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2014

Performance Evaluation of North Dakota Workforce Safety and Insurance

September 3, 2014

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Governor of North Dakota
The Legislative Assembly
Chairman of the Workforce Safety and Insurance Board of Directors
Chairman of the Workforce Safety and Insurance Board Audit Committee
Executive Director of Workforce Safety and Insurance

We are pleased to submit this report summarizing the results of the 2014 Performance Evaluation of Workforce Safety and Insurance (WSI). The Performance Evaluation primarily covers activities at WSI during Calendar Years 2011 through 2013, although some components of the evaluation cover a broader time span.

One purpose of this Performance Evaluation was to assess certain aspects of WSI and to provide recommendations for improvement. Another purpose was to evaluate certain North Dakota statutory provisions and administrative practices as compared to similar provisions and practices that we observe around the country and provide recommendations. Various financial impact estimates are made pertaining to Element Eight – the evaluation of Post-Traumatic Stress Disorder.

The Performance Evaluation features eight Elements including:

- Independent Medical Evaluations
- Fraud
- Certain Aspects of Claim Processes
- Vocational Rehabilitation
- Designated Medical Provider programs
- Narcotic Utilization
- Cost of Living Adjustments, and
- Post-Traumatic Stress Disorders.

This performance evaluation also included a review of a limited number of recommendations from the 2010 performance evaluation. Recommendations in this evaluation were made pertaining to each of the Elements where we felt opportunities existed to improve performance, establish greater cost efficiencies, or reasonably modify statutory provisions. Forty recommendations were made.

The report consists of an executive summary, sections pertaining to each Element, recommendations, WSI responses to the recommendations, and various supporting exhibits. In some instances, we added a reply to follow up on a WSI response to a recommendation.

We want to thank all those at WSI who assisted us in the Performance Evaluation process with a special note of thanks to the Internal Audit staff.

Sedgwick CMS – Risk Services Practice

Roseville, California

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Executive Summary

Topics selected for this 2014 Performance Evaluation provided opportunities not only to assess the performance of WSI but also to evaluate workers' compensation benefit provisions and practices at a high level. Notable in the latter category were such topics as the Designated Medical Provider program, narcotics utilization, cost of living adjustments and the value of covering North Dakota workers for certain types of psychiatric injuries where no physical injury has occurred.

Given the spectrum of topics, some recommendations made in this evaluation will require both the initiative of WSI to draft appropriate legislation and the thoughtful consideration of the legislative and executive branches of government in North Dakota. To support the legislature's efforts in this endeavor, we have sought to provide a financial impact analysis where meaningful statutory changes are recommended. Financial projections were provided through a consulting actuary retained by Sedgwick and limited to our evaluation of Post-Traumatic Stress Disorders (see Element Eight).

In addition to our contracting with an actuary, we also relied on our company's internal resources to better understand workers' compensation statutes and practices in other jurisdictions and a pharmacy benefits management firm with whom both we and WSI work to evaluate narcotic utilization in workers' compensation jurisdictions around the country. We also obtained information on such topics as fraud and denial rates from other workers' compensation professionals around the country. And we relied on certain industry publications, court cases, WSI's own reports and other materials to compile our findings throughout the performance evaluation.

Overall in this evaluation, we have made forty recommendations. Within the report, we have made no more than eight recommendations for any one of the elements. As noted in the table below, nearly all recommendations are considered either high or medium priority.

Element	High Priority	Medium Priority	Low Priority	Total
One	8	0	0	8
Two	5	1	0	6
Three	1	2	0	3
Four	5	2	1	8
Five	4	1	1	6
Six	4	1	0	5
Seven	0	0	0	0
Eight	2	1	1	4
Total	**29**	**8**	**3**	**40**

More specific commentary about each of the eight Elements included in the evaluation is provided throughout the balance of this executive summary.

Of the ten prior recommendations that we evaluated from the 2010 Performance Evaluation, we found that two had been fully implemented, three were partially implemented and five were not implemented. More information is provided on these prior recommendations in Elements One and Six.

Element One – Independent Medical Examinations

Our objectives in this Element included a complete evaluation of the Independent Medical Examination (IME) process with comparisons to other jurisdictions. To assess WSI's process, we reviewed policies and procedures and examined 75 time loss claims on which IME services were provided. We also reviewed approximately 150 claims from other states where IME services were provided to compare/contrast to trends observed in the North Dakota cases.

We observed that WSI also uses its contracted medical consultants to review cases for compensability determinations, which we believe should be supplanted by the IME process. We continue to believe that an injured worker whose case is to be reviewed for compensability deserves to be examined by the provider making that determination.

We found that IME costs average a little more than $4,000/case when all associated costs, including travel expenses, are tallied. It is noteworthy that no North Dakota licensed physician performed any of the examinations in our claim review sample. About 16% of the evaluations were conducted in North Dakota but all were by physicians licensed elsewhere. About 3 of every 5 exams in the sample were conducted in Minnesota.

We found that the last time WSI made a concerted effort to recruit physicians from within North Dakota occurred in 2010. As such, we have made a recommendation that WSI renew efforts to identify providers within the state who can provide the IME service. We should also point out that WSI refers to one of two IME vendors for most of these services. This is not atypical in the industry, but what is atypical is that no providers are retained in-state. For a comparison of this trend and how other states compare to North Dakota, please refer to Table 1.7 in Element One.

Element Two – Fraud

In this Element, we sought to review fraud detection policies, procedures and practices and where possible to compare those to what we observed in other jurisdictions. We should point out that because North Dakota is a monopolistic workers' compensation jurisdiction more comprehensive data is available statewide than would be true of states that are not monopolies. The simple reason for this is that in non-monopolistic states fraud is detected by insurance companies and third party administrators

and so there is no comprehensive database documenting fraud outcomes. Fraud outcomes may be maintained by individual companies but not centrally. Even in Wyoming which is the only other exclusive workers' compensation monopoly data collection is not comprehensive.

As part of our review, we reviewed more than 100 claims on which fraud was suspected. For claims within our sample on which a fraud order issued, we reviewed the accuracy of cost avoidance calculations as accomplished by WSI. Cost avoidance represents the amount of money WSI believes it has avoided paying as a consequence of discovering fraud. Coupled with restitution, these values are then used to calculate a return on investment against WSI's internal overhead expenses tied to the Special Investigations Unit (SIU) and the costs of external investigations.

Fraud is a topic that has been reviewed in other performance evaluations and a consistent finding has been what appears to be an uncoordinated effort at investigating potential medical provider fraud. This evaluation is no different in that regard. We recommended that more be accomplished to pursue potential medical provider fraud with WSI's business partner, CGI Federal and its ability to identify billing patterns that may be suggestive of inappropriate practices.

WSI also acknowledges that it needs to prepare a new Policies and Procedures Manual pertaining to Fraud as the current manual is outdated and not used. With that said, we did find good coordination of fraud detection between the SIU, Claims, and Policyholder Services staff. SIU staff also reported that since the conclusion of our field work in the Performance Evaluation that they have ramped up communication and fraud detection efforts with CGI Federal.

Element Three – Aspects of the Claim Process

In Element Three, we were required to evaluate various aspects of the claim process with a focus on denials that reached the Decision Review Office (DRO), the appeal process, and claims department staffing levels at WSI.

As a standard practice, WSI compiles an adjusted claim acceptance rate calculation that is included in its quarterly operating reports. During the performance evaluation period, the acceptance rate ranged from 90% to 92%. When compared with acceptance rates in other jurisdictions, the rate in North Dakota is similar. This was true whether we compared outcomes to monopolistic jurisdictions or states where workers' compensation programs are managed by insurance carriers, employers and third party administrators.

In reviewing the role of the Decision Review Office in the evaluation of denials, we observed that the DRO helps WSI and injured workers arrive at reasonable dispute resolutions. These resolutions may include a settlement of benefit entitlements through Stipulations or an agreement on the part of WSI to accept a claim that has previously been denied. Table 3.7 in Element Three provides a summary of our findings on how denials have been resolved. Of note are the following facts:

- roughly 80% of the cases in our sample were resolved without a change in WSI's original decision or by Stipulations
- slightly more than 10% of the cases were changed
- in only two instances where the case proceeded to hearing was there a judicial ruling that held WSI liable (one of the cases was a reversal and the other was a split decision)

In our review of the appeals process, we compared the North Dakota approach to other jurisdictions and found that North Dakota's appellate options create a reasonably streamlined approach to dispute resolution. We also reviewed metrics used by both WSI and the Office of Administrative Hearings (OAH) which measure the timeliness of steps through the litigation process and made one recommendation on how those metrics can be enhanced. Specifically, we think cases that move through the process without delays caused by the parties should be captured uniquely. Delays caused by the parties due to schedule conflicts or injured worker availability are not within the control of OAH so those kinds of cases should be tracked separately.

Finally, we reviewed WSI's decision to retain non-benefited claims adjusting staff to assist in the claims management workload. Given the increased frequency of claims we observed year over year within the performance evaluation period, we believe WSI has acted responsibly in creating these positions. Simply put, as there are more claims to service a higher headcount is required.

Element Four – Vocational Rehabilitation

In this Element, we reviewed all facets of the vocational rehabilitation process in North Dakota. We also reviewed the vocational rehabilitation statutes in several other jurisdictions to see how those laws compared to those in North Dakota. We assessed policies and procedures and evaluated the transition that has occurred during the performance evaluation period from an outsourced service to one where WSI provides vocational services in-house. We also assessed current metrics that WSI uses to measure performance.

An important finding in this evaluation is that most states deploy a tiered approach to the selection of vocational plans. By that, we mean that statutory preferences are given to shorter term plans that attempt to achieve job placement through the injured worker's transferable skills. Plans of longer duration such as formal training or self-employment programs are generally seen as plans of last resort. The statutory scheme in North Dakota mimics what we observed in other jurisdictions.

One of the more challenging aspects of vocational rehabilitation for WSI is the influx of cases involving workers who reside in states other than North Dakota. There is less familiarity with labor markets in other states and more research is required to manage certain claim processes. For example, finding a reliable provider to conduct a functional capacities evaluation (FCE) can take additional time, and the FCE is an integral part of the vocational process because baseline physical capabilities need to be understood so plan selection fits the injured worker's limitations.

WSI has established policies and procedures to manage its vocational responsibilities pursuant to the North Dakota Century Code Chapter 65-05.1. WSI has also begun a process of capturing relevant data to measure performance and we made a recommendation on how that data can be better used to support their metrics.

We also found when comparing the costs of in-house v. outsourced services that WSI has saved close to $500,000 in administrative costs annually through this change, a change that was recommended in the 2010 Performance Evaluation and that the legislature supported.

Element Five – Designated Medical Provider Program

In this Element, we evaluated how the Designated Medical Provider (DMP) program works and whether employers have benefited from the program. We relied on a review of claims among employers who participate in the program and evaluated DMP claims against non-DMP claims to assess outcomes. We also considered how networks generally work in other states and contrast that to North Dakota.

First, our outcomes measures suggest there is little difference in disability duration or claim cost when comparing DMP to non-DMP programs. With the exception of Calendar Year 2011, average medical costs on the two claim groups are essentially the same. And when looking at disability durations, DMP claims are similar to their non-DMP counterparts. For more details on these outcomes, please review Tables 5.1 and 5.2.

When comparing DMP programs to networks in other states, we found that the programs are really not comparable. North Dakota's DMP programs are managed by individual employers and there is no credentialing process or vetting by a central manager. Also, the North Dakota program serves employers more from a premium discount perspective than one that is outcomes driven. WSI also has no role in the provider selection process.

We observed that the costs to WSI related to DMP programs are nominal and we also found that opt out provisions are designed appropriately. By opt-out provisions, we are referring to the right of employees to choose to be treated by physicians of their choice even if their employers have a DMP program.

Element Six – Narcotic Utilization

This Element called for us to assess patterns of narcotic utilization in North Dakota as compared to experience in other jurisdictions around the country. We found that on average narcotic utilization in North Dakota is both slightly more frequent and makes up a slightly higher percentage of overall prescription costs when compared to national averages. In some respects, this result in North Dakota is not surprising because of two factors:

- WSI typically does not settle workers' compensation claims such that medical benefit entitlement is closed out
- Medical benefit settlements do occur in other states and such settlement costs would not be captured by pharmacy benefits management firms whose data we rely upon to make comparisons between states

The assessment also required us to evaluate prescribing patterns among providers in the state and we found prescribing patterns in Burleigh County to be of substantially greater concern than what we observed in other counties around the state. This is a pattern we observed in the 2010 Performance Evaluation and as we did then we can attribute this result to a limited number of medical providers who specialize in pain management.

As you read through Element Six, you will find that the majority of all narcotics related expenses are driven by older claims. As a consequence of this finding, our recommendations focus in large measure on the management of cases where narcotic use has become chronic.

Element Seven – Cost of Living Adjustments

For this Element, we were asked to evaluate the process whereby cost of living adjustments (COLAs) are provided to injured workers or their dependents and how North Dakota's statutory provisions compare to other jurisdictions.

We observed that in two recent years, COLAs amounted to approximately 10%/year due to increases in the State Average Weekly Wage (SAWW). These increases occurred at a time of significant economic growth in North Dakota and also at a time when costs of living in certain parts of the state (notably in cities and towns near the oil fields) have also increased significantly. We noted when comparing North Dakota to other states that some states cap their COLAs and some do not. We also observed that some states qualify injured workers for COLAs earlier in the claim process than is true in North Dakota.

Given the economic climate in North Dakota and our comparisons to other states, we made no recommendations that COLA calculations be modified.

Element Eight – Post-Traumatic Stress Disorders

Currently, North Dakota's workers' compensation statutes do not allow for coverage of injuries to the psyche unless the injured worker can show that the dominant cause of his/her injury is related to physical injuries s/he has sustained in the workplace. In this Element, we were asked to consider whether North Dakota should consider providing workers' compensation benefits for those whose injuries do not involve a physical injury but for whom a diagnosis of post-traumatic stress disorder (PTSD) has occurred and that diagnosis has been tied to a workplace event or events.

During the performance evaluation period, we also streamlined the analysis of PTSD scenarios to include injuries arising out of three possible circumstances:

- First responders
- Victims of violent crimes
- Unusual and extraordinary events

We found that in our survey of states that about 70% of all states allow claims for psychiatric injuries while the other 30% do not. For purposes of comparison to North Dakota, we selected states whose statutes allow for a narrow selection of psychiatric injuries in keeping with the scenarios referenced above.

We have provided recommendations in this Element to allow for PTSD claims in North Dakota but we have also placed controls in our recommendations on how coverage should be controlled. These controls include coverage caps relating to disability duration and also a sunset provision to the enabling legislation during which time WSI and the legislature can reliably measure costs associated with these injuries.

Element One: Review of Independent Medical Evaluations (IME's)

Introduction

For this Element, the State of North Dakota is interested in:

- A review of the entire IME process, with a comparison to Sedgwick's IME national best practices developed in 2012.
- An analytical review of the overall number of "lost time" claims.
- A review of a sample of a minimum of 75 "lost time" claims that included the use of an IME during the evaluation period (calendar years 2011, 2012 and 2013). An evaluation of each of the sample items to determine:
    - If the use of an IME and the process used to assign the IME physician complied with all applicable laws, rules, regulations as well as WSI policies and procedures;
    - The percentage of times the IME physician disagreed with the opinion of the claimant's treating physician;
    - How this percentage compares with similarly calculated percentages in at least five comparable workers' compensation systems and analyze the reasons for significant differences. In addition, compare this percentage to national statistics;
    - If the specialty of the IME physician was either the same as the claimant's treating physician or was a specialty better versed in the specific injury;
    - If the use of an IME significantly delayed resolution of the claim.
- An analysis of the percentage of times an IME was used for "lost time" claims processed by WSI for each year covered by the performance evaluation, and a comparison of this percentage to the percentage of times an IME was used for "lost time" claims in at least 5 comparable workers' compensation systems.
- A review of the total costs for the use of IME physicians and any other third parties related to IME's for each of the calendar years covered by the performance evaluation, including relevant travel expenses for the IME physician and the claimant and WSI's costs of using other organizations to locate and/or recruit physicians to conduct IME's.
- A review of the process WSI follows to locate and/or recruit IME physicians. Determine if the agency is following relevant state statutes, administrative code, and WSI policies and procedures including preference for an IME physician licensed in the state in which the employee resides (NDCC Section 65-05-28). Also, a determination as to if five comparable workers' compensation systems, at a minimum, use more effective or efficient processes to locate and/or recruit in-state physicians.
- A review of the percentage of times the IME's for calendar years 2011, 2012 and 2013 were conducted by North Dakota physicians, and a comparison of this percentage to at least five comparable workers' compensation systems, and, if available, national data.

In the context of this Element, we will also address how WSI has implemented recommendations 1.3, 5.1, and 5.4 of the 2010 Performance Evaluation.

Background

Our approach to address this topic utilized a combination of activities including:

- We interviewed WSI staff from Claims and Medical Services
- We reviewed WSI policies and procedures related to Independent Medical Evaluations
- We reviewed pertinent North Dakota Century Codes
- We reviewed the pertinent Administrative Rules and Regulations
- We reviewed minutes from North Dakota House Bills No. 1080 and No. 1163, and Senate Bills No. 2080 and No. 2298, all passed in 2013.
- We reviewed case law from *Mickelson v. WSI, 2012 ND 164*
- We reviewed data extracted from the WSI claims management system identifying all claims in the evaluation period that were scheduled with an IME from CY 2011, CY 2012 and CY 2013
- We obtained the number of indemnity and medical only claims filed in the CY 2011, CY 2012 and CY 2013 evaluation period.
- We reviewed prior Performance Evaluation Reports.
- We reviewed various documents and websites from comparable states and multiple employers to obtain data on IME usage and results. We elected Alaska, Kansas, Michigan, Washington and West Virginia to make comparisons. These are states that are either monopolistic or rural in enough parts of the respective states to create some of the same travel issues that might be encountered in North Dakota
- We consulted with various State Experts at Sedgwick on processes for selecting Independent Medical Evaluators and obtained related documentation pertaining to specific states.
- We reviewed 75 cases on which IMEs took place and gathered information on a form with sufficient detail to meet element objectives (see Exhibit 1.1)

Context

An independent medical examination (IME) is a legal term referring to a physician with subject matter medical expertise, who is a neutral party to the claim performing a medical examination to draw conclusions and produce a special report that determines certain factors as presented. An IME is designed to give an unbiased opinion of the injury or injuries, the cause, the prognosis, the appropriateness of treatment and work restrictions, etc.

An Independent Medical Review (IMR) refers to a subject matter expert physician that is also a neutral party, who performs a medical evaluation and creates a special report solely by review of the medical records submitted. The IMR is the claims professional's opportunity to place the injured worker's past medical records in front of a neutral party that has the medical expertise to make a medical/legal

determination as to the issues as outlined by the referring party without the costs associated with a face-to-face examination process.

Neither the IME nor the IMR treat the patient. Both the IME and the IMR review medical reports, diagnostics, prior medical records and possibly video evidence; however, the IME is the only physician that physically meets with the patient and discusses the history of the injury, pre-injury and post-injury medical events. It is in this two-way meeting that any questions regarding the mechanism of injury and medical evidence may be resolved, unknown medical history may be solicited, and the patient's physical condition and demeanor may be assessed.

Findings

Review of WSI's Compliance with the IME Process

We began this evaluation process by reviewing the definition of the Independent Medical Examiner and the Independent Medical Reviewer in the North Dakota Century Code (NDCC) §65-05-28 and the Administrative Rules found in Chapter 92-01-02, which describe the Medical Services and Claims and Compensation directives in the State of North Dakota. As a monopolistic state, North Dakota has given authority to Workforce Safety and Insurance (WSI) to utilize "Consulting doctors" and to obtain "Special reports" to obtain information on specific conditions and for Utilization Review purposes. We then reviewed rules associated with the actual examination of the injured employee found in North Dakota Century Code (NDCC) §65-05-28 (3).

We held a number of open discussions with Claims department staff to discuss the IME process. Many of the staff members were under the impression that the IME process contained many drawbacks to the claim process. Their impression is that that the process of setting up the IME is time consuming administratively, that it creates a large charge to the employer, and that it takes the claimant away from work - often out of state because of the state's rural base and the lack of North Dakota physicians qualified and available to perform these specialty examinations. They also commented that the IME process extends the time to obtain issue resolution; however, they don't see any other way of meeting their legislated responsibility. WSI claims staff also felt that they were sending more claims through the IME process since the prior performance audit, primarily because of the new legislated requirement to obtain "objective medical evidence". They indicate that legislators have also complained about the increase in frequency of IMEs as well.

WSI is highly detailed and very specific in their claim process documentation. There are 108 pages of internal WSI claim procedures that link to their IME process. These range from identifying the types of issues that may justify the need for an IME to how payment is to be made for charges related to the IME process. A number of changes were made to Claims Procedures in calendar year 2013 due to a number of changes in legislation in calendar year 2013.

Claim Procedure 310 begins with WSI's legal authority to require an IME (Independent Medical Examiner) or IMR (Independent Medical Review) under NDCC § 65-05-28 (3) and Administrative Rule 92-01-02-41 to:

A. Establish or to clarify a prior diagnosis.
B. Establish medical information on relatedness of a medical condition.
C. Determine whether a claim should be reopened on the basis of aggravation or significant change in a compensable medical condition.
D. To determine whether treatment is necessary if the injured worker appears to be making no progress in recuperation.
E. To establish a percentage of rating in permanent impairment.
F. To determine whether and to what extent a preexisting medical condition is aggravated by an occupational injury.

Claim Procedure 310-1 provides sample questions for claims examiners to be used in the cover letter to the evaluating physician. The questions as outlined are helpful in defining not only the rationale for the IME examination, but also help frame issues based upon North Dakota Century Code and Legislative intent:

- Diagnoses
- Etiology/Causation
- Trigger/Aggravation
- Psychological issues
- Physical Function
- MMI/Pre-Injury Status
- Treatment Recommendations
- Prescription Issues
- Prognosis

The IME process in any claims organization usually begins with an issue that arises in one or more of the medical events listed. It is no different for WSI. For example, an x-ray or MRI report received documents degenerative changes in a body part that is part of the alleged or accepted work injury. Or a request for prior medical records divulges heretofore unknown pre-work injury treatment. Utilization review may receive a request for a diagnostic procedure or approval for a surgery that needs further investigation to determine appropriateness or medical necessity. Once the issue is identified, a WSI claim staffing or multi-disciplinary triage meeting is held to discuss the issue(s) and make decisions regarding next steps. It is at this juncture that the resolution process may take a number of different paths at WSI:

1) WSI staff denial based upon statute, rule, regulation or medical guideline
2) A referral for an IMR by one of WSI's two Medical Consultants, the result of which is utilized by the claims staff to accept or deny the claim or issue under question
3) Questions formulated by triage consensus (claims, legal, medical, Return-To-Work, managed care)to be sent to the treating physician to facilitate an appropriate decision

4) Recommendation from Medical Services or Legal for an outsourced IME to make a medical determination. Twenty-six percent of the IMEs in the sample were recommended by the Medical Director or Consulting Physician prior to a compensability decision being issued by WSI. Thirteen percent of the IMEs in the sample were either recommended by WSI Legal or were agreed upon by WSI Legal prior to a claim compensability decision. In states outside of North Dakota, it is a recognized practice for defense litigation specialists to recommend IMEs to resolve disputed medical issues in a workers compensation claim.

If the decision is made to move to an IME, WSI's claims department initially contacts one of two Preferred IME Vendors to schedule the evaluation. If the claimant's location is outside of the network, WSI's Medical Director is consulted to locate an appropriate IME in close proximity to the claimant's current location. WSI issues an appointment notice to the claimant, with a copy to the Employer, along with an enclosure that explains what an Independent Medical Exam is, and a form to report expenses associated with the appointment. When air travel is necessary, WSI uses a Travel Vendor partner to schedule the flights. A cover letter is generated for the IME with questions specific to the issues on the case. Medical records from the claim are submitted to the IME for review. In some instances, claims technicians "sleuth through" claim file documentation to determine if prior medical records are needed for the IME to review. In the majority of the claims, WSI makes good use of the IME to assist with any other issue that is unresolved, or for which they may need guidance. For example, when tasked with assessing surgical risk, the IME may also be asked to address whether there are any disabling factors unrelated to the work injury, and to assess the ability of the claimant to participate in a Functional Capacity Evaluation or provide work restrictions.

Once the IME report is returned, it is reviewed in a staffing/triage meeting. The claim procedure requires that a copy of the report to be sent to the claimant and the treating physician, requesting concurrence with the IME opinion(s). A second request is sent if a timely response is not elicited from the treating physician. Thereafter, WSI makes the decision to approve, deny or modify the issue(s) under consideration. Formal Administrative Orders are usually issued awarding or denying benefits. When medical procedures are at issue, standard Utilization Review documentation is issued to the requesting provider. The claimant and the employer are sent any formal documentation. If the claimant is represented, a copy of any notice to the claimant is also sent to the attorney. If there is any disagreement on the part of the claimant/attorney, WSI follows the administrative process of referring the claimant to the Decision Review Office (DRO) for assistance within 30 days of the decision. The other alternative is to write WSI and request a hearing within 30 days of the decision. Utilization Review and Managed Care departments utilize standard form letters that contain binding dispute resolution language, and the website address for a dispute resolution form.

After a procedural review of the claim processes in the 75 claims selected for review, we identified IME Claim Procedures were not consistently followed. The following are areas wherein this review has demonstrated that WSI needs to consistently apply their IME Claim Procedures, more specifically #120, #310, #310-1 and #1102:

- Obtaining all the prior work and non-work related injury and treatment information for the IME to review. Then documenting and sending prior work and non-related injury information located

in the WSI claim system from prior claims to the IME. Two claims have histories of prior work related back injuries reported in the WSI system under a prior employer. The claims in question were denied for priors. The prior work history and medical records from the prior medical only claims were not submitted to the IME for review. In another case the IME reported that he did not believe that he received all the records to review on the claim. Four years of lab results ordered were not provided. They were necessary to determine if there was a history of problems. Prior medical records could have avoided the need for an IME if they had been available early in the claim, as they would have documented a non-compensable mental condition. In another claim, most of the information needed to assess surgical risk was not provided to the IME at the time of the appointment. Chiropractic records were missing on another case at the time of the examination. In only one of the aforementioned cases was the missing evidence (medical or prior injury information) provided to the IME so that an adequate context was presented into evidence. A cornerstone to an appropriate medical/legal evaluation is the ability to review all pertinent evidence. Absent the review of all the records, the IME's ability to adequately report is lacking, and may indeed impact the decision made for or against the claimant. (see recommendation 1.1)

- Obtaining original diagnostic films for the IME to review. The IME for one claim was not sent films and diagnostic reports. This is a standard in the workers' compensation community to request that original films/scans be available for an IME to review. (see recommendation 1.1)
- Providing a copy of the IME report to the treating physician if the IME is in disagreement with the treating physician. The IME report includes a medical records review as well as an assessment of the claimant's presentation and affect. The treating physician is entitled to respond to the IME report. This unintentional withholding of medical evidence from the treating physician reduces the amount of relevant evidence the treater has in support of his opinion. It also supports the treatment process, as the report is technically a second opinion, a fresh set of eyes viewing the case, with recommendations for treatment and future evaluation. Historically, the greater weight for these cases has always been given to WSI because the treating physician's opinion does not have the girth to support or substantiate his/her opinion. The ability to comment on the medical record as a whole is one step toward increasing the treating physician's credibility in the IME process, demonstrating an opinion based upon the record as a whole. (see recommendation 1.1)
- If the treating doctor disagrees with the IME results and this will result in an adversarial result for the claimant, there is a lack of documented discussion between the claims adjusters and the unit supervisors to determine if another evaluation is necessary to provide a decision for WSI to determine liability. This is a part of the WSI written claim process, and therefore should be evident in application. (see recommendation 1.7)
- Treating physicians often do not respond to requests to review and comment on the results of the IME. Only 28% of the claims reviewed in this evaluation period have treating physician comments post-IME. Therefore, we recommend that claimants be copied on letters to their treating physician so that they are aware that requests have been made of their medical provider. (see recommendation 1.7)

- Invoking the aggravation statute when the prior injury, disease or condition is not known in advance of the work injury, and there is not documented evidence that it caused previous work restriction or interference with physical function. The language in the Aggravation section of Claim Procedure 1102 is not as clear as that in the statute, and may be misleading to claims staff applying it. Physical restrictions placed on the claimant at home or work as a result of a previous injury also define injuries that may be denied under the pre-existing injury, disease or condition standard. The IME in one claim advised that the injury was a temporary aggravation only, but the treating physician disagreed. WSI made the decision to "not deal with the aggravation issue" and allow the claim to continue under full acceptance. Treatment for chronic longstanding pre-existing conditions was not denied in another case. (see recommendation 1.7)

Analysis of the Percentage of Times an IME Was Used for "Lost Time" Claims

We acknowledge that states have various schemes for determining how they will manage and implement the IME process. In some states, the use of an IME is highly limited in scope because the primary treating physician has the presumption of correctness. In other states, there are more complex and rigorous medical dispute mechanisms in place, providing IME type evaluations wherein both the payor (insurance carrier, third party administrator, etc.) and the injured worker have the opportunity to participate in the selection of the IME and to submit evidence for review. We have reviewed practices in other states, and based upon North Dakota's monopolistic status, we have selected Sedgwick's internal best practices for State Funds as the tool to compare WSI's policies and procedures, as there is no national best practice to utilize.

The Medical Management section of Sedgwick's *WC Claim Administration for Monopolistic States* best practices defines the purpose and scope of the IME process for monopolistic states. A comparison of the types of issues that the IME and IMR may address in North Dakota NDCC §65-05-28 and Sedgwick's WC Claim Administration Best Practices for Monopolistic States confirms that the issues and resolutions processes are similar, and that the use of IMEs as documented in the WSI Claims Procedures are therefore appropriate for comparison purposes.

North Dakota divides their claim inventory into three categories: auto adjudicated, no time loss and time loss claims based upon the claim severity and the benefit levels that are being provided by WSI. Other jurisdictions categorize their claims based upon the severity and benefits that are being claimed by the injured worker. Therefore, to effectively evaluate North Dakota "lost time" claims against at least five other jurisdictions, it was necessary to review those WSI claims with designations of both no time loss and time loss to capture data that compares with other states. WSI provided a list of claims from their claim system with independent medical evaluations (IMEs) scheduled in CY 2011, CY 2012 and CY 2013. The list included claims with both no time loss designations (N) and time loss designations (T).

Table 1.1 below provides a snapshot of the number and type of claims filed in the evaluation period.

Table 1.1: Count of claims reported and IMEs scheduled by Calendar Year (2011 – 2013)

Reported Claims	CY 2011 Reported	2011 IMEs	%	CY 2012 Reported	2012 IMEs	%	CY 2013 Reported	2013 IMEs	%
No Time Loss	20,331	12	0.1%	22,070	13	0.1%	22,809	18	0.1%
Time Loss	**2,964**	**41**	**1.4%**	**3,296**	**61**	**1.9%**	**3,417**	**72**	**2.1%**
Total	23,295	53	0.23%	25,366	74	0.29%	26,226	90	0.34 %

There were a total of 217 claims in the three years of this evaluation period. Fewer than 2% of all the "time loss" claims had IME evaluations scheduled at some point. A very small percentage of those scheduled were cancelled or "no shows" on the part of the claimant.

In the sample of 75 WSI claims selected for this review, 12 were designated by WSI claim numbers as having no time loss, and 63 were designated as time loss cases. We confirmed that each of the claimants in the sample of 75 claims lost some time from work to meet the request for a "lost time" claim evaluation. One of the claims evaluated had three scheduled IMEs and three other claims had two scheduled IMEs each. Therefore, there were a total of 80 IME evaluation processes reviewed on 75 claims.

In all instances, the IME physician was licensed in the state in which s/he practiced. The specialty of the IME physician selected was either the same as the claimant's treating physician or was a specialty as well or better versed in the specific injury or issue(s) raised. In all but one instance, the IMEs completed an appropriate physical examination, documented her/his review of the medical records received, and answered all the questions posed by WSI. To rectify this particular instance on one claim, WSI scheduled a new IME appointment with another specialist to obtain the information needed to evaluate the issues. The claimant was adequately compensated for the additional travel and the issue was resolved appropriately.

WSI has instituted a practice of sending an IME Survey to all claimants that attend the IME to obtain feedback regarding the IME process. The survey gives the claimant the opportunity to comment on WSI's customer service level by ranking them (1-5 with 5 being completely satisfied) in three categories: explanation of the purpose of the IME, scheduling of the IME, and professionalism and courtesy of WSI staff. They are also provided the opportunity to rate the examination experience with the IME (1-5 with 5 being completely satisfied) in six categories: the amount of time the evaluator spent with them, how satisfied they were with the thoroughness of the medical history questions asked by the IME provider, the amount of time the IME spent with them, the professionalism and courtesy of the IME, the office environment (temperature, cleanliness) of the exam, and the overall experience. There is also an area for comments. The Claims Manager reviews all the surveys returned by claimants and provides both negative and positive feedback to the IME organizations regularly. She also provides feedback to the Supervisors regarding both positive and negative feedback related to how WSI was perceived by the claimant in the IME process.

Review of the Percentage of Time the IMEs Were Conducted by North Dakota Physicians

WSI claims staff advised that the IME assignments are alternated whenever possible. Sixty-one percent of the IMEs were performed by EvaluMed, 34% by ExamWorks, with the balance by others including the referrals from Best Doctors. WSI made well documented attempts to provide the IME appointment date and time within a reasonable timeframe, and within 275 miles of the claimant's location. When travel required of claimants was greater than 275 miles, documented attempts were made to locate another vendor in closer proximity.

In the group of 75 claims/80 IME evaluations, WSI scheduled IMEs for claimants that resided in 18 different states at the time of the examination. Chart 1.2 below identifies the different states that claimants resided in at the time of their evaluation, the number of claimants in each of the states, and the percentage of all IMEs needed for that group of states.

Table 1.2: State Locations where IMEs are needed (2011 – 2013)

Claimant State Location	Number of Claimants/State	% of IMEs Needed
AK, AR, CA, KY, MT, NE, NV, SD, WA, WY	1	13%
CO, ID, KS, MI, WI	2	13%
IN	3	4%
MN	5	6%
ND	**52**	**65%**

Chart 1.3 below identifies the states in which the actual IME evaluation took place, and the number of IMEs that took place in each of these states. Sixty-five percent of the claimants evaluated lived in the State of North Dakota at the time of their IME, however only 16% of the examinations took place in the state of North Dakota. Fifty-nine percent of the IMEs took place in Minnesota, the home base of the ExamWorks and EvaluMed organizations. Both ExamWorks and EvaluMed have scheduled IMEs in a pre-determined North Dakota location. The availability of these site appointments are not under WSI's control. WSI has not identified or investigated a location to hold these examinations on behalf of their constituency. (See recommendation 1.5)

Table 1.3 State Locations where IMEs where held (2011 – 2013)

IME State Location	Number of IMEs/State	Actual % of IMEs
AR, KY, MD, MT, WA, WI, WY	1	9%
CO, ID, NV	2	8%
IN	3	4%
MI	4	5%
ND	**13**	**16%**
MN	47	59%

The average number of days between the date of the IME and the date of the IME report is 13 days. Twenty-three percent or 18 of the reports were received within 10 days of the IME appointment. There were 11 reports submitted between 30-38 days, and one received 46 days from the examination date. The greatest delay was found with one report that was signed 93 days from the date of the IME appointment. Benefits were provided to the claimant in the delay window on this claim. The largest delay was inconsequential as benefits continued to be payable because the result was in favor of the claimant. The 46 day delay did create an overpayment in benefits for WSI, as the claim was not able to be closed for 75 days post IME. The claims staff reports that while the reports generally come in approximately four weeks after the appointment date, the reports are thorough and useful. Using less than 30 days as the acceptable number of days between the date of the evaluation and the receipt of the evaluation report, 15% of the IME reports received in the 75 claims/80 IMEs caused a delay in the claim process. (See recommendation 1.4)

Review to Determine if an IME Significantly Delayed Claim Resolution

Table 1.4 below represents the cases on which obtaining an IME lead to a delay in resolving the claim. We found that only about 15% of all North Dakota cases which were reviewed saw a delay in resolution arising out of the IME process. The balance appeared to resolve more expeditiously due to the IME. North Dakota IME delayed resolutions are within a reasonable time frame when compared with those of the five comparable jurisdictions we sampled.

Table 1.4 IME Evaluations Delayed Resolution of Claim (2011 – 2013)

State	% of IMEs Which Delayed Resolution
Alaska	24%
Kansas	14%
Michigan	16%
North Dakota	**15%**
Washington	13%
West Virginia	7%

Review of IMEs in Disagreement with the Treating Physician

Seventy-five percent of the IME decisions in the evaluation group of 75 claims/80 evaluations were made in favor of WSI. Only 23% of the IME decisions agreed with the treating physician in the North Dakota sample. In two claims, 2% of the total number of IMEs reviewed, the IME agreed with the treating physician on some issues and with WSI on others. In cases where compensability was not the primary issue, the treating physician was asked whether or not s/he concurred with the opinion of the IME. Where the treating physician and the IME agree, there is swift resolution to the claim.

The majority of issues requiring IME attention pertained to claims compensability decisions. There were a few IMEs that are used routinely based upon their medical specialty (e.g., orthopedic surgery,

neurology). These physicians tended to disagree with the treating physician more than they agreed. For those IMEs that saw more than one claimant in the evaluation period they were twice as likely to make a determination in WSI's favor. These kinds of cases represented the most complex of the claims on which an evaluation was undertaken.

Utilization Review results were more consistently decided in WSI's favor because of clear regulatory guidelines.

There were only two IMEs pertaining to case management; one found for the treating physician and the other for WSI.

Many claimants are from states outside of North Dakota where work does not have to be the only cause of an injury. If a person does something at work that causes him or her to become disabled, the claimant is entitled to benefits. The old principle of the event creating a worsening in the condition obligates the system to return the claimant to the state immediately prior to the event. There is very little information available to help the injured worker or the treating physician understand the North Dakota benefit structure.

The letters included verbiage explaining the regulatory standard. Each cover letter is tailored to the specifics of the individual claim. Part of the IME process is to review the full medical record, some of which may not have been available or provided to the treating physician.

Table 1.5 below represents the percentage of cases on which an IME was obtained in five comparable jurisdictions where the IME disagreed with the findings of the treating physician. We include North Dakota in the table for comparison purposes. In general, we found that on average 43% of IMEs across all five jurisdictions disagreed with the findings of the treating physician. For the cases where the IMEs were in disagreement, approximately 14% obtained a supplementary opinion from the treating physician for comment on the findings with the IME. We did observe that the decision to obtain a review by the treating physician relating to the IME was strongly correlational to the jurisdiction of the injury. Eighty-two percent of the cases which saw a supplemental report from the treating provider with comment on the IME occurred in the state of Washington. Further, of the cases where the treating physician reviewed the opinions of the IME, around 60% gave an opinion in which they concurred with the IME. It appears that in states where it is routine to request the opinion of the treating physician as it relates to the IME, swifter resolution is seen as the differing opinions are addressed by the medical professionals as opposed to other parties, such as legal counsel.

Table 1.5: IMEs in Disagreement with Treating Physician (2011 – 2013)

State	% of IMEs in Disagreement
Alaska	41%
Kansas	17%
Michigan	61%
North Dakota	**75%**
Washington	53%
West Virginia	43%

It is possible that the North Dakota result is, at 75%, higher because Independent Medical Examinations are proportionately less frequent when compared to the overall claim volume. If there is greater selectivity in the use of IMEs then a higher rate of disagreement may be expected.

Review to Determine the Total Costs for the Use of IME Physicians

With regard to total costs for the IME process for the use of IME physicians and any other third parties related to IME's during this evaluation period, WSI is unable to glean this information from its claim system. To comply with this request for information, we have extracted payment information for the 75 claims/80 IMEs reviewed in this performance evaluation by drilling down into the claim system's payment summary on a claim-by-claim basis.

Paid amounts aggregated below by category in Table 1.6 below were located by selecting name of the IME Company, travel agency, and the claimant's mileage, meals, hotel and cab reimbursements, and WSI Consultant fees. Injured workers have up to one year from the date of the IME to submit their expenses. At no time did the injured worker receive payment for IME related expenses if their reimbursement request was submitted late. We estimate the total costs for all IME related expenses for the 80 IMEs reviewed to be $328,448, with an average cost per claim of $4,106 over a 3 year claim period. The average cost per claim for non-litigated claims alone would be $3,314 per claim.

