COMPARISON OF STATE WORKERS' COMPENSATION MANAGED CARE PROGRAMS AND FEE SCHEDULES

Texas Department of Insurance
Workers' Compensation Research Group

Table 1: States with Statutory Workers' Compensation Managed Care Programs

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
Arkansas		X		A managed care mandate was repealed in 1997. The employer has a right to choose a treating doctor from the lists of doctors associated with managed care plans that are certified with the state. The employer may receive a premium credit from an insurance carrier if the employer uses the carrier's network of doctors exclusively.
California			X	Employees have a choice to enroll in the employer's managed care plan or pre-designate their own treating doctor. If the employee does not pre-designate a treating doctor, the managed care plan can select a treating doctor for up to 90, 180, or 365 days depending on certain circumstances. If the employer does not have a managed care plan, then the employer can direct the employee's care for the first 30 days and then the employee can choose their own treating doctor.
Colorado	X			Insurance carriers are mandated to offer a managed care plan to policyholders if there is a network in the policyholder's geographic area (generally larger counties only). Insurers/employers that do not offer full managed care must offer medical case management services.
Connecticut		X		Insurance carriers or employers may establish a managed care plan subject to the approval of the state. If a managed care plan exists, an injured employee must seek medical care from a provider within the plan. If an injured employee seeks medical treatment from a provider who is not part of the managed care plan, then the employee may lose his or her right to receive workers' compensation benefits, subject to the order of the workers' compensation commissioner.
Florida		X		Insurance carriers and self-insured employers may contract directly with managed care organizations. These contracts may include capitated arrangements, in which an insurer pays directly or indirectly a fixed amount to a health care provider in exchange for future rendering of medical services. If a managed care contract exists, injured employees must receive medical care within the managed care network.

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
Georgia		X		An employer or an insurance carrier may contract directly with a managed care organization. Employers in Georgia have three options for providing medical care to injured employees: 1) A Traditional Panel of at least six non-associated physicians, including an orthopedic physician, and a minority physician, where feasible. No more than two physicians on the panel shall be from industrial clinics. 2) A Conformed Panel of at least 10 physicians or professional associations. This panel shall include the same physicians required in the Traditional Panel of Physicians plus a chiropractor and a general surgeon. 3) A Workers' Compensation Managed Care Organization certified by the state. A "Workers' Compensation Managed Care Organization" means a plan certified by the state that provides for the delivery and management of treatment to injured employees under the Georgia Workers' Compensation Act.
Kentucky		X		Employers may contract directly with managed care organizations. If no managed care arrangement exists, employees may choose their own treating doctors. Even if the employer has a managed health care arrangement, the employee may elect to continue treating with a doctor who provided emergency medical treatment to the employee.
Massachusetts			X	Insurance companies/employers may enter into preferred provider arrangements. If a preferred provider arrangement exists, the injured employee must seek initial treatment with a provider in the preferred provider network. After the initial visit, injured employees may select a treating doctor outside of the network.

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
Minnesota			X	Insurance carriers and self-insured employers may contract directly with state certified managed care plans. An injured employee may select a treating doctor outside of the managed care organization if the doctor has a documented history of treating the employee, agrees to make all medical care referrals within the managed care plan, and agrees to abide by the terms and conditions of the managed care plan.
Missouri		X		Employers may contract with managed care organizations, but regardless, employers have the ability to select the injured employee's treating doctor.
Montana			X	An injured employee has the ability to choose the initial treating doctor regardless of whether the insurance carrier has contracted with a managed care organization. However, if an injured employee wants to change treating doctors and a managed care contract exists, then the employee must select a doctor from the managed care organization's provider network. Additionally, if an injury results in: a loss of total wages for any period of time; a permanent impairment; the need for a specialized evaluation or medical treatment; or specialized diagnostic tests, then the injured employee must seek medical care from the managed care organization if available. After the initial visit, the injured employee is responsible for 20 percent (not to exceed $10) of the cost of each subsequent medical visit to a health care provider and $25 for each subsequent visit to a hospital emergency department, unless the visit is to a health care provider who is part of a managed care organization's network.

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
Nebraska			X	An insurance carrier or self-insured employer may contract directly with a managed care organization. If a managed care contract exists and the compensability of the injury has been accepted, then the employer may require an injured employee to seek medical care within the managed care organization's network, unless the employee selects a treating doctor who agrees to make all referrals for additional treatment within the managed care organization's network. If the insurance carrier denies injury compensability, then the injured employee may leave the managed care plan and the employer is liable for the cost of the medical care previously provided.
Nevada		X		Self-insured employers or employer associations may contract directly with managed care organizations, and if a managed care contract exists, injured employees must receive medical care within the managed care network. If no managed care network contract exists, then the injured employee selects a treating doctor from a list of doctors maintained by the state workers' compensation agency.
New Hampshire		X		An employer or an insurance carrier may contract directly with managed care organizations. If a managed care contract exists, then the injured employee must seek medical care within the managed care organization's network.
New Jersey		X		The employer has the right to select the injured worker's treating doctor for all work related injuries.
New York			X	Insurance carriers and self-insured employers may contract with preferred provider organizations that are certified by the state. An injured employee must seek initial treatment from the preferred provider organization and may opt out of the network only after 30 days from the date of the initial medical visit.
North Carolina		X		Employers and insurance carriers may contract directly with managed care organizations. If a managed care contract exists and the employer has accepted compensability of the injury, then an injured employee must seek medical care from the managed care organization.

