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Transparency of Evidence

Evidence-based medicine gains momentum for cutting into the worst cases of workers' comp fraud, but is it enough? BY STEVE TUCKEY

Workers' compensation fraud comes in many flavors but probably the most costly and insidious takes place at the hands of the doctors, hospitals and other healthcare professionals who see the system ripe for the plucking rather than healing.

While out-and-out fraud remains a problem, grayer areas of so-called abuse or overutilization continue to vex payers, insurance companies and lawmakers eager to maintain the financial stability and integrity of the system that has protected workers for nearly a century.

Today, the trend toward the use of evidence-

based medicine (EBM) standards in determining medical treatments and procedures in the workers' compensation arena provides hope that some very costly and in some cases dangerous medical practices can be arrested.

California pioneered the use of EBM guidelines with landmark workers' compensation reform legislation passed in 2004. In November, New York will roll out its own set of guidelines that will attempt to eliminate not only the most egregious of fraudulent medical procedures but in the long run provide the best care possible.

Doug Markham, executive vice president for Columbus, Ohio-based Avizent Managed Care, said that EBM standards will not only fight fraud but, more importantly, will ensure that workers get the right care and are returned to work quickly.

He cautioned that the proper use of EBM

summary

- Evidence-based standards to determine medical treatments and procedures could significantly slow the incidence of fraud.
- Evidence-based medical treatment guidelines have been in place in the managed-care universe for some time; states are now moving in that direction in the workers' comp realm.
- Increasing EBM usage will impact only one area of medical fraud, even as the workers' comp sector is vulnerable to any number of medical-provider fraud gambits.

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- Six strategies to combat claims fraud, according to Peter Rousmaniere.
- Ernst & Young on claims.

guidelines is both an art and a science.

"The insights and experience of trained providers must not be ignored," said Markham. "There will be times when other factors come into play. But when we can apply scientific data and knowledge to injuries, we should."

As chairman of the California Fraud Assessment Commission, William Zachry sees the problem first hand on a day-to-day basis and helps guide state funds to state and county law enforcement officials to combat the dollar drain.

Claimant fraud may prove to be the most troublesome to employers since they tend to personally know the worker faking or exaggerating an injury for an extended vacation, Zachry said. "But it is not necessarily the biggest cost driver."

That honor, he asserted, belongs to the medical-provider fraud category, which can range from a back surgeon performing an unnecessary and possibly dangerous procedure simply because of its reimbursement potential, to a doctor charging for as many as four visits when only one took place.

"When we started, about 90 percent of arrests were for claimant fraud," Zachry said. "I would say that now 20 percent of arrests are for claimants, and the rest are for medical provider and employer fraud."

The number of arrests serve as only one data indicator for a problem that has proved difficult to quantify over the years, especially on a dollar basis.

A series of legislative reforms enacted in California five years ago that included the use of EBM guidelines, Zachry said, put a dent in the so-called "surgery mills" that had sprung up in the state over the years to take advantage of a lax utilization review protocol that had taken hold in the state.

"This was one of the worst frauds and abuses," Zachry said. "These people would get three or four surgeries when the first was unnecessary. They destroyed people's lives."

Managed-care consultant Joseph Paduda said that, in California prior to the 2004 reform, "medical necessity" would constitute whatever the treating provider said it was.

"So if the treating provider said you need two gold coins planted in your forehead, then that was deemed to be medically necessary," Paduda said.

With EBM, a specific procedure performed over a period of time gets varying results for a certain percentage of the time. These results are recorded for future reference by all stakeholders in the comp medical care arena. "You just can't say doctor so and so said it is good. The data has to support that," Paduda said.

Great variance can exist in chosen courses of treatment that, with the exception of the most egregious cases, does not necessarily indicate fraud. Paduda cited the fact that the back surgery rate for Naples, Fla., is five times as great as it is for Miami.

"That doesn't mean that is fraud. It just means there are different practice patterns," he said.

