Approved awP 3-6-90
Date

MINUTES OF THE HOUSE COMMITTEE ON LABOR & INDUSTRY.

The meeting was called to order by Vice-Chairperson Dorothy Flottman at
Chairperson

9:06 a.m./p.m. on February 26, 1990 in room 526-S of the Capitol.

All members were present except:
Representative Anthony Hensley - Excused
Representative Carl Holmes - Excused
Representative Arthur Douville - Excused

Committee staff present:
Jerry Donaldson - Legislative Research Department
Jim Wilson - Revisor of Statutes' Office
Cindy Wulfkuhle - Committee Secretary

Conferees appearing before the committee:

Robert Anderson - Director of Workers Compensation
Terry Leatherman - Kansas Industrial Council
Tom Slattery - Associated General Contractors of Kansas
Tom Bell - Kansas Hospital Association
Jerry Slaughter - Kansas Medical Society
Harold Rieham - Executive Director of Osteopathic Medicine

The meeting was called to order at 9:06 a.m. by Vice-Chairperson Flottman.

HB 3069: Concerning the Workers Compensation Act

Robert Anderson, Division of Workers Compensation, appeared before the committee and distributed a handout, Attachment #1. House Bill 3069 proposes amendments to the Workers Compensation Act which will eliminate existing problems and reduce litigation. Here is the list of the amendments: Sections 1, 4, 8-12, 15 and 16 of the proposed legislation change the term "physician" to the term "health care provider". Section 2 is to define the terms health care provider, utilization review, peer review and peer review committee. Section 3 is to provide that the director by rule and regulation establish a maximum fee schedule for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided by health care providers. In Section 5 the amendment is to provide that the director adopt and use a schedule for determining the degree of permanent impairment based upon medically or scientifically demonstrable findings. Section 6 is to substitute the term vocational assessment for vocational evaluation; also to define vocatio assessment. Section 7 is to provide that a penalty for each past due medical bill shall be assessed in an amount equal to the larger of either $25 or a sum equal to 10 percent of the amount past due. In Section 13 the amendment is to propose legislation that would provide director's orders on review of preliminary findings shall be issued within 30 days of oral argument or submission of the case. Section 14: the amendment is to provide that any party may notify the director if a district court has not issued judgement on review within 60 days after submission so that the director can request the district court judge to render a decision.

Terry Leatherman, Kansas Industrial Council, spoke as a proponent of the bill and had a handout, Attachment #2. He stated that workers' compensation insurance, and all other health care insurance, has experienced soaring premium costs in recent years. The major concern over adoption of cost control measures is that medical providers will refuse to participate. However, that has not been the case with other forms of health insurance established cost containment programs. The Advisory Panel would assist the director in the annual review of the medical fee schedule and would be well represented by members from the medical community, who will insist the fee schedule be reasonable.

Tom Slattery, Associated General Contractors of Kansas, spoke as a proponent of the bill. We have started our own self-insured health group, and about one month ago the board voted to support the fee schedule, for the same reasons Director Anderson has said to you this morning.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON LABOR & INDUSTRY,

room 526-S, Statehouse, at 9:06 a.m./~~p.m.~~ on February 26, 1990.

Tom Bell, Kansas Hospital Association, spoke as an opponent of the bill and distributed a handout, Attachment #3. He stated that they are opposed to the idea of a fee schedule for workers' compensation. Their major concern is that a fee schedule will not turn out to be the panacea many are expecting. We are in support of an efficient and effective utilization review program within the workers' compensation system. Many times costs can be controlled by limiting utilization than by setting fees.

Jerry Slaughter, Kansas Medical Society, spoke briefly to the committee as an opponent to the bill and distributed a handout, Attachment #4. He stated that they are opposed to statutorily imposed fees schedules. Such efforts to contain costs generally hurt access to health care for those who are injured or ill. Certain payors cut reimbursements to unreasonably low levels. While a utilization review system by qualified professionals can be an effective method of analyzing the use of resources in a third-party system, it must have safeguards so that quality care is maintained.

Harold Rieham, Executive Director of Osteopathic Medicine, addressed the committee and distributed a handout, Attachment #5. He stated briefly that they are opposed to the extension of fee regulation. Our concern is that the physicians would be in a system where all the fees are being regulated and where their costs are not. He asked that the Osteopathic physicians be noticed and be incorporated into the Advisory Panel.

Vice-Chairperson Flottman stated that the hearings on HB 3069 and HB 3028 would be continued tomorrow. The meeting was adjourned at 9:50 a.m. The next meeting of the committee is on Tuesday, February 27, 1990 at 9:00 a.m.

GUEST LIST

COMMITTEE: Labor + Industry DATE: February 26, 1990

NAME	ADDRESS	COMPANY/ORGANIZATION
S. B. Siffers	S.M. Ks.	
Ed DeSoignie	Topeka	Kansas Contractors Assoc.
Charles Smena	Topeka	KS Foundation for Medical Care
Jim DeHoff	Topeka	KS AFL-CIO
Tom Slattery	Topeka	AGC of Ks.
Chip Wheelen	Topeka	Ks Medical Soc.
Jerry Slaughter	"	" " "
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
Bob Williams	Topeka	Ks Pharmacists Assoc.
Lori Callahan	Topeka	Am. Ins. Assn.
Bob Alderson	"	Ks. Chiropractic Assoc.
Arthur J. Boyle	Atchison	Knights of Columbus
Richard Cox	Topeka	DPS
Harold Riehm	Topeka	KAOM
Kelly Waldo	Topeka	KCA
Larry Magill	"	I.I.A.K.
Terry Leatherman	"	KCCI
Robert A. Anderson, Director, Division of Workers Comp	Topeka	

KANSAS DEPARTMENT OF HUMAN RESOURCES

DIVISION OF WORKERS COMPENSATION
600 Merchants Bank Tower, 800 SW Jackson
Topeka, Kansas 66612-1227
(General Information: 913-296-3441)

Mike Hayden, Governor

Ray D. Siehndel, Secretary

296-4000 Director's Office
296-2050 Rehabilitation
296-2996 Claims Advisory
296-3606 Self Insurance
296-7012 Law Judges

February 26, 1990

The Honorable Arthur Douville
Chairman, House Labor & Industry Committee
State Capitol, Room 115-S
Topeka, KS 66612

Re: House Bill 3069

Dear Chairman Douville:

Thank you for allowing me to appear before your committee today to testify in support of House Bill 3069.

House Bill 3069 is a codification of the recommendations that I made in paragraph 6 of my January 23, 1990, letter to you and your committee as proposed amendments to the Workers Compensation Act which will eliminate existing problems and reduce litigation. I briefly discussed each of those proposed amendments with your committee on January 23, 1990, and was instructed by you to assist Jim Wilson, Revisor of Statutes in preparing the language for those amendments.

Although HB 3069 has 18 separate sections and proposes to amend 16 existing statutes; in 9 sections of the proposed legislation the only change is the term "physician" is changed to the term "health care provider."

Sections 1, 4, 8-12, 15 and 16 of the proposed legislation, HB 3069, are amendments to existing statutes [K.S.A. 1989 Supp. 44-501; 44-510c; 44-515; 44-516; 44-518; 44-519; 44-528; 44-5a04; and 44-5a18] to change the term physician to the term health care provider.

Section 2, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-508] to define the terms health care provider, utilization review, peer review and peer review committee.

These additional definitions are needed, if the proposed maximum medical fees schedule and utilization review measure proposed in Section 3 are adopted.

Section 3 of HB 3069 is an amendment to an existing statute [K.S.A. 1989 Supp. 44-510] to provide that the director by rule and regulation establish a maximum fee schedule for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees including costs and charges for medical records and testimony.

This section of the statute further provides that the director create an advisory panel to assist in the adoption of maximum fees and to annually review and approve the maximum fees; authorizes the director to hear and determine all disputes and prescribe procedural rules to be followed in the resolution of disputes; authorizes the director to investigate health care providers and health care facilities to assure compliance; and, authorizes development of utilization review procedures including show cause hearings if it is determined that a health care provider overutilized or ordered unjustified medical treatment.

Although the existing statute gives the director the authority, (and arguably the responsibility) to establish a medical fee schedule, I feel it is important that the enabling legislation be very specific and allow for the adoption of a fee schedule and utilization measures that will insure that medical care for injured workers is not more expensive than medical care for non-workers and that the fees and costs of services provided by those who health care providers refer patients to, or order tests and treatment from, are not more expensive than treatment for non-workers compensation injuries. It is also important that the medical providers are involved in initially establishing these maximum fees and in reviewing them on an annual basis. Another major consideration is that maximum fees must be sufficient to ensure availability of such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employer from the effects of the injury. Finally, there must be a provision to allow utilization review and peer review, if needed. The proposed enabling legislation should accomplish all of those goals while helping to reduce rising cost for injured employees, employers and insurance carriers.

