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ASSEMBLY COMMITTEE ON WAYS AND MEANS
AND
SENATE COMMITTEE ON FINANCE

LEGISLATIVE PUBLIC HEARING TESTIMONY
HUMAN SERVICES

GOVERNOR'S PROPOSED BUDGET FOR STATE FISCAL YEAR 2016-2017

ON

TUESDAY, FEBRUARY 9, 2016

AT

LEGISLATIVE OFFICE BUILDING, HEARING ROOM B

ALBANY, NEW YORK

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My name is Jeffrey Lozman, M.D., President for the New York State Society of Orthopaedic Surgeons, Inc (NYSSOS). On behalf of NYSSOS and the 1,600 physicians, fellows and residents we represent, let me thank you for providing us with this opportunity to present our views on the sweeping changes to the Workers' Compensation program as proposed in the Governor's Budget. NYSSOS maintains a specific focus on improving access to care, promoting public health and facilitating improvement of patient safety and quality of care. Respectfully, this is the lens through which we will provide our comments.

Workers compensation represents an important and major component of New York's health care system. OSHA estimates that work-related musculoskeletal disorders in the United States account for over 600,000 injuries and illnesses that are serious enough to result in days away from work (34 percent of all lost workday injuries reported to the Bureau of Labor Statistics (BLS)). These disorders now account for one out of every three dollars spent on workers' compensation. It is estimated that employers spend as much as \$15-\$18 billion a year on direct costs for MSD-related workers' compensation, and up to three to four times that much for indirect costs, such as those associated with hiring and training replacement workers.

A U.S. Department of Health study showed that from 1996 to 2004 managing musculoskeletal disease, including lost wages, cost an average \$850 billion annually, making it the largest workers' compensation expense. For employers paying workers' compensation claims, the economic strain has reached a tipping point. How significant is this specific category of injuries? Consider:

- 80 percent of all claims under workers' compensation are musculoskeletal sprain/strain injuries, with lower back injury consuming more than 33 percent of every workers' compensation dollar.
- Back pain causes more than 314 million bed days and 187 million lost work days yearly (data from the U.S. Department of Labor, 1998 to 2005).

Nearly all orthopaedic surgeons treat workers compensation patients. NYSSOS believes that properly designed and efficiently run workers compensation managed care programs can provide high-quality health care to injured workers and minimize their disabilities.

The proposed changes in the Governor's Executive budget seek to ensure the system provides more timely and appropriate medical and wage replacement benefits to workers; provide broader and more accessible options for medical care; make hearings more accessible through flexible scheduling and use of virtual hearings; and streamline Workers' Compensation Board processes and administration to expedite decision making.

While we support these general concepts, we are concerned several of the proposals will result in broad authority of the Workers' Compensation Board in decision making without oversight and continued marginalization of physician participation in the program. This type of shift has grave potential to negatively impact access to care for the injured worker.

The proposals of specific concern include provisions that would:

- Expand existing categories of health care providers
- Create an authorization agreement without specification
- Remove the role of medical societies not only from the approval process but for removal of providers from the system
- Extend the opt-out period from employer-selected Preferred Provider Organization from 30 days to 120 days.

Training and Education

I would like to take this opportunity to review the level of training and education that clearly establishes why Orthopaedics is the specialty best positioned to treat injured workers.

Orthopaedics is the medical specialty that focuses specifically on injuries and diseases of the body's musculoskeletal system. This complex system includes bones, joints, ligaments, tendons, muscles, and nerves and allows one to move, work and be active.

Orthopaedic Surgeons manage special problems of the musculoskeletal system including:

- Diagnosis of an injury or disorder

- Treatment with medication, exercise, surgery or other treatment plans
- Rehabilitation by recommending exercises or physical therapy to restore movement, strength and function
- Prevention with information and treatment plans to prevent injury or slow the progression of diseases

While orthopaedic surgeons are familiar with all aspects of the musculoskeletal system, many orthopaedists specialize in certain areas, such as the shoulder, spine, hip, knee, hand or foot. They may also choose to focus on specific fields like joint replacement, trauma or sports medicine. Some orthopaedic surgeons may specialize in several areas.