But the use of evidence-based guidelines will in the end smooth out such discrepancies along with doing away with the egregious cases of the fraudsters, who under previous guidelines could get away with just about anything.

Markham said there will always be certain types of fraud, particularly in the area of stress-related and musculoskeletal treatments, which will be hard to prove.

"However, as we get more data and studies, and as we in the industry share and communicate among ourselves, it becomes easier to identify, prove and address virtually all types of fraud," he said.

EBM FINALLY SPREADING

As for the rest of the nation, Paduda said that, while evidence-based medical treatment guidelines have been in place in the managed-care universe outside workers' comp for quite some time, states are now moving in that direction in the comp realm.

"New York is going in this direction and they

recently promulgated their guidelines. And other jurisdictions have come up with guidelines for final review," Paduda said. "So this is definitely something that is becoming more common."

It has taken some time for most states to get on the bandwagon for any number of reasons. Top on the list is the fact that the comp sector is such a relatively small part of the overall healthcare universe so there has not been any great impetus for change. The exception is California, where everything seems outsized, including the dollar amounts of medical fraud.

Markham said that EBM guidelines can only be effective when there is plenty of "E"—evidence—to back them up.

"The best evidence-based medicine programs can be developed by relying on the depth and breadth of experience—incorporating an average of 20 to 30 journal articles, research papers and studies to ensure there is a reliable and recognized consensus on optimal treatment approaches," he said.

Still, some employers may shy away for reliance on such data fearing litigation, for example, if an injured worker returns to work too soon and suffers a relapse.

"However, if we as an industry reach out to our

clients, to provide them with assurances and the education necessary to understand the role of EBM, we can overcome these concerns," Markham said.

Return-to-work guidelines, as opposed to medical treatment standards, today remain for the most part voluntary suggestions without the force of law. States can choose the Official Disability Guidelines, or those from the American College of Occupational and Environmental Medicine, or a combination of both, as was the case in New York.

Phil Denniston, president and publisher of the San Diego-area based ODG, said implementation of medical treatment standards will help speed care to injured workers because doctors will no longer have to worry about whether a procedure will be reimbursed.

Today, 23 states and Canadian provinces have adopted ODG standards, but listing an exact number of states that impose EBM rules can be tricky because there is no consensus as to what exactly constitutes standards, according to Paduda.

At the federal level, one of the main cost-control elements in the Obama healthcare reform proposal has been creation of a board, akin to the Federal Reserve Board, which can rule on standards used to determine treatments.

IN-DEPTH RISK & INSURANCE

Fighting the Dollar Drain A Three-Part Series

Over the next three issues Risk & Insurance® will take an in-depth look in a three-part series at the kinds of fraud plaguing the workers' compensation system around the country, and the steps being taken to uncover it and prosecute the wrongdoers.

Oct. 1, 2009

Part 1: Fraud and Medical Providers

Fraud and abuse practiced by medical providers will come under focus. Practices range from needless and dangerous operations performed on willing accomplice workers for their reimbursement potential, to problems in the pharmaceutical area including drug diversion for resale or recreational use. The report will examine how the use of evidence-based medicine (EBM) in California and other states has helped curbed the most egregious examples of abuse by ensuring that doctors justify their actions with available data. But EBM use faces challenges that include the lack of a standard set of evidence that all can agree should be the final word on reimbursement and the fact that different states use their own guidelines. Other practices that have recently come to light include billing both group health and workers' compensation carriers for the same procedures and doctoring medical records to make one visit look like four. In the pharmaceutical area, the report examines how the drug Embeda holds out some hope for cutting down on the recreational and resale use of workers' compensation drugs since it loses all potency once it is ground up.