As a minor example, bills for copying charges of medical records are often received for $25 to $50 for a single sheet of paper. These expenses are often paid by insurance carriers without objection and the costs are passed on to the employer through premium increases. Injured employees, who order these records, may not initially pay for those charges, but will reimburse their attorney for these "cost of the litigation".

In August 1989, the task force to evaluate medical cost containment and fee schedules for workers compensation in Kansas issued their report. You were all provided with a copy of that report on January 23, 1990.

The task force noted in the report that: All other insurance lines of business have implemented methods to control both medical utilization and individual fees. This means "cost shifting" could be taking place and workers compensation is paying the highest rates. Two actual examples gathered by the task force follow:

	Managed Care	Group Health	Champus	Workers Comp
Laminectomy	$1,625	$2,365	$2,714	$2,987
Ortho Office Visit	$ 20	$22 to $24	$ 25	$ 27

The task force received the most accurate data on medical costs and indemnity increases from the largest employer in Kansas - the State of Kansas. This data (attachment #4 marked as Exhibit A) is directly out of the claims department and Claims Manager George Welch reports the number of claims did not vary significantly during the time period covered by the table. These medical costs have increased by 97 percent over a 5-year period - compared to the CPI medical costs 32 percent to 34 percent over a 6-year period.

The Kansas State data is also important because we can analyze the percentage of medical costs compared to total costs. This indicates Kansas paid almost as much in medical costs as in indemnity. Or, 45 percent to 49.7 percent of the workers compensation payments are made for medical care. The National Council on Compensation Insurance has advised us this range should actually be 30 to 40 percent.

The state of Kansas has since created an office of Risk Management, entered a contract with a Topeka hospital on a trial basis before contracting on a statewide basis for managed care of their injured workers and has prepared a return to work policy, all of which should reduce costs. Based upon the 1988 medical payout figures and a 22 - 25 percent projected savings, the state of Kansas would save between $627,742 and $713,343 a year on medical cost under a maximum medical fee schedule.

The fiscal impact of employment of additional personnel and clerical support staff to implement and administer a maximum fee schedule would be as follows:

Salaries and fringe benefits for one Range 27C	$38,883
Salaries and fringe benefits for two Range 24	64,594
Salaries and fringe benefits for ~~one~~ two Range 13	39,480

Telephone and Postage	9,500
Supplies	4,000
Medical fee schedule book (printing 10,000 copies)	170,000
Telephone system and installation	4,500
Maintenance and Repair	2,500
Travel and Subsistence	6,000
Furniture, Equipment and Mobile file system	65,230
Computer cost, including programming and related charges	64,496
Allocated Overhead (DHR)	14,250
TOTAL	**$483,433**

Although the start-up cost for this new section seems high, those that pay this assessment are very much in support of its adoption. After the first year the cost would be on salaries and benefits, etc; however, the printing cost would be reduced and any cost for printing would be reimbursed by charging for the printed schedules. Finally, if a medical fee schedule and utilization review are adopted as medical cost containment measures in Kansas, employers, insurance carriers and injured workers, based upon national data, can expect the overall cost of medical care in Kansas for injured workers to be reduced by an average of 22 to 25 percent. Based upon the 1988 statistical data of actual costs paid for medical care for injured workers, that would mean an annual savings of $13 million to $17.6 million.

In 1965, 12 states used fee schedules; by 1985, 17 states were using them. In 1989, 23 states had fee schedules, 2 others had schedules pending, and several more were considering their adoption, according to the Workers Compensation Research Institute. Today, 31 states have some form of legislatively authorized fee schedule. See Chart Exhibit 1.

Specific language was inadvertently left out of this enabling statute in subsections (6) and (8), and a balloon amendment is offered to add the additional language. *Attached as exh. 5.*

Section 5, of HB of 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-510e] to provide that the director adopt and use a schedule for determining the degree of permanent impairment based upon medically or scientifically demonstrable findings and to further provide pending adoption of such permanent schedule that the Guides to the Evaluation of Permanent Impairment by the American Medical Association shall be the temporary schedule for use under this section. The statute now provides that functional impairment be established **by competent medical evidence.** (Since July 1, 1987)

According to the U.S. Department of Labor, Employment Standards Administration, who published a chart entitled "The Use of American Medical Association Guide in State Workers Compensation Agency, March 1988", 37 states use the AMA Guides and 21 states have mandated use by statute, directive, policy, rule or regulation. A copy of that report is attached as Exhibit 2 and another copy of the map showing the use of AMA Guides as Exhibit 3.

Adoption of the AMA Guides would reduce litigation and establish more certainty and uniformity in the rating of permanent impairments. Adoption of the AMA Guides should insure that the injured worker who is unrepresented by counsel, treated and released, would be getting a fair and equitable settlement; and it should reduce the use of the "medical-legal experts" or multiple rating doctors.

On January 23, 1990, your committee was provided with the hard copy of the overlays, Dr. Alan L. Engelberg, M.D., M.P.H. presented as the keynote speaker at the Division's Annual Seminar entitled: Use of the AMA Guides to the Evaluation of Permanent Impairment (3rd Edition). Dr. Engelberg was the editor of the 2nd edition (1984) and 3rd edition (1988) of the AMA Guides.

Dr. George M. Smith, M.D., M.P.H. the author of Chapters 1 and 2 of the 3rd edition of the AMA Guides to the Evaluation of Permanent Impairment spoke at Wichita Seminar on the AMA Guides. Attached as Exhibit 4 is a copy of Dr. Smith's outline entitled "Assessment of Impairment and Disability in Accordance with the AMA Guides."

This statute would provide that a Kansas Administrative Regulation would be drafted to adlopt the AMA Guides and other generally accepted guides could also be incorporated. However, until the Kansas Admininstrative Regulation was drafted the AMA guides would be used.

Section 6, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-510g] to substitute the term vocational assessment for vocational evaluation; to define the term vocational assessment and to provide that if an employee is receiving unemployment compensation benefits, no temporary total or temporary partial disability compensation shall be payable under this section.

The first part of the amendment will prohibit an injured worker from receiving both temporary total disability benefits and unemployment compensation during the same weeks. Although this has certainly been the exception and not the rule, employers across the state have raised this issue when they realize they are paying for

both of these benefits for the same weeks. This amendment should help encourage employers to voluntarily provide benefits when they know there is no longer a loophole in the system that provides an employee to earn more while they are off work than when they were working.

This second part of the amendment was intended to be placed in the language of HB 3028, which is the proposed amendment to K.S.A. 44-510g which the Workers Compensation Joint Advisory Committee unanimously recommended but was inadvertently placed in HB 3069. It is language that needs to be a separate subsection of K.S.A. 44-510g to help clarify the purpose of assessment and the procedure.

Section 7, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-512a] to provide that a penalty for each past due medical bill shall be assessed in an amount equal to the larger of either $25 or a sum equal to 10 percent of the amount past due on the medical bill. The statute now provides that the penalty for each past due medical bill is $25.

This is a much needed amendment. As the statute now exists, there is no incentive to file a 44-512a demand for payment of a court-ordered medical bill, as the civil penalty is only $25. Likewise, an employer or insurance carrier in theory will not fear not paying a $5,000 or $10,000 bill if the only penalty is $25. However, with a potential civil penalty of 10 percent of the bill amount, medical bills will be paid more promptly.

Although the Act protects the injured worker from being initially sued for payment or collection of the medical bills, this amendment should keep the injured workers from receiving collection notices and when and if they do, there will be a more effective remedy to provide for future payment.

This amendment should help reduce the overhead of medical providers and insure prompt payments, which should help reduce the cost of medical care in Kansas.

Section 13, of HB 3069, is an amendment to an existing statute [K.S.A. 44-551] to provide that a director's review of a preliminary award under K.S.A. 44-534a shall not be conducted unless it is believed the administrative law judge exceeded his authority in entering the award. The proposed legislation further provides that director's orders on review of preliminary findings shall be issued within 30 days of oral argument or submission of the case on the record and any other director's orders shall be issued within 90 days of oral argument or submission of the case on the record.

The statute does not now have a time limitation for issuance of a director's order on review. K.A.R. 51-3-5a now provides that a director's review of a preliminary award shall not be entertained except if it is believed the administrative law judge exceeded the authority of an administrative law judge in entering the award.

