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INTRODUCTION

Thank you very much for the opportunity to discuss the Illinois Workers' Compensation System on behalf of the Illinois State Medical Society. My name is Preston Wolin. I am an orthopaedic surgeon with 25 years of experience practicing within the system.

I was trained and continue to practice sports medicine, but I came to realize long ago that carpenters, plumbers, electricians and iron workers (among others) have the same injuries as athletes. They also deserve the same quality of care.

I have spoken many times before workers' compensation lawyers, case managers and employers. While I see many workers' compensation patients, I also do many Independent Medical Evaluations and chart reviews for employers and insurance companies. I am the Director of Workers' Compensation for Weiss Memorial Hospital in Chicago and its Chicago Center for Orthopaedics. Finally, I am an Assistant Professor of Orthopaedic Surgery at the University of Illinois-Chicago where I teach medical students, residents and fellows about treating workers' compensation patients.

As you know the Workers' Compensation Act of 2005 brought several changes to the system including implementation of a fee schedule and allowance of utilization review. These two changes directly affected physicians. It is my understanding that the legislature is examining the system with a view toward possible changes. In addition to the two areas listed above, the issues of choice of physician and cost of benefits are also being reviewed.

PHYSICIAN CHOICE

Our nation recently engaged in a lengthy debate regarding health care. It has been a spirited discussion with strongly held views on both sides. However, there has been consensus by all involved that patients need to maintain the right to choose their physicians. Illinois and 25 other states have placed that power in the hands of the worker/patient. My own experience has confirmed the wisdom of maintaining those rights.

At the present time, employers can "direct" patient's by suggesting they be treated at certain physicians and health care facilities. While many of these physicians and facilities provide good care, unfortunately I have seen many cases where care is delayed or withheld. Necessary diagnostic testing is not ordered. Perhaps even worse, testing is performed at a facility which has a pre-arranged fee discount with employers/insurance carriers. The studies are suboptimal. Diagnoses are missed. There are failures to refer to an appropriate specialist in a timely manner and treatment is denied or delayed. Many of these patients later come to be treated by specialists of their choice. Tests need to be redone (increasing overall costs to the workers' compensation system). Care becomes more complicated and therefore more expensive. I have seen multiple cases where a relatively simple procedure such as a rotator cuff repair could have been performed initially. However, by the time the patient reached a competent specialist this was no longer possible. Tendon transfer (a major reconstructive procedure) or joint replacement became the only alternative.

A system in which the employer controls choice of physician is simply antithetical to patients' rights. Since employers/insurance companies/rehabilitation nurses would totally control referrals, physicians would be incentivized to produce "results" that would benefit employers. Patients and patient care would suffer.

FEE SCHEDULE

The implementation of the Workers' Compensation Fee Schedule represented a significant change from the previous system of reasonable and necessary fees. The net effect was to lower physician and hospital revenue.

If the Illinois schedule is among the highest, important other factors need to be considered. First, the cost of practicing medicine in Illinois is also among the highest in the country. With the recent Supreme Court ruling that malpractice caps are unconstitutional, it is very unlikely that malpractice insurance premiums will decrease. Physicians also face the same challengers as other Illinois businesses. Salaries are higher in Illinois since the cost of living is higher.

Second, the workers' compensation system requires that physicians who treat these patients spend more time on paperwork as compared to non-workers compensation patients. Because of the litigation process, physicians are constantly asked to write reports dealing with causality, disability, and the need for tests/surgery/physical therapy.

Office visits take extra time because the patient is often accompanied by a rehabilitation nurse who wants additional information. HIPAA and workers' compensation laws prevent disclosing information to a third party without patient's consent so the physician must give information to the patient about his/her condition in detail, ask the patient's permission to talk to the rehabilitation nurse and then repeat the information to the nurse.

The system is also becoming more burdensome because more rehabilitation nurses are becoming adversarial. Apparently they believe that it is their job to challenge the treating physician regarding patient care rather than to report it. On average the workers' compensation patient office visit is twice as long as that of another patient.

Third, the workers' compensation system in Illinois has now added another obligation to the treating physician: Utilization Review. I will discuss this in more detail below. Suffice to say that responding to utilization review requires many, many more hours of non-treatment time. Even if the UR system worked (which it does not), this would still be true. In the current environment the time spent in peer review, report writing, and conversation with attorneys is exhaustive.

Fourth, hospitals as well as physicians would be adversely affected by a fee schedule decrease. The schedule determines payouts to hospitals for surgical procedures as well as tests such as MRI and CT scans. Hospital budgets are based in part on the predicted revenue stream generated by the workers' compensation system. In this era of shrinking reimbursement, a decrease in the schedule will adversely affect hospital ability to provide services to local communities. The net affect could well be more hospital closures.