Using the total number of WSI claims filed in each of calendar years 2011, 2012 and 2013, and applying the average cost per claim for an IME from the evaluation period, we then extrapolate the costs of the IME process for each calendar year from 2011 to 2013 using the assumption that there will be one IME per claim to $175,667 in CY 2011, $245,270 in CY 2012 and $298,302 in CY 2013. We realize that the variability in the number of IMEs per claim, the type of evaluation required, and the length of any litigation process will greatly affect this estimate, as the average cost per IME that includes litigation expenses is $4,379 per claim.

Table 1.6: IME Costs in Claims Reviewed in the Evaluation Period (2011 – 2013)

IME Examination Fees Paid	Claimant IME Expenses Paid	IME Exam Fees Paid	IME Deposition Fees Paid	WSI Contracted Medical Consultant Fees Paid
75 Claims	$22,382	$239,100	$63,291	$3,675
Average per claim	$298	$3,188	$844	$49
80 IMEs	$22,382	$239,100	$63,291	$22,382
Average per IME	$280	$2,989	$791	$46

Review to Determine How IMEs are Located or Recruited

WSI Medical Services staff was interviewed to determine the process WSI used in this evaluation period to locate and/or recruit physicians to complete independent medical evaluations on behalf of WSI. Staff members advised that the last time any work in this area was done was in calendar year 2010. There was a survey of in-state physicians to see if there was any interest in becoming an IME. Only two physicians showed any distinct interest at that time. Both physicians were contacted, interviewed and the recommendation was made that they get enrolled in one of the two panels that WSI uses. Neither was successful in enrolling and no additional contact was made with either physician to determine why, or to move in any other direction. Both WSI Medical Services staff and WSI claims examiners advised that local physicians in Bismarck have declined to participate because they are busy with their own practices, and the requirements for scheduling, reporting and medical-legal documentation are too onerous. (See recommendation 1.6)

WSI continues to use a network of IME's provided through three agencies; EvaluMed, ExamWorks and via independent referral from Best Doctors. All three provide IME related services to the workers' compensation community on a semi-national level. These organizations maintain a proprietary network of credentialed healthcare practitioners and medical specialists. They offer the ability to schedule appointments online or by phone, as well as offering staff to assist with identifying the correct specialty to address the issue, coordinate the scheduling of the examinations, produce the medical-legal reports and related invoices, and more often than not, provide the location for the examination.

As requested, we reviewed the processes that the five comparable workers compensation systems use to locate and/or recruit in-state physicians for the purpose of Independent Medical Evaluations. Where possible, statute information is provided for reference:

Alaska

In the event of a medical dispute in the state of Alaska, an employer may obtain an Independent Medical Evaluation with a provider of their choosing. However, if there is a dispute between the primary treating physician and the employer's Independent Medical Evaluation, then the State Board may require a second Independent Medical Evaluation (AS 23.30.395). The Alaska Workers' Compensation Division maintains a limited list of medical providers who are authorized to serve as Independent

Medical Examiners. Of interest is that in a recent list of 50 physicians which was published, most of the authorized examiners are located in states other than Alaska, with only five physicians who practice exclusively in Alaska and another three providers who have offices in Alaska as well as another state.

Kansas

In case of a dispute as to the injury, the director, in the director's discretion, or upon request of either party, may employ one or more neutral health care providers, not exceeding three in number, who shall be of good standing and ability. The health care providers shall make such examinations of the injured employee as the director may direct. The report of any such health care provider shall be considered by the administrative law judge in making the final determination. If at least two medical opinions based on competent medical evidence disagree as to the percentage of functional impairment, the matter may be referred by the administrative law judge to an independent health care provider who shall be agreed upon by the parties. Where the parties cannot agree, an independent healthcare provider shall be selected by the administrative law judge. The health care provider agreed to by the parties or selected by the administrative law judge shall issue an opinion regarding the employee's functional impairment which shall be considered by the administrative law judge in making the final determination. (KS 44-516)

Michigan

In the state of Michigan, Independent Medical Evaluators are selected by the requesting party based on the type of injury, and the state plays no roll in assigning an IME on a specific case. There is no approved list of Independent Medical Evaluators in the state. Any licensed physician can be used.

Washington

In the state of Washington, "[t]o ensure that independent medical examinations are of the highest quality and propriety, examiners and firms (partnerships, corporations, or other legal entities) that derive income from independent medical exams must" apply to become an approved independent medical examination (IME) provider (Washington Administrative Code 296-23-317). In addition to various criteria relating to medical licenses, lack of restrictions or complaints, and codes of conduct, etc., of note is that doctors licensed in medicine & surgery, osteopathic medicine & surgery, podiatric medicine & surgery or dentistry can be licensed either in or outside of the state of Washington, but doctors licensed to practice Chiropractic must be licensed within the state of Washington.

West Virginia

In the state of West Virginia, registered providers may apply to the Commission to be recognized as Independent Medical Examiners (West Virginia Code 85-20-5.9). With regards to permanent impairment ratings, only when the rating from the primary treating physician exceeds 15% may any party order an IME (West Virginia Code 85-20-6.4).

In reviewing the locations where IMEs occurred in other comparable states, Table 1.7 below represents the percentage of IMEs which took place in state, as well as were performed by physicians licensed in-state. We found that most (90%) of IMEs were performed in-state with the exception of claimants who had moved out of state or where the employer and/or employee addresses were located very near state lines in which cases IMEs sometimes occurred in neighboring states. The latter occurred only in Kansas and West Virginia. Alaska of course has no neighboring states, but we did see that 38% of IMEs had

licensure and addresses located in states other than Alaska, which perhaps could be representative of seasonal populations. There were no In-State Physician IMEs held in North Dakota. (see recommendation 1.4)

Table 1.7: IME Evaluations Performed by In-State Physicians (2011 – 2013)

State	% of IMEs Performed In-State	% of IMEs Performed by In-State Physicians
Alaska	79%	79%
Kansas	86%	88%
Michigan	96%	100%
North Dakota	**16%**	**0%**
Washington	97%	97%
West Virginia	93%	93%

In summary, we find that WSI:

- Has internal policies and procedures in place to meet and facilitate compliance with most of the applicable North Dakota laws, rules and regulations with regard to IME use. WSI has not made a reasonable effort to designate a duly qualified doctor licensed in the state to perform IMEs. NDCC Section 65-05-28 subsection 3 requires compliance in this area.
- Regularly updates its policies and procedures to address changes in legislative intent
- Has developed a preferred vendor panel for Independent Medical Evaluations
- Is referring fewer claims for IMEs than what we observed from the other jurisdictions with which they were compared
- Has IME relationships that find in favor for WSI at a much higher rate than the other jurisdictions with which they were compared
- Needs to provide additional training to reinforce many of its internal claims policies and procedures so that all medical data relevant to the claim will be sent to the Independent Medical Evaluators for review, to produce an accurate and sound medical/legal report
- Needs to comply with internal procedures by sending copies of the Independent Medical Evaluation report to the claimant and the treating physician
- Needs to utilize IMEs sooner in the life of claims to effectively identify claims with pre-existing conditions earlier and reduce claim overpayments
- Needs to identify regional sites in the State of North Dakota where IMEs may be held to reduce the travel requirements for claimants injured and residing in the State of North Dakota
- Needs to offer online training opportunities to help North Dakota physicians become more familiar with the rules, regulations and case law in the State that may affect their patients when filing a workers compensation claim

Recommendations from 2010 Performance Evaluation

In the 2010 Performance Evaluation, we made a number of recommendations and ten of them required review in this report. Seven of them related to Narcotic Utilization and those are covered in Element Six. The other three (recommendations 1.3, 5.1 and 5.4.) are reviewed here. The first two recommendations were considered high priority, while recommendation 5.4 was considered medium priority.

The recommendations in the 2010 performance evaluation period were intended to encourage more frequent use of IMEs over the use of in-house Medical Consultant reviews. There was a perception in the community that the internal medical review process could be biased, thereby calling into question the claim decisions being made by WSI. As this topic has been discussed in prior evaluations (BDMP 10/2008, Conolly 3/2008, and Dronen 2/2007), we felt it important to make a recommendation that would support WSI's fiduciary responsibility while ensuring that the claimant would receive a fair and impartial medical evaluation. We believed an independent neutral party designated to review all pertinent medical evidence, interview the claimant in person, afforded the opportunity to confirm the veracity of the medical record, perform a complete medical records review and then generate an impartial medical/legal report would be fair to both WSI and the claimant.

Recommendation from 2010 Performance Evaluation 1.3: High Priority

WSI should utilize the IME process to obtain the necessary responses to the questions asked in FL332 if the treating physician does not reply timely or does not provide answers to the medical/legal questions contained in the document. Use of the WSI Medical Director's internal medical review to deny a claim continues to support the public perception that WSI possesses an unfair advantage.

For Recommendation 1.3, we conclude that this recommendation was **not implemented** by WSI. WSI continues to issue claim denials in certain claims after a review by the internal Medical Consultant. The intent of this recommendation was to encourage more frequent use of independent medical evaluations when claim denials are a possible outcome following a review of case circumstances. Independent Medical Evaluators have distinct advantages over in-house medical directors or consultants in that they examine the patient. A denial of benefits absent the treating physician's agreement with the IMR is not perceived as due process for the claimant. It is difficult at best for those adversely affected to view an agent of WSI as a neutral party. (See recommendation 1.3)

Recommendation 5.1 from 2010 Performance Evaluation: High Priority

WSI should amend the existing internal WSI Claims Procedure 120 to require claims adjusters to send a questionnaire to the treating physician and/or an IME to inquire as to whether the employment substantially accelerated the progression or substantially worsened the severity of the pre-existing injury, disease or condition. Provide training to all affected WSI Claim and DRO staff.

For Recommendation 5.1, we conclude it was **partially implemented**. A change to Claims Procedure 120 requires form FL332 to be sent to the treating physician "only" when the FL332 information is not supplied in existing medical notes. WSI advises that there is still some latitude in application of this

process by leaving some judgment to the Claims Adjuster. The FL332 is not always sent to the treating physician when information is not supplied in existing medical notes, and a question arises as to whether the employment substantially accelerated the progression or substantially worsened the severity of the pre-existing injury, disease or condition.

The compensability questions are, however, routinely asked of the forensic evaluator in IME cover letters. HB No. 1163 passed in April of 2013. Claims Procedure 1102 was revised in August 2013 in response to the passing of this piece of legislation. Section D, page 3 of 25, *Prior Problems Not WSI Liability* requires that a review of previous medical records be made to determine if there is a possibility of the injured worker having a pre-existing condition. The issues to review cover if the employment injury:

- substantially aggravated the severity of the underlying medical condition
- substantially worsened the severity of the underlying condition
- substantially accelerated the progression of the underlying condition

As early as claims in CY 2011, there is evidence that IMEs were being questioned regarding whether "the pre-existing condition significantly aggravated" a condition, or if the "work event was a substantial and contributing factor". IME responses included the wording "credible objective evidence" and "substantial acceleration" of underlying disease processes in work events). In CY 2012, IME cover letters included more refined language, such as "did the work injury substantially accelerate the progress or substantially worsen the severity" or "is work a substantial contributing factor? Did it trigger symptoms but not substantially worsen the pre-existing condition?" Unfortunately, the treating physicians more often than not have not been made privy to the updated standards for compensability.

If North Dakota treating physicians are not asked to, and are not trained to participate in the complexities of workers' compensation claim evaluation process, the medical community, and thereby the claimants, will most likely always be in an adversarial position with WSI. The claim evaluation process should always begin with inquiries at the treating physician level. If the FL332 is not the vehicle to do this, WSI should implement some other appropriate process to fully inform the treating physician of the level of detail that is required to meet the test of "objective medical evidence" that gives the treating physician the opportunity to represent the claimant in this process. (See recommendation 1.8)

Recommendation 5.4 from 2010 Performance Evaluation: Medium Priority

WSI should utilize the IME process to resolve disputes arising out of claim denials for pre-existing conditions, prior conditions and degenerative conditions.

Recommendation 5.4 is considered **not implemented**. This recommendation was made to be consistent with an earlier recommendation in Element One where we point out the advantages of IMEs over in-house Medical Consultants in making compensability determinations. WSI did not concur with this recommendation. There is evidence in this performance review that WSI continues to utilize their internal Medical Consultant review process to make some compensability decisions resulting in benefit denials prior to independent medical evaluations.

New Recommendations

Recommendation 1.1: High Priority

We recommend that when a new claim is filed, the WSI claim system will be reviewed for all prior claims filed under the claimant's social security number to identify prior claims already in the WSI claim system. A synopsis of related body part injuries and medical conditions will be documented in the notepad, along with the name and location of any prior treating physicians, and the location of any diagnostic testing for the related body part or part(s) in questions. This will allow claims examiners the ability to identify and review all prior notes, medical records, and claims decisions made on prior work related injuries that were WSI's liability. This will also assist the staff with requesting prior medical records and diagnostic test results (lab, x-rays, scans, etc.) for treating physician and potential future IME review. Special medical releases may need to be sent to the claimant to obtain medical evidence from states other than North Dakota.

> **WSI Response: Concur.** Searching our claims system for prior claims for the injured workers legal entity and entering a synopsis of related body parts and injuries should already be occurring. However we do not keep actual films on file at WSI therefore we are unable to send those from our office. We do however, request that the doctor's office in which they are stored send them to the IME provider.
>
> To the extent this did not occur on a particular claim is likely an oversight and a training issue.

Recommendation 1.2: High Priority

We recommend that WSI should utilize more IMEs to facilitate claim resolution and manage claim costs. The standard claim investigation process in the majority of the states is to identify potential issues early in the life of the claim, and to get them resolved as quickly as possible. This involves taking statements, requesting medical records at the beginning of the claim, setting baselines, reviewing records for potential cost drivers, and working with the treating physician in managed care strategies. An IME is useful in early stages to set expectations, and again at the next juncture at which the specific claim type should have been resolved based upon the nature and severity of the claim, ODG guidelines, and/or best practices. It is also useful at the time a new condition or body part is migrating into the claim.

While not all time loss cases need an IME, the use of an IME on claims that are open for one year or slightly more is helpful to define what is preventing the claim from closing, which allows the claims organization to begin working more diligently with the treating physician and injured worker at setting goals for claim resolution. WSI's use of IMEs has been very cost effective, in that appropriate denials associated with IMEs have been very effective at reducing the future cost of the claim files.

> **WSI Response: Concur.** WSI will look to use these evaluations in greater numbers. The organization still faces significant scrutiny regarding the use of IME's and as a result we have used them judiciously. Currently they are used only in cases where in our judgment the medical evidence conflicts or doesn't make sense. Typically these are our most contested matters.

Recommendation 1.3: High Priority

We recommend that upon receipt of an internal IMR (WSI Medical Consultant medical records review) that raises a dispute in compensability that would preclude benefit provision to a claimant, that WSI will first solicit concurrence from the treating physician. If the treating physician does not agree with the IMR, or does not respond to the request for concurrence, WSI will proceed with the IME process to resolve the dispute that was created with a records review. This would require that WSI refrain from issuing decision notices without at least two attempts to obtain concurrence from the primary treating physician.

> **WSI Response: Partially Concur.** WSI agrees that internal IMR should be sent to the treating physician for their review/opinion.
>
> We do not agree that an IME is necessary or cost effective if the treating physician does not respond. There are physicians who simply will not respond. WSI receives complaints from providers about the "voluminous" amount of correspondence and a balance must be maintained.
>
> North Dakota law provides that ultimately it is the responsibility of the injured employee to prove entitlement to benefits. WSI attempts to gather as much information as reasonably possible in an effort to minimize that role, but in these instances, it is our position the injured employee is in a better position to complete this inquiry.
>
> **Sedgwick Reply**: If the injured worker is ultimately responsible for proving his/her entitlement to benefits, we think the injured worker should be advised of WSI's communication to the treating physician and receive a copy of the IMR.

Recommendation 1.4: High Priority

We recommend that WSI immediately resume its attempts to locate North Dakota physicians that will serve as Independent Medical Evaluators to improve the frequency of use of North Dakota physicians in this area. Not one in-state medical provider was utilized to perform an IME for North Dakota constituency in the past three years. Coupled with the fact that the last attempt to generate some interest in this area made was four years ago gives the appearance that this is not an area of great importance. Our review of five comparable states found that in-state medical providers were used 79% of the time at the very least. In one state, 100% of the IMEs were in-state providers. There are most certainly highly qualified physician specialists in the state of North Dakota that are both competent and highly respected for their ability to produce a sound and well-reasoned second opinion on any of the claim related subject matters that WSI requires. WSI needs to reach out and develop relationships within the state's medical community, offer training and provide incentives to welcome its in-state medical partners into their IME preferred vendor pool.

> **WSI Response: Concur.** WSI will conduct another survey of the provider community within the state in an effort to discover interest from individual providers willing and able to perform IMEs.

WSI agrees that finding North Dakota physicians that will conduct IMEs is the best solution, but all efforts in this area continue to produce unproductive outcomes. WSI does actively refer any physician interested to handing firms for management. Anytime a practitioner communicates with WSI about conducting IMEs, we immediately follow-up on the contact. The conclusion "There are most certainly highly qualified physician specialists in the state of North Dakota that are both competent and highly respected for their ability to produce a sound and well-reasoned second opinion on any of the claim related subject matters that WSI requires," has not proved to be the case however.

Recommendation 1.5: High Priority

We recommend that WSI locate space in medical facilities to host IMEs in strategic locations throughout the state of North Dakota to serve its injured North Dakota constituents. Sixty-five percent of the IMEs in the evaluation sample were needed in North Dakota. Locations near North Dakota's most populated areas will reduce claimant time loss from work, hotel, meal and mileage reimbursements. The costs associated with IME travel will be offset by reduced claimant reimbursements.

WSI Response: Partially Concur. The majority of WSI IMEs are conducted by IME companies. Facility rent is an element contemplated within their fixed costs. WSI will insist that when possible, the IME examination be conducted in an appropriate in-state facility.

Sedgwick Reply: The intent behind this recommendation is to encourage WSI to work with providers, (e.g., occupational clinics) who may be able to provide examination space around the state of North Dakota. In this way, injured workers may be able to obtain their examinations at locations that are closer to their residence thereby minimizing travel expenses.

Recommendation 1.6: High Priority

WSI should develop and provide web based training opportunities for North Dakota treating physicians designed to improve communication and help the medical community understand how the workers' compensation system works in North Dakota. The outreach curriculum should include FAQs and links to applicable statutes, codes and case law citations that are most frequently applied and misunderstood. A more in depth program will need to be developed to provide training to potential IME physicians in North Dakota laws, rules, regulations and case law.

WSI Response: Concur. Web based information and training is an efficient and effective mode to communicate to providers within and outside the state. Posting information and FAQ's for access will be completed. However resource availability, development, and feasibility will need to be evaluated regarding web based training.

Recommendation 1.7: High Priority

WSI should review its IME related Claims Procedures in their entirety with current staff, more specifically Supervisors, to ensure that the procedures and processes as documented are being followed.

Further, claims with IME requests should be sampled regularly by Supervisory staff to ensure that all procedures/processes that pertain to claimant advocacy issues have not been overlooked.

> **WSI Response: Concur.** IME related claims procedures will be reviewed in their entirety with the current staff, including the claims supervisors. The portion of the recommendation that IME requests be sampled regularly by the claims supervisors, however, is problematic with the current staffing levels—especially in light of the recommendation that we increase our use of IME's.

Recommendation 1.8: High Priority

The claim evaluation process should always begin with inquiries at the treating physician level. If the FL332 in the claim procedure manual is not the vehicle WSI uses to do this, WSI should implement some other appropriate process to fully inform the treating physician of the level of detail that is required to meet the test of "objective medical evidence" that gives the treating physician the opportunity to represent the claimant.

> **WSI Response: Concur.** Ultimately everyone is best served by quality understandable communications. WSI will review the forms in an effort to determine whether more clarifying language can be used to elicit treating physician's responses.

Element Two: Evaluation of Fraud Investigations

Introduction

For this element, the State of North Dakota is interested in:

- Review WSI processes, procedures and policies as they relate to claims handler functions to identify suspicious claims. Analyze fraud personnel procedures to review/ determine/document and investigate suspicious claim activity in all facets of the workers' compensation system. Other state policies and procedures will be compared to those of WSI

- Determine the areas of responsibility within the department to appropriately and effectively investigate suspicious claims in the three specific areas of workers compensation fraud: employee, employer, and provider. Review workloads/workflows to determine if WSI has the necessary resources to address these specific areas and if the resources are being utilized appropriately

- Review the current software being utilized by the department to identify potential fraud in all aspects of the workers' compensation system. Determine if the software has impacted the identification of fraud and if those programs are sufficient to properly identify fraud. Through the review of the comparable workers compensation investigation departments, determine possible enhancements to technology programs to enhance the effectiveness of fraud identification

- Review current training documents of claim handlers and fraud investigators to determine if the training program provides the necessary knowledge and skills to identify and investigate fraudulent claims in all areas of the workers' compensation system

- Analyze all suspicious claim investigation undertaken by the department for 2011, 2012 and 2013. Determine and categorize investigations by party (i.e. employee, employer or provider fraud). Review those claims by category and determine financial outcomes of each claim to include recoveries and cost avoidance

- Evaluate current WSI performance indicators/metrics to determine if those performance objectives are appropriate in properly evaluating the departments' personnel in the identification and investigation of suspicious claims

- Determine WSI's mechanism for capturing and tracking ROI data and provide an analysis of that data as it relates to the comparable states fraud investigation program

Background

To address the various components to this Element, we conducted the following activities:

- Interviewed with and collected data from WSI staff as well as stakeholders from the comparable states mentioned in this element
- Evaluated staffing of the Special Investigations Unit (SIU)
- Reviewed current WSI processes, policies and procedures relevant to the following departments within WSI: SIU, Claims, Bill review, and Internal Audit
- Reviewed over 100 WSI claims
- Reviewed current procedures and policies from the comparable states, which are:
    - Washington
    - Wyoming
    - New Mexico
    - Ohio
    - Montana
    - West Virginia

Findings

For this element, there is interest in assessing WSI's approach to managing fraud related to injured workers, employers and providers. The first several sections of this element address how fraud is managed by WSI and we conclude with a review of six states and what they do in the area of fraud management.

In the selection of states, we want to point out that broad, state specific information is generally available for states that are either exclusive monopolies (e.g., Wyoming) or are workers' compensation insurance monopolies, as is the case with Ohio and Washington. Those states have special investigations departments that work with other agency departments to detect and manage fraud from initial suspicion to resolution.

States that are not monopolies typically don't have access to the full fraud story. Those states are ones where claims departments, such as those at insurance companies or third party administrators, will manage suspicious cases but the authority to pursue fraud will ultimately exist with county district attorneys who prosecute the cases to conclusion. How orders of restitution related to fraud outcomes are aggregated may occur at the state level but it is much more likely to occur at the individual company that pursued the suspicious case in the first place. Even then, aggregated data may be difficult to acquire.

With this in mind, we report first on what we observed about WSI's overall management of suspected fraud and conclude the section with commentary related to the sampled states.

Policies and Procedures – State of North Dakota

Claims Adjusters:

Suspicious claims are generally identified at the claims adjuster level in several different ways. From the initial reporting of the claim, claims adjusters obtain telephone statements from workers, employers, medical providers and possible witnesses. Claims adjusters also utilize WSI insurance forms and questionnaires to determine the specific facts surrounding the alleged injury as well as time loss and medical issues. Claims adjusters also obtain results from the Index System, a repository of prior injury information which may include work-related claims in other states or other injuries that a person may have sustained, such as in an auto accident. Index system checks are accomplished through a daily feed on all newly registered claims. Checks may also occur during the life of a claim at the discretion of the claims adjuster. Claims adjusters utilize these various processes to identify and follow up on suspicious claims.

One of the first aspects of the claim adjusters' investigation is the review of the first notice of loss, specifically as it relates to the employer. The first notice of loss document, as well as subsequent conversations with the employer, will determine if the employer questions the validity of any part of the claim. Claim Procedure 115 provides more details on the various possible components to a claim investigation.

Claims adjusters receive training in suspicious claim indicators or "red flags" and are encouraged to ask questions and seek guidance when their investigation suggests possible issues with the reliability of a claim history as developed. For example, Claim Procedure #118 outlines situations which may lead to a need for additional investigation, such as an assignment for field investigation or referral to WSI's Special Investigation Unit (SIU). The document also provides information on how to make those referrals and what is necessary for an SIU investigation. Claim Procedure 214 states that the claims adjuster has discretion but should consider a field investigation when the case involves a serious injury or is complex.

Fraud Personnel:

SIU (Fraud Personnel) processes generally begin when a claims adjuster alerts SIU. The process may involve a round table session with SIU staff and the claims adjuster. At that time, a decision can be made to refer the claim to SIU for additional review and further investigation. Once a referral occurs, WSI has two people on staff that receives the referral, triage the information, and assign investigation work to either the WSI SIU investigator or a third party investigative firm depending on the investigation necessary. Referrals are documented on a spreadsheet. Each referral to the WSI SIU requires an acknowledgement note be placed into the notes section of the claim system for that specific claim. The accompanying note will indicate who the investigation was assigned to as well as a time frame for a status report.

In cases of suspicious activity as it relates to employer fraud, WSI SIU is generally notified by members of the Employer Services group, who have received or developed information from various sources. The Employer Services group will communicate concerns, through a meeting with WSI SIU and discuss the information obtained and any investigation that may be appropriate. Decisions are made to consider issues of "non-compliance" or "intentional non-compliance" and whether the apparent issue can be dealt with by educating the employer or if an investigation needs to be opened. Depending upon those issues, SIU will be asked to open an investigation (for intentional non-compliance) or close the investigation. The investigative notes and subsequent investigation reports and results are contained within the WSI PICS system (managed by the Employer Services group) as well as the SIU database.

Potential suspicious cases involving providers are generally brought to the attention of SIU via the Bill Review Unit. WSI advised they also relied for a time on a third party vendor, CGI Federal (CGI), to assist in the identification of potential billing irregularities. The practice of reviewing standard monthly reports was suspended in July 2011 due to what were described by WSI staff as "higher priorities and resource availability." CGI reports have been generated since then at the request of WSI upon the identification of a potential suspicious billing trend. Suspicious trends may be identified for staff either in Medical Services or the Claim Department, and they will then engage SIU. Following review, a determination will be made to address any potential issue either as an "educational" opportunity or to move forward with an official investigation. (It is our understanding from discussions with WSI staff that monthly meetings have been scheduled commencing in June 2014 with CGI to review provider trends although we did not review any information related to the substance of those meetings.)

WSI SIU also utilizes a telephone "hotline" for citizens of North Dakota to utilize to report possible fraud in any area of the workers' compensation system. The "hotline" does provide anonymity to anyone who chooses to report suspicions. In addition, the WSI website also provides a form for citizens to use to report fraud in the workers' compensation system. These two avenues for public reporting are monitored by the SIU.

In each area of fraud within the workers' compensation system, WSI's SIU appears to ensure it considers all known information, direct communication with stakeholders and a team approach when determining how to proceed.

One notable shortcoming is that WSI's SIU does not have current policies and procedures. On July 18, 2012, the WSI Internal Audit Department issued an audit report on the WSI SIU program. This report issued nine recommendations to the SIU Department. Recommendation #6, of that report suggested SIU review and update the SIU procedure manual to reflect current department procedures related to injured workers, employer and medical provider allegations. The SIU Manual was created in 2005. The SIU department concurred with the recommendation and indicated it would implement by June 1, 2013. This manual still requires updating. (See Recommendation 2.1)

Investigation of Fraud:

WSI SIU staff consists of an SIU Director, one SIU investigator and two SIU paralegals. In addition, the SIU has a panel of private investigation companies who provide a variety of investigative services at the direction of the SIU.

The investigative process begins with communication via a claims adjuster, employer services representative, or from the bill review unit. Based on those communications, a full review of the claim file, policy information or medical reports will be undertaken by a member of the SIU.

Once the review has been completed, an investigative plan is established which includes input from the SIU Director. Depending on the investigation needs, background information may be obtained, telephone interviews may be undertaken and assignments to a private investigator to conduct field investigations will occur. The SIU utilizes tools and resources such as subpoenas for personal financial records, business records, and criminal history/court searches. The specific SIU personnel assigned to the investigation manages the investigation activities by all involved, reviews investigative reports and other information, and continues to ensure all investigative steps are being performed timely.

WSI's SIU has instituted a fourteen (14) day benchmark for initial investigative steps to be completed. The SIU utilizes the claim system to keep claims personnel and other stakeholders apprised of investigative updates as well as monitoring the fourteen day status requirements. During the investigative process, changes can be made to the investigative plan and/or required completion dates. Such changes are suggested by SIU staff and discussed with the SIU Director. At the conclusion of the investigative process the SIU will determine final outcome, based on the information obtained and indicate that outcome to the appropriate stakeholder.

The outcome of the investigation may result in a "Fraud Order" being prepared by SIU and reviewed by the SIU Director and a member of WSI's legal department. The Fraud Order, which can be challenged by the offending party, will generally indicate the alleged offense committed and the result that offense has on the current workers' compensation claim, an employer's policy or a medical provider's standing with WSI. As well, the Fraud Order could include expectations about restitution. If the Fraud Order is not contested, the order stands. In the event the Fraud Order is contested the matter is set for hearing. A referral to the appropriate state's attorney is made to generate a criminal complaint.

Roles and Responsibilities

Employee Fraud:

WSI may refer out for a field investigation when there is suspicion about the validity of some aspect of a claim involving an injured worker. Investigative firms may take statements, conduct surveillance, gather records and conduct other tasks designed to gather information about a case. WSI's SIU assists in making these assignments to investigative companies but is not involved in the investigation unless or until the investigation reveals information that suggests red flags or a possible fraudulent claim.

The investigation of suspicious employee fraud claims within the WSI rests ultimately with the SIU. All employee fraud referrals are assigned to the SIU. SIU staff has the responsibility to ensure a complete review, investigation and disposition of the investigative case. As previously noted, SIU currently has one staff SIU investigator who predominantly conducts investigative activities over the telephone. The investigator does, on very rare occasions, conduct investigations in the field when possible and appropriate. The two SIU paralegals conduct their investigative tasks solely in an office environment. The previous SIU Director, who was an attorney, did on occasion represent WSI at court proceedings in SIU-related matters.

As mentioned above, WSI's SIU staff retains the services of firms who have staff trained to perform field investigations. This practice appears to be a necessity due to both SIU's current staffing limits as well as geographic distances within the State of North Dakota. The WSI does not employ staff SIU investigators outside the Bismarck office.

Table 2.1 indicates total field investigations conducted by WSI over the performance evaluation period. Note that the table contains references to injured worker, employer and provider investigations during the performance evaluation period. Table 2.1 also combines in the employer category any investigation conducted by WSI pertaining to an employer's sub-contractor.

By field investigations, we mean those cases where a referral was made and an investigation conducted primarily as part of a general claim investigation. A segment of those claims was ultimately investigated for possible fraud.

Table 2.1: Field Investigations by Type for 2011 – 2013

Year	Injured Workers	Employers	Providers
2011	328	42	4
2012	308	47	10
2013	267	73	4
Total	**903**	**162**	**18**

Of the investigations conducted during the performance evaluation period, roughly 84% pertained to injured workers, 15% to employers and 1% to providers. We reviewed our 2004 performance evaluation

report for trends at that time just for comparison purposes. Based on values we had for 2003, about 89% of all investigations then pertained to injured workers and 11% pertained to employers. There was at that time virtually no investigation of providers. In making this comparison between the current performance evaluation period and what we observed in 2004, the percentages are similar.

Employer Fraud:

The investigation of employer fraud issues is another area of combined effort and responsibility within WSI. The Policyholder Services Department makes initial inquiries when suspicion arises to determine the validity of the concern and if communication with the SIU is appropriate. Any formal investigation activities become the responsibility of the SIU. The workflows remain consistent with the other areas of suspicious claim investigations. A member of the SIU is tasked with overseeing the investigation, which may include assignments to investigative companies, record retrieval, telephone interviews and ultimately conclusion.

To provide some detail on the processes employed by the Policyholder Services Department, WSI has an audit selection methodology that includes a number of criteria that are weighted to identify employers who may warrant a premium audit. A premium audit conducted by Policyholder Services personnel could lead to further investigation including the engagement of SIU. In addition, WSI examines claims filed against class codes and payroll information to determine if there are potential irregularities with the class coding. The underwriter assigned to a particular employer is responsible for following up on such cases.

WSI also has a Non-Compliance team made up of staff from Policyholder Services and SIU to review hotline referrals. This review includes a determination that:

- Provides that no further action is required with a reason why
- Referral to SIU
- Referral for Premium Audit
- Referral to Underwriting

Further documentation from the respective team member will include how the matter was ultimately resolved.

The process of the investigation of employer level fraud culminates with a discussion of whether the facts support issues of “non-compliance” or “intentional non-compliance” on the part of the employer. The Policyholder Services Department appears to utilize these investigations, at least initially, to assist in the education of employers for the purposes of understanding their legal obligations. In those cases where it is believed clear “intention” was a factor additional steps are taken which may include the issuance of a fraud order.

In Table 2.1 above, we note that employer investigations are up by more than 50% when comparing 2013 to 2012. This jump has occurred primarily because of many more out of state employers. WSI has identified these employers through a combination of methods including:

- Job Service Cross Reference – employer data between the two organizations is shared to identify those employers who have opened a North Dakota Job Service account but have failed to secure coverage
- First Reports of Injury – Information gathered from these reports can trigger an investigation of employers who are non-responsive or who refuse to furnish the information required to assess coverage obligations
- Reciprocal Denials – Between states, reciprocal agreements may last for a specific length of time affording coverage for an employer who resides out of state but has employees in state or vice versa. NDCC Section 65-08-04 contains a statutory reference to these agreements

Provider Fraud:

The investigation of provider fraud issues involves claims adjusters, the bill review staff as well as CGI, a third party service provider. Claims staff may become aware of an issue with a particular provider during the life of the claim. As an example, a provider may be identified as one who up-codes, a practice where a standard procedure code is used to describe a level of service that is beyond the service rendered.

The SIU is again charged with investigation of these types of cases and decides if the facts warrant an investigation. The SIU utilizes its own staff, investigation companies, and CGI to assist in provider investigations. CGI can provide analytical research and reporting in an effort to determine possible issues within the provider billing arena.

Historically, instances of documented provider fraud in North Dakota have been virtually non-existent and we found little change in that pattern in this evaluation. A total of 18 provider investigations occurred during the performance evaluation period.

We observe that provider fraud is generally more complex than other fraud types. This is particularly so when compared to injured worker fraud where the issue there may be something as simple as employees not reporting wages at times when they are receiving temporary total disability benefit payments.

Both in reviewing CGI reports and through discussions with WSI staff, we conclude that a full vetting of the CGI data is not accomplished and in those instances when it is WSI is more apt to take an approach of educating the provider to modify their billing issues as opposed to treating the situation as clearly intentional. Availability of providers to treat North Dakota injured workers may be a factor in this practice. (See Recommendation 2.2)

Overall Analysis:

The information provided by WSI indicated the SIU had some involvement in 1,083 claim, policy or provider investigations during the performance evaluation period. The total number of referrals in all

categories for each year of the performance evaluation period are 374 (2011), 365 (2012), and 344 (2013). The average number of referrals/month range from a high of about 31 in 2011 to a low of about 29 in 2013.

The SIU paralegals are involved in assigning general field investigation cases to investigative service companies and the SIU staff does review those general field investigation reports upon completion. They are not involved in the day to day management of those investigations; however, this oversight does require SIU resources in a significant volume of claims that do not appear to be fraud-related.

WSI SIU staffing levels necessitate a "case management" approach to suspicious claim investigation, which requires a high percentage of investigative actions be undertaken by outside investigation companies and managed by a member of the SIU staff. Based on the current information and processes WSI staff levels appear adequate to properly address fraud issues.

Software. WSI does not currently utilize any type of software that is intended to "score" claims based on red flag indicators, alert claims adjusters to possible suspicious information/activity or identify possible fraud in the intake, handling or disposition of a workers' compensation claim.

The Policyholder Services Department does not utilize any type of fraud related software.

WSI does utilize the services of CGI, for the purposes of medical bill review to audit medical billing, which includes review for suspicious activity. CGI provides monthly reports, based on the bill review information provided to them from WSI and also provides specific ad hoc reports at the request of the SIU or bill review team. This service has also been utilized in an effort to combat prescription drug fraud activities within the context of worker fraud issues. Our understanding of how WSI and CGI have worked together is that there was a period of time from about mid-2011 to mid-2014 where little of the information potentially available from CGI had been used by WSI. (See recommendation 2.3)

Training. Specific fraud training of claim adjusters may occur several times per year. (This appears to be somewhat at the discretion of claims supervisors/managers.) The SIU utilizes PowerPoint presentations to highlight actual case summaries to include all types of fraud the claims adjusters may encounter, red flag indicators, investigative steps, and outcomes. These training sessions are welcomed by the claims staff and they offered very positive feedback about the training. As a sample of the training conducted, we reviewed the February 2014, SIU presentation to the claims staff.

For new adjusters, anti-fraud training is included during their six week orientation and training program. This training, like that provided periodically to seasoned claims adjusters, includes red flag indicators and specific examples of past fraud.

The SIU staff does not utilize any specific training document. SIU staff members have attended fraud training conferences but there does not appear to be any formal training policy for the SIU staff.

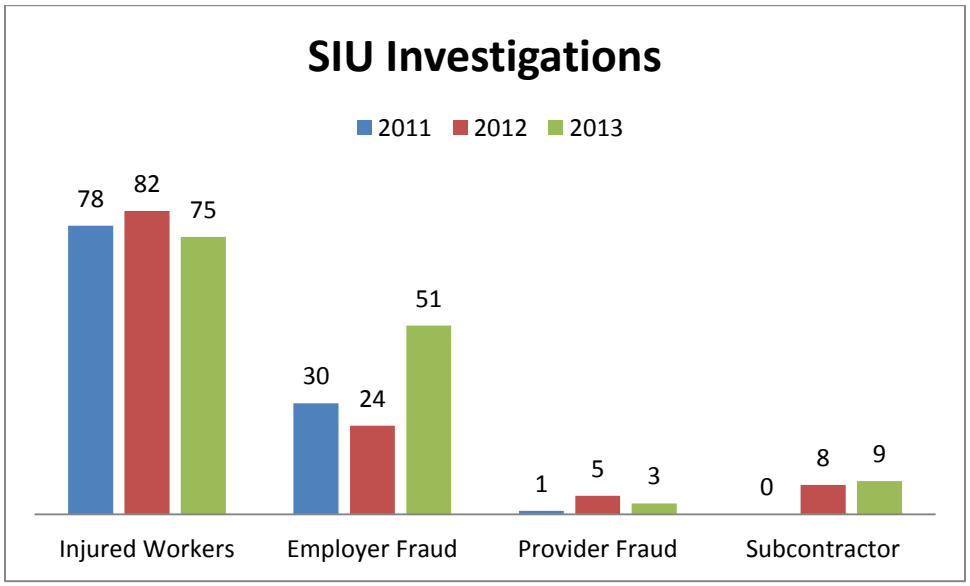
Fraud in the Workers Compensation system may be an area of increased focus for WSI staff. (See recommendation 2.4)

Claim Analysis, Recoveries and Cost Avoidance

The evaluation of this section consisted of claim review, employer policy review and provider file review. A total of 117 files/policies were reviewed from within the sampling of cases on which SIU conducted some level of investigation. Most of the cases reviewed pertained to claims involving injured workers. As well, WSI SIU provided us with reporting documents which contained information regarding each fraud investigation undertaken by the WSI SIU as well as cost avoidance and recovery figures for each evaluation year.

This illustration (Table 2.2) represents all SIU Investigations reported by WSI SIU for the evaluation period, based on type of fraud. You'll see from the count of cases that injured worker cases remained relatively stable during the performance evaluation period while the case count related to employers increased. Note that the subcontractor totals are related to employer cases but are in addition to those reported under employer fraud.

