WORKERS' COMPENSATION ADVISORY COUNCIL
MINUTES ~ APRIL 20, 2007 ~ MEETING [9:30 A.M.]
FIRST FLOOR HEARING ROOM
ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE

The meeting was called to order at 9:30 a.m by Mr. Dale Sims, State Treasurer. A quorum of voting members was present; therefore it was not necessary to conduct the meeting electronically. The following lists each member of the Advisory Council and indicates whether they attended the meeting:

***CHAIR:** Dale Sims, State Treasurer - Present

***VOTING MEMBERS:**

Employee Representatives

> Jack A. Gatlin - Present
> Jerry Lee - Present
> Othal Smith, Jr. - Present

Employer Representatives

> Thomas Hayes - Absent
> Bob Pitts - Present
> Gary Selvy - Present

***NONVOTING MEMBERS:**

Kitty Boyte [TDLA representative] - Present
Tony Farmer [TTLA representative] - Present
Kenny McBride [local governments representative] - Absent
Jerry Mayo [insurance companies representative] - Present
Sam Murrell, MD [health care providers representative -TMA] - Absent
A. Gregory Ramos [TBA representative] - Absent
David Stout [health care providers representative-THA] - Absent

***EX OFFICIO MEMBERS**

Commissioner Leslie A. Newman - Present
Commissioner James G. Neeley - Absent [Sue Ann Head, Administrator, Division of Workers' Compensation, was present.]

1. APPROVAL OF MINUTES

Prior to the meeting, the draft minutes for the March 16, 2007, meeting had been provided to the members for review. Mr. Selvy noted the draft minutes erroneously noted Mr. Farmer was not present at the March 16 meeting. Ms. Hughes stated she would make the correction. No other corrections or changes were suggested by any member.

ACTION: **The minutes, as amended by the notation of Mr. Farmer's presence, were unanimously approved by the voting members.**

2. PRESENTATIONS re: LOSS COSTS FILING EFFECTIVE JULY 1, 2007 FILED BY THE NCCI [National Council on Compensation Insurance, Inc.]

The Workers' Compensation Advisory Council is required Tennessee Code Annotated §§ 50-6-402(b) to meet and consider each loss costs filing submitted by the NCCI. The NCCI submitted a Law-Only Loss Cost Filing to the Commissioner of Commerce and Insurance on March 1, 2007. The effective date of the filing was July 1, 2007 and it related to the impact of changes and amendments to the Tennessee medical fee schedule since July 1, 2005, the effective date of the medical fee schedule.

During the meeting, the Advisory Council members received comments from its consulting actuary, Mr. Greg Alff; Ms. Carolyn Bergh, Practice Leader and Senior Actuary with NCCI; and Mr. Thomas Meyer, the consulting actuary to the Department of Commerce and Insurance, Thomas Meyer.

Mr. Alff noted the law-only filing included the effects of changing from the 2004 Medicare Schedule to the 2005 Medicare Schedule, which had higher conversion factors. This resulted in an increase in physician's cost of +1.8%. The second portion of the analysis was the conversion from the 2005 Medicare Schedule to the 2007 Medicare Schedule which resulted in -1.2% because several RBRVS factors had actually decreased from 2005 to 2007. The third part of the analysis involved changing from the Tennessee Geographic Practice Cost Index (GPCI) and substituting the national average GPCI. Ms. Sue Ann Head, Administrator of the Division of Workers'' Compensation, indicated the intent of the original medical fee schedule was to utilize the national GPCI. This portion of the analysis resulted in an impact of +7.0%.

Mr. Alff agreed with the NCCI''s methodology of converting the overall impact on physician''s costs (+7.5%) by multiplying the physician costs as a percentage of medical costs (52.5%) and then multiplying by the medical costs as a percentage of overall workers'' compensation costs (61%). This resulted in a total impact on overall workers'' compensation system costs of +2.4%.

Ms. Bergh testified that +2.2% of the overall +2.4% law-only filing was the result of the change to the national GPCI. She stated the changes made to the physician charges due to the

changes in Medicare from 2004 to 2007 and other smaller physician cost changes was only +0.2% of the law-only filing.

