Adoption of the ODG Treatment Guidelines for Medical Necessity Determinations in Workers’ Comp

FAQ’s:

- What is ODG?
- What is the purpose of adopting ODG?
- Why is it necessary?
- What states have done this already, and what are the results?
- Cui Bono (who benefits)?
- What type of organization is Work Loss Data Institute (WLDI)?
- What is the cost?
- Where will likely opposition come from?
- Are there alternative guidelines in workers’ comp to ODG?
- Why aren’t other multidisciplinary workers’ comp guidelines in the marketplace?
- Can we speak to references in ODG states?
- Where can we learn more?

Work Loss Data Institute
“The Evidence-Based Guideline Company”
www.worklossdata.com
**What is ODG?**

ODG is the most widely used work-injury treatment and return-to-work (RTW) guideline in the world, with an associated Drug Formulary, fully automatable using national and international medical coding, used primarily in English-speaking countries with workers’ compensation systems, including the USA, Canada, Australia, and New Zealand. ODG is delivered online in a Software-as-a-Service subscription website, or inside claims and medical systems from an Application Programming Interface (API).

ODG leverages a world renown ongoing and systematic medical literature review, evidence-based editorial process, and claims data analytics to deliver medical necessity and RTW guidelines with automation tools. Established in 1995, ODG is comprehensive, multidisciplinary, and evidence-based. Published by Work Loss Data Institute, ODG is part of MCG Health and Hearst Corporation’s Hearst Health Network, the worldwide leader in evidence-based medical guidance.

**What is the purpose of adopting ODG?**

The purpose of adopting ODG as an insurance carrier or regulatory body is to set health policy in workers’ compensation using evidence-based medicine to safeguard access to quality care while limiting excessive or inappropriate utilization of medical services, creating clarity for healthcare providers.

**Why is this necessary?**

Workers’ comp is the only area of medicine where health encounters are not reasonably well scripted by health policy guidelines. General health insurance plans set and publish their own health policy statements, or “treatment guidelines”. These guidelines limit the amount and conditions under which care is provided. Care is further limited by cost-sharing (deductibles, copays and coinsurance). Workers’ compensation systems are unique in typically having none of these limiting factors. Workers’ comp insurers cannot set their own health policy and patients shoulder no portion of the cost because of the “grand bargain”, where employers must pay for 100% of all reasonable and necessary medical care. Traditionally, doctors were left to determine medical necessity, but with a fee-for-service model, they are financially incentivized only to perform and bill for reimbursement codes, preferably higher margin codes. Without policy limits, workers’ comp attracts those who are most aggressive. This drives up costs to employers and is dangerous to patients (unnecessary surgery, i.e. spinal fusion, failed back syndrome, permanent disability, opioid overuse/abuse/addiction/overdose). Further, many good doctors are less likely to take workers’ comp patients, where such excesses cause overinvestment in utilization review (UR) by payers, which can make it difficult to get approval for genuinely needed medical care.

**What states have done this already, and what are the results?**
Ohio, North Dakota, Texas and Kansas were the first states to adopt ODG in the USA in 2003, 2005, 2007 and 2009, respectively. Each are now among the best performing workers’ comp systems in the country in industry studies. The National Academy of Social Insurance ranks Texas #1, while the other widely followed study, the Workers’ Comp Premium Rate Ranking published by the State of Oregon, puts North Dakota at #1. Texas, like the other big population centers New York, California and Illinois, was one of the worst systems until adopting ODG in May 2007. It is now one of the best. Below are the results:

- Workers’ comp premiums are down 51%
- Average lost-time per claim is down 34%
- Median disability duration is down 20%
- RTW rates are up in all stages, acute, sub-acute AND chronic cases
- Average medical costs are down 30%
- Total drug costs are down 30%
- Opioid costs down 18%
- Access to care is up 42%

North Dakota, unlike Texas, had one of the best performing workers’ comp systems in the country when the state adopted ODG in 2005, and workers’ comp premiums subsequently dropped another 40%, with $52M in premium returned to North Dakota employers.

