

Controlling Medical Costs in the Texas Workers' Compensation System

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In response to the perception that Texas workers' compensation had reached a state of systemic crisis in the late 1980s, the system underwent a major legislative overhaul in 1989. Regarded by most system participants to be a success, the 1989 reforms have resulted in significant improvements, especially in the area of workers' compensation insurance rates.¹ However, many system participants (including both employers and injured workers) expressed concern that these reforms did not adequately address the cost and quality of medical care provided to injured workers in the system.

In addition, insurance carriers and self-insured employers indicated that medical costs were higher in Texas than in other states, and some injured workers argued that too many barriers existed in the Texas system, preventing them from receiving quality medical care.

Independent research supported these medical cost and quality-of-care assertions.² According to the National Council on Compensation Insurance (NCCI), policy year 1995 data showed that the average medical cost per claim in Texas exceeded the national average by almost 80 percent (\$4,912 in Texas compared to \$2,735 nationwide). Another report by the Workers Compensation Research Institute (WCRI) indicated that "the average medical payment — paid and incurred — per claim with more than seven days' lost-time in Texas was the highest of the (eight) states in (the) analysis. In claims from (injury year) 1996, the average medical payment per claim was \$6,495, 35 percent higher

¹ In 1992, Texas changed the way it sets workers' compensation insurance rates to a file-and-use system where each insurance carrier is responsible for filing rates based on its own individual loss experience. Additionally, the Texas Workers' Compensation Fund was created in 1992 to increase competition in the voluntary market and serve as the insurer of last resort. Rates have steadily declined since 1991 to more than 30 percent below the 1991 workers' compensation benchmark rate. See Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System*, August 1998.

² See National Council on Compensation Insurance, *Annual Statistical Bulletin, 1999*; Fox, Sharon, et al, *Benchmarking the Performance of Workers' Compensation Systems: Compscope Multistate Comparisons*, Workers' Compensation Research Institute, July 2000; Gotz, Glenn A., et al, *Area Variations in Texas: Benefit Payments and Claim Expenses*, Workers' Compensation Research Institute, May 2000; and Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System*, August 1998.

than the average state.” A second report by WCRI compared medical costs in seven geographic areas in Texas, demonstrating that the average medical costs per claim differed by as much as 50 percent between low cost areas (Austin/San Antonio) and high cost areas (El Paso).

A fair question was whether higher costs resulted in higher quality medical care. However, in a 1998 survey of Texas injured workers by the Research and Oversight Council on Workers’ Compensation (ROC), 79 percent said that their health care provider gave them “adequate medical care that met their needs,” yet almost half (46 percent) reported that they had difficulty securing some of those medical treatments.

These concerns led to the passage of HB 3697 by the 76th Texas Legislature in 1999. This legislation required the ROC, in conjunction with the Texas Workers’ Compensation Insurance Fund (now known as the Texas Mutual Insurance Company), to conduct a series of studies examining the cost and quality of medical care in the Texas workers’ compensation system. The studies were published and presented to the Texas legislature in January 2001.³

The HB 3697 studies addressed three main goals:

- 1) to investigate the quality and cost-effectiveness of the current workers’ compensation health care delivery system, as compared to other state workers’ compensation systems and other health care delivery systems in Texas;
- 1) to examine workers’ compensation medical provider treatment patterns and insurance carrier utilization review practices in Texas; and
- 2) to analyze methods to improve worker safety and facilitate an injured worker’s ability to return to productive employment following an injury.

Overview of the Texas System

³ 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, 2001.

The Texas workers' compensation system is designed as a "fee for service" system which allows health care providers to submit bills and receive payment for each service they deliver to injured workers without the use of pre-paid case rates, co-payments, deductibles or co-insurance arrangements.⁴

Injured workers in Texas have the ability to select their own initial treating doctor. In turn, the treating doctor provides medical care to the injured worker and submits those bills to the employer's insurance carrier for payment. The insurance carrier (either internally or through the use of a utilization review agent or URA) has the ability to review the medical necessity of treatments provided to injured workers and pays medical bills in accordance with the fee guideline established by the Texas Workers' Compensation Commission (TWCC).

HB 3697 Studies: Data Sources, Methods, and Considerations

Data Sources. A variety of data sources were utilized in this study, including:⁵

- Medical, claim, and income benefit data from the Texas Workers' Compensation Commission (TWCC);
- Medical, claim, and income benefit data from a large national insurance carrier with significant market share in Texas and other states;
- Medical data from a national workers' compensation data clearinghouse, representing four workers' compensation insurance carriers;
- Medical data from a large group health insurance carrier in Texas covering State of Texas employees (data from the Preferred Provider Organization, or PPO, plan administered by the Employees' Retirement System of Texas);
- Medical and claim data from four large employers with business operations in Texas and other states; and

⁴ A pre-paid case rate refers to one reimbursement amount pre-paid to health care providers for each employee covered under a group health insurance plan regardless of whether the employee uses the medical services.

⁵ Confidentiality agreements and masked data prevent the ROC from disclosing the names of the individual insurance carriers and employers who agreed to provide the necessary data for this project.

- Outcomes survey data from a random, stratified sample of injured workers in Texas and the comparison states.

Methods for Selecting States. States were selected for the multi-state medical cost comparisons because they met at least one of the following five criteria:

- a population size similar to Texas;
- offered insights into innovative and potentially useful medical and disability management methods;⁶
- a mix of employer and employee initial choice of doctor;
- a similar mix of industries to Texas; or
- available and reliable workers' compensation data.

