



Texas Department of Insurance

Workers' Compensation Research and Evaluation Group

This report was published by the Research and Oversight Council on Workers' Compensation (ROC). ROC is now [Workers' Compensation Research and Evaluation Group](#) in the Texas Department of Insurance.

More reports by the WC Research and Evaluation Group at Texas Department of Insurance Website: www.tdi.texas.gov/wc/regulation/roc

More information regarding workers' compensation issues, please visit Division of Workers' Compensation, Texas Department of Insurance:
www.tdi.texas.gov/wc/indexwc.html

Per Chapter 405 of the *Texas Labor Code*, the Workers' Compensation Research and Evaluation Group (REG) at the Texas Department of Insurance is responsible for conducting professional studies and research on various system issues, including:

- the delivery of benefits;
- litigation and controversy related to workers' compensation;
- insurance rates and rate-making procedures;
- rehabilitation and reemployment of injured employees;
- the quality and cost of medical benefits;
- employer participation in the workers' compensation system;
- employment health and safety issues; and
- other matters relevant to the cost, quality, and operational effectiveness of the workers' compensation system.

For more information regarding workers' compensation, please contact us via email: WCResearch@tdi.texas.gov

**Biennial Report of the
Research and Oversight Council
on Workers' Compensation**

December 31, 2002



Research and Oversight Council on Workers' Compensation

Board of Directors

Chair

Rep. Scott Hochberg

December 31, 2002

Vice Chair

Sen. John Carona

Members

Rep. Kim Brimer
Rep. David Counts
Sen. Troy Fraser
Nancy Moore
Rebecca F. Olivares
Sen. Leticia Van de Putte
Lonnie Watson

The Honorable Rick Perry, Governor of Texas
The Honorable Bill Ratliff, Lieutenant Governor
The Honorable James E. "Pete" Laney, Speaker of the House

Gentlemen:

In accordance with Section 404.007(b), *Labor Code*, we are pleased to submit this *Biennial Report* of the Research and Oversight Council on Workers' Compensation (ROC).

In this report the ROC is mandated by law to report on:

- the activities of the agency;
- the status of the effectiveness of the workers' compensation system; and
- any problems in the system, with recommendations for regulatory and legislative action.

The Texas workers' compensation system is currently poised between two significant events: the passage of a major workers' compensation reform bill last session (i.e., House Bill 2600, currently in the implementation stage), and the scheduled Sunset Review of the Texas Workers' Compensation Commission (TWCC) in 2005. The coming years will be a busy period for the system and ROC's *Biennial Report* provides a useful context for this activity.

We respectfully submit this report to you for your consideration.

Representative Scott Hochberg, Chair

Contents

Executive Summary	vi
Introduction.....	1
Section I: Activities of the Research and Oversight Council on Workers' Compensation	5
Research Activities	5
Oversight Activities	9
Section II: Status of the Effectiveness of the Texas Workers' Compensation System.....	11
1. Safety	13
2. Coverage	20
3. Medical Care and Rehabilitation	29
4. Benefit Adequacy.....	47
5. Benefit Equity	55
6. Effective Delivery of Benefits	61
7./8./9. Agency Control, Policy Control & System Monitoring	77
10. Return to Work	94
11./12. Insurance, Economic Viability	99
13. Cost Internalization.....	111
14. Cost Transfer.....	117
Section III: Recommendations.....	127
A. Recommendations from ROC Staff and/or System Participants	130
B. Recommendations from Other State Agencies	170

EXECUTIVE SUMMARY

This 2002 Research and Oversight Council on Workers' Compensation (ROC) *Biennial Report* is prepared pursuant to Section 404.007 (b) of the Texas *Labor Code*, which requires the ROC to report to the Governor, Lieutenant Governor, and Speaker of the House of Representatives not later than December 31 of each even-numbered year on:

- (1) the activities of the council;
- (2) identification of any problems in the workers' compensation system, with recommendations for regulatory and legislative action based on research or testimony; and
- (3) the status of the effectiveness of the workers' compensation system to provide adequate, equitable, and timely benefits to injured workers at a reasonable cost to employers, with recommendations for any additional necessary research.

This *Biennial Report* contains three key sections: Section I, which includes an overview of the activities of the ROC during the last biennium; Section II, which provides a detailed summary of the status of the workers' compensation system; and Section III, which outlines the legislative, regulatory and research recommendations put forward by ROC staff as well as ROC staff's response to the legislative recommendations submitted by other state agencies.

Section I – Activities of the ROC

In fiscal year (FY) 2001, ROC staff completed a series of research studies mandated by House Bill (HB) 3697 (76th Legislature, 1999) designed to examine the cost and quality of medical care provided to injured workers in Texas, including:

- *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System;*
- *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System;* and

- *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs.*

These studies served as the basis for the House Bill (HB) 2600 reforms enacted by the 77th Texas Legislature in 2001. In FY 2002 the ROC devoted a significant amount of its research and oversight activities to the implementation of HB 2600, including:

- the development of a methodology to monitor the practice and review patterns of health care providers, Texas Workers' Compensation Commission (TWCC) Designated Doctors, and insurance carriers;
- assisting the Health Care Network Advisory Committee (HNAC) with the regional network feasibility study required by Article 2 of HB 2600;
- compiling estimates of the future cost of multiple employment income benefits and the impact of these benefits on the financial solvency of TWCC's Subsequent Injury Fund (SIF);
- assisting TWCC staff with the completion of the drug-free workplace study required by Article 13 of HB 2600; and
- monitoring TWCC's rulemaking initiatives to ensure that they comply with the statutory intent of HB 2600 and providing comment, when necessary.

In addition to these activities, ROC staff also completed several other research projects on issues such as return-to-work, employer participation in the Texas workers' compensation system; change of treating doctor provisions; and fraud detection. ROC staff also continues to provide assistance to workers' compensation constituents (e.g., injured workers, health care providers, employers, insurance carriers, and legislative offices) who have difficulty accessing the workers' compensation system or require other assistance.

Section II – Status of the Effectiveness of the Texas Workers' Compensation System

In 1987, the 70th Texas Legislature established the Joint Select Committee on Workers' Compensation Insurance to conduct a study on the problems in the Texas workers' compensation system and recommend appropriate changes. In its report, the Joint Select Committee developed a set of fourteen policy objectives that the system should address. As part of its Biennial Report, ROC staff focuses on the current status of the workers' compensation system in relation to each of these fourteen objectives, including:

1. Safety

Historically, Texas has had low non-fatal occupational injury and illness rates compared with the national averages. According to annual reports by the U.S. Department of Labor, Bureau of Labor Statistics and the Texas Workers' Compensation Commission (TWCC), the non-fatal occupational injury and illness rates in Texas have been consistently below the national average since 1992 (in 2000, the most recent year for which data are available, Texas' rate was 4.7 injuries and illnesses per 100 full-time workers, compared with 6.1 nationally). Despite reductions in the non-fatal injury and illness rate over time, the number of work-related fatalities in Texas has continued to fluctuate since 1992 (from a low of 459 fatalities in 1997 to a high of 572 work-related fatalities in 2000).

Other than the publication of the ROC research report entitled *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs* in February 2001, there has been little legislative, regulatory, or research activity in the area of safety during the biennium. One notable exception is Article 13 of HB 2600, which requires TWCC to analyze the possibility of mandating a workers' compensation premium discount program for employers with a drug-free workplace. TWCC is required to report the findings of this study to the 78th Texas Legislature and the ROC by February 1, 2003.

2. Coverage

Texas remains the only state in the country that truly allows employers not to purchase workers' compensation insurance coverage. A study of Texas employers conducted by the ROC in the fall of 2001 indicates that an estimated 35 percent of Texas employers do not carry workers' compensation insurance; however, since larger employers are more likely to purchase coverage for their employees, approximately 84 percent of Texas employees are covered by workers' compensation insurance. Many employers who do not purchase coverage (commonly referred to as nonsubscribing employers) provide alternative occupational benefits to their injured employees. More than half (56 percent) of the nonsubscribing employers surveyed indicated that they pay either medical, wage replacement or both types of benefits in the case of a work-related injury.

Information from ROC's study also reveals that Texas employers are becoming more sensitive to price increases in their workers' compensation premiums, and many indicated that they would consider dropping their coverage even if their premiums rose only marginally (i.e., by less than 20 percent). The only legislative activity in this area during the last biennium was Article 16 of HB 2600, which prohibited nonsubscribing employers from asking their employees to sign pre-injury waiver agreements under which the employee relinquished his or her right to sue the nonsubscribing employer over a work-related injury in exchange for on-the-job injury benefits, or a higher level of benefits. This provision passed after the Supreme Court of Texas ruled that these arrangements were enforceable since the legislature had not specifically prohibited them previously.

3. Medical Care and Rehabilitation

Findings from ROC's HB 3697 research studies indicated that Texas had higher medical costs than other state workers' compensation systems and group health plans in Texas, and that the amount and duration of medical treatment provided to injured workers were the primary cost drivers. Despite receiving more treatment, the studies also found that Texas injured workers had more difficulty going back to work after their injuries and did

not appear to be more satisfied with the medical care they received than injured workers in other states.

These study results formed the basis for significant discussions during the 77th Texas Legislature about how to address medical cost and quality of care issues. After a number of negotiations with various stakeholder groups, legislators passed HB 2600, the most comprehensive piece of workers' compensation reform legislation since the 1989 overhaul of the system. Several provisions of HB 2600 dealt directly with efforts to reduce high medical costs and improve the quality of medical care provided to injured workers in Texas, including:

- The establishment of monitoring programs for health care providers, TWCC Designated Doctors, insurance carriers and their utilization review agents (URAs);
- The introduction of regional workers' compensation health care delivery networks in which participation would be voluntary for both insurance carriers and injured workers. HB 2600 created a Health Care Network Advisory Committee (HNAC) to oversee a feasibility study on these networks and authorized TWCC to initiate network contracts based on this study;
- The elimination of the spinal surgery second opinion process (spinal surgeries now require pre-authorization or pre-approval from the insurance carrier before they can be rendered);
- The addition of a statutory minimum list of medical services requiring pre-authorization and the addition of concurrent review (an extension of treatment for specific services that have already been pre-authorized by the insurance carrier) and pre-certification processes (voluntary pre-authorization for those medical services that do not require it by TWCC rule);
- The requirement that the workers' compensation billing, coding and payment structure be aligned as much as possible with the Medicare system (the revised TWCC Medical Fee Guideline is currently the subject of a lawsuit between

- TWCC and the Texas Medical Association and Texas AFL-CIO over the fee amount rather than the alignment with Medicare's payment policies);
- The repeal of TWCC's medical treatment guidelines and the addition of new statutory criteria that any future treatment guideline adopted by TWCC must be "nationally recognized, scientifically valid, and outcome-based;" and
 - The addition of an open pharmaceutical formulary with an emphasis on generic equivalents to prescription drugs and the allowance of over-the-counter alternatives where medically appropriate.

4. Benefit Adequacy

Three significant changes have occurred in this policy area during the last biennium:

- Article 10 of HB 2600 included a provision that allows injured workers with more than one job to have their income benefits calculated on Internal Revenue Service-reportable wages from all of their jobs, rather than just the job where they were injured. This statutory change, effective July 1, 2002, incorporated what is often called a "multiple employment" provision into the Texas workers' compensation system. Article 10 also allowed insurance carriers to seek reimbursement from TWCC's Subsequent Injury Fund (SIF) for any additional income benefits they paid out as a result of this multiple employment provision;
- Article 9 of HB 2600 expanded the statutory eligibility criteria for Lifetime Income Benefits (LIBs) to include injured workers who suffer certain severe burns; and
- In early 2001, the 3rd Court of Appeals in Austin, Texas invalidated TWCC's "90-day rule" for disputing a finding of maximum medical improvement (MMI) or impairment rating. TWCC's rule required injured workers and insurance carriers to dispute an assessment of MMI or an impairment rating within 90 days or have it become final. This invalidation means that there is no time limit to dispute an impairment rating or MMI determination regardless of whether the injured worker

involved has experienced a substantial change of condition. However, statutory limits on temporary income benefits still apply.¹

5. Benefit Equity

An important aspect of benefit equity includes the accurate assessment of when an injured worker has reached MMI and an accurate calculation of the worker's impairment rating. A worker's MMI date determines the beginning of that worker's eligibility to receive Impairment Income Benefits (IIBs) – benefits that are paid to injured workers in order to compensate them for any permanent impairment they incurred as a result of a work-related injury – and determines the number of weeks of IIBs a worker will receive (for each percentage of impairment, an injured worker receives three weeks of IIBs), as well as eligibility for Supplemental Income Benefits (SIBs).

Since the 2000 *Biennial Report*, one major legislative change was made to the process by which injured workers receive an MMI determination or an impairment rating. Article 5 of HB 2600 specified that if an insurance carrier wants the injured worker to be examined to determine whether the worker is at MMI and what, if any, impairment the worker has sustained, the insurance carrier must first request an examination by a TWCC-assigned Designated Doctor. Designated Doctor examinations are considered to be independent, since the Designated Doctor does not represent the interests of either the insurance carrier or the injured worker, and these examinations by statute have presumptive weight in dispute hearings. Once a Designated Doctor has examined the worker, an insurance carrier may require the injured worker to see a Required Medical Examiner (RME), a doctor chosen by the insurance carrier. Prior to this statutory change, insurance carriers were allowed to send injured workers directly to their RME doctors for MMI and impairment rating exams. Article 5 also requires the ROC to evaluate the impact of this provision and report on it to the 79th Texas Legislature by December 31, 2004.

¹ See Texas *Labor Code* Section 401.011(30)(b).

6. Effective Delivery of Benefits

While the effective delivery of both income and medical benefits are a concern to system administrators, recent legislative and regulatory activity has focused primarily on the delivery of medical benefits – particularly the quality of medical disputes involving workers' compensation claims. An effective Medical Dispute Resolution (MDR) system is essential to ensuring that parties can resolve disagreements over the necessity of medical services and the appropriate payment of services in accordance with TWCC's Medical Fee Guideline. Article 6 of HB 2600 significantly changed the process by which medical disputes over retrospective denials of medical necessity and prospective denials of medical care are handled.

In response to concerns with the Medical Dispute Resolution process - particularly the issue of appropriate medical expertise in decision-making - Article 6 of HB 2600 required that disputes related to medical necessity (both prospective and retrospective disputes) be decided by Independent Review Organizations (IROs). IROs are used in the group health insurance setting to review denials by Health Maintenance Organizations (HMOs), use doctors to perform their reviews, and typically operate within much shorter timeframes than had the TWCC MDR process. In December 2001, TWCC adopted new Medical Dispute Resolution rules, effective January 2, 2002, to implement the change to the IRO process and other MDR process changes.

As the new process has been in effect for less than a year, it is difficult to draw firm conclusions about its long-term effectiveness in meeting HB 2600's goals of better and more rapid medical decisions. As part of its approved FY 2003 Research Agenda, ROC staff is currently working on a research project to analyze the preliminary data associated with IRO decisions compared with the MDR process before HB 2600.

However, the new MDR process has seen some legal challenges. One recent challenge by a health care provider alleges that the provision in TWCC's rule requiring that the medical dispute requestor pre-pay the IRO fee before the IRO initiates the review is unconstitutional because it creates an improper barrier to due process. The same health

care provider (along with a select group of other providers) has also begun bypassing the statutory MDR process by filing individual medical disputes directly into Justice of the Peace or District Courts.

Another issue raised by some health care providers in response to the new MDR process relates to the difficulty in disputing relatively low cost services. A health care provider who is denied payment based on a medical necessity determination for a service costing only \$100, for example, may find it unreasonable to have to pay (and risk) more than six times this amount to dispute the denial (the IRO fee costs between \$460 or \$650 depending on the medical specialty of the reviewer). TWCC is aware of the potential problem with low-cost services in dispute, but the *Labor Code* does not at present allow a lower cost alternative for resolution of these disputes.

Another provision of HB 2600 that was designed to improve the effective delivery of medical benefits is Article 4 related to initial pharmaceutical coverage. In the time immediately following an injury, uncertainty may exist as to the existence of an injury, the coverage status of the injured employee's employer, and other issues, and this uncertainty may increase the likelihood of a pharmacist being unwilling to fill a prescription for fear that he or she will be paid. In an attempt to remedy this situation, Article 4 allowed TWCC to adopt rules stipulating that insurance carriers are responsible for the payment of pharmaceutical benefits sufficient for the first seven days following an injury, provided that the pharmacist receives verbal confirmation of a report of injury from either the employer or insurance carrier. The statutory language also allow for insurance carriers to claim reimbursement for these pharmaceutical benefits from the Subsequent Injury Fund (SIF) if the injury is later determined not to be compensable.

7./8./9. Agency Control, Policy Control, and System Monitoring

Along with concerns about medical costs, the area of system monitoring probably has been the subject of more scrutiny than any other aspect of the Texas workers' compensation system in recent years. TWCC's success in implementing the medical monitoring components of HB 2600 will be key to the success of the legislation in

promoting higher-quality, more cost effective medical care. Specifically, HB 2600 gave TWCC expanded authority to monitor and impose sanctions on health care providers and insurance carriers through a variety of methods including:

- Requirements that by September 1, 2003 doctors must register and receive TWCC-approved training in order to treat workers' compensation patients (prior to HB 2600, every doctor licensed in Texas was able to treat workers' compensation patients);
- The addition of a Medical Advisor and Medical Quality Review Panel (MQRP), which provide TWCC with access to medical expertise in order to exercise better oversight of medical management issues. The Medical Advisor and MQRP have several statutory charges; however, their primary charge is to review and recommend sanctions against health care providers and insurance carriers who abuse the system (to date the initiation of these reviews has been slow for a variety of reasons described in more detail in the report);
- The ability to impose a wide range of sanctions on abusive health care providers and insurance carriers, including administrative penalties, license restrictions, mandatory pre-authorization of all medical care, required education or training, and suspension or deletion from the system.

Aside from monitoring quality of care issues, TWCC has been seeing increased number of referrals alleging that a violation of the Act or rules has occurred (3,707 received in FY 1999, compared to approximately 9,085 in FY 2002). Perhaps most significant is an increase in the number of referrals from health care providers alleging non-payment or inappropriate payment of medical bills from insurance carriers.

Article 6 of HB 2600 also called for the creation of a schedule of administrative penalties by TWCC, which would specify penalty amounts for particular violations of the Act or rules. TWCC has attempted to gather stakeholder input on the administrative penalty schedule and held a stakeholder meeting in May 2002 with discussion on this issue on the

agenda. As of this writing, TWCC intended to propose a schedule of administrative penalties at its December 2002 public meeting.

Pursuant to a request from the ROC Board in 2000, both TWCC and the Texas Department of Insurance (TDI) began reporting select information related to the workers' compensation system to the ROC on a quarterly basis in early 2001. TWCC reports have continued sporadically since that time. In summer 2002, however, with most of the HB 2600 implementation deadlines in the past and a clearer picture of the new processes in place, ROC staff and TWCC staff met to develop a new outline for the Quarterly Reporting process. By late October 2002, ROC had received a report with detailed information for the first three quarters of calendar year 2002. ROC staff considers this information vital to ongoing monitoring of the system and appreciates TWCC's staff's work in providing this information on a quarterly basis in the future.

10. Return to Work

Previous research findings from the ROC highlighted the problems Texas injured workers have going back to work after they are injured. In response to these and other research findings, legislators included Article 3 in HB 2600, which:

- Required TWCC to collect return-to-work outcome data, as well as information on patient satisfaction and patient functional outcomes (i.e., whether the worker recovered from the injury);
- Required employers to disclose, upon request, the availability of modified duty or other return-to-work programs to health care providers, injured workers and insurance carriers. This provision was designed to improve the communication about return-to-work options between employers and other system stakeholders; and
- Required insurance carriers to offer return-to-work coordination services to their policyholders, such as job task analysis, job modification, and medical or vocational case management service; however, insurance carriers are not required to physically make or pay for workplace modifications.

TWCC is developing methods to collect return-to-work data as part of its Business Process Improvement (BPI) system re-design process. To date TWCC has held several stakeholder meetings on these issues, but there has not been widespread agreement from system stakeholders on the preferred method for collecting this information. TWCC has also hired a return-to-work coordinator to assist the agency in return-to-work outreach efforts.

ROC staff is also in the process of summarizing data from a recent injured worker survey (this survey was implemented as part of ROC's efforts to build an injured worker report card for the Article 2 regional health care delivery networks), which can serve as a starting point from which annual surveys of injured workers can be built. ROC staff is also in the process of completing an employer survey to determine whether Texas employers are aware of the legislative changes made by Article 3 of HB 2600. The results from both of these ROC projects should be available in the spring of 2003.

11./12. Insurance, Economic Viability

The cost of workers' compensation coverage for Texas employers declined steadily between 1993 and 1999, from \$3.42 per \$100 of payroll in 1993 to \$1.87 per \$100 of payroll in 1999. However, over the past two policy years (2000 and 2001) insurance costs have begun to rise again. In 2000, employers paid an average of \$1.97 per \$100 of payroll, and in 2001 this increased to \$2.41 per \$100 of payroll. Recent employer survey data collected by the ROC corroborates findings that insurance costs are on the rise. In that survey approximately 42 percent of employers with workers' compensation coverage indicated that the cost of their most recent policy had increased since their last renewal date.

In addition to rate increases, the number of insurance carrier insolvencies is on the rise. Over the past two years, the Texas Property and Casualty Insurance Guaranty Association (TPCIGA) – the state-created entity charged with assuming the payment of workers' compensation claims if an insurance carrier becomes insolvent – has seen a

higher than normal amount of insolvencies occur, and is now handling its largest property and casualty insolvency to date, that of the Reliance Insurance Company of Pennsylvania, which entered liquidation in October 2001.

While bills such as HB 2600 were filed to help alleviate high medical costs and reduce insurance carrier losses in the long-term, no bills were filed during the 77th legislative session to change the way that insurance carriers write workers' compensation policies in Texas. HB 3458 was the only significant workers' compensation insurance-oriented piece of legislation passed in 2001. HB 3458 modified the structure of the Texas Workers' Compensation Insurance Fund, one of the largest WC insurance carriers in Texas and the "insurer of last resort" for Texas employers unable to obtain coverage in the voluntary market. The legislation changed the name of the Fund to the Texas Mutual Insurance Company. As a mutual, the company becomes a member-owned entity, with any surpluses in operations available to be passed back to members (i.e., policyholders) as dividends.

13./14. Cost Internalization, Cost Transfer

While the concept of cost internalization is to keep work-related injury costs *within* the workers' compensation system rather than diverting them into group health plans or social support programs (such as Social Security, food stamps, etc.), the issue of cost transfer involves keeping non-work-related injury costs *out* of the system. Historically, the debate regarding cost internalization has been focused on the adequacy of income benefits for severely injured workers, since the statute caps those income benefits at 401 weeks from the date of injury, unless the worker is qualified for Lifetime Income Benefits (LIBs). Previous ROC research has also shown that although a small percentage of injured workers reach this 401 weeks statutory limit on income benefits, those workers who do reach this cap, or who lose their eligibility to Supplemental Income Benefits (SIBs) – the income benefit that is paid to severely injured workers who have not yet gone back to work but have received all of their IIBs - often turn to alternate means to replace their lost wages, including federal and state assistance programs.

While few legislative or regulatory changes have been made that directly affect the issue of cost internalization, certain provisions of HB 2600, discussed in more detail in the Benefit Adequacy section, may have some impact on this issue. Additionally, HB 1562, a general fraud-detection bill, included a provision that allows group health insurance carriers access to confidential TWCC claim data as a subclaimant for the purpose of determining whether a health care provider has erroneously or fraudulently billed both workers' compensation and group health. However, TWCC and group health insurance carriers have not been able to come to an agreement on how to share this information, and a recent Attorney General's opinion held that unless the group health insurance carrier could prove that it was a subclaimant in a particular claim, it could not access TWCC's data.

Discussion regarding the cost transfer policy objective usually focuses on fraud detection and prevention. TWCC's fraud detection unit continues to receive and process fraud referrals from system participants and in general, the number of fraud investigations completed by TWCC has increased since the last biennium. However, a relatively small percentage of fraud investigations completed at TWCC result in a notice of violation or warning sent to the violator (6.1 percent of all fraud investigations completed in FY 2001) or the filing of criminal charges (3.4 percent of all fraud investigations completed in FY 2001). The vast majority of investigations (55 percent) were concluded without any final determination by TWCC due to insufficient evidence or low probability of prosecution. Aside from HB 1562 and HB 2600 provisions requiring health care providers to disclose financial interests in the clinics and practices to which they make referrals and expanded TWCC authority to enforce rule violations, little legislative or regulatory activity has been seen in the cost transfer area during the last biennium.

Section III - ROC Staff Recommendations and Staff Responses to Recommendations Made by Other State Agencies

ROC staff sought system stakeholder input and relied upon its own research and oversight activities in developing the recommendations included in Section III of this report. Because of the significant workers' compensation-related legislative activity in 2001 with the passage of HB 2600, and the pending Sunset Review of TWCC in 2005, ROC staff focused its recommendations on only those areas that seemed to be in greatest need for immediate consideration. Staff also did not consider suggestions that called for sweeping changes in the medical or income benefit delivery models in the system, since the changes made by HB 2600 have not yet had time to be fully evaluated and are likely better left to Sunset Review.

ROC staff developed a "short list" of issues and discussed these with system stakeholders at an October 2002 meeting, as well as in follow-up correspondence. While the diverse stakeholders in the system did not unanimously agree with ROC's suggested options for every issue, there was general agreement that most of the issues identified were at least worthy of discussion and possible legislative and/or regulatory action this session.

ROC staff's recommendations are as follows.

1. Medical Dispute Resolution (MDR) is the process by which parties can resolve disputes over the necessity or pricing of medical treatments and services provided to injured workers. Staff identified the following MDR issues for potential modification:
 - A legislative change to allow TWCC to designate an alternate dispute resolution process for low-cost medical services. Review of medical services costs at least \$460 in the current system, and this may not be an appropriate fee for services that cost much less than the review.
 - Consideration of legislative changes to allow TWCC to bar future access to the dispute resolution process a party that does not pay the fee associated with a review. Currently TWCC requires parties to pay in

advance to avoid non-payment of the review fee; pending the outcome of litigation on this pre-payment requirement, it may be necessary to amend the *Labor Code* to minimize the possibility of a party refusing to pay the fee.

- Statutory clarification of the status of services not covered under the Medicare payment policies. These policies, mandated for use by TWCC in HB 2600, exclude payment for services deemed to be ineffective or not medically necessary. ROC staff suggests that in accordance with the provisions of HB 2600, the statute be clarified to limit access to the MDR process for these “uncovered” services and instead require parties to petition TWCC to consider the merits of adding such a service and, if necessary, amending the fee guideline.
 - Requirement for preauthorization of “investigational and experimental” services. HB 2600 added this general category of services to those requiring insurance carrier approval prior to delivery. However, since the Medicare-based payment policies exclude coverage for many of these services, it may be more logical to allow TWCC to add specific services that fall in this category to its preauthorization list, but not mandate the broad category by statute.
 - TWCC jurisdiction over medical disputes. Some health care providers have attempted to circumvent the TWCC MDR process and take disputes directly to court. A statutory clarification is proposed to reinforce TWCC’s primary jurisdiction over disputes arising under the Workers’ Compensation Act, with court access only allowed after the TWCC administrative process.
2. *Downs* Court Decision. This decision involves the timeframe in which an insurance carrier may contest the compensability of a workers’ compensation claim. Under a current court interpretation of the statute, a carrier must pay or deny income benefits within seven days of notice of an injury or lose the right to dispute compensability. Insurance carriers argue that this timeframe is

unrealistically short, difficult to comply with, and almost impossible to apply in cases in which an injured employee does not lose time from work and therefore is not eligible for income benefits. Although there is significant stakeholder disagreement over whether this issue needs to be addressed, ROC staff has included several policy options to clarify an insurance carrier's timeframe to pay or dispute compensability.

3. TWCC Compliance and Enforcement Efforts. To set the stage for Sunset Review in 2005, ROC staff recommends a focused review of TWCC's programs in these areas and discussion with system stakeholders about enforcement priorities and stakeholder expectations.
4. Finality of Impairment Ratings ("90-day rule"). As a result of litigation in the interim, there is currently no requirement that a dispute over an injured worker's certification of maximum medical improvement (MMI) or impairment rating occur within a certain timeframe. Prior to court action, a 90-day timeframe for contesting this assessment and/or rating was applied by TWCC rule. Policy options are included to establish some general finality for impairment ratings but allow for a reconsideration in cases that warrant it due to an injured worker's "substantial change of condition."
5. Designated Doctor Selection. Changes made to the manner by which Designated Doctors are selected by TWCC to perform MMI and impairment rating exams have resulted in a more complex and time-intensive selection process. This new process has also been challenged in litigation brought by the Texas Chiropractic Association. ROC staff offers policy options to meet the intent of the changes made by HB 2600 using less complex selection methods.
6. Interaction of *Insurance Code* Provisions on Equity of Payment and TWCC's 2002 Medical Fee Guideline. HB 2600 requires TWCC's fee guidelines to comply with provisions of the *Insurance Code* relating to equity in payment for medical professionals performing similar services. A rule modification by TWCC is recommended to ensure that the *Insurance Code* provisions are followed. In the long term, modification to the *Labor Code* should be considered

- to exempt workers' compensation from this equity provision and align with Medicare's payment structure.
7. Extent of Injury Dispute Timeframe. It is not uncommon in the workers' compensation system for disputes to arise over both the medical necessity of a service provided to an injured employee *and* the relatedness of this service to the employee's injury. However, these issues are handled through distinct dispute processes at TWCC. As a way to highlight any underlying issues involving the relatedness of an injury early in the process and minimize "crossover" disputes later, ROC staff recommends examination of ways to utilize existing statutory and rule provisions to this end. A further step could involve a general timeframe (after receiving a bill related to a medical condition) in which an insurance carrier must dispute the relatedness of the condition or waive the right to dispute this issue.
 8. Use of TWCC's Medical Advisor and Medical Quality Review Panel (MQRP). In an attempt to control medical quality and cost issues, TWCC was provided unprecedented authority under HB 2600 to review and impose sanctions on doctors and insurance carriers in the system. Key tools for these new initiatives are the TWCC Medical Advisor and MQRP, a panel of doctors to review and recommend sanctions against abusive medical and utilization review practices. While some progress has been made in these areas to date, ROC staff recommends a number of steps to better utilize these resources and inform policymakers and stakeholders about Medical Advisor and MQRP activities.
 9. Pharmaceutical Issues. Issues surrounding the payment, denial and dispute of pharmacy bills continue to be a problem for the workers' compensation system. ROC staff suggests data collection on pharmacy issues and further study of this data, particularly as it relates to pharmacy bill denials, as well as consideration of some short-term policy options that may help alleviate related issues.
 10. Access to Workers' Compensation Data. Access to non-confidential data held by TWCC is important for a variety of stakeholders in monitoring and interacting with the system, and some stakeholders have requested that TWCC improve its methods to allow data access. ROC recommends TWCC incorporate the goals of

providing better access into its information system redesign efforts, consider the model used by the Texas Health Care Information Council (THCIC) for providing non-confidential administrative data, and utilize a TWCC-ROC review panel for consideration of more complex research-related data requests.

11. Increased Public Input in TWCC Rulemaking Process. As part of the HB 2600 implementation process, TWCC has held regular meetings with stakeholders who participated in the legislative discussions on this bill (or who have since asked to be included) about pending commission rules or policies. Some stakeholders have requested that TWCC allow more informed input on these issues by providing draft rules or policies prior to such meetings. ROC staff recommends TWCC consider distributing draft proposals or policies to primary stakeholder associations prior to proposing a rule.
12. Access to Workers' Compensation Data for Anti-Fraud Activities. HB 1562, passed in the 77th session, was intended to allow group health insurance carriers to access TWCC data to search for possible double-billing and other potentially fraudulent activity. Further clarification of the statute may be necessary to ensure that this access can occur as intended; in addition, further clarification of a related Attorney General's opinion as to the confidentiality of workers' compensation medical records may also be needed.
13. Return to Work. Emphasis on safe and timely return to work for injured employees is a key policy goal for the system. While ROC staff does not recommend major statutory changes in this area, staff does recommend that TWCC and the Texas Rehabilitation Commission (TRC) work together more closely to share information, and consider statutory options to facilitate such sharing if necessary.
14. Alignment with Medicare Policies and Features. While HB 2600 mandated use of some aspects of the Medicare system (such as payment policies) other features of the Medicare system that may be desirable to many system participants (such as electronic billing, less up-front documentation, and greater ability to recover overpayments) are not yet in place. ROC recommends a focused stakeholder

committee evaluate the differences between the workers' compensation and Medicare models and prepare recommendations for Sunset Review in 2005.

15. ROC "Data Calls." While ROC is charged with examining the operational effectiveness of the workers' compensation system, the agency does not have independent authority to request data from system participants. ROC staff recommends the agency be given authority to initiate data calls related to projects on its approved Research Agenda.²
16. Recovery from a Third Party when the Subsequent Injury Fund (SIF) is the Beneficiary. The Workers' Compensation Act allows insurance carriers to pursue subrogation against a third party whose actions caused or contributed to an employee's injury or death. In fatality cases in which the injured employee has no beneficiaries, the carrier pays benefits into TWCC's SIF, however, and the statute does not specifically allow a carrier in these cases to pursue subrogation to recover these costs. Since the intent of allowing subrogation is the same regardless of the identity of the beneficiary, ROC staff recommends allowing a carrier to pursue a liable third party in cases where the SIF is the beneficiary.
17. SORM Medical Management Activities. In light of significant expected increases in the cost of SORM's medical utilization review contract with an outside vendor, and the significant changes forthcoming to medical billing and payment rules in general, ROC staff suggests that SORM consider several options to enhance medical management of the state's workers' compensation claims. These include expanding SORM's medical expertise by hiring or contracting with a Medical Director; considering the feasibility of contracting with other large carriers for medical management functions; and tightening the performance expectations for utilization review when negotiating a new contract.

ROC staff also responded to the following legislative recommendations made by TWCC. Paperwork reduction and technical clean-ups to the statute suggested by TWCC

² At the request of TWCC, and based on action taken by the ROC Board in approving this report, this recommendation was expanded to include data call authority for TWCC, as well.

and responded to by ROC are not included in this Executive Summary, but are addressed in the full report.³

18. TWCC Commissioners' Structure. ROC staff agreed with a TWCC recommendation to provide for two-year terms for TWCC's six Commissioners. This recommendation was offered to address a change to the Texas Constitution requiring state boards to have an odd number of members or provide for two-year terms.
19. TWCC Audit and Billing Provisions. ROC staff conditionally agreed with a TWCC recommendation related to the commission's authority to review and audit entities other than insurance carriers (generally, health care providers), and to clarify that insurance carriers may audit health care providers. ROC staff supports TWCC's request to amend the statute to clearly state that TWCC has this audit authority over providers, and that carriers may perform audits. ROC staff also agrees TWCC should be able to bill a provider for a review or audit if the provider was identified as a potential "outlier" by initial analyses, but only if certain procedural safeguards exist and if the provider has the right to a review of TWCC's fee.
20. Defense of Medical Quality Review Panel (MQRP) Doctors. ROC staff agreed with TWCC's recommendation that further liability protection be sought for doctors serving on TWCC's MQRP. This may include a written agreement or statutory provisions ensuring Attorney General representation for MQRP doctors if sued while acting in good faith, changes to allow MQRP doctors to be covered by state litigation insurance, or expanded immunity provisions for review doctors under contract to TWCC.
21. Appeal of an Independent Review Organization (IRO) Decision to the State Office of Administrative Hearings (SOAH). ROC staff disagreed with a TWCC recommendation to eliminate the possibility of an appeal of an IRO decision on a medical necessity issue to SOAH. ROC staff believes that the recent, significant

³ In addition, ROC staff included one issue received from the Texas Property and Casualty Insurance Guaranty Association (TPCIGA) in the full report, but since it does not involve a specific recommendation at this time, it is not included in this summary.

changes to the medical dispute resolution process make it premature to change the process so significantly; however, ROC does support adequate funding of TWCC to pay SOAH costs, which the commission is required to bear.

22. Admission of Evidence at SOAH. ROC staff also disagreed with a TWCC recommendation to prohibit introduction of new evidence at a SOAH hearing without “good cause.” The TWCC medical dispute resolution process remains a paper review process with no opportunity for discovery or argument, and at this juncture, parties may need the protection that allowing introduction of new evidence at SOAH affords.
23. Appeal of Commissioner-Imposed Sanctions. ROC staff agreed in part with a TWCC recommendation that sanctions imposed on doctors by the TWCC Commissioners be effective during any appeal. ROC staff agreed that sanctions short of removal of the ability to practice in the system should be binding during an appeal; however, for cases in which TWCC believes public safety is endangered and outright removal from the system is justified, cooperation with licensing boards that already possess this authority (such as the Board of Medical Examiners and Board of Chiropractic Examiners) is a better option.
24. *Downs* Decision. Please refer to ROC’s discussion of the *Downs* issue in the previous portion of the Recommendations section.
25. Generic Substitution. ROC staff disagreed with the method suggested by TWCC to correct an inconsistency between the *Texas Pharmacy Act* and TWCC’s pharmacy rules. TWCC recommended a statutory amendment to stipulate that an injured worker may not refuse generic substitution of pharmaceuticals unless the prescribing doctor indicates the brand name drug is necessary. Many group insurance plans allow patients to pay the difference between a brand name and generic drug if the patient desires the brand name; under TWCC’s recommendation, an injured employee would not be allowed this option. ROC staff believes the group health approach is also appropriate in workers’ compensation, and that injured workers should be allowed to pay the difference for a brand-name drug, provided that related necessary statutory clarifications occur to ensure this cost is not borne by the system.

26. Records Access. ROC staff agreed with a TWCC recommendation to establish that all system participants are required to provide the commission with reasonable access to records.
27. Sanction Authority. ROC staff disagreed at this time with a TWCC recommendation to expand the commission's authority to impose sanctions on health care providers who are not doctors (e.g., physical therapists, nurses, etc.). Although ROC staff believes this change may be appropriate at some point, the commission should first gain meaningful experience using its existing sanction authority against doctors.
28. Immediate Suspension from TWCC's Approved Doctors List (ADL) Pending Hearing. ROC staff took the same position on this issue as described in number 23 above.
29. Reimbursement from the Subsequent Injury Fund (SIF) for Summary Judgments. ROC staff disagreed with a TWCC recommendation to bar insurance carriers from being reimbursed from the SIF based on summary judgments. Under the statute, a carrier is allowed to seek reimbursement from the SIF, a special dedicated fund administered by TWCC, for benefits paid based on TWCC orders that are later overturned. ROC staff understands TWCC's concern for protecting the SIF from reimbursing in cases involving summary judgments with a weak basis; however, ROC believes TWCC should intervene in these cases to protect the SIF's interest rather than statutorily bar all summary judgments.
30. Filing of Court Petitions and Appeals. ROC staff agreed with a TWCC recommendation that the commission receive notice of appeals and petitions of decisions made in the TWCC dispute resolution process, and that the court should not have jurisdiction if the commission is not given notice. This change would provide TWCC another opportunity to intervene as appropriate in court action involving workers' compensation issues.
31. Admissibility of TWCC Hearing Record in Court. ROC disagreed with a TWCC recommendation to make commission hearing records admissible in court. Courts are unlikely to give much weight to this testimony, since it was not taken

- under Rules of Civil Procedure, and there does not appear to be a compelling reason to create an exception to the civil evidentiary framework.
32. Required Medical Examination (RME) Statutory Text. ROC staff disagreed with TWCC recommendation to eliminate an insurance carrier's ability to suspend income benefits based on the findings of a carrier-selected RME in a Maximum Medical Improvement (MMI) and impairment rating exam. TWCC's argument for making this change relates to the fact that HB 2600 changed the order for carrier-selected RME and TWCC-selected designated doctor exams on MMI and impairment rating issues, placing more emphasis on the Designated Doctor's exam. However, carriers were previously allowed to suspend based on an RME's finding even if a Designated Doctor opinion had been offered, and protections exist to ensure that an injured worker's benefits are not unfairly suspended. ROC staff suggests that this recommendation be revisited after ROC performs its legislatively mandated research project on the impact of the HB 2600 changes to this process in 2004.
33. Deceptive Practices. ROC staff agreed with a TWCC recommendation to add statutory language prohibiting use of names and logos deceptively similar to TWCC's, provided that such conduct cannot be deterred under current provisions.

INTRODUCTION

The mission of the Research and Oversight Council on Workers' Compensation (ROC) is to support the development of an effective and efficient workers' compensation system serving all Texans. The ROC carries out this mission by conducting professional studies and research; monitoring, assessing and making recommendations concerning the operational effectiveness of the workers' compensation system; and providing policymakers and other interested parties with objective and timely information regarding workers' compensation.

Section 404.007, Texas *Labor Code*, requires the ROC to "report to the Governor, Lieutenant Governor, and Speaker of the House of Representatives not later than December 31 of each even-numbered year." This report must include:

- a discussion of the activities of the ROC;
- a report on the status of the effectiveness of the workers' compensation system to provide adequate, equitable, and timely benefits to injured workers at a reasonable cost to employers, with recommendations for any additional necessary research; and
- identification of any problems in the workers' compensation system, with recommendations for regulatory and legislative action based on research or testimony.

The 2002 *Biennial Report* is based on information gathered by the ROC through its ongoing research and oversight activities. In addition, the ROC received input from system participants as well as other interested parties. All recommendations received by the ROC were considered in the development of this report.

Background: The Texas Workers' Compensation System

Workers' compensation is a form of insurance that may be carried by employers to pay for the medical and income losses incurred by employees who are injured on the job. Texas is the only state in which workers' compensation coverage is truly optional for

employers. Companies that wish to obtain coverage can do so from commercial insurance carriers or the Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund). Companies that meet certain requirements can also insure themselves through the Certified Self-Insurance Program, administered by the Texas Workers' Compensation Commission (TWCC). Public entities (such as cities and school districts) may self-insure individually, participate in a risk pool, or purchase commercial coverage. The State of Texas self-insures most state employees and administers most claims through the State Office of Risk Management (SORM), although certain state agencies and entities (namely the University of Texas System, Texas A&M University System, and the Texas Department of Transportation) administer their own workers' compensation programs.

Following is a brief description of the principal agencies and entities that make up the Texas workers' compensation system:

Texas Workers' Compensation Commission (TWCC)

TWCC was created during the workers' compensation system reforms of 1989 and replaced the Industrial Accident Board (IAB) in 1990. The TWCC is charged with one primary responsibility: administering the workers' compensation system in Texas. It does this through its central facility in Austin and 24 field offices around the state. Other specialized services of the TWCC include health and safety, medical review, compliance and practices, dispute resolution, ombudsman assistance, and self-insurance regulation programs.

Texas Mutual Insurance Company (TMIC)

(formerly the Texas Workers' Compensation Insurance Fund)

Texas Mutual is an insurance company created by the state to write workers' compensation insurance in Texas. Although created by state action, Texas Mutual is not a state agency and does not receive legislative appropriations.

Texas Mutual began operations on January 1, 1992 with three objectives:

- to lower workers' compensation insurance rates by becoming a competitive force in the marketplace;
- to guarantee that workers' compensation insurance is always available to eligible Texas employers; and
- to serve as the insurer of last resort for employers who want workers' compensation insurance but cannot find it elsewhere.

Texas Department of Insurance (TDI)

TDI regulates most lines of insurance in Texas, including workers' compensation. TDI's responsibilities in terms of workers' compensation include ensuring that insurance companies are solvent; ensuring that rates are reasonable and calculated correctly; ensuring that policies and forms comply with the law and are easy to understand; protecting policyholders and the public from fraudulent and unethical behavior by insurance companies, agents, adjusters, and medical utilization review agents; and developing insurance data, such as detailed claims information and unit statistical data, for use by the Legislature, the public, insurance companies, and other interested parties.

Three TDI divisions are involved in monitoring and regulating workers' compensation insurance:

- Workers' Compensation Division – responsible for operational programs affecting workers' compensation policyholders, including experience modifiers, deductibles, the Small Employer Premium Incentive Program, group purchase of workers' compensation, and policy and rule development;
- Technical Analysis Division – accepts and evaluates rate filings and collects and analyzes statistical data; and
- Financial Services Division – monitors insurance carriers for solvency.

Texas Property and Casualty Insurance Guaranty Association (TPCIGA)

TPCIGA is a non-profit, unincorporated association of all Texas admitted property and casualty insurance companies. TPCIGA handles claims against all covered insolvent

property and casualty insurance companies, including those that write workers' compensation insurance.

State Office of Risk Management (SORM)

SORM administers workers' compensation benefits for most state employees and approves and inspects state agency risk management programs. It was created in 1997 by the 75th Legislature by merging the Workers' Compensation Division of the Office of the Attorney General and the Risk Management Division of the TWCC.