Oct. 15, 2009

Part 2: Fraud and Employers

Employers rip off the workers' compensation carriers and the healthcare system in general too, through schemes that include failure to purchase comp coverage to misclassification of employees to reflect a payroll that has less risk of injury than otherwise would be the case. Some studies have indicated that overall employers have failed to report up to 20 percent of all employees to carriers. Since every employee, reported or not, obtains treatment if injured, the honest employers end paying the freight for the fraudsters through higher premiums. Misclassification, for example, would have an employer list 20 clerical workers and five roofers on the payroll, when in fact a reversal of the numbers would reflect the truth. Other schemes include classifying workers as independent contractors rather than employees when in fact they are for all intents and purposes employees. Such practices are particularly prevalent in the taxi and trucking industries. The report will also examine efforts by state insurance departments to track down those employers who are committing the most fraud in this area. Meanwhile, regulators are getting into the act which in some cases include failing to grant rate hikes to comp carriers unless they promise to carry out more vigilant anti-fraud efforts.

Nov. 1, 2009

Part 3: Fraud and Claimants

These articles will examine what most people think of when they think of workers' compensation fraud: claimant or worker fraud. Workers' comp expert Peter Rousmaniere estimates that so-called "red flags" for prosecutable fraud appear in about 5 percent of all lost time compensable claims. The first line of defense is the claims adjuster, who after spotting such a flag can alert the carrier's Special Investigations Unit or order surveillance, or both. One expert at a national carrier estimates that about 2 percent of all claims involve fraud from the outset in which a real injury may have been falsely connected to the workplace, for example. Plenty of opportunities for fraud and abuse exist during the life of the claim when the worker begins other employer or continues to fake physical and psychological impairment. One insurance carrier official said an investigator looks at about half of all lost time claims. Of the estimated third of those investigations that result in a denial of claim, a very small portion could be attributed directly to fraud. For every claim sent to prosecutors, at least ten fraud claims will be mitigated in the workers' compensation system, according to Rousmaniere.



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As a first step, Congress has already approved nearly \$2 billion in stimulus funds for so-called comparative effectiveness research studies. The end product could serve as the basis for the kind of federal EBM standards that may one day rule the roost when it comes to medical treatment decisions.

Paduda said it will be years, even more than a decade perhaps, before such standardization can make its way into the workers' compensation realm. Already, Denniston said, opposition has arisen from applicants' attorneys, who might see some financial loss if

overall settlements are reduced.

EBM IN ACTION

New York, however, has proved that does not have to be the case.

Brian Mittman, a claimant's attorney who co-chairs the worker advocacy group the New York Workers' Compensation Alliance, was quoted recently as saying the guidelines should speed up resolution of comp disputes, especially in cases where insurance companies resort to independent medical examinations (IME).

"The treatment guides will give us



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“Some payers don't do a very good job of tracking the pain medication that their claimants use.”

—Joseph Paduda, principal, Health Strategy Associates

Diverting Diversions

Will Embeda, an anti-chronic pain drug, provide the answer to drug diversion and compounding problems plaguing the workers' compensation drug distribution system?

In August, the U.S. Food and Drug Administration approved the use of the pain-relieving drug developed by King Pharmaceuticals that aims to foil abusers who want to grind it up for their own recreational use.

Dr. Nathaniel Katz, president of the Analgesic Research Institute at Tufts University, said the drug is the pain relief solution the industry has been waiting for in that it “employs technologies designed to reduce drug liking and euphoria associated with nonmedical uses.”

Managed care consultant Joseph Paduda said so-called drug diversion, or the sale or distribution of pain drugs obtained through the workers' compensation system for personal profit or recreational use, remains a challenge for a number of reasons.

“Some payers don't do a very good job of tracking the pain medication that their claimants use,” he said. “They don't mine the data to determine where there is more than one physician dispensing the same medication, or one physician dispensing multiple narcotic opioids.”

Paduda, principal of Health Strategy Associates, said Embeda was the “first script out there specifically aimed at drug diversion.” He believes it could gain acceptance in those areas of the country, such as the Appalachian states, where there is a real concern about the issue.

Compounding represents a different challenge to workers' compensation stakeholders seeking to keep a lid on rising medical costs.