ACTION: **No specific action was required to be taken by the members regarding this agenda item.**

3. DISCUSSION AND RECOMMENDATION(S) BY ADVISORY COUNCIL re: LAW ONLY FILING

ACTION: **After discussion of the various presentations and comments of the members, the voting members of the Workers' Compensation Advisory Council unanimously approved a recommendation that the NCCI's proposed filing (law only) of +2.4% be approved effective July 1, 2007.**

4. CONSIDERATION OF AMENDMENTS TO WORKERS' COMPENSATION BILLS & COMMENTS OF MEMBERS

The Advisory Council members were requested to review proposed amendments to proposed legislation the Council had discussed in its March, 2007 meeting. The following summarizes the practical effect of the amendment and the comments of the Council concerning each proposed amendment:

- **AMENDED SB 1748 by Ketron / HB 1645 by Mumpower**
  The amendment re-wrote the original bill.

Practical Effect of Amendment

The amendment requires every person engaged in the construction industry - including principal contractors, intermediate contractors, subcontractors, sole proprietors and partners - to carry workers' compensation insurance EXCEPT those persons who build or repair their own property for their own use and those persons who perform home repairs/improvements to a residential dwelling for the owner of the dwelling - provided the total cost of the labor and materials is less than $5,000.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

The members of the Council are supportive of the concept to require any person in the construction industry to have workers' compensation insurance. They believe the amendment is a good policy that moves the state toward a better system in terms of coverage and provides more clarity as to who is required to have workers compensation coverage and who is not.

The members of the Council have concerns related to the language in Section 1(b) of the proposed amendment (the exemption for any sole proprietor or partner who performs maintenance, repair or improvements on a residential dwelling provided the total cost is less than $5000). Although the members understand the intent of the supporters of the amendatory language is that the exemption applies only when there is a direct agreement or contract between the sole proprietor/partner and the homeowner, Section 1(b) does not include such language.

The voting members suggest Section 1(b) could potentially be improved by clarifying the intent of the provision is that there be a direct relationship, direct contract or direct agreement between the sole proprietor/partner and the homeowner to eliminate the possibility of a person trying to defeat the purpose of the exemption if the language of Section1(b) is left unchanged.

- **AMENDED SB 445 by Burchett / HB 454 by Hackworth**

Practical Effect of Amendment

This amendment makes it clear that in order for a health care provider to be paid less than the amount set out in the medical fee schedule there must be a contract directly between the health care provider and the employer, pool or trust, insurer or network administrator. The amendment specifically prohibits an entity who has a contract with a health care provider from selling or assigning the negotiated fees to another entity. Finally, the amendment clarifies those instances in which negotiated fees in commercial health insurance can be applied to workers' compensation services by requiring a contract that specifically permits such application.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

EMPLOYER REPRESENTATIVES:

Mr. Bob Pitts — Mr. Pitts stated he had two concerns about the amendment as drafted:

1. The language that prohibits the negotiated rates from being "accessible to" any party other than the one that has a direct contract with the provider could prohibit an employer, trust/pool or someone from simply learning what the negotiated rates are.
2. The amendment, as drafted, would appear to prevent an owner (or estate of the owner) of a company that functions as a "network administrator" and has direct contracts with providers for discounted rates from selling the business to another person or entity because the provider contracts could not be assigned to the new owner.

ATTORNEY REPRESENTATIVES:

Mr. Tony Farmer — Mr. Farmer stated he thinks this amendment will solve the problem that has arisen in East Tennessee where providers are receiving payments at a discounted rate from an entity with which there is no agreement to accept a payment less than the medical fee schedule.

INSURANCE COMPANY REPRESENTATIVE:

Mr. Jerry Mayo — Mr. Mayo had concerns that the proposed amendment will hurt small self-insured employers who are not large enough to negotiate their network of providers who will agree to accept payments less than the medical fee schedule. He stated he needs more time to analyze the language of the amendment to determine whether the insurance industry can support the amendment.

- **AMENDED SB 496 by Burchett / HB 1603 by Overbey**

Practical Effect of Amendment

The amendment nullifies the rules adopted by the Department related to penalties for violating the medical fee schedule. The amendment requires the payor to (1) notify the health care provider of the overpayment, (2) give them an "appropriate" time to respond and (3) exhaust all appeals before any civil penalty can be assessed by the commissioner.

