Texas Association of Accredited Pain Programs

Promoting a Higher Standard of Care for Texas' Rehabilitation Programs

March 25, 2004

Chairman Todd Staples
Members of the Committee
Senate Select Interim Committee on Workers' Compensation

Regarding: Public Testimony; Committee Charges Four and Five

Dear Chairman Staples, Committee Members, and Staff,

Please accept this letter as written testimony of Mr. Greg Garland as President of the Texas Association of Accredited Pain Programs (or TAAPP). I thank the Committee for allowing me to provide input on this important issue on behalf of my Association. As an association of health care providers, almost all of our members have two roles in the workers' compensation system-as purchasers of workers' compensation insurance for our employees and as medical providers to injured workers.

About the Association: TAAPP is a statewide, non-profit corporation comprised of CARF-accredited providers of hterdisciplinary Pain Rehabilitation (IPR). As credible, nationally accredited providers of IPR, our organization is working to encourage quality, outcome-based care in our industry through the development and promotion of unambiguous Quality Assurance Standards.

About the Problem: TAAPP developed out of a growing concern among CARF accredited providers that many substandard programs were being created in Texas and were being aggressively marketed in workers' compensation. Many of these accredited providers of IPR had watched during the mid 1990's as small, usually D.C. based clinics that were inadequately staffed and over utilized had developed Work Hardening programs. During this period, the "high profit" type of Work Hardening program became predominant in the Texas Workers' Compensation system. You may have heard examples of some of these programs: a bus picks up 25 or 30 workers' compensation patients from various clinics and transports them to a rented Quality Inn hotel swimming pool for a "group physical therapy/exercise program" largely unsupervised therapy that

is billable under WC at $64/hour. Thirty patients for three hours in the pool, 3 days a week, generate $17,280 in billings for the clinic! Our concern was that the same fast growth of dubious Work Hardening Programs that occurred during the mid 1990's was going to occur in IPR.

The consensus among TAAPP members is that the massive growth of substandard pain programs that we had feared has now occurred. The biggest problem we're all dealing with is bad competition. Many facilities in Texas, who historically have focused on charge generation as opposed to quality care, have realized that they can bill a "Chronic Pain Program" if they plug in the right clinical specialties. In Dallas and around the state, we now have "drop by clinicians" (MD, PT, OT, Psyc.) that stop briefly at these facilities, provide a modicum of care, sign notes and move on to the next "pain program". This allows these facilities to bill $125 per hour for a program without providing true interdisciplinary care. And the money they save by not having adequate clinical staffing they spend on advertising for more patients. Most significantly, the patients who are run through these high profit programs are not going to get a second opportunity to obtain services from a quality provider. These patients are left with little or no improvement, angry case managers and employers, and very little hope of overcoming their maladies and becoming productive. Chronic pain patients when left improperly rehabilitated, shift their ongoing care to their families, local health services (uncompensated), and to local and federal financial assistance programs. The result is the worst of all worlds, unreasonable and unproductive expense to employers and long-term burdens on families and local community services.

The growth of these high profit providers is unchecked. At a recent Texas Chiropractic Association meeting in Dallas, a crowd of approximately 60 was asked, "How many of you are operating a chronic pain program?" to which more than half replied in the affirmative, most of whom were running the program periodically with contractors when they could "gather enough patients," When pressed as to why they would run such makeshift programs, the general reply was that the new Medical Fee Guideline had cut their fees, and they had to make up the revenue somehow.

About Solutions to TAAPP Recognized Problems: For two years TAAPP has been working on Quality Assurance Standards that, if adopted by the workers' compensation system, would eliminate most of these substandard programs. Specifically, TAAPP requires of its membership and is promoting as a TWCC requirement for providing these services, Quality Assurance Standards in the following areas:

- CARF Accreditation
- PLUS
    - Standardized Outcomes Reporting
    - Pain Team Clinical Requirements – **full time and on site**
    - Patient / Clinical Staffing Ratios
    - Patient / Treatment Area Ratios
    - Pain Team Consistency, Integration and Experience

TAAPP believes that CARF accreditation is an excellent starting point, but that additional Quality Assurance requirements are critical to insure high quality patient outcomes. Our "CARF Plus Approach" to quality standards has been developed with the participation of 84% of the states' CARF accredited IPR programs. Additionally, we have sought input from the insurance industry by having IPR pre-authorization doctors participate in our standards development process. We believe, and seem to be supported in our belief, that our interests are very much in line with the interests of the TWCC, the insurance industry, the business community, and ultimately, the patients served by the state's IPR programs. We would welcome an opportunity share the details of our Quality Assurance Standards and several proposed implementation strategies with the committee.

