STATE OF TENNESSEE

Workers' Compensation Advisory Council

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WORKERS' COMPENSATION ADVISORY COUNCIL

REPORTS TO GENERAL ASSEMBLY & JOINT COMMITTEE

MARCH 2003

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The General Assembly of the State of Tennessee has directed the Workers' Compensation Advisory Council to study and report on three issues. This document addresses each issue separately and in detail. However, to assist the reader in assimilating the information and in determining the findings and recommendations of the Advisory Council the following summary is provided.

Issue: Findings and recommendations, if any, on methods to control the growth of medical costs within the workers' compensation system. [Acts 2002, ch. 695, § 2, effective May 1, 2002.]

Advisory Council Comments & Recommendations:

The Advisory Council took steps to gather information on the issue of medical costs from a variety of sources including input from interested parties. After review of all the information available to it, the Advisory Council does not suggest in this report that Tennessee workers'
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compensation medical costs are growing more rapidly than medical costs in general. The members of the Advisory Council, however, do not believe there is consensus in the workers' compensation community as to what medical costs are and are not proper. While data suggest workers' compensation medical costs are rising, data also suggest that all medical costs are increasing countrywide in the group health arena as well as in the workers' compensation arena. Rising health care costs are a national debate issue that is not restricted to workers' compensation costs in Tennessee.

The Advisory Council has reviewed the cost containment strategies currently in place in Tennessee and in other states as well as the available data on medical costs reported by insurance carriers in Tennessee. The Advisory Council found that Tennessee has enacted legislation that authorizes the use of all cost containment strategies available in other states except for medical fee schedules. However, the Medical Care and Cost Containment Committee provides medical care providers, insurers and employers with a remedy when the amount of the medical charges is in dispute. As a result of the information reviewed, the **Advisory Council does not recommend any additional cost containment initiatives at this time.** The Advisory Council will continue to monitor the medical costs issue and that it report to the General Assembly periodically as additional facts and information warrant.

Issue: The impact of the statutory requirement that all employees who sustain a back injury in the course and scope of their employment be provided a panel choice of medical care providers that includes a chiropractor. [Acts 2000, ch. 990, §4, effective June 27, 2000]

Advisory Council Comments & Recommendations:

The Advisory Council has considered this issue since 2000. It has sought input from the members of the Council as well as the Tennessee Chiropractic Association and other interested parties. The Advisory Council was unable to locate any specific Tennessee data on chiropractic utilization and costs. While it is hoped future research data will provide more detailed information, the Advisory Council does not currently have sufficient information to draw any conclusions as to the effectiveness [on either a medical outcome basis or a cost effectiveness basis] of the statute at this time. Neither has the Advisory Council discerned any outstanding "hue and cry" either for or against the chiropractic panel requirement.

Therefore, from the information available to it, the **Advisory Council recommends** that it continue to monitor the issue to attempt to obtain Tennessee specific data and that it report back to the General Assembly on or before January 31, 2005. Further, the **Advisory Council recommends** that the General Assembly consider legislation to provide for a two (2) year extension to this statute so that it sunsets as of July 1, 2005.

Issue: The impact of *Tennessee Code Annotated* §50-6-110(c) on the payment of a health care provider's claim for emergency and stabilization services provided to an employee covered by workers' compensation and notification of providers of health related to the workplace injury. [Acts 2002, ch. 695, § 6, effective May 1, 2002.] (This statute is related to the issue of an employer's defense to a workers' compensation claim based on the employee's intoxication by either alcohol or drugs.)

Advisory Council Comments & Recommendations:

This matter arose during the legislative session of 2002 and the Advisory Council was requested to study it. The entity that was interested in this issue has suggested to the Advisory Council that it is continuing to research the issue and recommends that the subject continue to be tracked and studied until more information can be developed.

The Advisory Council has conducted a survey of other states to determine how the matter of payment of medical expenses incurred by an intoxicated injured worker is handled. It appears there are only a few states that have addressed the issue and it is treated by those states in various ways. While the discussion of payment for these medical expenses has uncovered a potential problem with both the denial of workers' compensation coverage (for injuries sustained by employees who are intoxicated) and the denial of medical benefits by group health coverage, no solutions are currently apparent. As this is an issue that bears further study and consideration, the **Advisory Council has no recommendation for action by the General Assembly.** The **Advisory Council will continue** to monitor the issue, to gather any additional information interested parties are able to share regarding the issue and to report to the General Assembly when more information has been developed.