The "backlog" that had existed at least since March 1985 (according to Division memorandum) was finally eliminated January 1, 1990, after an 18 month effort. Although I am confident that there will never be another judicial backlog at either the administrative law judge level or the director's level during the time I remain as director, I realize I serve at the pleasure of the Secretary of Human Resources, and as an unclassified employee, this position can change with administrations. Because of that there is a need to insure that the parties have some statutory remedy if another judicial backlog at the director's review level should occur.

Under the proposed amendment, if an order wasn't issued on a preliminary award within 30 days, or final award within 90 days, a party could seek civil relief through mandamus.

Section 14, of HB 3069, is an amendment to an existing statute [K.S.A. 1989 Supp. 44-556] to provide that any party may notify the director if a district court has not issued judgment on review within 60 days after submission so that the director can request the district court judge to render a decision. The statute now provides that only the appealing party shall notify the director.

Section 14 further provides that when the compensation paid during pendency of review where the benefits awarded by the director or district court are ultimately reduced by decision on appeal and the balance due the employee exceeds the amount of reduction, the employer shall receive a credit for all amounts paid in excess of the benefits the worker is entitled to as determined by the final decision on appeal. The credit to the employer is applied to the any lump sum due under the award and any additional credit is applied against the last compensation payments to the employee by reducing the period of time over which payments are made without interrupting payment of benefits after the decision.

The first charge under Section 14 would allow <u>any</u> party to have their appeal to the district court decided in a timely manner by having the director notify the district court judge it has been over 60 days. Under the current statute, parties fear being labeled as the "appealing party" that has questioned the timeliness of the district court review.

The second change would allow the employer or insurance carrier to take a credit for any payment of temporary total, partial or total disability or permanent partial or total disability after a district court has reduced or disallowed some compensation, if that credit can be taken from a lump sum due and owing the claimant without stopping or reducing the weekly compensation amount. In those cases where the lump sum would not be enough to take the credit from, the credit must be taken from the last weeks of compensation due under the district court or appellate court award.

This amendment will prevent those cases where the claimant receives a "windfall" because of the court decision that provides that the only way to get reimbursed is from the Workers' Compensation Fund and does not allow a credit from the worker's future compensation payments.

This amendment will encourage employers to voluntarily pay compensation prior to a court order and insure that all a claimant gets is just compensation, no more, no less, and will insure that neither side is penalized when it can be avoided.

This amendment should reduce the amount of money that is reimbursed by the Workers' Compensation Fund each year which should have an effect on the cost of the system. This amendment will also express how credits are to be taken and avoid the current methods, attempted by respondents which end up being litigated and subject to K.S.A. 44-512a penalties.

Finally, this amendment would legislatively change the judicial determination in Johnson v. Tony's Pizza Service, 232 Kan. 848, Syl.1, 658 P.2d 1047 (1983) which holds where a workers' compensation award is reduced or totally disallowed by a district or appellate court, K.S.A. 1982 Supp. 44-556(d) provides the sole means by which the employer and its insurance carrier may be reimbursed for any excess payment of compensation. Said statute provides that such reimbursement shall be from the Workers' Compensation Fund upon certification of the amount by the Director of Workers Compensation and is not limited in application to reimbursement of overpayment which exceeds the balance due claimant on the award as modified.

In Johnson v. Tony's Pizza Service, the Workers' Compensation Fund's brief was devoted to the policy argument that the claimant should not receive a windfall to which he or she is not entitled except when he or she would have to dig into his or her own pocket to repay the overpayment. The court noted and agreed with the claimant's counsel that the policy argument would be better addressed to the Legislature as its implementation would entail

substantial statutory modification. Id. at 852. This amendment is <u>that</u> substantial statutory modification.

In conclusion, I submit that these proposed amendments should eliminate some existing problems and reduce litigation. If the maximum medical fee schedule is adopted, it should reduce the costs of the workers compensation system which will help reduce workers compensation insurance costs. The domino effect is that workers will be retained in their jobs where drastic premium increases would cause layoffs and business closings. Industry will be encouraged to expand or come to Kansas which will help the economy.

These minor amendments and the maximum medical fee schedule will promote health care cost containment and efficiency in the system, without reducing justified benefits, and I encourage you and all committee members to pass this proposed legislation on to the entire house for their consideration along with your strong recommendation that the HB 3036 be passed.

Thank you again for allowing me to appear before you.

Yours truly,

Robert A. Anderson
Workers Compensation Director

mr

Enclosures

pc: Each Committee Member
Secretary Ray D. Siehndel

State Self-insured Fund
(State employees)

	1984	1985	1986	1987	1988
Disability	1,462,435	1,757,426	2,307,906	2,616,108	3,339,984
Medical	1,447,813	1,344,492	2,096,788	2,163,847	2,853,375
Total	2,910,248	3,101,918	4,404,694	4,779,955	6,193,359
Medical cost changes:		-7.6	155%	103%	131%
Medical as % of total	49.7	43.3	47.6	45.2	46.0

Exh. 1.

MEDICAL BENEFITS AND FEE SCHEDULES

Jurisdiction	Full Benefits: In Law	Full Benefits: Law Authorizes Extension Without Limit	Fee Schedules(1)
Alabama	Yes		
Alaska	No	Yes	authorized
Arizona	Yes		rel. value
Arkansas	No	Yes	authorized
California	Yes		rel. value
Colorado (2)	No	Yes	rel. value
Connecticut	Yes		DRG
Delaware	Yes		
Dist. of Columbia	Yes		
Florida	Yes		max.
Georgia	No	Yes	
Hawaii	Yes		max.
Idaho	Yes		
Illinois	Yes		
Indiana	Yes		
Iowa	Yes		
Kansas	Yes		
Kentucky	Yes		authorized
Louisiana	Yes		authorized
Maine	Yes		authorized
Maryland	Yes		rel. value
Massachusetts	Yes		medicaid
Michigan	Yes		max.
Minnesota	Yes		max. percentile
Mississippi	Yes		authorized
Missouri	Yes		
Montana	Yes		rel. value
Nebraska	Yes		rel. value
Nevada	Yes		rel. value
New Hampshire	Yes		
New Jersey	Yes		DRG
New Mexico	Yes		
New York	Yes		max. & DRG
North Carolina	Yes		rel. value & max.
North Dakota	Yes		
Ohio (3)	Yes		
Oklahoma	Yes		authorized
Oregon (3)	Yes		max. percentile
Pennsylvania	Yes		
Rhode Island	Yes		medicare
South Carolina	Yes		max.
South Dakota	Yes		
Tennessee	Yes		
Texas	Yes		rel. value
Utah	Yes		rel. value
Vermont	Yes		
Virginia	Yes		
Washington	Yes		rel. value
West Virginia	Yes		authorized
Wisconsin	Yes		
Wyoming	Yes		rel. value
Longshoremen	Yes		

(1) States which have legislatively authorized. Some may not have adopted as yet.

(2) Colorado: There is a $20,000 maximum on both W.C. and O.D. medical benefits; however, there is a Major Medical Insurance Fund Act which defrays all medical, hospital, surgical, nursing, and drug expenses in excess of the $20,000 limit.

(3) The Ohio and Oregon laws set no initial amount or period; all medical benefits authorized by the administrative agency. In Ohio, in silicosis cases, no medical benefits payable except in cases of total disability or a change of occupation.

Attachment #1–11

Exh. 2.

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Ks. St. Workers Compensation

The Use o merican Medical Association Gu
in State Workers' Compensation Agency

State	AMA Guide Used	Mandated
Alabama	Yes	No
Alaska	Yes	Yes-by statute
Arizona	Yes	Yes-by rule
Arkansas	Yes	No
California	No	No
Colorado	Yes	No
Connecticut	Yes	No
Delaware	Yes	Yes-by policy
District of Columbia	Yes	Yes-by policy
Florida	Yes	Yes-by statute
Georgia	Yes	Yes-by statute
Hawaii	Yes	Yes-by policy
Idaho	Yes	No
Illinois	No	No
Indiana	Yes	No
Iowa	Yes	Yes-by rule
Kansas	No	No
Kentucky	Yes	Yes-by statute
Louisiana	Yes	Yes-by statute
Maine	No	No
Maryland	Yes	Yes-by statute
Massachusetts	Yes	No

The Use of American Medical Association Guide
in State Workers' Compensation Agency (Cont.)

