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Jacqueline Kurth
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Industrial Commission of Arizona
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Dear Ms. Kurth:

There is a proposal before the Industrial Commission of Arizona to change the 2017/2018 Physicians' and Pharmaceutical fee schedule. Please consider this letter as comments and documentation supplementing my presentation before the Commission on April 27, 2017.

As I was able to briefly point out to the Commission, there is an enormous amount of non-clinical and for the most part non-reimbursable work and effort that goes into the care of Arizona's injured workers. According to an article by Stephanie Goldberg, Business Insurance, March 22, 2015, Mr. Joe Paduda stated (principal of Madison, Connecticut-based health Strategy Associates L.L.C.) "Workers comp is a more complex, cumbersome and difficult process for physicians. There's a lot more paperwork. You have to deal with return-to-work issues. You have to deal with employers. Establishing a relationship with quality medical providers is essential."

With each and every injured worker we evaluate, we as providers must address issues of causation, functional embellishment, preexisting conditions, treatment recommendations, permanent and stationary status, maximum medical improvement, permanent impairment ratings, supportive care, and the injured workers' work status. In addition, we often have to spend time discussing the cases with nurse case managers that may be present prior to, during, or after the injured worker's visit. They often contact us telephonically and we, as providers, must avail ourselves to these calls. In addition, peer review is becoming an increasingly more common practice in order to obtain approval for our treatment recommendations. This alone is a huge impact on our time as providers. Often, we have to "hunt down" the caller at a time that is more convenient for them rather than when we are available. (And just as an aside, I would encourage the Commission to review the increasing amount of peer review requests that come from out of state, non-Arizona licensed physicians.) Representatives from the employer may accompany the injured worker to their office visit. The injured worker may have legal representation. There are additional administrative tasks that need to be completed by the

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provider to include the overwhelming amount of paper work that needs to be addressed such as update status forms from the insurance companies, insurance forms and FMLA paper work to be filled out on behalf of the injured worker, and work status forms. Therefore, to treat a Group Health insurance patient is vastly different and significantly less time consuming than treating the injured worker. What could be a five minute visit for the Group Health patient may become a thirty minute visit for the workers' compensation patient. Both may have a torn meniscus and may require a "knee scope", however, there is a significant difference in the patient population which requires important consideration. These are challenging patients and are considered a distinct entity. (Gruson et al, Journal of the American Academy of Orthopaedic Surgeon's 2013) Workers' compensation places a greater emphasis on return to function (NCCI research). As a consequence of treating Arizona's injured workers, we see a lower volume of patients due to the time it takes to manage these cases. Although appreciation is given to the proposed increase to the "E&M" codes for office management, it does NOT make up for the difference in the proposed reductions in surgical procedure reimbursement. One of my colleagues, who performs many revision surgeries that no one else does, indicated that he would opt out of the proposed change in fee schedule and would charge a "cash price" for his expertise.

I asked the Commission "How do you do workers' comp?" This question presumes a level of knowledge and expertise. This is a question that I have been asked frequently over the many years I have managed and treated Arizona's injured workers. The reality is that most Arizona physicians do NOT want to treat workers' compensation patients. This is confirmed by conversations with multiple insurance adjusters, nurse case managers, and employers who have expressed frustration with trying to find good providers who understand the workers' compensation system. I often hear "we don't want to lose those doctors who understand the system." They express frustration with providers who don't understand causation, maximum medical improvement, impairment ratings, and return to work issues. And as I stated before the Commission, when I speak with out-of-state insurance adjusters, they will frequently comment on the great care that we provide here in Arizona and they wish that other states were LIKE Arizona. That is a comment which reflects the type of care provided by those of us who have dedicated our practices to the care of Arizona's injured workers.

If the Commission allows the proposed changes to go into effect, this would result in a detrimental impact on the care of Arizona's injured workers. The current level of reimbursement allows for fair compensation for the level of service we provide. A reduction in fees WILL lead to a reduction in services. Again, for the most part, the additional services we provide are non-clinical and non-reimbursable. A reduction in fees will lead to a delay in getting injured workers seen in a timely fashion. This will lead to a loss of productivity in which ultimately the employer pays the price. We will no longer be able to afford the time to complete forms or meet with nurse case managers. There will be fewer postoperative follow up visits which can lead to prolonged disability times and extend case times. We will be less likely to take over care of injured workers treated elsewhere either in Arizona or out of state. We might not be able to provide impairment ratings which will result in an increased need for IME's and increased cost to insurance companies.

