Annual Report on Cost Containment

Fiscal Year 2010

State Office of Risk Management

December 2010

Introduction

The State Office of Risk Management (Office) administers the workers' compensation and risk management programs for client state agencies. Under the authority of Chapters 412 and 501 of the Texas Labor Code, the Office's mission is to provide active leadership to enable State of Texas agencies to protect their employees, the general public, and the State's physical and financial assets by reducing and controlling risk in the most efficient and cost-effective manner.

Senate Bill 1, 81st Legislature, RS, requires the Office to submit an annual report detailing the effectiveness of cost containment measures undertaken during the fiscal year and proposing additional measures to reduce workers' compensation payments in future years. This document is the report on cost containment for Fiscal Year 2010.

Summary of Cost Containment Savings: Fiscal Year 2010

During Fiscal Year 2010, cash basis claim expenditures totaled $43.3 million, $26.3 million of which were medical expenditures. The Office's cost containment measures in FY 2010 resulted in savings of $69.6 million for the workers' compensation claims fund and Texas taxpayers. A breakdown by amount for FY 2008 through FY 2010 is provided below.

SUMMARY OF COST CONTAINMENT SAVINGS

STRATEGY	2008 SAVINGS	2009 SAVINGS	2010 SAVINGS
Total Medical Bill Audit Savings	**64,899,875**	**64,462,103**	**63,929,545**
Duplicate Bill Savings*	**(5,448,966)**	**(6,959,964)**	**(2,881,201)**
Net Medical Bill Audit Savings	**59,450,909**	**57,502,138**	**61,048,345**
PPO/PBM Savings**	**1,068,546**	**1,208,564**	**2,924,884**
Pre-Authorization of Medical Services***	**5,663,830**	**4,627,442**	**5,034,394**
Subrogation Recovery	**875,144**	**638,590**	**616,953**
TOTAL COST CONTAINMENT SAVINGS	**$67,058,429**	**$63,976,735**	**$69,624,576**

** Duplicate Bill Savings are not reported in the total savings, but are included to show potential exposure.*
*** PPO/PBM Savings are as reported by the cost containment vendors for bills paid during the fiscal year. Figures may be subject to revision on audit.*
**** Cost of procedures not performed at time of request, as estimated by the cost containment vendor. (See explanation in "Pre-Authorization of Medical Services" text below.)*

COST CONTAINMENT STRATEGIES

The Office pursues all available cost containment measures at its disposal to meet the Office's fiduciary responsibilities to the taxpayers of Texas while ensuring injured state employees receive their full workers' compensation benefits as provided by law. The Office continues to refine its cost containment strategies and to seek new strategies that can reasonably assist in ensuring injured workers receive the benefits they are due while avoiding unnecessary cost. The following discussion summarizes the cost containment strategies utilized by the Office during FY 2010.

Medical Bill Audit

Except regarding certified health care networks, the Texas Department of Insurance (TDI), Division of Workers' Compensation (DWC) requires health care providers to submit bills for medical procedures and services based upon the "usual and customary fees" normally charged by the health care provider. By law, DWC promulgates fee schedules for services under the workers' compensation system. Insurance carriers are required to audit bills submitted by health care providers to reduce billed amounts to the maximum allowable rates under the appropriate fee schedule. In addition to auditing to fee guideline, bills are also reviewed for medical necessity and relatedness to the compensable injury. Charges reduced as a result of such reviews represent savings from the billed amounts. In the case of the State's self-insured workers' compensation program administered by the Office, these savings accrue to the benefit of the state's taxpayers.

The Office's medical cost containment vendors audited approximately 121,000 medical and pharmaceutical bills during FY 2010. The Office reviews the performance of medical cost containment vendors' services with its own medical bill quality control staff, including reviewing audited bills and identifying errors requiring re-audit.

Pre-Authorization of Medical Services

The Texas Workers' Compensation Act and the rules adopted by DWC provide that health care providers are required to obtain preauthorization of certain medical procedures (e.g., psychiatric care and non-emergency hospitalizations) from workers' compensation insurance carriers prior to such services being provided. Preauthorization savings represent the avoidance of expenses related to unreasonable or unnecessary procedures or services prior to them being provided and billed. In the event a treatment or service was not authorized and no billing was received, the savings reported are cost-avoidance estimates provided by the Office's cost containment vendor. It should be noted that health care that was not preauthorized may be approved at a later date if there is a change in medical diagnoses or documentation provided to support the request or there may be approval of alternative treatment. Under these circumstances, "savings" attributable to preauthorization will not accurately reflect the true cost of treatment.