SECTION I
ACTIVITIES OF THE RESEARCH AND OVERSIGHT COUNCIL
ON WORKERS' COMPENSATION

The Research and Oversight Council on Workers' Compensation (ROC) monitors the Texas workers' compensation system to identify problems and make recommendations for improvement.

Research Activities

FY 2001 Research Summary

In 2001 ROC produced a series of reports based on the HB 3697 (76th Legislature, 1999) research mandate to examine medical cost, quality, and return-to-work issues in the Texas workers' compensation system. The titles published for this mandate were:

- *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*
- *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System*
- *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs*

These reports were utilized by the legislature to develop the reforms enacted in HB 2600 in the 77th Legislature. ROC also completed the following research projects in 2001:

- “Texas Workers’ Compensation Medical Costs: A Geographic Overview” (*Texas Monitor* 6:2, Summer 2001)
- “Maximum Weekly Compensation Amount: A Multi-State Comparison” (*Texas Monitor* 6:2, Summer 2001)
- “Perceptions of Injured Workers Who Requested a Change of Treating Doctor” (*Texas Monitor* 6:2, Summer 2001)
- *Fraud Detection and Prevention in the Texas Workers' Compensation System* (Web publication)

- *Multiple Employment in the Texas Workers' Compensation System: Features and Benefits* (Web publication)

FY 2002 Research Summary

ROC research staff completed the following projects in FY 2002:

Doctor and Insurance Carrier Monitoring

1. Development of a Designated Doctor monitoring plan in conjunction with the Texas Workers' Compensation Commission (TWCC) (implementation component of Article 1 of HB 2600)
2. Creation of the research design to assess the impact of both the Designated Doctor monitoring plan in Article 1 and the usage of designated doctors rather than insurance carrier Required Medical Examiners specified in Article 5 of HB 2600
 - ROC Publication: “Designated Doctor Monitoring Results: Wide Variation in Average Impairment Ratings” *Texas Monitor* Vol. 7, No. 2, Special Edition, August 2002.
3. Development of a quality of care/treatment utilization monitoring plan for treating and referral doctors in conjunction with TWCC (implementation component of Article 1 of HB 2600)
 - ROC Publication: “Health Care Provider Monitoring Results for Physical Medicine Services” *Texas Monitor* Vol. 7, No. 2, Special Edition, August 2002.
4. Development of a utilization review monitoring plan for Utilization Review Agents (URAs) and insurance carriers in conjunction with TWCC and the Texas Department of Insurance (TDI) (implementation component of Article 1 of HB 2600)

- ROC Publication: "Insurance Carrier Monitoring: A Comparison of the Amount of Physical Medicine Services Paid by Insurance Carriers in Texas" *Texas Monitor* Vol. 7, No. 3, Fall 2002.

Alternative Workers' Compensation Health Care Model – Voluntary Regional Health Care Delivery Networks

5. Analysis of workers' compensation managed care program standards used in other states in conjunction with the Health Care Network Advisory Committee (implementation component of Article 2 of HB 2600)

- ROC publication: *An Analysis of Managed Care Network Standards in Other State Workers' Compensation Systems* (July 2002)

6. Development of a workers' compensation health care delivery network report card in conjunction with the Health Care Network Advisory Committee (implementation component of Article 2 of HB 2600)

- ROC publication: *Health Care Network Report Cards: Requirements in Other State Workers' Compensation Systems and Other Health Care Delivery Systems* (August 2002)

Return to Work and Other Health Care Quality Issues

7. Creation of the research design to collect and measure injured worker return to work outcomes in conjunction with TWCC

8. Analysis of return to work rates for individual state agencies in conjunction with State Office of Risk Management (SORM)

Medical Dispute Resolution

9. Creation of a research design to assess the impact of the use of Independent Review Organizations (IROs) on the frequency, quality, and cost effectiveness of medical dispute decisions in Texas

Multiple Employment/Subsequent Injury Fund (SIF)

10. Estimates of the frequency of injured workers who receive increased income benefits due to their multiple employment status

11. An assessment of the impact of HB 2600 on the economic viability of the Subsequent Injury Fund (SIF)

- ROC publication: *The Multiple Employment Provision of HB 2600 and Its Impact on the Subsequent Injury Fund* (August 2002)

Employer Participation Rates and Other Insurance Issues

12. An analysis of employer participation in the Texas workers' compensation system (update of employer subscription and nonsubscription estimates)

- ROC publication: *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates* (February 2002)

13. Creation of a research design to measure actual workers' compensation insurance rate fluctuations for various industry sectors in Texas

Worker Health and Safety Issues

14. Creation of a research design to analyze drug-free workplace programs and the possibility of instituting a premium credit for employers who maintain a drug-free workplace program in conjunction with TWCC's Worker Health and Safety Division

Oversight Activities

ROC oversight and research staff assisted Texas policymakers in the 77th Legislative Session in drafting House Bill (HB) 2600, a comprehensive workers' compensation bill that represented the most sweeping changes to the system since the reforms of 1989. Initially, the bill was comprised of six articles designed to address the medical cost and quality issues raised by the HB 3697 (76th Legislature) studies. The final bill contained 17 articles, many of which were originally filed as separate bills and later attached to the omnibus.

Although HB 2600 dominated much of the workers' compensation policy discussion during the 77th Legislature, there were numerous other bills filed relating to workers' compensation issues for which ROC staff provided information and assistance. Of these, 10 passed while another 60 did not win final approval. However, as mentioned, several of these were included in HB 2600 and were thus enacted into law.

Agencies Monitored

During FY 2001 and FY 2002, the ROC continued its statutory role of assessing the operational effectiveness of the workers' compensation system. In this capacity, ROC staff regularly monitored the activities of Texas Workers' Compensation Commission (TWCC), the Texas Department of Insurance (TDI), the Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund), the Texas Property and Casualty Insurance Guaranty Association (TPCIGA), and the State Office of Risk Management (SORM).

Constituent Oversight Activity

Among the responsibilities tasked to the ROC is responding to system participants attempting to access various aspects of the workers' compensation system. ROC's primary role is to direct these individuals to the TWCC staff or field office that can most appropriately meet their needs. In addition, the oversight staff serves as a liaison in those cases that require additional monitoring or follow up. Finally, oversight staff provides

assistance to legislators and state leaders who may need assistance outside of the normal TWCC channels. This type of constituent work provides valuable information about the effectiveness of the workers' compensation system, allowing ROC staff to identify the need for new procedures and policies. In FY 2001 and 2002, oversight staff handled 431 constituent requests. Requests remained open for an average of 25.7 days.

Other Oversight Activities

In addition to regular monitoring and oversight activities, ROC staff produced the *2002 Biennial Report*; produced a special edition of the *Texas Monitor* summarizing all legislative activity of the 77th Legislature pertaining to workers' compensation as well as future issues to be considered; and wrote articles on a variety of topics for the *Texas Monitor*, including:

- “Litigation Trends and the Use of Liability Waivers by Nonsubscribing Employers” (*Texas Monitor* Vol. 6, No. 4, Winter 2001)
- “Impact of Reliance Insolvency on Workers’ Compensation in Texas” (*Texas Monitor* Vol. 6, No. 4, Winter 2001)
- “Mid-Biennium Status of ROC’s 2000 *Biennial Report* Policy Options and Recommendations” (*Texas Monitor* Vol. 7, No. 1, Spring 2002)

ROC staff also participated in the Workers’ Compensation Legislative Workgroup organized by the staffs of Representative Kim Brimer and Senator Troy Fraser. In September 2002 ROC staff took on a greater role in organizing these meetings, in conjunction with Representative Scott Hochberg’s office. The workgroup provides a forum for briefing legislative staff on recent developments in workers’ compensation, promoting discussion and leading to a better understanding of policy proposals and problems. The workgroup also provides an additional point of contact between TWCC, SORM and the ROC, facilitating additional direct communication between the two agencies.

SECTION II
STATUS OF THE EFFECTIVENESS OF
THE TEXAS WORKERS' COMPENSATION SYSTEM

Background

When the 70th Texas Legislature began the process of reforming the workers' compensation system in 1987, it established the Joint Select Committee on Workers' Compensation Insurance to conduct a study on problems in the system and to make recommendations for change. The Joint Select Committee developed a set of fourteen policy areas that the system was designed to address:

1. Safety
2. Coverage
3. Medical Care and Rehabilitation
4. Benefit Adequacy
5. Benefit Equity
6. Effective Delivery of Benefits
7. Agency Control
8. Policy Control
9. System Monitoring
10. Return to Work
11. Insurance
12. Economic Viability
13. Cost Internalization
14. Protection Against Cost Transfer

This *Biennial Report* utilizes those fourteen policy objectives as the foundation on which to assess the operational effectiveness of the system in 2002. For organizational purposes, Agency Control, Policy Control, and System Monitoring will be discussed in one section; Insurance and Economic Viability will also be discussed together. Most sections are divided into descriptions of basic data and information related to the area of the system and discussion of recent legislative and regulatory activity and specific research, although organization varies slightly from section to section. Each section

begins with a policy statement mirroring the language found in the Joint Select Committee's report.

1. SAFETY

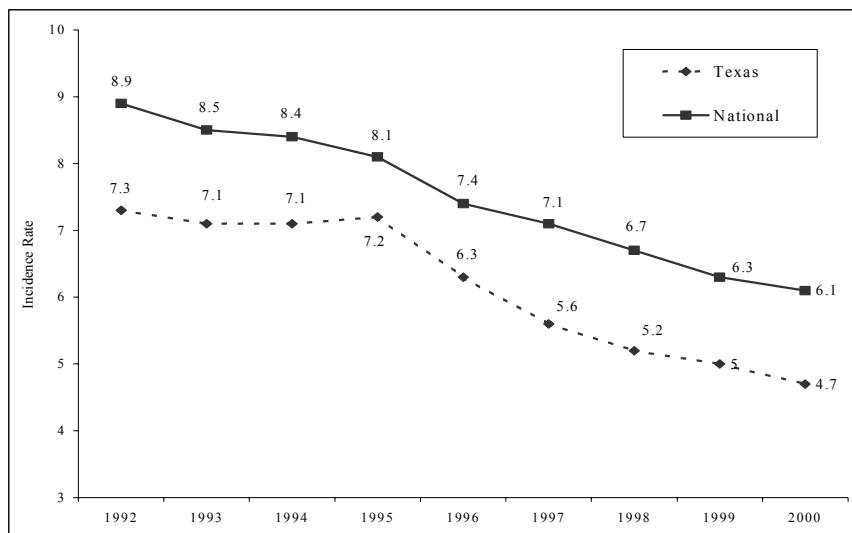
The system should promote safety and health in the workplace through an appropriate employer incentive system.

Maintaining safe workplaces is a key factor in minimizing on-the-job injuries. This section examines recent activity in the area of safety.

Injury Rate

An important statistic in measuring safety is the nonfatal occupational injury and illness rate. This rate calculation is currently based on an annual survey of Texas employers conducted by the U.S. Department of Labor, Bureau of Labor Statistics (BLS) and the Texas Workers' Compensation Commission (TWCC). Between 1992 and 2000, the nonfatal occupational injury and illness rate in Texas decreased 36 percent, from 7.3 to 4.7 per 100 full-time workers. The most significant injury rate declines occurred between 1995 and 2000. The injury rate in Texas has been consistently below the national average since 1992 (see Figure 1).

Figure 1
Texas and National Nonfatal Occupational Injury/Illness Rates
Per 100 Full-time Workers (1992-2000)

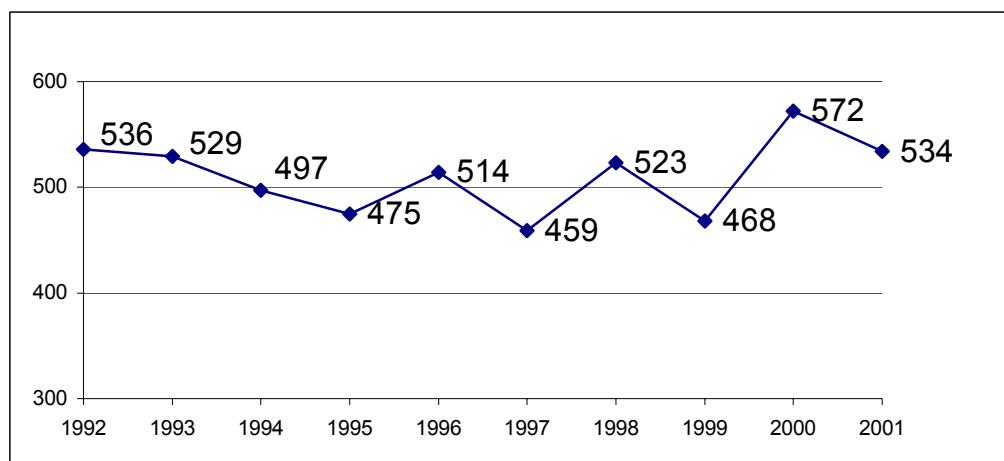


Source: Texas Workers' Compensation Commission and U.S. Department of Labor: Bureau of Labor Statistics, *Annual Survey of Occupational Injuries and Illnesses*, 2000.

While the BLS injury rate provides a useful measure of workplace safety, it is also important to remember that the rate is based on self-reported employer data rather than on workers' compensation claim data reported to TWCC. In addition, because the data are based on a sample of all Texas employers, this injury rate includes Texas employers who do not carry workers' compensation insurance. While this provides a good picture of the state's overall injury rate – and is directly comparable to injury rates in other states also measured by BLS – it would be most useful for analyzing the Texas system if the rate could be further broken down by subscription status (i.e., whether or not an employer is covered by the Workers' Compensation Act).

The number of fatal occupational injuries in Texas decreased by 7 percent in 2001, from 572 to 534 (see Figure 2).⁴ This positive trend, however, follows a 22 percent increase in fatalities from 1999 to 2000. The number of fatal injuries in Texas is now virtually unchanged over the last ten years, but somewhat higher than the 10-year average of 510.⁵

Figure 2
Number of Fatal Injuries in Texas by Year, 1992-2001



Source: Texas Workers' Compensation Commission and U.S. Department of Labor: Bureau of Labor Statistics, *Census of Fatal Occupational Injuries*, 2002.

⁴ The Texas Workers' Compensation Commission's Census of Fatal Occupational Injuries (CFOI) Program collects this information as a joint effort with the U.S. Department of Labor's Bureau of Labor Statistics. According to this report, transportation incidents, including auto accidents and workers being struck by vehicles, are the primary cause of workplace fatalities in Texas.

⁵ Although the number of fatalities is nearly identical to what it was in 1992, a smaller percentage of the workforce is involved in fatal claims than was the case at that time, due to expansion of the workforce over the past nine years.

In 2001 the construction industry reported the highest number of fatalities (20 percent of the total), followed by retail and wholesale trade (17 percent) and agriculture, forestry, and fishing (12 percent).

Employer Incentive Programs for Safety

Several premium incentive programs in the Texas workers' compensation system, including experience rating and deductibles, currently exist to encourage employers to create safe workplaces.⁶ Another option for large Texas employers is the TWCC Certified Self-Insurance Program. Self-insurance encourages employers to implement injury prevention and disability management programs by allowing them to be responsible for paying for their own losses and claims administration.

In addition to premium incentives and self-insurance, employers have access to several TWCC-sponsored health and safety programs. TWCC offers free safety materials and videos and provides employers with a comprehensive "how to" guide for creating an effective accident prevention plan.⁷ In addition to TWCC's efforts, all insurance carriers, including the Texas Mutual Insurance Company, offer accident prevention services to their policyholders. TWCC also provides several safety training and consultation programs, such as the Rejected Risk, Hazardous Employer, and Occupational Safety and Health Consultation (OSHCON) programs, which help employers identify hazardous workplace conditions and recommend possible solutions. Between 2,500 and 3,100 employers a year have requested OSHCON consultations over the past five years, and in 2001, employers who participated in the program experienced a 19 percent reduction, on average, in injuries (see Table 1). Additionally, employers who were identified as

⁶ Experience rating is a method of adjusting an employer's premium based on that employer's own claim and loss experience compared to the claim and loss experience of other employers in the same industry. Experience rating allows employers who have fewer injuries and losses to pay lower premiums than employers with numerous work-related injuries, while deductibles offer lower premiums to employers who are willing to assume part of the workers' compensation loss risk.

⁷ In 2001, TWCC distributed 229,152 safety publications, 6,271 safety videos and 4,704 drug-free workplace guides to Texas employers. See Texas Workers' Compensation Commission, *System Data Report*, June 2002. Since July 2000, these totals have also included publications and materials downloaded from TWCC's website, www.twcc.state.tx.us. In 1999, prior to online materials being included, TWCC distributed 80,168 safety publications, 6,529 safety videos, and 1,455 drug-free workplace guides.

"Hazardous" and subsequently participated in this safety program in 2001 saw an impressive 73 percent reduction, on average, in injuries in 2001 (see Table 2). TWCC also offers a toll-free safety hotline to encourage the reporting of unsafe working conditions. In 2001, TWCC received 528 health and safety complaints on the hotline and corrected 477 safety hazards.⁸

**Table 1
Occupational Safety and Health Consultations (OSHCON), 1997 - 2002**

	1997	1998	1999	2000	2001	2002 (Jan-June)
Employers requesting consultation	2,561	2,725	2,887	2,880	3,074	1,521
Number of Consultations	2,862	2,907	2,955	3,023	3,235	1,628
Number of Workers employed by identified employers	124,197	130,633	132,620	134,364	138,107	69,115
Injuries 12 months prior to consultation	3,557	4,654	4,400	5,695	2,085	*
Injuries 12 months after to consultation	3,054	3,965	3,832	4,642	1,696	*
Percent reduction	14%	15%	12%	18%	19%	*

Source: Texas Workers' Compensation Commission, *System Data Report*, June 2002.

Note: *Not available.

**Table 2
Hazardous Employer Program Participation, 1997 - 2002**

	1997	1998	1999	2000	2001	2002 (Jan-June)
Total employers identified	140	92	637	737	1,013	493
Private employers	*	*	533	649	913	448
Public employers	*	*	84	88	100	45
Workers employed by identified employers	26,212	35,415	147,296	136,669	224,331	68,558
Employers completing program with injury data for 12 months after notification	20	54	43	41	62	27
Injuries 12 months prior to notification	154	680	637	790	876	*
Injuries 12 months after to notification	52	533	162	219	236	*
Percent reduction in injuries	66%	22%	75%	72%	73%	*

Source: Texas Workers' Compensation Commission, *System Data Report*, June 2002.

Note: *Not available.

⁸ See Texas Workers' Compensation Commission, *System Data Report*, June 2002. Totals include multiple safety hazards corrected for individual employers.

Recent Activity – Safety

Drug-Free Workplace Study (Article 13, HB 2600)

Article 13 of HB 2600 (77th Legislature, 2001) directed TWCC to study the possible system impact of adopting a workers' compensation insurance premium discount program for employers who maintain a drug-free workplace (DFW).⁹ TWCC is required to report findings to the Texas Legislature and the Research and Oversight Council on Workers' Compensation (ROC) no later than February 1, 2003.

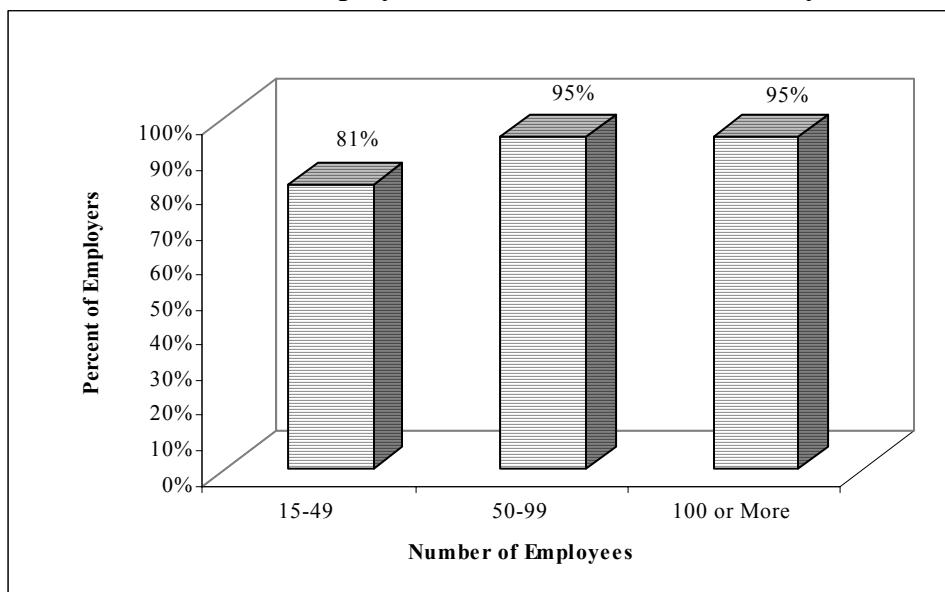
TWCC, with assistance from ROC, conducted a survey of Texas employers in May and June of 2002 to provide a benchmark for the percentage of covered employers that utilize various DFW program components (e.g., written policies, pre-employment drug testing, random drug testing, post-accident drug testing, or assistance with treatment options for drug or alcohol problems). In addition, the survey sought to determine the percentage of private sector employers in Texas that may be impacted by a workers' compensation DFW premium credit program, should such a program be implemented.

All Texas employers that are covered by workers' compensation insurance *and* employ 15 or more workers are required by law to have a written DFW policy, and to distribute a written copy of that policy to their employees.¹⁰ The survey results show that the vast majority (86 percent) of employers comply with the statutory requirement. As Figure 3 illustrates, compliance is even higher among large employers. In addition, 95 percent of companies with 50 or more employees indicated that they have a written DFW policy.

⁹ See Texas *Labor Code*, Section 411.093.

¹⁰ See Texas *Labor Code*, Section 411.091.

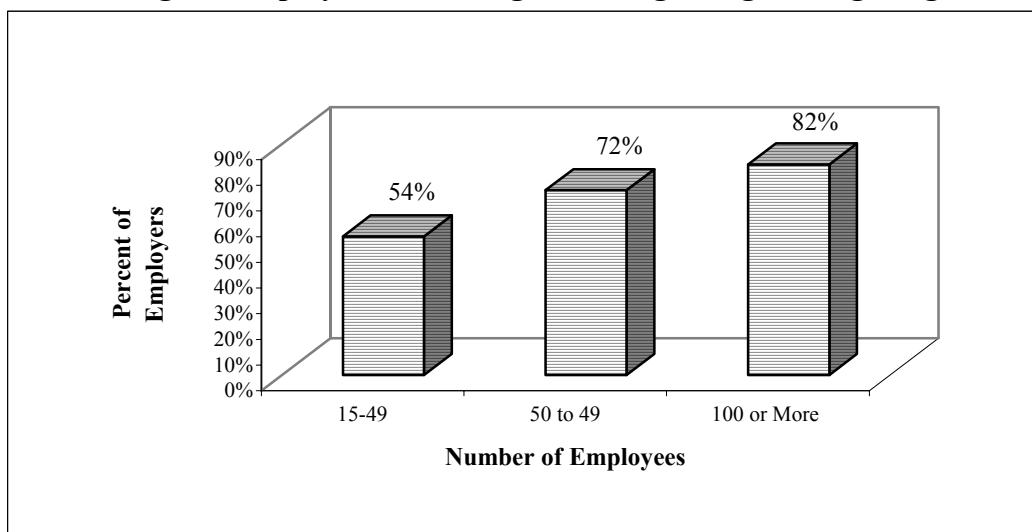
Figure 3
Percent of Employers with a Written DFW Policy



Source: Texas Workers' Compensation Commission and Research and Oversight Council on Workers' Compensation, *Survey of Texas Employers Regarding Drug-Free Workplace Policies*, 2002.

A significant proportion (63 percent) of employers with 15 or more workers go beyond a written DFW policy and currently have a drug screening or drug testing program in place. As Figure 4 illustrates, the tendency of employers to have drug testing programs increases significantly with the number of workers employed. While more than half (54 percent) of smaller companies (those with 15 to 49 workers) had a drug testing program, a significantly higher percentage of larger employers (72 percent of those employers with 50 to 99 workers, and 82 percent of those with 100 or more workers) have such programs in place.

Figure 4
Percentage of Employers with Drug Screening/ Drug Testing Programs



Source: Texas Workers' Compensation Commission and Research and Oversight Council on Workers' Compensation, *Survey of Texas Employers Regarding Drug-Free Workplace Policies*, 2002.

The general consensus among surveyed employers is that drug and alcohol abuse in the workplace is a significant workers' compensation system cost driver and that comprehensive DFW programs help to reduce on-the-job injuries and create a safer work environment for employees.

Conclusion – Safety

Decreasing injury rates suggest that accident prevention and safety programs have been successful in recent years. The overall number of fatal occupational injuries in Texas is no lower now than it was ten years ago, although there were fewer fatalities in 2001 than in 2000. TWCC's recommendations on possible incentives for employers to provide drug-free programs are still forthcoming as of this writing; preliminary benchmark measures indicate that Texas employers are predominantly in compliance with current statutory requirements relating to drug-free workplaces.

2. COVERAGE

The system should provide broad coverage of employees and work-related injuries and diseases regardless of fault.

Overview

An essential consideration in any discussion of workers' compensation coverage in Texas is the unique nature of the state's workers' compensation system. Since the Texas workers' compensation law was enacted in 1913, private sector employers have been allowed to opt out of the state system.¹¹ Elective workers' compensation systems, like the one currently in place in Texas, were fairly common until the mid-1970s. During the 1970 to 1975 period, 21 states changed their statutes to require employers to carry workers' compensation coverage. This sudden shift to mandatory coverage requirements was related to the work of the National Commission on State Workmen's Compensation Laws, which included mandatory workers' compensation coverage as one of its 19 essential recommendations.¹² When South Carolina made coverage mandatory for employers in July 1997, Texas became, and currently remains, the only state in the country with a truly elective workers' compensation system for private sector employers.¹³

Current Coverage Rates

According to a recent study of Texas employers conducted by the ROC in the fall of 2001, an estimated 35 percent of employers in Texas do not carry workers' compensation coverage. Since larger companies are much more likely to purchase workers'

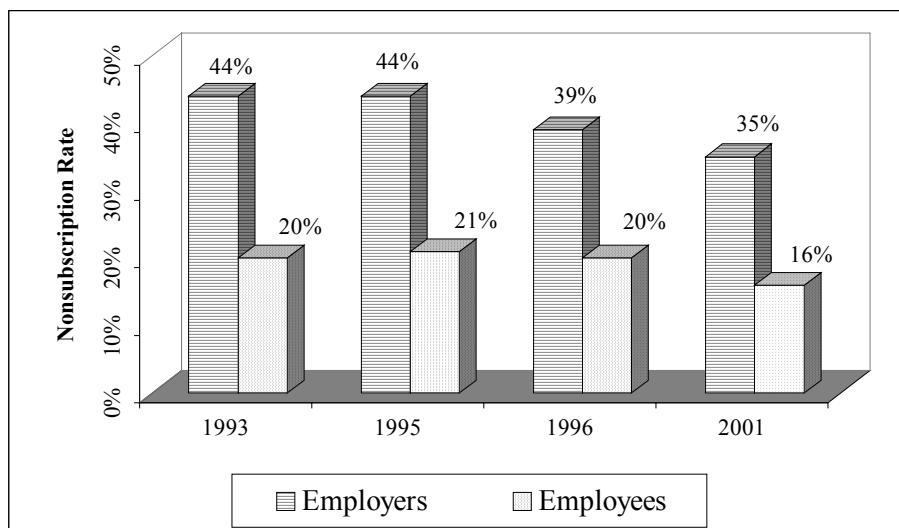
¹¹ Governmental employers in Texas are currently required to provide workers' compensation coverage to their employees.

¹² See National Commission on State Workmen's Compensation Laws, *The Report of the National Commission on Workmen's Compensation Laws* (Washington D.C., July 1972).

¹³ New Jersey is the only other state that currently does not require employers to carry workers' compensation coverage. However, due to the restrictive nature of its statute, all employers in New Jersey have thus far chosen to carry workers' compensation coverage. New Jersey law allows two alternatives for employers: 1) the standard workers' compensation statute; and 2) a form of employer liability based on traditional common law remedies. It is required that every employer in New Jersey choose one of the two options. It should also be noted that while Texas is now the only truly elective state, a number of other states do offer elective provisions for private employers with relatively few employees or those in particular sectors of the economy.

compensation insurance, an estimated 84 percent of the Texas workforce is employed by employers with workers' compensation coverage. Based on this estimate, approximately 1.4 million workers in Texas are employed by nonsubscribing employers. As reflected in Figure 5, this rate of participation in the Texas workers' compensation system (65 percent of employers and 84 percent of employees) represents the highest coverage rates recorded since the system was overhauled in 1989.¹⁴

Figure 5
**Employer Nonsubscription Rates and Percentage of Workers'
Employed by Nonsubscribers: 1993-2001**



Source: Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 1996 and 2001; and Texas Workers' Compensation Research Center and the Public Policy Research Institute at Texas A&M University, 1993 and 1995.

Once employers in Texas make a decision regarding workers' compensation coverage, they tend to stick to it. The vast majority of Texas employers have either always had workers' compensation coverage (60 percent) or have never had workers' compensation coverage (26 percent). Only the remaining 14 percent of employers in Texas have moved in and out of the workers' compensation system at various points in their company's history.

¹⁴ See Research and Oversight Council on Workers' Compensation, *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates*, 2002.

Information collected in the ROC's 2001 survey of Texas employers reveals, however, that companies may be becoming more price sensitive and open to reconsidering their coverage options if workers' compensation insurance costs continue to rise (see the section on Insurance and Economic Viability, for more information on rate trends). When current subscribers to the Texas workers' compensation system were asked what percentage increase in workers' compensation premiums it would take to make them seriously consider opting out of the system, almost half (48 percent) said they would re-evaluate their workers' compensation coverage decision if their premiums rose even marginally (i.e., by an increment less than 20 percent). If insurance rates continue to rise, this price sensitivity reported by Texas employers could result in lower workers' compensation coverage rates in coming years. This is an area that will require continued monitoring by the ROC.

Alternative Occupational Benefits Plans by Nonsubscribers

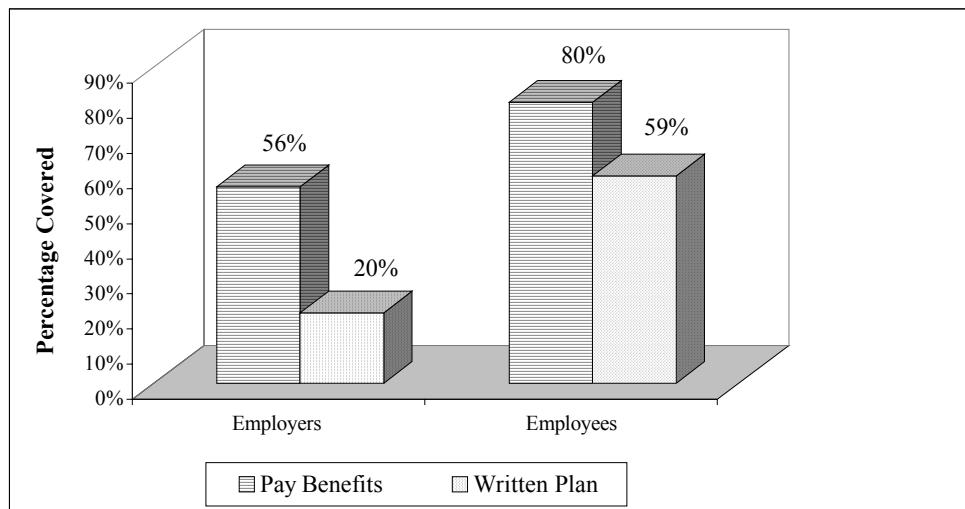
It is also clear from the ROC's 2001 study and from previous research conducted by the ROC and its predecessor agency, the Texas Workers' Compensation Research Center, that many employers that have opted out of the workers' compensation system still provide alternative protection to their employees for work-related injuries. According to the ROC's 2001 study, more than half (56 percent) of employers without workers' compensation coverage (i.e., nonsubscribers) indicated that they pay occupational benefits to injured workers. Of these nonsubscribers that pay benefits:

- 70 percent said they pay both medical and wage replacement benefits;
- 22 percent said they pay medical benefits only; and
- 8 percent indicated that they pay wage replacement benefits only.

The study also indicated that larger nonsubscribers are more likely to have an alternative occupational benefits plan, and the majority of the non-covered workforce are employed by companies that pay some type of occupational benefits to workers injured on the job. It is important to note, however, that significantly fewer nonsubscribers have *written* occupational benefits plans. Only 20 percent of nonsubscribing firms indicated that their plans to pay occupational benefits to injured workers were in writing. Again, since larger

companies are more likely to have formal, written plans, these firms employ almost 60 percent of the nonsubscriber workforce. (See Figure 6.)

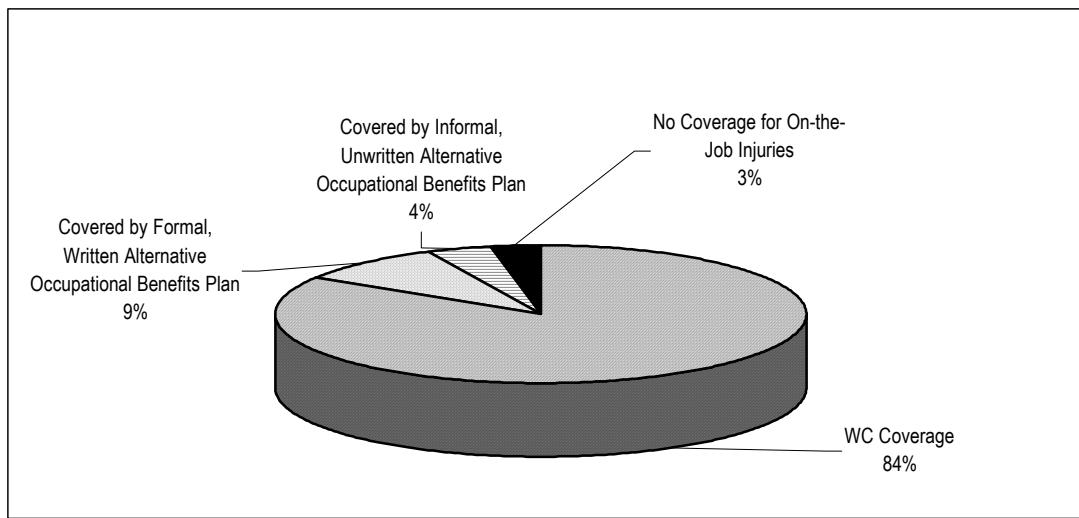
Figure 6
**Prevalence of Alternative Occupational Benefit Plans
and the Proportion of the Nonsubscriber Workforce they Cover**



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

The nonsubscription study found that an estimated 84 percent of the workers in Texas are covered by workers' compensation, and another 9 percent are employed by nonsubscribing firms with written alternative occupational benefits plans. Another 4 percent of the Texas workforce is employed by companies without workers' compensation coverage, but which indicated that they do pay benefits to injured workers, though without a written plan to do so. The remaining 3 percent of the Texas workforce, or an estimated 280,000 workers, are employed by nonsubscribers that do not pay benefits to injured workers (see Figure 7). The only apparent recourse for these workers if injured on the job would be to sue the employer.

Figure 7
Coverage for On-the Job Injuries in Texas
By Percentage of Workforce



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

Decision Drivers for Nonsubscribing Employers

During the course of the ROC's 2001 nonsubscription survey, employers without workers' compensation coverage were asked to rate the importance of various factors which may have impacted their decision to opt out of the workers' compensation system. The reasons why employers decided to go without workers' compensation coverage varied significantly with firm size. Reasons cited as important by small employers tended to focus on cost, low incidence of injury, and having too few employees. However, reasons commonly cited by larger firms shed considerable light on some areas of the workers' compensation system that warrant attention. Table 3 provides a complete list of decision drivers along with the percentage of employers that rated the reason as important.

Table 3
Important Reasons for Not Carrying Workers' Compensation Coverage
By Employer Size

Reason for Not Carrying WC Coverage	Percent of Nonsubscribing Employers Rating Reason as Important		
	1 to 49 Employees (Small)	50 to 99 Employees (Medium)	100 or More Employees (Large)
Quoted premiums were too high	60%	82%	87%
Your company had too few employees	67%	21%	1%
Not required to have WC coverage by law	57%	39%	49%
Your company had few on-the-job injuries	61%	36%	34%
Company cost-cutting measure	33%	63%	61%
Competition does not carry WC coverage	25%	13%	23%
Medical costs in the WC system were too high	44%	51%	54%
Dissatisfaction with service from WC insurance carrier	18%	15%	43%
Alternative occupational benefits plan was a better value than WC coverage	39%	59%	80%
Wanted more control over choice of medical providers	28%	32%	78%
Administrative process associated w/filing a claim	24%	21%	33%
Felt company could do a better job than WC system at providing occupational benefits	36%	38%	58%
Concerns about TWCC dispute resolution process	17%	16%	34%
Concerns about fraud in the WC system	23%	35%	47%
High experience modifier which made WC insurance unaffordable	11%	24%	33%

Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

Note: "Important" is defined as assigning a rating of 4 or 5 on a scale of 1 to 5, where 1 means *Not at all Important* and 5 means *Extremely Important*.

Premium costs were cited as an important factor for not carrying workers' compensation coverage by significant percentages of large (87 percent), medium (82 percent) and small (60 percent) employers. "Few on-the-job injuries," and "too few employees" tended to be important factors only for smaller nonsubscribers. Conversely, larger nonsubscribers (those with 100 or more employees) were much more likely to opt out of the workers' compensation system because they felt that their alternative occupational benefits plan was a better value than workers' compensation coverage, because they felt they could do a better job than the workers' compensation system at ensuring their injured workers obtained appropriate benefits, or to gain more control over choice of medical provider. In addition, larger nonsubscribing firms also were more likely to be more concerned about workers' compensation fraud and the TWCC dispute resolution process.

It is evident from these survey results that there are areas in which the workers' compensation system can be improved to try to make workers' compensation coverage a more attractive alternative to companies wrestling with the nonsubscription decision. For instance, it is clear that dissatisfaction with medical costs and medical case management, insurance carrier service, and fraud are key issues that contribute to the ultimate decision by many large companies to opt out of the workers' compensation system. HB 2600, passed by the 77th Legislature in 2001, included provisions intended to address some of these perceived problems, particularly high medical costs and poor outcomes; however, not enough time has yet elapsed to evaluate its full impact in meeting these goals. It is still beneficial to employers, injured workers, and insurance carriers in Texas that discussions continue so these and other key employer concerns are addressed in a meaningful way.

Recent Activity – Coverage

Use of Liability Waivers by Nonsubscribers

As noted, many nonsubscribers purchase alternative occupational benefits insurance or establish self-funded plans to cover work-related injuries. In the past, some nonsubscribers asked their employees to sign liability waiver agreements under which the employee relinquished his or her right to sue the employer over a work-related injury in exchange for some consideration (e.g., participation in an alternative occupational benefits plan, or a higher level of plan benefits).¹⁵ After the Supreme Court of Texas in April 2001 upheld decisions of lower courts that such waivers contained in nonsubscriber employee benefits plans were enforceable, the 77th Legislature passed Article 16 of HB 2600, which voided and outlawed waiver agreements in which the injured employee waives his or her right to sue at some point *prior* to the time of injury.¹⁶ This provision of

¹⁵ Estimates from ROC's 2001 study indicate that a relatively small percentage of nonsubscribers – seven percent – asked their employees to sign liability waivers. However, more than a quarter (27 percent) of firms with 50 or more workers reported that they utilized waiver agreements. Since waivers were more frequently used by larger firms, an estimated 18 percent of the nonsubscriber workforce was employed by firms that used liability waivers.

¹⁶ The cases appealed to the Supreme Court of Texas were *Lawrence v. CDB Services, Inc.* and *Lambert v. Affiliated Foods, Inc.* Both of these cases involved instances where the Amarillo Court of Appeals upheld waivers contained in employee benefits plans.

HB 2600 was effective June 17, 2001. Post-injury waivers, in which the employee waives his or her right to sue at some time *after* the injury has occurred, were not addressed by this legislative change.

Binding Arbitration Agreements

Some nonsubscribing employers also utilize binding arbitration as a method for resolving disputes with employees regarding work-related injuries while reducing the likelihood of suit. The Supreme Court of Texas was asked to rule on a case in which an employer sent notice of a new dispute resolution program (which involved binding arbitration as a remedy) to an employee informing him that his continuing employment would constitute acceptance of the new plan. When the employee was later demoted, he filed suit against his employer rather than adhere to the arbitration provision in the new dispute resolution plan. In *re Halliburton Company and Brown & Root Energy Services*, argued on November 7, 2001, the Supreme Court of Texas concluded that this arbitration provision was enforceable under general contract principles, that a valid arbitration provision exists between the employee and employer, and that the trial court should have granted the employer's motion to use arbitration to resolve the dispute.¹⁷ Although this case did not involve a nonsubscriber benefit program *per se*, this ruling may have significant implications for nonsubscribing employers who choose to use binding arbitration.

Conclusion – Coverage

Texas remains the only state in which workers' compensation coverage is truly optional for non-governmental employers. Despite the elective law, the majority of employers (65 percent) and workers (84 percent) in Texas are covered by the workers' compensation statute, and a significant portion of nonsubscribing employers (56 percent, employing 80 percent of the employees who work for nonsubscribers) provide occupational benefits to injured workers. It is also noteworthy that both subscribing and nonsubscribing employers reported generally high levels of overall satisfaction with their respective

¹⁷ See Supreme Court of Texas, No. 00-1206, *In re Halliburton Company and Brown & Root Energy Services, Relators*, On Petition for Writ of Mandamus, Argued on November 7, 2001.

decisions to purchase or not purchase workers' compensation coverage, according to the 2001 ROC estimates (60 percent of subscribers and 68 percent of nonsubscribers reported they were at least "satisfied" with their decision). Continued research on both subscribing and nonsubscribing employer and injured worker populations will be critical in the coming years as workers' compensation insurance costs rise and more companies consider their coverage options.

Legislation passed by the 77th Legislature in 2001 effectively prohibited the use of pre-injury liability waivers by nonsubscribing employers. However, nonsubscribers still have options to reduce the risk of litigation associated with work-related injuries, despite their lack of protection from suit under the Workers' Compensation Act. The Supreme Court of Texas ruled that binding arbitration may be used by employers as a method of settling disputes, and post-injury waivers (i.e., waiver agreements signed by employees at some point after an injury has occurred) were not barred by HB 2600. It will be important to monitor the use of these arrangements in the future to ensure that injured workers continue to be treated fairly both in and outside of the Texas workers' compensation system.

3. MEDICAL CARE AND REHABILITATION

The system should provide appropriate and quality medical care directed toward prompt restoration of the worker's physical condition and earning capacity.

Overview: Recent Medical Cost and Quality of Care Issues

Most system participants agree that the 1989 workers' compensation reforms resulted in significant improvements in the operational effectiveness of the Texas workers' compensation system – primarily in the areas of increased availability of insurance coverage, reduced litigation, increased safety awareness, and structured income benefits. However, many have expressed concern that the reforms did not adequately address the cost and the quality of medical care provided to injured workers in Texas. In response to these concerns, the 76th Texas Legislature passed House Bill (HB) 3697, which commissioned ROC staff to conduct research studies to compare Texas' workers' compensation medical costs and outcomes with other state workers' compensation systems and other health care delivery systems in Texas.

The findings from the HB 3697 studies confirmed that for similar types of injuries, Texas' workers' compensation medical costs were higher than many state workers' compensation systems and significantly higher than group health systems in Texas.¹⁸ These cost differences resulted primarily from more diagnostic testing, surgery and physical medicine treatment being provided to Texas injured workers for longer periods of time than for workers with similar types of injuries in other state workers' compensation systems and other group health plans.

Despite receiving more treatment for longer periods of time, the studies also found that

¹⁸ For more information on the specific HB 3697 research findings, see *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System: A Report to the 77th Texas Legislature, 2001*; Research and Oversight Council on Workers' Compensation, *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System A Report to the 77th Texas Legislature, 2001*; and *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs: A Report to the 77th Texas Legislature, 2001*. These three reports are available at no cost and can be ordered directly from the ROC or online at www.roc.state.tx.us.

Texas injured workers had more difficulty returning to work after their injuries and did not appear to be more satisfied with the medical care they received than workers in other states.