As a result, eight states — California, Florida, New Jersey, Oregon, Minnesota, Kentucky, Georgia, and Colorado — were selected for comparison with Texas.

Methods for Comparing Medical Costs. To ensure “apples to apples” comparisons of injuries, similar medical diagnoses were grouped together into diagnostic “buckets” (e.g., one diagnostic bucket covers several similar diagnoses for simple low back pain). In the same fashion, similar types of medical treatments were also grouped into resource “buckets” (e.g., one resource bucket —“office visits” — covers several different medical procedure codes for office visits). These types of groupings are often found in national and state treatment guidelines and allow more accurate comparisons to take place, since injuries of the same severity are typically grouped together. Similar treatment patterns exist for each diagnostic group.

Injury year 1997 was chosen for this analysis since most of these workers have reached statutory maximum medical improvement (MMI) in Texas (i.e., 104 weeks from the date the worker began to accrue income benefits).⁷ This timeframe after the injury allowed

⁶ Several states, notably Colorado, Florida, Minnesota, and Oregon were included based on their reputation for innovative medical and disability management practices.

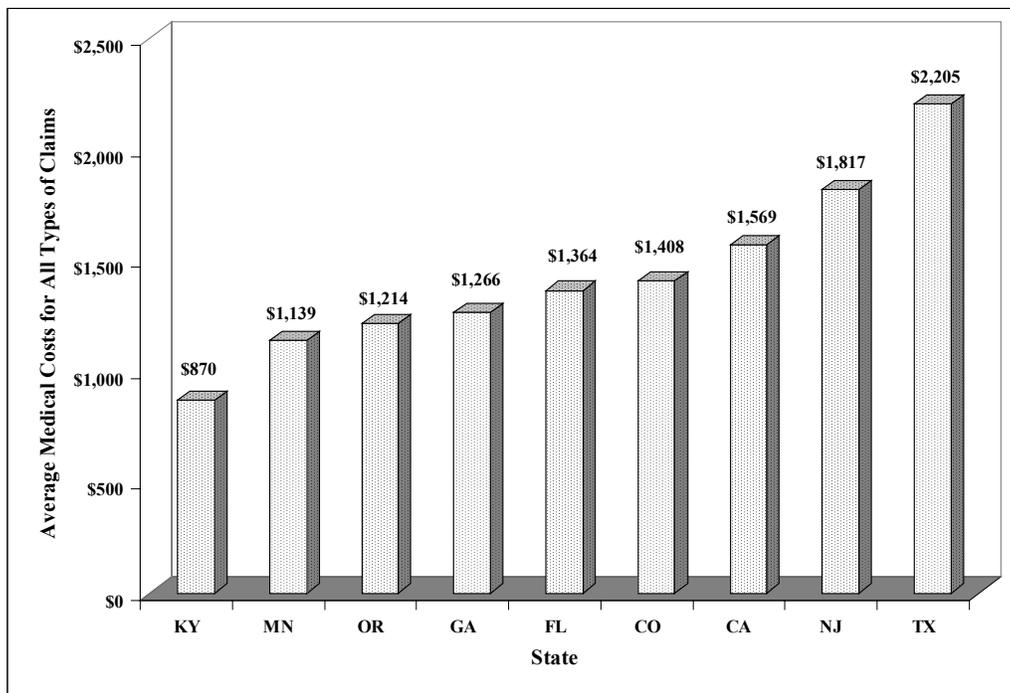
⁷ See Section 401.011, Texas *Labor Code*.

for a more complete examination of a worker's medical treatment and return-to-work history.

Key Findings

Medical Cost Comparisons. Of the nine state workers' compensation systems included in this analysis, Texas had the highest average medical costs per claim (more than 20 percent higher than the second-highest state, New Jersey, and more than 2.5 times higher than the lowest-cost state, Kentucky) (see Figure 1).

Figure 1
Average Workers' Compensation Medical Costs Per Claim,
Texas and Other States, One-Year Post-Injury



Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000.
Note: Based on an analysis of multi-state insurance carrier data for injury year 1997.

Compared with these same state systems, Texas also had the second-highest average pharmaceutical cost per claim (more than 23 percent higher than the third-highest state, Florida, and more than 2.2 times higher than the lowest-cost state, Minnesota).

When similar types of injuries and illnesses were compared in Texas and other states, Texas had the highest average medical costs for eight of the top ten types of injuries.

When compared with group health (a State of Texas employee PPO group health plan), average workers' compensation medical costs for injured State of Texas employees were approximately six times higher per worker (\$578 per worker in this group health system compared to \$3,463 per worker in the Texas workers' compensation system, 18 months post-injury).⁸

When similar types of injuries were compared in the group health and workers' compensation systems, Texas had higher average medical costs for the top five types of injuries.

In addition to overall cost differences, the cost of individual medical treatments was lower under the group health system due to the impact of PPO discounts as well as the impact of co-payments and deductibles. For example, the average medical payment for a manipulation, CPT code 97260, was \$17.50 in this group health system compared to \$35 under the existing TWCC Medical Fee Guideline. It was estimated that PPO discounts under this group health system resulted in a savings of approximately 10 percent on office visits and physical medicine and 15 percent on diagnostic tests.

