



Sedgwick CMS

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2010

Performance Evaluation of North Dakota Workforce Safety and Insurance



August 9, 2010

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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 2010 Performance Evaluation of Workforce Safety and Insurance (WSI). The Performance Evaluation primarily covers activities at WSI during Calendar Years 2008 and 2009, 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 and financial impact estimates on any proposed changes.

The Performance Evaluation features eight Elements including Claims (Denials, Claims Adjudication, and the Permanent Partial Impairment Threshold); Contracts; Internal Audit; the Post Retirement Benefit Statute (Additional Benefit Payable); Comparisons to Other State Laws in the areas of prior injuries, pre-existing conditions and degenerative conditions; Narcotic Utilization; the 6th Edition of the AMA Guides; and, Prior Recommendations from the 2008 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 benefit provisions. Fifty 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

Oakland, California

Executive Summary

Topics selected for this 2010 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 Permanent Partial Impairment (PPI) threshold; the post-retirement benefit; the management of prior injuries, pre-existing and degenerative conditions in the context of other state practices; narcotic utilization as compared to national and other state averages; and, various editions of the *AMA Guides to the Evaluation of Permanent Impairment*.

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 financial impact analyses where meaningful statutory changes are recommended. These financial projections were provided with the support of WSI's consulting actuaries, who relied on a combination of historical obligations in certain benefit areas, analyses as developed by our evaluation team, and projected change-in-benefit scenarios.

In addition to WSI's consulting actuaries, 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 we work to evaluate narcotic utilization in workers' compensation jurisdictions around the country. The information provided by these resources assisted us in Elements One, Four, Five, Six, and Seven.

Overall in this evaluation, we have made fifty recommendations with nearly one-third tied to the management of contracts. 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	6	4	0	10
Two	6	8	2	16
Three	0	1	0	2
Four	2	1	0	3
Five	3	2	0	5
Six	8	1	0	9
Seven	4	0	0	4
Eight	1	1	0	2
Total	30	18	2	50

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

Element One – Claims

Our objectives in this Element were to assess the reasonableness of WSI practices pertaining to claim denials and timely adjudication. As well, this Element also required an evaluation of the Permanent Partial Impairment (PPI) threshold.

Benefit denial practices at WSI have been the subject of prior independent reviews over the past several years. Generally, evaluators have found WSI's practices in this area to be sound and consistent with statutory language and administrative rules and regulations. Our findings are not dissimilar, although we believe that greater use can be made of independent medical evaluators (as opposed to the WSI Medical Director) in resolving compensability questions.

Regarding timely adjudication, we believe WSI would benefit from the development of a formal benefit delay process when additional information needs to be gathered prior to determining if a claim is compensable. In this way, a cleaner metric for measuring claim decision making in undisputed cases can be derived.

The PPI threshold was also included in this Element, and we felt that in combination with our findings in Element Seven (whether to adopt the AMA Guides – 6th Edition) that the threshold should be lowered. We provided one option that we believe to approximate a cost neutral outcome for consideration by WSI and the legislature. We also believe a statutory language change is needed to have WSI drive the PPI evaluation process instead of having to wait for the injured worker to concur that they want the evaluation.

Element Two – Contracts

In this Element, we evaluated whether WSI managed the contract process (elements of procurement, the evaluation and selection process, and the management of its vendors) efficiently and effectively. Contracts reviewed were limited to those that met a specific dollar threshold or were part of an aggregate set of contracts that combined to reach that dollar threshold.

This Element of the report produced the most recommendations, not because procurement processes or evaluation activities were found deficient, but because we believed service requirements could be enhanced with a number of the vendors.

We also recommended that WSI develop a business plan to bring vocational rehabilitation services in house. There has been a prior legislative provision to cover staff costs for this possibility, and we believe WSI has piloted in house vocational services to some extent in the recent past and can, in

our opinion, manage the workload successfully going forward. The business plan should include a logical transition with the current business partner.

Element Three – Internal Audit

In our review of the Internal Audit department, we were tasked with assessing performance over the past three calendar years. In that time frame, performance within the department has varied widely reaching a nadir in mid-2008 when there was nobody in the department for a period of approximately four months. A prior independent evaluator has chronicled this department's past history.

However, despite its unsteady past, we did observe substantially improved performance by the current Internal Audit staff. The current Internal Audit processes are well-defined, documentation is thorough, and the staff is purposeful in making sure recommendations from its own and other evaluations are implemented. For this Element, we only made one medium priority recommendation.

We also should note that both auditors in the Internal Audit department are seeking their independent auditor certifications, which should further enhance their competence. We had no recommendations to add staff at this time but consider it something WSI should consider at a point in the future when most evaluations of its performance may be managed through the IA department rather than through outside evaluators. As readers of this report are well aware, WSI came under much closer scrutiny in the past few years than we expect will be typical of the organization in the future.

Element Four – Post Retirement Benefit Adequacy

The post-retirement benefit is referred to as the Additional Benefit Payable (ABP), and we evaluated this benefit in the context of benefit structures in other state jurisdictions. Our findings suggest that the ABP is a unique benefit when compared to other states.

Other benefit types including death and permanent total disability may have expected durations in some jurisdictions while in others benefits may be paid for life. North Dakota has provisions for paying lifetime benefits for certain injuries dating back many years. Benefits may also be paid for an individual's lifetime if they are declared to be catastrophically injured as is commonly the case with certain classes of injury such as quadriplegia or blindness in both eyes.

We have made relatively minor recommendations in this area for the extension of regular workers' compensation benefits beyond the presumptive retirement age in instances where the disabling injury occurs close to retirement age. As the law exists in North Dakota today, a person injured six months before their retirement date would receive benefits for a shorter duration than someone who

is injured while working and beyond their presumptive retirement date. This imbalance should be remedied and can be done so at very little cost.

We also included a review of a Utah case where a Social Security Retirement offset provision was found to be unconstitutional because it violated the uniform operation of laws provision in the Utah state constitution. We wondered whether a similar argument could be successfully made in North Dakota.

Element Five – Prior Injuries, Pre-Existing Conditions and Degenerative Conditions

In this Element, we reviewed statutory language in all other workers' compensation jurisdictions relating to the aforementioned injuries and conditions and compared them to those provisions applicable in North Dakota. We provided an extensive exhibit (5.2) summarizing our findings within those other states and we provided a lengthy overview of the North Dakota statutes in this area.

We concluded with a significant recommendation that the aggravation statute should be eliminated. The annual cost of eliminating this statute according to WSI actuaries is approximately \$4.8 million. In our research of other state laws, we find different provisions outlining circumstances under which benefits become due or not, predicated on compensability criteria governing prior injuries, pre-existing conditions or degenerative conditions. But once those criteria are met, benefits are paid in full until such time as the person returns to pre-injury status or a statutory provision can be applied to deny future benefit entitlement.

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.

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. Notably five providers in Burleigh County account for more than half the narcotics costs in the entire state, and this pattern has persisted over the past five years.

We also reviewed narcotic use guidelines to assist in developing recommendations in this area and these recommendations are intended to provide WSI with approaches to opioid management from the time of the second narcotic fill or prescription through the treatment of those injured workers who wind up in long-term pain management programs. This group of recommendations includes processes whereby WSI can reasonably institute medical management strategies to curtail the use of

narcotics and can also evaluate periodically whether medication is being diverted for unintended uses.

We also should mention that we worked with the North Dakota Medical Association on the distribution of a questionnaire tied to narcotic utilization but the response to this questionnaire from North Dakota providers was too small to consider in our evaluation. The response rate was less than 10% of the physicians to whom we believe the questionnaire was provided. A copy of the questionnaire is included as Exhibit 6.6.

Element Seven – Evaluation of the 6th Edition of the AMA Guides to the Evaluation of Permanent Impairment

For this Element, we were asked to determine whether WSI should adopt the 6th Edition of the Guides in place of the 5th Edition that is currently used to measure permanent impairment. Through an assessment of more than 50 North Dakota cases previously rated under the 5th Edition on which impairment ratings of at least 10% existed, we concluded that the 6th Edition should be adopted. We also concluded that the 6th Edition should be used to measure pain and psychiatric impairment rather than other methods.

The adoption of this recommendation is expected to reduce PPI awards by about \$1.1 million per year absent a change to the PPI threshold. So, we urge that our recommendations in this Element be viewed in the context of overall benefit provision, as suggested by our findings and recommendations in Element One, Part C.

We also wanted to report that when we have conducted assessments of previously rated cases in other jurisdictions that the reliability of prior ratings has been low. In North Dakota, we found that the PPI evaluation process is substantially more reliable than that observed in other jurisdictions, and we tie this finding to the reliability of the PPI evaluators (though they are limited in number) and the scrutiny provided to ratings by WSI staff.

Assuming the 6th Edition is to be adopted, we have recommended that WSI arrange suitable training programs for the new impairment rating methods so the change can be managed efficiently.

Element Eight – Prior Recommendations

In our review of the prior 46 recommendations made by Berry, Dunn, McNeil & Parker in their 2008 Performance Evaluation, we found that 22 (48%) had been fully implemented. Of the remaining 24 recommendations, we found 14 that had been partially implemented and 10 that were not implemented.

For the 24 recommendations that were either partially or not implemented, we expect WSI staff to continue to work toward full implementation. The current documentation and follow-up process

managed through the Internal Audit department should lead to completion of many of these recommendations before year-end. There are a small number of these recommendations where we consider the recommendation closed even though the recommendation was not fully implemented. In those cases, we provide an explanation why we expect no further activity from WSI.

Element One: Part A – Claim Denials

Introduction:

Our objectives in this segment of Element One were to analyze the overall denial rate (unadjusted and adjusted rates) and to analyze the trend in denied claims from fiscal years 2005 – 2009. We were also asked to evaluate whether each denial in the sample reviewed was in accordance with state law, administrative code and WSI policies; to evaluate the reasons for the denials; provide information regarding reconsiderations and appeals, and, provide a trend analysis of the percentage of initial denial decisions that were reversed during the period covered by the evaluation.

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

- WSI staff interviews
- Review of WSI policies and procedures
- Review of pertinent North Dakota state laws and administrative codes
- Review of WSI Operating Reports
- Data extracted from WSI claims management system (various data from CLO961.xls reports) identifying new claims filed from FY 2005 – FY 2009, and claims filed from CY 2008 to the third quarter of CY 2009 from which the random sample was selected.
- Review of claim notes, medical records, medical reports, form letter requests, form letter responses, investigation reports, WSI Orders, defense and applicant legal work product, and WSI legal work product, and Office of Administrative Hearing legal findings.
- Review 2008 Berry, Dunn, McNeil & Parker (BDMP) Performance Evaluation Report
- Review Marsh Report (3/4/08)
- Review the Conolly & Associates Report to the Board of Directors (3/5/2008)
- Consider State expert surveys regarding compensability decision timelines

Background:

Claim denial practices have been reviewed by a number of evaluators both as part of previous performance evaluations and other independent assessments. Highlighting each of the more recent reports has been commentary regarding North Dakota's high claim denial rate in comparison to surrounding states (e.g., see the 2008 BDMP Performance Report and the 2008 Conolly Report). Note has been made that while North Dakota's denial percentage rate is lower than the national average, it is worthy of further analysis to determine if the denials are appropriate based upon state law, administrative code and WSI internal claims practices.

In Fiscal Year 2005, WSI initiated an early claim reporting program to incentivize employers in the state to report work-related claims more promptly. As a result of this new policy, employers

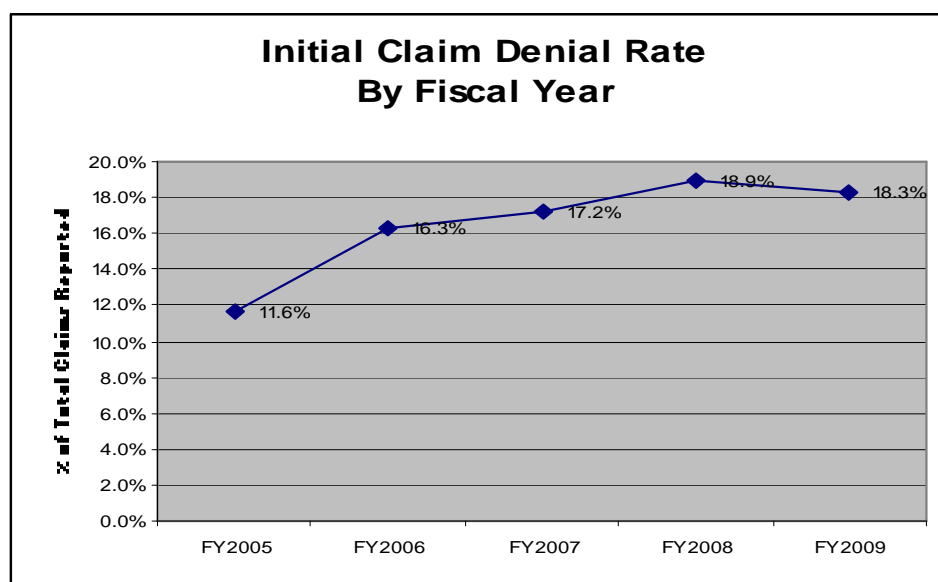
began to report more incident-only events to avoid a \$250 or \$350 late reporting assessment. Many of the claims reported never resulted in an injured worker's submitting a corresponding "C1" first report of injury form or seeking any relevant medical treatment. In an effort to accommodate this new behavior, WSI began reporting adjustments to their denial rates, called "adjusted denial rate", reporting which excluded denials associated with the increased de facto incident reporting. Denials designated "adjusted" are denials associated with this increased employer activity.

A change in management philosophy took place in 2007 with a more focused claim investigation process where it appeared that the injury may be related to a pre-existing or chronic medical condition. This approach was encouraged to be applied to claims with prior injuries, pre-existing and/or degenerative medical conditions in support of NDCC statutes. A more rigorous review of medical evidence became a best practice.

Findings:

The historical data provided by WSI for the number of claims filed in FY 2005 through FY 2009 was used to analyze the claim denial trends for both unadjusted and adjusted denials. The initial claim denial rate (unadjusted rate) rose 28% from FY 2005 to FY 2006. A less dramatic increase occurred in unadjusted claim denials in FY 2007 and FY 2008; 5% and 9% respectively. The number of unadjusted claim denials decreased by 3% in FY 2009. The decrease in the FY 2009 claim denial rate is commensurate with a corresponding 3% drop in claims reported in FY 2009. The overall trend in initial claim denials from FY 2005 to FY 2008 is a continuous increase, with a slight decrease occurring in FY 2009.

Table 1.1 – North Dakota Initial (Adjusted) Claim Denial Rate Trends by Fiscal Year



To identify reasons for the trends identified, we reviewed 100 denied claims in our sample from calendar year 2008 and the first 3 quarters of calendar year 2009, along with 10 accepted claims to determine how compensability eligibility was determined. 63 claims were from CY 2008 reported injuries, and 47 were from CY 2009 reported injuries. Of the 100 denied claims reviewed in the sample, 58% of the denials retained their initial denied status. 42% of the denied claims were reversed from initial denial status to a current acceptance status through reconsideration or appeal processes. WSI's Decision Review Office (DRO) was involved in 4 of the denied sample cases.

In North Dakota, there is no statutory compensability decision date, a date by which WSI must affirmatively act to issue a decision of acceptance or denial of benefits. It took an average of 29 days to complete the claim investigation process on this sample group of claims. Outliers included 180 days for a heart case, 90 days for a pre-existing medical condition, 74 days for a case involving self-employment, and 65 days for a case where the employee first report of injury (C1) was not signed.

By far, the majority of the claims had well documented 2-point contact (or attempts) with the injured worker and employer within 24 hours of the claim's registration date. There was documented use of WSI internal forms to request missing information from injured workers, employers and medical providers according to WSI claim procedures. Second requests were issued with some variability in timeliness where questionnaires were not returned within the time lines documented on the request. Outside investigators were used infrequently, but when utilized, the assignment was for an appropriate reason and was managed through the Special Investigations Unit. Each initial claim decision was formally outlined in a WSI Notice of Decision Denying Benefits (NOD) according to Claim Procedure 703. The circumstances outlined in the NOD were documented in the claim file notes or file documentation, and the initial claim compensability decisions documented were based upon a state law, administrative code or WSI policy. Most of the claim denials held claim file notes of Supervisor approval, but some lacked this documentation.

Administrative denials, those associated with no medical treatment, no signed C1, treatment outside designated medical providers, statutory coverage issues, etc., account for 52% and 59% of the initial claim denials in FYs 2008 and 2009, respectively; a trend that has steadily increased from 49% in FY 2005. These types of denials are appropriate, in accordance with state law, administrative code and/or WSI policies. It is positive to see that claims that do not meet the initial threshold of compensability are being recognized and being investigated more thoroughly. Other denials related to claims with non-specific mechanisms of injury, potentially fraudulent claim reporting, and pre-existing medical conditions create more complex claim decision-making.

The denial decisions associated with these claims were well documented, and were generally part of a triage or staffing to provide claims adjusters with additional comment and/or supervision.

Some claim denial decisions were reversed after the injured worker requested reconsideration. The reconsideration process at times included the review of additional medical reports, a review by a medical provider or WSI's Medical Director, or even in one instance where WSI Legal made a recommendation to approve a reversal on a factual basis. A few cases demonstrated WSI's neutrality when it acquiesced and provided the injured worker with the benefit of the doubt, awarding full claim acceptance or limited benefits (i.e. specific body parts, dates of treatment, etc.).

Table 1.2 outlines the reasons for the initial claim denials and the percentage of the total for fiscal year 2008, fiscal year 2009, and the evaluation sample from calendar year 2008 and the first three quarters of calendar year 2009.

Table 1.2. North Dakota Initial Claim Denial Reasons (FY 2008-2009 and CY Review Sample)

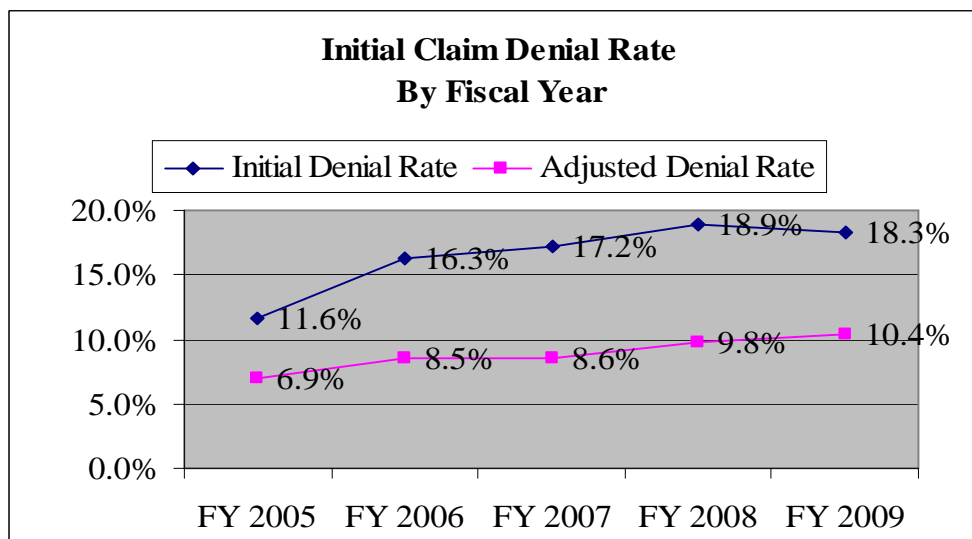
<i>Percentage of Denials</i>	<i>FY2008</i>	<i>FY2009</i>	<i>CY08-09</i>
Agriculture - no optional	0.5%	0.6%	0.6%
Broken Glasses - No Injury	0.0%	0.0%	0.0%
Claim Comment	29.6%	31.5%	31.2%
Claim Withdrawn	3.4%	3.2%	3.4%
Common to General Public	0.1%	1.0%	0.7%
Corporate Officer - no	0.2%	0.1%	0.1%
Fainting	0.3%	0.6%	0.5%
False Statement re: Priors	0.0%	0.0%	0.0%
Family Member - no	0.1%	0.0%	0.1%
Federal Employee	0.0%	0.1%	0.1%
Independent Contractor	0.2%	0.2%	0.2%
Injury due to	0.5%	0.4%	0.5%
Negative Blood Test	0.0%	0.0%	0.0%
No Known Exposure to TB	0.1%	0.0%	0.1%
No Medical Records	2.5%	3.5%	3.1%
No Medical Treatment	10.6%	10.8%	10.7%
No signed C1	29.3%	26.1%	26.1%
Not Covered by NDWSI	2.3%	1.9%	2.0%
Not Timely Filed	0.5%	0.5%	0.6%
Out of ND > 30 Days	0.2%	0.1%	0.1%
Self-employed - no	0.1%	0.1%	0.1%
Student - no optional	0.0%	0.1%	0.0%
Treatment not by DMP	1.6%	1.1%	1.4%
Uncooperative	17.8%	18.1%	18.4%
Volunteer - no optional	0.0%	0.0%	0.0%
Grand Total	100.0%	100.0%	100.0%

Within the evaluation sample, 37% of the reported claims were reported by the employer as work related injuries absent a request for benefits from the injured worker; that is, there was no signed C1 and no medical treatment was sought. If we were also to add administrative denial categories beyond the lack of employee first reporting category (claim not filed timely, treatment not provided by a designated medical provider, claim withdrawn and injury not covered by NDWSI), the total number of claims initially denied for administrative reasons would increase to 44%.

Most notable among other denials are the *Uncooperative* and the *Claim Comment* categories with 18% and 31%, respectively. These two categories are an outgrowth of the more aggressive claims scrutiny process put in place in FY 2007 to facilitate appropriate claim compensability

determinations. Claims initially denied in these categories are denied because injured workers and/or medical providers fail to provide adequate information to complete the investigation process.

Table 1.3. North Dakota Adjusted Initial Claim Denial Rates by Fiscal Year



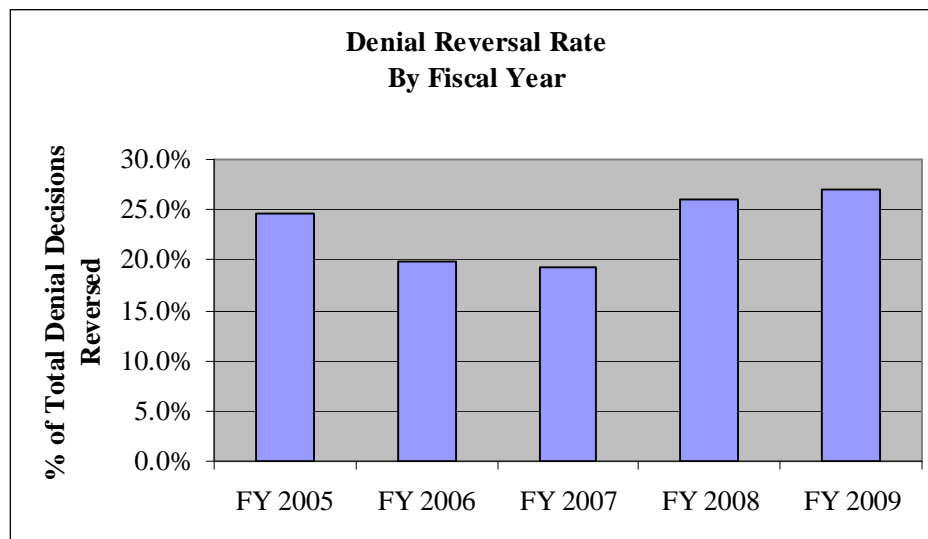
To review the WSI adjusted denial rate, we combine and remove categories of denials that can be attributed to administrative reasons; that is, no signed C1, no medical treatment sought, claim not filed timely, treatment not provided by a designated medical provider, claim withdrawn and injury not covered by NDWSI.

With the aforementioned modifications, we note that the WSI Adjusted Denial Rate trends upward from FY 2005 through FY 2009. This rate increase parallels the Initial Denial Rate statistics from FY 2005 through FY 2008, in that both rates jumped dramatically from FY 2005 to FY 2006 due to the change in organizational policy review of prior injuries. The Adjusted Denial Rate increased at a less steep rate from FY 2007 to FY 2009, primarily due to increased injured worker and medical professional compliance with the reconsideration process, the return of previously requested information, and injured workers seeking treatment with providers within the designated provider listing.

Claim processes are well documented in the Claim Procedure Manual to assist the claims unit in following a systematic process for claim denial reconsideration. The original denial notice adequately documents the timeline in which an injured worker must file a written request for reconsideration with WSI, requests that the injured worker explain why they think the decision is wrong, and what they think the correct decision should be. Additional evidence in support of the injured worker's position is also accepted; however, any additional evidence solicited by the injured worker in support of the reconsideration effort (i.e. copies of medical records, additional

evidence from a more current medical examination) is gathered at his/her own expense. If the request for reconsideration is not submitted within the stated timeframe, WSI's denial decision is final. A select group of claim dismissals are eligible for reversal if the documentation is received within one year of the date of injury (also in Claim Procedure 703). WSI Claims Supervisors, the Claim Director and WSI in-house Legal are actively involved in the reconsideration process.

Table 1.4. North Dakota Claim Denial Reversal Rate by Fiscal Year



The trend in initial denials that were ultimately reversed to claim acceptance decreased from FY 2005 to FY2007, but turned around dramatically in fiscal years 2008 and 2009 as more injured workers participated in the reconsideration investigative process. The following chart identifies the percentage of initial denials overturned purely for administrative and cooperation compliance reasons. Administrative reasons include the injured worker's return of a signed C1 form and documentation of medical treatment sought. Cooperation reasons include seeking medical treatment with a designated medical provider, responding to phone calls, returning medical records or other investigative claim forms, physicians responding to requests for information and attendance at medical evaluations.

Table 1.5. North Dakota Denial Decision Reversal Reasons by Fiscal Year

Compliance	FY 05	FY 06	FY 07	FY 08	FY 09
Administrative	48%	50%	45%	45%	39%
Cooperation	49%	47%	53%	53%	59%
% of Total	97%	97%	98%	98%	98%

Reverse decisions associated with claim denials in the evaluated group of claims generally occurred more quickly when required paperwork is submitted, or the facts surrounding the work place incident are further detailed. Within the evaluation sample 42% of claim denial decisions were reversed from initially denied to acceptance. The vast majority of the reasons for the reversal were administrative, the result of the injured worker returning the required forms to allow WSI to complete its investigation. Other reasons for reversed denial decisions included employer compliance with paperwork and the medical provider's submission of medical information. One claim denial was overturned under reconsideration that had originally been denied as a pre-existing/trigger claim (Claim # 12). Another pre-existing/trigger case was reconsidered, and the denial upheld by WSI Order (# 11). Three claims remained denied, but were resolved via Stipulated agreement providing some level of benefit to the injured worker (#16, # 34, and # 95).

Recommendations:

Recommendation 1.1: WSI has a current metric (see Recommendation 1.4) which it consistently cannot reach. The primary reasons for this shortcoming pertain to additional investigative processes that are needed to make correct compensability determinations. These additional processes typically pertain to claims where additional information is needed, most frequently either from injured workers or medical providers. For all claims in this delayed group, we recommend that WSI target a decision date no later than 60 days from date of registration.

Priority Level: High

WSI Response: Concur. Currently WSI generates reports for all claims adjudicated within 14 days, 31 days, 60 days and 90 days. Those claims hitting 60 days require documentation and escalation along with the reasons and plans for resolution. Currently WSI's targets are for claims adjudication of all claims within 31 days. Metrics indicate this is reached in a majority of claims.

Sedgwick CMS Reply: WSI suggests in its response that it actually has a more ambitious target (31 days) to adjudicate all claims. In our review of denied claims, we noted that 31 claim decisions out of 100 were made 31 days or more after notice to WSI. Only seven of those claims were resolved more than 60 days after notice. So, we reiterate our recommendation to adjudicate **all** claims within 60 days, and we consider in our target past WSI practices and processes required to make an accurate claim decision.

Recommendation 1.2: Standardize the claim denial processes among the WSI claim supervisors, particularly where those denials pertain to North Dakota statutes and administrative codes. As supervisors provide the first level of claim denial oversight, denial consistency can be enhanced if supervisors view denial rationale in a consistent fashion.

Priority Level: High

WSI Response: Concur. WSI maintains and continually updates a detailed Claims Policy Manual that standardizes claims decision making. The Claim's Supervisors are the organization's most centralized resource to assist efforts in minimizing the variability in claim benefit provisions; however, they too are guided by our Claims Policy Manual and NDCC Title 65 for decision guidance. In order to reduce variability within the adjudication process, WSI will revamp the training for claims staff with greater focus on consistency.

Recommendation 1.3: 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.

Priority Level: High

WSI Response: Concur. WSI will continue to use IME's as deemed appropriate.

Sedgwick CMS Reply: We read WSI's response to mean that they actually do not concur as it appears WSI's plan is to continue to use IMEs in the same fashion as always. The intent of this recommendation is 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 in that they examine the patient and take a history from the patient, as well. Given the questions raised in FL332, we think an in-person evaluation is also necessary for the evaluator to arrive at a comprehensive conclusion.

Element One: Part B – Adjudicated Claims

Introduction:

Our objective in this segment of Element One is to evaluate the percentage of claims adjudicated within 14 days and provide a trend analysis for fiscal years 2005 – 2009. We are also asked to provide an analysis of the causes as to why WSI has not been able to meet its established 75% target in this area by identifying how the target was established, to identify the challenges WSI faces in meeting this target, to identify similar performance targets from other states, workers compensation insurance providers and industry standards, and lastly, to provide recommendations to assist WSI in improving its performance.

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

- WSI staff interviews
- Review of WSI policies and procedures
- WSI Operating Reports from FY 2005 through FY 2009
- Data extracted from WSI claims management system (various data from CLO961.xls reports) identifying new claims filed from FY 2005 – FY 2009, and claims filed from CY 2008 to the third quarter of CY 2009 from which the random sample was selected.
- Review of claim notes, medical records, medical reports, form letter requests, form letter responses, investigation reports, WSI Orders, defense and applicant legal work product, and WSI legal work product, and Office of Administrative Hearing legal findings.
- Prior Performance Evaluation Reports
- State expert surveys regarding compensability decision timelines

Background:

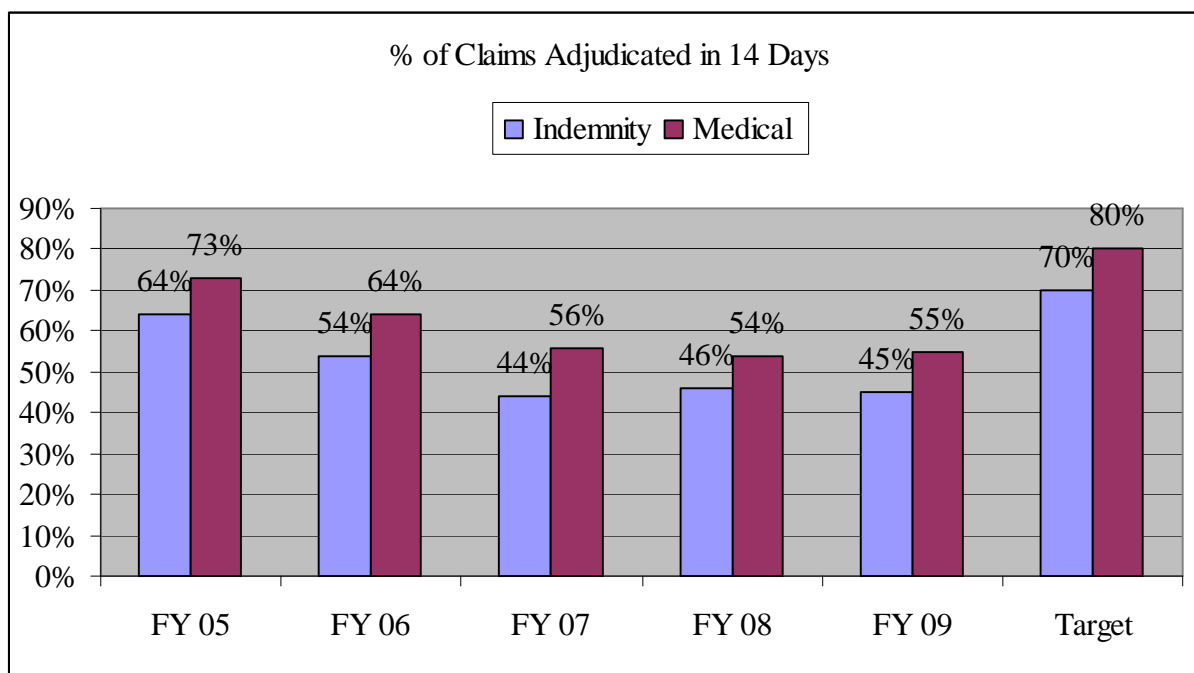
As earlier noted in Part A, in Fiscal Year 2005, WSI initiated an early claim reporting program to incentivize employers in the state to report work-related claims more promptly. As a result of this new policy, employers began to report more incident-only events to avoid a \$250 or \$350 late reporting assessment. Many of the claims reported never resulted in an injured worker's submitting a corresponding first report of injury form (C1) or seeking any relevant medical treatment.

We know that generally speaking a common practice through statutory schemes, carrier and TPA (third party administrator) best practices is to issue the first disability payment within 14 days. To achieve this result, a compensability decision must be made within 14 days. Bear in mind that issuing the first disability payment within 14 days reflects a reasonable practice to issue wage replacement benefits within a reasonable period of time. As such, it is well worth the effort to identify the challenges WSI faces in this endeavor.

Findings:

In 2007, management in the WSI Claims Department set a benchmark for claims compensability decisions in the absence of statutory guidelines. This benchmark, called the *Percent of Claims Adjudicated within 14 days*, required that the claims unit make a decision to accept or deny a claim within 14 days of the claim registration date. Mirroring our prior comments on this practice, WSI's focus and drive to meet this target was based on industry standards and the timing of a first benefit payment. WSI created its internal target to make initial compensability decisions on 75% of its indemnity and medical only claims registered within 14 days. A review of WSI's Operating Report data from FY 2005 to FY 2009, as depicted in Table 1.6 below, chronicles WSI's inability to meet its target of making claim compensability decisions on 75% of its cases within 14 days of the registration date since FY 2005.

Table 1.6. WSI Operating Report Performance Indicators for Claim Adjudication



To benchmark North Dakota's performance in this area, we reviewed jurisdictional requirements in the area of claim compensability decision-making. We determined that 38 out of 50 states have some type of statutorily specified period of time which qualifies for the designation of timely initial first payment. Making a compensability determination (claim adjudication) is a prerequisite to issuance of the first payment. Therefore, using the date by which the first payment must be made, we can determine how quickly a claims organization must make its adjudication decision to meet statutory guidelines.

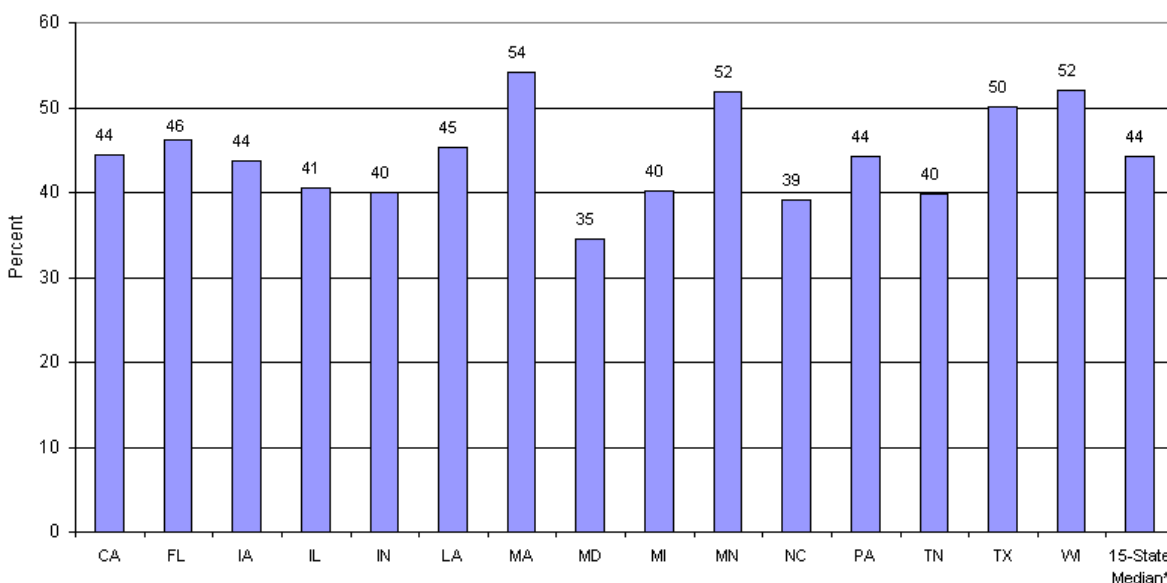
Table 1.7. Jurisdictional Compensability Determination Deadlines

# Days	# States
N/A	12
10	1
14	17
15	3
18	1
20	3
21	8
28	2
30	3

Table 1.7 identifies the number of days within which a compensability decision must be made in certain jurisdictions and the number of states that have statutory compliance regulations within that timeframe. The time periods range from 10 days to 30 days, with 18 of the 50 states requiring the first payment within 14 days.¹ Twenty additional states must resolve compensability issues within 30 days. Twelve states have either no time frame required by statute or operate under a “reasonableness” test; that is, a reasonable amount of time to obtain the information necessary to complete the investigation process and make a decision. The decision date is usually calculated based upon the date of notice of disability or the date the adjusting agency first receives notice of disability. At least 15 states have a provision allowing them a specified amount of additional time to pursue an investigation with state agency approval. Many states have higher compliance levels because benefit providers are required to issue some type of benefit (medical treatment or disability) during this period with a reservation of rights, or operate under stiff penalties for lack of compliance. Given what we observe in other states, WSI’s performance indicator of a 14-day adjudication decision date is aggressive and meets the objective of the industry standard.