Neither the amendment nor any other statute or rule defines what is to be considered an "appropriate" time for the response to be made by a provider to a payor who notifies the provider of an overpayment. In addition, there are no statutes or rules that create a right to appeal any issue associated with a payor's payments made in excess of the fee schedule.

Therefore, practically speaking, it will be impossible for any payor to meet the criteria set out in the amendment. Thus, it appears the commissioner could never penalize a provider for violating the medical fee schedule.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

After an opportunity to hear from representatives of the Tennessee Hospital Association and the Administrator of the Division of Workers' Compensation and after further discussion of the amendment, the Advisory Council members unanimously urge the sponsors to consider an amendment to SB496/HB1603 that provide that no penalty will be assessed for pattern or practice for any acts occurring before July 1, 2008. This would give the interested parties an opportunity to think through the bigger issue of whether there is a need to penalize at both the provider and payor level.

AMENDED SB 1474 by McNally / HB 1518 by Hackworth

The amendment re-wrote the original bill and addressed a subject entirely different from the subject matter of the original bill.

Practical Effect of Amendment

The bill alters the current medical fee schedule which does have a bifurcated reimbursement system dependent on whether the physical/occupational therapy is provided by an independent facility or a physician affiliated facility. The reimbursement rate is less for services provided by a physician affiliated facility than the rates provided to the entity that is not associated or affiliated with a physician. The amendment does provide a mechanism where a bifurcated reimbursement system can be implemented if over-utilization occurs in one type facility.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

Mr. Dale Sims, Chair, questioned how passage of the amendment to eliminate the bifurcated payment system for physical therapy and occupational therapy will affect the amount of reimbursement for all providers of these services. Whether it will result in an increase in reimbursement rates or a decrease in reimbursement rates will depend on the actions the Department of Labor will take to amend the medical fee schedule to set a new reimbursement rate. Either way, it will have a fiscal impact on local and state governments.

The members of the Advisory Council observed that if the amendment passes as drafted, it would preclude the Department of Labor/WFD from determining if there is overutilization of physical therapy/occupational therapy in the workers' compensation arena regardless of the ownership of the OT/PT entity.

EMPLOYER REPRESENTATIVES:

Mr. Bob Pitts

Mr. Pitts suggested the sponsors consider changing the effective date from "immediately on passage" to a specific date in the future to permit the Department sufficient time to promulgate rules implementing the change.

Mr. Pitts observed the amendment authorizes a bifurcated system only if the Department shows such a system will control overutilization. As drafted, it precludes the Department from adopting a bifurcated system to see if it could control overutilization regardless of ownership of the facility.

ATTORNEY REPRESENTATIVES:

Ms. Kitty Boyte — Ms. Boyte suggested the rule that limits the number of PT/OT visits an employee should resolve overutilization issues. She observed that a treating doctor probably has more confidence in the expertise of physical therapists over whom s/he has control.

EX OFFICIO MEMBERS

Ms. Sue Ann Head — Ms. Head, the Administrator of the Division of Workers' Compensation, noted the Department adopted the bifurcated system of payment based on data from the Workers' Compensation Research Institute and the National Council on Compensation Insurers. The Department is in the process of obtaining medical data from insurance companies that will provide more detailed information from which to evaluate the bifurcated system and overutilization. Until they have finished the collection and analysis of the data necessary to make a determination as to the effectiveness of the bifurcated system, they do not favor the bill.

▸ **AMENDED SB 322 by Haynes / HB 1818 by Hackworth**

Practical Effect of Amendment
In those instances where the Commissioner orders two carriers/self-insured employers to pay benefits to an injured employee, the Commissioner is authorized to require them to equally pay any expenses associated with the claim.

The Joint Committee would cease to exist as of June 30 this year without the amendment that extends the Committee for five (5) years.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

The members of the Council had no comments concerning the specific amendments presented by the sponsors. However, they did have additional comments concerning the issue addressed by the main bill.

EMPLOYEE REPRESENTATIVES:

Mr. Jerry Lee — Mr. Lee stated anything that can be done to expedite payment to injured employees must be done because the employee can be harmed substantially to wait a long period of time to receive benefits until the issue of which carrier is responsible is resolved. A large payment two years later does not help the employee financially after they have lost their house, etc.