Medical Cost Drivers. In general, the amount of medical treatment (often called treatment utilization) and the length of medical treatment (often called treatment duration) provided to Texas injured workers accounted for the majority of these cost differences between other state workers' compensation systems and other health care delivery systems. Additional differences between Texas workers' compensation and Texas group health systems also widened the cost gap. These differences included the lower cost of many individual medical treatments in group health (due to the PPO or

⁸ The average cost figures for this group health and workers' compensation comparison do not include pharmaceutical costs, since neither the group health nor the TWCC databases used capture this information. Group health and workers' compensation medical cost comparisons were conducted using an 18-month cutoff point to provide ample time for medical treatment after an initial diagnosis in the group health dataset. This cutoff point differs from the one-year post-injury point used in the multi-state comparison.

other negotiated discounts), the existence of pharmaceutical formularies in group health, and in the case of workers' compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning).

Five medical treatment areas accounted for the majority (approximately 91 percent) of total payments made in the Texas workers' compensation system:

- Hospitalization/surgery (48 percent);
- Physical medicine (e.g., manipulations, therapeutic exercise, hot and cold packs, etc.) (21 percent);
- Office visits (with primary and referral health care providers) (11 percent);
- Diagnostic testing (e.g., MRIs, CT scans, plain x-rays, electrophysiology testing) (8 percent); and
- Pharmaceutical drugs (3.5 percent).

Of the nine state workers' compensation systems compared, Texas had either the highest or second-highest utilization rates for the following services:

- Surgery (see Table 1);
- Injections;
- Physical medicine (see Table 2 for an example – manipulations);
- Office visits; and
- Diagnostic testing rates per claim for the same kinds of injuries.

Table 1
Average Number of Surgeries Per Injured Worker Who Received Surgery, Texas
and Other States, Averages for the Top Six Diagnostic Groups
(highest rates are shaded)

State	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Compression Injuries	Hand & Wrist Soft Tissue Injuries
FL	2.5	2.7	2.5	2.1	2.1	1.9
KY	1.9	2.5	1.8	1.9	1.7	1.8
NJ	2.7	2.3	4.8	1.8	2.3	1.7
OR	1.9	2.0	1.8	2.1	1.6	1.5
MN	2.1	1.7	2.0	1.8	1.7	1.6
CA	2.6	2.4	2.6	2.1	2.3	2.1
CO	2.4	2.0	1.8	1.9	1.6	1.8
GA	2.2	2.5	3.6	2.3	2.1	1.5
TX	3.4	3.4	2.7	2.3	2.7	1.9

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000.
 Note: Based on an analysis of multi-state insurance carrier data. Each surgery included in this table may include multiple individual surgical procedures.

Table 2
Average Number of Manipulations Per Injured Worker Who Received These
Services, Texas and Other States, Averages for the Top Six Diagnostic Groups
(highest rates are shaded below)

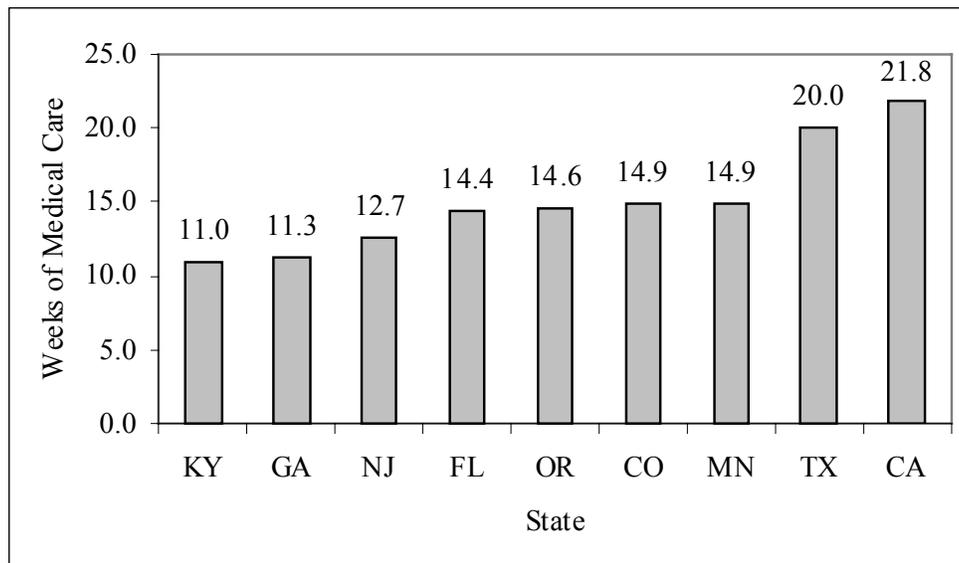
State	Overall Utilization Rate for Top 10 Diagnostic Groups	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Compression Injuries	Hand & Wrist Soft Tissue Injuries
FL	8.7	10.9	7.4	9.5	9.9	10.2	7.9
KY	14.4	21.1	15.3	18.9	13.2	12.7	5.3
NJ	11.9	10.9	10.0	24.8	15.3	12.8	8.5
OR	8.5	9.8	7.6	12.4	10.4	11.3	7.0
MN	11.7	14.3	10.7	18.5	11.8	16.3	7.0
CA	23.7	29.5	26.1	36.5	19.4	25.0	14.3
CO	12.4	16.0	13.1	13.8	10.8	10.6	8.2
GA	7.5	9.4	5.6	7.0	9.7	10.8	7.0
TX	26.4	28.5	27.2	38.2	21.5	27.5	24.3

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000.
 Note: Based on an analysis of multi-state insurance carrier data. Includes manipulations conducted by all health care provider types (including M.D.s, P.T.s, and Osteopaths). For comparability purposes, office visits made by chiropractors were included in manipulation rates rather than office visit rates since it more accurately reflects the common usage of those medical procedure codes.

Additionally, a higher percentage of workers in the Texas workers' compensation system received these medical treatments than workers with the same kind of injury in the comparison states.

