

Defining Documentation Requirements for Coding Quality Care in Workers' Compensation

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Every year in the United States, more than one million workplace injuries or illnesses occur that are severe enough to result in days lost from work.¹ Injured workers require medical care and careful attention to factors that will help them recover their ability to work, but American medical practice focuses on disease diagnosis and treatment and pays little attention to functional ability. In the workers' compensation arena, health care providers must address causation, functional impact, and return-to-work planning, issues that are not represented in the most widely used payment systems, which are based on codes and coding rules designed for primary care and other group practice settings. These coding rules fail to capture and incentivize the delivery of services that are critically important in the workers' compensation arena, while reimbursing other services that have little value.

The American College of Occupational and Environmental Medicine (ACOEM) supports modifying the rules for documentation of care in workers' compensation in order to provide reimbursement and other incentives to deliver care

that adheres to best practices, including focus on assessing and improving patient function. The recommended changes include alternative ground rules for documentation and coding evaluation and management encounters, physician case management services (E&M codes), and consultation services, as they relate to workers' compensation care. These alternative rules may be adopted by states or payers seeking to realign incentives toward improved functional and clinical outcomes and decreased costs.

The cost of disability due to reported work-related illnesses and injuries in the American workforce is very large.² In 2014, on the basis of data from the US Bureau of Labor Statistics, the rate of cases of a work-related illness or injury requiring at least 1 day away from work was 107 cases per 10,000 full-time workers among all US employers, totaling 1,157,410 cases; median days off work was 9 days, an increase by 1 day from the previous year.³ The actual impact is likely to be even higher, considering that as many as two-thirds of work injuries may go unreported, according to a 2009 report by the Government Accountability Office.⁴ The nation has unrealized opportunities to achieve substantial savings in the treatment of these injured workers, as well as better health outcomes.

Care for injured workers is provided via systems mandated by state and federal laws. Compensation to medical providers in those systems is based on payment paradigms that were designed for other purposes (primary care and group health), largely ignoring issues related to work and disability. At present, high value services in workers' compensation are frequently discouraged by lack of reimbursement.⁵ The resulting misalignment is a detriment to patient health outcomes, creates a serious barrier to best medical care, and is responsible for very large unnecessary medical and disability costs.

ACOEM proposes a number of changes to the current rules used for coding

and billing outpatient visits related to treating injuries and illnesses under workers' compensation and contends that such changes are likely to improve care and reduce overall costs by aligning appropriate payments with clinical quality. In particular, ACOEM recommends that state workers' compensation systems and/or workers' compensation carriers adopt improved documentation ground rules for many of the E&M codes, a subset of the Current Procedural Terminology (CPT) codes (CPT is a registered trademark of the American Medical Association). The College further recommends recognition of consultation codes [no longer recognized by Centers for Medicare and Medicaid Services (CMS) but still critically important in the workers' compensation arena], and case management codes, with new ground rules appropriate to workers' compensation care. Where there are no appropriate codes that could be applied with appropriate ground rules, new codes may be needed. A new work injury in an established patient would count as a new patient encounter. Adoption of these coding ground rules appropriate for workers' compensation care would take account of a worker's functional status, projected recovery, and other clinical details that are pivotal for the successful course of a workers' compensation case. All physicians who provide care in workers' compensation would then be encouraged to follow improved evidence-based practices when these changes are implemented.

WORKERS' COMPENSATION: A UNIQUE AND EXPENSIVE HYBRID SYSTEM

In the US, workers' compensation systems differ fundamentally from other health insurance systems in that they firmly entwine eligibility for medical care with disability compensation. Under workers' compensation systems, injured workers are entitled to medical care, wage loss replacement, and vocational retraining if needed and shown to be claim related.

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Workers' compensation is thus a unique hybrid of insurance that deals concurrently with both health and disability. Also, compared with other government-mandated social support systems, workers' compensation has two characteristics that make it substantially different.

First, workers' compensation systems fall under the jurisdiction of each state (a small fraction of workers fall under federal jurisdiction), but the costs are borne almost totally by employers, without significant government monetary contributions (other than for government employees). Second, private for-profit insurance companies administer most workers' compensation benefits, although certain workers receive their benefits from their own self-insured employer.

Only four states—North Dakota, Ohio, Washington, and Wyoming—have monopolistic state funds. In states with monopolistic state funds, all workers' compensation insurance is sold by a state-controlled entity. Most of the remaining 46 states also have nonmonopolistic state funds, which generally serve to administer the claims of failed insurance companies, and to insure risk classes that for-profit insurers would rather not insure.