State	AMA Guide Used	Mandated
Michigan	No	No
Minnesota	No	No
Mississippi	Yes	No
Missouri	No	No
Montana	Yes	Yes-by statute
Nebraska	Yes	No
Nevada	Yes	Yes-by statute
New Hampshire	Yes	Yes-by statute
New Jersey	No	No
New Mexico	Yes	No
New York	No	No
North Carolina	No	No
North Dakota	Yes	Yes-by directive
Ohio	Yes	No
Oklahoma	Yes	Yes-by statute
Oregon	Yes	Yes-by statute
Pennsylvania	No	No
Rhode Island	Yes	No
South Carolina	Yes	No
South Dakota	Yes	Yes-by policy
Tennessee	Yes	Yes-by statute
Texas	Yes	No

Attachment #1-13

State	AMA Guide Used	Mandated
Utah	Yes	No
Vermont	Yes	Yes-by regulation
Virginia	No	No
Washington	Yes	Yes-by regulation
West Virginia	No	No
Wisconsin	No	No
Wyoming	Yes	No

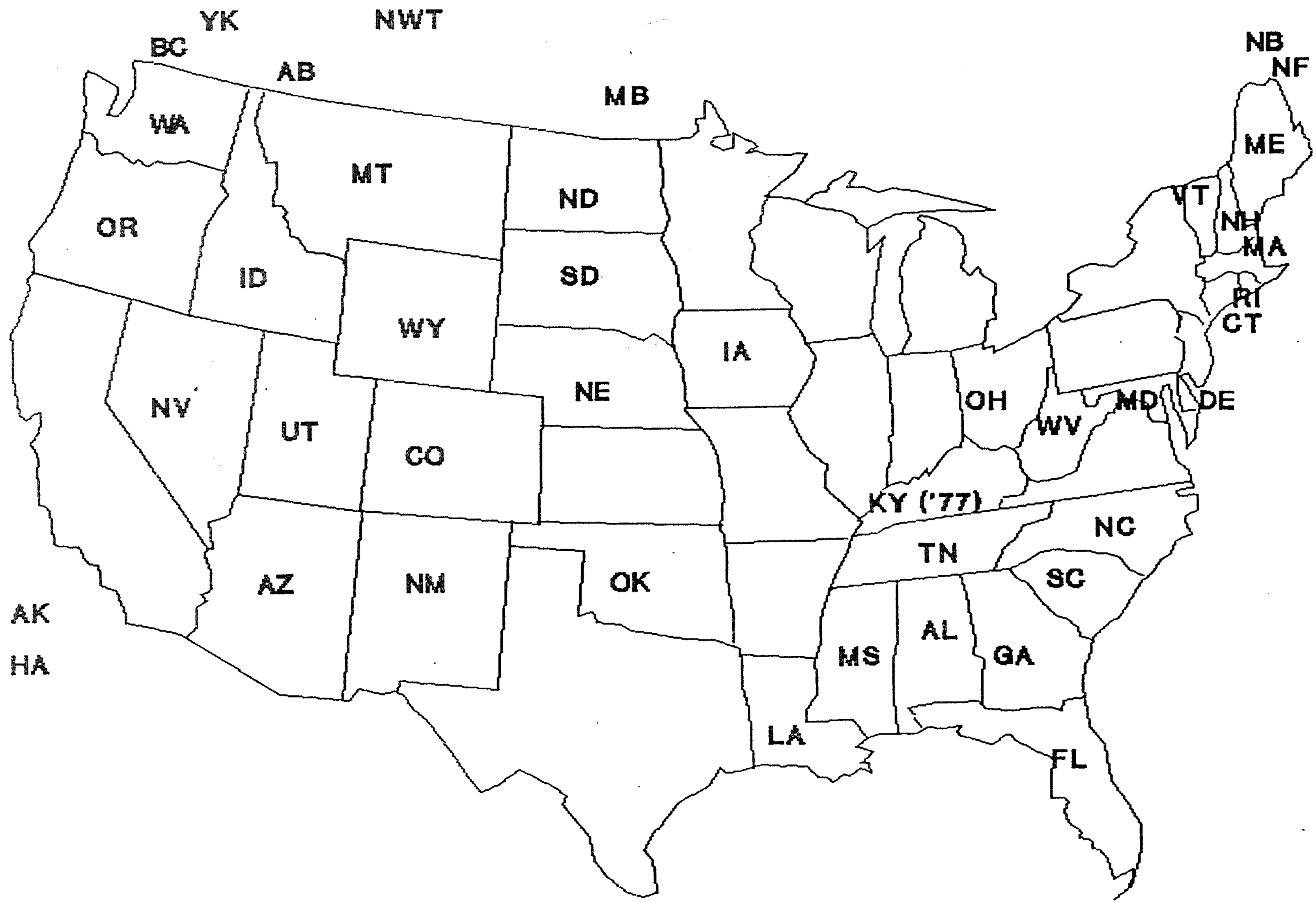
U.S. Department of Labor
Employment Standards Administration
Office of State Liaison
and Legislative Analysis
Division of State Workers'
Compensation Programs

March 1988

Exh. 2

Attachment #1-15

States & Prov. That Use the Guides in Workers Compensation



Ex 4.

ASSESSMENT OF IMPAIRMENT AND DISABILITY IN ACCORDANCE WITH THE AMA "GUIDES"

George M. Smith, M.D., M.P.H.

1. How is medical information communicated in a non-medical setting?

   A. What is "medical technical" information?
   B. What is "medical non-technical" information?
   C. How is each kind of medical information used?
   D. What is necessary for successful "medical" to "non-medical" communication?

2. How are impairment, disability, handicap and functional capacity related?

   A. What is impairment?
   B. What is disability?
   C. What is a handicap?
   D. What is functional capacity?

3. How is impairment evaluated in accordance with the AMA _Guides to the Evaluation of Permanent Impairment_?

   A. When is impairment "permanent?"
   B. What is an "impairment evaluation"?
   C. What is a "medical evaluation protocol"?
   D. Who carries out the "impairment evaluation"?

4. How is impairment rated in accordance with the _Guides_?

   A. What is the difference between "measuring" impairment and "rating" impairment?
   B. How are the results of an impairment evaluation recorded?
   C. How are the results of an impairment evaluation reported?
   D. Who rates the impairment and how?
   E. Why are medical records important?

5. Rather than disability, why not look at employability?

   A. What is employability?
   B. How are employability determinations made?
   C. When does an employer have a legitimate interest in the health of an applicant or employee?

G.M. Smith Associates, Inc.
Bethesda, Maryland

October 20, 1989

6. How is medical information properly used in the employability determination?

   A. What do you need to know about the job?
   B. What do you need to know about an individual's health?
   C. Why are these medical determinations often the subject of controversy and conflict?
   D. What are the respective roles of the "treating" physician and the "other" physician?
   E. Is a special evaluation really necessary?
   F. Is there a relationship between employability and permanent disability?

7. How is information about medical impairment appropriately used in connection with disability determinations under workers' compensation laws?

   A. What is "workers' compensation"?
   B. What kinds of payments are made under workers' compensation laws?
   C. Why is the report of impairment evaluation more important than the impairment rating itself?
   D. How is information about impairment incorporated into the disability determination?
   E. Who makes the disability determination?
   F. How is it used?
   G. What is "apportionment"?

8. How are the interests of the injured employee best served?

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MANAGEMENT / MEDICAL SERVICES

Use of Medical Information in a Non-Medical Setting

With respect to this model, we consider two types of medical information. Medical Technical Information is used by medical personnel and consists of the information that physicians develop and use in managing their patients. This type includes the results of the medical history, physical examination, laboratory tests, x-rays, special diagnostic procedures as well as the diagnosis. Medical Non-Technical Information is conveyed to non-medical people and consists of statements like, "This individual does (or does not) meet medical standards." Or, "Review of the medical documentation does not support a conclusion that the individual's medical condition precludes travel to and from work, being at work or performance of assigned tasks and duties." As illustrated in the diagram, there is an interface across which information must pass from the medical technical side to the medical non-technical side.

In effect, medicine offers a statement of opinion that the non-medical user receives as if it were fact. To be accepted by the non-medical user, the information in the statement must meet the four conditions listed at the bottom of the diagram: it must be understandable, supportable, reasonable and useful. Interestingly enough, it does not have to be correct to be accepted and used. While, in a particular instance, supportability is enough, correctness is vitally important in the overall process. If the information provided by medicine is incorrect often enough to cause problems on the non-medical side, the user of the information will either tend to discount its value or ignore it altogether. But the decision requirements do not go away. Therefore, the role of medicine in an organizational setting is to provide input to management decision processes so that management can make informed decisions about management matters and not be held hostage by what medicine says.