In addition to receiving more medical treatments, Texas injured workers also had longer treatment durations compared to workers in other states. Of the nine state workers' compensation systems compared, Texas ranked second only to California in the longest duration of medical care for injured workers (see Figure 2).

Figure 2
Average Duration of Medical Care for Top 10 Diagnostic Groups, Texas and Other States



Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000.

Note: Based on an analysis of multi-state insurance carrier data.

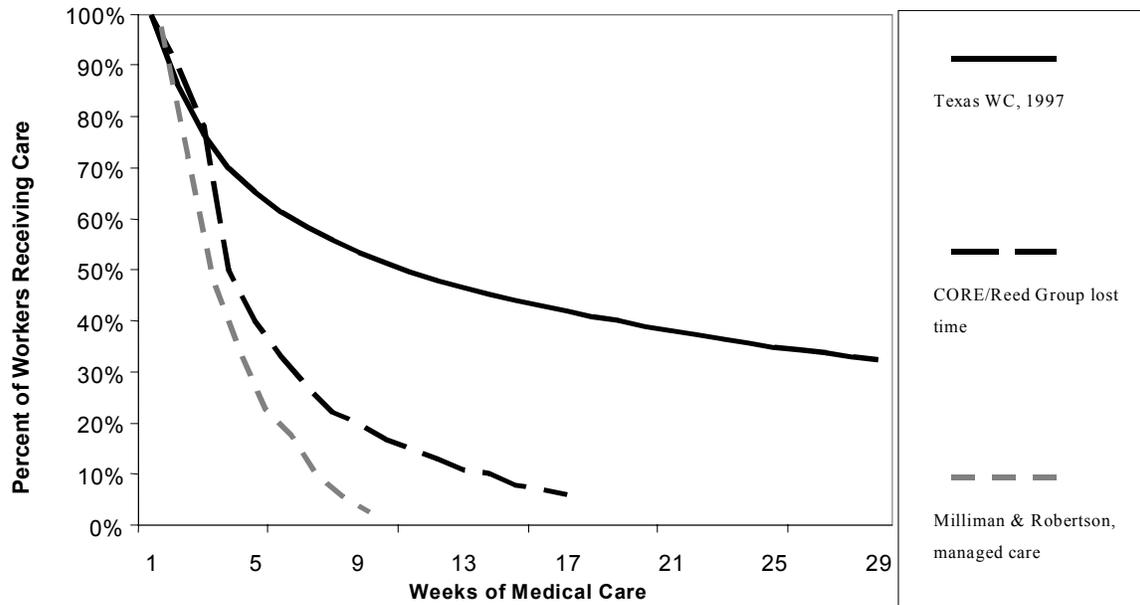
When compared with group health (a State of Texas employee PPO group health plan), injured State of Texas employees had higher utilization rates of:

- Surgery;
- Injections;
- Physical medicine; and
- Diagnostic testing rates.

Additionally, a higher percentage of injured State of Texas employees received these medical treatments than state employees with the same kind of injury treated under group health.

Overall, the amount and duration of medical care provided to all injured workers in Texas exceeded the levels recommended in most national treatment guidelines (including proprietary guidelines used by insurance carriers to review medical care and guidelines developed by medical associations) (see Figure 3).⁹

Figure 3
Comparison of Medical Treatments and Services Provided to Texas Injured Workers with National Guideline Recommendations



Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000.

Note: Based on TWCC data and information from Bruckman, R.Z., Rasmussen, H. *Healthcare Management Guidelines: Volume 7, Workers Compensation*. Seattle: Milliman & Robertson, 1996; and Reed PO (ed.). *The Medical Disability Advisor, 3rd Edition*. Boulder, Co: The Reed Group, Ltd., 1997.

⁹ Examples of these guidelines include: The American College of Occupational and Environmental Medicine's practice guidelines, the Agency for Health Care Policy and Research guideline on acute low back problems, the Medical Disability Advisor, the Mercy chiropractic guidelines, and the Milliman & Robertson workers' compensation health care management guideline, among others.

Vague treatment guidelines and lack of adequate medical expertise at TWCC made it difficult to resolve medical disputes—especially disputes over medical treatments that had not been deemed medically necessary.¹⁰

Other Medical Cost Drivers. In addition to over-treating injured workers with the same kinds of injuries for longer periods of time and paying more for medical treatments and pharmaceutical drugs, there were other issues that contributed to the state’s workers’ compensation medical cost gap:

- A small percentage of workers’ compensation claims were responsible for the majority of costs. Twenty percent of claims accounted for 80 percent of total medical costs in Texas.
- A small number of health care providers were responsible for the majority of workers’ compensation medical costs. Seven percent (roughly 4,000 health care providers, including M.D.s, chiropractors, osteopaths, physical therapists, etc.) accounted for 80 percent of professional service medical costs in Texas (i.e., non-hospital medical costs).

When analyzed further, it appeared that an even smaller number of doctors (about 2,200 M.D.s, chiropractors, and osteopaths) could be characterized as “high dollar/high volume” providers since they treated most of the expensive workers’ compensation claims. These 2,200 doctors comprised roughly 5 percent of the approximately 40,000 doctors who submitted workers’ compensation medical bills in Texas for any given year.