ATTORNEY REPRESENTATIVES:

Ms. Kitty Boyte — Ms. Boyte stated she understands the bill is trying to address the problem when an employee finds himself in a Catch 22 of which carrier has coverage. She noted, however, the issue is going to become a real quagmire in more types of cases given the present state of case law as to when the date of injury occurred, especially in gradual injuries situations. The Supreme Court has issued inconsistent decisions concerning when the date of injury occurs in gradual injury cases [when the injury first mentions the problems; when the employee first filled out a report; when the employee first misses work irrespective of when the report is filled out]. She suggested it may be a bad time to try to require carriers to share coverage because there will probably be more cases than expected.

Mr. Tony Farmer — Mr. Farmer suggested the two insurance carriers are in a better position to bear the financial burden of waiting until the issues are resolved than the injured worker who is not able to work.

INSURANCE COMPANY REPRESENTATIVE:

Mr. Jerry Mayo — Mr. Mayo suggested the bill should address which carrier is going to actually adjust the claim in addition to addressing the sharing of expenses.

▸ **AMENDED SB 425 by Crutchfield / HB 1822 by Buck**

Practical Effect of Amendment

It appeared the intent of the amendment is to reduce the cost to the department for providing copies of the records, as required by the original bill. The amendment puts the burden on the producing party to supply copies to the other party and if there is something that is to be copied by the department, the amendment sets the reimbursement rate at the same rate for copying medical records as contained in *TCA* §50-6-204(a)(1).

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES:

Mr. Tony Farmer — Mr. Farmer said the intent of the amendment is to relieve the department of the financial concerns with the bill.

EX OFFICIO MEMBERS

Ms. Sue Ann Head Ms. Head said the Department is fine with the amendment.

- **AMENDED SB 1775 by Southerland / HB 2128 by Fitzhugh**
  The amendment re-writes the entire bill.

During the discussion of this amendment it was noted there is no current law in the workers' compensation statutes that addresses the issue of receipt of unemployment benefits and temporary total disability benefits for the same period of time. However, it was suggested there are policies and/or laws or rules/regulations of the Employment Security Division of the Department of Labor/WFD that address this issue. Ms. Head agreed to make an inquiry on the issue and report the results to the Executive Director. Additionally, Ms. Teresa Bullington, Director of Benefit Review Program, explained the 2004 Reform Act provides if an employee does not appear for a benefit review conference (mediation), the Commissioner may dismiss the employee's claim. The statute does provide a "safety net" if the employee contacts the Department and attends a benefit review conference within 60 days following the order of dismissal. She notes this is already a significant penalty for an employee who fails to appear (and therefore does not provide someone with authority to settle the claim). This penalty is codified in TCA §50-6-203(f).

Practical Effect of Amendment

*Section 1 will prohibit an injured worker from receiving temporary total disability benefits if the employee has been laid off from the employer or the employer has gone out of business and the employee (1) has been released to return to work with restrictions the employer could not accommodate, or (2) the employee has not reached maximum medical improvement or (3) the employee has not been released to return to full duty. Under present law, an employee who has neither returned to work nor reached maximum medical improvement, would be paid temporary total disability benefits (66 2/3 of the average weekly wage - subject to the maximum weekly rate of $750 (110% of State's Average Weekly Wage which for July 1, 2006 through June 30, 2007 is $682.00).

*Section 2 will apply the penalty for not appearing at the benefit review conference (mediation) to the employee. The amendment may be directed at situations where the employee is not represented by an attorney, the employer has requested the mediation and the employee fails to appear. The amendment will not alter the specialist's current ability to exercise judgment as to whether the parties' actions (related to authority to settle) support a referral for a hearing to determine whether a penalty should be assessed.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

***SECTION 1 (Unemployment Benefits & TTD Benefits)**

ATTORNEY REPRESENTATIVES:

Mr. Tony Farmer — Mr. Farmer said the Department requires an employee to agree to notify the Department [Employment Security Division] if they are later compensated for the same period they received unemployment benefits and requires them to pay back the unemployment benefits.