The remainder of this document contains a more detailed discussion of each issue.

METHODS AVAILABLE TO CONTROL MEDICAL COSTS

Acts 2002, Ch. 695, Section 2 amended *Tennessee Code Annotated* §50-6-121(e)(3) to require the Advisory Council to report to the special joint committee on workers' compensation its findings and recommendations, if any, on methods available to control the growth of medical costs within the workers' compensation system. This statute became effective on May 1, 2002.

It is clear to the Advisory Council that the issue of rising medical costs is a national issue that is not restricted to only workers' compensation. In addition, the issue of controlling workers' compensation medical costs is one in which all stakeholders have been interested for many years. Indeed many states, including Tennessee, enacted a variety of medical cost containment laws in the early 1990's.

Thus, when the Advisory Council approached the task of reviewing the literature and determining how the issue is being handled across the nation, it decided to obtain information from as many entities as possible, including national research organizations, the National Council on Compensation Insurance (hereinafter, NCCI) and interested stakeholders. The Advisory Council invited interested parties to submit written comments and information to the Council. The NCCI was requested to provide historical information regarding the medical expenses paid by insurance carriers in Tennessee. Research by Council staff revealed the issue has been studied by scholars and research organizations for several years. In December, 2001, the Workers' Compensation Research Institute (hereinafter, WCRI)[1] published "Managed Care and Medical Cost Containment in Workers' Compensation - A National Inventory, 2001-2002". The WCRI was requested to make a presentation to the Advisory Council to summarize the results of their study.

The October 10, 2002 meeting of the Advisory Council was devoted to a discussion of the issue of medical costs and cost containment methods. The NCCI and the WCRI made presentations and interested parties addressed the members. The written comments of interested

[1] According to WCRI publications, it "is a non-partisan, not-for-profit research organization providing objective information about public policy issues involving workers' compensation issues. It does not take positions on the issues it researches; rather it provides information obtained through studies and data collection efforts that conform to recognized scientific methods, with objectivity further ensured through rigorous peer review procedures." WCRI is located in Cambridge, Massachusetts and its web address is www.wcrinet.org.

parties are attached to this report as Appendix A. The Advisory Council further discussed the issue at its December 18, 2002 meeting and the final draft of these reports were approved by the Advisory Council at its January 30, 2003 meeting. The following summarizes the findings of the Advisory Council from the information received by it from the various sources.

Workers' Compensation Research Institute

At the October 10, 2002 meeting, the WCRI made a presentation that summarized data and findings from three of its publications.[2] The presentation included information related specifically to Tennessee, information related to all states, and information related to the twelve (12) states[3], including Tennessee, that are included in its third edition of the CompScope™ research project that is due for publication later in 2003. WCRI's representative, Ms. Stacey Eccleston, shared the following information with the Advisory Council members:

> While private sector initiatives are a key component of medical cost containment, the strategies are enabled or mandated by statutes and regulation. Both are interdependent. In its survey of states WCRI concentrated on statutes and regulations.
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> There was significant growth in state strategies for utilization management or cost containment during the early 1990's. However, there have been few regulation efforts since 1997.

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[2] "The Anatomy of Workers' Compensation Medical Costs and Utilization"; "National Inventory of Managed Care and Medical Cost Containment"; and "Benchmarks for Designing Workers' Compensation Medical Fee Schedules".

[3] California, Connecticut, Florida, Georgia, Indiana, Illinois, Massachusetts, North Carolina, Pennsylvania, Tennessee, Texas and Wisconsin.

Medical costs in both group health and workers' compensation increased during 1990 through 1999. However, the costs in group health have increased by a greater percentage than have the costs in workers' compensation. In fact, medical costs in workers' compensation showed declines each year from 1992 through 1998, with an increase in 1999.

The percentage change in medical costs from 1985 through 1999 was approximately +150% for group health and approximately +90% for workers' compensation.

There are two types of medical cost containment strategies:

1. Utilization Control Strategies:
    - Controlling provider choice and change [direction to initial provider and direction for continuing change]
    - Utilization Review
    - Mandated managed care
    - Treatment guidelines
2. Price Management Efforts
    - Provider fee schedules (non-hospital)
    - Hospital payment regulation
    - Bill Review

42 of 50 states have a workers' compensation fee schedule. The fee schedules are varied and while most states set workers' compensation fees from 25% to 60% above Medicare rates, 17 states are outside the typical range. Interstate differences in fees are not related

to the provider practice expenses. Most state fee schedules provide incentives that favor surgery vs. less invasive care.