¹⁰ Disputes arising over medical issues (such as the medical necessity or the appropriate reimbursement for a treatment) are handled through TWCC’s administrative medical dispute resolution process. This process includes a paper review of the dispute by TWCC staff, followed by an appeal to the State Office of Administrative Hearings (SOAH). In response to concerns about the speed at which these medical disputes are resolved, TWCC initiated a pilot project in 2000 to telephonically mediate medical fee disputes through a “center of excellence” established in Waco. TWCC reports that this pilot has been successful in reducing the resolution timeframe for fee disputes to less than 30 days from a previous timeframe of six months or longer. Although steps have been taken to reduce the timeframe for resolving fee disputes, some system participants have expressed concern with the quality of dispute decisions and the lack of medical expertise available to resolve the more complicated pre-authorization and medical necessity disputes.

While there were certainly a small number of these 2,200 doctors who significantly over-treated injured workers, the cost gap in Texas cannot be explained by a few doctors alone. The high utilization of medical care seen in Texas is widespread across the spectrum of health care providers involved in workers' compensation.

From injury year 1996 to 1998, chiropractors and physical therapists saw increases in total workers' compensation market share in Texas, while institutional providers (e.g., hospitals, free-standing medical clinics) experienced a decline. The market share of M.D.s, osteopaths, and licensed occupational therapists remained fairly stable over time.

Although surgery and physical medicine treatments (such as manipulations and therapeutic exercises, among others) are commonly used by doctors in Texas to alleviate pain and promote physical recovery, an analysis of Texas workers' compensation medical data showed that these treatments do not seem to statistically improve overall medical outcomes (i.e., an injured worker's physical recovery or ability to return to work).

High Texas workers' compensation medical costs were also attributed to variations in the way that individual insurance carriers (and their URAs) review proposed medical treatments and pay medical bills. On-site visits and interviews with 20 insurance carrier URAs highlighted the reasons for these variations. These URAs process the vast majority of workers' compensation claims in Texas. Ineffective review practices observed included:

- accepting medical diagnoses without clinical validation;
- using "screening lists" that search for key words rather than reviewing the medical necessity of treatments using the worker's natural medical history and clinical evidence;
- misapplication of the URA's screening criteria (i.e., the proprietary treatment guidelines carriers use to screen for the medical necessity of treatments);
- lack of training for staff in areas such as anatomy, physiology, and the clinical evidence that supports the URA's screening criteria; and

- inadequate provision, collection, and management of information on a worker's clinical condition, physical limitations, and work status to help determine the medical necessity of certain types of treatments and services (e.g., work hardening/conditioning or therapeutic treatments).

Based on the results of these URA site visits and interviews, it was estimated that most medical bills in the Texas workers' compensation system were reviewed by URAs who exhibit some or all of these ineffective review practices.

Quality and Outcomes of Medical Care. Because the Texas workers' compensation system does not collect adequate medical outcome data (i.e., whether the injured worker went back to work after the injury or the degree of satisfaction with the medical care received), a multi-state injured worker survey was constructed to capture this information.

The survey focused on workers with similar types of injuries, and was administered in Texas and other states (primarily California and Florida, both of which allow employers or carriers to participate in managed care arrangements for workers' compensation). The survey covered issues such as access to care, choice of doctor, satisfaction with medical care, physical and mental functioning after the injury (i.e., whether the worker got better), and return-to-work outcomes. Results from the survey provided important insight into the outcomes of medical care provided to injured workers in Texas.¹¹

For example, Texas injured workers reported that they were not more satisfied with their medical care than injured workers in other states. Worker dissatisfaction with medical care primarily stemmed from workers' perceptions that their doctors did not communicate their medical conditions in a way they could understand and did not try to understand their daily job tasks and duties.

¹¹ The results presented in this paper for other states represent the combined results for California and Florida.

Fewer injured workers in Texas (64 percent) reported that they were currently working more than two years after their injury, compared with injured workers in other states (75 percent).

For those who said they were currently working, fewer Texas injured workers said they went back to the same employer as before their injury (62 percent in Texas compared to 79 percent in other states) and were doing the same kind of work they did before the injury (61 percent in Texas compared to 76 percent in other states). Additionally, more Texas injured workers said their current take-home pay was lower than it was before the injury (28 percent in Texas compared to 13 percent in other states).

Compared with injured workers in other states, Texas injured workers had lower levels of physical and mental functioning after their injury (i.e., they were less likely to get better after their injury and more likely to experience depression and alienation).¹²

Workers who reported that their employer worked with their doctor on appropriate modified duty or other return-to-work options had significantly higher levels of physical and mental functioning after their injury than those whose employers did not.¹³

Conclusions from the HB 3697 Studies

The research studies commissioned by HB 3697 confirmed earlier perceptions by system participants that Texas workers' compensation medical costs exceed those in other states and other health care delivery systems. These cost differences resulted primarily from more medical testing and treatment provided to Texas injured workers for longer periods of time than workers with similar injuries in other state workers' compensation systems and in group health plans.

¹² Physical and mental functioning scores were measured using the SF-12 standardized health survey.

¹³ In 1999, the 76th Legislature enacted HB 2513, which authorized TWCC to require a treating or examining doctor to provide a functional capacity examination (FCE) to an injured worker upon request from the employer or insurance carrier. These FCEs can be used to facilitate an injured worker's placement into a modified duty position.

Despite extensive, and often excessive medical treatment, Texas injured workers did not appear to be more satisfied with their medical care than workers in other states, and fewer reported that they had physically recovered and were back at work with the same earnings they had prior to their injuries.

While the responsibility for this medical cost trend largely fell to health care professionals who provide the medical care and insurance carriers whose responsibility it was to review the appropriateness of care and pay medical bills, the system's administrators must also take responsibility for the lack of coordinated and consistent monitoring of medical issues since the reform in 1989. Less than adequate resource allocation and inconsistent regulatory efforts by system administrators have bred variation in medical treatment and review practices, which has not only affected the cost and quality of medical care provided to injured workers in Texas, but also contributed to health care provider practice patterns that differ for occupational and non-occupational injuries.