An orthopaedic surgeon completes up to 14 years of formal education:

- Four years of study in a college or university
- Four years of study in medical school
- Five years of study in orthopaedic residency at a major medical center
- One optional year of specialized fellowship education

The New York State Society of Orthopaedic Surgeons represents physicians who best serve injured workers with the highest quality of care and provide easy accessibility. According to the American Academy of Orthopaedic Surgeons, musculoskeletal injury accounts for 30% of all workplace injuries requiring time away from work and is the leading cause of disability claims. Orthopaedic surgeons and our treatments enable injured workers with sometimes devastating injuries to return to the workforce, improve and restore function, and foster active lives.

Orthopaedic Value

Musculoskeletal (MSK) disorders can result in pain, loss of active lifestyles and the inability to return to the workforce, and decline in mental health. Working with orthopaedic specialists, patients who experience these injuries must decide what treatment option(s) will work for them, both financially and physically.

Studies have shown that **early** intervention by an orthopaedic surgeon for musculoskeletal injuries decreases the overall cost of care by allowing the musculoskeletal expert to develop a

treatment plan that may or may not involve surgery. Studies also show that **delays** in direct, appropriate care can result in high percentages of patients not returning to work, essentially increasing costs to the overall system. For instance, literature shows that if a spine patient is out of work for 6 months, there is only a 50% chance that he/she will return to work.

Patients are not the only ones affected by these injuries — there is a cost and a benefit to the society for each treatment. Researchers from IHS Global Inc. and KNG Health Consulting are working to uncover the costs and savings of common procedures and services.

This information — the indirect economic impact, combined with the patient’s quality of life and the direct medical costs — is needed to fully understand the net value of treatment options available.

The results of these value studies provide a more comprehensive picture of the value of orthopaedic treatment, enabling patients and their families to further weigh all factors when determining which course of treatment is best. Research clearly documents the value of orthopaedic care to the injured worker.

For instance:

- Savings to society for Total Knee Arthroscopy varies from \$10,000-\$30,000 per patient depending on age with younger patients getting more benefit. Most of the value accrues to the patient and employer. *Source: Ruiz JBJS 2013*
- Average savings to society for rotator cuff repair was \$13,771 compared to non-operative care. The range of benefit is valued at \$77,662-\$11,997 depending on age with younger patients generating more benefit. *Source: Mather JBJS 2013*
- Workers treated with surgery vs non-operative care missed less work (7.6 v 10.6 days).
Source: Koenig CORR 2014
- In the short to intermediate term, ACL reconstruction was both less costly (a cost reduction of \$4503) and more effective (a QALY gain of 0.18) compared with

rehabilitation. In the long term, the mean lifetime cost to society for a typical patient undergoing ACL reconstruction was \$38,121 compared with \$88,538 for rehabilitation. ACL reconstruction resulted in a mean incremental cost savings of \$50,417 while providing an incremental QALY gain of 0.72 compared with rehabilitation. Effectiveness gains were driven by the higher probability of an unstable knee and associated lower utility in the rehabilitation group. Results were most sensitive to the rate of knee instability after initial rehabilitation. *Source: JBJS 2013 95 (19) 1751-9*

Budget Concerns

The Executive Budget would now define providers in the system to include: acupuncturists, chiropractors, nurse practitioners, occupational therapists, physical therapists, physician's assistants, podiatrists, psychologists, and clinical social worker. Clarification as to how these non-physicians will coordinate with other practitioners when these patients are in need of specialized care is crucial.

The proposal would not only expand the categories of health care providers to include nurse practitioners, physician's assistants and clinical social workers, but it would also permit those particular providers to render treatments and offer opinions on issues such as casual relationship of the injury to the accident and level of disability. Again, clarification is needed if these non-physicians will serve as independent medical examiners with the ability to contradict recommendations of an injured worker's treating physician.

In addition, provisions in the proposed budget will expand the use of employer-selected Preferred Provider Organizations by extending the opt-out period for workers from 30 days to 120 days. These extensions will undoubtedly adversely impact the injured worker creating unnecessary delays in care, resulting in extended patient suffering, patient safety concerns, and overall increased costs to the health care system.