Many states adopted a Medicare based fee schedule back in the 1980s and 1990s. At that time the Medicare fee schedule more closely reflected the costs of providing care to workers' compensation patients. After states adopted the Medicare fee schedule, the schedule began to deteriorate because of the flawed method by which the federal government adjusts the schedule. In 2005, when Illinois adopted a fee schedule and eliminated balance billing, organized labor recognized that injured workers in other states experienced problems with access to care where fees were based on Medicare. The Illinois schedule is based on usual and customary fee data collected on a geographic basis. The top 20th percentile of charges was removed and a 10% discount was applied to the 80th percentile to determine the maximum charge.

The Workers' Compensation fee schedule is based on discounts to what physicians billed for their services. It also accounts for differences in costs of doing business, since it also takes zip codes into account. In other words, it costs less to have a procedure in Carbondale than in Chicago because the cost of managing a medical practice and providing care is less in southern Illinois.

Employers have options they can sometimes use when paying for physician services. First, employers and insurers can negotiate contracts with physicians at larger discounts than are provided in the Workers' Compensation Act. Secondly, some preferred provider network contracts cover workers' compensation claims and reimburse physicians at these contracted rates which may be significantly less than the fee schedule.

If a Medicare based fee schedule were adopted in Illinois, the results would be disastrous. Medicare payments have long passed the point where they keep up with the costs of practicing medicine. Medicare fees are scheduled to be reduced by approximately 25% over the next two years (see attached chart). A 2010 Northwestern University study showed that almost half of physicians trained in Illinois are leaving the state to practice. One of the main reasons is the economics of practicing in this state with its high malpractice premiums and relatively lower salaries. A reduction in the workers' compensation physician fee schedule would only accelerate this trend of our younger physicians refusing to stay in Illinois after completing their training. And, a reduction in the fee schedule would most certainly deprive injured workers of access to the care they need and deserve.

Finally, physicians took a decrease in 2005 with the implementation of the current fee schedule and the elimination of balance billing. Are physicians really the appropriate group on whom a revenue cut should be imposed?

UTILIZATION REVIEW

The current legislative discussion should include changes in utilization review. Utilization review has had direct and often negative impact on treating physicians. Illinois Workers' Compensation law allows the evaluation of proposed or provided healthcare services to determine the appropriateness of both the level of healthcare services medically necessary and the quality of healthcare services provided to a patient.

Utilization review organizations are to be accredited. The evaluation is to be based on (a) medically accepted standards, (b) nationally recognized peer-reviewed standards, or (c) nationally recognized evidence-based standards. In theory UR could improve the quality of care by weeding out substandard practitioners. It could also decrease costs by prohibiting unnecessary tests and procedures. Finally, it could also help cut down on workers' compensation fraud. Substandard practice, unnecessary costs and fraud do exist. Unfortunately as currently used in Illinois, UR is having a significantly negative effect.

Utilization review has become a cottage industry. Workers' Compensation insurance carriers have hired legions of nurses and physicians to perform reviews. They have adopted standards based on peer reviewed literature and "national" guidelines. UR has become so pervasive in Illinois that it is unusual for any proposed treatment to proceed without such review. The problems with the current use of UR in Illinois are multiple.

The standards and guidelines used by UR companies have been generated by the American College of Occupational and Environmental Medicine (ACOEM). Virtually every UR document or peer review references ACOEM guidelines. While they are touted as being "nationally recognized", ACOEM is not a neutral party. It is a professional association that represents the interests of its company-employed physicians. Moreover the methodology used in arriving at the guidelines is flawed. Despite representations to the contrary, the use of peer reviewed literature does not insure best practice guidelines. Many of these articles are flawed methodologically themselves. Some opposing articles are not considered because they may fall just short of statistical standards of significance. Finally, the guidelines do not allow for personal judgment and experience. Not allowing both can result in the denial of good medical care to patients.

California has actually given these guidelines the power of law (as compared to Illinois where they can be presented to the Workers' Compensation Commission in support of respondent's position but can be challenged by petitioner). In 2005 the Rand Corporation studied the ACOEM as well as the related Intercrop and ODG guidelines. Five specific guidelines were presented to a panel of 11 experts. Seven of the 11 experts concluded that the guidelines were not as valid as 'everyone would want in a perfect world'. The study concluded, "California could do a lot better by starting from scratch." Despite these findings, UR documents continue to cite the guidelines as the reason for denial of care. I have even had the occasion of one peer review physician tell me that any discussion regarding treatment has to begin (and end) with the guidelines because, "After all, they are the law." He was not an Illinois physician and clearly did not know that the guidelines are not law in this state.

