement information is available[17].

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[12] Norman V. Carroll, Ph.D. "Research in Pharmacy Benefit Management in Outpatient Prescription Programs: A Review and Critique" Internet Presentation; 2002.

[13] Scott Leitz and Julie Sonier "An Overview of Health Care Costs in Minnesota: Presentation to the Joint Task Force on Health Care Cost and Quality Minnesota" St. Paul, Minn; Department of Health; Health Economics Program; Jan. 11, 2002.

[14] Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: http://www.doli.state.mn.us/pdf/mtf9_9_pharmacy.pdf

[15] Ibid.

[16] Minnesota Rules Part 5221.4070.

[17] The inability or unwillingness of providers to share information about reimbursement from HMOs and commercial insurers was a constant problem for the task force. In most instances, this means comparisons with other payment systems are limited to public programs such as Medicare and Medicaid.

Table 1	Ingredient reimbursement	Dispensing fee
Minnesota WC – current	100 percent AWP	$5.14
Minnesota Medicaid – current	86 percent AWP	$3.65
Washington state WC	90 percent AWP	$4.50
2001 national survey of HMOs[18]	86 percent AWP	$2.21
Other Medicaid jurisdictions[19]	Avg. 89.6 percent	AWP Avg. $5.10

Department recommendation: Change the current reimbursement formula to the one used by Minnesota Medicaid:

- maximum allowable charge (MAC)[20] plus a dispensing fee of $3.65; or

- 86 percent average wholesale price (AWP) plus a dispensing fee of $3.65, if no MAC price is available.

The department also discussed the use of pharmacy benefit managers (PBMs). These corporate entities control the utilization and cost of pharmacy products on behalf of payors.

A typical PBM would assist a health care insurer in the design and management of pharmacy benefits, claims processing, drug utilization review, formulary development, pharmacy network management and cost discounting, demand management and customer service.

While a number of PBMs advertise full-service programs specifically for the workers' compensation market, the key component of success is access to a pharmacy network. Patients are restricted, in most circumstances, to using the network outlets for filling prescriptions. Pharmacists in the network are paid a negotiated rate and dispensing fee. "Point of service" technology available to participating pharmacies permits immediate calculation and submission of allowed charges, online adjudication of the claim and imposition of any dispensing restrictions.

Based on feedback from stakeholders at its November 2002 meeting, the department recommended to the task force that pharmacy networks be specifically authorized in Minnesota workers' compensation.

Department recommendation: Allow an employer/ insurer to contract with and negotiate rates with a pharmacy network from which the injured employee must select a pharmacy to fill perscriptions. Mileage parameters would be included to ensure reasonable access.

During the task-force's discussion, numerous concerns were raised about the business practices of existing PBMs and whether the savings derived from negotiated prices with pharmacists will actually be passed on to insurers.

Department recommendation: Require pharmacy benefit managers to disclose to employers and insurers any rebates or discounts received from drug manufacturers or pharmacists.

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[18] Pharmacy Benefit Management Institute *2002 Takeda Prescription Drug Benefits Cost and Plan Design Survey Report* Albuquerque, N.M.; Wellman Publishing, Inc., 2002.

[19] Based on DLI analysis of 44 jurisdictions (other than Minnesota) that use AWP in determining ingredient reimbursement; data taken from: Gencarelli DM "Average Wholesale Price for Prescription Drugs: Is There a More Appropriate Pricing Mechanism?" NHPF Issue Brief No.775/June 7, 2002.

[20] The "maximum allowable cost" is the reimbursement set by Medicare and Medical Assistance for many commonly used drugs.

Finally, the department considered the use of formularies. Formularies limit the specific drugs that may be prescribed and dispensed to a patient. In general health care plans, drugs not included in the formulary are either not reimbursed or require a higher co-pay.

While there was no support for the development of a workers' compensation formulary as such at the November 2002 meeting, there was interest in some of the benefits of a formulary.

However, it was noted that the benefits of a closed formulary can be achieved by changing the way physicians prescribe medications rather than by interfering with the dispensing of medications by the pharmacist:

- encouragement of generic substitution (when a generic, less costly version of a drug is dispensed instead of the brand-name form that may have been prescribed; e.g. a patient would receive generic ibuprofen instead of Motrin™);

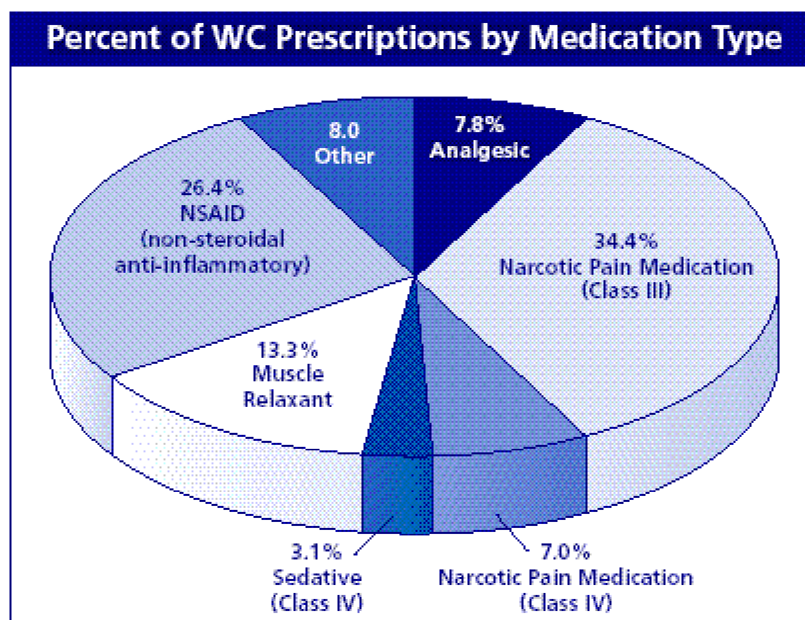
- support of therapeutic substitution, if appropriate (when the patient receives an equivalent, alternative drug to the one actually prescribed; e.g. a patient would receive ibuprofen instead of Celebrex™);

- prior authorization (used to limit access to particularly expensive medications, drugs with misuse potential, or prescription of drugs for "off-label" uses);

- quantity limitation (used to limit the number of doses that can be dispensed per prescription or the number of refills allowed; targets drugs used for short-term therapy to prevent excessive or inappropriate use).

Moreover, since just a few classes of drugs account for almost all of the pharmacy costs in workers' compensation – nonsteroidal anti-inflammatories, muscle relaxants and narcotic analgesics – this narrows the scope of the problem.

Figure 3



From: CWCI Reports ***Pharmaceutical Cost Management in California Workers' Compensation*** Oakland, Calif; California Workers' Compensation Institute, November 2002

The Minnesota workers' compensation system has a methodology for this type of focused intervention on health care provider behavior: treatment parameters. This has led the department to recommend using the treatment parameters to realize the potential benefits of a formulary without having to create a formulary.

Department recommendation: Amend the workers' compensation treatment parameters to provide:

- rules for use of specific classes of drugs (such as use of narcotics for musculoskeletal pain); and
- time and quantity parameters for the use of selected drugs for specific conditions (such as nonsteroidal anti-inflammatories for initial treatment of musculoskeletal injuries.

Task-force deliberations: Mark Arrington, director of Claims Operations at State Fund Mutual Insurance, offered testimony in support of pharmacy networks and negotiated price discounts. He noted that pharmacy networks, designed to provide suitable geographical access, would offer efficient delivery of medication to injured workers with simplified authorization and billing procedures.

Moreover, pharmacy benefit management companies are offering medications at prices lower than the maximum fees currently allowed by the Minnesota workers' compensation medical fee schedule.

Tim Gallagher and Joanne Schwecke, from Western National Insurance, testified that they had realized savings of 32 percent with their current PBM arrangement.

Gallagher, however, was concerned about the department's original recommendation to lower the dispensing fee paid to pharmacists to $2.21; he argued that the maximum fee allowed under the department's first proposal would not cover the pharmacist's overhead costs. He declined to share with the task force any information about payment rates for other types of insurance. Gallagher and some members of the task force were also concerned about the possible shifting of any profit from the pharmacist to the PBM.

There was a concern that the use of PBMs simply shifted costs within the system with any savings from reduced payments to pharmacists being negated by the administrative costs charged by the PBMs. Others noted that an insurer would have no incentive to contract with a PBM unless there were some savings.

Based on these concerns, the department modified its final recommendations to the task force, increasing the dispensing fee and adding a recommendation that PBMs be required to disclose to insurers the rebates and discounts they receive.

