

Annual Report on Cost Containment

Fiscal Year 2009

State Office of Risk Management

November 2009

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.

House Bill 1, 80th Legislature, Regular Session, 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 2009.

Summary of Cost Containment Savings: Fiscal Year 2009

During Fiscal Year 2009, cash basis claim expenditures totaled \$45.2 million, \$28 million of which were medical expenditures. The Office's cost containment measures in FY 2009 resulted in savings of almost \$64 million for the workers' compensation claims fund and Texas taxpayers. A breakdown by amount for FY 2007 through FY 2009 is provided below.

SUMMARY OF COST CONTAINMENT SAVINGS

STRATEGY	2007 SAVINGS	2008 SAVINGS	2009 SAVINGS
Total Medical Bill Audit Savings	74,499,274	64,899,875	64,462,103
Duplicate Bill Savings*	(10,622,218)	(5,448,966)	(6,959,964)
Net Medical Bill Audit Savings	63,877,055	59,450,909	57,502,138
PPO Savings**	954,269	1,068,546	1,208,564
Pre-Authorization of Medical Services***	7,056,576	5,663,830	4,627,442
Subrogation Recovery	684,121	875,144	638,590
TOTAL COST CONTAINMENT SAVINGS****	\$72,572,021	\$67,058,429	\$63,976,735

* Duplicate Bill Savings are not reported in the total savings, but are included to show potential exposure.

** PPO Savings are as reported by the cost containment vendor. 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.)

**** Decreasing savings trend due to both internal and external factors, including but not limited to reductions in total number of claims, as well as changes in preauthorization rules and conversion factors promulgated by TDI-DWC and recent court cases interpreting stop-loss methodologies promulgated by TDI-DWC.

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 workers' compensation benefits are fairly paid to injured state employees. The Office continues to refine its cost containment strategies and to seek new strategies that can reasonably assist in ensuring that 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 2009.

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 that provide maximum allowable fees 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 2009. 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. Pre-authorization savings represent the avoidance of expenses related to unreasonable or unnecessary procedures or services prior to their 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 the circumstances 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 that necessary and proper care is provided while avoiding the costs 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 the 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 in the elimination of unnecessary care in excess of the cost of such reviews.

Pharmacy Benefits Management/Preferred Provider Organizations

The pharmacy benefits management contract with vendors Forté, Inc. and ScripNet, 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 realized significant savings from this voluntary program.

The cost containment vendor, CorVel Corp., utilized 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 represent savings to the Office and the State's taxpayers.

Medical Case Management

Medical Case Management involves the use of a certified medical case manager to serve as a liaison between the injured employee, the employee's health care provider, and the Office. Savings from medical 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.

Case management is considered within the workers' compensation insurance industry to be an effective method for reducing claims costs. 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 operates a triage case management program that utilizes the skills of an Agency Case Management Nurse. In this capacity the nurse case manager performs telephonic case management in all cases where an injured worker loses more than seven days from work with a focus on contact with the injured worker, treating doctor, and employer to obtain information to assist the adjuster in developing a claim handling strategy to ensure quality health care delivery and accelerating return to work.

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 a physician. Both the injured employee and the insurance carrier have a right to dispute an impairment rating. A review of questionable impairment ratings, those not in line with the American Medical Association guidelines, or with 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 made provision for an independent review of impairment ratings by a DWC-assigned Designated Doctor. These procedures help ensure the accuracy of the assigned rating and, in some cases, decrease impairment income benefits paid as a result of errors and the differences between the original impairment ratings and the Designated Doctor ratings.

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 claimant 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

Subrogation is the legal assignment of the rights of the insured to recover the amounts of a loss from one legally liable for the loss to an insurer following payment of a loss. 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 satisfy the Office's lien. 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.

Claims Operations

To emphasize cost containment, the Office operates a Medical Management Review Team to target claims that require additional scrutiny because of significant or ongoing medical activity. Over the past five years, the Office has also implemented improved criteria for case closures, refined practices for the effective maintenance of claims, and emphasized ongoing professional training of claims staff.

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, employee wellness, accident prevention, and loss control.

PROPOSED ADDITIONAL MEASURES

Substantial Loss of PBM/PPO Savings

During FY 2009, 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.

However, the Office is being advised that legislation passed during the 81st Legislature will prohibit contractual PPO savings not received through a certified Workers' Compensation Health Care Network (WCHCN) and will also prohibit all contractual savings on pharmaceutical costs. No available WCHCN currently meets the State's unique needs under the existing statutory structure (see below), and implementing and maintaining a WCHCN would result in no cost savings. Anticipated losses to the State's cost containment savings under current operations will exceed \$1.2 million per year if the Office is prohibited from utilizing contractual discounts.

Workers' Compensation Health Care Networks

During FY 2007 the Office published a Request for Proposal to procure a Workers' Compensation Health Care Network for injured state workers. After review of proposals, the Office's selection committee concurred in a final decision, determining to decline to make an award and to suspend the RFP for Workers' Compensation Health Care Network Services. 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 WCHCN, 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 requested resources to

continue to pursue network implementation in its Legislative Appropriations Request to the 81st Legislature.

Return-To-Work (RTW) Initiatives

The Office underwent Sunset Review in the 80th Legislative Session, resulting in a mandate to develop RTW services for covered entities. The Office has been actively evaluating approaches to address emphasis on RTW, including evaluating available case management and disability management approaches, considering appropriate guidelines and standards, and evaluating multiple methods for incentivizing RTW, and for tracking RTW outcomes. The Office did not receive the Sunset-recommended resources for implementation of the programs(s) and service(s) and requested necessary resources in its Legislative Appropriations Request to the 81st Legislature to implement required RTW initiatives. The 81st Legislature granted the Office three additional full-time equivalents, to be hired as Nurse Case Managers. These additional nurse case managers will assist the Office in early intervention of complex workers' compensation cases and will help identify medical issues and RTW options for injured state employees.



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