These studies tended to support a growing contention that workers' compensation medical costs in Texas could be better controlled, and that the quality of medical care delivered to injured workers could be better monitored to improve outcomes. Looming also for the coming years was the possibility of a double-digit annual increase in workers' compensation insurance premiums for Texas employers.

Addressing Medical Cost and Quality Through Statutory Reform – The Passage of House Bill (HB) 2600 in 2001

The call to address rising costs and increase quality monitoring of medical benefits - coupled with specific research findings identifying key problem areas - led to the filing of House Bill (HB) 2600 in the 77th Texas Legislature (2001). In its initial form, the bill contained six articles focused on those basic goals, with provisions 1) increasing the Texas Workers' Compensation Commission's (TWCC's) statutory authority to monitor doctors and insurance carriers in the system; 2) establishing voluntary regional networks

for workers' compensation medical services with built-in incentives for injured workers to utilize the networks; 3) improving communication among system participants about return-to-work issues; 4) increasing the use of independent medical evaluations (also known as designated doctor examinations in Texas) to resolve impairment rating and maximum medical improvement (MMI) disputes; 5) improving the quality of medical dispute resolution by introducing the concept of Independent Review Organizations (independent panels of doctors that resolve preauthorization and retrospective medical necessity disputes in the same manner as HMO disputes are currently handled in Texas); 6) requiring that treatment guidelines adopted by TWCC must be “nationally recognized, scientifically valid, and outcome-based”; and 7) aligning the workers’ compensation billing and payment structure for medical services with the federal Medicare system.

Given the omnibus scope of the bill and the interest of workers' compensation system stakeholders (i.e., employees, employers, insurance carriers and medical providers) in its provisions, a working group was formed in an attempt to craft a bill with broad-based support. Hours of negotiation and discussion, along with modifications before the House Committee on Business and Industry, the full House, the Senate Committee on Business and Commerce and, finally, the full Senate, led to the creation of a more comprehensive workers' compensation reform bill. While the central tenets of the bill relating to the cost and quality of medical care in the system remained, a variety of other provisions were added (for a total of 17 articles in all), including more equitable income benefits for employees with multiple jobs, the payment of attorney's fees, a prohibition on certain employee waivers by employers who do not purchase workers' compensation insurance, and the allocation of workers' compensation and risk management costs among state agencies.

In the end, the version of HB 2600 approved and signed into law on June 17, 2001 represented by far the most sweeping change in the Texas workers' compensation system since the reforms of 1989. Fundamentally, HB 2600 aimed to increase system accountability through improved monitoring, provided for a far more extensive use of

medical expertise in decision-making, and shifted the emphasis of system activities from processes to outcomes.

Article 1 of HB 2600 – Tools for Quality and Cost Control

The provisions of Article 1 established a registration process for doctors who participate in the system - including those who: provide care to injured workers as treating doctors; serve as required medical examination doctors or designated doctors; provide care on referral from a treating doctor; or who perform utilization review services for insurance carriers. Requiring registration for those doctors wishing to participate in the system was intended to help make TWCC's Approved Doctor's List (ADL), which includes all of the approximately 80,000 doctors currently and previously licensed to practice medicine in the state, much more manageable.

In addition, TWCC was required to develop, by rule, appropriate training and quality of care monitoring requirements for doctors in the system. With the exception of designated doctors, doctors treating workers' compensation patients were not previously subject to workers' compensation-specific training or quality monitoring requirements. These new training provisions under Article 1 now provide TWCC with the tools to ensure that injured workers receive quality medical care in an efficient manner.

Article 1 also required TWCC to improve its coordination of regulatory activities with health care provider licensing boards and the Texas Department of Insurance, and allowed progressive sanctions to be imposed on either a doctor or an insurance carrier for rule violations.

This article of the bill not only gave TWCC more authority to apply appropriate sanctions, but also rewards to doctors in the system. For example, just as a doctor can be required under the article to submit to more stringent preauthorization of medical care, preauthorization requirements can also be lessened for doctors with a record of providing quality, cost-effective care. Article 1 also required TWCC to collect information on

return-to-work outcomes, patient satisfaction, and the cost and utilization of health care, so that these factors can be considered in the monitoring of medical care.

In addition, Article 1 formalized the role of TWCC's Medical Advisor, who serves an important function in creating monitoring requirements and related rules under this article and others in the bill. The advisor is assisted by a Medical Quality Review Panel of doctors created under this article, solidifying the in-house medical expertise that TWCC had lacked in the past.

Article 2 – A New Model: Regional Health Care Networks

While Article 1 addressed medical care provided in the workers' compensation system in general, Article 2 allowed for the creation of a new model for the delivery of care. Article 2 introduced the concept of regional medical networks into the Texas workers' compensation system. The article called for a feasibility study on the creation of regional workers' compensation health care delivery networks and created a Governor-appointed Health Care Network Advisory Committee (HNAC) to set the standards for health care provided through these regional networks. The committee is also responsible for establishing a network report card to measure employee satisfaction and return-to-work outcomes. Under Article 2, the ROC is required to report on the progress of establishing these regional networks biennially. The networks created under Article 2 are required to meet the minimum standards established under state law for Preferred Provider Organizations (PPOs), along with any other standards set by the HNAC.¹⁴

If a network is created in a region, insurance carriers writing workers' compensation policies in that region will have the option to participate. In turn, employees of companies covered by participating insurance carriers would have the choice of receiving medical care for on-the-job injuries through the network. The employee's voluntary election to participate is on a “per-injury” basis; this and the other voluntary aspects of the networks provide a direct incentive for the medical networks to provide high quality care and increase patient satisfaction.