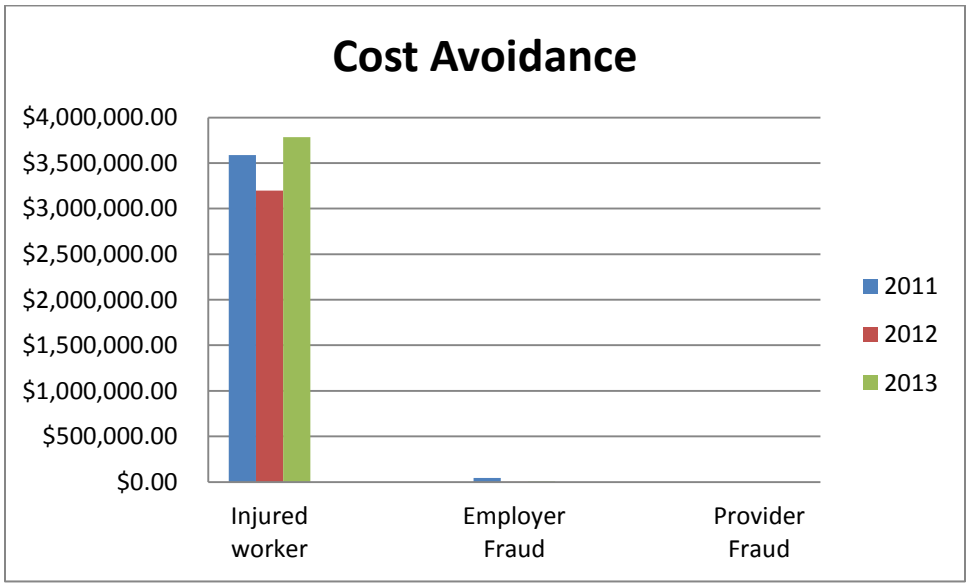
Table 2.2: SIU Investigations by Type from Calendar Year 2011 - 2013



Total investigated cases for each year are 109 in 2011, 119 in 2012, and 138 in 2013.

In Table 2.3, Cost Avoidance information is derived from the monthly and annual tracking spreadsheets provided by WSI SIU.

Table 2.3: Cost Avoidance Estimates by type for Calendar Years 2011 – 2013



Of the more than $10.6 million reported in cost avoidance over the three-year period, all but about $52,000 pertains to injured worker cases. None of the cost avoidance pertains to provider fraud. Cost avoidance totals, exclusive of actual recoveries, for all three years include the following amounts by calendar year:

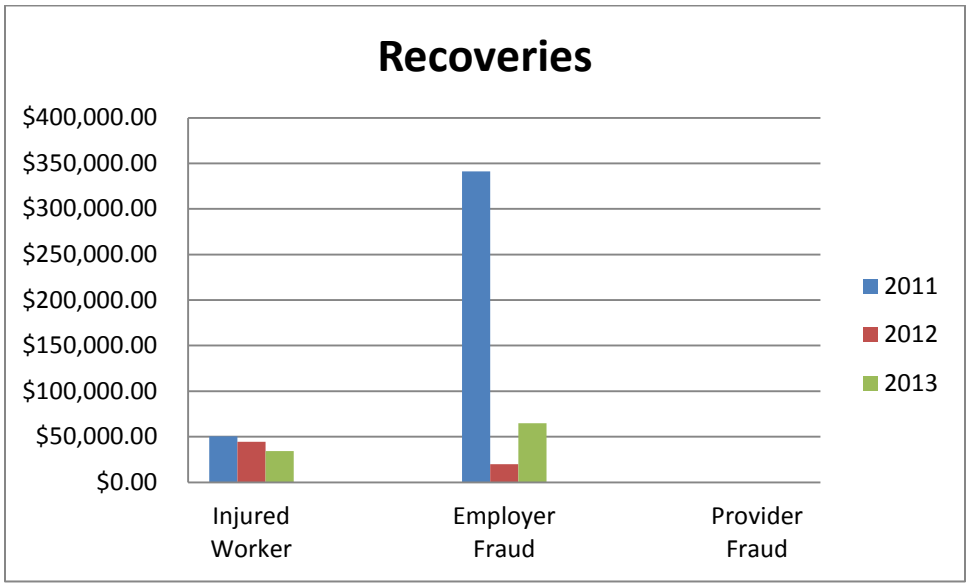
2011: $3,631,227
2012: $3,199,558
2013: $3,790,223

When we reviewed the cases on which a cost avoidance calculation had occurred, we discovered that this roughly $10.6 million in cost avoidance came from 119 cases of which 17 were cost avoidance related to employers. This means that on average each employer cost avoidance calculation amounted to an average of about $3,000. Cost avoidance as defined by WSI relating to employers pertains to advance or estimated premium for the upcoming policy period.

By contrast, cost avoidance on employee cases averaged more than $100,000. The reason for this high average is driven by the way in which cost avoidance calculations are accomplished on fraud cases. (See our comments later in this element concerning the way in which Return on Investment (ROI) is calculated when assessing cost avoidance. Cost avoidance is another way of saying that this is what WSI thinks they would have spent on a claim if the case had not been found to be fraudulent.)

The analysis of "Recoveries" for the performance evaluation period is illustrated in the Table 2.4. This summary information was also obtained from the tracking spreadsheets provided by WSI SIU.

Table 2.4: Recoveries by Type for Calendar Years 2011 - 2013



Of the roughly $555,000 in recovery amounts received by WSI, between 75% and 80% was received from employers. The remaining amount came from injured worker restitutions. Recovery totals for all three years include the following amounts by calendar year. Note that 2011 is unexpectedly high primarily because of a single recovery made from one employer in the sum of $250,000.

2011: $391,586
2012: $64,383
2013: $99,079

In our claim sampling, we sought to evaluate whether the amounts as reported on WSI's reports matched the figures we would see either in recoveries or cost avoidance. In that sample, we reviewed claims that comprised slightly more than $2.9 million on WSI's reports. We observed that their figures on the report matched those that we could document on individual case file reviews.

Recovery (sometimes referred to as restitution) is a simple figure to validate. These are the funds WSI recouped from injured workers or employers based on findings of fraud. Generally, these monies were amounts that had been paid on claims but based on the eventual evidence of fraud they should not have been.

For employer fraud, the monies represent the true cost of the policy/premium had the employer provided accurate information.

SIU tracked "recoveries" within monthly and annualized spreadsheets. Those spreadsheet reports allow the SIU to track the amount ordered, amount paid, and any balance due on recoveries.

We observed that when a fraud order was issued by WSI, it would typically include a restitution amount. When we reviewed cases, documentation of restitution activity sometimes was inconsistent insofar as payments being made or in the case of Stipulations occurring after the order that those resolutions were appropriately documented. Stipulations could lead to a situation where the party no longer needed to make restitution or possibly the restitution value was compromised. (See Recommendation 2.5)

Metrics

In our review of existing metrics, we met with members of WSI's claims department, SIU, and the bill audit/review staff.

SIU Performance Metrics:
In relation to field investigations and SIU investigations, a 14-day reporting period has been established. Investigation referrals assigned by the claims staff routinely indicate an expected turnaround of 14 days.

A sampling of claims files suggests SIU is providing timely status reports to the appropriate parties. There does not appear to be a mechanism of tracking that information within SIU. Similarly, referral acknowledgement and assignment by the SIU staff is done timely but there does not appear to be any formal data capture on those items.

The SIU staff does review investigations/documents conducted by the investigative services companies and will resolve any issues directly with that company's personnel. Aside from the turnaround time referenced above, we were not able to determine/document any specific performance indicators or metrics of the SIU staff.

Claims/Employer/Bill Review Metrics:
We did not find any specific performance indicators or metrics compiled by any of these business units relating to suspicious claim activity. (See Recommendation 2.3)

Return on Investment (ROI) Information
In evaluating how WSI calculates Return on Investment, they take total savings and total restitution and divide that by SIU's total investigative costs and the SIU budget. In this formula, savings is the same as cost avoidance. Restitution is synonymous with recoveries.

The SIU tracks these different data fields monthly to determine an ROI, which is annualized as a final calculation/percentage. Below is the example provided by SIU for their ROI calculation for the period July 2012 through June 2013.

Total Savings	$2,864,703
Total Restitution	$101,950
Total SIU Investigation Cost	$96,739
Total SIU Budget	$159,444

Calculation	**11.58**

In this particular example, total savings plus restitution equals $2,966,653. The total investigation cost plus SIU budget amounts to $256,183. Savings and restitution are 11.58 times greater than costs and budgeted amounts.

While restitution, investigative cost and budgets are easily determined, tracked and validated, the category of cost avoidance is calculated on a case-by-case basis to establish the amount saved.

The protocol for determining a "cost avoidance" figure requires claims staff as well as SIU staff. At the conclusion of a fraud investigation, the SIU will request, via claim note, that designated members of the claims team calculate the cost avoidance figure on that specific claim. The claims team includes six claims adjusters from the Resource Unit. The six adjusters break up into two three-person review teams to review the claim file and determine a figure for cost avoidance. One adjuster from the other team reviews the calculations and will concur with the findings or request additional review. Once finalized, the information is provided to SIU staff.

The team will review the alleged injuries, medical diagnosis, treatments, disability benefits, prescription drug information, re-training/educational services and all other aspects of the claim. While the review is very thorough, we found in some cases that the cost avoidance amount is substantially different from the outstanding reserve at the time the Fraud Order is issued. For example, we took a look at three cases where the cost avoidance as calculated amounted to more than $2.5 million. In one of the cases, the difference between the outstanding reserve and the cost avoidance value was about $100,000. For the other two, the cumulative difference between outstanding reserve and cost avoidance was more than $1.4 million. When we looked at the cost avoidance as calculated for the performance evaluation period, there were 102 cases. The three cases referenced above accounted for about 15% of the total cost avoidance so they have a significant impact on the ROI calculation. We realize there will be subjectivity in cost avoidance estimates, but we would expect some similarity between outstanding reserves at the time fraud is discovered and the amount claimed as cost avoidance. (See Recommendation 2.6)

Other State's Policies and Procedures

Of the states referenced below, Ohio, Washington and Wyoming operate as monopolies. Of the three, only Wyoming is an exclusive monopoly, similar to North Dakota. The other three states we reference (New Mexico, Montana and West Virginia) are not monopolistic.

State of Ohio Bureau of Workers' Compensation (BWC)

The Special Investigations Department (SID) employees conduct Fraud Red Flag training seminars to teach others to identify and report suspected fraud. Recipients of the training include other Ohio BWC employees, Managed Care Organization (MCO) employees, businesses/employers, and members of associations, such as Chambers of Commerce, Safety Councils, and Ohio State Bar Association. SID employees conduct the training at conferences with significant target audience attendance, such as the annual Ohio Safety Congress, IASIU National Conference, and the Ohio Automobile Dealers Association Fraud Webinar.

The SID maintains special investigation units (SIUs) located within each BWC service office. This practice affords proximity/access to claims service specialists, employer service specialists, and medical service specialists. Placement of staff thus promotes prompt and collaborative review of suspicious claims, policies, and/or provider billing data.

BWC Claims employees use an index system to identify other property/casualty claims filed by claimants. This can be helpful in identifying prior injuries or claims potentially relevant to claims under investigation.

Starting in 1995, fraud personnel have documented all investigative actions steps within a proprietary application Fraud Management System (FMS). The application currently contains more than 112,000 records pertaining to external and internal subjects in the following statuses:

- New and pending allegations
- Rejected allegations
- Open cases
- Closed cases (with either founded or unfounded dispositions).

The system contains various functions designed to track different case elements including aspects of the investigation (e.g., status, action and work lists, evidence) as well as costs related to the investigation and savings achieved, which can be calculated off overpayments, premium and penalties and actuarial projections. The system also tracks fraud-related documents and the users who have uploaded or modified those documents.

Other sources of information include both a fraud hotline and a web form on which someone may report potential fraud.

Assigned Ohio Assistant Attorneys General have view access to all systems pertaining to fraud investigations and materials.

The Ohio Bureau of Workers' Compensation relies primarily on its data warehouse to compile and analyze for possible red flags. The data warehouse contains operational data (e.g., claims, policy, medical billing, and payments) which it is able to mine for a specific red flag, combination of red flags, or perform peer and/or outlier comparison. Another source of data to identify fraud is through

partnerships with external entities and/or public information. Through contracts, memoranda of understanding or general data exchange, BWC has access to additional information to match against its own data to generate additional leads for possible fraud.

BWC also accesses law enforcement/criminal investigation data such as credit reports and is able to conduct background checks (commonly, this consists of systems that track prior claims, motor vehicle and court records). BWC will also validate professional license holders and will check databases of deceased Ohioans.

The Special Investigations Department (SID) calculates a Return on Expenditure (ROE) by taking total savings divided by total disbursements. Total savings are the sum of overpayments identified, premium and penalty dollars owed and actuarial savings based on BWC's actuarial firm's assessment and rate determination. Total disbursements are the total dollars spent on payroll, training and operational costs specific to the SID.

State of Wyoming Department of Workforce Services

Approximately 18,000 workers' compensation claims opened per year with about fifty referrals made to the Special Investigations Unit (SIU) annually.

When an injury report is received, it is reviewed by the claims analyst and scored using common red flag indicators. If it scores high, the claim is sent to the SIU Director for additional review and a determination will be made as to whether an investigation is warranted.

SIU use an index system's Key Indicator Report to review suspect claims. These reports are generated using common red flag indicators, including whether there had been SIU involvement on a prior claim in which the claimant was involved.

Wyoming's DWS SIU currently employs an SIU Director and no additional staff. Investigations of all types are completed using the services of investigative service vendors.

Once claims enter the system and there are no red flags or other indicators of fraud, it becomes a little more difficult to objectively determine whether the claims contain a fraud component. For instance, DWS SIU may receive a tip that the claimant may be working while receiving temporary total disability benefits and this can lead to further investigation. The Department of Workforce Services will retain outside resources in an effort to substantiate these tips. If there is an indication a tip is valid, the SIU Director will assign the case for additional investigation using one of its contract investigators.

Wyoming did not offer any information pertaining to employer or provider fraud investigations. As reported earlier in this section, the Department of Workforce Services has about fifty potential employee fraud cases reported to its Special Investigative Unit.

SIU use ISO's (Insurance Services Organization) Key Indicator Report to review suspect claims as they enter the system. DWS is in the process of transitioning from one application to another for investigation tracking purposes. DWS also relies upon an index system to evaluate prior claims and relies on other state databases and resources within state government to check for potential fraud.

Currently, DWS is just starting the process of tracking "cost avoidance." DWS plans to use claim reserves to assess savings when calculating cost avoidance.

State of Washington Labor & Industries

At Labor & Industries (L&I) in Washington, the Detection and Tracking team is the initial intake for referrals. The team includes referrals for fraud audit, provider fraud, and claim investigation. They use a methodical system of fraud detection through various cross match queries, deep web searches, and a variety of tools to assist in the identification of suspicious claim activities. They also have a fraud hotline and web fraud report form. In addition to investigation referrals from the Detection and Tracking team, investigation referrals are made directly by L&I Insurance Services staff.

Database searches are conducted to obtain information on the suspected party, and surveillance is an investigative tool to address suspicious claims.

L&I employs twelve Full-Time Employees (FTEs) to detect/track fraud and conduct outreach activities. L&I employs sixty five FTEs for investigations and an additional 2 FTEs for "significant case" investigations. In addition, the department employs staff to deal with compliance, audit, collections, appeals, review and administrative functions.

Audits are an important tool in ensuring that employers report their worker hours correctly and pay appropriate premiums. L&I has a standard audit process that involves checking business records and conducting interviews to determine facts. Examinations may include verifying the number of workers reported and that all hours are reported in the correct risk class. Reviewing the records helps an auditor determine if fraud is occurring.

Upon audit completion, L&I provides a closing conference with the employer. Typically this involves a phone conversation, but sometimes it is an in-person meeting. This post-audit conference is an important part of the process and required on every audit. It provides employers with an opportunity to better understand the reporting process. Auditors supply educational materials and explain how to keep better records. It is also a chance to answer questions the employer may have and helps prevent further issues.

Audits are targeted at employers who are most likely to have premiums due. A focused approach means less impact on employers who follow rules and makes better use of L&I resources. In the most recent year (FY 2013), premium assessments grew by $4.2 million from the previous year, despite the fact that 849 fewer audits were conducted. L&I attributed this result to improved identification of employers

with potential payroll reporting shortcomings. Audits assessed a total of $28.8 million in premiums owed. Four out of five employers selected for audits owed L&I premiums.

The Provider Fraud unit audits and investigates health care and vocational providers suspected of criminal fraud. Examples of providers include translators, chiropractors, physical therapists, medical equipment retailers and doctors. L&I constantly monitors and reviews the services and billing practices of providers. The unit educates providers on proper billing codes. Identifying billing issues early prevents ongoing overpayments and possible fraud. Provider investigations are typically complex and labor-intensive. In FY 2013, the program identified/realized almost $2 million in overpayments and penalties.

L&I has a variety of fraud-finding tools. Staff scours databases using discovery software. They share data with other agencies. Tips from the public and other programs lead to investigations.

Internally L&I uses its data warehouse and software tools to routinely perform data queries matching an element of a claim with different variables. As an example, they cross match the total temporary disability payments with wage payments reported to Employment Security by employers during the same quarter.

Return on investment compares the Detection and Tracking team's operating costs to the money recovered, collected and expenses avoided during the year. Operating costs include salaries, benefits and capital outlays.

State of New Mexico Workers' Compensation Administration (WCA)

Unlike North Dakota, Ohio, Wyoming and Washington, New Mexico is not a Workers' Compensation monopolistic entity and does not have specific requirements for fraud training. However, the department does regulate insurance company personnel and mandates that carriers submit suspicious claims to the WCA. The WCA employs one director and two full time non-sworn investigative personnel.

The Enforcement Bureau at WCA receives referrals through a variety of sources, which are mostly from parties to a pending workers' compensation claim. Upon receipt of a new referral, an acknowledgement letter is sent and the referral is logged into a database. The referral is typically assigned to an investigator, who is required to send a NOPI (Notice of Pending Investigation) under WCA rules.

The investigator will gather evidence, take statements, and, sometimes, conduct surveillance and submit a summary report. A paralegal and Enforcement Bureau chief will review the investigator's report and the evidence to determine charges. If the investigation supports a criminal charge, a request to retain a Special Prosecutor appointment from the appropriate District Attorney will be submitted to proceed through the criminal process.

In the event the investigation supports an administrative charge, a Notice of Pending Action will be filed with the WCA Clerk of Court and submitted to the Director for his probable cause evaluation. In an

administrative proceeding, evidence is presented by the Enforcement Bureau and by the suspected party. The Director makes his finding following the hearing and may issue a penalty.

The investigative staff does receive in-house training from the current department director in investigation techniques and fraud information. There is no specific format or frequency.

New Mexico does not utilize any specific software applications or predictive modeling type programs in the investigation of workers' compensation claims. Those applications would be utilized by insurance carriers' licensed to conduct business in the state.

The State of New Mexico does not currently calculate any type of "cost avoidance" or ROI measurements.

State of Montana Commission of Securities and Insurance (CSI)

The State of Montana CSI does not have any specific policies or procedures pertaining to claim handler functions to identify suspicious claims. Those duties are left to the individual workers' compensation insurance carriers operating in the state.

Montana's CSI has a staff of four full time employees in the fraud bureau which handles all insurance fraud cases. Although there are no stated guidelines, the investigators are handling between 25-30 cases per month.

Montana does not utilize any anti-fraud based software programs as those tools would be utilized by the carriers during the claim investigation process.

Montana has not developed any type of "cost avoidance" or "ROI" calculation to date. They simply investigate appropriate cases and conduct annual performance reviews on their investigative staff and quality control audits on their work product.

State of West Virginia: Offices of the Insurance Commissions, Fraud Division

West Virginia has not been a workers' compensation monopolistic state since 2005 so there is no comprehensive state-wide information on fraud management in West Virginia. The Fraud Division has twenty one field investigators located throughout the state and handles investigations on all lines of insurance.

Since the State of West Virginia is no longer monopolistic the admitted insurance carriers are responsible for the identification and investigation of suspected insurance fraud cases and to forward those suspicious claims to the Fraud Division. The division receives fraud referrals from a variety of sources including law enforcement, insurance carriers and private citizens. West Virginia is a mandatory reporting state in regards to suspicious insurance activities.

West Virginia does not utilize any workload protocols, meaning they do not rely on an average monthly total of investigations for each investigator to assist in determining performance or workload issues. They have indicated they evaluate each case on its merit, complexity and strive to ensure quality investigation as opposed to a certain quantity. They are a law enforcement organization. To elaborate slightly on the notion of an average workload, employee fraud may take a modest amount of hours to investigate while provider fraud, which usually consists of more elaborate schemes, may take hundreds of hours.

The department does not have "divisions" within the fraud investigation arena. All department investigators will be assigned cases involving any type of insurance fraud which would include provider and employer fraud.

The department does not use any red flag or anti-fraud software as this remains the responsibility of the individual carriers.

The State of West Virginia will compile restitution monies ordered by the court and/or received when those become available. However, they report that the different courts are not mandated to provide them that information at the conclusion of a case so they do not have what we would consider a benchmark or valid information.

Recommendations:

Recommendation 2.1: High Priority

We recommend the WSI SIU Department review the old SIU manual, update it according to current SIU practice, policy and procedures and provide to all SIU staff.

> **WSI Response: Concur.** WSI will complete an updated practice, policy and procedure manual for the SIU Department Staff.

Recommendation 2.2: High Priority

We recommend that WSI develop a process in conjunction with its medical vendors (CGI, PMSI) to review atypical payment trends as a starting point for provider investigation. One component of this process should include an assessment of referral patterns for ancillary medical services in which a treating provider has a financial interest. Information of this sort could be available through state records relating to corporate filings. Another way of obtaining this information would be to require by statute that providers disclose any financial interest they have in ancillary services if that interest is equal to or greater than 5%. Once WSI has this information, they can evaluate trends by comparing providers of like specialties treating injuries in the same geographic area.

WSI Response: Concur. WSI will explore the area of atypical payment trends with our vendors, including referral patterns for ancillary medical services in which a treating provider has a financial interest, to determine the best available options for WSI to pursue.

Recommendation 2.3: High Priority

We recommend that WSI develop techniques in data mining to detect fraud, notably as regards medical providers given the relative lack of provider fraud detected not only in the performance evaluation period but before that as well. We're not sure what the data mining results will be but we provide two examples. First, let's say within the bill review area that WSI tracks the frequency with which certain follow-up office visit codes are used by medical providers in the state. WSI may learn that many providers use relatively simple or low-level procedure codes when submitting their bills for reimbursement. Other providers may tend to use higher, more complex codes. Such trends can then be measured and filtered by provider as a way of better understanding individual provider billing practices and validating that the more complex codes are justified or not, as the case may be. A broad-based metric tied to this effort would be a report that sorts by billing code and then monitors how trends may change over time. A second approach should be tied to Recommendation 6.4 in the Narcotics Utilization section of this report where we recommend provider profiling. Once prescribing patterns are better understood, something may be gleaned from the analysis that suggests fraud or at least a need to educate providers who are outliers when compared to their peers.

WSI Response: Concur. WSI will work with CGI and PMSI to explore data mining techniques related to detecting provider fraud to determine the best available options for WSI to pursue at this time.

Recommendation 2.4: High Priority

We recommend that upon implementation of Recommendations 2.2 and 2.3 that WSI expand its training of staff in the claims, medical and policyholder services areas. The training should feature any new fraud detection practices that have been developed as well as information on trends observed through the data mining process. We also recommend that when fraud has been detected, particularly in instances when the type of fraud constitutes a unique or new approach, that information be disseminated around the organization to appropriate staff.

WSI Response: Concur. To the extent new fraud detection practices are developed and trends are observed, WSI will provide this information to relevant staff during the regularly scheduled staff trainings. We will also provide information to appropriate staff regarding new or novel fraud occurrences that are detected.

Recommendation 2.5: Medium Priority

WSI collects information on cases where restitution is made. To the extent changes occur in restitution expectations, we recommend that these changes be tracked so there is a comprehensive means of

accounting for expected restitutions and ultimate recoveries. In short, it would be wise to have comprehensive information on what is compromised as well as solid rationale for the reduction of the initial obligation.

> **WSI Response: Concur.** WSI will add appropriate fields to the spread sheet where this information is stored, so an explanation as to modifications in the original restitution amounts are provided.

Recommendation 2.6: High Priority

We recommend WSI SIU reassess its method of calculating cost avoidance. When the amounts in outstanding reserves and cost avoidance are drastically different it suggest to us either that reserves are woefully understated or that avoided costs are inflated or possibly both. We recommend that as WSI reassesses its methods for calculating cost avoidance that it considers how medical treatment patterns have changed over time. More recent years of payment activity should be given precedence in the calculation as these years are more reliable predictors of future cost.

> **WSI Response: Concur.** The cost avoidance committee will continue to utilize the tools available to them including ODG, reserves identified by the claims adjustor, and how medical treatment patterns change over time, to determine cost avoidance. Ultimately, cost avoidance involves professional judgment. We are satisfied the cost-avoidance committee, comprised of seasoned claims staff, prepares reliable cost avoidance calculations that are well-documented and justified.

Element Three: Evaluation of Aspects of Claim Processes

Introduction

For this element, the State of North Dakota is interested in a review/evaluation of:

- The Appeals process available to claimants to include a comparison of this process to five other states and any "best practices" that may exist pertaining to the appeals process
- Denied claims that were submitted to the Decision Review Office (DRO) during calendar years 2011 – 2013 with an analysis of the number of times a decision was modified and whether the denials were supported by state law, administrative code, and WSI's policies and procedures
- The denial rate calculation process to include the rationale and accuracy for denial rate adjustments, the rate of denials in calendar years 2011 – 2013, and how these rates compare to national norms and the averages of five comparable states
- Claims filed trends over the performance evaluation period, and recognizing that claims filed year over year within the evaluation period how that has influenced WSI's staffing and their claim processes
- The appeal system as managed by the Office of Administrative Hearings and whether alternative forms of dispute resolution could enhance the process from a timing and cost perspective

Context

To achieve the above objectives, we accomplished the following activities:

- Interviewed WSI staff who are familiar with the appeals process in North Dakota
- Obtained information on the appellate processes available to injured workers in five other states (Florida, Oregon, Texas, Washington and Wyoming)
- Reviewed 75 claims that were denied by WSI and then sent to DRO (this sample included 22 claims from 2011, 25 from 2012 and 28 from 2013 in the performance evaluation and was weighted based on the type of DRO resolution)
- Reviewed calendar year information from DRO on their workload
- Reviewed denial rate calculations as performed by WSI for the performance evaluation period
- Reviewed an internal audit work paper (dated June – November 2013) pertaining to the adjusted denial rate
- Interviewed WSI staff involved in the denial rate calculation process
- Reviewed an internal audit report dated 11/28/12 concerning the Legal Department
- Reviewed HB 1464 passed in 2009 which included relevant statutory language on the administrative requirements of the Office of Administrative Hearings (OAH)

- Reviewed OAH Guidelines for Processing Workforce Safety and Insurance Hearings as articulated on 7/28/08
- Reviewed OAH biennial reports that are the outgrowth of one of the provisions of HB 1464
- Reviewed two service agreements negotiated by WSI and OAH collectively covering the period 7/1/11 – 6/30/15
- Reviewed data contained in WSI's presentation to the Interim Legislative Workers' Compensation Review Committee Meeting of 8/21/13
- Reviewed claim reporting information as provided by WSI and through various Operating Reports
- Reviewed changes in claims department headcount over the performance evaluation period
- Reviewed how the Claims Department headcount relates to annual claim reporting trends
- Considered based on prior experience how companies manage staffing needs as active claim inventory grows
- Obtained denial rates for all other monopolies (OH, WY, WA) as well as national denial rate data from other sources

Findings

This particular element contains several different components as articulated in the introduction. However, the topics can essentially be whittled down to three topics: Denials, Staffing and the Litigation Process. Of the three, the Denials and Litigation Process topics have multiple features to review and you will find sub-sections that address relevant facets.

Denials:

Introductory Information:
WSI initiated an early claim reporting program to incentivize employers in the state to report work-related claims more promptly. As a result, employers began to report more incident only events to avoid a penalty for late reporting.

In seeking to validate this assumption that employers would report their injuries more timely, we reviewed an operating report that was compiled during 2005 that showed the rate at which employers reported injuries within 14 days of the date of injury and compared it to more recent data using the same measurement (see Table 3.1). Years prior to 2005 were selected because they show reporting patterns prior to the incentive program.

Table 3.1: Reporting Timeliness by Fiscal Year Measured 14 Days from Date of Injury

Fiscal Year	% Reported in 14 Days	Fiscal Year	% Reported in 14 Days
2002	65%	2008	86%
2003	68%	2009	85%
2004	72%	2010	85%

As demonstrated in Fiscal Years 2008 – 2010, employers have improved their reporting timeliness notably since the incentive came into play.

Another measure that we reviewed from the same set of operating reports related to the incidence of time loss claims per 100 workers. One factor in early reporting that is well-documented in the workers' compensation literature is that if claims are reported sooner there will be a lower cost. One way to look at that is through lost time claim frequency. Earlier reporting, which leads to earlier treatment, should result in proportionately fewer lost time claims.

In reviewing the data from the above-referenced operating reports, we observed in the earlier years that the rate of time loss claims in the covered workforce was between .81 and .85 per 100 workers. In the more recent years cited above, that rate declined to a range of from .69 to .70 time loss claims per 100 workers.

Commentary on Adjusted Acceptance Rates for FY 2011 Only:

When WSI calculates its initial and adjusted acceptance rates and reports rates on its quarterly operating reports, certain cases are not included in the calculation. These are denied cases that fall into one of four categories: **withdrawn, no medical treatment is sought, no signed injured worker report is received or the injured worker is uncooperative** meaning they probably have not provided some form of documentation that has been reasonably requested. Next, we provide a summary of the process employed by WSI to complete the acceptance calculation.

(Note that we are providing detailed information on the calculation for FY 2011 data because it is the one year where the operating report footnote matches the calculation methodology.) The operating report contains a count of total claims filed and for FY 2011 ending on June 30, 2011 a total of 21,693 claims were filed. Of that number, 471 were categorized as transferred or consolidated. These claims are duplicate claims. Duplicate claims can be set up because documentation of an injury may come from multiple sources around the same time and the initial claim is not recognized at the time the duplicate is set up. As a consequence, WSI properly excludes these cases from the calculation and for FY2011 we therefore start with 21,222 claims (21,693 – 471) to complete the calculation.

For FY 2011, of the 21,222 cases, 17,872 were initially accepted and 3,350 were denied. So the unadjusted acceptance rate is 84.2%. WSI then adjusts the acceptance rate by taking out the four claim types that are highlighted above. In FY 2011, there were 1,298 claims that fell into one of those four claim types. With the exclusion of this group of 1,298 claims, the number of total claims amounts to 19,924 of which 2,052 were denied. That amounts to an adjusted acceptance rate of 89.7%, which is rounded on the operating report to 90%.

Relationship of Early Claim Reporting Incentive to Adjusted Acceptance Rate:

NDCC Section 65-05-07.2 contains a provision that incentivizes employers to report their injuries within one business day of the accident. If they meet this filing deadline, then WSI pays the first $250 in

medical expenses on the claim at no cost to the employer. As a consequence of this incentive, it is believed that employers would be more apt to file incident only cases, or cases that might not be reported to WSI if the incentive were not in place.

To test this theory, we reviewed the data available on losses from FY 2011. As we noted above, WSI received 21,693 cases in FY 2011 of which 471 were duplicates (transferred/consolidated). That leaves 21,222 claims. Within our data set, we filtered all cases reported where the date of injury and the reported date are no more than one day apart. Within the data set, there were 10,196 cases reported within that time frame. We further filtered the data set and found that of the claims that were denied and that were reported within one day, 730 of them were denied due to a lack of cooperation, no medical treatment being provided, no signed C1, or withdrawal. Of that number, 720 were considered medical only claims or cases that could more reasonably be thought of as potential first aid or incident only claims. This group of 720 cases represents about 55% (720 of 1,298) of the cases that are excluded from the adjusted acceptance rate.

In looking at the Operating Report for FY 2011, 47% of all claims were filed within one day from the date of injury. So, the percentage of all claims filed within one day of the date of injury is somewhat lower than the percentage of claims that were filed within one day that are excluded from the adjusted acceptance rate. This tends to support the theory that at least some percentage of the excluded claims is filed because of the incentive to report claims early.

We've also commented in a prior performance evaluation that WSI has a practice of sending out denial notices on claims where no medical treatment is sought. In most jurisdictions, these kinds of claims tend to be classified as "Closed No Pay" rather than denied. So, it makes sense to us to exclude these kinds of claims from the adjusted acceptance rate.

We think there is enough information in the data we have reviewed to support the notion that in some instances claims are reported to WSI for incidents that may not have been reported to WSI except for the incentive. It is difficult to quantify with specificity. At least we can see that of the cases that are excluded from the adjusted acceptance rate that proportionately more of those claims (about 55%) are reported within one day of injury than the claim set as a whole (47%).

Commentary on Adjusted Acceptance Rates for FYs 2012 and 2013 Only:

When examining how the adjusted acceptance rate was calculated in FY 2012 and 2013, we came across a change in the methodology that we itemize in Table 3.2 below. In the calculation we referenced above for FY 2011, we observed that the adjusted denial rate was calculated after backing out four denial types. Those denial types are listed under FY 2011 in Table 3.2. However, when we looked at FY 2012 and 2013, we observed a change in the calculation method. With this change, there comes a higher acceptance rate. We should also point out that while the claim types that were backed out of the calculation have been modified somewhat, the footnote on the operating report explaining how the adjusted acceptance rate is calculated is the same on the 2011, 2012 and 2013 operating reports.

(Parenthetically, we point out that we used FY data to obtain annual adjusted acceptance rates so we had three complete years of data.)

Table 3.2: Claim Types Backed out from Adjusted Acceptance Rates (2011 – 2013)

Denial Claim Type	FY 2011	FY 2012	FY 2013
Withdrawn	135	188	183
Uncooperative	47	39	
No Medical Treatment	509	520	504
No Signed C1	607	964	856
Elements of Filing		887	
Claim technical denial and elements of filing			1008
Total backed out	1298	2598	2551
Acceptance rate	90%	92%	92%

By adding in the denial types bolded in the above table in FYs 2012 and 2013 to the group of denied cases that are excluded from the acceptance rate calculation, the effect of that change is to give the appearance that a higher percentage of claims is accepted once these adjustments have been made. We note that the operating report footnote explaining categories included in the adjustment was modified in December 2013. That footnote removed "uncooperative" as a category and added "claim technical denials." However, the calculation methodology changed as of 7/1/11, but that change was not acknowledged in the report for more than two years. (See Recommendation 3.1)

Other States Claim Acceptance Rates:

This element also requires that we evaluate WSI's acceptance rate in the context of other jurisdictions. We have obtained data from each of the monopolistic states (OH, WA and WY) and we have obtained denial rates for other selected states through other means.

The data we have from the monopolistic states is provided by fiscal year (from July to June) which mirrors the way WSI captures that data in its Operating Report The exception to that statement is Wyoming whose data is captured by calendar year.

Table 3.3 displays the acceptance rate from each monopolistic state. We include WSI data in the table for ease of comparison.

Table 3.4 displays acceptance rate information from other states. This table shows acceptance rates by claim type for calendar years 2011 – 2013. Claim types are broken out between medical only (MO) and time loss (TL) claims. States included in Table 3.4 represent those states that are geographically close to North Dakota.

Table 3.3: Acceptance Rates for Monopolistic Programs by Fiscal Year

State	FY 2011	FY 2012	FY 2013
North Dakota	**90%**	**92%**	**92%**
Ohio	90%	90%	90%
Washington	N/A	86%	86%
Wyoming – by calendar year, not fiscal year	89%	89%	91%

Table 3.4: Acceptance Rates by Claim Type and State by Calendar Year

State with claim type	CY 2011	CY 2012	CY 2013
Iowa (MO)	95%	93%	94%
Iowa (TL)	88%	85%	83%
Idaho (MO)	90%	94%	94%
Idaho (TL)	93%	90%	82%
Minnesota (MO)	94%	93%	94%
Minnesota (TL)	85%	81%	79%
Montana (MO)	96%	94%	93%
Montana (TL)	88%	86%	76%
Nebraska (MO)	98%	97%	97%
Nebraska (TL)	87%	87%	85%
South Dakota (MO)	97%	94%	96%
South Dakota (TL)	87%	89%	86%
Wisconsin (MO)	96%	96%	95%
Wisconsin (TL)	84%	83%	81%

For all seven states over the three year period, the medical only claim acceptance rate never fell below 90%. And within the medical only group, all acceptance rates but one were at 93% or higher.

For time loss claims, the acceptance rates generally ran in the high mid to high 80's. With only one exception (Idaho in CY 2011), acceptance rates among time loss claims ran lower than those for medical only claims.

Review of Denied Claims:

We reviewed 75 claims that were denied by WSI where the injured worker subsequently sought assistance from the Decision Review Office. Injured workers must have their cases reviewed by the DRO if they plan to pursue more formal litigation after the DRO process has concluded and they want their legal fees paid (payment of legal fees will occur if the injured worker prevails at the Administrative Law Judge level or beyond).

To select claims for the review, we first identified fully denied claims during the performance evaluation period that reached DRO. DRO processed 288 such requests over the three years. DRO also captures

the outcome of the process on each of these claims and they categorize the cases into one of four groups: Affirmed, Changed, Stipulation, or Untimely. Table 3.5 shows how these cases break out by year and by resolution type.

Table 3.5: Decision Review Office Resolution Types on Denied Claims (Calendar Years 2011 – 2013)

Resolution Type	2011	2012	2013
Affirmed	61	74	91
Changed	10	7	5
Stipulation	11	17	11
Untimely	1	0	0
Total	**83**	**98**	**107**

From these cases, we selected a sample as outlined in Table 3.6 below. The sample was weighted by the resolution type and the relative frequency of DRO involvement year-over-year.

Table 3.6: Sample of Denied Claims (Calendar Years 2011 – 2013)

Resolution Type	2011	2012	2013
Affirmed	16	19	24
Changed	3	2	1
Stipulation	3	4	3
Untimely	0	0	0
Total	**22**	**25**	**28**

For each case we reviewed, we completed a review worksheet that we provide as Exhibit 3.1. The review worksheet was designed to capture the reason for the denial, how cases were resolved following DRO review, and how cases were resolved at the ALJ level if they proceeded to that point or beyond.

Results of these reviews are summarized below. Results were compiled based on case reviews that occurred between January and June so for some of these cases the way we have categorized them may not represent the most current status. These categories reflect case circumstances at the time of our reviews. We have provided a listing of the cases reviewed with their status at time of review so if WSI wished to update any of these numbers they will be able to do so.

Calendar Year 2011:

Of the 22 cases that were reviewed,

- 8 were affirmed by DRO with no additional activity (of the eight, four injured workers indicated that following DRO's decision to affirm WSI's denial that they were planning to proceed with litigation but they subsequently withdrew their appeals)
- 3 of the affirmed cases were re-affirmed by an ALJ
- 1 case was affirmed at the Supreme Court level

- 1 case was a split decision with WSI being found to be partially responsible for claimed injuries (denial of a shoulder injury was affirmed while a neck injury was found compensable)
- 1 is still in litigation
- 4 were accepted with limited liability (i.e., a stipulation)
- 4 were accepted outright (i.e., changed)
- Total - 22

Cases involving stipulations are ones where the parties agree to compromise to resolve disputes. Typically, this means that WSI pays for a limited amount of medical treatment at fee schedule rates and the parties agree to absolve WSI of any future liability on such cases. Changed cases are ones where WSI agrees to pick up liability on a case after originally denying the claim

With regard to changed case decisions and stipulations, we noted that in our original sample that there were only three changed cases and only three stipulations. In our recap, we show four of each. The reasons for these differences are that two cases in the affirmed category as captured by DRO had activity subsequent to DRO involvement that led to these changes.

Calendar Year 2012:
Of the 25 cases that were reviewed,

- 9 were affirmed by DRO with no additional activity (of the nine, one injured worker indicated that following DRO's decision to affirm WSI's denial that she was planning to proceed with litigation but she subsequently withdrew her appeal)
- 6 of the affirmed cases were re-affirmed by an ALJ
- 1 case was reversed by an ALJ
- 6 were accepted with limited liability (i.e., a stipulation)
- 3 were accepted outright (i.e., changed)
- Total – 25

As occurred in 2011, a few cases counted by DRO as affirmed had later developments to re-categorize outcomes. There was one case that moved from affirmed to changed and two others that moved from affirmed to stipulation.