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
North Dakota	X			The exclusive state fund contracts with a third party administrator to provide managed care services. Every injured employee has the ability to select his or her initial treating doctor; however, once the exclusive state fund accepts compensability of the claim, it may require the injured employee to choose another treating doctor from a panel of three doctors who specialize in the treatment of the employee's injury. Employers who maintain a state-approved risk management program can direct their injured employees directly to "preferred providers;" however, an employee can choose to opt out of the preferred provider arrangement if the employee notifies the employer prior to suffering a work-related injury.
Ohio	X			The exclusive state fund contracts with various managed care organizations to provide medical care to injured employees. Employees may select a treating doctor from the managed care organization's provider panel, if available. If a provider panel is available and the employee chooses not to be treated by a panel provider, then only the employee's initial or emergency treatment is generally authorized. Self-insured employers may contract with "Qualified Health Plans," which meet the standards for qualification developed by the state's health care quality advisory council and is certified with the exclusive state fund.
Oklahoma			X	Employees have the option of not enrolling in their employer's or insurance carrier's managed care plan. However, if the employee does not enroll in the managed care plan, the employee must designate his or her own list of physicians at the time of enrollment. Each physician on the employee's list must have a documented history of treating the worker or a documented history of treating an immediate family member of the employee.

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
Oregon			X	Insurance carriers and self-insured employers may contract directly with a managed care organization. After a work-related injury, an insurer may enroll an employee in the managed care plan. If enrolled, injured employees must seek future medical treatment from health care providers who are part of the managed care organization's network. If the insurer requires an injured employee to receive medical care from the managed care organization's network, and then later denies the compensability of the claim, then the insurer must pay the costs of medical care rendered until the employee receives notice of the claim denial. However, if an insurer does not enroll an injured employee into the managed care plan and later denies the compensability of the claim, then the insurer is not liable for the medical services provided to the employee.
Pennsylvania			X	Employers may contract directly with a managed care plan (referred to as a "coordinated care plan") that is certified by the state. Injured employees must choose a treating doctor from a list of at least 6 providers (no more than 4 of these providers can be part of the employer's coordinated care plan) chosen by the employer. Once a treating doctor has been designated, an injured employee must continue to receive medical treatment from the designated treating doctor for at least 90 days from the date of the first medical visit. After 90 days, an injured employee may select a treating doctor not on the employer's list.
Rhode Island			X	Employees have the ability to select their initial treating doctor even if the employer or insurance carrier has an approved preferred provider network. However, if the employee wants to change treating doctors, then the employee must select a doctor listed on the employer's or insurance carrier's preferred provider network panel.

State	Mandated	Regulated but not mandated (employees must treat within plans)	Regulated but not mandated (employees may opt out of plan under certain circumstances)	Notes
South Dakota	X			Every insurance carrier must certify to the state each year that it has provided the services of a managed care plan (referred to as case management plans in South Dakota) to its policyholders, and every self-insured employer must certify to the state each year that it has adopted a managed care plan for its employees. Injured employees may choose a treating doctor who is not part of the managed care plan, but the doctor must agree to abide by the terms of the managed care plan agreement.
Utah			X	Insurance carriers and self-insured employers may contract directly with a managed care organization. Injured employees may choose a treating doctor outside of the managed care organization after the employee seeks initial treatment within the managed care organization.

Source: Tanabe, Ramona P. and Susan M. Murray, *Managed Care and Cost Containment in Workers' Compensation, A National Inventory: 2001-2002*, Workers' Compensation Research Institute, 2001; various state workers' compensation system websites; and the Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Table 2: State Managed Care Program Certification Requirements, Network and Quality of Care Standards, Fee Arrangements with Network Providers, Medical Dispute Resolution Requirements

State	State Certification Required?	Requires Specific # & Type of Provider in Networks	Requires Network to Have/Use Treatment Guidelines	Requires Network to Have Utilization Review (UR) Function	Requires Network to Have Internal Dispute Resolution Function	Requires Network to Have Case Management Function	Is Network Prohibited from Negotiating Fees with Providers?
Arkansas	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
California	Yes	Yes	Yes	Yes	Yes	Yes	No
Colorado	No	No, but plan must ensure adequate access	Yes	No	No	Yes	No
Connecticut	Yes	Yes	Yes	Yes	Yes	No	No
Florida	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
Georgia	Yes	Yes	Yes	Yes	Yes	Yes	No
Kentucky	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
Massachusetts	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	No	No
Minnesota	Yes	No, but plan must ensure adequate access	No	Yes	Yes	Yes	No
Missouri	Yes	Yes	No	No	No	No	No

State	State Certification Required?	Requires Specific # & Type of Provider in Networks	Requires Network to Have Treatment Guidelines	Requires Network to Have Utilization Review (UR) Function	Requires Network to Have Internal Dispute Resolution Function	Requires Network to Have Case Management Function	Is Network Prohibited from Negotiating Fees with Providers?
Montana	Yes	Yes	No	Yes	Yes	No	No
Nebraska	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
Nevada	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
New Hampshire	Yes	Yes	Yes	No	No	No	No
New Jersey	No	Yes	Yes	Yes	Yes	Yes	No
North Carolina	Yes	*	*	*	*	*	*
North Dakota	Yes	No, but plan must ensure adequate access	No	Yes	No	Yes	No
Ohio	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
Oklahoma	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
Oregon	Yes	Yes	Yes	Yes	Yes	Yes	No
Pennsylvania	No	*	No	Yes	Yes	Yes	No

State	State Certification Required?	Requires Specific # & Type of Provider in Networks	Requires Network to Have Treatment Guidelines	Requires Network to Have Utilization Review (UR) Function	Requires Network to Have Internal Dispute Resolution Function	Requires Network to Have Case Management Function	Is Network Prohibited from Negotiating Fees with Providers?
Rhode Island	Yes	Yes	No	No	No	No	No
South Dakota	Yes	No, but plan must ensure adequate access	Yes	Yes	Yes	Yes	No
Utah	No	Yes	No	No	No	No	No

Source: Tanabe, Ramona P. and Susan M. Murray, *Managed Care and Cost Containment in Workers' Compensation, A National Inventory: 2001-2002*, Workers' Compensation Research Institute, 2001; Research and Oversight Council on Workers' Compensation, An Analysis of Managed Care Network Standards in Other State Workers' Compensation Systems, 2002; various state workers' compensation system websites; and the Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: * North Carolina: Managed care arrangements are not regulated under the state's workers' compensation Act or rules. The state insurance commissioner licenses all PPOs and HMOs operating in the state. * Pennsylvania: State law allows employers to put together a list of providers that the injured employee must choose from. No more than four of the doctors on this list can come from the employer's coordinated care organization (CCO).