The Minnesota Pharmacists Association (MPhA) and the Minnesota Retailers Association (MnRA) later submitted a written opinion opposing the final recommendation as well, noting that it costs a Minnesota pharmacist $7.21 to fill a prescription and, because of this, the Minnesota Medicaid formula proposed by the department would result in a $5.94 profit on a brand-name drug but a $0.37 loss on a generic.

Further, they argued that the administrative costs to the pharmacist in workers' compensation are higher than in other payment systems (because of billing procedures, payment delays and the risk a claim may be denied) and proposed that the reimbursement formula for medications include a "processing fee" in addition to the dispensing fee to account for these additional costs.

This would allow pharmacists to continue using third-party agents that pay the pharmacist a negotiated discount from the current maximum allowable fee and then bill the insurer for the maximum.

The department noted it would prefer the discount go to the insurer, thus realizing savings to the workers' compensation system. The MPhA and MnRA generally supported the other pharmacy recommendations with some added suggestions[21].

There was a general concern among task-force members that pharmacy networks could result in access problems if small-town pharmacists refused to accept the levels of reimbursement offered by the network.

The department pointed out that the recommendation included provisions to guarantee injured workers geographically convenient access to pharmacy services.

If a network did not have an outlet within the required mileage, the injured worker would be able to go outside the network to obtain their medication. These provisions would also offer some leverage to small town pharmacists in negotiating with the networks.

Hospital costs

Department presentation: Hospital charges accounted for 32.4 percent of the costs in Minnesota workers' compensation in 1989; but by 2001, that had risen to 41 percent[22]. And the rate of growth in payments per claim to hospitals was greater than for any other provider group, excluding pharmacies.

Moreover, the distribution of services provided by hospitals to workers' compensation claimants was markedly different than those to general medical care patients, especially at small hospitals. While 67 percent of hospital charges are for inpatient services in general medical care, only 50 percent of large hospital and 18 percent of small hospital charges are for inpatient services in the workers' compensation system.

In Minnesota workers' compensation, hospitals are reimbursed 85 percent of each hospital's usual and customary charge (U and C) costs, unless[23]:

1. The hospital has 100 or fewer licensed beds (i.e. is a *small* hospital), in which case all of the services provided by the small hospital are paid at 100 percent U and C; or

2. The service is provided by a hospital with more than 100 licensed beds (i.e. it is a *large* hospital) in an outpatient setting, in which case the service is paid at the medical fee schedule rate, if it applies, or 85 percent U and C if it does not.

Because there is no control on how hospitals set their U and C charges and only 32 percent of the outpatient services billed by large hospitals are subject to the medical fee schedule, these statutory provisions mean there are very few limits on what hospitals can charge and receive for services provided to workers' compensation claimants.

The overall effective reimbursement rate (the actual percentage of the amount billed that is paid) is 79.7 percent for large hospitals and 100 percent for small hospitals.

[21] Minnesota Pharmacists Association and Minnesota Retailers Association "Pharmacy Providers Respond to Workers' Compensation Medical Cost Task-force Pharmacy Recommendations" available at: www.doli.state.mn.us/pdf/mctf12_02_recommend4.pdf.

[22] Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: www.doli.state.mn.us/pdf/mtf9_23_hospitalcosts.pdf.

[23] Minnesota Statutes section 176.135 subd 1b; available at: www.revisor.leg.state.mn.us/stats/176/.

In comparison, the reimbursement rates reported by hospitals to the Minnesota Department of Health for other payment systems are far lower.

Table 2

Hospital reimbursement in general health care – 2001

	Total charges	Total payments	Payment/ charge ratio
Medicare	$4,647,546,260	$2,148,770,143	46.2%
MA/GAMC/MNCare	$1,441,926,499	$678,672,543	47.1%
Private Managed Care	$3,022,295,868	$1,593,265,943	52.7%
Commercial/ Non-profit health plans	$2,573,032,139	$1,679,724,328	65.3%
Total	$12,608,778,199	$6,704,182,843	53.2%

The overall average reimbursement rate for hospital services is 53.2 percent, as compared to the Minnesota workers' compensation average rate of 84.3 percent for all hospitals. Therefore, the department recommended large-hospital reimbursement rate for all services not subject to the Medical Fee Schedule be tied to the average reimbursement rate of other payment systems.

Department recommendation: For all services not covered by the medical fee schedule, pay noncritical-access hospitals at the most recent average overall payment-to-charge ratio for all hospitals plus 15 percent (53 percent + 15 percent = 68 percent). Adjust this reimbursement rate annually with updated data from the Department of Health.

When arriving at the recommendation, the department believed that linking the workers' compensation reimbursement rate to the average reimbursement rate in the Department of Health data benchmarks workers' compensation to the other payors in the state, which have the resources and data to determine market-based compensation unrelated to the hospitals' U and C charges. It also reduces the likelihood that any biller could successfully "game" the system by simply raising U and C charges to increase workers' compensation payments (since the average reimbursement rate, determined by the other systems, would simply fall, thereby reducing the ultimate workers' compensation payment).

The department also examined whether small hospitals should continue to receive a higher rate of reimbursement. This statutory provision was originally enacted in 1992, to help financially struggling rural hospitals. However, there have been a number of changes in the hospital industry since then. Many hospitals have become part of larger health care systems that include hospitals of varying sizes, along with other health care businesses. And hospitals have expanded to include clinics and other outpatient venues. Some small hospitals continue to be at particular financial risk when delivering inpatient care and are the only source of these health care services in their geographical area. And other payment systems, in particular Medicare, pay some Minnesota hospitals at a higher rate.

In light of the continuing problems for some hospitals, the department recommended replacing the classification of hospitals based on the number of hospital beds, with the distinction made by Medicare and administered by the Joint Commission on the Accreditation of Hospitals of "critical-access hospitals." A critical access hospital is a hospital with a patient census of less than 25 and is located more than 35 miles from a hospital or another critical-access hospital, or is certified by the state as being a necessary provider of health care services to residents in the area[24].

[24] www.jcaho.org/accredited+organizations/critical+access+hospitals/.

Department recommendation:

- Identify critical access hospitals for increased reimbursement.
- Pay inpatient services at critical-access hospitals at 100 percent U and C.
- Pay all other services at the medical fee schedule rate *plus* 15 percent, if it applies, or at the average payment-to-charge ratio for all hospitals *plus* 30 percent, if it does not apply.

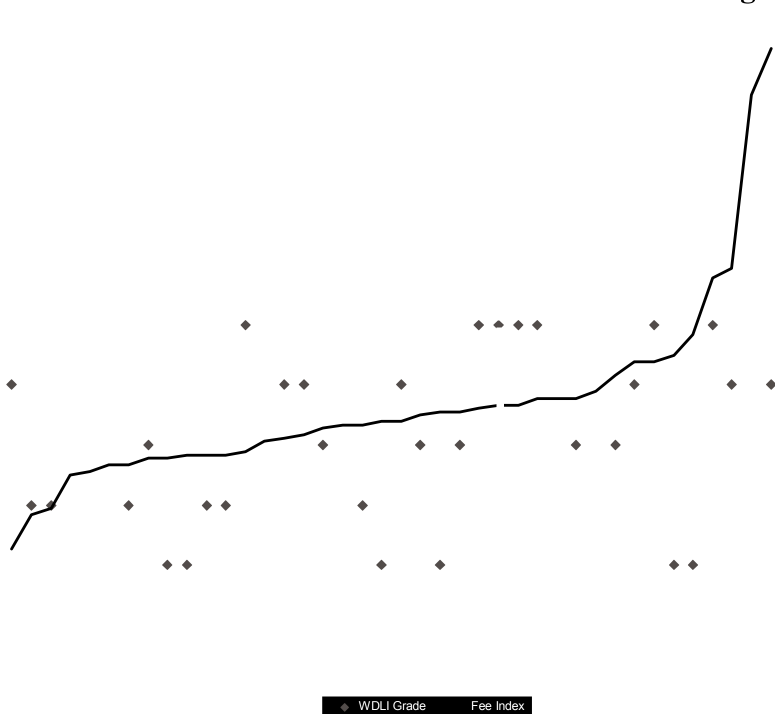
Task-force deliberations: Gary Strong, president, Fairview Southdale Hospital, testified to the task force on behalf of the Minnesota Hospital Association (MHA). He argued that there was no cost problem in Minnesota workers' compensation: premiums are 43 percent lower than 10 years ago and Minnesota's costs are average compared to other states. Moreover, he argued that insurers and employers get "good value" for the money paid, according to a study done by the Work Loss Data Institute (WLDI).