Calendar Year 2013:
Of the 28 cases that were reviewed,

- 14 were affirmed by DRO with no additional activity (of the fourteen, two injured workers indicated that following DRO's decision to affirm WSI's denial that they were planning to proceed with litigation but they subsequently withdrew their appeals)
- 5 of the affirmed cases were re-affirmed by an ALJ
- 5 are still in litigation
- 3 were accepted with limited liability (i.e., a stipulation)
- 1 was accepted outright (i.e., changed)

- Total – 28

We recap the results for the three years in an aggregated fashion in Table 3.7 below.

Table 3.7: Recap of Denied Cases Reviewed by DRO

Category	CY 2011	CY 2012	CY 2013	Total
Affirmed	12	15	19	46
Split Decision	1	0	0	1
Reversed	0	1	0	1
In litigation	1	0	5	6
Stipulation	4	6	3	13
Changed	4	3	1	8
Total	**22**	**25**	**28**	**75**

When we consider the results in Table 3.7, we see that 59 of the 75 cases were either re-affirmed through DRO and subsequent litigation or cases were settled via Stipulations. Of the remaining 16, six are still in litigation. That leaves only ten other claims where an ALJ reversed or issued a split decision or where the original denial decision was changed to accepted.

We observed no trend to deny claims inappropriately. We did come across a few cases where we felt that a more thorough investigation in the early going could have reduced the number of cases where WSI changed the case status from denied to accepted, but the incidence of this particular issue was rare. And it isn't anything we wouldn't expect to see if we were reviewing other claims departments.

As regards to cases that are currently in litigation, we came across one case that we reviewed in June 2014 where the hearing was in January 2014 yet no decision had yet been received. That delay in rendering a decision seemed to be an exception.

Finally, one of the difficult aspects of the law for injured workers to understand may well be the "trigger" statute. NDCC Section 65-01-02 (10) (b) (7) states: "The term [compensable injury] does not include…injuries attributable to a preexisting injury, disease, or other condition, including when the employment acts as a trigger to produce symptoms in the preexisting injury, disease, or other condition unless the employment substantially worsens its severity." This provision was amended in 2013 to include the following language as a consequence of the North Dakota Supreme Court's decision in Mickelson: "Pain is a symptom and may be considered in determining whether there is a substantial acceleration or substantial worsening of a preexisting injury, disease, or other condition, but pain alone is not a substantial acceleration or a substantial worsening."

We found cases in the review where a denial issued because the events of employment appeared to act as a trigger and cases were legitimately denied for that reason. But that process leading to a legitimate denial may be one where the injured worker sees his/her medical provider, provides a history of injury that the treating physician believes to be work-related, and then because of the existence of a pre-

existing condition receives a denial notice that may well have been substantiated by an independent medical records review (IMR) by one of WSI's medical consultants who has not examined the patient. We found in our review that there are a number of instances where the medical consultant's opinion is given greater weight by WSI, DRO and ALJs, and injured workers may have a hard time understanding how someone who has not examined them can be seen in a more authoritative light. This is a process we have struggled with in prior performance evaluations and have recommended that IMEs be used to address compensability rather than IMRs. (See also our commentary in Element One pertaining to prior recommendations and the use of IMEs to address compensability.)

Staffing:

In our review of staffing during the performance evaluation period, we first obtained staff and annual claims filed over the past several years. Currently, WSI has ten claims teams each comprised of a supervisor and about six claims adjusters. One of the units is a Resource unit (Team 6). The six adjusters in this unit are not assigned a caseload; rather, they cover for adjusters who may be on vacation or absent. They may also manage overflow work from one team or another.

For the other nine teams, they have active caseloads. In Table 3.8 that follows, the count of adjusters reflects only those nine teams. The table also includes non-benefited adjusters. These are adjusters who have been retained and trained just like a regular adjuster but for whom there is no FTE position available. Non-benefited adjusters have been retained to assist in the management of the increased workload that has occurred due to increased claim filings. The increased workload is driven not only by the overall increase in claim filings but also by the fact that claims filed with out of state addresses have risen by more than 100% when comparing FY 2010 to FY 2013. Time loss claims during that period have also risen significantly (by about 44%).

Note that in the table below, FY 2014 data is provided through 12/31/13 which constitutes the end of the performance evaluation period. Put another way, the values in the FY 2014 table represent six months of data while all other years capture twelve months.

Table 3.8: Claim and Resource Trends at WSI (FY 2010 – FY 2014)

Category	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014 @ 6 months
Benefited adjusters with caseloads	44	45	46	45	49
Non-benefited adjusters with caseloads	0	0	2	5	4
Medical only claims	17,029	19,036	21,681	22,436	11,919
Indemnity claims	2,359	2,657	2,966	3,399	1,479
Total claims filed	19,388	21,693	24,647	25,835	13,398
Claims filed with out of state addresses	2,647	3,577	5,349	5,898	3,103

Out of state claims by their nature are typically more time-consuming to manage. Medical providers are unfamiliar with the workers' compensation reporting obligations in a state where they don't practice.

As well, there may be issues from the medical provider's perspective in accepting the medical fee schedule. The further someone happens to be from their workplace the more difficult it is apt to be to return them to work. For example, employees of firms with business in the oil fields may house their workers in man camps. If they can't work, these employees go home. Home could be 1500 miles away so the logistics of return to work become more of a challenge.

One encouraging statistic in the data provided by WSI insofar as caseloads are concerned has to do with the average number of active indemnity claims managed by adjusters. Indemnity or time loss claims, by their nature, take more time to manage. But during this uptick in claim filings, indemnity caseloads have remained stable ranging from an average of 60 to 63 over the last several years.

The average number of medical only claims has also not varied appreciably ranging from a low of 147 to a high of 166. With relative stability in the average active caseload brought about through the retention of a limited number of non-benefited adjusters, we think WSI has reacted wisely to the trend in claim filings.

WSI has historically managed caseloads in a way that is different (not better or worse) from what we see in other jurisdictions. In most other claim operations, adjusters are retained with varying degrees of training and expertise. The most common staffing model is one where the more seasoned adjuster services indemnity claims only while junior staff will manage medical only claims. WSI's model is to assign adjusters by policyholder whether the case is a medical only or indemnity claim. This means that if we were to look at average caseloads around the industry, WSI would at an average of around 220 cases appear high. But in other operations, indemnity claims examiners may have caseloads around 130 – 150 while those servicing medical only desks could have around 300 claims.

The key measure for us in this analysis is that caseloads for each adjuster have not changed much although job demands are somewhat greater due to the higher incidence of out-of-state claims.

When WSI decided to retain non-benefited staff, those adjusters were hired and trained with the same expectations as any of the benefited adjusters. Their job duties are the same. The first non-benefited adjuster was retained in January 2012 and the most recent additions during the performance evaluation period occurred in December 2013. During that two-year period, WSI retained 20 different non-benefited adjusters. Five have terminated their employment with WSI. And of the remaining fifteen, nine have been hired as full-time employees. The other six adjusters are non-benefited (two of whom were in training as of the end of the performance evaluation period). Being able to move non-benefited adjusters into full-time positions has meant that open positions have been filled with people who are already familiar with the duties and responsibilities of the job.

Regardless of the average caseload figures that have remained relatively constant, WSI has instituted certain changes in their claim processes to reduce workload. These changes include:

- Moving the 21-day action plan requirement for pending claims to 28 days. The gist of this change is that WSI has one more week to acquire requested information before updating their action plans on pending cases
- Discontinuing 28-day contacts on lost time cases if those injured workers are involved in training programs. The rationale for this is that the person responsible for monitoring training programs in RTW Services is already making regular contact
- Discontinuing 60-day action plans for those injured workers who are engaged in vocational plans involving schooling. Contact is already being made by RTW Services in those cases
- Eliminating the initial 90-day action plan. Sixty-day action plans are required on all lost time claims so the one-time 90-day action plan was seen as unnecessary
- Claim triage is managed differently. First, triage is more focused on medical case management and vocational issues. As well, meetings were occurring where all adjusters from a claims team might sit in a meeting while one adjuster discussed his/her claims. Now, WSI limits adjuster participation to that time when their cases come up on the agenda. This practice eliminates non-productive time
- WSI's procedure manual is online which allows adjusters easier access to the manual. Search capabilities are available in the usual search fashion (hit Control F on your keyboard and enter the desired term)
- Certain utilization review functions tied to physical medicine services have been moved away from adjusters to the Utilization Review staff

These ideas for reducing workload came out of a Streamlining Committee formed to evaluate the reasonableness of suggestions posed by adjusters. Each of these efforts at reducing workload makes sense to us from a time management or avoidance of duplicate effort perspective. With that said, we think WSI should look for signs of leakage. As an example, WSI's target for the percent of claims pending over 31 days is 10%. That target percentage was last achieved in FY 2010 and has been at either 13% or 14% over the past three plus years. Possibly, the decision to increase the 21-day action plan to 28 days on pending claims is a factor in that result. A negative trend we see is that fewer claims are adjudicated within fourteen days of registration ranging from a high of 49% in FY 2011 to a low of 42% during the first half of FY 2014. WSI's target is 60%. This adverse trend is likely a consequence of increased claim filings from one fiscal year to the next.

As we mentioned above, comparing WSI to other states is a bit like comparing apples and oranges because of the way WSI manages adjuster workload (by account, not by claim type). But it would be fair to say that as workload demands increase, companies will look for ways to streamline work processes, something WSI has sought to accomplish. (See Recommendation 3.2)

Further, in reviewing the operating reports for the last few years, we see that the expense ratio has declined for each of the past three fiscal years. Expense ratios are derived by taking premiums earned less discounts and dividing that into unallocated loss adjusting expenses plus general and administrative expenses. In FY 2011, the expense ratio was 12.72%. In 2012, it dropped to 11.12%, and in 2013 it

dropped again to 9.13%. Those rates adjust down further when safety expenditures for safety grants are removed to 11.85%, 9.10% and 8.31% for FYs 2011, 2012 and 2013, respectively. It is not atypical in the insurance industry for expense ratios to run at approximately 30%.

In summary, WSI has retained non-benefited adjusters to meet servicing needs and has kept caseloads at roughly the same level over this period of growth in claim filings. Some processes have been modified to reduce workload. Non-benefited adjusters are provided the same training and given the same responsibilities as their benefited peers.

Appeal Process:

Before an injured worker begins the appeal process, WSI will issue a Notice of Decision (NOD) indicating that they are denying benefits. The injured worker must then file a request for reconsideration. The process for filing requests for reconsideration is spelled out at NDCC Section 65-01-16 (4) and must be made in writing within 30 days of the date the NOD was mailed. The injured worker may also provide "additional evidence not previously submitted" to WSI. WSI then has sixty days to issue an Administrative Order. If the injured worker disagrees with the Order, then he/she has thirty days to file a request for assistance from the Decision Review Office. The Decision Review Office (DRO) then begins its investigation, reviews case circumstances, gathers evidence, and discusses the case with the employee, WSI and others connected to the case. Following its review, the DRO will document its completion of the case. Cases are typically resolved with DRO indicating one of three outcomes:

- DRO agrees with and affirms WSI's decision
- WSI agrees to change its determination
- The parties resolve the case via Stipulation

When WSI changes its determination or when a case is resolved via Stipulation, no further litigation on the original issue is likely. For cases on which DRO affirms WSI's decision, the injured worker's next level of appeal is to request a hearing before the Office of Administrative Hearings (OAH). Per NDCC Section 65-01-15 (7), the injured worker has 30 days from date DRO mails its certificate of completion to make a hearing request. Proceeding through the DRO process is a pre-requisite for injured workers to get their attorney's fees paid, assuming they prevail in the litigation process.

At the OAH level, the parties submit evidence and the Administrative Law Judge (ALJ) makes a finding based on the preponderance of the evidence. WSI's target with OAH from request for hearing to resolution is 160 days.

If either party is aggrieved of a determination made by the ALJ, then the next level of appeal is to District Court. The final level of appeal is the North Dakota Supreme Court. Whether at the District Court or Supreme Court, decisions will issue relying on the facts in evidence, as presented to the ALJ. NDCC Section 65-10-01 states that "any appeal to the district court shall be heard on the record, transmitted from the organization [WSI], and, in the discretion of the court, additional evidence may be presented pertaining to questions of law involved in the appeal."

This summary represents the appeal process available to injured workers in North Dakota.

Other State's Workers' Compensation Appeals Processes:

Florida:

Florida Statute 440.191 addresses the creation of the Employee Assistance and Ombudsman Office to inform and assist injured workers, employers, carriers, health care providers and managed care arrangements in fulfilling their responsibilities. If at any time the employer or its carrier fails to provide benefits to which the employee believes she or he is entitled, the employee can contact the Office to request assistance in resolving the dispute. The Office may attempt to facilitate an agreement between the employee, and the employer or carrier. The employee, employer and the carrier must cooperate with the office and have to timely provide any documentation requested. The Office may compel parties to attend conferences in person or by telephone in an attempt to resolve disputes quickly and in the most efficient manner possible.

Florida Statute 440.192 indicates that the ombudsman may, at the employee's request, assist the employee in drafting a petition for benefits and explain the procedures for filing petitions. The injured worker also has the option to retain an attorney to file a petition for benefits on their behalf. Within 14 days after receipt of a petition for benefits by certified mail or approved electronic means, the carrier must either pay the requested benefits without prejudice to its right to deny within 120 days from receipt of the petition or file a response to petition with the Office of the Judges of Compensation Claims.

Florida Statute 440.25 provides that 40 days after a petition for benefits is filed, the judge of compensation claims must notify the interested parties by order of a mediation conference concerning the filed petition unless the parties have notified the judge that a private mediation has been held or is scheduled. Mediation, whether private or public, shall be held within 130 days after the filing of the petition. The mediation conference is informal. The employer may be represented by an attorney at the mediation conference if the employee is also represented. Participation in a mediation conference does not preclude any party from requesting a hearing following the mediation.

In the event either party refuses to agree to the results of the mediation conference, the results of the mediation conference, as well as the testimony, witnesses, and evidence presented at the conference shall not be admissible at any subsequent proceeding on the claim.

If the parties fail to agree to written submission of pretrial stipulations, the judge of compensation claims shall conduct a live pretrial hearing. The judge of compensation claims has to give the parties at least 14 days advance notice of the pretrial hearing by mail.

The final hearing must be held and concluded within 90 days after the mediation conference is held, allowing the parties sufficient time to complete discovery. Continuances may be granted only if the requesting party demonstrates to the judge of compensation claims that the reason for requesting the continuance arises from the circumstances beyond the control of the parties. The final hearing has to

be held within 210 days after receipt of the petition for benefits in the county where the injury occurred.

To expedite dispute resolution and enhance the self-executing features of the system, petitions filed that involve a claim for benefits of $5,000 or less for medical benefits only or reimbursement for mileage for medical purposes only shall, in the absence of compelling evidence to the contrary, be presumed to be appropriate for expedited resolution. Notice of the expediting hearing has to be provided within 15 days prior to the hearing. No pretrial hearing will be held or mediation scheduled unless requested by the parties. The judge of compensation claims has to limit all argument and presentation of evidence to 30 minutes.

Procedures with respect to appeals from orders of judges of compensation claims are governed by the rules adopted by the Supreme Court. The appellant or the appellant's attorney if represented must indicate in their verified petition that the notice of appeal is filed in good faith and there is a probable basis for the District Court of Appeal, First District to find reversible error and state with particularity the specific legal and factual grounds for the opinion. This is further addressed in Florida Statute 440.271.

The final appeal available is to the Supreme Court of Florida.

Similar to North Dakota and its use of the DRO, there is an effort to resolve cases through an informal process before cases proceed to a judge of compensation, a trier of fact similar to an ALJ.

Oregon:

In Oregon, all determination orders have various appeals periods depending on the nature of the dispute. Oregon has allowance orders on every claim (both medical only and indemnity claims) and a closure order is required on indemnity claims.

When initially filing an appeal, the appellant may request an arbiter exam to make a further determination or may request a hearing. From either of these situations an Opinion and Order will issue.

There is a subsequent appeal right from an Opinion and Order and the next decision rendered is called an Order on Review. Following an Order on Review, the final level of appeal is to the Court of Appeals.

Texas:

In Texas, when an injured worker begins to pursue legal remedies they may choose to represent themselves, be represented by counsel or retain an Ombudsperson. An ombudsperson serves an advocate for the employee and may represent the employee through the appeal process.

The first level of review is through a Benefit Review Conference (BRC). Either the employee or the employer/carrier may request a benefit review hearing. The purpose of the hearing is to mediate the dispute and the mediation is managed by a Benefit Hearing Officer. No decision is made at the BRC; rather, it is just an effort to resolve disputes informally.

If the issues are not resolved, the claim is sent to a Contested Case Hearing (CCH). This is a formal hearing that is managed by an Administrative Law Judge. Decisions at this level are binding if not appealed. (The CCH level of hearing might be thought of in a manner that is similar to the OAH proceeding in North Dakota.)

The next level of appeal is via an Appeal Panel Review conducted by three ALJs based in Austin, TX. Note that the CCH decision is binding during the time leading up to the Appeal Panel's review and decision.

If a party is still not satisfied, then the next step is via judicial review before a judge and jury. The trial is conducted not entirely in a "de novo" manner because evidence of the decision in the earlier proceedings is admissible. As such, a heavier burden of proof is on the appealing party.

The final step in the appeal process is to the Texas Supreme Court.

Regardless of how the case is resolved, attorney's fees for injured workers are only paid by the carrier or employer if there is an award of indemnity benefits as part of the resolution.

Washington:

As we saw in Oregon, all benefit determinations are issued by Order, either by the Self-Insured employer or the State Department of Labor. But in a slightly different fashion from Oregon, Washington requires allowance orders only on indemnity claims while requiring closure orders on all claims. Any order (allowance or denial) has sixty days to be appealed.

If a party appeals, the first round of appeals is at the Department level where there are two levels of department adjudicators. The first level issues Orders while the second level addresses appeals. Once a new Order issues, a party may again appeal within sixty days.

The next phase is through the Board of Industrial Appeals. If items are unresolved, then mediation will take place. Following this step, a judge will issue a proposed decision or order based on the evidence presented at hearing.

Once the proposed decision is issued, either party has thirty days to request a Panel Judge Review. If the case is further appealed after the decision and order becomes final and/or the Panel issues a new determination, then the next and final phase of appeal is to the Superior Court.

Wyoming:

Like North Dakota, Wyoming is a monopolistic workers' compensation environment so initial orders and decisions issue from the claims department. The employee has the right to object and request a hearing. If a hearing is requested, the case gets referred to the Office of Administrative Hearings, the Medical Commission or an Internal Hearing Unit.

Referrals are directed to each office depending on case circumstances. To wit,

- Disputes relating to the termination of Temporary Total Disability, partial permanent impairment, permanent total, and complex medical cases go to the Medical Commission
- The Internal Hearing Unit only hears matters relating to timely hearing filing questions
- OAH hears any other type of dispute

At this stage, the employee is entitled to representation and Wyoming monopoly is ultimately responsible for paying attorney's fees, irrespective of outcome. Mediation can be requested through the hearing body but is non-binding.

After a hearing decision is issued, a further appeal can be taken which would first go to a State District Court and then to the Wyoming Supreme Court as a final step. As is true in North Dakota, the record relied upon at either the District Court or the Supreme Court is the one created at the initial hearing level.

Summary Comments after Reviewing Other States:

In considering how North Dakota manages appeals in comparison to other states, we don't have any recommendations on how this process might change. From our analysis of other states, there appear to be opportunities in most venues to resolve disputes informally. Mediation is a good first step, something that is provided in a way through the DRO.

When we first started reviewing cases, the role of DRO and the appeal process in general, one idea we considered was whether for cases involving complete denials if the DRO process should be removed allowing the injured worker an opportunity to go to OAH. Essentially, the idea would be to fast track litigation where the injured worker is receiving no benefits. But after reviewing case outcomes involving DRO, we're not sure that would be a good idea.

Consider that in our review of cases that 46 of the 75 cases were affirmed by DRO, some of those subsequently affirmed through the hearing stages with few cases going any further in the litigation process once an ALJ had issued an opinion. Another 13 cases were resolved via some form of Stipulation. Another eight cases led to WSI making a change in their initial determination. That left only eight other cases in our sample and six of those at time of review were still in litigation.

DRO also had a hand in most of the cases that resulted in changes in compensability determination or stipulations, so the findings support keeping things as they are.

We also don't have any recommendations about choosing an alternate process for the hearing stages. The first stage essentially requires that the parties be ready to proceed and with all their evidence in place. Ample time exists from date of injury to hearing date for the parties to gather their evidence so having further appeals limited only to matters of law also seems reasonable.

The Role of the Office of Administrative Hearings:

Litigation costs in North Dakota as a percentage of overall claim costs are quite low. WSI, in its operating reports breaks out those costs in a section referred to as Paid Cost Data. The December 31, 2013 Operating Report contains history of those costs starting with FY 2011 (7/10 – 6/11) and we provide that data in Table 3.9 below. Note that the FY 2014 data represents only half the fiscal year's data.

Table 3.9: Paid Cost Data from FY 2011 through 12/31/13 by FY

Paid Costs	FY 2011	FY 2012	FY 2013	FY 2014 @ 6 Mos.
Indemnity	$47,611,066	$54,471,527	$65,091,921	$38,208,118
Medical	$72,650,342	$76,068,092	$104,639,702	$53,644,245
ALAE (non-legal)	$2,598,522	$1,842,753	$1,999,546	$1,210,480
ALAE (legal)	$1,422,683	$1,885,986	$1,788,746	$1,211,696
Total	**$124,282,613**	**$134,268,358**	**$173,519,915**	**$94,274,539**

The Allocated Loss Adjusting Expense (ALAE) that is categorized as legal in Table 3.9 represents between 1% and 2% of total claim costs. It includes legal fees paid to attorneys for injured workers, attorneys for WSI, costs to OAH, court reporter fees, third party attorney fees (e.g., subrogation matters) and miscellaneous fees. OAH costs for the 3.5 years amount to $1,294,065, or about 20.5% of all legal fees paid.

Biannually, WSI has negotiated service agreements with OAH. The service agreements spell out the duties and responsibilities of OAH, fees that WSI agrees to pay for those services, training obligations and statistical reports summarizing OAH hearings. The contract contains specific language on the average time allotted for ALJs to issue decisions following the closure of hearings and that average is 25 days.

In addition to the agreements that exist between WSI and OAH, OAH also has a responsibility to report to the governor and the state advisory council. This responsibility grew out of HB 1464 as articulated at NDCC Section 54-57-01 (6). We have reviewed the last two reports prepared by OAH covering the periods 2009 – 2011 and 2011 – 2013.

OAH also issued guidelines for processing WSI Hearings in a memorandum dated 7/28/08. That memorandum provides the following time frames within which OAH should accomplish certain tasks:

- Receipt of WSI case at OAH to issuance of letter by OAH designating ALJ for assignment – 2 days
- Issuance of a "First Significant Action" by ALJ – 10 days. Depending on case circumstances, this action may include the issuance of a pre-hearing or hearing notice, continuance, delay or return to WSI for cause
- Receipt of WSI case file by OAH to first scheduled hearing date – 60 days

- Hearing date to file closure – 50 days
- Hearing closure to file closure – 25 days (this is the guideline that is included in the contract between OAH and WSI)
- Receipt of file from WSI by OAH to file closure – 110 days

In the biennial report submitted by OAH to the Governor dated 11/5/13, OAH compiled similar (not identical) statistics related to its hearings on behalf of WSI. The report also includes a statistic showing average duration from receipt of request to hearing held and this piece of information is helpful because it provides the difference between when the first hearing was initially scheduled and when it actually occurred. In this particular report, the difference is about 39 days.

The report shows for all cases reviewed in the biennial report that the average duration from receipt of the file to file closure is 176.4 days. If we subtract the 39 days referenced above because the hearing did not occur when it was initially scheduled, then this average drops to 137.4 days.

WSI also has its own target measure that tracks cases from time of hearing request to OAH to OAH decision at 160 days, so the targets set by OAH are within the average target set by WSI for the entire process to unfold. Further, we can see that if hearings had occurred when initially scheduled that the 160 day target in WSI's own measures would have been met. (See Recommendation 3.3)

In summary, costs for OAH services represent about 20% of the overall cost of litigation, which as a percentage of all claim costs is very low in North Dakota. The benchmark of attempting to get from request for OAH involvement to file closure in less than six months is reasonable given our experience in other jurisdictions. Good measures are in place at OAH to track their performance through the hearing process and if Recommendation 3.3 is implemented a more reliable valuation of OAH timeliness can be provided.

Recommendations

Recommendation 3.1: High Priority

We recommend that the operating report provide an appropriate footnote to describe the denial types that are excluded from the adjusted acceptance rate. For instance, when referring to claim technical denials it would be useful to know the kinds of cases that fall into this category.

> **WSI Response: Concur.** The Operating Report footnote will be reviewed and revised as necessary.

Recommendation 3.2: Medium Priority

To the extent WSI can develop an informal network of treating doctors who practice out-of-state and who are familiar with and accepting of WSI's requirements, we think this could help WSI better manage out-of-state claims. Matching might occur by comparing provider zip code to the zip code associated

with the injured worker's residence. Adjusters should also be pooled for names of those out-of-state providers with whom they have worked successfully.

> **WSI Response: Concur.** In December 2013 an RFP was issued requesting bidders to provide nationwide out of state medical services to non-local injured workers. On February 19, 2014, WSI entered into a contract with Bunch CareSolution to provide all aspects of a PPO. This program is in development and under evaluation.

Recommendation 3.3: Medium Priority

We recommend that WSI work with OAH to amend the calculations it does on cases so that an average duration from receipt of file to file closure breaks out those cases that proceeded to hearing when the hearing was initially set and another data set for those cases where hearings occurred later than when originally set. Hearing delays typically will occur because one of the parties has requested a delay or continuance and some instances of delay can be weather-related. WSI would be well-served if it can identify all cases that don't meet the 160-day target when hearings occur as initially scheduled. WSI might then publish two rates, with the second rate including the average duration from OAH receipt to OAH closure when delays have occurred because the hearing did not occur on the original hearing date.

> **WSI Response: Concur.** WSI will work with OAH to identify a method to best track a data set for those cases in which a hearing occurs as initially scheduled and another data set for those cases where hearings occurred later than when originally scheduled.

Element Four: Evaluation of Vocational Rehabilitation

Introduction

In this Element, the State of North Dakota is interested in:

- A determination into whether WSI has sufficient policies and procedures established to guide the staff and to establish protocol to ensure consistent, quality services for the return-to-work of injured workers.
- An evaluation as to whether or not WSI has performance measures in place to adequately evaluate the performance of the vocational rehabilitation division.
- A comparison, to the extent data is available, of WSI performance measures to those measures used in at least five other states
- A determination as to whether WSI surveys claimants who used return to work services or if any other means are utilized to determine claimant satisfaction and provide an analysis of those results
- A review of 75 claims on which vocational rehabilitation services were provided to assess how policies and procedures are followed as well as assess compliance with various ND Century Code statutes that define vocational obligations
- A determination of how WSI compares with at least five other comparable workers compensation systems in returning injured workers to the work force
- To the extent national benchmarks may be available, compare how WSI is in returning workers to the workforce against those benchmarks

Background

To achieve the above objectives, the following activities were undertaken:

- Reviewed WSI policies and procedures relating to vocational services (these documents included the Vocational Case Management Referral and Process, the Vocational Case Manager's Report, the Waiver Agreement, the Work Search Assistance Guide, the School Monitoring Guide, Preferred Worker Program information, and various other Vocational documents addressing work processes)
- Reviewed financial measures on the cost to WSI both before and after WSI brought VR services in house
- Reviewed a document titled, "Workforce Safety and Insurance Business Plan for Transitioning Vocational Rehabilitation Services In-House," that essentially spanned a period from late 2010 to mid-2011 during which time the transition actually occurred

- Reviewed workload and staff measures for the Performance Evaluation period and prior
- Reviewed the organization chart for Return to Work Services
- Requested performance measures relied upon by WSI and reviewed what they provided
- Reviewed the "Assessment of Injured Workers Referred to WSI's Rehabilitation Programs" dated November 2013
- Reviewed an internal audit report pertaining to Return to Work services dated April 25, 2013
- Reviewed a document called, "Return to Work Audit Requirements" updated through 1/9/14 that is an outgrowth of the 4/25/13 internal audit report
- Reviewed various CL0958 Rehab Cases by Close Option report covering the Performance Evaluation period along with CL0956 reports. The CL0956 reports cover active cases opened during a particular window of time
- Reviewed various reports that are available in WSI's Rehab/Legal database
- Reviewed 75 vocational rehabilitation cases that were identified as closed during the Performance Evaluation period
- Obtained and reviewed documentation on vocational rehabilitation statutes in the states of Arkansas, Connecticut, Florida, Idaho, Maryland, Nevada, Vermont, Virginia and Washington

In addition to these reviews, we also reviewed our findings from the 2010 Performance Evaluation report wherein we had recommended that WSI discontinue the outsourcing of vocational services to CorVel in favor of an in-house staffing arrangement. As a follow-up to this recommendation, we wanted also to assess how the transition was managed as part of our review of vocational services in 2014.

Findings

Bringing services in house at WSI has saved administrative expenses. During Fiscal Year 2010, WSI paid CorVel $1,084,796 in vocational rehabilitation service costs. The following year, that amount increased modestly to $1,129,309. Starting on 7/1/11, WSI had transitioned vocational services in-house.

During Calendar Year 2012, WSI reported vocational rehabilitation services payroll, fringe benefits and department expenses (limited to those who are providing services comparable to those previously accomplished by CorVel) in the amount of $737,662. That total in Calendar Year 2013 amounted to $897,353

Table 4.1 below provides this comparison with total costs over a 24-month period.

Table 4.1: Cost Comparison of CorVel to In-House Service Providers

Period	CorVel	In-House
July 1, 2009 – June 30, 2010	$1,084,796	
July 1, 2010 – June 30, 2011	$1,129,309	
January 1, 2012 – Dec. 31, 2012		$737,662
January 1, 2013 – Dec. 31, 2013		$897,325
Total	**$2,214,105**	**$1,634,987**

In comparing periods, we see that if we simply look at the administrative cost savings over a two-year window depicted in these financials we see a cost reduction of $580,000. However, there are two other factors to consider. CorVel likely would have received a fee increase during the years that WSI has been providing vocational services. We project that increase for the first two years following the transition at $137,000. WSI has also increased headcount during the post-transition period due to increased demand. Under the prior arrangement with CorVel, WSI paid a flat fee for vocational counselors at a monthly rate. Conservatively, that cost was $10,000/month per counselor or $120,000/year. Had CorVel been required due to service demand to add two employees, then it is reasonable to estimate WSI's additional staffing costs to increase by another $240,000. In short, by bringing services in-house, we estimate administrative savings for the last two calendar years that amount to about $957,000.

In North Dakota, vocational rehabilitation service responsibilities spelled out in NDCC Sections 65-05.1-01, 65-05.1-02, 65-05.1-06.1 and 65-05.1-06.2 are the subject of this review. Briefly, those statutes include a preferential set of plan options, specifics on post-injury earnings and the effect of those earnings on future benefits, responsibilities to develop vocational plans and issues orders, long-term training requirements, and rules governing the retention of external vendors. Plan options, a key factor both in North Dakota and other states, are listed below in order of preference:

- Return to the same position
- Return to the same occupation, any employer
- Return to a modified position
- Return to a modified or alternative position, any employer
- Return to an occupation within the local job pool either of the locale where the claimant was living at the time of injury or where the employee currently resides
- Return to an occupation in the statewide job pool
- Retraining of one hundred four weeks or less
- Retained earning capacity

<u>Policies and Procedures:</u>

Since moving services in-house, vocational services have been managed through the Return to Work Department. This department historically included medical case management, school monitoring and the Preferred Worker Program. With the addition of vocational counselors, the department has doubled in size. Positions added include two supervisors and twelve counselors.

Policies and procedures exist that define service expectations from the time of initial referral via Form Letter C121 (FL C121) to file closure. The FL C121 is completed by the claims adjuster and reviewed by the RTW Director to determine which counselor should receive the case based on the type of the assignment, current caseloads, vocational expertise, and the residence of the injured worker.

The vocational counselor will make contacts with the claims adjuster, the injured worker, the employer and the injured worker's attorney if the injured worker is represented. Most vocational referrals from claims adjusters to the RTW Services Department occur while injured workers are still recovering from the effects of their injuries and they are receiving temporary total disability. The preferred practice at WSI, and one that we support, is that referrals tend to be made at the earliest reasonable point during the recovery process when the potential for RTW services is believed to exist.

Early referrals can be valuable for several reasons, which include:

- If preliminary services to plan identification are needed, such as skills assessment, academic testing or skills upgrading, this work can be accomplished during the recovery time
- In some instances, injured workers may prove to be more motivated in their recovery following notification from WSI of the potential need for VR services
- Generally speaking, whatever can be done to shorten the time frame between last day worked and commencement in re-employment activities is apt to lead to a more successful outcome

Because of the timing of initial referrals, the vocational manager's report (VCR) may not be created for several months. (The VCR is the report that documents the vocational plan, expected costs and outcomes, etc.) Leading up to that report, other vocational services occur. One common component in the vocational process is a functional capacities evaluation (FCE) to establish the physical capabilities of the injured worker. Treating physicians are disinclined to recommend an FCE until such time as they believe the injured worker's condition has stabilized. As the FCE will establish on an arduousness scale the injured worker's capabilities which can then be tied to certain job types, the timing of the FCE must make sense.

Academic testing is also important when considering realistic job or retraining options. Given the proliferation of computer-related jobs in the workplace in general, computer skills upgrading is a common offering. But there may be little value in providing such skills training to individuals who have low grade level math or writing skills. Another common step in this process is the development of a suitable resume to be used when seeking employment. We observed practices on the part of WSI vocational counselors demonstrating a logical service progression in the early stages of the vocational assessment process.

Staffing of cases (triage) can occur at any point in the vocational process and can include such topics as an absence of job goals, non-compliance on the part of an injured worker, or situations where treating providers don't approve of an FCE or job goals. And a standard and integral part to the entire process is the documentation in the VCR as to why a particular plan choice was made ranging from a return to the usual job to formal retraining.

Following the issuance of the VCR, WSI is required by statute to issue an Order within 60 days. In our review of 75 cases, we found that the Order issued within 60 days of the VCR in 58 of 75 instances, or 77% of the time. WSI has measured timeliness of Orders with the day count commencing on the date

the VCR is approved, not the date received. In that context, 70 of the 75 orders were timely. (See Recommendation 4.1)

To accomplish our review of 75 cases on which vocational services were provided, we relied on reports generated by WSI. These reports were labeled CL0958 and show a summary count of all vocational cases closed within a six-month window starting with 1/1/11 – 6/30/11 and concluding with 7/31/13 – 12/31/13. There were six such reports. On this report, vocational cases are categorized in many ways. In selecting cases for review, we focused on the tiered vocational plan options that exist in North Dakota. These tiers in order of plan choice priority include:

- Return to same position, same employer (8)
- Return to same position, any employer (19)
- Return to modified position, same employer (5)
- Return to modified or alternate position, any employer (10)
- Job search within 35 miles of injured worker's home (4)
- Job search within the statewide labor market (11)
- Long-term training (9)
- Paragraph 6 (retained earnings capacity) (9)

We took a representative sampling of cases. Case counts by plan type are identified in parentheses next to the plan options based on this sampling approach. Further, the sampling roughly coincided with the frequency with which each plan option was selected. For example, there were almost twice the number of cases on the CL0958 reports where a return to same position, any employer plan type was identified in comparison to the return to modified or alternate position, any employer plan type and the sample size (19 v. 10 – nearly double) in those categories reflects our sampling approach. In selecting cases that were on the CL0958 reports, we also could evaluate cases through the Order phase of the vocational process. And most cases in the sample (primarily with the exception of some of the long-term training programs) had concluded at the time of our review.

The case file reviews revealed the following:

- Plan choices are well-justified
- Cases are appropriately documented insofar as wages at time of injury and expected wages upon successful plan completion
- Wages documented at time of file closure may represent actual wages following return to work or expected wages based on an average earning capacity for jobs in the labor market for which an injured worker is qualified and job openings exist
- In instances where a temporary partial disability obligation exists, benefit rates are accurately calculated. The formula applied is: Wages at time of injury less retained earnings capacity multiplied by 2/3rds. For example, one of the cases reviewed showed pre-injury earnings of $1,764 and retained earnings of $848.00. The difference between the two is $916. Two-thirds of that is $611, which was the benefit rate being paid on that case.

- We saw frequent communication to injured workers about the Preferred Worker Program
- Long-term training programs spelled out all facets of expense and benefits including the rehabilitation allowance, travel, tuition, books, fees, equipment, tools, supplies, etc.
- Work search was consistently included in the VCR and in Orders from WSI so injured workers could see when their plans would terminate. Work search, when included, was consistently limited to two months
- And in some of the older cases where CorVel was involved, their engagement on those cases was appropriate and they did have the necessary qualifications to provide services.

One oddity that we observed in our review of cases pertains to the method of calculation of temporary partial disability benefits for injured workers who have returned to work but are making less than their pre-injury wages. We provide an example of this oddity in the following paragraph.

The statute requires that WSI pay a temporary partial disability benefit to injured workers whose post-injury earnings are less than 90% of their pre-injury earnings. As an example, one injured worker had pre-injury earnings of $598.00 and post-injury earnings of $514.00 for a difference of $84.00. WSI pays TPD benefits at a rate that is 2/3rds of that difference, or $56.00. When you add the post-injury earnings and the TPD benefit, the total paid amounts to $570 or over 95% of the employee's pre-injury income. If the injured worker had post-injury earnings of $538.20 or 90% of their pre-injury earnings, they would receive no TPD benefit. In short, the way this benefit works now, injured workers may earn more in total income by getting paid less. (See Recommendation 4.2)

Other States:

In examining how other states provide vocational rehabilitation services, we reviewed statutes and obtained other documentation. In our information gathering process, we focused primarily on how the obligation to provide services is statutorily defined and whether there is any reliable data on vocational benefits and performance measures in these other states.

We selected a range of states around the country with varying degrees of vocational obligations. We report on each of those states below:

Arkansas:
The Arkansas workers' compensation system allows for vocational rehabilitation services but the services are only to be provided if offered by the employer or insurance carrier. The statute includes language stating that an employer will be liable to pay the employee the difference between benefits received and the average weekly wages lost during the period when re-employment is not provided for a period of up to one year in duration.

There is no prioritized or tiered approach to vocational rehabilitation plan options nor are there any published guidelines. Plans are reviewed for reasonableness by the Arkansas Workers' Compensation Commission to make sure they are suitable for injured workers given their level of disability. One value to employers and carriers in providing vocational services can be to establish that an injured worker has

not suffered a permanent and total disability. So the vocational statute functions more as a way of encouraging employers to return their employees to work rather than as a full-fledged vocational scheme. In that vein, the statute states: "The purpose and intent of this [Rehabilitation] section is to place an emphasis on returning the injured worker to work, while still allowing and providing for vocational rehabilitation programs when determined appropriate by the commission."

Connecticut:

Vocational rehabilitation in Connecticut is managed through the Connecticut Workers Rehabilitation Services (WRS), a separate entity outside the framework of the standard workers' compensation system. Services are offered when an employer cannot accommodate an injured worker through either a light duty or permanent placement program.

WRS evaluates each case for services. Services may include advocacy on behalf of the injured worker for return to work their employer at time of injury, vocational evaluation, aptitude testing, vocational counseling, formal training, on-the-job training and job seeking skills/placement assistance.

Florida:

Florida Statute Section 440.491 and Florida Administrative Code 69L-22 address reemployment/rehabilitation of injured workers. The Administrative Code states, "a vocational assessment shall determine the relevance and weight of the following factors in the case:

- the permanent physical restrictions, if any, present in the case
- the availability of employment with the employer at the time of the injury
- the injured employee's transferable skills and the labor market
- whether the injured employee conducted an unsuccessful job search, and the reasons the job search was unsuccessful
- the injured employee's education and academic skills and vocational education
- the injured employee's motivation
- the injured employee's financial ability to complete a training and education program
- the availability of transportation to allow the injured employee to complete a training and education program."

Further, "the vocational assessment shall determine whether the injured employee is ineligible to receive reemployment services, or is eligible to receive reemployment services. If the injured employee is eligible to receive reemployment services, the vocational assessment shall determine which of the following shall be offered to the injured employee: placement, and/or on-the-job training, and/or a vocational evaluation, and/or a training and education program costing less than $2,500 and lasting twelve (12) months or less." In short, Florida uses a tiered approach to the provision of services and also has some fairly conservative controls on program duration and associated expenses for training and education programs.