Future efforts in cost containment are expected to concentrate on the following:

- Surveys of patient outcomes
- Effect of treatment guideline usage
- Effect of managed care on quality of care
- Development of a methodology to measure quality

The WCRI recently finished its preliminary data collection and draft of its third edition of the CompScope™ study. It is expected to be published in mid-2003. While the normal cost of being included in a CompScope™ study is approximately $190,000, Tennessee was included in the third edition without charge as WCRI had already collected the Tennessee data. If Tennessee wishes to be included in future editions, the State and/or private interested parties will have to pay to be included in the research project.

The CompScope™ study uses benchmarks to identify key medical cost drivers including:

- Medical costs per claim
- Price
- Utilization [number of visits per claim and number of services per visit]
- Costs by provider type
- Costs by type of medical service

Preliminary CompScope™ data indicates payments per indemnity claim (1999 claims evaluated at the end of 2000) range from a low of approximately $2,800 in Massachusetts to a high of approximately $8,000 in Texas. Tennessee was next highest to Texas at approximately $7,100.

The CompScope™ study initially produces its general data and then follows with a more detailed report regarding specific cost drivers. Therefore, while the first report will give general information, it is expected the detailed data will provide more specific Tennessee information regarding costs by provider types, costs by medical service and more information regarding utilization specific to Tennessee. This more detailed information will not be available until later in 2003. Therefore, the Advisory Council suggests continued follow-up with the WCRI to obtain this more detailed information from the data collected for the third edition of CompScope™.

National Council on Compensation Insurance

In addition to the information provided by the WCRI, the Advisory Council also requested information from the National Council on Compensation Insurance, the state's designated rate making organization. According to the NCCI, medical benefits constitute the majority of total benefit costs in Tennessee with 53% of the benefit dollar covering the costs of medical care and 47% of the dollar covering indemnity benefits. The countrywide data indicates 45.4% of the benefits costs are medical while 54.6% are indemnity.

The NCCI's data is ***projected***[4] financial data that takes the actual medical costs reported by the various insurers for specific policy years or accident years and develops the actual costs to "ultimate". Based on its financial data calls and its detailed claim information database, the NCCI provided the following information to the Advisory Council:

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[4] Projected costs differ from the actual costs expended in one calendar year. It is a projection over many years as to the expected total payout for medical care per claim (i.e., costs developed to ultimate). It is not the same as the actual medical costs paid in one specific year.

Tennessee's average ***projected*** medical cost per claim has increased from Policy Year 1993 [$15,700] to Policy Year 2000 [$17,100] with a peak in Policy Year 1997 of $20,000.

The average ***projected*** medical cost per claim for Accident Year 2001 (claims that arose during calendar year 2001) was $18,100.

The total ***projected*** dollars paid for medical care for years 1995 through 1998 [5] indicate total cost in dollars as follows:

1995 = $292,638,175

1996 = $278,163,269

1997 = $323,079,077

1998 = $367,097,673

These data indicate a **decrease** of 5% from 1995 to 1996; an **increase** of 14% from 1996 to 1997 and an **increase** of 12% from 1997 to 1998.

The majority of medical costs are incurred, not unexpectedly, in the cases involving permanent partial disability

Note: It is important to appreciate the difference between the information provided by the WCRI and the NCCI regarding medical payments per claim. The WCRI reports Tennessee's average medical payment per indemnity claim for 1999 is approximately $7200 while the NCCI reports an average of approximately $17,100 for Policy Year 2000. First, the NCCI's figure includes

[5] The NCCI's statistical plan data, which would be ***projected*** (or developed to ultimate) medical costs is not available for years 1999 and later. Therefore, the most recent data NCCI was able to provide was for 1998. The information for 1993 and 1994 was not available.

medical only claims and all of its data is projected to ultimate - it is NOT the exact amount spent on medical costs for the claims during 2000. Therefore, care should be used when comparing these figures. They are not an apples to apples comparison. However, this difference does point out the difficulty for policy makers when reviewing various studies on workers' compensation costs. Often, the data reported uses different benchmarks and different data sets.

