California SB 899 Medical Provider Networks (MPNs)

This update contains important information about a significant legislative change providing an opportunity to control claims related medical costs and the ways ESIS is ready to assist our clients with this opportunity. The change is part of SB 899, the last major California workers’ compensation reform bill enacted on April 19, 2004.

Starting on November 1, 2004 insurers and self-insurers will have the ability to seek approval to use a “Medical Provider Network” (“MPN”). A MPN is a group of physicians or medical providers created to provide exclusive medical treatment for injured employees in connection with occupational claims. Approved MPNs become effective on January 1, 2005.

It is important to note that the rules and regulations regarding MPNs have not yet been finalized as of print, but are scheduled to be made available by November 1, 2004. Any changes to the final version which alter the substance or implementation of the MPN will be subsequently be communicated by ESIS.

By working with ESIS’ recommended MPN, the work flow and management of the MPN will be seamless to clients and their employees. ESIS has worked diligently to identify the highest quality MPN and one tailored to our clients’ geographical needs and expectations. ESIS has selected and recommends Concentra, a certified Health Care Organization (HCO), as the MPN to offer to our clients. ESIS will work with our self-insured clients and our insured clients to provide assistance throughout the application process. For those customers currently enrolled in the Medex HCO program, we have also partnered with Medex as an MPN.

Concentra is a statewide network with more than 50,000 medical care providers from which ESIS will select an exclusive provider group as our MPN. The Concentra medical provider network offers a proven tool for companies and organizations looking to get their workers compensation costs under control, while offering quality care to their employees. The results of many studies indicate Concentra delivers closed cases with a higher ratio of medical only to lost time claims, a lower percentage of litigated claims, and lost-time claims with dramatically fewer lost days than published norms. Concentra’s network of physicians believe their extensive workers’ compensation experience supports the premise that a combination of accurate diagnosis and prompt appropriate medical treatment regularly produces superior results with positive outcomes for patients and payers alike.

You can learn more about Concentra by going to their website at: www.concentra.com. To find a list of medical providers for Concentra, please go to the ESIS website located at www.esis.com (click on “Provider Search” and then double click on “California”).

Our Southern California Workers’ Compensation Center is hosting a “MPN and SB 899 Follow-up” seminar on Thursday, November 18, 2004 at the Calabasas Inn, about 7 miles from the Woodland Hills office. We will also offer a seminar in our Northern California ESIS Workers’ Compensation Center at the World Trade Club in San Francisco on Friday, November 19, 2004. We strongly encourage attendance so that additional information and specific questions or concerns can be addressed.

ESIS felt it was important to take this opportunity to communicate our efforts so that you can be confident that we are taking the necessary steps to allow our clients to take advantage of this cost savings opportunity. Please contact your ESIS Account Manager if you have any questions.

Other SB 899 Readiness Activities

Posting Notices, DWC-1 and New Employee Brochure
A letter to clients, explaining the existing requirements under Labor Code section 3550 and new requirements per SB 899 was sent out in August. ESIS provided existing clients with the new DWC-1 (Employee’s First Report) forms and will continue to send the new form to new clients via the ESIS Claim Kits.

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THE LEGAL CORNER

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Benefit Letters
All of the benefit letters (DWC letters) have been updated to meet the new requirements under SB 899. Additionally, we transferred the DWC letters, along with a majority of our WORD documents into Electronic Form Fill (EFF) system for more efficient processing.

Medical Treatment
In SB 899, employers are to provide medical care for a claims injury upon receipt of a claim form regarding notice of injury. While a claim is being delayed to determine compensability, a statutory cap of $10,000 of medical benefits applies. Thus, timeliness is critical. ESIS has joined forces with our medical case managers on Telephonic Case Management (TCM) and Field Case Management (FCM), in order to ensure we take advantage of the various medical cost saving measures in situations where medical bills are being received and the claim is not yet determined to be compensable.

ESIS will also continue to use our full array of medical programs and vendors to prospectively and retrospectively manage utilization and treatment charges.