Insofar as any metrics gathered, a Florida publication titled, "2013 Division of Workers' Compensation Results and Accomplishments" cites the following: "During Fiscal Year 2012-2013 the Reemployment Services Team received 280 requests for screening submitted through the Injured Worker Web Portal…and assisted 166 injured workers (98% of the injured workers eligible to receive reemployment services) to return to work."

Idaho:

The state of Idaho provides vocational rehabilitation through the state industrial commission. The services are provided at no cost to the employer or employee and anyone (employer, employee, third party administrator, etc.) can make a service request to the commission.

Idaho tiers its vocational options in a manner similar to North Dakota. The only notable difference is that Idaho limits job search to fifty miles from the injured worker's residence while North Dakota has a statewide job search option. Formal training is the next option in the tier in both states.

Maryland:

Vocational rehabilitation is mandated through the workers compensation system under Title 14, Subsection 09. Like many of the other states we sampled, Maryland requires that when vocational rehabilitation is provided that a tiered set of options is to be followed per statutory preference. Those options include:

- "Returning the disabled covered employee to the same job with the same employer
- Modifying the same job with the same employer
- Finding a new job with the same employer
- Finding a job with a new employer
- On the job training
- Formally retraining the disabled covered employee for a period of time designed to lead to suitable gainful employment
- Self-employment"

Nevada:

The state of Nevada provides vocational rehabilitation as a benefit in qualifying workers' compensation cases. Nevada sets preferential options within the statute at NRS 616C.530. Those priorities are:

- "Return the injured employee to the job the injured employee had before his or her injury
- Return the injured employee to a job with the employer the injured employee worked for before his or her accident that accommodates any limitation imposed by the injury
- Return the injured employee to employment with another employer in a job that uses the injured employee's existing skills
- Provide training for the injured employee while the injured employee is working in another vocation
- Provide formal training or education for the injured employee in another vocation"

Nevada's statute also includes certain provisions related to plan duration. For example, if an employee has transferable skills as defined by the state, they are only entitled to job search assistance for a period of six months. Training duration is also linked to the amount of the permanency award ranging from a low of nine months to a high of eighteen months.

Employees who live more than fifty miles from a Nevada border are only eligible for a lump sum vocational buyout of up to $20,000.

An employee may also accept a lump sum buyout in lieu of a training option but the minimum offer must be at least 40% of the maintenance benefit (equal to the TTD rate) for the training benefit period. For example, if an employee were to be paid $800/week in a maintenance benefit and had a training entitlement of 9 months (39 weeks), then the buyout could be no less than $12,480 (39 X $800 X .4).

Vermont:

Vermont has provisions in its workers' compensation statute requiring employers to furnish vocational rehabilitation when employees are unable to return to their usual jobs. In Vermont, a tiered or preferential approach also exists. Specifically, the order of preference is:

- Return to same employer in a modified or different job
- Return to a different employer in a modified or different job
- On-the-job training
- New skill training or retraining
- Educational/Academic program
- Self-employment

Vermont requires a mandatory referral for vocational rehabilitation assessment at 90 days of lost time for possible entitlement to vocational services.

Virginia:

While vocational rehabilitation is a feature of the workers' compensation system in Virginia, the state does not include a preference for vocational plan options in its statute.

Virginia has a cap on disability benefits of 500 weeks. Let's assume that an injured worker received 50 weeks of TTD and 25 weeks of permanent partial disability benefits, this would mean that they have a statutory benefit balance of 425 weeks.

The employer's claims administrator or carrier will retain a vocational counselor to manage the injured worker through the rehabilitation process in an effort to find employment as close to pre-injury wages as possible. Using the above example with the remaining 425 weeks, if an injured worker returns to a job at less than their pre-injury earnings then he/she is entitled to 2/3rds of the difference as a temporary partial disability (TPD) benefit. As earnings increase, the TPD rate is reduced but if the injured worker continues to be employed throughout the duration of the 425 weeks at earnings below his/her pre-injury income, TPD benefits will be paid.

Washington:

Washington includes vocational rehabilitation provisions in its workers' compensation statute and the costs are covered by Labor and Industries (the state's WC insurance monopoly) or by self-insured employers. Like most of the other states sampled, Washington has a tiered approach to services. The preferences are:

- Return to the previous job with the same employer
- Modification of the previous job with the same employer including transitional return to work
- A new job with the same employer in keeping with any limitations or restrictions
- Modification of a new job with the same employer including transitional return to work
- Modification of the previous job with a new employer
- A new job with a new employer or self-employment based upon transferable skills
- Modification of a new job with a new employer
- A new job with a new employer or self-employment involving on-the-job training
- Short term retraining and job placement

If none of the above options will work, injured workers are eligible for formal retraining programs.

Washington also includes a provision to settle the vocational benefit for an amount equal to six months of TTD benefits. This statute is referred to as Option 2 (see RWC 51.32.099 (4) (b)) which states in part: "A worker who elects option 2 benefits shall not be entitled to further temporary total, or to permanent total, disability benefits except upon a showing of a worsening in the condition or conditions accepted under the claim such that claim closure is not appropriate, in which case the option 2 selection will be rescinded and the amount paid to the worker will be assessed as an overpayment." In short, when an injured worker settles the vocational benefit the settlement comes with some contingencies.

Available Data by State and General Trends:

In checking with Sedgwick staff in the states referenced above, only Florida had any measurement data and that data was limited to referral tracking. So while we have no specific data on the success of vocational programs and how effective they may be at returning injured workers to employment, we do know that plans that achieve an earlier return to work relying to some extent on transferable skills are generally more successful. So the tiered options in North Dakota as expressed in NDCC Section 65-05.1-01 (4) and (6) represent a responsible method of managing vocational plan options. Further, this approach follows what we see in many of the other jurisdictions reviewed above. In short, we consider the tiered approach a best practice.

Common in vocational systems are such features as paying for travel expenses, books, tuition and the like when employees participate in formal training programs. Generally, formal training programs may last from 52 to 104 weeks, and they are consistently viewed as a final or very late option when it comes to plan preferences.

When employees return to work at less than their pre-injury wage, statutory language exists that creates a temporary partial disability obligation for some period of time. In our review, it appeared that of the states reviewed that Virginia's obligation was potentially of the longest duration.

Some states (including some not specifically reviewed above) allow the vocational benefit to be settled. (See Recommendation 4.3)

Metrics:

As noted in the previous section, there is little state specific information available on vocational rehabilitation performance. Further, as regards WSI's own performance metrics on vocational rehabilitation there are none included in WSI's Operating Report, published quarterly.

WSI is in the midst of developing and fully releasing a Rehab/Legal data system. This system, when fully functional, should be able to track key performance metrics related to vocational rehabilitation. Currently, that system is used to generate various vocational rehabilitation reports. Details are provided on the reports that follow so our recommendations may be better understood:

CL0956:

This report lists all claims opened over a specific period. We reviewed the report for the period 4/1/14 – 6/30/14. The report was produced on 7/1/14. It includes a cover page showing the number of cases by type opened during the period sorted by assignment type (consult, re-open, limited assignment, work search). Page 2 of the document shows how these assignments break out by vocational case manager and whether the assignments pertain to in-state or out-of-state workers. The rest of the report provides a claim-by-claim listing of these new assignments. The totals provided on the first two pages match with the individual case counts. However, the claim-by-claim portion of the report identifies all case assignments as out of state when only 65 of the 161 assignments actually are out of state so this flaw needs to be corrected. (See Recommendation 4.4)

CL0958:

This report provides a summary of the cases closed during a particular period. As with the CL0956, we have reviewed the CL0958 report for the period 4/1/14 – 6/30/14 with the report having been generated as of 7/1/14. The first page of this report sorts cases by close option. The report includes close options that on their face appear to duplicate each other. For instance, there is one close option titled "Paragraph 6" and another close option titled "Paragraph 6 – Retained Earnings Capacity." WSI uses different but similar terms to distinguish cases that were managed during the CorVel period as distinguished from those they now manage in house. The report provides a summary of plan options showing pre-injury average weekly wages and post-injury average weekly wages and we were able to validate a small sampling of those calculations. Page 2 of the report itemizes the cases by vocational case manager showing the cases closed in-state and out-of-state. The totals on the first two pages match. The balance of the report lists all cases that were closed and includes an out-of-state column that is functioning as it should. The detail portion of the report shows 41 out-of-state cases, the same as

on page 2. The CL0958 sorts the close options alphabetically rather than by plan preference. If there is a way to sort the first page of the report by preference starting with "Return to same position – same employer," we think there would be some value in that. We also think this report could include on page 1 an additional column that shows the percentage that the post-average weekly wage is of the pre-injury weekly wage. In the plan results we reviewed on this report, local labor market and return to same position – same employer produced the most favorable post-injury earnings.

CL0959:

This report is a secondary summary of other vocational cases that closed during the period. The difference in this report as compared to the CL0958 is that this report looks at close options that don't pertain to the standard vocational plan options as spelled out in NDCC Section 65-05.1-01 (4) and (6). This report includes such cases as those where an injured worker has died, where there is non-compliance, and many other case types. Page 2 of this report sorts the closings by vocational case manager and shows in-state and out-of-state counts. The subsequent pages of the report list the claims that were closed and correctly show out-of-state designation. Taken as a package, the CL0956, CL0958 and CL0959 show new referrals and closings for a period. Ideally, we hope to see more cases close in a period than open. In the reports we reviewed for the period from 4/1/14 – 6/30/14, new case assignments totaled 161 while case closures amounted to 185 so that objective was met.

CL0954:

This report provides a status at a glance of open rehab cases by consultant. The Return-to-Work Services Director can use this report to monitor caseloads, which is essential to know when determining to whom to assign new referrals. For most of the case managers, open caseloads range from about the mid-thirties to the mid-forties.

CL2100 and CL2101:

These reports are works in progress that are designed to provide metrics by case manager on the timing of certain task completions (i.e., the initial rehabilitation consult and the vocational case manager's report). The samples we reviewed of these reports include some case manager names that should be excluded and in the case of the CL2101 are lacking data. The objective of the CL2101 is to show details pertaining to plan option types and we think this will be a good report once the underlying data is correctly populated on the report. Certain options types also need to be re-labeled. For instance, there are options currently showing as K and M and when considering option types available in the statute, having choices through from Option A - Option H should suffice. (See Recommendation 4.4)

Surveys:

On behalf of WSI, Issues and Answers Global Marketing Research conducts quarterly surveys of injured workers. We reviewed the survey results from November 2013, which also included aggregated information from the prior fourteen quarterly surveys going back to February 2010.

Surveys are conducted of those injured workers whose vocational rehabilitation plans have concluded in the preceding quarter. Surveys include an executive summary, satisfaction with vocational services, skill upgrading services, work search assistance, current employment, employment information comparing pre-injury to post-injury, retraining programs, and quarterly and aggregate trends. The survey results also include comments from respondents and a copy of the survey itself.

One finding in the survey data pertains to the number of injured workers interviewed depending upon the year involved. Table 4.2 provides this summary by survey year. No survey was done in the third quarter of 2013 so in Q4 the survey was expanded to include those injured workers who would otherwise have been surveyed in Q3.

Table 4.2: Number of Injured Workers Identified for Survey and Survey Respondents by Calendar Year

Calendar Year	Injured Workers to Survey	Actual Respondents
2010	393	243
2011	251	148
2012	185	110
2013	206	118
Total	**1,035**	**619**

(See Recommendations 4.5 and 4.6)

Satisfaction ratings are captured in relevant categories on a five point scale ranging from most satisfied (5) to least satisfied (1). Summary data is captured using three categories where respondents who gave a 4 or 5 response are grouped in the Satisfied category; those who responded with a 3 rating are considered neutral; and, other respondents (1 or 2) are considered dissatisfied.

Details on File Reviews:

For each of the 75 cases reviewed, we completed a review form that we attach as Exhibit 4.1. This form was developed by reviewing NDCC Sections 65-05.1-0, Subsections 3 – 10, 65-05.1-02, 65-05.1-06.1 and 65-05.1-06.2. We summarized our findings in the file reviews earlier in this report. During the review itself, we identified a few files which we want to mention here.

- We came across a case where we believe the injured worker is entitled to a reopening of vocational services
- We came across another case where closer school monitoring potentially could have led either to a greater effort on the part of the injured worker to succeed in his classes or an earlier cessation of benefits. The injured worker “achieved” a grade point average of 0.00 during the Spring semester and benefits were suspended in September

- Most of the Orders we reviewed contained a detailed summary of the training costs associated with long-term training. In one case, the Order just mentioned that WSI would pay training costs without the details
- Any case number where the plan option is return to pre-injury job with the pre-injury employer. This option only has to do with returning an injured worker to his pre-injury job, and the only real difference between this "option" and a person who returns to their regular job in the normal course of recovery is that WSI didn't assign a vocational case manager to the claim – See Recommendation 4.8

Recommendations

Recommendation 4.1: High Priority

We recommend that WSI issue its Orders pertaining to Vocational plans in a timely manner. If the legislature believes that an Order is issued timely within 60 days of final approval of the VCR, then we suggest the statute be amended to reflect that intent.

> **WSI Response: Do Not Concur.** NDCC 65-05.1-06.1(1) provides in pertinent part "Within sixty days of receiving the final vocational report, the organization shall issue an administrative order…detailing the employee's entitlement to disability and vocational rehabilitation services." The vocational report is final when reviewed and signed off by the Director of Rehabilitation Services.
>
> Of the 6.7% of cases that extended beyond that date, a review indicates they were timely referred for orders but questions arose regarding the plans. Further review was necessitated.
>
> **Sedgwick Reply**: The statute says the Order should issue within 60 days of receipt of the vocational case manager's report. If the legislature is comfortable with WSI's interpretation of the statute, then WSI need not change their process. However, we observed that one Order issued 132 days after receipt of the report while another issued 130 days following receipt.

Recommendation 4.2: High Priority

We recommend that WSI prepare legislation governing the payment of temporary partial benefits for vocational plan participants to be amended such that the combined value of post-injury earnings and TPD may not exceed 90% of one's pre-injury earnings.

> **WSI Response: Concur.** WSI will evaluate the need for any changes in legislation necessary to implement this recommendation.

Recommendation 4.3: High Priority

Assuming that WSI and the injured worker settle a vocational rehabilitation entitlement, we recommend that the statute should be written in such a way that if an employee wishes to return to work in North Dakota in the same or similar position after acceptance of a vocational benefit settlement and they claim a worsening of their condition causing additional disability that WSI be allowed to take a credit up to the full value of the settlement against future disability benefits. Such a provision would mimic the State of Washington's Option 2 language.

> **WSI Response: Concur.** WSI will review the State of Washington's option and the need for legislation.

Recommendation 4.4: High Priority

As a preliminary statement to this recommendation, we know that WSI is in the midst of a project to create a data collection and reporting environment for rehabilitation and legal services. This environment is functioning to some extent but not yet optimally. So the recommendations here are made with the understanding that these metrics should be available as functionality exists in the environment to capture the required elements accurately. Metrics should include:

- Continue the CL0954, 0956, 0958 and 0959.
- Add a column to the CL0958 so it captures the percentage that the average post-injury average weekly wage (AWW) is of the average pre-injury AWW as this percentage will show the extent to which injured workers have on average achieved a post-injury wage that is at least equal to 90% of their pre-injury wage. (This percentage can be displayed both on the summary page – page 1 of the report and throughout the detail portion of the report on each case)
- When closing out a case, build in a data element that identifies whether the post-injury weekly wage is based on earning capacity when the injured worker has not returned to work or actual wages. (This particular data element is relevant to Recommendation 4.7 below on injured worker surveys)
- For long-term training programs that can by statute run for up to 104 weeks, have a flag to capture those programs that are extended beyond 104 weeks. Use that data to evaluate the reasons for program extensions and whether there is anything WSI and the injured worker could have done to complete the program as originally scheduled
- For cases on which an FCE occurs, track that date. Vocational services often kick into a higher gear once the FCE is completed and the treating physician has signed off on the capabilities identified through the FCE. The FCE approval date from the treating physician should be tracked and then a date set for completion of the vocational case manager's report should follow. Assuming that the injured worker is not in the middle of skills upgrading or obtaining a GED at the time the FCE is approved, we think a target date for the VCR should be 45 days unless a long-term training program is to be recommended and then we would allow 75 days.

- Track plan options by case manager so the RTW Services Director can evaluate how effectively they are pursuing the preferred plan options. For instance, if an average case manager has 60% of their cases pursuing options that are among the first four plan types, the Director can evaluate a case manager who falls well below that average. Similarly, if someone is more successful, then perhaps their approach can be evaluated so other case managers can learn from that approach. It might be useful to link this type of data collection to the residence of the injured worker to see if later plan options tend to occur more frequently among those who live in more remote areas
- Include summary data from the CL0958 in the quarterly operating report. The values to include would be the number of cases closed, the average pre-injury wage and the average post-injury wage

WSI Response: Concur. WSI currently is in the process of developing these items. It is still unknown whether any complications will arise that will prevent implementation of any single item. The work is progressing and will continue with the development team assigned to the legal/rehab system and evaluate the ability to implement these additional metrics.

WSI will strive to meet the recommendation to change the target date for the VCR from 60 days to 45 days and for retraining programs a change from 90 days to 75 days. Barriers in meeting these new deadlines are raised due to caseload increases with out-of-state claims.

Recommendation 4.5: Medium Priority

WSI should examine the reason for the decline of those in the survey pool when comparing older years to newer ones. We recommend that if the underlying pool should be roughly the same year over year that the survey pool should in future surveys include more injured workers.

WSI Response: Concur. WSI has examined the reason for the decline in the survey pool. Current surveys include only those claims where a return-to-work option was identified at the time of closure. Based on feedback from WSI's contracted survey company, WSI now eliminates claims from the survey pool that were not true closures. For example, a claim that had a change in Vocational Case Manager or there was only an employability assessment. This change has reduced those in the pool, however the remaining pool for survey now reflects true Vocational Rehabilitation Service closures.

Recommendation 4.6: Low Priority

We recommend that the survey include questions relating to the respondent's education level and whether services were provided during vocational rehabilitation to improve that. (For example, if the injured worker had a ninth grade education, was a GED program part of the vocational process)

WSI Response: Concur. WSI will work with the contractor hired to conduct the surveys to include this information.

Recommendation 4.7: High Priority

We recommend that the survey be expanded to include a sampling of injured workers a second time. This sampling would be limited to workers who were not working at the time of the initial survey and timed to occur one year after the quarter in which they were initially surveyed. The survey would be limited to whether or not they have returned to work, how long they have been working, what kind of work they are doing, whether they are working part-time or full-time, and what their current earnings are. For those who have returned to work, we recommend that injured workers be asked if they think something could have been done in their vocational rehabilitation experience that they believe could have led to an earlier return-to-work.

> **WSI Response: Concur.** WSI will work with the contractor hired to conduct the surveys to include this information.

Recommendation 4.8: Medium Priority

Rather than being required to issue a formal Order when injured workers referred for vocational services return to their regular job, we recommend that WSI issue a notice similar to what it would issue when an employee returns to his/her regular job following a period of temporary total disability. For cases of this type, we also don't see the need for WSI to compile a full vocational case manager's report.

> **WSI Response: Concur.** WSI will submit legislation for the 2015 Legislative Session.

Element Five: Evaluation of the Preferred Provider Program

Introduction

The objective of Element 5 is an evaluation of the existing WSI preferred provider program. We further understand that we will:

- Conduct a complete and thorough review of the program including the legislative history of 2013 House Bill 1051, comparing the claims results and outcomes to the intended results in the bill to determine the success of the program.
- Perform a thorough review and audit of the credentialing policies and procedures as well as the provider quality assurance program to ascertain whether the qualifications of the selected providers are appropriate for the program.
- Compare the previous claims outcomes to the current program outcomes. This will demonstrate the benefits to the employees and employers. It will also measure the overall effectiveness of the program.
- Review the administrative costs of operating the program.
- Compare the current WSI opt-out policy to other states to determine the overall effectiveness of the WSI opt-out. This would include consideration of eliminating the policy.
- Send questionnaires to and utilize on-line surveys for employers and employees to evaluate their understanding of the program.

Background

To achieve the above objectives, the following activities were undertaken:

- We reviewed all relevant Legislative History related to NDCC §65-05-28.1.
- Interviewed WSI staff to better understand the reasons behind North Dakota House Bill 1052 including the notice provision amendment to NDCC §65-05-28.1.
- Reviewed the opt-out provision of the program and compared the provision to other relevant state opt-out provisions.
- Reviewed return to work and overall claims cost of all employer's utilizing the Designated Medical Provider ("DMP") program to those not utilizing the program in order to compare outcomes.
- Interviewed Workforce Safety and Insurance staff for information on utilizing the Designated Medical Provider program as a component of the Safety Action Menu (SAM) program to identify how the SAM program educated employers on the Designated Medical Provider Program.

- Reviewed all forty claims from 2011 through 2013 where the primary reason for denial was identified as not using the Employer's Designated Medical Provider.
- Reviewed fifty claims of employers utilizing the Designated Medical Provider.
- Reviewed statutory requirements for WSI to credential Designated Medical Providers and interviewed WSI staff to identify if any provider credentialing occurs and WSI associated costs for implementing and maintaining the DMP program.
- Identified standard provider network credentialing documents and information for Workers Compensation programs.
- We prepared a written questionnaire for North Dakota employer's using the Designated Medical Provider program.
- We prepared a telephonic questionnaire for North Dakota employees of employers using the Designated Medical Provider Program.

Findings

Program Review of Claims and Outcomes:

North Dakota House Bill 1051 specifically states:

> During the 2013-14 interim, the workers' compensation review committee shall study the workforce safety and insurance preferred provider program created under NDCC sections 65-05-28.1 and 65-05-28.2. The committee may conduct this study by including the study as one of the elements to be evaluated in the Workforce Safety and Insurance independent performance evaluation conducted under NDCC section 65-02-30. The study should include consideration of the legislative history and intent of creation of the program; whether the program has been successful in furthering the intent of the program; the qualifications of the preferred providers and preferred provider networks selected by employers under the program; whether employers and employees have benefited under the program and whether there are *any* associated costs to the program; the process workforce safety and insurance utilizes in considering whether to allow an employee to opt-out of the program; and whether employers and employees participating in the program are familiar with the terms of the program. The committee shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the legislative management.

In order to determine the legislative intent for the program, the legislative history of the initial house bill (1995 House Industry, Business and Labor HB1221), the house bill identifying the study of the Designated Medical Provider program as component of the performance evaluation (2013 House Industry, Business and Labor HB1051) and the house bill modifying the notice provision (2013 House Industry, Business and Labor HB1052) were reviewed.

Testimony provided under HB 1221, identifies the program as a means for cost containment by limiting who may provide treatment of the injured worker. Essentially, the testimony identifies the program's main function as providing control of the decision of treating providers in the hands of the employer.

According to testimony, by allowing the employer the control of the choice of providers the program will help to ensure quality and consistent care for the injured workers.

During the testimony of HB 1551, the benefit of the DMP program was presented more as the relationship between the physician, employer, and the injured worker. Through knowing an employer's industry and through past experience with an employer's injured workers, the designated medical provider (DMP) should know the type of work available, the ability to come back to alternate duties, whether the injured worker can return to work and in what capacity. According to the testimony presented, the intent of the DMP program is the building of a close relationship between the treating provider and the employer providing an overall better result for the injured worker.

Finally, the testimony pertaining to HB 1552 reiterates the intent of the DMP program as building the relationship between the designated medical provider and the employer which, in turn, provides for a smoother transition back to work for the injured worker. And the DMP benefits by being ensured an ongoing group of patients. (See Recommendation 5.1)

HB 1552 further demonstrates a clear concern regarding the notice to employees of the employer's use of the DMP program as well as notifying the employees of their rights to elect alternative providers both prior and subsequent to injury. The entire change to the DMP program as a result of HB 1052 was to provide additional notice requirements on the part of employers. Accordingly, we looked at claims denied because the injured worker did not utilize the designated medical provider to see whether WSI looked into whether the employee was aware of the program and the selected designated medical provider (s).

In summary, the intent of the program is to generate a relationship between provider and employer in order to achieve an overall better outcome for the employer's injured worker. Also there is a clear legislative concern about employees having knowledge of the DMP program and knowledge of the employer selected providers.

To be consistent with the legislative intent we compared outcomes data from employers that utilized the Designated Medical Provider program with employers that did not utilize the program. The data set included a comparison of return to work and medical cost per claim. A statistically significant data set for both components was collected for the years 2011, 2012, and 2013. The averages for each year were obtained.

We determined that it would be better to compare the employers using the Designated Medical Provider with the Non-Designated Medical Provider employers over the same period of time as opposed to comparing outcomes to previous years. Medical costs fluctuate year to year. Tables 5.1 and 5.2 display outcomes comparisons for medical costs and return to work.

Table 5.1: Medical Cost per Claim Comparison

Category	CY 2011	CY 2012	CY 2013
Number of DMP Claims	476	678	1054
Number of Non-DMP Claims	22,128	24,675	25,146
Avg. Medical Cost per DMP Claim	$2,148	$2,506	$2,680
Avg. Medical Cost per Claim Non-DMP	$2,865	$2,539	$2,767
Average Difference Per Claim	$427	$33	$88
Percent Decrease in DMP Medical Claims	14.9%	1.29%	3.16%

Table 5.2: Return to Work Comparison

Category	CY 2011	CY 2012	CY 2013
Number of DMP Claims	695	641	777
Number of Non-DMP Claims	1012	1142	1182
Avg. Number of Days DMP Claims	105	99	81
Avg. Number of Days Non-DMP Claims	96	94	80
Average Difference Per Claim	-9 days	-5 days	-1day

The outcomes data demonstrate little difference between using the Designated Medical Provider program and not using the program. In Table 5.1, we see that medical cost per claim savings was more than nominally different only in 2011. And in Table 5.2 we see that the number of days for return to work was actually slightly better for the non-DMP employers. The data suggests that the outcomes of the claims are not materially impacted by the Designated Medical Provider program.

It should be noted that severe injury claims can skew results. But based on the fact that the data covers three years, the averages are relatively consistent throughout the years, and the number of claims is statistically significant, the outcomes data is sound. And we conclude there is little difference in the outcome data between those employers using the DMP program and those who are not.

Notice

As previously indicated, North Dakota House Bill 1552 provided for a more stringent notice requirement for the Designated Medical Provider Program. With that legislative intent in mind we took a look at 2011, 2012, and 2013 claims that were denied wherein the primary reason for the denial was not using the designated medical provider. The review was two -fold: to see whether the injured worker went to the DMP and whether there was any documentation that the injured worker had notice as to the designated medical provider.

We reviewed all the claims that identified the denial was based primarily on not using the designated medical provider. This amounted to 14 claims in 2011, 15 claims in 2012, and 11 claims in 2013. All the claims were reviewed to identify the actual treating physician and the designated medical provider. The

results were as expected – the injured worker treated with a provider other than the designated medical provider(s).

The more interesting evaluation was the documentation of notice being provided to the worker. WSI, for the most part, made certain that the injured worker was aware of the DMP program and the identity of the designated medical provider. Below are some examples of WSI validating employee notice of the program and the designated provider.

One claim was denied for three reasons: failure to prove compensable damages, pre-existing conditions, and not using the designated medical provider. The employer initially indicated that the company had an employee executed Designated Medical Provider form. WSI requested a copy of the form and the employer was unable to produce it. Accordingly, WSI denied the claim for the other two reasons.

Another case was denied specifically because the injured worker did not go to the designated medical provider. WSI requested and received the Designated Medical Provider form signed by the Injured Worker. It is interesting to note that the injured worker complained that the designated medical provider was too far and that she had no means of transportation to get her there.

One of the reasons this claim was significant is that it brings up an interesting point. Most certified networks and managed care organization networks have provider geographical requirements that preclude enforcing the denial of a claim if there is insufficient coverage within a certain distance from an injured worker's residence. There are no such geographical requirements in the DMP program.

Another claim was denied for not going to the designated medical provider. WSI requested and received the employee signed DMP form. The interesting component of this claim was that on the form, the injured worker had opted to ***add*** an additional provider. However, the injured worker elected to go to another alternative provider. Consequently, the claim was denied.

A case was denied for several reasons including the injured worker did not seek treatment from the designated medical provider. The employer notified WSI that the injured worker did not treat with the DMP and that the worker did not opt-out. WSI did not make the request for the DMP form. However, there were other issues with the claim that could cause the denial.

Another claim was denied for not going to the designated medical provider. The injured worker was contacted and asked if the worker was aware that his employer had a designated medical provider. The worker acknowledged that he was aware but thought that he could treat with an alternative provider. The employer sent over the signed DMP form and the claim was denied.

One other case example is one of a DMP denial due to the execution of a DMP form by the injured worker. WSI asked if the employer wanted to deny the claim based on the fact that they did not seek treatment from the DMP. The employer sent the signed DMP form and the claim was denied.

Commentary on Auto-Adjudicated Claims:

Auto-adjudication is the process of managing a claim through standard case criteria without requiring the services of an adjuster. Claims managed in this fashion require fewer resources than standard medical only claims. Roughly 25% of WSI claims are auto-adjudicated. We identified a potential issue with the DMP program as it applies to auto-adjudicated claims. Whether an injured worker goes to an employer's designated medical provider is not considered in an auto-adjudicated claim. As such, the claim is not denied if an injured worker does not seek treatment from a designated medical provider. If an auto-adjudicated claim at some point converts to a manually adjudicated claim, WSI could deny the claim for not going to the DMP and *retroactively* seek reimbursement from the injured worker. (See Recommendation 5.2)

Credentialing:

We first interviewed WSI to determine the extent of any credentialing program.

To assist in identifying the scope of a credentialing program, below is an illustration of the credentialing program developed by a major Preferred Provider Network. The example identifies the significant documents required as well as complex verification of provider credentials and certifications.

Preferred Provider Organization Credentialing Policy & Process

1. Current State Licensure
   Document the validity of state professional licensure for all licensed practitioners. If a practitioner practices in multiple states, an active, valid license must be verified in each state
2. Board Certification
   Specialty board certification is verified if reported. If the practitioner is a non-physician, the highest certification is verified with the primary source.
3. Physician Liability Insurance (PLI)
   Verify up to date Physician Liability Insurance
4. Malpractice History, State and Federal Sanctions/Exclusions
   The National Practitioner Databank (NPDB) is the National Committee for Quality Assurance (NCQA)-accepted source to document closed cases of malpractice history as well as sanctions or disciplinary actions reported by state and federal agencies.
5. DEA Certification
   Verify active DEA license
6. Hospital Privileges
   Identify and document all hospitals where the provider has privileges
7. Monitoring State and Federal Sanctions
   Federal sanctions are verified through queries of the National Practitioner Data Bank (NPDB) and the OPM database. State sanctions are queried using the primary source verification state licensing boards.

The following lists the categories of practitioners and facilities that are credentialed:

1. Independent Practitioners -Credential all provider types required by the National Committee for Quality Assurance / Utilization Review Accreditation Commission/ Centers for Medicare and Medicaid.
2. Facilities - Facility categories require full credentialing.

Standards for facility verification include evidence of current licensure, accreditation, certification, and absence of federal sanctions through the OIG/OPM. Recognized accreditation organizations include Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Clinical Laboratory Improvement Amendments (CLIA), Commission on Accreditation of Rehabilitation Facilities, Community Health Action Partnership, (CHAP), College of American Pathologists (CAP), Commission on Office Laboratory Accreditation (COLA), and Accreditation Commission for Health Care (ACHA).

Provider Notification:

The completed file is reviewed by the Credentialing Committee. After the committee decision is complete, staff will approve the provider's application. Credentialing will then generate welcome/approval letters for each new and re-credentialed provider. Providers are to be re-credentialed every three years. Additionally, there is verification of correct addresses and acceptance of new Workers compensation patients.

North Dakota Credentialing Process

WSI does not perform any credentialing of providers in the Designated Medical Provider program. It is important to note that the *employer* chooses the Designated Medical Providers and not WSI. Considering the employer chooses the provider(s), requiring WSI to credential these providers would prove impractical, cost prohibitive, and would increase the possibility of legal liability. Additionally, because employers are free to select any provider or medical facility as a DMP, effectively, WSI would be credentialing all North Dakota providers.

However, WSI could identify active licensed North Dakota providers in order to assist employers in the selection of their designated medical providers. (See Recommendation 5.3)

Administrative Costs of Program Operations:

In reviewing the legislative history of HB 1051, the intent of this provision of Element 5 was to determine whether there were additional administrative costs associated with the operation of the Designated Medical provider program. We interviewed WSI staff and determined that costs associated with the operation of this program were nominal.

The nominal costs for the DMP program would include a portion of the costs of an administrative position in the Safety Action Menu Program (SAM), a portion of the SAM employer educational process and corresponding copying and paper costs. The SAM program includes the employer education on the Designated Medical Provider program as portion of one of the eight programs it educates employers on as part of the entire Safety Program.

The costs associated with the DMP program would also include a portion of the claims adjusters' administration of claims. But considering that the proportion of employers using the DMP program represents less than 6 percent of the total employer population (1280 out of over 22,000) determining the costs would be too speculative but would clearly be nominal.

Opting Out:

We reviewed the opt-out requirement under NDCC Sections 65-05-28.1 and 65-05-28.2 with other state programs, state certified networks, and state operated managed care organizations (MCOs).

The current North Dakota designated provider legislation permits the worker two opportunities to opt-out of the Designated Medical Provider Program. Under NDCC section 65-05-28.2 (2), an employee of an employer that has elected to use the DMP may choose to be treated by a non-designated provider provided the employee makes the election and notifies the employer in writing prior to the occurrence of an injury. Under NDCC section 65-05-28.2 (3), an injured worker may elect to change to a non-designated provider thirty days following the injury. The provision requires the written notice to be delivered to the employer at least thirty days prior to the change in providers. Effectively, this provision allows a change from a DMP sixty days from the initial injury.

NDCC Section 65-05-28.2(4) allows a procedure for the employer to object to the employee's election. To summarize, the employer must give a detailed description and grounds for the objection. The employer has five days to provide the objection to the employee and WSI. The employee has five days to respond in writing to the objections; providing a copy to the employer and WSI. WSI has fifteen days to rule on the objection. A lack of response by WSI constitutes an approval of the objection. The injured worker is obligated to continue treating with the Designated Medical Provider until WSI rules on the objection. It is important to note that during our interviews with WSI staff no one recalls ever receiving an objection by an employer.

A more detailed analysis of the opt-out provisions is provided in order to better identify the strengths and weakness of this provision for the Designated Medical Provider Program. As illustrated below, the opt-out requirements vary substantially in complexity, procedure, and limitations on choices. It should be noted that all of these programs provide exceptions to the use of in-network providers for emergency treatment of the injured worker. Additionally, most of these programs also have geographical requirements that mandate sufficient in-network provider access in close proximity to the injured worker's home. Table 5.3, which appears toward the end of the Other States section, provides the summary of the employee opt-out provision of the comparable MCOs and certified networks.

Other States:

Illinois Preferred Provider Program (PPP)

The least restrictive employee opt- out provision is contained in the Illinois Preferred Provider Program. Under the Illinois PPP statute, any time after the work related injury, the injured worker can opt-out. The only requirement of the worker is to provide to their employer in writing that they are electing to opt-out of the Illinois PPP. At that point, they can choose any out of network provider. Moreover, the

employer is obligated to inform the employee of this right at the time of injury. Electing to opt –out of the Illinois PPP does constitute a "choice" of medical providers. And under the statute the injured worker is limited to two provider choices per injury.

Of the major state Managed Care Organizations programs, the Illinois PPP provides the greatest opportunity and easiest procedure for the employee to opt-out of the provider network. And the PPP represents a substantially more employee friendly opt-out provision than the DMP.

California Medical Provider Network

The California Medical Provider Network (MPN) opt-out provision limits the provider choices and the timeframe for an election of a provider outside the MPN. The election of the provider must occur ***prior*** to injury and the employee must choose their regular treating physician. Additionally, the election must be in writing. And the employee is limited to their regular treating physician if the employee has non-occupational group health insurance. The regular treating physician must also agree to the pre-designation.

Under the California MPN, in order to be considered as a qualified regular treating physician, the provider must be licensed and must have previously directed the employee's medical care. The provider must retain medical records of the employee- including their medical history. The treating physician has to provide comprehensive medical care predominantly for non-occupational injuries or illness. Finally, the primary treating physician can be a medical group as long as the medical group is either a single corporation or partnership comprising only physicians.

The limitations and requirements necessary for an employee to elect an out of network provider under the California MPN regulations make it a rarely utilized option. As such, the California MPN is, in effect, a no opt-out program.

New York Certified Direction of Care Program (DOC)

The New York DOC requires the injured worker to use an in network provider during the first thirty days after the work related injury. The opt-out provision for the New York DOC arises after the first thirty days of treatment. The injured worker election to opt-out must be in writing and provide a specific reason for electing to seek an out of network provider. Based on the employee's reason, the employer has the right to seek a second opinion from an in-network provider. A copy of all employee executed opt- out forms are required to be submitted to the New York Department of Workers Compensation.

The New York DOC opt-out provision is similar to provision 65-05-28.3 of the North Dakota Designated Medical Provider program. 65-05-28-3 is the opt-out provision that permits the injured worker to choose an alternative provider thirty days after the injury occurs. However, unlike the New York DOC, the Designated Medical Provide program requires an additional waiting period so that effectively the transition occurs sixty days after the injury occurs.

Arizona Self-insured Employer Direction of Care

The Arizona self-insured direction of care program allows the employer to direct care to specifically identified providers. Under the Arizona program, a self-insured employer has the opportunity to provide a program plan to the Arizona Industrial Commission that lists the providers that the employer

will direct injured workers to for work related injuries. The plan includes the effective date of the plan, a description of how the plan will operate, a description of how the employer will provide notice to the workers as well as a list of the providers with the addresses and phone numbers. The Arizona Industrial Commission must approve the plan prior to the implementation.

Like the Designated Medical Provider program, the employer chooses the providers that the employees are required to see for work related injuries. And also like the DMP program the Arizona DOC Network does not list minimal provider number geographical standards. But unlike the DMP program the Arizona program does not provide any employee opt-out provision. Additionally, contrary to the DMP program there is a government agency approval process associated with the Arizona program.

Kentucky Managed Health Care Program

The Kentucky Managed Health Care Program (MHCP) requires the injured worker to seek treatment from an in-network provider. The initial treating provider also known as the gatekeeper is limited to one of the following disciplines: physician, surgeon, psychologist, optometrist, dentist, podiatrist, osteopathic or chiropractic practitioner. The only opportunity for an injured worker to obtain treatment outside the KY MHCP network is by a referral from the gatekeeper provider to an out of network provider. The Kentucky MHCP does not have an employee opt-out procedure.

Texas Health Care Network

The Texas Certified Heath Care Network (HCN) does not contain a provision permitting an injured worker from opting-out of the Certified Health Care Network. Although every state operated MCO has employee notice provisions, no plan has clearer or more specific notice requirements as the Texas HCN. And if it can be shown that the employer did not abide by the provisions, out of network provider services are covered. There are employee notice provisions at the time of implementation, at the time of new hire and at the time of injury. Additionally, notices are required to be prominently posted in the same facility place as the OSHA and other federal postings are located.

Connecticut Medical Care Program

The Connecticut Medical Care Program (MCP) does not contain any provision that would permit an injured worker from opting –out of the state certified network. There are, however several situations where an injured worker is permitted treatment out of network. If the required specialty is not available as part of the network, then the injured worker can receive treatment out of network so long as the treatment is pre-approved. And as with the other MCOs, an injured worker can seek treatment outside the certified network if it is an emergency situation.

West Virginia Managed Health Care Plan

The West Virginia Managed Health Care Plan (MHCP) does not contain a provision to allow employees to opt-out of the network. There are limited situations where an injured employee can seek out of network treatment. Specifically, the MHCP allows out of network treatment for acute emergency care, for authorized treatment when the treatment is unavailable in the MHCP, in order to obtain a second opinion when an MHCP physician recommends surgery and another qualified physician within the plan is not available for consultation.

South Dakota Case Management Program

The South Dakota Case Management Program does not have an employee opt-out provision. As with most other MCOs that do not have the opt –out opportunity, the CMP has exceptions that permit limited out of network provider services to be covered. The CMP allows for out of network emergency care treatment, pre-approved services where the specialty is not contained in the network and pre-approved services when there are insufficient network provider coverage choices in a geographical area. Additionally the South Dakota CMP permits the injured worker to choose any provider they want for the first visit. After the first visit, the injured worker must choose an in-network provider.