The results from these studies formed the basis for significant discussions during the 77th Texas Legislature about how to address medical cost and quality issues. After a number of unprecedented negotiations between representatives of business, health care provider, labor, and insurance carrier groups, legislators passed HB 2600, the most comprehensive piece of workers' compensation reform legislation since the overhaul of the system in 1989. While the primary components of HB 2600 focused on proposals to address the specific medical cost and quality of care issues identified in the HB 3697 studies, HB 2600 also included proposals to improve return-to-work communication among health care providers and employers, increase the ability for injured workers to secure attorney representation at District Court proceedings, and expand income benefits for injured workers with multiple jobs and for workers with severe burn injuries, among others. While many of the components of HB 2600 are discussed in other sections of this report, this section in particular focuses on Articles 2, 4, and 6 of HB 2600, specifically:

- the establishment of monitoring programs for health care providers, designated doctors, insurance carriers and their utilization review agents (URAs);
- the feasibility of regional workers' compensation health care delivery networks;
- the elimination of the spinal surgery second opinion process, and replacement of this process with required preauthorization;
- the addition of a minimum list of services requiring preauthorization and the addition of concurrent review and optional pre-certification processes;
- changes to the medical billing and payment structure of the Texas Workers' Compensation Commission (TWCC) fee guidelines;
- the repeal of the TWCC medical treatment guidelines; and
- the addition of an open pharmaceutical formulary for workers' compensation, along with requirements for usage of generic drugs (unless a physician prescribes a brand-name drug), and allowance of over-the-counter alternatives to prescription drugs.

Recent Activity – HB 2600 Components

Monitoring Programs for Health Care Providers, Designated Doctors, and Insurance Carriers

Article 1 of HB 2600 gave TWCC greater authority to monitor and discipline health care providers, designated doctors, and insurance carriers (including their utilization review agents, or URAs) whose medical practice and/or review patterns are “substantially different from those [TWCC] finds to be fair and reasonable based on either a single determination or a pattern of practice.”¹⁹ It also created a statutory role for TWCC’s Medical Advisor and created a Medical Quality Review Panel (MQRP) to conduct quality-of-care reviews and make recommendations to TWCC’s Commissioners regarding possible sanctions or, in the case of health care providers, possible removal from TWCC’s Approved Doctor List (ADL) and/or Designated Doctor List (DDL).²⁰

In order to facilitate these new monitoring initiatives at TWCC, ROC staff has worked closely with TWCC’s Medical Advisor over the past year to develop an effective and scientifically valid methodology for identifying individual health care providers, designated doctors and/or insurance carriers that warrant further clinical scrutiny by the MQRP.²¹ As part of this collaborative work, several monitoring initiatives were developed:²²

- A health care provider “data mining tool” (i.e., a computer program that analyzes large quantities of data) to perform an initial review of medical care utilization patterns and later to analyze diagnostic accuracy and return-to-work outcomes for individual health care providers;

¹⁹ See Texas *Labor Code*, Section 408.0231.

²⁰ See Texas *Labor Code*, Sections 413.0511 and 413.0512.

²¹ Three different monitoring projects were included on ROC’s FY 2002 approved Research Agenda: one each for health care providers, insurance carriers (URAs), and designated doctors.

²² Other Medical Advisor and MQRP initiatives include reviews of medical dispute decisions made by Independent Review Organizations (IROs).

- An insurance carrier “data mining tool” that mirrors the structure of the health care provider program described above by comparing the medical care utilization patterns paid for by insurance carriers for similar types of injuries; and
- A designated doctor “data mining tool” to compare the average impairment ratings assigned by designated doctors to injured workers with similar types of injuries.

In May 2002, ROC staff presented TWCC’s Medical Advisor with a list of designated doctors ranked from highest to lowest average impairment rating by injury type (i.e., diagnostic group) as well as the methodology for continuing this data monitoring in the future. This list served as the basis for the first set of MQRP clinical reviews initiated under HB 2600, as TWCC identified 18 designated doctors for a first round of reviews in July and August 2002.

The ROC also presented TWCC with a second list of health care providers analyzed by their utilization of physical medicine services in the summer of 2002, along with the methodology for analyzing physical medicine services in the future.²³ It is anticipated that this second list of health care providers will serve as the basis of the second round of MQRP clinical reviews in early FY 2003. The total number of designated doctors and health care providers selected for clinical review from these lists in FY 2003 are subject to budgetary, staffing, and other resource constraints at TWCC; however, it is likely that the resources that are available will be concentrated on those doctors and other health care providers whose practice patterns are least likely to be “fair and reasonable” (i.e., furthest from the norms on a consistent basis) when compared to the universe of designated doctors or health care providers as a whole.

Descriptions of the methodologies and results of initial data analyses for health care providers, designated doctors, and insurance carriers (none identified by name) were

²³ This list consisted of the median number of services per patient and the median duration of care for all providers (the comparison group) and a list of high-volume providers whose patterns of care placed them at various percentiles.

published in two editions of the *Texas Monitor* (7:2 Special Edition, Summer 2002 and 7:3, Fall 2002).

Feasibility of Regional Health Care Delivery Networks

Article 2 of HB 2600 introduced a new health care delivery model to the Texas workers' compensation system: namely, the concept of creating regional health care delivery networks that would provide higher quality medical care while decreasing overutilization of medical services and improving return-to-work outcomes. By statute, participation in these networks would be voluntary for employees and for insurance carriers. Under the structure of Article 2, a Governor-appointed Health Care Network Advisory Committee (HNAC) is responsible for overseeing a feasibility study that would develop proposed network standards and report card requirements for networks as well as examining the feasibility of initiating one or more regional networks.²⁴ As a separate component of Article 2, the ROC is required to report on the progress of establishing these networks biennially to the legislature.

In June 2002, the HNAC selected a consultant to complete the feasibility study. In order to assist the feasibility consultant in meeting aggressive project timelines, ROC staff, as part of its FY 2002 approved Research Agenda, completed two projects to analyze network standards and report card requirements used in other state workers' compensation managed care networks and in other health care delivery systems.²⁵

To date the HNAC has given preliminary approval to draft network standards and report card requirements, but a full draft of the feasibility report (including any proposed legislative recommendations to enhance network feasibility) will not be considered for adoption by the HNAC until late November 2002. After the feasibility study results have been fully adopted by the HNAC, ROC staff will compile and present a draft status report to the ROC Board for consideration prior to the convening of the 78th Texas Legislature

²⁴ See Texas *Labor Code* Sections 408.0221 and 408.0222.

²⁵ See Research and Oversight Council on Workers' Compensation, *An Analysis of Managed Care Network Standards in Other State Workers' Compensation Systems* (July 2002) and Research and Oversight Council on Workers' Compensation, *Health Care Network Report Cards: Requirements in Other State Workers' Compensation Systems and Other Health Care Delivery Systems* (August 2002).

in January 2003.

Elimination of the Spinal Surgery Second Opinion Process

Historically, the Texas workers' compensation system has given special attention to requests to perform spinal surgery on injured workers. Prior to the passage of HB 2600, such requests were subject to a process that allowed both insurance carriers and injured workers to request a second opinion examination to determine if the spinal surgery was appropriate. This process, however, did not appear to be an effective means to scrutinize spinal surgery requests, and resulted in an extremely high percentage of spinal surgery approvals, and consequently, higher spinal surgery rates in Texas compared to other state workers' compensation systems.²⁶

In an attempt to increase scrutiny of spinal surgery requests in Texas, Article 4 of HB 2600 eliminated the spinal surgery second opinion process and required spinal surgery requests to be preauthorized (approved before the surgery is performed) by insurance carriers. If preauthorization is denied, the doctor or the injured worker can request a review by an Independent Review Organization (IRO) with the opportunity to appeal the IRO's decision using TWCC's dispute resolution process under Chapter 410 of the *Labor Code* (For more information on the role of the IRO in the medical dispute resolution process, see the section on the Effective Delivery of Benefits).

While these changes are expected to expedite spinal surgery decisions (since the duration of the preauthorization process is generally shorter than the prior spinal surgery second opinion process) and ensure that adequate scrutiny is placed on the medical efficacy of these surgery requests, it is too early to evaluate the outcomes of this statutory change. However, as part of its approved FY 2003 Research Agenda, ROC staff plans to begin evaluating the effect of requiring preauthorization for spinal surgeries in preparation for

²⁶ According to an analysis of TWCC data, the vast majority of spinal surgery second opinions (approximately 82 percent for injury year 1997) resulted in a concurrence or approval of the original doctor's recommendation for surgery. This finding, coupled with the HB 3697 research findings indicating that Texas had higher spinal surgery rates than most comparison states (particularly for "soft-tissue" injuries, which typically do not require surgery) fostered the need to change the spinal surgery review process in Texas.

TWCC's Sunset Review in 2005.

Creation of a Statutorily-Required Minimum Preauthorization List and the Addition of Concurrent Review and Pre-certification Processes

While the *Labor Code* has always allowed TWCC to establish a list of medical services requiring preauthorization by insurance carriers, prior to HB 2600, the statute had never specifically named medical services for which preauthorization should be required. Article 4 of HB 2600 set up a minimum list of services requiring preauthorization by insurance carriers before they can be performed on injured workers, including:

- spinal surgery;
- work-hardening or work-conditioning services provided by a health care facility not credentialed by an organization recognized by TWCC rule;
- inpatient hospitalization;
- outpatient or ambulatory surgical services; and
- any investigational or experimental services.²⁷

In November 2001, TWCC adopted revisions to its preauthorization rule to include these statutory minimum services on the preauthorization list. The changes were effective February 1, 2002.²⁸ A previous rule proposal would have added several other services to the preauthorization list (such as manipulations beyond a certain number and acupuncture), but was modified as a result of concerns from some health care provider groups who felt that their medical specialties were being targeted for additional review, and from some insurance carriers, who were concerned that adding new services to the preauthorization list would increase dispute costs for relatively low-cost services.²⁹

As part of the preauthorization rule adoption, and in accordance with HB 2600 requirements, TWCC Commissioners approved a one-year exemption (expiring

²⁷ See Texas *Labor Code* Section 413.014.

²⁸ See TWCC Rule 134.600.

²⁹ Under changes to the medical dispute resolution process made by HB 2600, insurance carriers are responsible for the cost of any medical dispute involving a service or procedure on the preauthorization list. For more discussion of the medical dispute resolution process, see the Effective Delivery of Benefits section of this report.

December 31, 2002) to the work-hardening and work-conditioning preauthorization requirement for health care facilities whose programs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). In October 2002, TWCC proposed an extension of the preauthorization exemption until December 31, 2003, to give TWCC staff more opportunity to collect data on whether CARF-accredited facilities provide higher quality services that help injured workers get back to work as quickly and safely as possible, and whether they should continue to be given greater leeway to operate without preauthorization controls. TWCC Commissioners will likely vote on this proposed extension at their December 2002 public meeting.

In addition to establishing a minimum preauthorization list, Article 4 of HB 2600 also gave TWCC the authority to specify medical services that are subject to concurrent review. Concurrent review is a process by which a health care provider requests an extension of treatment for specific medical services that have already been preauthorized by the insurance carrier. As a component of the preauthorization rule passed in November 2001, TWCC specified that the following services were subject to concurrent review:

- length of stay for inpatient hospitalization;
- work-hardening or work-conditioning services;
- investigational or experimental services or use of devices;
- rehabilitation programs;
- durable medical equipment (DME) in excess of \$500 per item and TENS unit usage;
- nursing home, convalescent, residential, and home health care services; and
- chemical dependency or weight loss programs.

Article 4 of HB 2600 also included a provision clarifying that TWCC could not prohibit insurance carriers and health care providers from voluntarily discussing and coming to agreement on the approval or payment of specific medical services not on the list for which preauthorization is required. Prior to this statutory clarification, TWCC had taken the position in some Commission advisories that insurance carriers and health care

providers could not voluntarily discuss or pre-certify medical services that were not specifically on the list of services requiring preauthorization. During the discussions preceding the passage of HB 2600, many health care providers and some insurance carriers argued that they should be allowed to discuss and pre-certify treatment plans or specific medical services rather than have to deny and dispute them retrospectively.

An earlier version of HB 2600 would have created a more structured pre-certification process that required insurance carriers to review and approve or deny all pre-certification requests made by health care providers. However, prior to passage of the bill, this provision was altered because insurance carriers did not want to incur mandatory prospective review costs for pre-certification reviews, and such reviews would likely be subject to the procedural requirements of the Texas *Insurance Code*.³⁰ Subsequently, insurance carriers and health care providers reached a compromise in HB 2600 to allow health care providers to request and insurance carriers to agree to pre-certify treatment plans or specific medical services on a voluntary basis. It is not clear how well this process is working: recent complaints from health care providers suggest that few insurance carriers have agreed to pre-certification of treatment plans or specific medical services.

ROC staff believes that more time is needed to determine whether legislative or regulatory changes to the voluntary pre-certification provision might yield fewer medical disputes or simply add administrative burdens to an already complex utilization review process.

Changes to TWCC Fee Guidelines

ROC's HB 3697 research studies showed that it is the amount and duration of medical treatment – rather than the cost of individual medical services – that are the primary cost drivers in the Texas workers' compensation system. However, the report did point out that some pricing discrepancies did exist for individual treatments, particularly between the workers' compensation and the group health reimbursement structures – largely due

³⁰ See Article 21.58A, Texas *Insurance Code*, relating to procedural requirements for utilization review.

to preferred provider organization (PPO) discounts, copayments, and deductibles in the group health system. Additionally, survey findings in the report illustrated that both health care providers and insurance carriers felt that the 1996 TWCC Medical Fee Guideline (the guideline in effect at this time of writing) led to many medical disputes, because it used outdated 1995 Current Procedural Terminology (CPT) codes for medical treatments, and contained a completely different set of payment policies and billing ground rules than those used in other health care delivery systems.

These findings laid the groundwork for a varied list of medical pricing policy options in ROC's *Striking the Balance* report (one of the HB 3697 studies), including: 1) that TWCC revise its fee guidelines to include the most current CPT codes for medical services and tie workers' compensation fees to a national standard, such as Medicare's Resource-Based Relative Value System (RBRVS) or a market-based standard; 2) that TWCC establish a fee guideline or individual reimbursement amounts for outpatient surgery and ambulatory surgery services, which are currently reimbursed at vaguely-defined "fair and reasonable" amounts; and/or 3) that TWCC implement "case rates" (i.e., set reimbursement amounts for particular injury types, rather than reimbursements at the individual treatment level).

Article 6 of HB 2600 incorporated many of these policy options by requiring TWCC's fee guidelines to "adopt the most current reimbursement methodologies, models, and values or weights used by the federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services, or CMS), including applicable payment policies relating to coding, billing, and reporting."³¹ The statute also allows TWCC to make only "minimal modifications" to the standardized Medicare reimbursement structure as necessary to meet occupational injury requirements. In essence, this mandate required TWCC to adopt the payment policies of the Medicare system, which control how services may be billed, how they are coded, and ultimately paid, with only essential modifications.

³¹ See Texas Labor Code Section 413.011.

Although HB 2600 did not specifically address what the actual reimbursement levels should be for various medical services in the new fee guidelines, it did indicate that TWCC must use the Medicare methodology as a base for the workers' compensation fees, and required TWCC to develop conversion factors or other payment adjustment factors that must be applied to the Medicare base. In developing these workers' compensation conversion factors, HB 2600 required TWCC to take into account "economic indicators in health care" and the statutory requirements that fee guidelines must be "fair and reasonable and designed to ensure quality medical care and to achieve effective cost control."³² HB 2600 specifically prohibited TWCC from adopting conversion factors that were solely based on Medicare's fee structure. Policymakers also carved out one exception to the Medicare reimbursement methodology in HB 2600 by allowing chiropractors to remain treating doctors and incorporating *Insurance Code* provisions prohibiting any discrimination in payment that would have prevented chiropractors from being paid the same as medical doctors or osteopaths for similar medical services.³³

In June 2001, TWCC proposed a new professional services fee guideline (the guideline that would set pricing for most non-hospital physician services) that did not include the Medicare payment policies and proposed a workers' compensation conversion factor of 125 percent of Medicare. TWCC's conversion factor proposal was based on a report by a consultant hired to support the Medical Fee Guideline development project, Milliman USA, which indicated that workers' compensation medical fees under the 1996 TWCC Medical Fee Guideline were being paid at 130 percent of Medicare's current fees, and recommended a five percent reduction in those fees to 125 percent.

In the midst of the fee guideline proposal process, TWCC was sued by Patients Advocates of Texas (PAT), which alleged that the Commission had violated state purchasing rules when it contracted with Milliman USA. In August 2001 a Travis County District Court issued an injunction preventing TWCC from proceeding with its

³² See Texas *Labor Code* Sections 413.011 (b) and (d).

³³ See Texas *Labor Code* Section 413.011 (c).

professional services agreement with Milliman USA, and preventing TWCC from paying any additional funds to the consultant. While this injunction did not prevent TWCC from using Milliman USA's report to support a fee guideline proposal, it did prevent TWCC from asking Milliman USA to respond to questions about the report or to testify on the report's findings during the rulemaking process.

After considerable public comment about the lack of inclusion of the Medicare payment policies in accordance with HB 2600's requirements, and questions about the substance of Milliman USA's analysis, TWCC withdrew its fee guideline proposal in October 2001. TWCC replaced it in December 2001 with a new proposal that incorporated all of Medicare's payment policies by reference, with any changes or modifications to be made by TWCC as the need arises. Using an updated analysis which indicated that the 1996 TWCC Medical Fee Guideline was paying medical treatments at a rate that was approximately 140 percent of Medicare's rate, TWCC staff recommended a new workers' compensation conversion factor of 120 percent of Medicare (a twenty percentage point reduction).

Through the rule public comment process, TWCC received a considerable amount of input from system participants both supporting and opposing the proposed conversion factor. Health care provider and labor groups were concerned that the lower conversion factor would cause an access to care problem for injured workers, particularly in specialty medical services. They also felt that TWCC's proposal did not adequately consider "economic indicators in health care," since, they asserted, medical inflation has increased significantly since 1996. Employers and insurance carriers argued that the lower conversion factor still more than adequately compensated health care providers for the administrative burdens of the workers' compensation system, and that the 1996 TWCC Medical Fee Guideline had overcompensated for certain services such as surgery, while undercompensating for primary care services. TWCC also advanced this argument, contending that its 120 percent across-the-board conversion factor would actually increase fees for primary care services, while decreasing them for the specialties that TWCC argued were overpaid under the 1996 guideline.

After another round of public input on the second fee guideline proposal, TWCC Commissioners voted in April 2002 to adopt a staff recommendation regarding the professional services fee guideline with only one substantial change – namely, to raise the workers' compensation conversion factor from 120 to 125 percent of Medicare. TWCC Commissioners also designated a September 1, 2002 implementation date for the new professional services medical fee guideline.

In response to these actions, the Texas Medical Association (TMA) and the Texas AFL-CIO filed suit against TWCC alleging that the adopted guideline (in particular, the adopted workers' compensation conversion factor of 125 percent) did not meet the statutory test of being "fair and reasonable" and did not take into account "economic indicators in health care." They alleged that the adopted conversion factor already had caused some providers to cease taking workers' compensation patients and argued that if implemented, the new professional services medical fee guideline would adversely impact injured workers' access to quality health care providers.

In an effort to support TWCC's adopted conversion factor, the Texas Association of Business (TAB) intervened in the lawsuit on behalf of TWCC. TMA and the Texas AFL-CIO sought a temporary injunction in state District Court in order to halt the implementation of the new fee guideline, and on August 21, 2002, just ten days before the scheduled implementation date, a Travis County District Court enjoined TWCC's 2002 Medical Fee Guideline from going into effect, based on the judge's finding that TWCC did not identify in the rule preamble a "reasoned justification" for its 125 percent workers' compensation conversion factor. The 1996 TWCC Medical Fee Guideline was left in effect pending the outcome of the injunction.

The temporary injunction left TWCC with three general options: 1) to have a full trial on the merits of a permanent injunction at the District Court level; 2) to remand the rule to TWCC staff for revision; or 3) to appeal the temporary injunction to the 3rd Court of Appeals. TWCC Commissioners at the September 2002 public meeting asked staff to

make a recommendation for action, and also requested that system stakeholders submit any data they believed would assist the Commissioners in making a decision. As of the writing of this report, TWCC Commissioners have not taken any official action to revise the rule; however, a permanent injunction hearing date has been set for January 6, 2003. If a settlement cannot be reached between TWCC/TAB and TMA/Texas AFL-CIO prior to the 78th Legislative session, it is likely that one or both sides will seek legislative relief to support their positions as to how the workers' compensation conversion factor (or factors) should be calculated.

TWCC is also in the process of developing an inpatient hospital, outpatient surgery and ambulatory surgical center fee guideline that would set pricing for these services and apply the relevant Medicare payment policies. TWCC staff has solicited suggestions as to the creation of this fee guideline through system stakeholder meetings, but it is unclear how stakeholders will react to another fee guideline proposal, considering the litigation on the professional service fee guideline. TWCC staff was scheduled to propose this fee guideline at the November 2002 TWCC public meeting; however, cancellation of this meeting means the guideline will likely be proposed in December 2002.

Repeal of the TWCC Treatment Guidelines

Previous research studies by the ROC found that TWCC's consensus-based treatment guidelines were not specific enough to provide useful guidance to health care providers or insurance carriers on the recommended amount and duration of medical services provided to injured workers with particular medical conditions.³⁴ In fact, the vagueness and permissiveness of these guidelines were deemed by researchers and system participants to be a cost driver in the system, since they were often used by health care providers to justify likely medical treatment overutilization during medical disputes.

In response to these findings, policymakers added provisions to Article 6 of HB 2600 which abolished TWCC's consensus-based treatment guidelines effective January 1,

³⁴ See Research and Oversight Council on Workers' Compensation, *Workers' Compensation Treatment Guidelines in Texas*, 1999; and *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System: A Report to the 77th Texas Legislature*, 2001.

2002, and made TWCC's creation of treatment guidelines optional rather than mandatory. The statute went further to require that if TWCC adopts any treatment guidelines in the future, they must be "nationally recognized, scientifically valid and outcome-based."³⁵

In October 2001, TWCC proposed a combined treatment and return-to-work guideline based on a proprietary guideline produced by a company called Intracorp. This guideline was intended to speak not only to the appropriateness of treatment, but also durations of lost time for particular types of injuries. This proposal was withdrawn in February 2002 after considerable public comment. Particular concerns by stakeholders over the adoption of the Intracorp guideline involved a perceived lack of clarity about the intended or required use of the guideline; the unknown cost of the guideline based on its proprietary nature; specific criticisms of its treatment and lost time duration provisions; and concerns that the proposed guideline did not meet the statutory requirement that it must be "nationally recognized, scientifically valid and outcome-based." TWCC has not yet proposed a replacement treatment or return-to-work guideline primarily because of uncertainty as to what type of guideline would be sufficient to meet the statutory criteria and be cost-effective for system participants.

Many system participants, however, contend that the Medicare payment policies, which were adopted by reference as part of the new TWCC Medical Fee Guideline, when effective, will provide significant guidance regarding medical necessity in lieu of a treatment guideline. However, the implementation of these payment policies has been delayed by the pending lawsuit over the workers' compensation conversion factor.

Addition of an Open Pharmaceutical Formulary/Generic Drug Requirements/Allowance of Over-the-Counter Alternatives to Prescription Drugs

Pharmaceutical issues continue to be a source of controversy for the system, even after the passage of HB 2600. Several provisions in HB 2600 addressed inconsistencies in the way that pharmaceuticals were treated in the workers' compensation system compared

³⁵ See Texas Labor Code Section 413.011 (e).

with other health care delivery systems: namely, that the workers' compensation system prior to HB 2600 did not give preference to generic drugs; did not allow for the payment of over-the-counter alternatives to prescription drugs; and did not utilize a pharmaceutical formulary. ROC's HB 3697 research studies highlighted the importance of addressing pharmacy issues in either the legislative or regulatory arena, since cost comparisons with other states as part of the HB 3697 studies indicated that Texas had some of the highest pharmaceutical costs per claim.

In response to these findings, policymakers approved provisions in Article 6 of HB 2600, which required TWCC to adopt an open formulary and required the use of generic pharmaceuticals unless otherwise specified by the prescribing doctor. Article 6 also added coverage for clinically appropriate over-the-counter alternatives to prescription medications and required TWCC to adopt rules allowing injured workers to purchase and obtain reimbursement for over-the-counter alternatives prescribed or ordered by a doctor.³⁶ In December 2001, TWCC adopted an open formulary requiring generics unless otherwise specified by the prescribing doctor, and allowing over-the-counter drugs to be prescribed at the doctor's discretion.³⁷ The formulary adopted was very general, in that it included all drugs approved by the federal Food and Drug Administration (FDA), and did not speak to the appropriateness of particular drugs for particular medical conditions, as do some stricter formularies. While insurance carriers and the business community contend that they would prefer that TWCC adopt a more restrictive formulary to control costs and reduce disputes, pharmacists and TWCC staff indicate that the usage of the term "open formulary" in the statute precludes the adoption of such a formulary.

In an attempt to reduce pharmacy payment disputes, TWCC's new pharmacy rule, effective in March 2002, required that insurance carriers request a "statement of medical necessity" from the prescribing doctor prior to denying any pharmacy bill based on reasonableness or medical necessity. Insurance carriers claimed that this statement of medical necessity requirement was an undue burden, since the statute only provides 45

³⁶ See Texas *Labor Code* Section 408.028 (d).

³⁷ See TWCC Rule 134.502.

days to review and pay or deny medical bills. They argued that the timeframe for requesting and receiving the statement of medical necessity from the prescribing doctor would make meeting the 45 day timeframe extremely difficult and, as a result, insurance carriers would likely approve these bills more frequently, exacerbating an already significant medical cost problem.

Pharmacists, on the other hand, favored the statement of medical necessity requirement because they said it gave them important information to use to support their position in medical disputes. Historically, pharmacists also have argued that since they only fill the prescriptions that doctors write, they are not in a position to question the medical necessity of the prescription, but can be denied payment if the prescription is later deemed medically unnecessary by the insurance carrier. In addition, some doctors saw this requirement as a new administrative burden for workers' compensation cases, since they are prohibited from billing and receiving reimbursement for completing these statements of medical necessity.

After receiving complaints about the newly-implemented pharmacy rule from system participants, TWCC proposed revisions to the rule in August 2002. Proposed revisions include deletion of the statement of medical necessity requirement for insurance carriers, instead allowing carriers to request a statement of medical necessity from the prescribing doctor if the carrier felt it needed additional information prior to issuing a denial. TWCC has already taken public comment on the proposed changes to the pharmacy rule and tentatively plans a vote on the proposed rule at the November 2002 public meeting.

Regardless of whether the proposed changes to the pharmacy rule are adopted, many system participants argue that the real problem for pharmacists is the uncertainty in whether the prescriptions they fill will be denied because of medical necessity issues that they do not control. Additionally, pharmacists contend that the lack of a low-cost medical dispute resolution process in the statute (which would more easily allow pharmacists to dispute a denial) results in more pharmacies refusing to accept workers' compensation prescriptions. However, insurance carriers are concerned about the

absence of a more restrictive pharmaceutical formulary and lack of definitive information showing that the generic and over-the-counter provisions in HB 2600 are saving the system money. Such disagreements make it difficult to reach consensus on a legislative or regulatory fix to resolve pharmacy dispute issues. Also affected by this debate are injured workers, who might have difficulty getting their prescriptions filled, do not usually understand why a pharmacy will not fill a prescription, and have few options to force a resolution of the underlying dispute.

In an effort to shed some light on the types of pharmaceutical medications that are particularly prone to denial, TWCC proposed to ask for a variety of pharmaceutical data from insurance carriers (currently, TWCC does not regularly collect pharmacy data). ROC staff recognizes that without additional data, it will be difficult not only to assess the impact of the Article 6 changes, but to come to an understanding on which proposed solutions will ensure proper access to pharmaceuticals without contributing to higher medical costs. For more discussion and possible policy options to address pharmacy issues, see the Recommendations section of this report.

Conclusion – Medical Care and Rehabilitation

As a result of legislative activity by the 76th and 77th Texas Legislatures, significant changes are under way in the manner through which the workers' compensation system assures the delivery of quality medical care to injured workers. Some of the provisions of HB 2600 are more developed than others, and progress in some areas has been impeded by disagreement among opposing system stakeholders and TWCC rule priorities that sometimes conflicted with HB 2600 requirements. ROC has been actively involved in helping implement the changes mandated by the bill by incorporating many of the data needs in its FY 2002 and FY 2003 Research Agendas. ROC also continues to broker much of the ongoing discussion and negotiation between and among system stakeholders as the details of the reforms are developed.

4. BENEFIT ADEQUACY

The system should provide: 1) temporary benefits that replace a high proportion of after-tax lost earnings; and 2) benefits for permanent disability that substantially alleviate the economic duress that occurs or may be expected to occur because of the disability.

One of the key goals of the workers' compensation system is to provide injured employees with income benefits that replace a high proportion of after-tax, pre-injury earnings. Five types of income benefits are currently payable under the Texas Workers' Compensation Act. These are:

- Temporary Income Benefits (TIBs) – paid during the period of temporary disability (lost time from work) while the worker is recovering from an on-the-job injury;
- Impairment Income Benefits (IIBs) – paid to injured workers for permanent impairment (impairment evaluations are currently based on the *Guides to the Evaluation of Permanent Impairment*, 4th Edition, published by the American Medical Association);
- Supplemental Income Benefits (SIBs) – paid to injured workers for ongoing disability after IIBs have been exhausted, with all eligibility for SIBs ending at 401 weeks after the date of injury;
- Lifetime Income Benefits (LIBs) – paid for the life of the injured worker for specific catastrophic injuries as set forth in Section 408.161 of the Texas *Labor Code*;
- Death Benefits (DBs) and Burial Benefits – paid to the deceased workers' spouse or eligible beneficiaries as a result of a death from a compensable injury.

Interstate Income Replacement Rates

The 1972 National Commission on State Workmen's Compensation Laws recommended an after-tax income replacement rate of at least 80 percent of the injured worker's pre-injury net income. According to findings from a 1995 research study, the average income replacement rate for injured workers who have missed at least four weeks of work is 88

percent, well above the minimum level of 80 percent recommended.³⁸ It should be noted, however, that for those workers whose temporary disability did not last long enough for them to receive TIBs for the first seven days of disability, the average income replacement rate was only 41 percent.

Recent Activity – Benefit Adequacy

Multiple Employment (HB 2600, Article 10)

Since the major Texas workers' compensation system reform in 1989, income benefits for injured employees had been calculated based only on the Average Weekly Wage (AWW) earned at the job where they are injured.³⁹ Over the ensuing years, some policymakers have shown an interest in how this method of calculating the AWW and resulting benefit levels might impact injured employees who rely on income from more than one job, but are compensated only for lost wages from the job where the injury occurs.

During the 77th Legislative session in 2001, a proposal allowing injured employees to claim wages from any employment, rather than just the job where their injury occurs, won approval. This proposal – Article 10 of House Bill (HB) 2600 – allows an injured employee to claim any IRS-reportable wages toward the calculation of his or her AWW. The statutory change, effective July 1, 2002, incorporated what is often called a “multiple employment” provision into the Texas workers’ compensation system.⁴⁰

³⁸ See Texas Workers’ Compensation Research Center, *Income Replacement from Temporary Income Benefits under the Workers’ Compensation System*, 1995. This is the most current data available at this time; although there is no reason to think this has changed significantly, additional research may be necessary in the future to identify more current income replacement rates.

³⁹ Prior to 1989, statutory language related to “same or similar employment” by an injured employee led to court interpretations that allowed some consideration of multiple employment in income benefit levels. This allowed to a limited consideration of multiple employment. See ROC online publication *Multiple Employment in the Texas Workers’ Compensation System: Features and Benefits*, August 2001, available online at <http://www.roc.tx.us/Multemp.htm> for more details on pre-1989 interpretations of multiple employment-related system features.

⁴⁰ For more information on this statutory change, see *The Multiple Employment Provision of HB 2600 and its Impact on the Subsequent Injury Fund*, Research and Oversight Council on Workers’ Compensation, August 2002.

The cost of this new provision was a concern for business and insurance carriers, so a mechanism was included in the statute to allow carriers to be reimbursed for these additional costs. Specifically, insurance carriers that pay additional benefits based on this multiple employment provision are eligible to request reimbursement from the Subsequent Injury Fund (SIF). The SIF is a special, dedicated state fund managed by TWCC; its revenue is paid by insurance carriers from death claims in which no beneficiary survives the injured employee.⁴¹ The SIF's original and primary obligation was the payment of LIBs for injured employees who qualified based on a subsequent injury (for example, an injured worker who is blind in one eye and then loses sight in the other as the result of a compensable work-related injury). The SIF also is responsible for reimbursement of insurance carriers who pay benefits based on TWCC interlocutory orders that are later overturned.⁴²

Based on August 2002 ROC projections of the cost of the multiple employment provision, the SIF appears adequate to provide a short- to medium-term source of funding for carrier reimbursements (i.e., through FY 2007-2008), but is unlikely to be able to play this role on an ongoing, long-term basis. These projections involved estimation of the SIF's future revenues and expenses, as shown in Tables 4 and 5. As the tables indicate, ROC also used two "learning curves" to estimate utilization of the new multiple employment provision by injured workers, since it is extremely unlikely that all potentially eligible injured workers will use the new provision immediately. Much more detail can be found in the ROC report, *The Multiple Employment Provision of HB 2600 and Its Impact on the Subsequent Injury Fund* (2002).

⁴¹ For more detail on the SIF's obligations and revenues, see Section 403.007 006, Texas *Labor Code* and the previously cited report.

⁴² TWCC may issue such an order during a dispute, to ensure that an injured employee receives necessary benefits while the dispute is being decided. If the carrier eventually prevails, it may be entitled to SIF reimbursement for benefits paid based on the order.

Table 4
Projected SIF Revenues, Expenditures, and Year-end Assets –
Four-year “Learning Curve” applied to Multiple Employment Utilization

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Revenue: SIF death benefits	\$4.5 mill.	\$4.8 mill.	\$4.8 mill.	\$5.0 mill.	\$5.1 mill.	\$5.3 mill.
Revenue: Interest	\$1.0 mill.	\$1.2 mill.	\$1.2 mill.	\$741,211	\$327,287	(\$189,423)
SIF LIBs liabilities (reserved)	\$9.5 mill.	\$10.2 mill.	\$10.8 mill.	\$11.3 mill.	\$11.8 mill.	\$12.4 mill.
Expenditures: Carrier reimbursement, non multiple employment	\$942,642	\$1.0 mill.	\$1.0 mill.	\$1.0 mill.	\$1.0 mill.	\$1.1 mill.
Expenditures: Multiple employment reimbursements	\$0	\$0	\$3.5 mill.	\$8.8 mill.	\$14.3 mill.	\$16.9 mill.
Estimated year-end available assets (cash value)	\$22.6 mill.	\$25.9 mill.	\$26.2 mill.	\$21.7 mill.	\$11.2 mill.	(\$2.1 mill)
Estimated year-end available assets (present value)	\$23.1 mill.	\$26.9 mill.	\$27.6 mill.	\$23.7 mill.	\$13.7 mill.	\$741,603

Source: Research and Oversight Council on Workers' Compensation, *The Multiple Employment Provision of HB 2600 and Its Impact on the Subsequent Injury Fund*, 2002.

Table 5
Projected SIF Revenues, Expenditures, and Year-end Assets –
Three-year “Learning Curve” applied to Multiple Employment Utilization

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Revenue: SIF death benefits	\$4.5 mill.	\$4.8 mill.	\$4.8 mill.	\$5.0 mill.	\$5.1 mill.	\$5.3 mill.
Revenue: Interest	\$1.0 mill.	\$1.2 mill.	\$1.0 mill.	\$603,591	(\$22,435)	(\$732,144)
SIF LIBs liabilities (reserved)	\$9.5 mill.	\$10.2 mill.	\$10.8 mill.	\$11.3 mill.	\$11.8 mill.	\$12.4 mill.
Expenditures: Carrier reimbursement, non multiple employment	\$942,642	\$1.0 mill.	\$1.0 mill.	\$1.0 mill.	\$1.0 mill.	\$1.1 mill.
Expenditures: Multiple employment reimbursements	\$0	\$0	\$5.9 mill.	\$13.4 mill.	\$16.6 mill.	\$17.8 mill.
Estimated year-end available assets (cash value)	\$22.6 mill.	\$25.9 mill.	\$23.8 mill.	\$14.4 mill.	\$1.3 mill.	(\$13.5 mill.)
Estimated year-end available assets (present value)	\$23.1 mill.	\$26.9 mill.	\$25.1 mill.	\$16.1 mill.	\$3.4 mill.	(\$11.0 mill.)

Source: Research and Oversight Council on Workers' Compensation, *The Multiple Employment Provision of HB 2600 and Its Impact on the Subsequent Injury Fund*, 2002.

The multiple employment provision has been in effect only since July 1, 2002, and little data have yet accrued on how often injured workers are utilizing these new benefits. ROC plans to continue monitoring the liabilities, expenditures and revenues of the SIF over the next few years and revisit cost projections after the system has actual experience with the multiple employment provision.

Lifetime Income Benefits For Burn Victims (HB 2600, Article 9)

As noted, Lifetime Income Benefits (LIBs) are paid for the life of injured employees who suffer certain severe, statutorily-defined injuries. Prior to the 77th Legislative session, these were:

- (1) total and permanent loss of sight in both eyes;
- (2) loss of both feet at or above the ankle;
- (3) loss of both hands at or above the wrist;
- (4) loss of one foot at or above the ankle and the loss of one hand at or above the wrist;
- (5) an injury to the spine that results in permanent and complete paralysis of both arms, both legs, or one arm and one leg; or
- (6) a physically traumatic injury to the brain resulting in incurable insanity or imbecility.⁴³

Prior to the 77th session, an explosion and fire at a facility in the Houston area increased awareness of the potential impact of severe burns on employees who suffer this type of injury. This led to a proposal during the Legislative session to add certain severe burns to the list of injuries for which LIBs are paid. The statutory change, included in Article 9 of

⁴³ For injuries occurring on or prior to September 1, 1997, the description "an injury to the skull resulting in incurable insanity or imbecility" applied.

HB 2600, extended LIBs eligibility to injured employees who suffer third degree burns covering 40 percent of the body and requiring grafting, or third degree burns covering the majority of both hands or one hand and the face.⁴⁴ This provision applies to compensable injuries occurring on or after June 17, 2001, the general effective date of HB 2600.

As part of the assessment of the fiscal impact of HB 2600 conducted prior to the bill's passage, ROC staff attempted to estimate the cost of additional LIBs benefits from this statutory change. Based on historical data on the number of injured employees who suffer burn injuries and also have very high impairment ratings (e.g., 50 percent or higher), ROC staff estimated that approximately three injured employees per year will qualify for LIBs based on this provision. This would mean that about \$3 million in additional LIBs costs would be paid for the injured employees who qualify each year over the lives of the employees.⁴⁵

Statutory Maximum Benefit Levels

Although wage replacement levels in Texas are generally high compared to those in most states, income benefit adequacy is still an often-discussed issue within the workers' compensation system.⁴⁶ One issue frequently discussed are the statutory caps on income benefits. The maximum weekly benefit for TIBs, LIBs and Death Benefits is defined as 100 percent of the State Average Weekly Wage (SAWW), as calculated by the Texas Workforce Commission. For IIBs and SIBs, the statutory maximum is 70 percent of the SAWW.⁴⁷ These statutory maximum rates may result in benefits that are significantly lower than actual pre-injury wages for employees who are high-wage earners.

⁴⁴ See Texas *Labor Code* Section 408.161 (a) (7).

⁴⁵ Data on the severity of burns or portions of body affected are not captured in the workers' compensation system, so high impairment rating (e.g., 50 percent or higher) burn claims were used as a proxy in these estimates. Lifetime cost figures also assume an average lifespan for these severely injured LIBs recipients, which may overestimate the true costs.

⁴⁶ Most recently, in the 77th Legislative session, a bill was introduced (HB 159) to increase the cap on Impairment Income Benefits (IIBs) to 100 percent of the State Average Weekly Wage (SAWW). This bill did not pass.

⁴⁷ See Texas *Labor Code* Section 408.061.

Article 2 of HB 2600 calls for a feasibility study on the possible creation of regional workers' compensation health care networks (see Section 3 of this report, on Medical Care and Rehabilitation, for more information on this provision of HB 2600). If these regional networks are found to be feasible and are created, injured employees who elect to participate will be eligible for a maximum weekly benefit rate for TIBs of 150 percent, rather than 100 percent, of the SAWW.⁴⁸ The increase in the cap on TIBs for employees participating in regional networks could provide a valuable opportunity to examine the frequency of high-wage earners receiving greater than the standard cap on benefits, the impact on income benefit costs, and any possible effects on return-to-work rates.

Maximum Medical Improvement (MMI) and Impairment Rating Disputes / Substantial Change of Condition

In recent years, injured workers and insurance carriers have been required by TWCC rule to dispute an assessment that the worker has reached Maximum Medical Improvement (MMI) and the resulting impairment rating within 90 days, or have it become final. TWCC rule also established that this finality could only be challenged for a few, very specific reasons, such as an error on the part of the assigning doctor. Impairment ratings are critical in establishing an injured worker's eligibility for both IIBs and SIBs, and some system participants, particularly labor groups and other advocates for injured workers, argued that the 90-day timeframe should not apply in cases involving a "substantial change of condition" for the injured worker after the worker had been found at MMI.

In early 2001, the 3rd Court of Appeals in Austin, in response to a lawsuit involving this 90-day dispute requirement, declared it invalid because it had no statutory basis.⁴⁹ In response, TWCC repealed the 90-day provision and issued an advisory to explain that it can no longer be utilized to finalize an assessment of MMI or an impairment rating.⁵⁰ As a result, there is currently no timeframe in which an assessment of MMI and impairment

⁴⁸ See Texas *Labor Code* Section 408.0222 (m) (2).

⁴⁹ The 90-day timeframe was included in TWCC Rule 130.5 (e). The case involved was *Fulton v. Associated Indemnity Corporation*, Cause #03-00-00449-CV.

⁵⁰ See TWCC Advisory 2002-04; Status on Fulton Decision (signed March 4, 2002), available online at www.twcc.state.tx.us.

rating must be disputed, regardless of whether a substantial change of condition occurs.⁵¹ Some insurance carriers are now concerned that this lack of finality will prevent the closing of impairment ratings on claims, thereby increasing costs. For more discussion on the 90-day rule issue, see the Recommendations section of this report.

Conclusion – Benefit Adequacy

HB 2600 significantly improved benefits for multiply-employed injured workers and for burn victims. In general, income replacement levels in Texas indicate that the system generally meets its goal of replacing a high percentage of pre-injury earnings. However, specific issues such as the effects of income benefit caps, the adequacy of income benefits for severely injured workers, and income replacement rates for workers who do not miss enough time to receive benefits for the first seven days of disability, may merit further examination. In addition, the ROC must monitor the ongoing implications of benefit expansions included in HB 2600, such as the multiple employment provision, expansion of LIBs, and potential escalation of the statutory caps on TIBs for injured workers participating in regional workers' compensation health care delivery networks.

⁵¹ While there is no statutory timeframe to dispute an MMI finding or impairment rating *per se*, the general statutory requirement that an employee be found at MMI and assessed an impairment rating no later than 104 weeks after the date income benefits begin to accrue effectively limits the employee's eligibility for additional Temporary Income Benefits based on a revised MMI date. However, a revised impairment rating might increase the employee's amount of Impairment Income Benefits and entitlement to Supplemental Income Benefits. See Texas Labor Code Section 401.011 (30) (B).

5. BENEFIT EQUITY

The system should provide similar benefits to claimants in similar circumstances and it should provide benefits that are reasonably proportionate to the severity of the injury.

A primary goal of the Texas workers' compensation system is to ensure the delivery of fair and equitable compensation to injured workers. This section examines recent developments in the area of benefit equity.

Recent Activity – Benefit Equity

Changes to the Required Medical Examination Process for Maximum Medical Improvement and Impairment Rating

As discussed in the Benefit Adequacy section, an important aspect of benefit equity is the accurate assessment of when an injured employee has reached Maximum Medical Improvement (MMI) and the assignment of an impairment rating. An injured employee's impairment rating controls the employee's eligibility for ongoing income benefits.⁵²

Article 5 of HB 2600 revised the process by which injured employees undergo Required Medical Examinations for issues involving MMI and the assignment of impairment ratings. Prior to HB 2600, an insurance carrier was allowed to request that an injured employee be examined for evaluation of MMI and assignment of an impairment rating by a carrier-selected doctor, an examination referred to as a Required Medical Examination, or RME. Previous research conducted by the ROC examined the impairment rating process to assess the prevalence of impairment ratings for the same injury, disparities in multiple impairment ratings, and the length of time between the first and last rating given to injured workers.⁵³ This research indicated that generally, treating and designated doctors tend to assign similar impairment ratings for the same injury, with a greater

⁵² Each percentage of an injured employee's permanent impairment qualifies the employee for three weeks of Impairment Income Benefits (IIBs). Further, injured employees with impairment ratings of 15 percent or greater may be eligible for Supplemental Income Benefits (SIBs).