¹ http://www.wcrinet.org/wclaws2009/tables_print.pdf

Table 1.8. Workers Compensation Research Institute (WCRI) Benchmarks: Percentage of Claims with More Than 7 Days of Lost Time in Which Date of First Indemnity Payment Was within 21 Days from Date of Injury, 2007/2008



Note: the measure listed does not purport to show compliance with individual state requirements for timely payment. The WCRI data include claims that were denied and/or litigated but paid within the evaluation cutoff, as well as claims in which the workers were not continuously disabled from the date of injury, so the obligation to pay did not arise until later in the claim.

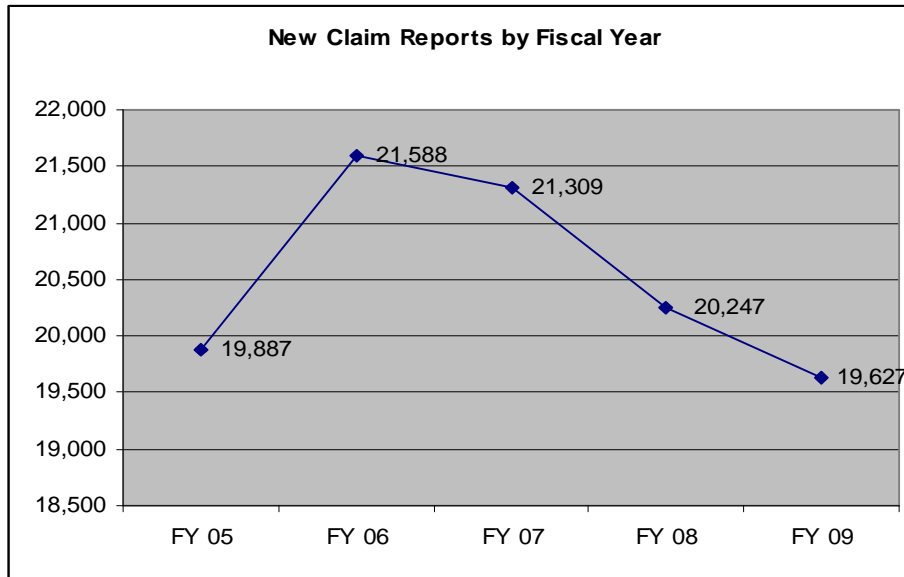
Another useful industry standard to review with regard to WSI's timeliness of a compensability decision is one of WCRI's performance benchmarks for timely first indemnity payment. This benchmark measures the percentage of claims with more than seven days of lost time with the first indemnity payment made within 21 days of the date of notice. While not a measure of timeliness of the compensability decision, timely claim acceptance supports timely initial benefit provision. WCRI's most recent report draws data from claims arising in October 2006 through September 2007, evaluated as of March 2008.² With a 15 state median of 44% reaching the goal of 14 days, the report shows a success rate of timeliness in this area between 35% and 54 %. While WSI is not meeting its own internal goal of 75% for timely adjudication, its indemnity decision date performance meets the national average of 44%, assuming the first indemnity payment is made within one week of the adjudication decision date.

When reviewing some of the factors that affect the claim adjudication date, we need to take a look at the number of claims filed in the organization and the staff available to manage the claims process. Our survey of claims organizations indicates that with some customers caseload averages are low, ranging from 130 to 150 per adjuster. However, within the industry a more common average caseload ranges from 150 to 250 claims, particularly when adjusters are not

² http://www.wcrinet.org/benchmarks/benchmarks_09/benchmarks_09_fig_6.html

dedicated to a particular account. We reviewed the number of WSI cases filed in each fiscal year and the number of WSI claims adjusters available to manage these claims. The number of new claims reported to WSI has been decreasing since FY 2006, as noted in Table 1.9.

Table 1.9. WSI New Claims Filed by Fiscal Year



WSI has no benchmark for the maximum number of claims to be assigned to a claims adjuster. In FY 2007, WSI recognized that caseloads needed to be adjusted based upon the inability to meet many of their targets and the increase in reported losses, as depicted in Table 1.10 below. Five FTEs were added to the claims adjuster staff in FY 2008. Three-point contact statistics show that employee/employer/provider contacts are made within 24 hours of claim registration, and that this rate is well over 90%. Initial timely payments also increased slightly as a result of the staffing changes; however, the outcomes for the 14-day target for timely adjudication did not change either for medical only or indemnity claim results.

Table 1.10. North Dakota WSI Operating Report Performance Indicators for Average Active Claims and New Reports per Claim Adjuster (Indemnity and Medical Only Claims)

Fiscal Year	Average Active	Average New
FY 05	208	496
FY 06	264	554
FY 07	275	546
FY 08	221	479
FY 09	219	467

Statistics in the Operating Report and conversations with WSI staff indicate that WSI staffing is adequate to manage the number of new claim reports received as well as the average active open

caseload per adjuster. Given the blend of indemnity and medical only claims types, and the average active adjuster claim counts detailed in the Operating Reports, we agree with WSI in its determination that they have adequate staffing.

We used the denied claim sample selection of 100 claims from the prior section in Element One, Part A, tracking the number of days it took for WSI to make a compensability decision. Eighty-six percent of the denied claims in the sample took more than 14 days to make a compensability claim decision. Table 1.2 cites the reasons for the claims reviewed from calendar year 2008 and the first three quarters of calendar year 2009. The reasons varied from a lack of required forms to awaiting a triage date to discuss the claim particulars. Out of the evaluation group, ten claim decisions were delayed to investigate pre-existing conditions or injuries that may have triggered pre-existing conditions. The longest decision in the group of denials took 98 days, the shortest decision was 12 days, the average 45 days. The following table identifies the number of days within a range of days to make a compensability decision on the claims in the evaluation group.

Table 1.11. Number of Days to Make a Compensability Decision for Cases beyond 14 Days

# Days	# Claims
15-30	55
31-45	18
46-60	6
61-100	7

Again we raise the issue of the change in management philosophy in FY 2007 that required a more focused claim investigation process to claims with prior injuries, pre-existing and/or degenerative medical conditions in support of NDCC statutes. In the 61-100 day grouping, there were two unreturned paperwork claims, one late claim filing, one no signed C1, one self-employed filer, and two pre-existing/trigger claims. Based upon WSI claims procedures, all but the pre-existing/trigger claims should have been issued initial denials in a much faster timeframe. It is possible that the pre-existing/trigger claims could take up to 90-100 days for a complete investigation to be completed. The lag time in obtaining information from the injured worker and medical professionals, and the additional time it takes to gather and document the factual, medical and legal evidence in this process, along with the appropriate supervisory oversight can and does increase the time it takes to make adjudication decisions in cases with complex medical, factual and legal issues.

A closer review of the actual claim process and claim procedures shows that a number of claim forms require a “wet signature” at the time a claim is filed. Additional forms used to gather claim evidence are sent when there is further medical evidence necessary for review.

- C96a: Prior Injury & Pre-existing Condition follow up questionnaire – 14 day return process
- C63: Repetitive Motion Questionnaire – 14 day return process

- C109: Carpal Tunnel Questionnaire – 14 day return process
- C151: Chemical Exposure Questionnaire – 14 day return process

The use of these forms builds in a delay of up to 14 days from the date the form is issued, not including mailing time. If the form is not returned timely, WSI sends a second request with a 14 day return deadline. The WSI target of a 14-day compensability decision cannot consistently be met with the current procedural workflow. The more common result is that a final decision is made within 30 to 60 days of WSI's notice of injury. As mentioned earlier, our survey of other workers' compensation jurisdictions indicates that at least 15 states have the ability to extend a compensability decision timeframe. The extensions range from 30 days up to an additional 150 days from the initial compensability due date.

Note that the target of 75% in the Operating Report is a benchmark that is not tied to claim type in a logical way. The Operating Report indicates that a 14-day adjudication target of 80% should be achieved on medical only claims. For indemnity claims, the target is 70%. The overall target is 75%. However, when considering the claim mix, the overall target should be about 78%.

Given the preponderance of delays that occur to gather records, to obtain missing information, to complete investigations and myriad other tasks that need to be done to assess compensability, we see a 75% metric as a reasonable target as long as recommendations developed herein are implemented. WSI may actually discover that the percentage can be raised if it removes timely delayed claims from its calculations.

Recommendations:

Recommendation 1.4: Because of legitimate reasons for adjudication determinations to be delayed, as noted in Recommendation 1.1, we recommend that the timely adjudication metric be changed from 75% to 60%.

Priority Level: High

WSI Response: Concur. WSI will review the historical data to determine if the metric change to 60% is appropriate.

Recommendation 1.5: When the injured worker has not completed or signed a C1, WSI should seek information in its employee contact calls whether the injured worker has or intends to seek medical treatment for the alleged injury. Employer level contacts should be encouraged to solicit this information at the time the claim is filed so that it is available for claims adjusters within 1-2 days after registration. If no medical treatment is going to be sought, the claim can be denied expeditiously. Should the employee have a change of mind later, the claim can be reopened and a new decision made based upon more current information and the appropriate form submission.

Priority Level: High

WSI Response: Concur. WSI agrees that it should seek this information in telephone calls on wage loss claims. However, WSI does not agree that this is feasible with the number of medical only claims that are filed with WSI. Typically, WSI is unable to reach the injured employees on medical only claims due to their working hours. Also, WSI believes the 14 day benchmark is less critical for medical only claims because those injured employees are not waiting for an indemnity payment.

Sedgwick CMS Reply: WSI's response reads like a partial concurrence, rather than full concurrence, if our assumption about three-point contact as summarized below is correct. Within WSI's Operating Report, there is a metric for timely three-point contact. Our understanding of this metric is that it applies to all claims except auto-adjudicated claims. If that assumption is accurate, then we think the request for the injured worker to complete a C1 makes sense whether the claim is a medical only claim or an indemnity claim because employee contact is being attempted regardless of claim type. If three-point contact applies only to indemnity claims, then it is reasonable to limit the C1 request to that claim type.

Recommendation 1.6: For claims that require extended questionnaire requests, WSI should obtain the information required in the questionnaires via three-point contact calls. After internal completion of the form, send a copy of the completed form to the injured worker with a document requesting that they confirm the information by signature within five business days. In the interim, medical records requests may be generated and records returned and evaluated without delay.

Priority Level: Medium

WSI Response: Concur. WSI agrees that information from extended questionnaire requests should be obtained via three-point contact calls. WSI will mail the completed documentation to the injured employee for signature.

Recommendation 1.7: Encourage policyholder use of business facsimile and electronic mail options to facilitate the return of injured worker completed forms when the employee has not returned them within a reasonable timeframe.

Priority Level: Medium

WSI Response: Concur. WSI currently sends letters to injured employees when additional forms or documentation is necessary for claims processing. Some of these forms are currently carbon copied to the employer and some are not. There is an opportunity for WSI to carbon copy the employer to assist in obtaining the information.

There is also an opportunity for WSI to add language to the form letters that indicates they could return the requested information via a fax number or WSI's general email address.

Element One: Part C – Permanent Partial Impairment (PPI) Threshold

Introduction

This part of Element One requires that we evaluate the Permanent Partial Impairment (PPI) threshold that exists in North Dakota. North Dakota Century Code (NDCC) §65-05-12.2 describes this benefit, one that we review in greater detail below.

In our evaluation, we are to examine North Dakota's current statutory threshold of 16% impairment in the context of other state's workers' compensation organizations as well as industry best practices. We also examine WSI's policies and procedures for determining maximum medical improvement to determine their appropriateness and WSI's adherence to them. We are to provide an analysis of any financial impact that may result from a change in the threshold, and we are to identify through a review of cases whether or not benefits are issued timely.

Background

To achieve these objectives, we undertook the following:

- A review of our study looking at the PPI threshold that we completed at the request of WSI approximately ten years ago
- A survey of Sedgwick CMS state experts on the ways in which PPI is evaluated in other jurisdictions
- A review of statutory language governing PPI benefits in North Dakota
- A review of claims with possible PPI benefit obligations to assess compliance and timeliness
- Discussions with WSI staff and its actuarial consultants on financial implications given different threshold scenarios
- A review of our findings pertaining to Element Seven as any move to the 6th Edition of the AMA Guides has its own financial impact

We also consider industry best practices in our findings and commentary.

Context

To start, we acknowledge that states have various schemes for assessing permanent partial impairment. In some states, permanent partial impairment benefits may be paid predicated on a wage loss formula meaning that if an injured worker returns to work with earnings equal to or greater than their pre-injury wages, they receive no permanent impairment benefit.

Nevada uses a statutory formula tied to the percentage of impairment and the worker's earnings to award impairment benefits that are payable at a low benefit amount either to age 70 or for a period of 260 weeks, whichever may occur later.

However, most workers' compensation jurisdictions tie their permanent partial disability benefit payment structure to ratings derived through one or another Edition of the AMA Guides. The AMA Guides are used to define impairment in terms of whole person impairment (WPI). Further, starting with a percentage rating of 1%, benefits are commonly payable for a fixed number of weeks at a statutorily determined benefit rate. That rate may match the temporary total disability (TTD) benefit rate or it may be less; in some instances, substantially less than the TTD rate.

Workers' compensation jurisdictions also often include a method to pay workers for scheduled injuries. These injuries most commonly apply to amputations where a fixed number of weeks of benefits are allotted for these injuries. Other scheduled injuries can include those pertaining to loss of sight in an eye or disfigurement.

When we studied the history of PPI benefits in North Dakota in 2000, we reviewed cases that had been rated under the 4th Edition of the AMA Guides. WSI's methods for PPI rating validations were not of the same standard as they are today. So we cannot vouch for the accuracy of the ratings provided then in the same manner that we can today.

Nonetheless, data was available at that time which revealed dramatic changes in the frequency of PPI awards. You will see from a review of Table 1.12 provided below how the award distributions occurred between FY 1987 – 1988 through FY 1998 – 1999.

**Table 1.12: North Dakota Workers Compensation Bureau
PPI Awards That Have Not Been Cancelled
PPI'S Awarded From 07/01/87 - 06/30/99**

PPI'S AWARDED IN FISCAL YEAR	TOTAL # PPI'S	TOTAL \$ PPI'S
07/01/87 - 06/30/88	294	876,568.50
07/01/88 - 06/30/89	415	1,232,444.10
07/01/89 - 06/30/90	487	2,656,242.30
07/01/90 - 06/30/91	787	4,779,835.52
07/01/91 - 06/30/92	807	6,214,863.01
07/01/92 - 06/30/93	1,037	7,872,858.14
07/01/93 - 06/30/94	1,366	9,096,309.67
07/01/94 - 06/30/95	1,398	7,835,864.28
07/01/95 - 06/30/96	1,502	9,270,600.21
07/01/96 - 06/30/97	625	4,195,524.05
07/01/97 - 06/30/98	114	832,726.73
07/01/98 - 06/30/99	101	1,055,674.63
	8,933	55,919,511.14

Broken down into three groups, the first three fiscal years ('87/'88 through '89/'90) show an average of just under 400 PPI claims per year. Fiscal years '90/'91 through '96/'97 saw an average of about 1,075 PPI cases. In fiscal years '97/'98 and '98/'99, which was after the 16% PPI threshold became part of the law, we see a total of only 215 PPI cases in two years or an annual average of 107 claims.

In Exhibit 7.1 which provides a financial impact assessment of a move to the 6th Edition of the Guides, we noted that WSI actuaries relied to some extent on PPI cases rated over a four-year period (FY 2004 – 2007). In that window of time, WSI had 415 PPI cases with 101 of them occurring as scheduled injury ratings. Thus, 415 PPI cases in a four-year window average to about 104 claims/year suggesting that PPI frequency has run just over 100 claims/year for a good part of the past decade or more.

When we completed the 2000 study on PPI benefits, we provided a split of the ratings by percentage, and we include that information in the following Table 1.13.

Table 1.13 – Distribution of impairments with ratings from the 4th Edition for cases prior to 1995

Percentage Impairment	Percentage of All Impairments	Cumulative Percentage
1	5	5
2	5	10
3	5	15
4	5	20
5	25	45
6	2.5	47.5
7	2.5	50
8	2.5	52.5
9	2.5	55
10	10	65
11	8.5	73.5
12	1.5	75
13	1	76
14	1	77
15	5	82
16	1	83
17	1	84
18	1	85
19	1	86
20	6	92
21	.5	92.5
22	.5	93
23	.5	93.5
24	.5	94
25	2	96
26-42	3	99
43-100	1	100

We provide this information for two reasons. First, the table gives us information on the relative frequency of PPI ratings at one percentage level or another. For instance, the table tells us that 82% of all PPI awards issued were rated at 15% or lower, a meaningful number given the current threshold level. Second, this data set was relied upon by WSI consulting actuaries for some of their financial projections, specifically those occurring at or above 10%. Admittedly, there are reliability issues in using a data set this old and we collectively acknowledge this. These cases were rated under the 4th Edition of the AMA Guides. Currently, WSI uses the 5th Edition. Also, WSI did not then enjoy the same kind of PPI rating scrutiny that is currently provided by WSI staff. But we wanted to use this data set as a possible indicator because prior studies of AMA Editions completed have tended to show that the 4th Edition produces results that are closer to the 6th Edition.

We also observe that when the threshold was enacted in the 1990's that WSI correctly maintained that the benefit structure had been devised such that the most seriously injured workers, those with substantial PPI impairments would receive more in PPI benefits. That crossover point actually occurs at an impairment of 50%, meaning that under the new statute injured workers with impairments over 50% receive a higher impairment multiplier than they did under the pre-threshold statute. Further, if Table 1.13 is a reliable indicator of PPI frequency above 50% then this expanded benefit applies to a very small percentage of the injured workers. That is, in Table 1.13, 18% of the ratings exceeded 15% and only 1% of the ratings produced a rating equal to or greater than 43%.

Findings

The state of the current PPI audit process in North Dakota is that ratings are derived accurately using the 5th Edition. We reference rating accuracy in Element Seven in a more detailed manner. But it is important to know that because ratings are done accurately it tells us that injured workers who are entitled to impairment awards are not being denied because of overly conservative rating methodologies employed by WSI's PPI Auditor or their primary PPI evaluator. Further, when a PPI rating is determined to result in a monetary award, benefits are invariably paid within days of the order awarding benefits.

Our sampling of audited files included cases both below and above the threshold and so we were able to determine that benefits were or were not provided according to reliable rating outcomes. We also reviewed various case decisions on the subject of PPI evaluations and noted the Court's recognition of evaluator competence in the assessment of PPI.

NDCC §65-05-12.2 spells out the methods by which PPI awards are to be administered. It includes provisions that govern benefit rate calculations, the timing of evaluations, the method by which evaluations are to be accomplished, the rating schedule itself for awards at 16% or higher, scheduled injury benefit levels, how attorney's fees are to be paid, the methods for resolving disputes and the way in which additional awards may be managed.

One provision of the statute requires an injured worker, upon notice of a potential impairment award, to request a medical evaluation to determine the actual impairment level. This provision is atypical when compared to the practices of other jurisdictions. Normally, the obligation falls on the carrier, employer or third party administrator to arrange the evaluation once the potential benefit entitlement is recognized and it is believed the parties would benefit from an impairment evaluation. This evaluation process occurs routinely without the injured worker having to initiate anything. In the absence of an evaluation in other jurisdictions, an award may simply be issued based on the opinion of the treating physician, assuming the treating physician has reliably rated the impairment. In other jurisdictions, injured workers may have to take a more active role when the level of impairment is disputed. For instance, they may need to retain counsel to pursue their

benefit entitlement. North Dakota is also somewhat unique in the evaluation of impairment given the limited medical resources able to evaluate according to the AMA Guides coupled with the fact that for attorney fees to be paid, the injured worker must first pursue disputes through the Decision Review Office.

As you will see in Element Seven of this report, our analysis of the 6th Edition of the Guides as compared to the 5th Edition suggests that if the 6th Edition is adopted that PPI benefits will decline by about \$1.1 million. (This finding is covered in more detail in Element Seven, but one reason for the decline is that awards under the 6th Edition are more directly the result of functional impairment rather than the combination of functional impairment along with the medical procedure that has been performed.) Because of this finding, we discussed with WSI staff and its actuaries whether we could identify a threshold level that might be cost neutral. Because of the uncertainty of ratable cases that may be near, at or above a reduced threshold we did not ultimately come up with a financial model that would allow us a high degree of confidence in such a forecast. However, we did provide a scenario to WSI actuaries to modify the current threshold of 16% to 10% and we gave them a benefit model to use for their calculations. The model is described in Table 1.14, which shows current and alternate permanent impairment multipliers tied to PPI percentages.

Table 1.14 – Comparison of current PPI schedule (10% to 26%) to alternate schedule

PPI Percentage	Current Multipliers	Proposed Multipliers
10	0	10
11	0	10
12	0	10
13	0	15
14	0	15
15	0	15
16	10	20
17	10	20
18	15	20
19	15	25
20	20	25
21	20	25
22	25	30
23	25	30
24	30	30
25	30	35

The alternate threshold at 10% obviously lowers the threshold and it also increases the impairment multiplier for those in the 16% to 25% PPI impairment range. The only exception is that the multiplier for those with 24% impairment stays level at 30 weeks. Multipliers for impairment levels above 25% are not changed in this alternative PPI model.

Along with any revision to the threshold would come increased costs associated with impairment evaluations and possible other friction costs, such as litigation. WSI has projected the impact of those friction costs to be approximately \$2,000/claim excluding travel, meals and lodging costs to the injured workers, and it does not include any additional administrative costs associated with more frequent impairment evaluations.

When combining the PPI cost increases brought about by a drop in the threshold to 10% with the increased costs of impairment evaluations, the financial impact as estimated through our sample set amounts to \$227,401. The sample set included 30 claims with impairment ratings between 10% and 15% and 20 claims with impairment ratings at or higher than 16%. Relying on the impairment multipliers in Table 1.14 and a reasonable distribution of PPI ratings between 10% and 25%, the threshold reduction to 10% leads to increased costs of about \$90,000. The increased costs for evaluations are estimated at \$137,778. This figure is based on more evaluations occurring down to a level of 5% given that there will be some cases requiring an evaluation because of PPI level uncertainty below a 10% threshold.

Over the past several years, WSI has averaged about 80 non-scheduled PPI awards per year. That is four times the sample size of the 20 cases in the mix of PPI cases referenced above where the ratings were equal to or greater than 16%. The sample set between 10% and 15% amounted to 30 claims so if we quadruple that sample, we might more closely approximate the impact of a reduction of the threshold from 16% to 10%. We would then have 120 new cases included with PPI awards in the 10% to 15% range. Increasing the financial impact analysis four-fold produces an estimated financial impact of \$909,604. This is an amount that is not all that dissimilar to the cost reduction expected if ratings are accomplished according to the 6th Edition.

WSI also currently has a PPI review process in place. One component of the procedure reads as follows: “If the injured worker has had previous PPI evaluations or a previous PPI payment the program specialist will make a notepad entry outlining the results of the review and route the [appropriate WSI form] to the PPI auditor and the claims adjuster and refer them to the notepad for a summary.” The procedure is silent on what the adjuster might do if the injured worker has had prior injuries for which no PPI award or PPI evaluation has been accomplished, but for which impairment may exist. What does the adjuster do in such a circumstance?

In the Shiek decision, the Court provides examples of how PPI awards may be combined to create a WPI (whole person impairment). The Court cites Saari and Feist. The Court comments notably about Feist that the injuries were to two separate parts of the body and applied to two distinct

injuries. So, if that is the way that Court has ruled, WSI would have an obligation when evaluating PPI to determine whether there are prior injuries for which no rating or award issued but for which some impairment may have existed. More specifically, the Feist Court described the “Combined Values Chart” when discussing how to rate two or more impairment values. Relying upon the Court’s logic, we foresee situations where injured workers may have impairments that have not been specifically determined from prior injuries. If these values were known and combined with a subsequent impairment producing injury, it is possible that they would be entitled to a PPI award (see Recommendation 1.10 below).

Recommendations

Recommendation 1.8: Develop a process whereby WSI initiates the PPI evaluation process on its own initiative rather than requiring that the injured worker to request the evaluation. As part of this process, WSI could send its appointment letter via certified mail. Once WSI receives notice that the appointment letter has been received by the injured worker, it can contact the injured worker to confirm he/she will attend the appointment and travel arrangements (when required) can be finalized as well.

Priority Level: Medium

WSI Response: Concur. N.D.C.C. 65-05-12.2 (3) requires WSI notify injured employees by certified mail when they become potentially eligible for a permanent impairment award. The injured employee has 180 days to respond.

The impairment process is initiated by WSI via certified mail to the injured employee notifying them of their entitlement to a PPI evaluation. WSI will follow-up with the injured employee via phone call to determine if they would like WSI to schedule an appointment and to make any other necessary arrangements.

Sedgwick CMS Reply: It appears that WSI does not concur with this recommendation. It is our position that the statute should be modified to require WSI to schedule the evaluation when the potential for benefit entitlement is realized by WSI. WSI already has a process for scheduling medical evaluations when it deems them necessary (e.g., in cases where compensability is questioned) without gaining the concurrence of the injured worker. Determining PPI benefit entitlement should require no different a process than determining overall benefit entitlement. In adding a phone contact after transmitting the certified letter to the claimant, we think WSI is suggesting a modification to its current process and that modification would not satisfy the intent of the recommendation.

Recommendation 1.9: Develop a revenue neutral model for the PPI threshold given the expected reduced frequency of PPI awards should a shift occur from the 5th Edition of the AMA Guides to the 6th Edition, as recommended in Element Seven. We have provided one option (reducing the threshold to 10%) for achieving that objective that is admittedly a rough estimate based on available information at the time of this performance evaluation.

Priority Level: High

WSI Response: Concur. WSI will prepare legislation for the Interim Legislative Workers Compensation Review Committee's consideration for a projected revenue neutral implementation of the 6th Edition.

WSI recognizes this recommendation is based solely on a benefit level alteration which is within the legislative purview. As a result, WSI intends to provide meaningful analysis of the effects of the proposed recommendation to the Legislature.

Sedgwick CMS Reply: When WSI introduces this legislation to the Interim Legislative Workers Compensation Review Committee, we strongly prefer an option that lowers the threshold as opposed to one where the threshold stays the same but the multiplier is increased.

Recommendation 1.10: Prior to closing a case that is not in the auto adjudication claim set, we recommend that WSI note in a consistent place in the claims system whether the injured worker had no PPI or may have had an undetermined level of PPI that did not rise to the level of a PPI evaluation. For those with no PPI, the note can read "zero PPI." For those with an uncertain level of PPI, the note can read, "unknown PPI." Cases in the unknown grouping should then be considered for review in conjunction with subsequent injuries to determine if the overall effect of combining injuries will produce a ratable impairment.

Priority Level: Medium

WSI Response: Concur. Currently it is WSI's practice that upon the closure of time loss claims, a review for PPI eligibility is done and entered as a notepad. In conjunction with this event, a review of prior claims with evaluations and those involving the same body part are reviewed and factored into the consideration.

For injured employees with an uncertain or unknown PPI levels, staff will review for eligibility with the threshold in mind. Notepad entries will identify status of the PPI review. If the injured employee may reach the threshold or be entitled to an additional award, they will be notified of the possibility to participate in an evaluation.

Sedgwick CMS Reply: As we read case law in North Dakota (notably Feist), it is our belief that the “Combined Values Chart” is to be used when two injuries, irrespective of part of the body, can be combined to create or better determine the extent of a PPI benefit obligation. Here is an example of a scenario we are trying to adequately address in this recommendation. Injured worker Jones has an injury in 2006 to his back and WSI recognizes that some impairment is likely but not at a level that will reach the threshold so no PPI evaluation is accomplished. Our recommendation is that in such cases at time of closure, a case comment will be made saying, “unknown PPI.” To follow this recommendation to the next step, injured worker Jones has another injury (this time to the knee) and again the impairment on its own may not be one that will rise to the level of the threshold. However, it may be that the combined effects of the injuries according to the Combined Values Chart would lead to an award. We just want WSI to have a simple method of identifying prior cases that should be factored into the overall potential for PPI benefit entitlement.

Element Two: Evaluation of Contracts

Introduction

For this Element, our objective was to review WSI's vendor contracts. There were approximately 31 contracts subject to review that cover the following services: Information Technology Support, Vocational Rehabilitation Services, Medical Case Management, Ergonomics Services, Reinsurance, Claim Reserving, Physician Review Services, Data Mining, Hearing Officer Services, Private Investigations, Litigation Services, Learning Management System (LMS), and Cleaning Services. The contracts for review were selected based on the parameters given in follow up RFP Questions and Answers document. Our review consisted of:

- an analysis of the performance and cost effectiveness of the vendors for each of the large vendor contracts
- a review of the cost of the services to determine whether the prices charged by vendors are reasonable in comparison with other workers' compensation organizations
- an evaluation of the outside vendor's performance and whether it is reasonable in relation to the contract and to the performance of similar duties in other workers' compensation organizations
- a determination of whether contracting the services with outside vendors is more efficient or effective than performing the services in-house

We reviewed whether the contracts were appropriately bid and awarded in compliance with state laws, rules and regulations as well as WSI policies. We also evaluated the contracts that were extended rather than re-bid, and determined if these also were awarded appropriately (in compliance with state laws, rules and regulations and WSI policies). Finally, we evaluated whether the extension was beneficial to WSI vs. re-bidding the contract. Therefore, the recommendations we give in this section may range in scope from in-sourcing the contracted services to ways to simply improve the performance of the vendors.

To accomplish this, we:

- reviewed the contracts and their associated costs
- interviewed key WSI personnel who manage the vendor relationship
- reviewed the resulting work products of the vendors, looking at effectiveness and timeliness
- interviewed key recipients of the services, and then compared the work of these vendors (and their costs) with the services that other workers' compensation organizations are receiving
- interviewed WSI Legal Department to determine their role in the contract process
- interviewed key members of WSI management to understand the rationale behind choosing to outsource these services

- reviewed state laws, rules and regulations and WSI policies pertaining to awarding business contracts

Background

We met with two of WSI's Legal Counsel and the Procurement Officer to gain an understanding of the policies pertaining to awarding business contracts. We also reviewed the document titled "North Dakota State Procurement Manual - Level 1 Certification" from the North Dakota OMB website. The following is a brief summary of the process.

- For contracts with a total cost of less than \$2,500, only one bid is needed.
- For contracts with a total cost between \$2,500 and \$24,999, WSI must obtain at least three bids, and the lowest bidder who is responsive to the specifications wins. Sometimes, WSI might opt to issue an informal request for proposal (IRFP) to ensure needed standards are met. If less than three bids are received, then a justification must be given, such as "there are only two known vendors that can provide the service."
- For contracts with a total cost of over \$25,000, WSI must follow a formal RFP process, giving notice to approved bidders on the State Bidders List and posting on the State Procurement Online website.
- WSI uses evaluation sheets to score RFP responses. Generally, a weight of 65% is assigned to the technical capabilities and 35% is assigned to price, but they have the liberty to adjust these percentages if they feel technical capabilities are more important. For example, with the claim system RFP, WSI scored responses by weighting 85% on technical merits and 15% on cost. During the review process for the claim system, the reviewers didn't know the price that the potential vendors proposed so they wouldn't be swayed to decide one way or another. The proposals were evaluated solely on technical aspects first.
- When obtaining competitive bids is not possible, such as when there is only one source for the service, an alternate procurement procedure is followed. WSI has the authority to obtain such services if the total price is under \$25,000, but they must obtain prior approval of all limited competitive or noncompetitive purchases over \$25,000.
- Currently long term projects are generally bid for two year periods with a two year option to renew. After the two year renewal period is over, a new RFP is issued.
- Sometimes a "letter of intent" is issued saying WSI intends to renew a contract with an existing vendor. WSI does this when they believe they are using the only service provider of that type in the area. If anyone objects (i.e., if someone thinks they can provide the same service), then an RFP is issued and bids taken.
- The direct supervisor of the work (the contract manager) is usually the one who decides whether a service should be done in-house or outsourced.
- For the State of North Dakota, the Information Technology Department (ITD) is responsible for the wide area network services planning, selection, and implementation for all state agencies. They have created an extensive vendor pool. WSI doesn't need to

issue an RFP if they are choosing from the ITD vendor pool list for projects costing less than \$250,000. If the project costs more than \$250,000, then they need approval first, but they still can use the vendor pool.

The following is a discussion of each of the contracts. In all the cases where contracts were extended rather than re-bid, we found that these were awarded in compliance with state laws, rules and regulations as well as WSI policies. Examples of such extended contracts included Litigation Services and the Learning Management Systems contracts.

Discussion of the Individual Contracts: IT Contracts

Contract #1248: Intertech

This contract is for a Client Server/Programmer Analyst (PowerBuilder, PL/SQL, Oracle), and is a continuation from the previous year. This Analyst supports the current employer client server system so that the WSI internal IT staff can work on managing WSI's transition from the existing claims system to the new iVOS claims system. The performance on this contract is satisfactory and the price is reasonable.

Contract #1247-2009: Intertech

This contract is for Database Administration. This contract was added largely because of staff losses within the WSI IT Department so as to not interrupt the usual day to day business. It was difficult to find resources to commit to working internally at WSI because the future was uncertain with the change to the new system. WSI didn't think it would be wise to hire a new full time employee and then let them go in a year or two. This contractor's performance has also been satisfactory and the price is fair.

Contract #1281: Intertech

The purpose of this is to contract with a programmer to rewrite current batch printing applications as WSI transitions to the FileNet P8 System. The contractor is also to upgrade the Robots which handle the management of the external forms that interface with File Net and Docu Match printers. Additionally, WSI will occasionally use this programmer to help convert reports for the new iVOS and the COTS applications, especially as internal WSI resources are devoted to the iVOS conversion. The contractor is located in Fargo and travel expenses are included in the contract, although he does not travel all the time. Sometimes he works from the Fargo office to minimize travel costs. The performance on this contract and the price are reasonable.

Discussion of the Individual Contracts: Vocational Rehabilitation Services

Contract Number 1186: CorVel Corporation

CorVel Corporation (CorVel) has been the exclusive provider of consultative vocational rehabilitation services on behalf of WSI and North Dakota injured workers for many years. CorVel provides services to facilitate return to work when it appears unlikely that an injured worker can return to their usual work. These services are provided subject to tiered vocational options with shorter term vocational services being the preferred alternatives.

Over the years, WSI has sought competitive bids for vocational services and CorVel has been the logical choice as it has been the only company with North Dakota resources already in place to provide the requested services. As recently as the latter part of 2008 and into early 2009, WSI sought bids for vocational services and again CorVel was the only provider in the marketplace that could satisfy WSI's needs.

Over the last several years, vocational rehabilitation outcomes for North Dakota injured workers have improved. WSI has worked diligently to increase the frequency with which shorter term vocational plans are implemented. As well, the 104-week cap on temporary total disability benefits has served as an inducement to injured workers to start the vocational process earlier. It is a well-known fact in the workers' compensation community that the longer someone is out of work the harder it is to get him/her back to work.

As part of its efforts to improve return to work outcomes, WSI has added a limited number of staff positions to perform vocational and/or job development services. Further, in early 2009, HB 1021 authorized WSI to retain "up to ten full-time employee positions in addition to the full-time equivalent employee positions" already authorized within the bill. The bill identified that these positions should be filled if WSI believed that it could manage vocational services in-house in a more economic and efficient manner.