Table 5.3: State Certified Network and Managed Care Organization Opt-Out Comparison

State	Statutory Reference	State MCO	Opt-out Provision
Arizona	ARS Section 23-1070	Self-Insured Employer Direction of Care	No opt-out
California	CA Labor Code § 4600(d).	Medical Provider Network (MPN)	Prior Written Notice primary provider only
Connecticut	CGS 31-279-10	Medical Care Program (MCP)	No opt-out
Illinois	820 ILCS 305/8.1a	Preferred Provider Program (PPP)	Opt out at any time written notice
Kentucky	803 KAR 25:110	Managed Health Care Plan (MHCP)	No opt-out
New York	N.Y. WKC. LAW § 354	Certified Direction of Care	Opt out after 30 days by written notice
Texas	TEX IN. CODE ANN. § 1305.005	Health Care Network (HCN)	If Statutory Notice provided - No opt-out
South Dakota	SD 47:03:04:05	Case Management Program (CMP)	Any qualified provider First visit Must be in Network Provider after the first visit
West Virginia	W. Va. Code § 23-4-3 (b)(2)	Managed Health Care Plan (MHCP)	No opt-out

To eliminate the DMP employee opt-out provisions would be unnecessary and inconsistent with the purpose of program. As previously indicated, the purpose of the DMP program is to develop a relationship between employer and provider in order to produce a better outcome for the injured worker. If the employee has established a previous relationship with a provider, this, in turn, could also produce a better overall outcome. Moreover, if an injured worker has been treating with the DMP for thirty days and believes there is a better provider option, to preclude them from the opportunity of going to an alternative provider will not generate a better outcome. The better alternative is to simplify and clarify the employee opt-out provision. (See Recommendation 5.4 and 5.5)

Questionnaires:

Employer Survey:

We sent out by mail one hundred and fifty questionnaires to randomly selected North Dakota employers using the Designated Medical Provider program. The objective of the questionnaire was to determine the employers use and knowledge of the DMP program. The questions submitted to the employers fall

into four basic categories: The relationship between the employer and the Designated Medical Provider (Question 1); Information and Notice about the DMP provided to employees prior to an injury (Questions 2, 3, 6, and 7); Information and direction of care to the designated medical provider at the time of Injury (Questions 4 and 5); and general comments about the program (Questions 8 and 9). Additionally, the questions determine what components of the DMP program are documented by the employer. The Information letter and questionnaire provided to the employers are attached as Exhibits 5.1 and 5.2.

Of the one hundred and fifty questionnaires sent twenty-eight were retuned. The breakdown of the result of questions 1 through 7 is provided in below. Because questions 8 and 9 are related to comments and improvements to the DMP program those answers are provided separately.

Question 1

Have you notified your Designated Medical Provider(s) (DMP) that they are the designated provider(s) for your Company's injured workers?

No	8
Unknown	1
Yes	18
Unanswered	1

If yes, how was the Designated Medical Provider notified

Written	10
Verbal	6
Written and Verbal	2

Have you documented in writing the arrangement with your DMP Provider(s)?

Yes	13
No	5

Question 2

How do you provide information about the Designated Medical Provider to your current employees?

Employer didn't notify	7
Unknown	2
Employer Notifies	19

If the employer notifies, how are the employees notified

At Meeting	4
Time of Hire	9
Written*	10

* Written requirement can occur at the time of hire or at a meeting

Six employers responded in writing and did not disclose when the employee was notified.

Question 3

Do you document in writing that the employee understands the DMP program?

Unanswered	4
No	8
Yes	16

Was the Document signed by employee ?

Yes	14

Question 4

How do you notify your employee at the time of injury of your company's designated medical provider?

Do not Notify	8
Unanswered	4
Yes	16

If notified, was it in writing?

Verbally	15
In Writing	0
Unanswered	1

Question 5

How do you direct the injured workers to the designated medical providers for non-emergency treatment?

Do not direct	8
Unanswered	1
Direct to DMP	19

If you directed the injured worker, how was the injured worker directed

Verbal	12
Transport Worker	4
Verbal and Transport	3

Question 6

Do you inform your employees of the opportunity to request in writing additional (Non – DMP) Providers prior to the time of injury?

No	9
Unanswered	1
Yes	18

If yes, when did you notify the employee?

At the Time of Hire	9

At internal Meeting	4
Unanswered	5

Question 7

Do you post information about the Designated Medical Provider program at your worksite(s)

No	5
Yes	19
Unanswered	4

There are a number of comments both favorable and critical of the DMP program provided to question eight of the Employer Questionnaire. The most relevant comments are provided below.

Favorable

"I think it is an amazing program that helps us manage the care of our injured employees. Our DMP is aware of work we perform and restrictions we can accommodate – to help with lost work time and to get everyone back sooner."

"Easy to work with – creates a great working relationship with doctors. I believe provides better service to employees and gets them back to work."

"Good program – promotes better communication between employee, employer and DMP."

"Helps maintain injury information and paperwork. Easy for employees to follow company policies – better relationship with medical staff."

"I think it's a good idea to streamline appointments and makes it easier to have one place to communicate with."

"Good to work with providers that understand out business and what is expected of our employees."

The comments provided as well as the affirmative answers in questions 1 through 7 are commensurate with the legislative intent of building of a close relationship between the treating provider and the employer providing an overall better result for the injured worker.

Critical

"Not much value for a small county –it's a lot of paperwork for the outcome."

"We did not know about this program so I would say someone has not communicated this to us."

> "I like the program but do not like that claims will be denied if the DMP is not used and employee did not inform me ahead of time. I question thought clarity of injured workers. Denied claim is too harsh."
>
> "We don't like it. Clinics are truly not going to participate unless there is money involved. If we paid them sure, but we really don't see our value in doing it."

The critical comments as well as the negative responses to questions demonstrate that some employers have misconception of the requirements of the program or are unaware that they are signed up for the program.

Question nine of the Employer Questionnaire asks if there are any comments about improving the program. Below are the relevant comments provided by employers.

> "[The program would be improved by] not having an opt out program"
>
> "I would like to see the program still effective if the employer has documented that the DMP information and acknowledgement forms have been sent, even if the employee is not sending back his acknowledgement form. I don't think it's fair if the employer does their part and the employee chooses not to do their part (especially if they get injured and decide s to see their own doctor even after they did not elect one prior to injury)."
>
> "If WSI wants to push this they need to do a better job of selling the value. This DMP safety component may need to be revamped. It is dated and has not been updated in quite some time."

(See Recommendation 5.6)

Employee Survey:

The focus of the employee survey was to identify their general knowledge of their employer's workers compensation program, their knowledge that their employer's program directing them to specific providers, and how that information was provided to them by the employer. The key information obtained would be their general knowledge of the DMP program, their knowledge of the opportunity to opt-out, and how notice of the DMP program was provided by their employer.

We contacted telephonically employees of companies that use the Designated Medical Provider program. The contacted employees were randomly selected and had a worker compensation claim in the past. The reason for contacting telephonically was to help ensure sufficient number of employee contact to achieve relevant information. Employees move and therefore addresses could not be trusted.

The number of questions was kept to three in an effort to maintain the employee on the phone. Additionally, the questions were placed from the most general to specific. This was done in an effort to keep the conversation brief. If the employee answered "no" to the initial question, the number of follow-up questions was greatly reduced. The information was kept much more general than the employer survey. While an employer would know a great deal about the Designated Medical Provider

program – the identification of a program that limited the provider choices would be a clear indication that the employee was aware of the program. A copy of the survey is attached as Exhibit 5.3

The total number of calls placed exceeded 1250 calls. As expected, a substantial majority of these calls went unanswered. The number of actual telephonic contacts with employees was one hundred and thirty-five. And of the employees that answered the phone, ninety-one declined taking the survey. Below are the results of the employee telephonic survey.

Question 1

Do you recall if your Company has anything posted where you work about their Workers compensation program?

No	18
Yes	26

If yes; do you recall if the notice discussed which doctors or medical facilities you should go to if you are injured on the job?

Uncertain	1
No	4
Yes	21

Question 2

Since you were hired, do you recall if your employer has discussed or provided information about your company's Workers Compensation program?

No	12
Yes	20
Unanswered	12

If yes; do you remember if the Employer informed you about which doctors or medical facilities you should go to?

No	2
Yes	18*

If yes, was the information in writing

In Writing	9

*Two employees that indicated that they were not informed about the employer's workers compensation program since being hired –indicated that they were informed about the direction of care.

Do you remember if you were allowed to add doctors to the list?

Yes	11
No	8
Uncertain	1

Question 3

If you are injured on the job and it's not an emergency have you been told who to contact in the company?

No	0
Yes	24
Unanswered	20

If yes, who were you to contact?

Supervisor	10
Employer Nurse	2*
Human Resource	4

Management	6
Safety Officer	3**

*One answered Employer Nurse and Management
**One answered Management or Safety Officer

The results indicate that the employees are provided inconsistent information on the designated providers and their rights within the program. The answers reflect that the employee knows what to do and who to report to if they are injured on the job. However, the responses are inconsistent as to the direction of care and any notice being provided about the Designated Medical Provider program.

Recommendations:

Recommendation 5.1: High Priority

We recommend that WSI develop a Designated Medical Provider Acknowledgement form to be submitted to the provider by the employer.

- The legislative intent identified the purpose of the Designated Medical Provider program to be the development of a relationship between the employer and the provider in order to improve the quality of care provided to the injured workers. By providing the acknowledgement form to the provider, WSI is ensured that there is an established communication between the employer and provider and that the provider wants to have the injured workers directed to their care.
- The Acknowledgement should provide the requirements of the program and the expectation of the designated provider.
- The form should require signature by the provider indicating an understanding of the program as well as a willingness to be the designated provider.
- The Acknowledgement form should be maintained at the Employers office or facility and be available to WSI upon request.

If the employer elects to change the Designated Medical Provider, a notice of the termination should be submitted to the current designate provider and the DMP acknowledgement form should be submitted to the new designated provider.

> **WSI Response: Partially Concur.** WSI has developed a template form as described, but only requires usage within our Return to Work DMP Safety Program.
>
> WSI will ask for these documents to be returned during the final audit process for the safety credit application.
>
> Usage of this form is driven by participation and employers seeking safety credits from WSI. The suggested changes will significantly narrow participation to employers with resources large enough to complete the contemplated steps. Basically the DMP will become more narrowly tailored to those larger employers in the state.
>
> Philosophically, WSI does not concur with the increased requirements and a narrowing of the potential participants. Requiring this additional step will significantly increase the administrative burden in program administration.
>
> **Sedgwick Reply:** The legislative intent of the DMP program is to develop a relationship between the employer and the provider in order to improve the quality of care provided to the injured workers. Limiting the acknowledgment form to the Return to Work DMP Safety Program is inconsistent with this legislative intent. The acknowledgement helps to ensure that the provider is aware of the program, is educated about the program, and accepts being a part of the DMP program.

Recommendation 5.2: High Priority

We recommend that WSI establish a formal policy not to retroactively seek reimbursement from the injured worker on auto-adjudicated claims when the claim is ultimately denied due to the injured worker not going to the employer's designated medical provider. The auto-adjudication process does not contemplate the DMP program and does not identify whether an injured worker went to the designated medical provider. To retroactively seek payment because the claim becomes manually reviewed due to additional bills at a later date and denied due to the injured worker selecting a non-designated provider is not only unjust but would lead to litigation.

> **WSI Response: Do Not Concur.** Within the auto-adjudication process there are numerous "edits" in existence that allow certain medical only, low dollar (under $1,500 total) medical payments to be released automatically. Numerous other edits exist as well. If for some reason the claim comes out of auto-adjudication and the adjuster notices an error, WSI will correct that error. If that means the reversal of a payment, that will occur. It is WSI's position that correcting errors should never be classified as "unjust." Such categorization does not consider the employers being charged with a claim cost in error.

Recommendation 5.3: Low Priority

We recommend that WSI post on their website providers that have their license suspended or revoked.

- WSI is not and should not be required to credential DMP program providers. The employer selects the program provider and not WSI.
- To require WSI to credential all DMP providers would be cost prohibitive, unduly burdensome, and unnecessary.
- In lieu of credentialing all DMP program providers, WSI should identify providers with suspended or revoked licenses.
- The information could be obtained by the North Dakota Board of Medical Examiners.
- This would provide employers easy quality assurance check by providing access to information verifying the license of their selected DMP.

> **WSI Response: Partially Concur.** WSI staff should not be responsible for the risks of updating a state board's statistics and information. WSI will integrate on our website a hyperlink to the North Dakota Board of Medical Examiners website which includes a "verify license status" feature.

Recommendation 5.4: High Priority

We recommend that WSI develop a formal policy permitting an injured worker to opt-out if their residence is more than a specified distance from the employer's designated medical provider.

- The legislature will need to establish a fair and reasonable distance from the injured workers residence to the DMP office.

- Most state certified networks and state operated managed care organizations have legislation requiring sufficient provider coverage within a certain geographical distance from the injured worker's residence.
- Developing a formal policy clearly defining the distance from the injured worker's residence can be from the designated provider's office will provide uniformity in adjudicating the DMP claims.
- To require an injured worker to travel in excess of thirty miles to obtain treatment unduly burdensome and cost prohibitive for the employee.

  WSI Response: Do Not Concur. The current system allows for any employee to elect treatment other than the DMP prior to injury.

  Treatment that requires an injured employee to travel more than 50 miles one way or more than 200 miles in a month is currently reimbursable. This coupled with the ever changing dispersal of not only providers but employees would create a significant administrative burden with no perceived corresponding increase in value.

  Sedgwick Reply: Many of the employers that use the DMP program have workers who reside out of state. To require these employees to use an in-state Designated Medical Provider as opposed to a provider in their home state is a major inconvenience and would be cost prohibitive for WSI and the injured worker.

Recommendation 5.5: Medium Priority

We recommend WSI simplifies and expedites the Designated Medical Provider thirty day opt-out provisions.

- The thirty day opt-out requirement actually takes sixty days from the date of first treatment to take effect.
- Our findings indicated that the employer objection provision of the DMP program is rarely if ever employed.
- A simple notification in writing by the employee provided to the employer any time after thirty days of treatment would simplify and expedite the process –creating a true opt-out opportunity to the injured worker.
- At the same time the injured worker provides the notice to the employer, the notification could be provided to WSI.

  WSI Response: Do Not Concur. Once an injured employee enters care, irrespective of a DMP selection, transfers can only occur with the organization's concurrence. NDCC 65-05-28(1). Once under care, continuity is essential, and as a result WSI is ultimately the regulator of that process. Introducing employer and employee choice will complicate this process.

Recommendation 5.6: High Priority

We recommend that WSI contact all employers using the Designated Medical Provider program and receive an acknowledgement in writing that they are aware of the fact that they are in the program and want to remain in the program

- The Employer Questionnaire identified a significant number of employers that were unaware of the program.
- The Employer Questionnaire indicated that a significant number of employers were unaware of the requirements of the Designated Medical Provider Program.
- WSI should create an employer written acknowledgement form that provides the purpose of the program, the requirements of the program, and the employer's consent to continue the program. This will ensure that employer's using the program understand the program.
- By obtaining an affirmative written acknowledgement from the employers using the program, WSI will confirm that the employers are aware of the program, its requirements and its purpose.
- By obtaining a negative acknowledgement form, WSI will eliminate the employers who have signed up for the program and no longer want the DMP program.

WSI Response: Concur. WSI will develop a questionnaire and engage services to contact those known DMP participants within our system. Update will include information regarding the purpose of the program, requirements and consent to continue participation.

Element Six: Evaluation of Narcotic Utilization

Introduction

For this Element, the State of North Dakota is interested in:

- A review of WSI policies and procedures relating to the use of narcotics
- An evaluation of North Dakota's narcotic utilization trends with a comparison to at least five comparable workers compensation systems (when adjusted for North Dakota's labor force and age of the claims)
- An evaluation and comparison of utilization trends among localities and medical specialties within North Dakota
- An analysis of potential causes for variations with at least five other comparable workers compensation systems as well as within the localities and medical specialties within North Dakota

In the context of this Element, we also need to address how WSI has implemented recommendations 6.1 – 6.6 and 6.9 of the 2010 Performance Evaluation. An evaluation of narcotic utilization was also part of that evaluation and these prior recommendations tie in and in some cases overlap with areas of interest in this Performance Evaluation.

Background

To achieve the above objectives, the following activities were undertaken:

- We reviewed relevant data at WSI that exists on prescription drug use including reports from US Script (WSI's former Pharmacy Benefits Manager) and PMSI (WSI's current Pharmacy Benefits Manager)
- We compared this information to what we observed in other states. Data was obtained on other states from PMSI, which is also Sedgwick's Pharmacy Benefits Manager
- We interviewed WSI's Pharmacy Director for information regarding North Dakota pharmacy utilization, policies and procedures, and matters relating to narcotic use and management in other jurisdictions
- We reviewed various documents from other states addressing narcotic use and its management as well as other publications on narcotic use in workers compensation
- We reviewed HB 1054 which passed the House but not the Senate during the 2011 legislative session. We also reviewed the minutes from the Workers Compensation Review Committee dated 9/15/10 to understand the context for HB 1054 as well as other pharmacy related bill drafts (HB 1052 and HB 1053)
- We reviewed and evaluated documentation available through WSI's Internal Audit Department pertaining to the implementation of prior recommendations

- We reviewed pharmacy management standards or guidelines from other jurisdictions
- We reviewed a 2014 study from the Workers Compensation Research Institute that forecasts the impact of other states using the closed formulary approach adopted by the State of Texas

As a starting point for this Element, we sought to evaluate narcotic utilization in a manner that mimics the approach we took in the 2010 Performance Evaluation. A series of tables with explanations follows that accomplishes that objective.

We also should point out that WSI changed its pharmacy benefits manager effective 11/1/13. By way of background, a pharmacy benefits manager is typically a third party administrator that works with its customer to process drug payments, to contract and discount with pharmacies and to maintain a formulary (i.e., medications that are permitted without authorization, medications that require pre-approval and medications that are not authorized) To the extent we may summarize data for 2013 relying only on information through the first ten months of 2013, we identify those circumstances.

Findings

To evaluate North Dakota against at least five other jurisdictions, we elected to select states that are either reasonably close to North Dakota geographically or where monopolistic workers compensation systems are in place. To that end, the tables below show narcotic utilization trends for calendar years 2010 – 2013 in Colorado, Minnesota, Montana, South Dakota, Washington and Wyoming. Table 6.1 displays the narcotic-related transactions processed by North Dakota's current pharmacy benefits manager (PMSI) against all pharmacy transactions processed in the respective states. Table 6.2 displays the narcotic-related costs processed by PMSI against all pharmacy costs in the respective states. Table 6.1 and 6.2 also include North Dakota narcotic pharmacy trends and those values, provided by WSI, are in bold for ease of comparison.

Table 6.1: Pharmacy Transaction Trends (Narcotics as a Percentage of All) for 2010 – 2013

State/Year	2010	2011	2012	2013
Colorado	33.6%	33.8%	34.3%	37.2%
Minnesota	35.2%	35.2%	35.5%	33.9%
Montana	33.3%	33.3%	34.8%	33.3%
North Dakota	**41.5%**	**43.7%**	**45.3%**	**46.0%**
South Dakota	31.8%	34.1%	35.7%	35.7%
Washington	35.4%	39.2%	42.6%	40.3%
Wyoming	34.0%	30.4%	47.1%	39.1%

Table 6.2: Pharmacy Cost Trends (Narcotics as a Percentage of All) for 2010 – 2013

State/Year	2010	2011	2012	2013
Colorado	39.0%	34.2%	31.0%	25.8%
Minnesota	34.8%	34.8%	32.5%	30.0%
Montana	31.2%	31.4%	31.9%	31.1%
North Dakota	**41.6%**	**41.4%**	**40.6%**	**39.6%**
South Dakota	31.0%	26.9%	26.3%	29.1%
Washington	27.1%	30.6%	34.3%	29.8%
Wyoming	45.0%	38.3%	41.1%	40.9%

When comparing North Dakota results to other states in tables 6.1 and 6.2, we see that North Dakota percentages are consistently higher than the values in other states for similar time frames. We discuss various factors below suggesting reasons for these differences.

First, and as a standard practice, WSI does not settle an injured worker's entitlement to medical treatment. Injured workers are routinely afforded lifetime access to care for their injuries assuming that sufficient proof is provided to trace the need for care to the workplace injury. Other states allow employers and carriers the opportunity to resolve medical benefit entitlement.

Further, when that medical benefit entitlement is resolved, it will be part of an overall claim resolution typically approved by the workers' compensation judicial body that oversees case resolutions or issues final orders. As such, settlement payments that are made to resolve pharmacy entitlement will not show up in the data of a pharmacy benefits manager, nor is it likely that those payments will be specifically coded to a pharmacy pay code by a carrier or claims administrator.

In North Dakota, in those instances where a case does settle WSI will issue the formal Order. Settlements on North Dakota claims typically only occur with out of state workers or in situations where there may be a benefit dispute and the parties are able to stipulate to or compromise to reach an agreement.

How might these differences be proven?

If in North Dakota claims involving long-term injuries contribute substantially to the results we see in managing narcotic costs, then we might observe that in the way we look at data. We mentioned at the outset of this element that WSI has retained a new pharmacy benefits manager, PMSI. At the time of our review, PMSI had limited data on WSI's program but we were able to obtain information that helps to prove where narcotic related expenses are occurring based on the age of a claim.

PMSI provided us with data showing that in the first five months (11/13 – 3/14) of their work with WSI a total of $1,621,214 was spent on narcotic prescriptions. PMSI grouped these costs based on the age of claims as displayed in Table 6.3 which follows:

Table 6.3: Billed Narcotic Amounts Grouped by Age of Claim (November 2013 – March 2014)

Age of Claim Grouping	Total Billed
0 – 2 Years	$174,348
2 – 4 Years	$98,701
4 – 6 Years	$86,278
6 – 8 Years	$92,669
8 – 10 Years	$97,046
10+ Years	$1,072,173
Total	**$1,621,214**

As you can see from the billed value in the 10+ year grouping, injured workers with old claims dominate the narcotic cost spectrum. In this case, they account for 66% ($1,072,173 of $1,621,214) of the total cost over a recent five-month window (11/13 – 3/14).

In looking at our own experience at Sedgwick, this result is not particularly surprising. Our trends show that in about 90% of all cases in which a narcotic is prescribed that no refill is subsequently provided. Of the 10% of cases on which a refill is provided, fully 60% of those have only one additional prescription. Put another way, 96% of all cases in which narcotics are used have no more than two narcotic prescriptions filled. In short, the problem of long-term opiate use is limited to a small segment of the overall injured worker population, something we will see in the next set of tables.

When we evaluated narcotic utilization in 2010, we compiled tables that displayed narcotic fills in three distinct groups. These tables provided the number of prescriptions written for injured workers whose annual narcotic costs reached certain thresholds. We further provided counts of claims that fell within each of these thresholds as well as the count of prescriptions written for these injured workers. We repeat that information for years 2010 – 2013 below in Tables 6.4 – 6.6.

Table 6.4: Distribution of Narcotic Fills by Claim Cost Grouping (2010 – 2013)

Population	2010 Rx Count	2011 Rx Count	2012 Rx Count	2013 Rx Count as of 10/31/13	2013 Rx Count Annualized
$10K or More	2,210	2,409	2,424	1,593	1,912
$5K or More	4,786	5,323	5,135	3,422	4,106
Top 200	5,865	5,959	5,910	4,563	5,476
All	38,388	41,682	44,396	38,046	45,655

Table 6.5: Distribution of Narcotic Costs by Claim Cost Grouping (2010 – 2013)

Population	2010 Cost	2011 Cost	2012 Cost	2013 Cost as of 10/31/13	2013 Cost Annualized
$10K or More	$1,099,073	$1,188,100	$1,224,763	$939,842	$1,127,810
$5K or More	$1,765,259	$1,901,076	$1,894,576	$1,521,984	$1,826,381
Top 200	$1,948,841	$2,028,021	$2,033,007	$1,769,216	$2,123,059
All	$2,951,766	$3,094,404	$3,162,531	$2,604,535	$3,125,442

Table 6.6: Count of Claims by Claim Cost Grouping (2010 – 2013)

Population	2010 Claim Count	2011 Claim Count	2012 Claim Count	2013 Claim Count as of 10/31/13	2013 Claim Count Annualized
$10K or More	66	72	72	58	70
$5K or More	158	172	170	141	169
Top 200	200	200	200	200	200
All	5,394	5,982	6,162	5,782	6,938

Note that data for 2013 was provided by WSI's former pharmacy benefits manager (US Script) and their data is available through October 2013. We annualized that data to allow for more reasonable comparisons to other years in the tables.

From tables 6.4 – 6.6, we summarize that data to show the proportionate share of narcotic prescriptions filled and costs associated with the top 200 claims in each of the last four calendar years.

Table 6.7: Top 200 Injured Worker Narcotic Users as Percentage of All Users Showing Cost and Transactions (2010 – 2013)

Category	2010	2011	2012	2013
Top 200 as % of all injured workers receiving narcotic medications	3.7%	3.3%	3.2%	2.9%
Top 200 as % of all narcotic prescriptions filled	15.3%	14.3%	13.3%	12.0%
Top 200 as % of all narcotic costs	66.0%	65.5%	64.3%	67.9%

When you look at the bottom row of data in Table 6.7, you see that the top 200 cases accounted for about 2/3rds of all narcotics costs in the last four calendar years. The percentage of narcotics prescriptions filled in this group is not so substantial (see the row of data in the next to the bottom row). This result means that for long-term opioid users they are much more likely to receive brand named medicines (as opposed to generics). From our own experience, the results shown in Table 6.7 are not atypical, that a small percentage of claims accounts for a large percentage of the overall cost.

The data as reported by PMSI and depicted at Table 6.3 suggests that older claims are responsible for producing the highest narcotic costs. To determine the accuracy of this assumption, we looked at the age of the 58 claims referenced in the 2013 data in Table 6.6. We wanted to see how these 58 claims broke out by date of injury. Would older claims dominate the list as Table 6.3 suggests?

We found that of the 58 claims, all but ten of them were at least ten years old. Of the remaining ten, only one occurred during the performance evaluation period. The rest occurred with dates of injury between 2005 and 2010. The oldest claim on the list of 58 cases goes back to 1982 with the most recent case among those that are at least ten years old having occurred in March 2004.

As noted earlier when we compared North Dakota utilization to several other states (see Tables 6.1 and 6.2), we suggested that a primary driver in North Dakota's overall narcotics costs as compared to other states is the fact that medical benefit entitlement is not settled in North Dakota. That is, the longer cases remain open with a medical obligation the greater the ongoing expense. We see how that conclusion is supported when we evaluate the cases that contribute the most to the narcotics costs in North Dakota.

Further, as you will see later in this section, another factor in play in North Dakota concerns its formulary that will contribute to overall cost reductions.

Another area of interest in this Element is how costs broke out within North Dakota as well as out-of-state narcotic pharmacy costs. This cost breakout is provided in the following Table.

Table 6.8: Narcotics Costs by Locality (2010 – 2013)

Locality	2010 Narcotic Spend	2011 Narcotic Spend	2012 Narcotic Spend	2013 Narcotic Spend as of 10/31/13	2013 Narcotic Spend - Annualized
Burleigh Co	$1,612,569	$1,653,282	$1,713,491	$1,417,862	$1,701,434
Cass Co	$230,867	$310,289	$400,652	$275,803	$330,964
Grand Forks Co	$169,536	$188,449	$212,606	$180,330	$216,396
Other counties	$323,013	$392,569	$456,619	$330,291	$396,349
All N. Dakota	$2,335,985	$2,544,589	$2,783,368	$2,204,285	$2,645,143
Non-N. Dakota	$371,986	$370,263	$363,681	$391,297	$469,556
Null zip codes	$221,882	$167,852	$5,278	$2,832	$3,398
Sub-Total	$593,868	$538,115	$368,959	$394,129	$472,954
Total	**$2,929,853**	**$3,082,703**	**$3,152,327**	**$2,598,415**	**$3,118,097**

As was true of some of our earlier tables in this Element, we annualized data from 2013 because US Script data was only available through October 2013. (Note that very modest financial differences exist in annualized data calculations when comparing Tables 6.5 and 6.8. These differences are not material to any of our overall findings or recommendations.)

One notable change in the data, when comparing 2010 and 2011 to 2012 and 2013, is that few providers were unidentified by zip code in the later years. As a consequence, there is a slight uptick in narcotic costs specifically related to North Dakota providers. This simply suggests that most of the null zip code values in 2010 and 2011 pertained to North Dakota providers, as would be expected.

One favorable finding in the data is this: From Calendar Year 2011 to Calendar Year 2013, total claim filings increased from 23,295 in 2011 to 26,226 in 2013. That difference amounts to a 12.6% increase in reported claims. During that same window of time, indemnity claims increased from 2,964 to 3,417 for a percentage increase of about 15.3%. However, during the 2011 to 2013 time frame, narcotic costs increased by only $35,394 or 1.1%.

We also observe that along with the increase in claim volume over the years, that there has been an increase in the number of employees whose claims are filed with out-of-state home addresses. For instance, in FY 2011, WSI reported it received 3,577 claims with out-of-state addresses. For FY 2013, that number grew to 5,898 or by a margin of nearly 65%. In Table 6.8, we see that narcotics cost in out

of state zip codes grew from 2011 to 2013 by a margin of $99,293 (from $370,263 to $469,556) or about 26.8%. Claim growth significantly outpaced narcotics cost growth in this out-of-state comparison.

Table 6.8 also aggregates narcotics costs for counties other than Burleigh, Cass and Grand Forks over each of the four years between 2010 and 2013. None of these other counties has a single year in which narcotics expenses exceeded $80,000. There are seven counties around the state where narcotics expenses topped $20,000 in each of the past three years. Three counties are in the western half of the state (Ward, Stark and Adams). Four counties are in the eastern half (Stutsman, Foster, Ramsey and Walsh).

We also observe, just as was true in 2010, that providers who most frequently prescribe opioids in North Dakota are specialists in the field of pain management.

When evaluating WSI policies and procedures specifically related to narcotic utilization, we find a combination of processes in place. These policies were developed primarily following the defeat of HB 1054 during the 2011 legislative session. That bill represented an effort by WSI to implement some of the recommendations made related to narcotic utilization management that grew out of the 2010 Performance Evaluation.

For the most part, policies and procedures related to narcotic utilization management are encompassed in claims operations protocols. For example, Form Letter 423-1 is sent to treating physicians when one of their patients has been receiving narcotics for about 30 days. These individuals are identified via the Patient Utilization Report (see Recommendation 6.1 in the recommendation section that follows). The form letter contains appropriate reminders and treatment management suggestions to treating physicians including the following:

- Limiting the prescribing of opioid analgesics to one provider
- Using the lowest does of pain medication to achieve the desired result
- Evaluating side effects
- Evaluating functional status
- Evaluating pain
- Considering random drug screens

The form letter also encourages treating providers to use narcotic treatment agreements and it provides a web address that providers can access to review information concerning the appropriate continual use of opioid analgesic medications. This form letter is a good initial approach for the management of cases involving injured workers whose narcotic therapy has continued beyond 30 days. (See Recommendation 6.2.)

Once cases reach 90 days of ongoing narcotic use, they are reviewed in greater depth. Cases will be reviewed by the Pharmacy Director and the claims adjuster to determine an appropriate course of action. One option they will consider is a request for a second opinion or a more formal independent medical examination. A case may also be assigned to a medical case manager.

WSI also developed a formulary through its Pharmacy and Therapeutics Committee. The committee is comprised of three pharmacists and three physicians. The committee meets quarterly to review all classes of medications most applicable in the treatment of work-related injuries.

This committee makes a recommendation as to which medications should be available without prior authorization, ones that require prior authorization and ones that WSI should not cover or pay for at all. The recommendations then go to a fee schedule hearing before updates are finalized and posted to the WSI website.

The committee evaluates each medication according to the following priority:

- Safety
- Efficacy
- Uniqueness
- Cost

There are also certain circumstances that may arise, such as an injured worker participating in a detoxification program, where medications not typically allowed will be approved during the weaning period.

In evaluating WSI's formulary, we compared the opioid drug list against the opioid portion of the closed formulary adopted by the State of Texas. This particular formulary has gained a significant amount of press and attention in the workers' compensation industry. The Texas Department of Insurance posted a press release on their website on June 19, 2012 indicating that, "fewer opioids, narcotics and other 'not recommended' drugs are being prescribed in the Texas workers' compensation system." The article went on to state that "the frequency of opioid prescriptions dispensed to injured employees decreased by 10 percent and the costs associated with opioid prescriptions decreased by 17 percent."

In June 2014, the Workers' Compensation Research Institute (WCRI) published research suggesting that if more states were to adopt a closed formulary comparable to what they observed in Texas that reductions in pharmacy costs could be expected. WCRI noted scenarios for how a closed formulary could vary across states. Depending on the scenario, cost reductions could be expected from as little as 2% to as much as 29%.

We think the experience in Texas is noteworthy for North Dakota because the North Dakota formulary relative to opioids mirrors in many respects what we observed in reviewing the opioid portion of the Texas formulary. That is, a drug that is routinely authorized in North Dakota is likely routinely authorized in Texas. Similarly, opioids that are questioned or not approved in North Dakota are managed the same way in Texas. (See Recommendation 6.5.)

In summary, we find that WSI:

- Has developed policies and procedures to address the early and ongoing use of narcotic medications

- Has compiled a formulary that compares favorably to what we observe in the Texas program, a program that has received a favorable review from the Workers Compensation Research Institute
- Can trace higher patterns of narcotic use to chronic opioid users
- Can trace narcotic use patterns primarily to the more populated areas in the state
- Has a longer life of claim payout pattern in its claims that what we would see in other states primarily because medical benefit entitlement is provided for lifetime and is not settled

Recommendations from 2010 Performance Evaluation

In the 2010 Performance Evaluation, we made nine recommendations pertaining to Narcotic Utilization. Of the nine, the 2014 Performance Evaluation requires that we review seven of them (6.1 – 6.6 and 6.9). All seven of these recommendations were considered high priority.

We made recommendations for WSI in 2010 because we felt opportunities existed to improve the overall way in which narcotic use was managed. These recommendations focused on narcotic prescriptions beyond a first fill and continuing through with the development of a reasoned approach to managing injured workers with chronic opioid medication needs.

We noted in the 2010 performance evaluation that of the North Dakota injured workers who had been prescribed a narcotic for the first time that fully half of them received narcotics within one week of their injury. In short, this suggested to us a change in treatment pattern from what we may have seen in the 1990's when physicians were more apt to rely exclusively on non-steroidal anti-inflammatory drugs (NSAIDs) in their early treatment of injured workers. And, as we have seen in the data for this performance evaluation, the greatest driver of higher costs in the workers' compensation setting is that group of patients with a chronic opioid need.

In summary, we have more frequent use of opioids in the early stages of injury but the primary driver of opioid expense relates to a very small percentage of injured workers with chronic opioid therapy needs.

<u>Prior Recommendations:</u>

In this section of Element 6, we review the extent to which WSI has implemented the 2010 Performance Evaluation recommendations.

Recommendation 6.1 from 2010 Performance Evaluation: High Priority

WSI should develop an early intervention program for narcotic utilization. The process should include the following steps:

- A review of the case by WSI medical staff to determine whether the second narcotics fill seems reasonable.

- If the second fill seems reasonable, then the medical staff should document when a subsequent review of prescribed narcotics would be warranted.
- If the second fill does not seem reasonable, then a peer-to-peer conversation should occur between the WSI Pharmacy Director or comparably qualified doctor and the prescribing physician.
- Whenever contact is made by the Pharmacy Director or his designee, the outcome of the call should be a clear understanding of why the narcotic is needed and a target date for concluding reliance on narcotics. Alternative medications for treatment of pain should be considered as part of this process.
- To the extent WSI may establish through treatment guidelines or other evidence-based methods that the ongoing use of narcotic medicines may not be necessary, WSI should arrange for independent medical evaluations to assess medication needs. Depending on the results of those evaluations, WSI may make medical payment authorization decisions in keeping with established case law in North Dakota concerning the relative weight of medical evidence.

For Recommendation 6.1, we conclude that WSI **partially implemented** this recommendation but that in several ways the spirit of the recommendation has been fulfilled. WSI started using Form Letter 423-1 to address matters pertaining to the ongoing use of narcotics beyond thirty days. We had suggested at the second fill. While the timing may vary between when a second fill is dispensed and the thirty day notice, the objective of managing opioid use at an early point in the life of the claim has been achieved. One of the key features of the FL 423-1 is that it seeks medical documentation showing that the ongoing use of opioids is accomplishing the dual objectives of decreasing pain and improving functionality. (See also new recommendations 6.1 and 6.2 in the New Recommendations section that follows.)

Recommendation 6.2 from 2010 Performance Evaluation: High Priority

Related to the first recommendation above, WSI should institute a policy that no later than 30 days after the treating physician begins treating the injured worker with the opioid medication(s) for chronic pain, the treating physician must submit a report to WSI which includes the following:

- A treatment plan with time limited goals
- Relevant prior medical history that should explain the rationale for ongoing use of narcotic medicines
- A statement that the physician has conducted appropriate screening factors that may significantly increase the risk of abuse or adverse outcomes
- An opioid treatment agreement that has been signed by the worker and the attending physician that must outline the risks and benefits of opioids use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in pain and function, and the injured workers responsibilities. Included in this agreement should be language that indicates that the injured worker may be required

to submit to blood and urine screens at the physician's discretion or upon a reasonable request from WSI

For Recommendation 6.2, we conclude that WSI **partially implemented** this recommendation. In addition to FL 423-1 referenced above, WSI also makes available to treating providers a sample pain management contract agreement through its website and referenced in the FL 423-1. Making an agreement like this mandatory for providers and patients at an appropriate interval seems a reasonable expectation. (See Recommendation 6.3 in the New Recommendations section that follows where with the help of legislative authority WSI can mandate this practice.)

Recommendation 6.3 from 2010 Performance Evaluation: High Priority

When narcotic medications are being prescribed in chronic pain cases for more than ninety days, we recommend a collaborative review by claims and medical staff to evaluate the ongoing need for these medicines and the reasonableness of the current treatment plan. The team would conference to review the narcotics being dispensed, physician progress reports as it relates to those cases, demonstrated functional improvement of injured worker, decrease in pain of the injured worker, results of any drug screenings and an assessment of the ongoing need for opioids along with a determination if opioid tapering appears appropriate.

Recommendation 6.3 was **fully implemented**. Initially, triage meetings occurred to address these kinds of cases. In 2012, that process changed to include only the claims adjuster managing the case, his/her claims supervisor, and the Pharmacy Director. In both approaches, the recommendation's intent is being met.

*Recommendation 6.4 from 2010 Performance Evaluation***:** High Priority

In those instances where opioid medications can be expected to be prescribed beyond ninety days, WSI should require supplemental Functional Progress Reports from the treating physician no less than quarterly and the report should document the following:

- Pain summary (perception of pain)
- Functional progress summary

Recommendation Note: Guidelines for the treatment of pain suggest that for the ongoing use of narcotic medicines, some reduction in pain should be obtained by the injured worker or there should be some demonstrable improvement in function.

Recommendation 6.4 was **not implemented**. WSI had hoped to address this recommendation through HB 1054 which failed to pass in the North Dakota Senate during the 2011 session. We view functional progress reports as an important component of medical case management where opioid use extends beyond 90 days. Other jurisdictions require physicians to report on any number of injury related matters including updates on the medical treatment plan and disability status. Requiring progress

reports that document pain and functional levels is a logical step in validating that opioid therapy is needed. (See new recommendation 6.3.)

Recommendation 6.5 from 2010 Performance Evaluation: High Priority

Prior to participation of an injured worker with a pain management provider, WSI should consider on a case-by-case the value of a comprehensive assessment of the injured worker. This assessment may involve physicians or other medical specialists from physical or mental health disciplines and should seek to establish baseline functionality and pain complaints. Blood and urine testing should be included in this assessment. WSI should also investigate whether there are existing or emerging medical technologies that may assist in the assessment of functional capabilities and compliance.

Recommendation 6.5 was **not implemented**. WSI had hoped to address this recommendation through HB 1054 which failed to pass in the North Dakota Senate during the 2011 session. (See new recommendation 6.3.)

Recommendation 6.6 from 2010 Performance Evaluation: High Priority

A process for the profiling of pain management providers should be developed. Cases in the sampling should track medical costs and disability days from the date of the first visit with the pain management provider. A data sub-set of the medical spend should include the cost of narcotic medicines, including the comparative costs for dispense as written, generic and brand medicines. Profile results should be shared with the providers in the sample and with other interested stakeholders around the state. Injured workers should never be identified in the profiling.