⁵³ See *Impairment Rating Trends in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, August 1999.

divergence in impairment ratings between the insurance company doctors and treating doctors.

Under the changes made by HB 2600, either an insurance carrier or an injured employee can now request an examination by a TWCC designated doctor for an MMI assessment and assignment of an impairment rating. The designated doctor opinion carries presumptive weight, meaning that it is presumed correct in a dispute unless the great weight of the medical evidence is to the contrary. Insurance carriers are still allowed to request that an injured employee be examined by a doctor of the carrier's choosing after the designated doctor examination. Requiring that the employee first be examined by a designated doctor, rather than the carrier-selected doctor, may reduce the number and cost of unnecessary additional impairment rating examinations and result in lower overall system costs. An analysis of the effects of these changes by the ROC is required by December 31, 2004.

One clear consequence of this change has been a significant increase in the number of designated doctor assignments (and a decrease in the number of carrier RMEs for MMI/impairment rating purposes). Table 6 shows a comparison of designated doctor assignments for the first three months of calendar year (CY) 2001 and 2002. The first three months of CY 2002 represent the first three months of the new HB 2600 designated doctor process.

Table 6
TWCC Designated Doctor Assignments
First Three Months of CY 2001 and CY 2002

	2001	2002	% Increase
January	3,187	4,217	32.3%
February	2,699	5,980	121.6%
March	3,438	7,597	121.0%
TOTAL	9,324	17,794	91.0%

Source: TWCC Staff Report to TWCC Commissioners, April 25, 2002

Some increase in designated doctor examinations was anticipated, since insurance carrier requests for RMEs on MMI and impairment rating issues were now being conducted by TWCC designated doctors, instead. Through August 2002, designated doctor exams

continued at a greater rate, with a total of 53,212 (an average of 6,652 a month) assigned. TWCC also reports that for exams conducted between January and June 2002, the designated doctor found the injured employee to be at MMI 70.5 percent of the time (27,619 times of 39,156 exams conducted).⁵⁴

A further change was also made in Article 5 of HB 2600 to the designated doctor selection process. Prior to this change, TWCC generally selected designated doctors for evaluation by “matching” the licensure of the employee’s treating doctor.⁵⁵ In other words, if the employee’s treating doctor was a chiropractor, the designated doctor chosen to conduct the exam would also be a chiropractor.

HB 2600 attempted to provide more flexibility in assignment of designated doctors by allowing assignments to be made to doctors not of the same specialty as the treating doctor, but still qualified to perform MMI and impairment ratings assessments for the employee in question. The specific language in HB 2600 stated that the designated doctor must be “trained and experienced with the treatments and procedures used by the doctor treating the patient’s medical condition, and the treatment and procedures must be within the scope of practice of the designated doctor.” In addition, the designated doctor’s “credentials must be appropriate for the issue in question and the injured employee’s medical condition.”⁵⁶

This statutory change led TWCC to develop a matrix for assigning designated doctors that involves compiling information about the treatment the employee has received and attempting to match it with the qualifications of a designated doctor. This process was also implemented January 1, 2002 and is significantly more complex and time-intensive

⁵⁴ Texas Workers’ Compensation Commission, Quarterly Report to the Research and Oversight Council on Workers’ Compensation, October 2002.

⁵⁵ This was in accordance with Texas *Labor Code* Section 408.122 (b), which prior to amendment by HB 2600 read in part, “To the extent possible, a designated doctor must be in the same discipline and licensed by the same board of examiners as the employee’s doctor of choice.”

⁵⁶ See Texas *Labor Code* Section 408.122 (b).

than the previous licensure match system.⁵⁷ It is also the subject of a legal challenge from the Texas Chiropractic Association (TCA), which alleges that it does not meet the statutory language or intent. For more discussion on designated doctor selection, see the Recommendations section of this report.

The new emphasis placed on designated doctor examinations by the changes in Article 5 makes monitoring of the quality of these decisions even more important. As discussed in the section on Medical Care and Rehabilitation, monitoring programs have been developed to allow initial scrutiny of impairment ratings of designated doctors, and TWCC's Medical Quality Review Panel is beginning reviews of designated doctors, as well. ROC is required by statute to report to the legislature by December 31, 2004 on the changes made by Article 5 of HB 2600 and the designated doctor/RME process for MMI and impairment rating exams.

Average Weekly Wage Calculation For School District Employees (Article 10, HB 2600)

Income benefit amounts for injured employees are based on the Average Weekly Wage (AWW) the employee earns. For most full-time employees, the AWW is computed by dividing the total wages the employee earned during the previous 13 weeks by 13.

For some employees, this method of calculation can produce results that do not reflect the wages the employee would have earned during the period of lost time from work. For example, due to variable contract lengths for some school district employees, inconsistencies in calculating the AWW may result. An employee's contract could cover a nine- or twelve-month period, resulting in an AWW that may be far higher or lower than the employee would have earned. In an attempt to address inconsistencies that can be caused by contract length, a portion of Article 10 of HB 2600 changed the AWW calculation process for school district employees. Specifically, this provision called for the AWW to be calculated based on the wages *earned* in a week rather than the wages

⁵⁷ The complexity of the new process, is part of the basis (along with the overall increase in requests for designated doctor examinations related to the other changes made by Article 5 of HB 2600) for TWCC's request for eleven new staff positions in its FY 2004/2005 Legislative Appropriations Request (LAR).

paid.⁵⁸ Wages earned in a given week are defined as the amount that would be deducted from the employee's salary if the employee were absent from work for one week without leave to compensate him or her. Also significant was a provision allowing an insurance carrier to adjust the employee's AWW as often as necessary to more accurately reflect the wages the employee could reasonably expect to earn. For a period the employee would not have earned wages, the AWW may be adjusted to zero, and no minimum benefit payment is required.

In response to this change, TWCC amended and adopted rules with instructions for calculating the AWW for school district employees in accordance with the new law.⁵⁹ For determining the amount of Impairment Income Benefits, Lifetime Income Benefits, Supplemental Income Benefits or Death Benefits, the AWW is computed by adding the total wages earned by the school district employee during the 12-month period immediately preceding the injury and dividing the result by 50.

Conclusion – Benefit Equity

The quality of MMI and impairment rating determinations remains an issue in need of further examination, as poor ratings can result in income benefit inequity or inadequacy and increased disputes. As discussed in the Medical Care and Rehabilitation section, ROC has been working with TWCC on development of a monitoring program for designated doctors, focusing on the accuracy of permanent impairment ratings assigned by these health care providers.⁶⁰ TWCC has been working to develop appropriate doctor training and quality of care monitoring requirements to ensure fair and accurate determinations of MMI and impairment ratings. Effective impairment rating training and monitoring programs are designed to reduce inconsistencies and improve the general quality of ratings by designated doctors. The impact of the changes made to the process by which designated doctors are used in MMI assessments and impairment rating

⁵⁸ See Texas *Labor Code* Section 408.0446.

⁵⁹ See TWCC Rules 128.1 and 128.7.

⁶⁰ See *Texas Monitor* Volume 7, Number 2; Special Edition, *Monitoring Programs for Health Care Providers, Designated Doctors, and Insurance Carriers in the Texas Workers' Compensation System*, August 2002.

assignments will be the subject of ongoing monitoring and a report by the ROC to the 79th Legislature in 2005.

6. EFFECTIVE DELIVERY OF BENEFITS

The system should provide both income and medical benefits which are adequate, equitable, and appropriate in a manner which is timely, humane, and cost-effective.

- (a) Temporary, permanent, and medical benefits should be provided promptly.*
- (b) The likelihood of disputes should be minimized, but when they occur they should be identified and resolved promptly and fairly.*
- (c) All participants should know their rights and responsibilities.*
- (d) There should be objective criteria regarding the entitlement to benefits and the amount of the entitlement.*

Like many aspects of the Texas workers' compensation system, the area of benefit delivery has seen a number of significant developments in the past two years. Many of these have involved changes mandated by House Bill (HB) 2600.

This section will examine several general areas relevant to the effective delivery of benefits in the workers' compensation system, including:

- 1) Effective delivery of medical benefits, with central emphasis on medical dispute resolution (MDR);
- 2) Effective delivery of income benefits;
- 3) Other general issues relevant to both medical and income benefits; and
- 4) A summary of recent related legislative and regulatory activity.

Effective Delivery of Medical Benefits

Access to Care

One important aspect of the effective delivery of medical benefits involves the availability of high-quality health care providers to treat injured employees. While the general availability of medical care has not been an issue of major system concern or research in recent years, recent ROC research conducted in response to House Bill (HB) 3697 (76th Legislature, 1999) indicates that outcomes of care for injured employees in

areas such as return to work are poorer in Texas than in other comparable states.⁶¹ Such results could indicate that while in general, medical care is available, the system needs to focus on improved access to high-quality care. This is the focus of several key aspects of HB 2600 discussed elsewhere in this report, including improved monitoring of health care providers participating in the system and a regional workers' compensation health care network feasibility study.⁶² Both initiatives would attempt to place more emphasis on outcomes of care such as return to work, functional outcomes, and patient satisfaction.

As noted in the section on Medical Care and Rehabilitation, some recent discussion about the general availability of health care providers to treat injured employees has occurred in the context of the new Medical Fee Guideline adopted by TWCC in April 2002 and scheduled for an effective date of September 1, 2002, before being enjoined from implementation because of a lawsuit brought by the Texas Medical Association (TMA) and Texas AFL-CIO. One of the arguments advanced by the TMA and AFL-CIO was that the reimbursement levels proposed in the new fee guideline (generally, 125 percent of the Medicare reimbursement amount) were too low, and that many providers – particularly surgeons – would leave the system if the guideline was implemented.

The new guideline is not yet in effect as of this writing, and it is impossible to know for certain at this point if availability of medical care will indeed become an issue with the new reimbursement amounts, whatever they may be. If and when the new guideline is effective, further research may be required to determine if the reimbursement levels included create a problem with access to care.

Medical Dispute Resolution

One area of medical benefit delivery that has been closely scrutinized in recent years is the Medical Dispute Resolution (MDR) process. An effective MDR system is essential

⁶¹ See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and Med-FX, LLC, January 2001.

⁶² The Workers Compensation Research Institute (WCRI) is currently in the process of producing a standardized injured worker survey instrument that will eventually be used to compare return-to-work, access to care, and patient satisfaction outcomes for several states, including Texas. Preliminary survey results for Texas are expected by the end of calendar year 2002.

to ensuring that parties can resolve disagreements over the necessity of medical services and the appropriate payment of services in accordance with TWCC's Medical Fee Guideline.

Prior to the passage of HB 2600, much of the system concern with the MDR process centered on two basic issues: the lack of medical expertise in TWCC MDR decision-making, particularly for disputes involving the necessity of medical care; and the length of time required for the MDR process.

TWCC staff responsible for making medical decisions in disputes were not doctors, and did not, many felt, possess the expertise necessary to make some medical necessity determinations. Timeframes for disputes also were extremely long: in 1999, retrospective medical necessity disputes took an average of 366 days to work through the system, and fee disputes 449 days. Preauthorization disputes, in which the medical care in dispute cannot be delivered until the dispute is resolved, were resolved much more quickly, at 38 days.⁶³

It appears that in the ensuing years, TWCC was successful in significantly decreasing the timeframe for medical dispute resolution. According to the *System Data Report* from June 2002, the average timeframe for retrospective necessity disputes in 2001 (prior to HB 2600 implementation) was down to 141 days; for fee disputes, down to 43 days; and for preauthorization disputes virtually unchanged, at 40 days.⁶⁴ However, it is clear that the outcomes of the medical dispute resolution process did not improve as did the timeframes.

In response to continued concerns about outcomes of the MDR process – particularly the issue of appropriate medical expertise in decision-making – Article 6 of HB 2600 required that disputes related to medical necessity of treatment or services be decided by

⁶³ See TWCC's *System Data Report*, June 2002.

⁶⁴ The extreme decreases in duration reported in the *System Data Report* (particularly for fee disputes, from 449 days to 43) should be regarded carefully; it is not indicated how many unresolved fee disputes with no known duration remain that could increase these averages. In any case, it seems likely that durations have improved to some extent, if not quite as dramatically as these numbers suggest.

private entities called Independent Review Organizations (IROs). IROs, which are certified by the Texas Department of Insurance (TDI), have been used since 1997 in the group health insurance setting to review denials by Health Maintenance Organizations (HMOs). IROs use doctors to perform their reviews and typically operate within shorter timeframes than were achievable under the TWCC MDR process. In December 2001, TWCC adopted new Medical Dispute Resolution rules, effective January 2, 2002, to implement the change to the IRO process and other MDR process changes.⁶⁵ TWCC also indicated at the time of this adoption that it intended to revisit the rules six months post-implementation, in part to address system stakeholder concerns about several aspects of the rule.

Under the new process, IROs decide both prospective (prior to the delivery of service) and retrospective (after the delivery of service) disputes over the necessity of medical care. One significant difference between these dispute types, however, is that in the case of services required by TWCC rule to be preauthorized (approved by the insurance carrier prior to delivery), the carrier is responsible for the cost of the review, regardless of outcome (i.e., whether the IRO finds the service is medically necessary or not). In the case of disputes about services subject to retrospective review, the *non-prevailing* party in the dispute must pay the cost of the review.⁶⁶ Generally, this would mean that if the service is found not to have been medically necessary, the health care provider requesting IRO review would pay; if it is found to have medically necessary, the insurance carrier would pay.

As the new IRO process has been in effect for less than a year, it is difficult to draw firm conclusions about its long-term effectiveness in meeting HB 2600's goals of better and more rapid medical decisions.

As of this writing, ROC staff was in the process of completing a report based on initial data (the first six months) on disputes under the new Medical Dispute Resolution process.

⁶⁵ See TWCC Rules 133.305, 133.307 and 133.308.

⁶⁶ See Texas Labor Code 413.031 (h), (i), and (j).

Items to be analyzed include the numbers of disputes (both retrospective and prospective), dispute outcomes, durations of the dispute process, and others. TWCC staff has also agreed to report similar information to the ROC as part of the Quarterly Reporting process discussed in the section on Agency Control, Policy Control and System Monitoring.

At present, ROC and TWCC staffs are still working to ensure that the methodologies used to compile data on the new MDR process are sound and consistent. Preliminary data, however, indicate some interesting trends; IRO dispute outcomes, for example, suggest that insurance carriers are prevailing more often than are health care providers, and more often than they were under the prior TWCC-based process.⁶⁷ This change in outcomes was expected, given the overutilization of services in the Texas workers' compensation system highlighted in previous studies, such as those mandated by HB 3697.

While a variety of system stakeholders are pleased with the additional medical expertise afforded by the IRO process, some have questioned the specific provisions of the TWCC rules under which it is implemented. IRO review is an expensive process, generally more expensive than was TWCC's in-house MDR; reviews cost either \$650 or \$460, depending on the medical background of the reviewer.⁶⁸ TWCC rule also requires that the party requesting review pay the IRO fee up-front for retrospective (i.e., loser-pay) disputes. Since the requesting party in such disputes is almost always a health care provider, this rule essentially implements a \$460 or \$650 fee in advance of a dispute that is then refunded to the requestor if the requestor prevails.

⁶⁷ For example, preliminary data indicate that carriers prevailed in about 65 percent of preauthorization disputes and 62 percent of retrospective medical necessity disputes during the period analyzed by the ROC (January-June 2002). Average decision ratios based on data in TWCC's Medical Dispute Resolution Information System (MDRIS) for 1997-2001 (prior to the IRO process) indicate that carriers prevailed in 60 percent of preauthorization and 34 percent of retrospective disputes, based on a yearly average.

⁶⁸ See Texas *Administrative Code* 12.402 and 12.403. "Tier one" (\$650) fees are paid for independent review of medical or surgical care rendered by a doctor of medicine or doctor of osteopathy; "Tier two" (\$460) for independent review in the specialties of podiatry, optometry, dental, audiology, speech-language pathology, master social work, dietetics, professional counseling, psychology, occupational therapy, physical therapy, marriage and family therapy, and chemical dependency counseling, and any subspecialties thereof.

This pre-pay provision was inserted in the rule in part to address the issue of non-prevailing parties refusing to pay the IRO fee. However, a lawsuit has been brought by a health care provider contending that the pre-payment provision is an unconstitutional bar to his right to due process.⁶⁹ This case may be heard in December 2002.

Another issue raised by some health care providers in response to the new MDR framework relates to the difficulty in disputing relatively low cost services. A health care provider who is denied payment based on a medical necessity determination for a service costing only \$100, for example, may find it unreasonable to have to pay (and risk) more than six times this amount to dispute the denial.⁷⁰ TWCC is aware of the potential problem with low-cost services in dispute, but the *Labor Code* does not allow a lower cost alternative for resolution of these disputes. Alternately, since disputes of services denied for which preauthorization is required are always paid for by the insurance carrier, regardless of outcome, it is also possible that some health care providers could request IRO review on all preauthorization denials, creating a disincentive for the carrier to deny. As more experience accrues with the IRO process, this is another area that will need to be monitored for potential abuse.

Another recent development in medical dispute resolution is that certain health care providers have attempted to bypass the TWCC MDR process altogether, and take medical disputes directly into Justice of the Peace or District Courts. To date, hundreds of these filings have been made by a select number of providers in varying jurisdictions. For further discussion on these and other MDR process issues, please see the Recommendations section of this report.

HB 2600's changes to the MDR process also included a clarification that injured employees are allowed to access dispute resolution for cases in which they pay out-of-

⁶⁹ See Robert Howell, D.C. and First Rio Valley Medical, P.A. v. TWCC and Envoy Medical Systems, L.L.C., filed in Travis County District Court. Envoy is one of the IROs performing reviews in the workers' compensation system.

⁷⁰ Preliminary analysis of TWCC's Medical Dispute Resolution Information System for dispute year 2001 indicates that about 31.5 percent of medical necessity disputes involved services costing less than \$500.

pocket for medical services and are denied reimbursement. Specifically, TWCC is required to “specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement.”⁷¹

To fulfill this requirement, TWCC’s adopted MDR rules provide that in cases in which an injured employee has paid out of pocket, been denied reimbursement, and is seeking resolution, access to the IRO process is allowed. These disputes are distinct from any other handled by IROs, however, since they involve retrospective denial of payment, but are *not* loser pay as to the liability for the IRO fee. Since the *Labor Code* clearly states that an injured employee is not be required to pay “any portion of the cost of the review,” TWCC rule requires insurance carriers to pay the IRO cost for these disputes.⁷²

Some insurance carriers have raised concerns with the fairness of IRO review of this particular type of dispute, since the carrier is required to pay regardless of outcome, and the statute would appear to allow TWCC to use a less expensive, non-IRO process for these disputes. Although ROC staff did not consider this issue worthy of legislative change at this time, it will be very important as the IRO process matures to ensure that circumvention of the retrospective, loser-pay IRO process does not occur by health care providers, who might ask claimants to pay for treatment out of pocket to avoid dispute liability if reimbursement is denied. Although a claimant might decide to pay out of pocket for medical services in certain very specific circumstances, and the statute does establish a dispute resolution process if he or she is denied reimbursement, it is contrary to the basic goals of the system for claimants to be paying out of pocket on a large scale. In fact, the *Labor Code* prohibits a provider from billing an injured worker for the cost of health care services except under very specific circumstances.⁷³ Monitoring of employee reimbursement disputes will be necessary to ensure that circumvention of the intent of the IRO process (i.e., a “loser pay” system for retrospective disputes) does not occur.

⁷¹ See Texas *Labor Code* Section 413.031 (f).

⁷² See Texas *Labor Code* Section 413.031 (j).

⁷³ See Texas *Labor Code* Section 413.042. A provider may not bill a claimant for all or part of the cost of health care services unless: 1) the claimant’s injury is finally adjudicated as non-compensable; or 2) the claimant violated *Labor Code* provisions related to selection of a treating doctor, and the provider billing did not know of the violation. Technically, provider billing of a claimant in any other situation is a violation of the statute.

It is important to note that while *medical necessity* disputes are now being made external to TWCC, Commission staff continue to decide *medical fee* disputes (i.e., disputes involving the appropriate payment of medical bills according to coding, billing, and payment policies). Medical fee dispute resolution is also likely to undergo changes as the billing, coding and payment policies of the workers' compensation system align more closely with those of the Medicare system. This alignment has required and will require significant training for dispute decision-makers. It has also been suggested that one way TWCC can ensure that fee disputes are handled in accordance with Medicare rules and regulations is to explore the possibility of contracting with an independent third party to either resolve some or all of these disputes on behalf of TWCC or provide TWCC with needed medical expertise.

As indicated when the MDR rules were adopted in December 2001, TWCC has offered changes to the rule and reopened it to public comment through the Administrative Procedures Act (APA) process to allow additional stakeholder input. Significant aspects of TWCC's proposed changes related to the process by which disputes are filed (the current rule requires simultaneous filing with the insurance carrier and with TWCC; the revised rule would route all disputes through TWCC) and the timeframe for responding to a dispute by an insurance carrier (the carrier's timeframe is proposed to be extended). Public comment on these rule revisions ended in October 2002; TWCC plans to adopt the rule with changes in November 2002.

Other Medical Dispute Resolution Issues

Interaction with income benefit disputes

Appropriate interaction between income benefit and medical disputes has been a challenge for some time in the workers' compensation system. It is not uncommon for an insurance carrier to challenge both the *medical necessity* of a service or treatment and the *relatedness* of the service or treatment to the compensable injury, for example. Medical necessity disputes are handled through the MDR process, while relatedness and extent of

injury disputes are handled through the indemnity benefit dispute process. TWCC has attempted to clarify the appropriate track for disputes by advising system participants that, if extent of injury or relatedness is the basis for an insurance carrier's denial of a medical bill, the carrier should file the appropriate form (a TWCC-21) to deny on this basis, which may in turn lead to resolution of this underlying contested issue. The carrier may in these cases still contest the medical necessity of the services.

It is not entirely clear at present how well existing statutory and rule provisions related to this issue succeed in highlighting extent or relatedness issue early in the process of treating an injury or conditions. Another option to accomplish this goal and limit "crossover" disputes of medical necessity and extent of injury or relatedness would be to limit an insurance carrier's timeframe to dispute extent of injury for a particular condition. The *Labor Code* provides a statutory timeframe to dispute the compensability of an injury, but there is no similar timeframe for extent or relatedness disputes. However, there is not widespread agreement from system stakeholders that this issue needs to be addressed or would have a positive impact on the system if implemented. For more discussion on this issue, see the Recommendations section of this report.

Medical Interlocutory Orders

In response to TWCC concerns that it lacked clear, broad authority to intervene in particular claims through the issuance of medical interlocutory orders, the 76th Legislature in 1999 included in HB 2512 a provision allowing the Executive Director to issue such an order (i.e., an order to provide medical benefits while a dispute is pending, when ordinarily such benefits would be delayed). The statutory charge is sufficient to allow medical interlocutory orders to be issued in the case of a medical service being disputed, a medical service delayed because of an ongoing income dispute, or a variety of other situations. TWCC has yet to implement a process to alert Commission decision-makers to claims that may require the issuance of a medical interlocutory order, or to cleanly link field office personnel to TWCC's Medical Advisor (or other expertise) for consultation on specific cases.

Effective Delivery of Income Benefits

Delivery of Supplemental Income Benefits (SIBs)

SIBs are paid to injured workers with impairment ratings of at least 15 percent who remain unable to work due to an on-the-job injury after TIBs and IIBs have been exhausted. While SIBs are paid infrequently in the workers' compensation system (historically, to less than 1,000 claimants per year, compared to some 80,000 who receive Temporary Income Benefits (TIBs)), SIBs claims are particularly prone to dispute. In 1997, for example, SIBs eligibility issues accounted for 19.9 percent of all issues at TWCC Benefit Review Conferences (BRCs) and 24.7 percent of all issues at Contested Case Hearings (CCHs).⁷⁴

SIBs are paid on a quarterly (three month) basis, with the injured employee's eligibility during the previous quarter dictating whether or not he or she receives benefits in the current quarter. Frequent areas of dispute include a "good faith effort" requirement that an injured employee look for work within his or her ability to do so, and whether the injured employee's inability to work is a "direct result" of the compensable injury or due to other factors. Injured employees sometimes complain that the SIBs eligibility process is too difficult to meet and/or too vaguely defined for an employee to know in advance how to ensure eligibility for or payment of SIBs. These concerns have drawn some media attention during the interim.

Previous legislative action was directed at the issue of eligibility for injured employees who have been receiving SIBs for some time, in an effort to reduce unnecessary disputes of eligibility in cases where the employee's medical condition has not changed. HB 1826 (76th Legislature, 1999) stipulated that in cases where an injured employee has received SIBs for two years or more, and in which there is a dispute over whether the injured employee can work, the injured employee be directed to a TWCC designated doctor for a work-ability determination. However, when ROC mentioned this provision (*Labor Code*

⁷⁴ See *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, August 1998.

Section 408.151) in response to a specific constituent assistance request in July 2002, TWCC staff indicated that it had not to that point been implemented by field staff. TWCC now indicates that the provision will be used as statutorily required.

ROC staff and TWCC staff have also had discussions in the interim about the potential for broader use of designated doctors in resolving SIBs disputes, and perhaps in resolving them prior to a denial of benefits. For example, if a designated doctor could address a claimant's ability to work prior to a SIBs qualifying period, this could eliminate uncertainty about what eligibility criteria the employee must meet. TWCC has indicated that it does not see avenues within the current structure of the statute or rules to allow such a process.⁷⁵

At the same time, insurance carriers have expressed concern that the change from the 3rd to the 4th edition of the American Medical Association's *Guidelines for Permanent Impairment* may increase the number of employees whose impairment ratings are at least 15 percent, and who are therefore eligible for SIBs.

Given these concerns with the SIBs process and potential eligibility issues, this is an area that may merit inclusion in a future ROC research agenda.

General Benefit Delivery Issues

Timeliness of payment

Timeliness is an important component of effective benefit delivery. Table 7 shows the timeliness of the first payment of income benefits to injured employees and the timeliness of payment for properly submitted medical bills, both of which have been relatively stable over the past few years.

⁷⁵ Specific points raised by TWCC staff are that a designated doctor in a return-to-work dispute does not have presumptive weight, and that Commission rules for the SIBs process stipulate that an employee is required to make a good faith effort to obtain employment if any medical records (including a report of a carrier RME) indicate that the injured employee can return to work. See TWCC Rule 130.102 (d) (4).

Table 7
Timeliness of payment – Income and Medical benefits

	1998	1999	2000	2001	2002 ⁷⁶
Median number of days for first benefit payment	13	14	15	14	13
Average number of days for payment of medical bills correctly submitted by health care providers	25	25	26	24	20

Source: Texas Workers' Compensation Commission, *System Data Report*, June 2002.

Injured Worker Assistance and Representation

The major 1989 reform of the workers' compensation system led to a significant decrease in attorney representation of injured employees. Data from the mid-1990s indicated that less than 10 percent (8.7 percent) of workers' compensation claimants are represented by an attorney, and there is little evidence to suggest that this number has increased substantially in the ensuing years.⁷⁷ While attorney representation rates remain low, assistance is available to injured employees through the TWCC ombudsman program, which provides free assistance to injured workers not represented by attorneys in the TWCC dispute resolution process. Previous research on the ombudsman program indicated that injured employees who used ombudsmen for assistance were about as satisfied with the assistance they received as were injured employees who hired attorneys.⁷⁸

One legislative change in the 2001 session was directly focused on improved access to attorney representation for injured employees in certain appeals to District Court. Article 8 of HB 2600 stipulated that, in cases where an insurance carrier appeals a final decision of TWCC regarding the compensability of or eligibility for income or death benefits and subsequently loses the District Court appeal, the carrier must pay the injured employee's attorney fees. This provision expires on September 1, 2005, unless extended by

⁷⁶ Includes only data from January to June 2002. See TWCC *System Data Report*, June 2002.

⁷⁷ See *Attorney Involvement in the Texas Workers' Compensation System*, Texas Workers' Compensation Research Center, June 1995.

⁷⁸ See *A Comparison of Injured Workers who use Attorneys or Ombudsmen in the Texas Dispute Resolution System*, Research and Oversight Council on Workers' Compensation, 1997. Sixty-five percent of injured employees surveyed who had used the ombudsman program reported that they were "satisfied" or "very satisfied" with their ombudsman; 60 percent of injured employees with attorney representation indicated the same.

Legislative action. It remains to be seen to what extent this provision improves attorney access in those cases involving a final TWCC decision in the injured employee's favor, and further examination of this issue will be required prior to the statutory Sunset date.

Some injured employees continue to raise concerns about their inability to find an attorney who will take their case, and about the lack of assistance available in contesting difficult issues (such as the outright denial of a claim, appeals to District Court, or a complex medical dispute). As the topic of the attorney representation and ombudsman assistance has not been the subject of detailed analysis since 1997, ROC believes this is an area that may merit further research prior to the 2005 Legislative session, particularly in light of the pending sunset provision of Article 8 of HB 2600 and the need for information on this provision's effectiveness.

Recent Activity – Effective Delivery of Benefits

Recent legislative and regulatory developments not covered in the previous discussion but related to the effective delivery of benefits are summarized below.

Changes to the designated doctor process – Article 5, HB 2600

As discussed in the section on Benefit Equity, HB 2600 changed the process by which injured employees undergo Required Medical Examinations (RMEs). Under previous law, insurance carriers were allowed to request that an injured employee be examined by a carrier-selected doctor no more than every 180 days, with certain exceptions. One of the more common reasons for RME requests was to make an assessment of whether the employee had reached Maximum Medical Improvement (MMI), and, if so, to assign the employee an impairment rating. Article 5 stipulates that, effective January 1, 2002, MMI or impairment rating exams be performed first by a TWCC designated doctor, rather than a carrier-selected doctor. Such a designated doctor exam may be requested by an insurance carrier or an injured employee. Although the designated doctor's opinion has presumptive weight, an insurance carrier may still request a follow-up exam by a doctor of its own choosing if it wishes to gather evidence to dispute the determination.

Another change made by Article 5 of HB 2600 allows designated doctor MMI and impairment ratings exams to be conducted much more often than were carrier-selected RME exams. Under the old process, insurance carriers could only request an injured worker undergo an examination by an RME doctor every 180 days; post-HB 2600, insurance carriers can now request designated doctor exams as often as every 60 days.

Since the finding of MMI and assignment of an impairment rating carry great importance in terms of eligibility for future benefits, changes to the process by which these assessments occur will have to be monitored closely for their impact on the effective delivery of benefits and other areas of the system.⁷⁹ ROC is required by statute to report on the effects of this change by December 31, 2004. (For more details on the changes made through Article 5 of HB 2600, please see the Benefit Equity section of this report.)

Initial Pharmaceutical Coverage

Article 4 of HB 2600 attempted to address a potentially problematic situation for injured employees in getting prescriptions filled in the period just after an on-the-job injury. In the time immediately following an injury, uncertainty may exist as to the existence of the injury, the coverage status of the injured employee's employer, and other issues, and this uncertainty may increase the likelihood of a pharmacist being unwilling to fill a prescription for fear that he or she will not be paid. In an attempt to remedy this situation, Article 4 allowed TWCC to adopt rules stipulating that insurance carriers are responsible for the payment of pharmaceutical benefits sufficient for the first seven days following an injury, provided that the pharmacist receives verbal confirmation of a report of injury from either the employer or insurance carrier. The statutory language also required that if the Commission adopted such rules, the rules allow for insurance carriers to claim reimbursement for the cost of these pharmaceuticals for the 7-day period from

⁷⁹ Each percentage of an injured employee's permanent impairment qualifies the employee for three weeks of Impairment Income Benefits (IIBs). Further, injured employees with impairment ratings of 15 percent or greater may be eligible for Supplemental Income Benefits (SIBs).

the Subsequent Injury Fund (SIF), if the injury is later determined not to be compensable.⁸⁰

In summer 2002, TWCC proposed Rule 134.501, related to this initial pharmaceutical provision. In October 2002 TWCC adopted this rule, with an effective date applying it to injuries on or after December 1, 2002.

The initial TWCC rule proposal was more broad than the finally adopted rule in one important sense. The initial proposal appeared to require insurance carriers to pay for pharmaceuticals sufficient for the first seven days post-injury, regardless of issues of compensability, liability, or *medical necessity*, in order to practically guarantee that a pharmacist would receive payment for providing this initial supply. In other words, the carrier could not deny the pharmacist payment for the supply sufficient for the first seven days. In the case of an injury later deemed non-compensable, the carrier could seek reimbursement from the SIF.

The adopted rule, however, clarifies that a carrier *may* still deny for medical necessity reasons, removing the guarantee that the pharmacist will be paid, but eliminating the possibility that the pharmacy bill will be denied for reasons other than medical necessity (assuming that the bill is properly submitted). The statutory language was broad and not completely clear as to which approach was indicated; TWCC, in opting for the more limited guarantee of payment for the first seven days, cited the fact that a carrier is only eligible for reimbursement in claims shown to be non-compensable, not for those in which the prescription is found not to have been medically necessary.

This issue also ties in to the broader discussion about potential avenues to minimize disputes over the reasonableness and necessity of pharmaceuticals, as discussed in detail in the Medical Care and the Recommendations sections of this report.

⁸⁰ See Texas Labor Code Section 413.0141.

Electronic Funds Transfer (EFT)

Legislation in the 76th session in 1999 (HB 729) requires insurance carriers to provide electronic funds transfer (EFT) at the request of an injured worker who is entitled to payment of benefits "for a sufficient duration."⁸¹ In December 1999, TWCC adopted Rule 124.5, requiring carriers to pay benefits electronically to employees who are expected to be eligible for at least eight weeks of benefits from the time the employees makes a written request for EFT, and who provide the necessary information for EFT to occur.

In Fall of 2002, TWCC added information regarding EFT payment options to the initial information provided to injured workers. Because of this rather recent development, however, it is not clear at this time to what extent EFT is being utilized by injured employees.

Conclusion – Effective Delivery of Benefits

In general, the Texas workers' compensation system provides income and medical benefits in an efficient and timely manner. Much of the system concern in recent years has been on the effective delivery of medical benefits, particularly the area of Medical Dispute Resolution (MDR). This concern led to major changes to the MDR system through the passage of House Bill (HB) 2600 by the 77th Legislature in 2001. Insufficient data have accumulated about the revised processes at this time to make conclusive statements about whether it has improved the system; further monitoring will be critical to assessing the impact of these changes. Other areas of particular concern to some system participants include the adequacy of assistance provided to injured employees and the delivery of Supplemental Income Benefits (SIBs), and further research may be required in these areas prior to TWCC sunset review in 2005.

⁸¹ See Texas Labor Code Section 409.0231.

7./8./9. AGENCY CONTROL, POLICY CONTROL & SYSTEM MONITORING

The system should provide a mechanism for continued monitoring by and input from business and labor interests.

Policymakers in the Legislature and the Texas Workers' Compensation Commission (TWCC) should be able to ensure that the system operates in accordance with the law and policies properly established.

TWCC should have the authority and resources to administer and enforce the law and its rules, including the ability to promptly detect and appropriately address acts or practices of non-compliance on the part of any participant.

Overview

In conjunction with concern about medical costs, the area of system monitoring probably has been the subject of more scrutiny than any other aspect of the Texas workers' compensation system in recent years. The component of system oversight relating to TWCC's ability to monitor and regulate health care providers and insurance carriers in the system was one of the major focuses of House Bill (HB) 2600. In addition, TWCC's general compliance programs have seen a significant increase in potential violations referred for action. TWCC's success in implementing the components of HB 2600 related to improved medical monitoring will be key to the success of the legislation in promoting higher-quality, more cost effective medical care.

This section will examine components of appropriate system monitoring, agency control, and policy control, including:

- 1) Appropriate monitoring and input from business and labor interests;
- 2) System Monitoring, with a primary focus on TWCC's provider and insurance carrier monitoring efforts and other features of HB 2600; and
- 3) Agency and Policy Control issues.

Unlike some other sections of the report, this section will not be broken down into portions dealing with general system descriptions and those related to recent activity.

This is because the level of recent activity in this area has been so significant that almost every portion could fairly be placed in that section.

Monitoring and Input from Business and Labor

As part of the 1989 reform, the Texas Legislature replaced the Industrial Accident Board (IAB) with the Texas Workers' Compensation Commission (TWCC), and changed the makeup of the governing board to six part-time commissioners (three representing employers and three representing wage-earners), appointed by the Governor, whose primary responsibility is to establish rules and procedures to implement the Texas Workers' Compensation Act. These Commissioners currently serve six-year terms.

The construction of TWCC's governing board is designed to provide representation for both employer and employee interests, but the fact that it consists of an even number of members can result in split votes. This possibility, and other Legislative interest in establishing the most effective TWCC governance possible, led to the introduction of legislation in the 77th session to replace the six-commissioner structure with a single commissioner arrangement similar to that used for the Texas Department of Insurance (TDI). This legislation (HB 1205) did not pass, but various stakeholder groups have continued to express either support or opposition to the idea of revising TWCC's governing board structure. TWCC has proposed a legislative recommendation to address its governance to comply with a change to the Texas Constitution requiring state agency boards to have an odd number of members or shorter terms. For more information on this proposed change, see the Recommendations section of this report.

Another aspect of appropriate monitoring from business and labor interests – as well as other stakeholder groups, such as health care providers and insurance carriers – is reflected in the collaborative manner in which HB 2600 was developed. Policymakers involved recognized that legislation to address medical cost and quality issues was unlikely to win approval without broad-based stakeholder support. As a result, a number of meetings were held with a variety of stakeholders prior to the passage of the bill. TWCC has also continued to use this stakeholder group as a resource in the development

of rules and policies to implement HB 2600. Although stakeholders have sometimes raised concerns that their positions were not reflected in the final product (the adopted TWCC rule or policy), most seem to generally prefer advance stakeholder participation to a purely responsive process.

System Monitoring

As discussed in other sections of this report, a major impetus for HB 2600 was the desire for improved monitoring and oversight of system participants associated with medical cost and quality control – specifically, health care providers and insurance carriers. This section will describe additional tools available to TWCC to act on data about the practices of health care providers and insurance carriers, and to improve system oversight in the medical arena in other ways.

Approved Doctor List Registration and Training Requirements

Historically, TWCC's Approved Doctors List (ADL) has included every doctor licensed to practice medicine in the state.⁸² Over time some doctors have been removed from the list, usually either because of death, retirement, or loss of license, but in general doctors on the list have not been subject to meaningful regulation and/or potential ADL removal based on the quality of care they provide.

HB 2600 made significant changes to the manner in which the doctors are added to, and deleted from, the ADL. Rather than a licensure-based, automatic registration, doctors are required to register to be on the list. TWCC is also mandated to establish training, impairment rating testing, and financial disclosure requirements for doctors applying for inclusion on the ADL.⁸³ HB 2600 allowed TWCC a period not to exceed 18 months after the adoption of rules to implement these provisions before doctors must comply with the new ADL registration, training, and other requirements, in order to provide time for new training to be conducted and registration to occur.

⁸² Texas *Labor Code* Section 408.023(a) provided (prior to changes made by HB 2600) that every doctor licensed to practice medicine in Texas on January 1, 1993 was on the Approved Doctors List, unless subsequently deleted and not reinstated.

⁸³ See Texas *Labor Code* Section 408.023.

In response to this charge, TWCC in March 2002 adopted significant changes to Commission rules governing the ADL.⁸⁴ The new rules require that, on and after September 1, 2003, doctors wishing to provide services in the workers' compensation system be on the ADL and have completed the necessary mandates for training and testing.⁸⁵

TWCC Sanction Authority

Article 1 of HB 2600 also provides greater authority to TWCC to impose sanctions on doctors who, based on the monitoring efforts described earlier or other criteria defined by TWCC, do not appear to be providing high-quality, cost-effective care, or whose outcomes of care in areas such as return-to-work are deficient. The available sanctions are wide-ranging, from additional education or training, to greater preauthorization requirements, to outright removal from the ADL. Some of these same sanctions may also be applicable to insurance carriers or their agents who exhibit review patterns that fall outside the bounds of high-quality review of care.⁸⁶

Medical Advisor and Medical Quality Review Panel (MQRP)

It was clear that TWCC would require greater access to medical expertise in order to provide better oversight of medical management issues, and that the Commission might benefit in general from better access to this expertise. Accordingly, HB 2600 directed TWCC to employ or contract with a Medical Advisor – who must be a doctor – to act as a sort of “head of medical policy” for the commission.⁸⁷ These broad duties include making recommendations for TWCC action on medical guidelines and other rules, recommendations for sanctions against health care providers and insurance carriers, identification of minimal modifications to the Medicare reimbursement methodology and

⁸⁴ See TWCC rules 180.20 through 180.26.

⁸⁵ TWCC Rule 180.23 generally allows two levels of certification for doctors participating in the system, with stricter training requirements for doctors in the second level.

⁸⁶ A description of potential sanctions is included in TWCC Rule 180.26.

⁸⁷ TWCC already had utilized a Medical Advisor on a part-time basis prior to the passage of HB 2600. The bill provided statutory definition for the position and its duties.

model required for the workers' compensation system, chairing the Health Care Network Advisory Committee, and other duties.

TWCC's first and current Medical Advisor is Dr. William Nemeth, an orthopedic surgeon.⁸⁸ Dr. Nemeth has announced his intention to leave the agency, effective the end of calendar year 2002. As of this writing, TWCC has not named a replacement.

The new Medical Advisor will face many of the same challenges as did Dr. Nemeth: attempting to appropriately define the role of the position in the TWCC organizational structure; ensuring that monitoring programs and reviews based on those programs move forward and produce measurable results; and providing needed medical expertise in other areas of TWCC, such as guideline development. Strong leadership from this position will be essential to the success of the key HB 2600 initiatives.

While the Medical Advisor is an essential resource on staff for TWCC, no one person can provide all the medical expertise needed in reviewing the practices of health care providers and insurance carriers, or in other areas. For this reason, HB 2600 directed the creation of a Medical Quality Review Panel (MQRP) to assist the Medical Advisor in performing his or her duties. As the process has been described and envisioned, MQRP members (who are also required to be doctors) would perform reviews of actual cases of those providers or carriers identified based on monitoring, and for whom the data validation indicates that the monitoring results were correct. After review of a sample of cases to evaluate the actual circumstances of the provider's care or the carrier's review practices, the MQRP member or members – TWCC has indicated that more than one MQRP reviewer is likely to be involved – would recommend action (if necessary) to the Medical Advisor, possibly including the sanctions discussed earlier in this section. Dr. Nemeth has also indicated that he plans to utilize an Executive Council of MQRP members to consult with him on any recommendations for action, although the final decision on whether to recommend action would be his. TWCC indicated in late October

⁸⁸ During a leave of absence by Dr. Nemeth in 2001, Dr. Robert Conte served as interim Medical Advisor.

2002 that it was in the process of gathering recommendations to perform quality of care reviews for eleven doctors.

MQRP members are also envisioned to be a major part of TWCC's other medical monitoring programs. Aside from focusing on appropriate utilization and high-quality outcomes for health care providers and insurance carriers, TWCC is also implementing programs to monitor the quality of designated doctor impairment ratings and of medical dispute resolution decisions made by Independent Review Organizations (IROs). The designated doctor monitoring effort is the more developed of these two initiatives, as TWCC has programs available to compare the impairment ratings assigned by designated doctors and identify those doctors whose ratings seem to be significantly outside the norm of their peers.⁸⁹ These doctors could then be subject to case reviews by MQRP members to determine if the American Medical Association's *Guides to the Evaluation of Permanent Impairment* were properly applied. Sanctions, including removal for the designated doctor list, could follow.

TWCC indicates that it has initiated reviews of designated doctors based on the monitoring results. In late October 2002, TWCC reported to ROC that Dr. Nemeth had met with his Executive Council on reviews of six designated doctors. Of the six, two did not seem appropriate for any action (i.e., the case reviews revealed that the doctors were performing their duties properly), three were recommended for retraining on aspects of the *AMA Guides* and perhaps ongoing oversight by TWCC staff, and one acknowledged shortcomings in his or her ratings and voluntarily submitted to retraining or review.

TWCC also indicated in late October 2002 that about \$14,000 had been expended thus far in the MQRP review process. MQRP members are paid \$100 an hour for reviews, but are not paid for travel or other per diem expenses. As of late October, there were 31 MQRP members.

⁸⁹ Since the assessments of Maximum Medical Improvement (MMI) and impairment ratings given by designated doctors are given presumptive weight (that is, assumed to be correct unless the great weight of medical evidence is to the contrary) in dispute proceedings, these assessments are particularly important in the workers' compensation system.

The IRO monitoring program is not in as advanced a state, partly because only a relatively short time (since January 2, 2002) has passed since IROs began receiving medical disputes and issuing decisions. However, this program will be very important to the long-term quality assurance of the medical dispute resolution process.