See also, above, ESIS implementation of the Medical Provider Network.

Medical – Legal Practice (Disputes)
SB 899 allows for an unrepresented employee a choice a Qualified Medical Examiner (QME) panel of three. If the employee does not make the choice and the appointment within the prescribed timeframes set by the law, the employer may make the choice.

ESIS representatives have been trained in the proper channels for referring cases to state Qualified Medical Exams for un-represented injured workers. We also ask cooperation and timely responses from employers when the employee does not meet the 10-day timeframe for QME selection.

Training was conducted regarding the revision of DWC forms and how to use the forms to comply with these new rules for State QME referrals.

ESIS representatives have also been trained for medical disputes with represented employees.

ESIS conducted training to the W.C. claims staff regarding the use of apportionment where there was a previous permanent disability award to same body part, as well as if there were non-industrial factors.

Supervisors will also be critically important, ensuring the appropriate direction to the adjusters on SB 899 rules, specifically those that help our defense in the application of the apportionment capabilities.

Disability and Permanent Partial Benefits (Indemnity)
All of the new charts for Temporary Total Disability changes with regards to the 104 week cap as well as the exception injuries/diseases have been implemented along with the new procedure for payment of permanent disability once the 104 weeks have been paid. The staff has also been trained on the new weekly allowance charts per the AMA guidelines including the new weekly allowances for permanency ratings between 70% and 99.75%.

Return to Work Programs
On a case-by-case basis we will be assisting employers on ways to get employees back to transitional programs with the assistance of our Telephonic Case Managers (TCM).

Please join us for our one of our November 18th or 19th, 2004 sessions. For details on both sessions, please go to www.esis.com.

Tennessee Workers’ Compensation Reforms
The legislature in that State adopted House Bill 3531 on 5/20/04. This new Bill provides for a modest reform package.

The Bill reduces the statutory multiplier for permanent partial disability claimants who return to work at full wages from 2.5 to 1.5, but leaves intact the 6.0 multiplier for claimants who do not do so. Although this new provision will provide modest relief to employers and insurers, it fails to significantly reform Tennessee’s PPD approach, which is one of the most expensive in the nation. The reduction of the 6.0 multiplier or adoption of various other PPD approaches that have proven successful in other jurisdictions would result in greater cost savings.

The bill authorizes the Commission of Labor and Work Force Development to create a rule establishing a medical fee schedule covering physicians, surgeons, hospitals, prescription drugs and ancillary services. This provision defers all issues regarding proper design of the various fee schedules to the regulatory process, leaving open the possibility that Tennessee’s already high medical costs will remain unchanged or possibly increase.

The new legislation prohibits claims from being filed in the Court-based system until the parties have exhausted the “benefit revives conference” process. This represents a good first step toward eventual elimination of Tennessee’s inefficient Court-based system. However, there is an escape provision that permits claimants to go to Court if an agreement is not reached during the administrative process. This exception renders unlikely any meaningful reduction of system costs.

The Bill substantially increases penalties imposed against employers and insurers for late payment of temporary total disability benefits. The new penalties will be 6% of any late installment after fifteen (15) days and 25% after twenty (20) days. The Bill also includes a provision reciting that a failure to pay along with the new procedure for payment of permanent disability once the 104 weeks have been paid. The staff has also been trained on the new weekly allowance charts per the AMA guidelines including the new weekly allowances for permanency ratings between 70% and 99.75%.

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any workers compensation benefits is an unfair claims practice if the Insurance Commissioner finds a “pattern or practice” or non-payment. This enhanced penalty appears unnecessary since current law already provides the regulator with adequate tools to address late payments. There are also insufficient safeguards on the Commissioner’s discretion to determine whether the carrier has engaged in unfair practices.

The Bill prohibits claimants and employers or insurers from including the issue of future medical benefits in a settlement for three (3) years following a settlement or order. Moreover, there is a permanent prohibition against including future medical benefits for permanent total disability claimants in a settlement. This provision will serve as a disincentive to settlements and will lead to increase litigation and higher system costs.