The department noted that while workers' compensation costs per $100 of payroll declined 48.4 percent from 1993 to 2000, they have increased 17.6 percent since then. While it may be true that insurer business practices and low returns in the investment markets have contributed to increased costs, it is certainly true that benefit costs per $100 of payroll have increased substantially and have created cost pressures independent of any other factors[25].

The department also noted that the WLDI study report is based on Bureau of Labor Statistics (BLS) data derived from OSHA logs, not actual workers' compensation data and, while the claim is made that Minnesota's "A" rating shows that employers and insurers receive "good value" for the medical costs incurred in the workers' compensation system, there is no apparent correlation between the WLDI grade and measures of medical cost across states[26].

As indicated in Figure 4, there is no consistent relationship between grade and medical fee index; the WLDI grades are scattered randomly around the fee index line.

Figure 4



[25] D. Berry "Workers' comp system cost bumps up in 2001"; Research and Statistics, Minnesota Department of Labor and Industry; available at: www.doli.state.mn.us/wn02dec1.htm.
[26] Oct. 29, 2003, Memorandum to Medical Cost Task Force; available at: www.doli.state.mn.us/pdf/mctf10_28_wldireport.pdf.

The MHA opposed any changes to current hospital reimbursements. They objected to tying workers' compensation payments to Medicare and Medicaid, but declined to share information about rates of reimbursement from other payers.

The MHA also opposed cutting the rate of reimbursement to small hospitals or paying inpatient and outpatient services at small hospitals at different rates. They noted that some small hospitals receive higher payments from Medicare, Medicaid and many private health plans, such as Blue Cross Blue Shield of Minnesota.

The department noted that the proposal does not link reimbursement in workers' compensation with Medicaid or Medicare, but with the average reimbursement from *all* payers in the state. Based on the testimony the department's final proposal recommended a reimbursement rate lower than the current 85 percent of U and C but higher than the next best source of payment, commercial insurers (68 percent versus 65 percent).

The department's final proposal for critical-access hospitals continued the current payment of 100 percent of U and C for inpatient services and recommended less reduction in the rate of payment for outpatient services.

Kathryn Marks and Margaret Kasting, State Fund Mutual, presented data that indicate wide variations among hospitals in the U and C charge for a variety of common services. In some instances, the more expensive hospital charges as much as 583 percent more than the least expensive hospital.

Some members of the task force were concerned about using U and C charges as the basis for hospital payments. A variety of alternative payment systems for hospital services were discussed: using hospital-specific payment-to-charge or cost-to-charge ratios to determine reimbursement rates, establishing prevailing cost to replace hospital U and C charges or implementing the Medicare diagnosis-related group (DRG) prospective payment system. The department, for administrative reasons, considered none of these suggestions as viable solutions.

Some members of the task force were concerned that lowering reimbursement to hospitals would restrict access, especially in rural areas of the state.

Medical fees

Department presentation: Slightly more than half (51 percent) of the services provided to workers' compensation claimants are subject to the Minnesota workers' compensation medical fee schedule (MN-MFS).

In 1992, the Minnesota Legislature directed the Department of Labor and Industry to develop a new relative-value fee schedule, specifically authorizing the use of the resource-based relative-value system (RBRVS) developed by Medicare[27]. Relative-value fee schedules are used by 33 of the 42 states that have any form of a workers' compensation fee schedule, with more than half using the federal RBRVS.

The RBRVS was designed to replace charge-based payment systems with one that pays physicians based on the resources required to produce specific services. Each service is assigned a numeric relative-value that is the sum of the provider work, practice expense and malpractice expense incurred to deliver the service. The relative values were established based on extensive survey research done by the federal Health Care Financing Agency (HCFA).

When adopting the Medicare RBRVS in 1993, the department made some modifications. First, there are differences in the scope of services allowed that had to be reconciled through rules (e.g. Medicare only pays chiropractors for manipulations, while workers' compensation pays them for office visits, radiology and physical medicine services as well). Next, the application of the relative values had to be adapted to the bill review and

[27] Minnesota Statutes section 176.136 subd. 1a; available at: www.revisor.leg.state.mn.us/stats/176.

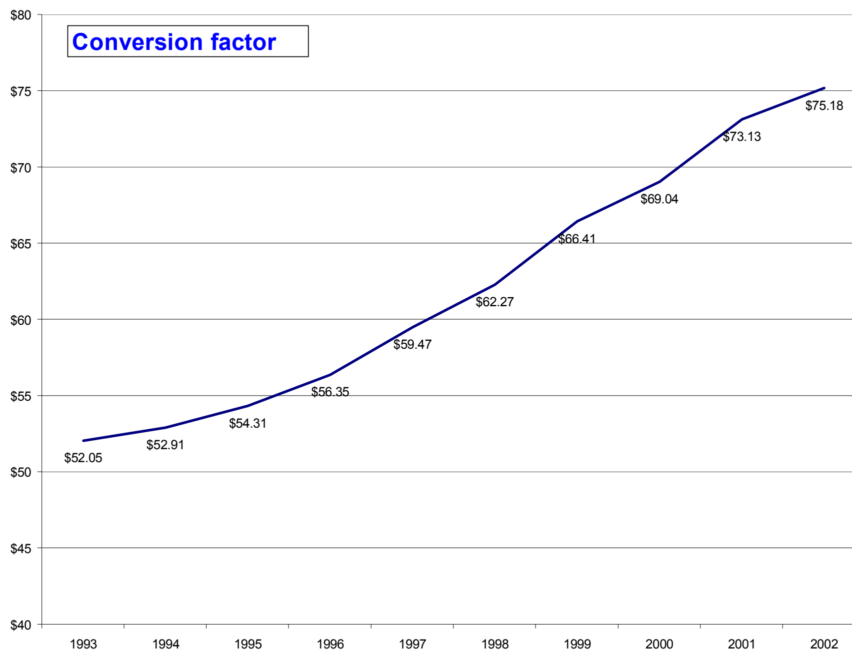
payment rules used in the workers' compensation system. Also, the relative values were mathematically revised to reflect Medicare's procedures for geographical market adjustments. Then, rules were added to allow multiple procedure discounting. Finally, services were assigned to one of four groups pursuant to a legislative direction that the fee schedule differentiate among health care providers: medical and surgical services provided primarily by M.D.s, pathology and laboratory services, physical medicine and rehabilitation services provided primarily by physical therapitsts and occupational therapists, and chiropractic services[28].

In order to implement the RBRVS, a conversion factor (CF) had to be established. The CF represents the dollar value of a relative-value unit (RVU). The 1992 legislation authorizing the adoption of a relative-value fee schedule also directed the department to effect a 15 percent overall reduction in payments in workers' compensation from that allowed by the 1991 fee schedule. This was accomplished during the calculation of the 1993 conversion factor. To apply the 15 percent reduction separately to each of the four groups identified above, while setting a single conversion factor for administrative ease, the RVUs for pathology and laboratory services, physical medicine and rehabilitation services, and chiropractic services were reduced or "scaled."

Since the new MN-MFS was introduced in 1993, there have been three updates. In 1995, the 1995 Medicare RVUs replaced the RVUs used in 1993. In 1997, new chiropractic manipulation therapy (CMT) codes and RVUs replaced the older codes used in 1993. In 2001, the 1995 RVUs were replaced by 1998 Medicare RVUs (and one 1999 physical therapy code), and CPT coding (the system used by M.D.s) was introduced for all chiropractic services.

The 1992 legislation also provided that the conversion factor must be adjusted annually "by no more than the percentage change (in the state-wide average weekly wage)[29]." Until 2002, the CF was increased by exactly the change in the SAWW (in 2002 and 2003, the CF was increased by the change in the producers price index for physicians). Using the increase in the SAWW as the annual adjustment has led to a 44.4 percent increase in the cost of services covered by the MN-MFS.