He said the amendment is unnecessary because the Department already requires the employee to pay back unemployment benefits received if they subsequently receive workers' compensation benefits for the same period. Passage of the amendment will cause a direct conflict with the rules of the Department regarding repayment of unemployment benefits. It creates a real hardship on an employee.

***SECTION 2 (Penalty For No One With Authority At BRC)**

The members of the Advisory Council indicated they were unsure of the intent of the amendment. It was noted the current statutory language concerning a possible penalty does not apply to the employee who "fails to provide a person with authority to settle". It was assumed the intent is to apply equity and make the possibility of a penalty applicable to all parties to the benefit review conference.

- **AMENDED SB 1797 by Southerland / HB 2129 by Fitzhugh**

Practical Effect of Amendment

The amendment returns the law to the way it existed prior to the 2004 Reform Act and permits an employer or insurer to settle the entire claim by paying a monetary amount to the employee in return for his giving up the right to lifetime medical benefits for the work-related injury. For claims that were settled before the 2004 Reform Act, the Department or Court that approved a settlement had to determine the settlement (disability and future medical settlement) was in the best interest of the employee. The amendatory language requires the Court or Department to find the settlement of medical benefits is in the best interest of ALL parties.

With regard to employees who are permanently totally disabled, the amendment permits these workers to accept money in lieu of lifetime medical benefits IF the employer had claimed the injury was not work-related (i.e., the employer contested compensability of the injury). Therefore, if an employer contested an injury as not work-related and subsequently decided to settle the claim by paying permanent total disability benefits - the employer could pay a small sum for medical expenses and get the employee to settle on this basis. Under federal law

- this could pose real problems for Medicare Set Aside liability for am employee who is so injured they can never work again if one assumes this type injury would require additional and ongoing medical treatment.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

Note: The discussion of this issue by the members of the Advisory Council was robust and lengthy. Thus, the comments of the members are not divided by category, but are presented in the time frame as the comments were made.

Mr. Farmer stated he believes this amendment opens the Department of Labor/WFD to an extremely complex issue in advising an unrepresented worker - the Medicare Set Aside issue. This issue could dramatically impact that employee's right to medical treatment of any kind in the event medical coverage under the workers' compensation statute is terminated for any amount of money. Mr. Farmer said he knows the Department is not prepared to address the issue of Medicare Set Aside because no one is in the position to do that - all attorneys are having to get outside services to evaluate the complex issue of Medicare Set Aside. More importantly, the 2004 Reform Act had as a primary objective of allowing workers to move through the system without being bogged down by lawyers. That has produced a very significant increase in the number of unrepresented workers. With these workers being presented with a few hundred dollars to terminate medical coverage that they don't even understand - he personally feels this is morally corrupt. He does not believe the business people think there is a positive aspect to this bill. He believes the bill is irresponsible as far as the state government and the federal government are concerned and it is motivated primarily and essentially by greed. There are situations on doubtful and disputed claims where it is convenient to be able to close future medicals but the inconvenience of waiting three years to be able to close future medicals does not outweigh the potential harm that the bill provides to the worker.

Ms. Boyte stated she is personally unaware of any situation since the 2004 Act where a case did not settle that would have settled had the parties been able settle medicals simply because of the new law - it became a non-issue. Mr. Farmer said the specialists could give many examples of the issue being raised as a problem - it is constantly discussed in the Knoxville office by defense lawyers and adjusters that they need the ability to close medicals. He said unrepresented workers are not in a position to evaluate that decision and they are running the risk that they will not be eligible for Medicare benefits if they terminate medical care under workers' compensation. This is a very sophisticated issue and one that is being picked up and run with by Medicare and Health and Human Services.

Mr. Sims noted this is probably an issue the Administration should be pondering - as it reverses a key feature of the Governor's workers' compensation reform proposals. He said he recalls discussions before committees as a feature the Administration felt was a significant protection for workers.

Ms. Head agreed the three year provision regarding the settling of medicals was a major issue in the reforms. The Department feels the issue of settling medicals has made an impact in the Benefit Review Program and is a regular situation raised in the program. Ms. Teresa Bullington, Director of the Benefit Review Program, agreed the section of the statute that prevents closing of future medicals for claims over the statutory monetary threshold for those cases in which the amount in controversy could be $200,000 if the case is compensable or $0 if the claim is not compensable has been an impediment to compromising and settling disputed claims. In the past the parties might compromise and settle this type of claim for $75,000 but most carriers will not want to compromise and settle a disputed claim without the ability to also settle medical benefits.