Recommendation 6.6 was **not implemented**. WSI indicated that they were unable to implement this recommendation because their prior pharmacy benefits manager (PBM) did not have the data capture capabilities to profile providers in a fashion consistent with this recommendation. With a new PBM on board, this recommendation should be addressed anew. WSI also did not implement this recommendation due to the failure of HB 1052. (See new recommendation 6.4.)

Recommendation 6.9 from 2010 Performance Evaluation: High Priority

WSI should consider the adoption of a Model Policy for the Use of Controlled Substances for the Treatment of Pain. The Model Policy for the Use of Controlled Substances for the Treatment of Pain was developed in collaboration with pain experts around the country to provide guidance to state medical boards in developing pain policies and regulations. Written in the form of a model policy document, the guidelines provide model language that may be used by states to clarify their positions regarding the use of controlled substances to treat pain, alleviate physician uncertainty about such practice and encourage better pain management. This policy can be found at www.fsmb.org.

Recommendation 6.9 is considered **fully implemented**. WSI adopted the Official Disability Guidelines (ODG) for the use of controlled substances for the treatment of pain.

New Recommendations

Of the recommendations made below, we view Recommendations 6.3 and 6.4 as most significant. Recommendation 6.3 suggests ways the statute can be modified to support reasonable opioid management requirements on workers' compensation claims. Recommendation 6.4 suggests a way WSI can work with the provider community on cases involving higher opioid prescribing patterns among providers and use by certain of their patients to bring about lesser reliance on opioids in the long run. Recommendation 6.4 is an outgrowth of the narcotic use patterns we observed where we found that less than 4% of those receiving opioids account for about 2/3rds of the cost.

Recommendation 6.1: High Priority

Since the change from US Script to PMSI, the new pharmacy benefits manager has not produced the Patient Utilization Report. This report is used to identify patients whose opioid use has continued for at least 90 days. We recommend that WSI work with PMSI to re-initiate this report.

> **WSI Response: Concur.** PMSI has developed the report and placed it into production July 2014. In addition, WSI has also requested that PMSI institute the 90 day opioid Clinical Escalation Alert which will alert WSI in real time when the IW has reached the 90 day mark and will be in production September 2014.

Recommendation 6.2: Medium Priority

When WSI sends out the FL 423-1, we recommend it be accompanied by a form letter to the provider asking them to identify a date when they believe their patient will be able to discontinue use of opioid treatment. (As we pointed out earlier in this Element, proportionately few patients receive more than two narcotic prescriptions so addressing those cases with a potential for a third fill seems a reasonably prudent step in opioid management.)

> **WSI Response: Concur.** WSI will develop the accompanying form to be included with the initial letter sent to the treating provider.

Recommendation 6.3: High Priority

We recommend that WSI draft legislation to be considered in the next biennium that seeks to accomplish the following:

- Require the pain management contract be signed by the injured worker and treating physician in all cases where opioid therapy has extended beyond 90 days
- For cases of opioid use beyond 90 days, require no less frequently than quarterly that the treating physician address how the current opioid regimen is either decreasing pain or improving function (In those instances where neither is demonstrated, WSI may use independent medical evaluations to determine if ongoing opioid therapy is necessary. These

evaluations could lead to a decision by WSI to disallow certain opioids, to reduce the dosage or to allow the treatment to continue as is.)

- For cases of opioid therapy beyond 90 days, mandate that appropriate and random drug screens are accomplished to ascertain if medication is being taken as prescribed. Drug screens should occur no less frequently than semi-annually and may at the treating physician's discretion be conducted more frequently up to four times annually. Failed tests would be considered a breach of the pain management contract and under such circumstances WSI should have the discretion to discontinue payment for opioid therapy

  WSI Response: Concur. WSI will draft legislation that would require the treating provider to initiate a pain contract for all IW's on chronic opioid therapy and to provide to the agency monitoring of the effectiveness of the opioid regimen in reducing pain and/or increasing function.

  WSI already has an administrative rule in place to allow for random urine drug testing and a policy committee is in place that will define how and when the agency requests random urine drug testing.

Recommendation 6.4: High Priority

Provider profiling was recommended in the prior Performance Evaluation but the prior PBM could not accomplish that. We recommend that WSI pursue the profiling recommendation made in 2010 with the new PBM, PMSI.

To accomplish the profiling, we recommend that WSI profile and manage results according to the following criteria:

- Identify those physicians who have prescribed opioid medications over a certain dollar threshold in the past year (consider $20,000 as a starting point to see what the data reveals)
- Create a report that goes to the physicians who hit this threshold that provides for their patients the names of the injured workers, their dates of injury, when they commenced on opioid therapy, the amount prescribed in morphine equivalencies, and a return to work date (if one exists)
- Schedule peer to peer meetings on cases selected by WSI with these treating physicians to include a review of the current opioid intake, morphine equivalencies, opportunities to reduce or discontinue opioid use, pain level, functional level, urine drug screening outcomes and the use of generic medications in lieu of brand name
- Establish goals or revised treatment plan objectives on each case and follow for compliance.
- Pay treating physicians for their time at an appropriate professional hourly rate for participating in these reviews

  WSI Response: Partially Concur. WSI will work with our current PBM to develop the capabilities for provider profiling which will identify providers based on set criteria (e.g. annual opioid drug

spend in excess of a threshold and/or average morphine equivalent prescribed in excess of a threshold).

WSI does not currently have the medical personnel available to conduct qualified peer-to-peer meetings on selected claims. WSI is currently in the pilot phase of a program with a vendor who is doing peer-to-peer reviews on high dollar drug spend legacy claims. WSI will assess the impact of the pilot project and determine whether or not the agency will continue with this vendor. Providers are reimbursed as part of the pilot project for the office visit with the vendor's representative.

In order to fully concur with the recommendation, WSI would need to engage a credentialed pain management physician who would be tasked with conducting the peer-to-peer meetings with the identified providers.

Recommendation 6.5: High Priority

We recommend that WSI evaluate its current formulary and build in a prior authorization process for long acting opioid medications that are requested within the first three months post-injury.

WSI Response: Concur. The formulary status of the long-acting opioid medications will be reviewed during the 3rd quarter Pharmacy & Therapeutics Committee.

Element Seven: Evaluation of the Basis for Determining Annual Cost of Living Adjustments (Supplementary Benefits)

Introduction

The objective of this Element is to evaluate the basis for determining annual cost of living adjustments (supplementary benefits). Further, the objectives of this Element include the following:

- Review the process for determining the annual cost of living adjustments (COLAs) provided to certain benefit recipients after three consecutive years of disability.
- Compare the process for determining the annual COLA with at least five comparable workers' compensation systems providing for a COLA including comparing and contrasting eligibility requirements to qualify for COLA as well as the basis used to determine COLAs.
- Identify national best practices, if available for this area and compare to North Dakota's processes and determination of the COLA.

Context

To achieve the above objectives, the following activities were undertaken:

- We reviewed relevant data at WSI pertaining to COLAs (supplementary benefits) including NDCC Section 65-05.2.
- We interviewed WSI staff for information regarding North Dakota's COLA criteria and calculation methods.
- We consulted with various State Experts at Sedgwick on COLA criteria and calculations, and obtained COLA-related documentation pertaining to specific states.
- We compared the process for determining the annual COLA with at least five comparable workers' compensation systems providing for a COLA including comparing and contrasting eligibility requirements to qualify for COLA as well as the basis used to determine COLAs. The five states which were evaluated most in depth were:
    - California
    - Connecticut
    - Massachusetts
    - Minnesota
    - Washington
- We reviewed data from the U.S. Chamber of Commerce 2013 Annual Analysis of Worker's Compensation Laws as they pertain to COLA criteria and calculations.
- We used the data above to identify national best practices and compared to North Dakota's processes and determination of the COLA.

The areas of focus for comparison of COLA requirements across states were:

- Benefits eligible for COLAs
- Timing of Initial COLA
- Basis for COLA calculations and applicable caps
- Whether benefit rates may be decreased in the event of a year over year decline in the underlying index or state average weekly wage

Findings

To evaluate North Dakota against at least five other jurisdictions, we elected states which also have COLA requirements, including one additional monopolistic workers' compensation system.

In the state of North Dakota, pursuant to NDCC Section 65-05.2-01, for injuries before January 1, 2006 a claimant receiving temporary total disability benefits (TTD), permanent total disability benefits (PTD), or death benefits, and who has been receiving disability or death benefits for a period of three consecutive years is eligible for supplementary benefits. For injuries after December 31, 2005 claimants receiving permanent total disability or death benefits who have been receiving these benefits for a period of three consecutive years are eligible for supplementary benefits.

Once eligibility has been determined, WSI applies the statutory formula to calculate the appropriate COLA. The benefit is initiated once the three consecutive years of benefits has been paid and then each July 1 thereafter. For those injured workers whose benefit amount is at least 60% of the state average weekly wage (SAWW), their benefit is adjusted by the amount of the increase in the SAWW. For example, an injured worker receiving a weekly benefit of $700 whose benefit is subject to revision due to a 5% increase in the SAWW would receive $735 at time of adjustment ($700 x 1.05 = $735).

For injured workers whose benefit amount at date of first disability is less than 60% of the SAWW at that time, the benefit adjustment is accomplished using the following approach in Table 7.1:

Table 7.1: Calculation Methodology for COLA when Benefit Rate is Less Than 60% of SAWW

Methodology	Factor/Result
Date of 1st Disability	7/15/10
Weekly benefit at 1st date of disability (before any Social Security offset)	$200
SAWW at date of 1st disability	$682
Ratio of weekly benefit to SAWW	200/682 = 29.3%
Date of COLA eligibility	7/15/13 (three years following date of 1st disability)
SAWW at time of COLA eligibility	$878
New weekly benefit (effective 7/15/13)	0.293 X $878 = $257
New weekly benefit (effective 7/1/14) assuming 5% increase in SAWW	$257 X 1.05 = $270

Tables 7.2 and 7.3 below display the amounts paid in supplementary benefits over the last four fiscal years and the number of benefit recipients, respectively. Data in these tables was provided by WSI staff and included both paid cost reports and open claims with reserves sorted by indemnity benefit type.

Table 7.2 North Dakota Supplemental Benefits Paid by Year

Fiscal Year	Supplemental Benefit (SUP)
2011	$ 9,818,913
2012	$ 10,622,588
2013	$ 12,318,525
2014	$ 14,716,937

Table 7.3 North Dakota Supplemental Benefit Recipients by Year Based on DOI

Fiscal Year	Through 12/31/2005	From 01/01/2006	Total
2011	1083	30	1113
2012	1044	41	1085
2013	996	49	1045
2014	970	62	1032

In Table 7.2, we see the most notable year over year increases when we compare 2013 to 2012 and then 2014 to 2013. Those jumps fall in line with the increases in the state average weekly wage commencing for benefit recipients on 7/1/12 and beyond. The state average weekly wage increased by 9.9% as of 7/1/12 and by 10.3% as of 7/1/13.

In Table 7.3, we see gradual declines in the number of claims on which a COLA (supplementary benefit) is being paid. The gradual decline in numbers is likely attributable to the retirement presumption as well as attrition (e.g., the deaths of benefit recipients). For supplementary benefit recipients in this category, benefits stop when the individual becomes eligible for Social Security retirement. In its place, injured workers receive an Additional Benefit Payable on which supplementary benefits are not paid.

Table 7.4 below provides a summary of maximum and minimum benefit rates for TTD and Death as well as the PPI rates. These rates are provided by fiscal year with effective dates. The SAWW is also provided by fiscal year and the final column of the table shows how the SAWW has changed going back over the past twenty years. The table shows that within that 20-year time span there were five years when the COLA changed by more than 5%. For all other years benefit rates changed within a range of from 2.2% to 4.8%.

Table 7.4 North Dakota Weekly Benefit Levels

Effective	Max [1]	Min [2]	PPI [3,4]	SAWW	% Change [5]
7/1/2014	1,143	549	320	914	4.1%
7/1/2013	1,098	527	308	878	10.3%
7/1/2012	995	478	279	796	9.9%
8/1/2011	905	435	254	724	----
7/1/11 to 7/31/11	905	435	242	724	6.2%
7/1/2010	853	410	228	682	2.6%
8/1/2009	832	399	222	665	----
7/1/09 to 7/31/09	732	399	222	665	6.2%
7/1/2008	689	376	209	626	5.6%
7/1/2007	653	356	198	593	4.6%
7/1/2006	624	341	189	567	3.3%
7/1/2005	604	330	183	549	4.8%
7/1/2004	577	315	175	524	4.0%
7/1/2003	555	303	168	504	3.3%
7/1/2002	537	293	163	488	4.1%
7/1/2001	516	282	157	469	4.0%
7/1/2000	497	271	151	451	3.4%
8/1/1999	480	262	146	436	----
7/1/99 to 7/31/99	436	262	146	436	4.6%
7/1/1998	417	251	139	417	3.7%
7/1/1997	402	241	134	402	3.9%
7/1/1996	387	233	129	387	2.9%
7/1/1995	376	226	126	376	2.7%
7/1/1994	366	220	122	366	2.2%

1 Effective August 1, 2009, the maximum weekly benefit is equal to 125% of the SAWW and is 110% of the SAWW effective August 1, 1999.
2 The minimum benefit is equal to 60% of the SAWW unless this amount exceeds the employee's net wages (gross wages minus deductions for federal income tax and social security) in which case the employee receives net wages as a weekly compensation rate.
3 The PPI rate is equal to 33 1/3% of the SAWW in effect on the date of the impairment evaluation.
4 Effective August 1, 2011 the PPI rate is 35% of the SAWW in effect on the date of the impairment evaluation.
5 Annual COLA (Supplemental Benefit) is equal to the percent increase in the SAWW.

Having provided an overview of how the COLA process works in North Dakota, we next compare North Dakota to five other states.

Table 7.5 below represents the benefits eligible for COLAs and timing of initial COLA in the five comparable states. We include North Dakota in the table for comparison purposes.

Table 7.5 Benefits Eligible for COLAs & Timing of Initial COLA by State

State	Eligible Benefits	Timing of Initial COLA
California	TTD, PTD, Life Pension [(1)]	Two years from Date of Injury
Connecticut	TTD, PTD	Five years from Date of Injury
Massachusetts	PTD, Death	On the 1st of October following Date of Injury
Minnesota	TTD, TPD, PTD, Death	Three years from Date of Injury
North Dakota	**Pre – 2006: PTD, Death, TTD** **2006 to present: PTD, Death**	**Following three consecutive years of benefits**
Washington	TTD	On the 1st of July following Date of Injury

1 Life Pension applies to permanent disability benefit recipients whose award is at least 70%.

As you can see from Table 7.5, there is no standard pertaining to eligible benefits and timing for COLA recipients. The most prevalent trend in the table is that those receiving permanent total disability benefits generally receive a COLA. As well, this trend applies to other states that include a COLA in their statutory schemes; that is, permanent total disability benefit recipients are the group of injured workers most likely to receive a COLA.

North Dakota is somewhat unusual when compared to other states in that the COLA applies for benefit recipients only after three **consecutive** years of benefits. In looking at the data provided across all states by the U.S. Chamber of Commerce in the 2013 Annual Analysis of Worker's Compensation Laws, there are only 2 other states which require consecutive receipt of benefits to be eligible for a COLA and in both those states the requirement is for 52 weeks of consecutive benefits. However, given the benefit types (PTD or Death) for which a COLA is allowed in North Dakota, we don't see the requirement that benefits be consecutive as significant.

All states of comparison were found to have a statutory requirement for annual recalculation of COLAs after the initial eligibility requirement had been met. We found this practice generally to be true of states around the country, not just those referenced in the table above.

In looking at the basis for COLA calculations in the five comparable states, four of the five use the SAWW. Details are provided in Table 7.6.

The state of Connecticut links the COLAs directly to the current maximum TTD rate, but the TTD rate is in turn based upon the SAWW, so there is a direct correlation. The one outlying state is Massachusetts in which COLAs are calculated using a multiplier provided by the state which is based on the CPI (Consumer Price Index) for the NE Urban Region.

Again, looking at the data provided across all states by the U.S. Chamber of Commerce in the 2013 Annual Analysis of Worker's Compensation Laws, there were nine additional states (for a total of 14) for which data was available on the basis for COLA calculations. If we take the fourteen states and examine their resource base for establishing a COLA, five states use a form of the CPI, seven use the SAWW, and the remaining two states have a set percentage at which benefits increase each year. Given this pattern, we see that North Dakota is a state that relies on the most common model; that is, the COLA is tied to a percentage increase in the SAWW.

Table 7.6 Basis for COLA Calculations

State	Basis for Calculations
California	SAWW
Connecticut	Current Max TTD Rate, which is tied to SAWW
Massachusetts	Chart Multiplier provided by DIA (Calculated using CPI for NE Urban Region)
Minnesota	SAWW
North Dakota	**SAWW**
Washington	Multiplier, the denominator of which shall be the average wage in the state for the fiscal year in which such person's compensation was established and the numerator of which shall be the average monthly wage in the state

In North Dakota, pursuant to 65-05.2-02(3), "an annual recalculation of supplementary benefits may not result in a rate less than the previous rate." We therefore wanted to review trends in other jurisdictions

pertaining to the existence of caps and whether or not rates may decrease. Table 7.7 below provides a recap of our findings.

Table 7.7: Caps and/or Decreases to COLAs

State	Cap	Rates Able to Decrease
California	No	No
Connecticut	No [1]	No
Massachusetts	Adjustment Benefit Not to Exceed 3x Original Benefit Amount	No
Minnesota	2% Before 10/1/13, 3% After 10/1/13	Yes, has occurred once on 10/1/10
North Dakota	**No**	**No**
Washington	No	No

1 Prior to 7/1/93, Connecticut had a cap in place that did not allow the maximum weekly COLA increase to exceed $15, but at present there is no cap.

In looking at broader trends across other jurisdictions, we reviewed five additional jurisdictions, including Maryland, Montana, Nevada, South Dakota and Wyoming, for a total of ten states other than North Dakota. We found that five had no cap and five had caps ranging from 3% - 5%. States that may decrease a COLA from one year to the next are rare.

In summary, North Dakota has a process for COLA benefits that occurs after three years of consecutive benefits, slightly later in the benefit cycle than for several other jurisdictions. The calculation methodology is reasonable when compared to other jurisdictions. Given the increase in the SAWW in Fiscal Years 2013 and 2014, benefit recipients enjoyed more substantive increases than what we observed in any of the other years going back to 1994. Some states cap increases in their COLA rates, and some do not. The trend there is about 50/50. Most states don't permit a benefit decrease if the underlying rate tied to CPI or SAWW declines.

Recommendations

We considered making a recommendation to implement a cap on supplementary benefits. However, in general, increases in wages are tied to economic prosperity in an area, which can also be linked to an

increased cost of living. Were claimants on a fixed wage subject to caps that run below the increased cost of living experienced in the state, they could be proportionately more affected. Further, the increases in SAWW in 2012 & 2013 appear to be anomalies when compared to the 20-year history of changes in SAWW as reported above at Table 7.4.

We also considered making a recommendation for changing the requirement for 3 years of consecutive benefits prior to being eligible for COLA to a shorter time frame. Given the benefit types (Death and PTD) to which COLAs are applied we determined that three years is reasonable and relatively in line with national averages. The lack of a cap means that once COLAs commence recipients will see benefit increases in line with growth in the SAWW. The timing of the first COLA means that increases are delayed to some extent by the fact that no COLA is paid until three consecutive years of disability benefits have been paid.

Given our review of North Dakota in the context of other states, the methods of benefit calculation, and the timing of COLA increases, we have no recommendations.

Element Eight: Review of Providing Coverage for Post-Traumatic Stress Disorder

Introduction

In this element, the State of North Dakota is interested in:

- An evaluation of post-traumatic stress disorder (PTSD) in five comparable workers' compensation systems to include an identification of any trends in coverage along with eligibility requirements for receiving coverage in each of the systems selected
- A determination of the economic impact on WSI of providing coverage for post-traumatic stress disorder for any type of compensable injury
- The pros and cons of providing post-traumatic stress disorder coverage and the various conditions associated with eligibility requirements

Within the original request for proposal (RFP) on this project, there had been a provision to suggesting that if national data were available relating to coverage of PTSD that we provide that information. National data in the workers' compensation community is not available nationally and is also difficult to obtain on a state by state basis. The RFP further suggested that if national data were not available that we work with the Evaluation Coordinator to estimate a cost to survey states so national trends could be identified.

Since the issuance of the proposal, we have worked with the Evaluation Coordinator and indirectly with the workers' compensation committee of the legislature to scale this element to specific types of PTSD circumstances and to forecast potential costs in keeping with those criteria.

Background

To achieve the above objectives, the following activities were undertaken:

- We reviewed the relevant sections of the North Dakota Century Code along with WSI's policies and procedures related to circumstances under which a claim for coverage of psychiatric condition is considered work-related
- We reviewed the current definition of PTSD as contained in the DSM-V (the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association. This latest revision occurred in 2013.
- We reviewed a 2014 publication jointly compiled by the Workers Compensation Research Institute (WCRI) and the International Association of Industrial Accident Boards and Commissions (IAIABC) to gain a general understanding of state laws and whether mental injury claims are covered, not covered or if there may be limitations on coverage

- We selected five states to review in the context of this project (the five states selected are states which allow coverage under more narrow definitions of circumstances leading to a covered event)
- We reviewed statutory language in various jurisdictions to get a flavor for the variety of coverage afforded
- We reviewed all cases in North Dakota over the performance evaluation period where the nature of injury was designated by WSI as mental stress
- We reviewed PTSD literature specifically relating to the rate of PTSD among first responders, the percentage of crime victims who develop PTSD, and PTSD treatment costs
- We gathered statistics related to violent crime rates by type of crime nationally and in North Dakota, workplace violent crimes rates by occupation, and employment by occupation both nationally and in North Dakota.
- We developed different forecasting scenarios to assess the economic impact of any changes the legislature may decide to make to cover PTSD claims arising out of workplace experiences
- We obtained information from state subject matter experts in our own company to address particulars of the laws governing PTSD coverage
- We limited our analysis to the three following scenarios: a.) first responders; b.) victims of violent crimes where no physical injury is involved; and, c.) witnesses to sudden and extraordinary events in workplace environments
- We reviewed case law in North Dakota and other jurisdictions
- We read proposed legislation that the North Dakota legislature has considered during both the 2011 and 2013 sessions relating to PTSD (see proposed SB 2093 and HB 1427 from the 2011 session, and HB 1376 from 2013)

Findings

We include as Exhibit 8.1 the definition of Post-Traumatic Stress Disorder, a disorder first recognized in 1980, as it appears in the DSM-V published by the American Psychiatric Association. In summary, the definition spells out the kinds of stressors that one must experience for a diagnosis of PTSD to apply. Symptom clusters (intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and activity) are next discussed. Other attributes of the diagnosis include duration of symptoms, functioning and exclusions. One interesting feature of the diagnosis for consideration in statutory language and management by WSI is the duration component. Specifically, factors leading to a PTSD diagnosis must be present for a period of at least a month. As such, statutory language regarding the filing of a claim for benefits would have to take into account the minimum of a one-month lag time to satisfy diagnostic criteria. (See New Recommendation 8.1)

WSI's current procedure for paying for workplace psychiatric injuries is limited to cases that arise from physical injuries. The policy states in part, "NDCC 65-01-02 (10) (b) (10) and 65-01-02 (10) (a) (6) outline WSI responsibility in adjudicating mental or psychological conditions. A mental injury arising from a mental stimulus is not a compensable injury. A mental or psychological condition caused by a physical

injury may be compensable if the physical injury is determined to be 50% of the cause of the condition with reasonable medical certainty and the condition did not pre-exist the work injury." (See New Recommendation 8.2)

For a national overview of how each state chooses to cover (or not) workplace mental injuries, we provide Table 8.1. This table shows states according to specific groupings. Those groupings are:

- states that do not cover mental injuries where there is no physical injury
- states that do not cover mental injuries where is no physical injury except in very specific exceptions
- states that do cover mental injuries but in a somewhat narrow manner
- states that cover mental injuries with fewer restrictions on coverage (note that Minnesota is the most recent addition to this group of states allowing PTSD claims for injuries occurring on or after 10/1/13)

You will see in the table below that there are 15 states that don't allow coverage, two that do under very specific circumstances, seven that allow coverage but with certain restrictions that are less restrictive than the second group, and 26 that allow coverage more broadly.

Table 8.1: Coverage of Mental Injury by State where there is no physical injury

Coverage Grouping	States
No allowance	AL, CT, FL, GA, ID, IN, KS, KY, MY, ND, OH, SD, TX, WV, WY
No allowance except in violent crimes	AR, OK
Allowance with certain restrictions	AK, CO, MD, MI, NE, NH, UT
Broader coverage allowed	AZ, CA, DE, HI, IL, IA, LA, ME, MA, MN, MS, MO, NV, NJ, NM, NY, NC,, OR, PA, RI, SC, TN, VT, VA, WA, WI

As mentioned in the Introduction of this Element, we have agreed to limit our analysis of potential PTSD coverage to specific accident types. Those three accident types include the following circumstances:

- First responders
- Victims of violent crimes
- Exposure to unusual and extraordinary events

States that meet these criteria in one way or another include Arkansas, Colorado, Maryland, Nebraska and Oklahoma. We next provide background on those states.

First Responders (Nebraska):

In 2010, Nebraska passed legislation (Legislative Bill 780) allowing for mental injury claims for first responders. First responders are defined in the legislation in a manner that is similar to language considered by the North Dakota legislature in HB 1376 during the 2013 session. Specifically, the Nebraska legislation allows claims for mental injury to be submitted only by police and fire personnel as well as emergency medical staff.

Language in LB 780 allows for coverage for first responders in those situations that are "extraordinary and unusual in comparison to the normal conditions of the particular employment." Viewed in the context of exposure to unusual and extraordinary events generally, we view first responder claims as a sub-set of the broader class of injuries that could fall within that definition.

When Nebraska's legislation was enacted in 2010 it included a sunset provision in 2014. The legislature wanted to determine how this law might impact costs in the intervening years. By 2013, the legislature decided to remove the sunset provision because the frequency of claims had been so low that the cost impact had proven negligible. We were not able to obtain any hard data on claim cost but anecdotal information suggested less than ten claims of this type had been filed within the first three years following enactment. One case apparently cost about $85,000 to resolve but most cases resolved for much more modest amounts.

In short, the Nebraska law is of recent vintage, and claim frequency and cost have been low. That state chose to limit coverage to certain occupations, notably those who are first on scene and who are exposed to accidents that may be categorized as horrific on a repetitive basis. The legislature chose not to include healthcare workers who work in trauma settings even though their exposure could be just as frequent.

Victims of Violent Crime (Arkansas and Oklahoma):

Arkansas and Oklahoma have statutes that allow for mental injury claims but only in circumstances tied to violent crimes. The Arkansas statute (A.C.A Section 11-9-113) states that no mental injury is allowed unless there is a physical injury and the mental illness arises from that injury. The only exception to that rule is the "physical limitation shall not apply to any victim of a crime of violence."

Oklahoma's statute (Title 85 – 3, paragraph 13, c) states that "Injury or personal injury shall not include mental injury that is unaccompanied by physical injury, except in the case of rape which arises out of and in the course of employment."

Arkansas imposes further limitations on coverage of mental injury claims that do not involve physical injury in this fashion:

- Mental injury disability benefits are limited to 26 weeks
- Death benefits may only be claimed if the death occurs within one year of the original injury

SB 2093 that was considered by the North Dakota legislature in 2011 applies to this category of coverage. Language in that bill sought to limit both the types of claims that might be covered due to violent crime and included duration and cost caps, as well.

We do not have specific mental injury costs from either Arkansas or Oklahoma on claims arising out of these kinds of workplace exposures.

Unusual and Extraordinary Events (Colorado and Maryland):

Colorado and Maryland have statutes that allow for mental injury claims that arise from unusual and extraordinary events in the workplace. In Colorado, injuries may be covered when no physical injury has occurred but instead "consists of a psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances."

In Maryland, the court opined in Belcher v. T. Rowe Price that a mental injury could occur as a consequence of an unexpected and unforeseen event that occurs suddenly or violently. In this particular case, Ms. Belcher was seated at her desk on the top floor of an office building adjacent to a construction site. A 3-ton steel beam attached to a crane broke loose and crashed through the roof and landed about five feet from Ms. Belcher. Her claim of PTSD was found to be compensable. In Maryland, an individual may also claim PTSD as an occupational disease claim, something that occurred in Means v. Baltimore County. Means was a paramedic exposed to repeated, horrific accident scenes and over time she developed PTSD. The court commented that occupational disease cases by their nature occur slowly and insidiously. The court felt Means met that test.

In a manner akin to what we observed in Arkansas, the state of Colorado imposes a limitation on the amount of disability benefits a person may receive for a claim of mental injury. That limit is twelve weeks of disability benefits. That limit applies to the combination of temporary total and permanent disability. Note that these limits do not apply if the mental injury is a consequence of a physical injury. For purely mental injury claims, there is no limit on duration of medical treatment.

We do not have any objective financial information on mental injury claims either in Colorado or Maryland. In discussing claims of this type with claims professionals who work in those states, they have indicated that claims of this type are rare. One mentioned that she had personally managed only one accepted claim of this type and it was for a lineman who had witnessed a co-worker get electrocuted. Such a claim would be in keeping with the standard established in Belcher.

Economic impact on Any Type of Compensable Injury:

North Dakota already has in place statutory language that permits coverage for mental injury claims if they arise out of a physical injury. Hypothetically, we consider the cases of severe burn victims or amputees who continue to be psychologically impaired and in need of treatment due to the consequences of their injuries. WSI already pays benefits in such cases as long as the injured worker

meets the statutory requirement that, “a mental or psychological condition [is] caused by a physical injury, but only when the physical injury is determined with reasonable medical certainty to be at least fifty percent the cause of the condition as compared with all other contributing causes combined, and only when the condition did not pre-exist the injury.” See NDCC Section 65-01-02 (10)(a)(6).

When we consider the “impact on any type of compensable injury,” we provide that forecast elsewhere in this section. Having said that, we did review the decision of a North Dakota Administrative Law Judge in a case involving a truck driver who sustained relatively minor injuries in a traffic accident in which the other driver was killed. The truck driver was subsequently diagnosed with PTSD but his psychological injury arose out of the experience of the accident rather than his physical injuries. As a consequence, the ALJ ruled that no compensable mental injury had occurred. Under a workers’ compensation statute that recognizes mental injuries without corresponding physical injuries such cases could well prove to be compensable. It is cases like this one along with first responders and victims of violent crimes that we consider in our financial forecasts.

Regarding the economic impact of expanding workers’ compensation coverage of PTSD, we have developed projected medical and indemnity costs related to covering first responders, victims of violent crime (in which no physical harm occurs), and those who are exposed to unusual and extraordinary events. Our findings are summarized in Exhibit 8.2 under a variety of scenarios. We have also provided projections both including and excluding correctional officers, as it is unclear if they would be considered to be first responders.

Methods:

We separately calculated the impact of extending North Dakota workers’ compensation coverage to PTSD claims for first responders, victims of violent crime with no bodily injury, and witnesses of traumatic events. For each of these categories we used a 2-step approach. First we estimated the number of expected PTSD claims, and second we estimated the cost per claim. The total cost is then the product of the number of claims times the cost per claim. Using high and low projections of both claim counts and costs per claim we estimated a range of costs.

First Responders:

The following is a description of the methods we used to project medical and indemnity claims costs for first responders.

1. Projected Number of Claims: We produced two estimates of the number of claims. One estimate is based on the experience of other states, and the other is based on academic literature regarding levels of PTSD in first responders.

a. Experience of Other States: We identified three states (Nebraska, Missouri, and Arkansas) that have some coverage for PTSD experienced by first responders. Using data from the U.S. Bureau of Labor and Statistics, we first identified the number of first responders in each state (Exhibit 8.9). We then calculated the frequency of PTSD claims by dividing the actual number of PTSD claims experienced in each state to the number of first responders in the state in (Exhibit 8.8). Based on the experience in these three states we selected an annual PTSD frequency of 0.00025 PTSD claims per first responder.

   One of the weaknesses of this approach is that the definition of PTSD and the employees covered for PTSD are not identical among the three states we looked into, nor would they be identical to what may be implemented in North Dakota. One of the advantages of this approach, however, is that it is based on workers' compensation claims as opposed to the incidence of PTSD. It appears to us that workers' compensation PTSD claim reporting is below the projected incidence of PTSD.

b. Academic Literature: There are many studies of PTSD, including ones that investigate the frequency of PTSD for police officers, firefighters, and emergency medical personnel. Unfortunately the studies are often based on small sample sizes and at times PTSD experience in foreign countries. Partly for this reason the literature points to a wide range of PTSD incidence.
   i. Snapshot of Incidence of PTSD (Exhibit 8.6): The top part of the chart on Exhibit 8.5 shows the low and high range of the incidence of PTSD at a given point in time as described in the literature. Based on this range we selected a specific incidence rate that is between the low and high end of the range. By "snapshot" we mean the percentage of a population that would be identified as having PTSD if that population were surveyed all at once. Given that people often experience PTSD for extended periods of time, this snapshot is very different from the number of people in the population who develop PTSD on an annual basis.

   ii. Conversion from Snapshot to Annual Incidence of "New" PTSD: In order to calculate this conversion, it's important to know how long PTSD is experienced. We used data from the National Comorbidity Survey (NCS) to estimate the percentage of PTSDs that last 3 months, 12 months, or longer ("lifetime"). This, combined with the average tenure of a first responder, tells us how many times a specific employee with PTSD would be counted in annual snapshots of PTSD. For example, if someone had PTSD for 3 months, then there would be a 25% chance that their PTSD would be included in an annual survey of PTSDs of a given population. On the other hand, if someone had PTSD for 10 years, then they would be included in 10 annual snapshot surveys. Based on this

information we calculated that a first responder with PTSD is likely to be counted 6.33 times in annual snapshots (Exhibit 8.7). This means that the frequency of new PTSD incidences is equal to the snapshot frequency divided by 6.33. Thus the conversion factor from snapshot frequency to annual "new" frequency is 0.16 (=1/6.33).

iii. Annual Incidence of PTSD (Exhibit 8.6): We calculated the annual incidence of PTSD by multiplying the snapshot frequency of PTSD (step b-i) by the conversion factor of 0.16 (step b-ii).

iv. Projected Number of Claims (Exhibit 8.5): This equals the number of first responders times the Annual incidence of PTSD.

One of the weaknesses of this approach is that it only identified the projected incidence of PTSD, and this can be very different from the number of PTSD claims that are filed. As we have discussed earlier, the number of PTSD claims filed in other states is lower than the projected incidence of PTSD. If this also holds true in North Dakota, then this method will substantially overestimate the number of PTSD claims that are filed.

2. Average Claim Size: We looked at the experience in other states as well as a "bottom up" approach in order to estimate the average size of a PTSD claim.

   a. Experience of Other States: the average size of PTSD claims in Missouri and Arkansas has been under $6,000 (Exhibit 8.8). This is based on legislative analysis performed by Nebraska when they were considering covering PTSD in workers' compensation. While we do not have the exact experience for Nebraska, it is our understanding that of the six claims they have experienced, five were minor and one was larger. Based on this information from other states we selected an average claim size of $5,000.

   b. "Bottom Up" Approach (Exhibit 8.4): This approach involves separately estimating the various components of workers' compensation benefits for PTSD claims. Temporary disability benefits are based on the maximum weekly benefit times the number of weeks of PTSD. This assumes that employees with PTSD are not able to perform their normal job functions. Based on the very low cost per PTSD claim in Missouri and Arkansas, it seems that in many cases those who file PTSD workers' compensation claims continue to work or are able to get back to their regular job duties rather quickly without incurring a lot of temporary disability. For this reason we ultimately developed projected annual costs both including and excluding temporary disability benefits. We have assumed that there will be no permanent disability benefits for PTSD claims, and annual medical costs are based on a recent study comparing the cost of therapy and drug treatment for PTSD (See footnote 3 at Exhibit 8.4 for the complete reference).

3. Average Annual Cost: This is calculated based on the projected number of claims (step #1) times the projected average cost per claim (step #2). We developed a range of indications based on the different projections of claim counts and average claim size. This produces a wide range, primarily because the workers' compensation claims experience in Missouri and Arkansas is below what we would have expected if everyone who had an incidence of PTSD filed a workers' compensation claims. So the estimates that utilize actual workers' compensation experience in other states are below the estimates that are based on the estimated incidence of PTSD.

Witnesses to Sudden and Extraordinary Events in Workplace Environments

The following is a description of the methods we used to project medical and indemnity claims costs for people who experience traumatic events at the workplace.

1. Projected Number of Claims: In order to project the number of claims in this category, we have assumed that the extraordinary events are primarily based on witnessing violent crime at the workplace. We first projected the number of workplace violent crimes and assumed one witness per event. We then projected the number of PTSD claims based on the number of projected witnesses times a probability of a witness developing PTSD.

    a. Projected Number of Workplace Violent Crimes: In order to project the number of workplace violent crimes in North Dakota, we started with national statistics on violent crime at the workplace by job classification (U.S. Department of Justice) and applied those rates to North Dakota's distribution of employees by job classification (U.S. Bureau of Labor and Statistics, Exhibit 8.11). We excluded law enforcement since PTSD from first responders is already considered separately, and we did not want to double-count this exposure.

    Next we adjusted for the fact that North Dakota tends to have a lower rate of violent crime than the U.S. in general (Exhibit 8.13). Based on data from the Uniform Crime Reporting Statistics, we found that between 2010 and 2012 North Dakota had a violent crime rate of 240.9 crimes per 100,000 of population. This is about 39% lower than the average U.S. violent crime rate of 392.8. As a result we reduced the estimate of workplace violent crimes by 39%, since those estimates were based on U.S. crime rates (Exhibit 8.11).

    One of the weaknesses of this approach is that it assumes that PTSD from witnessing traumatic events at the workplace is only from violent crime. While this is a very imperfect assumption, it is the best we could reasonably assume given the information available.

b. Number of Witnesses: We assumed that there is roughly one witness per workplace violent crime. This is a very imperfect projection, but it is the most reasonable assumption we could arrive at given the lack of available information. In general we assume that a lot of workplace violent crime occurs when there are no witnesses, but there are also events (such as those involving active shooters) in which there are many witnesses to a single event. Hence we arrived at the assumption of an average of one witness per crime.

c. Number of PTSD Claims: We have assumed that the percentage of witnesses of violent crime who develop PTSD is 8% and 24% at the low and high end, respectively (Exhibit 8.10). The literature suggests that somewhere between 15% and 24% of people who experience serious crime develop PTSD. On the low end we adjusted the 15% to 8%, under the assumption that witnesses are less likely to experience PTSD than direct victims. We did not adjust the high end estimate.

2. Average Claim Size: This is based on the exact same method as of first responders.

3. Average Annual Cost: This is calculated based on the projected number of claims (step #1) times the projected average cost per claim (step #2). We developed a range of indications based on the different projections of claim counts and average claim size.

Victims of Serious Workplace Crimes Who Do Not Experience Physical Harm:

The method we used to project medical and indemnity claims costs for people who are victims of serious workplace crime but do not have physical injuries is identical to the method used to estimate the costs of those who experience workplace trauma but with two exceptions. The results are calculated in Exhibit 8.10, and the two exceptions are detailed as follows:

1. Violent Crimes Not Involving Physical Harm: Once we have calculated the number of workplace violent crimes, we needed to consider the percentage of those crimes that do not result in injuries to the victim. We looked at the violent crime rates by category and judgmentally assigned a probability that the crime would result in physical harm (Exhibit 8.13). We assumed that 100% of murder, manslaughter and rape result in physical harm. By definition 100% of assault does not result in physical harm, since assault is defined as creating apprehension of harm without actually creating that physical harm. We assumed that 50% of robberies result in physical harm. Since over 75% of violent crime in North Dakota has historically been categorized as aggravated assault, the assumption regarding assault was most influential to our results. Overall we assumed that about 80% of violent crime does not result in physical harm.

2. Witnesses: Since this section deals directly with victims of crime, we did not have to assume a specific ratio of crime victims per crime.