Table 3: States with Provider Fee Schedules

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Alabama	Yes	Rule	Alabama uses the Blue Cross/Blue Shield PMD schedule + 7.5 percent, with a 2.5 percent specific add-on if approved by the governor. Annual increases are tied to the consumer price index.
Alaska	Yes	Rule	Alaska bases its provider fee schedule on the usual and customary provider charges as determined by insurance carrier payment data. The fee schedule is reviewed on an annual basis.
Arizona	Yes	Rule	Arizona bases its provider fee schedule on the usual and customary provider charges as determined by insurance carrier payment data, Medicare and Medicaid reimbursement amounts, private insurers, and public comment.
Arkansas	Yes	Rule	Arkansas bases its provider fee schedule on the usual and customary provider charges as determined by insurance carrier payment data.
California	Yes	Current statute reduces existing provider fee schedule by 5 % through 2005 and then gives the administrative agency authority to set reimbursement amounts by rule.	California has developed its own Relative Value Scale using insurance carrier payment data.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Colorado	Yes	Rule	Colorado uses the Relative Value for Physicians (RVP) as a basis for the guideline. The fee schedule is reviewed on an annual basis and updates are formulated using input from a Medical Care Advisory Committee.
Connecticut	Yes	Rule	Connecticut bases its provider fee schedule on the usual and customary provider charges as determined by insurance carrier payment data and input from stakeholder advisory committees.
Delaware	No		
Florida	Yes	Rule	Florida bases its provider fee schedule on the state's Medicare fee schedule.
Georgia	Yes	Rule	Georgia bases its provider fee schedule on the usual and customary provider charges as determined by insurance carrier payment data and input from stakeholder advisory committees.
Hawaii	Yes	Statute	Hawaii bases its provider fee schedule on the Medicare fee schedule + 10%. Public hearings are used to determine fee schedule changes.
Idaho	Yes	Rule	Idaho bases its provider fee schedule on statewide insurance carrier payment data.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Illinois	No		
Indiana	No		
Iowa	No		
Kansas	Yes	Rule	Kansas bases its provider fee schedule on a combination of Medicare reimbursement rates, a survey of physician charges, Blue Cross/Blue Shield and self-insurer payment data.
Kentucky	Yes	Rule	Kentucky bases its provider fee schedule on the state's Medicare fee schedule. Conversion factors are calculated using provider input.
Louisiana	Yes	Rule	Louisiana bases its provider fee schedule on the mean of the state's Medicare fee schedule and the usual and customary charges reported by providers.
Maine	Yes	Statute	Maine bases its provider fee schedule on the federal Resource Based Relative Value Scale with a conversion factor of $60.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Maryland	Yes	Rule	Maryland develops its provider fee schedule using input from a fee schedule committee, consisting of employers, employees, insurance carriers, and health care providers.
Massachusetts	Yes	Rule	Massachusetts bases its provider fees on the state's Medicare reimbursement schedule with multiple modifiers established by the state workers' compensation agency.
Michigan	Yes	Rule	Michigan bases its provider fees on the state's Medicare reimbursement schedule, but not the most recent version of the Medicare RVUs.
Minnesota	Yes	Rule, but statute requires that the relative value fee schedule differentiate among different types of health care providers.	Minnesota bases its provider fee schedule on the federal Resource Based Relative Value Scale, using 1998 RVUs. There is one conversion factor that is tied to the annual increase in the producer price index for physician offices.
Mississippi	Yes	Rule	Mississippi bases its provider fees on the state's Medicare reimbursement schedule, but not the most recent version of the Medicare RVUs. The state's conversion factors were developed using a consultant and usual and customary charge information.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Missouri	No		All charges should be "fair and reasonable" and subject to regulation by the state. All fees shall be based on UCRP.
Montana	Yes	Rule	Montana uses the *St. Anthony's Relative Value for Physicians* as the basis for its fee schedule, along with state-specific conversion factors. Reimbursement rates are updated annually using the percentage increase in the State Average Weekly Wage.
Nebraska	Yes	Rule	Nebraska bases its provider fee schedule on the state's Medicare fee schedule. The state calculates conversion factors using provider charge and payment data.
Nevada	Yes	Rule	Nevada uses the *St. Anthony's Relative Value for Physicians* as the basis for its fee schedule, along with medical charge and payment data from insurance carriers, providers, HMOs and PPOs.
New Hampshire	No		
New Jersey	No		
New Mexico	Yes	Rule	New Mexico bases its reimbursement rates on the 60th percentile of current charges for New Mexico's providers.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
New York	Yes	Rule	New York bases its provider schedule on its own relative value scale developed using insurance carrier medical payment data.
North Carolina	Yes	Rule	North Carolina bases its provider fee schedule on the state's Medicare fee schedule with multiple conversion factors adopted by the state.
North Dakota– exclusive state fund	Yes		North Dakota uses the *St. Anthony's Relative Value for Physicians* as the basis for its fee schedule. Conversion factors are calculated using information on Medicare's reimbursement rates, insurance carrier payment data, and other state workers' compensation data.
Ohio – exclusive state fund	Yes	Rule	Ohio bases its provider fee schedule on the federal Resource Based Relative Value Scale and calculates conversion factors using workers' compensation payment data and input from providers.
Oklahoma	Yes	Rule	Oklahoma uses the *St. Anthony's Relative Value for Physicians* as the basis for its fee schedule and calculates conversion factors using information on Medicare reimbursement rates, insurance carrier payment data, and worker' compensation payment data from other states.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Oregon	Yes	Rule	Oregon bases its fee schedule conversion factors on a survey, the physician's component of the CPI, or other state agency data. Fee schedules are reviewed on an annual basis.
Pennsylvania	Yes	Rule	Pennsylvania sets provider fees at 113 percent of the state's 1994 Medicare fee schedule. If there is no Medicare charge, then fees are set at 80 percent of the UCRP.
Rhode Island	Yes	Statute	Rhode Island sets provider fees using a fee schedule, however, the statute states that fees cannot the 90th percentile of the usual and customary charges charged by health care providers in Rhode Island.
South Carolina	Yes	Rule	South Carolina bases its fee schedule on the federal Resource Based Relative Value Scale. The state calculates the fee schedule's conversion factors.
South Dakota	Yes	Rule	South Dakota bases its provider fee schedule on McGraw-Hill's *Relative Value for Physicians*.
Tennessee	No		