Figure 5

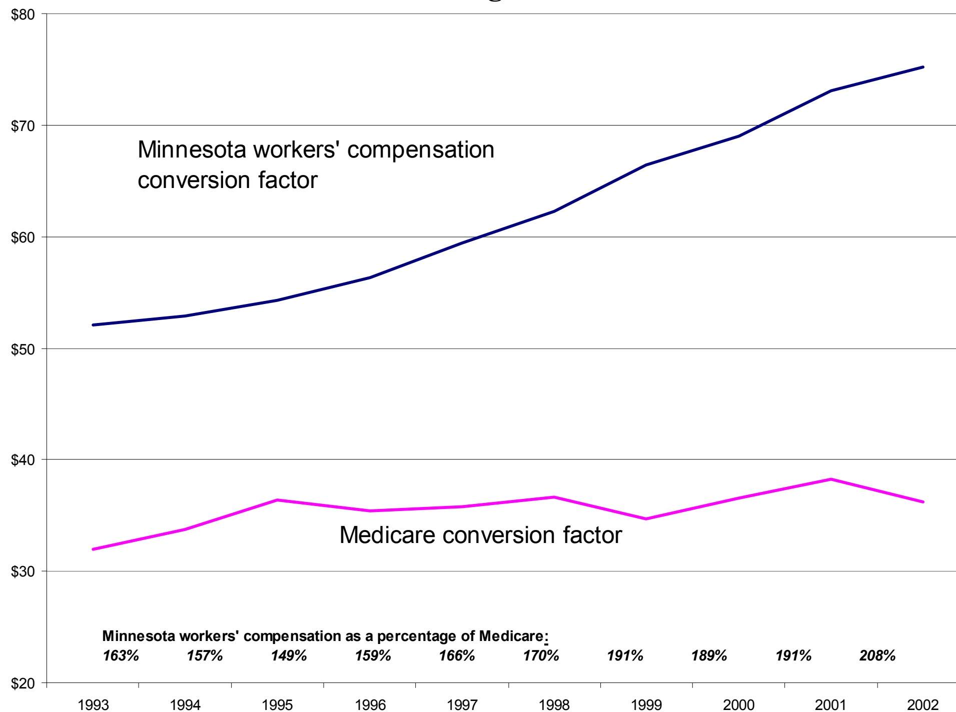


Research and Statistics, Minnesota Department of Labor and Industry, 2003

[28] Minnesota Statutes section 176.136 subd. 1a; available at: www.revisor.leg.state.mn.us/stats/176.
[29] Ibid.

Because Medicare uses the same relative-value system but with a different conversion factor, the payments in the two systems can be directly compared. In 1993, the first Minnesota workers' compensation CF was 163 percent of Medicare's CF; by 2002, it was 208 percent of the Medicare conversion factor.

Figure 6



Research and Statistics, Minnesota Department of Labor and Industry, 2003

In a study done by the Workers' Compensation Research Institute (WCRI), Minnesota was 20th out of 40 states studied in the size of the "premium"[30] over Medicare paid for health care services to injured workers[31]. Furthermore, the WCRI researchers found there was no relationship between the interstate differences in workers' compensation payments and the underlying costs to the provider for doing business in their state.

Additional analysis shows that Minnesota's "middle of the road" position depends on the distinction made between providers in the fee schedule and that the RVUs in the Minnesota workers' compensation medical fee schedule are those introduced by Medicare in 1998. If all Minnesota health care providers were paid without the application of the scaling factors developed in 1993, and if the RVUs were updated to those currently used by Medicare, Minnesota would have the highest payments of any state using a relative-value system fee schedule[32].

The department also attempted to learn how medical fees in Minnesota workers' compensation compared to those in other payment systems in the state. Unfortunately, the only detailed and publicly available comparisons are with the Medicare and Medicaid systems. Private payors declined to share any payment information with the department because of confidentiality agreements. A letter from Dr. Paul S. Sanders, chief executive officer of the Minnesota Medical Association

[30] The percentage above (or in two cases – Florida and Massachusetts – below) the Medicare payment paid by workers' compensation insurers for the same health care services.

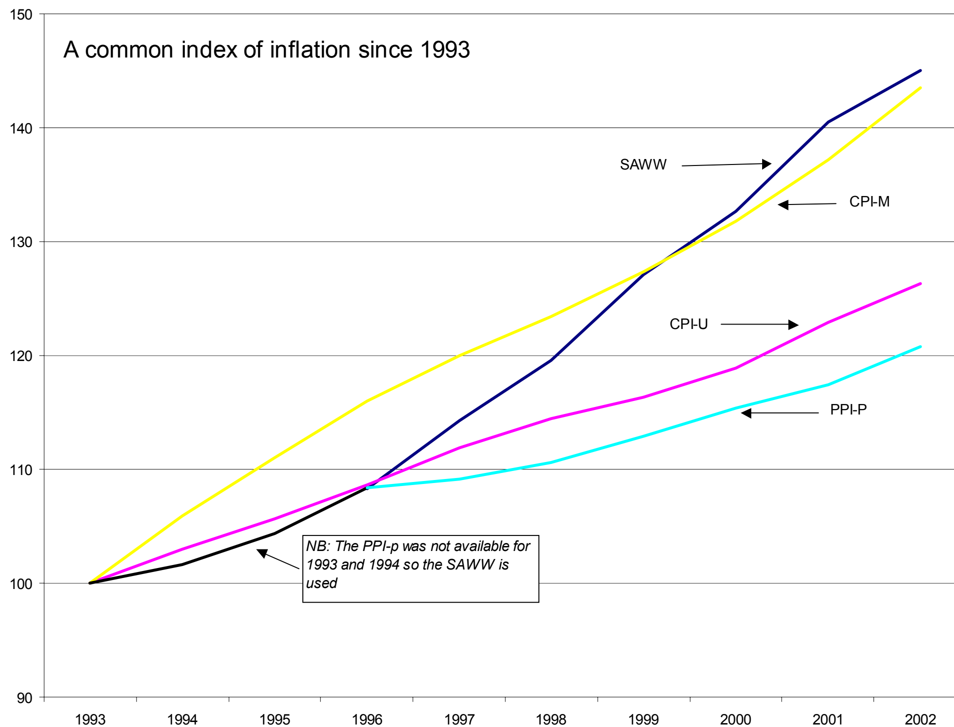
[31] WCRI Benchmarks for Designing Workers' Compensation Medical Fee Schedules, 2001-2002 Cambridge, MA; 2002.

[32] Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: http://www.doli.state.mn.us/pdf/mtf10_14_mfs.pdf and http://www.doli.state.mn.us/pdf/mctf10_28_addendum.pdf.

(MMA), indicated that, nationally, private payors reimbursed physicians at approximately 130 percent of Medicare rates in 2002, in contrast to the Minnesota workers' compensation rate of 208 percent for the same year.

The department also considered whether the MN-MFS conversion factor has been increasing too fast. A number of alternatives to using the change in the SAWW as an inflation adjustment were considered: the consumer price index (CPI-U)[33], the consumer price index for medical care (CPI-M)[34], or the producer price index for physician services (PPI-P)[35]. The choice is important, because the rate of inflation since 1993 has been markedly different among these indices.

Figure 7



Research and Statistics, Minnesota Department of Labor and Industry, 2003

Based on the available evidence and the original legislative mandates that led to the development of the current MN-MFS, the department recommended that both issues – the right price for health care services in workers' compensation and how fast should those prices be allowed to increase – could be addressed by focusing on the appropriate measure of price inflation and then applying it retrospectively to the conversion factor beginning in 1994 (the first time the original CF was adjusted).

This recommendation assumes the original CF – $52.05, representing a 63 percent premium over Medicare's 1993 conversion factor (even after the 15 percent reduction in workers' compensation payments from 1991 levels required by the Legislature) – was an appropriate price for services,

[33] The CPI-U is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.
[34] The CPI-M is a component of the CPI-U and is a measure of the average change over time in the prices paid by consumers for prescription drugs and medical supplies, physicians' services, eyeglasses and eye care, and hospital services.
[35] The PPI-P measures the average change over time in the revenues received by health care providers for their services, and would include payments made by health insurers as well as those made directly by consumers.

recognizing any increased administrative burdens created by the workers' compensation system. The annual change in the PPI-P is recommended as the appropriate adjustment for the conversion factor, because it is a measure of the increase in health care provider revenues based on the entire health care market, including both government and private payment systems.

Department recommendation:

- The appropriate inflator for the conversion factor is the PPI-P.

- Readjust the Minnesota workers' compensation medical fee schedule conversion factor to what it would have been had the PPI-P been used for annual adjustments since 1993 – $62.86. And, in the future, adjust by PPI-P.

Not all outpatient services are covered by the MN-MFS. Currently services that are not covered by the fee schedule are paid at 85 percent of the U and C charge[36], the same rate as applied to large-hospital services. In light of the recommended reductions in payment rates for hospital services and services in the MN-MFS, the department recommended the following.

Department recommendation:

- Pay nonhospital services not covered by the fee schedule at 68 percent of U and C charge.

