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WCRI Annual Issues & Research Conference

TAKING OUR PULSE

The Workers Compensation Research Institute (WCRI) is an organization that "takes the pulse" of our industry in accordance with the following mission statement:

> The Workers Compensation Research Institute is an independent, not-for-profit research organization providing high-quality, objective information about public policy issues involving workers' compensation systems. Organized in late 1983, the Institute does not take positions on the issues it researches; rather, it provides information obtained through studies and data collection efforts, which conform to recognized scientific methods. Objectivity is further ensured through rigorous, unbiased peer review procedures.

Broadspire financially supports the work of WCRI, and I serve on its research committee, participating in the selection of priority topics and reviews of draft studies.

Its annual **Issues & Research Conference** took place recently, and what follows is a summary of some key take-aways.

JUST WHAT THE DOCTOR ORDERED

- WCRI retiring president, Dr. Rick Victor, discussed the impact of health care reform on WC. It is expected that the ACA will drive (and already has) a group health shift into accountable care organizations (ACOs), which are often capitated/prepaid plans. There may be a financial incentive for an ACO to case-shift certain conditions into WC coverage, and this is most likely to occur for borderline soft- tissue cases which could be wrongly attributed to occupational factors. The message is that WC payers/managers will need to be increasingly vigilant in their determinations about causality/compensability to avoid any inappropriate shift of questionable claims from the group health system.

- Physician dispensing (physicians providing medications to their patients in their own offices) is a major concern due to the high cost of these drugs, and the inherent conflict-of-interest it presents.

Eighteen states have developed rules concerning maximum pricing of dispensed medications, and in these states there has been a decrease in costs, although office-dispensed drugs are still significantly higher cost than pharmacy-dispensed drugs. Additionally, evidence was presented that demonstrates that physicians who dispense are providing unnecessary opioid drugs. Studies done by the California Workers Compensation Institute (CWCI) confirm that when a claimant receives office-dispensed medications both total medical and indemnity costs are higher, and return-to-work is delayed. Our continuing efforts to mitigate physician dispensing are critical.

- The National Council on Compensation Insurance (NCCI) presented an analysis of the impact of state fee schedules, which often have unintended consequences. One message was that fee schedules, and even discounts from fee schedules, are no guarantee that the service is actually being reimbursed at "market rates". Many state fee schedules remain considerably higher than group health or Medicare rates, and it is important to benchmark accordingly, and identify opportunities to reimburse providers at market rates.

- A separate WCRI study indicated that in a few states with very low fee schedules (e.g. CA, MA, FL), one may see physicians make more frequent use of physician dispensing, and upcode the intensity of office visit codes, i.e. a higher percentage of level 4-5 codes, and a lower percentage of levels 1-3. This suggests that scrutiny of coding practices is more critical in lower fee schedule states. Several other examples of provider behavior change in response to fee schedule changes were provided.

- For decades, healthcare pundits have been busy analyzing the phenomenon of variation of medical practice patterns in different geographic areas, and have been able to explain these variations to a great extent. One more piece of the puzzle emerged via a study comparing the rates of spine and knee surgeries in different regions. Knee surgeries seem to vary just modestly based on "local factors". However, spine surgeries vary dramatically from place to place. An example of a local factor is the fee schedule reimbursement for the procedure and how it compares to Medicare or prevailing group health rates. Where the payment is high, the back surgery is done more frequently, and the opposite holds true where payment for back surgery is low. The researchers' inference is that knee surgery rates don't fluctuate too much because the criteria for these procedures are fairly clear-cut. On the other hand, spine surgery is not as clear-cut, and therefore surgeons seem to make their decisions less from evidence-based medicine than from the prevailing local factors such as competition and reimbursement levels. Once again, this confirms that spinal MRIs and interventional procedures will benefit from review of clinical appropriateness.

- Another provocative study explored the relationship of "provider choice", (the degree to which claimants can select their treating WC physician) to medical costs per claim. States were divided into two broad categories: those with primarily employer choice of provider, and those with a high degree of employee choice of provider. States with intermediate grades of choice were excluded from the analysis. Paradoxically the researchers found that total medical costs were lower in the employee choice states, on average. However, when they examined subsets of the highest cost claims (the 5 or 10% highest), the reverse was true: costs were lower in the employer choice states. Their inference was that for more routine claims, employees sought their own physicians whom they were comfortable with, and this resulted in better outcomes. On the other hand, the more complex claims benefited from direction to preferred providers. These results may have implications for network development and direction strategies.

- An analysis of expenses to manage WC claims revealed the following (expenses being defined as total of medical management and litigation-related expenses for claims with >7 days lost time): expenses range widely across states, with a median of $5K; represent 10-20% of total claim cost;

medical management constitutes 40-70% of expenses; trending up at 4-11% a year. The impact of various state regulations on WC expenses was evaluated. The unanswered question was: what is the "right amount" of expense per claim. The data derived in this study may be helpful for benchmarking analysis on a state-specific and aggregate basis.

The remaining presentations covered specific state initiatives and their outcomes, as well as legal and jurisdictional issues.

CIRCULATING IN THE PRESS

Several issues ago, the topic of medical marijuana was addressed and our policy was clarified. Essentially, cannabis is not approved for coverage as it is not an FDA-approved pharmaceutical. The only exceptions are the FDA- approved drugs Marinol and Cesamet when used for their approved indications and for compensable conditions.

Considerable pharmacological research, as described in the article below, is underway to validate the current uses of cannabinoids (for nausea, vomiting and appetite stimulation), and to evaluate their potential for treating/preventing pain, glaucoma, epilepsy, muscle spasticity, cancer, auto-immune diseases and Alzheimer's disease. Undoubtedly, in the future we will have safe and effective pharmaceutical preparations of specific cannabinoid components which are targeted to achieve desired results without unwanted side effects.

"Marijuana's Medical Future", David Noonan, Scientific American, February 2015.

> The chemical that induces marijuana's trippy effects, delta-9 tetrahydrocannabinol (THC), was isolated in 1964. Several other components have been described since, including cannabidiol, the compound used by epilepsy patients, which does not make people high.
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> Drug companies are already in pursuit, working on compounds that show the benefits without the cognitive problems. GW Pharmaceuticals, a British firm, has developed two marijuana-derived drugs, Epidiolex and Sativex. Epidiolex, a purified form of cannabidiol, is intended to treat seizures and is being tested in an international clinical trial led by the University of California, San Francisco, Epilepsy Center. It has already been granted orphan drug status – a path to approval based on smaller clinical studies than normal – by the Food and Drug Administration. Sativex, a mouth spray that contains THC and cannabidiol, is approved in Canada and several other countries, but not the U.S., for the treatment of muscle spasticity in multiple sclerosis. It is also being tested as a pain treatment. Pharmaceutical cannabinoid medicines offer consistent potency and make dosage easier to control – critical factors in many cases, especially with pediatric patients.