Tennessee Statutory Medical Cost Containment Methodologies

The Workers' Compensation Reform Acts of 1992 and 1996 enacted several medical cost containment strategies. Some strategies have been in the law for many years. The following is a listing of the cost containment strategies that are available to the employers and insurers of Tennessee under Tennessee workers' compensation law:

- Limited Initial Provider Choice [*TCA* §50-6-204]

  The employer provides the employee with a panel of approved medical care providers from which the employee chooses the attending physician/practitioner.

- Limited Provider Change [*TCA* §50-6-204]

  The employee cannot change the authorized attending physician without approval of the employer/insurer. The employer may require the employee to submit to independent medical examination.

- Mandated Case Management [*TCA* §50-6-122,123] [Regulation 0800-2-7]

  Case management is mandated for claims that reach either of three thresholds: (1) the total medical costs are expected to exceed $10,000 (2) hospitalization is

required or (3) the employee misses seven (7) days of work. Case management is permitted in all cases.

- Mandated Utilization Review [*TCA* §50-6-122,123] [Regulation 0800-2-6]

  The statute authorizes the Commissioner of Labor and Workforce Development to establish a system of utilization review through rule/regulation. A system of pre-admission review of all hospital admissions and review of emergency admissions within one day is mandated.

- Medical Cost Disputes [*TCA* §50-6-125]

  The Commissioner of Labor and Workforce Development appoints members of a Medical Care and Cost Containment Committee. Disputes between medical care providers and the insurance carrier, self-insured employer or third party administrator may be submitted to the Committee for review and determination as to whether the charges comply with the "usual and customary" requirement of Tennessee law. [6]

- Managed Care [*TCA* §50-6-123]

  Managed care is permitted by statute but is not mandated.

After review of the information available to it, the Advisory Council is unable to say that Tennessee workers' compensation medical costs are too high or "out of control" as there is no

[6] The Medical Care and Cost Containment Committee made a presentation to the Advisory Council at its December 2002 meeting. The Committee reported it has determined more money was due the provider in 54% of the cases reviewed and that no additional money was due in 32% of the cases submitted to it. The remainder of the cases were held over for more information or dismissed as they were not within the jurisdiction.

consensus as to how such a determination can be made. While it could be considered that costs are not "out of control" as long as parties are able to pay the costs, it would be ignoring the reality of a national debate to assume a cavalier approach to the problem. Medical costs in all aspects of society are increasing. The question remains, however, as to how much increase can the system withstand.

The members of the Advisory Council do not believe there is consensus in the Tennessee workers' compensation community as to whether medical costs are "too high". While data suggest workers' compensation medical costs are rising, data also suggest that medical costs are increasing countrywide in the group health arena as well as the workers' compensation arena. Rising health care costs are a national debate issue that is not restricted to workers' compensation costs in Tennessee.

The Advisory Council has reviewed the cost containment strategies currently in place in Tennessee and in other states as well as the available data on medical costs reported by insurance carriers in Tennessee. Thus, the **Advisory Council does not recommend any additional cost containment initiatives at this time.** The Advisory Council will continue to monitor the medical costs issue and report to the General Assembly periodically as additional facts and information warrant.

IMPACT OF CHIROPRACTIC STATUTE ON WORKERS' COMPENSATION

In 2000, the Tennessee General Assembly enacted an amendment to *Tennessee Code Annotated* §50-6-204(a)(4)(B) that requires an employer or insurer to provide an employee who sustains a back injury in the course and scope of employment a panel choice of four (4)

physicians/providers that shall include a chiropractor. In the same legislation, the Advisory Council was directed to report on the effect the implementation of the statute has had on the Tennessee workers' compensation system.

A subcommittee of the Advisory Council was appointed to study this issue and report to the members. The Tennessee Chiropractic Association was invited to share information with the members and was given an opportunity to address the subcommittee. In addition, the Advisory Council attempted to locate data specific to Tennessee that would provide insight into the issue and that would determine how the parties were implementing the statute. However, the Advisory Council was unable to locate any specific Tennessee data on chiropractic utilization and costs.

The Advisory Council discussed this issue for a final time at its December, 2002 meeting. While it is hoped future research data will provide more detailed information, the Advisory Council determined it does not have sufficient information to draw any conclusions as to the effectiveness [on either a medical outcome basis or a cost effectiveness basis] of the statute at this time. Anecdotal evidence known to the members of the Advisory Council did not support a conclusion that the statute was detrimental to the system.

Therefore, from the information available to it, the **Advisory Council recommends** that it continue to monitor the issue to attempt to obtain Tennessee specific data and that it report to the General Assembly on the issue on or before January 31, 2005. Further, the **Advisory Council recommends** that the General Assembly consider legislation to provide for a two (2) year extension to this statute so that it sunsets as of July 1, 2005.