There is a favorable difference and an expertise that we provide and should be compensated fairly for the services that are expected and that we have been appropriately providing. The current level of compensation that we receive for surgical procedures compensates us fairly for those additional services and time. After discussions with many of my colleagues, the availability of knowledgeable providers to take care of the injured workers will drastically reduce. According to the report by Goldberg, 2015, "Low fee schedules can reduce injured workers' access to care." "Some state workers compensation systems are increasing provider payments to ensure that injured workers are treated quickly and effectively." In the same article, Darrell Brown from Sedgwick Claims Management Services "preferred provider organization discounts that are often applied to fee schedule rates further lower reimbursement." Access to ancillary services such as out-patient surgical centers, (which significantly reduce costs per NCCI analysis), surgical equipment, and anesthesiologists will reduce as well. As a result, this will lead to delays in treatment, limited access to treatment, longer treatment periods, reduced access for treatment of complex problems, and delays in getting the injured worker back to work which will lead to an increase cost per claim. This can also affect the ability to attract and maintain business in Arizona. According to Darrell Brown "we want really good medical outcomes, we want faster return to work, and sometimes that doesn't come at the cheapest price." Per Ron Vianu, CEO of Spreemo "Their ultimate goal is getting (their employees) better and back to work, and they understand that better physicians may be more capable of doing that". "Instead of looking to see if a provider has decreased medical costs . . . , payers should focus on quality of care", Dr. Kathryn Mueller, medical director for the Colorado Division of Workers' Compensation and president of the American College of Occupational and Environmental Medicine. A best practice for payers would be to develop and maintain relationships with quality providers. Per Mr. Paduda "Establishing a relationship with quality providers is essential." I feel that those relationships exist, but can be jeopardized with the proposed reduction in surgical reimbursement. In my opinion, reducing reimbursement for surgical procedures will merely shift profits to insurance companies and the employers who pay the premiums will never realize the savings.

Decreased reimbursement is not a deterrent to decreased utilization. This will reduce the costs per individual surgical procedure; however, it will result in increased overall costs per claim. Decreased reimbursement will lead to increased disability, increased permanent work restrictions, and increased loss of earning capacity which will all lead to increased employer costs. Some providers only look at the bottom line. A decrease in reimbursement will result in the need to do *more* procedures, not less. According to a study reported by Jones November 2010, "the right treatment can reduce return to work times by 90%, while the wrong treatment can extend recovery times 10,000% or more." The indications for surgery depend primarily on the diagnosis, origin, severity, and duration. We need to ensure access to quality care for the injured workers and to compensate the providers who are judicious with surgical recommendations for the additional administrative responsibilities that are attached to treating Arizona's injured workers. Per NCCI, fee schedules are effective in controlling workers' compensation medical costs. Our goal as providers is to encourage the rehabilitation of the injured worker and not disability.

Based on simple economic principles and supported by David Henderson, author of The Concise Encyclopedia of Economics, research fellow at Stanford University and former senior economist with President Ronald Reagan's Council of Economic Affairs, "the most important building block of economic analysis is the concept of demand. The most famous law in economics is the law of demand." This law states that when the price of a good rises, the amount demanded by consumers falls. Additionally, when the price falls, the amount supplied falls. Therefore by applying this law, if reimbursement remains fair, then availability of providers will not go down, but if reimbursement goes down, then, this will create a decrease in supply of providers. As stated earlier, most physicians do not want to participate in the workers' compensation system. Lowering fees is a disincentive to participate in the system, not an incentive. By paying providers less will not increase participation, but rather further decrease participation. The concept of decreasing the fees to lead to an increase in providers is flawed and contradicts well established and proven economic law. Therefore, I disagree with the proposed percentage of decreases in the fees for many of the surgical codes.

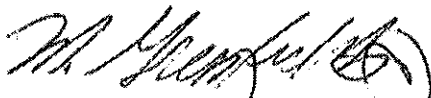
I do understand the Commissions' proposed change in methodology from the seven state model to a RBRVS system. I could support a "stop-loss" concept, as proposed by Mr. Older, Executive Vice-President of Arizona Medical Association. I too, would also urge the Commission to disallow the use of network discounts. According to Darrell Brown "preferred provider organization discounts that are often applied to fee schedule rates further lower reimbursement."

Each state has their own special circumstances. Here in Arizona, the current system works. With any change to the system, as well as any change to the fee schedule, we need to ensure access to quality care for Arizona's injured workers and that compensation for providers remains fair.

"It's not just scoping a knee."

I would like to acknowledge and thank the plaintiff attorneys for their support and concerns about losing providers who understand the workers' compensation system.

I would like to thank the Commission for their time, consideration and hard work.



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