While some progress has been made in implementing these key components of HB 2600, there are still concerns about how the new processes will work and when they will yield meaningful results. As noted in this section, the Medical Advisor has named members to the MQRP, and some reviews of health care providers are under way, based on the monitoring results discussed previously. Specific concerns have involved the prospect of legal action against MQRP members; although HB 2600 provides protection from civil action for acts performed in good faith, and grants MQRP members the same protections afforded to Commission members in this regard, TWCC has indicated that additional statutory language may be needed to ensure state representation if legal action is brought, or to procure insurance to cover MQRP members. For more discussion on this topic, please see the section of the report on TWCC's legislative recommendations.

Stakeholder concerns about the implementation of the MQRP have focused on perceptions that the panel is not moving forward or receiving the necessary support within the agency to achieve its goals, and a lack of information about the status of the panel and its activities. Many of these concerns were voiced at the ROC stakeholder meeting on *Biennial Report* issues held in October 2002, prompting TWCC to offer to hold a stakeholder meeting to update the status of Medical Advisor and MQRP activities.

ROC has also handled several inquiries from legislative offices regarding how TWCC might use the expertise of the Medical Advisor and/or MQRP in resolving problematic medical issues or analyzing complaints about inappropriate medical management on particular workers' compensation claims. It was clearly envisioned that the Medical Advisor and MQRP would use the circumstances of particular claims retrospectively to potentially target health care providers (or insurance carriers) for further scrutiny of their

overall practice or review patterns. Through legislative referrals in which the ROC has been involved, some case-specific complaints about poor medical management and outcomes that might have been preventable if the Medical Advisor's expertise had been utilized have been raised. The Medical Advisor has performed several case-specific reviews of such complaints, and has indicated that these complaints could form the basis for further systematic review. TWCC has also indicated, however, that it envisions no role for the Medical Advisor in providing medical expertise to help resolve problems with particular claims as they occur. ROC staff has raised the issue that case-specific intervention involving the Medical Advisor might be appropriate for some cases, and would not be dissimilar to other processes used by TWCC to pro-actively avoid indemnity benefit disputes when possible. However, it is also clear that at present, TWCC has not established the processes necessary to ensure that such reviews would not become an overwhelming responsibility for the Medical Advisor and his limited staff.⁹⁰ For more discussion on Medical Advisor and MQRP issues, see the Recommendations section of this report.

General TWCC Compliance and Enforcement Issues

An important aspect of the 1989 reform of the workers' compensation system was the creation of the Compliance and Practices Division, and other auditing functions, within TWCC. The Industrial Accident Board, TWCC's predecessor agency, had virtually no enforcement authority to investigate fraud or perform audits or other important administrative functions. The reform gave TWCC expanded authority to more effectively implement and enforce the Workers' Compensation Act and rules through its Compliance and Practices Division.

Generally, the Compliance and Practices Division's activities can be divided into three areas, post-HB 2600:

1. Fraud investigations;

⁹⁰ At present, the Medical Advisor's office has a staff of two, in addition to the Medical Advisor himself. One of these staff members is a registered nurse.

2. Working with the Medical Advisor and MQRP, reviewing quality of care issues through Quality Reviews and Quality Audits; and
3. Compliance Audits and Violations Reviews, to determine compliance or non-compliance with basic statutory duties and requirements.

Activity in the first area – fraud – is described in the section on Cost Transfer. Activity in the second area was previously described in this section.

The third area – compliance audits and violations reviews – have also been the subject of recent discussion and scrutiny by system participants. The number of violation referrals received by Compliance and Practices has increased sharply in recent years, as Table 8 reflects.

Table 8
Violation Referrals Received and Reviewed by Compliance and Practices

	FY 1999	FY 2000	FY 2001	FY 2002
Referrals Received	3,707	5,142	7,226	9,085
Referrals Reviewed	2,749	3,940	5,268	8,640

Source: Materials provided for TWCC Commissioners' Meeting, October 2002.

Aside from an obvious increase in the overall volume of referrals in the last four years, there are also some interesting changes in the types of referrals received by Compliance and Practices. Perhaps most significant is an increase in the number of referrals from health care providers regarding insurance carriers, typically related to allegations of non-payment or inappropriate payment of medical bills. For those referrals received between January and August 2002 (the final eight months of fiscal year 2002), 57 percent came from health care providers. As Table 9 shows, this is nearly three times the complaint volume received from any other single referral source.

**Table 9
Violation Referral Sources, January to August 2002**

	Number of Referrals	Percentage of Referrals
Health Care Provider	3,917	56.6
TWCC Field Offices	1,310	18.9
Employee	563	8.1
Insurance Carrier	391	5.6
Attorney	342	4.9
TWCC Central Office	242	3.5
Other	128	1.9
Employer	34	0.5

Source: TWCC Quarterly Report to ROC, October 2002.

Insurance carriers were also the subject of almost three-quarters of the violation referrals received by TWCC between January and August 2002, as Table 10 indicates. These numbers have changed significantly, as in fiscal year 1999 when, for example, carriers (41.7 percent) and health care providers (39.7 percent) each were the subject of about the same number of referrals.

**Table 10
Subjects of Violation Referral, January to August 2002**

	Number of Referrals	Percentage of Referrals
Insurance Carrier	5,124	74.0
Health Care Provider	1,308	18.9
Employer	246	3.6
Claimant	124	1.8
Other	105	1.5
Attorney	20	0.3

Source: TWCC Quarterly Report to ROC, October 2002.

Table 11 shows the ten most common types of referrals handled by TWCC. The top two, and the majority of those on this list, relate to allegations that would typically be made by health care providers against insurance carriers. Together, these ten violation types account for about two-thirds of all violations referrals received by TWCC.

**Table 11
Top Ten Types of Violation Referrals, January to August 2002**

	Number of Referrals	Percentage of Referrals
Failure to pay or dispute medical bill within 45 days	1,527	22.0
Failure to timely respond to reconsideration request on a medical bill	560	8.1
Failure to timely file a TWCC-69	511	7.4
Failure to pay according to medical fee guideline/medical policies	365	5.3
Failure to annotate medical bill	330	4.8
Failure to timely file a correct TWCC 73	326	4.7
Failure to provide a specific reason for reduction or denial of benefits	304	4.4
Failure to provide a copy of a peer review with appropriate information	265	3.8
Pursuing a private claim against a claimant	255	3.7
Failure to continue to timely pay TIBs as and when accrued	196	2.8

Source: TWCC Quarterly Report to ROC, October 2002.

Not all referrals received by Compliance and Practices result in actual findings of non-compliance with the Act or rules and violations being issued. Referral outcomes for the January-August 2002 period are as shown in Table 12.

**Table 12
Violation Referral Outcomes, January to August 2002**

	Number of Type of Action	Percentage of Outcomes
Notice of Violation Issued	1,320	21.4
Warning Issued	1,627	26.4
No Violation Found	1,978	32.1
Other Outcome ⁹¹	1,232	20.0

Source: TWCC Quarterly Report to ROC, October 2002.

Historically, one complaint raised by stakeholders about the compliance process is the amount of time needed to complete a review. Between January and August 2002, the average number of days from receipt of a violation referral to completion of the review of that referral was 139.4 days (roughly four and half months) for the 6,157 referrals that saw an outcome during this period. As of September 1, 2002, an additional 2,190 referrals were still in "initial referral status," according to TWCC, and are not included in the 6,157 referrals for which an outcome occurred.

⁹¹ By TWCC's definitions, other outcome includes: insufficient evidence; low probability of prosecution; or "alternative enforcement" (i.e., the outcome of the proceeding served as an appropriate sanction, for example.)

Compliance and Practices also initiated 120 audits between January and August 2002: 46 of health care providers; 42 of insurance carriers, focusing on income issues; four of insurance carriers, focusing of medical benefit issues; and 28 of insurance carriers, focusing on accurate and appropriate submission of data to TWCC.

A finding that a violation occurred may result in an administrative penalty being issued by TWCC. Table 13 shows the amount of administrative penalties collected from each system participant type for 1999, 2000, 2001 and 2002 (January to August).

Table 13
Administrative Penalties Collected⁹²
1999-2002

Type of System Participant	1999	2000 ⁹³	2001	2002 (Jan.-June)
Insurance Carrier ⁹⁴	\$677,105	\$2,302,341	\$1,055,276	\$699,467
Health Care Provider	\$19,744	\$30,764	\$41,229	\$53,051
Employer	\$23,894	\$22,027	\$8,901	\$6,520
Injured worker	\$2,825	\$600	\$2,100	\$200
Attorney	\$0	\$934	\$359	\$280
Other	\$713	\$6,763	\$638	\$0
TOTALS	\$724,281	\$2,363,429	\$1,108,503	\$759,518

Source: TWCC *System Data Report*, June 2002.

As previously noted, Article 6 of HB 2600 called for the creation of a schedule of administrative penalties by TWCC, which would specify penalty amounts for particular violations of the Act or rules.⁹⁵ TWCC has attempted to gather stakeholder input on the administrative penalty schedule and held a stakeholder meeting in May 2002 with discussion on this issue on the agenda. Stakeholders at the meeting asked a number of questions about TWCC's general compliance program and approach to conducting

⁹² Table 13 reflects penalties *collected* rather than penalties *assessed*. The assessed totals for the four years in question were, respectively: \$889,053; \$2,695,771, \$1,249,067; and \$842,247. The ratio of penalties collected to penalties assessed has varied from 81 to 90 percent over these four years, and has increased slightly each year.

⁹³ In 2000, TWCC concluded a number of audits for which field work had been completed in previous years, and also began conducting audits of information collected via Electronic Data Interchange (EDI). TWCC indicates that the totals are higher in 2000 for these reasons.

⁹⁴ Clearly, insurance carriers are assessed (and pay) far more in administrative violations than any other system participant. In each of the years shown, carriers paid between 92 and 98 percent of all administrative penalties.

⁹⁵ See Texas Labor Code 415.021 (a).

compliance audits and handling referrals, but have since offered little specific input on the penalty schedule, according to TWCC staff. As of this writing, TWCC intended to propose the schedule of administrative penalties at its December 2002 public meeting. For more discussion on general Compliance and Enforcement issues, see the Recommendations section of this report.

Agency and Policy Control

Quarterly Reporting from TWCC and TDI

Pursuant to a request from the ROC Board in 2000, both TWCC and the Texas Department of Insurance (TDI) began reporting select information related to the workers' compensation system to the ROC in early 2001. This process has continued sporadically since that time. In part because of the significant TWCC implementation requirements of HB 2600, and the likelihood of changes in the information ROC would request from TWCC given changes in medical dispute resolution, ADL regulation, and other areas, TWCC did not continue regular quarterly reporting from mid-2001 to mid-2002. In summer 2002, however, with most of the HB 2600 implementation deadlines in the past and a clearer picture of the new processes in place, ROC staff and TWCC staff met to develop a new outline for the Quarterly Reporting process. By late October 2002, ROC had received a report with detailed information for the first three quarters of calendar year 2002 (January through September). ROC staff considers this information vital to ongoing monitoring of the system and appreciates TWCC staff's work in providing this information on a quarterly basis in the future.

As an additional tool to identify particular system issues that may require attention, ROC staff also builds and maintains a Policy Development Log (PDL). Issues are added to the PDL by ROC staff when they are raised through constituent assistance, interaction with system participants, or research findings. The PDL is the basis for ongoing discussions between ROC and TWCC staff about regulatory and TWCC policy issues, and ROC intends to continue using this tool for discussions with TWCC in the interim, and as a valuable resource for potential issues to address during TWCC sunset review in 2005.

TWCC Business Process Improvement Project

TWCC is currently in the process of building and implementing an agency-wide information systems redesign, an effort known as the Business Process Improvement Project, or BPI. TWCC's current information application system is more than 20 years old, and although it has been modified many times over the years, needed improvements in information management, public access to non-confidential statistical data and customer service are not feasible if the system is not redesigned or replaced. Compliance with the federal Health Insurance Portability and Affordability Act (HIPAA), expected to become the standard for health care information exchange, will also be extremely difficult or impossible without an updated system. The BPI project is designed to replace the old system, move many of the agency's paper-intensive communications to electronic means, improve internal processes and the ease with which external parties interact with TWCC, and provide better and easier access to workers' compensation data for analysis and reporting.

TWCC received \$3.56 million in the FY 2002/2003 biennium (as an exceptional item to its budget) to fund the BPI project. TWCC originally intended to request an additional \$10.7 million in its 2004/2005 Legislative Appropriations Request (LAR) toward the overall cost of the BPI project, originally estimated at \$20 million. However, TWCC has since indicated that it can accomplish more this biennium with the available funding than originally anticipated, and also believes that the overall cost of the BPI initiative can be reduced from \$20 million to \$13 million. TWCC's LAR for FY 2004/2005 therefore requested that the \$3.56 million appropriated in the current biennium be continued in the agency's baseline budget, but did not request additional exceptional item funding for the BPI project.

TWCC has divided the BPI project into discrete phases, or tiers. Tier One BPI projects are scheduled for implementation on September 1, 2003; major components of Tier One including important system participant identification items, as well as coverage and incident information. Included in the system participant identification items are the new

ADL registration process, which was demonstrated for system stakeholders at a presentation in late October 2002.

In general, TWCC has provided a significant amount of useful information to stakeholders about the BPI process and its goals in the last several months. BPI was the subject of a TWCC stakeholder meeting in July 2002, and its status is updated through regular newsletters. TWCC staff has also committed to providing as much advance notice of specific new requirements to system participants (generally, in this area, insurance carriers) as possible, since these decisions affect the system participants' operations. As TWCC is sometimes criticized by external stakeholders for not providing enough information about agency initiatives (such as the MQRP, for example), BPI might provide a good model for other TWCC ventures in terms of sharing information and updates.

One essential concern for a number of system stakeholders is that the BPI project result in better, easier access to non-confidential TWCC data for external parties. This issue is discussed further in the Recommendations section of the report.

Cost Allocation (Risk-Reward) Program for State Agency Workers' Compensation Claims Administered by the State Office of Risk Management (SORM)

As noted in the introduction to this report, the State Office of Risk Management (SORM) is responsible for the payment of most state agency workers' compensation claims. As an incentive to encourage agencies to improve workplace safety and reduce injuries, the Appropriations Act prior to the 77th Legislature required agencies to be responsible for 25 percent of their workers' compensation claims costs. As a further incentive, the original enabling legislation for SORM in the 75th Legislature in 1997 called for the development of a broader cost allocation program. Statutory design problems with this section of the law, however, made it non-operational, and it was removed in the 76th session.

In the 77th Legislature in 2001, two proposals (HB 2976 and Article 14 of HB 2600) were introduced to establish a cost-allocation program based on a "risk-reward" model. Under

this model, agencies would be responsible for 100 percent of their costs, with SORM tasked to develop an annual assessment for each agency. This assessment would represent a sort of baseline workers' compensation cost for each agency. The total assessments of all state agencies covered must be sufficient to pay the state's total workers' compensation costs, but how each individual state agency's assessment is calculated would depend on a variety factors related to its size and claims history.⁹⁶ The "risk-reward" element for agencies relates to how the agencies' actual costs compare to their assessments; if agency costs are higher than its assessment, the agency will be in a position of finding new funding in its budget or asking for a special appropriation, while an agency that spends less than its assessment could, subject to the appropriations process, be allowed to retain this funding.

Interest in the new allocation program rose significantly when SORM distributed proposed assessments for FY 2002 to state agencies. Some agencies raised concerns that their assessments were unfairly high, and asked SORM to adjust its formula for calculating assessments. By the time SORM staff received requests to revisit the assessment formula for FY 2002, however, a large percentage of agencies had already signed contracts with SORM to pay their assessments, and SORM staff stated that it would be practically impossible to change the FY 2002 assessment method at that stage. However, discussion continued on ways to adjust the FY 2003 assessment formula, and after a series of informal group meetings with representatives of interested agencies and a period of official public comment, the SORM Board adopted revised FY 2003 assessments in October 2002. ROC staff plans to continue monitoring the implementation of the risk-reward cost allocation program.

⁹⁶ Texas *Labor Code* Section 412.0121 (c) lays out the factors to be considered by SORM in developing assessments. They include: (1) The number of employees of the agency compared with the total number of employees of all state agencies to which this chapter applies; (2) the dollar value of the agency's property and asset and liability exposure compared to that of all state agencies to which this chapter applies; and (3) the number and aggregate cost of claims and losses incurred by the state agency compared to those incurred by all state agencies to which this chapter applies. 412.0121 (d) also allows SORM to consider "other factors it deems relevant, including an agency's risk management expenditures, unique risks, and established programs."

Conclusion – Agency Control, Policy Control, and System Monitoring

Appropriate control and monitoring of the workers' compensation system has always been a vital system goal; changes mandated by HB 2600 increase the emphasis on this area in several meaningful ways. The legislation gave TWCC unprecedented expertise and statutory tools to address medical quality and cost issues. Some progress has been made in this area, but system stakeholders remain anxious for significant, measurable changes. The success or failure of the new authority given TWCC in addressing these key system issues will likely guide future legislative initiatives to either reinforce the commission's authority and resources or examine other options for controlling medical costs and addressing quality issues.

General TWCC compliance programs, while aggressive compared to those in most other states, are also frequently the subject of system scrutiny. This trend is likely to increase as more system participants look to TWCC for guidance on proper application of related statutes, TWCC rules and policies, particularly in the medical area. A broader examination of compliance goals and programs may be warranted.

10. RETURN TO WORK

The system should encourage the speedy return to employment that is safe, meaningful, and commensurate with the abilities of the accident victim.

Overview

One of the most basic objectives of the Texas workers' compensation system is to return injured workers to safe and productive employment. In 1999, during the 76th Legislative session, policymakers were concerned about whether the system was meeting its goal of timely and productive return to work for injured workers, along with general concerns about medical quality and cost. These concerns led to the passage of House Bill (HB) 3697, which charged the ROC to examine several issues related to quality and cost of medical care and return-to-work outcomes of injured workers in Texas.

The results of the HB 3697 studies, released by the ROC in February 2001, indicated that injured workers in Texas were, on average, off work longer due to their injuries than were injured workers in other states. Fewer injured workers in Texas (64 percent) indicated that they were working two years after their injuries, compared to 75 percent of the injured workers in other states. Further, Texas workers were more likely to report that their take-home pay was less than it was prior to the injury than were injured workers in other states. More than a quarter (28 percent) of Texas workers indicated that their post-injury take-home pay was lower, compared to just 13 percent of the injured workers surveyed in other states.⁹⁷

Another significant issue for injured workers identified by the HB 3697 studies was a lack of communication with their health care providers on optimal return-to-work options. Only about two-thirds of injured workers in Texas and other states indicated that their treating doctor discussed activities that could be safely performed at home, steps to manage pain, and ways to prevent re-injury from occurring. Only about half of these

⁹⁷ See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and Med-FX, LLC, February 2001.

injured workers said that their doctor talked to them about a mutually agreed-upon return-to-work date.⁹⁸

Return-to-Work Outcomes for State Agencies

At present the workers' compensation system does not routinely collect return-to-work data. However, a good proxy, or substitute, for determining the amount of time employees are off work due to injury is the duration of Temporary Income Benefits (TIBs) they receive. In FY 2002, ROC conducted a research study to analyze the return-to-work patterns of state agencies. Objectives of this study included comparisons of lost time for injured workers of various state agencies and between state agencies as a whole and the workers' compensation system as a whole. The ROC study found that there was significant variation in the average TIBs durations of similarly injured workers at different state agencies.⁹⁹ For example, the median time off work for state workers at various agencies with shoulder soft tissue ranged from 7.9 to 38.1 weeks. The ROC will continue to monitor these TIBs durations and also work with the State Office of Risk Management (SORM) to address these variations in lost time.

Recent Activities – Return-to-Work

Article 3, House Bill 2600

As noted in other sections of this report, House Bill 2600, passed by the 77th Legislature in 2001, contained several significant changes to the Texas workers' compensation system. Several sections of HB 2600 related to return-to-work issues, specifically to data collection improvements and encouraging return-to-work communication:

- Articles 1 and 3 require TWCC to collect data on return-to-work outcomes as well as information on patient satisfaction and the cost and utilization of health care.¹⁰⁰

⁹⁸ See Research and Oversight Council on Workers' Compensation and Med-FX, LLC, *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to The Texas Workers' Compensation System* (2001).

⁹⁹ See Research and Oversight Council on Workers' Compensation, *A Comparison of Return-to-Work Outcomes for Texas State Agencies:A Report to the 78th Texas Legislature*, 2002 which can be obtained at ROC's website at www.roc.state.tx.us.

¹⁰⁰ See Texas Labor Code Section 413.021 (e).

- Article 3 seeks to improve employer communication about return-to-work options by requiring employers to disclose, upon request, the availability of modified or other return-to-work programs.¹⁰¹
- Article 3 also requires insurance carriers to offer return-to-work services to policyholders, such as job task analysis, job modification, and medical or vocational case management services.¹⁰²

Return-to-Work Data Collection

The initial research on return-to-work outcomes required by HB 2600 will be conducted in FY 2003 as part of the ROC's approved Research Agenda, and will serve as a starting point from which annual surveys of injured workers regarding functional outcomes (including post-injury RTW experiences) and patient satisfaction can be built.

The FY 2003 study will attempt to address the following key research questions:

- 1) What are the return-to-work (RTW) patterns of injured workers who *did not* suffer a permanent impairment as a result of their on-the-job injury?;¹⁰³
- 2) What are the RTW patterns of injured workers *with* permanent impairments resulting from their work-related injuries?;
- 3) How satisfied are injured workers with the medical treatment they received by health care providers and with the assistance they received from providers in assisting them with their post-injury return to work?
- 4) How satisfied are injured workers with how insurance carriers handled their workers' compensation claims, and with the assistance they received from insurance carriers to safely and successfully return to work following their on-the-job injury?

¹⁰¹ See Texas *Labor Code* Section 409.005 (j).

¹⁰² See Texas *Labor Code* Section 413.021. Insurance carriers are not required to provide physical workplace modifications and are not liable for the cost of modifications.

¹⁰³ Patterns include: single absence, currently employed; single absence, currently not employed due to the injury; multiple absences, currently employed; multiple absences, currently not employed due to the injury. These same RTW categories were previously developed by William Johnson, Richard Butler, and Marjorie Baldwin in their 1994 research on permanently impaired workers in Canada, and then subsequently used by the Texas Workers' Compensation Research Center in a 1995 RTW-related survey of injured workers.

- 5) To what degree did injured workers, particularly those with permanent impairments, face personal and economic hardships?;
- 6) What factors are significantly associated with successful post-injury returns to work?¹⁰⁴; and
- 7) To what extent are injured workers aware of the changes in the workers' compensation statute made by HB 2600 related to communications between employers, injured workers, health care providers, and insurance carriers regarding return to work?

In addition to the proposed research mentioned above, the ROC is currently conducting a survey of employers, providers and insurance carriers on RTW issues. The primary research objectives for the survey are:¹⁰⁵

- To assess the knowledge level of employers, carriers, and health care providers regarding the RTW provisions of HB 2600;
- To examine system participants' familiarity with and use of the TWCC-73 Work Status Report, a form used by doctors to report the return-to-work capacity of injured workers;
- To determine baseline level of information sharing between employers, health care providers, and insurance carriers;
- To identify barriers among system participants in facilitating injured workers' return to safe and productive employment; and
- To assess the long-term impact of HB 2600 on communication about the availability of employer modified duty options.

¹⁰⁴ Possible factors include: worker's age, gender, marital status, occupation type, pre-injury wage level, education level, injury type and severity, attorney representation, employment tenure, industry in which worker was employed at time of injury, communication with physician regarding RTW, availability of modified or alternative duty with at-injury employer, and pre-injury work history.

¹⁰⁵ Additionally, the Workers Compensation Research Institute (WCRI) is currently in the process of producing a standardized injured worker survey instrument that will eventually be used to compare return-to-work, access to care, and patient satisfaction outcomes for several states, including Texas. Preliminary survey results for Texas are expected by the end of calendar year 2002.

TWCC Efforts to Collect Return-to-Work Data

Articles 1 and 3 of HB 2600 reinforced previous statutory requirements for TWCC to collect return-to-work outcomes data for injured workers. In response to this requirement, TWCC has begun to develop methods to collect return-to-work outcomes as part of its Business Process Improvement (BPI) initiative. To date, TWCC has held several stakeholder meetings on this issue, but there has not been widespread agreement from system stakeholders on the preferred method for capturing this information.

TWCC Return-to-Work Coordinator

Statutory changes by the 76th Texas Legislature required TWCC to develop return-to-work outreach efforts for employers as part of its health and safety outreach activities. In 2000, TWCC hired a Return-to-Work Coordinator to fulfill this statutory requirement by improving return-to-work educational efforts in the business community. To date TWCC's Return-to-Work Coordinator has developed a manual to aid employers in the creation of return to work programs, as well as identify factors that influence lost time from work. TWCC's Return-to-Work Coordinator also travels and gives presentations to businesses on the keys to successful and effective return-to-work programs.

Conclusion – Return to Work

Research indicates that cooperation between system participants on return-to-work plans for injured workers results in improved physical and mental functioning and shorter durations of lost time. With that in mind, HB 2600 sought to improve communication between employers, providers, insurance carriers and injured workers about RTW issues. In addition, HB 2600 requires TWCC to collect information about return to work and functional outcomes in order to monitor the effectiveness of the workers' compensation system in the return-to-work arena and identify target areas for improvements.

11./12. INSURANCE, ECONOMIC VIABILITY

The system should provide a system of insurance, which is secure and efficient in the delivery of benefits.

Workers' compensation insurance should be available to employers at rates that are not burdensome so that the provision of coverage does not hinder the creation of jobs and economic development.

Overview

Prior to the workers' compensation system reforms of 1989 and 1991, many insurance carriers were discontinuing their operations in the Texas, and affordable coverage for employers was becoming increasingly scarce. Legislation passed in 1989 and 1991 included significant workers' compensation insurance-related changes, as well as other major modifications to the Texas workers' compensation system (i.e., the delivery of income benefits, the administration of the system, implementation of a new administrative dispute resolution system). It was anticipated that these reforms would lead to increased competition in the workers' compensation insurance market, resulting in lower premiums for employers and higher rates of employer participation in the voluntary workers' compensation system.

The following represent the more significant insurance-related changes made to the Texas workers' compensation system during the 1989 and 1991 Legislative sessions:

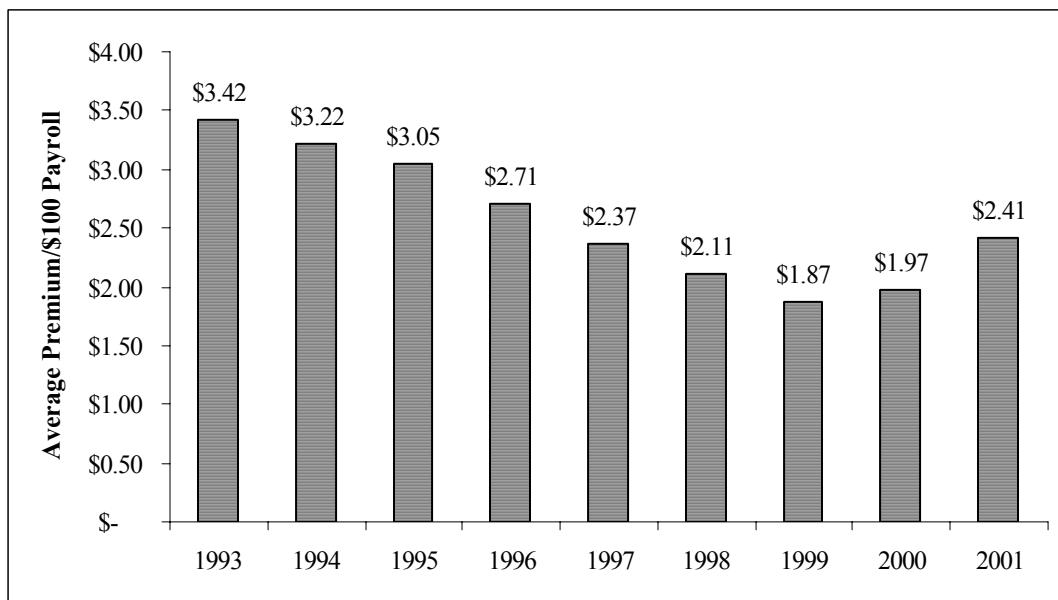
- Implementation of a "file and use" system for determining workers' compensation insurance rates replacing the "promulgated" (set by regulation) premium rates;
- Establishment of large and small (promulgated) deductible options for employers seeking workers' compensation coverage;
- Creation of a competitive state workers' compensation fund to compete with private market insurance carriers and serve as the insurer of last resort;
- Establishment of the Certified Self-Insurance Program, which is administered by TWCC; and
- The elimination of insurance carrier assessments to pay deficits for the assigned risk pool, which was managed by the Texas Workers' Compensation Insurance

Facility.

Cost of Workers' Compensation Insurance Coverage

The cost of coverage for Texas employers declined steadily from 1993 to 1999, from \$3.42 per \$100 to \$1.87 per \$100 of payroll. However, in the last two policy years (2000 and 2001), insurance costs have begun to rise again. In 2000, employers paid an average of \$1.97 per \$100 of payroll, and that rate increased by 22 percent in 2001 to \$2.41 per \$100 of payroll. (See Figure 8.)

Figure 8
Average Premium Per \$100 of Payroll, 1993 – 2001



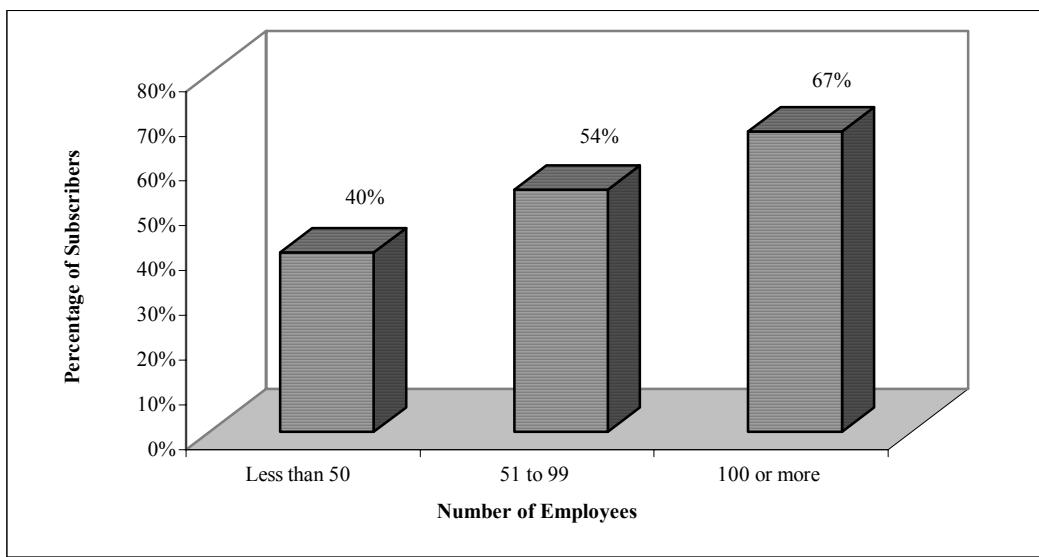
Source: Texas Department of Insurance, based on data reported in the 12/31/2001 Texas Workers' Compensation Financial Data Call and material taken from 2002 Class Relativity Study.

Information collected by the ROC corroborates the findings from the 2002 TDI data call reported above. In the fall of 2001, the ROC conducted a study of nonsubscription to the Texas workers' compensation system. In that survey of over 2,800 employers, employers with workers' compensation coverage (i.e., subscribers), were asked if they had observed a change in the cost of their most recent workers' compensation insurance premium. A substantial percentage (42 percent) of employers indicated that the cost of their most recent premium had increased since their last renewal date. This is up from 1996, when

30 percent reported a premium increase.

As Figure 9 illustrates, larger firms were more likely to report an increase in workers' compensation premiums than were smaller businesses. Approximately two thirds (67 percent) of companies with 100 or more workers reported an increase in premiums, compared to 54 percent of businesses with 50 to 99 workers and 40 percent of firms with less than 50 employees. There has been a significant increase in the percentage of large employers experiencing an increase in workers' compensation premiums in 2001 compared to 1996, when only 15 percent of firms with 50 or more employees reported an increase in premiums for their most recent workers' compensation policy. This rise in workers' compensation insurance costs, particularly among large firms, is likely the result of insurance carriers cutting scheduled credits previously granted to policyholders, less negotiation of experience modifiers, and perhaps rate increases filed by some insurance companies.

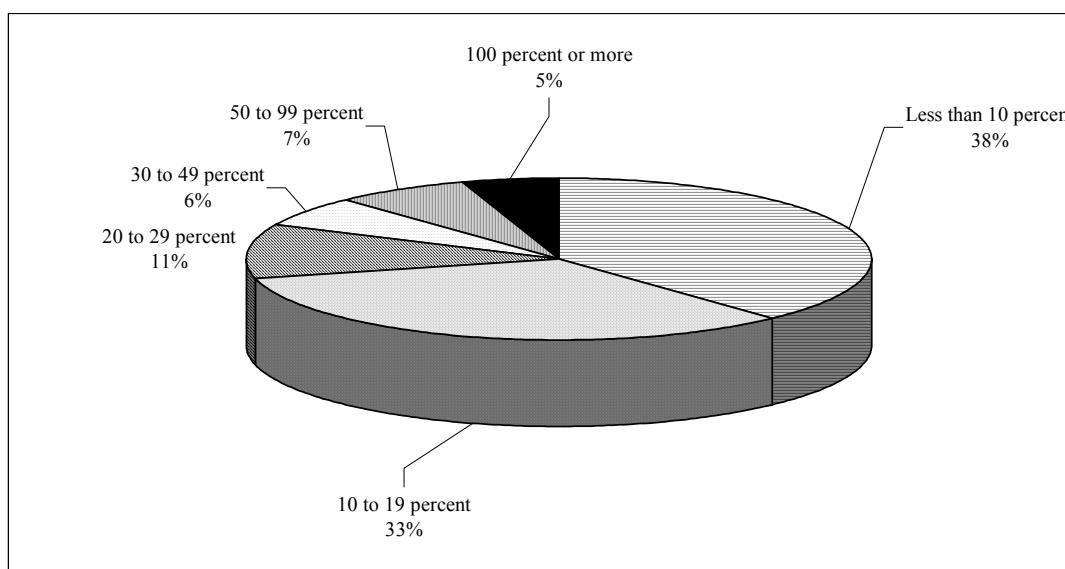
Figure 9
**Percentage of Employers Experiencing an Increase
in the Premium Paid for their Most Recent Workers' Compensation Policy,
by Employer Size**



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

The majority of the companies that reported a recent increase in workers' compensation premiums indicated that their workers' compensation costs increased by either less than 10 percent (38 percent) or by 10 to 19 percent (33 percent). Seventeen percent noted that their premiums increased by 20 to 49 percent and 12 percent reported an increase of 50 percent or more. (See Figure 10.)

Figure 10
Size of Recent Workers' Compensation Premium Increase



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

A recent study by the Council of Insurance Agents and Brokers, released in January 2002, confirms the fact that the property and casualty (P&C) insurance market, in general, and the workers' compensation insurance market, in particular, continue to harden. Insurance agents and brokers report that during the final quarter of 2001, both national P&C rates and P&C rates specific to the southwest region (Southern California, Arizona, New Mexico, Oklahoma, Texas) increased significantly during the October 1, 2001 to January 1, 2002 period for accounts of all sizes.¹⁰⁶ Depending upon the size of the account, between 41 and 54 percent of agents and brokers surveyed reported that the

¹⁰⁶ The Council of Insurance Agents and Brokers, *Commercial Property—Casualty Market Survey: 4th Quarter 2001* (January 2002).

average increase in P&C premiums was between 10 and 30 percent. A substantial percentage of agents and brokers indicated that the average P&C premium increase for the 4th Quarter of 2001 was between 30 and 50 percent. See Tables 14 and 15.

Table 14
Average Change in Property & Casualty Premium Rates,
October 1, 2001 to January 1, 2002
All Regions of the United States

Account Size	Down 1 to 10%	No Change	Up 1 to 10%	Up 10 to 30%	Up 30 to 50%	Up 50 to 100%	Up Over 100%	No Answer
Small (<\$25K Comm. & Fees)	1%	5%	24%	54%	14%	1%	0%	1%
Medium (\$25K-\$100K)	0%	1%	12%	49%	31%	5%	0%	2%
Large (>\$100K)	0%	0%	9%	41%	27%	11%	2%	8%

Source: The Council of Insurance Agents and Brokers, January 2002.

Table 15
Average Change in Property & Casualty Premium Rates,
October 1, 2001 to January 1, 2002

Southwest Region: Southern California, Arizona, New Mexico, Oklahoma, Texas

Account Size	Down 1 to 10%	No Change	Up 1 to 10%	Up 10 to 30%	Up 30 to 50%	Up 50 to 100%	Up Over 100%	No Answer
Small (<\$25K Comm. & Fees)	0%	5%	27%	50%	18%	0%	0%	0%
Medium (\$25K-\$100K)	0%	0%	9%	41%	18%	18%	0%	14%
Large (>\$100K)	0%	0%	9%	41%	17%	17%	0%	16%

Source: The Council of Insurance Agents and Brokers, January 2002.

The study by the Council of Insurance Agents and Brokers also shows that national and southwest regional workers' compensation insurance rates were up significantly over the same three-month period. Nationally, approximately two-thirds of agents and brokers

reported that workers' compensation premiums were up by either 10 to 30 percent (49 percent) or 30 to 50 percent (17 percent) over the October 1, 2001 to January 1, 2002 period. Results for the southwest region are even more dramatic: 70 percent indicated that workers' compensation premiums were up an average of 10 to 30 percent; and 13 percent noted that premiums were up an average of 30 to 50 percent in the 4th Quarter of 2001.

Table 16
Average Change in Workers' Compensation Premium Rates,
October 1, 2001 to January 1, 2002
National and Southwest Region Averages

	No Change	Up 1 to 10%	Up 10 to 30%	Up 30 to 50%	Up 50 to 100%	Up Over 100%	No Answer
National	4%	24%	49%	17%	1%	0%	5%
Southwest Region	0%	9%	70%	13%	4%	0%	4%

Source: The Council of Insurance Agents and Brokers, January 2002.

In addition to information collected by TDI in the 2002 special data call, the studies by the ROC and the Council of Insurance Agents and Brokers, TDI also reports that some insurance carriers are filing for rate increases in 2002. Specifically:

- 39 percent of the 264 workers' compensation carriers that made a rate filing with TDI filed for increases;
- 59 percent of the insurance companies made submissions with no rate changes or just adopted the new relativities; and
- 2 percent of the insurance companies filed for rate decreases.

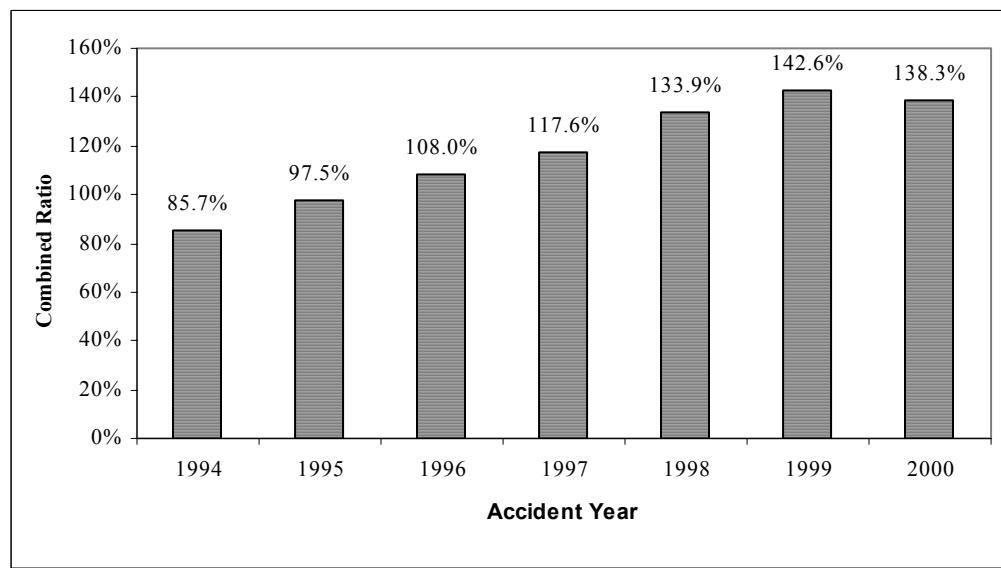
The net effect of the rate filings amounted to a 4.5 percent overall rate change for all carriers. Increased losses, as opposed to issues related to the September 11th terrorist attacks or reinsurance availability problems, were most commonly cited as the actuarial justification for the rate increase. However, many observers believe that when reinsurance policies come up for renewal in 2003, rates will rise and problems with the

cost and availability of reinsurance will become more evident.¹⁰⁷

Workers' Compensation Insurance Losses

The combined ratio is a key measure of health for the workers' compensation insurance industry. This ratio, which is a gauge of insurance carrier profitability, increased steadily from 86 percent in 1994 to 143 percent in 1999, before dropping slightly to 138 percent in 2000 (see Figure 11). A combined ratio of 138 percent means that the average insurance carrier in Texas expects to pay \$1.38 in administrative and workers' compensation claim costs for every dollar in workers' compensation premiums collected from policyholders.

Figure 11
Combined Ratio for the Workers' Compensation Insurance Industry in Texas,
1994 – 2000



Source: Texas Department of Insurance, data from NCCI Financial Data Call, Texas Compilation of Page 14/15 and Texas Compilation of IEE (2002).

Note: Numbers exclude large deductible policies that are excluded from the financial Data Call.

Though the combined ratio data reported above shows that, on average, insurance carriers in Texas are losing money on workers' compensation (and have been since 1996), carriers have historically been able to remain profitable through reliance on other lines of

¹⁰⁷ Jones, Stephanie K, "Workers' Comp Texas: A League of Its Own," *Insurance Journal-Texas/South Central*, March 25, 2002.

insurance and from investment income. In 1999, a substantial proportion of insurance carriers (43 percent) reported a heavy reliance on investment income to cover operating losses in the workers' compensation line of business.¹⁰⁸ As a result of the downturn in the U.S. and global economies, and subsequent declines in the equity markets, it is unlikely that the insurance industry can continue to rely on investment income to subsidize workers' compensation insurance market losses, and insurance rates will likely continue to rise.

Use of Large (Negotiated) and Small (Promulgated) Deductibles by Employers

According to the most recent data released by TDI, the number of workers' compensation policies written with small, or promulgated, deductibles accounts for a very small proportion of the policyholders with annual premiums of \$100,000 or less.¹⁰⁹ Of the 39,634 workers' compensation insurance policies written during the 2nd quarter of 2001, only 113 included small deductibles for which modest premium credits are promulgated by TDI. Another 554 (1.4 percent) of these employers with annual premiums of \$100,000 or less had policies which contained a large deductible provision.¹¹⁰ The percent reduction in premiums for these policies was 80.5 percent.

It is also clear from the data contained in TDI's recent report that the use of large deductibles by larger employers in the state continues to be a popular election. During the 2nd quarter of 2001, a total of 971 workers' compensation insurance policies with large deductibles – typically involving per-accident deductibles of \$250,000 or more and often involving aggregate loss caps¹¹¹ – were written in Texas. Assuming that all of the policies written under large (negotiated) deductible plans involved employers with annual premiums of \$50,000 or more, 42 percent of the companies in Texas with annual premiums at or above this \$50,000 threshold have policies that contain large deductibles.

¹⁰⁸ See Research and Oversight Council on Workers' Compensation, "Survey of Workers' Compensation Insurance Companies," *Texas Monitor* 4:2, Summer 1999.

¹⁰⁹ See Texas Department of Insurance, *Quarterly Legislative Report on Market Conditions: 2nd Quarter 2001*(September 4, 2002).

¹¹⁰ It should be noted that it is most likely that the majority of these policies were written for employers with annual premiums between \$50,000 and \$100,000, rather than the smaller firms in the state.

¹¹¹ See Texas Workers' Compensation Research Center, *Texas Workers' Compensation Insurance Deductibles: A Descriptive Analysis of 1992 Policies* (June 1994).