It takes place when a physician orders a drug made of several different ingredients that is not available from a manufacturer but rather from pharmacies that have specialized in the profitable practice.

“One of the problems with compounding medications is that to my knowledge there has never been any peer reviewed medical research that has established their effectiveness,” Paduda said.

Because there is no established price, Paduda said, retail pharmacies charge what appears to be an “exorbitant” amount for these concoctions.

In Texas, the pharmacists are lobbying the Division of Workers' Compensation as it attempts to implement a legislative mandate to close the drug formulary, or list of approved drugs. They want to maintain the loose regulation of compounding but are facing opposition from the industry group Insurance Council of Texas (ICT).

“ICT members have reported that compounding has been an unnecessary system cost driver for prescription drug costs in other workers' compensation jurisdictions,” the council noted in its comments filed with the division, as reported by workcompcentral.com.

Furthermore, the group argued that the Texas workers' compensation system was not established for the purpose of funding research, training or chemical analysis. “Compounding should be an exception rather than a common practice when drugs are dispensed to injured workers in Texas,” the group said, and urged that all compounded drugs should be preauthorized.

William Zachry, chairman of the California Fraud Assessment Commission, said other drug-related fraud gambits include dispensing higher priced or no generic drugs when cheaper or generic equivalents exist. In addition, doctors dispensing sample drugs, or in general acting as their own pharmacy can lead to fraud and abuse scenarios.

Paduda said that advocates of the practice of doctors dispensing their own drugs will claim that the injured worker will get the pain relief much quicker. Critics noted, however, that prices of repackaged drugs can be up to 20 times greater than if they were purchased at a retail pharmacy.

The ICT also noted that the practice of doctors dispensing drugs is a significant trend in California and Florida and could impede efforts in Texas to impose a closed formulary if that trend migrates to the state in any significant way.

Although the group did not condemn the practice it did say, “the prescribing and dispensing of drugs are two separate and distinct acts that are most often undertaken by two different entities.”

—By Steve Tuckey

“WHEN WE STARTED, ABOUT 90 PERCENT OF ARRESTS WERE FOR CLAIMANT FRAUD. I WOULD SAY THAT NOW 20 PERCENT OF ARRESTS ARE FOR CLAIMANTS AND THE REST ARE FOR MEDICAL PROVIDER AND EMPLOYER FRAUD.”

—William Zachry, chairman, California Fraud Assessment Commission

a minimum standard so we can avoid IMEs and other garbage that comes up over little things in workers' compensation disputes," he said.

Denniston said that there has been some pushback in California, where some workers have not gotten proper treatment in the new regime.

"Doctors don't want cookbook medicine, but if it is done right, it should not be cookbook medicine," Denniston said. "There is no one treatment that everyone gets. There are a lot of treatments based on the medical evidence."

In Texas, doctors got behind the

EBM movement. "They used to talk about the workers' comp system in Texas in which a provider could do anything, but anything could be denied," Denniston said. "So with treatment guidelines, doctors know that if they do the right thing they will get paid. They don't have to wait



for, 'Mother, may I?'

Denniston said there are procedures where doctors can appeal for treatment outside the guidelines for certain patients but the overall ability to game the system is limited. Texas, like California, has had its share of abusive procedures.

Some chiropractors in the state would advertise in billboards that suggested that, for instance, if you were injured on the job, you could in essence get a two-year paid vacation.

"And they would do 100 treatments over two years and tell the guy he should never go back to work or he will be reinjured," Denniston said.

At the end of the two years, the money would run out. "And these people would by then be vegetables or drug addicts," he said.

ODG guidelines would limit such visits to fewer than 20, if they are proven to be working. "But you can't do 100," he said.

ITS LIMITS

The increased use of EBM guidelines will impact only one area of medical fraud, even as the workers' comp sector is vulnerable to any number of medical provider fraud gambits.

Consultant Doug McCoy said that some attorneys and medical providers are tempted to abuse the system because the insurance industry has not scrutinized workers' compensation medical claims as carefully as it has other medical costs.