One factor that we consider in evaluating service performance from an external vendor is their ability to limit turnover, just as this is a meaningful statistic to WSI in the management of its own workforce. By way of example, WSI's turnover statistics over the past three fiscal years (which includes a time of great turmoil within the agency) are 10.1% (for FY 2007), 15.8% (for FY 2008) and 3.6% (for FY 2009). CorVel, under its current agreement with WSI, has nine vocational consultants servicing cases in North Dakota. During Fiscal Years 2008 and 2009, CorVel had ten vocational consultants providing North Dakota vocational services leave its employ. So, turnover has been a much more significant issue for CorVel than it has for WSI.

WSI's current agreement contains language that identifies how much CorVel will charge WSI monthly for each consultant. Those fees include "wages, benefits, overhead costs, office supplies, telephone, cell phone, computer, printer/fax and office start-up." The contract also provides additional compensation to CorVel for some travel time as well as business expenses associated

with vocational travel and services. As such, WSI may reasonably compare the anticipated costs of staffing for vocational services internally.

Recommendation 2.1: WSI should pursue the option of retaining its own staff to manage the vocational rehabilitation services in the State of North Dakota. We further recommend that WSI partner with CorVel in an orderly transition of services. This could result in an agreement between the parties that WSI phase the transition to cause as little disruption to current injured workers participating in the vocational process as well as to the consultants providing vocational services, many of whom may wish to seek employment with WSI. WSI should develop a business plan that includes staffing, expenses, places of operation, position requirements, and training. The plan should also include how the new staff will be managed and by whom, including whether or not any additional management, supervisory or administrative staff need to be retained to meet service objectives.

Priority Level: High

WSI Response Concur. WSI will further explore opportunities in this area.

WSI will develop a business plan for consideration by the 2011 Legislative Assembly in regards to bringing vocational rehabilitation services in-house.

Discussion of Individual Contracts: Case Management Services

Contract Number 1040: Trinity Health

Contract Number 1044: Altru Health System

Contract Number 1042-1: Mid Dakota Work Life

Contract Number 1039: Med Center One Occupational Health

Contract Number 1041: MeritCare Occupational Health

WSI has contracted with Six Case Management Companies with five being reviewed for the purpose of this audit as the annual cost is estimated to be over \$100,000 per year.

The purpose of the case management vendors is to provide on-site return to work Registered Nurse case managers to service injured workers who seek medical attention with providers associated with the contractor.

The contracts listed above were evaluated. In review of the contracts for the case management services it was determined they are considered waived as part of the procurement process per N.D.A.C rule: 4-12-09-03 (d). The rule provides that a waiver is allowed when contracting for services involving medical doctors, psychologists, dentists or other medical specialists.

Interviews were conducted with key personnel who manage the vendor relationships. These interviews included the Director of Return to Work Services and WSI Legal Department, each of whom was involved in evaluating the appropriateness of the waiver.

We also reviewed contracts with case management vendors and metrics in place for WSI to ensure the vendor is performing duties as required per contract.

Review of Services:

WSI has contracts with six firms to support the early intervention disability management process in North Dakota. Only five of six firms are being reviewed as their contract value is considered to be over \$100,000 per year. The firms are Trinity Health, Altru Health System, Mid Dakota Work Life, Med Center One Occupational Health and MeritCare Occupational Health.

The case management services involve the RN's in the above designated medical facilities to service the injured workers being seen at their medical facilities. The case manager is responsible to assist the employer, the medical provider, injured worker and WSI in coordinating transitional work whether it is temporary in nature until full duty can be resumed, or permanent modified work is deemed appropriate with the employer at time of injury.

We reviewed the scope of services that should be provided by the return to work case manager. Contractually disability managers are required to conduct an initial audit of medical documentation on new workers' compensation cases to determine if a case warrants any disability management (DM) services. The disability manager must consider the work status of the injured worker and the complexity of the case in deciding whether to open a DM case.

The next process is a screening, in which the disability manager contacts the employer, the employee and the medical provider and issues a report summarizing the injured worker's work status, medical care, etc. The disability manager submits this report within 72 hours of initiating the screening process.

If following the screening, the disability manager determines that a wage loss claim is likely to occur or work restrictions coupled with extended medical care prevent the injured worker from performing his/her regular job duties, then disability management services may be provided to coordinate return to work efforts.

While disability management services are being provided, the disability manager reports to WSI approximately every two weeks with return-to-work status updates.

An assessment was performed August 19, 2005 by Octagon Risk Services in which several recommendations were made specific to Disability Management Services for WSI. The majority of

the recommendations were adopted and fully implemented. These fully implemented recommendations have led to tools to audit performance of outside case management services. Recommendations were made to serve WSI, its policyholders and injured workers more efficiently.

A summary of the DM performance related recommendations are as follows:

- The way in which disability managers are retained by WSI needs to change so that a greater emphasis is placed on claims where the disability managers can make a difference. The redirected emphasis should occur through the following steps:
 - On claims where restrictions exist and the employee has returned to work and the employer can accommodate the restrictions the claims analyst should manage the disability aspect of the claim. If during a period of restriction, the employer is not able to accommodate, the analyst can refer the case back to the disability manager.
 - Disability Managers should also play an ongoing role in cases where an employer cannot accommodate the injured worker's restrictions or where an employee is temporarily totally disabled. The duration of their involvement on time loss cases should be driven not by contract terms, but by whether or not the treating physician has permanently ruled out a return to work with the employer at the time of injury.
 - Disability managers should not be involved in medical only claims in which no restrictions apply.
 - WSI should abandon its current pricing format in its contracts with the disability manager. In its place, disability firms and WSI should agree on a cost/disability manager/year. And they should also agree on how many staff positions should be required for each of the DM firms.
 - Claim analysts, claim supervisors and the return to work staff should identify controls they wish to have in place over the utilization of disability managers.
 - To accomplish a more thorough understanding of the workplace where disabling injuries occur, we strongly encourage the disability managers to visit these workplaces to understand better the work involved and the possible options that exist to provide modified duty.

- Claims analysts will assume the responsibility for all restricted duty claims and to manage those cases to a full work release. Disability Managers' involvement should occur only in instances of intractable restrictions, those that may exist for longer than 90 days.
- WSI should develop measurement tools to identify how well the DM firms are doing at assisting WSI in returning injured workers to work.
- WSI to negotiate fees for the DM services for the balance of the biennium. In addition it was also suggested that disability managers track their time so WSI has an opportunity to validate the headcount allocation to which each of the DM firms may commit. Time should be tracked in quarter hour increments by injured worker. Time should be reported monthly to the return-to-work supervisor.
- WSI was encouraged to review treatment patterns on cases where time loss was less than 30 days. A concern was raised where DM firms are also providing medical service that there may be an incentive to route injured workers for more medical services in-house than would be true of those injured workers who are being treated elsewhere.

Following assessment in 2005 WSI implemented changes to restructure the Disability Management Program which has resulted in greater oversight of the Case Management Vendors.

A summary of the key changes for the Case Management area are as follows:

- The screening process used with the return-to-work case managers requires that the screening process be completed on each case. The screening allows for the claims to be categorized into two groups. The first group is where restrictions apply and the employer is able to accommodate. The second is where restrictions apply and the employer is not able to accommodate. Once case managers are assigned to claims they will remain on them until it is determined they are no longer having an impact. If during the period of restriction the employer is not able to accommodate or in instances where the intractable restrictions exist for longer than 90 days, then reassignment of the RTW case manager may take place.
- Disability managers should also play an ongoing role in cases where an employer cannot accommodate an injured worker's restrictions or where an employee is temporarily totally disabled. The duration of their involvement should not be driven by contract terms, but by whether or not the treating physician has permanently ruled out a return to work with the employer at the time of injury. WSI has implemented a triage process to manage claims aggressively from the beginning of the claim. The claims unit is responsible to ensure that the claims are included in the triage staffing. Triage is

applicable for all claims with time loss with five or more consecutive days of lost time. Triage is held every week. According to the triage schedule, cases that are subject to review may be staffed by among others in-house medical professionals, medical case managers and vocational rehabilitation professionals to provide oversight with medical services and disability management.

- Case Management should not be involved in a medical only claim where no restrictions apply.
- A new pricing format was suggested and adopted in which the Case Management Vendors are paid a flat monthly rate.
- Supervisors and return to work staff should work with the claims analysts to determine the necessity of ongoing return to work case managers at the 90th day and every 60 days thereafter. WSI has put controls in place and also adopted the triage process to aggressively manage the claim and determine whether or not the RTW case manager continues to be necessary in the claims management.
- Disability Managers are encouraged to conduct job site visits. WSI was drafting a new service contract July 2009 where this would be contractually required.
- The Official Disability Guidelines (ODG) has been implemented by WSI to track the on-site RTW case management providers. WSI developed a database to track the ODG at-risk days and the ODG benchmarking percentage. Each quarter WSI assesses the information within the report to identify any trends, red flags or areas to be used as a training tool.
- WSI is also utilizing the ODG guidelines and triage to determine if treatment within the corresponding medical facilities is appropriate. If any adverse treatment patterns are discovered WSI will address them with the medical facility.

In the discussion with the Return to Work Services Director it appears there is a great deal of oversight over the outside RTW Case Management Services. The cases being treated by the external case management vendors are reviewed every 28 days to assess performance of outside return to work case managers. The internal triage process as well as the reviews being performed has resulted in greater effectiveness of the program.

In reviewing the contracts it has been determined that a survey is being completed by the claims team for the work being performed by each one of the return to work case management vendors prior to the contract being renewed. The survey covered the period of 7/1/2007 - 6/30/2009.

The overall responses indicate that the claims team ranks the overall satisfaction of the onsite case management program as follows:

Table 2.1. Return to Work Case Management Vendor Survey Results

	Very Satisfied	Satisfied	Needs Improvement	N/A
Altru Health Systems	33.3%	44.4%	14.8%	7.4%
Medcenter One Occ. Health	74.1%	18.5%	7.4%	0.0%
Meritcare Occ. Health	63.0%	33.3%	0.0%	3.7%
Trinity Health	63%	25.9%	3.7%	7.4%
Mid Dakota Worklife	59.3%	29.6%	3.7%	7.4%

A brief sampling of survey responses follows:

There is a concern that the return to work case manager should be more aggressive in asking pointed questions in return to work situations with the doctor and the employer. Return to work case managers should also be more aggressive in obtaining job descriptions from the employer.

It is perceived that there sometimes may be an inherent conflict between the return to work case manager and the medical facility. The case manager may be reluctant to address return to work concerns with physicians with whom they work.

A suggestion was also made that if return to work case managers are following a case and the treating physician refers a patient to another provider it would be helpful if the return to work case manager would continue to oversee the case. This would lighten the load on the WSI return to work case managers.

Next, in reviewing the audit tools put in place by WSI to audit performance of Return to Work Case Management Vendors they appear to be adequate.

WSI generates reports on a weekly basis to measure the number of open and closed Return To Work cases assigned to each of the Medical Facilities as well as which Return To Work Case Managers are handling each of the files. WSI also tracks each case assigned to the Case Manager with detailed information on the adjuster and the injured worker and the date it was assigned.

One of the reports WSI generates is an ODG Benchmark Facility Report. This report demonstrates the ODG at Risk Days in comparison to the actual TTD days on the claim. The report indicates on a per claim basis whether or not the TTD is less than or equal to the ODG days.

The following illustrates the ODG Benchmarking Report for the period of Oct. – December 2009 in a summary fashion.

Table 2.2. ODG Benchmarking Report, October – December 2009

Medical Case Manager	# of Claims	ODG at Risk Days	TTD Days	ODG-TTD %	TTD<or= ODG Days
Altru Health Systems	61	5967	1891	68.30%	91.80%
Medcenter One Occ Health	47	4777	5067	-6.10%	74.50%
Meritcare Occ Health	51	5233	3378	35.40%	80.40%
Trinity Health	40	4336	2615	39.70%	77.50%
Mid Dakota Worklife	67	6358	4939	22.30%	76.10%

(Note: The Occupational Disability Guidelines (ODG) establish at risk days according to diagnosis. The penultimate column in the table shows the difference between the ODG at Risk Days column and the TTD Days column. When that number is higher, it is expressed as a negative. The final column of the table shows the percentage of individual cases where TTD days were limited to an amount that was less than or equal to the at risk benchmark according to the ODG.)

From this summary, the experience of Medcenter One Occupational Health at keeping the TTD days below the ODG at risk days is not favorable. Out of the 47 claims assigned, 12 cases had TTD days exceed the ODG at risk days. In this summary, Altru Health Systems had better experience in keeping the TTD days below the ODG at Risk Days than any of the other case management firms.

The current metric used by WSI to measure performance of the case management firms is predicated on the at-risk day count tied to a specific ICD-9 (diagnosis code) and their relative success against that measure. In reviewing measures recommended by the Work Loss Data Institute, it appears that WSI would also benefit in measuring RTW success against the mid-range day count that is linked to the ICD-9. For instance, if the mid-range day count for a particular diagnosis is 16 days, WSI could measure the percentage of cases where RTW occurs on or before that number of days. The higher the percentage is, then the greater the success.

To summarize, significant favorable changes have occurred over the past few years in the way Return to Work Case Management firms are deployed. Early intervention protocols are appropriate, and there is the correct focus on time loss claims.

Injury management and monitoring tools have been implemented to ensure the Return to Work Case Managers are opening services when review of the initial medical information indicates that the injury resulted in time loss of five or more consecutive calendar days. The audit tools also show the length of time cases have been open so independent review by the claims examiner and a referral to triage can occur, as appropriate.

Recommendations for Case Management Vendors

Recommendation 2.2: WSI should develop a metric that evaluates Return to Work Case Managers' effectiveness based upon the ODG mid-range days. The metric would be based on the mid-range day count and would capture how many claims are resolved within the mid-range as a percentage of all claims in each case manager data set. The metric would not only include an evaluation of the outliers (cases exceeding the at-risk days) but also include an evaluation of some of the cases between the mid-range date and at-risk date to see what could be done to shorten disability periods between those two dates. To establish the metric it will be necessary to capture cases by the following:

- Onsite Return to Work Case Manager
- Injured Worker Name and Claim Number
- ICD9 Code
- ODG Mid Range Days
- ODG At Risk Days
- Actual TTD Days
- Total # of cases that hit Mid Range Days by Return to Work Case Manager as a % of all claims in the data set

Once WSI has had this metric established for a period of six months to a year, WSI should develop an incentive program for its case managers to achieve higher levels of RTW performance.

Priority Level: High

WSI Response: Concur. WSI currently has the capability to capture this information based on individual on-site case management facilities. WSI will work with information services to update the current management system to allow tracking of these measures by individual on-site case managers and facility. A review will be conducted on the strengths, weaknesses, opportunities and threats of incorporating an incentive program attached to the outcomes of the metric system.

Recommendation 2.3: Audit the results of the Return to Work Case Managers so a determination can be made on their effectiveness in Return to Work. WSI should develop a metric that would look at all reported losses in 2008, actual TTD being paid in 2008 and compare to all reported losses in 2009 and actual TTD being paid in 2009. Take this analysis year over year and make sure cutoff periods are the same. This should allow WSI to ensure the effectiveness of the Return to Work Case Managers to facilitate return to work and decrease the need for TTD.

Priority Level: Medium

WSI Response: Concur. WSI will work with the appropriate individuals to assess the ability and format to accomplish this recommendation by on-site case management facility versus individual case managers.

Recommendation 2.4: Utilize the ODG Benchmarking Facility Report to determine which facilities are performing better than others at keeping the TTD days below the ODG at risk days. This report allows for WSI to review performance of Return to Work Case Managers to determine if spikes are due to unusual claim activity, if the employer is unable to accommodate return to work restrictions, or if there are areas of concern with a designated case manager or medical facility.

Priority Level: High

WSI Response: Concur. To the extent possible, WSI will utilize the ODG Benchmarking Facility Report to determine which facilities are performing better than others at keeping the TTD days below the ODG at risk days.

Recommendation 2.5: Files with complex medical issues are being referred to triage. As part of the triage process the files are reviewed by the triage team including in-house medical staff as appropriate. A recommendation for further plans of action should be documented in the claim file under the “Triage” notepad entry. The plan of action should consist of a synopsis of the claim, issue being reviewed in triage, and the plan of action that would include plans to address complex medical issues, pharmacological issues, and other mitigating medical factors in the claim.

Priority Level: Medium

WSI Response: Concur. WSI will implement a system of documentation.

Discussion of Individual Contracts: Ergonomic Initiative Program On-site Services

Contract Number 1256-3: Applied Medical Inc.

Contract Number 1256-2: Altru

Contract Number 1256-5: First Choice Physical Therapy

Contract Number 1256-4: Axis Clinic

Contract Number 1256-8: Medcenter One Occupational Health

Overview and Analysis

As WSI had noticed that about 35% of all reported claims over the last five years were cumulative trauma type of injuries, they decided to start an Ergonomic Initiative Program to help reduce these types of injuries. The Ergonomic Initiative Program is designed to offer North Dakota employers the ergonomics expertise as well as financial resources to assist them in reducing their cumulative trauma injuries.

The program consists of three components. The first component is that WSI has set up a network of ergonomics providers, primarily occupational and physical therapists, throughout the state. The second component is financial assistance for the providers' services. These services may consist of ergonomic worksite assessments, subsequent recommendations, assistance with equipment selection, and/or training. WSI pays for 75% of the ergonomic providers' services, while the employer pays the remaining 25%. Finally, a third component is providing financial assistance for the purchase of ergonomic equipment.

Our task was to review the contracts with the Ergonomic Initiative Program service providers. At the time of our review, there were 13 such contracts that collectively were worth over \$100,000. Consistent with contract selection protocols agreed upon at the outset of this project, we picked a representative sample of the contracts (5 of the 13) to review. Based on calendar year 2009 payments, these 5 contracts accounted for \$163,475 of the total \$190,079 spent on ergonomic services, or 86%. Those five vendors are listed above.

We interviewed the ergonomics contracts manager. We also reviewed the providers' applications and bidding/award process, the contracts themselves, and representative work products from each of the five vendors.

Provider Bid Process

WSI issued an RFP for On-site Services for the Ergonomic Initiative Program on September 11, 2008, and proposals were due by October 22, 2008. The intent of the RFP was to solicit providers in eight regions across the state; therefore, multiple contracts were awarded. Each provider gave their location and their willingness to travel, thereby allowing WSI to create a

network of providers across the state. These contracts are slightly different in that the price to be paid to the vendor was stated up front in the RFP: “All travel that is less than 40 miles round-trip: \$125/hr for actual assessment time and preparing the subsequent documentation. For travel greater than 40 miles (round trip), in addition to the \$125/hr, offerors will be reimbursed: \$50/hr for travel time plus mileage at the current State rate.” Therefore, each vendor is paid the same hourly rate and price was not one of the elements scored on the RFPs. The evaluation criteria and scoring system were given to the potential bidders in the RFP, and the subsequent proposal scoring sheets (used by three separate evaluators) showed that they followed through with using this system. It appeared that these five contracts were awarded within the requirements of the state laws and WSI policies as described above.

After the bidders were awarded and the network of ergonomic vendors was established, the process of beginning a new project is actually initiated by employers that contact WSI regarding their desire to participate in the program. The employer submits a description of the potential problem(s) they would like to address using the Ergonomic Initiative Program. After approval by WSI, the employer receives a list of the network providers in their area and can pick the provider they wish to use. The provider then performs an initial assessment and develops a plan, complete with an estimate of total hours to completion and submits this plan to WSI for approval. We understand that sometimes there are negotiations between WSI and the vendors regarding the number of hours necessary to complete the project. Once a final amount of time is decided and approval is given by WSI, the work can proceed. If a provider has not completed a project and determines more hours are needed to complete the work, then they must get approval from WSI before more hours are granted.

During the limited pilot phase of the program, WSI paid 100% of the vendors’ costs. After the pilot phase (beginning in 2009), WSI pays 75% of the cost, while the employer pays the remaining 25% of the cost.

We noticed that one vendor, Applied Medical, Inc., accounts for 55% of the total amount paid to all the vendors in calendar year 2009. This is due to the fact that this vendor has multiple offices in locations all over the state. They also have approximately 40 employees, some of whom are focused solely on providing services for the Ergonomic Initiative Program. The other vendors tend to have a much smaller number of locations and employees. We also understand that they spend a lot of effort in marketing, so when employers are given a choice of which vendor to pick from, Applied Medical is the one with whom they are most familiar.

The hourly rate paid in these contracts is reasonable when compared to the rates charged by other, similarly credentialed professionals in the Midwest. In reviewing the vendors’ work products, we found their performance to be reasonable when compared to the contract and to the ergonomic services typically received by other workers’ compensation organizations. In general, their ergonomic approaches were thorough and well-rounded. In the work products we reviewed, the number of hours to complete the work was also very reasonable.

For this service, outsourcing is better than providing the services in-house for several reasons. First, it minimizes the inconvenience, expense and time of traveling around the state. Secondly, a contracted third party may be perceived by employers as more neutral and their recommendations may be better received by employers than if it were coming from a WSI employee. We also appreciate that employers have cultivated relationships with these vendors and they have become comfortable with each other. Finally, there is sometimes a sporadic and/or seasonal nature to ergonomics work that might make it hard for scheduling the projects among only one or two internal employees. For example, there would be times when an internal resource could be overwhelmed with projects and other times they might not have much to do. Having a number of vendors that take part in the network of providers can better help meet the demands of the program and ensure more timely service.

We feel it was appropriate to extend the current contracts, as the WSI contract manager feels he is overall getting good service from the existing vendors, as well as reasonable prices. In the small number of instances he has suspected that either the service provider has not been responsive, or if projects were consistently not being bid appropriately the first time (i.e., the provider continually asks for more hours during the middle of the project), then attempts were made to correct this with the service provider. It appears these efforts were successful.

Discussion of Individual Contracts: Brokerage Services

Contract Number 1252: Guy Carpenter & Company, LLC

WSI has for many years not purchased reinsurance. But during calendar year 2009, WSI decided to go out to market. To do that, WSI needed to identify a broker to take it through the insurance purchasing process. WSI went out to bid, identified five candidates, and evaluated those candidates. Guy Carpenter won the bid. WSI evaluators included the COO and heads of departments in Injury and Medical Services, Policyholder Services, Legal and Finance. The process employed was compliant with stated procurement practices.

Broker services supported WSI's objectives and a reinsurance agreement went into effect on 1/1/10. The reinsurance agreement covers specific workers' compensation losses and employers liability claims at an amount of \$5,000,000 in excess of \$5,000,000. A second coverage layer also exists with \$10,000,000 in coverage in excess of \$10,000,000. For each of these two reinsurance policies, multiple subscribing insurers are participating.

Through the performance evaluation period, Guy Carpenter provided efficient, effective services that could not have been sourced within WSI.

Discussion of Individual Contracts: Other States Coverage

Contract Number 1228: Accident Fund Insurance Company of America/Trean Corp

WSI provides to its policyholders an insurance product through Accident Fund Insurance Company of America (Accident Fund) that pertains to out of state coverage. The policy specifically covers employers in North Dakota who have temporary and incidental workers' compensation exposure outside the State of North Dakota. Temporary and incidental coverage pertains to workers whose consecutive period of out-of-state employment is for thirty or fewer days. Through this coverage arrangement, WSI helps to satisfy insurance requirements on behalf of its customer base that may have out-of-state exposure.

The most recent renewal during the performance evaluation period with the Accident Fund occurred in 2009. During that renewal, the Service Requisition process occurred late. This process (form) provides supporting documentation and rationale for the service being requested including the expected costs for the service. WSI noted that the process occurred late due to a change in the contract period. WSI recognizes the process should have occurred sooner.

In 2007, Accident Fund was the carrier providing this coverage and consulting services tied to this agreement were provided through Aon Re. The individual specifically assigned to consult on these services was a national expert in workers' compensation insurance matters. In 2009, WSI moved the consulting piece of this business to Trean Corporation at a time that roughly coincided with the national expert's move to that company. WSI appropriately decided to use the Alternate Procurement Request (limited) process to move the consulting services from Aon Re to Trean to continue its working relationship with this individual. A timely Service Requisition process was completed in preparation for this change.

The reason this coverage is purchased is that WSI is not licensed to write workers' compensation coverage outside the state of North Dakota. Further, this coverage is limited to the states in which there is a private insurance market, meaning coverage applies to all other states except for Ohio, Washington and Wyoming. The national expert functions in the roles of both broker and consultant in support of this program.

One finding of note in our review of this program is that in the six years the program has been in place, no claims have occurred within the definition of temporary or incidental employment that have ultimately been managed through the out-of-state coverage. In its own documentation as to the rationale for this coverage, WSI states that the "ongoing purpose [for this coverage] is to close the coverage gap for North Dakota employers who have temporary and incidental workers' compensation exposure outside the boundaries of North Dakota. Historically, an employer who travels outside the state runs the risk that an insurance regulator might deem it non-compliant with the workers' compensation laws of that other state."

We further noted that there are consultative services that Trean provides to WSI that are outside of the specific services noted in the Temporary/Incidental Coverage Agreement, and we have

recommended that WSI better document the extent of these services, as noted in Recommendation 2.7.

Other than North Dakota, the State of Wyoming is the only other exclusive workers' compensation monopoly in the United States, and per WSI's own staff Wyoming does not offer temporary/incidental coverage to its policyholders.

Recommendation 2.6: WSI should determine whether Temporary/Incidental insurance is in the best interests of its policyholders given the fact that in the six years the coverage has been in place no claims have been managed through this out-of-state program. As part of this evaluation, we recommend WSI canvas other state regulators about the need for this coverage given the jurisdictional requirements that exist in their respective states. Further, WSI should consider this coverage in the context of the number of claims that actually do occur out of state, and there are hundreds annually, as one factor in its determination about whether this coverage is actually needed.

Priority Level: High

WSI Response: Concur. The temporary/incidental insurance product originated based on ongoing concerns of WSI policyholders that conduct business across state lines on a temporary or incidental basis. Historically, there has been an ongoing dialogue with officials from other states. Many other state funds have secured a fronting company to resolve this issue in their respective states. WSI recently completed an other states request for proposal process for alternative solutions that included participation by relevant stakeholders. No viable proposals were received. As discussed at the exit conference, WSI has negotiated a universal product for all active accounts that will greatly simplify the administration of this program and be much more cost effective.

Recommendation 2.7: WSI should more adequately document the full scope of its consultative/broker arrangement with Trean Corporation (Trean). To the extent Trean provides consultative services that are beyond those performed in conjunction with Accident Fund, those services and associated professional fees should be well-defined in a separate service agreement.

Priority Level: Medium

WSI Response: Concur. WSI has implemented a universal All States product, effectively providing temporary/incidental coverage to all active policyholders. In addition to those services required to support this expanded All States product, Trean will be required a) to provide consulting services to WSI on broader, extraterritorial, other states and jurisdictional issues; b) maintain records of the professional consulting services it provides to WSI.

Discussion of Individual Contracts: Claim Reserving

Contract Number 1093: Fair Isaac

With an OMB procurement waiver in 2002, modifications were made to WSI's internal claims management system to interface with the first version of MIRA (Micro Insurance Reserve Analysis), an internet based claims reserving tool that projects the lifetime costs of work-related injuries using national data. WSI used this version of the tool from 2002-2003, terminating its use due to very limited success. In 2007, WSI entered into a 5 year non-competitive procurement process with Fair Isaac to upgrade to their most current version of the software tool, MIRA Claims Advisor for Reserving (version II). The upgrade was recommended because it was adaptable to WSI's unique claim system, and there were already some compatibility issues based upon earlier agency-wide adoption of the first MIRA software version. Reports can be run at multiple levels, including Unit and adjuster level for reserve accuracy comparison purposes. OMB again granted approval with state ITD oversight in September 2004 for this WSI system upgrade. The contract term ran from December 2004 through December 2009, including customization and setup fees, usage fees and initial training. The negotiated price reflected credit for prior use of MIRA I. There is an annual flat fee for renewal that has been paid for calendar year 2010.

WSI claim staff was trained to use the updated version of the tool, but found that over time, very few were using the tool, including claim department management. Additional training was needed due to staffing changes and a general lack of understanding in how to use the product effectively. In March 2009, an additional training session was held for the claims staff. With the exception of fee-based training sessions, there has not been much in the way of customer service follow up. To date, there is very limited use of the tool in the reserving process at WSI. On the whole, management sees it as an advisory tool only, and the claims staff generally sees it as an unnecessary workflow process. Claims staff utilizes life expectancy tables to assist them with indemnity benefit reserving, as MIRA II does not address ND Death Benefits, Additional Benefits Payable and Permanent Impairment benefits. The staff also uses Occupational Disability Guidelines to assist with medical benefit reserving. It is also difficult to document MIRA's predictions, as WSI is in a scanning environment; the tool is not print friendly. WSI continues to include plans for the product as an interface with its new *Aon* (IVOS) claim system upgrade.

The cost of this reserving product is not unreasonable in comparison with similar other workers' compensation reserving products. The specialized nature of the product makes it a more efficient and cost effective service to outsource.

Recommendation 2.8: WSI should evaluate its commitment to the utilization of the MIRA II product before investing any additional resources into creating management processes surrounding its use and future application in the new claims management system.

Priority Level: High

WSI Response: Concur. WSI agrees that evaluation of the MIRA II product and its effectiveness is necessary.

WSI has developed a committee made up of supervisors, senior adjusters, claims adjusters, Director of Claims, and Chief of Injury Services to evaluate this product.

Recommendation 2.9: WSI should identify at least one management level report that will be run at least quarterly to identify any shifts in the organization's incurred values, and to identify trends in reserving amongst the claim units.

Priority Level: Low

WSI Response: Concur. WSI will investigate what report fulfills this recommendation best.

Discussion of Individual Contracts: Physician Review Services

Contract Number 1022: Physician/Medical Advisor

WSI has contracted with two Physician Advisors, one whose annual cost is estimated to be over \$100,000 per year.

The purpose of the Physician Advisor is to monitor and evaluate medical, surgical, and hospital treatment used by and provided to claimants.

In review of the contract for Physician Review Services, it was determined standard procurement processes are considered waived per N.D.A.C. rule 4-12-09-03 (d). As noted earlier in this Element, a waiver is allowed when negotiations are occurring with medical professionals.

Interviews were conducted with key personnel who managed the vendor relationships. These interviews included the Medical Services Director and WSI Legal Department, each of whom was involved in the waiver determination.

We also reviewed the contract with the Physician Advisor and the metrics in place for WSI to ensure the vendor is performing duties as required per contract.

Review of Services:

The Medical Advisor is responsible to monitor and evaluate medical, surgical and hospital treatment used by and provided to claimants. Monitoring consists of assisting WSI in making medical determinations regarding the appropriateness of requested services, the quality of treatment, and the right of providers to receive payment for services rendered or proposed. Evaluation will include the clinical effectiveness of treatment and the frequency and duration of proposed treatment. If a request is inappropriate, the physician advisor will provide an alternative recommendation to the requesting physician that is in accordance with ODG and other treatment guidelines. He also provides WSI with technical expertise in resolving disputes arising from the administration of WSI's managed care program.

WSI recently expanded the services with the Medical Advisor concerning medical consultation. The Medical Advisor's services have been expanded to four hours a day or 20 hours a week. This was based on a recommendation from the Marsh Report 5.0/5.5 which would allow for better utilization of the Medical Director's time for other value added activities.

If a request for Utilization Review (UR) is sent to the Medical Advisor the UR Department tracks the date and time the request was sent. The Medical Advisor has 72 hours to respond to the request. It should be noted effective April 1, 2008, NDAC rule 92-01-02-34(9) was amended to extend the timeframe for a utilization review response from WSI's Medical Director from 24 to 72 hours. The Medical Advisor also receives requests for review and will make his decision (via Form UR2) and return to a WSI nurse reviewer. The date and time are tracked within the UR Department to ensure compliance with the 72 hour guideline. At the end of each month the Medical Advisor will fax his list of completed UR2's. The Intake Coordinator compares that list against a spreadsheet they have maintained to confirm that each entry they show as being referred to the Medical Advisor has been completed and returned.

The Medical Advisor reviews the following services for WSI:

- Botox and Myobloc injections
- Chronic Pain Program
- Dental procedures done as surgical procedures if outside of WSI Guidelines
- Electro diagnostic Studies if outside of WSI Guidelines
- Epidural Steroid Injections if outside of WSI Guidelines
- Epidurogram
- EMG/NCS corresponding paraspinal (NC-stat and surface EMG's not reimbursable)
- Facet joint injections
- Facet nerve blocks
- Facet rhizotomy
- Hyperbaric Oxygen Chamber Treatments

- Intra-articular injection of hyaluronic acid viscosupplementation if outside of WSI Guidelines
- Myelograms
- Nerve injections
- Nerve root blocks
- Pain pump
- Peripheral nerve blocks
- Plasma rich injection if outside of WSI Guidelines
- Radio frequency lesioning if outside of WSI Guidelines
- Retrospective reviews for services authorized to review
- SI joint injections
- Stellate ganglion blocks
- Sympathetic nerve blocks

The Medical Advisor utilizes the 2010 Official Disability Guidelines as well as the Medical Disability Advisor, Utilization Management Knowledgebase and the North Dakota Century Code as guidelines for his utilization reviews.

Table 2.3 shows the reviews conducted by the Medical Advisor from February – December 2009.

Table 2.3. The Medical Advisor's 2009 Reviews

	OP Surg	Injection	Electro Studies	IP Stay	IP surg.	CT	CT Myelogram	MRI	Imaging	PT	Bone Scan	Other	Total
Jan													
Feb	11	82	4	0	5	0	0	2	0	0	0	0	104
March	7	79	9	0	3	1	0	2	2	0	0	0	103
April	3	84	4	1	6	4	0	2	0	0	0	0	104
May	11	83	3	0	4	5	0	0	3	0	0	0	109
June	7	91	7	0	4	1	0	1	1	1	0	0	113
July	6	79	6	1	0	1	0	4	2	0	0	1	100
Aug.	12	68	5	0	3	2	0	1	4	0	0	0	95
Sept.	6	99	6	0	7	1	2	2	0	0	1	0	124
Oct.	11	89	4	0	4	0	2	0	5	0	0	0	115
Nov.	14	81	6	0	5	1	1	1	1	0	0	0	110
Dec.	5	98	9	0	11	2	0	0	6	0	0	1	132
Total	93	933	63	2	52	18	5	15	24	1	1	2	1209

The following table summarizes the percentage of review types to overall requests:

Table 2.4 – Distribution of Medical Advisor services

Type of Request	# of Services	Percentage of Overall Requests 2009
OP Surgery	93	.08%
Injection	933	78%
Electro Studies	63	.06%
IP Stay	2	.01%
IP Surgery	52	.05%
CT	18	.02%
CT Myelogram	5	.01%
MRI	15	.02%
Imaging	24	.02%
PT	1	.008%
Bone Scan	1	.008%
Other	2	.01%

As one can see from either Table 2.3 or 2.4, the vast majority of the reviews going to the Medical Advisor are requests for injection services.

Note that certain referrals are made to the Medical Director via Form C141. These referrals are made to the Medical Director for review of proposed treatment of the following:

- Chronic Pain Program
- Direction on management of complex medical issues
- Determine cause of claimed injury, illness or condition
- Review request for Sanders Cervical Home Traction
- Determine is treatment related to compensable work injury
- Determine if ICD9/diagnosis is compensable work injury
- Other medical determinations

The following shows the distribution of Utilization Reviews from C141's on a monthly basis:

Table 2.5. Distribution of work for the Medical Advisor, 2009

	C141's	Utilization Review
January		
February		104
March		103
April		104
May		109
June		113
July		100
August		95
September		124
October	1	115
November	10	110
December	6	132
Total	17	1209

Table 2.6 shows the distribution of approvals and denials for the review period noted in earlier tables.

Table 2.6. The Medical Advisor Utilization Reviews – Approved and Denied in 2009

	Approved	Denied	Total	% Approved	% Denied
January					
February	100	4	104	96.2%	3.8%
March	99	4	103	96.1%	3.9%
April	102	2	104	98.1%	1.9%
May	106	3	109	97.2%	2.8%
June	109	4	113	96.5%	3.5%
July	92	8	100	92.0%	8.0%
August	90	5	95	94.7%	5.3%
September	118	6	124	95.2%	4.8%
October	106	9	115	92.2%	7.8%
November	108	2	110	98.2%	1.8%
December	130	2	132	98.5%	1.5%

On average the number of reviews being processed by the Medical Advisor is approximately 105 per month with approximately 95.9% of the reviews being approved and 4.1% being denied.

Of the denials it appears that 84% of the denials involve requests for injections. This would be anticipated since we observed that 78% of the utilization review requests are for injection services.

We also reviewed the number of appeals being generated by the denials performed by WSI Medical Director and Medical Advisors as a whole, and we then looked at appeals generated by the work of the Medical Advisor. Of those appeals generated by the Medical Advisor, we looked at the number of appeals that were upheld or overturned, and if overturned, the reason for the reversal. The Medical Advisor subject to review here is noted below as Dr. C.