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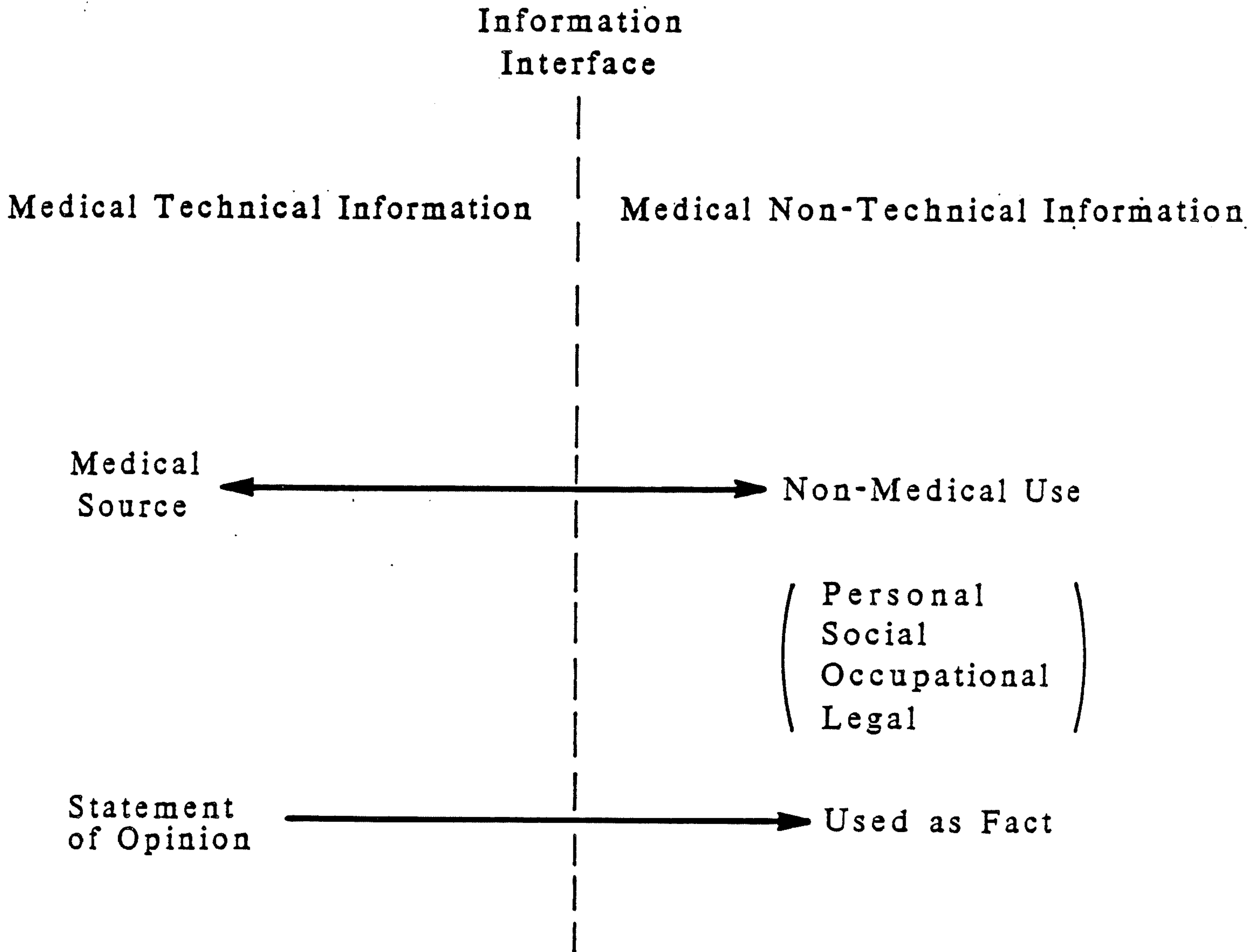
THE USE OF MEDICAL INFORMATION IN A NON-MEDICAL SETTING



To be accepted across the interface, the information contained in the statement must be

- UNDERSTANDABLE
- SUPPORTABLE
- REASONABLE
- USEFUL

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MANAGEMENT / MEDICAL SERVICES

Medical Determinations Related to Employability

As explained in the Model for Use of Medical Information in a Non-Medical Setting, it is necessary to distinguish between medical and non-medical matters in management decision procedures.

While every job is defined by a job description that may be formal or informal and may or may not be written, the job description alone is not sufficient to understand a job. Beyond the description, the job must be analyzed to define tasks, duties and conditions of employment specifically related to the particular job in the particular organizational location under the particular manager with a particular organizational mission. However, these specifications themselves are not enough to characterize the job, for, in addition, management's expectations of the incumbent must also be specified in the form of performance standards, requirements for reliability, expected duration of useful service life and whatever else is considered important. These expectations, which are called Demand Criteria under the Model, are exactly those requirements against which qualification and suitability for employment are initially assessed.

In accordance with this Model, the Demand Criteria are analyzed to determine what kinds of information are needed about the health of an applicant or employee, and to what degree of specificity, to make decisions about the health with respect to those criteria. The results of this analysis are then used to develop a medical evaluation protocol, a set of instructions to a physician on how to carry out the examination of the individual. Because techniques of medical evaluation are well enough standardized for this purpose, it can be expected that two physicians examining the same person at the same time using the same protocol will have about the same set of findings. Accordingly, <u>any</u> physician can perform the evaluation. The results of the evaluation are then analyzed to reach conclusions about the health of the individual for comparison with the Demand Criteria. It is always possible to reach a valid decision about the individual's health with respect to the Criteria because the evaluation protocol was specifically devised to obtain the medical information necessary to make the comparison.

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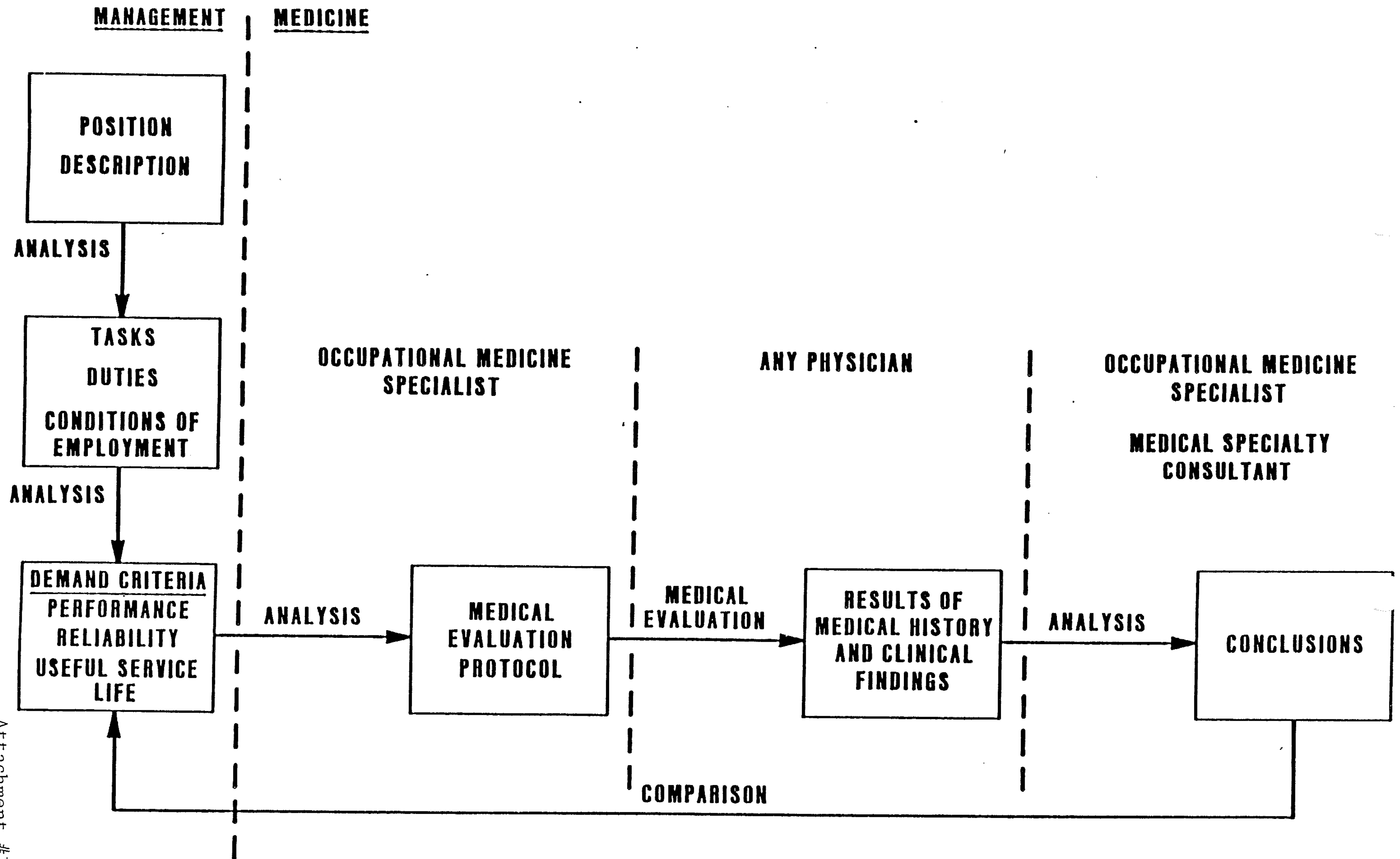
It is clear that the processes carried out in the upper left portion of the Model are administrative in nature, belonging appropriately to management, and that the processes of the lower right portion are medical in nature and belong in the medical domain. Accordingly, the boundary between management and medicine in the model is quite naturally drawn vertically along the left hand column of boxes.