¹⁴ See Article 3.70-3C, Texas Insurance Code.

Those employees who choose to receive medical care through the network would receive care under a different model than that of the workers' compensation system in general. An injured worker in the network would retain the right to choose his or her own treating doctor, but would be required to choose one from a list of doctors provided by the network. Prior to the employee's election to enter the network, the employee would also be provided with information on the network's performance, including patient satisfaction information and other topics. As an added incentive to utilize the medical networks, some employees who participate in the networks will also be eligible for increased income benefits: 1) the cap on weekly temporary income benefits (TIBs) payments would be raised by 50 percent; and 2) participating employees will receive income benefits for their first week of lost time after two weeks rather than four weeks of lost time.

It should be noted that many insurance carriers currently have voluntary contract arrangements with certain networks to provide care to injured workers; however, injured workers are not required to use the networks and can choose or change their own doctor at any time. As part of the work group compromise, Article 2 allowed insurance carriers to continue operating their own health care networks; however, it does place carrier networks under the same minimum standards as the regional networks established by the HNAC.

Article 3 – Return-to-Work Communication

The interim HB 3697 studies by the ROC also indicated that return-to-work rates in Texas were lower than those in comparable states – that fewer Texas injured workers returned to employment after they were injured, and that in general, they earned less after they returned to work.¹⁵

¹⁵ See *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation and Med-FX, LLC, 2001; and *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs*, Research and Oversight Council on Workers' Compensation and Research and Planning Consultants, L.P., 2001.

Article 3 of the bill attempts to improve return-to-work outcomes and communication about return-to-work issues. This article required employers to provide, upon request, information about whether they offer modified duty opportunities or modified-duty return-to-work programs to transition injured employees back to work. Insurance carriers are also required, with the consent of an employer, to provide return-to-work coordination services including analyses of job requirements, assessments of job modifications to facilitate return to work, and case management. Based on negotiations by the business and insurance carrier communities, TWCC was prohibited from adopting rules on these notice requirements until 2004 to allow the system the opportunity to implement these notice requirements without agency regulation.

The article also required TWCC to use return-to-work experts to train its staff on the coordination of return-to-work services and to report twice a year to the ROC on the implementation and outcome of return-to-work initiatives.

Article 4 – Spinal Surgery and Preauthorization Changes

Article 4 of HB 2600 also made changes to the process by which spinal surgery is approved. HB 3697 research findings highlighted the fact that Texas had extremely high spinal surgery rates compared with other states. Under HB 2600, the old spinal surgery second opinion process was eliminated, and spinal surgery requests were instead made subject to preauthorization by insurance carriers. If preauthorization is denied, a review is conducted by an Independent Review Organization (IRO), and claimants still denied a request for surgery at the IRO level have access to TWCC's dispute resolution process under Chapter 410 of the *Labor Code*. The changes were designed to expedite decisions regarding spinal surgery while ensuring that qualified medical experts conduct those reviews.

Along with spinal surgery, Article 4 also set up a minimum preauthorization list for certain other medical procedures. These included 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 identified by TWCC rule. This list of services requiring preauthorization reflected only those specifically required in the statute and does not prohibit TWCC from requiring by rule preauthorization of other services.

Article 5 – Required Medical Examinations for Determining Impairment Ratings, Maximum Medical Improvement

Article 5 changed the process by which injured employees undergo required medical examinations (RMEs). Under the old law, insurance carriers were allowed to request that an injured employee have an examination by a carrier-selected doctor to evaluate issues related to the employee’s medical condition every 180 days, with certain exceptions. This article changed that process by stipulating that for issues involving the assignment of impairment ratings or attainment of maximum medical improvement (which constitute a significant percentage of RME exams), injured workers will be sent not to a doctor chosen by the insurance carrier, as under old law, but first to an independent doctor selected from TWCC’s list of designated doctors.

Designated doctors are already used by TWCC to provide independent medical evaluations and help resolve disputes, and the opinions of designated doctors carry “presumptive weight” (i.e., they are presumed in a dispute to be correct unless the great weight of the medical evidence is to the contrary). The intent of this change was to bring an independent medical evaluation into the RME process quicker and minimize the number of physical examinations for injured employees.

Article 6 – Medical Dispute Resolution and Medical Guidelines

Several items in HB 2600 relate to this broad category. One significant change included in Article 6 of the bill requires TWCC to utilize Independent Review Organizations (IROs) to resolve medical disputes. These entities have been used for some time to resolve medical necessity disputes involving Health Maintenance Organizations (HMOs) in Texas. IROs are utilized to produce decisions with greater medical expertise in a more efficient manner than TWCC's current in-house medical review process. The cost of review by an IRO would be paid by the insurance carrier in disputes involving services

that require preauthorization; otherwise, the cost would be paid by the entity (e.g., insurance carrier or medical provider) who fails to prevail in the dispute. Article 6 also required TWCC to publish its medical dispute and IRO decisions on its Internet website, including decisions of the State Office of Administrative Hearings (SOAH).

In addition, Article 6 required TWCC to adopt a fee schedule based on the reimbursement methodologies, models, and values or weights used by the federal Medicare system, with minimal modifications necessary to meet occupational injury requirements. The intent of this provision was to bring the reimbursement structure in the Texas workers' compensation system into closer alignment with the structures used in other health care delivery systems. The actual reimbursement amounts are determined by TWCC rule and are not adopted in full from any other delivery system.

