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TESTIMONY OF THE

PENNSYLVANIA ORTHOPAEDIC SOCIETY

HOUSE LABOR AND INDUSTRY COMMITTEE

HB 1800

MARCH 17, 2016, 9:00 AM
G-50 IRVIS OFFICE BUILDING

Thank you Chairwoman Gingrich and committee members for this opportunity to testify on HB 1800 PN 2681. I am James McGlynn, chairman of the Pennsylvania Orthopaedic Society's Workers' Compensation Committee. I appreciate your willingness to hear our Society's views on this important legislation.

As you know, HB 1800 would require the use of treatment guidelines as part of the dispute resolution process in Workers' Compensation (WC) cases. Given that the large majority of cases in the WC system are not disputed, HB 1800 would not have broad application in the WC system. It would, however, have a significant impact on those injured workers who find their medical care under dispute as well as the physicians who treat them.

The Pennsylvania Orthopaedic Society (POS) is engrossed in WC issues. From a medical professional viewpoint, orthopaedic surgeons treat more injured workers than any other type of physician. In addition, the patients we treat are often severely injured. We care deeply for our patients and we hope this legislation will not adversely impact them or the patient/physician relationship.

With that said, if properly implemented, treatment guidelines can be a benefit to the WC system. Many states have adopted guidelines and Colorado's version is considered by some provider groups as a national model. The POS welcomes the opportunity to work with you as the House Labor and Industry Committee deliberates HB 1800.

After reviewing HB 1800, our Society adopted three principles in regard to WC treatment guideline legislation. This action was taken at our February board meeting.

First, lawmakers must understand that treatment guidelines should be merely that, guidelines. POS will not agree to legislation that imposes treatments and procedures upon patients and orthopaedic surgeons. Although that is not the intent of HB 1800, we are concerned that some advocacy groups may see this legislation as a vehicle to prescribe treatment protocols in the WC system. Guidelines should also not become de facto policy on the part of insurers.

Second, treatment guidelines should be specific to Pennsylvania. HB 1800 calls for the adoption of national guidelines. These may be instructive for Pennsylvania policymakers, but they have limited value to the practicing physician who is treating work-related injuries, each with their own set of nuances. The POS

suggests that the legislation establish a workgroup of healthcare providers charged with the duty to develop Pennsylvania-specific treatment guidelines within a certain time period. The Secretary of Labor and Industry could then promulgate that work product as Pennsylvania's treatment guidelines.

We make this suggestion because HB 1800 requires the implementation of national guidelines within 60 days. A lengthy process of proposing modifications, public notice, and comment would begin thereafter. It would be far more efficient and less costly to delay implementation of any guidelines, allow a workgroup to modify existing state or national guidelines, and then implement one set of Pennsylvania-specific guidelines instead of two (a national guideline, then a future Pennsylvania modification of that national guideline). All parties in the WC system should have notice of one set of guidelines.

Third, treatment guidelines must be flexible enough to incorporate new or emerging techniques, procedures and technology. This principle is obviously related to the first two. With innovation a constant in orthopedics and other medical specialties, treatment guidelines cannot be static. Pennsylvania's regulatory review process, however, is very cumbersome. Pennsylvania-specific treatment guidelines should contain provisions that allow for the rapid application of new innovations in the delivery of care without waiting through the state's daunting process. Obviously this principle is in the best interest of the injured worker.

Our Society has seen in other contexts how guidelines can become de facto regulations, or even outright bans, on physician practices. At times, this is due to insurer reimbursement activities that deny payment for necessary and proper treatment that just happens to be more than they wish to pay. The POS does not want HB 1800 to become a tool for any player in the WC system to dictate the type of care provided to injured workers.

A troubling provision of HB 1800 is the language on page 4, line 2. Currently in utilization review, the moving party is the employer or insurer. HB 1800, however, shifts this burden to the injured worker. Our concern with this burden shifting provision is that employers or insurers will be in the position of dictating care to injured workers and the physicians who treat them. In fact, the bill reads in relevant part, "An injured worker may challenge **an employer's determination** of reasonableness or necessity" (bold added). The POS firmly believes that

employers or insurers are in the least able position to determine the reasonableness or necessity of medical treatment. Employers already have the authority to require injured workers to seek care from employer-selected provider panels for 90 days. Giving employers the authority to select care and forcing injured workers to contest employers' determinations is inappropriate in regard to the delivery of quality care and will inevitably lead to more frequent and protracted litigation.

As you continue your review of HB 1800, please consider these relevant facts which demonstrate that Pennsylvania physician costs are lower relative to other states according to the Workers' Compensation Research Institute's *Medical Benchmarks for Pennsylvania*, October, 2015:

- Of 17 study states, the average physician payment per claim of the median state was $4357. Pennsylvania ranked 15th of the 17 with an average payment per claim of $3605. However, Pennsylvania's average payment ranks for chiropractic and physical therapy were 1 and 4, respectively. The average chiropractic claim for Pennsylvania was $3619 while the median state was $1619. The average physical therapy claim for Pennsylvania was $3648 while the median state was $2719.