Task-force deliberations: A number of comments reviewed by the task force were sent to the Workers' Compensation Advisory Council in February 2003, from health care providers that contended it is it more expensive to deliver health care services to workers' compensation patients and, therefore, a higher rate of payment is justified:

- *Care of injured workers requires a physician to take a more elaborate history, do a more thorough examination or spend more time in counseling than care in the general medical setting.* The department noted that physician office visits are already billed according to the amount of work done in these activities; so no matter where the conversion factor is set, physicians that do more work – a longer history, a more detailed physical examination or more time talking to the patient – get paid more.

- *Caring for an injured worker requires a physician to deal with lawyers and qualified rehabilitation consultants (QRCs), work not required in general medical care.* The department noted that physicians are allowed to, and do, charge lawyers and others for conferences and reports directly. These charges are in addition to any charges for the medical care delivered to the injured employee. Meetings with QRCs can be, and are, billed separately using the fee schedule.

- *Caring for an injured worker requires more time, effort and expertise than caring for other patients. Even the levels of reimbursement in nongovernmental general health plans would not be enough.* The department noted that almost all work-related conditions are common medical problems that also occur in the general public. The unique aspects of caring for injured workers are the need to cooperate with rehabilitation and return to work, and the increased administrative burden.

- *Health care providers must complete required forms free of charge. Because of the claims implications of medical opinions, physicians may be burdened to a greater*

[36] Minnesota Statutes section 176.135 subd 1b; available at: www.revisor.leg.state.mn.us/stats/176/.

degree than in general medical care by calls from employers, case managers and claims adjusters. The department acknowledged these are valid issues. The burden of administrative requirements in workers' compensation is higher, on a regular basis, than in general medical care. In fact, the perception of an increased administrative burden is, perhaps, the major reason that some additional percentage of compensation over Medicare reimbursement rates has been almost universally accepted in workers' compensation systems throughout the United States.

Michael Goertz, M.D. and Janet Silversmith testified to the task force on behalf of the Minnesota Medical Association (MMA). The MMA presented many of the same objections as the MHA during the discussion of hospital costs (see above):

- workers' compensation system costs are down 44 percent since 1993; and
- Minnesota gets "good value" as demonstrated by the WLDI report.

The MMA also pointed out:

- physician services as a percentage of all services has gone down;
- physician fees were cut 15 percent when the RBRVS fee schedule was implemented; and
- the RVUs in the current MN-MFS are out-of-date.

The MMA opposed any cut in the CF and changing to the PPI-P as an inflation adjustor. Instead they proposed updating the RVUs and using the CPI-U as the inflation adjustment, which they feel better reflects the increased costs of doing business.

David Thoreson, RPT, testifying for the Minnesota Chapter of the American Physical Therapy Association (MN APTA) concurred with the MMA's general positions that there is no evidence of a workers' compensation cost problem and that Minnesota gets "good value." The MN APTA also opposed any cut in the CF and recommends updating the RVUs, but did not take a position about the appropriate inflation adjustment.

The department noted that while physician services as a percentage of all services has gone down, payments to physician per claim have increased 126 percent; physician services as a percent of the whole have gone down only because the rate of growth for other services has been even higher.

The department acknowledged that the RVUs currently used in the MN-MFS are from 1998. However, simply updating the RVUs, without any corresponding cuts to the CF would increase medical costs 3.9 percent and total system costs 1.4 percent.

John Whisney testifying for the Minnesota Medical Group Management Association, pointed out that a clinic's administrative overhead costs are greater for a workers' compensation claim than for other medical claims. More staff time is needed to identify the insurer, process specialized claims forms and submit accompanying medical records. Workers' compensation claims spend more than twice as much time in a clinic's accounts receivable than others.

Mary Beth Misner, DC, and Tim Mick, DC, testified for the Minnesota Chiropractors Association (MCA) about the scaling factors incorporated into the current MN-MFS. The MCA contends chiropractors are paid less than other providers for the same services. This issue was brought before the WCAC in 2001, and extensively studied by the MSRB. The MSRB recommended to the WCAC that scaling factors be removed for manipulations and physical medicine services. However, the WCAC took no action on this recommendation.

The MCA recommends all scaling factors be removed. Terry Cahill, M.D., testifying for the MMA, strongly opposed eliminating the scaling factors applied to the RVUs for office visit services. The MN APTA supported eliminating the scaling factors for manipulations and physical medicine services.

The department noted that removing all scaling factors from the current fee schedule, without any corresponding change in the CF, would by itself raise medical costs 3.3 percent and total system costs 1.2 percent.

A number of commentators and task-force members raised concerns about restricting injured workers' access to care if there were any reductions in reimbursement. The department noted there was no data presented that indicated any loss in access at the proposed rates of reimbursement .

Service utilization

Department presentation: Total medical costs are the final product of the prices per services paid and the number of services allowed. Overall costs can increase because prices are rising, the number of services provided is increasing or both. Increases in the number of services may be appropriate or inappropriate. The number of services provided to a patient population may increase appropriately if the types of health conditions being treated and their severity have changed. Conversely, providing services that are ineffective or unnecessary results in excessive and inappropriate treatment.

There are a variety of studies, both from Minnesota and elsewhere in the United States, that indicate inappropriate utilization is a problem in workers' compensation. The 1989 Minnesota medical study showed the duration of treatment was higher for certain classes of injuries in workers' compensation compared to a similar population in general health care. These differences were most marked for physical medicine services[37] in the treatment of common musculoskeletal injuries such as low back pain and strains/sprains.

Numerous studies of managed care in workers' compensation have shown dramatic reductions in the utilization of health care services in the managed care population, without any significant differences in treatment outcomes[38].

A 2002 study done by the Workers' Compensation Research Institute in Texas found large and unexplainable differences between different regions of the state in the number of physical medicine services prescribed by physicians to claimants with comparable injuries[39].

Another 2002 WCRI study looked at 52,000 workers' compensation claims from five states (Connecticut, Texas, Massachussetts, Florida, California)[40]. It found that back and upper extremity injuries accounted for two-thirds of physical medicine costs. For cases with the same duration of work loss, chiropractic care cost more in four of the five states studied, even though chiropractors were paid less per visit than other health care providers. This difference in cost was attributable to physical medicine costs, especially the higher number of treatment visits for patients taken care of by chiropractors. Of note, the only state in which this pattern was not found (Florida) had strict limits on the number of reimbursable visits per case for these kinds of treatment[41].

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[37] Physical medicine services include the types of treatments provided by physical therapists, occupational therapists and chiropractors.

[38] Summarized by Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: www.doli.state.mn.us/pdf/mtf9_9_cmcare.pdf.

[39] WCRI "Targeting More Costly Care: Area Variations in Texas Medical Costs and Utilization" Cambridge, MA; 2002.

[40] R.A. Victor, D. Wang Patterns and Costs of Physical Medicine: Comparison of Chiropractic and Physician-Directed Care Cambridge Mass.; WCRI, December 2002.

[41] At the time the study was done, Florida law limited chiropractic treatment to 18 visits or eight weeks, whichever came first.

Data from Minnesota also shows the importance of physical medicine services in overall medical costs[42].

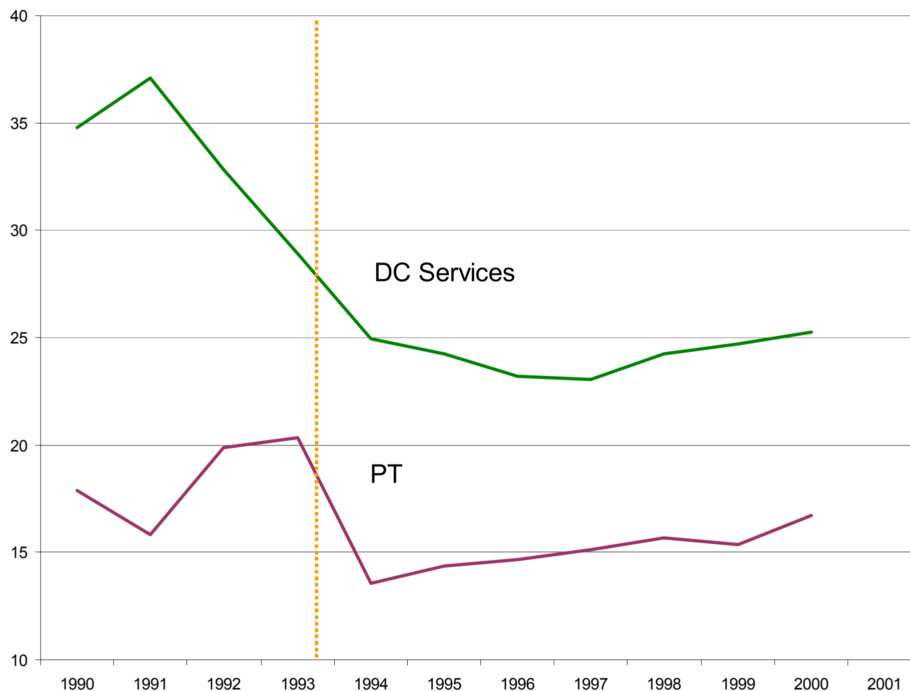
Table 3

Service groups	Percent of all services
Office visits	11.5
Physical medicine*	34.0
Chiropractic manipulation therapy	6.8
Medical imaging	4.0
Surgery	0.7
Laboratory testing	2.42
All others	38.5