IMPACT OF *TCA* §50-6-110(c) ON PAYMENT OF HEALTH CARE COSTS

Acts 2002, Ch. 695, Section 6 requires the Advisory Council to "study and report on the impact of *Tennessee Code Annotated* Section 50-6-110(c), on the payment of a health care provider's claim for emergency and stabilization services provided to an employee covered by workers' compensation and notification of providers of health related to the workplace injury." This statute is related to the issue of an employer's defense to a workers' compensation claim based on the employee's intoxication (by alcohol or drugs).

In 1996, the General Assembly passed the Drug-Free Workplace Statute (codified in *Tennessee Code Annotated*, Title 50, Chapter 9) that established a mechanism by which an employer can be certified by the Department of Labor and Workforce Development as a "Drug-Free Workplace". Such a certification provides a discount on workers' compensation insurance and shifts the burden of proving the intoxication defense from the employer to the employee to prove the injury was not caused by the employee's intoxication.

It has been longstanding law in Tennessee, and certainly prior to the enactment of the drug-free workplace statute, that employers have the right to deny a workers' compensation claim and to deny payment of any medical expenses if the employer determines the injury was due to the employee's intoxication. It appears the only difference in Tennessee law regarding denial of a claim due to intoxication is the shift of the burden of proof from the employer to the employee for those employers that maintain a certified drug-free workplace. Employers who are not "certified" drug-free workplaces are still allowed to deny a claim based on the intoxication defense and are still allowed to deny payment of any medical expenses incurred by the employee.

It came to the attention of the Advisory Council that medical care providers, most of which are hospitals providing emergency care, are being denied payment of the medical expenses by employers and/or insurers due to the employee's intoxication at the time of the work-related injury. In 2002, a bill was introduced in the General Assembly that sought to address this issue. As a result, the Advisory Council was directed to study and report on the issue.

The Advisory Council reviewed Tennessee law as it relates to the "intoxication defense" for employers who have and those who do not have a certified drug-free workplace. In addition, it reviewed the laws of other jurisdictions to determine how other states handle the issue of payment of medical expenses when the employee's injury was caused by intoxication.

Tennessee is one of 17 states[7] that are members of the Southern Association of Workers Compensation Administrators (SAWCA). Of the 17 SAWCA states, only seven (7) have enacted a drug-free workplace statute. Each state handles the issues of payment of compensation, burden of proof and payment of medical expenses differently. Of the seven (7), only Florida and Louisiana provide for payment of medical expenses when the employee tests positive for drugs/alcohol. Florida requires the employer to pay all authorized treatment provided prior to denial of benefits and reasonable notice of denial must be made to the health care provider that gives a date certain for the termination of benefits. In Louisiana, if emergency care is provided to an employee who is later presumed or found to be intoxicated, the employer is required to pay for the reasonable care provided to the employee until stabilization and discharge from an acute care facility.

[7] The Virgin Islands is also a member of SAWCA, but its laws were not reviewed.

Maryland does not have a drug-free workplace statute, but its workers' compensation law provides if the injury is solely caused by the effects of drugs or intoxication the employee is not entitled to ANY benefits. However, if the injury was primarily caused by intoxication the employee loses indemnity benefits but not the medical benefits. New Mexico reduces compensation by 10% if the intoxication or drug use is the contributing not sole cause of the injury.

A representative of Vanderbilt University appeared at the December, 2002 meeting of the Advisory Council and addressed its interest in the proposal introduced during the 2002 legislative session. He stated Vanderbilt is continuing to study and track the issue to determine how it is impacting the recovery of its medical costs. He indicated Vanderbilt has determined it is not a black and white issue but one that merits further study. It is the intent of Vanderbilt to continue to develop data that it will share with the Advisory Council.

This question of payment for medical expenses incurred by an intoxicated injured employee is one that bears further study and consideration. Therefore, the **Advisory Council recommends** that the General Assembly not consider any legislation regarding this issue. The **Advisory Council recommends** that it continue to monitor the issue, to gather additional information from interested parties and to report to the General Assembly when more information has been developed.

Note: Two other issues were revealed during the study of this question. The first is the potential problem with a positive drug test resulting in denial of workers' compensation benefits (both medical and indemnity) when the drug may have been used as long as 30 days prior to the

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