- Of 17 states studied, Pennsylvania has the 3rd highest average payment per claim for physical medicine. But for two of the most commonly provided physician services -- Major Surgery and Evaluation & Management - Pennsylvania ranks 13.

As you can see, the physician compensation component of Pennsylvania WC is well below what you may expect. POS members pride themselves on delivering the highest quality care within a reasonable reimbursement system. We hope to continue to do so.

The POS believes it is important to remember that HB 1800's provisions would affect a limited number of cases; those cases in which medical treatment is in

dispute. The creation of treatment guidelines, however, may have a larger impact upon the WC system depending on how employers and insurers decide to use them to determine the reasonableness and necessity of treatment. We ask the Committee to carefully consider our concerns as you review HB 1800.

In conclusion, the POS stands ready to work with Representative Mackenzie and this committee to craft reasonable and effective legislation regarding WC treatment guidelines. Thank you for the opportunity to be here today.

PENNSYLVANNIA CHIROPRACTIC ASSOCIATION

RECOMMENDATIONS: The PCA formally opposes any adoption of Evidence Based Medical Treatment due to the failures of HB1800 to address how the PA Worker's Compensation plan will address known inherent flaws of EMBT. These concerns include but are not limited to the flare to address all forms of research bias, industry financial supportive evidence selection bias, and the clear guidelines on which research and criteria will apply in both treatment and in the URO / PRO processes, a method of clear standardization across all carriers in the marketplace so doctors do not have different standards for each carrier, etc. We feel the current HB1800 is too vague and allows selection bias in favor of insurance carrier financial bottom lines over healthcare provider's knowledge and individual case judgment which will ultimately affect patient's quality of care and safety. The concern is HB1800 will instead continue to drive up costs, restrict access to patient care choices, and allow the industry unfettered abuse of the URO system to deny care to providers after the fact with no course for reimbursement eventually driving providers out of the worker's compensation system and limiting patient access to quality care. The PCA feels that EBMT is being introduced too fast, that it's not ready yet in the current form, and that when the day comes it should be written to include a Conservative Care First approach, written into the bill.

Excerpt from HB1800:

(i) For purposes of this section, reasonable and necessary treatments, services, products or accommodations shall be those treatments, services, products or accommodations that are consistent with or recommended by ***evidence-based medical treatment*** *guidelines selected and referenced by the department by publication in the Pennsylvania Bulletin.*

PCA Commentary:

"**Evidence Based Medical Treatment**" or **EBMT** is the new key catch phrase that is sweeping the nation in the post **Affordable Care Act** whirlwind of cost savings strategies. This is at the heart of the entire problem with HB1800, the assumption that good research driven medical evidence will improve all health care thru reducing costs through efficiency, all the while improving patient outcomes. What doctor, nurse or patient wouldn't stand up and cheer at the notion of a streamlined cutting edged science founded system that delivers on these idealistic goals! However, like all things, the devil is in the details.

More importantly WHICH details are chosen, WHO chose them, and WHO funded the research.

First let us define the word "evidence":
1) the available body of facts or information indicating whether a belief or proposition is true or valid.
2) that which tends to prove or disprove something; ground for belief; proof.

Most people would agree that all quality health care treatment should be based on research EVIDENCE and on science, whenever possible. Good medical practice is not just an "art" but an applied science that takes all available knowledge into consideration and applies it to the individual patient using careful judgment, compassion, patient input and some general common sense. **EBMT is a worthy goal**; but as currently implemented nationwide, has fallen short of its potential... and as currently written HB1800's poor implementation will be no better.

We have already seen the failures of previous EBMT in the commonwealth and across the United States, to the tune of billions of dollars in unintended consequences. It's first nationwide failure, created the massive resurgence of Heroin.

A few years back the evidence pointed to the miracle of opioid medications for pain management, and doctors often driven by insurance requirements to write more and more scripts as industry guidelines attempted to reduce other more costly treatments like surgery or therapy. The so called "evidence" was at the time touted opioid medications as the solution to ALL the pain problems of Americans were facing from cancer to back pain. The rules were created, standards adopted, and off we went on a noble experiment based in research and evidence.

This was explored in a 2011 article, **The Doctor's Dilemma: opiate analgesics and chronic pain**, detailing the history of how the opioid epidemic exploded based on funded scientific research, "Those practitioners who favor broader acceptance of use for chronic non-malignant pain (e.g. low back pain, neuropathic pain) argue that it is unconscionable to withhold adequate treatment from any patient complaining of severe pain, whatever the cause. Furthermore, they assert that addiction is rare when opioid analgesics are used appropriately (e.g. Edlund et al. (2007)." [1]