The Bill would (1) permit either party to demand an Independent Medical Examination (IME) when a dispute exists as to the degree to medical impairment; (2) replace the American Academy of Orthopedic Surgeon’s impairment rating guide as an alternative to the AMA Guides with “any appropriate method used and accepted by the medical community” in cases not covered by the AMA Guides; (3) expand the list of individuals eligible to determine an impairment rating from a single entry (physicians) to include chiropractors or medical practitioners permitted to give expert testimony in a Court of Law who have provided medical treatment to an employee. These changes will likely result in increased system costs and enhanced use of IMEs.

The Bill eliminates provisions that (1) prohibit second injury fund claimants from receiving compensation in excess of 100% permanent disability; (2) require the fund to pay compensation for subsequent compensable injuries for claimants with 100% disability; and (3) place the burden of proving the existence of previous awards for permanent disability on the party claiming compensation against the fund. These changes will enhance the role of the second injury fund and thereby increase costs for all insured employers who will be responsible for paying the fund’s unfunded deficit.

Lastly, the Bill requires security bonds posted by self-insured employers to contain a provision requiring the bond insurer to give the Commissioner of Commerce and Insurance ninety (90) days written notice of its intention to cancel the bond. The insurer may not cancel the bond without written approval or it will be liable to the employees of the self-insured employer for any lawful workers compensation claims that were incurred on or before the date the bond was cancelled up to the maximum penal sum of the bond. The Bill also requires the security bond be written by an insurer maintaining at least an “A” rating from A.M. Best. This provision places unnecessary restrictions on security deposit bonds and insurers that will increase the costs of bonds, and discourage insurers, making individual business judgments, from offering this product.

Most of the provisions contained in this new Bill have an effective date of 7/1/04 and pertain to injuries on or after that date. However, several provisions, including those pertaining to the medical fee schedule and the establishment of an independent medical examination registry to settle disputes as to an injured worker’s payment rating, have an effective date of 7/1/05 and pertain to injuries that occur on or after that date.

TWCC Abolishment Proposed
The Sunset Commission voted 11-0 to abolish the Texas Workers’ Compensation Commission (TWCC). The Sunset Commission is composed of six Senators, six House members and two public members. The Commission is chaired by Rep. Burt Solomons of Carrollton. The Sunset commission reviews all state agencies to determine whether they are efficiently meeting their mission and goals. The TWCC was slated for an early review to gauge the effectiveness of the 2001 reforms contained in H.B. 2600.

The Sunset Advisory Commission plan to require the workers’ compensation system to function like group health insurance, abolish TWCC and transfer the regulation of workers’ compensation insurance to the Texas Department of Insurance (TDI).

This vote also recommends transferring TWCC’s educational functions to the Texas Workforce Commission. It would allow insurance carriers to offer workers’ compensation through networks and applies the protections and regulations of group health to those networks. These protections include the prompt pay requirements passed by the Texas Legislature in 1999 which have never been applied to workers’ compensation. Solomons’ plan would also create a new Office of Employee Assistance to represent injured workers as their cases move through the new system and would offer improved coordination of occupational retraining, physical rehabilitation and provide other services to injured workers.

The next step in the Sunset process is to incorporate these decisions into legislation, which will be filed during the next legislative session.

Texas Appellate Court Upholds Medical Fee Schedule
A major victory for insurers and employers
A Texas appellate court has upheld the medical fee schedule promulgated by the Texas Workers’ Compensation Commission (TWCC). In Texas Medical Association (TMA) v. TWCC, the third Court of Appeals affirmed last year’s district court ruling

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upholding the fee schedule. The TWCC issued a Medicare-based fee schedule in 2002, but TMA and organized labor filed a declaratory action against the fee schedule alleging that the TWCC did not provide reasonable justification for the adoption of its 120% conversion factor and that this conversion rate did not guarantee access to quality care or provide fair reimbursement to medical providers, among other things.

