

Montana Workers' Compensation

The Perspective of the Treating Physician

Introduction

Perhaps more than any other segment of the healthcare arena, Workers' Compensation systems from New York to California are frustrating physicians, insurance carriers, injured workers, and employers alike. Physicians don't like working in the system, carriers don't like working with physicians who don't like the system, injured workers complain about delays in treatment and claim denials, and employers complain about rapidly escalating premiums. This short paper will describe the problem from the standpoint of the treating physician.

The Treating Physician

When a physician accepts a Workers' Compensation patient and agrees to become the "treating physician," the physician is agreeing to more than providing that patient with medical/surgical care for a specific problem. The treating physician is agreeing to become embroiled in what is often a legal battle, which entails responsibility for a patient's entire medical and economic future. The physician is really agreeing to accept responsibility for an "injured worker." Insurance carriers, employers, attorneys, and courts will subsequently look to the physician to answer, in a legally binding way, a wide variety of questions. The physicians' answers to these questions will have a great impact on an "injured worker's" future. Further, when injured workers find themselves in pain, unable to work, and subject to an unfriendly complex bureaucratic system they carry a substantially higher risk for emotional and psychological complication of the primary injury. The prolonged bureaucratic wrangling often delays treatment and increases the risk that patients develop yet another complication, specifically, a drug dependency. Moreover, injured workers are generally aware that there are lifestyle and economic consequences, which follow from how they report their symptoms to the treating physician. These social, emotional and psychiatric issues have a markedly detrimental impact on how these patients will respond to any particular treatment of the primary injury. There is ample scientific evidence that Workers' Compensation status is one of the most predictive pre-operative data points for adverse outcome with a wide variety of treatments. Thus, when a treating physician accepts a Workers' Compensation patient they know a priori that the patient is at high risk for below average response to treatment or even treatment failure. There are few things more burdensome to a physician than patients who are

in pain and not responding to treatment. Combine the increased difficulties associated with treating the primary injury with legal depositions and a raft of paperwork which lands on a physician's desk for months, even years following the treatment and it is a wonder that physicians have agreed to treat these patients at all. It is worth emphasizing here that medical care under the Workers' Compensation system is so dramatically different from other medical care that the patient/doctor relationship must be renamed the "treating physician/ injured worker" relationship.

Patient Advocate

For an injured worker, the physician represents the primary point of human contact for their journey through a bewildering maze of contending interests. When assuming this complex role, a treating physician must necessarily become the patient's advocate in each arena where he/she may be called to render an opinion on behalf of the injured worker. A physician's charge is always to do what is in a patient's best interest. This moral obligation cannot be confined only to medical treatments; it must extend into other socio-economic realities stemming from the disease. Further, a treating physician must regard the professional implications of their actions. A treating physician who renders a legal opinion that cuts against a patient's economic interests will severely damage that doctor/patient relationship which is the centerpiece of medicine. Disgruntled patients pose significantly increased medical malpractice liability and can damage a physician's reputation in the community.

Conflict of Interest

Many Workers' Compensation carriers will find contest over the causation of the patient's symptoms and the disease process, which requires treatment and interferes with their ability to work. In such cases, the treating physician is then called upon to determine "on a more probable than not basis" whether the disease was caused by events at work. The truth in these cases is often quite ambiguous. For example, a patient who obviously has longstanding arthritis of shoulder but minimal symptoms is injured at work. In this case the treating physician will be asked if the "injury" is responsible for the patient's subsequent reports of shoulder pain and need for surgery. If the physician believes that there is a causal relationship, the physician will then be asked to "proportion" the illness between the pre-existing condition and the "injury." In some cases, these difficult (if not impossible)

determinations will affect whether or not an injured worker has any insurance coverage for a disease process that may need costly treatment. Thus, given that physicians rarely turn away patients in need, treating physicians are frequently charged with making ambiguous judgments, which determine whether or not they will get paid for services rendered.

A second major conflict of interest arises after a patient has been treated. The treating physician is charged with determining whether a patient can return to “the time of injury job” or, for that matter, any type of employment. This decision-making entails review of job analyses, functional capacity evaluations, and answering letters from attorneys, carriers, employers, and government agencies. In many cases the injured worker is reporting failure of all treatments to relieve debilitating symptoms often without definite medical evidence to explain the failure. Such all too frequent circumstances place the physician in a serious bind. Despite an impression that a patient's reported symptoms and inability to function do not fit the objective clinical evidence, the physician is morally bound to document the patient's reports and act as the patient's advocate. For, a physician to call out such a discrepancy would violate the patient/doctor relationship and expose the physician to litigation and adverse effects on their reputation in the community.