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Texas	Yes	Rule	Texas bases its provider fee schedule on the state's Medicare fee schedule. The state calculates the fee schedule's conversion factors.
Utah	Yes	Rule	Utah bases its provider fee schedule on the federal Resource Based Relative Value Scale. Conversion factors are determined using input from system stakeholders and an analysis of Medicare reimbursement rates.
Vermont	Yes	Rule	Vermont bases its provider fee schedule on the rates of various Blue Cross/Blue Shield fee schedules.
Virginia	No		
Washington – exclusive state fund	Yes	Rule	Washington bases its provider fee schedule on the state's Medicare fee schedule. Washington reviews utilization patterns and adjusts the fee schedule's conversion factors in order to maintain aggregate payment levels.
West Virginia– exclusive state fund	Yes	Rule	West Virginia bases its provider fee schedule on the state's Medicare fee schedule. The state calculates fee schedule conversion factors using prior workers' compensation payment data.

State	Does State Have a Provider Fee Schedule?	Are Provider Reimbursement Amounts Determined By Statute or Rule?	What is the Basis of the Fee Schedule?
Wisconsin	No		
Wyoming - exclusive state fund	Yes	Rule	Wyoming uses the *St. Anthony's Relative Value for Physicians* as the basis for its fee schedule.

Source: Tanabe, Ramona P. and Susan M. Murray, *Managed Care and Cost Containment in Workers' Compensation, A National Inventory: 2001-2002*, Workers' Compensation Research Institute, 2001; various state workers' compensation system websites; and the Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Diagnostic Testing Trends in the Texas Workers' Compensation System

Texas Department of Insurance

Workers' Compensation Research Group

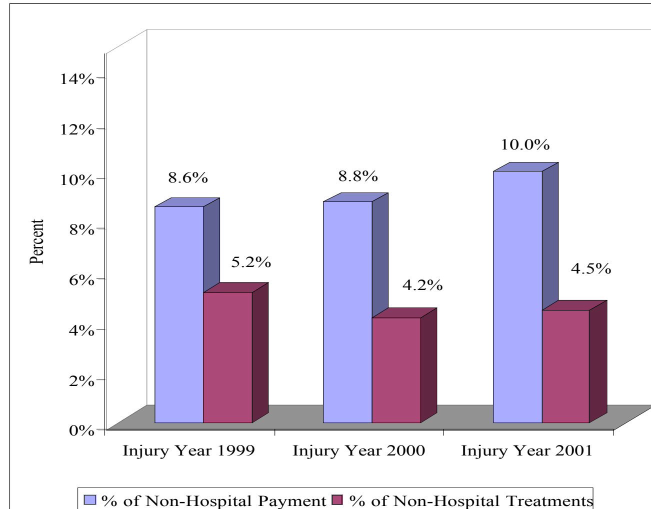
1

Three areas of focus for the medical cost portion of this analysis:

- The average number of diagnostic testing services per injured worker
- The average number of diagnostic testing services per visit
- The average number of diagnostic testing visits per injured worker

2

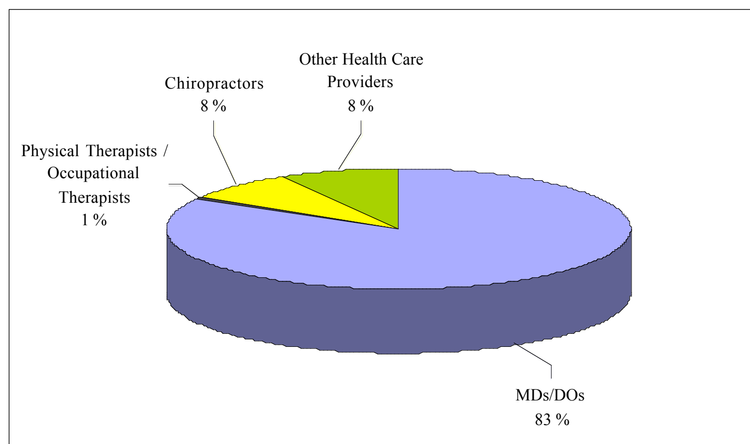
Percentage of Total Non-Hospital Medical Payments and Treatments That Are for Diagnostic Testing Services, Injury Years 1999-2001, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: Percentage of total non-hospital medical payments do not include pharmacy costs.