Following ODG adoption in Ohio, average medical cost per claim was reduced by 60% and average lost time per claim was reduced 66% (123 days to 42 days). Treatment delay was reduced 77%. ODG approval by healthcare providers was measured at 84% (4.18 out of five).

More US states have recently adopted ODG, including Oklahoma, New Mexico, Arizona, and Tennessee, along with several Canadian Provinces and major clients in the Australian states.

**Cui Bono (who benefits)?**

ODG is successful only by improving healthcare outcomes in workers’ comp, thus generally all stakeholders benefit except those that have made a racket of excessive treatment, unnecessary utilization review, inflated medical device sales, or permanent disability settlements.

Those who benefit most are (1) injured workers’, authorized to receive quality medical care quickly while shielded from unwarranted, often dangerous medical procedures and/or opioid/drug therapy, and (2) employers, that will no longer be on the hook to pay for medical interventions without efficacy. The ultimate measure of post-injury success in workers’ comp is disability duration / return-to-work. Average disability duration in ODG states is down 34%, and RTW rates are up across the board.

Medical providers benefit from reduced uncertainty in workers’ comp and timely approval and payment for services, if they practice evidence-based medicine. Medical denial rates in ODG states have been cut in half since adoption of the guidelines, and access to care is up, with more providers participating.
The publisher of ODG, Work Loss Data Institute, generally sees a modest increase in sales from subscriptions to the ODG guidelines, though summaries are made available for free to health care providers, and most insurance and utilization review companies already subscribe to ODG.

**What type of organization is Work Loss Data Institute (WLDI)?**

WLDI is an independent, for-profit database development LLC focused on workplace health, absence and productivity established in 1995 with offices in Texas and California, and owned by Hearst Corporation, as part of MCG Health. Unlike many participants in workers’ comp, WLDI has aligned interests with those of the injured worker, employer, and policymaker. WLDI is only successful if ODG adoption improves workers’ comp health and return-to-work outcomes, with cost-savings as a byproduct. WLDI believes the only way to achieve real and lasting-improvements in workers’ compensation systems (and therefore cost-savings) is by using evidence-based medicine to safeguard access to quality care while limiting excessive/unnecessary/dangerous procedures.

The ODG Editorial Board consists of about 100 different physicians of all medical specialties active in workers’ comp, brought together for the advancement of evidence-based medicine.

**What is the cost?**

Passing legislation (or a regulatory rule) adopting ODG at the state level costs nothing. There is also no cost borne by the government or stakeholders, unless they voluntarily choose to subscribe to the ODG guidelines online because they determine the guidelines deliver enough value to their practice to justify the cost. They may simply prefer to use free summaries of ODG made available by WLDI to providers in ODG states. For those that do wish to subscribe, the cost is $200-$599 for an annual subscription, depending on total quantity of users. This subscription fee supports ongoing research and product development, plus training, support, and administration. Use of the ODG Helpdesk is complimentary.

**Where will likely opposition come from?**

Initially, it may come from (1) medical associations, (2) labor and (3) trial attorneys, but medical providers and labor are easily won over with review of the ODG guidelines, and education on track record in improving healthcare outcomes. They may suggest that adoption of treatment guidelines will cause an exodus of providers from the workers’ comp system. This, however, is not accurate. Access to medical care in ODG states improves dramatically; billing data shows 42% more doctors taking workers’ comp patients. Doctors operate under treatment guidelines already in the form of policy statements from health insurers. They reduce uncertainty, facilitate prior authorization and improve billing.