Self-insured employers are typically large companies that can prove to state regulators that they have the financial capability of covering the benefits established by the laws of the respective states in which they exist. It also is not uncommon for governmental agencies to self-insure their own workers' compensation liability.

The number of dollars that flow through the various workers' compensation systems is enormous. According to a 2015 report by the National Academy of Social Insurance (NASI),⁶ in 2013, workers' compensation total benefits paid were \$63.6 billion, an increase of 8.2% over 2009, with the increase explained primarily by increases in covered employment. Medical payments to providers were \$31.5 billion, a 10.3% increase over 2009.

In addition to the direct costs of medical care for individual patients, the workers' compensation system has even larger economic effects due to wages paid to absent employees, high-cost replacement workers (overtime pay for other employees and/or temporary workers), and administrative costs of managing absenteeism.⁷ Moreover, the cost of unreported or untreated injuries further swells the true cost of occupational injury.

The annual cost to the American economy from illnesses and injuries covered under workers' compensation—including both direct costs and the indirect costs of lost productivity—accounts for at least 5% of payroll across the nation. The

unexplained variance in these costs is enormous, and many studies have demonstrated huge opportunities for improved disability management among the nation's health care providers. The potential savings resulting from optimal disability management combined with well targeted wellness programs may be as high as 10% of payroll using various strategies, including careful attention to evidence-based practice guidelines.^{8–12}

CLINICAL QUALITY INDICATORS IN WORKERS' COMPENSATION

Clinicians who treat patients under workers' compensation will typically need to focus on clinical factors that are of tangential importance in general health care. Conversely, some factors that are routine in general health care are irrelevant and might even be excluded from payment in workers' compensation. For example, the workers' compensation provider must often assess factors beyond the patient's immediate health status, including workplace exposures and forensic details related to the mechanism of a work injury, in order to determine causation (ie, whether a medical problem is work-related or not), and how best to return injured workers to the job and keep them functioning without further jeopardizing their own health or the health of coworkers. Accordingly, the workers' compensation provider must often gather information that other medical examinations disregard, and will apply specialized knowledge and skill in compiling and evaluating such information viewed by employers, per the Genetic Information Nondiscrimination Act (GINA). In the typical primary care encounter, there are no incentives for obtaining more occupational history than stating the patient's job, while in a workers' compensation related encounter, it can be critically important to determine the tasks, physical demands, environmental conditions, protective gear, etc.

Measuring the quality of care in a workers' compensation setting also requires separate quality metrics, which generally are not considered in general medical care.¹³ This issue was addressed in a report written by ACOEM in collaboration with the International Association of Industrial Accident Boards and Commissions (IAIABC).⁵ A prominent recommendation in that report was the need to compensate physicians for the additional time and expertise devoted to assessing medical causation and minimizing needless disability.

Outpatient medical care quality metrics used in primary care include patient

satisfaction, hospitalization rates, preventive services, and chronic disease management. Most of these metrics have very little relevance to workers' compensation visits, where the most value is found in the following areas, beyond diagnosis and appropriate treatment:

1. Clarity of documentation and rationale;
2. Causation analysis;
3. Functional assessment;
4. Return to work planning at each visit;
5. Use of evidence-based guidelines;
6. Assessment and mitigation of disability risk;
7. Communication and coordination with claims adjuster, employer, and possibly other treating providers.

Critical services, such as obtaining a detailed work history, evaluation of worksite ergonomics, and discussion with employers regarding purposeful return to work, are often unreimbursed under current workers' compensation systems. Conversely, noncontributory documentation, such as obtaining a detailed family history, is typically required for payment for specific levels of care based on documentation rules in general health plans, and hence, this documentation is carried over to workers' compensation practices that follow the same coding rules. This type of payment disconnect can lead to the provision of unnecessary services (with increased cost), while failing to obtain valuable information and provide other services beneficial for the injured worker and the employer.

Compensation influences provider behavior directly and indirectly. Whereas workers' compensation payment systems vary state-by-state, other health care reimbursement programs generally have national standards. Despite the structural differences between the two systems, many state-run workers' compensation programs adopt the documentation and coding rules used for general health care without regard to the differences discussed previously.

Indeed, the value of physician attention to disability prevention goes far beyond the realm of workers' compensation. Instituting an improved system to track and compensate such important data would deliver huge savings by preventing needless work disability in both the workers' compensation and general medicine realms.