Data for the 2nd quarter of 2001 show that premium credits applied to deductible policies in Texas reduced the total premium volume by over \$329 million (39.7 percent). This includes percentage reductions of between 14.5 percent and 19.4 percent for small (promulgated) deductible plans,¹¹² and premium reductions of 82 percent for policies written under large deductible plans. It is important to note that while deductible plans offer employers a viable method to share the risk of workers' compensation losses with carriers, and realize substantial cost savings on their premiums, research has indicated these types of risk-sharing arrangements are also effective at creating employer-based financial incentives which lead to fewer workers' compensation claims (i.e., safer work environment) and lower claims costs (i.e., better claims management practices and less severe injuries).¹¹³

Insurance Company Insolvencies

As described in the introduction to this report, the Texas Property & Casualty Insurance Guaranty Association (TPCIGA) is an entity that assumes payment of Texas claims for insurers who become insolvent.¹¹⁴ In the past two years, TPCIGA has seen a higher than normal number of insolvencies occur, and is now handling its largest property and casualty insolvency to date, that of the Reliance Insurance Company of Pennsylvania. Reliance was placed into liquidation on October 3, 2001, and while the World Trade Center disaster was cited as the immediate reason for liquidation, the movement of Reliance into rehabilitation proceedings in May 2001 suggested that liquidation was possible.¹¹⁵

¹¹² Percentage reductions in premiums for the three promulgated deductible plans are as follows: 1) per-accident deductible plan (61 policies, 14.5 percent reduction); 2) aggregate deductible plan (39 policies, 19.1 percent reduction); and per-accident/aggregate combination plan (13 policies, 19.4 percent reduction).

¹¹³ See Shields, Joseph, Xiaohua Lu, and Gaylon Oswalt, "Workers' Compensation Deductibles and Employer Costs," *The Journal of Risk and Insurance*, 1999, Vol. 66, No. 2, pp. 207-218.

¹¹⁴ TPCIGA was created to provide a mechanism for the payment of covered property and casualty claims; to avoid financial loss to claimants or policyholders because of the impairment of an insurer; to assist in the detection and prevention of insurer insolvencies; and to provide an association to assess the cost of that protection among insurers. The Association provided funds to the Texas Department of Insurance Liquidation Division for the payment of covered claims until January 1, 1992, when it became charged with the responsibility to handle claims directly.

¹¹⁵ Texas Property and Casualty Insurance Guarantee Association, *2001 Annual Report*, 2002.

Reliance was a significant player in the Texas workers' compensation market. According to Texas Department of Insurance figures, the company was the fourth-largest workers' compensation carrier in the state in direct premiums written, at about \$99.3 million, or 5.7 percent of the market for the four quarters ending September 30, 1999.¹¹⁶

TPCIGA approved an initial \$62 million assessment (revised to \$31 million in December 2001) on the insurance industry in Texas to cover the cost of Reliance's workers' compensation claims. The scope of the Reliance insolvency – believed to be one of the largest property and casualty insurance receivership in history – and the complex relationships between the various branches of the company, the third party administrators (TPAs) that directly paid its claims, and the employers it covered have made the transition of files to TPCIGA particularly challenging. It was initially estimated that TPCIGA would receive between 6,000 and 7,000 workers' compensation claims from Reliance. As of May 2002, a count of Reliance claims being handled by TPCIGA totaled approximately 3,000. Some of these files have been very slow in coming, in part because of Reliance's frequent use of large deductible policies with little or no direct involvement of Reliance. TPCIGA officials have reported that it was not uncommon for Reliance's large deductible insureds to hire a TPA and largely handle their own claims, with little if any involvement from Reliance. These factors, along with the relatively short notice of the company's insolvency, have slowed the process of moving claim files from Reliance or its TPAs to TPCIGA. The guaranty association estimates Reliance's claim liability for all lines of insurance in Texas at \$400 million.

In addition to the Reliance liquidation, four other companies were placed into receivership in 2001. These companies included Acceleration National (Ohio), Great States (California), HIH American (California), and International Indemnity (Georgia). The "impairment orders" issued for these companies by the Texas Commissioner of Insurance resulted in the acquisition of less than 100 claim files.¹¹⁷

¹¹⁶ Texas Department of Insurance, *Quarterly Legislative Report on Market Conditions*, 3rd Quarter 1999.

¹¹⁷ Texas Property and Casualty Insurance Guaranty Association *Annual Report*, 2001.

In 2002, TPCICA assumed the claims management responsibilities of seven insurers that were placed in receivership. Six of those new receiverships have varying degrees of workers' compensation exposure: Petrosurance Casualty Company, Paula Insurance Company, Legion Insurance Company, Colonial Casualty Insurance Company, Villanova Insurance Company, and PHICO Insurance Company. While these individual companies were not as substantial as Reliance in terms of workers' compensation premium written, collectively they represent a substantial proportion of the direct written volume in 2000 (\$65 million, or 3.3 percent), and, to a lesser extent, in 2001 (\$20 million, or 0.8 percent).

TPCIGA is now handling twice as many claims now as it was on September 1, 2001, with the largest portion of the new claims being workers' compensation, and the association is expecting significant new receiverships before the end of the year. It is likely that this increase in receiverships and claims management responsibilities by TPCIGA will result in larger member assessments in the future.

Recent Activity – Insurance/Economic Viability

There were relatively few bills passed by the 77th Legislature that were directly related to the workers' compensation insurance market. HB 2600, the major piece of workers' compensation legislation passed in 2001, included a wide variety of elements relating to the cost and quality of medical care provided to injured workers in Texas, which are likely to have a long-term impact on the profitability of the workers' compensation insurance industry in Texas.

There was only one significant workers' compensation insurance-oriented piece of legislation passed in 2001. HB 3458 modified the structure of the Texas Workers' Compensation Insurance Fund, one of the largest workers' compensation insurance carriers in Texas and the "insurer of last resort" for Texas employers unable to obtain coverage in the voluntary market. The legislation changes the name of the Fund to the Texas Mutual Insurance Company. As a mutual, the company becomes a member-owned entity, with any surpluses in operations available to be passed back to members (i.e.,

policyholders) as dividends.

Conclusion – Insurance/Economic Viability

Prior to the events of September 11, 2001, it is clear that employers in Texas were already experiencing rising workers' compensation insurance costs. According to the recent survey by the Council of Insurance Agents and Brokers, the cost of P&C insurance in general, and workers' compensation coverage in particular, continued to escalate significantly in the 4th quarter of 2001. It is also apparent that the cost and availability of reinsurance may become a serious issue as current policies expire in late 2002 and early 2003.

Since Texas is the only truly voluntary workers' compensation state in the country, rapidly rising workers' compensation costs are of particular concern to regulators and policymakers in Texas. Recent survey results suggest that higher rates may have a subsequent impact on the percentage of firms that decide to drop their workers' compensation coverage and become nonsubscribers to the Texas workers' compensation system.

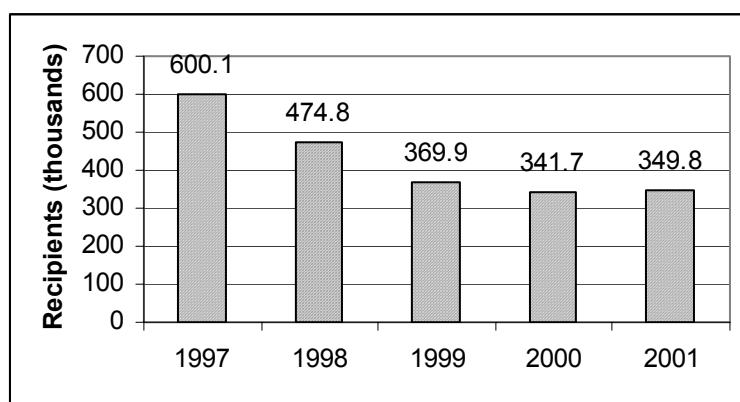
13. COST INTERNALIZATION

The system should protect and relieve public and private programs of the financial burdens of work-related injuries by appropriately allocating such costs to employers.

Overview

Cost internalization is the concept that costs associated with work-related injuries should remain internal to the workers' compensation system. Cost internalization is also closely related to benefit adequacy (discussed earlier), since costs can be diverted into social support programs (Social Security, food stamps, aid for dependent children, other insurance programs, etc.) if medical or income benefits are inadequate. While cost internalization has always been important to the system, the general tightening of social support/welfare programs in recent years has further intensified the need to ensure workers' compensation benefit adequacy. The number of Texans receiving welfare benefits has only recently leveled off after several years of decline (see Figure 12).

Figure 12
Average Number of Texans Receiving
Temporary Assistance for Needy Families (TANF)
1997-2001



Source: Texas Department of Human Services Annual Report, 2001.

This section will examine several areas related to cost internalization, including:

1. Adequacy of Income Benefits for Severely Injured Workers;
2. Internalization of Medical Costs; and
3. Recent Activity.

Adequacy of Income Benefits for Severely Injured Workers and Relationship to Cost Internalization

Previous ROC research highlighted benefit adequacy issues for claims in which severely injured workers qualify for Supplemental Income Benefits (SIBs). This area has not been studied since 1999 but still represents an area where injury costs may be transferred outside the workers' compensation system.

An injured worker must have a permanent whole body impairment rating of 15 percent or higher to qualify for SIBs, which are designed to provide additional wage replacement benefits after TIBs and IIBs have expired until the injured employee returns to work, up to a statutory limit of 401 weeks (7 years, 8 months). As discussed in the section on Effective Delivery of Benefits, the impairment rating threshold and the fact that an injured worker has not returned to work are not the sole qualifications for SIBs eligibility.

A 1998 ROC survey found that almost 70 percent of one-time SIBs recipients who were no longer receiving SIBs (for any reason) still had not returned to work, and were turning to alternate means to replace lost wages, including Social Security Disability Income (SSDI) benefits, family and friends, food stamps, public assistance, or aid for dependent children.¹¹⁸ The same year as the above cited study (1998), the first group of SIBs recipients under the reformed workers' compensation system began to reach the statutory 401 week limit on benefits. A second ROC study in 1999 found that only 5 percent of those SIBs recipients reaching 401 weeks were able to return to work.¹¹⁹ Although the number of SIBs recipients is small to begin with, and the number reaching the 401 week limit is even smaller (only 57 cases at the time of the 1999 study), the severity of these cases makes them among the most costly in the system.

¹¹⁸ See *Supplemental Income Benefits: Statistical Update and Survey Results*, Research and Oversight Council on Workers' Compensation, 1998.

¹¹⁹ See *The 401-Week Limit on Income Replacement Benefits and its Effects on Injured Workers in Texas*, Research and Oversight Council on Workers' Compensation, 1999.

Potential Externalization of Medical Costs

There is anecdotal evidence that some injured workers intentionally avoid the workers' compensation system because they perceive their group health coverage to be easier to deal with or they have difficulty finding a doctor willing to take a workers' compensation case. This concern – and the related concern that some doctors may become unwilling to participate in the system – have also emerged recently in discussions about reductions in reimbursement rates in TWCC's Medical Fee Guideline. The ROC surveyed Texas doctors in 1996 and 1998 and found broad consensus for the perception that the workers' compensation system is a difficult one in which to work due to complex and costly medical dispute resolution process, paperwork requirements, preauthorization requirements, and problems with insurance carriers denying or downcoding payments.¹²⁰ Although the ROC studies did not measure the number of doctors actually unwilling to practice in the workers' compensation system, the aforementioned concerns are frequent topics in testimony before policymakers. The impact of these perceptions may be to transfer work-injury costs outside of the workers' compensation system (either because the injured worker cannot or does not want to pursue a workers' compensation claim). It should be noted that it is unknown precisely how doctors' stated concerns about system burdens and other issues actually impacts their decision to leave the system.

Another possibility for medical costs to be externalized occurs in disputes over the compensability of an injury. Health care providers have raised concerns (most recently through a TWCC rule petition brought by the Texas Orthopedic Association, or TOA) about the avenues available for providers to receive payment for health care provided in cases where compensability is challenged by an insurance carrier. For example, if compensability is denied by an insurance carrier, and the injured worker involved is no longer receiving income benefits or active medical care, the worker may have no incentive to dispute the denial. But the *Labor Code* also prohibits a health care provider from billing an injured worker unless the claim is "finally adjudicated" as non-

¹²⁰ See *Survey of Texas Doctors Who Participate in the Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 1996 and *Experiences of Doctors Who Practice in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 1998.

compensable, a decision that involves a potentially lengthy TWCC hearing process.¹²¹ In rejecting the TOA rule petition, TWCC pointed out that a provider may file as a subclaimant to a compensability dispute and attempt to force a “final adjudication,” but some providers feel that this avenue is a difficult one to pursue the issue, and that a simpler remedy should exist.

Recent Activity – Cost Internalization

HB 1562 (77th Legislature, 2001)

This legislation addressed insurance fraud generally, and included a provision specific to workers’ compensation to allow group health insurance carriers to access TWCC’s claims data as a subclaimant on a workers’ compensation claim, giving the carrier more tools to determine if costs are being transferred out of the workers’ compensation system. Furthermore, the bill allowed group health carriers to access TWCC’s claims data as a whole, under a confidentiality agreement, to determine if subclaims exist.¹²² The ultimate goal of such data sharing is to achieve the correct allocation of costs between workers’ compensation and group health systems. To date, however, TWCC and group health carriers have not been able to agree over how this data sharing is to be done. One carrier has submitted an Open Records request for data access to TWCC, and in response to a TWCC request, the Office of the Attorney General issued an opinion in October 2002 that such information should generally not be released without authorization of the claimant involved. For more discussion on this issue, see the Recommendations section, specifically the ROC staff item relating to Access to Information.

HB 2600 (77th Legislature, 2001)

HB 2600 included a number of provisions designed to improve benefit adequacy and hence lessen the likelihood that injured workers will have to go outside the system to pay for work-related injury expenses:

¹²¹ See Texas *Labor Code* 413.042.

¹²² See Texas *Labor Code* 402.084.

- Article 4 makes the insurance carrier liable for pharmaceuticals for the first seven days if injury and coverage are confirmed, a cost that may have been previously externalized;
- Article 9 expands the list of injuries qualified for Lifetime Income Benefits (LIBs) by adding certain severe burn injuries; and
- Article 10 provides benefits based on multiple employment rather than just wages from the job where an injury occurs.

ROC Study of Nonsubscription

This study, based on a 2001 survey, updated estimates of employers who opt out of the system as well as the percentage of workforce covered by workers' compensation insurance. From the perspective of the Texas workers' compensation system, these workers are outside the responsibility of the system and therefore do not technically represent externalized costs (i.e., injury costs borne by social support programs and family, etc.). However, from a policy perspective, costs incurred by injured Texas workers with no workplace injury benefits – according to ROC estimates, about 280,000 workers in Texas (see the section on Coverage in this report) – may be transferred to outside social support programs. These employees – about 20 percent of the 16 percent of those in the state who work for nonsubscribing employers – have no medical or income replacement coverage of any kind in the event of a work injury, and their only apparent recourse is a lawsuit against the employer.¹²³

Conclusion – Cost Internalization

While the tightening of social support programs seems to have leveled off, overall levels of such support are lower than they were in the past and underscore the need to keep legitimate workers' compensation costs within the workers' compensation system.

Of continued concern are the poor return-to-work outcomes for severely injured workers receiving SIBs. It remains to be seen what effect the reforms enacted by HB 2600 will

¹²³ See *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates*, Research and Oversight Council on Workers' Compensation, 2002.

have on return-to-work outcomes and increased benefit adequacy. Also of concern is the fact that the data sharing provisions of HB 1562, designed to help achieve the correct allocation of costs between benefit systems, have yet to be implemented effectively.

14. COST TRANSFER

Costs that are not caused by work-related injuries and illnesses should not be transferred into the system.

While cost internalization aims to keep work-related injured costs *within* the workers' compensation system, the issue of cost transfer involves keeping non-workplace injury costs *out* of the system. One primary way that non-injury-related costs are transferred into the workers' compensation system is through fraudulent activity.

Fraud

System stakeholders often carry different perceptions of the activities that constitute fraud, as well as the responses that constitute effective anti-fraud efforts. For purposes of this discussion, there are some basic categories that can be used to define fraudulent activity in workers' compensation:

1. Workers who receive improper benefits through intentional deception;
2. Health care providers, attorneys, and others who bill for services not rendered, misrepresent their services, receive kickbacks for referrals and/or contribute to a worker receiving improper benefits;
3. Employers who avoid payment of proper insurance premiums, often to gain a competitive advantage in the marketplace;
4. Employers, carriers, and medical agents/experts who knowingly act to deny or dispute legitimate claims by workers; and
5. Officers and agents who market illegal insurance products and those who raid the assets of insurance companies, creating financial distress.

A review of the literature reveals that no proven method exists to quantify the extent of fraud that occurs in workers' compensation – or, for that matter, in any other line of insurance. Devices such as claim audits and fraud indicators are commonly used in private and public insurance programs to identify suspicious patterns that could point to fraud. However, most regulatory efforts, including those by workers' compensation

regulators, account for fraud in the system by tracking fraud referrals and the prosecution of those referrals, a process that only accounts for reported cases.

Workers' compensation fraud in Texas is referred to TWCC's Office of Investigations, a department within the Division of Compliance and Practices. Total fraud referrals were up steeply (89.5 percent) in 2001 from 2000, following a downward trend in 1999-2000 (see Table 17). The increase can be largely attributed to a rise in injured worker benefit fraud referrals, up 128 percent from the previous year. In contrast, insurance carrier fraud referrals were up by 66 percent, employer fraud referrals by 25 percent, and health care provider fraud referrals by 13 percent. Continuing the upward trend in 2002 (although there is not a full year of data at this point), fraud referrals are already significantly higher in all violator categories, with injured worker fraud again comprising by far the largest share. As has been the case historically – and even more so in 2001 – injured worker fraud accounts for the vast majority of the cases, and is thus the primary driver of fraud statistics.

Table 17
Number of Fraud Cases Referred to TWCC for Investigation,
Calendar Years 1997-2002

Subject of Referral	1997	1998	1999	2000	2001	2002 to date (Jan-Sept.)
Insurance Carrier	19	29	13	9	15	30
Injured Worker	562	575	368	280	638	1163
Employer	84	83	19	12	15	40
Health Care Provider	48	118	110	82	93	139
Attorney	10	17	15	11	6	10
Other	34	65	27	27	31	37
Total	757	887	552	421	798	1419

Source: Texas Workers' Compensation Commission, Violation Tracking System, October 2002.

Note: "Other fraud" includes fraud involving insurance adjusters and "violator type listed but not in the TWCC database for identification".

The number of fraud investigations completed in 2001 was also up from the previous year, though not as sharply (see Table 18). Total completions were up 44 percent in 2001

compared to 2000. Partial data from 2002 (January through September) suggests that there will be fewer completions in 2002 than in 2001.

Table 18
Number of Fraud Investigations Completed by TWCC,
Calendar Years 1997-2002

Subject of Investigation	1997	1998	1999	2000	2001	2002 to date (Jan.-Sept.)
Insurance Carrier	7	14	9	11	19	7
Injured Worker	389	501	298	274	416	302
Employer	33	69	67	22	13	4
Health Care Provider	32	31	36	93	127	32
Attorney	5	13	6	4	12	5
Other	25	44	28	27	33	9
Total	491	672	444	431	620	359

Source: The Texas Workers' Compensation Commission, Violation Tracking System, October 2002.

Note: "Other fraud" includes fraud involving insurance adjusters and "violator type listed but not in the TWCC database for identification".

With the exception of injured worker fraud investigations, most violation referrals take between one to two years to complete (see Table 19). Cases involving injured workers were concluded in 4.8 months, on average, in 2001.

Table 19
Fraud Investigations Completed, 2000-2001
By Average Length of Time to Complete

Violator Type	FY 2000		FY 2001	
	Number	Avg. Days (Months)	Number	Avg. Days (Months)
Insurance Carrier	11	584 (19.5)	19	443 (14.8)
Injured Worker	274	225 (7.5)	416	143 (4.8)
Employer	22	401 (13.4)	13	573 (19.1)
Health Care Provider	93	597 (19.9)	127	508 (16.9)
Attorney	4	229 (7.6)	12	434 (14.5)
Other	27	227 (7.6)	33	323 (10.8)
Totals	431		620	

Source: The Texas Workers' Compensation Commission, Violation Tracking System, April 2002.

Note: "Other fraud" includes fraud involving insurance adjusters and "violator type listed but not in the TWCC database for identification".

Only a small percentage of investigations result in an action taken toward the alleged violator (see Table 20). In 2001, 9.5 percent of investigations resulted in either a warning or the filing of criminal charges. "No violation" was found in 35 percent of the cases. The majority of investigations in 2001 (55 percent) were concluded without a finding (either positive or negative) due to insufficient evidence or low probability of prosecution.

Table 20
Fraud Investigations Completed, 2000-2001
By Outcome

Outcome	FY 2000		FY 2001	
	Number	Percent	Number	Percent
Notice of Violation or Warning Issued	58	13.5	38	6.1
Criminal Charges Filed	38	8.8	21	3.4
No Violation Found	65	15.1	219	35.3
Other	270	62.7	342	55.2
Totals	431	100.1	620	100

Source: The Texas Workers' Compensation Commission, Violation Tracking System, April 2002.

Note: "Other" outcome includes Insufficient Evidence, Low Probability of Prosecution, and Alternative Enforcement.

According to TWCC, fraud investigations are prioritized according to three main criteria:

1. Overall impact to the system (in terms of dollars and/or individuals affected);

2. Cost-effectiveness of the investigation; and
3. Probability of successful prosecution.

Previous ROC research has shown that fraud involving either health care providers, employers, or insurance carriers is far costlier to the system than injured worker benefit fraud.¹²⁴ However, injured worker fraud is the least complex form to prosecute, and hence makes up the majority of cases that are completed. Given limited resources, the more complex cases become less cost-efficient to pursue and hence are often relegated to the “other” category.

High monetary loss thresholds for prosecution are a factor in all lines of insurance fraud, at both the state and federal level. Insurance fraud investigative organizations in Texas report that most district attorneys are reluctant to prosecute complex “white collar” fraud cases involving less than \$100,000 in losses.¹²⁵ This is understandable, given that these district attorneys are charged primarily with protecting citizens from violent crime, and that many districts have a significant backlog of criminal cases. Therefore, a number of significant but relatively small dollar criminal fraud cases are not likely to be prosecuted in either federal or state systems. This lack of prosecution of small offenses can be a source of frustration for employers, insurers, policyholders, and investigators.

In 1997, the 75th Texas Legislature appropriated \$83,294 under a contingency rider for FY 1998 to be used by TWCC for grants to district attorneys to encourage prosecution of workers’ compensation fraud cases. However, the results of the grant program were not as encouraging as hoped, primarily because the amount of funding was too limited to encourage a district attorney to staff a prosecutor focused on workers’ compensation.

Of the cases in which criminal charges were referred to the district attorney in 2001, eight involved injured worker benefit fraud and eight involved health care provider fraud (see

¹²⁴ See *Fraud in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 1998.

¹²⁵ See *Fraud Detection and Prevention in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 2001.

Table 21). There were no criminal charge referrals for insurance carrier or employers in 2001 or 2000. There were nine criminal convictions in 2001 – six involving health care providers and three described as “other.” The “other” category covers other system participants that could include insurance adjusters or unlisted participant types. It should be noted that criminal convictions in 2001 do not necessarily stem from criminal charges referred in 2001, but could reflect cases that had been in process for some time.

Table 21
Criminal Charges Referred by Violator Type
Including Estimated Dollar Amount of Fraud Detected

Violator Type	FY 2000		FY 2001	
	Number	Fraud \$	Number	Fraud \$
Injured Worker	3	\$17,326	8	\$73,228
Health Care Provider	34	\$4,903,670	8	\$6,673,997
Other	1	0	5	\$254,160
Totals	38	4,920,996	21	7,001,385

Source: The Texas Workers' Compensation Commission, Violation Tracking System, April 2002.

Note: “Other fraud” includes fraud involving insurance adjusters and “violator type listed but not in the TWCC database for identification”.

Confirming previous ROC studies, injured worker fraud has a much lower financial impact than other types of fraud by system participants. In 2001, the average amount of fraud detected for injured worker cases was \$9,153, while for health care provider fraud in 2001 the average was \$834,250. Notably, the amounts *detected* do not mean amounts *recovered*. Some future system savings might be expected due to the fact that these perpetrators were caught and, presumably, will not further drain the system.

These data do provide a glimpse into the possible system impact of fraud. Of the 620 fraud investigations completed in FY 2001, only 35 percent were found to be clear of any violation, while another 9.5 percent were found to be in violation (6.1 percent given notice or warning, 3.4 percent referred for criminal charges). The remaining 55 percent (342 cases) were not cleared of wrongdoing but, due to external factors (i.e., resource constraints, insufficient evidence, low probability of prosecution) were effectively written off. These cases written off could easily represent cost transfer into the Texas workers’ compensation system of significant proportions.

Recent Activity – Cost Transfer

HB 1562 (77th Legislature, 2001)

House Bill 1562, related to fraud detection and prevention in all lines of insurance, including workers' compensation, requires the Insurance Fraud Unit created under Article 1.10D of the *Insurance Code* to report annually to the Commissioner of Insurance on fraud activity and the cases it has completed, as well as make recommendations for new regulatory and statutory responses to fraud. The bill also expanded a good faith immunity provision for those reporting suspected fraud to include reports to fraud investigators working for insurers, and specified confidentiality and other duties for insurers receiving the information. HB 1562 also requires fraud warning statements on insurance claim forms; requires any insurer that collects direct, written premium to adopt an antifraud plan; and defines and stipulates penalties for health care providers committing fraud.

HB 2600 (77th Legislature, 2001)

HB 2600, an omnibus workers' compensation bill, also included fraud prevention-related provisions. Articles 1 and 6 of the bill require health care providers in the workers' compensation system to disclose financial interests in other health care providers, using the definition of financial interest adopted by the Medicare program.¹²⁶ Failure to report conflicts constitutes a violation.¹²⁷

Research Findings

In August, 2001, ROC published *Fraud Detection and Prevention in the Texas Workers' Compensation System*, a comprehensive best-practices review of anti-fraud programs in place in Texas and other states.¹²⁸ The report identified effective fraud detection and prosecution efforts in other states, based on recommendations found in the National Association for Insurance Commissioners (NAIC) and Coalition Against Insurance Fraud

¹²⁶ See Texas *Labor Code* Section 413.041 and TWCC Rule 180.24.

¹²⁷ See Texas *Labor Code* Section 415.0035.

¹²⁸ The information in this report was also largely reprinted in the *Texas Monitor*, Volume 6, Number 3, Fall 2001.

(CAIF) model fraud act provisions. While the specific features vary, at least five broad characteristics of effective fraud detection and prevention programs were identified:

1. *The state identifies a focal point for insurance fraud prevention responsibility, although separate agencies and prosecuting authorities may be involved.* These focal points are most commonly placed with the office of the state's attorney general (OAG) or with the insurance commissioner/department of insurance (DOI). These agencies are chosen typically because of the OAG's civil and criminal prosecution authority, or, in the case of the DOI, because of its strong insurance control authority. In practice, the two agencies work hand-in-hand on fraud investigation and prosecution where states chose to split the responsibility.
2. *The state commits dedicated legal resources to insurance fraud prosecution, and establishes some form of statewide prosecution authority.* The state commits to insurance investigation training programs to make prosecutors feel more comfortable taking on insurance fraud cases, and includes very specific insurance fraud statutes in its penal code to improve prosecutor familiarity and juror understanding of the prohibited conduct.
3. *The state adopts a high-profile public awareness campaign to deter fraud.* Included in this effort can be mandatory fraud warnings on insurance documents, medical billing statements, and benefit checks, advertising the names and facts surrounding convictions, the establishment of fraud-stopper reward programs, and/or requirements that insurance companies report suspected fraud to a central fraud bureau. The public awareness campaigns are designed to deter opportunistic fraud, help the public recognize the cost to consumers, and to help the public recognize and report suspicious conduct regarding insurance. These states also generally make effective use of the media to publicize programs and reinforce desired behavior.
4. *The state recognizes that systematic fraud detection requires significant data automation and research capabilities, and it requires coordination among state agency programs and insurance carriers.* The state also takes steps to identify barriers to information exchange between state agencies and insurance companies,

and begins to coordinate detection and prosecution support programs, with appropriate privacy and confidentiality safeguards.

5. *Adequate funding is provided primarily through insurance assessments.* These aggressive state programs require insurance companies to fund the programs through assessments, and, as noted, they commit significantly greater funding for fraud prevention overall than does Texas.

Conclusion – Cost Transfer

By all accounts, there is currently no way to accurately measure the amount of cost transferred into the Texas workers' compensation through fraudulent activity. Fraud that is detected is often either too complicated to pursue given available TWCC resources, or not complicated, but of low financial impact. Still, a sizeable amount of fraud is detected, prosecuted, and stopped each year.

Recommendations from previous ROC biennial reports have suggested improved reporting requirements to obtain more accurate measures of fraud, and a more comprehensive approach to workers' compensation fraud generally, with the goal of increasing resources allocated to fraud prevention, detection, and prosecution. The model anti-fraud provisions developed by the NAIC, mentioned above, would provide a good starting place for increasing the commitment to fraud abatement in Texas.

SECTION III RECOMMENDATIONS

Overview

This section of the report focuses on recommendations for improvements to the Texas workers' compensation system. It is divided into two subsections: the first consisting of issues identified by ROC staff or by system participants; the second consisting of ROC staff's response to legislative initiatives offered by the Texas Workers' Compensation Commission (TWCC) and other state agencies.

In considering issues for the former list, ROC staff attempted to be very selective, for two main reasons. One is that the last Legislative session in 2001 included major legislation (House Bill 2600) designed to address basic system issues of medical quality and cost. As this legislation was significant in scope and has not yet had time to be fully evaluated, ROC staff did not consider items for this list that involved broad, systemic changes to the Texas workers' compensation models of medical benefit or income benefit delivery.

In addition to the significant activity in the 2001 session, TWCC is scheduled for Sunset Review in 2005. Historically, Sunset Review of an agency such as TWCC involves an examination of almost all areas of the agency's operations, including the underlying statutory structure that it oversees. In anticipation of this occurring in 2005, ROC tended to defer issues that seemed better left to the sunset process.

Issues that are included in these recommendations generally met most of the following criteria, developed by ROC staff to assist in honing legislative and regulatory priorities:

1. They *were not* already the subject of recent statutory or regulatory action that has not yet had time to be fully evaluated;
2. They represent major operational issues in the system that cannot be delayed without the potential for significant administrative or operational problems;

3. They are items that have emerged during the House Bill 2600 implementation process with a clear need for a statutory or regulatory remedy in order to meet the original intent of the legislation;
4. They *are not* issues that are better left to TWCC's Sunset Review in 2005; and
5. They lend themselves to clear legislative and regulatory options to resolve the issue.

In order to allow system stakeholder participation in the development of the 2002 *Biennial Report*, ROC staff in May 2002 asked stakeholders to identify issues that they would like to be considered for inclusion. A number of stakeholders responded with suggestions. ROC staff used these suggestions, along with staff's own list of potential issues, to develop a focused "short list," based on the criteria stated.

ROC staff then in early October 2002 distributed this "short list" of issues to a group of stakeholders involved in the HB 2600 development and implementation process (along with some who have joined the stakeholder group in the interim) and invited them to a ROC-sponsored *Biennial Report* stakeholder meeting to discuss these issues in more detail. Legislative offices that participate in the monthly Workers' Compensation Legislative Workgroup meetings (discussed in Section I) were also notified, along with ROC Board members. In preparation for this meeting, ROC staff asked that the members of the stakeholder group be prepared to discuss the issues on the "short list" and help assess whether statutory or regulatory changes or further research was indicated to address them. Stakeholders were also asked to bring issues that had not been included on the "short list," but that they felt merited discussion by the full group, to this meeting.

The ROC *Biennial Report* stakeholders meeting was held October 23, 2002. The meeting was attended by representatives of the Texas Workers' Compensation Commission (TWCC), the State Office of Risk Management (SORM), Texas Mutual Insurance Company, Texas Association of Business, Texas Medical Association, Texas AFL-CIO, Texas Pharmacy Association, Texas Association of School Boards, Texas Physical Therapy Association, Texas Orthopedic Association, Texas Association of Responsible

Nonsubscribers, American Insurance Association, Insurance Council of Texas, University of Texas System, House Speaker's Office, Representative Burt Solomons' office, Representative Scott Hochberg's office, several private insurance carriers, and three of the Independent Review Organizations (IROs) certified to perform reviews of workers' compensation cases. Numerous others were invited. While this diverse group certainly did not agree on the proper approach to each issue, general agreement was reached as to the importance of the issues raised as well as appropriate policy options to address a significant number (but not all) of the issues.

The recommendations immediately following in subsection A were developed by ROC staff and/or identified by system participants. ROC also asked TWCC, the Texas Department of Insurance (TDI), State Office of Risk Management (SORM), and Texas Property and Casualty Insurance Guaranty Association (TPCIGA) to identify issues those agencies felt required legislative or regulatory changes, or further research. Recommendations were received only from TWCC and TPCIGA, and these are included in subsection B, along with ROC staff's responses.

A. RECOMMENDATIONS FROM ROC STAFF AND/OR SYSTEM PARTICIPANTS

1. Medical Dispute Resolution (MDR). Several specific areas of the new HB 2600-created MDR process were identified for possible legislative or regulatory action or further research. These are discussed below:

- Alternative model for low-cost services in dispute. Some health care providers have contended that the cost of the IRO review process (either \$650 or \$460, depending on the specialty of the reviewer) makes it unfeasible to dispute health care services that cost less, in some cases much less, than the cost of the review.¹²⁹ When this issue was raised during public comment on the MDR rules in December 2001, TWCC responded that it disagreed with establishing a different process for reviews of low-cost services because the Texas *Labor Code* does not provide for any distinction.

One of the IROs performing reviews suggested an alternative low-cost service process that would also be conducted by IROs (on a voluntary basis), would involve a less intensive “desk review” by a doctor, and cost in the range of \$100-\$200, rather than the regular IRO review cost.

While health care providers tended to feel that the low-cost service issue was one that needed to be addressed soon, some insurance carriers suggested further study before changes are made.

ROC Staff Recommendation: Staff understands the concerns about the cost of the IRO process relative to the cost of services being disputed. However, staff also believes that at this point, there is no one, clear process that should be implemented by statute. Staff recommends that *Labor Code* Section 413.031 be

¹²⁹ Recent data from TWCC's Medical Dispute Information System indicates that prior to HB 2600, approximately 30 percent of medical necessity disputes handled by TWCC in 2001 involved medical treatments that cost less than \$500. This suggests a significant percentage of potential disputes involve relatively low cost services.

modified to provide TWCC the authority to designate a lower cost medical dispute process, allowing time for further stakeholder discussion and data analysis about the particular method of dispute resolution that would be most appropriate.

- Pre-payment of IRO fee. At the time the new MDR rules were being considered, a major concern of the IROs was how to ensure that in retrospective medical necessity disputes – which are paid for by the non-prevailing party – the non-prevailing party does not refuse to pay the IRO.¹³⁰ The Texas *Labor Code* does not specifically indicate when the payment to the IRO is to occur; this was left to the rule-making process to decide. In its adopted MDR rule, TWCC required that the requestor in a retrospective medical necessity dispute (in most cases, a health care provider) pay the IRO fee in advance, before the dispute is considered by the IRO. If the requestor does not prevail, the IRO keeps the fee; if the requestor does prevail, the fee is refunded and the insurance carrier must pay the IRO.

While pre-payment is clearly an effective means to avoid non-payment of the IRO by the non-prevailing party, it is also the subject of a legal challenge by a health care provider, who claims it is an unconstitutional bar to dispute resolution.¹³¹ As of this writing, this suit was scheduled to be heard in mid-December 2002.

Several possible options exist to modify the IRO payment process to address this concern, if necessary. One of the IROs suggested a model in which TWCC would pay the IRO fee, then collect the amount of the fee from the non-prevailing party. In the event the losing party does not pay TWCC, the agency could levy an administrative violation or take other action – including, potentially, removal from the Approved Doctors List (ADL) – against the provider. This option may be worth exploring, but it would require significant statutory changes that may not

¹³⁰ Non-payment has not been an issue in IRO review of adverse determinations of Health Maintenance Organizations (HMOs), in part because in these disputes the HMO pays the cost regardless of outcome. The contracted HMO-provider relationship in that model also differs significantly from the multiple carrier-any willing provider arrangement currently in place in workers' compensation.

¹³¹ See Robert Howell, D.C. and *First Rio Valley Medical, P.A. v. TWCC and Envoy Medical Systems, LLC.*, filed in Travis County District Court.

be necessary if the pre-payment system is upheld. It would also put TWCC and the State of Texas in the position of collecting money from providers who may not want to pay for an IRO review that did not agree with their position.

Another option is to allow a party to pay the IRO fee post-review, unless and until that party refuses to pay the fee, in which case he or she could be barred from further dispute resolution until the fees are paid, or required to pay up-front in future cases.

It has also been suggested that the pre-payment requirement simply be placed in statute; however, if a court finds that there is a constitutional issue in requiring pre-payment, placing this mandate in the statute would not resolve the constitutionality concern.

ROC Staff Recommendation: As a precautionary measure, legislative action may be warranted to clarify that failure to pay an IRO fee as and when owed constitutes a specific administrative violation and may result in TWCC sanctions, including but not limited to removal from the Approved Doctor List (ADL). In addition, legislative language to clarify that TWCC may bar a non-paying party from future access to dispute resolution would also be a viable option as a contingency if general pre-payment is no longer allowed. Further legislative action is not likely needed, unless the outcome of the current lawsuit dictates a particular corrective measure, and this is not yet known.

- IRO application of Medicare payment policies, and disputes of services not covered by Medicare. One of the main reasons for moving toward Medicare-based policies for billing, coding and payment of medical services was to promote standardization between workers' compensation and an established and well-known health care delivery system. By statute, TWCC is allowed to make only "minimal modifications" to Medicare policies as necessary to meet occupational

injury regulations or requirements.¹³² It was hoped that standardization would lead to fewer administrative burdens for participating health care providers and insurance carriers and fewer disputes. In particular, the Medicare payment rules include policies related to services that have been found by the Medicare system to be of no medical efficacy or of an “experimental and investigational” nature. Generally, once the Medicare payment policies are in place, it is envisioned that these services would not be paid for in the workers’ compensation system, just as they are not paid for in the Medicare system, unless TWCC, by rule, makes a specific exception under the “minimal modifications” provision.

However, TWCC’s MDR rule stipulates that IRO decisions on retrospective medical necessity disputes are made on a case-by-case basis, and do not specify that IROs are required to consider or use the TWCC (soon to be Medicare-based) payment policies when rendering these decisions.

As justification for this position and support for a statutory change that would establish that IRO decisions should take precedence over payment policies, TWCC has argued that injured employees are statutorily entitled to “all health care reasonably required by the nature of the injury as and when needed to cure or relieve the effect naturally resulting from the compensable injury, promotes recovery or enhances the ability of the employee to return to or retain employment.”¹³³ Further, TWCC staff has stated the position that, “to the extent that this entitlement may differ from the entitlement of Medicare recipients, the medical necessity of the health care for a particular injured worker must take precedence over the provisions adopted or utilized by CMS (the Centers for Medicare and Medicaid Services) in administering the Medicare program. The Act specifically acknowledges the necessity to make ‘minimal modifications’ to the reimbursement methodologies as necessary to meet occupational injury requirements. Although the Commission is monitoring IRO decisions to

¹³² See Texas *Labor Code* Section 413.011(a).

¹³³ See Texas *Labor Code* Section 408.021.

determine whether commission rulemaking action would be appropriate, exceptions on a case-by-case basis through Independent Review Organization (IRO) decisions are essential to ensure appropriate medical care is provided to injured workers in accordance with the statute.”¹³⁴

ROC Staff Recommendation: As noted, Texas *Labor Code* Section 413.011 mandates the adoption of the health care reimbursement policies and guidelines of the Medicare system, with minimal modifications as necessary to meet occupational injury requirements. In keeping with the letter and intent of the current statute regarding use of the Medicare payment policies, the statute and rules should clarify that medical services not covered by the Medicare system for reasons of medical necessity or efficacy are not disputable through the MDR process if denied.¹³⁵

Rather, these services could be subject to a review by TWCC’s Medical Advisor and the consideration for a rule amendment if it can be demonstrated that such services meet the “minimal modifications” standard. Although clarification of the statute in this regard would be useful, the current statutory language would seem to allow this clarification through rule amendment to the TWCC Medical Fee Guideline. However, modification to Texas *Labor Code* Section 413.031 may also be necessary to ensure that general statutory provisions involving access to dispute resolution are aligned with the model described above, in which services not paid under the Medicare program for reasons of medical necessity or efficacy are not disputable through the medical dispute resolution process.

In addition, the MDR rule should also be clarified to require that IROs consider

¹³⁴ At the ROC Board meeting in December 2002 at which the 2002 *Biennial Report* was approved, TWCC staff presented this language as a proposed substitute for the ROC Staff Recommendation. Although the Board declined to make this substitution, the Board voted to add the additional language on TWCC’s position so it would be represented in the final report.

¹³⁵ It is important to note that some services (such as prescription drugs) are not covered by the Medicare system, but *not* for reasons of medical efficacy (i.e., some services are not covered because of budgetary constraints of the federal government). These services are still payable under the workers’ compensation system.

TWCC's treatment/fee guidelines and payment policies when making decisions on medical necessity, either prospectively or retrospectively.

- Requirement for preauthorization of “investigational and experimental” services. HB 2600 amended Texas *Labor Code* Section 413.014 to add “any investigational or experimental services or devices” to the list of services for which preauthorization is required. Such services are defined by statute as “a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.”

TWCC Rule 134.600 added “investigational and experimental” services, including the statutory definition, to the preauthorization list, but did not specify how a system participant would know whether a particular service meets this definition. In addition, the Medicare payment policies – which will be the basis for TWCC’s payment policies – stipulate that some services are not covered *because* they are investigational or experimental.

ROC Staff Recommendation: If the statute and/or TWCC rules clarify that services and procedures not covered by the Medicare system for reasons of medical necessity or efficacy are not covered by the workers’ compensation system unless specified by rule (as discussed in the previous recommendation), then it would seem unnecessary to require preauthorization for all investigational and experimental services. Also at issue is the fact that the rule requirement for these services to be preauthorized is not operational as written, since it is unclear what specific services fall into this category. ROC staff recommends amending Section 413.014 to indicate that services or treatments deemed investigational and experimental may be placed on the preauthorization list by rule, but that only those services identified by TWCC be required to undergo preauthorization. In this way, TWCC could avoid requiring preauthorization for services that are not generally covered in the workers’ compensation system, but reserve the

possibility of naming specific services by rule. It has been suggested that the federal Food and Drug Administration's Center for Devices and Radiological Health, which speaks to whether a service or device can be marketed in the United States based on its safety, might be a good resource for identifying specific services, and TWCC should investigate this resource for possible use.

- TWCC Jurisdiction over Medical Disputes. In recent months, some health care providers have begun submitting medical bills that have been reduced or denied by workers' compensation insurance carriers directly to court (usually to county justice of the peace courts), rather than taking them through the administrative dispute resolution process required by statute. One of the primary arguments of those health care providers pursuing their disputes in county courts is the allegation that the "pre-pay" requirement in TWCC's MDR rule is unconstitutional. TWCC has attempted to intervene in some of these cases to establish its jurisdiction over medical disputes, and some affected insurance carriers have attempted the same. The phenomenon is still developing and its eventual outcome in the courts is unclear.

ROC Staff Recommendation: TWCC's primary jurisdiction over issues arising under the Workers' Compensation Act – with access to the court system only occurring after TWCC's administrative process – is one of the most basic features of the system. Although the statute already speaks to the intended role of court review after the TWCC process and not before, clarification to Texas *Labor Code* Sections 413.031 and 410.251 is appropriate to more clearly state that judicial review is only available after administrative remedies have been exhausted.

2. *Downs v. Continental Casualty* decision. Texas *Labor Code* Section 409.021 (a) requires an insurance carrier to, no later than the seventh day after written notice of an injury, either begin the payment of benefits to an injured employee or notify TWCC and the employee of its refusal to pay benefits. Section 409.021 (c) states that if an insurance

carrier does not contest the compensability of an injury within 60 days of the day it is reported in writing, the carrier waives its right to contest.

The *Downs* case involved whether an insurance carrier's failure to meet the requirement of Section 409.021 (a) – to either pay or deny benefits within seven days of the carrier's notice of the injury – waived the carrier's right to dispute compensability within 60 days. During the 77th session in 2001, two legislative proposals (SB 1395 and HB 3151) were offered to make an insurance carrier's failure to comply with Section 409.021 (a) an administrative violation, but to clarify that the carrier does not lose its opportunity to dispute compensability within 60 days. However, neither of these proposals passed. In June 2002, the Texas Supreme Court held that a lower court had been correct in its interpretation that a failure to pay or deny within seven days waived the 60-day period to review and dispute compensability. The Supreme Court rejected a motion for re-hearing, rendering this decision final.