Peer Reviews and Required Medical Exams

The Office utilizes Peer Reviews of medical services and pharmaceuticals and Required Medical Exams of injured workers as an additional medical cost control strategy as authorized by law and regulation. Peer Reviews and Required Medical Exams are conducted to verify the medical necessity and reasonableness of prescribed pharmaceuticals and treatments, to determine whether such prescriptions and treatments are related to compensable injuries, and to ensure the injured employee receives quality medical care, when such a determination requires medical expertise beyond what may be expected of a licensed adjuster. These exams are a way of ensuring necessary and proper care is provided

while avoiding the cost of unreasonable or unnecessary medical treatment. Use of these services has been emphasized by the Office and these services have significantly improved the Office's decision making. Unnecessary and unrelated medical services that were paid in prior years are now more timely identified and audits of the claims can be conducted with the benefit of these medical opinions. The opinions obtained form the basis of actions taken by the Office and establish the factual and medical evidence necessary to defend the Office's determinations through the dispute resolution process. As a result of these opinions, more appropriate care is provided to injured workers while delivering savings through the elimination of unnecessary care in excess of the cost of such reviews.

Pharmacy Benefits Management/Preferred Provider Organization

The pharmacy benefits management contract with ScripNet, Inc. allowed the Office access to a passive pharmaceutical preferred provider program. The pharmacy benefits manager (PBM) provides a prescription card to all workers' compensation claimants who are prescribed medications. Participation in this program is entirely voluntary for injured workers. When the card is presented at any participating pharmacy, the pharmacy can quickly provide the necessary medication to the injured worker, avoiding unnecessary delays in beginning treatment. The Office receives a discount below the Pharmaceutical Fee Guideline on the medicine provided. The Office continues to realize significant savings from this voluntary program.

The cost containment vendor, Forté, Inc., utilizes a preferred provider organization (PPO), an independent network of physicians available to treat injured workers for negotiated fees. The difference between non-PPO charges and the PPO negotiated fees represents savings to the Office and the State's taxpayers.

It should be noted that this type of informal network has been eliminated as of Jan. 1, 2011, pursuant to House Bill 7, 79th, R.S. This is discussed in more detail below.

Medical Case Management (Return to Work Initiative)

Case management is considered within the workers' compensation insurance industry to be an effective method for reducing claims costs. Case management involves the use of a case manager to serve as a liaison between the injured employee, the employee's health care provider, and the Office. Savings from case management are derived from two sources: decreased medical expenses due to the avoidance of unnecessary or prolonged medical treatment; and decreased future income benefit payments through improved return-to-work outcomes. The Claims Operations staff continues to stress adjuster awareness of the benefits of this service and the importance of early case management intervention.

The Office underwent Sunset Review in the 80th Legislative Session, resulting in a mandate to develop return-to-work (RTW) coordination services for covered entities. The Office actively evaluates approaches to address emphasis on improved RTW outcomes, including

identifying available disability management options, considering appropriate guidelines and standards, assessing methods for incentivizing RTW, and developing automated processes for tracking RTW outcomes.

The Office currently operates a disability management program that utilizes the skills of three agency Case Management Nurses. In this capacity the Case Management Nurses perform telephonic case management in all cases where an injured worker loses time from work, with a focus on assisting with early medical intervention strategies. The Agency Case Management Nurse helps facilitate early medical intervention strategies by maintaining contact with the injured worker, treating doctor, employer, and external certified field case manager, if applicable, to develop a disability management profile. The disability management profile is used to assist the internal adjusting staff with developing a positive outcome-focused claim handling strategy to ensure quality health care delivery and accelerating RTW.

Impairment Ratings Reviews

Cost savings are also realized from the review and dispute of incorrect impairment ratings. Under the Act, injured employees may be entitled to impairment income benefits (IIBs), determined by a whole body impairment rating assigned to the injured employee by an examining physician. Both the injured employee and the insurance carrier have the right to dispute an impairment rating. A review of questionable impairment ratings, those not in line with the proper edition of the American Medical Association guidelines or including disputed body parts, ensures the accuracy of the indemnity benefits to injured state employees and reduces overpayment of benefits. The Office utilizes an established review process for impairment ratings involving analysis by the assigned claims adjuster, in-house medical staff, and/or external independent physicians. In addition, the Texas Workers' Compensation Act and DWC-adopted rules have provisions for an independent review of impairment ratings by a DWC-assigned Designated Doctor.