The trial court granted TMA a temporary injunction on the basis that TWCC’s Preamble to the original fee schedule failed to provide sufficient “reasoned justification” for the 120% conversion factor. During the trial, TWCC provided new evidence and was able to substantiate a 125% conversion factor. The new Preamble became effective August 1, 2003. TMA and organized labor filed an appeal of the district court’s ruling. The Third Court of Appeals affirmed the district court’s ruling upholding the 125% reimbursement factor.

**Medicare Set Aside Class Action Update**

There have been recent developments in the pending class action that has been dormant for some time. The original complaint was filed on July 10, 2002 asserting a violation of the Medicare Secondary Payer regulation and seeking to certify as a class of plaintiffs all workers’ compensation claimants who settled their medicals without a MSA (Medicare Set Aside) subsequent to the passage of the regulation in 1989. The suit also seeks to certify a class of defendants as all the carriers and self insured employers who settled medicals with this class of plaintiffs without a MSA during this time period. The carrier defendant filed a very convincing motion to dismiss on September 12, 2002. The case was initially assigned to a U.S. Magistrate Judge who held this motion under submission until March 11, 2004, over a year and a half after it was submitted. The Magistrate made a recommendation that the case be dismissed.

However, the plaintiff objected to this recommendation and sought review from a U.S. District Judge. It was assigned to U.S. District Judge U. W. Clemmon. Judge Clemmon entered an order on June 28, 2004 allowing the plaintiff to cure any defect in their pleading, which was part of the motion to dismiss, thus allowing the parties to leave to proceed with discovery on the class certification issue. It appears this case will not be dismissed by Judge Clemmon and will now enter the discovery phase.

**Living the Dream**

Most of us have a hobby, sport or other “diversion” that we enjoy so much that we dream of giving up the rat-race and boredom of our everyday job to make a living doing that one thing that we love to do above all others. That dream is usually tempered by the personal and fiscal realities of life that convince us that the dream must remain a dream, at least for now.

One Florida man found a way to have it all; unfortunately it involved committing insurance fraud against his employer. This claimant was involved in two traffic accidents while working for his employer, a beverage company. Claiming incapacitating injuries that rendered him unable to work or to play his cherished game of golf, he was off work disabled since 1999. He also claimed that he had to drive extended distances to receive specialized physical therapy and submitted claims for mileage reimbursement. His deposition and testimony before the Workers Compensation Board described a life of pain, misery and incapacitation.

The reality of his life was quite different. Realizing that the claimants stated restrictions simply did not match the objective findings of various medical professionals, the ESIS claims professional referred the case to the SIU for further investigation. Surveillance showed that this claimant was frequenting and playing golf regularly at a highly regarded Florida course. Further investigative efforts with the golf course revealed that the claimant was employed at the course as a greens keeper and part time golf pro. He took full advantage of the golfing privileges on this exclusive course that were part of his employment package. He was fulfilling his lifelong dream, with just a little help from the workers compensation system to the tune of $46,000.00 in benefits to which was never entitled.

Not satisfied with just the disability payments, he also submitted numerous false requests for mileage reimbursement for the extended distances he had to travel to receive his specialized physical therapy. In reality he never made the trips to the clinic but submitted mileage reimbursement for the extended distances he claimed to have travelled to receive his specialized physical therapy. This claimant was convicted of insurance fraud and is facing trial, jail time and restitution.

The dream became a nightmare when the SIU Specialist referred the case to the Florida Fraud Bureau. Based on the evidence gathered by the ESIS Claims/SIU investigation he was arrested and charged with Grand Theft, Perjury and Insurance Fraud, held at the county jail in lieu of $15,000 bail, and is facing trial, jail time and restitution.

Everyday, working closely with claims and our clients, the ESIS SIU uncovers evidence of abuse of the claims process in both workers compensation and the casualty. Cases of abuse and criminal conduct are aggressively pursued and working with state authorities, referred for prosecution when the facts warrant.