The court decision did not specifically address claims in which no income benefits have accrued (for example, "medical-only" claims, with no lost time at the time of the injury, but which may have lost time later), and what an insurance carrier must do in these cases to preserve its right to dispute compensability within 60 days. As a result, carriers have begun filing forms with TWCC (i.e., the TWCC-21 form) indicating that they will pay benefits "as and when they accrue," in an attempt to meet the burden of *Downs*. Insurance carriers also have specific concerns about death claims, where significantly more than seven days may be necessary to investigate and make an initial compensability determination as well as identify eligible beneficiaries. In general, insurance carriers are extremely concerned about the current interpretation of the law and the administrative burden it places on them to fulfill this reporting requirement.

Other system participants, such as labor groups, have argued that it is appropriate to require quick action by an insurance carrier once a claim is made, and to provide a significant incentive for this action, as the court interpretation certainly does. As the recipient of the additional TWCC-21 forms mandated by the *Downs* decision, TWCC

indicates that this new reporting requirement has significantly increased filings of TWCC-21 forms as well, adding to the paperwork TWCC must handle.

ROC Staff Recommendation: The literal interpretation of Texas *Labor Code* Section 409.021 is contrary to longstanding TWCC and system participant interpretations of the role and interactions of the seven-day and 60-day requirements in the 1989 reform act. Further, it is probably not operational for medical-only disputes, and extremely challenging in death claims.¹³⁶

Labor groups such as the Texas AFL-CIO, however, while apparently open to discussion of the *Downs* issue and possible solutions, are likely to oppose statutory changes to “correct” the decision without further significant discussion and negotiation. At the October 23 *Biennial Report* stakeholder meeting, ROC staff suggested that a workgroup be formed to consider the implications of the *Downs* issues further and attempt to reach a compromise that is tenable for all interested parties.

Several possible alternatives and considerations present themselves:

- A statutory change could be made to Texas *Labor Code* Section 409.021 to clarify that insurance carriers do not have to notify TWCC and the employee of a decision to pay or deny within seven days *if no income benefits have yet accrued*. Another exception may be necessary to provide additional time to properly investigate death claims. This would eliminate the need for hundreds of thousands of carrier notifications to pay benefits “as and when they accrue,” as these notifications serve no useful purpose other than (perhaps) preserving the carrier’s 60-day review rights.¹³⁷ One disadvantage of this approach is that it would apply different timeframes to different types of injuries, which was a concern for some stakeholders at the October 23 meeting when the prospect was discussed.

¹³⁶ It is interesting to note that the *Downs* case involved a death claim.

¹³⁷ In October 2002, for example, TWCC indicated it received 21,225 of these notifications.

- A broader change could also be made to Texas *Labor Code* Section 409.021 to clarify that while a carrier's failure to pay or deny benefits that are due is an administrative violation, it does not waive the 60-day review of compensability by the carrier. This is in line with the legislative initiatives proposed in the 77th session. The main disadvantage of this approach is that it would probably be even more difficult to garner widespread stakeholder support for it, since it is the same approach insurance carriers proposed in the 77th session that was opposed by labor.
- It should also be noted that the seven-day timeframe for action by the insurance carrier is more problematic for certified self-insurers. Texas *Labor Code* Section 407.061 (c) requires a certified self-insurer to "designate(s) a qualified claims servicing contractor" (i.e., a third party that handles the self-insured's employees' claims). Since technically, the certified self-insurer is both employer and insurer, Section 409.021 could be interpreted to require action within seven days of an injury, since notice to the self-insurer may be almost immediate. However, since the statute requires certified self-insurers to contract with a third-party entity for actual claims administration, it seems reasonable that the seven-day "pay or dispute" requirement should not apply until this third party receives notice.

3. Compliance and Enforcement (General). The last two ROC *Biennial Reports*, in 1998 and 2000, recommended a focused discussion between system stakeholders and TWCC staff about TWCC's general compliance and enforcement programs. As discussed in the System Monitoring section of this report, some dialogue on compliance issues occurred during TWCC's rule-making process for the schedule of administrative penalties required by Article 6 of HB 2600, but important opportunities remain to begin the broader discussion ROC previously recommended. While TWCC's regulatory and enforcement efforts are aggressive compared to those in most other states, there appears to be a significant growth in referral volume and continued dissatisfaction among system stakeholders regarding TWCC's efforts in medical regulation and investigation of alleged

unreasonable acts of insurance carriers, employers, and health care providers.

ROC Staff Recommendation: Recent sunset reviews of other state agencies have focused significant attention on appropriate responses to complaints and referrals, and in the context of TWCC's pending review in 2005, the increasing volume of violation referrals and the suggestion of stakeholder dissatisfaction with TWCC enforcement efforts are even more significant issues. The system in general needs to attempt to reach consensus on the extent of enforcement that is possible given TWCC's available resources, and whether this meets the system's needs.

ROC recommends that TWCC Commissioners consider appointing a committee of system participants to review TWCC's current enforcement efforts and recommend changes in compliance programs, regulatory rules, and the Texas *Labor Code* prior to the 2005 session and Sunset Review. To support this function, ROC staff expects to include a review of TWCC's current general compliance and enforcement efforts in its FY 2004 or 2005 Research Agenda.

4. Finality of Impairment Rating (90-day rule). According to the provisions of TWCC Rule 130.5 (e), injured workers and insurance carriers were required to dispute an assessment of maximum medical improvement (MMI) and its accompanying impairment rating within 90 days, or have it become final. The rule also established that the finality of a rating could only be challenged for a few, very specific reasons, such as an error on the part of the assigning doctor. MMI determinations and impairment ratings are essential in calculating the appropriate amount of Impairment Income Benefits (IIBs) an injured worker receives and in establishing a worker's eligibility for Supplemental Income Benefits (SIBs). In addition, some system participants, particularly labor groups and other advocates for injured workers, argued that the 90-day timeframe should not apply in cases involving a "substantial change of condition" for the injured employee after the MMI assessment and impairment rating assignment.

In its 2000 *Biennial Report*, ROC staff recommended a study of injured workers who may have experienced a “substantial change of condition,” with the analysis of these claims to point to possible legislative or regulatory changes. However, court action in the interim intervened to change the context of this issue significantly. In early 2001, the 3rd Court of Appeals in Austin, in response to a suit involving the 90-day dispute requirement, declared it invalid because it had no statutory basis.¹³⁸ In response, TWCC repealed the 90-day provision and issued an advisory to explain that it can no longer be utilized to finalize an assessment of MMI or an impairment rating.¹³⁹

As a result of this court ruling, no injured worker is limited by a time-certain deadline in disputing an assessment of MMI or impairment rating, whether he or she experiences a “substantial change of condition,” or not.¹⁴⁰ Some insurance carriers and other system participants are now concerned that the lack of finality in impairment ratings will leave ratings “open” to dispute far past the date of MMI, and contend that the lack of a timeframe will increase system costs because workers with natural degeneration of their medical condition will have the ability to be re-rated multiple times.

ROC Staff Recommendation: When this issue was discussed at the October 23 stakeholder meeting, ROC staff asked the insurance carriers present to provide information on how many impairment ratings had been “re-opened” that otherwise would have been precluded from this by the 90-day rule. As of this writing, such information has not been provided, and it may take some time to collect and analyze. Labor groups, which once were anxious to initiate a discussion about the “substantial change” issue, are

¹³⁸ The case involved was *Fulton v. Associated Indemnity Corporation*, Cause #03-00-00449-CV.

¹³⁹ See TWCC Advisory 2002-04; Status on Fulton Decision (signed March 4, 2002), available online at www.twcc.state.tx.us.

¹⁴⁰ While there is no statutory timeframe to dispute an MMI finding or impairment rating *per se*, the general statutory requirement that an employee be found at MMI and assessed an impairment rating no later than 104 weeks after the date income benefits begin to accrue effectively limits the employee’s eligibility for additional Temporary Income Benefits based on a revised MMI date. However, a revised impairment rating might increase the employee’s amount of Impairment Income Benefits and entitlement to Supplemental Income Benefits. See Texas *Labor Code* Section 401.011 (30) (B).

likely to oppose any proposed legislative change designed solely to provide finality to impairment ratings.

One policy option would be to place a time-certain limitation (like that formerly in TWCC Rule 130.5 (e)) in the *Labor Code*, while allowing for exceptions based on a “substantial change of condition,” and providing some statutory guidance for how such a change could be determined to have occurred (for example, allowing a reopening of an impairment rating within a certain timeframe after spinal surgery). There is insufficient data at this point to suggest the magnitude of any problems that may result from an open-ended process for impairment rating disputes, and any proposed legislative changes that are not negotiated are likely to meet with opposition from labor groups. If negotiation on this issue cannot occur at this time, ROC would recommend further research prior to TWCC’s Sunset Review in 2005 to allow more time to examine this important aspect of the system and build consensus on how it should function.

5. Designated doctor selection. In addition to modifying the process by which designated doctors are used to provide assessments of MMI and impairment ratings, Article 5 of HB 2600 also changed the process by which designated doctors are selected to perform examinations. Prior to this change, TWCC generally selected designated doctors by “matching” the licensure of the employee’s treating doctor.¹⁴¹ In other words, if the employee’s treating doctor was a chiropractor, the designated doctor chosen to conduct the review would also be a chiropractor.

HB 2600 attempted to provide more flexibility in assignment of designated doctors by allowing assignments to be made to doctors not of the same specialty licensure as the treating doctor, but still qualified to perform MMI and impairment ratings assessments for the employee in question. The specific language in HB 2600 stated that the designated doctor must be “trained and experienced with the treatments and procedures

¹⁴¹ This was in accordance with Texas *Labor Code* Section 408.122 (b), which prior to amendment by HB 2600 read in part, “To the extent possible, a designated doctor must be in the same discipline and licensed by the same board of examiners as the employee’s doctor of choice.”

used by the doctor treating the patient's medical condition," and that "the treatment and procedures must be within the scope of practice of the designated doctor." In addition, the designated doctor's "credentials must be appropriate for the issue in question and the injured employee's medical condition."¹⁴²

This statutory change led TWCC to develop a matrix for assigning designated doctors that involves compiling information about the treatment the injured employee has received and attempting to match it with the qualifications of a designated doctor. This process was implemented January 1, 2002 and is significantly more complex and time-intensive than the previous licensure match system. In addition, since it is not within the scope of practice of chiropractors to perform invasive procedures or prescribe medications, TWCC's matrix eliminates a chiropractor from consideration as a designated doctor if the injured employee is currently taking prescription medication, for example. Partly as a result, chiropractors received a smaller percentage of designated doctor assignments in 2002 than they had previously.¹⁴³ The Texas Chiropractic Association (TCA) has filed suit against TWCC contending that the new matching process is incompatible with the statutory language. ROC staff has also received several complaints from injured workers who had to travel long distances to see a designated doctor who met the matrix qualifications, and is currently working with TWCC to examine the designated doctor matching procedures and evaluate whether travel distance for injured workers has in fact increased.

ROC Staff Recommendation: Without commenting on the merits of the TCA litigation, the new selection process is more complex and time-consuming for TWCC staff, as well as confusing to many stakeholders. The complexity of the new process is part of the

¹⁴² See Texas *Labor Code* Section 408.122 (b).

¹⁴³ Data from TWCC for the first eight months of 2002 indicated that chiropractors received about 16 percent of all designated doctor appointments during this period. For contrast, during the first three months of 2001, chiropractors received about 40 percent of all assignments. It is interesting to note that despite the decrease in the *percentage* of assignments to chiropractors, the total *number* of assignments to chiropractors has not changed as dramatically. According to TWCC data, during the first three months of 2002, for example, chiropractors conducted 3,310 designated doctor exams; during the same period of 2001, the total was 3,755. This is due to the overall increase in designated doctor exams that is largely attributable to the other Article 5 changes. (*Source: TWCC Quarterly Report to ROC, October 2002, and TWCC staff report to TWCC Commissioners, April 25, 2002.*)

basis (along with the overall increase in requests for designated doctor examinations related to the other changes made by Article 5 of HB 2600) for TWCC's request for eleven new staff positions in its FY 2004/2005 Legislative Appropriations Request (LAR).

In the event a simpler approach that would still allow the assignment flexibility envisioned in HB 2600 is desired, or if TCA's litigation forces another option to be developed, several possible alternatives could be considered:

- Revision of the statutory language to return to licensure matching (as required pre-HB 2600) but with the stipulation that a Doctor of Osteopathic Medicine (DO) may perform an examination on a claim in which a Doctor of Chiropractic Medicine (DC) is the treating doctor;
- Continuation of the current selection process, but with clarification that if the injured employee's treating doctor is a DC, the designated doctor selected *may* be (but not must be) a DC; or
- Removal of the statutory language that led TWCC to implement the current matching procedure and a requirement that the examination be conducted by the next available designated doctor within a reasonable travel distance, as chosen from TWCC's designated doctor list. Since the issue in question is a finding of MMI and assignment of impairment rating, and designated doctors are placed on the list because they have been trained and certified by TWCC to perform such assessments, any designated doctor selected should be qualified to serve.

If the current selection process is continued, ROC staff proposes to continue working with TWCC staff to ensure that injured employees are not required to travel greater distances than necessary for examinations.

6. Interaction of TWCC Medical Fee Guideline and *Insurance Code* provisions related to equity of payment. While Article 6 of HB 2600 calls for use of the Medicare policies for payment, billing and coding, it also stipulates that this requirement "not be interpreted in

a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 3(d), Article 21.52, Texas *Insurance Code*, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle.”¹⁴⁴

Texas *Insurance Code* Section 3(d), Article 21.52 relates to a requirement for equity in payment among health care providers performing the same services, as long as those services fall within the scope of practice of the provider performing them. ROC has received comments from a chiropractic provider indicating that TWCC did not appropriately account for this payment equity issue in its recently adopted 2002 Medical Fee Guideline, since the Medicare payment policies TWCC adopted by reference reimburse chiropractors and osteopaths differently for similar services.

ROC Staff Recommendation: In order to comply with the provisions of HB 2600, ROC staff recommends that TWCC review the Medical Fee Guideline, Medicare payment policies, and the Physician’s Current Procedural Terminology (CPT) 2002 manual to identify inconsistencies with *Insurance Code* Section 3(d), Article 21.52, clarify the intended use of that coding relative to adopted rules, and correct any reimbursement inequities to conform to applicable law. TWCC should further request that the stakeholder community identify any needed clarifications in these areas of the Medical Fee Guideline and include these issues, as appropriate, in modifications to the adopted rules.

However, the fact that Medicare’s fee structure (which is based on the relative value of services being provided based on the actual cost to provide the service) includes differences in reimbursement amounts for different types of providers should also be noted. These reimbursement differences serve as a reasonable basis to evaluate the relative cost of providing medical services in the workers’ compensation system and the appropriateness of applying Article 21.52 of the *Insurance Code* in the future.

¹⁴⁴ See Texas *Labor Code* Section 413.011 (c).

7. Extent of Injury Dispute Timeframe. Appropriate interaction between indemnity and medical disputes has been a challenge for some time in the workers' compensation system. It is not uncommon for an insurance carrier to challenge both the *medical necessity* of a service or treatment and the *relatedness* of the service or treatment to a compensable injury. However, medical necessity disputes are handled through the MDR process, while relatedness and extent of injury disputes are handled through the indemnity dispute process. In addition, relatedness and extent of injury disputes are underlying issues that should, if possible, be decided before a dispute over the necessity of a particular service is decided, since if a condition is unrelated to the employee's compensable injury, arguments about medical necessity need not occur. TWCC has attempted to clarify the appropriate track for disputes by advising system participants that, if extent of injury or relatedness is the basis for an insurance carrier's denial of a medical bill, that the carrier should file the appropriate form (a TWCC-21) to deny on this basis, which may in turn lead to resolution of the contested issue through the indemnity dispute process. Resolution of a medical necessity dispute at this point would not resolve the underlying dispute of relatedness or extent of injury.

ROC Staff Recommendation: Enforcement of existing statutory and rule language may be sufficient to avoid situations in which an insurance carrier's true basis for denial is relatedness or extent, but in which the carrier does not file a TWCC-21. Texas *Labor Code* Section 408.027 and TWCC Rule 124.3(c) speak to these issues, and the rule provision requires a carrier that receives a medical bill it believes to be unrelated to the compensable injury to file a notice to dispute relatedness or extent (the TWCC-21), and to do so not later than the date of denial or the date the bill was due. These provisions already embody the intent of pushing any relatedness or extent of injury dispute to the forefront as soon as possible.

If enforcement of existing provisions is insufficient to ensure that relatedness or extent of injury disputes are raised as soon as possible, another option would be to restrict an insurance carrier's timeframe to dispute extent of injury for a particular condition, rather

than just for a particular medical bill. The *Labor Code* provides a statutory timeframe to dispute the compensability of an injury, but there is no similar timeframe for relatedness. Such a timeframe could require that, within a certain number of days from receiving a bill for a particular condition, the insurance carrier must dispute relatedness or extent, or waive the right to do so for that condition. Payment of bills before this deadline would not constitute acceptance of the condition, and medical necessity could still be disputed for individual bills with the appropriate timeframes to pay or dispute. Such a timeframe would place more emphasis on prompt review of extent and relatedness issues and could minimize the likelihood of challenges on both medical necessity and extent of injury issues occurring at the same time and becoming muddled together in the dispute process.

Carriers have indicated concern about or opposition to such a timeframe. One carrier group commented that the real problem in bringing extent of injury issues to the forefront early in treatment lies with treating doctors who do not clearly document that a "new" condition is being treated or share records with the carrier. ROC staff acknowledges that if a dispute timeframe or related legislative change is proposed, these are issues that would also need to be considered.

If no statutory changes are made in this area, ROC staff plans to work with TWCC staff to further examine ways to alleviate problematic dispute issues in anticipation of Sunset Review in 2005.

8. Use of TWCC's Medical Advisor and Medical Quality Review Panel (MQRP). Article 1 of HB 2600 gave TWCC unprecedented access to medical expertise through the formation of TWCC's Medical Advisor position and creation of the Medical Quality Review Panel (MQRP), and unprecedented authority to monitor and regulate health care providers, insurance carriers and utilization review agents who violate the Act and TWCC rules. The 77th Texas Legislature also gave TWCC a \$1.5 million appropriation for the 2002-2003 biennium to implement HB 2600, with the anticipation that a significant portion of that appropriation would be spent on health care provider and

insurance carrier monitoring activities.¹⁴⁵ However, the implementation of the MQRP has been slow (as of late October, TWCC reported that six designated doctors had been reviewed by the MQRP Executive Council, and that TWCC was in the process of gathering records on eleven other doctors for quality of care reviews).¹⁴⁶ While the MQRP is now in the process of performing some reviews, TWCC has not formally imposed sanctions (i.e., made recommendations to TWCC Commissioners that they penalize, restrict, or suspend) any health care provider, insurance carrier or designated doctor for quality of care issues or excessive medical care using the authority granted under Article 1 of HB 2600.

TWCC indicates that several issues have hampered its ability to more aggressively pursue doctors and insurance carriers. These include questions about the immunity of MQRP members and about TWCC's ability to request records from doctors who are being reviewed (see Recommendations 20 and 26 for TWCC's recommended legislative changes to address both of these concerns, and ROC staff's response to these recommendations). Another concern raised by TWCC is the potential cost of defending imposed sanctions at hearings held by the State Office of Administrative Hearings (SOAH) or in litigation.

ROC staff has also received complaints that TWCC has not yet established and publicized the process by which the Medical Advisor and MQRP will conduct clinical reviews and recommend sanctions to TWCC Commissioners for their consideration or the progress made in these efforts. Interested stakeholders (which include representatives from the business, insurance carrier, health care provider and labor communities) contend that they are unaware of the number, cost and status of MQRP reviews, and some

¹⁴⁵ It should be noted that additional funding for the Medical Advisor and MQRP activities also might be available. HB 2510, passed during the 76th legislative session, authorizes TWCC to accept a grant from the Texas Workers' Compensation Insurance Fund (now known as the Texas Mutual Insurance Company) for up to \$2.2 million "in order to implement specific steps to control and lower medical costs in the workers' compensation system and to ensure the delivery of quality medical care." This grant authorization expires on September 1, 2003. As of the writing of this report, TWCC has not submitted a grant proposal to Texas Mutual to fund any of its medical management activities.

¹⁴⁶ Statistics provided by TWCC at the October 28, 2002 workers' compensation legislative workgroup meeting.

question whether TWCC has focused enough attention on implementing what many considered to be the cornerstone of HB 2600 – quality of care monitoring efforts. Health care providers in particular contend that TWCC has overemphasized the development and defense of its fee guideline at the expense of building the MQRP.

In the absence of a clear commitment by TWCC to take “bad actors” out of the system given its statutory authority to do so, some system stakeholders have questioned whether policymakers should begin discussing how to restructure TWCC as a precursor to the Sunset Review process, and whether more restrictive medical care models should be evaluated for the Texas workers’ compensation system (i.e., models that would promote employer choice of doctor or reduce the role of chiropractors in the system). Internally, TWCC has struggled to incorporate into its operations the statutory responsibilities of its Medical Advisor, and in September 2002 TWCC’s Medical Advisor tendered his resignation (although he has since agreed to serve on a month-to-month basis until a replacement is hired).

In response to some of these criticisms regarding the lack of information for stakeholders on MQRP activities, TWCC in December 2002 held a stakeholder meeting to present its plans to monitor health care providers, designated doctors and insurance carriers. Important issues about which stakeholders should be informed on an ongoing basis include the number of budgeted MQRP reviews planned and the general status of ongoing reviews, as well as a description of the processes used to identify, review and sanction outlier health care providers, designated doctors and insurance carriers.¹⁴⁷ ROC staff has offered to participate in these educational efforts and brief stakeholders on the data mining methodology it created with TWCC staff to identify health care providers who warrant further MQRP scrutiny (this methodology was described in ROC’s August 2002 special edition of the *Texas Monitor*).

¹⁴⁷ At the ROC Board meeting in December 2002 at which the 2002 *Biennial Report* was approved, TWCC commissioners on the ROC Board indicated that TWCC was committed to moving forward with establishing goals for the MQRP process related to reducing overutilization of medical services in particular areas identified by previous ROC and other research.

ROC Staff Recommendation: ROC staff supports TWCC's decision to sponsor a stakeholder meeting to present its plans for how the Medical Advisor and MQRP will monitor health care providers, designated doctors and insurance carriers. However, ROC staff recommends that TWCC's Medical Advisor (or TWCC staff, in the absence of a Medical Advisor) also present these plans to TWCC Commissioners during a public meeting, so that the Commissioners have the opportunity to monitor the status of MQRP reviews and understand the types of sanctions they will be asked to consider for health care providers and insurance carriers in the future.

ROC staff notes that the current MQRP implementation efforts are very focused on litigation with system participants who may fight TWCC's efforts to remove them from the system (as highlighted by the fact that a significant portion of HB 2600 MQRP funds are being held in reserve for future payment of SOAH hearings and litigation costs to defend TWCC sanctions that have not yet been imposed). ROC staff recommends that TWCC re-examine its current MQRP plan to include more resources for reviews and publication of the general results of those reviews, so the health care provider and insurance carrier communities are aware of TWCC's activities in this area. As demonstrated in ROC staff's fiscal note calculations, such educational efforts might also accomplish significant system savings without incurring costs to defend sanctions.

To ensure that TWCC has adequate financial resources to perform these reviews and defend the sanctions it levies on providers or carriers, ROC staff also recommends that TWCC utilize the authority it was given by the 76th Texas Legislature to accept grant funding from the Texas Mutual Insurance Company before it expires in September 2003 (the legislature specified that TWCC could accept up to \$2.2 million for medical management efforts). ROC staff recommends that TWCC staff develop a grant proposal to pay for MQRP reviews or educational outreach efforts for providers and carriers utilizing this funding source.

9. Pharmaceutical Issues. Despite the passage of HB 2600, pharmaceutical issues remain

a particularly troublesome area in the workers' compensation system. System participants' perceptions of pharmacy-related problems vary: insurance carriers and employers point to increasing pharmacy costs in general; prescribing doctors complain about attempts by TWCC to require carriers to request letters of medical necessity prior to denying bills; pharmacists argue that the cost of medical dispute resolution prevents pharmacists from filling future prescriptions for workers' compensation patients; and injured workers complain that they must "shop" their prescriptions with multiple pharmacists before they can get their medications. All of these stakeholder groups agree that pharmacy issues are a significant problem, but there is considerable disagreement among these stakeholder groups regarding possible solutions.

ROC staff has received various legislative recommendations from system stakeholders to address pharmaceutical issues, including:

- that the Legislature should require TWCC to adopt a more restrictive pharmaceutical formulary to more clearly specify the appropriate medications and dosages for particular medical conditions;
- that the Legislature should require TWCC to offer a lower cost dispute resolution process for pharmacists (see Recommendation 1);
- that TWCC should encourage the use of insurance carrier Pharmacy Benefit Managers (PBMs);¹⁴⁸
- that the Legislature should require TWCC to incorporate aspects of a PBM into its medical billing rules for pharmacy;
- that the Legislature should clarify extent of injury issues, since many pharmacy denials are associated with disagreements over whether a drug is associated with the compensable injury or an unrelated medical condition; and
- that the Legislature should add all frequently disputed pharmaceutical medications to TWCC's required preauthorization list, so that pharmacists would know if a prescription will be reimbursed prior to filling it.

¹⁴⁸ A "Pharmacy Benefit Manager" (PBM) is an entity that reviews the medical necessity of pharmacy bills on behalf of an insurance carrier, similar in function to a utilization review agent (URA).

ROC Staff Recommendation: Considering the lack of available information and research on pharmacy issues, the lack of consensus on possible solutions, and the fact that these issues are a probable area of discussion during TWCC's Sunset Review in 2005, it is unlikely that significant legislative changes will take place in this area during the 78th Legislative session. However, several public policy options exist that could alleviate problems in the short-term and set the stage for broader discussions next session:

- Currently TWCC does not collect pharmacy bill data, but has identified data collection in this area as one of its Business Process Improvement (BPI) goals during the next biennium. TWCC is also in the process of initiating a short-term “data call” (a request for aggregate information, usually from insurance carriers) to determine which prescription medications are most frequently denied. ROC staff supports TWCC’s efforts to collect pharmacy data as part of TWCC’s Tier One BPI process list for September 2003 implementation, but would encourage TWCC to specify the intended use of this data and allow insurance carriers adequate notice to meet reporting requirements. Most important, ROC staff recommends that TWCC incorporate a data integrity plan for all types of reported data as part of its BPI redesign efforts to specifically outline the edits that TWCC will use to screen incoming data and describe the resources that TWCC will use to audit samples of incoming data for accuracy. Lack of a data integrity plan would severely compromise the usefulness of the information for quality of care monitoring and research purposes.
- Many of the complaints from pharmacists relate to the assertion that the absence of a low-cost dispute resolution process prevents them from disputing denials, since the cost of the IRO review usually exceeds the cost of the medication in dispute. TWCC indicates that the current statute does not allow it to create a separate process from the IRO for low cost medical disputes. ROC staff therefore reasserts its medical dispute resolution recommendation that the *Labor Code* be changed to provide TWCC the authority to designate a lower cost medical dispute process. Giving TWCC this authority will allow stakeholders the opportunity to

provide input on the structure and cost of this alternative dispute model through the rulemaking process and provide a more viable method for dispute resolution for pharmacists.

- Insurance carriers, health care providers and pharmacists agree that without better communication about the proper usage of certain prescription drugs, retrospective denials and disputes will continue to occur. While system stakeholders do not uniformly agree that requiring a more restrictive pharmaceutical formulary is the answer, they generally do agree that adopting prescription drug treatment protocols by rule for certain contentious medical conditions would be a first step in providing more guidance to prescribing doctors and pharmacists about the proper duration of use, generic equivalents and dosage guidelines for specific medications. Reaching agreement on these treatment protocols or guidelines would also reduce the variability of insurance carrier reviews of pharmacy bills.

Article 1 of HB 2600 (Section 413.0511, Texas *Labor Code*) outlines the statutory duties for TWCC's Medical Advisor. One of these duties is to make recommendations regarding the development of treatment guidelines under Section 413.011 of the Texas *Labor Code*; however, Section 413.011 requires that any treatment guideline (and therefore any individual treatment protocol) adopted by TWCC must be "nationally recognized, scientifically valid and outcome-based." This strict set of criteria for treatment guidelines currently prevents the development of individual prescription drug treatment protocols that outline the suggested use of many frequently disputed prescription medications (such as chronic pain medications and psychotropic drugs) since there are not "nationally recognized" prescription drug treatment protocols for many occupational injuries.

ROC staff therefore recommends that *Labor Code* Section 413.011 (e) be clarified to allow that if a nationally recognized treatment guideline or treatment protocol is not available, TWCC's Medical Advisor not be prevented from developing a treatment guideline or individual treatment protocol, so long as it meets the

"scientifically valid and outcome-based" statutory criteria. ROC staff would further recommend that TWCC's Medical Advisor begin the development of individual prescription drug treatment protocols (concentrating on those medical conditions that are subject to inappropriate usage of chronic pain and psychotropic medications) with an additional goal of creating a method by which pharmacists can electronically obtain and adjudicate pharmacy bill denials.

ROC staff also suggests that TWCC's Medical Advisor and Medical Quality Review Panel (MQRP) use these treatment protocols to identify and impose sanctions on doctors who over-prescribe these medications.

Regardless of whether statutory changes are made, ROC staff recommends that TWCC utilize information from its data call to identify those situations which often trigger pharmacy bill denials and encourage pharmacists to seek pre-certification from the insurance carrier in those situations. To promote the use of pre-certification, insurance carriers should be reminded (perhaps by TWCC Advisory) that disputes over pre-certification denials are "loser pay" disputes, meaning that the party who does not prevail (rather than necessarily the carrier) must pay the IRO fee. If insurance carriers do not embrace the concept of pre-certification, TWCC may have to consider adding some pharmaceutical medications to the formal preauthorization list in order to add more certainty to the review process.

With the knowledge that pharmacy concerns will likely be one of the issues discussed by the 2005 Legislature as part of TWCC's Sunset Review process, ROC staff proposes to include one or more projects on its approved Research Agenda to examine these issues and develop more specific legislative and/or regulatory recommendations prior to the next legislative session.

10. Access to Workers' Compensation Data. In order to effectively gauge the impact of workers' compensation statutory and regulatory reforms, system participants need access

to accurate and timely workers' compensation data. However, accessing public use data files or supporting data for specific rulemaking proposals at TWCC has been a source of considerable controversy and frustration for certain system participant groups in recent years.

Historically, TWCC has tried to meet public demand for data by responding to individual open records requests and issuing its *System Data Report* (SDR), which contains aggregate level data on various workers' compensation performance measures (for example, the number of injured workers receiving Temporary Income Benefits by injury year, or the number of preauthorization disputes found in favor of the insurance carrier).¹⁴⁹ Recently TWCC also initiated an interactive data analysis page on its website that allows members of the public to produce their own customized data reports using certain data fields (for example injury year, injury nature, body part, etc.).

However, ROC staff has received complaints from certain system participants (particularly insurance carriers, business groups and health care provider organizations) who claim that TWCC's open records process is very cumbersome, often taking months to complete a request for non-confidential data due to resource constraints at TWCC. They further argue that there is considerable inconsistency in TWCC's interpretation of which data fields are deemed "confidential", and that this confusion further complicates the open records process if a requestor is trying to compare data over several years. While many system participants appreciate the information that can be found in TWCC's SDR and on TWCC's interactive website, they argue that inconsistencies in the publication schedule of the SDR (first quarterly, then biannually, and now every 8-9 months) and in updates to the website, coupled with changes in reporting methodology, require system participants to use the open records process more frequently in order to get the information they require for evaluating the impact of TWCC proposed rules.

ROC has also received some requests for workers' compensation data, but since TWCC and not ROC is the official record keeper for claims, medical and dispute resolution data,

¹⁴⁹ TWCC's *System Data Report* can be found on its website at www.twcc.state.tx.us.

ROC has not released public use data files unless it is to a consultant of the agency and relates to a particular project on the ROC's approved Research Agenda. Instead, ROC staff has tried to assist members of the public in filing their open records requests to TWCC. ROC staff also conducts specific analyses on an ad hoc basis for the public if that work does not conflict with the completion of the agency's Research Agenda.

It is also uncertain whether the business and insurance carrier communities will support ongoing expenditures for TWCC's Business Process Improvement (BPI) redesign project if it does not improve access to information for stakeholders.¹⁵⁰ ROC staff has received a request that legislation be considered to require TWCC to make available public use data files of workers' compensation data, or alternatively, require other state agencies such as ROC or the Texas Health Care Information Council (THCIC) to house these public use datasets. Additionally, concerns about the possible impact of state medical privacy legislation and federal Health Insurance Portability and Affordability Act (HIPAA) confidentiality requirements on the availability of future workers' compensation medical cost data are also fueling the pressure for TWCC to provide timely public use data files that still meet state confidentiality requirements.

ROC Staff Recommendation: In an effort to provide more accurate and timely data on workers' compensation issues, ROC staff recommends that TWCC consider implementing one or more of the following regulatory actions (none of which require legislative changes):

- TWCC should consider incorporating the goal of providing public use data files (particularly medical cost and medical dispute resolution data) into its Business Process Improvement (BPI) Tier 1 or 2 Process Lists. Providing a clear business plan for which data sets and data elements will be available for use by the public will assist TWCC in its efforts to secure funding for its continued BPI efforts in the future.

¹⁵⁰ TWCC's legislative appropriations are currently funded by a maintenance tax placed on all insurance carriers who are licensed to write workers' compensation insurance coverage in Texas and often passed through to policyholders in the form of increased premiums.

- TWCC should consider adopting the model currently used by the THCIC to provide access to public use data sets and research data sets. The THCIC's website (www.thcic.state.tx.us) contains a user manual (i.e., a list of the different data sets, data fields and formats), a data use agreement and an order form that a member of the public can use to request quarterly hospital discharge data files. Using this format, every requestor knows up front which data sets and data fields are available for request and which data fields are deemed protected and/or confidential by state or federal law. While providing these data sets does require programming resources that are currently scarce at TWCC, it would likely reduce TWCC's ongoing burden in answering individual open records requests and explaining the methods used by TWCC programmers to produce individual data files.
- For more detailed data requests, ROC staff recommends that TWCC and ROC work together to establish a model for releasing research data files that contain more fields than the public use data files, but require up front approval from a review panel consisting of TWCC and ROC staff. THCIC currently uses a similar model to review research requests made by an individual, group, university or governmental agency. Under THCIC's model, the requestor reviews the data sets and data fields that are available in the research data set and submits a request that includes a description of the requestor's proposed research design as well as a description of the intended use of the data (the research data set never contains any data element that has been deemed confidential by state or federal law). THCIC's Scientific Review Panel then reviews and ultimately approves or denies the request for the research data file. Using a similar approach, TWCC and ROC can encourage the proper use of workers' compensation data for research purposes while ensuring that each request receives equal consideration.

11. Increased Public Input during TWCC Rulemaking Process. During the 77th

Legislative session, representatives from the labor, business, insurance carrier and health care provider communities came together to negotiate and craft a comprehensive package of medical and income benefit reforms, which were later passed as HB 2600. Throughout the negotiations, stakeholder representatives agreed that the implementation of these reforms would be a difficult task for TWCC due to the sheer number of statutory changes the bill contained, and as a result, these stakeholders agreed that they would need to be active participants in the rulemaking process.

In the initial months of implementing HB 2600, TWCC proposed a considerable number of rules, some of which were required by HB 2600 and some of which were continuations of previous rulemaking initiatives. Some of the latter were perceived by system stakeholders to be out of line with the statutory requirements of HB 2600. After multiple proposals of TWCC's preauthorization and medical fee guideline rules and withdrawal of TWCC's proposed treatment and return-to-work guideline, some system stakeholders complained that TWCC's lack of a comprehensive HB 2600 implementation plan as well as TWCC's initial reluctance to discuss rules prior to initial proposal, caused delays in the implementation of key HB 2600 provisions. In response to these concerns, TWCC has organized a series of stakeholder meetings to discuss issues relating to pharmacy, return to work, hospital fee guidelines, and medical dispute resolution, among others.

Stakeholder representatives generally appreciate TWCC's recent efforts to offer opportunities for input on issues prior to the formation of rule proposals by TWCC staff, and most everyone involved agrees that these meetings are a step in the right direction to keep the lines of communication open between key stakeholder groups and TWCC.. However, some stakeholders have argued that these meetings do not achieve their intended goal because TWCC does not typically provide written proposals or options for stakeholders to discuss with their associations in advance. On the other hand, TWCC staff has pointed out that some stakeholders do not regularly attend these meetings and do not come prepared to discuss the issues on the agenda or offer possible solutions to identified problems. Along these lines, ROC staff has received a request that TWCC post draft rules and "non-rule policies" for public input prior to publication as formal

proposals in the *Texas Register*. Stakeholders point to similar efforts by the Commissioner of Insurance to post draft rules and argue that posting draft rules on TWCC's website is the logical next step for TWCC in its efforts to be more inclusive and to help focus discussions during stakeholder meetings.

ROC Staff Recommendation: In order to enhance the focus of stakeholder meetings and provide TWCC with quality input on selected issues, ROC staff recommends that TWCC consider distributing draft rule proposals or proposed TWCC policies to primary stakeholder associations prior to stakeholder meetings rather than posting draft rules on TWCC's website. ROC staff agrees with TWCC staff's concern that posting draft rule proposals on TWCC's website prior to publication in the *Texas Register* might cause confusion among the general public as to whether the pre-draft rule had been formally proposed. The purpose of distributing draft rules or proposed TWCC policies would be to give the stakeholder associations the opportunity to discuss various options with their members, collect data that would be useful to TWCC during the rule proposal process, and come to the stakeholder meetings more prepared to provide input to TWCC staff. TWCC staff would be able to incorporate this input into formal rule proposals that would then go through the formal APA rulemaking process to collect public comment.

12. Access to Workers' Compensation Data for Anti-Fraud Activities. HB 1562, an anti-fraud bill passed by the 77th Legislature, clarified that group health insurance carriers are permitted access to TWCC claims data as subclaimants for the purpose of determining if health care providers have billed both workers' compensation and group health carriers for medical care associated with a particular claimant, a practice that could represent an error or outright fraud.¹⁵¹ However, group health insurance carriers interested in this data and TWCC staff have disagreed about whether the statutory language in HB 1562 was sufficient to classify group health insurance carriers as subclaimants under the *Labor Code*. One group health insurance carrier submitted an open records request to TWCC for access to this data, and TWCC in turn requested an Attorney General's opinion to

¹⁵¹ See Texas *Labor Code* Section 402.084.

clarify whether group health carriers can be defined as subclaimants and therefore receive otherwise confidential workers' compensation claim data. On October 30, 2002 the Attorney General's office issued an opinion stating that TWCC should withhold confidential claim identifying information from the requesting group health insurance carrier because the carrier had not submitted information to TWCC identifying itself as a subclaimant on a specific claim. Further, the Attorney General's office ruled that access to this type of medical data is governed by the Medical Practice Act (Chapter 159 of the *Occupations Code*), and that medical data may be released only if the individual patient signs a written consent form authorizing the release of his or her medical records.

ROC Staff Recommendation: ROC staff recommends that the statutory language defining a "subclaimant" be examined further to determine whether legislative change is needed to meet the statutory intent of HB 1562. However, if the definition of "subclaimant" is clarified to include group health insurers, ROC staff would recommend statutory changes to require group health insurers to work with TWCC's fraud investigations unit if duplicate billings are found in order to determine whether TWCC should pursue a fraud investigation. More important, however, ROC staff believes that TWCC should clarify how the October 2002 Attorney General's opinion, particularly the interpretations of the applicability of the Medical Practice Act, could impact the availability of public use data sets and open records requests for medical billing data.

13. Return-to-Work. While the policy goal of returning injured workers to productive employment as quickly and safely as possible has been the subject of some stakeholder discussion since the passage of HB 2600, there has not been much agreement on the best way to improve return-to-work outcomes in Texas. As part of its BPI redesign efforts, TWCC has discussed ways to collect return-to-work data in order to measure the percentage of injured workers who are not yet back at work, yet there are concerns from insurance carriers that new data collection requirements will add new administrative burdens. Carriers argue that TWCC has not fully explored using Texas Workforce Commission (TWC) Unemployment Wage data, combined with injured worker surveys,

as a more efficient and possibly more accurate alternative to widespread administrative data collection on return-to-work outcomes.

TWCC has also designated a return-to-work coordinator to organize its outreach efforts. Despite not having a budget until the spring of 2002, TWCC's return-to-work coordinator has made several presentations and distributed thousands of program guides to Texas employers. Some stakeholder groups such as labor and health care provider organizations cite previous ROC research on return-to-work outcomes to demonstrate that TWCC historically has not adequately prioritized return-to-work issues and has consistently under-funded return-to-work outreach initiatives.¹⁵² TWCC points to return-to-work coordination problems with agencies such as the Texas Rehabilitation Commission (TRC, the agency that handles vocational rehabilitation referrals of workers compensation claimants from TWCC), since TRC claims that its privacy regulations prevent TWCC from knowing whether the injured workers it refers to TRC actually received vocational rehabilitation services. TWCC and TRC are currently exploring options to develop an injured worker release statement allowing information to be shared between the two agencies.

ROC Staff Recommendation: Many system stakeholders assert that until TWCC or the Legislature establishes a system goal for improving return-to-work outcomes and insist that TWCC prioritize return-to-work efforts, the issue of improved return-to-work outcomes will not receive adequate focus.¹⁵³

Considering that TWCC is scheduled for Sunset Review in 2005, ROC staff would not recommend major legislative action to add new return-to-work coordination requirements for TWCC at this time. However, to facilitate TWCC's efforts to determine the status of its referrals to the Texas Rehabilitation Commission (TRC), ROC staff recommends that

¹⁵² See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 2001. ROC staff is currently in the process of updating these return-to-work results.

¹⁵³ In response to discussions at the December 2002 ROC Board meeting, TWCC Commissioners on the ROC Board indicated that commissioners plan to move forward with setting goals to reduce overutilization of medical treatment and improve outcomes (such as return-to-work outcomes) in the system.

if TWCC and TRC cannot come to an agreement on a method that would allow the agencies to share information, then statutory options should be examined to remove these barriers.

14. Further Alignment with Medicare Policies and Features. Article 6 of HB 2600 aligned the medical billing, coding and payment policies of the workers' compensation system with those of Medicare. The 2002 TWCC Medical Fee Guideline (passed by TWCC Commissioners in May 2002 and currently in litigation over the pricing aspect of the guideline) adopted by reference all of Medicare's payment policies with limited exceptions (including the ability for chiropractors to remain treating doctors and the addition of impairment rating examinations, among others). However, many system participants assert that if the statutory intent of HB 2600 was to closely align the workers' compensation system with Medicare, then there are certain provisions in the *Labor Code* and TWCC rules which must be examined further since they currently overlap or possibly conflict with the Medicare billing and payment structure.

For example, the Medicare system does not require preauthorization (i.e., pre-approval of medical services by insurance carriers prior to delivery), but rather sets clearer guidelines on the appropriateness of medical services through its payment policies, and then relies on retrospective reviews (referred to as either pre-payment or post-payment reviews in Medicare terminology). Under the current *Labor Code* and TWCC rules, certain medical services must be preauthorized before a health care provider can render them in a workers' compensation case.

Under the Medicare program, health care providers whose practice patterns warrant further scrutiny are subject to "probe reviews," similar to the clinical reviews envisioned by the MQRP under the workers' compensation system, and are subject to sanctions, such as mandatory pre-payment reviews of all of their billed services, also similar to the types of sanctions that may be used for health care providers under Article 1 of HB 2600. Since Medicare's payment policies are relatively specific, providers who bill according to

Medicare's rules are generally required to provide less upfront documentation regarding the medical necessity of their services, with the focus again on Medicare initiating probe reviews and sanctions if over-treatment or over-billing occurs. This is in contrast to the current workers' compensation system model, which requires more upfront documentation of medical necessity issues, which is considered by many health care providers to be a significant administrative burden.

Another difference between the Medicare and workers' compensation payment models is that under Medicare the "insurance carrier" (in this case Medicare's intermediary, Trailblazer Health Enterprises, LLC), has the ability to recoup overpayments or inappropriate payments on a post-payment basis, and can even reduce subsequent bills on different claims if billing or documentation issues are discovered. Currently, workers' compensation insurance carriers do not have the ability to recoup overpayments or inappropriate payments unless TWCC issues an order for the provider to reimburse the carrier. Many carriers contend that some providers do not comply with these orders, and that because of the relatively small amounts of money each of these reimbursement orders generally represent, TWCC cannot effectively enforce its orders.

One major complaint that insurance carriers have with the recently adopted 2002 TWCC Medical Fee Guideline is that medical services deemed not to be medically efficacious and therefore not reimbursed under the Medicare payment policies are still billable under the new guideline, and may be individually disputed by a provider if denied by an insurance carrier. Carriers argue that this dilutes the impact of the adopted Medicare payment policies and allows IRO decisions to effectively "trump" Medicare payment policies, which are adopted by rule.