Ms. Boyte stated she believes the biggest impediment to settling claims is the provision of the law that sets a monetary cap of 10 times the minimum weekly compensation rate for the settlement of disputed claims and suggests deleting *TCA* §50-6-206(b) - in addition to or in lieu of deleting *TCA* §50-6-206(a)(2). Mr. Farmer agreed the monetary cap on disputed claims is an inhibitor on the settlement of the disputed claims.

Mr. Sims suggested if there has been an inadvertent consequence of leaving the medicals open for three years that the Department is aware of, it is incumbent on the Department review the issue and to bring a solution to what appears to be a rather complicated issue. If this is a problem, he stated he would appreciate the Department's advice on what the most appropriate solution is, keeping in mind open medicals is a significant issue and in terms of the Medicare Set Aside issues.

Mr. Farmer suggested the priorities of defense attorneys, the priorities of the Department and his priorities may be different. He stated his top priority is not to see every case resolved by settlement - his top priority is to see every worker fairly compensated.

Mr. Lee stated when the Reform Act was being negotiated, the provision was initially five years for non-settlement of medicals and a compromise was struck at three years. He feels the three years was reasonable then and it is still reasonable. Mr. Lee said he doesn't know many workers who have been injured and off work who wouldn't jump at a chance to settle a claim for medicals for 5, 10 or 15 thousand dollars when their income has been interrupted. He thinks the three years should be kept to see if the worker is going to continue to need future medical treatment and feels it would be egregious to take that option away from the employee.

- **AMENDED SB 1043 by Finney, L. / HB 595 by Turner, M.**

Proposed Amendatory Change
The amendment is a technical correction. It deletes the word "co-chair" and substitutes the term "vice-chair", which is the correct committee designation.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

The Council defers to the General Assembly as to the composition of the membership of the Advisory Council. The Council notes the amendment to SB322(Haynes)/HB1818(Hackworth) continues the Joint Committee and the chair and vice-chair of the Joint Committee are ex officio members of the Council.

- **AMENDED SB 1805 by Tracey / HB 1569 by Curtiss**

Practical Effect of Amendment
Because the amendment removes Section 3 of the original bill, the Medical Impairment Rating Registry program will continue as currently administered pursuant to the rules and regulations adopted by the Department of Labor and Workforce Development.

COMMENTS OF ADVISORY COUNCIL MEMBERS:

ATTORNEY REPRESENTATIVES

Ms. Kitty Boyte — Ms. Boyte stated she does not understand why Section 3 is being deleted as the changes being made by it to the MIRR program was one of the smartest bills being proposed. She said (as a friend of system) the original intent of the MIRR program was an effort to get unrepresented employees through the system at their greatest advantage. If they were unhappy with their impairment rating they had an opportunity to go to the Department and have the employer pay for an independent medical evaluation instead of having to hire an attorney and the lawyer sending them out to a doctor for a higher rating. This MIRR rating was to be the trump card and, therefore, the employee could go to the benefit review conference unrepresented and not worry about a very low rating from the treating doctor. Dr "MIRR" was going to be the correct rating and the parties could decide what settlement the employee would receive. The way the rules were promulgated completely deleted that particular accomplishment of the whole program. Now, you have to have two ratings before you can access the program. Neither of the attorneys are going to want to access the MIRR program except in very limited circumstances

because they do not want the "trump card" of the MIRR doctor - they would rather argue why their particular doctor's rating is the correct one. The original bill (Section 3) returned to the original purpose of why the MIRR program was enacted and she is shocked it is being deleted.

Mr. Tony Farmer — Mr. Farmer agreed the original Section 3 of the bill addresses the original intent of the 2004 Reform Act to prevent "dueling doctors". As implemented, you cannot access the program without two doctor ratings. He believes the entire system of workers' compensation in Tennessee both for the employer and the employee would be more efficient and effective without the Medical Impairment Registry Program and it would be easier on the Department.

The meeting was adjourned at 12:45 p.m.