Table 2.7. UR Reviews and Appeals 2009 by Medical Director and Medical Advisors

	Dr. A	Dr. B	Dr. C	Totals
2009 UR Review	11	423	1209	1643
2009 Generated Appeals	0	38	6	44
2009 Ratio Appeals to Reviews	0%	9.0%	0.5%	2.7%

Of the appeals generated by the Medical Advisor referenced above as Dr. C, we found that all six were subsequently overturned. The initial review decision was appropriate but sufficient additional medical documentation was subsequently provided to WSI's to satisfy the medical service request.

Table 2.8. Total Payments to the Medical Advisor for Utilization Review and C141's 2009

	Monthly Total	Quarterly Total	Annual Total
January	\$50.00		
February	\$8,550.00		
March	\$8,062.50	\$16,662.50	
April	\$8,250.00		
May	\$8,775.00		
June	\$8,775.00	\$25,800.00	
July	\$7,837.50		
August	\$7,237.50		
September	\$10,350.00	\$25,425.00	
October	\$12,262.50		
November	\$11,662.50		
December	\$12,412.50	\$36,337.50	
Totals			\$104,225.00

During the Performance Evaluation period, the Medical Services Director completed a survey for the work being performed by the Medical Advisors prior to their contract being renewed. The Medical Services Director surveyed the UR Staff to determine the quality and timeliness of work being performed and to determine the overall effectiveness of the contractor. Conducted in early 2009, survey results deemed work quality effective, work timeliness highly effective and the overall service highly effective. The cost for services also was under budget.

To summarize, the work being performed by the Medical Advisor is effective. He has a very low rate of appeals as we noted above those appeals occurred because the provider did not submit the appropriate information with the initial service request. Upon proper submission, the appeal was overturned.

The Medical Advisor role was expanded as previously suggested in the 2008 Marsh Report which allowed the WSI Medical Director to attend to other value added activities.

Internal Audit also conducted a review of the work being performed by the Utilization Review Physician Reviews for the pre-certification process. The work performed by the Medical Advisor properly met the UR guidelines being reviewed.

Recommendation for Physician Review Service Vendors

Recommendation 2.10: Develop a metric which measures the work product of the Physician Advisors. Measurements would include number of reviews being performed, types of requests being reviewed, timeframe for completion of reviews, outcome of request, appeals generated, outcome of appeal (upheld or overturned), and if overturned, was additional medical information received that supported the subsequent approval. The audit results could be reviewed to ensure performance expectations are being met and would be useful when contracts are being reviewed for renewal.

Priority Level: High

WSI Response: Concur. The Medical Services Director receives a monthly report that includes many of the recommendation measurements such as:

1. number of reviews being performed
2. types of requests being reviewed
3. outcome of requests
4. appeals generated
5. outcome of appeals (upheld or overturned)

Two measures, timeframe for completion of reviews, and whether additional medical information was received are not currently captured. These parameters will need to be incorporated. If not feasible, the report will identify the specific reviews and the measurements can be manually documented and tracked.

An additional section to the report combining these parameters will provide the measurements.

Recommendation 2.11: Create surveys which would be completed by UR Department and Claims Team prior to Physician Advisor contract renewals that would solicit information about provider performance and satisfaction scores amongst the UR and Claims Departments. These surveys could be utilized as training tools for the Physician Advisor if areas were discovered where the satisfaction score may have declined. These surveys would also become part of the contract renewal record that could benchmark performance and satisfaction over time.

Priority Level: Medium

WSI Response: Concur. The contract manager will utilize a survey process to obtain feedback on contract renewals. This will be completed prior to finalizing the Service Evaluation form utilized in the contract renewal process.

Recommendation 2.12: As part of the expansion of service for the Medical Advisor it was suggested that he come to the WSI office in Bismarck for training in January 2009. WSI should confirm that this was completed. We also recommend that regular meetings are held with the Medical Director and UR Director and staff on a regular basis so any issues can be addressed and to further the development of the team and UR processes.

Priority Level: Medium

WSI Response: Concur. Beginning July 1, 2010, and on a quarterly basis thereafter, WSI's Medical Consultant(s) will be scheduled to attend the UR staff meetings. The WSI Medical Director will also be invited to attend the meetings.

Discussion of Individual Contracts: Medical Data Mining

Contract Number 1246: CGI Federal Inc.

In past performance evaluations, it has been noted that WSI has a minimal record of investigating medical provider fraud. In an effort to enhance its ability to identify medical provider fraud, WSI retained through an appropriate bid process in 2009 the services of CGI Federal, Inc. (CGI). The bid process consisted not only of review by WSI staff but also by the State's IT and Risk Management departments, the Attorney General's office and the Office of Management and Budget.

CGI offers medical data mining services to assist WSI in evaluating patterns of care, recognizing service provider outliers, detecting possible fraud and abuse, and identifying areas of waste or error. WSI, CGI and WSI's pharmacy benefits manager (US Script) have, as an initial step in the business relationship, agreed upon content for data feeds to allow CGI to implement business intelligence models that will allow it to meet the stated service objectives. These data feeds occur monthly and quarterly, depending on the data source.

The CGI contract commenced on 4/30/09 and most of the rest of calendar year 2009 was spent working out data feed requirements, working through bugs in those transmissions and beginning modest reporting. Because the service is just getting off the ground, we cannot evaluate as yet whether the service is effective. Essentially, WSI and CGI expect the two-year period of the agreement to be a time to prove the concept, so the value of the service to WSI will be learned at a later point in time.

Recommendation 2.13: In evaluating patterns of care, we expect to see different cost outcomes and utilization patterns depending on the specialty of the provider involved. In our review of the data elements being transmitted by WSI to CGI, we did not see a specialty indicator. We recommend that this field be captured so provider analysis can be part of the suite of report offerings available to WSI.

Priority Level: Medium

WSI Response: Concur. WSI is already addressing this issue. Transmittal of these specialties is challenging because WSI's electronic data fields are not fully populated. WSI is in the process of creating the indicators and establishing a process for maintaining them.

Discussion of Individual Contracts: Hearing Officer Services

Contract Number 1034: Office of Administrative Hearings

From 1995 to 2006, WSI contracted with the Office of Administrative Hearings, an independent state agency, to provide independent fact finders for the dispute resolution process. At the time, North Dakota was the only workers' compensation jurisdiction in the United States that allowed the payer to make the final administrative decision in disputes between payers and the injured workers and employers. According to WSI, one of the reasons the organization initially decided to contract service to OAH in 1995 was because they were having a difficult time finding attorneys with workers' compensation knowledge in the state to be hearing officers. In 2007, WSI discontinued utilizing the services of OAH and began contracting individually with administrative law judges to serve in the role of independent fact finders. The objective of this change was to reduce the timeline for recommending a decision. WSI was successful with its selection and training, and timelines were reduced by 100 days. However, significant public concerns were raised regarding the use of hired independent contractors to perform this service.

BDMP's 2008 performance evaluation found no indication of impropriety or inappropriate influence of decisions made by ALJ's or hearing officers; however, they recommended that the perception of fairness and overall effectiveness of the system could be improved by shifting the role of independent fact finder out of WSI's authority and allowing the independent fact finders' decisions to be final but appealable to the District Court. WSI concurred with the findings and effective August 2008 the responsibility for providing Administrative Law Judges to preside over administrative hearings requested by aggrieved claimants of WSI decisions was turned back over to the Office of Administrative Hearings. That office is now responsible for training of its personnel, as well as timeliness of decision-making.

WSI developed policies and procedures with benchmarks at the time their internal program was created in 2007. Contracts were written by WSI's Legal Department and the Hearing Officer Services program was run by an Executive Support employee outside of WSI's Legal Department. Effective August 1, 2008, OAH became a WSI contracted vendor service. WSI utilizes the State Contract Alternate Procurement process. In the transition, they hired all the Hearing Officers and assumed all existing WSI contracts in this area. WSI negotiates hourly rates and expense caps at contract renewal; there are no financial incentives associated with decision making timelines. WSI audits invoices for services performed, and conducts performance evaluations every 2 years to ensure benchmarks are met. WSI has no control over who OAH uses, but does provide feedback via the performance evaluation process. Hearing related services are paid off appropriate claim files. WSI does bear some of the financial burden in the general budget for training of the ALJs.

The cost of OAH services is reasonable in comparison with other workers' compensation organizations. The duties performed by OAH are similar in nature to other state's legal systems, in

that the state itself is the employer. This type of service is more efficient and cost effective to contract with outside vendors if it is not provided through the state.

During the course of our fieldwork during the performance evaluation, we were advised by WSI staff that OAH incurred expenses for training preparation that exceeded the amount budgeted by WSI for that service. Provisions were revised to cap training time in the 2009 contract to prevent a recurrence of this issue.

Discussion of Individual Contracts: Private Investigations Services

Contract Number 1231: Evans Investigations

Contract Number 1295: WT Butcher & Associates, Ltd.

Contract Number 1238: Rollie Port Investigations

Contract Number 1239: Great Plains Claims, Inc.

Contract Number 1233: Quality Investigations & Recovery Service

The WSI Special Investigations Unit (SIU) was created in 1995 in an effort to combat fraud. A group of handpicked private investigators were selected to perform these services. In October 2007 WSI formally began utilizing the State's procurement requisition process to manage this outsourced service. A proposal was issued for a statewide pool of private investigators for investigating all aspects of WSI's Administration of North Dakota's workers' compensation system, including the area of fraud, general claim compensability, subrogation, and collection of money judgments.

Investigation assignments are funneled from WSI departments into the SIU where paralegals make the assignments, provide oversight and manage any service issues. The highest volume of service requests are related to field investigations. The geographical spread and commodity nature of the service require a large number of vendors to cover the state. Therefore, it is more efficient to have the services performed on a contract basis with outsourced vendors. A sample of at least three claims per contract reviewed demonstrates that the firms are in compliance with licensing, timelines, reporting, and invoicing. Proper oversight is provided by members of the SIU.

While there is no formalized performance evaluation process, SIU surveys affected WSI departments periodically to obtain feedback. The outcome of these service evaluations determines whether WSI exercises the option to renew the contract. Service issues do result in cutbacks in referrals for firms, and firms have been dropped from the panel for cause. WSI departments acknowledge an improved level of service. On the whole, WSI is satisfied with the services as currently provided by the contracted vendors.

The cost of private investigation services provided by the selected vendors is reasonable in comparison with other workers' compensation organizations. The duties performed by them are similar in nature to other private investigative firms. In 2009, WSI determined that their

standardized service contract for all private investigation firms did not adequately consider the amount of time involved in writing investigative reports in cases requiring multiple interviews, and that the mileage rate in the existing contract was lower than the current mileage reimbursement rate adopted by the ND General Assembly. WSI appropriately created a contract amendment in May 2009 to address these deficiencies, setting competitive flat rates for all investigative report writing and upgrading the mileage rate to the U.S. General Services Administration rate for mileage reimbursement. Effective June 1, 2009, each private investigation firm under contract had been contacted, had signed off and was operating under the amended contract. Contracts negotiated after June 1, 2009 contained the updated compensation rates.

Recommendation 2.14: Extract standard key performance indicators from the service contract and create a more formalized performance evaluation process for both field and fraud investigations.

Priority Level: Medium

WSI Response: Concur. The use of standard key performance indicators as part of a more formalized performance evaluation process will benefit the management of the vendor contracts.

Discussion of Individual Contracts: Litigation Services

Contract Number 1128: Nilles, Ilvedson, Stroup, Plambeck & Selbo

Contract Number 1134: Crowley Fleck/ Fleck, Mather & Strutz

Contract Number 1176: Morley Law Firm LTD

Prior to 1995, in-house counsel represented WSI in all legal matters. Due to unfavorable timeline results, WSI began their RFP process for outsourced legal counsel services in 1995. Legal services are contracted for Injury services (e.g., claim disputes, subrogation, and fraud) and Policyholder services (e.g., premium, rate class, fraud, and collection of premium). NDCC Section 54-12-08 states WSI may employ attorneys to represent them and that the Attorney General must appoint them as special assistant attorney generals. Since WSI's outside counsel is appointed by the Attorney General as special assistant attorney generals, contracts for these services are not subject to competitive bid procurement. WSI does, however, follow the State's *Guidelines to Managing Contractual Risk* process.

Contracts run for 2 years with a 2 year perpetual renewal clause. Performance evaluations are done every two years. Firms are renewed if they meet predetermined benchmarks. Costs for legal services are paid off claim files for specific claim related expenses, and out of WSI's budget for general items. Three firms have been selected to cover the entire state. Each firm is given a

minimum of two cases per month. Contact between WSI and outside counsel is managed by WSI Legal. There is minimal contact with the WSI Claim Department.

The cost of legal services provided by the selected vendors is reasonable in comparison with other workers' compensation organizations. The duties performed by them are similar in nature to other defense legal firms. This type of service is more efficient and cost effective to contract with outside vendors.

Recommendation 2.15: Utilize outside counsel to provide semi-annual training for WSI departments, providing case law updates and strategies to improve claims handling processes and outcomes and manage risk on the policyholder side.

Priority Level: Medium

WSI Response: Concur. WSI currently has outside counsel conduct some training for staff. We will continue to work with outside counsel to increase training efforts throughout the agency.

Discussion of Individual Learning Management System and Content

Contract Number 1173: GeoLearning, Inc.
Learning Management Systems

Contract Number 1179: PureSafety
Content for the LMS system

WSI provides its employers with complimentary online safety training. The platform that houses this material is provided by GeoLearning, Inc., while the online content is provided by PureSafety. The alternate procurement process (requiring state approval) was followed for implementing both of these contracts, as they cost more than \$250k each.

WSI has been very happy with the services of GeoLearning and PureSafety. They are quick to fix any problems that arise with the software, the content of the courses is very extensive and broad, there is a variety in the formats of the courses that are offered (i.e., sometimes a video format is used, sometimes a PowerPoint format is used, etc.), and new content is being added to the system on a regular basis. There were about 211 different safety courses on the system at the time of our review. Detailed statistics are kept regarding which courses are being taken and by whom, as well as their scores at the end of the program. The system also provides a resource center for sharing of information between employers. It appears that this learning system is more extensive than is currently being offered in any other state. The cost of the content and the platform, when considering the number of users, appears to be very reasonable.

Typically, the users of learning management systems will either own the content (the courses) that is housed on the platform or they will work out an arrangement to use content that is owned by another company. In this case, WSI is using the content that is owned by PureSafety.

Recommendation 2.16: When it is time to re-bid this contract, you might consider whether there would be a financial advantage to outright purchasing and owning the content of the system. It may cost more up front to own the content, but if the content would be in use for a number of years, it could be less expensive for WSI overall. One important consideration in this process would be whether you anticipate that the content would need frequent updates. If so, who (within WSI or outside of WSI) would be capable of updating the content and how much expense would be associated with it? Would that added expense still mean a savings to WSI?

Priority Level: Low

WSI Response: Concur. The current contract with Pure Safety expires June 30, 2011. WSI will consider and determine if there is a financial advantage to outright ownership versus rebidding or renewal of the current contract arrangement with Pure Safety.

Discussion of Individual Contracts: Cleaning Services for Century Center

Contract Number 1184: Automated Maintenance Services, Inc.

WSI is the owner and landlord of the Century Center building and leases out some of the office space to other state agencies. Therefore, this contract is for the cleaning services of the entire office space – not just the office space that WSI occupies. The number of gross square feet of this building is 116,000, of which almost 80% is office and/or storage space.

The RFP for cleaning services was issued on March 1, 2007. Two bids were received, and the work was awarded to AMS. Their contract began on 7/1/2007, and on 7/1/2009 the services were renewed for another two years. The contract will go out to the RFP process again at the end of this renewal period. This complies with the state policies and practices.

The vendor, Automated Maintenance Services (AMS) agrees to provide WSI with a crew of four cleaners each night and one cleaner each day, for a total of 40 cleaning hours per day. The contractor provides all cleaning equipment and supplies, except for consumables such as paper products, can liners, etc. The contractor is required to provide proof of commercial general liability, automobile liability, and workers' compensation coverage. The contractor is also insured against employee dishonesty. Additionally, employees of the vendor undergo a background check prior to their work. The vendor will also provide extra cleaning services as needed (such as carpet cleaning, windows, emergency cleaning, etc.) for a pre-agreed upon price that is specified in the contract.

It appears that the cleaning services that WSI has been receiving have been quite satisfactory. The contract manager indicated that on the occasions he has come to them with issues, they are addressed quickly. We also reviewed the results of an annual building wide survey that was conducted to determine employees' satisfaction with the cleanliness. On a range of 1 to 5, with 1 being "not satisfied" and 5 being "completely satisfied," responses averaged over 4.

It appears that the prices negotiated for the services are reasonable. If services were brought internal and managed through WSI, the going rate for custodians is about \$1,300 – 1,400/month, plus 40% for benefits (this would total about \$9,450 per month in salaries alone, and does not include cleaning supplies that the contractor currently supplies). If brought internal, there would be more management and oversight needed. They are currently paying \$10,733/month this year and \$11,034 next year and AMS provides their own cleaning equipment and supplies.

Element Three: Evaluation of the Internal Audit Division

Introduction:

This Element requires that we review the Internal Audit Division at Workforce Safety and Insurance with an emphasis on performance over the past three calendar years (2007 – 2009).

Objectives here include:

- Evaluating the appropriateness of the reporting structure to ensure independence
- Process followed for selection of internal audit topics conducted during the past three calendar years
- Analysis of audits conducted to assess benefit provided to WSI
- Determination of the adequacy of resources

Background:

To assess the IA Department, we:

- Reviewed historic Internal Audit staffing
- Reviewed the Conolly report, which documented issues with the Internal Audit department in 2008
- Reviewed annual Internal Audit plans and the Internal Audit charter
- Reviewed current staffing, their backgrounds and their ongoing plans to obtain credentials as Certified Internal Auditors
- Reviewed Risk/Fraud Assessment results
- Reviewed several Internal Audit activities, including projects completed from 2007 - 2009
- Interviewed Internal Audit staff and other WSI personnel concerning the Internal Audit function, both historically and currently

We also noted that commencing with the partial audit plan developed by the Internal Audit Director for the period 1/1/09 – 6/30/09 that it contained new information including a mission statement, the department's independence within WSI, and staff along with the audit plan specifics. Starting with fiscal year 2009-10, a budget component has been added to the Audit Plan document.

Context:

WSI's Internal Audit Division has had a history of high turnover when compared to the rest of the organization. For example, in 2005 the division had a manager and two auditors. The manager at that time subsequently left the organization, and one of the auditors moved to a supervisor role within the claims department. A new Internal Audit manager was retained who managed the audit

department with the one remaining auditor. In 2008, the Internal Audit Manager left the organization and the remaining auditor moved to another position within WSI. For a period of approximately four months, there was no internal audit staff. The current Internal Audit Director was hired in September 2008, and she hired a new auditor in December 2008. That staff has comprised the Internal Audit Division since. To summarize, four internal audit staff that were in place in 2005 or more recently either left the organization by the middle of 2008 or moved to other jobs within WSI. The current staff has been in place for between one and two years.

Findings:

Both the Internal Audit Director and the Auditor are pursuing credentials as Certified Internal Auditors. This is a four module program including the following topics:

- Internal Audit Role in Governance, Risk & Control (Part I)
- Conducting the Internal Audit Engagement (Part II)
- Business Analysis and Information Technology (Part III)
- Business Management Skills (Part IV)

Both have completed Parts I and II and the Internal Audit Director has completed Part IV.

The Internal Audit Director reports to the WSI Board Audit Chair and all IA Division strategic activities are managed through that relationship. The Internal Audit Director also reports via a dotted line to WSI's Director on administrative matters, such as vacation. In his position, the Board Audit Chair is involved in such activities as:

- A review of outstanding recommendations that have not been validated
- A review of the results of the various risk assessments performed around the organization and how those assessments may influence future audit topics
- Participation in the performance evaluation (for instance, the Board Audit Chair attended the exit interview on June 3, 2010 when we presented our recommendations for this performance evaluation)
- A review of draft reports that have been prepared by Internal Audit division staff
- The performance evaluation and mid-year review of the Internal Audit Director

In evaluating the evolution of the Internal Audit Division over the last three years, we find, as should be expected, a more solid body of work in 2009 than in prior years. We observed audit work schedules for each of the three years subject to this evaluation. For 2007, most of the scheduled audits were accomplished but others were not. In 2008, most of the audit work that was scheduled was not accomplished. For 2009, all audits in the schedule were completed.

Audit projects for each year fall into one of five categories: Risk Assessment, Rotational projects, Ad hoc projects, Recommendations from other sources, and the Financial Audit.

We reviewed a number of audits conducted over the past three years and believe the current approach to be comprehensive and sound. As well, the level of cooperation observed from WSI staff in internal audit projects is high.

Each audit has a standard process with appropriate preparation time taken with staff, a clear set of expectations via planning memoranda, work paper checklists, and deliverables that include both draft and final reports. The planning memoranda are notable in that they spell out the rationale for and the scope of the IA work.

Internal audit subjects that we reviewed for 2009 included activities in the following areas:

- Internal Audit Disability Management Report completed in 2005 and on which Internal Audit staff continued to follow up as recently as 2009 to assure full implementation of recommendations
- Utilization Review and Physician Review wherein various processes pertaining to pre-certification, concurrent reviews, retrospective reviews, physician reviews and appeals were evaluated
- Internal Audit Telecommunications Report from 2005 on which an evaluation was done to assess compliance with recommendation implementation. Internal Audit staff correctly concluded that recommendations had been partially implemented and developed new and revised recommendations
- Internal Audit reviewed a Vendor Processing report dating to 2005 to determine the extent to which recommendations made in the prior report had been implemented.
- Home Health Care Report dating back to 2005 wherein eight recommendations had been made. Internal Audit established that seven of the eight recommendations had been fully implemented. The eighth recommendation no longer applied. However, IA turned up an expense code error and made a new recommendation pertaining to that matter. The value of the error was minor (\$17,342) against a total medical spend subject to review of \$51,656,150. Regardless of the size of the error, a correction was made.

Other areas that were reviewed included Information Security and Authorization, a Building Security Report, a review of the HELP Grants Program, and a quarterly review of the Special Investigations Unit (SIU) Performance Indicators. These activities spanned the evaluation period from 2007 – 2009. Each audit was found to be of benefit to WSI. For instance, the Information Security and Authorization audit detected flaws in system access from a security perspective, and these shortcomings were appropriately addressed by WSI.

Commonly, the above audits will include the Audit Program. In addition, the audit file contains recommendations and supporting documentation to show how the recommendations were addressed

including a Recommendation Control Sheet with sign-offs from the business owner, an executive committee member, quality assurance staff and internal audit staff. The Recommendation Control Sheet was updated consistent with a prior recommendation made in the 2008 performance evaluation.

On another topic, we note that the department takes a far more substantial role currently in validating performance evaluation recommendations than we have seen in prior performance evaluations in which our firm has been involved. This process includes evaluating the implementation of recommendations from more than just the most recent performance evaluation.

We do not believe that WSI needs to add more IA staff at this time. At a time when WSI is less subject to external evaluators, it may be appropriate to consider retaining one more staff person. We also point out that over the course of the last two fiscal years IA had a line item in the budget of \$40,000 to support the retention of outside consultants to support IA initiatives.

We also note that the Decision Review Office Director reports to the Board Audit Chair and made a recommendation relative to that area.

In conclusion, performance of the Internal Audit department prior to 2009 was sub-standard but no recommendations are made herein about that period of time given the significant performance changes that have occurred since 2009.

Recommendations

Recommendation 3.1: The Decision Review Office (DRO) and Internal Audit both report to the Board Audit Chair. Opportunities may well exist in the future for the Board Audit Chair to recommend audit topics that grow out of potentially adverse trends observed by DRO staff. We recommend that the Board look for such opportunities in the future.

Priority Level: Medium

WSI Response: Concur. Internal Audit has hours budgeted within their audit plan for audit topics requested from the Board. The Audit Committee was reminded of this during their June 16, 2010 meeting.

Element Four: Evaluation of the Adequacy of Post Retirement Benefits

Introduction

The objective of this Element is to evaluate the adequacy of North Dakota's Post Retirement Benefit (Additional Benefits Payable). Further, the objectives of this Element include the following:

- To evaluate the additional benefit payable (ABP) benefit structure (as contemplated by the 2009 legislation) that comprises the post-retirement benefit structure available to an individual whose disability benefits end at the time of the social security retirement eligibility. As well, this evaluation shall focus on identifying the advantages and disadvantages of the current system as compared to other state workers' compensation systems.
- To determine how current ABP recipient's total benefits received are impacted when Social Security retirement benefits are considered in conjunction with ABP.
- To recommend whether changes are desirable to the ABP structure, to articulate what those changes might be, and to forecast the fiscal impact of the proposed changes.

Context

The North Dakota Century Code contains language governing Social Security offsets, Retirement offsets, the Retirement presumption, and the Additional Benefit Payable structure at §65-05-09.1 through §65-05-09.5.

Since January 1, 1980, §65-05-09.1 has been effect. This section substantially states that, "When an injured employee, or spouse or dependent of an injured employee, is eligible for and is receiving permanent total or temporary total disability benefits...and is also eligible for, is receiving, or will receive, benefits under Title II of the Social Security Act [42 U.S.C. 423], the aggregate benefits payable...must be reduced, but not below zero, by an amount equal as nearly as practicable to one-half of such federal benefit."

This offset applies to injured employees, spouses and dependents irrespective of the age of the employee at the time he/she becomes eligible for the benefits under Title II per the above.

The statute goes on to describe how the offset will occur for either temporary total disability (TTD) or permanent total disability (PTD) benefits. As an example, if an injured employee received a weekly TTD benefit of \$400 and a monthly Social Security Disability (SSD) benefit of \$1500, the WSI weekly benefit would be reduced according to the following calculation:

Category	Amount
Monthly SSD benefit	\$1500
SSD benefit at weekly rate	\$346.15
Offset amount (50% of SSD weekly rate)	\$173
WSI weekly benefit rate before offset	\$400
WSI weekly benefit after offset	\$227
Aggregate weekly benefit (SSD and WSI)	\$573.15

Note that the offset amount, per §65-05-09.1, is taken as “the amount rounded to the next lowest dollar...amount.” Thus the weekly SSD benefit rate of \$346.15 when halved and rounded comes to \$173.00.

The retirement offset provision of §65-05-09.2 differs from the prior statutory reference in that the offset is limited to 40% of the Social Security Retirement (SSR) benefit. Note that this offset applies to SSR benefits, as distinguished from SSD benefits in the table above.

NDCC §65-05-09.3 established the retirement presumption that allows disability benefits to be terminated upon retirement. In §65-05-09.3 (2), the statute reads in part, “An injured employee who begins receiving social security retirement benefits or other retirement benefits in lieu of social security retirement benefits, or who attains retirement age for social security retirement benefits unless the employee proves the employee is not eligible to receive social security retirement benefits or other benefits in lieu of social security retirement benefits is considered retired.”

NDCC §65-05-09.3 (3) allows disability benefits to be paid for up to three years for those who are injured after they reach their presumptive retirement age. The section applies to those injured workers with a date of first disability or successful reapplication after July 31, 1995.

Practically speaking, how do these statutes apply to injured workers?

Generally, for injuries before 7/1/89, there is no retirement offset and §65-05-09.2 does not apply. These disabled workers are entitled to lifetime benefits.

Generally, for injuries on or after 7/1/89 and before 8/1/95, §65-05-09.2 does apply. This group of disabled workers is entitled to lifetime benefits and will have their permanent total disability benefits offset by no more than 40% of their SSR benefits.

Generally, for injuries on or after 8/1/95, the retirement presumption applies against most disability benefits. PPI awards are payable irrespective of this retirement presumption.

This summary of offsets and retirement presumption language serves as a lead-in to the additional benefit payable structure. There are two statutes governing the additional benefit payable which might more aptly be called a post-retirement benefit. Principally, NDCC §65-05-09.5 applies to a small group of injured workers whose date of injury occurred before 8/1/95 but whose first date of disability occurred on or after that date. These injured workers are entitled to an additional benefit payable award that assumes their first date of disability is their date of injury. However, the primary statute defining additional benefits payable (ABP) is NDCC §65-05-09.4. This statute defines the ABP amount and benefit duration to which an injured worker is entitled upon reaching his/her presumptive retirement date.

This statute states that an injured worker must have received benefits for at least one year prior to his/her presumptive retirement date to be eligible for ABP. Assuming benefits have been issued for at least that one year, a sliding scale of benefit entitlement and duration is included in the statute ranging from a low of 5% of the weekly benefit to a high of 50% of the weekly benefit. For the latter benefit to be paid, a worker must have been off work for at least twenty years. The exception to this benefit structure is that catastrophically injured workers will receive lifetime benefits at 100%.

The additional benefit payable statute is not easily compared to other state statutes. Some states apply a post-retirement offset against Social Security Retirement benefits or other retirement benefits such as an employer funded pension. In West Virginia, employees cannot receive temporary total disability if they are retired.

In states like Delaware, Washington and Pennsylvania, benefits may be terminated or suspended after retirement if it can be shown that the injured worker has retired from the workforce, but in these states it may be difficult to establish this fact to the satisfaction of the courts.

In South Dakota, for injuries occurring on or after 7/1/93, if an employee is receiving permanent total disability benefits and subsequently receives Social Security Retirement (SSR) benefits, his/her workers' compensation benefits are calculated at that time by taking 150% of the TTD benefit less the full retirement benefit. But this provision does not apply to those injured workers who were already on SSR at the time of their injury.

In Kentucky, for injuries occurring on or after 12/12/96, income benefit payments terminate when the injured worker qualifies for normal SSR benefits or two years after the injury or last exposure, whichever occurs later.

In most states we found that offsets are not taken. We also did not find a benefit structure that is exactly like the ABP statute.

One state of interest is Utah. Their state Supreme Court handed down a decision in the case of Nathan H. Merrill v. Utah Labor Commission, et. al. that held that a Social Security retirement benefit offset provision is deemed unconstitutional and creates a separate class of benefit recipients (those who are SSR entitled and those who are not). When the Utah Supreme Court issued its decision, it stated: “The classification at issue in this case, however, is more complicated than simply whether an individual is over the age of sixty-five. The classification also depends on whether an individual is eligible for social security retirement. Eligibility for social security retirement is based on several factors, including the number of years an individual has worked and contributed to the social security fund. Individuals who are over the age of sixty-five and not receiving social security retirement benefits are treated differently than individuals over the age of sixty-five and receiving social security benefits.” In summary, Merrill was successful in asserting that the offset provision violated Utah’s uniform operation of the law guarantee and the case was remanded.

NDCC §65-05-09.3 (2) suggests that if an injured worker can prove that he/she is not eligible to receive SSR benefits or other retirement benefits in lieu of SSR benefits that they can then successfully rebut the retirement provision. We are not sure that if a fact pattern were presented to the North Dakota court whether it would rule in a similar manner to the Merrill court.

Findings:

As a first step in our consideration of the impact of the ABP on injured workers, WSI provided a list at our request of the injured workers who are currently receiving that benefit. This information was provided in mid-March, 2010, and there were 62 injured workers on the list. The oldest injured worker on the list was born in 1934 and the youngest in 1946. This particular worker may have been the only one on the list receiving early SSR benefits, given that at this time he/she would not have reached their presumptive full retirement age.

There are many examples we might provide as to the financial impact on injured workers when the ABP provisions apply. Here are a few.

A worker who is injured less than one year prior to his/her presumptive retirement date is not eligible for ABP because the minimum disability duration to qualify for ABP is one year.

A worker who is injured at the age of 63.5 and is receiving TTD benefits at the time of presumptive full retirement would receive 5% of his/her TTD rate for 18 months. If we assume a TTD rate of \$400, then their ABP would be \$20, and they would receive that benefit for 18 months or approximately 78 weeks amounting to \$1,560. Had he/she been eligible for TTD benefits for those 18 months, the benefit paid during that time would have amounted to \$31,200. As such, SSR benefits during this time would have to amount to \$29,640 or a monthly benefit of \$1,647. Note that other factors could influence post-retirement benefit entitlement in the absence of the retirement presumption. For example, TTD benefits are subject to a 104-week cap. At the end of the cap, an employee's temporary benefit could be reduced if they show demonstrable earning capacity.

Workers who are injured and receiving continuous benefits for more than three years are entitled to supplementary benefits that adjust their benefit rate based on a cost of living adjustment tied to changes in the state's average weekly wage. This benefit applies to two groups of injured workers slightly differently. For those injured workers with filed claims before 1/1/06, the supplemental benefit applies to TTD, PTD or death benefits. For claims filed on or after that date, it applies only to PTD and death benefits. The reason for this difference is that the 104-week cap on TTD went into effect on 1/1/06, so there are those with injuries prior to 1/1/06 who can be receiving TTD for more than three years. Let's consider an individual who has been disabled for seven years, who has qualified for supplemental benefits and who had an initial benefit rate of \$400. Assuming a 4% increase in their benefit rate over the past four years of the seven years of disability will produce a benefit rate of \$468. At retirement in this situation, the injured worker would receive 20% of their weekly benefit as an ABP or \$93.60. Over the next seven years, the injured worker would receive \$34,070 in ABP. Had they continued as a benefit recipient for that time frame they would have received \$170,352 assuming a flat benefit rate of \$468/week. The difference between these two amounts is \$136,282. For the SSR benefit to make up that difference, it would have to be paid at a monthly amount of \$1,622.

Another historical factor that we considered in our review of this benefit is that North Dakota had in the 1980's and early 1990's a significant number of claims that it considered to be permanent total disability claims. The statute tended to support PTD determinations when injured workers were not able to return to work irrespective of the physical extent of their injuries. In other words, when vocational rehabilitation was not successful, PTD could result. Further, the organization at that time had a tendency to encourage injured workers to apply for SSD benefits, a benefit which by its nature presumes that an injured worker is essentially precluded from work. So this led to a plethora of cyclic and ultimately PTD claims.

Organizational practices and statutory changes have led to fewer PTD claims. As an example, one Operating Report we reviewed showed that in FY 2005 there were 89 PTD cases; in 2006, that number dropped to 38; in 2007, there were 36 cases; and, in the first half of FY 2008 only twelve such claims. With a decline in PTD claims, a statutory cap on TTD at 104 weeks, and better vocational outcomes, fewer injured workers will qualify for an ABP simply because few of them will be receiving benefits when they reach their full retirement age. And there were only 62 of these claims when we checked in mid-March.

With that said, we should point out that the statutory language on benefits both post-retirement and just prior to full retirement age does have some inconsistencies that we believe should be cleaned up. Notably, if the statute allows injured workers who are disabled following retirement to receive up to three years of benefits, why should injured workers who are disabled six months before retirement only be entitled to those six months of benefits and no ABP?

To resolve this inconsistency, language such as the following could be used to define benefit entitlement for both groups of workers: “For injured employees injured within two years prior to their presumed retirement date, the organization may not pay disability or rehabilitation benefits for more than two years. Should the duration of disability or rehabilitation benefits extend beyond their presumed retirement date, the organization shall convert the benefit to an additional benefit payable at the date the disability ends or upon the accumulation of two years of benefits, whichever comes first.” ABP would then be paid for the duration of time that these workers received disability benefits. WSI’s consulting actuaries have indicated that a change of this type would have a negligible impact on benefit costs.

In summary, there are few injured workers who are impacted by ABP. Further, this benefit type is atypical in the workers’ compensation community but it appears to be a reasonable way to supplement retirement income for those injured workers who are the most disabled; that is, they have been receiving benefits for an extended period of time and their post-retirement benefit is greater than would be the case for those who have been injured closer to their full retirement age and who presumably have paid into Social Security for a much longer period of time, thereby insuring a higher monthly benefit at retirement.

Recommendations:

Recommendation 4.1: WSI should review retirement presumption statutory language in the context of the Merrill decision in Utah to determine if that case may have relevance in North Dakota. Our concern is the unequal application of the statute predicated on whether or not a person is entitled to SSR benefits or a retirement benefit in lieu of SSR.

Priority Level: Medium

WSI Response: Concur. WSI reviewed and analyzed the Merrill decision when it was issued. In the Merrill decision they acknowledge courts around the nation have decided this issue differently. WSI will continue to monitor case developments in other jurisdictions.

Sedgwick CMS Reply: Our concerns in making this recommendation hinged on provisions within both §65-05-09.2 and §65-05-09.3 (2). We would encourage WSI to meet with the Legislature's Workers' Compensation Review Committee to evaluate the case law around the country that it references in its response and the relevance of that case law to the statutory provisions at hand. This evaluation could be made in the context of the overall post-retirement benefit as well as to consider the recommendations below (4.2 and 4.3).

Recommendation 4.2: We recommend that WSI propose language to the 2011 Legislature with changes relating to the ABP benefit statute that address those workers who are injured close to their retirement age (as more fully described earlier in this section) such that they may receive benefits prior to ABP entitlement for up to two years.