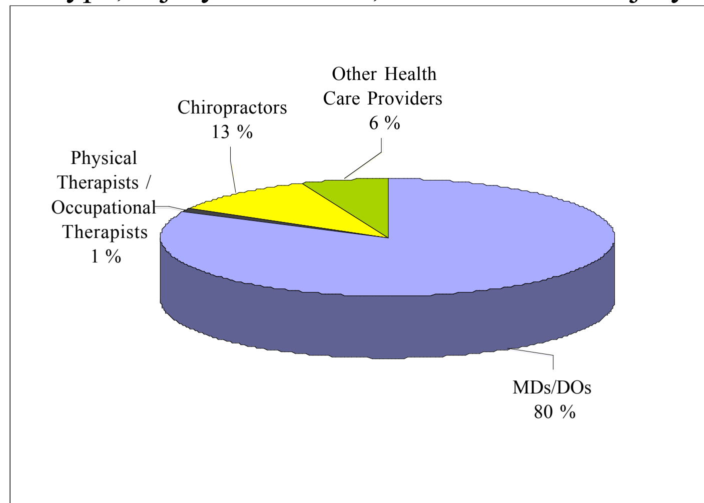
Distribution of Payments for Diagnostic Testing Services by Provider Type, Injury Year 2001, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other health care providers" includes podiatrists, physician assistants, and other health care providers not able to be classified using TWCC's data.

Distribution of Diagnostic Testing Services by Provider Type, Injury Year 2001, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other health care providers" includes podiatrists, physician assistants, and other health care providers not able to be classified using TWCC's data.

5

Average Number of Diagnostic Testing Services and Average Payment Per Injured Worker Who Received These Services, Injury Years 1999-2001, One-Year Post Injury

(average payment per worker in parentheses)

Type of Diagnostic Testing Service	Injury Year 1999	Injury Year 2000	Injury Year 2001
Nerve Conduction Studies	11.8 ($623)	13.1 ($677)	15.0 ($711)
MRIs	1.6 ($839)	1.6 ($865)	1.7 ($901)
CT Scans	1.4 ($362)	1.4 ($356)	1.4 ($358)
Other Diagnostic Tests	2.5 ($113)	2.6 ($116)	2.6 ($124)

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

6

Average Number of Diagnostic Testing Services Per Injured Worker Who Received These Services by Provider Type, Injury Year 2001, One-Year Post Injury

Type of Diagnostic Testing Service	MDs/DOs	Chiropractors	Physical Therapists / Occupational Therapists	Other Health Care Providers
Nerve Conduction Studies	12.4	16.8	12.5	14.1
MRIs	1.6	1.8	1.6	1.4
CT Scans	1.4	1.1	1.3	1.3
Other Diagnostic Tests	2.5	2.4	1.6	2.1

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other health care providers" includes podiatrists, physician assistants, and other health care providers not able to be classified using TWCC's data. "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

7

Average Number of Diagnostic Testing Services Per Visit, Injury Years 1999-2001, One-Year Post Injury

Type of Diagnostic Testing Service	Injury Year 1999	Injury Year 2000	Injury Year 2001
Nerve Conduction Studies	9.8	10.6	12.0
MRIs	1.4	1.4	1.4
CT Scans	1.3	1.2	1.2
Other Diagnostic Tests	1.5	1.5	1.5

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

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Average Number of Diagnostic Testing Services Per Visit Who Received These Services by Provider Type, Injury Year 2001, One-Year Post Injury

Type of Diagnostic Testing Service	MDs/DOs	Chiropractors	Physical Therapists / Occupational Therapists	Other Health Care Providers
Nerve Conduction Studies	10.6	14.4	11.8	12.8
MRIs	1.4	1.4	1.6	1.3
CT Scans	1.2	1.1	1.3	1.2
Other Diagnostic Tests	1.5	1.9	1.5	1.6

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other health care providers" includes podiatrists, physician assistants, and other health care providers not able to be classified using TWCC's data. "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

Average Number of Diagnostic Testing Visits Per Worker, Injury Years 1999-2001, One-Year Post Injury

Type of Diagnostic Testing Service	Injury Year 1999	Injury Year 2000	Injury Year 2001
Nerve Conduction Studies	1.2	1.2	1.3
MRIs	1.2	1.2	1.2
CT Scans	1.2	1.1	1.2
Other Diagnostic Tests	1.7	1.7	1.7

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

Average Number of Diagnostic Testing Visits Per Worker Who Received These Services by Provider Type, Injury Year 2001, One-Year Post Injury

Type of Diagnostic Testing Service	MDs/DOs	Chiropractors	Physical Therapists / Occupational Therapists	Other Health Care Providers
Nerve Conduction Studies	1.2	1.2	1.1	1.1
MRIs	1.2	1.2	1.0	1.1
CT Scans	1.1	1.1	1.0	1.1
Other Diagnostic Tests	1.7	1.3	1.1	1.3

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other health care providers" includes podiatrists, physician assistants, and other health care providers not able to be classified using TWCC's data.

11

Summary

- With the exception of nerve conduction studies, there has not been a significant increase in the utilization of diagnostic testing services from injury year 1999-2001, one-year post injury.
- This is in contrast with the increased utilization of physical medicine services (covered in the previous presentation to the committee) over the same time period.
- When the utilization of these diagnostic tests are analyzed by provider type, chiropractors and physical/occupational therapists tend to have higher utilization of nerve conduction studies per worker, compared with MDs/DOs and other health care providers.

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Summary

- However, there has been an increase in the average payment for diagnostic testing services per worker during injury year 1999-2001, which warrants further review, but may be the result of providers billing for more expensive diagnostic tests rather than billing for more diagnostic tests.

Comparison of State Workers' Compensation Programs Supplementary Analysis

Texas Department of Insurance

Workers' Compensation Research Group

1

Purpose of This Analysis

- To analyze the factors that drive medical and income benefit cost differences among the state self-insured workers' compensation programs.