Another related element of Article 6 required TWCC to adopt an open formulary requiring the use of generic pharmaceuticals unless specified otherwise by the prescribing doctor. It also added coverage for clinically appropriate over-the-counter alternatives to prescription medications. TWCC was also directed to adopt rules allowing an employee to purchase and obtain reimbursement for over-the-counter alternatives prescribed or ordered by a doctor.

This article also made TWCC's creation of treatment guidelines optional rather than mandatory. This change was made in reaction to the fact that TWCC's consensus-based treatment guidelines were identified in the HB 3697 research studies as contributing to Texas' overutilization problem. If treatment guidelines are adopted under HB 2600, the bill required them to be "nationally-recognized, scientifically valid and outcome-based." TWCC's existing treatment guidelines were abolished effective January 1, 2002.

Current Status of HB 2600 Programs

As with any major reform, there has been considerable discussion and attention placed on TWCC's implementation of HB 2600 by system participants. TWCC has spent much of

the past biennium adopting rules to implement the various provisions of HB 2600. Despite the fact that overutilization of medical care was the primary cost driver identified by the HB 3697 studies and addressed by HB 2600, a considerable amount of time and effort has been spent by TWCC developing and now defending its professional services fee guideline required by Article 6 of HB 2600. In the spring of 2002, the Texas Medical Association (TMA) and the Texas AFL-CIO sued TWCC over its professional services fee guideline. TMA and the Texas AFL-CIO were able to secure an injunction against the guideline, which will be revisited in court in April 2003. Interestingly, the contention over the fee guideline does not stem from the requirements of HB 2600, namely the application of a RBRVS system and the usage of Medicare's billing, coding, documentation and payment policies, but rather TWCC's calculation of the workers' compensation conversion factor (the percentage of payment above Medicare that is used to calculate the health care provider's fee). The adopted conversion factor was 125 percent of Medicare, which was lower than the estimated conversion factor based on the previous fee guideline (140 percent of Medicare), which was adopted in 1996.

The registration process for doctors under HB 2600 is scheduled to take place this fall and TWCC has developed an on-line training module and registration form for doctors. However, the outcome of the fee guideline lawsuit may impact the success of this registration process since many health care providers have threatened to drop out of the system if the conversion factor isn't increased.

TWCC has hired a Medical Advisor and has established a Medical Quality Review Panel (MQRP), which is currently in the process of reviewing approximately 100 designated, treating and referral doctors based on medical practice pattern data compiled by the Research and Oversight Council on Workers' Compensation (ROC). TWCC is in the process of negotiating progressive disciplinary agreements with several of these doctors and plans to use the results of these clinical reviews during the doctor registration process this fall. These clinical reviews, however, have taken longer to implement than previously expected by system participants for a variety of reasons. Some system participants have argued that TWCC's prioritization of adoption of the professional

services fee guideline slowed down the progress of the MQRP, while TWCC argues that a lack of resources and concerns over the immunity of MQRP members are responsible for the delay.

In October 2001, the Governor appointed members to the Health Care Network Advisory Committee (HNAC) and in June 2002, the HNAC hired a consultant to conduct a feasibility study on whether voluntary workers' compensation health care delivery networks in Texas would be economically feasible. In January 2003, the HNAC approved the results of the feasibility study, which indicated that voluntary workers' compensation health care delivery networks in Texas would be economically feasible if at least 20 percent of the state's workers' compensation medical costs were handled within the network. Currently the HNAC is working to secure bids from networks for a state employee pilot project; however, there is proposed legislation pending that would set up a state employee pilot project in statute.

Although it is too early to tell whether the HB 2600 reforms have had a significant impact on workers' compensation medical costs in Texas (ROC staff is planning to begin an analysis to estimate the impact of HB 2600 reforms on medical and indemnity claims costs in anticipation for the 2005 Sunset Review process for TWCC), ROC does have some preliminary estimates on the impact of Article 5 (replacing Required Medical Examinations with Designated Doctors for impairment rating and MMI disputes) and the impact of Article 6 (replacing the TWCC medical dispute process with IROs). According to two recent studies by the ROC, Article 5 has resulted in fewer multiple impairment ratings for injured workers (the cost savings associated with fewer impairment rating examinations is estimated to be approximately \$1.8 million per year) and fewer impairment rating disputes (the cost savings associated with fewer disputes is still being calculated).¹⁶ Another study by the ROC on the results of the first six months of the new IRO medical dispute process have shown fewer medical disputes filed under the new process and a reversal in the percentage of disputes resolved in favor of the health care

¹⁶ See upcoming Texas Monitor article entitled "Significant Impact Seen Following Changes to the Impairment Rating Process for Injured Workers in Texas, Research and Oversight Council on Workers' Compensation, 2003.

provider (just previous to HB 2600, TWCC resolved most medical disputes in favor of the health care provider and under HB 2600, it appears that most IRO decisions are being made in favor of insurance carriers).

In short, research findings have played an important role in defining public policy changes in Texas over the recent biennium, culminating in the passage of HB 2600 – the most comprehensive set of workers’ compensation reforms since 1989. While the total impact of HB 2600 changes are yet unknown, it appears that if the system prioritizes its resources on implementing the portions of HB 2600 designed to reduce the overutilization of medical care, then the true impact of these legislative changes will be realized. The HB 2600 model requires a significant shift in thinking – namely target those providers and insurance carriers who are outliers and reduce administrative burdens for the remaining players in the system. This model will continue to be tested over the next biennium in the context of TWCC’s Sunset Review process.