Traditional medical encounters assign highest risk to threats to patient life or limb, and reimburse physicians for the cognitive work in managing these risks. There is research showing that chronic work disability is a risk factor for medical morbidity and early mortality.¹⁴ ACOEM

proposes adding the category of chronic work disability as a high-risk outcome, equivalent to loss of life or limb, in workers' compensation encounters, and recognizing the value of the cognitive work needed to recognize and manage this risk.

THE WAY IT IS NOW: CURRENT CODING AND REIMBURSEMENT MODELS

Workers injured on the job typically receive their medical care under state or federal workers' compensation laws specific to that jurisdiction. Although payment systems (fee schedules) for workers' compensation care vary by state/jurisdiction, the coding systems for billing for care are typically identical to those in use in general medicine. Current payment systems used in workers' compensation in the vast majority of jurisdictions are based on the Centers for Medicare and Medicaid Services rules ("CMS rules") for encounters using the AMA CPT coding system, which was designed for use in general medical care and does not address many important elements of workers' compensation. Payment calculations typically depend on coding rules for the E&M codes, promulgated for Medicare or Medicaid billing. Of note, these rules take no account of occupational exposures, functional capacity, work disability risk, or employment status. The resulting misalignment between these coding rules designed for other purposes and occupational medicine best practices has often hurt medical outcomes for injured workers, and has created barriers to improved health care quality and the provision of high value services, and has needlessly increased medical and disability costs.⁵

The rules for documenting and billing a specific E&M code for the office visit follow the same set of coding ground rules as does Medicare, published by CMS as the "Documentation Guidelines for Evaluation and Management Services" for either the 1995 or 1997 CPT manuals.¹⁵⁻¹⁷ In many jurisdictions, the health care provider is free to choose either the 1995 or 1997 documentation guidelines in preparing such bills (The 1995 CPT guidelines typically require a lower level of documentation to support a particular level of billing. By contrast, the 1997 CPT guidelines use a system of "bullets" for the physical examination, reflecting clinical details that must be documented in the clinical note, and then tabulated, in order to achieve a particular level of billing).

Under current CMS coding rules, the appropriate level of billing is determined by considering four factors: (1) the setting for the visit ("new" or "established" office patient, or other visit setting); (2) the extent

of the medical history; (3) the extent of the physical examination; and (4) the complexity of the "medical decision making" involved. We next consider several of these factors in the context of an outpatient visit under workers' compensation.

In considering the extent of the medical history, the medical provider's fee will depend on documenting several specific elements, including up to four to six specific details in the history of present illness, immunizations history, prior hospitalizations, the health status of near relatives, and the presence of hereditary diseases. But, under current coding rules, the level of history will not depend on or be enhanced if the provider gathers information about how a potentially work-related condition arose or how workplace conditions may affect the patient's ability to function. To be more specific, any mention of "occupational history," whether cursory or thorough, will count toward a "detailed" history under the CMS coding rules and will merit the same level of billing. As a result, information that is critical to the adjudication of a workers' compensation claim and return to function, including work status of others at home, history of adverse childhood experiences, job description, details of job tasks, personal protective equipment, job hazards, previous workers' compensation claims, strained relations with the employer, and career goals, are essentially unrecognized and unrewarded under these current coding rules.

Similarly, the coding rules for the complexity of the physical examination reward the documentation of certain examination elements, which are tabulated as "bullets." However, these "bullets" bear little correlation with established guidelines for treating common musculoskeletal work injuries. For example, for an examination of the lumbar spine, the 1997 CPT Guidelines allow one "bullet" for a "range-of-motion" examination, while the ACOEM *Practice Guidelines* specify that a low back examination should test range of motion in multiple directions.¹⁸ For a shoulder examination, the 1997 CPT Guidelines specify one "bullet" for a strength examination and one for a range-of-motion examination, while the ACOEM *Practice Guidelines* call for six measurements each for range-of-motion and strength against resistance.¹⁹ Furthermore, specific provocative tests after the first such test are given no weight in the CPT Guidelines. For example, a physician who documented several recommended neurological maneuvers in a patient with low back pain (such as a supine straight leg raise, seated straight leg raise, test for strength in the hallux extensors, and others) would receive only one "bullet" whether performing one such test or

multiple tests. Finally, certain "bulleted" elements explicitly mentioned in the CPT Guidelines, such as "station" and "stability" are poorly defined, and are not likely to be helpful for tracking the progress of an injury, compared with other measurements.