Too often guidelines are painted or seen by medical associations as tools used by insurance companies to limit care. Once they have a chance to review ODG, they are much more receptive because they see it
as comprehensive, evidence-based and well balanced. However, many doctors may prefer no guidelines, or the illusion of guidelines created by advancing those without meaningful restrictions, if given the choice. There is also a powerful contingent of spinal implant surgeons that oppose treatment guidelines in workers’ comp, where approximately 30% of these procedures (spinal fusions, artificial disc replacements) are paid for, even though workers’ comp represents just 1.5% of total medical costs. Outcomes from these procedures in patients that are not carefully selected are very poor, which is why these procedures are so severely limited in general healthcare policy statements.

Labor representatives can also be won over, once they see the favorable health and quality of life outcomes in ODG states. However, some labor reps, like many trial attorneys, feel they serve their clients best interest by maximizing permanent disability benefits. These groups may never be reached, because the objective of ODG is to help injured workers get better and return to the activities of daily living without permanent disability or impairment. ODG is not an Impairment Guide, however, so will not impact the ratings for permanent disability cases. ODG is focused on temporary disability cases.

**Are there alternative guidelines in workers’ comp to ODG?**

There are no alternatives that have a proven track record of success. Some states write their own guidelines, typically by asking a panel of in-state treating doctors to do so. Device manufacturers advocate this approach because they can stack the panels with “friendly” providers. This is akin to asking NASCAR drivers to set the speed limits. It codifies excessive treatment into the regulatory framework and renders UR mechanisms impotent. Further, this approach is not evidence-based, which would require a comprehensive review of the literature and transparent, reproducible evidence-weighting process. Without those, it is simply a consensus-based process, without proven success.

Rather than starting from scratch, these volunteer panels will generally borrow from other state guidelines in the public domain – typically seeking the least restrictive guidelines they can find – most notably the Colorado Guidelines. Colorado, however, is unlike most state workers’ comp systems. As an employer-choice of physician state, excessive utilization of medical services is not a problem, and thus the state’s guidelines do not have meaningful limits (nor do they use medical coding or have automation and application tools). When applied in other states like has been done in Delaware or Louisiana, the results have not been good. Oklahoma was the first state to do this, adopting the Colorado Guidelines in 2005. The state quickly dropped from the 15th to the 4th most expensive state in the country, until replacing the Colorado Guidelines with ODG and the ODG Formulary in 2011. Since moving to ODG, workers’ comp premiums have come down 44% per NCCI, with improved RTW outcomes.

Another option has been to use existing treatment guidelines from medical specialty societies (i.e. AAOS, AAPM, ACA, ACOEM, APTA, etc). The problem with this approach is any one specialty guideline is too limited in scope to apply to other provider groups, but each does a very good job of promoting the interest of its members. So, each guideline will favor one provider group over the others. Because they are written by volunteer panels, they are also not generally comprehensive, up-to-date, nor do they
have application and automation tools. The Institute of Medicine’s *Clinical Practice Guidelines We Can Trust* also cautions against using guidelines from specialty societies, which tend to exhibit bias.

An example of this approach is California, which adopted the ACOEM Guidelines. The ACOEM Guidelines are the specialty guidelines of the American College of Occupational and Environmental Medicine. They are clinical practice guidelines written by occupational doctors for occupational doctors, and are therefore limited in scope, promoting occupational medicine, not other specialties like orthopedic surgery, physical medicine, chiropractic, acupuncture, etc. The result was significant delays, disputes, denials and friction in the delivery of multidisciplinary medical care. California has been using the ACOEM Guidelines since 2003, and remains the highest cost state in the USA, with poor RTW outcomes.

**Why aren’t there other multidisciplinary workers’ comp guidelines in the marketplace?**

ODG has done very well keeping costs/prices down by focusing on the workers’ compensation niche. The big guideline publishers in general healthcare all exited the workers’ comp market years ago, because it is relatively small and could not command the license fees supported in group health.

**Can we speak to references in ODG states?**

Please contact Work Loss Data Institute via 800-488-5548, 760-753-9992, or ODG@worklossdata.com, to be put in touch with stakeholders and clients in ODG states.

**Where can we learn more?**

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