Upon examination of the model, it is not difficult to understand some of the problems encountered in carrying medical determinations as part of human resource management processes. If, for all practical purposes, the boundary between management and medicine is drawn horizontally above the bottom row of boxes, the box in the lower left hand corner is seen belong to the medical domain. When this happens in a human resource system, the Demand Criteria are not defined by management. It is left up to medicine to guess what should go into that box. Moreover, the three medical steps are operationally collapsed into one, for the applicant or employee is sent for a medical examination without a set of medical instructions. The examining physician, without sufficient information about the job or knowledge of what is acceptable to management, is asked to determine whether or not the individual is "medically" qualified for the job or "can do" the job, and, in effect to make management decisions.

MEDICAL DETERMINATIONS RELATED TO EMPLOYABILITY



Attachment #1-22

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MANAGEMENT / MEDICAL SERVICES

Verification of a Medical Condition to Support an Employee's Request for Sick Leave, Accommodation, Special Treatment or Benefit

This model characterizes the relationship between the two levels of documentation of a medical condition (self-certification by the employee and full justification by a physician with sufficient medical office and hospital records for the purpose of professional review) and the structure of the decision making process that an employer must use in making decisions about the day to day duty status of employees. The flow chart illustrates the management steps and communications pathways needed for timely and effective decision making. Implementation of a policy and procedures based on this model can assist management in using information about the medical condition of an employee in making fully informed, rapid, fair and defensible decisions regarding the approval of an employee's request for a benefit.

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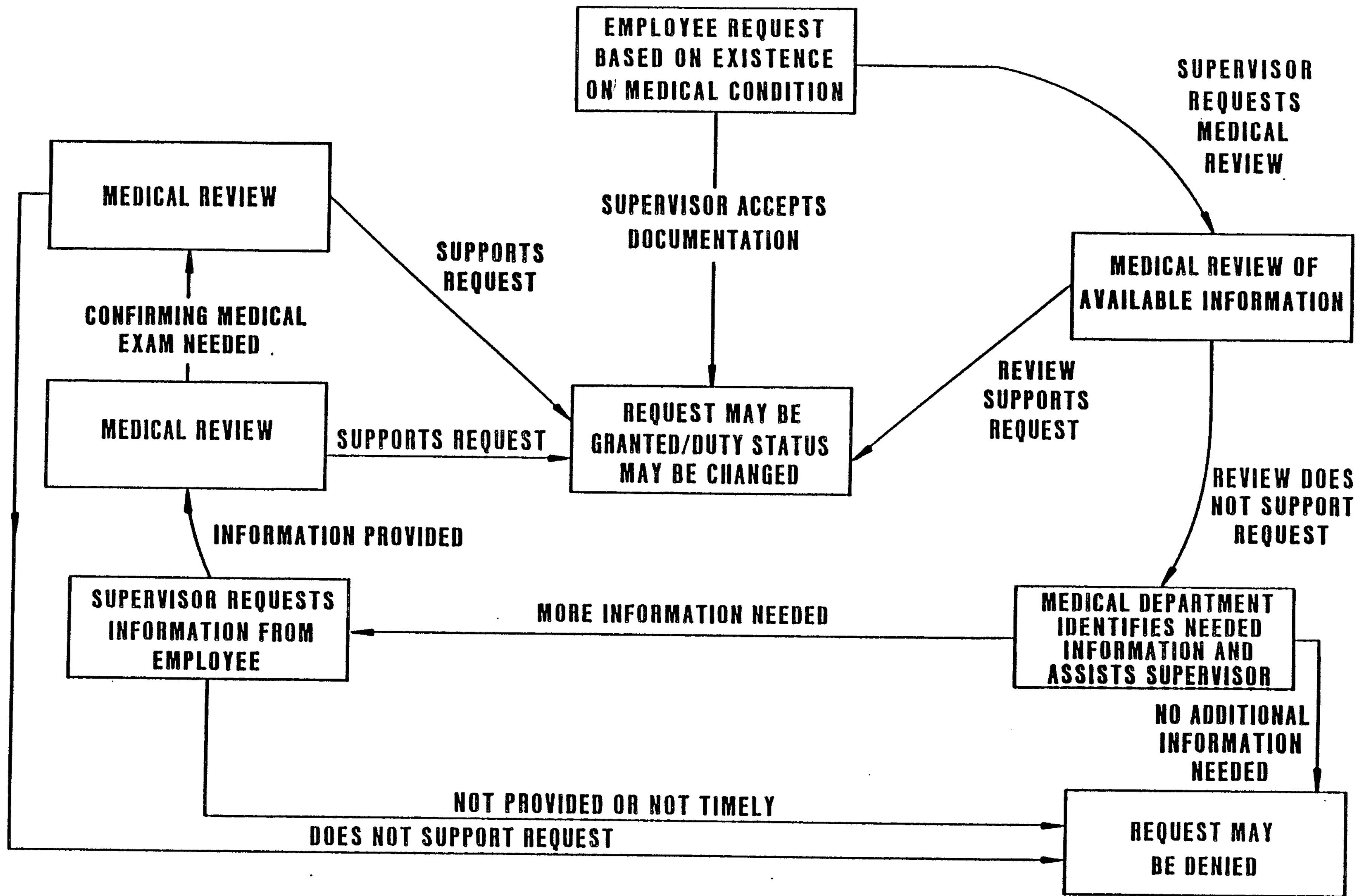
VERIFICATION OF A MEDICAL CONDITION TO SUPPORT AN EMPLOYEE'S REQUEST FOR ACCOMMODATION, SICK LEAVE, SPECIAL TREATMENT OR BENEFIT



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1-24

(ii) The impact upon cost to employers for providing a level of fees for treatment, care and attendance which will ensure the availability of treatment, care and attendance required for injured employees;

(iii) The potential change in workers compensation insurance premiums or costs attributable to the level of treatment, care and attendance provided; and

(iv) The financial impact of the schedule of maximum fees upon health care providers and health care facilities and its effect upon their ability to make available to employees such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury.

(4) Any contract with or any billing or charge by any health care provider, hospital, person, or institution to any patient for services rendered in connection with injuries covered by the workers compensation act or a fee schedule adopted under this section, which are or may be in excess of or not in accordance with such fee schedule are unlawful, void and unenforceable as a debt.

(5) The director shall have jurisdiction to hear and determine all disputes as to such charges and interest due thereon *and shall prescribe procedural rules to be followed by the parties to such disputes.*

(6) The director is hereby authorized to investigate health care providers and health care facilities to determine if any health care providers or health care facilities are in compliance with the provisions of the workers compensation act and rules and regulations adopted by the director thereunder or if any health care provider or health care facility is ~~requiring~~ providing or ordering *unjustified treatment, hospitalization or office visits. If the director finds that a health care provider or health care facility has made excessive charges or ~~required~~* provided or ordered *unjustified treatment, services, hospitalization or visits, the health care provider or health care facility shall not receive payment pursuant to this section from an insurance carrier, employer or employee for the excessive fees or unjustified treatment, hospitalization or visits and such health care provider or health care facility shall repay any such fees or charges collected therefor.*