In determining the "complexity of medical decision making," the provider must weigh the risk of "complications and/or morbidity or mortality." Although the guidelines do not clarify the meaning of "morbidity" in this context, we contend that the possibility of delayed return-to-work constitutes a significant "morbidity" risk, as flawed decision-making about disability management even at the earliest visit is often associated with an appreciable risk of delayed recovery, with important implications for long-term function of the patient.¹³

Accordingly, a significant number of clinical elements that are critically important in clinical care provided under workers' compensation are not "rewarded" by the CPT coding rules, which means that providers are not paid any more or less if they include or exclude these elements. However, providers may include all of these important elements and a comprehensive examination related to the injured part of the body, but if they miss documentation of some elements irrelevant to most workers' compensation encounters (eg, complete review of systems or examination of parts of the body that are not relevant to the injury), the encounter may not be coded at a level that reflects the actual comprehensiveness of the examination. Medical providers may also be required to submit follow-up documentation to a workers' compensation carrier if the encounter notes do not provide sufficient information about work causation; usually, there is no additional fee offered for such additional documentation.

Quality practice in a workers' compensation setting requires the provider to deliver other services and perform other clinical tasks that currently have no relevant CPT codes at all. Accordingly, providers who perform tasks such as telephoning an employer, vocational/rehabilitation provider, or return-to-work coordinator regarding work restrictions, conducting a group case conference with multiple stakeholders, consulting a prescription drug database when renewing a prescription for opioid medications, or reviewing old medical reports or previous workers' compensation claims will often have no mechanism to bill for these services. These important case management activities, and others, are not included in the current rules for using case management and telephone service codes. In complex workers' compensation cases, it

is essential that a consultant explains the basis for his or her conclusions and the underlying thought processes. Some state systems and payers recognize the value of consultation codes and permit their use in workers' compensation. However, consultation codes have been eliminated from CMS payment, and are not recognized in many workers' compensation payment systems. This removes an important option for coding when doing work involving medical-legal decisions about causation in disputed workers' compensation cases.

Current payment systems query the reason for an encounter, but largely do not value a detailed history of how the condition arose, its cause as related by the patient or other sources, or significant information regarding the patient's work. Current payment systems include in-depth capture of immunizations, prior hospitalizations, health status of near relatives, and hereditary diseases, but lack focus on any correlation to the current reported work injury. Some of this information (such as family health history) is not only largely irrelevant, but actually may be illegal to report in an employment-related venue due to federal Genetic Information Nondiscrimination Act (GINA) that "prohibits use of genetic information in employment decision-making, restricts acquisition of genetic information, requires that genetic information be maintained as a confidential medical record, and places strict limits on disclosure of genetic information."²⁰

Current rules for coding encounters limit use of a new patient code if the patient was seen in the previous 6 months in a given practice. This makes sense when the setting is primary care and the same doctor or team follows the patient continuously for care. It does not make sense in a workers' compensation setting, when a patient may present with totally unrelated injuries at different times, and each requires a detailed causation and functional impact analysis. A new injury or illness claim warrants use of a new patient encounter code in a workers' compensation setting; this is permitted in some state systems (eg, Washington and Colorado) that recognize the value of a comprehensive new patient history and examination in each new workers' compensation injury claim.

In general, state workers' compensation systems may legally choose to redefine and/or create billing codes for use within their own state that may differ from the CPT codes, along with a corresponding schedule of medical fees; and many states have already done so for specific purposes, including the preparation of specialized reports, communication with employers

or other stake-holders in the workers' compensation system, and the delivery of certain services related to chronic opioid prescribing.

In summary, the above discussion of the current CPT coding and documentation rules illustrates a glaring discrepancy between the actual needs of good workers' compensation care and current payment systems. This discrepancy results in misaligned incentives for providers who treat patients under workers' compensation. Compensation is an important driver of provider behavior and thus outcomes. This discrepancy between the current payment systems directed at procedures and designed for a different purpose, versus the actual needs of workers' compensation care, results in misaligned incentives for the treating physician in workers' compensation. Workers' compensation systems need coding ground rules specific for the cognitive work required in order to provide excellent patient care and good service in this system.

ECONOMIC BENEFITS OF PAYING FOR HIGH-VALUE SERVICES

There is at present no widely used system of provider compensation that is specifically geared toward maximizing outcomes for both patient health and patient work function. However, there is evidence that even modest changes to compensate physicians for useful services specific to workers' compensation care can produce large benefits.