Injured workers gave up the right to sue their employers in exchange for high quality care that restores function and returns them to work. There is no clarity as to how this broad expansion of providers and opt-out period will increase direct access to the high quality care provided to these patients. Rather it leaves tremendous uncertainty as to how these non-physicians will coordinate patient care delivery and only dilutes the care received by injured workers.

The proposal goes on to expand the Workers' Compensation Board's authority with the creation of an "authorization agreement" between providers and the Workers' Compensation Board. The agreement will permit the provider to render treatment and require the providers to abide by the terms, condition and limitations outlined in the agreement or face steep fines. However, the contents of the authorization agreement are not defined in the Budget.

In addition, the budget language changes the traditional working relationship that exists for medical societies to recommend physicians or independent medical examiners into the program, an important peer-reviewed function of the community. It also will eliminate their working relationship with the Department of Education to remove physicians from the program when appropriate.

We have significant concerns this type of broad authority may result in unilateral decisions not in the best interest of the patient or his/her treating physicians. This centralization of power, in concert with the imposition of the Board's Medical Treatment Guidelines, relegates the care delivered to these patients and ultimately marginalizes the role of physicians.

Administrative Challenges

The treatment of these injured workers is often complicated and fraught with volumes of administrative challenges to both the surgeon and the surgeon's administrative staff resulting in an increase of administrative costs to take care of this population compared to Medicare, commercial, or traditional insurance.

They require (including but not limited to):

- Increased staff time to complete forms, authorizations and Medical Treatment Guidelines.
- Increased physician time to document and establish work injury.
- Navigating the billing and customer service departments of a multitude of Worker's Compensation insurance carriers.
- Increased staffing and resources to follow up on receivables. These expenses are markedly higher than for commercial patients.

- There is burdensome clarification of claims, controverted status, billing and insurance information.
- There is uncertainty over coverage, payment, and coordination of benefits among carriers.
- Unbillable and unreimbursed physician and staff time dedicated to dealing with attorneys, carriers, employers and the Workers Compensation Board each of which are all extensive.

According to a survey conducted by the New York State Society of Orthopaedic Surgeons, Inc., participants stated that their offices spend more than 4 hours a day on administrative time directly related to Workers Compensation patients alone.

In addition, a survey conducted by the Medical Society of the State of New York (where more than 50% of the respondents identified themselves as orthopaedic surgeons) showed that:

- Over 80% of the responding physicians indicated that treating injured workers takes **at least** twice the time as other patients, and over 40% indicate that it takes **more than** double the time;
- Nearly 90% of responding physicians indicated that administrative tasks associated with treating injured workers, for physicians and their staff, take **at least** double the time, with nearly 60% indicating that it takes **more than** double the time.

For example, a large practice in the Capital Region area has indicated that Workers Compensation patients make up approximately 8% of their total patient visits for the year. With 18 employees in their billing office, 6 of them (more than 1/3) work solely on Workers Compensation patients and billing.

To fully appreciate the complexity of the Workers Compensation system, we invite you and your staff to visit one of our leadership's practices and experience the process firsthand.

Budget Concerns

The Executive Budget proposal does not speak to any of these issues. Orthopaedists have clearly identified these administrative challenges as primary reasons for resigning from the program. In recognition of the above, the Workers Compensation fee schedule has offset the costs through higher reimbursements in comparison to commercial, private, Medicare and Medicaid health plans despite no fee enhancements for many years even to account for the cost of living.

While, NYSSOS continues to work proactively with the Workers' Compensation Board to address these issues and protect patient access, we are concerned that the current proposals may only exasperate the overall frustrations, increase access to care issues, and adversely impact the current fee schedule which offsets a proportion of the overall costs.

The American Academy of Orthopaedic Surgeons (AAOS), our parent association, has released a paper entitled, "*Reductions in Workers Compensation Fee Schedules Threaten Patient Access to Quality Care,*" highlighting studies that show in every state that adopted a low Resource Based Relative Value System (RBRVS) fee schedule, they experienced immediate and long-standing negative impacts on access and quality of care.

In its' paper, AAOS cites that in every one of the states with low-multiple fee schedules, less than half of private practice orthopaedist offices are willing to treat workers' compensation patients at the mandated fee schedule amount.