*From all providers including physical therapists, occupational therapists and chiropractors

In fact, physical medicine services are eight of the top 10 most frequent services provided to workers' compensation patients in Minnesota, with these eight services accounting for 31.8 percent of all services. The frequency of these services is increasing, even though there are fewer overall work injuries in Minnesota and fewer are so severe as to cause lost time from work. For comparable groups of short-duration mild low back injuries, there has been a marked variation in the number of physical medicine services per claim. After marked declines in the frequency of these services after the implementation of the 1992 workers' compensation reforms, there has been a steady increase.

Figure 8



Research and Statistics, Minnesota Department of Labor and Industry, 2003

[42] Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: www.doli.state.mn.us/pdf/mctf10_28_utilization.pdf.

In response to the problem of inappropriate and excessive physical medicine services, at least nine states limit some aspect of physical medicine treatment to workers' compensation claimants without prior authorization:

- AL: Only six total treatment visits allowed in the first six months.
- CO: Only 34 manipulations allowed per case
- FL: Chiropractic treatment limited to 24 treatments or 12 weeks.
- KS: Physical medicine treatment limited to 21 visits.
- NC: Physical therapy limited to 30 visits; chiropractic care limited to 20 visits.
- OR: Chiropractor may only be the treating provider for 30 days or 12 visits.
- RI: Any palliative care, including physical medicine, after MMI limited to 12 visits.
- WA: Chiropractic care limited to 60 days or 12 visits and chiropractor cannot provide physical therapy services on more than six visits.
- CA: Physical therapy and chiropractic treatment limited to 24 visits each.

In addition, Medicare and Medicaid both limit physical medicine services.

- As of Sept. 1, 2003 Medicare limits physical therapy and occupational therapy services to $1,590 each per calendar year and only reimburses chiropractors for manipulation for spinal subluxation (i.e. does not pay for office visits, other physical medicine treatments, medical imaging or for treatment of conditions other than back pain).

- Minnesota Medical Assistance, General Assistance Medical Care and Minnesota Care only pay for manipulation of the spine for treatment of spinal subluxation and X-rays that are needed to support a diagnosis of subluxation. Furthermore, manipulations are limited to six in a month and no more than 24 in a calendar year.

Department recommendation: Based on the available data, amend the statute to limit physical medicine modalities and procedures to 24 visits per injury.

Besides the changes in the number of services provided, changes in the types and proportions of services can also strongly affect overall costs. The changing mix of services is really three distinct problems:

1. The substitution of more expensive options for less costly ones; e.g. ordering a SPECT scan instead of a bone scan or prescribing OxyContin™ instead of Vicodin™.

2. The introduction of new treatment technologies; e.g. intra-discal electrotherapy (IDET) for treatment of low back pain.

3. The addition of new types of therapy to the conventional regimens; e.g. involving massage therapists in treatment programs already including physical therapists and chiropractors or the use of herbal medications in addition to prescription drugs.

These have in common the widespread use of new interventions before there is any evidence of their efficacy or advantage over established treatments. A classic example in Minnesota's workers' compensation system was the extensive use of chymopapain injections for the treatment of low back pain before well-controlled scientific studies called into question their usefulness. By the time the studies were done and the results widely disseminated in the medical community, a large number of injured workers had been subjected to a costly and often ineffective treatment. Since delaying the introduction of new technologies until there is evidence that they work can only prevent these kinds of problems, the department made the following recommendation.

Department recommendation: Amend the statute to define any technology not approved by the FDA prior to the date of enactment as "not reasonably required" unless approved for use by the commissioner in consultation with the MSRB.

Task-force deliberations: Thomas Mottaz, testifying for the Minnesota Trial Lawyers Association, opposed any statutory limitations on healthcare services.

Treatment parameters

Department presentation: The 1992 legislative reforms directed the department to establish treatment parameters for the most common and costly workers' compensation injuries[43]. The parameters were intended to decrease unexplained variation in treatment between injured workers with similar injuries and to help define which treatments are "reasonable and necessary."

In consultation with the Medical Services Review Board the department promulgated permanent treatment parameters in 1995, covering general medical practices, medical imaging, hospitalization, selected surgeries, chronic management, administrative procedures, low back pain, neck pain, thoracic back pain, upper extremity disorders and reflex sympathetic dystrophy[44].

In 1999, the department, in cooperation with Stratis Health, completed a study, funded by the Robert Woods Johnson Foundation about the effectiveness of the treatment parameters[45]. A group of claimants with low back injuries were followed for the first six months after the date of injury.

In this group only 70.8 percent of the cases received treatment that was completely compliant with the low back pain parameter. In comparing those patients who received compliant care versus those who did not, the study found:

Table 4

Outcome measured	Results
Improvement in pain	No difference
Improvement in function	No difference
Satisfaction with care	No difference
Satisfaction with job	No difference
Work status at six months	No difference
Mental health	No difference
Physical health	Maybe better in those who had compliant therapy
Lost work-time	Less lost time in those who had compliant treatment
Medical cost	Lower costs in those who had compliant treatment

D. Gilbertson, W. Lohman, "Mandatory Treatment Parameters Evaluation"

Further analysis found that noncompliance with those parts of the parameter regulating passive care (mostly physical medicine treatments) and the use of diagnostic testing (mostly medical imaging techniques) were particularly responsible for the increased lost work-time and increased costs in cases that had noncompliant care.

More recently, the department has examined groups of similar low back injuries occurring during 1990 to 2001[46]. This study looked at the cost and utilization of treatments in the first 16

[43] Minnesota Statutes section 176.83 subd. 5; available at: www.revisor.leg.state.mn.us/stats/176/.

[44] Minnesota Rules Parts 5221.6010 through 5221.8900; available at: www.revisor.leg.state.mn.us/arule/5221/.

[45] D Gilbertson, W Lohman "Mandatory Treatment Parameters Evaluation" RWJ Workers' Compensation Health Initiative; details available at: www.umassmed.edu/workerscomp/grants/grant16.cfm and www.doli.state.mn.us/pdf/mctf10_28_utilization.pdf.