In addition to our Quality Assurance Standards, we are also developing the following initiatives that would further promote quality and insure effective programs for the state's injured workers:

- Work to **expand the TAAPP concepts** of Quality Assurance Standards, etc., to all Return to Work Programs (Work Hardening/Conditioning, Outpatient Medical Rehabilitation). We have developed Quality Assurance Standards for these other programs and are currently in the process of sending out applications to facilities that have these other CARF accredited Return to Work programs.

- Evaluate with the goal of endorsement of ***nationally recognized treatment algorithm/guidelines*** for Return to Work Programs that will reduce some of the unnecessary care seen today and reduce disputes regarding necessary care.

- Work to ***standardize outcomes reporting*** and set up an independent agent, possibly a university, to evaluate and report on these outcomes to insure that workers' compensation payers get good bang for their bucks.

- Evaluate the possibility of ***pre-screening mechanisms*** (FCE and/or other admission criteria) by an independent entity for admission to programs.

TAAPP Input Regarding Cost-Containment Methods Being Considered:

- Choice of Doctor Should Remain with Worker: The Association strongly believes that a worker should continue to be allowed to select the doctor that provides care. Studies in Washington State and those conducted in Texas reflect higher satisfaction with care if the worker selected the doctor. Improving the quality of outcomes and reducing cost can be achieved by implementing the program standards suggested above and through aggressive monitoring of quality using the tools provided by HB 2600 by the agency responsible for administration of the WC system.

- Preauthorization Should Include a Peer to Peer Discussion of Patient's Needs rather than how a utilization review agent or carrier can save money by denying care. Achieving greater consistency in identifying patients that could benefit from Return to Work programs can be achieved by adopting guidelines for patient need/admission as discussed above, and by requiring preauthorization in a peer to peer setting, or through a timely independent review setting. Patient needs that are avoided by the workers' compensation system are simply being shifted to other social and health programs. Given that research in Texas demonstrates poorer return to work outcomes and longer use of medical care, we owe it to injured workers to use quality Return to Work programs to get them focused on productive, self-sustaining behaviors.

- Co-payments and Deductibles are rarely used in workers' compensation systems because of the underlying trade-off of patient and employer rights. The majority of occupationally injured workers' are typically living from paycheck to paycheck. Co-payments or deductibles would take money away from family necessities and workers would have to make choices about feeding the family or getting the care needed to regain health.

- Carrier or Payer Controlled Panels of Doctors within Network Structures: Networks and managed care organization discussions from previous legislative sessions have gotten a lot of attention. However, those discussions/models lacked adequate safeguards to insure a meaningful patient choice of doctors, and gave payers the right to empanel or select doctors aligned with the payer's cost cutting goals. As noted earlier, shifting needed care to local community heath services is not a good alternative, but it would certainly reduce WC costs. Although much of our non-occupational health care is delivered in a network environment today, many citizens lack confidence that the bottom line financial emphasis of HMO's is consistent with appropriate medical care decisions.

TAAPP Commitment to Quality and Availability as Resource to the Committee: TAAPP's greatest concern is that without implementing some kind of meaningful Quality Assurance Program, the lure of easy money will continue to promote the exponential growth of substandard, ineffectual programs, aggregate Return to Work Program outcomes will plummet, and the perceived value of these programs as an effective treatment option will be jeopardized. There is a substantial body of research that supports the fact that injured workers truly benefit from quality, interdisciplinary, outcome based rehabilitation programs. Substandard programs are a waste of money and deprive the patient of an opportunity to make meaningful improvement. TAAPP is currently compiling supporting research materials to share with the Committee.

What TAAPP is proposing through its Quality Assurance Standards is a way to:

1. **Control Costs** – by eliminating 30% to 50% of the existing Return to Work Programs that don't meet the standards and produce little or no healing or return to work, and

2. **Improve Quality** – by requiring all provider participants to meet a much higher standard of care and use standardized outcome reporting to measure results.

As an organization we would like to offer ourselves as a resource to the committee to work together in identifying solutions to the problems of poor quality and over utilization. Thank you for your time and consideration.

Sincerely,

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Enclosures: TAAPP Association Membership List