2

The State's WC programs include:

- State Office of Risk Management (SORM)
- University of Texas System (UT)
- Texas A&M University System (A&M)
- Texas Department of Transportation (TXDOT)

3

Five areas of focus for this analysis:

- Percentage of injured workers who received physical medicine and diagnostic testing services
- Number of physical medicine and diagnostic testing services received per injured worker
- Geographic distribution of state WC claims
- Wage differences between injured state workers
- Sick and annual leave usage by injured state workers

4

Data Sources

- Texas Workers' Compensation Commission (TWCC) medical database
- SORM medical data
- TWCC benefit database
- Sick and annual leave data from SORM, UT, and A&M

5

Methods for Medical Cost and Medical Care Utilization Analysis

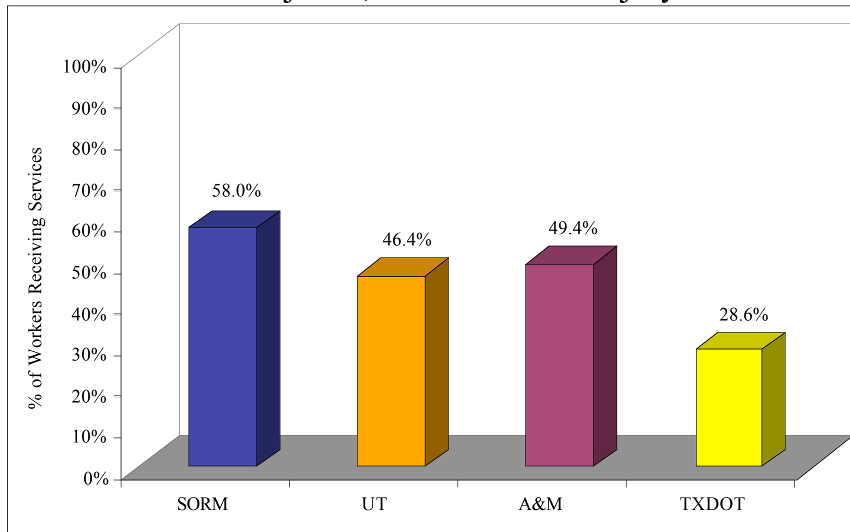
- To ensure an "apples to apples" comparison, TDI grouped all diagnoses into diagnostic "buckets" according to a methodology prescribed by the American College of Occupational and Environmental Medicine (ACOEM).
- Medical and indemnity cost comparisons in this presentation were calculated for injury years 1999-2001 at twelve months post-injury to ensure that all claims included in the analysis have the same claim maturity.
- Given the relatively small number of claims for each of the state WC programs, it is difficult to compare the utilization of specific physical medicine and diagnostic testing services for each state WC program for each injury year. However, to compare the overall utilization of physical medicine and diagnostic testing services among the state WC programs, TDI combined all of the claims for injury years 1999-2001.

6

Physical Medicine Findings

7

Percentage of Injured State Workers Who Received Physical Medicine Services, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

8

Mean (Average) Number of Physical Medicine Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury

(results shown for 10 most frequent physical medicine services provided to injured state workers)

Type of Physical Medicine Service	SORM	UT	A&M	TXDOT
Therapeutic Exercises	26.0	18.2	24.4	18.7
Hot & Cold Packs	9.6	8.1	9.9	7.6
Electrical Stimulation – unattended	10.9	8.8	10.8	9.5
Myofascial Release	11.9	8.0	12.7	8.6
Therapeutic Exercises – one on one	12.8	8.5	14.1	8.2
Manipulation	22.0	15.3	24.6	13.3
Massage Therapy	12.7	7.8	12.0	8.3
Electrical Stimulation – manual	13.7	8.8	15.3	6.7
Joint Mobilization	9.7	5.2	7.6	6.2
Neuromuscular Education	10.3	8.0	7.4	8.6

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

9

Median Number of Physical Medicine Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury

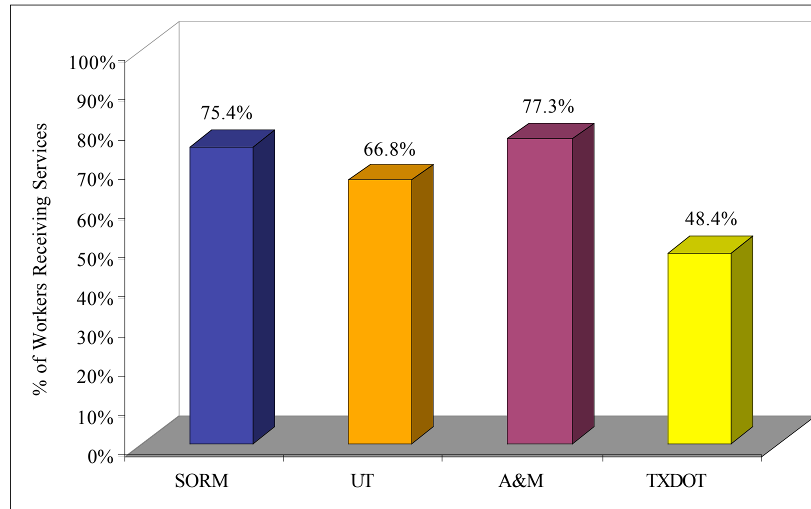
(results shown for 10 most frequent physical medicine services provided to injured state workers)

Type of Physical Medicine Service	SORM	UT	A&M	TXDOT
Therapeutic Exercises	13.0	11.0	13.0	10.0
Hot & Cold Packs	6.0	6.0	8.0	5.0
Electrical Stimulation – unattended	7.0	6.0	8.0	6.0
Myofascial Release	7.0	5.0	10.0	5.0
Therapeutic Exercises – one on one	5.0	4.0	10.0	3.0
Manipulation	13.0	12.0	16.0	6.0
Massage Therapy	7.0	5.0	7.0	6.0
Electrical Stimulation – manual	8.0	6.0	12.0	4.0
Joint Mobilization	5.0	2.0	4.5	3.0
Neuromuscular Education	6.0	5.0	3.0	5.0