Washington State has a monopolistic state fund that is responsible for that state's workers' compensation system. In an effort to reduce long-term disability, the state's Department of Labor and Industries developed a program called "Centers of Occupational Health and Education," more popularly known in that state by its acronym "COHE." A fundamental issue that the program was designed to implement and test was whether disability could be reduced if health care providers seeing injured workers were offered modest financial incentives for engaging in one or more of four specific occupational medicine best practices:

1. Prompt submission of the report of accident form (so that claims can be promptly opened and medical care can be promptly paid).
2. Health care provider calls the employer if a worker is to be taken off work or put on restricted duty (to help the employer's understanding of the situation, and to arrange for any needed adjustments to keep the employee at work or return to work as soon as possible).

3. Health care provider sees the injured worker at least every 2 weeks, and completes an activity prescription form at each visit.
4. If at 4 weeks the worker is not back to work, without clear medical explanation to explain why (eg, awaiting surgery), then perform a complete disability assessment examination.

The program also gave providers the assistance of health service coordinators to facilitate consultations, interface with claim managers, and assist with employee communications and other services that help providers return their patients to health and employment.

After implementation of incentive payments for these elements, data analysis by the University of Washington provided the following findings²¹:

- Disability days per claim were reduced by 4.1 days ($P = 0.004$).
- Disability costs were reduced by \$347 per claim after subtracting the costs of the program itself ($P \leq 0.001$).
- Medical costs per claim were reduced by \$245 after subtracting the costs of the program itself ($P \leq 0.001$).
- There was a 20% reduction in the likelihood of 1-year disability.
- There was a 30% reduction in disability in claims for back injuries.
- The patients of participating providers who consistently engaged in the best practices outlined above had 57% fewer disability days than did the patients of participating providers who did not consistently engage in providing those same best practices.
- In one industrialized area near Seattle, 4800 days (13.2 years) of disability were avoided per 1000 workers treated by providers in the COHE program.
- In a multi-county rural area that also included the city of Spokane, 5800 days (15.9 years) of disability were avoided per 1000 workers treated by providers in the COHE program.

The Washington Department of Labor and Industries has concluded that a small investment of money to incentivize providers to follow a few best practices can produce very large returns in the health and satisfaction of workers, and cost savings for employers. For example, opioid prescription in workers' compensation leads to worse outcomes: more disability days, higher costs, and sometimes lifelong clinically unnecessary work disability. Most opioids prescribed in workers' compensation-related care are inappropriate, per evidence-based guidelines such as ACOEM's. Yet, opioid use in workers'

compensation is an enormous and ongoing problem, which may be heading in the wrong direction, based on a recent *New York Times* article, which reported that workers' compensation paid about 17% of the \$8.34 billion dollar opioid bill in the US in 2012, even though workers' compensation only accounts for 1.5% of the total US medical spending.²² ACOEM's *Practice Guidelines* state that opioid prescription is not clinically indicated for most musculoskeletal injuries, including low back pain.²³

What would happen if treating providers were incentivized to follow evidence-based guidelines in workers' compensation care? The experience in Washington State again provides some clues. Washington has also introduced both incentives and controls in order to promote appropriate use and monitoring of opioids in workers' compensation.²⁴ This comprehensive approach, which also includes education for providers on both following the guidelines and obtaining reimbursement for the additional cognitive effort, has been instrumental in decreasing opioid use in workers' compensation.²⁵

The Colorado workers' compensation system instituted a number of measures in the early 1990s, including medical treatment guidelines emphasizing return to work and disability management coupled with additional payments for disability management care and patient education on return to activity. Colorado saw a dramatic decrease in both medical costs and disability costs initially, which has been maintained over time.²⁶

AN IMPROVED SYSTEM FOR BETTER OUTCOMES AND LOWER COSTS

Incentives for health care providers are important to both encourage best practices in providing care as well as to attract and keep the best practitioners as participants in the workers' compensation system. "Many parts of the country are dealing with a chronic and worsening shortage of physicians who are willing to treat workers' compensation injuries and who are familiar with the special issues that arise in occupational injury and disease."⁵

ACOEM's recommendations would encourage physician attention to critical factors in workers' compensation that are absent or minimized in current payment system coding, by financially recognizing the actual value, expertise, and effort provided for a given high-quality occupational and environmental medicine (OEM) level of service.