Assumptions & Limitations:

Our approach to estimating the economic impact of PTSD on workers' compensation in North Dakota has several key assumptions and limitations, including the following:

1. We have only estimated the impact on medical and indemnity costs. We have not estimated the impact on loss adjustment or other expenses.
2. We have assumed that the expansion of benefits would only affect PTSD claims and would not increase utilization of any other types of claims. Some states assume that an increase in benefits, particularly indemnity benefits, will result not only in an increased cost per claim but also an increase in claim frequency.
3. To the extent possible we have utilized workers' compensation PTSD experience in other states. However, there may be several differences between those states and North Dakota, including the workers' compensation environment, the economic environment, the definition of PTSD, and the job classes that may file workers' compensation claims for PTSD.
4. There is no definitive literature regarding the probability that people who experience traumatic events or are victims of crime will develop PTSD. We had to utilize studies that included small sample sizes and populations in environments very different from those in North Dakota in order to estimate some of these key assumptions. The applicability of these assumptions is a major limitation of our results.
5. It is unclear how many people who would be eligible to file workers' compensation PTSD claims will actually do so. Workers' compensation PTSD data from other states suggests that a significant percentage of eligible people do not file workers' compensation PTSD claims.
6. We have used violent crime as a proxy for extraordinary events that could induce PTSD among witnesses. It is likely that there are other types of events other than violent crime that could trigger PTSD, but our best proxy for these extraordinary events is violent crime.

General Factors to Consider:

Post-traumatic stress disorder was not recognized as a disorder by the American Psychiatric Association until 1980. Arguably many Vietnam and other earlier war veterans experienced PTSD without the diagnosis. Similarly, we can be sure that before the diagnosis appeared that workers encountered various workplace situations where a claim of PTSD could have been asserted.

In the introduction, we referenced a review of claims submitted to WSI during the performance evaluation where the nature of injury was mental stress. There were ten such claims over that three-year window (2011 – 2013). Of the ten, only two of the cases appeared to have met the qualifying circumstances we are considering for potential coverage under the workers' compensation system. One was a first responder case where the employee had been exposed to repeated death scenes. The other

was a police officer involved in multiple police officer shootings where deaths had occurred. The other eight chiefly pertained to employer – employee relations issues that were either specific or cumulative in nature.

When Minnesota enacted a law in 2013 allowing PTSD claims, it appeared that the passage of the law came about at least in part because of a school shooting that occurred in that state in 2005. A teacher at the school filed a claim for PTSD, which was denied, as no law existed in Minnesota to allow such a claim at that time. Estimates, on the potential cost of this new law, range from .5% to 4% of premium. (As reported on WSI's June 2013 Operating Report, premium earned for FY 2013 amounted to about $334 million before accounting for premium discounts and ceded reinsurance premiums. Net premium earned amounted to about $310 million. Were we to apply a similar financial estimate from the state of Minnesota to North Dakota and we base our estimate on net premium earned, then a premium increase of between approximately $1.55 and $12.4 million could be expected in North Dakota. See also Exhibit 8.2 where we project a mid-range cost of PTSD at slightly more than $4.5 million.)

The Minnesota statute is also written to require that the law only applies to workers who experienced (a) traumatic event(s) on or after 10/1/13; that a diagnosis of PTSD is required that is consistent with the diagnostic requirements as spelled out by the DSM-V; and, that the diagnosis must be made by a licensed psychologist or psychiatrist.

Newtown, CT is the town where school shootings in late-2012 left 26 people dead, including 20 young school children. Connecticut does not cover mental injuries in the absence of a physical injury so claims made by safety officers or school teachers/administrators that experienced these events are not covered. At this writing, Connecticut was considering passage of a law that would allow for PTSD claims given the horrific nature of this event.

Common in the statutory schemes of various state's workers compensation systems is language akin to that found in North Dakota's proposed 2013 HB 1376; namely, that, "a mental injury arising from mental stimulus does not include a mental injury that results from an event or series of events that are incidental to normal employer and employee relations, including a personnel action by the employer such as a disciplinary action, work evaluation, transfer, promotion, demotion, salary review, or termination."

We reviewed various decisions related to coverage for mental injury claims in Illinois starting with a case called Pathfinder Company v. Industrial Commission. In that case, a worker was instructing a co-worker how to operate a machine and during the training the co-worker's hand was severed. The instructor reached into the machine, retrieved the hand, promptly fainted and subsequently experienced psychological injuries due to the shock of the event. The court ruled the psychological injury was compensable. The courts in Illinois have over time ruled that some mental injury claims are not compensable including ones involving cumulative workplace stressors such as verbal assaults or poor working conditions.

Pros and Cons:

The third part of this element asks us to consider the pros and cons of providing post-traumatic stress disorder coverage and the various conditions associated with eligibility requirements. We cover the cons first:

- Uncertainty exists as to the financial impact of covering this class of injuries
- In the minds of some, too much subjectivity may exist in making a diagnosis of PTSD for there to be a high degree of confidence in diagnostic accuracy
- A potential window may open for employees who now have no mental health coverage and their assertion of work-related PTSD could provide that coverage
- The workers' compensation system functions just fine as it is with respect to claims of mental injury, so why make a change
- About 30% of the states afford no mental injury coverage at all unless there is a physical injury that leads to the psychological condition

The pros:

- Employees have a no-fault way to receive benefits for workplace traumatic experiences as may be defined by statute
- Benefits can be statutorily structured to cure or relieve PTSD injuries to include certain cost controls
- It is reasonable to provide care for people if legitimately injured on the job whether the injury is physical or mental
- Workers' compensation systems change over time to recognize new ideas and improve benefits
- About 70% of the states afford some mental injury coverage ranging from very specific to broader circumstances

No doubt a broader list of pros and cons could be compiled.

One of the items we became aware of in our research of this project related to a claim of mental injury following a bank robbery that occurred in Gilby, ND. An editorial in the Fargo Forum took issue with the lack of coverage afforded to a bank employee who suffered mental trauma as a consequence of this experience. The Forum editorial also mentioned that the injured employee's medical costs amounted to about $1,000. Given what we have learned in our research of PTSD, we're not sure that her injuries would have been covered if a PTSD law existed because the worker may not have had symptoms long enough to support a PTSD diagnosis.

But the case is illustrative for a different reason. The Forum editorial indicated that the cost of treatment amounted to only about $1,000. While this may not be a typical experience for traumatized workers, we think it somewhat more likely that workers who have a one-time experience with a violent or horrific experience will have less expensive and less frequent claims than those workers (e.g., long-

time first responders) who may legitimately assert that they have been repeatedly traumatized by gruesome workplace events. For this latter group, the need to work in a new job may be a more likely consequence. As such, mental injury claims for this group could be more expensive given the greater likelihood that vocational rehabilitation services would be required.

Following traumatic events in the workplace, it is not uncommon for employers to provide crisis management professionals through employee assistance programs to address mental healthcare needs. Whether North Dakota chooses to enact a PTSD law or not, we assume that employers will continue to provide such services.

Summary Comments:

In considering what kind of recommendation to make related to coverage of PTSD in North Dakota, we focused our analysis on three case types (first responders, victims of violent crimes and those who have experienced unusual and extraordinary events). We have also found that in the states of Colorado and Arkansas benefit caps exist. And when we looked at Nebraska, we found that they introduced a bill for first responders in 2010, that this bill had a sunset provision, and that the frequency and cost of injuries related to the bill after roughly three years of experience were negligible.

Employees go to work as they are. Some have pre-existing conditions that influence claim decisions when they have workplace injuries. Some are more physically capable, some are more mentally astute, and some have greater coping mechanisms than their peers. When a worker is injured in the workplace, it is often as a consequence of his/her own failure to apply safe work methods. But coverage is not denied for that reason.

In most of the case circumstances we have referenced above, coverage is afforded for injuries to the psyche when the event or events are so out of the ordinary that the development of a psychological condition (PTSD) is viewed as a real and understandable consequence. Examples we referenced included witnessing a co-worker lose her hand, seeing a co-worker electrocuted, and the cumulative effects of psychological trauma for a first responder in Maryland.

We also provided in Exhibit 8.1 the current definition of PTSD according to the American Psychiatric Association, which requires a fairly rigid set of criteria be met to support the diagnosis. As well, certain exclusions apply. And a patient must have symptoms for at least a month to support the existence of PTSD in that individual. (See Recommendation 8.3)

In the event that WSI submits legislation that passes relating to Recommendation 8.3, then the legislature may also be required to amend the Century Code to address providers who are included in the Designated Medical Provider program. (See Recommendations 8.4, in that context.)

New Recommendations

Recommendation 8.1: Low Priority

If the legislature adopts a statute covering PTSD claims, we recommend that to the extent statutory language currently exists to require injured workers to file their claims within certain time frames that this language be amended (if needed) to extend that time frame. The extension should be in keeping with when injured workers knew or should have known that they have a PTSD injury and that the condition is related to workplace experiences.

(Note on recommendation 8.1 – The reason for this recommendation is to provide statutory relief for timely claim filing in keeping with the period of time that must elapse for the condition to actually manifest itself. WSI may believe that NDCC Section 65-05-01 would already achieve this objective, which is why we categorize this recommendation as low.)

> **WSI Response: Do Not Concur.** Existing law adequately addresses the timely filing concerns posed by this recommendation.

Recommendation 8.2: High Priority

When WSI currently pays for mental or psychological injuries arising out of a physical injury, at least 50% of the mental injury must be attributable to the work-related injury given other possible causes. We recommend application of the same 50% threshold should the legislature adopt statutory language to cover workplace PTSD where no physical injury has occurred. See NDCC Section 65-01-02 (10) (a) (6) in this regard.

> **WSI Response: Concur.** Should the legislature adopt statutory language to cover workplace PTSD, WSI will consider this recommendation.

Recommendation 8.3: High Priority

We recommend that

- WSI submit legislation to allow mental injury claims under one or more of the three scenarios we referenced in our findings. Those scenarios include first responder claims, victims of violent crimes and workers who experience unusual and extraordinary events. In the event that legislation is submitted to cover workers who experience unusual and extraordinary events as the primary qualifying characteristic, we recommend that this language would be understood to include first responders and victims of violent crimes
- WSI establish a cap on disability benefits in the legislation in a manner that is similar to the law in the State of Arkansas; that is, that temporary total disability benefits will not be paid for more than 26 weeks and no death benefit will be paid if the death occurs more than one year from the date of injury

- Vocational rehabilitation services should be provided if as a consequence of the mental injury a return to the usual job is not possible
- A PTSD diagnosis must be made by a qualified healthcare professional in the field of mental health before any benefit may be paid
- Language should be included in new legislation that excludes from coverage any claim that allegedly arises out of "normal employer and employee relations"
- A sunset provision should exist of no shorter than two years and no longer than four years during which time WSI should develop measures designed to identify the actual benefit costs to providing coverage for injuries of the types contemplated in the proposed legislation
- WSI identify as part of its metrics those injured workers whose temporary total disability benefits end because they have exhausted the 26-week cap (this should be part of an overall metric that includes a total claim count, and total and average medical and indemnity costs as compared to average costs of other workers' compensation claims in North Dakota)
- That if a bill is submitted specifically related to first responders that they are identified/limited by occupation
- That claims for PTSD would only be accepted based on an event date that the legislation would establish (e.g., the legislation may state that PTSD claims will only be accepted for events on or after 4/1/15)

> **WSI Response: Concur.** Legislation of this kind has been introduced in the past by various entities without success. WSI will draft legislation for consideration by the Workers' Compensation Review Committee. In that process, WSI will consider the specific criteria provided in this recommendation.

Recommendation 8.4: Medium Priority

In the event the legislature adopts legislation to cover mental injury claims, then Designated Provider Programs should include at least one psychologist or psychiatrist as a designated provider.

> **WSI Response: Do Not Concur.** Under the current law, employers choose their own designated medical providers. WSI is not in a position to mandate inclusion of specific providers to employers. However, employers may select a specific mental health care provider as they deem appropriate.
>
> **Sedgwick Reply**: To the extent WSI is in a position to influence the selection by employers of DMP members by specialty, we encourage inclusion of an occupational health provider, an orthopedist, a dermatologist and if a PTSD statute is added a psychiatrist. Networks in other states typically require that an employer include physicians of various specialties and the inclusion of the specialists we have mentioned would be a good start.

Exhibits

Exhibit 1.1 – IME Review Worksheet

Demographic Data

Claim #: _____ Claim Type/Status: _____ DOI: _____

Injured Worker Name: _____ Occupation: _____

IW Home State: _____ Adjuster: _____ Supv: _____

Description of Injury/Body Part(s) Injured:

_____

_____

Policyholder Name: _____ Employer Loc/ Industry: _____

Summary of medical services provided prior to determination of IME need/requirement:

_____

_____

_____

_____

IME/IMR Process

Date IME or IMR requested by CE: _____ C121: Y/N C141: Y/N
Claim Procedure(s): _____

Issue(s)/Reason(s) stated for IME/IMR: Diagnosis/Prognosis/Treatment/Fees
Why IME vs IMR, etc.

_____

_____

_____

_____

Examiner Selection: _____
C141 requested: Y/N Staffing with Med Dir/Advisor: Y/N

Date of IME: _____ Date of IMR: _____ Specialty: _____
Reasonable effort made to designate ND licensed physician: Y/N/No info
IME Selected: _____ Same Specialty: Y/N _____
Exam Location: _____ Site > 275 miles from EE residence: Y/N
Physician State License: _____Vendor/Group/Health System: _____
Notes in claim system: _____
IW Notified: Y/N PTP Notified: Y/N

Objection(s) by any party:_____ _____ _____
_____
_____
Resolution(s) to objection(s):_____ _____
_____
_____
IW request designated physician present/review: At exam: Y/N Post-exam: Y/N
IW request travel reimbursement w/in 1 year: Y/N Original receipts provided: Y/N
Travel paid: _____ Personal expenses paid: _____
Wages paid: _____
_____
_____

Records/Diag requested: Y/N Records reviewed/documented: Y/N Records used: Y/N
C141 prepared: Y/N C141 info used in cover letter to IME: Y/N vs boiler plate
Comments: _____
_____
_____
_____

If multiple IMEs, complete information for each – use additional sections

PE1010-1.0/1.3: Use IME process to obtain info in FL332 that treater fails to respond to.

Treater _____ failed to respond med/legal question(s) in FL332? Y/N

IME used to resolve: Y/N _____
_____
_____

PE2010-5.0/5.4: PE conditions, prior conditions, and degenerative conditions.

Claim denied: Y/N Date claim denied: _____ Reason: _____ _____ _____
Issue(s): _____ _____ _____ _____
_____
_____ _____

IME used to resolve any issue(s): _____
_____
_____

IME/IMR Process

Date IME or IMR requested by CE: _____ C121: Y/N C141: Y/N
Claim Procedure(s): _____

Issue(s)/Reason(s) stated for IME/IMR: Diagnosis/Prognosis/Treatment/Fees
_____
_____
_____
_____

Examiner Selection: _____
C141 requested: Y/N Staffing with Med Dir/Advisor: Y/N

Date of IME: _____ Date of IMR: _____ Specialty: _____
Reasonable effort made to designate ND licensed physician: Y/N/No info
IME Selected: _____ Same Specialty: Y/N _____
Exam Location: _____ Site > 275 miles from EE residence: Y/N
Physician State License: _____Vendor/Group/Health System: _____
Notes in claim system: _____
IW Notified: Y/N PTP Notified: Y/N
Objection(s) by any party:_____ _____
_____
_____

Resolution(s) to objection(s):_____ _____
_____
_____
IW request designated physician present/review: At exam: Y/N Post-exam: Y/N
IW request travel reimbursement w/in 1 year: Y/N Original receipts provided: Y/N
Travel paid: _____ Personal expenses paid: _____
Wages paid: _____
_____
_____

Comments regarding IME selection/notification process/travel&expense processes
_____
_____
_____
_____
Records/Diag requested: Y/N Records reviewed/documented: Y/N Records used: Y/N
C141 prepared: Y/N C141 info used in cover letter to IME: Y/N
Comments: _____
_____
_____

Post IME

Report Date: _____ Date of Receipt: _____ IME agree w treater: Y/N
IME answer questions asked in cover letter from C141: Y/N
If IME disagrees, IME report sent to treater with letter asking for concurrence: Y/N
If treater disagrees with IME, next steps taken: _____
_____
_____
_____

NOD issued: Y/N #_____: Statute: _____
_____
_____

Treatment under review accepted/denied/provided: _____
_____
_____
IME bill paid: Y/N _____

Denial reason (circle one): factual, legal, medical, other:
_____
_____
_____

Supervisor review and approval: (Y/N) _____

Result of denial (circle one): no contest, appeal, overturned

Reconsidered: (Y/N) _____
_____

Appealed: (Y/N) _____
_____

C39: (Y/N) _____

Comment:

_____
_____
_____
_____
_____
_____

Litigation Process

EE Unrepresented: (Y/N) OIR involved: (Y/N) _____

Issue to be resolved (circle one): Medical Factual Legal Jurisdictional

Resolution Attempts: _____
_____
_____

Timeliness of dispute resolution (circle one): timely, prolonged

Appeal Filed: _____
_____

Overturned: (Y/N) _____

Represented Date: _____WSI Legal Rep: _____

Defense Firm: _____ Representative: _____

Assign Date/Purpose: _____

Method used to resolve: _____
_____
_____

Negotiation outcome: _____

Additional processes:
_____
_____
_____
_____
_____
_____
_____

Other comments:
_____
_____
_____

Exhibit 3.1 - DRO Review Worksheet

Demographic Data

Claim #: _____ Claim Type/Status: _____ DOI: _____

Injured Worker Name: _____ Occupation: _____

Employer: _____ Adjuster: _____ Supv: _____

Reason for Denial:

Complete Option A or Option B

Option A

If case was affirmed, did it lead to an additional appeal? Y/N (If yes, what was outcome?)

Option B

Describe what happened to change or Stipulate:

Exhibit 4.1: Rehabilitation Form

Claim Number: _____ Claimant: _____ DOI: _____

Section 65-05.1-01: Plan Development

Plan Type: _____

(Options for plan type include a.) return to the same position; b.) return to the same occupation, any employer; c.) return to a modified position; d.) return to a modified or alternative occupation, any employer; e.) return to an occupation within the local job pool of the locale in which the claimant was living at the date of injury or of the employee's current address which is suited to the employee's education, experience and marketable skills; f.) return to an occupation in the statewide job pool which is suited to the employee's education, experience, and marketable skills; and, g.) retraining of one hundred four weeks or less.

Training required if option c – f was selected: _____ Part-time employment applicable if option a – f was selected? _____ If option g selected, did ee accept retraining option timely? _____

Wages at time of injury: _____ Wages at time of file closure _____

SAWW at time of vocational report per section 65-05.1-02.1 _____

Paragraph 6 applicable? _____ Valid calculation of TPD _____

Income test waiver applicable _____

Comment:

_____

_____

_____

Section 65-05.1-02.1: Vocational report Content:

First appropriate option identified? _____ Why higher plan options not selected _____

Identify jobs in the local or statewide job pool and the employee's anticipated earnings from each job, as applicable _____

Describe an appropriate retraining program, anticipated opportunities upon completion, and anticipated earnings, as applicable _____

Date of report: _____

Comment:

_____

_____

Section 65-05.1-06.1: Rehabilitation Award

Date administrative order issued spelling out employee's entitlement to disability and VR services:

_____

If short or long term training option, does the award include:

Rehabilitation allowance equal to benefits received prior to award_____

Travel _____ Allowance limited to 104 weeks _____

Extension of benefits given beyond 104 weeks: _____

Award include cost of books, tuition, fees, equipment, tools, supplies _____

Cost comparison done to chosen school v. public college or university in state where benefits provided

_____

Relocation expenses applicable? _____

Additional work search limited to two months of benefits? _____

Partial disability benefits paid after completion of program _____

Any other disability benefit paid after completion of program justified _____

Comment:

_____

_____

Section 65-05.1-06.2: Contract for vocational services

Proof of vendor qualifications obtained? _____

Comment on external vendor performance:

_____

_____

Exhibit 5.1: DMP Program Questionnaire Letter

Employer Letter enclosed with Designated Medical Provider Employer Questionnaire

Dear Employer,

§65-02-30 of the North Dakota Century Code requires a performance evaluation of Workforce Safety and Insurance (WSI). This performance evaluation is overseen by the Office of the State Auditor and is funded through a continuing appropriation by the state legislature. This year, a team of workers' compensation professionals from Sedgwick CMS were chosen to conduct the evaluation.

The subjects selected for review in each performance evaluation are referred to as elements, and at each evaluation several elements are developed in coordination with the legislature's workers' compensation review committee, the Office of the State Auditor and WSI.

One of the elements selected this year pertains to Designated Medical Provider ("DMP") Program – an optional Workers Compensation program that permits employers to select medical provider(s) to treat their injured workers. Your company has been identified as one that currently uses the DMP program. And Sedgwick is interested in your use and opinion of the DMP program.

Answers provided to the enclosed questionnaire may be used in the final report in this year's performance evaluation but pursuant to §65-02-20 of the North Dakota Century Code no employer will be identified by name in the report nor will their identities be revealed in any work papers Sedgwick must provide to the State Auditor's office.

As such, we encourage your participation to assist in the evaluation into the use of the Designated Medical Provider program for North Dakota employees who sustain injuries at work.

We are providing this questionnaire to you through Sedgwick and would ask that you return your replies in the self-addressed stamped envelope provided to Patrick Beck; Sedgwick CMS; 7731 E. Kemper; Cincinnati, OH 45249. If you have any questions about the survey, please email them to the following address: Patrick.Beck@sedgwickcms.com, We hope that your responses, which we ask you to complete before July 4, will help us in our assessment. Thank you for the courtesy of your reply.

Exhibit 5.2 DMP Employer Questionnaire

Designated Medical Provider Program Survey

Your Company's Name _____

Question 1: Have you notified your Designated Medical Provider(s) (DMP) that they are the designated provider(s) for your Company's injured workers?

If yes, how was the DMP notified?

Have you documented in writing the arrangement with your DMP Provider(s)?

Question 2: How do you provide information about the Designated Medical Provider to your current employees?

Briefly describe the information provided.

Question 3: Do you document in writing that the employee understands the DMP program?

If you answered yes, briefly describe the document

Question 4: How do you notify your employee at the time of injury of your company's Designated Medical Provider?

Question 5: How do you direct the injured workers to the Designated Medical Providers for non-emergency treatment?

Question 6: Do you inform your employees of the opportunity to request in writing additional (Non – DMP) Providers prior to the time of injury?

Question 7: Do you post information about the Designated Medical Provider program at your worksite(s)

Question 8: What is your overall opinion of the Designate Medical Provider program?

Question 9: Please provide any additional comments that may assist with improving the DMP program

Exhibit 5.3 Designated Medical Provider Employee Questionnaire

Designated Medical Provider Telephonic Questionnaire to Employees

Is (name of injured worker) there?

My name is (Sedgwick Employee) and I have been asked to conduct a short survey related to workers' compensation on behalf of the State of North Dakota and I'm wondering if you have a few minutes to answer a few questions.

I am specifically calling about your employer's Designated Medical Provider program where your employer selects medical providers for work related injuries. You had a work-related injury in the past few years and have been selected at random to discuss your awareness and experience with your employer's Designated Medical Provider program. I want to assure you that all answers will be maintained in a confidential manner. Further neither your name nor the name of any other survey respondents will be mentioned in any of the work we are doing on behalf of the State. May I proceed with the survey?

Question 1: Do you recall if your Company has anything posted where you work about their Workers compensation program?

a. If yes; do you recall if the notice discussed which doctors or medical facilities you should go to if you are injured on the job?

Question 2: Since you were hired, do you recall if your employer has discussed or provided information about your company's Workers Compensation program.

a. If yes; do you remember if the Employer informed you about which doctors or medical facilities you should go to?

b. If yes; do you remember if it was put in writing and did you have to sign it?

c. And do you remember if you were allowed to add doctors to the list

Question 3: If you are injured on the job and it's not an emergency have you been told who to contact in the company

a. If yes; who is the contact

Exhibit 8.1: Definition of Post-Traumatic Stress Disorder

DSM-5 Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (1). The diagnostic criteria are specified below.

The criteria below are specific to adults, adolescents, and children older than six years. Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: **(one required)**

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): **(one required)**

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks), which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: **(one required)**

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: **(two required)**

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: **(two required)**

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hyper-vigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

Criterion F: duration

Symptoms referenced in Criteria B - E must persist for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment must exist (e.g., social or occupational settings).

Criterion H: exclusion

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).

De-realization: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

Exhibit 8.2: North Dakota: Cost of Post-Traumatic Stress

Protective & Emergency Medical, Workplace Violence Victims & Witnesses

Projected Cost

	Protective All[1]	Protective ex Correctional[1]	Workplace Violent Crime Victims[2]	Workplace Violent Crime Witnesses[3]	Total All	Total ex Correctional
Low	5,113	3,463	689,934	461,056	1,156,103	1,154,453
Low-Mid	12,577	8,518	1,103,895	1,383,168	2,499,639	2,495,580
Mid	103,375	70,012	2,206,410	2,268,395	4,578,180	4,544,817
Mid-High	312,560	206,960	13,950,473	9,322,550	23,585,583	23,479,983
High	6,319,963	4,184,731	22,320,756	27,967,651	56,608,371	54,473,139

[1] Exhibit 8.3

[2] Exhibit 8.10

[3] Same as cost of victims. Assumes on average one witness per crime.

Exhibit 8.3: North Dakota: Cost of Post-Traumatic Stress

Protective & Emergency Medical

Projected Cost

	Police	Fire	EMT	Correctional	Other	Total
# of PTSD Occurrences[1]						
Based on Literature: Selected	23	7	12	21	na	63
Based on other States	0.4	0.1	0.2	0.3	na	1.0
Average Cost per Claim						
Based on other States[2]	5,000	5,000	5,000	5,000	5,000	5,000
Medical Only[3]	12,300	12,300	12,300	12,300	12,300	12,300
"Worst Case"[3]	101,100	101,100	101,100	101,100	101,100	101,100
Projected Total Cost[4]						
Low	1,813	638	1,013	1,650	na	5,113
Low-Mid	4,459	1,568	2,491	4,059	na	12,577
Mid	36,649	12,890	20,473	33,363	na	103,375
Mid-High	116,000	32,640	58,320	105,600	na	312,560
High	2,345,520	659,981	1,179,230	2,135,232	na	6,319,963

[1] Exhibit 8.5

[2] Exhibit 8.8

[3] Exhibit 8.4

[4] Low = Other states occurrence x other state cost per claim

Low-Mid = Other states occurrence x Medical Only cost per claim

Mid = Other states occurrence x "worst case" cost per claim

Mid-High = Occurrences in literature x other state cost per claim

High = Occurrences in literature x "worst case" cost per claim

Exhibit 8.4: North Dakota: Post-Traumatic Stress Claims

Projected Average Claim Size: "Worst Case"

	3-month	12-month	24+ month	Total
Temporary Disability				
# of weeks	13	52	104	
Weekly benefit[1]	1,120	1,120	1,120	
TD cost	14,560	58,240	116,480	88,800
Permanent Disability[2]	-	-	-	-
Medical				
# of Years of Treatment	0.25	1.00	2.00	
Annual Cost of Treatment[3]	8,090	8,090	8,090	
Total Medical	2,023	8,090	16,180	12,300
Total Cost per Claim[4]	16,583	66,330	132,660	101,100
Distribution of PTSD[5]	10%	30%	60%	

[1] Based on current weekly max of $1,098 increased by 2%

[2] Assume no Permanent Disability benefits allowed

[3] Le QA, Doctor JN, Zoellner LA, Feeny NC (2014) Cost-effectiveness of prolonged exposure therapy versus pharmacotherapy and treatment choice in posttraumatic stress disorder (the Optimizing PTSD Treatment Trial): a doubly randomized preference trial. *J Clin Psychiatry*. 2014 Mar;75(3):222-30 2012 cost of $7,778 adjusted to 2014 at 2% per year

[4] Sum of TD, PD, and Medical costs. Total based on weighted average using distribution of PTSD

[5] Based on distribution of PTSD claims from the National Comorbidity Survey (NCS)

Exhibit 8.5: North Dakota: Incidence of Post-Traumatic Stress

Protective & Emergency Medical

Projected Number of Annual Incidence

	Police	Fire	EMT	Correctional	Other	Total
# of Employees[1]	1,450	510	810	1,320	2,910	-
Annual Frequency of PTSD[2]						
Based on Literature: Low	1.4%	0.8%	0.9%	na		
Based on Literature: High	5.1%	2.6%	3.7%	na		
Based on Literature: Selected	1.6%	1.3%	1.4%	1.6%	na	
Based on other States[3]	0.03%	0.03%	0.03%	0.03%	na	
Projected # of Incidences[3]						
Based on Literature: Low	21	4	7	na	na	
Based on Literature: High	74	13	30	na	na	
Based on Literature: Selected	23	7	12	21	na	63
Based on other States[3]	0.4	0.1	0.2	0.3	na	1

[1] Source: Bureau of Labor and Statistics: http://www.bls.gov/soc/home.htm
[2] Sources for frequency of PTSD literature
[3] Exhibit 8.8
[4] Equals # of employees x annual claim frequency

Exhibit 8.6: North Dakota: Incidence of Post-Traumatic Stress

Protective & Emergency Medical

Claim Frequency Rates per Employee

	Police	Fire	EMT	Correctional	Other
Snapshot Frequency of PTSD[1]					
Based on Literature: Low	8.9%	5.0%	5.6%	na	
Based on Literature: High	31.9%	16.3%	23.0%	na	
Based on Literature: Selected	10.0%	8.0%	9.0%	10.0%	na
Annualization Adjustment Factor[2]	0.16	0.16	0.16	0.16	0.16
Annual Frequency of PTSD[3]					
Based on Literature: Low	1.4%	0.8%	0.9%	na	na
Based on Literature: High	5.1%	2.6%	3.7%	na	na
Based on Literature: Selected	1.6%	1.3%	1.4%	1.6%	na

[1] This represents the frequency in a sampled population at a moment in time

fire lo	Del Ben, K.S., Scotti, J.R., Chen, Y., & Fortson, B.L. (2006). Prevalence of posttraumatic stress disorder symptoms in firefighters. *Work and Stress, 20*, 37-48.
fire hi	Heinrichs, M., Wagner D., Schoch W., Soravia L.M., Hellhammer DH, Ehlert U (2005). Predicting Posttraumatic stress symptoms from pretraumatic risk factors: a 2-year prospective follow-up study in firefighters. *Am. J. Psychiatry*, 162(12), 2276-86, 20, 37-48.
pol lo	Asmundson, Gordon J.G. and Stapleton, Jennifer (2008). Associations between dimensions of anxiety sensitivity and PTSD symptom clusters in active-duty police officers. *Cognitive Behaviour Therapy* Vol. 37, No. 2, 66-75
pol hi	Deborah B. Maia, Metzler T., Nobrega A., Berger W., Mendlowicz M., Coutinho E., Figueira I. (2008). Abnormal serum lipid profile in Brazilian police officers with post-traumatic stress disorder. *J Affect Disord.*, 107(0): 259–263.
pol other	Violanti JM, Fekedulegn D, Hartley TA, Andrew ME, Charles LE, Mnatsakanova A, Burchfiel CM. (2006) Police trauma and cardiovascular disease: between PTSD symptoms and metabolic syndrome. *International Journal of Emergency Mental Health*, 8(4), 227-237association
Amb low	Bennett P, Williams Y, Page N, Hood K, Woollard M, Vetter N. (2005) Associations between organizational and incident factors and emotional distress in emergency ambulance personnel. *Br J Clin Psychol.* 44(2), 215-226
Amb high	William Berger, Figuera I., Maurat A.M., Bucassio E. P., Vieira I., Jardim S., Coutinho E., Mari J.J., Mendlowicz M. (2007) Partial and full PTSD in Brazilian ambulance workers: Prevalence and impact on health and on quality of life. *Journal of Traumatic Stress*, Vol. 20 (4), 637-642

[2] Exhibit 8.7

[3] This represents the annual incidence of PTSD

Exhibit 8.7: North Dakota: Post-Traumatic Stress Claims

Adjustment from Snapshot to Annual Frequency

	3-month	12-month	24+ month	Total
Average Length of Service (Years)[1]	10	10	10	
Distribution of New PTSD[2]	10%	30%	60%	
# of Times Counted in Annual Survey[3]	0.25	1.00	10.00	6.33
Adjustment Factor to Annual Frequency[4]				0.16

[1] Based on police & fire combined
[2] Based on distribution of PTSD claims from the National Comorbidity Survey (NCS)
[3] Assumes 24+ months is lifetime PTSD
[4] Equals 1/(total # of times counted in annual survey)

Exhibit 8.8: North Dakota: Post-Traumatic Stress Claims

Experience of Other States

	Nebraska	Missouri	Arkansas	Selected
# First Responders[1]	7,150	30,640	12,370	
Annual # of Claims[2]	2	7	3	
# of Claims per First Responder	0.00028	0.00023	0.00024	0.00025
Average Claim Size[2]	na	5,627	2,385	5,000

[1] Exhibit 8.9
[2] Nebraska legislative analysis

Exhibit 8.9: Protective & Emergency Medical Employment by State

Bureau of Labor & Statistics: May 2014

Occupation (Standard Occupational Classification code)	North Dakota	Nebraska	Missouri	Arkansas	Description
First-Line Supervisors of Correctional Officers(331011)	220	320	300	260	Correctional
First-Line Supervisors of Police and Detectives(331012)	170	720	2,420	990	Police
First-Line Supervisors of Fire Fighting and Prevention Workers(331021)	70	320	1,340	510	Fire
First-Line Supervisors of Protective Service Workers All Other(331099)	130	280	910	290	Other
Firefighters(332011)	440	1,200	6,340	2,510	Fire
Fire Inspectors and Investigators(332021)	-	60	210	30	Fire
Forest Fire Inspectors and Prevention Specialists(332022)	-	-	-	160	Fire
Bailiffs(333011)	210	80	230	110	Correctional
Correctional Officers and Jailers(333012)	890	2,170	8,270	5,160	Correctional
Detectives and Criminal Investigators(333021)	240	350	1,630	530	Police
Parking Enforcement Workers(333041)	-	-	60	-	Other
Fish and Game Wardens(333031)	60	-	-	180	Other
Police and Sheriff's Patrol Officers(333051)	1,040	3,490	12,190	5,410	Police
Animal Control Workers(339011)	-	80	310	160	Other
Private Detectives and Investigators(339021)	-	-	1,020	120	Other
Gaming Surveillance Officers and Gaming Investigators(339031)	60	-	200	-	Other
Security Guards(339032)	1,750	4,060	15,790	5,540	Other
Crossing Guards(339091)	-	110	300	160	Other
Lifeguards Ski Patrol and Other Recreational Protective Service Workers(339092)	390	1,180	3,870	440	Other
Transportation Security Screeners(339093)	140	230	520	170	Other
Protective Service Workers All Other(339099)	150	610	1,430	600	Other
Protective Service Workers Misc.	230	410	90	60	Other
Emergency Medical Technicians and Paramedics (SOC code 292041)	810	1,010	6,510	2,230	EMT

Exhibit 8.9: Continued

	North Dakota	Nebraska	Missouri	Arkansas	Description
Totals					
Police	1,450	4,560	16,240	6,930	
Fire	510	1,580	7,890	3,210	
EMT	810	1,010	6,510	2,230	
Correctional	1,320	2,570	8,800	5,530	
Other	2,910	6,960	24,500	7,720	
Subtotal 1st Responder (ex Correctional, Other)	2,770	7,150	30,640	12,370	
Grand Total	7,000	16,680	63,940	25,620	
Total Protective Service Occupations(330000)	6,190	15,670	57,430	23,390	

Source: Bureau of Labor and Statistics: http://www.bls.gov/soc/home.htm

Exhibit 8.10: North Dakota: Cost of Post-Traumatic Stress

Victims of Workplace Violent Crime

Projected Cost

	Victims with no Physical Harm	Witnesses
# of Workplace Violent Crimes (Annual in ND)[1] (ex Law Enforcement)	920	1,153
% Victims that Will Develop PTSD[2]		
Low	15%	8%
High	24%	24%
% PTSD from Victims of Workplace Violent Crimes[3]		
Low	138	92
High	221	277
Average Cost per Claim		
Based on other States[4]	5,000	5,000
Medical Only[5]	12,300	12,300
"Worst Case"[5]	101,100	101,100
Projected Total Cost[6]		
Low	689,934	461,056
Low-Mid	1,103,895	1,383,168
Mid	2,206,410	2,268,395
Mid-High	13,950,473	9,322,550
High	22,320,756	27,967,651

[1] Exhibit 8.11

[2] Wolff, N. L., & Shi, J. (2010). Trauma and incarcerated persons. In: Scott, C. L. (Ed.), *Handbook of Correctional* Mental *Health (2nd ed.)* (pp. 277-320).
Low projection assumes witnesses are 50% less likely to develop PTSD than victims

[3] Projected # of Victims x % of Victims the Develop PTSD

[4] Exhibit 8.8

[5] Exhibit 8.4

[6] Low = Low # Claims x other state cost per claim
Low-Mid = High # Claims x other state cost per claim
Mid = Average High & Low # Claims x Medical Only cost per claim
Mid-High = Low # Claims x "worst case" cost per claim
High = High # Claims x "worst case" cost per claim

Exhibit 8.11: Workplace Violent Crime Estimates

North Dakota

Projected Number of Annual Incidences

	Rate of Workplace Violent Crime1	# of Employees: North Dakota2	# of Employees: U.S.2	Adjustment for General Differences in Violent Crime (N.D. vs. U.S.)3	Projected # of ND Workplace Violent Crimes4
Medical	5.1	23,560	7,848,640	0.61	74
Mental health	20.5	2,690	2,421,440	0.61	34
Teaching	6.5	22,580	8,400,640	0.61	90
Law enforcement	47.7	2,440	1,213,870	0.61	71
Retail sales	7.7	27,330	8,500,690	0.61	129
Transportation	12.2	40,760	9,005,120	0.61	305
Other/unspecified	2.8	303,570	95,198,410	0.61	521
Total ex Law Enforcement		420,490	131,374,940		1,153
Total		422,930	132,588,810		1,224
Weighted Workplace Violent Crime Rate					
Ex Law Enforcement		4.5	4.5		
Total All		4.7	4.9	0.61	

[1] Source: Department of Justice, Report Workplace Violence, 1993-2009 NCJ 233094;
Table 2. Workplace and nonworkplace violence, by occupation, 2005-2009
Rate of workplace violence per 1,000 employed persons aged 16+

[2] Source: Bureau of Labor and Statistics: http://www.bls.gov/soc/home.htm

[3] Exhibit 8.13

[4] U.S. Rate of Workplace Violent Crime x # of ND Employees / 1,000 x Adj. Factor for Differences in Violent Crime

Exhibit 8.12: Workplace Violent Crime Estimates

North Dakota

Projected Number of Annual Incidence with No Physical Harm

	Projected # of ND Workplace Violent Crimes[1]	% of Violent Crime with no Physical Injury[2]	Projected # of ND Workplace Violent Crimes w/no Physical Harm3
Medical	74	80%	59
Mental health	34	80%	27
Teaching	90	80%	72
Law enforcement	71	80%	57
Retail sales	129	80%	103
Transportation	305	80%	243
Other/unspecified	521	80%	416
Total ex Law Enforcement	1,153		920
Total	1,224		977

[1] Exhibit 8.11
[2] Exhibit 8.13

Exhibit 8.13: Violent Crime Rates (Workplace and non-Workplace)

North Dakota vs. United States Violent Crime Rates[1]

	Violent Crime rate	Murder and nonnegligent manslaughter rate	Forcible rape rate	Robbery rate	Aggravated assault rate
North Dakota					
2010	229.5	1.5	36.3	13.3	178.3
2011	248.1	3.5	38.8	13.3	192.5
2012	244.7	4.0	38.9	18.7	183.1
Avg.	240.9	3.0	38.0	15.1	184.7
United States					
2010	404.5	4.8	27.7	119.3	252.8
2011	387.1	4.7	27.0	113.9	241.5
2012	386.9	4.7	26.9	112.9	242.3
Avg.	392.8	4.7	27.2	115.4	245.5
Avg. N.D./U.S.	0.61	0.64	1.40	0.13	0.75
% Not Involving Bodily Harm	80%	0%	0%	50%	100%
3 Yr Avg. Violent Crime Rate Not Involving Bodily Harm					
North Dakota	192.2	-	-	7.6	184.7
Unites States	303.2	-	-	57.7	245.5
Avg. N.D./U.S.	0.63	na	na	0.13	0.75

[1] Source: Uniform Crime Reporting Statistics
http://www.ucrdatatool.gov/
Violent Crime Rates per 100,000 in population