Despite all of the recent disagreement between health care providers and insurance carriers/employers/TWCC on the fee amounts adopted as part of the 2002 TWCC Medical Fee Guideline, there has been little disagreement to date on the proper application of the Medicare payment policies. Stakeholders have instead generally supported the concept that services not covered by the Medicare payment policies for

reasons of medical inefficacy not be disputable through the IRO process. However, this may change once the payment policies actually go into effect and health care providers assess the impact on their practice.

ROC Staff Recommendation: Due to the ongoing litigation of the 2002 TWCC Medical Fee Guideline, it is uncertain when the new workers' compensation billing, coding, and payment policies will go into effect. Considering the proximity of TWCC's Sunset Review in 2005 and the myriad of implementation issues that will likely arise during the initial months after the effective date of the Guideline, ROC staff does not recommend making any additional significant statutory changes to further align workers' compensation billing, coding and payment policies with Medicare at this time, outside of the medical dispute resolution recommendations made in this report.

However, ROC staff does recommend that TWCC form a Medical Fee Guideline implementation advisory committee consisting of TWCC staff and representatives from various stakeholder groups to examine any inconsistencies between workers' compensation regulations and Medicare, and recommend appropriate statutory or regulatory changes prior to the commencement of the 79th Texas Legislature in 2005. Additionally, ROC staff recommends that this advisory committee work with TWCC's BPI redesign team to initiate efforts to facilitate the electronic submission of medical bills from health care providers to insurance carriers.

15. Ability of ROC Staff to Initiate "Data Calls". Although it is the state agency that is statutorily charged with researching the operational effectiveness of the workers' compensation system, currently ROC does not have the authority to formally initiate a "data call" (a request for data from workers' compensation system participants, generally insurance carriers) in order to collect information that may be vital to answering public policy questions or projecting the impact of proposed legislation or TWCC rules. While ROC currently has the ability to request that system participants provide information on a voluntary basis, ROC does not have the ability to compel that certain information be

reported, and often must rely on a select few respondents (generally a handful of insurance carriers) to provide information that is not otherwise collected by TWCC or the Texas Department of Insurance (TDI). Other agencies, such as TDI, have the ability to compel data under their general regulatory authority, but it is not always feasible for ROC to pursue data calls under this authority.

As specifically discussed in ROC staff's responses to TWCC Recommendations 19 and 26, TWCC also has data collection and enforcement needs that might be enhanced by specific data call authority.¹⁵⁴

ROC Staff Recommendation:¹⁵⁵ To improve ROC and TWCC's ability to compel the provision of information that may be necessary for research and oversight purposes, or for regulatory or rulemaking purposes, staff recommends that the *Labor Code* be amended to provide ROC and TWCC authority to request that a regulated entity under the Act (usually, in this case, an insurance carrier or health care provider) provide information requested by the ROC or the Commission within certain timeframes. Changes to *Labor Code* Section 404.009 would accomplish this for the ROC's authority, and to a similar change could be made to TWCC's authority under the *Labor Code*.

ROC staff also recommends that the *Labor Code* be amended to specify that the identity of an entity that responds to a ROC or TWCC data call is confidential and not subject to public disclosure under Chapter 552, *Government Code*. A list of names of those responding would not be confidential, nor would aggregate or information of a statistical nature, but the specification of the company that reported specific data would be

¹⁵⁴ At the ROC Board meeting in December 2002 at which the 2002 *Biennial Report* was approved, TWCC staff asked that the ROC recommendation related to data call authority be extended to TWCC, as well; the Board approved this addition.

¹⁵⁵ The language in this ROC recommendation related to data call authority was submitted by TWCC at the December 2002 meeting of the ROC Board and adopted by the Board. The intention of the change offered by TWCC was to provide data call authority for both ROC *and* TWCC (the original ROC recommendation had only recommended it for ROC). It should be noted that the language added related to the confidentiality of information collected under a data call conflicts with ROC Staff Recommendation 10 (related to Access to Workers' Compensation Data), and that additional discussion is necessary to determine whether a compelling need exists to maintain a different confidentiality standard for data collected for research purposes by ROC and data collected for regulatory purposes by TWCC.

confidential. This change would mirror an existing statutory provision that protects the identity of ROC survey respondents.

To ensure that system participants have the opportunity to provide input on research projects that would potentially result in a data call, ROC staff also recommends that data calls be restricted to those research projects that are approved by the ROC Board as part of the ROC's Research Agenda.

16. Recovery From Third Parties When the Subsequent Injury Fund is the Beneficiary.

Chapter 417 of the Texas *Labor Code* allows a workers' compensation insurance carrier to pursue a liable third party that caused or contributed to an injured employee's accident or damages. The insurance carrier can sue in the name of the injured employee or the injured employee's legal beneficiary.

In some fatalities, however, the deceased employee has no workers' compensation beneficiaries, and the workers' compensation insurance carrier pays benefits to the Subsequent Injury Fund (SIF) of the Texas Workers' Compensation Commission instead. There is no explicit provision in Chapter 417 that enables the insurance carrier to pursue a liable third party that caused an accident when the SIF is the workers' compensation beneficiary. At least one court case has held that the insurance carrier has no remedy in this situation.¹⁵⁶ ROC received feedback from an insurance carrier asking that this situation be clarified and that subrogation recovery be allowed.

ROC Staff Recommendation: Since one of the underlying reasons for statutory workers' compensation subrogation is to keep the costs of workers' compensation insurance low by making a liable party pay for an injury it causes, it seems reasonable that subrogation should also apply to situations in which the SIF is the workers' compensation beneficiary. While ROC staff would not classify this statutory change as among the higher priorities included in the report, staff does recommend that Chapter 417 of the *Labor Code* be

¹⁵⁶ See *Texas Employers Ins. Assoc. v. Myers*, 496 S.W.2d 940 (Tex. Civ. App.—San Antonio 1973).

amended to allow a carrier to seek subrogation from a third party in cases where the carrier pays into the SIF.

17. State Office of Risk Management (SORM) Medical Management Activities.

SORM – the state agency responsible for the administration of the state employee workers’ compensation program – currently contracts with a private utilization review company to review the medical necessity of SORM’s medical bills and ensure that these bills are paid according to the TWCC Medical Fee Guideline. This contract expires in 2005. SORM’s current utilization review contractor has indicated that if SORM decides to renew the contract, it can expect an increase of approximately \$1.3 million over the current rate (an estimated \$2.6 million per year, compared to approximately \$1.34 million per year in the current agreement). In August 2002, SORM’s governing board included this \$1.3 million request as an exceptional item in SORM’s 2004-2005 Legislative Appropriations Request (LAR).

Also at present, the state Comptroller’s office is completing its biennial claims review study, which involves a claim-level audit of a sample of SORM’s medical bills. While the findings of this audit have not been released as of the writing of this report, preliminary findings indicate that there may be some medical management issues with SORM’s utilization review contractor that will need to be addressed in the next biennium.¹⁵⁷

Another initiative that may impact the structure of SORM’s medical management processes in the future is the feasibility study on regional workers’ compensation health care delivery networks required by Article 2 of HB 2600. As described in the Medical Care and Rehabilitation section of this report, the Governor-appointed Health Care Network Advisory Committee (HNAC) is currently overseeing this study to determine

¹⁵⁷ SORM is currently in the process of responding to the findings of the Comptroller’s study and indicates that they are exploring options to hire registered nurses as adjustors to process medical bills and reduce overpayment errors. To facilitate the expansion of their medical expertise, SORM has included a request for additional staff as part of its 2004-2005 Legislative Appropriations Request (LAR).

whether a voluntary “managed care-type” network would reduce medical costs and improve the quality of medical care. If deemed feasible, the statutory model for this network requires SORM and other self-insured state entities (such as the Texas Department of Transportation, Texas A&M University and the University of Texas System) to offer this network alternative to state employees (although employee participation is optional). The feasibility study is currently scheduled for completion by the end of calendar year 2002.

ROC Staff Recommendation: The expected increase in the cost of SORM’s utilization review contract presents SORM with the opportunity to consider the following policy options for improving its medical management functions:

- Expansion of its medical expertise by hiring or contracting with a Medical Director or a Medical Advisor (an M.D., D.C. or some other type of health care provider) to assist staff in developing utilization review standards, provide medical expertise to SORM staff in individual claim reviews and medical disputes, and assist SORM staff with evaluating the performance of its utilization review contractor.
- Tightening performance expectations in the Request for Proposals (RFP) and utilization review contract, and expansion of SORM’s authority to audit its contractor for compliance with those expectations.
- Evaluation of whether contracting with another private or public insurance carrier to conduct utilization review activities would improve the quality of SORM’s medical management. One of the challenges SORM has in the next biennium is to ensure that its staff and its utilization review contractor become familiar with the application of Medicare payment policies, since TWCC’s recently adopted Medical Fee Guideline will, when effective, require all medical bills to be reviewed under these new standards. SORM should consider whether aligning its utilization review activities with another insurance carrier’s would improve

SORM's transition from the old workers' compensation ground rules to the new Medicare's payment policies as required by HB 2600 and TWCC's 2002 Medical Fee Guideline.

If the regional health care networks are deemed feasible by the HNAC, SORM and other self-insured state entities will be required to offer this network option to their employees. If these regional networks are effective at reducing medical costs and improving the quality of care, it will likely set the stage for discussing whether all state employees should be required to use network medical services in the future.

B. RECOMMENDATIONS FROM OTHER STATE AGENCIES

Texas Workers' Compensation Commission (TWCC) Recommendations

The following legislative recommendations (numbers 18-40) are presented as they were written by TWCC staff and approved by TWCC Commissioners in September 2002. A ROC staff response is attached to each.

18. Amend the Texas Workers' Compensation Act to provide for two-year terms for the six TWCC Commissioners. (TWCC Recommendation 1)

TWCC Recommendation: The 76th Legislature (1999) amended the Texas Constitution to require that all agency governing boards either serve two-year terms or be composed of an odd number of three or more members, by September 1, 2003. Since the Commission's six governing board members serve six-year terms, either the number of Commissioners or the length of the members' terms will have to be statutorily modified during the 78th Legislature. It is the opinion of the current Commissioners that the balance in the number of Commissioners representing employers and wage earners has profoundly and favorably influenced the manner in which the state's workers' compensation statutes have been administered and how policy decisions have been made. In order to retain this balance and meet constitutional requirements, the Commissioners strongly urge the Legislature to provide for two-year terms for the members of the Texas Workers' Compensation Commission.

ROC Staff Response: ROC staff generally supports this recommendation. One concern with limiting terms to two years is that, given the learning curve involved with workers' compensation, shorter terms may make orienting new TWCC Commissioners to the system more challenging and possibly reduce the continuity of agency rulemaking. Though they have not been used in the past when six-year appointments were in place, reappointments may provide an opportunity to maintain continuity longer than two years.

19. Audit and Enforcement Authority. (TWCC Recommendation 2)

TWCC Recommendation: Affirm the Commission's responsibility and authority to review and audit entities other than carriers and provide for the Commission to bill the cost of those audits. Affirm the authority of insurance carriers to review and audit health care providers and other billing entities. Provide authority to the Commission to bill for audits regardless of whether the provider has been found in violation of a Commission fee or utilization guideline.

ROC Staff Response: ROC staff generally agrees with this TWCC recommendation, with the conditions described below.

- **TWCC Review and Audit Authority:** ROC staff agrees that recent court decisions and legal arguments raised in other litigation have created uncertainty regarding TWCC's statutory authority to audit and review entities other than insurance carriers (e.g. health care providers). Although a request for Supreme Court review of one decision is pending, the Texas *Labor Code* should clarify that TWCC's authority to review the conduct of participants in the system includes audit and review of records authority, as was intended by the 1989 reforms. TWCC audit and review authority has not been significantly challenged until this point, and this authority is critical to the successful implementation of the 1989 reform act and the recent HB 2600 provisions aimed at controlling the practices of certain abusive health care providers and insurance carriers.
- **TWCC Ability to Bill for Audits:** ROC staff also supports TWCC's request for authority to bill health care providers for audits absent a finding of a violation of a fee or treatment guideline, but only in some cases. It seems reasonable that TWCC be able to collect the cost of those audits from providers only if certain procedural safeguards exist. Specifically, the Texas *Labor Code* and TWCC rules should provide that TWCC may recover the cost of a health care provider review if the audit was initiated based on a good faith belief that the provider's practices were excessive or of questionable value to the recovery of the provider's patient, or a similar standard.

Also, the Texas *Labor Code* and TWCC rules should afford a medical provider with the opportunity for a due process review of TWCC's charges if the provider challenges the charge based on expert opinion evidence. Some health care providers have asserted that TWCC's audit and review charges are excessive and unreasonable given the scope and the quality of the review. TWCC reports that review and audit charges for medical issues can range from \$800 to \$10,000, depending on the scope and complexity of the review. If TWCC is to be given broader authority to charge for reviews and audits of health care providers, it should also be required to prove up the reasonableness of the charge if the audited party challenges the amount as unreasonable.

Health care provider audits that are not related to a good faith TWCC belief of abusive or unwarranted practices (i.e., general compliance audits, as compared to targeted individual health care provider audits) should continue to be funded by the system as a whole.

- Insurance Carrier Audit Authority: ROC staff agrees that the Texas *Labor Code* should be clarified to reinforce the fact that insurance carriers are authorized to audit the medical and billing records of health care providers who submit bills for payment. Litigation over TWCC's 1996 Medical Fee Guideline appears to have called into question the authority of carriers to perform on-site audits. While carrier audits are an important part of the system and should be allowed, the statute and/or TWCC regulations should also establish procedural safeguards to ensure that these audits are appropriate in scope and warranted by the facts to avoid unnecessary business interruption or harassment.

20. Defense of Medical Quality Review Panel (MQRP)/Doctors Acting on Behalf of the Commission. (TWCC Recommendation 3)

TWCC Recommendation: MQRP members and other doctors acting on behalf of the Commission have statutorily limited liability when acting in good faith in the execution of their duties as panel members, but they are not immune from suit. Amend the *Labor Code* to provide Office of Attorney General representation if sued, and to authorize litigation insurance coverage to be purchased by or on behalf of the Commission.

ROC Staff Response: ROC staff agrees that the TWCC Medical Advisor and other doctors acting on behalf of TWCC by contract or employment (including MQRP members) should be protected by the state from the burdens of defense of litigation when acting in good faith in this capacity. TWCC and the Office of the Attorney General should attempt to reach a written agreement to provide the necessary legal representation. If, however, TWCC and the Attorney General are unable to come to an agreement, then ROC staff recommends that the statute be amended to ensure that the Office of Attorney General provides legal representation if the Medical Advisor or MQRP panelists are sued based on the good faith execution of their duties.

Additionally, TWCC should be allowed to obtain litigation protection insurance coverage with the approval of the State Office of Risk Management (SORM) in coordination with the Office of the Attorney General. Currently, TWCC asserts that the statute prohibits it from purchasing this type of insurance coverage for MQRP members, since they are contractors and not state employees. If the statute does prohibit TWCC from purchasing coverage for MQRP members, then ROC staff recommends that the Texas *Labor Code* be amended as necessary to allow this to occur.

21. Appeal of an Independent Review Organization (IRO) Decision to the State Office of Administrative Hearings (SOAH). (TWCC Recommendation 4)

TWCC Recommendation: The existing statute, *Labor Code* Section 413.031, requires that disputes as to medical necessity be resolved by an Independent Review Organization (IRO), and allows a party who disagrees with the IRO decision to appeal to the State Office of Administrative Hearings (SOAH), which conducts a hearing. TWCC proposes amending the statute to state that an IRO decision ends the dispute process, just as it does in the Health Maintenance Organization (HMO) IRO model, rather than the decision being appealed to SOAH. By incorporating the IRO process for workers' compensation medical necessity disputes, decisions as to medical necessity are made by qualified health care providers. SOAH reviews of IRO decisions are not conducted or decided by health care providers.

In addition, costs charged to the Commission by SOAH have increased significantly during recent years. Unlike most agencies which have disputes resolved by SOAH, many of the disputes for which TWCC is obligated to pay SOAH do not involve TWCC directly. The disputes are often between an injured worker and a carrier or a health care provider and a carrier. TWCC has no control over what is taken to SOAH by the third parties, nor any control or influence over SOAH's costs of adjudicating the matter. In fiscal year 2002, TWCC's cost for SOAH hearings was approximately \$280,000.

ROC Staff Response: ROC staff understands the spirit of this recommendation to further streamline the process, but disagrees that the time is appropriate to make the recommended change.

As discussed in the Effective Delivery of Benefits section of this report, the Medical Dispute Resolution process was entirely overhauled through HB 2600, and ROC staff feels it is simply too early to implement TWCC's recommendation, or even to evaluate its merits. In response to this recommendation, health care providers and insurance carriers both stated that they value the safeguards offered by the SOAH administrative

hearing option, which allows for a full development of the facts, and ROC staff has received negative feedback on this recommendation from a number of system participants.

It is true that SOAH's costs (which one could argue are analogous to court costs) are charged to TWCC, while in civil court these costs are usually ordered paid by the losing party. Specifically, TWCC bears the cost of the SOAH administrative hearing, while the opposing parties bear the cost of their lawyers and experts. However, this is not inconsistent with the income benefit dispute resolution process, in which TWCC is charged with mediating and deciding disputes in which the agency is also not a party.

ROC staff also understands TWCC's concerns about the budgetary implications of payment for SOAH hearings, and believes these issues should be re-visited after the HB 2600 provisions regarding medical regulation and dispute resolution reforms have had more time to mature. In the meantime, ROC staff agrees that TWCC should be adequately funded to provide access to the SOAH dispute resolution mechanism. TWCC has requested additional funding for SOAH costs of \$261,000 in FY 2004 and \$278,000 in FY 2005. Although not certain, it is reasonable to expect SOAH funding requirements to peak at some point after the HB 2600 reforms and then gradually diminish, as adopted medical regulations become more stable and medical practice abuses are more effectively controlled. In addition, ROC staff understands that as a part of SOAH's Sunset Review process (which is currently underway), various funding options for state agencies that utilize SOAH, such as TWCC, are currently being discussed. These funding options may help alleviate some of the financial burdens of agencies that often incur SOAH hearing costs.

22. Admission of Evidence at SOAH. (*TWCC Recommendation 5*)

TWCC Recommendation: Amend the statute to prohibit introduction of new evidence at SOAH unless there is good cause. This provision is currently in Commission Rule

148.18(a), but SOAH has declined to enforce it, allowing parties to present for the first time evidence they could and should have presented to the Commission or to the IRO for review. This increases expenses for all parties at the SOAH level, including the Commission.

ROC Staff Response: ROC staff generally agrees that a full development of the facts at the lowest stage in dispute resolution is preferred. However, ROC staff disagrees with the TWCC recommendation at this time because the TWCC medical dispute process is currently a paper review process that does not offer the parties the opportunity for discovery or argument, and because limiting additional evidence at SOAH could compromise the quality of evidence available for SOAH decisions.

In addition, removing the prospect of introducing new evidence at SOAH could, depending on the outcome of litigation and other proposed statutory changes, leave insurance carriers with very limited ability to perform reviews of medical services as the system envisions. For example, if current court decisions disallowing the ability of insurance carriers to audit health care providers stand (or are not clarified in statute), carriers would have no ability to audit a health care provider, no ability to engage in discovery at TWCC, and limited ability to add evidence at SOAH.¹⁵⁸

Both health care providers and insurance carriers need the protection of full discovery and development of the facts at SOAH until the HB 2600 reforms and prescribed medical regulations are more mature, and TWCC can ensure high quality decisions on both medical necessity disputes and medical fee disputes.

¹⁵⁸ See Supreme Court of Texas, *Texas Workers' Compensation Commission v. Patient Advocates of Texas and Allen J. Meril, M.D.*

23. Appeal of Commissioner-Imposed Sanctions. (TWCC Recommendation 6)

TWCC Recommendation: Clarify that a sanction imposed on a doctor by action of the TWCC Commissioners is binding during any appeal from the Commissioners' action. If a doctor is removed from the ADL or otherwise sanctioned, the removal should be effective during any appeals to SOAH or the courts because of the lengthy time appeals take until final.

ROC Staff Response: The Texas *Labor Code* and rules adopted by TWCC authorize the Commissioners, by majority vote, and after notice and the opportunity for a hearing, to impose a sanction that deprives a person of the right to practice or right to receive remuneration in the workers' compensation system for greater than 30 days. ROC staff agrees, in principle, that allowing a doctor to continue to practice in the system during appeal of TWCC-imposed sanctions undermines TWCC's ability to impose meaningful sanctions and remove problem doctors from the system.

However, ROC staff also feels that this recommendation should be viewed in the light of creating a balance between the rights of an accused versus the need of the state to quickly control behavior that poses an immediate public health risk. One option to balance these interests would be to establish that TWCC may impose restrictions on a doctor's practice that are binding during the pendency of an appeal, but stopping short of allowing for a full suspension pending appeal. Applicable restrictions on a doctor's practice could include required carrier pre-certification for all or certain medical services, required monitoring by an assigned peer, or others.

In the event of more serious threats to the public health where quick suspension seems warranted, TWCC should petition the appropriate regulatory entity (e.g., Texas Board of Medical Examiners (BME) or Texas Board of Chiropractic Examiners (BCE)) to use its statutory authority to suspend or revoke a provider's license. In an effort to ensure that TWCC, BME, and BCE work together to protect injured workers from inappropriate and potentially dangerous medical practices, ROC staff recommends that TWCC enter into a

Memorandum of Understanding (MOU) with both of these licensing boards. This MOU could govern how TWCC sends its referrals, along with the evidence it had gathered during MQRP quality of care reviews, to BME and BCE, and how these entities would process, review, and potentially take action against providers who meet a mutually-agreed upon definition of a “public health risk.” Furthermore, the legislature should consider whether amending the Medical Practice Act to eliminate confidentiality barriers that make it difficult for the BME, BCE, and TWCC to share information and cooperate on joint investigations would facilitate medical enforcement activities in the workers’ compensation system.

24. *Downs Decision. (TWCC Recommendation 7)*

TWCC Recommendation: Amend *Labor Code* Section 409.021 to provide that an insurance carrier is not required to notify the Commission within 7 days of written notice of injury, of its intent to pay income or death benefits, if benefits have not yet accrued. This amendment would prevent the submission of thousands of TWCC-21 forms to the Commission certifying that income/death benefits will be paid as and when they accrue, as these types of notice have no direct impact on the delivery of income/death benefits to the injured employee. This method would also, in accordance with HB 2511, 76th Legislature, reduce the volume of paper in the workers’ compensation system. It will not affect the delivery of benefits to the injured employee or proper notice to the employee and the Commission.

ROC Staff Response: Please refer to ROC’s discussion of the *Downs* issue in the previous portion of the Recommendations section.

25. Generic Substitutions. (TWCC Recommendation 8)

TWCC Recommendation: The Texas Pharmacy Act, Section 562.009 (*Occupations Code*) requires a pharmacist to either inform patients of their right to refuse generic equivalent substitution or to display a sign that informs patients of their right to refuse generic substitution. Although in many non-workers' compensation insurance plans the patient is required or permitted to pay a co-payment and the patient may refuse a generic substitution in those plans, the Commission's position is that a claimant may *not* do so in the Texas Workers' Compensation system. The Pharmacy Board has taken the position that the workers' compensation patient *does* have the right to refuse a generic substitution. Amend the statute to affirm that a workers' compensation patient may not refuse a generic substitution unless the prescribing doctor has prohibited the substitution of a generically equivalent drug by writing on the prescription "brand necessary" or "brand medically necessary."

ROC Staff Response: ROC staff agrees that the Texas *Occupations Code* and the Texas *Labor Code* should be aligned to eliminate this conflict. However, ROC staff disagrees that TWCC's recommended solution is the best way to reconcile this conflict.

One broadly supported objective of HB 2600 was to align workers' compensation administrative requirements with those of other health care systems except when differences must be maintained to accomplish unique occupational injury management functions. Allowing the worker the option to choose a brand name drug (and pay the difference) while ensuring the system does not pay for that higher but not medically required option is more consistent with the HB 2600 objective to align workers' compensation with other health systems, and this option should be incorporated into the Texas *Labor Code*. However, any statutory change to allow an injured worker to pay for a brand name drug when a generic is prescribed should also specify that the worker is not entitled to seek reimbursement or dispute a denial of reimbursement in this situation.

26. Records Access. (TWCC Recommendation 9)

TWCC Recommendation: Specify that *all* system participants are required to cooperate with the Commission and provide access to records. Currently the statute only says insurance carriers.

ROC Staff Response: ROC staff agrees with clarification of the statute in this area. Any system participant who provides services or seeks reimbursement for services under the auspices of the Texas *Labor Code* and TWCC Rules is subject to TWCC's enforcement authority and therefore should be required to provide TWCC with access to records as necessary to ensure adequate compliance.

27. Sanction Authority. (TWCC Recommendation 10)

TWCC Recommendation: HB 2600 greatly expanded the Commission's authority to take actions to ensure quality of care in the system. However, the language in Section 408.0231 only provides for sanctions of doctors and carriers while omitting other providers. While the treating doctor is responsible for ensuring efficient utilization of care etc., other types of health care providers have important roles and should be subject to appropriate sanctions.

ROC Staff Response: ROC staff agrees in principle that TWCC should have appropriate regulatory authority to control abuses from all types of health care providers in the system (e.g., physical therapists, nurses, etc.). However, given the relatively small numbers of health care provider quality reviews initiated so far under TWCC's authority, ROC staff does not recommend expanding TWCC authority to impose sanctions on other types of health care providers at this time. ROC staff believes that TWCC should be encouraged to use its existing sanction authority to regulate all types of treating and insurance doctors (including M.D.s, chiropractors, and osteopaths) and, after gaining

meaningful experience in the use of these sanctions, request that the legislature broaden this authority to include other types of health care providers.

28. Immediate Suspension from Approved Doctor List (ADL) Pending an Expedited Hearing. (TWCC Recommendation 11)

TWCC Recommendation: Amend the statute to provide for an immediate suspension of a provider whose conduct endangers the public or injured employees, followed by an expedited hearing. Several licensing boards have this authority, including the Board of Medical Examiners, the Pharmacy Board, the Chiropractic Board, the Dental Board, and the Physical Therapist Board.

ROC Staff Response: See ROC staff response to TWCC recommendation #6.

29. Reimbursement from Subsequent Injury Fund (SIF) for Summary Judgment. (TWCC Recommendation 12)

TWCC Recommendation: Existing law allows an insurance carrier to seek reimbursement for any overpayments of benefits made under an interlocutory order or decision, if that order or decision is "reversed or modified" by final arbitration, order, or decision of the commission or a court. Existing law also states that, for purposes of reimbursement from the SIF, the following do not constitute a modification or reversal of an appeals panel decision: a settlement before judgment, an agreed judgment, or a default judgment. These provisions, in part, provide needed disincentive for an insurance carrier to appeal a case for the sole purpose of securing reimbursement from the SIF (e.g., if all income benefits have already been paid, the carrier may file for judicial review of an appeals panel decision; the claimant may be a no-show, as there are no income benefits due in the future.) The SIF has now been receiving requests for reimbursement based upon a Summary Judgment in court. A summary judgment may be based upon as little as a single affidavit or a request for admissions to which there is no response ("deemed

admissions"). The number of summary judgments based on deemed admissions has increased significantly. As is the case with agreed and default judgments, carrier reimbursement should not be based upon a summary judgment supported only by a request for admissions for which no response has been filed. This statutory change will benefit claimants by preventing future medical benefits being shut-off by the court without evidence.

This was a 2001 Commission legislative initiative.

ROC Staff Response: ROC staff agrees that summary judgments based on a single affidavit or "deemed admissions" are potentially problematic for the SIF if TWCC chooses not to intervene in these cases. However, barring SIF reimbursements for all summary judgments to get at the few mentioned here is also problematic, since a summary judgment is based on a finding of evidence.¹⁵⁹ ROC staff disagrees with this recommendation for the same reasons stated in its response in the 2000 *Biennial Report*: namely, that it would deny an insurance carrier a legitimate recovery if the injured worker or TWCC failed to answer and defend the suit. ROC staff understands that a select number of system participants are responsible for the majority of these types of summary judgment requests, and suggests that once TWCC receives notice of appeal from one of these system participants, it intervene to ensure that the SIF is protected from unsubstantiated reimbursement requests and that the worker involved is protected from having his or her future medical benefits cut off by failure to respond. To ensure that TWCC receives advance notice of appeals and has the opportunity to intervene prior to a settlement or summary judgment, the 75th Legislature amended Section 410.258 of the Texas *Labor Code*, at the request of TWCC; this change should help TWCC identify cases where intervention is appropriate.

30. Filing of Court Petitions and Appeals. (TWCC Recommendation 13)

¹⁵⁹ TWCC reports that in FY 2001, 12 out of 106 requests paid by the Subsequent Injury Fund were these types of summary judgments.

TWCC Recommendation: Amend Section 410.253 of the Texas *Labor Code* to ensure the Commission receives notice of every petition and notice of appeal at the time it is filed with the district court or court of appeals. In the past, the Commission has not been notified of petitions and/or appeals filed involving the interpretation of Commission rules. As a result, the Commission could not timely intervene in the trial court proceedings and was not able to present evidence on behalf of the Commission. The existing statute does not provide a penalty for failing to notify the Commission. It is important the Commission receive notice of every petition and/or notice of appeal filed so the Commission may intervene, when appropriate, to represent the Commission's interests in these proceedings.

This 2001 Commission legislative initiative was sponsored by Rep. Kenn George (HB-3212) last session. The bill was reported favorably from the House Committee on Business and Industry as amended and recommended for the House Local and Consent Calendar where it died.

ROC Staff Response: ROC staff supports this recommendation and agrees that TWCC should receive notice of every petition and notice of appeal at the time it is filed with the district court or court of appeals, and that the court should not have jurisdiction if TWCC is not put on notice. It should be noted, however, that *Labor Code* Section 410.258 already provides for advance notice to TWCC of a pending settlement or judgment. TWCC indicates that it must already prioritize constitutional issues and major statutory challenges, so it is unclear whether the agency has adequate resources to intervene in every lawsuit that involves a TWCC rule even if it were aware of them.

31. Admissibility of Commission's Administrative Hearings Record in Court. (TWCC Recommendation 14)

TWCC Recommendation: Amend Section 410.306(b) to make the Commission's hearing records admissible in court. The Texas *Labor Code* requires that the appeals panel *decision* be submitted to the jury and considered by the judge. Although the statute

also requires that the Commission make a certified copy of the TWCC record available to the judicial review parties, it also limits the admissibility of that record. A recent Texas Supreme Court decision held that a person's testimony at a TWCC hearing is not admissible unless that person is unavailable as a witness for the trial court hearing. *National Liability v. Allen*, 155 S.W.3d 525 (Tex. 2000). The impact of that ruling requires parties to call or depose witnesses that are available, resulting in substantial expense for all parties, including the Commission and the party in whose favor the Appeals Panel ruled. A defending party may not have the resources to do this. Amending the Act to admit evidence preserved at the Commission hearings will reduce expenses of the Commission and of other parties, necessary to call and/or depose witnesses for court cases, while still allowing additional evidence under the modified de novo appeal established in the Act.

This was a 2001 Commission legislative initiative.

ROC Staff Response: ROC staff disagrees with this recommendation for the same reasons it did not support it in the 2000 *Biennial Report*. TWCC has not established a compelling reason that supports the need to allow the admissibility of testimony taken at a TWCC hearing rather than the current evidentiary framework. Even assuming the admissibility of a TWCC hearing record, it is doubtful that the judge hearing the case would give much weight to TWCC hearing testimony, since it was not taken pursuant to the Texas Rules of Civil Procedure and there is no opportunity to cross-examine the witnesses. Additionally, allowing the admissibility of the TWCC hearing record could introduce hearsay and unsupported medical opinions into the court record.

32. RME Statutory Text. (TWCC Recommendation 15)

TWCC Recommendation: HB 2600 made numerous changes in the way RMEs are utilized in the system but an inconsistency was created. For example, an RME can not be used for MMI/IR purposes unless there has first been a Designated Doctor (DD) exam. By statute, this DD report has presumptive weight, yet the statute still provides that the carrier can suspend TIBs based upon the RME doctor's opinion that the employee has

reached MMI, if the Commission does not hold a BRC within 10 days. Few DD decisions are overturned and this provision in Section 408.004(f) regarding RMEs should be deleted.

ROC Staff Response: HB 2600 requires the ROC to evaluate the impact of the Article 5 provisions that re-ordered designated doctor and required medical examinations (RME) regarding impairment ratings and dates of maximum medical improvement, and report its findings to the Texas Legislature by December 31, 2004. Given the fact that this evaluation has not taken place, and that prior to HB 2600 insurance carriers also had the right to suspend benefits based on a RME exam even if there was a designated doctor exam on the record, ROC staff disagrees with this recommendation at this time. Since the statute requires TWCC to automatically issue an interlocutory order to pay benefits if it cannot hold an expedited Benefit Review Conference (BRC) within 10 days, the injured worker is protected from having his or her income benefits cut off completely under the current statutory structure.

ROC staff suggests that this recommendation be revisited in 2005 once ROC's evaluation of Article 5 can be completed and TWCC's monitoring program for designated doctor examinations is implemented.

33. Deceptive Practices. (*TWCC Recommendation 16*)

TWCC Recommendation: Add a statutory provision prohibiting a business from using the acronym TWCC or the term "Workers' Compensation Commission" or any acronym or term deceptively similar to those words or initials that create the impression that the business is affiliated with, sponsored or approved by the Commission. The proposed statute should provide for civil penalties, administrative penalties and injunctive relief and should allow TWCC to recover investigative costs if a violation is proven.

This 2001 Commission legislative initiative was sponsored by Rep. Kenn George (HB-3213) last session. The bill was reported favorably from the House Committee on

Business and Industry and recommended for the House Local and Consent Calendar where it died.

ROC Staff Response: ROC staff agrees that the use of deceptive names, logos and state seals should be prevented to avoid confusion on the part of injured workers. The Office of the Attorney General should have the authority to deter this conduct. If it does not have adequate authority to prevent these deceptive practices, then ROC staff recommends additional statutory language and authority be provided to deter and prosecute these cases.

Note: TWCC described the following five recommendations as designed to accomplish paperwork reduction.

34. Mailing "Rights and Responsibilities" to Employer. (TWCC Recommendation 17)

TWCC Recommendation: The existing statute, Section 409.011 of the Texas *Labor Code*, requires that the Commission mail this statement to the individual employers annually. Amend the statute to require carriers to provide a *Statement of Employers' Rights & Responsibilities* to the employer when the policy is issued, and to state that Commission will provide employers and the public at large with access to "rights and responsibilities" and place them online. This change supports the paper reduction goals of HB 2511, 76th Legislature, by providing substantial paper and postage savings and encourages online public access to information.

ROC Staff Response: ROC staff generally agrees that the process by which educational notices are distributed to employers, as well as other parties in the system, could be more efficient. In this vein, ROC staff would support a statutory change to require that the insurance carrier provide its policyholder with a notice that describes how the policyholder can access a copy of the *Statement of Employers' Rights & Responsibilities* from TWCC's website or by mail, if the policyholder does not have access to the Internet. To reduce paperwork burdens for insurance carriers, ROC staff recommends

that this notice be incorporated into the policyholder's proof of coverage form or provided in another convenient insurance carrier mailing to the policyholder.

35. TWCC-2, Employer's Request for Reimbursement. (TWCC Recommendation 18)

TWCC Recommendation: The existing statute, Section 408.003(c), requires an employer to file a copy of the employer's request for reimbursement with the Commission. Amend the statute to state that this form does not have to be filed with the Commission unless requested by the Commission, but must continue to be filed with the carrier. TWCC has no need for this piece of paper and any impact that the employer's payments (full salary continuation) may have on indemnity benefits is reported to TWCC electronically. This change supports the paper reduction goals of HB 2511, 76th Legislature. Eliminating the need for this filing will save TWCC staff time by discontinuing data entry of receipt and system generation of letter that acknowledges receipt. Additional staff time will also be saved in TWCC central and regional mailrooms where these forms are received, sorted, date stamped, filed, and eventually microfilmed.

ROC Staff Response: ROC staff agrees with TWCC's recommendation.

36. TWCC-5, Employer's Notice of No Coverage or Termination of Coverage. (TWCC Recommendation 19)

TWCC Recommendation: The existing statute, Sections 406.004 and 406.007 require an employer to file a copy of this notice with the Commission. Amend the statute to state that this form does not have to be filed with the Commission unless requested by the Commission. The Commission receives quarterly data extracts from Texas Workforce Commission that identify Texas employers. The covered employer information received through the Proof of Coverage process allows the Commission to subtract the number of covered employers from the Workforce Commission employer data to determine employers that are not covered. TWCC receives benefits in staff time not receiving,

sorting, stamping, data entering, filing, and microfilming these forms. This change also supports the paper reduction goals of HB 2511, 76th Legislature.

ROC Staff Response: ROC staff agrees that historically there has been little compliance with the reporting requirements for the TWCC-5 form, and that TWCC's Proof of Coverage process may be able to identify employers who are nonsubscribers through a process of elimination. However, as it stands the TWCC-5 is the only "official" notice of non-coverage provided by nonsubscribers and can serve as an important validation tool for TWCC until the Proof of Coverage process can be fully implemented. In addition, one of the original reasons for including the TWCC-5 reporting requirement was to remind employers of their responsibility to report their coverage status to their employees, and it may increase the likelihood of this notification occurring. ROC staff also suggests that the TWCC-5 form could serve as a valuable tool for collecting coverage and (if slightly revised) alternative occupational benefit plan information. The TWCC-5 form can also be used by TWCC to track compliance with the nonsubscriber report of injury requirement. ROC suggests revisiting this recommendation once TWCC's Proof of Coverage process is fully implemented and further recommends that in the interim, TWCC evaluate whether this reporting requirement can be accomplished electronically through TWCC's BPI redesign process.

37. Independent Contractor Coverage Records (Joint Agreements). (TWCC Recommendation 20)

TWCC Recommendation: Amend *Labor Code* Sections 406.144 and 406.145 to omit the requirement for independent contractors and building and construction workers to file contractual coverage agreements with the Commission. Currently, about 95,000 such contracts are filed with the Commission annually and fewer than 75 inquiries relating to these contracts are received. This requires an inordinate amount of staff time to process and maintain. These contracts are also required to be filed with the insurance carrier and information needed by independent contractors or building and construction workers

could be retrieved from the insurance carrier by TWCC or any party requiring the information. The Commission by rule shall establish the retention requirements for parties within the workers' compensation system.

This 2001 Commission legislative initiative was sponsored by Rep. Kenn George (HB 3214) last session. The bill was reported favorably from the House Committee on Business and Industry and recommended for the House Local and Consent Calendar where it died.

ROC Staff Response: ROC staff supported this recommendation in the 2000 *Biennial Report* and generally agrees with it again, assuming that appropriate access to these records can be maintained through the carrier. ROC staff also recommends that, during the TWCC Sunset Review process, the broader issue of the value of continuing this voluntary joint agreement provision should be examined.

38. Notice of Benefit Review Conference. (TWCC Recommendation 21)

TWCC Recommendation: The existing statute, *Labor Code* Section 410.025, requires that a Benefit Contested Case Hearing (CCH) be scheduled at the time the Benefit Review Conference (BRC) is scheduled, even though many BRCs never go forward to a CCH. By requiring this CCH date be provided to the parties when the BRC is set, a great deal of confusion is created for customers and many unnecessary phone calls result. Amend the statute to state that "upon conclusion of the BRC, a CCH will be scheduled to address any unresolved issues." This should save staff time and also supports the paper reduction goals of HB 2511, 76th Legislature.

ROC Staff Response: ROC staff agrees with TWCC's recommendation.

Note: TWCC described the following two changes as administrative and/or technical clean-ups to the statute.

39. Employer reporting. (TWCC Recommendation 22)

TWCC Recommendation: *Labor Code* Section 409.005 was changed in the 1995 session to allow employers to notify carriers of injuries by telephone and assigned responsibility to the insurance carrier to provide notice of injury to the Commission via Electronic Data Interchange (EDI). The following changes are recommended for clarification and consistency:

- a) Amend Section 409.021 as follows: “An insurance carrier shall initiate compensation under this subtitle promptly. Not later than the seventh day after the date on which an insurance carrier receives ~~written~~ notice of an injury, the insurance carrier shall.”
- b) Amend Section 406.051(c) as follows:

“The employer may not transfer:

 - (1) the obligation to accept a report of injury under Section 409.001;
 - (2) the obligation to maintain records of injuries under Section 409.006;
 - ~~(3) the obligation to report injuries to the commission under 409.005;~~
 - ~~(3–4)~~ liability for a violation of Section 415.006 or 415.008 or of Chapter 451; or
 - ~~(4–5)~~ the obligation to comply with a commission order.”
- c) Amend Section 408.003(e) as follows: “If an employer does not notify the ~~commission carrier~~ of the injury in compliance with Section 409.005, the employer waives the right to reimbursement under this section.”

ROC Staff Response: ROC staff agrees with subparts (a) and (c). However, staff disagrees in part with the recommended changes in (b), and suggests that (b)(3) be amended to state “the obligation to report injuries to the insurance carrier under Section 409.005” rather than “the obligation to report injuries to the Commission under Section 409.005” since the employer still has a statutory obligation to report injuries to the insurance carrier in accordance with the statute.

**40. Correct statutory citation related to settlements or agreements. (TWCC
Recommendation 23)**

TWCC Recommendation: *Labor Code* Section 410.205 (c) was replaced by Section 410.209 during the 1999 legislative session; Sections 410.256(f) and 410.257(e), however, still make reference to the old section. Amend Section 410.257(e) as follows:

- a) Amend Section 410.256(f) to read as follows:

“Settlement or agreement of a claim or issue under this section does not constitute a modification or reversal of ~~the an appeals panel order or decision of the commission~~ awarding benefits for the purpose of Section ~~410.205~~ 410.209.”

- b) Amend Section 410.257(e) to read as follows:

“A judgment under this section based on default or on an agreement or settlement of the parties, or a summary judgment based upon deemed admissions, does not constitute a modification or reversal of an ~~appeals panel order or decision of the commission~~ awarding benefits for the purpose of Section ~~410.205~~ 410.209.”

ROC Staff Response: The changes suggested by TWCC in (a) have been recommended as a statutory citation correction. However, the change recommended in (b) is actually substantive, in that it would stipulate that a summary judgment does not qualify an insurance carrier to petition the SIF for reimbursement. ROC staff disagrees with this recommendation, as described previously.

Texas Property and Casualty Guaranty Association (TPCIGA)

41. Insurer Solvency-related Issues Identified by the Texas Property and Casualty Insurance Guaranty Association (TPCIGA). (TPCIGA Recommendation 1)

In response to ROC staff's request for input on potential *Biennial Report* issues, ROC staff received a request from the Texas Property and Casualty Insurance Guaranty Association (TPCIGA) that several issues related to insurer solvency be examined.

Specifically, TPCIGA noted the recent insolvency of the Reliance group of insurers of Pennsylvania, which accounted for approximately 5.5 percent of the workers' compensation market in Texas in 1999. Reliance was placed into liquidation in late 2001, and TPCIGA officials expect it to be the most challenging insolvency the Association has faced.

One particular concern for TPCIGA in handling Reliance's claims was the frequency of large deductible policies in which the employer buying the policy, rather than Reliance, was much more involved with the actual payment and administration of claims and would often contract with Third Party Administrators (TPAs) to assist with these duties. Since the vast majority of workers' compensation claims are not catastrophic, an employer with a large deductible policy would act essentially as a self-insured employer and pay those claims directly or through a contracted TPA. According to TPCIGA, the logistics of transferring Reliance claims files from hundreds of different sources (e.g., individual policyholders or their TPAs) – some of which resisted the requested transfer – pointed to a need for more information about the identification of TPAs by insurers in Texas. TPCIGA also asked for further examination of large deductible policies such as the type used by Reliance (essentially, self-funded and self-administered by employers) and how these may be impacted if the insurer writing the policy becomes insolvent. Suggestions offered by TPCIGA included examination of registration requirements and broader oversight over TPAs, perhaps through required registration with TWCC.

In response to the concerns raised by TPCIGA, a meeting was held in late October 2002 between Texas Department of Insurance (TDI), ROC and TPCIGA staff. After discussion about these issues, TDI staff offered to examine whether further information from insurance carriers on their use of TPAs, extent of control over these TPAs, and the frequency of the types of policies discussed would be useful in addressing the issues raised. ROC staff plans to continue to participate as needed in discussions of these and related issues, although at this point, no clear options for legislative or regulatory changes have been identified.