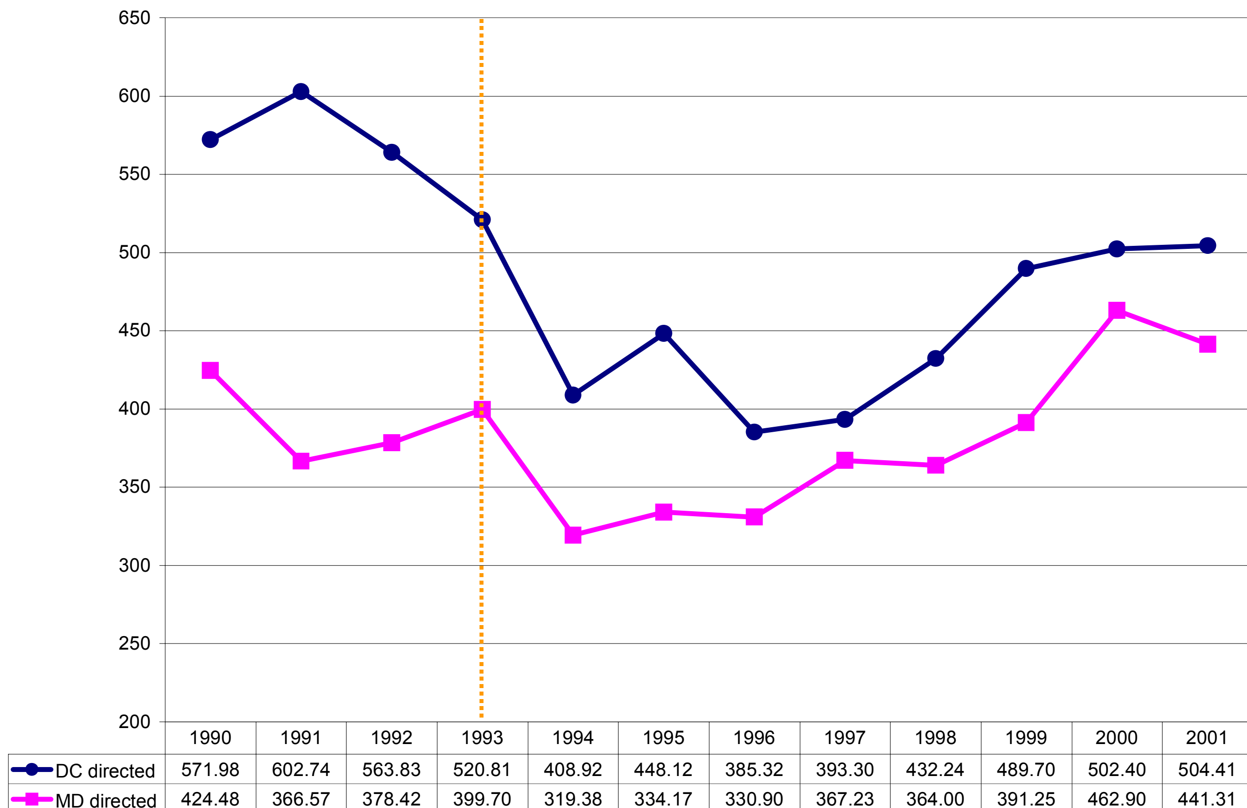
[46] Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: www.doli.state.mn.us/pdf/mctf10_28_utilization.pdf.

months after the date of injury. All of these workers had short duration, relatively mild low back injuries. The data shows there was a marked decrease in the frequency of services per claim for those types of services most affected by the treatment parameters at the time of their first implementation, particularly for physical medicine treatments (see Figure 8 on page 21). As already noted, there has been a gradual increase in the frequency of those services since that time, despite that there has been no change in the nature or severity of these injuries. There has also been a parallel increase in the cost of these claims, as shown below in Figure 9.

Figure 9

Average total payment/claim

includes payments for all services provided



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
DC directed	571.98	602.74	563.83	520.81	408.92	448.12	385.32	393.30	432.24	489.70	502.40	504.41
MD directed	424.48	366.57	378.42	399.70	319.38	334.17	330.90	367.23	364.00	391.25	462.90	441.31

Research and Statistics, Minnesota Department of Labor and Industry, 2003

The studies show that treatment parameters do work to control excessive and inappropriate treatment, but that compliance is an issue[47]. The department also noted the current parameters do not include a number of common and important workers' compensation injuries, e.g. lower extremity problems, which account for 22 percent of all occupational injuries in Minnesota[48].

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[47] For example, the Workers' Compensation Court of Appeals and compensation judges apply case law standards rather than the treatment parameters in disputes over the reasonableness of medical treatment if the parties have not raised the parameters as an issue; See, *Rosch v. Long Prairie Memorial Hospital* (WCCA 10-1-2003)

[48] B Zaidman *Minnesota Workplace Safety Report: Occupational Injuries and Illnesses, 2001* Research and Statistics, Minnesota Department of Labor and Industry; May 2003; available at: http://www.doli.state.mn.us/pdf/saferpt01.pdf

In addition, changes in medical science and the introduction of new technologies could be incorporated into the parameters. Based on all of the available evidence, and these administrative considerations, the department made a series of recommendations regarding the current treatment parameters.

Department recommendation: Add to the statutory definition of "reasonably required treatment":

- "as defined by any applicable treatment parameter";
- that treatment exceeding an applicable parameter is presumed to be "not reasonably required"; and
- this presumption is rebuttable by clear and convincing medical evidence that a reason for departure from the parameter exists in a particular case.

Department recommendation: Require judges and payors to apply the parameters:

- payors must cite parameters in denials of "unreasonable" treatment;
- fact finders must make decisions based on parameters; and
- if parameter was not used in adjudicating a claim, the fact finder must explain why it was not used.

Department recommendation: Authorize the department to use "expedited" rulemaking to update and extend parameters with a legal standard that the parameter must reflect evidence-based medical practice and be developed in consultation with MSRB.

Task-force deliberations: Testimony from the MHA, MMA and MN APTA was generally in favor of maintaining, updating and strengthening treatment parameters. Kristine Gjerde, testifying for MN APTA, called for more use of peer review in settling disputes regarding appropriate care. Thomas Mottaz, testifying for the Minnesota Trial Lawyers Association, opposed any changes in the legal status of the treatment parameters, but encouraged measures to update the parameters to be consistent with the most current medical science.

Certified managed care

Department presentation: The 1992 legislative reforms also directed the department to establish rules for the implementation and certification of managed care plans[49]. Managed care is a term used in the health care industry to describe health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by: making arrangements with selected providers to furnish health care services; having standards for selection of health care providers; and maintaining programs for ongoing quality assurance and utilization review[50]. The introduction of managed care in workers' compensation was intended to provide another mechanism for controlling inappropriate utilization of health care services.

A Minnesota employer may require that care for a work injury be received from a designated managed care plan[51]. Workers' compensation certified managed care plans (CMCs) are required to make treatment available that is geographically convenient and allows access to emergency services and any category of health care provider. CMCs are also required to provide peer review, utilization review, dispute resolution and case management services. By statutory decree, CMCs must allow the injured employee to treat with a health care provider with whom the employee has an established treating relationship, whether or not the provider participates in the managed care plan's network. By rule, CMCs must pay participating providers the amount allowed under the Minnesota workers' compensation medical fee schedule (MN-MFS) or 85 percent of the providers U and C charge if the service is not covered by the MN-MFS. In 1995, there were 10 CMCs in Minnesota; currently there are four.

The department first considered whether there was any evidence that managed care controlled costs while maintaining access to services and quality of care. Managed care for workers' compensation has not been studied in Minnesota, but has been extensively researched in other jurisdictions. Multiple studies show that medical costs are lower in the managed care plans with comparable treatment outcomes, though patient satisfaction is lower[52].

Minnesota differs from many other states by not allowing managed care plans to negotiate rates of payment with health care providers in the plan's network. A study done by the Workers' Compensation Research Institute, shows that up to 15 percent of the savings realized in some other states' managed care systems are attributable to negotiation of rates of payment with the plan's participating providers[53].

Department recommendation: Certified managed care plans be allowed to negotiate fees with participating providers.

Another significant difference between managed care in Minnesota workers' compensation and plans in some other states is the requirement that the CMC provide peer review, utilization review, dispute resolution and case management services. The department reviewed comments that argued managed care plans should be able to tailor the services offered to insurers and employers, rather than requiring a "one size fits all" approach.

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[49] Minnesota Statutes section 176.1351.

[50] National Conference of State Legislatures "What Legislators Need to Know About Managed Care" Washington, D.C.; 1997. Available at: www.ncsl.org/public/catalog/6642ex.htm.

[51] Minnesota Statutes section 176.135 subd. 1 (f).

[52] Summarized by Research and Statistics, Minnesota Department of Labor and Industry, 2003. Details available at: www.doli.state.mn.us/pdf/mtf9_9_cmcare.pdf.

[53] W.G. Johnson, M.L. Baldwin, S.C. Marcus The Impact of Workers' Compensation Networks on Medical Costs and Disability Payments Cambridge, Mass.; WCRI, 1999.

- *There are already noncertified managed care plans operating in Minnesota that offer workers' compensation insurers only a provider network*. The department noted that these noncertified plans do not have to meet any of the access requirements that are mandated for CMCs.

- *Some insurers have invested in developing in-house capabilities to provide some of these additional services, particularly case management, for all of their claims*. Some commentators noted that it is inefficient and sometimes detrimental to have duplication of these services.

Department recommendation: Make peer review, utilization review, case management and dispute resolution optional features of certified managed care.

Finally, certified managed care in Minnesota's workers' compensation system differs from managed care in general medical care by allowing injured workers to treat with a health care provider that is not part of the plan's network when there is a history of a previous treating relationship.

A study done by WCRI shows that medical costs are 16 to 46 percent lower if all of an injured worker's treatment is provided exclusively within a network, and up to 11 percent lower if most of the treatment is provided within a network[54]. Moreover, the use of the plan's network is strongly influenced by whether the first health care provider to treat the work injury was a member of the plan's network.