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

10

Percentage of Injured State Workers Who Received Physical Medicine Services, Injury Years 1999-2001 Combined, Low Back Soft Tissue Injuries, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

11

Average Number of Physical Medicine Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, Low Back Soft Tissue Injuries, One-Year Post Injury

(results shown for 10 most frequent physical medicine services provided to injured state workers)

Type of Physical Medicine Service	SORM	UT	A&M	TXDOT
Therapeutic Exercises	22.7	16.1	26.2	16.9
Hot & Cold Packs	9.1	7.2	9.6	6.6
Electrical Stimulation – unattended	10.6	7.0	12.6	9.3
Myofascial Release	10.5	7.2	10.1	8.1
Therapeutic Exercises – one on one	12.9	7.7	12.9	5.6
Manipulation	19.5	14.6	19.0	14.3
Massage Therapy	11.5	6.9	10.0	6.6
Electrical Stimulation – manual	13.4	9.4	11.4	5.9
Joint Mobilization	7.1	4.0	7.1	5.4
Neuromuscular Education	10.1	4.9	8.8	9.5

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

12

Median Number of Physical Medicine Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, Low Back Soft Tissue Injuries, One-Year Post Injury

(results shown for 10 most frequent physical medicine services provided to injured state workers)

Type of Physical Medicine Service	SORM	UT	A&M	TXDOT
Therapeutic Exercises	12.0	8.0	10.0	12.0
Hot & Cold Packs	6.0	5.0	6.0	5.0
Electrical Stimulation – unattended	7.0	5.0	12.0	6.0
Myofascial Release	6.0	5.0	6.0	6.0
Therapeutic Exercises – one on one	5.0	5.0	8.0	2.0
Manipulation	12.0	12.0	16.0	4.0
Massage Therapy	7.0	4.0	6.5	5.0
Electrical Stimulation – manual	8.0	7.0	5.0	4.5
Joint Mobilization	3.0	1.0	4.5	3.0
Neuromuscular Education	6.0	4.0	3.5	7.5

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

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Additional Physical Medicine Services That Warrant Further Review by Each of the State WC Programs

- **For SORM:** Diathermy, Whirlpool Therapy, Unlisted Modalities, Manual Traction, Aquatic Therapy, Acupuncture, Therapeutic Exercises – Group, Manual Therapy, Activities of Daily Living and Unlisted Procedures
- **For A&M:** Phonophoresis, Muscle Testing, Mechanical Traction, Chronic Pain Management
- **For UT:** Work Hardening
- **For TXDOT:** Chronic Pain Management, Work Conditioning

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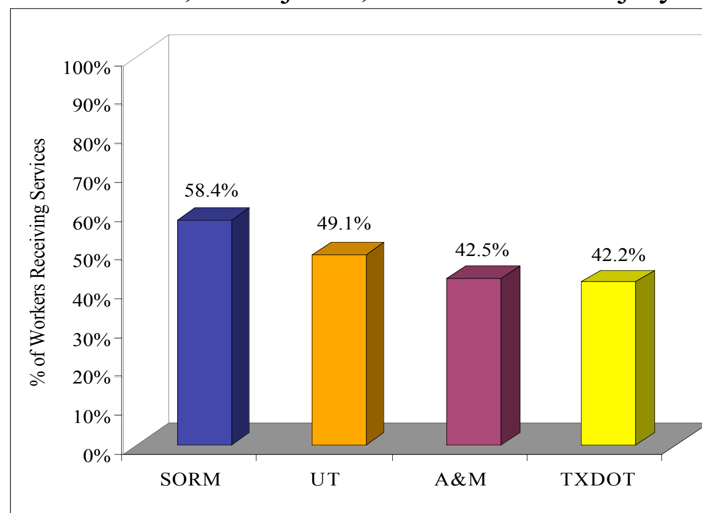
Diagnostic Testing Findings

15

Percentage of Injured State Workers Who Received Diagnostic Testing Services, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

16

Mean (Average) Number of Diagnostic Testing Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury

(results shown for 3 most frequent types of diagnostic testing services provided to injured state workers)

Type of Diagnostic Testing Service	SORM	UT	A&M	TXDOT
Nerve Conduction Studies	11.6	8.1	8.2	11.0
MRIs	1.6	1.4	1.4	1.4
CT Scans	1.4	1.2	1.2	1.5
Other Diagnostic Tests	2.8	2.2	2.0	2.3

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

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Median Number of Diagnostic Testing Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury

(results shown for 3 most frequent types of diagnostic testing services provided to injured state workers)

Type of Diagnostic Testing Service	SORM	UT	A&M	TXDOT
Nerve Conduction Studies	8	6	6	8
MRIs	1	1	1	1
CT Scans	1	1	1	1
Other Diagnostic Tests	2	1	1	1

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

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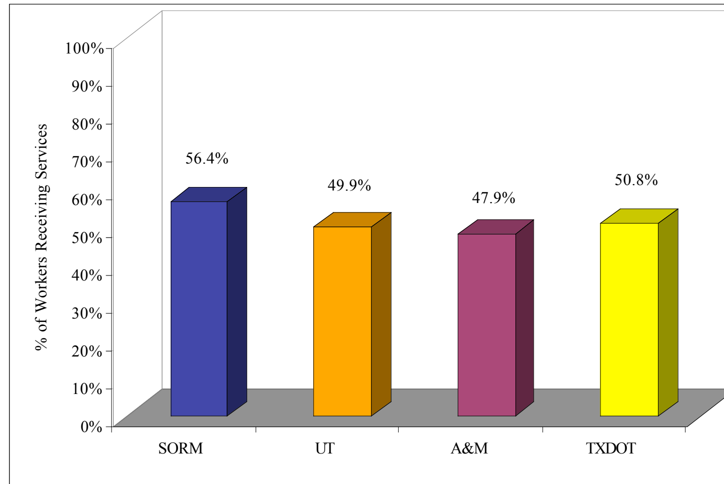
Percentage of Injured State Workers Who Received Diagnostic Testing Services, Injury Years 1999-2001 Combined, Low Back Soft Tissue Injuries, One-Year Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