Priority Level: High

WSI Response: Concur. WSI will prepare draft legislation for the interim Legislative Workers' Compensation Review Committee's consideration that extends benefits for up to two years prior to ABP conversion if an injury occurs within two years prior to their presumed retirement date.

Sedgwick CMS Reply: We believe legislation should be introduced to the full legislature. We also recognize that if this recommendation is adopted, then Recommendation 4.3 will not be applicable. Should this recommendation not be adopted by the legislature, then we should also add that Recommendation 4.3 should be introduced to the full legislature at an appropriate time.

Recommendation 4.3: If Recommendation 4.2 is not adopted by the legislature, then we recommend that an ABP benefit be made available to injured workers whose disabling injuries occur within one year of their retirement and that the ABP for these workers would extend for up to one year.

Priority Level: High

WSI Response: Concur. WSI will draft a proposal for the interim Legislative Workers' Compensation Review Committee's consideration.

Element Five: Comparison of Other State's Workers' Compensation Laws

Introduction:

The objective of Element Five is to compare other state's workers' compensation laws with respect to prior injuries, preexisting conditions and degenerative conditions. In that process we are to evaluate North Dakota's workers' compensation laws, administrative code and departmental policies regarding prior injuries, preexisting conditions and degenerative conditions and compare and contrast North Dakota's laws to the other state worker's compensation laws, rules and regulation in the other 49 states. We will also review this matter in the context of what constitutes a compensable injury in North Dakota versus other states.

We reviewed the following in our research:

- Conolly & Associates March 2008 report to the Board of Directors
- 2008 Marsh report
- Past North Dakota WSI Performance Evaluations
- NDCC statutes NDCC 65-01-02 (10)(b)(7)) and NDCC 65-05-15
- 1997 SB 1261 (65-05-15) and testimony
- North Dakota Supreme Court Case Law
- North Dakota Legislative History Summary
- Pre-existing Conditions State Statute & Case Law Research – Amber Buchwitz
- North Dakota WC Review Committee Report, 61st Legislative Assembly
- North Dakota WSI Claim Procedures
- State expert survey of 49 states and one District
- Review of at least 10 WSI denied claims from calendar year 2008 and the first three quarters of calendar year 2009 with denials related to prior injuries, pre-existing condition triggers and/or chronic conditions and aggravations

Background:

The resolution in HCR 3008 states in part, "...the 2008 performance evaluation included conclusions that none of the claims reviewed which involved preexisting conditions or degenerative conditions were inappropriately denied, but that North Dakota law is more conservative than most other jurisdictions as it relates to prior injuries, preexisting or degenerative conditions, triggers and aggravations..."

"Compensable injury", as currently defined by the North Dakota Century Code, means an injury by accident arising out of and in the course of hazardous employment which must be established by medical evidence supported by objective medical findings. This definition meets a very basic injury standard in line with other states' definitions of compensable injury.

North Dakota's threshold of compensability for worker's compensation claims is found in North Dakota Century Code (NDCC) 65-01-02(10). NDCC 65-01-02(10)(a) defines what is incorporated as a compensable North Dakota injury; NDCC 65-01-02(10)(b) defines what is not compensable in the state of North Dakota. The focus of our reporting is on excluded injuries in subsection (10)(b), more specifically, subsections (b) (7) (8) and (9) which state:

- (10)(b)(7) 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 accelerates its progression or substantially worsens its severity.
- (10)(b)(8) A non-employment injury that, although acting upon a prior compensable injury, is an independent intervening cause of injury.
- (10)(b)(9) A latent or asymptomatic degenerative condition, caused in substantial part by employment duties, which is triggered or made active by a subsequent injury.

The Aggravation statute, or NDCC 65-05-15, states that when a compensable injury combines with a non-compensable injury, disease, or other condition, the organization shall award benefits on an aggravation basis.

There are four bases under which the aggravation benefit will be covered and paid currently:

1. In cases of a prior injury, disease, or other condition, known in advance of the work injury, which has caused previous work restriction or interference with physical function the progression of which is substantially accelerated by, or the severity of which is substantially worsened by, a compensable injury, the organization shall pay benefits during the period of acute care in full. The period of acute care is presumed to be sixty days immediately following the compensable injury, absent clear and convincing evidence to the contrary. Following the period of acute care, the organization shall pay benefits on an aggravation basis.
2. If the progression of a prior compensable injury is substantially accelerated by, or the severity of the compensable injury is substantially worsened by a non-compensable injury, disease, or other condition, the organization shall pay benefits on an aggravation basis.
3. The organization shall pay benefits on an aggravation basis as a percentage of the benefits to which the injured worker would otherwise be entitled, equal to the percentage of cause of the resulting condition that is attributable to the compensable injury. Benefits payable on an aggravation basis are presumed to be payable on a fifty percent basis. The

party asserting a percentage other than the presumed fifty percent may rebut the presumption with clear and convincing evidence to the contrary.

4. When an injured worker is entitled to benefits on an aggravation basis, the organization shall still pay costs of vocational rehabilitation, burial expenses under section 65-05-26, travel, other personal reimbursement for seeking and obtaining medical care under section 65-05-28, and dependency allowance on a one hundred percent basis.

A Review of the Evolution of the Current Pre-Existing Condition Statute

- The pre-existing trigger language was initially created in 1989 under SB 2256. Testimony at the time as presented stated the intent was to preclude injuries... “attributable to a pre-existing condition if it was the independent intervening cause of the injury. The subsection does not prevent compensation where an employment injury has also contributed to the pre-existing condition by worsening its severity, or accelerating its progression.”
- The “trigger” exclusion was first introduced as 1991 SB 2206, which included the following language: NDCC 65-01-02(8)(b)(8) “A latent or asymptomatic degenerative condition, caused in substantial part by employment duties, which is triggered or made active by a non-employment injury.”
- 1995 HB 1225 added the language regarding objective medical evidence to the compensable injury definition.
- 1997 HB 1269 deleted wording that went along with “solely because” and added “substantially accelerates its progression or substantially worsens its severity. This is sometimes referred to as ‘the trigger’ statute. A workplace injury that ‘broke the camel’s back’ is not compensable. However, if the condition got worse much more quickly than it would have otherwise, or if additional damage was done on top of the degenerative condition making the result much more severe than otherwise would have been, then the injury would be compensable. It will be accepted for either full or partial benefits, depending upon the circumstances. The Bill also adopts language that better matches the language of the aggravation statute in NDCC 65-05-15.

A Review of the Evolution of the Current Aggravation Statute

- This statute has been around since 1931 when HB 209 included the following language...”In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for such proportion of the disability due to the aggravation of such prior disease as may reasonably be attributable to the injury.”
- Senate bills in 1939, 1943 and 1953 amend the statute to include a proportional limit and weekly payment limits.
- 1977 SB 2158 amended the statute to specify that pre-existing conditions were not covered under this Act, and are more appropriately covered under this section. It also held that if a physician is unable to estimate the degree of aggravation, but the Bureau is aware that there is a preexisting condition, the degree of aggravation attributable to the work related injury will automatically be 50%. Previously the ND Supreme Court had held that the determination of the degree of aggravation is essentially a medical question be answered by the employee’s treating physician. However, in many cases, the physician had been unable to give a reasonable estimate of the degree. When that occurred, the Supreme Court held that the Bureau had to pay on a 100% basis.
- 1981 SB 2127 added language to deal with non-employment injuries that occur after an employee has suffered an employment related injury which aggravates the prior employment injury, and may be more severe than the employment injury.
- 1989 SB 2239 recognized that only a handful of states had an aggravation statute, and that other states temper the harshness of aggravation statutes by reducing the award of permanent disability only. It amended the statute to pay benefits at 100% during the acute phase (no time limit designate) and to continue at the reduced rate on a continued aggravation basis where further treatment and/or periods of disability continue, on the basis that the pre-existing condition either impaired or disabled the claimant and was known in advance of the work injury. There must be medical evidence that the pre-existing condition and the work injury are both substantial contributing causes of the workers medical problem.
- 1997 HB 1261 amended the acute period to 60 days, amended substantial worsening language, provided for 50% payment when claims are accepted on an aggravation basis, and added 100% payment of vocational rehabilitation expenses.

Findings:

A prior North Dakota WSI 2008 performance evaluation of claim compensability decisions found that all of the degenerative disease claims evaluated did contain documentation of the

acceptance/denial rationale and all of those decisions appeared appropriate per state law, administrative code and WSI policies. Adjusters documented their search for prior injuries or pre-existing conditions on every evaluated degenerative claim, and the WSI Medical Director also reviewed nearly 40% of the claims before an initial compensability decision was made. However, while all claims followed the required investigation and documentation process, there was some variability in how the compensability decisions were applied to the evaluated group of degenerative condition claims.

The OSHA Recordkeeping Handbook (OSHA 3245-09R 2005, page 14) provides an industry example of the definition of a significant aggravation of a pre-existing condition. For the purposes of OSHA injury and illness recordkeeping, a significant aggravation of a pre-existing injury or illness is defined in the following manner:

“A preexisting injury or illness has been significantly aggravated, for purposes of OSHA injury and illness recordkeeping, when an event or exposure in the work environment results in any of the following:

- (i) Death, provided that the preexisting injury or illness would likely not have resulted in death but for the occupational event or exposure.
- (ii) Loss of consciousness, provided that the preexisting injury or illness would likely not have resulted in loss of consciousness but for the occupational event or exposure.
- (iii) One or more days away from work, or days of restricted work, or days of job transfer that otherwise would not have occurred but for the occupational event or exposure.
- (iv) Medical treatment in a case where no medical treatment was needed for the injury or illness before the workplace event or exposure, or a change in medical treatment was necessitated by the workplace event or exposure. “

OSHA further defines “significant workplace aggravation of a pre-existing condition as follows: “In paragraph 1904.5(b)(4), the final rule...requires that the amount of aggravation of the injury or illness that work contributes must be “significant,” i.e., non-minor, before work-relatedness is established. The pre-existing injury or illness must be one caused entirely by non-occupational factors...” “Paragraph 1904.5(a) states that an injury or illness is considered work related if “an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing injury or illness.” (OSHA 3245-09R, page 20)

Of the 49 states and one District surveyed, the most common practice in other states with regard to prior medical conditions is to accept the claim on its face value. Most states consider employees hired “as is” and any incident at work that aggravates, exacerbates, or triggers an underlying pre-

existing condition (known or unknown) and creates a need for work restriction and/or medical treatment is deemed compensable. In such cases, lost time and medical benefits are paid until the injured employee reaches a pre-injury status. These benefits are paid statutorily at 100%. Medical reports are used to determine when the injured worker achieves pre-injury status, for vocational feasibility determinations and whether there is the existence of any permanent impairment. Apportioned or reduced permanent impairment benefits for pre-existing and subsequent non-work related injuries are the norm nationwide.

There are states that are more restrictive when it comes to exclusions to benefit provision in the combination of prior injuries, pre-existing and degenerative condition and work related injuries. For example, Wisconsin precludes benefits for any injury or condition pre-existing at the time of employment with the employer against whom a claim is made. In Florida, if a work related injury combines with a pre-existing disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or benefits only to the extent that the work related injury is and remains more than 50 percent responsible for the injury as compared to all other causes combined, and thereafter remains the major contributing cause of the disability or need for treatment. Kansas requires that the work related injury produce increased disability above that found in the prior injury or previous condition. Alaska requires that the work related injury be the substantial cause of the disability, death or need for medical treatment as the threshold to benefits. Both Alaska and Connecticut preclude benefits if there is an aggravation to a pre-existing condition that happened 3 and 6 months, respectively, before the effective date of coverage. However, in most states once the claim is evaluated and determined to be compensable, benefits are provided at the 100% level – an all or nothing proposition - with the exception of permanent disability benefits. We have provided a list of how other state laws and regulations compare to North Dakota with respect to prior injuries, pre-existing conditions, and degenerative conditions in Exhibit 5.1.

Our review of denied claims with prior injuries or pre-existing conditions mirrors prior results from the performance evaluation in 2008. From anecdotal interviews with WSI claims staff, a review of claim file notes and documentation, there appears to be a focus on aggressive claims investigations surrounding degenerative and chronic medical conditions leading to a more aggressive denial decision-making. Our review suggests that some are accepted 100% (Claim #20) others have partial benefits paid (Claim #12), and yet others are denied outright (Claim #17).

It is WSI's claims practice to have supervisory oversight in the process of denying the types of claims that are under review in this section of the evaluation. However, there is no requirement for supervisory oversight when adjusters make the decision to accept a claim with priors or degenerative conditions. In our review of a few accepted claims, we found claims that adjusters had taken a great deal of latitude when determining the significance of prior conditions in their compensability decision. Decisions were made to accept claims with prior injuries, and decisions were made to deny claims under similar circumstances.

Under WSI Claims Procedure 120, general instruction is provided to the WSI claims staff on how to investigate claims presenting with priors and aggravations to pre-existing medical conditions, and to assist with the application of 65-01-02(10)(b)(7) and 65-05-15. Form FL332 (or the series of questions listed therein) is used almost exclusively to obtain medical evidence to make benefit determinations regarding prior injury/pre-existing conditions/aggravation claims. If the doctor checks box (a) of the FL332 form, the adjuster is directed that the claim can be denied as a trigger. They are then cautioned to consider if the underlying condition would have progressed similarly absent the work injury, however no medical information is requested to assist them in this determination. Then, if box (b) or (c) are checked, the case should be accepted for specific benefits or acceptance at aggravation or 100%, respectively. Please see Exhibit 5.2

The FL 332 form is short and specific in its request for information; so much so that the provider need not spend much time completing the form. However, the issues that surface in these areas of compensability are highly complex and WSI should elicit written responses from providers that are well reasoned and justified. In other words, the rationale obtained from a treating physician by WSI for acceptance or denial of benefits deserves a significantly higher level of involvement than a check the box response. For providers unfamiliar with the law in this area, there should be some definition of terminology used, and instruction with regard to how to apply it appropriately. One specific area that the form does not address at all is the issue of whether the condition is an asymptomatic condition previously unknown to the injured worker and untreated prior to the work incident. According to testimony in advance of the passage of HB 1261, if the preexisting condition is only discovered after the work injury, the claim has to be accepted in full. It is possible that there are cases that have been denied for triggering injuries that may actually be eligible for benefits at the 100% level because the answer to this question is not asked or considered when available.

We note testimony provided by WSI staff in 1997 in advance of the passage of HB 1269, which stated in part, “If the injury is not really affected by the presence of the preexisting condition then it is a ‘new and separate’ injury and is covered at 100% benefits.” The Geck and Bergum cases show that the processing of “trigger” denials is very dependent on thorough and supported analysis of the medical evidence because these denials hinge on evidence that is often subject to differing medical opinions. In Geck, the case involved an underlying asymptomatic disease at time of injury. We saw other examples in our review of claims that were initially asymptomatic, where an underlying disease process was identified and where benefits were ultimately denied. WSI might have two medical opinions in the file with at least one medical opinion supporting the cessation of benefits. By statute, this is a reasonable position to take.

Another discussion point surrounds what appear to be conflicts inherent within the claim procedure itself. The claims adjuster is counseled to engage in standard claims investigation techniques: make three- point contact with the injured worker, the employer and the physician, review the claim history, search for previous claims filed for the same or similar body part(s), and obtain copies of medical records. The procedure gives the adjuster license to obtain medical

evidence by advising that if prior problems appear to be significant, the claims adjuster may send a questionnaire to the treating physician to inquire as to whether the employment substantially accelerated the progression or substantially worsened the severity of the pre-existing injury, disease or condition. Further down in Procedure 120, however, the adjuster is counseled, “If the answer is “yes” to any of the questions and the prior injury, disease or condition is not WSI liability, the claim is possibly an aggravation case. If the claims adjuster determines that aggravation is a possibility the claim should be staffed with the claims supervisor and staff attorney”. Our review of claim file documentation supports supervisor concurrence with the adjuster’s denial more often than not, but there is no documentation regarding whether the claims adjuster/supervisor considered whether or not the underlying condition would have progressed similarly absent the work injury per WSI Procedure 120. The additional step of determining whether the triggering event substantially aggravated or accelerated the underlying condition has not been taken. When claims are filed with prior known or unknown medical conditions, we find that the claims unit lacks consistency in applying its internal procedures, resulting in an inconsistent application of the pre-existing/trigger statute.

Other claims jurisdictions make it a practice to schedule an Independent Medical Evaluation (IME) as a normal part of the investigative claims process to assist the claims adjuster in the process of unraveling contribution and causality issues. The goal of the IME is to provide the claims adjuster with a well reasoned, independent medical/legal opinion that outlines a baseline assessment of the injured worker’s medical condition and functional capacity pre-injury, an assessment the day of/after the injury (post-injury), and as of the date of the medical evaluation. Information provided to the IME includes an accurate history of the mechanism of the reported industrial injury, past and present medical records, a job description of the duties the injured worker was performing at/during the time of injury, and the authorization to perform any non-invasive diagnostic testing required for establishing an appropriate diagnosis. The injured worker and the treating physician also provide documentation outlining any change in the injured worker’s functional level of activity (including activities of daily living, if appropriate), change in any prior level of physical impairment, and/or a change in treatment frequency or severity attributed to the work incident. Engaging and successful partnering with the North Dakota treating physician community to obtain this type of probative information could result in less adversarial interaction with injured workers, medical practitioners, and reduced litigation. At the very least, it would highlight WSI’s strong intent to engage the injured worker and treating physician in the process of determining benefit eligibility.

Yet another discussion point for consideration is how employment related claims associated with cumulative trauma are to be adjudicated in North Dakota. Most jurisdictions cover the effects of long term heavy physical labor, repetitive motion, and heavy equipment use which may not manifest in a single work event under some type of cumulative exposure. NDCC 65-01-02(10)(a) finds injuries compensable which relate to disease(s) caused by a hazard to which an employee is subjected in the course of employment. The disease must be incidental to the character of the business and not independent of the relation of employer and employee. Occupational hazards

may cause both temporary and permanent injuries and illnesses. Some hazards will create an injury immediately, whereas others may not cause an injury or illness until much later in life. Hazards are generally classified as biological, chemical, ergonomic, physical, psychosocial and safety. Within the ergonomic and physical categories are injuries related to repetitive lifting and bending/stooping movements, pressure extremes, jarring motions, etc. We have reviewed claims presented in these categories that have been denied as non-specific individual traumas or pre-existing conditions with a lack of substantial acceleration documentation (Claim #15, #9, # 18).

With regard to the aggravation awards, WSI averages just over 40 aggravation cases per fiscal year. Anecdotal comments from WSI claim staff indicates that it is very difficult for the claim staff to identify an aggravation case when it is presented. When asked how they apply the concept of substantial acceleration or substantial worsening that appears in both NDCC 65-01-02(10)(b)(7) and NDCC 65-05-15, it does not appear to be sufficiently defined in the legislative language of the statute such that members of the WSI Claims Unit, Treating Physicians, Independent Medical Evaluators and the ND Legislative body can agree to apply the statute consistently to make meaningful medical, factual and legal determinations as to whether the injured worker is entitled to benefits. Based upon WSI Procedure 120, one can assume that if a medical provider answers “yes” to Part b of the questionnaire referenced above that the claim may be picked up on an aggravation basis; more specifically, that a medical provider’s affirmative response to Part b results in WSI’s 100% acceptance of a claim, usually for a specified period of time. Per statute, that specified period of time will be no less than 60 days from the date of injury. Claim # 21 is one example of how difficult it may be to make a determination as to the type of benefit(s), if any, that should be provided.

Given the common industry practice to award benefits at 100% if the claim is determined to be compensable, a benefit level pricing estimate was solicited to determine how a proposal to eliminate the aggravation category would impact claim costs. It was determined that if the aggravation statute were repealed and WSI paid benefits at the 100% level rather than at 50%, the claim cost would increase by 2.7%. By WSI’s calculations, this would result in a \$4.8 million dollar increase, resulting in a discounted premium rate level increase of approximately 2.2%.

Recommendations:

Recommendation 5.1: 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.

Priority Level: High

WSI Response: Concur. Claims Procedure 120, Investigation of Priors And Aggravation, will be updated to change the word “may” to “must”. The claims procedure will then say “If the prior problems appear to be significant the claims adjuster **must** send FL332 to the treating doctor to determine if the employment substantially accelerated the progression or substantially worsened the severity of the preexisting injury, disease or condition”.

WSI provides periodic training on the investigation of prior injuries. The claim’s staff and DRO are included in the training. Training will be provided at the time the claim’s procedure is updated and finalized.

Recommendation 5.2: At the time a compensability decision is made for a claim with a pre-existing/trigger defense, WSI claims adjusters and supervisors should determine if the underlying condition would have progressed similarly absent the work injury, per WSI Claim Procedure 120.

Priority Level: High

WSI Response: Concur. When pre-existing conditions are present, claims are compensable when the industrial incident substantially worsened or substantially progressed the underlying condition. As part of that review, the organization must determine whether the condition would have progressed similarly absent the industrial incident.

Sedgwick CMS Reply: WSI responds to this recommendation in a fashion suggesting staff already does what is intended by the recommendation. We disagree. We made this recommendation because of our finding as noted previously in this Element and repeated here: “Our review of claim file documentation supports supervisor concurrence with the adjuster’s denial more often than not, but there is no documentation regarding whether the claims adjuster/supervisor considered whether or not the underlying condition would have progressed similarly absent the work injury per WSI Procedure 120.” We simply would like to see documentation that reflects that the procedure was followed. Absent that documentation, the decision rationale is lacking.

Recommendation 5.3: In case circumstances where there is a prior medical condition or pre-existing work restriction, WSI should obtain this information to determine if there is a substantial objective baseline from which to proceed, such as input from treating physicians familiar with the patient’s medical condition(s). This would allow WSI to establish an objective baseline and an accurate fact basis from which to proceed. The injured worker and the treating physician should be asked to provide documentation outlining any change in the injured worker’s functional level of activity (including activities of daily living, if appropriate), change in any prior level of physical impairment, and/or a change in treatment frequency or severity attributed to the work incident.

Priority Level: Medium

WSI Response: Concur. To the extent information is available upon which an “objective baseline” is able to be established, WSI considers these findings in determining whether the industrial exposure substantially worsened or substantially progressed the underlying condition. When treating physician input is available, the same will be sought and reviewed by the organization.

Recommendation 5.4: Utilize the IME process to resolve disputes arising out of claim denials for pre-existing conditions, prior conditions and degenerative conditions.

Priority Level: Medium

WSI Response: Concur. Currently WSI employs the use of IMEs in order to resolve medical disputes, where appropriate. WSI will continue to use these experts in the areas which have a significant need.

Sedgwick CMS Reply: As is true of our perception of WSI’s response to Recommendation 1.3, where we point out the advantages of IMEs over medical directors in making compensability determinations, we believe that WSI does not concur with this recommendation. We reiterate here that independent medical evaluators have distinct advantages over in house medical directors in that they examine the patient and take a history from the patient, as well.

Recommendation 5.5: We recommend that WSI prepare legislation for consideration by the legislature which repeals the aggravation statute for injuries on or after a date in 2011 to be determined by the legislature.

Priority Level: High

WSI Response: Concur. WSI will prepare legislation for the interim Legislative Workers’ Compensation Review Committee’s consideration.

Element Six: Evaluation of Narcotic Utilization

Introduction:

For this Element, the State of North Dakota is interested in understanding patterns of narcotic use on workers' compensation claims. Specifically, the objectives of this Element are to:

- Evaluate North Dakota prescription narcotic utilization trends both at the national and local level.
- Evaluate if North Dakota's profiles are outside the national trends after adjustment for the State's labor force.
- Include recommendations for methods to control and address any variations in narcotic prescription rates and treatment methodologies.

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 Pharmacy Benefits Manager.
- We compared this information to what we observed in national trends. Data was obtained at the national level on a state by state basis from Sedgwick CMS' pharmacy benefits managers, Express Scripts.
- We reviewed files with varying degrees of pharmacy in the treatment plan.
- We interviewed WSI's Pharmacy Director for information regarding North Dakota pharmacy utilization, drug formulary and prior authorization requirements.
- We prepared a questionnaire for North Dakota medical providers and distributed it through the North Dakota Medical Association.
- We reviewed a NCCI Research Brief on narcotic utilization that was published in December 2009.^[3]

One objective of this Element is to identify whether there are patterns of narcotic use that can be discerned by locality within the State of North Dakota. For that assessment, we sorted narcotic spend by county over the past five years.

^[3] Lipton, B.; Laws, C.; and Li, L.; "Narcotics in Workers Compensation," NCCI Holdings, Inc.; December 2009.

As well, we wanted to assess when narcotics are used in the treatment of North Dakota injured workers. So for calendar year 2009, WSI and its Pharmacy Benefits Manager prepared a report showing the relationship between the date of injury and the first narcotic fill.

Another consideration in our data collection was the extent to which high cost cases influence overall trends. To that end, we identified the top 200 claims by cost of narcotics for each of the past five calendar years.

In summary, we wanted to have sufficient data to see patterns across the claim spectrum, in high cost claims, and around the state. And we wanted to be able to show how narcotic costs and fills compared from year to year within the State of North Dakota and how those trends compared to other states.

In the NCCI Research Brief referenced above, the national average narcotic expense approaches 25% of all pharmacy costs. This calculation was derived from a sample set of claims with dates of injury over a 14-year window from 1994 – 2007. The sample set also limited drugs dispensed to those “identified with a National Drug Code (NDC) or with a carrier specialized drug code.” As such, not all drug expenses on these claims were included in the sample. This is because some drug expenses are incorporated in other codes meaning the drug expense associated with those codes is not reported uniquely. Further, the NCCI Research Brief used a slightly more limited set of medications in its data set, which we more fully describe below.

First, to understand the history of narcotics spend over the past five calendar years, we worked closely with WSI’s Pharmacy Director on the development of reporting both through WSI’s own capabilities as well as those of their Pharmacy Benefits Manager, US Script. In some instances, we were able to use standard reporting provided by US Script to WSI. In other instances, we requested ad hoc reports to meet our research needs.

We also relied on Express Scripts to obtain narcotic spend information over the past five calendar years so we could compare North Dakota results against those of other states. For comparison purposes, both US Script and Express Scripts were asked to provide aggregated payment information on narcotics according to the three drug classes that make up opioid (narcotic) medications. Those three drug classes are opioid agonists, partial opioid agonists, and opioid combinations. Using all drugs in these three classes in our sample means that our data set includes some medicines not in the NCCI Research Brief.

Further, for our evaluation the only medications that would have been part of these data sets would be those that actually passed through the respective Pharmacy Benefits Manager. So, medications dispensed during an in-hospital stay or part of a hospital service would not be included in this analysis.

Another feature of the data gathered from both PBMs is that we did not restrict drug spend according to date of injury. If a medication was dispensed between 2005 and 2009 we captured that data irrespective of when the accident occurred. Our rationale for doing this is that the State of North Dakota is interested in an overall review of its narcotic utilization; thus, we chose to include all claims. In selecting the claims in this manner, we find that some claims can be categorized as outliers. For instance, in our sample we found one claim on which narcotic spend over the past five calendar years amounted to just under \$150,000. For another claim, the amount was slightly more than \$121,000. Other claims also had total narcotic spend exceeding \$100,000 in that five-year time frame. This information is an important consideration in understanding what drives overall cost as well as some of our recommendations that appear later in this Element.

Findings:

The national data we received from Express Scripts shows percentages of narcotic spend and percentage of narcotics dispensed against all medications prescribed. As an example, national results in the Express Scripts data for 2005 show that 38.44% of all pharmacy costs were for narcotics and narcotic prescriptions made up 35.04% of all prescriptions filled. Results for calendar years 2005 – 2009 are as follows:

Table 6.1. National trends in narcotic spend and narcotic fills (2005 – 2009)

Calendar Year	Narcotic Spend as % of All Rx	Narcotic Prescriptions as % of All
2005	38.44%	35.04%
2006	39.23%	35.01%
2007	40.04%	35.48%
2008	38.04%	34.79%
2009	38.53%	34.80%

We also provide in Exhibits 6.1 – 6.5 a summary of narcotic spend and narcotics filled by state so that you can see how North Dakota compares to all other states individually. The North Dakota data comes from US Script while other data comes from Express Scripts. Data is compiled by the year these prescriptions were filled.

We also caution that for some states data provided by Express Scripts may have been limited from a volume perspective. For example, Express Scripts had limited prescription drug data for the state of Wyoming so results in that state vary substantially from year to year. Nonetheless, for most states, the Express Scripts data set contains sufficient volume for you to compare North Dakota results to those observed in other states.

WSI narcotic spend and prescriptions written over the same time frame are as follows:

Table 6.2. North Dakota trends in narcotic spend and narcotic fills (2005 – 2009)

Calendar Year	Narcotic Spend as % of All Rx	Narcotic Prescriptions as % of All
2005	41.19%	39.99%
2006	40.53%	39.18%
2007	41.59%	40.61%
2008	40.90%	41.71%
2009	40.15%	41.13%

In comparing these tables we see that a slightly higher percentage of the overall pharmacy expense in North Dakota is narcotic-related than what we see around the country. We also see a gross average difference of about 5% in the narcotic medications that are filled as a percentage of all fills. One difference between the North Dakota and national results is that the percentage of prescriptions that are narcotic-related is gradually increasing over the past five years while the national result is relatively flat at around 35%.

There are a number of factors to consider. First, North Dakota rarely settles future medical exposure and then usually only on claims where the injured worker has moved out of state. By contrast, many jurisdictions around the country allow lump sum settlements to resolve all workers' compensation liability. These settlements often include lump sum allocations for future medical payments in such vehicles as Medicare Set-Asides where future pharmacy expense is absorbed in the overall claim resolution.

Second, the way in which high cost outliers influences the overall pattern is noteworthy and discussed in greater detail below.

Third, one of the factors that should work in favor of North Dakota is that proportionately fewer claims in the state include lost time benefits. A typical year in North Dakota may result in 15% of all claims filed producing lost time. In other states, the percentage can be as much as twice that rate or more. With more severe claims (i.e., more lost time claims) occurring more frequently in other states, we might expect narcotics costs to be higher as a percentage of all pharmacy spend, but that turns out not to be the case.

Because of these results and observations we wanted to see how costs broke down within the high-end users and patients who may receive narcotics for much shorter term use. The following tables help us understand the dramatic way in which high-end users influence the overall outcomes.

Each of the three tables that follow distribute narcotics spend and fills according to the number of narcotic fills, the cost of narcotics, and the number of claims in each of four cost groupings. For instance, in Table 6.3, for claims on which narcotic costs exceeded \$10,000 in 2005, there were a total of 1,447 prescriptions filled. In Table 6.4, the total narcotics spend on claims with more than \$10,000 in 2005 amounted to \$543,008. In Table 6.5, the total number of claims that had narcotics costs exceeding \$10,000 in 2005 totaled 39. In short, these three tables should be evaluated together to see how patterns emerge for high cost claims.

Table 6.3. Distribution of narcotic fills by claim cost grouping (2005 – 2009)

Population	2005 Rx Count	2006 Rx Count	2007 Rx Count	2008 Rx Count	2009 Rx Count
\$10K or more	1,447	1,558	1,705	2,023	2,063
\$5K or more	4,087	4,380	3,939	4,390	4,355
Top 200	5,861	5,964	5,980	5,751	5,582
All	29,164	30,880	33,338	35,391	36,856

Table 6.4. Distribution of narcotic costs by claim cost grouping (2005 – 2009)

Population	2005 Cost	2006 Cost	2007 Cost	2008 Cost	2009 Cost
\$10K or more	\$543,008	\$719,022	\$815,275	\$934,137	\$1,005,198
\$5K or more	\$1,166,723	\$1,382,657	\$1,333,038	\$1,520,056	\$1,586,499
Top 200	\$1,453,506	\$1,624,762	\$1,645,461	\$1,754,886	\$1,812,170
All	\$2,421,208	\$2,436,483	\$2,450,418	\$2,650,102	\$2,801,773

Table 6.5. Count of claims by claim cost grouping (2005 – 2009)

Population	2005 Claim Count	2006 Claim Count	2007 Claim Count	2008 Claim Count	2009 Claim Count
\$10K or more	39	43	48	59	64
\$5K or more	128	139	121	142	146
Top 200	200	200	200	200	200
All	4,408	4,514	4,579	4,814	4,949

Using the 2005 column as an example to demonstrate the impact of high cost claims we observe the following. There were 39 claims in 2005 on which more than \$10,000 was paid for narcotics. Those claims had 1,447 prescriptions filled at a total cost of \$543,008 producing an average cost per prescription of approximately \$375. In 2005, there were a total of 4,408 claims for which a narcotic was dispensed. If we take out the top 200 claims in the data set, that leaves 4,208 claims. On those claims, 23,303 prescriptions were filled at a total cost of \$967,702 producing an average cost per prescription of slightly less than \$42. In short, those injured workers who make modest use of narcotic medicines tend to receive generic medicines that are low cost. Those on the other end of the spectrum tend to receive higher cost, non-generic narcotic medicines.

Along with identifying that a relatively small percentage of the cases dominate overall narcotic costs, we also needed to assess how narcotics are prescribed according to locality. To do this, we sorted all providers who dispensed narcotics according to their zip code. The data was then sorted into meaningful groupings. For North Dakota providers, costs were grouped according to the county in which the provider conducts his/her business.

There was in the data set a group of providers for whom no zip code was provided so we did not attempt to assign those to any other data set. There were also many providers who were identified whose practices were in other states.

We observed that for calendar years 2005 and 2009 that about 81% to 82% of all narcotics costs for North Dakota injured workers occurred through prescriptions written by North Dakota providers. For calendar years 2006 – 2008, North Dakota prescribers accounted for between 87% and 89% of all narcotics costs.

Table 6.6 below shows the distribution of these narcotics costs according to the groupings referenced above.

Table 6.6. Narcotics costs by locality (2005 – 2009)

Locality	2005 Narcotic Spend	2006 Narcotic Spend	2007 Narcotic Spend	2008 Narcotic Spend	2009 Narcotic Spend
Burleigh County	\$1,191,388	\$1,361,259	\$1,402,480	\$1,543,508	\$1,575,973
Cass County	\$232,518	\$260,968	\$268,347	\$224,788	\$226,304
Grand Forks County	\$164,184	\$128,653	\$129,316	\$151,479	\$162,391
All Other Counties	\$381,413	\$368,259	\$347,913	\$373,189	\$332,642
All North Dakota	\$1,969,503	\$2,119,139	\$2,148,056	\$2,292,964	\$2,297,310
Non-North Dakota	\$182,813	\$161,578	\$211,628	\$277,055	\$335,393
Null zip code values	\$268,891	\$155,765	\$45,734	\$80,082	\$169,071
Sub-total	\$451,705	\$317,344	\$257,362	\$357,138	\$504,463
Grand Total	\$2,421,208	\$2,436,483	\$2,405,418	\$2,650,102	\$2,801,773

In light of these findings, we reviewed the prescriptions being dispensed within the State of North Dakota and found that the top five prescribers were from the Bismarck area. We observed the top prescriber dispensed 40% more prescriptions than the number two prescriber and the number one prescriber had prescribed prescriptions that cost 60% more than prescriber number two. We also observed that the top five prescribers were from the Physical Medicine and Rehabilitation (PM&R) and Anesthesiology specialties, and another of them was a Family Nurse Practitioner operating out of a Physical Medicine clinic. We also found that these providers are more frequently dispensing brand name prescriptions versus generic than their peers and the top prescriber had 77% more dispense as written (DAW) prescriptions than prescriber number two. WSI is aware of the providers referenced above. This pattern is a substantial reason for our profiling and network recommendations below.

We also observed that Burleigh County represents an average of 65% of the total Narcotic Spend in North Dakota over the past 5 years and 55% of the total Narcotic Spend for the same time periods. We also noticed that Burleigh County's Narcotic Spend has increased by more than 32% from 2005 until 2009. Other counties included in Table 6.6 have not experienced similar growth.

We also asked WSI to produce a report that identified claims where a narcotic medication was dispensed for the first time on a claim in 2009. We then compared the prescription date to the date of injury. Within that data set we found that roughly half of all narcotic fills for this group of claims occurred within the first week following the injury. Based on our review of claims in other jurisdictions and communication with some out of state physicians, this early pattern of narcotic use appears to be high when compared to practices elsewhere.

In summary, we have a pattern of use that suggests that narcotics are used often right after an injury, and we also have those who have been diagnosed with chronic pain who are high-end users of narcotic medications.

Along with our review of data, we also reviewed some claims to observe the extent to which pharmacy expense is managed by WSI. What we found suggests that the focus on prescription use is predicated on whether or not the medication dispensed is within the formulary meaning there is generally accepted use for the medicine at this strength for the injury requiring care.