Specifically:

- In Texas, three-quarters (77%) of orthopedists now limit Workers Compensation cases.
- In Florida physician participation declined significantly within 2 years after a reduction in fee schedules.
- In Hawaii, now 10 years since the decrease, less than 25% of specialists accept Workers Compensation patients.

According to a survey conducted by the New York State Society of Orthopaedic Surgeons, Inc., 82% of the orthopedic surgeons responded that they will be less likely to see Workers

Compensation patients if New York's Workers Compensation fee schedule was reduced to 130% of Medicare.

In addition, we have received tremendous feedback from orthopaedic surgeons across the state in the form of phone calls and letters indicating their concerns and requests for more information on how to resign from the Workers Compensation program.

In discussions with other executives representing orthopaedic surgeons across the country, we have learned that since South Carolina and Florida adopted the RBRVS fee schedule, surgical reimbursement continues to decline.

In Florida, where there is a higher multiplier/conversion factor for surgical codes, those rates still have not kept pace with how most other states reimburse surgical procedures under workers compensation. The Workers Compensation fee schedule in Florida has not been updated for six years and orthopaedists can anticipate further reductions next time an update occurs which continues to limit access to appropriate specialty care.

In South Carolina, the state has denied a separate conversion factor for surgical codes, and since RBRVS has been reducing surgical values in general over the last few years, the surgical reimbursement has continued to be reduced when compared to other codes (primary care, physical medicine, etc.).

They have not updated the South Carolina workers compensation fee schedule in 3 years and the next time they do, if there is no separate conversion factor, they anticipate the surgical codes to be reduced.

Simply, there are no time inputs in RBRVS for any of the activities associated with treating Workers' Compensation patients regarding increased paperwork and other services required of treating physicians. This alone should discount RBRVS as a reasonable methodology for valuing operative services. Workers' Compensation patients are not Medicare patients. RBRVS has no relation at all to the work necessary to treat Workers' Compensation patients and we continue to strongly recommend it should not be used as the standard for New York State's Workers Compensation fee schedule.

Quality of Care

A reduction in fee schedules also threatens patient access to quality care because physicians who do accept workers' compensation patients under low-multiple fee schedules tend to be less qualified, as demonstrated by board certification and education.

According to the American Academy of Orthopaedic Surgeons:

- Only 33% of those who continue to accept workers compensation patients in Texas and West Virginia attended a U.S. medical school and are board-certified.
- A reduction or loss of access to those providers with experience and expertise in certain specialties reduces the chance of receiving high quality care.

Conclusion and Recommendations

Thank you for allowing me, on behalf of the New York State Society of Orthopaedic Surgeons, Inc., to identify our concerns and suggestions for your consideration as you examine the proposed changes to the Workers' Compensation Program. Again, we invite you to experience the challenges first-hand in one of our leadership's practices.

To summarize, Orthopaedic surgeons and orthopaedic treatment facilitate the recovery of injured workers. The value of orthopaedic care provides indirect and direct economic impacts to the society as a whole because orthopaedic surgeons return people to the workforce when appropriate.

The expansions in non-physician providers and opt-out periods will undoubtedly adversely impact the injured worker creating unnecessary delays in care, resulting in extended patient suffering, patient safety concerns, and overall increased costs to the health care system.

We have significant concerns this type of broad authority granted to the Workers' Compensation Board may result in unilateral decisions not in the best interest of the patient or his/her treating physicians. This centralization of power, in concert with the imposition of the Board's Medical Treatment Guidelines, relegates the care delivered to these patients and ultimately marginalizes the role of physician.

The treatment of these patients is fraught with volumes of complicated and non-streamlined administrative challenges resulting in 2.5 to 3 times the hourly practice expense of Medicare patients.

The additional administrative and regulatory burdens associated with workers' compensation cases are often too cumbersome for physicians to justify insufficient compensation. The effects on access would be **immediate and long-standing**.

We strongly recommend reforms that preserve access to the physicians most qualified to care for injured workers. We do not believe that the New York State Workers Compensation Business Reengineering Process has adequately addressed these concerns with orthopaedists and other interested stakeholders.

The orthopedic community has spoken in no uncertain terms. We fear the proposal will result in access to care issues and poorer quality of care. This is the very opposite of the Workers Compensation mission and all those who have a vested interest in getting the injured patient back to a healthy, active and productive lifestyle.