(7) The director shall develop and implement, or contract with a qualified entity to develop and implement, utilization review procedures and standards of the services rendered by a health care provider, which services are paid for in whole or in part pursuant to this section. The director shall contract with a private foundation or organization to provide peer review after utilization review, as appropriate, of entities providing health care services pursuant to this section. Under the terms of such contract, the foundation or

to substantiate the nature and necessity of the service or charge

1 *organization shall establish and maintain a procedure by which a*
2 *peer review committee shall review the services rendered by a health*
3 *care provider or health care facility, which services are paid for in*
4 *whole or in part pursuant to this section.*
5 *(8) By accepting payment pursuant to this section for treatment*
6 *or services rendered to an injured employee, a health care provider*
7 *or health care facility shall be deemed to consent to submitting all*
8 *necessary records and other information concerning such treatment*
9 *to utilization review and peer review under this section. Such health*
10 *care provider shall comply with any decision of the director pursuant*
11 *to subsection (a)(9).*
12 *(9) If it is determined by a peer review committee that a health*
13 *care provider improperly overutilized or otherwise rendered or or-*
14 *dered unjustified medical treatment or services or that the fees for*
15 *such treatment or services were excessive, the director may order*
16 *the health care provider to show cause why the health care provider*
17 *should not be required to repay the amount which was paid for*
18 *rendering or ordering such treatment or services and shall provide*
19 *the health care provider a hearing thereon if requested. If a hearing*
20 *is not requested within 30 days of receipt of the order and the*
21 *director decides to proceed with the matter, a hearing shall be*
22 *conducted and if a prima facie case is established a final order shall*
23 *be issued by the director. If the final order is adverse to the health*
24 *care provider, the director shall provide a report to the licensing*
25 *board of the health care provider with full documentation of any*
26 *such determination, except that no such report shall be provided*
27 *until after judicial review if the order is appealed.*
28 *(10) All reports, information and records submitted to the di-*
29 *rector for the purposes of this section shall be confidential and*
30 *privileged and shall not be subject to discovery, subpoena, or other*
31 *means of legal compulsion for their release to any person or entity*
32 *and shall not be admissible in evidence in any judicial or admin-*
33 *istrative proceeding, except those authorized pursuant to this section.*
34 *(11) A health care provider or health care facility may not im-*
35 *properly charge or overcharge a workers compensation insurer or*
36 *charge for services which were not provided, for the purpose of*
37 *obtaining additional payment.*
38 *(12) Any violation of the provisions of this section which are*
39 *willful or which demonstrate a pattern of improperly charging or*
40 *overcharging workers compensation insurers constitute grounds for*
41 *the director to impose a civil fine not to exceed $5,000.*
42 (b) Any ~~physician~~ *health care provider*, nurse, medical supply
43 establishment, surgical supply establishment, ambulance service or

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the Kansas State Chamber of Commerce, Associated Industries of Kansas, Kansas Retail Council

HB 3069 February 26, 1990

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Labor and Industry

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

I am Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to express KCCI's support for HB 3069, which calls for the development and implementation of a medical fee schedule and utilization review for the Kansas Workers' Compensation system.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

House Labor & Industry
Attachment #2
02-26-90

In making the case for HB 3069, it is important to remind the Committee that workers' compensation is an insurance policy. Workers' compensation insurance, and all other forms of health care insurance, have experienced soaring premium costs in recent years. In fact, the Kansas Insurance Commissioner is currently considering a request to increase the average workers' compensation rate in Kansas 22.6%. If the request is approved, some businesses will see a 50% hike in workers' compensation premiums. The reason why there is pressure to increase workers' compensation rates can be directly traced to the cost of health care for the injured worker.

As mentioned before, all forms of health care insurance are being hit hard by spiraling health care costs. However, it is common practice in all forms of insurance, except for workers' compensation, to practice cost control measures to combat increasing medical costs. The time has come to arm workers' compensation with the same cost control methods which have been used for years by institutions like Blue Cross/Blue Shield and the Kansas Medicaid Program.

In the end, all parties should benefit from the adoption of HB 3069.

EMPLOYERS - Passage of HB 3069 should significantly reduce medical costs in workers' compensation. The National Council for Compensation Insurance suggests the institution of a medical fee schedule will reduce costs 11.9%. In Kansas, a conservative savings estimate would be over $10 million.

EMPLOYEES - The major concern over adoption of cost control measures is that medical providers will refuse to participate. However, that has not been the case when other forms of health insurance established cost containment programs. Blue Cross/Blue Shield has no trouble inducing physicians to treat patients who are Blue Cross/Blue Shield policyholders. 75% of physicians licensed to practice in Kansas have enrolled to participate in the Kansas Medicaid program, which reimburses medical providers at a lower level than private insurance companies.

MEDICAL PROVIDERS - The Advisory Panel, which would assist the director in the annual review of the medical fee schedule would be well-represented by members from the medical community, who will insist the fee schedule be reasonable. Because there will be a greater understanding of what medical fees should be charges, there should be less disputes over medical charges and more medical bills should be paid promptly. If a dispute should arise in medical service utilization, the peer review panel will judge a doctor's performance from a medical perspective.

LEGAL SYSTEM - The fee schedule and utilization/peer review should simplify medical charge disputes within the workers' compensation system. When disputes do require judicial review, the introduction of impartial medical opinions should bring more fairness to the judicial decision making process.

Thank you for the opportunity to express the Kansas Chamber's support for this legislation. I would be happy to attempt to answer any questions.

February 26, 1990

TO: House Labor and Industry Committee

FROM: Kansas Hospital Association

RE: HB 3069

The Kansas Hospital Association appreciates the opportunity to comment regarding HB 3069. Among other things, this bill would require the director of the Division of Workers' Compensation to implement a fee schedule for medical services under the workers' compensation program.

We certainly understand the reasons for interest in a fee schedule. Employers are facing rising costs in providing insurance covering medical services, whether it is for workers' compensation or traditional indemnity plans. Kansas hospitals, as major employers, certainly share these concerns. In response, many insurers have gone to a system of prospective payment, or set fees for particular services. It is natural, then, for the workers' compensation system to consider such a program.

The Kansas Hospital Association is opposed to the idea of a fee schedule for workers' compensation. A number of reasons can be cited, all of which are listed in the attached memo outlining the case against implementing such a fee schedule. Our major concern is that a fee schedule will not turn out to be the panacea many are expecting.

Our health care system is often described as a three-legged stool with the issues of cost, access and quality making up those three legs. Any time one part of the system is changed, there will likely be a spillover effect on the other two positions. In other words, a proposal to deal with cost issues could have an adverse impact on access or quality. For this reason, changes should be made cautiously.

We wish to emphasize that we do not support anyone taking advantage of the system. If charges are truly excessive, they should be disallowed. In addition, we also strongly support an efficient and effective utilization review program within the workers' compensation system. Many times costs can be better controlled by limiting utilization than by setting fees.

Thank you for your consideration of our comments.

/cdc

Attachment

The Case for Not Implementing A Workers Compensation
Fee Schedule in Kansas

For the past several months, a task force has been studying the issues surrounding the implementation of a workers compensation fee schedule in Kansas. Concerns have been raised about the costs of workers compensation and the seemingly larger increases in medical costs compared to increases in other components of the worker's compensation system. Proponents of a fee schedule have pointed to other states' experiences and have concluded that implementation of a fee schedule will reduce workers compensation costs from 15-40%. We believe that it is premature to consider implementation of a fee schedule in Kansas. Advocates for a fee schedule have been looking at one large lump sum figure for medical expenses without specifically identifying the detailed components of the total. The amount of increase attributable to utilization must be isolated and then the discounted rate of increase should be compared to other meaningful trends such as the rate of increase in cost for medical provider liability insurance. Data from fee schedule states is inconclusive. We need more data on the differences in administrative procedures and coverages provided in fee schedule states. The differences may influence the estimated impacts identified with fee schedule states.

Implementation of a fee schedule may result in unwanted outcomes. Potential adverse outcomes include: increased administrative expenses, increased utilization of medical services, increased litigation, decreased availability of participating physicians resulting in decreased quality of care, upcoding or reporting of more severe injuries and increased costs for the program because low charging physicians raise their fees to the fee schedule amounts. The medical component of workers compensation accounts for approximately 40% of the total payout of the program. It is important to look at factors affecting the other 60% of the payout costs as well as the medical component. Cost issues must be addressed without affecting the quality of care provided to recipients. A fee schedule might lead to a medicaid type of program with decreased access to quality care. This has happened in the Medicaid program in Topeka where Pediatricians have decided not to accept new Medicaid patients because the program simply does not pay enough to cover the costs associated with providing the care.

One argument in favor of implementing a fee schedule is that it will simplify the payor's job of determining what should be paid for a certain service. We don't believe that this is sufficient reason to make major changes in the system.

We recommend that several other measures be addressed before considering the implementation of a workers compensation fee schedule in Kansas. They are listed below for your consideration.