The UR provision allows for peer-to-peer review. In theory this process is supposed to be collegial and to foster discussion regarding treatment. In practice peer-to-peer review falls far short. The peer physicians on the other end of the phone are hired by the insurance companies. The compensation for peer review is a steady stream of dependable income. Many large medical groups contract with these companies. On more than one occasion my conversations have turned confrontational. I have actually had to tell one group that I will no longer talk to one of their physicians because of his attitude. Knowing that I would have to talk to the patient's attorney if they did not provide another reviewer, the group agreed.

Treating physicians are often faced with an unreasonable timetable in which to respond to the peer review. It has become routine for a reviewer to demand to speak with the treating physician within a handful of hours or else the review will proceed without the treater's input. This can be especially burdensome to a busy physician who happens to be operating that day or in an office seeing 40 or more patients. If that physician cannot respond within the time frame, the usual result is a denial of care due to lack of "evidence of the necessity of care." Another frequent problem is that the reviewer is not provided the up to date medical records and often uses that as a reason to deny care. This problem is particularly bothersome for those of us who utilize electronic medical records. These records are sent instantaneously to employers and insurance companies. One wonders why the peer reviewer is not provided these records.

True peer review would imply that the reviewer have equal training and experience to the treating physician. Unfortunately this does not occur in practice. I have actually had a conversation with a general surgeon who was acting as a peer reviewer. He denied surgery for a knee meniscus tear due to lack of evidence of failure of nonoperative treatment. A first year orthopaedic resident knows that the treatment is surgery. Another common scenario is when a physiatrist reviews an orthopaedic surgeon's request for physical therapy following surgery. The physiatrist cites the guidelines in stating that no more therapy will be allowed because the number of PT visits will exceed the guidelines. This often results in patients receiving 2 to 3 months of therapy when protocols well accepted by orthopaedic surgeons call for 6 months. While some practices employ physiatrists to supervise postoperative patients, the overwhelming number of patients have their rehabilitation supervised by the operating surgeon. Physiatrists cannot really be considered a peer in this setting, but they continue to be used in peer review.

In 2010 we live in an era of sub-specialization. Medical knowledge and treatment technology has exploded. It is hard enough for a treater to stay current in her/his subspecialty. In recognition of this change, subspecialty certificates are now being issued by the American Board of Orthopaedic Surgery in hand and sports medicine. These certificates acknowledge those physicians who have acquired knowledge and experience in those subspecialties. Utilization reviewers are commonly generalists or semiretired. Unfortunately they are not aware of the current state-of-the-art treatment. It is not uncommon for them to deny treatment simply because of their knowledge base. The net result is the denial of quality care to patients.

Utilization review is now being utilized by employers to defend their position regarding denial of care in the litigation process. Once a negative review has been completed, care usually stops unless or until (a) the parties can agree on treatment or (b) the case goes to the Workers' Compensation Commission. Either scenario takes time. Oftentimes the temporary total disability benefits continue to be paid, but the patient does not improve. The Commission is growing skeptical of utilization review for the reasons stated above. Therefore, the usual result is acceptance of the treating physician's recommendation. Treatment proceeds, but due to the delay it often becomes more complicated and therefore more expensive. Due to the delay in treatment the total disability time increases and so do the disability payouts.

AMERICAN MEDICAL ASSOCIATION GUIDELINES FOR DISABILITY RATING

It has been suggested that AMA Guidelines be used in determining a worker's disability following an injury. The problem is that the "Guides to the Evaluation of Permanent Impairment" are just that. They are designed to rate 'impairment' which is not the same as disability. Impairment refers to a person's ability to function in activities of daily living. Disability refers to a person's ability to function in the work place. An example is from page 417 of the most recent edition (6^{th}) of the guidelines. A 55 year old man with a torn biceps tendon is given an impairment rating of 6% of the upper extremity and 4% of the whole person. The biceps is the muscle responsible for bending the elbow and turning the forearm (supination). For someone working in an office a 4% impairment may very well be correct. But for someone whose job requires using a jackhammer or screw driver, that person may very well be totally disabled from doing her/his job.