We also observed that the timing of medications dispensed is reviewed to make sure that injured workers are not receiving medications too early in the dispensing cycle. Let's say that a dispensing cycle is thirty days and the PBM includes an edit/control that denies early fills prior to the 90th percentile. In this case, that would mean that a re-filled prescription could not be dispensed until the 27th day (90% of the dispensing cycle).

We also observed that utilization controls on narcotic medicines are generally lacking and tend to see this across our industry. Utilization review services often focus on the use of physical medicine services, the need for surgery, or the value of requested diagnostic services, but utilization review of pharmacy is less in vogue. Some of the recommendations that follow are designed to address the use of narcotics both in the short and long term.

Based both on discussions with physicians with backgrounds in pain management and occupational health and also in our review of treatment guidelines, we observe that one opportunity to manage narcotic fills should be at the second fill. That is because for the treatment of non-cancer pain, there are guidelines suggesting that chronic use commences either after more than seven continuous days of narcotic use or when narcotics are used for more than fourteen days in a thirty day span. A fair inquiry with a treating physician should include questions such as the following:

- Why does your patient need a narcotic medicine beyond the first fill?
- What is your target time frame for discontinuing use of the narcotic?
- Do you believe your patient is at risk for addiction?

To determine prescribing patterns among medical providers, we developed a questionnaire to go to 100 medical providers in North Dakota. We sought the assistance of the North Dakota Medical Association to distribute the questionnaire, a copy of which is attached at Exhibit 6.6. The 100 providers selected represented a reasonable mix of primary and specialty care providers around the state, and they also represented a reasonable cross-section of narcotic prescribers. The questionnaire was provided in May with a respected return date in early June. To date, less than 10% of the providers surveyed have responded, so we don't think we have a statistically relevant sample on which we can report results.

Along with the various trends we observed, we also know that policy makers are rightfully concerned with the matter of drug diversion. Prescribed medicines are dispensed but ultimately sold by some patients who are more inclined to seek medicines for profit as opposed to medical necessity. As such, we make recommendations below that include methods in which patients may be evaluated to assure medication compliance.

Finally, the purpose of these recommendations is multi-faceted. We want to make sure that there are reasonable methods by which WSI can manage the use of narcotic medications in conjunction with prescribers. We want those methods to include peer-to-peer reviews, early intervention, reasonable blood tests and urine screens, baseline assessments of pain and function, and the ongoing importance (or not) of narcotics in the treatment of injured workers. We also want specialty pain providers to be measured in reasonable ways against their peers and if results for some providers are well outside the norm, WSI should have the ability to create a network of approved providers whose results show greater functional restoration, better management of pain, and better outcomes for injured workers.

Recommendations:

Recommendation 6.1: 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.

Priority Level: High

WSI Response: Partially Concur. WSI would suggest a more global solution that limits the length of time that opioids will be paid by WSI as determined by approved treatment guidelines or by legislation. WSI's solution would be to differentiate between Acute and Long term opioid therapies. Long term therapies would require increased scrutiny and medical documentation. Coverage of long term therapies would require treating physicians to document improvement, achievable goals, drug screening and include an approved titration plan intended to wean the injured employee off of opioid medications in a safe and humane manner.

Sedgwick CMS Reply: First, the intent of this recommendation is to provide a process for the **early** engagement of WSI staff and the medical community on the most appropriate use of narcotics in the treatment of injured workers. It is not our expectation that the Pharmacy Director or his designee will contact a treating physician in all cases where a second fill has occurred, simply that this is an appropriate time in many cases to begin the dialog on how long narcotic medication will be needed. In developing this recommendation, we considered that there are narcotic use guidelines that suggest that the use of a narcotic for non-cancer pain can be considered chronic if it extends beyond seven consecutive days or fourteen days in a thirty-day time frame. As well, North Dakota is a state that enjoys a low lost time claim frequency. Lost time claims are generally considered a reliable indicator of injury severity. As such, we would have expected when compared to national norms that narcotic utilization would actually be less, but this is not the case. Thus, we think increased scrutiny of narcotics is warranted and that this process should begin early. Long term opioid therapies were not really considered in this recommendation; rather, we were looking more at what goes on in the management of opioid use early in the life of claims. We would also caution WSI that should it consider an endpoint for opioid therapies in the management of claims that it also consider that there are some injured workers who may have had a serious enough injury or a poor surgical outcome and whose medicine needs may well have to include opioids.

Recommendation 6.2: 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

Priority Level: High

WSI Response: Concur. WSI will develop an opioid usage form that will be sent to the treating physician no later than 30 days from the first indication of opioid usage and will include the bulleted items listed under this recommendation.

WSI will compensate providers for the time necessary to complete the requested documentation. Failure to complete the documentation will result in suspension of medical payments.

Recommendation 6.3: 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.

Priority Level: High

WSI Response: Concur. This could be incorporated into the existing triage process as guided by recommendation 6.1 which seeks to delineate acceptable time limits for the provision of opioid medications.

Recommendation 6.4: 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.

Priority Level: High

WSI Response: Concur. WSI will establish a policy regarding functional progress reports.

WSI will compensate providers for the time necessary to complete the requested documentation. Failure to complete the documentation will result in suspension of medical payments.

Recommendation 6.5: 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.

Priority Level: High

WSI Response: Concur. WSI will develop an assessment process to be employed in analyzing the progress and effectiveness of the treatment by the pain management provider. This assessment will likely include psychosocial aspects in order to determine the likelihood of effectiveness of the treatment regimen. Blood and urine testing are not currently authorized nor afforded by statute to WSI. This information would certainly aid in the administration of this recommendation.

WSI will explore possible new technologies that would provide objective evidence of one's functional abilities.

Sedgwick CMS Reply: The intent of this recommendation is for WSI to be able to establish baseline functional and pain levels prior to specialty pain management intervention. We also believe WSI should be allowed to establish through random blood and urine screens whether injured workers are compliant; that is, taking their medication as prescribed.

Recommendation 6.6: 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.

Priority Level: High

WSI Response: Concur. WSI has the capability to conduct pain management provider profiling that would include all of the parameters identified in the recommendation.

Recommendation 6.7: WSI may have adequate information currently to retrospectively develop data that meets the profiling characteristics suggested in recommendation 6.6 above. Regardless, if outcomes are so varied among providers that WSI believes it is in the best interest of policyholders and injured workers to limit pain management providers, WSI should develop a preferred provider network for that purpose.

Priority Level: High

WSI Response: Partially Concur. WSI does have adequate retrospective data on pain management providers to develop a preferred provider network. At question is whether there is an adequate number of pain management providers in each locality to allow for the formation of a preferred provider network.

Recommendation 6.8: We recommend that WSI have the authority to require that generic medicines be dispensed when they are available. WSI may, at its discretion, allow medicines to be dispensed as written. Dispense as written (DAW) medicines are an expensive component of current pharmacy expenses. Barring a reasonable and compelling medical reason for a brand medication to be prescribed, such as an adverse reaction to the generic or an ineffective outcome, generic medicines should be used when they are available.

Priority Level: Medium

WSI Response: Concur. WSI's current administrative rules allows for the dispensing of a branded product in lieu of the equivalent generic upon documentation by the treating provider that the equivalent generic resulted in an adverse reaction not experienced with the branded product or an ineffective outcome. Much of this is subjective in nature and WSI will seek stronger authority from legislation which specifically limits WSI's authority to pay above the "generic" level other than in cases of serious adverse reactions to the "generic" medication.

Recommendation 6.9: 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.

Priority Level: High

WSI Response: Partially Concur. WSI will review the Model Policy when drafting legislation and will incorporate it where appropriate.

Element Seven – Evaluation of a Move to the 6th Edition of the AMA Guides

Introduction:

The objectives of this Element are:

- To evaluate the impact of moving to the 6th Edition of AMA Guides to the Evaluation of Impairment. Currently, the State of North Dakota uses the 5th Edition of the AMA Guides to evaluate permanent partial impairment.
- To identify complications and methods for addressing them within any implementation and project the potential financial impact implementation would have.

Context:

Element Seven can be evaluated by readers of this report on its own merit, but it is also important to consider recommendations made herein along with those that follow our review of the PPI Threshold as discussed earlier in this report at Element One, Part C. That is, we present in this section recommendations pertaining solely to the impact of moving to the 6th Edition of the Guides. Element One, Part C also contains a financial impact analysis regarding a reduction in the PPI Threshold that should be considered in the context of our findings in this section.

Background:

The *AMA Guides to the Evaluation of Permanent Impairment*, published by the American Medical Association, are the most widely used criteria for determining permanent impairment. They are used by most workers' compensation jurisdictions, most often as a component in defining permanent disability awards. The Fifth Edition, published in November 2000, and the Sixth Edition, published in December 2007, reflect evolving concepts in defining permanent impairment. The *AMA Guides*, Fifth Edition, are currently used in the State of North Dakota.

As with other areas of medicine, concepts and approaches are improved with time; for example, in medicine, some treatments are found to be ineffective and are dropped from practice and new approaches are adopted. This also occurs with the medical assessment of impairment. With the change in impairment methodology, there will also be changes in impairment values associated with specific conditions. As clinical medicine evolves and there is increased efficacy of treatment, it is hoped that improved outcomes will reduce impairment previously associated with injury and illness.

The Sixth Edition introduces a new approach to rating impairment. An innovative methodology is used to enhance the relevancy of impairment ratings, improve internal consistency, promote greater precision, and simplify the rating process. The approach is based on an adaptation of the conceptual framework of the International Classification of Functioning, Disability, and Health, although many of the fundamental principles underlying the *Guides* remain unchanged.

There have been challenges associated with the use of the *Guides*, including criticisms of the *Guides* itself. Previous criticisms include the following:

- The method fails to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system.
- Impairment ratings do not adequately or accurately reflect loss of function.
- Numerical ratings are more the representation of “legal fiction than medical reality.”

In response to these criticisms, the following changes were factored into the Sixth Edition:

- Standardize assessment of activities of daily living limitations associated with physical impairments.
- Apply functional assessment tools to validate impairment rating scales.
- Include measures of functional loss in the impairment rating.
- Improve overall intra-rater and inter-rater reliability and internal consistency.

Some changes in the Sixth Edition have impacted impairment ratings. For example, impairment ratings are now included for conditions that may result in functional loss, but previously did not result in ratable impairment (such as nonspecific spinal pain and certain soft-tissue conditions). Additional impairment is typically not provided for surgical interventions, reflecting an underlying concept that treatment is designed to improve function and decrease impairment, with a focus on final outcome. Impairments associated with some diagnoses (e.g., total knee replacements, carpal tunnel release, and cervical spine fusion) were revised to more accurately reflect treatment outcomes.

The State of North Dakota, in certain circumstances, provides ratings for pain (up to 9% whole person permanent impairment) and for psychological impairments (Administrative Rules 92-01-02-25 (5)). These approaches are inconsistent with the AMA *Guides*, are unique to this jurisdiction, are controversial, and are likely to contribute to litigation.

Most ratable conditions are musculoskeletal disorders, often accompanied by pain complaints. In the Sixth Edition most impairment ratings are based on a diagnosis-based

approach with consideration of findings of function, physical examination and clinical studies. In defining the impairment values for these diagnoses pain was considered in defining the magnitude of the impairment for that diagnosis. With the Fifth Edition pain was limited to a maximum of 3% whole person permanent impairment and considerable problems were seen with inter-rater reliability. Pain is a subjective and difficult to assess and quantify.^[2] In developing the Sixth Edition there was extensive discussion and controversy about how to rate pain. The consensus was to focus on function rather than pain complaints and incorporate consideration of pain diagnoses and impact on activities of daily living. Assessment of pain-related impairment by the evaluating physician is a task complicated by two factors: (1) poorly validated criteria for certain diagnoses and (2) questions that can arise regarding the accuracy of patient self-reports.^[3] The approach of assigning impairment for subjective complaints of pain beyond that specified in the *Guides* has not occurred in any other jurisdiction that makes use of the *Guides*. The focus on pain is also inconsistent with current clinical standards which focus on function; the change in a focus on function versus subjective pain complaints results in improved clinical outcomes. Provision of impairment up to 9% whole person permanent impairment beyond the AMA *Guides* is not supportable by current accepted standards.

The assessment of psychological impairments which may accompany a work-related disorder is also controversial. The Fifth Edition is particularly problematic in this regard since it did not provide a quantitative basis for rating mental and behavioral impairment. In addition, controversy has occurred on whether certain conditions (such as pain) are most appropriately rated in the Fifth Edition using Chapter 14 (Mental and Behavioral Impairments) or Chapter 18 (Pain).

Many of the challenges the State of North Dakota faces with rating psychological impairments have been resolved with the more current Sixth Edition.^[4] The Sixth edition provides much more clarity than the Fifth Edition in determining precisely what type of impairments are rated using the Mental and Behavioral Disorders chapter (Chapter 14 in the Sixth Edition). The Mental and Behavioral Disorders chapter identifies the specific types of DSM-IV-TR diagnoses that are to be rated under the chapter. This chapter limits impairment evaluation to three categories of mental illness:

- Mood disorders (such as major depressive disorder),

^[2] Katz RT. Evaluating the Difficult Pain Patient. *Guides Newsletter*. May - June 2008.

^[3] Barth R. Examinee-Reported History Is Not a Credible Basis for Clinical or Administrative Decision Making. *Guides Newsletter*. September-October 2009.

^[4] Leclair N, Leclair S, Barth R. Assessing Mental and Behavioral Disorder Impairment: Overview of Sixth Edition Approaches. *Guides Newsletter*. November – December 2008.

- Anxiety Disorders, including generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder, and obsessive-compulsive disorder,
- Psychotic disorders, such as schizophrenia. (Section 14.1c, p. 349).

Some ratable disorders (e.g., schizophrenia) will not be caused by an industrial injury; therefore, they would not meet the requirements of most workers' compensation jurisdictions. Chapter 14 also identifies specific DSM-IV-TR diagnoses that are not "ratable", using the *Guides*, 6th edition. Diagnoses that are not ratable include the following: psychiatric reactions to pain (this addresses your problems with the symptom of "depression"), somatoform disorders (which includes all types of pain disorder), dissociative disorders, personality disorders, "psychosexual disorders", factitious disorders, "substance use disorders", sleep disorders, dementia and delirium, mental retardation, and psychiatric manifestations of traumatic brain injury.

In that the *Guides* is used in North Dakota to define permanent impairment awards with a threshold determinate of 16% whole person permanent impairment (WPI), it is necessary to determine whether changes in Editions result in different impairment ratings.

Study:

To determine the impact of changes in Editions, a study was performed to determine the impairment ratings resulting from use of the Fifth and Sixth Editions. Forty cases were randomly selected from cases previously rated in North Dakota and determined to have a rating of 16% whole person permanent impairment (WPI) or greater. Twelve cases previously rated in the range of 10% to 15% WPI were also selected reflecting a total sample of fifty two cases. While the selection of individual cases was done randomly, we did factor in a range of ratings and parts of body that were representative of the overall data set from which the sample was drawn.

Using the clinical data provided in the medical records, these cases were rated by the Fifth and Sixth Editions. Each of these cases had been previously rated; the purpose of re-rating by the Fifth Edition is to determine if the original ratings were correct and if not, what the impairment rating should have been; this assisted in assessing the practical impact of changes in the rating process. If the case reflected more than one diagnosis, each diagnosis was rated, and if both extremities were involved (e.g., a bilateral carpal tunnel syndrome), each was rated as a separate diagnosis since each would be associated with a separate impairment.

The following data elements were recorded for each case:

- Claim Number
- Date of Injury (date of the ratable injury)
- Date of Rating (date of the original rating by a physician)
- Date of Birth (of patient)
- Gender (of patient)
- Clinical summary (brief)
- Final (combined) whole person permanent impairment values
 - Fifth Edition
 - Sixth Edition
- Diagnosis specific ratings
 - Diagnosis
 - ICD-9 code
 - Classification of Problem
 - Surgical treatment – no/yes
 - Fifth Edition assessment
 - Rating
 - Explanation (brief)
 - Sixth Edition assessment
 - Rating
 - Approach (e.g. Diagnosis-Based Impairment, Range of Motion, etc.)
 - Table (primary table referenced)
 - Diagnosis-based Impairments
 - Problem Type
 - Diagnosis
 - Class Assignment
 - Adjustments
 - Functional
 - Physical Examination
 - Clinical Studies
 - Grade Assignment

Results:

Ninety diagnoses were associated with these fifty two cases and the majority of the diagnoses (68%) involved surgery. The average age of the patients was 45.8 years (range, 23-76 years), and the majority were male (83%). The average time between the date of injury and date of the original impairment evaluation was 5.5 years (range, 0.7 to 41 years)

63% of the Sixth Edition ratings (57 of 90) were based on the diagnosis-based impairment (DBI) approach, 23% of the ratings were based on range of motion (extremity cases), and 14% involved other approaches. Of the DBI ratings, most (56%) were class 1 (mild problem), 16% class 2 (moderate problem), 14% class 3 (severe problem) and 14% class 4 (very severe problem).

The results of the analysis of fifty two cases are presented in Table 7.1. Summary of Case Findings.

The average whole person permanent impairment (WPI) per case was opined previously per the Fifth Edition as 24.6% and on re-rating the average was determined to be 24.2% WPI; the average rating per the Sixth Edition was 16.5% WPI, 7.7% WPI less than the Fifth Edition. The overall average whole person permanent impairment for each diagnosis was opined previously as 16.4% WPI, re-rated by the Fifth Edition as 16.0% WPI and the Sixth Edition as 10.8% WPI. Of the thirty eight cases that had been rated 16% WPI or higher by the Fifth Edition, the average rating by the Fifth Edition was 28.5% WPI, whilst the average rating by the Sixth Edition was 19.6% WPI, an average reduction of 8.9% WPI.

The difference between average whole person impairment ratings was tested using a paired sample t-test analysis, with an alpha level set at the .05 level of significance. This analysis revealed a statistically significant difference between average whole person impairment ratings when comparing the Sixth Edition with the Fifth Edition. Statistics for the Simple Linear Regression Model (constant term, beta parameter, elasticity, standard errors of parameters, parameter T-Stats, ANOVA, Durbin-Watson, Von Neumann Ratio, least squares rho, maximum likelihood rho, serial correlation, Goldberger rho, and regression plots) are presented in Figure 7.1. Statistical Analysis.

Overall there was excellent reliability between the original ratings by the Fifth Edition and the re-ratings by the Fifth Edition. There were differences between the original Fifth Edition rating and the revised Fifth Edition rating in five of the cases (10%); one case was felt to have been underrated by 1% WPI and four cases overrated by an average of 4% WPI. Among the ninety diagnoses, there was a difference in ratings in six of the cases (7%).

Of the twelve cases initially rated as under 16% WPI with the Fifth Edition, on re-rating they were all agreed to; however, upon re-rating two more cases were interpreted as having less than 16% WPI. Of all the cases of less than 16% WPI, none had impairment over 16% WPI when rated by the Sixth Edition. Of the thirty eight cases determined to have 16% WPI or greater impairment per the Fifth Edition, eighteen of these cases (47%) would have been rated under 16% WPI by the Sixth Edition.

Table 7.1. Summary of Case Findings.

Case	Fifth Rating Prior WPI%	Fifth Rating WPI%	Sixth Rating WPI%	Body Part	Injury Date	Evaluation
1	10	10	9	Multi Body	7/22/2002	6/10/2009
2	10	10	10	Other - Eyes	6/23/2005	1/10/2008
3	10	10	3	Multi Body	7/22/2006	5/17/2008
4	11	11	11	U/E - Digit(s)	12/28/2006	10/3/2008
5	23	12	8	Multi Body	10/31/2002	2/23/2008
6	12	12	10	L/E - Ankle/Foot	12/29/2005	5/17/2008
7	12	12	11	L/E - Knee	1/14/2008	7/11/2009
8	13	13	7	U/E - Shoulder	12/14/2006	6/13/2009
9	17	13	9	Spine - Lumbar	1/8/2007	6/4/2008
10	14	14	5	U/E - Shoulder	11/23/2004	9/26/2008
11	15	15	9	L/E - Knee	1/2/1984	7/8/2008
12	15	15	8	L/E - Knee	7/8/1993	7/23/2008
13	15	15	8	L/E - Hip	1/22/2007	1/30/2008
14	15	15	7	Multi Body	7/26/2007	9/25/2009
15	16	16	12	Spine - Lumbar	7/30/2000	4/17/2009
16	17	17	15	Spine - Lumbar	6/21/2005	10/14/2009
17	17	17	7	U/E - Wrist	3/2/2007	7/23/2008
18	19	19	13	L/E - Ankle/Foot	5/27/1998	5/16/2009
19	19	19	9	Multi Body	10/26/2005	8/15/2009
20	20	20	12	L/E - Knee	9/18/2003	7/19/2008
21	22	20	5	L/E - Ankle/Foot	5/11/2004	5/17/2008
22	20	20	7	Spine - Lumbar	5/25/2005	1/16/2008
23	20	20	8	Spine - Lumbar	11/6/2006	4/12/2008
24	20	20	9	L/E - Hip	12/7/2007	4/22/2009
25	20	20	14	L/E - Hip	3/1/2008	11/19/2008
26	20	21	9	Multi Body	5/29/2007	4/1/2009
27	21	21	8	U/E - Multiple	7/24/2007	5/21/2009
28	24	22	17	Multi Body	3/16/2004	6/25/2008
29	22	22	16	U/E - Shoulder	8/1/2004	4/23/2008
30	22	22	17	Multi Body	1/11/2007	5/17/2008
31	23	23	27	Spine - Lumbar	8/10/1999	3/29/2008
32	23	23	16	Spine - Multiple	12/14/2004	5/13/2009
33	23	23	25	U/E - Multiple	5/19/2008	7/21/2009
34	24	24	14	Multi Body	5/29/2004	1/16/2008
35	25	25	18	U/E - Wrist	11/15/2006	6/10/2009
36	28	28	25	Spine - Lumbar	5/19/2006	9/17/2008
37	30	30	26	L/E - Multiple	11/22/2004	3/29/2008
38	30	30	15	Spine - Cervical	8/22/2005	3/17/2009

Case	Fifth Rating Prior WPI%	Fifth Rating WPI%	Sixth Rating WPI%	Body Part	Injury Date	Evaluation
39	30	30	25	L/E - Hip	9/25/2006	6/14/2008
40	30	30	30	U/E - Digit(s)	2/25/2008	4/22/2009
41	31	31	14	Spine - Multiple	1/8/1990	4/6/2009
42	31	31	27	Spine - Lumbar	10/13/1997	3/29/2008
43	31	31	18	Multi Body	4/28/2007	7/8/2009
44	32	32	32	U/E - Digit(s)	11/4/2006	1/6/2009
45	34	34	16	Spine - Multiple	2/16/2005	4/23/2008
46	34	34	9	Spine - Multiple	5/19/2005	2/5/2009
47	35	35	15	L/E - Knee	9/12/2001	9/20/2008
48	36	36	32	Multi Body	9/11/1995	12/10/2008
49	36	36	39	Spine - Cervical	2/7/2006	9/17/2008
50	49	49	23	Multi Body	12/9/1992	10/14/2009
51	56	56	29	Spine - Multiple	1/9/1968	6/3/2009
52	96	96	91	Spine - Cord	9/15/2006	3/29/2008

Figure 7.1. Statistical Analysis

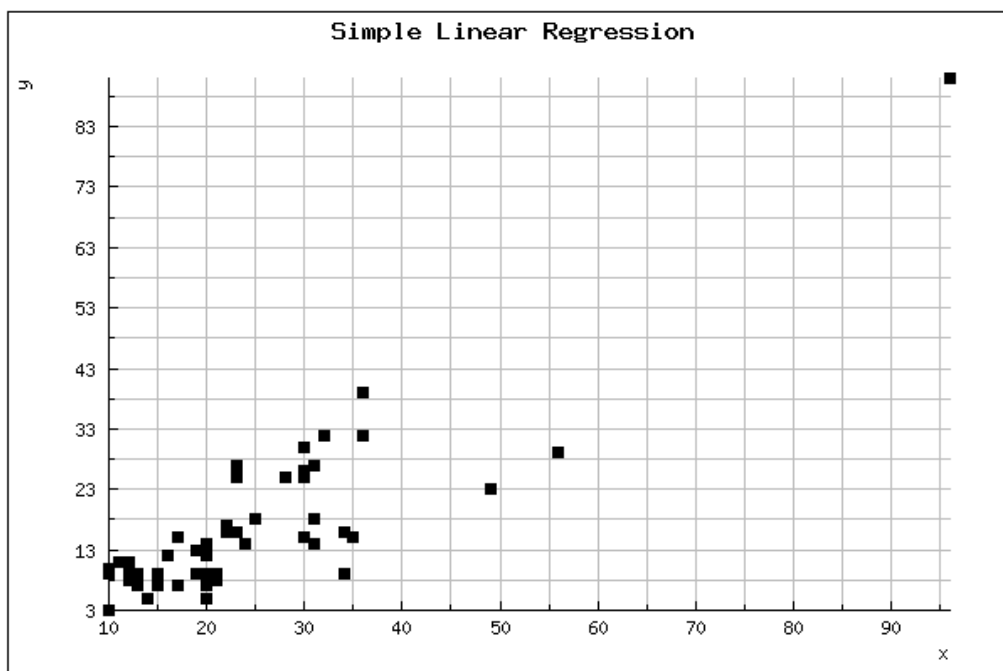
Where x = Fifth Edition ratings and y = Sixth Edition ratings, the following statistics were determined:

Simple Linear Regression - Ungrouped Data				
Parameter	Value	S.E.	T-STAT	Notes
Constant	-3.758817			
Beta	0.836872	0.066735	12.540273	H0: beta = 0
Elasticity	1.227542	0.097888	2.324513	H0: elast. = 1

Simple Linear Regression - Analysis of Variance			
<u>ANOVA</u>	DF	Sum of Squares	Mean Square
Regression	1.000000	7008.608204	7008.608204
Residual	50.000000	2228.372565	44.567451
Total	51.000000	9236.980769	181.117270
<u>F-TEST</u>	157.258448		

Simple Linear Regression - Autocorrelation	
Statistic	Value
Durbin-Watson	1.357250
Von Neumann Ratio	1.383862
rho - Least Squares	0.267282
rho - Maximum Likelihood	0.281575
rho - Serial Correlation	0.261460
rho - Goldberger	0.274335

Simple Linear Regression - Descriptive Statistics	
Statistic	Value
Mean X	24.230769
Biased Variance X	192.446746
Biased S.E. X	13.872518
Mean Y	16.519231
Biased Variance Y	177.634246
Biased S.E. Y	13.327950
Mean F	16.519231
Biased Variance F	134.780927
Biased S.E. F	11.609519
Mean e	0.000000
Biased Variance e	42.853319
Biased S.E. e	0.925779



Spinal impairments were most common, reflecting 36% of the ratable diagnoses, as shown in Table 7.2.

Table 7.2. Comparison of Average Whole Person Permanent Impairment Ratings by Sixth Edition Chapters

Chapter	Title	Fifth Prior WPI%	Fifth WPI%	Sixth WPI%	Difference WPI%	Count
12	Visual System	10.0	10.0	10.0	0.0	1
13	Nervous System	26.3	26.0	20.1	-5.9	8
14	Mental and Behavioral Disorders	20.0	20.0	14.0	-6.0	1
15	Upper Extremities	11.5	11.5	8.1	-3.4	22
16	Lower Extremities	15.2	14.7	9.8	-4.8	26
17	Spine	18.2	17.7	10.9	-6.8	32

Findings by regions are summarized in Table 7.3 for regions with 3 or more ratings.

Table 7.3. Comparison of Average Whole Person Permanent Impairment Ratings by Regions

Region	Fifth Prior WPI%	Fifth WPI%	Sixth WPI%	Difference WPI%	Count
Nervous System - Spinal Cord	33.8	33.8	26.0	-7.8	6
Upper Extremity - Hand	15.5	15.5	16.3	0.8	4
Upper Extremity - Wrist	16.3	16.3	10.0	-6.3	3
Upper Extremity - Shoulder	10.5	10.5	6.5	-3.9	11
Lower Extremity - Ankle/Foot	9.7	9.4	4.4	-5.0	7
Lower Extremity - Knee	16.9	16.9	12.1	-4.8	10
Lower Extremity - Hip	17.6	15.2	10.2	-5.0	6
Lower Extremity - Other	18.3	18.3	14.3	-4.0	3
Spine - Cervical	24.8	24.8	12.2	-12.6	9
Spine - Thoracic	9.7	9.7	4.3	-5.3	3
Spine - Lumbar	16.6	15.7	11.3	-4.4	20

With the Sixth Edition there were meaningful changes in impairment ratings as a result of not providing additional impairment for surgical (therapeutic) spine procedures and improved outcomes with total knee and hip replacement.

Table 7.4 illustrated the differences in ratings between the Fifth and Sixth Editions based on the value of a rating by an earlier edition; data presented are based on observations by case and diagnosis.

Table 7.4. Change in Impairments Compared With Fifth Edition Ratings, by Range

Fifth Edition Rating, %	No. of Cases	Fifth Edition Average, %	Sixth Edition Average, %	Difference Average, %
10-15	14	12.6	8.2	4.4
16-20	11	18.9	10.1	8.8
21-25	10	22.6	16.7	5.9
26-30	5	29.6	24.2	5.4
31-40	19	33.3	22.4	10.9
>40	3	67.0	47.7	19.3

These findings were similar to those found in a study involving the rating of two hundred cases using the Fourth, Fifth and Sixth Editions of the *AMA Guides*.⁴ In that study, which included a sample of cases that included zero ratings, the average whole person permanent impairment (WPI) per case was 6.3% WPI per the Fifth Edition and 4.8% WPI per the Sixth Edition. Of the twenty one cases in that study where the average WPI was greater than 16% WPI, the average Fifth Edition rating was 23.5% WPI, whilst the average Sixth Edition rating was 13.5% WPI, 10% WPI less. The changes observed in that study by the value of the Fifth Edition Rating are provided in Table 7.5.

Table 7.5. Change in Impairments Compared With Fifth Edition Ratings by AMA Guides Comparative Study - 200 Cases

Fifth Edition Rating, %	No. of Cases	Fifth Edition Average, %	Sixth Edition Average, %	Difference Average, %
10-14	15	11.9	9.6	2.3
15-19	8	16.5	12.9	3.6
20-24	8	20.9	9.6	11.3
25-29	6	26.2	15.0	11.2
≥30	2	41.5	25.5	16

⁴ Brigham CR, Uejo C, McEntire A, Dilbeck L. Comparative Analysis of *AMA Guides* Ratings by the Fourth, Fifth, and Sixth Editions. *Guides Newsletter*. January - February 2010.

Summary:

There is a statistically significant difference between average whole person impairment ratings when comparing the Sixth Edition with the Fifth Edition. Of the thirty eight cases that had been rated 16% WPI or higher by the Fifth Edition, the average rating by the Fifth Edition was 28.5% WPI, whilst the average rating by the Sixth Edition was 19.6% WPI, an average reduction of 8.9% WPI. This magnitude of change is consistent with changes seen in twenty one cases rated more than 16% WPI by the Fifth Edition by an earlier study. Of the cases rated 16% WPI or greater by the Fifth Edition in this study, 47% would have been rated under 16% WPI by the Sixth Edition.

Many of the more meaningful changes were for spine-related diagnoses that resulted in surgery, reflecting the Sixth Edition approach, which bases impairment ratings on the condition and outcome, rather than therapeutic interventions including surgery. Changes in values with the Sixth Edition were expected and primarily due to the recognition that (1) surgery and all therapeutic endeavors should improve function and therefore should not routinely increase impairment, and (2) there are improved functional outcomes for certain disorders, including total joint replacement.

Finally, WSI actuarial consultants were asked to project the overall financial impact of moving from the 5th Edition to the 6th Edition absent any change in the PPI threshold. Their assessment is provided in Exhibit 7.1. Their conclusion is that PPI benefits would decline by approximately \$1.1 million annually with the adoption of the 6th Edition.

Recommendations:

Recommendation 7.1: The most recent Edition, i.e. the Sixth Edition, of the *AMA Guides to the Evaluation of Permanent Impairment* should be used to determine impairment, including physical, pain and mental health and behavioral impairments.

Priority Level: High

WSI Response: Concur. The *6th Edition of the AMA Guides to the Evaluation of Permanent Impairment* is the latest version of the Guides and is the result of the evolution of medical science as well as research based medicine. The 6th Edition provides for a rating method not available in prior editions for mental and behavioral health impairments and a more explicit method of rating pain.

Recommendation 7.2: Implementation of the Sixth Edition should include training of the evaluating physicians and others to understand how to perform accurate ratings. Training should be followed by testing of competency on the use of the Sixth Edition.

Priority Level: High

WSI Response: Partially Concur. WSI will arrange for training in the use of the 6th Edition. WSI will to the extent possible only use providers who have completed 6th Edition training. WSI does not intend to require certification or require testing due to the onerous nature of this certification process. It is anticipated that so few will participate that this requirement would impair our ability to establish a broad enough pool of evaluators.

Recommendation 7.3: The assessment and any rating of pain should be consistent with the processes defined in the most recent Edition of the *Guides* (currently the Sixth Edition), If pain accompanies objective findings of injury or illness that permits rating using another chapter in the *Guides*, than pain-related impairments are not used as “add-ons” and pain impairments are limited to a maximum 3% whole person permanent impairment.

Priority Level: High

WSI Response: Concur. The 6th Edition provides for a more explicit and accurate method of rating pain than available in prior editions or the current administrative rules.

Recommendation 7.4: Mental and behavioral impairments, when rated, should be performed consistent with the processes defined in the most recent Edition of the *Guides* (currently the Sixth Edition).

Priority Level: High

WSI Response: Concur. The 6th Edition provides for a rating method not available in prior editions for mental and behavioral health impairments.

Element Eight – Prior Recommendations

Objective:

In this section, the objective is to review the prior recommendations made during the 2008 performance evaluation to determine the extent to which WSI has implemented each of the forty-six recommendations that were made. Note that one of the prior recommendations had seven components and we have treated each component separately for purposes of this summary. Each prior recommendation is categorized in one of three groupings, which are:

- Implemented
- Partially Implemented
- Not Implemented

Key Activities:

To assess the status of the recommendations, several approaches were taken. These included:

- Interviews with WSI staff
- Reviews of various reports and performance measures
- Reviews of correspondence
- Reviews of ad hoc reports created specifically to address one recommendation or another
- Review of claim files
- Review of substantial information available through the WSI Internal Audit Department

The table below sorts the prior recommendations by priority level and by degree of implementation.

Recommendation Priority Level	Implemented	Partially Implemented	Not Implemented
High	12	6	4
Medium	6	5	4
Low	4	3	2
Total	22	14	10

Overview and Analysis:

With every performance evaluation, one of the elements subject to review is the section on recommendations made in the prior biennial performance evaluation. Over the years, the implementation and validation process at WSI has evolved. Years ago, the responsible business owner would evaluate a recommendation, work within his/her department to implement a recommendation (or not, as the case may have been), and report a status on the recommendation to the Internal Audit Department.

The Internal Audit Department gathered this information and its compilations would be included in the Operating Report. At that time, the Internal Audit Department did not validate whether the recommendations were implemented.

Within the past several years, WSI added a level of recommendation compliance to the process through a Quality Assurance Director. It is the role of the Quality Assurance Director to work with the responsible business owner to move along the implementation process. For a time, the Quality Assurance Director performed without follow-up support or validation of an implementation status through Internal Audit.

In this Performance Evaluation, we found that the current process includes a broader array of parties who have various levels of responsibility to see a recommendation through. These individuals now include the responsible business owner, the Quality Assurance Director, the Internal Audit Department and a member of the Executive Committee. Most notably, the role of Internal Audit has been expanded to include a thorough documentation and validation process meaning that recommendations that are categorized as fully implemented by WSI have been vetted. This process leads to substantially greater consistency between the results documented internally by WSI and those we report herein, something we view as a favorable finding.

For those recommendations that we consider to be fully implemented, we provide commentary on how the recommendation was resolved. For other recommendations (partially implemented or not implemented) we provide a status. In some instances, we indicate our concurrence with WSI's decision not to implement a recommendation. Where we do not concur, we expect WSI to continue to work on prior recommendations until they are fully implemented.

A separate section of the report follows for each type of recommendation (fully implemented, partially implemented, and not implemented). The priority status is also noted for each recommendation.

Fully Implemented Recommendations

Recommendation 1.3 – High Priority

Market the STEP grant program more actively.