1. Direct the Worker's Compensation Division to conduct an indepth study of procedures, diagnoses and fees paid. Identify aberrant practices and develop programs to modify any abuses. Target the most frequent procedures or diagnosis and the most expensive charges and develop programs to insure appropriateness.

2a. Contact the Kansas Foundation for Medical Care to discuss the possibility of developing a utilization review program and a preadmission/preprocedure certification program.

2b. Develop a participating physician program. Exclude physicians when practices fall outside a certain range.

3. Contact Blue Cross and Blue Shield to discuss possible administration of a Workers Compensation program, case management of potentially expensive cases and possible utilization of their fee schedule.

4. Encourage the development of managed care programs where feasible. Introduce competition into the system.

5. Focus on prevention and educational programs. Develop accident prevention and risk management programs, provide adequate staffing and training.

6. Develop specific physical standards for employment and hire accordingly.

7. Develop return to work and light duty programs.

8. Encourage claims payment review to insure appropriateness.

9. Study structured settlements through the purchasing of annuities, providing regular payments to claimants. There is the potential for reducing ultimate costs and eliminating administrative expenses associated with claims handling.

10. Study the development of dispute resolution process to reduce the costs of litigation.

11. Study the impact of low wages and lack of adequate health insurance in shifting costs to workers compensation.

12. Determine what impact the implementation of a Medicare Resource Based Relative Value Scale will have on other payment programs.

13. Consider reduction of minimum weekly benefits to encourage workers to return to work more quickly.

Comments have been made that providers charge more for workers compensation cases than for other cases. If this is true, is there any justification for it? Are there increased costs associated with workers compensation cases, such as increased administrative and paper work requirements and increased legal requirements including depositions or court appearances? This should be studied to insure that administration of the workers compensation program is as efficient as possible.

In summary, we believe that implementation of a fee schedule in Kansas is not justified. There are many other factors with significant potential for cost containment that should be considered first.

John Wertzberger, M.D.
Phillip Godwin, M.D.
Mark Saylor, M.D.
Gary Caruthers

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

February 26, 1990

TO: House Labor and Industry Committee

FROM: Jerry Slaughter
Kansas Medical Society

SUBJECT: HB 3069; Medical Fee Schedules Under Workers' Compensation

The Kansas Medical Society appreciates the opportunity to comment on some of the provisions of HB 3069. Our comments will be restricted to those portions of the bill which mandate the Director of Workers' Compensation to implement a medical fee schedule and utilization review program.

At the outset, we would like to publicly thank Robert Anderson, Director of the Division of Workers' Compensation, for sharing a draft of the proposed legislation with us approximately one week ago. This opportunity did give us a chance to make several suggestions, many of which were incorporated into the bill. We would like to point out, that we have not yet had the opportunity to discuss HB 3069 with our Legislative Committee or Executive Committee, hence our comments today should be considered preliminary, as our final position may be different pending study by our committees.

It was clear to us that the Director under current law has the statutory authority to implement a medical fee schedule affecting all health care providers. In discussions with Mr. Anderson, it became clear that he intended to do so, but that he wanted more specificity written into the law including a provision mandating utilization and peer review. Generally, we are opposed to statutorily imposed fee schedules. Our experiences with Medicaid and Medicare have proven that such efforts to contain costs generally hurt access to health care for those who are injured or ill, or cause substantial cost shifting, as certain payors cut reimbursements to unreasonably low levels. For example, under the Medicaid program, physicians in Kansas generally are reimbursed in the range of 35-50% of their normal and customary fees. Obviously access to care becomes an issue, and we are concerned that any unreasonable fee schedules in the Workers' Compensation Program would have this same result.

To the several business organizations who have been noisy advocates for fee schedules, we must point out that the best way of achieving lower costs under workers' compensation is prevention of injury. The same interests that are promoting the provisions of HB 3069 should be looking inward to provide safer equipment, safer working conditions, better training for their employees, and aggressive risk management in general. We believe that prevention of injury should be the goal, rather than officially reducing costs after the injury occurs.

If there is evidence indicating that fees charged for health care provided to injured workers under the Workers' Compensation Program are higher than fees charged for similar services under other third-party reimbursement systems, it may be for a reason. Physicians indicate that it is more time consuming and more difficult to not only evaluate the extent of injury to patients under workers' compensation cases, but there are greater requirements for documentation of clinical findings. This could account for somewhat higher charges, and would not be unjustified. If however, fees sometimes charged by health care providers are truly excessive, we believe the Director has adequate authority under current law to disapprove them.

The provisions in the bill which establish a utilization review and peer review system still need some work. While a utilization review system by qualified professionals can be an effective method of analyzing the use of resources in a third-party payor system, it must have safeguards so that quality care is maintained. We would like to give further study to these provisions, and we will provide amendments intended to strengthen and clarify the concept at a later date.

We recommend and urge that prior to enactment of any fee schedule, that a thorough study be done of the current reimbursement system under workers' compensation. If there are excessive fees being charged by health care providers, such a study would reveal whether it is a widespread problem, or one that is confined to a few individuals and institutions. Such an evaluation must also include the perspective of the health care providers who deliver the services, for only they are able to determine the medical necessity and appropriateness of the services rendered.

In spite of the fact that we do not support a statutorily imposed fee schedule, I do again want to thank Mr. Robert Anderson for sharing with us a draft copy of the proposed legislation. As I mentioned above, while we are opposed to a mandated fee schedule, we will share this legislation with our appropriate committees as soon as possible, and provide additional comments at a later date. Thank you for the opportunity to appear today.

JS:nb

i sas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

TESTIMONY ON H.B. ~~3028~~ 3069 - CONCERNING THE WORKERS COMPENSATION ACT

FEBRUARY 26, 1990

Mr. Chairman and Members of the House Labor Industry Committee:

My name is Harold Riehm and I represent the Kansas Association of Osteopathic Medicine. I include herein a summary of my oral testimony presented on February 256.

We oppose the concept of establishing a fee schedule for medical payments under the Kansas Workers' Compensation Act., as proposed by Mr. Anderson in H.B 3069. We oppose such fee schedules not only because they do not correspondingly address the quality and access of medical care, but also because physicians are business-persons, and as such oppose all fee schedules that limit their control over the pricing mechanism of the valuable services they render while there is an absence of any controls over the many overhead costs which they must pay to operate their "businesses".

However, given the statement by Mr. Anderson that he plans to implement a fee schedule even with the failure of H.B 3069 to pass, and given the fact that H.B 3069 does establish a mechanism in which providers will be involved in determining the fees to appear on the schedule, we can state that if any fees are to be established, we prefer a method that <u>does</u> involve provider input.

<u>THIS BEING THE CASE, HOWEVER, IF H.B. 3028 IS TO PASS, WE STRONGLY URGE THE COMMITTEE TO INCLUDE AN OSTEOPATHIC PHYSICIAN ON THE ADVISORY PANEL WHICH IS PROVIDED, BY THE BILL, TO ASSIST THE DIRECTOR IN ADOPTING SCHEDULES OF MAXIMUM FEES.</u>

The osteopathic profession is not represented by the M.D. profession and the osteopathic profession does not use the services of the M.D Peer Review Committee--it has its own. In addition, while members of the osteopathic profession represent most of the medical specialties, i.e., orthopedics, many osteopathic physicians also provide osteopathic manipulative therapy, a modality of treatment unique to the osteopathic profession and one widely used in the treatment of some workers' compensation related injuries.

<u>FOR THESE REASONS, AND FOR THE BASIC REASON OF REPRESENTATIVE FAIRNESS, WE THINK THE OSTEOPATHIC PROFESSION NEEDS TO BE REPRESENTED ON THE ADVISORY PANEL. TO THAT END, IF THE BILL IS TO BE PASSED, WE URGE ADOPTION OF THE AMENDMENT NOTED IN THE BALLOON, BELOW:</u>

<u>PROPOSED AMENDMENT TO H.B. 3069 - Sec. 3(B) - Page 7, Lines 16-26</u>

(B) There is hereby created an advisory panel to assist the director in adopting schedules of maximum fees as required by this section. The panel shall consist of the commissioner of insurance, one representative each from the Kansas medical society, the Kansas hospital association and the Kansas chiropractic association, and two members appointed by the secretary. One member appointed by the secretary shall be classified as a representative of employers on the basis of previous vocation, employment or affiliation. The other member appointed by the secretary shall be classified as a representative of employees on the basis of previous vocation, employment or affiliation.

Add: , the Kansas association of osteopathic medicine

House Labor & Industry
Attachment #5
02-26-90

KAOM note: This would create a panel of seven (7) members. In most cases an odd numbered panel is preferred to an even numbered, to prevent tie votes.