A follow-up WCRI study, found that use of a plan's network and medical costs are reduced by 7 to10 percent if the employer controls the choice of health care provider[55].

Department recommendation: Redefine when there is a prior treating relationship.

Department recommendation: Require the employee to use the certified managed care plan's designated provider for the first 14 days of treatment.

Department recommendation: Even when the employer does not have a managed care plan, allow the employer to select the initial health care provider for the first 14 days of treatment.

Task-force deliberations**:** Pat Johnson, president of State Fund Mutual Insurance Company, presented testimony to the task force favoring the negotiation of fees with participating providers, more flexible arrangements of MCO operations between plans and insurers, and a new definition of the prior treating relationship.

Teri Simon, director of Comprehensive Managed Care, spoke for the four MCOs still operating in Minnesota. The MCOs favor "unbundling" of the various components of the current managed care plans to allow more flexible arrangements with insurers and would support elimination or redefinition of the prior treating physician exception. The plans were split on the issue of negotiating fees with participating providers. Simon agreed with Johnson that the current managed care rules are overly complex and onerous.

Several of the task-force's healthcare provider representatives stated that managed care plans would not negotiate fees but rather impose them unilaterally and health care providers would have no alternative but to accept these changes if they wanted to stay in the plan's network. Other members noted the plan would have to offer fees acceptable in the market or the providers sought after by the plans would in fact decline to participate. There were also general concerns that rules requiring timely and geographically convenient access be maintained.

Thomas Mottaz, testifying for the Minnesota Trial Lawyers Association, opposed any limitations on an employee's choice of treating health care provider.

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[54] S.E. Fox, R.A. Victor, X. Zhao The Impact of Initial Treatment by Network Providers on Workers' Compensation Medical Costs and Disability Payments Cambridge, Mass.; WCRI, 2001.

[55] R.A. Victor, D. Wang, P Borba Provider Choice Laws, Network Involvement, and Medical Costs Cambridge, Mass.; WCRI, 2002.

Cost implications

The department was asked to provide some information regarding the implications of its recommendations for workers' compensation medical costs and total system costs. The department used actual bills submitted to workers' compensation insurers that provided data to the department specifically for this purpose.

For the following recommendations, either the data available to the department lacks the necessary details to compute an estimation, or the size of the anticipated effect would be entirely dependent on unreliable assumptions about the future behaviors of insurers, health care providers, judges and injured workers.

- Setting the maximum allowable fee for medications at the MAC + $3.65 or at 86 percent AWP + $3.65, if no MAC price is available.
- Allowing an employer/insurer to contract with and negotiate rates with a pharmacy network from which the injured employee must select a pharmacy to fill prescriptions.
- Requiring pharmacy benefit managers to disclose any rebates to employers/insurers.
- Amending the workers' compensation treatment parameters.
- Allowing managed care plans to negotiate fees with participating providers.
- Making peer review, utilization review, case management and dispute resolution optional features of certified managed care.
- Redefining when there is a prior treating relationship with a provider who is not in a CMC's network.
- Requiring employees to use the CMC's designated provider for the first 14 days.
- Allowing employers to select the initial health care provider for the first 14 days of treatment.
- Adding to the statutory definition of "reasonably required treatment" – "as defined by any applicable treatment parameter" and that treatment exceeding a parameter is presumed to be "not reasonably required." This presumption being rebuttable by clear and convincing medical evidence that a reason for departure exists.
- Requiring judges and payors to apply the treatment parameters.
- Authorizing the department to use "expedited" rulemaking to update and extend parameters with a legal standard that the parameter must reflect evidence-based medical practice and be developed in consultation with MSRB.
- Amending the statute to limit physical medicine modalities and procedures to 24 visits per injury.
- Amending the statute to define any technology not approved by the FDA prior to the date of enactment as "not reasonably required" unless approved for use by the commissioner in consultation with the MSRB.

However, these recommendations are all extensions of cost control methods introduced in the 1992 legislative reform that resulted in a 13.7 percent decline from 1993 to 1994 in the average cost per claim or they are cost control measures that have been studied in other workers' compensation systems and found to be associated with medical costs savings.

Estimates of the impact on medical and system costs could be provided for the remaining recommendations.

For each option, the impact on medical costs and system costs is shown for that change *alone*. In addition, for the hospital recommendations, the impacts are shown for the scenario in which the fee schedule conversion factor is also changed according to recommendation 11 (because some hospital services are paid according to the fee schedule).

- Readjust the CF to what it would have been had the PPI-P been used when available ($62.86) and in the future adjust by PPI-P.

Change in medical costs:	**Change in system costs:**
-5.4 percent	-2 percent

- Pay nonhospital services not covered by the fee schedule at 68 percent of U and C.

Change in medical costs:	**Change in system costs:**
-4.7 percent	-1.7 percent

- Eliminate the small hospital distinction and instead separate *critical-access hospitals* reimbursement at the higher rate.

Change in medical costs:	**Change in system costs:**
-2.5 percent	-0.9 percent

  - In combination with change to conversion factor:

Change in medical costs:	**Change in system costs:**
-8.3 percent	-3 percent

- Pay noncritical-access hospital inpatient services and outpatient services not covered by the fee schedule at the average payment-to-charge ratio for all hospitals *plus* 15 percent (i.e. 53 percent + 15 percent = 68 percent).

Change in medical costs:	**Change in system costs:**
-9 percent	-3.3 percent

  - In combination with change to conversion factor:

Change in medical costs:	**Change in system costs:**
-14.9 percent	-5.4 percent

- Pay *critical-access hospital* inpatient services at 100 percent U and C; pay all other services at fee schedule + 15 percent, if it applies; otherwise, at average payment-to-charge ratio for all hospitals *plus* 30 percent (i.e. 83 percent).

Change in medical costs:	**Change in system costs:**
-2.8 percent	-1 percent

  - In combination with change to conversion factor:

Change in medical costs:	**Change in system costs:**
-8.7 percent	-3.2 percent

- Finally, the impact of implementing all of the above recommendations:

Change in medical costs:	**Change in system costs:**
-20 percent	-7.3 percent

Task-force recommendations

After receiving testimony from interested parties that had requested to speak to the task force, each member was asked to submit their recommendations for distribution and discussion. Members were asked to use the recommendations made by the department as a template for their submissions and were asked to comment about each topic discussed. These task-force recommendations were submitted prior to the Dec. 2, 2003 final meeting and were discussed then. Subsequently, the department has collated the comments and recommendations for this report. The actual submissions are attached as Appendix C and are summarized below.

Many of the general comments received from the members were similar to statements made by various parties during their testimony and discussed above.

Table 5

General comments from members	Number of members (of 12)
Given that workers' compensation costs are 43 percent less now than in 1994, there is no cost problem.	7
Cutting reimbursement to health care providers will result in less access to necessary services for injured workers.	5
The current treatment system gives good value for the price paid.	4
Because the task force only considered medical costs, it did not fulfill the legislative mandate to look at all cost-drivers.	2
Cutting workers' compensation reimbursement will imperil Minnesota's general health care system.	2

In regard to the department's recommendations, the labor representatives were universally opposed to *any* changes in the status quo, consistent with their opinion that there was no medical cost problem and their concern that the proposed changes would all have negative impacts on the injured workers' access to health care services. The pharmacy representative also opposed any changes to the current system.

The employer representatives generally endorsed the department's recommendations or offered no comment.

Among the remaining health care provider representatives, there was considerable variation in assessment of the department's recommendations. They unanimously opposed any reductions in payments for services, but frequently endorsed recommendations aimed at controlling inappropriate utilization.

Table 6

	For	Against
Pharmacy recommendations		3
Hospital cost recommendations		5
Medical fee schedule		5
Utilization control recommendations 1. Allow employer to select initial health care provider for the first 14 days of treatment.	1	1
2. Amend the statutory definition of "reasonably required treatment."	2	1
3. Require judges and payors to apply the parameters.	3	1
4. Authorize the department to use "expedited" rulemaking.	3	1
5. Amend the statute to limit physical medicine modalities and procedures to 24 visits per injury.	3*	1
6. Amend the statute to define any technology not approved by the FDA prior to the date of enactment as "not reasonably required."	2	2

* Two of the three recommended that this be done by treatment parameter instead of by statutory change.

Only two of the health care provider representatives offered any comments about the department's managed care recommendations.They both opposed any changes – especially allowing managed care plans to negotiate rates of payment with participating providers.