Fraud Detection and Investigation

The Office employs two full-time staff members to investigate potential fraud and abuse as a part of the Office's workers' compensation fraud detection program. The Office investigates both individual and medical provider fraud. The Office has a zero-tolerance policy for fraud and actively pursues administrative and criminal prosecution against those who attempt to receive monies and benefits to which they are not entitled.

Subrogation Recoveries

The Office's subrogation program focuses on the early identification of claims involving third-party liability, facilitates timely resolution of these cases, and maximizes recovery of claims payments from third parties.

The amount the Office collects through subrogation is limited to the amount that has been paid in workers' compensation benefits on the case in question and the amount available through third-party insurance policies or other payment sources. Subrogation reduces costs in two distinct ways. The first is the direct reimbursement to the Office of all or a portion of monies paid by a third party to reimburse the Office for monies already paid. The second is the avoidance of future expenses in an amount equal to the injured workers' direct recovery, as the Workers' Compensation Act identifies such recoveries as advances against future benefits. The Office seeks to identify all workers' compensation claims with subrogation potential in order to maximize subrogation recoveries from third parties for the benefit of the State. Any monies recovered through subrogation are returned to the client agencies in the form of reduced assessments the following year.

Risk Assessment and Loss Prevention Services

The accident that does not occur has the least direct cost to the State. While not reported as savings in this report, cost avoidance is inherent as a result of the decline of the number of injuries (both in absolute and relative terms) in the past biennium. The Office's Risk Management Specialists serve as consultants to state agencies, conduct risk assessments, and assist in developing and implementing risk management programs to prevent and control losses. During risk management program reviews and on-site consultations, particular emphasis is placed on policies, programs, and procedures that promote workplace safety and employee wellness, accident prevention, and loss control.

PROPOSED ADDITIONAL MEASURES

Loss of PBM/PPO Savings

Beginning with FY 2010, the primary contract for medical bill review and preauthorization services, including access to PPO savings, was awarded to Forté, Inc. A direct contract to access to PBM savings was awarded to ScripNet, Inc. The Office expected long-term significant increases in savings as a result of implementation of these new contracts.

House Bill 473, 81st RS, disallows voluntary or informal networks such as PPOs as of Jan. 1, 2011. The Office anticipates a cost to the program (claims costs) of approximately $2 million due to this legislative change. Similarly, prescription cost savings of $913,864 were realized through the use of the ScripNet PBM in FY 2010. After seeking an opinion from the Attorney General regarding whether PBMs were included in the legislation eliminating voluntary PPO networks, DWC adopted emergency rules allowing the continuation of PBMs at least until the Legislature has the opportunity to take action on this issue.

Workers' Compensation Health Care Networks

The Office designed a Request for Information (RFI) to collect necessary information to design its Request for Proposal (RFP), and during FY 2008 the Office published a RFP based on information

received during the RFI process. After extensive review, none of the proposals provided sufficient required information to determine that an award would be in the best interest of the State. This decision was not a finding that the State's self-insured workers' compensation program might not benefit from a properly constructed and well-managed workers' compensation health care network, but only that it was not possible to determine that such a network, as described in the proposals received, would be in the best interest of the State at that time.

The Office's Board of Directors has expressed interest in exploring all potential alternatives. One such alternative the Legislature may explore is an approach similar to provisions already in place for political subdivisions under Section 504.053, Texas Labor Code. This option is not currently available to state agencies operating statutory workers' compensation programs pursuant to Chapters 501-503 and 505 of the Labor Code (State Office of Risk Management, Texas A&M University System, University of Texas System, and Texas Department of Transportation). According to DWC's report card on health care networks, political subdivisions appear to have been successful in implementing networks under Section 504.053. The one 504 network large enough to be included in the report card showed lower medical costs than non-networks and lower utilization in most categories; higher access and satisfaction with care; higher RTW rates; and higher physical and mental functioning scores. Networks under Section 504.053 are significantly less cumbersome to create and implement for a governmental body and allow for network access in rural or low population areas where State facilities are frequently located, but specific statutory changes would be required to include these provisions in Chapters 412 and/or 501.

SORM
STATE OFFICE of RISK MANAGEMENT
300 W. 15th Street, Austin, Texas 78701
P.O. Box 13777, Austin, Texas 78711-3777
(512) 475-1440, FAX (512) 370-9025
www.sorm.state.tx.us