Resolution: At the time of the audit, information regarding the STEP program could be found on the WSI website in at least three places:

There is a grant link on the main WSI home page at:

<http://www.workforcesafety.com/>

A brief reference on the safety main page with a link to the next page (can be found at):

<http://www.workforcesafety.com/safety/losscontrol.asp>

And the link to more information leads to:

<http://www.workforcesafety.com/employers/grants/stepoverview.asp>

Additionally, a PowerPoint presentation was developed that loss control staff and consultants gave at the North Dakota Safety Conference, multiple focus group meetings, and North Dakota Chamber Workshop meetings held around the state during 2009. More presentations are being planned for 2010.

Finally, several publications and mailers with information regarding the grant programs were created and distributed. Postcards were mailed to policyholders, mailers were sent with payroll, and letters were sent with premium renewals.

Recommendation 1.4 – Low Priority

Improve the consistency and credibility of the grant approval process.

Resolution: The WIRC I & II and STEP I & II application processes now include references to both the criteria checklist and the electronic spreadsheet to use when evaluating a grant proposal. The processes also indicate that if a grant is denied, then a letter should be sent with an explanation of why the application was denied. Several examples of these processes being followed to completion were compiled in WSI Internal Audit's binder in which compliance with the 2008 safety grant recommendations is documented. Additionally, we reviewed two declined grant files and four accepted grant files (a mix of both STEP and WIRC applications), and this new process was followed

completely in these cases. Note: we noticed in some cases, the electronic scoring sheet was occasionally filled out manually by a reviewer instead of using the computer version. In none of these cases did we find calculating errors on the handwritten pages, and in some of the instances, we noticed that a second committee member had double-checked the scoring tallies and initialed them to verify that they were correct.

Recommendation 1.5 – High Priority

Determine how grant outcomes will be measured prior to the awarding of funds.

Resolution: WSI decided to use claim frequency and claim severity data broken down by employers and experience mod ratings to measure the impact of the grant programs. All the data needed for these calculations can be downloaded directly from the WSI databases, so they are not relying on the employers to provide this data. They intend to make these comparisons 2 years after the start of the grant, so some of the first calculations won't be completed until the fall of 2010. We have verified that the WIRC Grant Measurement Guidelines do specify that these measurements will be required. Additionally, the STEP Level 2 brochure for employers that details the application process, and included in this brochure is a term that states "WSI will periodically audit the financial and non-financial records of the program participants."

Recommendation 1.7 – High Priority

Improve the grant monitoring program.

Resolution: They are now requiring safety assessments be performed for all accounts requesting more than \$15,000 in equipment. They are also asking that equipment be labeled if it is purchased with WSI grant money. Purchase verification is required of the employers (they must provide original invoices & canceled credit cards or checks, and serial numbers if costing over \$10,000). Finally, for STEP grants (which apply to training services and not equipment), they require that copies of flyers/presentation materials be provided and/or documentation of work activities, such as a schedule of presentation.

We reviewed two WIRC grant files that were nearly closed, as they were only awaiting the final reimbursement requests from the employers. Both of these contained the Safety Consultant's report prior to awarding of the grant money. Invoices and canceled checks were also included in the files for a portion of the grant money, but because the grants were not completely closed yet, they had not yet received invoices/cancelled checks for some of the grant money. However, there was sufficient documentation to show they are pursuing the completion of this documentation from the employers. Finally, as WSI

Safety Consultants visit these employers after the grant equipment is purchased and installed, they will verify that the equipment is actually being used by the employer.

Recommendation 2.2 – High Priority

Fill the Internal Audit Manager position and give this person appropriate Board member support and resources to perform the function.

Resolution: We observed that the Internal Audit Director position has been filled and that one other auditor has also been hired since the time of the 2008 Performance Evaluation. As we noted in Element Three of this report, staffing is currently adequate for the Internal Audit Department to complete its assignments.

Recommendation 2.5 – Low Priority

Develop and maintain a formal Board handbook that captures key information required for Board membership and involvement in one easy-to-use reference.

Resolution: WSI's Board relies now on a software package called OurBoardRoom to keep track of Board membership and involvement. It is a single source for such topics as agendas, meeting minutes, operating reports and other important activities and documents relevant to the Board.

Recommendation 3.2 – Medium Priority

Provide adequate training and support for Board members to help them fully comprehend critical organizational performance measures.

Resolution: WSI provides a document titled "Operating Report Measure Definitions" to each new Board member. The report identifies the performance measures contained in the operating report, a definition of each performance measure and its purpose. It was updated in June 2009 to include the updated performance measurements, and to identify how projections and/or targets were determined. New members are further trained during orientation with information provided via the WSI "OurBoardroom" website, where orientation and resource materials on WSI and Policy Governance reside. When updates are made to the documents/materials, all existing Board members are notified via email. Board members may also ask questions concerning the Operating Report during the Audit Committee and Board meetings. The report is attached to the "OurBoardroom" website at least ten days prior to the scheduled meeting date for review.

Recommendation 3.4 – High Priority

Develop a formal process to approve future changes to the Operating Report.

Resolution: Effective October 15, 2009, WSI created a formal process to approve future changes to the Operating Report. The rationale for the change, supporting documentation, as well as its impact on any historical results will be provided. All documentation regarding any changes will be maintained according to the Operating Report backup retention schedule. All changes to the Operating Report will now be subject to Executive Team approval to ensure transparency in the process. All proposed modifications to the report must be granted approval by the Executive Team before any changes are implemented. Additionally, the Audit Committee will be notified of all changes to the Operating Report at the meeting immediately following the implementation of the change.

Recommendation 4.3 – High Priority

SIU should leverage PHS in determining which employer investigations should be performed.

Resolution: A detailed flowchart has been developed to assist WSI with its non-compliant employer investigations. The flowchart includes initial evaluation steps to determine possible non-compliance. A non-compliance committee meeting occurs within one week of referral. More information is developed as needed and further activities (either through SIU, Underwriting or Premium Audit) spelled out in the flowchart occur. Possible outcomes include the collection of premium plus penalties from the offending employer.

Recommendation 5.1 – Medium Priority

Require that recommendations be classified as “100%” complete only after Internal Audit has completed an independent validation of actions and final disposition.

Resolution: We reviewed Internal Audit work papers showing how the validation process occurs. IA has fully complied with the spirit of this recommendation and only classifies a recommendation as 100% complete when it should be.

Recommendation 5.2 – Low Priority

Improve the design and use of the “Recommendation Control Sheet”.

Resolution: The Recommendation Control Sheet has been modified to reflect the enhanced management of all performance evaluation recommendations. This sheet is used to document periodic efforts to meet recommendation objectives. The sheet also is used to capture the extent to which a recommendation is implemented, future actions needed and the sign-offs required by the appropriate business owner, a member of the executive team, the Quality Assurance Director and Internal Audit staff.

Recommendation 6.2 – High Priority

Implement the Injury Management pilot program across all 7 claim units by ensuring better utilization of the WSI Medical Director.

Resolution: By July 2009, the Medical Director was a regular participant in all Claim Unit Triage sessions. The Medical Director has become an active participant is helping the Claims Adjuster resolve questions brought to the meeting that include issues of medically related compensability, the appropriateness of treatment recommendations/plans, what diagnostic reports are telling them, as well as probative questions to ask to facilitate claim resolution. There is open dialogue amongst the team, and a vibrant learning environment has been created. The individual claims adjuster is responsible for documenting the claim with recommendations made by the Medical Director. At times, the Medical Director will make specific recommendations in writing after reviewing a medical report or request for diagnostic procedure. The Claims Unit has embraced the Medical Director as an important adjunct to their claims management process.

Recommendation 6.3 – High Priority

Decrease the amount of time the WSI Medical Director dedicates to the Utilization Review unit.

Resolution: Injury Management Services reviewed the services provided in the Unit and reallocated many of their resources. They created a plan to limit procedures/treatments that require pre-authorization to those where Utilization Review appeared to have an impact (D.C., chronic pain, etc.), and to utilize a medical contract service, rather than the Medical Director, to support the UR process. After adding one Nurse to the staff, the Medical Director trained all the Utilization Review Nurses to conduct the majority of the Utilization Reviews. The Medical Case Managers were also trained and authorized to do

perform limited Utilization Reviews on their assigned cases. Effective 2/3/09, more Physician Review Services were outsourced to the contract Medical Consultant. The determination was also made that CT scans no longer required pre-authorization in the first 30 days from the date of injury. This reassignment of workload freed up at least 70% of the Medical Director's time.

Recommendation 8.1 – Low Priority

Implement a procedure that provides for a documented review of experience rate changes posted to PICS.

Resolution: Policyholder Services has complied with this recommendation and we observed evidence of this in the Internal Audit Department's back-up work papers.

Recommendation 8.2 – Medium Priority

The risk based audit plan should incorporate a planned response and follow-up for premium audits with exceptions outside of tolerable ranges.

Resolution: Ranges were developed for premium audit when credits or debits exceeded certain dollar thresholds. Thresholds vary according to the premium category. For instance, for premiums of between \$5,000 and \$24,999 a credit of \$600 or a debit of \$1100 constitutes the range that is considered beyond tolerable. In the \$25,000 to \$99,999 premium range, higher credit and debit values have been selected.

Recommendation 8.3 – High Priority

WSI should formally review the premium audit function and determine whether additional staffing is necessary in order to comply with the stated audit plan.

Resolution: WSI reviewed this function and hired an additional FTE as of December 2008.

Recommendation 8.4 – High Priority

WSI should adopt a process that allocates policyholder dividends to active policyholders based on historical information.

Resolution: The Board passed a resolution to implement this recommendation in June 2008, and the recommendation was fully implemented as of November 2008. Dividends were calculated on a retrospective basis and validated.

Recommendation 8.5a – Medium Priority

Strengthen the overall documentation and discussion in the actuarial report.

Resolution: Internal Audit documentation contained reporting from Pacific Actuarial Consultants, WSI's actuary at the time of the 2008 Performance Evaluation, showing that documentation and discussion had been strengthened in reports following the evaluation. With a recent change in actuaries in 2010, WSI will simply have to make sure that compliance with this recommendation continues.

Recommendation 8.5b – High Priority

Include documentation of losses in excess of \$1,000,000 provision in future reports.

Resolution: We observed that documentation of these losses has been added to the annual Rate Review.

Recommendation 9.1 – High Priority

WSI and the North Dakota Legislature should seek legislative revision of the administrative dispute resolution process so that each final administrative decision is made by an independent, impartial hearing authority from an operating agency separate from WSI.

Resolution: The passing of the Initiated Measure on 11/4/08, which took effect on 12/4/08, required the "appointment of independent administrative law judges to conduct hearings and make final decisions." This portion of the Initiated Measure had the dual effect of creating a more independent judicial process and also the decisions are now considered final, rather than recommended.

Recommendation 9.2 – Medium Priority

Train Administrative Law Judges or Hearing Officers, using external experts in both North Dakota workers compensation and the administrative legal process.

Resolution: Training of administrative law judges (ALJ) is not now the responsibility of WSI. The ALJ function moved to the Office of Administrative Hearings (OAH) so OAH is responsible for training. That said, WSI has agreed to pick up some of the expenses associated with the training.

Recommendation 9.3 – Medium Priority

WSI should consider temporarily involving claims analysts to temporarily assist in preparing orders and contracting with WSI's defense attorneys to review and sign off on awards in order to eliminate current delays in the administrative hearing process.

Resolution: Since the 2008 performance evaluation, paralegal staffing was adjusted to more evenly distribute the administrative workload. An example of how the Legal staff has managed productivity can be seen in its performance metrics relating to orders processed relative to legal orders requested. In the first half of 2009, requests averaged 103/month and processed orders over those first six months averaged 102. In the second half of 2009, requests averaged 125/month while orders processed averaged 123. One other workload indicator is the number of hearings requested over the past five fiscal years. In Fiscal Years 2005 – 2007, the average annual number of hearing requests was 221. In Fiscal Years 2008 – 2009, the average annual number of hearing requests had dropped to 157, or a decline of about 29%.

Partially Implemented Recommendations

Recommendation 1.1 – Medium Priority

Create an Advisory Committee made up of both the employers and workers the grant program is designed to serve.

Status: Sedgwick interprets the spirit of the recommendation as needing to involve employers and employees more in the grant program. The BDMP 2008 Performance Evaluation report states the role of this advisory committee they are recommending (of which there are both employees and employers on the committee) is to discuss the needs of the community relating to safety, give advice on the re-design of the HELP program and review grant applications. They seem to be recommending WSI follow a model somewhat like what the State of Washington's – which BDMP cites in the report: *"The department will create an advisory committee representing the broadest spectrum of interests, appointed by the assistant director of the division of occupational safety and health (DOSH), and consisting of: three employer representatives; three employee representatives; two members with expertise in safety and health selected by the assistant director; and one nonvoting member from DOSH who will serve as committee chair."*

So, WSI has chosen to use focus groups instead of an advisory board so that a greater number/broader spectrum of employees/employers could be included. However, it seems that holding only about eleven 2-hour long meetings in various locations around the state (in 2009) isn't enough time to really involve employees/employers in the process, because other business is conducted at these focus groups. A typical agenda (copied from the Bismarck Focus Group Meeting Invitation from March, 2009) indicates that in the 2 hour meeting, they will:

- Enhance communications and collaboration between medical providers and employers
- Discuss the importance of return to work
- Learn about the new and existing WSI programs
- Share ideas on improving processes and interactions that increase efficiencies.

They may be able to *briefly* touch on the needs of the community relating to safety and ask participants for advice on the re-design of the HELP program, but they are not reviewing grant applications.

Recommendation 1.2 – High Priority

Utilize the public rulemaking process to engage the employer and employee constituencies in the development of HELP and STEP grant eligibility requirements, the application process, and the decision making process.

Status: The spirit of this recommendation seems to be to make the grant process more transparent and open to the public – so that changes aren’t seen as happening behind the scenes or with bias toward awarding certain employers.

As of April 1, 2009, some changes were made to the rules regarding safety grants. Among these changes, text was added to the rule 92-05-03-02 that specifies which types of organizations can apply for grants. Text was also added to rule 92-05-03-03 that specifies that a grant can be revoked if it is discovered that an organization gave false information on their grant application. These minor changes do not completely cover the details of grant eligibility requirements, the application process, and the decision making process that was recommended in the previous evaluation.

Per Internal Audit’s 12/23/08 meeting with the Loss Control Director and Chief of Employer Services, they have concerns about using the administrative rules for grant eligibility requirements, the application process and the decision making process. They would prefer to keep this in a general form, as the grant process is continually changing. They feel that if they “tied up” the grant details in the rulemaking process, then the grant program might become too rigid and unchanging to be beneficial to employers. Therefore, they concluded that adding more detail and regularly updating the grant guidelines as needed (that are housed on the WSI website) would satisfy this recommendation instead.

Recommendation 2.3 – Medium Priority

Clarify the process and responsibility for calculating the premium rates used to determine board member eligibility. WSI should seek a formal opinion from the Office of the Attorney General with respect to this issue.

Status: WSI reviewed the statute and applied the plain meaning of the statute along with a policy adopted on 6/2/08, which states in part: “Annual premium calculation at the time of the member’s appointment will be determined by using manual premium +/- the experience rate amount. Any prospective dividends or safety discounts will not be taken into consideration.” This recommendation is considered partially implemented only because a formal opinion from the Attorney General was not obtained.

Recommendation 2.4 – Medium Priority

Better focus the performance measurements reviewed by the Board and reduce the quantity of metrics to a more effective number.

Status: The Board considered this recommendation factoring the prior performance evaluator's assessment of the various metrics in the Operating Report. Essentially, the low priority metrics per the prior evaluator's assessment were removed although the Board preferred to keep a handful of those lower priority metrics. We noted in our review of Operating Reports that changes had occurred between ones with valuations of 12/31/07 and 9/30/09. We further note that a dashboard of key metrics is in the works, but has not as yet been implemented. See also our additional commentary immediately following at Recommendation 3.1.

Recommendation 3.1 – High Priority

Focus the Board's attention on the most important WSI performance measurements.

Status: WSI uses the WSI Operating Report as a management report, as well as a report for Board Officers and the Audit Committee. Under Policy Governance®, primary reporting to the Board will be provided through the Director's monitoring reports for the Board Executive Limitations and Ends policies, as well as reporting on the progress of the strategic plan. However, 21 out of the 59 performance measures in the report that were deemed of low importance were removed. 4 performance measures previously removed from the Operating report in calendar year 2008 were deemed important by the 2008 BDMP performance evaluation, and therefore added back into the group performance measures. Paid cost data and financial performance measurements were not considered for removal, as they are deemed important from a management perspective.

The number of performance measures within the WSI Operating Report was reduced, but still remains much higher than the targeted 15-25 as recommended. WSI advised that not all metrics listed in the Operating Report are addressed at each of the Board meetings. Only those that are deemed to be the most important at the time of the Board or Audit Committee meeting are addressed. The report is color coded to provide indicators identifying positive/neutral/watch performance levels. WSI Management and the Audit Committee have determined that it is important for the rest of the metrics to be reported on a quarterly basis to provide a continuing representative snapshot of the operation. WSI indicates there are no further plans to further reduce the number of performance measures contained in the Operating Report.

Recommendation 3.3 – Medium Priority

Benchmark performance against national standards in the workers' compensation industry more frequently.

Status: While some limited work has been done to compile information regarding national standards, WSI has nothing to report for this recommendation. See also the recommendation under Element One (b) 14 day Adjudication Process.

Recommendation 3.6 – High Priority

Perform a documented review of the information provided by the SIU Department that is included in the WSI Operating Report.

Status: SIU/Legal metrics presented in the WSI Operating Report were based on manually tracked statistics. In January 2009, WSI Internal Audit completed a review of the data submitted by the SIU from the 1st and 2nd quarters of Fiscal Year 2009. Differences were found in the Q1 report, resulting in an increase in the Return on Investment (ROI) from \$12.55 to \$13.73. The outcome of the review was presented to the Audit Committee on February 18, 2009. SIU indicators were removed from the quarterly Operating Report per the recommendations found in the 2008 Performance Evaluation Report. Internal Audit will continue to work with the SIU department quarterly to calculate/prepare metric results for internal management use. All future documentation and work papers will be kept within the Internal Audit Department.

Recommendation 4.1 – Low Priority

Track staff time and costs associated with fraud investigations.

Status: WSI indicated in its response to this recommendation in the 2008 performance evaluation that it intended to implement in two phases. First, they would track staff time periodically, something they accomplished for a quarter in 2009. Second, they also indicated that they would, once the new system was available, rely on it to more reliably track investigation costs. As the new system is not yet operational, this portion of the recommendation remains to be completed.

Recommendation 4.2 – High Priority

Increase focus on conducting provider and employer fraud investigations and strengthen collaboration between internal and external organization.

Status: A flowchart has been developed for PHS/SIU interaction on employer non-compliance investigations. WSI is also in the early stages in working with one of its business partners (CGI) on the identification of potential provider fraud. Further, some work has occurred between WSI and Job Service to evaluate WSI's Permanent Total Disability population against employment data being reported to Job Service. This process is a manual one and begs for a technology solution.

Recommendation 6.1 – High Priority

Revise the WSI Claim Procedure Manual to standardize “best practices” and train claims adjusters on new practices.

Status: No changes have been made to the claim manual. There is evidence of training on the use of the most current processes for new adjusters. WSI also held an annual training day during which the WSI philosophy of adjudicating claims with priors and use of provider form letter FL332 on 6/12/09 was discussed. There has been no attempt to quantify what the organization's “best practices” are at this time. There is anecdotal evidence of communication with other monopolistic states, sharing and obtaining feedback on claims related issues.

Recommendation 6.4 – Low Priority

Investigate additional sources for North Dakota IME providers and peer review.

Status: The Service Requisition for IME services has been signed and approved by WSI staff. This requisition is only step one in the process of developing a Request for Proposal that has been accomplished to date. We understand from further communication with WSI that additional work is in progress to expand IME services. See additional recommendations made under Element One (a) and Element 5 regarding the use of IMEs in the initial claim investigation process.

Recommendation 6.5 – Medium Priority

Enhance WSI's knowledge of industry best practices through staff attendance at appropriate industry conferences.

Status: WSI responds that they recognize the need for continual training of staff at all levels. However, due to its monopolistic nature, the training opportunities are outside the state, increasing the expense of training due to travel costs. No additional resources were allocated during FY 2008-2009 to send the staff to industry related/recommended conferences, however, a number of WSI Claim Staff were afforded the opportunity to attend AASCIF, NCCI Symposiums, APTA Insurance Forum, Pain Management and Occupational Medicine Symposiums, etc.

Recommendation 6.6 – High Priority

Review the North Dakota Statute in relation to other jurisdictions.

Status: WSI's Legal Services Director has gathered North Dakota Supreme Court cases and legislative history relating to pre-existing conditions and aggravation issues. Some additional research was done to obtain case law and statutes pertaining to all states on pre-existing conditions. The issue was under review by the North Dakota Industry Business & Labor Interim Committee. WSI chose to allow that forum to determine the appropriateness of this recommendation, and has performed no additional work on this recommendation.

Recommendation 8.5c – Low Priority

Disclose the impact of using discounted rates versus undiscounted rates and the effect of funding the Risk Management and Safety Incentive Program from surplus.

Status: This was a recommendation with which WSI partially concurred. WSI has disclosed the impact of using discounted rates versus undiscounted rates. However, WSI did not agree with that portion of the recommendation that pertained to the effect of funding the Risk Management and Safety Incentive Program from surplus. This is because the premium rating process no longer contains a provision for funding these programs.

Not Implemented Recommendations

Recommendation 1.6 – High Priority

Employ research expertise in the design and implementation of the HELP program results research.

Status: Not implemented, due to suspension of the HELP program.

Recommendation 2.1 – High Priority

Consider modifying Board member appointment criteria to include specific skills and experience relevant to a state workers' compensation fund.

Status: The Board considered this option and in its meeting of November 2008 indicated it did not concur with this recommendation.

Recommendation 3.5 – High Priority

Automate the preparation of as many metrics as possible following the migration to a new claim system.

Status: The recommendation is on hold for the AIM claim system project. Nothing further can be accomplished until WSI is closer to implementing this project.

Recommendation 4.4 – Medium Priority

PHS employees should receive training in order to conduct effective fraud investigations.

Status: Minimal effort has occurred to implement this recommendation. WSI identified a missing training opportunity in 2009, but nothing of substance has occurred subsequently.

Recommendation 8.5d – Low Priority

Document and explain why the discount rates used in the rate analysis (2.5%) and the reserve analysis (5.0%) are different and the impact of this difference on both the reserves and the rates.

Status: WSI indicated in its response to this recommendation that it concurred. However, the documentation and explanation requested in this recommendation was not in the most recent actuarial report. It is expected that an explanation will be provided in the next report.

Recommendation 8.5e – Medium Priority

PAC should add a range of rate indications to assist the Board of Directors in making rate change selections.

Status: WSI did not concur with this recommendation, taking the position that rate filings in the industry typically do not include a range. WSI noted that potential ranges are considered prior to the adoption of a particular rate level by the Board.

Recommendation 8.5f – Low Priority

Document and explain the following from the rate review:

- Derivation of the new minimum premium shown in Appendix M;
- Loss ratio of 87% used in Item B;
- The expense provision of \$10,600,000 in Item D does not match the expense provision of \$11,600,000 in Appendix A, Exhibit 6.
-

Status: This recommendation could just as easily been classified as not applicable. The recommendation applied to the 2006 – 2007 rate review, specifically to minimum premiums. The issues giving rise to the recommendation have not been present since.

Recommendation 8.5g – Medium Priority

Group assignments, and possibly other rating steps, should be made in a manner to ensure that the impact of a single class code on the group will be minimized.

Status: WSI concurred with this recommendation but indicated that it preferred to pursue “a refinement to the class ratemaking process” that would be superior to the suggested approach. Specifically, WSI accounts have been assigned NAICS codes. Some NAICS and NCCI codes did not match although WSI underwriters have been working on a solution to this shortcoming.

Recommendation 8.6 – High Priority

CACI recommends that WSI seek to modify the appropriate section of North Dakota statute to reduce the lower end of the required fund surplus range to 115% of the discounted loss reserves plus surplus.

Status: After consideration by both the Board and the Attorney General's office, and taking into account market conditions, WSI opted to leave the lower end of the required fund surplus range at 120% of the discounted loss reserves plus surplus.

Recommendation 8.7 – Medium Priority

CACI recommends that WSI request its actuary to provide confidence levels on the range of reserves shown on page 22 of the June 30, 2007 financial statement.

Status: WSI did not concur with this recommendation. This decision could at least in part have been driven by the reliability of initial actuarial forecasts when compared to ultimate losses many years later. Briefly, confidence factors are used to indicate the likelihood that a forecast will be exceeded. Losses at a 50% confidence level, often referred to as expected losses, are projected to be low 50% of the time and high the other 50%. In the prior performance evaluation, it was noted that ultimate losses over a ten-year period actually declined from initial to ultimate estimates by about 2.5%. If WSI had wide variability in its forecasts, confidence level information might be of much greater value.

Recommendations:

Recommendation 8.1: Referring back to prior recommendation 6.5, WSI management should make a continuing commitment to allocate sufficient resources in the budget to support and implement this recommendation, as the effort is designed to ensure a well educated, sophisticated Claims Department. WSI does not necessarily have to incur the expense of travel to conferences to provide a better understanding of best practices. Just as it has done in the past in providing continuing education of the Board, it can also bring in experts to discuss other aspects of insurance, loss control, claims, systems and other important topics to the WSI staff.

Priority Level: Medium

WSI Response: Concur. WSI will maintain an appropriate budget for continued staff training and development.

Recommendation 8.2: Referring back to BDMP’s prior recommendation 6.1, organizational development of and performance measurement by Best Practices are industry standards. WSI should develop standardized “best practices” and revise the Claim Procedure Manual.

Priority Level: High

WSI Response: Concur. The premise of the WSI Claims Procedure manual is to standardize and require adherence to industry best practices.

Sedgwick CMS Reply: Best practices articulate the why’s behind the procedure. For instance, a best practice related to documentation may say something as simple as, “WSI will provide thorough, pertinent documentation of all claim activities and claim decisions.” Then components within the procedure manual articulate how to achieve that best practice. As relates the BDMP recommendation from 2008, they indicated that there was “some variability in adjuster judgment in relation to the compensability” of claims with prior injuries, and pre-existing/degenerative conditions. A best practice tied to this issue could be, “WSI will provide benefits in accordance with workers’ compensation statutes and administrative rules so that determinations are made consistently on behalf of North Dakota injured workers and policyholders.”

Exhibits

Exhibit 1.1: PPI Threshold Change

PPI Threshold
Page 1

North Dakota Workforce Safety and Insurance
Proposed Benefit Change - Permanent Partial Impairment (PPI)
Estimated Effect of Lowering the Threshold to 10%

A. Data Sources

Dr. Brigham's 6th Edition ratings - Sample				
Percentage Impairment	# of cases	case distribution	Current Award	award distribution
10	2	6.1%	0	0.0%
11	2	6.1%	0	0.0%
12	2	6.1%	0	0.0%
13	1	3.0%	0	0.0%
14	3	9.1%	0	0.0%
15	3	9.1%	0	0.0%
16	3	9.1%	6,660	1.6%
17	2	6.1%	4,440	1.0%
18	2	6.1%	6,660	1.6%
19	0	0.0%	0	0.0%
20	0	0.0%	0	0.0%
21	0	0.0%	0	0.0%
22	0	0.0%	0	0.0%
23	1	3.0%	5,550	1.3%
24	0	0.0%	0	0.0%
25	3	9.1%	19,980	4.7%
26-42	8	24.2%	106,560	25.1%
43-100	1	3.0%	275,280	64.8%
	33	100.0%	425,130	100.0%
10-15	13	39.4%	0	0.0%
16-25	11	33.3%	43,290	10.2%
26-42	8	24.2%	106,560	25.1%
43-100	1	3.0%	275,280	64.8%
	33	100.0%	425,130	100.0%
16-100	20			

Pre-1995 4th Edition ratings normalized	
# of cases	case distribution
10	22.2%
8.5	18.9%
1.5	3.3%
1	2.2%
1	2.2%
5	11.1%
1	2.2%
1	2.2%
1	2.2%
6	13.3%
0.5	1.1%
0.5	1.1%
0.5	1.1%
0.5	1.1%
2	4.4%
3	6.7%
1	2.2%
45	100.0%
27	60.0%
14	31.1%
3	6.7%
1	2.2%
45	100.0%

Ratio:
cases <16%
to
Total #cases
over 15%
1.50
additional
cases
in
10% - 15%
interval
30

Bickerstaff, Whatley, Ryan & Burkhalter, Inc.

Exhibit 1.1: PPI Threshold Change (Continued)

PPI Threshold

Page 2

North Dakota Workforce Safety and Insurance
Proposed Benefit Change - Permanent Partial Impairment (PPI)
Estimated Effect of Lowering the Threshold to 10%

B. Comparison of Awards assuming a Lowering the PPI Threshold to 10%

Percentage Impairment	Manufactured 6th edition distribution using:				current benefit rate	current multiplier	proposed multiplier	current award	proposed award
	Dr. Dingham's Sample	pre-1995 4th edition	total	case distribution					
10		11.1	11.1	22.2%	\$222	0	10	0	24,667
11		9.4	9.4	18.9%	\$222	0	10	0	20,967
12		1.7	1.7	3.3%	\$222	0	10	0	3,700
13		1.1	1.1	2.2%	\$222	0	15	0	3,700
14		1.1	1.1	2.2%	\$222	0	15	0	3,700
15		5.6	5.6	11.1%	\$222	0	15	0	18,500
16	0.8		0.8	1.6%	\$222	10	20	1,744	3,489
17	0.8		0.8	1.6%	\$222	10	20	1,744	3,489
18	0.8		0.8	1.6%	\$222	15	20	2,616	3,489
19	0.8		0.8	1.6%	\$222	15	25	2,616	4,361
20	4.7		4.7	9.4%	\$222	20	25	20,931	26,164
21	0.4		0.4	0.8%	\$222	20	25	1,744	2,100
22	0.4		0.4	0.8%	\$222	25	30	2,180	2,616
23	0.4		0.4	0.8%	\$222	25	30	2,180	2,616
24	0.4		0.4	0.8%	\$222	30	30	2,616	2,616
25	1.6		1.6	3.1%	\$222	30	35	10,466	12,210
26-42	8.0		8.0	16.0%	\$222	no change		106,560	106,560
43-100	1.0		1.0	2.0%	\$222	no change		275,280	275,280
	20.0	30.0	50.0	100.0%				430,680	520,304
Scheduled Awards					13.9% of Non-Schedule PPI awards -->			59,865	59,865
Total PPI Awards								490,545	580,168

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Exhibit 1.1: PPI Threshold Change (Continued)

PPI Threshold
Page 3

North Dakota Workforce Safety and Insurance Proposed Benefit Change - Permanent Partial Impairment (PPI) Estimated Effect of Lowering the Threshold to 10%

C. Additional PPI Evaluation Costs

1. Cases in the 10% to 15% range				# of cases (from B. above)	estimated evaluation cost per case	evaluation cost
				30.0	\$2,000	60,000
2. Cases in the 5% to 9% range				(30 x 1.30) # of cases 5% to 9% range	estimated evaluation cost per case	evaluation cost
Pre-1995 4th Edition ratings normalized # of cases		ratio				
5% to 9%	10% to 15%					
35	27	1.30		38.9	\$2,000	77,778
3. Estimated total additional evaluation costs						137,778

D. Estimated Effect of Lowering the PPI Threshold to 10%

current threshold	proposed threshold	
490,545	717,946	46.4%

Notes:

1. Please note that the number of cases shown above do not represent the expected annual number of North Dakota PPI cases. They are either case counts from a statistical sample or a normalized count from a percentage distribution of PPI cases. The actual number of cases are likely to be significantly different.
2. The above calculations were put together at the request of Malcolm Dodge, Sedgwick CMS. BWR&B expresses no opinion as to the validity of the distribution of cases by impairment percentage in paragraph B. above manufactured from the two data sources in paragraph A.

Bickerstaff, Whatley, Ryan & Burkhalter, Inc.

Exhibit 5.1: Claim Form FL 332

«sysdate»

«to_recip_nm»

«to_recip_addr_block»

Injured Worker: «iw»

Birth Date: «bd»

Claim No.: «claimno»

Injury Date: «injurydt»

Body Part: «bodypt»

Dear Medical Provider:

The injured worker listed above has filed a claim for «expl».

«narr»

- 1) Do you believe «iw» has a pre-existing condition that is contributing to the current condition?

☐ No If "No", please explain. ☐ Yes If "Yes", continue.

- 2) Please check one of the three statements that best applies to the work injury:

A. ☐ The work injury made the pre-existing condition symptomatic but did not significantly worsen the condition.

B. ☐ The work injury temporarily worsened the pre-existing condition and this worsening has resolved or should resolve by this date: _____.

Or

C. ☐ The work injury significantly worsened and/or accelerated the pre-existing condition.

- 3) Time spent in review: _____ minutes.

Doctor's Signature

Date

Please forward your response to Workforce Safety & Insurance within 14 days from the date of this letter. If you prefer to fax this information to us, please fax it to 1-888-786-8695.

If you have any questions or concerns, please contact me or a customer service representative at 1-800-777-5033 or 328-3800.