A problem seen in a workers' compensation context requires the following as part of necessary services, unlike

nonoccupational settings for the identical clinical facts:

- Knowledge of workplace factors;
- Focus on minimizing avoidable work disability;
- Analysis of activity tolerance and functionality;
- Evidence-based medicine considerations in diagnosis, treatment, and disability determinations; in some jurisdictions, such reference is a legal requirement;
- Reports completed for regulatory reporting requirements;
- Specialized OEM knowledge may be needed for specific cases; for example, causation analysis, analysis of activities and functionality, ergonomics, as well as more arcane areas, such as toxicology, epidemiology.

Other factors that are included as legitimate elements for reimbursement in current payment systems are not relevant for workers' compensation and could be eliminated from analysis of level of service. In particular, history and physical examination of irrelevant body parts and systems should not be encouraged; health status of near relatives is often not relevant; and inquiries about hereditary diseases may be prohibited by law.

Injured workers themselves are likely to benefit from a coding system that encourages functional assessments and attention to other indicators of delayed recovery. A number of recent studies have demonstrated that injured workers whose return-to-work is delayed or is not carefully tailored to their functional abilities are likely to suffer higher wage losses, and are at a significantly higher risk of permanent disability.^{27,28} In particular, treating physicians oriented to "return-to-work" concepts tend to have fewer cases of delayed recovery.^{29,30} Improved communication among all stakeholders, including providers and work supervisors, appears to have a measurable impact on lifestyle quality in workers recovering from work injuries.³¹ Accordingly, we contend that creating incentives for treating physicians to focus on issues critical for successful return-to-work, including functional status, job requirements, stakeholder communication, and personal predictors of delayed recovery, will not only save money but will also likely improve the well-being of injured and recovering workers.

PROPOSED SOLUTION

1. ACOEM proposes a new set of ground rules for documenting E&M encounters in workers' compensation care, with a decreased emphasis on irrelevant

history and examination elements, and an increased emphasis on work-related factors, function, and mitigating the risk of work disability. To support the proper documentation of a comprehensive physical examination appropriate for a workers' compensation injury, ACOEM proposes an occupational medicine specialty musculoskeletal examination.

2. ACOEM also proposes recognition of codes for consultation in workers' compensation care. Although these codes are no longer recognized by CMS, they may be adopted by state or federal workers' compensation systems and are still used in some states. ACOEM supports specific new ground rules for the use of consultation codes in workers' compensation.
3. ACOEM supports the use of management codes with alternative ground rules appropriate for workers' compensation care.
4. For services with no existing CPT codes critical to workers' compensation care, that could be adopted with alternative ground rules, ACOEM supports the adoption of new codes with clear ground rules for their use.

A CALL TO ACTION

The advantage of using a properly focused payment system in workers' compensation should be clear. However, our focus on disability management may be useful to many other health care systems also. The focus on decreasing time off work for all injuries could increase productivity and decrease paid time off for employers. Potentially, this system, when used in general health care, could decrease Social Security disability.

ACOEM recommends that

- States pass legislation that aligns compensation with desired physician behaviors.
- Workers' compensation commissions or administrations adopt the alternative proposed ground rules for documentation of care for each level of service.
- Workers' compensation insurers, payers, and employers adopt the alternative proposed ground rules for documentation of care for each level of service.

CONCLUSION

Workers' compensation occupies a unique niche in the worlds of both medical care and disability insurance. It also requires knowledge, expertise, and attention to factors that lie outside the patient's body, including workplace conditions and exposures, medical-legal causation analysis, communication with the workplace to minimize needless work

disability, and adherence to legal standards and reporting requirements that vary from state to state.

Despite this, current compensation systems almost uniformly adhere to the CMS rules for applying the CPT system, which was designed for a different purpose and which causes misalignment of reimbursement for necessary physician activities regarding functional ability and work-relatedness. Current payment system fee structure redirects valuable provider resources and energies away from addressing productivity and preventing disability. Realignment of reimbursement for decision-making focused on function would provide incentive for providers to improve both health outcomes and other global outcomes (eg, return to work and contribution to the community).

The proposed changes in current payment system code rules recognize these additional elements that are so valuable and necessary in workers' compensation and encourage care directed at disability management. These changes will more correctly designate the levels of service provided in a relevant way. As seen in the examples of Washington State and Colorado, even modest compensation for attention to factors important to workers' compensation can produce enormous improvement to patient health outcomes as well as savings to the system.

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