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Mean (Average) Number of Diagnostic Testing Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, Low Back Soft Tissue Injuries, One-Year Post Injury

(results shown for 3 most frequent types of diagnostic testing services provided to injured state workers)

Type of Diagnostic Testing Service	SORM	UT	A&M	TXDOT
Nerve Conduction Studies	12.4	8.1	4.4	8.3
MRIs	1.5	1.3	1.7	1.4
CT Scans	1.5	1.0	1.4	1.1
Other Diagnostic Tests	2.7	2.0	1.9	1.7

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

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Median Number of Diagnostic Testing Services Per Injured State Worker Who Received These Services, Injury Years 1999-2001 Combined, Low Back Soft Tissue Injuries, One-Year Post Injury

(results shown for 3 most frequent types of diagnostic testing services provided to injured state workers)

Type of Diagnostic Testing Service	SORM	UT	A&M	TXDOT
Nerve Conduction Studies	9	8	3	8
MRIs	1	1	1	1
CT Scans	1	1	1	1
Other Diagnostic Tests	2	1	1	1

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

Note: "Other Diagnostic Tests" include radiologic examinations, myelography, and diskography, among others.

21

Geographic Analysis of State WC Claims

22

Distribution of State WC Reportable Claims by the Ten TWCC Field Offices with the Highest Average Medical Costs per Claim, Injury Years 1999-2001 Combined, All Injuries, One-Year Post Injury

Rank	TWCC Field Office	% of SORM Reportable Claims	% of UT Reportable Claims	% of A&M Reportable Claims	% of TXDOT Reportable Claims
1	Missouri City	3.5%	3.4 %	1.3 %	3.7 %
2	Weslaco	2.4%	1.9 %	0.9 %	1.7 %
3	Dallas	2.7%	7.3 %	2.2 %	5.4 %
4	Fort Worth	2.2%	3.3 %	3.3 %	6.1 %
5	Victoria	3.7%	1.8 %	2.5 %	3.4 %
6	Houston	11.3%	31.4 %	6.5 %	13.0 %
7	Lufkin	5.0 %	2.2 %	1.0 %	2.4 %
8	Midland/Odessa	3.1 %	0.5 %	0.0 %	2.8 %
9	Beaumont	2.8 %	1.1 %	.1 %	2.8 %
10	Corpus Christi	2.6 %	.5 %	8.4 %	3.0 %
TOTAL		40%	53%	26%	44%

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

23

- In order to understand whether the high medical costs associated with certain state WC programs were a result of having a large percentage of their claims in high cost geographic areas of the state, TDI created a medical cost index for each state WC program.

- Medical cost index for SORM, UT, A&M and TXDOT = SUM{(% of reportable claims for each TWCC field office) * (the average medical cost per claim for each TWCC field office)}

- <u>Conclusion:</u> Based on the medical cost index analysis, UT should have the highest medical cost per claim, followed by TXDOT, SORM, and A&M.

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Findings Regarding Wage Differences Among the State WC Programs

25

Average Weekly TIBs Compensation Rates for Each State Workers' Compensation Program, Injury Years 1999-2001

(Weekly TIBs Compensation Rate = 70% of Workers' Average Weekly Wage)

State Workers' Compensation Program	Injury Year 1999	Injury Year 2000	Injury Year 2001
SORM	$303.41	$320.47	$335.00
UT	$317.47	$333.89	$339.91
A&M	$250.46	$267.17	$263.95
TXDOT	$350.35	$295.06	$285.18

Source: Texas Department of Insurance, Workers' Compensation Research Group, 2004.

26

Sick and Annual Leave Usage by Injured State Workers

27

- In order to analyze the usage of sick and annual leave by state employees, TDI requested data from all of the state WC programs and received data from SORM, UT, and A&M.
- However, after closer analysis of this data, it appears that each state WC program is collecting this data differently making it difficult to accurately compare sick and annual leave usage by injured state workers in each state WC program.
- If the legislature is interested in comparing the sick and annual leave usage by injured state workers, there needs to be standardization in the collection of this information by the state workers' compensation programs.

28

Summary

- Compared to the other state WC programs, a higher percentage of SORM's claimants are receiving physical medicine and diagnostic testing services.
- Both SORM and A&M appear to have higher utilization of physical medicine services than the other state WC programs, while SORM and TXDOT appear to have higher utilization of diagnostic testing services than the other state WC programs.
- Based on the geographic distribution of claims for each of the state WC programs and an analysis of the geographic areas of the state with the highest average medical costs per claim, it appears that UT should have the highest average medical cost per claim rather than SORM.

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Summary

- After analyzing the average weekly Temporary Income Benefit (TIBs) compensation rates for injured workers in each of the state WC programs, it appears that UT injured workers have slightly higher weekly compensation rates. However, this slight differential in compensation rates does not fully explain why UT has higher TIBs payments per claim, when compared with SORM, A&M and TXDOT.
- Given the differences in the current sick and annual leave data collection processes for each of the state WC programs, it is not possible to accurately compare the usage of sick and annual leave by injured state workers.

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Future Analyses

- In the third phase of this project, the TDI Workers' Compensation Research Group plans to compare the medical treatment utilization of surgical procedures and injections for each of the state WC programs;
- Compare the negotiated discounts off the 1996 TWCC fee guideline for each of the state WC programs; and
- Analyze the distribution of each state WC program's medical costs by health care specialty.

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