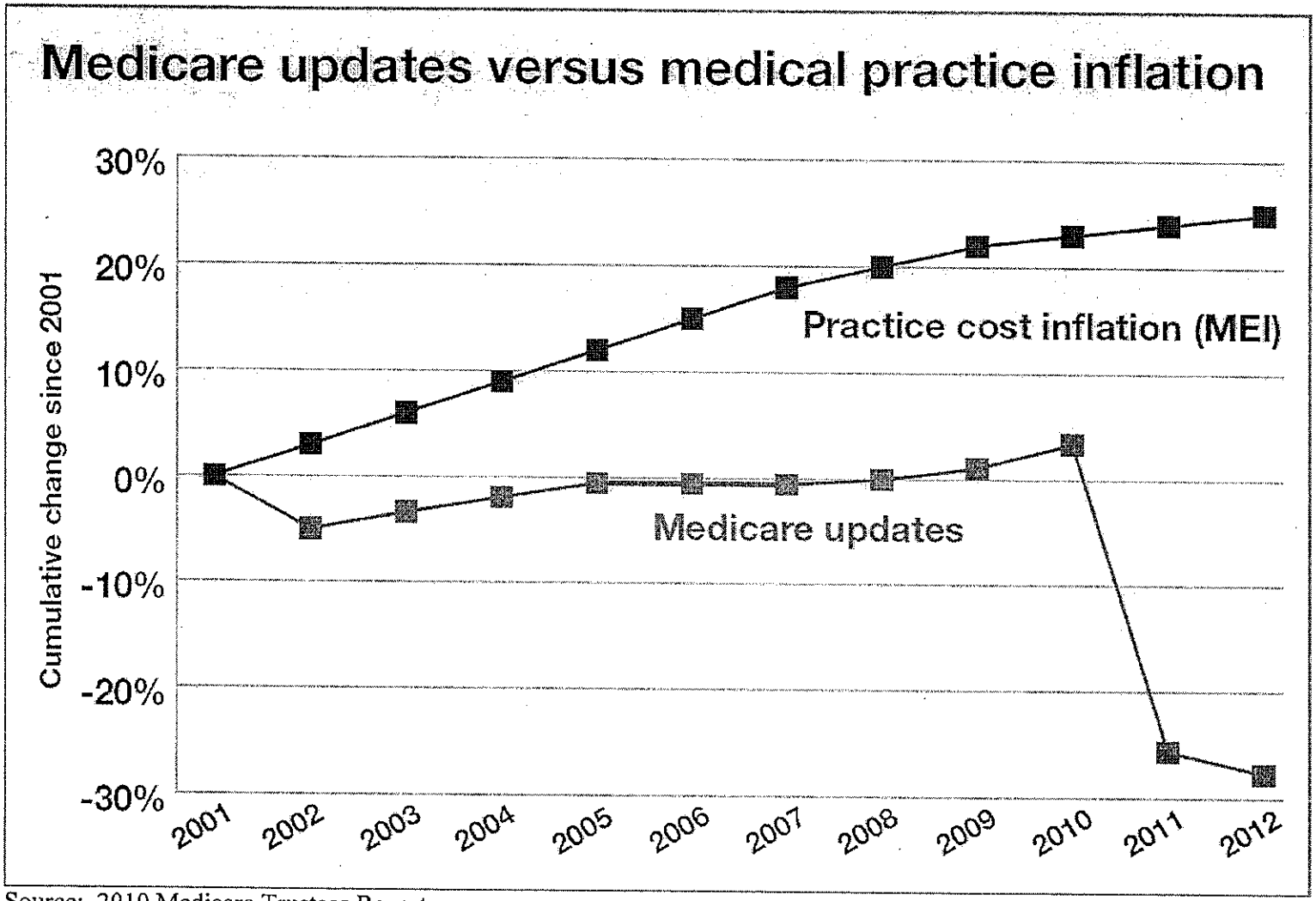
COSTS

The reason that employers want to change the Illinois Workers' Compensation system is the fact that costs have not decreased since the changes of 2005. Apparently it is felt that limiting patient's choice and decreasing the fee schedule will have this affect. Yet a closer analysis reveals the following: (1) There are large costs associated with employer directed care. (2) There are large costs associated with misapplied utilization review. We believe these issues should be addressed.

In the current environment an increasing number of quality physicians are becoming frustrated with the Illinois Workers' Compensation health care system. Although they try to be patient advocates, they simply do not have the time to contend with rehabilitation nurses and utilization reviewers. They do not have time to write reports challenging UR or to prepare for and sit for depositions. Over time these physicians will withdraw from the system. Patients will be left with the next tier of physicians. The costs to the system of missed diagnoses and improper treatment will be incalculable.

CONCLUSION

The Illinois Workers' Compensation System is dependent on quality care provided by quality physicians. The hardworking men and women of Illinois deserve that care. Unfortunately, the current system presents significant impediments to that goal. To date, Illinois law has been the result of the "agreed bill process." That process has included labor, management and attorneys. Medical providers have not been given the same access as the other parties, but are at least equally important. It is high time providers have "a seat at the table." It is clear that the system cannot work well without significant input from the medical community.



Source: 2010 Medicare Trustees Report.