Despite physician's best effort to make fair judgments, the conflict of interest described above should be obvious and concerning to anyone interested in Montana's Workers' Compensation system. The omnipresent conflicts of interest faced by physicians in this system dramatically increase the cognitive strain associated with treating injured workers. It has a markedly adverse effect on productivity and professional satisfaction.

Allegations of Profiteering

Montana currently enjoys the dubious honor of hosting one of the Nation's most dangerous workplaces. The strikingly high injury and death rate have been well documented. Surprisingly, the recent efforts by the Governor's Labor-Management Advisory Council (LMAC) and others to reform the Montana Workers' Compensation system have brought forth both explicit and implicit suggestions that physicians are responsible for the high cost of Workers' Compensation in Montana. There is evidence that the per injury medical service utilization rates in Montana are also higher than average. Rather than interpret these statistics as evidence that injured workers currently enjoy above average access to best possible

medical care, the LMAC has suggested that this is evidence of profiteering by doctors. That is, above average medical care with its attendant costs implies that physicians are acting in their own best interest rather than their patient's. The LMAC has suggested that physicians in Montana are over-incentivized and that reduced fee schedules will reduce medical service utilization to a more desirable level, the average. Physicians are aware of hallway chatter in the Capitol suggesting that the physicians are generating the high costs by performing surgeries for dubious indications and scheduling unnecessary office visits due to Workers' Compensation's relatively higher fee schedule. It is difficult to express the absurdity of this notion. As the foregoing discussion should make clear, the treating physician's experience is quite the reverse. The physician is frustrated by an inability to limit interactions with injured workers at the expense of other more satisfying patient interactions whose opportunity is lost.

Clinical Decision Making

When physicians evaluate patients, they must consider a wide variety of objective and subjective data pertaining to a specific clinical situation. They must consider subjective complaints, historical accounts, assessments of a patient's psychological condition, physical findings, laboratory data, radiographic data and their clinical experience in terms of their own ability to achieve a positive clinical outcome for a given clinical situation. Often the amalgam of all available data requires a very fine judgment. This is particularly true for surgeons who are considering an irreversible surgical intervention for pain. Given the fine granularity of case specific information required to make clinical decisions, physicians regard "treatment guidelines" from whatever source as a starting point for decision-making, not an endpoint. Montana's Department of Labor and Industry is currently in the process of implementing "Utilization and Treatment Guidelines" for Workers' Compensation, which in reality seeks to lower costs by preventing "medically unnecessary treatments." When a physician wishes to recommend treatment, which falls outside these guidelines, a physician will be required to enter a lengthy bureaucratic procedure to obtain approval from the insurance carrier. While potentially decreasing the number of treatments provided to injured workers, such a system will, of course, increase the cost of providing treatment for physicians. Importantly, the institution of "Utilization and Treatment Guidelines" will substantially aggravate Montana physician's already tenuous willingness to participate in the Workers' Compensation system.

Data Supports Rate Differentials

A brief review of provider rates in the region quite clearly demonstrates that other state

Workers' Compensation systems have found it necessary to compensate treating physicians at rates substantially higher than other providers working in the system. The foregoing discussion should make the justification for those rate differentials amply clear. For example, surgeons performing knee surgery are paid 429% of Medicare in Idaho, 351% of Medicare in Wyoming, 255% of Medicare in Colorado, and 211% of Medicare in California. Based on even a cursory overview of these figures it becomes clear that Montana treating physicians are currently paid quite poorly by regional standards at 174%.

Conclusions

People generally recognize the heavy responsibility which physicians assume when caring for patients, given the obvious implications for the patient's future. The massive additional burden, which physicians assume in the injured worker/treating physician relationship, has been overlooked. The weight of responsibility arising from the combination of an injured Worker's future physical health, emotional health, and economic future cannot be quantified. Although there is probably consensus amongst Montana physicians that Workers' Compensation needs reform, there is certainly consensus that the burden of that reform should not be borne almost exclusively by providers.

Most providers in the state of Montana would agree that our Workers' Compensation system is in need of reform. We would also agree that physician's working in the system in cooperation with the insurance carriers understand best how this system is working and where it is inefficient or failing. Any effort toward reform of this system must begin with input of those of us who live with the realities of Montana Workers' Compensation system.