"Under workers' comp, the rate of payment for hospitals, physicians, pharmaceuticals and other medical providers traditionally has been 50 percent higher than what has prevailed in employee benefits insurance," he said.

Insurers are still looking to technology in the effort to combat medical fraud, and the results for the most part have been mixed.

Boston-based Liberty Mutual Insurance Co. claims great success over the past several years in using its data-mining capabilities to weed out those providers who are not providing the most cost-efficient service to injured workers.

Michael Welch, manager of data analytics for Liberty Mutual, said that, in the spectrum from fraud to abuse to honest mistakes, so-called

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“upcoding” ranks in the least-offensive category. Nonetheless, it remains a costly trend that when corrected can save payers millions of dollars.

Welch defines upcoding as a pattern when a provider has an out-of-the-ordinary percentage of complex, costly visits. For example, a provider with an 80 percent rate of the costliest visits in his treatment schedule would raise a red flag.

This analysis comes after all the visits have been completed and billed for. So its main use is as an education tool for those providers who in the future can set their treatment schedule more within the norm. “We have had great results,” Welch said. “The providers we have talked to, quite a few of them have changed their behavior.”

In states that permit carriers to direct patient care, Welch said Liberty has the “stick” of no longer directing their patients to outlying providers. But in those states that don’t permit such direction, the carrier has to rely on the provider seeing eye to eye with the insurer to get results.

Zachry said that upcoding schemes can include scrambling the codes to imply that a single, one-hour office visit with four different procedures could actually be billed as four separate hour visits.

Welch said his data-mining system has not been designed to catch providers out to cheat the payers. Still, even if it were, technology can only do so much if the humans guiding it do not take the proper steps to use it to its best advantage.

Paduda has joined the chorus of many critics who believe the failure to connect the utilization review process that should weed out costly and ineffective procedure with the endgame bill review process has cost the industry millions.

“Workers’ comp payers spend hundreds of millions of dollars each year on medical management—precertification, utilization and peer review, case management and clinical guidelines and permutations thereof,” he said.

These payers range from so-called “mom and pop” shops to industry giants like Coventry and Genex.

What Paduda terms the “frightening, amazing and unconscionable truth” is that many nonapproved medical treatments are actually performed and billed for and likely paid because those determinations are not automatically fed into the bill review system’s database. Or the bill setup can’t link that determination to the bill or provider or claimant.

“How much of this actually occurs on a national basis is impossible to say, and there is no doubt some payers have the links in place to ensure most if not all medical management determinations are linked to the right claimant, provider and event,” he said.

Even where the link exists, it might not work very well. Or it may require a human to make the link, thereby increasing the opportunity for error, Paduda added.

“So the question remains how

much are payers spending on treatments that may not have been authorized, or were actually nonauthorized,” Paduda said.

Zachry said that much of medical fraud crime in the comp arena can be traced to the use of medical liens, which are often received months after the underlying case was concluded. “The problematic liens are generally medically related such as prescriptions, interpreters and sleep clinics and the like,” he said. “It is not unusual for the primary cases to settle at an amount far less than the liens which

were filed on the claim,” he said.

He asserted that for lien abuses to stop, at least in California, judges from the Workers’ Compensation Appeals Board need to look at them with greater skepticism.

“Whenever an unsupported lien is settled, it is only feeding the beast and allows the payment to be used in subsequent cases as evidence of what is generally paid within a geographic area,” he said.

Another ripe area for fraudsters is the practice of billing both the comp and group-health payer for the same treatment. One reputable study

indicates that such occurrences take place in 4 percent of comp medical billings, according to Zachry.

Zachry can take some satisfaction in that his state has the highest number of arrests and convictions for insurance fraud on a per capita basis. “But it is like playing whack-a-mole in that you whack them in one area and they just pop right up in another,” he said.

STEVE TUCKEY has written on insurance issues for a decade for several national media outlets. He can be reached at riskletters@lrp.com.



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