Sincerely,

«ca», Claims Adjuster

«calocation»

«cc_recip_nm»

FL332

Exhibit 5.2: State by State Comparison with Respect to Prior Injuries, Pre-Existing Conditions, and Degenerative Conditions

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Alabama	<i>Taylor v. Mobile Pulley & Mach. Works</i> , 714 So.2d 300 (Ala. Civ. App., 1997) If the employee was able to perform his duties prior to the injury, no preexisting condition is present for the purposes of workers compensation. If a job related injury combines with a preexisting condition to produce a disability, it does not affect a compensation award. Further, if a preexisting condition is aggravated by a work-related injury, the condition is still compensable even though the accident may not have caused the same injury in a normal person.	No statutory definition pertaining to subsequent non-work related conditions.	Ala. Code 25-5-57(a)(4)3: If an employee had a permanent disability or has previously sustained another injury than that in which he received a subsequent permanent injury by accident, such as is specified in the provision of this section defining permanent injury, he shall be entitled to compensation only for the degree on injury that would have resulted from the latter accident if the earlier disability or injury had not existed
Alaska	<i>AS 23.30.010(a)</i> : Employee must establish a causal link between the employment and the disability, death or the need for medical treatment ... Compensation or benefits under this chapter are payable for the disability, death, or need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability, death, or need for medical treatment. <i>AS 21.55.130(a)</i> : State Plan must include coverage of a preexisting condition unless the condition happened 3 months immediately before the effective date of coverage, which would cause a reasonable person to seek care, treatment, or medical advice or treatment was recommended or received within the period of 3 months immediately before the effective date of coverage. <i>Burgess Constr. Co. v. Smallwood</i> , 623 P.2d 312: It is well established in worker's compensation law that when a work-related injury aggravates a pre-existing condition a compensable claim arises.	No statutory definition pertaining to subsequent non-work related conditions.	If the work injury temporarily aggravates the pre-existing condition, the employer is responsible for bringing the employee back to a pre-injury status. If a work injury permanently aggravates a pre-existing condition, the employer is responsible for 100% of the benefits going forward.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Arizona	No statutory definition pertaining to pre-existing conditions.	<i>A.R.S. 23-1065-2c:</i> In claims involving an employee who has a preexisting physical impairment which is not industrially-related and, whether congenital or due to injury or disease, is of such seriousness as to constitute a hindrance or obstacle to employment or to obtaining reemployment if the employee becomes unemployed, and the impairment equals or exceeds a ten per cent permanent impairment evaluated in accordance with the American medical association guides to the evaluation of permanent impairment, and the employee thereafter suffers an additional permanent impairment not of the type specified in section 23-1044, subsection B, the claim involving the subsequent impairment is eligible for reimbursement, as provided by subsection D of this section (list of conditions)....	A.R.S.23-901.05: Where an occupational disease as defined by § 23-901 paragraph 13, subdivision (c) (substantial contributing cause” under § 23-1021 means anything more than a slight contributing cause), is aggravated by any other disease or infirmity not itself compensable, or where disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated or in anywise contributed to by an occupational disease, the compensation payable under this chapter shall be reduced and limited to such proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death, as such occupational disease were the sole cause of the disability or death, as such occupational disease as a causative factor bears to all the causes of such disability or death.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Arkansas	<i>A.C.A. 11-9-525 (a)(3)</i> : It is intended that latent conditions that are not known to the employee or the employer not be considered previous disabilities or impairments which would give rise to a claim against the fund. <i>Nashville Livestock Com'n v. Cox</i> , 787 S.W.2d 664: The court stated, "In workers' compensation law the employer takes the employee as he finds him and employment circumstances which aggravate preexisting conditions are compensable. <i>Parker v. Atlantic Research Corp.</i> , 189 S.W.3d 449: Employee had preexisting condition that was asymptomatic prior to the work activity. A rapid, repetitive motion injury is argued to be an aggravation of a preexisting condition if the claimant can prove it caused harm requiring medical services, arose out of and in the course of employment, was caused by rapid, repetitive motion, was the major cause of injury, and supported by objective medical evidence. Appellant's doctor testified within a reasonable degree of medical certainty that the work-related aggravation was the major cause of employee's disability and need for treatment.	No statutory definition pertaining to subsequent non-work related conditions.	<i>A.C.A. § 11-9-601(c)(1)</i> : Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease, the compensation payable shall be reduced and limited to the proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as the occupational disease, as a causative factor, bears to all the causes of the disability or death.
California	No statutory definition pertaining to pre-existing conditions. The employer is also allowed to join prior employers to contribute to the cost only if the employee has been with the employer less than one year.	No statutory definition pertaining to subsequent non-work related conditions.	<i>Cal. LC 4663</i> : In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for the portion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury. <i>Cal. LC 4664</i> : The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. <i>City of Glendale v. Indus. Acc. Comm'n of Cal.</i> , 314 P.2d 182: Where disability is due entirely to the lighting up or aggravation of preexisting conditions by industrial injury, employer is liable to compensate for entire disability, but where disability is partly due to industrial injury and partly due to normal progress of preexisting disease or condition, industrial accident Commission must apportion the percentage of disability due to injury and percentage due to continuance of disease apart from injury.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Colorado	No statutory definition pertaining to pre-existing conditions.	No statutory definition pertaining to subsequent non-work related conditions.	<i>C.R.S.A. 8-42-104</i> : The fact that an employee has suffered a previous disability or impairment or received compensation therefore shall not preclude compensation for a later injury or for death. An employee's recovery of permanent total disability shall not be reduced when the disability is the result of work related injury or work related injury combined with genetic, congenital, or similar conditions when an employee has suffered more than one permanent medical impairment to the same body part and has received a worker's compensation award or settlement, or when an employee has a non work-related previous permanent medical impairment to the same body part that has been identified, treated, and, at the time of the subsequent compensable injury, is independently disabling. The percentage of the non work-related permanent medical impairment existing at the time of the subsequent injury to the same body part shall be deducted from the permanent medical impairment rating for the subsequent compensable injury.
Connecticut	<i>C.G.S.A. 38a-476</i> : "Preexisting conditions provision" means a policy provision which limits or excludes benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. <i>C.G.S.A. 38a-553</i> : No preexisting condition exclusion shall exclude coverage of any preexisting condition unless the condition first manifested itself within the period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage; or the condition is pregnancy existing on the effective date of coverage. No policy shall exclude coverage for a loss due to preexisting conditions for a period greater than twelve months following the effective date of coverage.	No statutory definition pertaining to subsequent non-work related conditions.	<i>C.G.S.A. 31-275</i> : For aggravation of a preexisting disease, compensation shall be allowed only for that portion of the disability or death due to the aggravation of the preexisting disease as may be reasonably attributed to the injury upon which the claim is based, where "previous disability" means an employee's preexisting condition caused by the total or partial loss of, or loss of use of, one hand, one arm, one foot, or one eye resulting from accidental injury, disease or congenital causes, or other permanent physical impairment.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Delaware	If an injured worker has an asymptomatic degenerative condition which is accelerated or exacerbated by the work event, the workers' compensation carrier is 100% responsible for injury. If an injured worker has a symptomatic degenerative condition which is aggravated by the work event, the workers' compensation carrier may argue that the responsibility is only until the injured workers returns to baseline.	No statutory definition pertaining to subsequent non-work related conditions.	<i>19 Del.C. 2327:</i> Whenever a subsequent permanent injury occurs to an employee who has previously sustained a permanent injury, from any cause, whether in line of employment or otherwise, the employer for whom such injured employee was working at the time of such subsequent injury shall be required to pay only that amount of compensation as would be due for such subsequent injury without regard to the effect of the prior injury. <i>19 Del.C. 2329:</i> Whenever any disability from which any employee is suffering following the contraction of a compensable occupational disease is due in part to such occupations disease and in part to a preexisting disease or infirmity, the Board shall determine the proportion of such disability which is reasonably attributable to the occupational disease and the proportion which is reasonably attributable to the preexisting disease or infirmity and such employees shall be entitled to compensation only for that proportion of the disability which is reasonably attributable solely to the occupational disease.
Florida	<i>F.S.A. 440.09:</i> This chapter does not require any compensation or benefits for any subsequent injury the employee suffers as a result of an original injury arising out of and in the course of employment unless the original injury is the major contributing cause of the subsequent injury. Major contributing cause must be demonstrated by medical evidence only. If an injury arising out of and in the course of employment combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or benefits required by this chapter only to the extent that the injury arising out of and in the course of employment is and remains more than 50 percent responsible for the injury as compared to all other causes combined and thereafter remains the major contributing cause of the disability or need for treatment. Major contributing cause must be determined by medical evidence only. If a compensable injury, disability, or need for medical care, or any portion thereof, is a result of aggravation or acceleration of a preexisting condition, or is the result of merger with a preexisting condition, only the disabilities and medical treatment associated with such	No statutory definition pertaining to subsequent non-work related conditions.	<i>F.S.A. 440.09:</i> The degree of permanent impairment or disability attributable to the accident or injury shall be compensated in accordance with this section, apportioning out the preexisting condition based on the anatomical impairment rating attributable to the preexisting condition.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Florida (Cont'd)	compensable injury shall be payable under this chapter, excluding the degree of disability or medical conditions existing at the time of the impairment rating or at the time of the accident, regardless of whether the preexisting condition was disabling at the time of the accident or at the time of the impairment rating and without considering whether the preexisting condition would be disabling without the compensable accident. Medical benefits shall be paid apportioning out the percentage of the need for such care attributable to the preexisting condition.		
Georgia	<i>Harris v. Peach County Board Of Commissioners</i> , 674 S.E.2d 36: Court states that the employee's predisposition to dislocate her knee, per se, does not render her job-related injury non-compensable. The court also stated that "it is well established that an employee need not be in perfect health or free from disease at the time he received the injury to recover under the Act. <i>Union City Auto Parts v. Edwards</i> , 589 S.E. 2d 351: Employers are required to pay income benefits when a claimant is disabled because of aggravation of a preexisting hernia, but they are not required to pay medical expenses for aggravation of a preexisting hernia under OCGA § 34-9-261.	<i>Ga. Code Ann. 34-9-204</i> : No compensation shall be payable for the death or disability of an employee if his or her death is caused by or, insofar as his or her disability, may be aggravated, caused, or continued by a subsequent non work related injury which breaks the chain of causation between the compensable injury and the employee's disability.	<i>Ga. Code Ann. 34-9-241</i> : Limitation on compensation for permanent partial disability. If an employee received an injury for which income benefits are payable under Code Section 34-9-263 and has a preexisting bodily loss or loss of use as described under Code Section 34-9-263 which was increased by reason of the injury, the employee shall be entitled to income benefits under Code Section 34-9-263 only for the loss or loss of use as increased by the injury. This limitation, however, shall not prevent the employee from continuing to receive income benefits for the preexisting loss or loss of use to which the employee is otherwise entitled under Code Section 34-9-263

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Hawaii	HRS 386-3: An employee's injury caused by a disease is compensable as an "injury by disease", pursuant to this section, when the disease (1) is caused by conditions that are characteristic of or peculiar to the particular trade, occupation, or employment, (2) results from employee's actual exposure to such working conditions, and (3) is due to causes in excess of the ordinary hazards of employment in general. 94 H. 70, 9 P.3d 382.	No statutory definition pertaining to subsequent non-work related conditions.	HRS 386-33: (a) Where prior to any injury an employee suffers from a previous permanent partial disability already existing prior to the injury for which compensation is claimed, and the disability resulting from the injury combines with the previous disability, whether the previous permanent partial disability was incurred during past or present periods of employment, to result in a greater permanent partial disability or in permanent total disability or in death, then weekly benefits shall be paid as follows: (1) In cases where the disability resulting from the injury combines with the previous disability to result in greater permanent partial disability the employer shall pay the employee compensation for the employee's actual permanent partial disability but for not more than one hundred four weeks; the balance if any of compensation payable to the employee for the employee's actual permanent partial disability shall thereafter be paid out of the special compensation fund; provided that in successive injury cases where the claimant's entire permanent partial disability is due to more than one compensable injury, the amount of the award for the subsequent injury shall be offset by the amount awarded for the prior compensable injury; (2) In cases where the disability resulting from the injury combines with the previous disability to result in permanent total disability, the employer shall pay the employee for one hundred four weeks and thereafter compensation for permanent total disability shall be paid out of the special compensation fund; and (3) In cases where the disability resulting from the injury combines with the previous disability to result in death the employer shall pay weekly benefits in accordance with sections 386-41 and 386-43 but for not more than one hundred four weeks; the balance of compensation payable under those sections shall thereafter be paid out of the special compensation fund.
Idaho	No statutory definition pertaining to pre-existing conditions.	If an industrial injury is substantially aggravated by a subsequent non-industrial cause, there would be a defense that the WC surety would not be responsible for the medical care or any additional impairment/disability. This is determined on a case-by-case basis.	I.C. 72-406: In cases of permanent disability less than total, if the degree or duration of disability resulting from an industrial injury or occupational disease is increased or prolonged because of a preexisting physical impairment, the employer shall be liable only for the additional disability from the industrial injury or occupational disease.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Illinois	<i>HB6159</i> : Amends the Workers' Compensation Act as follows: defines "injury" as an injury that has arisen out of and in the course of employment; provides that an injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability; provides that an injury is deemed to arise out of and in the course of the employment only if specified conditions are met; provides that an injury resulting directly or indirectly from idiopathic causes is not compensable. It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed, outside of and unrelated to the employment in non employment life.	<i>HB0058</i> : In computing the compensation to be paid any employee who, before the accident for which he or she claims compensation, had previously sustained an injury resulting in the payment of compensation for a percentage of partial disability under this paragraph (d)2, that percentage of partial disability shall be deducted from any award or settlement made under this paragraph (d)2 for a subsequent injury.	<i>HB0058</i> : In computing the compensation to be paid any employee who, before the accident for which he or she claims compensation, had previously sustained an injury resulting in the payment of compensation for a percentage of partial disability under this paragraph (d)2, that percentage of partial disability shall be deducted from any award or settlement made under this paragraph (d)2 for a subsequent injury.
Indiana	IC 22-3-7-10: (a) As used in this chapter, "occupational disease" means a disease arising out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where such diseases follow as an incident of an occupational disease as defined in this section. (b) A disease arises out of the employment only if there is apparent to the rational mind, upon consideration of all of the circumstances, a direct causal connection between the conditions under which the work is performed and the occupational disease, and which can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as the proximate cause, and which does not come from a hazard to which workers would have been equally exposed outside of the employment. The disease must be incidental to the character of the business and not independent of the relation of employer and employee. The disease need not have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.	<i>IC 22-3-3-12: Sec.12:</i> That if the permanent injury for which compensation is claimed, results only in the aggravation or increase of a previously sustained permanent injury or physical condition, regardless of the source or cause of such previously sustained injury or physical condition, the board shall determine the extent of the previously sustained permanent injury or physical condition, as well as the extent of the aggravation or increase resulting from the subsequent permanent injury, and shall award compensation only for that part of such injury, or physical condition resulting from the subsequent permanent injury.	<i>IC 22-3-3-12: Sec.12:</i> That if the permanent injury for which compensation is claimed, results only in the aggravation or increase of a previously sustained permanent injury or physical condition, regardless of the source or cause of such previously sustained injury or physical condition, the board shall determine the extent of the previously sustained permanent injury or physical condition, as well as the extent of the aggravation or increase resulting from the subsequent permanent injury, and shall award compensation only for that part of such injury, or physical condition resulting from the subsequent permanent injury.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Iowa	No statutory definition pertaining to pre-existing conditions.	I.C.A. 85.34: An employer is fully liable for compensating all of an employee's disability that arises out of and in the course of the employee's employment with the employer. An employer is not liable for compensating an employee's preexisting disability that arose out of and in the course of employment with a different employer or from causes unrelated to employment.	I.C.A. 85.34: An employer is fully liable for compensating all of an employee's disability that arises out of and in the course of the employee's employment with the employer. An employer is not liable for compensating an employee's preexisting disability that arose out of and in the course of employment with a different employer or from causes unrelated to employment.
Kansas	<i>KSA 44-501c</i> : The employee shall not be entitled to recover for the aggravation of a preexisting condition, except to the extent that the work related injury causes increased disability. <i>KSA 44-510d</i> : Where disability in part results from the injury, the injured employee shall be entitled to the compensation provided in <i>K.S.A 44-510h</i> and <i>44-510i</i> .	No statutory definition pertaining to subsequent non-work related conditions.	<i>K.S.A. 44-510 (a)</i> : Any award of compensation shall be reduced by the amount that the prior disability contributes to the overall disability following the later injury. The reduction shall be made only if the resulting permanent total or permanent partial disability was contributed to by a prior disability and if compensation was actually paid or is collectible for such prior disability.
Kentucky	<i>K.S. 342.0011(1)</i> : Injury means any work-related traumatic event or series of traumatic events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. Injury does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment.	No statutory definition pertaining to subsequent non-work related conditions.	<i>KRS 342.7630(2)</i> : The period of any income benefits payable under this section on account of any injury shall be reduced by the period of income benefits paid or payable under this chapter on account of a prior injury if income benefits in both cases are for disability of the same member or function, or different parts of the same member or function, and the income benefits payable on account of the subsequent disability in whole or in part would duplicate the income benefits payable on account of the pre-existing disability.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Louisiana	No statutory definition pertaining to pre-existing conditions.	<i>RS 23:1225(3):</i> If an employee is receiving both workers' compensation benefits and disability benefits subject to a plan providing for reduction of disability benefits, the reduction of workers' compensation benefits required by R.S. 23:1225(C)(1) shall be made by taking into account the full amount of employer funded disability benefits, pursuant to plan provisions, before any reduction of disability benefits are made.	LSA-R.S. 23:1371: It is the purpose of this Part to encourage the employment of physically handicapped employees who have a permanent, partial disability by protecting employers, group self-insurance funds, and property and casualty insurers from excess liability for workers' compensation for disability when a subsequent injury to such an employee merges with his preexisting permanent physical disability to cause a greater disability than would have resulted from the subsequent injury alone. The disability resulting from the subsequent injury in conjunction with the preexisting permanent partial disability is materially and substantially greater than that which would have resulted had the preexisting permanent partial disability not been present, and the employer has been required to pay and has paid compensation for that greater disability.
Maine	<i>MN Title 39-A Part 1 Chapter 5 Section 201 (4):</i> If a work-related injury aggravates, accelerates or combines with a preexisting physical condition, any resulting disability is compensable only if contributed to by the employment in a significant manner. <i>MN Title 39-A Part 1 Chapter 5 Section 201 (6):</i> If an employee suffers a work-related injury that aggravates, accelerates or combines with the effects of a work-related injury that occurred prior to January 1, 1993 for which compensation is still payable under the law in effect on the date of that prior injury, the employee's rights and benefits for the portion of the resulting disability that is attributable to the prior injury must be determined by the law in effect at the time of the prior injury.	<i>MN Title 39-A Part 1 Chap 5 Section 201:</i> If an employee suffers a non work-related injury or disease that is not causally connected to a previous compensable injury, the subsequent non work-related injury or disease is not compensable under this Act.	<i>MN Title 39-A Part 2 Chap 15 Section 605:</i> When an occupational disease is aggravated by any other disease or infirmity not itself compensable, or death or incapacity from any other cause not itself compensable is aggravated, prolonged, accelerated or in any way contributed to by an occupational disease, the compensation payable must be reduced and limited to the proportion only of the compensation that would be payable if the occupational disease were the sole cause of the incapacity or death as the occupational disease, as a causative factor, bears to all the causes of that incapacity or death, the reduction in compensation to be effected by reducing the number of weekly or monthly payments or the amounts of the payments as, under the circumstances of the particular case, may be for the best interest of the claimant or claimants.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Maryland	<i>MD Code 9-501:</i> Employer liable regardless of fault.- An employer is liable to provide compensation in accordance with subsection (a) of this section, regardless of fault as to a cause of the accidental personal injury.	<i>MD Code 9-608:</i> Determination of percentage of contribution.- The Commission shall determine the percentage that an occupational disease contributed to the death or disability of a covered employee when the occupational disease is aggravated by another disease or infirmity that is not compensable; or the occupational disease accelerates, aggravates, prolongs, or in any way contributes to a disability or death from a cause that is not compensable.	<i>MD Code 9-608:</i> Determination of percentage of contribution.- The Commission shall determine the percentage that an occupational disease contributed to the death or disability of a covered employee when the occupational disease is aggravated by another disease or infirmity that is not compensable; or the occupational disease accelerates, aggravates, prolongs, or in any way contributes to a disability or death from a cause that is not compensable.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Massachusetts	<i>M.G.L. 152-26:</i> If an employee who has not given notice of his claim of common law rights of action under section twenty-four, or who has given such notice and has waived the same, receives a personal injury arising out of and in the course of his employment, or arising out of an ordinary risk of the street while actually engaged, with his employer's authorization, in the business affairs or undertakings of his employer, and whether within or without the commonwealth, he shall be paid compensation by the insurer or self-insurer, as hereinafter provided.	<i>M.G.L. 152-37:</i> Whenever an employee who has a known physical impairment which is due to any previous accident, disease or any congenital condition and is, or is likely to be, a hindrance or obstacle to his employment, and who, in the course of and arising out of his employment, receives a personal injury for which compensation is required and which results in a disability that is substantially greater by reason of the combined effects of such impairment and subsequent personal injury than that disability which would have resulted from the subsequent personal injury alone, the insurer or self-insurer shall pay all compensation provided by this chapter. If said subsequent injury is caused by the preexisting impairment said subsequent personal injury of such an employee shall result in the death of the employee, and it shall be determined that the death would not have occurred except for such pre-existing physical impairment, the insurer shall pay all compensation provided by this chapter. There shall be no reimbursement unless the employer had personal knowledge of the existence of such pre-existing physical impairment within thirty days of the date of employment or retention of the employee by such employer from either a physical examination, employment application questionnaire, or statement from the employee.	<i>M.G.L. 152-37:</i> Whenever an employee who has a known physical impairment which is due to any previous accident, disease or any congenital condition and is, or is likely to be, a hindrance or obstacle to his employment, and who, in the course of and arising out of his employment, receives a personal injury for which compensation is required and which results in a disability that is substantially greater by reason of the combined effects of such impairment and subsequent personal injury than that disability which would have resulted from the subsequent personal injury alone, the insurer or self-insurer shall pay all compensation provided by this chapter. If said subsequent injury is caused by the preexisting impairment said subsequent personal injury of such an employee shall result in the death of the employee, and it shall be determined that the death would not have occurred except for such pre-existing physical impairment, the insurer shall pay all compensation provided by this chapter. There shall be no reimbursement unless the employer had personal knowledge of the existence of such pre-existing physical impairment within thirty days of the date of employment or retention of the employee by such employer from either a physical examination, employment application questionnaire, or statement from the employee.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Michigan	<p><i>M.C.L.A. 418-301:</i> Mental disabilities and conditions of the aging process, including but not limited to heart and cardiovascular conditions, shall be compensable if contributed to or aggravated or accelerated by the employment in a significant manner. Mental disabilities shall be compensable when arising out of actual events of employment, not unfounded perceptions thereof.</p> <p><i>M.C.L.A. 418-401:</i> "Personal injury" shall include a disease or disability which is due to causes and conditions which are characteristic of and peculiar to the business of the employer and which arises out of and in the course of the employment. An ordinary disease of life to which the public is generally exposed outside of the employment is not compensable.</p>	<p><i>M.C.L.A. 418-431:</i> Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable, is aggravated, prolonged, accelerated or in any way contributed to by an occupational disease, the compensation payable shall be a proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as such occupational disease, as a causative factor, bearing to all the causes of such disability or death, such reduction in compensation to be effected by reducing the number of weekly payments or the amounts of such payments, as under the circumstances of the particular case may be for the best interest of the claimant or claimants.</p>	<p><i>M.C.L.A. 418-431:</i> Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable, is aggravated, prolonged, accelerated or in any way contributed to by an occupational disease, the compensation payable shall be a proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as such occupational disease, as a causative factor, bearing to all the causes of such disability or death, such reduction in compensation to be effected by reducing the number of weekly payments or the amounts of such payments, as under the circumstances of the particular case may be for the best interest of the claimant or claimants.</p>

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Minnesota	M.S.A. 176.021: Every employer is liable for compensation according to the provisions of this chapter and is liable to pay compensation in every case of personal injury or death of an employee arising out of and in the course of employment without regard to the question of negligence.	<i>M.S.A. 176.101 Subd.4a:</i> If a personal injury results in a disability which is attributable in part to a preexisting disability that arises from a congenital condition or is the result of a traumatic injury or incident, whether or not compensable under this chapter, the compensation payable for the permanent partial disability pursuant to this section shall be reduced by the proportion of the disability which is attributable only to the preexisting disability. An apportionment of a permanent partial disability under this subdivision shall be made only if the preexisting disability is clearly evidenced in a medical report or record made prior to the current personal injury. Evidence of a copy of the medical report or record upon which apportionment is based shall be made available to the employee by the employer at the time compensation for the permanent partial disability is begun	<i>M.S.A. 176.101 Subd.4a:</i> If a personal injury results in a disability which is attributable in part to a preexisting disability that arises from a congenital condition or is the result of a traumatic injury or incident, whether or not compensable under this chapter, the compensation payable for the permanent partial disability pursuant to this section shall be reduced by the proportion of the disability which is attributable only to the preexisting disability. An apportionment of a permanent partial disability under this subdivision shall be made only if the preexisting disability is clearly evidenced in a medical report or record made prior to the current personal injury. Evidence of a copy of the medical report or record upon which apportionment is based shall be made available to the employee by the employer at the time compensation for the permanent partial disability is begun
Mississippi	<i>Miss. Code Ann. 71-3-3:</i> "Injury" means accidental injury or accidental death arising out of and in the course of employment without regard to fault which results from an untoward event or events, if contributed to or aggravated or accelerated by the employment in a significant manner. Untoward event includes events causing unexpected results. An untoward event or events shall not be presumed to have arisen out of and in the course of employment, except in the case of an employee found dead in the course of employment. <i>Miss. Code Ann. 71-3-7:</i> Compensation shall be payable for disability or death of an employee from injury or occupational disease arising out of and in the course of employment, without regard to fault as to the cause of the injury or occupational disease. An occupational disease shall be deemed to arise out of and in the course of employment when there is evidence that there is a direct causal connection between the work performed and the occupational disease.	No statutory definition pertaining to subsequent non-work related conditions.	<i>Miss. Code Ann. 71-3-7:</i> Where a preexisting physical handicap, disease, or lesion is shown by medical findings to be a material contributing factor in the results following injury, the compensation which, but for this paragraph, would be payable shall be reduced by that proportion which such preexisting physical handicap, disease, or lesion contributed to the production of the results following the injury. The employer or carrier does not have the power to determine the date of maximum medical recovery or percentage of apportionment. This must be done by the attorney-referee, subject to review by the commission as the ultimate finder of fact. Apportionment shall not be applied until the claimant has reached maximum medical recovery.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Missouri	<p><i>V.A.M.S. 287.020:</i> The word "accident" as used in this chapter shall mean an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. "The prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability. It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non employment life. <i>V.A.M.S. 287.067:</i> An injury by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. The "prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability. Ordinary, gradual deterioration, or progressive degeneration of the body caused by aging or by the normal activities of day-to-day living shall not be compensable.</p>	<p><i>V.A.M.S. 287.190.3:</i> For permanent injuries other than those specified in the schedule of losses, the compensation shall be paid for such periods as are proportionate to the relation which the other injury bears to the injuries above specified, but no period shall exceed four hundred weeks, at the rates fixed in subsection 1. The other injuries shall include permanent injuries causing a loss of earning power. <i>V.A.M.S. 287.190.6(3):</i> Any award of compensation shall be reduced by an amount proportional to the permanent partial disability determined to be a preexisting disease or condition or attributed to the natural process of aging sufficient to cause or prolong the disability or need of treatment.</p>	<p><i>V.A.M.S. 287.190.3:</i> For permanent injuries other than those specified in the schedule of losses, the compensation shall be paid for such periods as are proportionate to the relation which the other injury bears to the injuries above specified, but no period shall exceed four hundred weeks, at the rates fixed in subsection 1. The other injuries shall include permanent injuries causing a loss of earning power. <i>V.A.M.S. 287.190.6(3):</i> Any award of compensation shall be reduced by an amount proportional to the permanent partial disability determined to be a preexisting disease or condition or attributed to the natural process of aging sufficient to cause or prolong the disability or need of treatment.</p>

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Montana	<p><i>MCA 39-71-119</i>: "Injury" or "injured" means internal or external physical harm to the body that is established by objective medical findings; An injury is caused by an accident. An accident is an unexpected traumatic incident or unusual strain, identifiable by time and place of occurrence, identifiable by member or part of the body affected, caused by a specific event on a single day or during a single work shift. "Injury" or "injured" does not include a disease that is not caused by an accident. <i>MCA 39-71-407</i>: Each insurer is liable for the payment of compensation to an employee of an employer covered that it insures who receives an injury arising out of and in the course of employment. If the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that a claimed injury has occurred, or a claimed injury aggravated a preexisting condition, proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.</p> <p>As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes. Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if: the occupational disease is established by objective medical findings; and the events occurring on more than a single day or work shift are the major contributing cause of the occupational disease in relation to other factors contributing to the occupational disease.</p>	<p><i>MCA 39-71-407</i>: If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury. <i>MCA 39-71-403</i>: If a worker suffers a subsequent compensable injury or injuries to the same part of the body, the award payable for the subsequent injury may not duplicate any amounts paid for the previous injury or injuries. <i>MCA 39-70-901</i>: "Person with a disability" means a person who has a medically certifiable permanent impairment that is a substantial obstacle to obtaining employment or to obtaining reemployment if the person should become unemployed, considering such factors as the person's age, education, training, experience, and employment rejection.</p>	<p><i>MCA 39-71-739</i>: If aggravation, diminution, or termination of disability takes place or is discovered after the rate of compensation is established or compensation is terminated in any case where the maximum payments for disabilities as provided in this chapter are not reached, adjustments may be made to meet such changed conditions by increasing, diminishing, or terminating compensation payments in accordance with the provisions of this chapter. <i>MCA 39-70-901</i>: "Person with a disability" means a person who has a medically certifiable permanent impairment that is a substantial obstacle to obtaining employment or to obtaining reemployment if the person should become unemployed, considering such factors as the person's age, education, training, experience, and employment rejection.</p>
Nebraska	<p><i>Neb Rev St. 48-101</i>: The accident requirement of the act is satisfied if the cause of the injury was of accidental character or the effect was unexpected or unforeseen, and happened suddenly and violently; and, furthermore, it is no longer necessary that the injury be caused by a single traumatic event, but the exertion in the employment must contribute in some material and substantial degree to cause the injury. The term "in the course of" refers to the time, place, and circumstances surrounding the accident. The term "arising out of" describes the accident and its origin, cause, and</p>	<p><i>Neb Rev St. 48-128</i>: If an employee who has a preexisting permanent partial disability whether from compensable injury or otherwise, which is or is likely to be a hindrance or obstacle to his or her obtaining employment or obtaining reemployment if the employee should become unemployed and which was known to the employer prior to the occurrence of a subsequent compensable injury, receives a subsequent</p>	<p><i>Yakal v. Henkle & Joyce Hardware Co.</i>, 145 Neb. 365, 16 N.W.2d 531: Award will be sustained when injury, resulting from an accident arising out of and in the course of employment and preexisting disease combined to produce disability. <i>Dymak v. Haskins Bros. & Co.</i>, 132 Neb. 308, 271 N.W. 860: Injury from strain or overexertion due to a physical condition predisposing the employee to injury is an injury under the terms of the Workmen's Compensation Act, even though, had the person been sound, the strain would not have been sufficient to occasion serious injury. <i>Gray v. Fuel Economy Contracting Co.</i>, 236 Neb. 937, 464 N.W.2d 366: This court has expressly disapproved of language in</p>

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Nebraska (Cont'd)	<p>character, i.e., whether it resulted from the risks arising within the scope or sphere of the employee's job. Employee can recover for accumulated effects of occupational disease when disability occurs.</p> <p>This section compensates injury caused to an employee by an accident arising out of and in the course of his or her employment; the phrases "arising out of" and "in the course of" are conjunctive and must both be established by a preponderance of the evidence. <i>Yakal v. Henkle & Joyce Hardware Co.</i>, 145 Neb. 365, 16 N.W.2d 531: Award will be sustained when injury, resulting from an accident arising out of and in the course of employment and preexisting disease combined to produce disability. <i>Jurgensen v. Rogers</i>, 139 Neb. 30, 296 N.W. 341: Where sudden jerk of road grading machinery results in injury to back of employee, it is sufficient to constitute an accident arising out of and in the course of his employment. <i>Neb Rev St. 48-137 & Snipes v. Sperry Vickers</i>, 251 Neb. 415, 557 N.W.2d 662: This section has at least two exceptions, including (1) where a "latent and progressive" injury is not discovered within 2 years of the accident which caused the injury and (2) where a material change in condition occurs which necessitates additional medical care and from which an employee suffers increased disability.</p>	<p>compensable injury resulting in additional permanent partial or in permanent total disability so that the degree or percentage of disability caused by the combined disabilities is substantially greater than that which would have resulted from the last injury, considered alone and of itself, and if the employee is entitled to receive compensation on the basis of the combined disabilities, the employer at the time of the last injury shall be liable only for the degree or percentage of disability which would have resulted from the last injury had there been no preexisting disability. For the additional disability, the employee shall be compensated out of the Workers' Compensation Trust Fund.</p> <p>As used in this subsection, preexisting permanent partial disability shall mean any preexisting permanent condition, whether congenital or the result of injury or disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee should become unemployed. No condition shall be considered a preexisting permanent partial disability under this subsection unless it would support a rating of twenty-five percent loss of earning power or more or support a rating which would result in compensation payable for a period of ninety weeks or more for disability for permanent injury as computed under subdivision (3) of section 48-121.</p>	<p>previous opinions which imposed an enhanced degree of proof by an employee with a preexisting disability or condition who is prosecuting a claim under the Nebraska Workers' Compensation Act. For an award based on disability, a claimant need only establish by a preponderance of the evidence that the employment proximately caused an injury which resulted in compensable disability.</p>

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Nevada	<p><i>NRS 616C.150:</i> An injured employee or the dependents of the injured employee are not entitled to receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS unless the employee or the dependents establish by a preponderance of the evidence that the employee's injury arose out of and in the course of his or her employment. <i>NRS 616C.160:</i> If, after a claim for compensation is filed The injured employee seeks treatment from a physician or chiropractor for a newly developed injury or disease; and the employee's medical records for the injury reported do not include a reference to the injury or disease for which treatment is being sought, or there is no documentation indicating that there was possible exposure to an injury, the injury or disease for which treatment is being sought must not be considered part of the employee's original claim for compensation unless the physician or chiropractor establishes by medical evidence a causal relationship between the injury or disease for which treatment is being sought and the original accident.</p> <p><i>NRS 616C.175:</i> If an employee subsequently sustains an injury by accident arising out of and in the course of his or her employment which aggravates, precipitates or accelerates the preexisting condition, shall be deemed to be an injury by accident that is compensable unless the insurer can prove by a preponderance of the evidence that the subsequent injury is not a substantial contributing cause of the resulting condition. <i>NRS 616C.480:</i> If an employee who has received compensation in a lump sum for a permanent partial disability is subsequently injured by an accident arising out of and in the course of his or her employment and is thereby entitled to receive compensation for a temporary total disability, the compensation for the subsequent injury may not be reduced because of the receipt of the lump-sum payment if the subsequent injury is distinct from the previous injury.</p>	<p><i>NRS 616C.175:</i> The resulting condition of an employee who sustains an injury by accident arising out of and in the course of his or her employment; and subsequently aggravates, precipitates or accelerates the injury in a manner that does not arise out of and in the course of his or her employment, shall be deemed to be an injury by accident that is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS, unless the insurer can prove by a preponderance of the evidence that the injury described in paragraph (a) is not a substantial contributing cause of the resulting condition.</p>	<p><i>NRS 616C.480:</i> Reduction of benefits for previous injury causing permanent partial disability prohibited. <i>NRS 616C.557/560:</i> If an employee of a self-insured employer has a permanent physical impairment from any cause or origin and incurs a subsequent disability by injury arising out of and in the course of his or her employment which entitles the employee to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone, the compensation due must be charged to the Subsequent Injury Account for Self-Insured Employers in accordance with regulations adopted by the Board.</p>

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New Hampshire	<p><i>N.H.Rev. Stat. 281-A:2 XI: "Injury" or "'personal injury" as used in and covered by this chapter means accidental injury or death arising out of and in the course of employment, or any occupational disease or resulting death arising out of and in the course of employment. Conditions of the aging process, including but not limited to heart and cardiovascular conditions, shall be compensable only if contributed to or aggravated or accelerated by the injury. N.H.Rev. Stat. 281-A:2 XIII: "Occupational disease" means an injury arising out of and in the course of the employee's employment and due to causes and conditions characteristic of and peculiar to the particular trade, occupation or employment. It shall not include other diseases or death therefrom unless they are the direct result of an accidental injury arising out of or in the course of employment, nor shall it include either a disease which existed at commencement of the employment or a disease to which the last injurious exposure to its hazards occurred prior to August 31, 1947. N.H.Rev. Stat. 281-A:16 For the purpose of determining the date of injury for an occupational disease, the date of injury shall be taken to be the last date of injurious exposure to the hazards of such disease or the date on which the employee first knew or reasonably should have known of the condition and its relationship to the employee's employment, whichever is the later. For an injury caused by cumulative trauma, the date of injury shall be the date of first medical treatment. For an injury or condition aggravated by cumulative trauma, the date of injury shall be the date of first medical treatment for the aggravation.</i></p>	<p><i>N.H.Rev. Stat 281-A:54: If the subsequent injury of such an employee occurring on or after July 1, 1975, shall result in the death of the employee and it shall be determined that the death would not have occurred except for such preexisting permanent physical or mental impairment, the employer or the employer's insurance carrier shall in the first instance pay the compensation prescribed by this chapter. However, the commissioner shall reimburse such employer or insurance carrier from the special fund created</i></p>	<p><i>N.H. Rev.Stat.281-A:54: If an employee who has a permanent physical or mental impairment, as defined in RSA 281-A:2, XIV, from any cause or origin incurs a subsequent disability by injury arising out of and in the course of such employee's employment on or after July 1, 1975, which results in compensation liability for a disability that is greater by reason of the combined effects of the preexisting impairment than that which would have resulted from the subsequent injury alone, the employer or the employer's insurance carrier shall in the first instance pay all awards of compensation provided by this chapter. However, the commissioner shall reimburse such employer or insurance carrier from the special fund.</i></p>

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New Jersey	<i>N.J.S.A. 34:15-7&30:</i> When employer and employee shall by agreement accept the provisions of this article compensation for personal injuries to, or for the death of, such employee by accident or any occupational disease arising out of or in the course of employment shall be made by the employer without regard to the negligence of the employer. <i>N.J.S.A. 34-15-31:</i> For the purpose of this article, the phrase "compensable occupational disease" shall include all diseases arising out of and in the course of employment, which are due in a material degree to causes and conditions which are or were characteristic of or peculiar to a particular trade, occupation, process or place of employment. Deterioration of a tissue, organ or part of the body in which the function of such tissue, organ or part of the body is diminished due to the natural aging process thereof is not compensable.	<i>N.J.S.A. 34:15-95:</i> The sums collected under R.S. 34:15-94 shall constitute a fund, to be known as the Second Injury Fund, out of which a sum shall be set aside each year by the Commissioner of Labor from which compensation payments in accordance with the provisions of paragraph (b) of R.S. 34:15-12 shall be made to persons totally disabled, as a result of experiencing a subsequent permanent injury under conditions entitling such persons to compensation therefore, when such persons had previously been permanently and partially disabled from some other cause.	<i>N.J.S.A. 34:15-12:</i> If previous loss of function to the body, head, a member or an organ is established by competent evidence, and subsequently an injury or occupational disease arising out of and in the course of an employment occurs to that part of the body, head, member or organ, where there was a previous loss of function, then the employer or the employer's insurance carrier at the time of the subsequent injury or occupational disease shall not be liable for any such loss and credit shall be given the employer or the employer's insurance carrier for the previous loss of function and the burden of proof in such matters shall rest on the employer.
New Mexico	<i>N.M.S.A. 1978 52-1-19:</i> As used in the Workers' Compensation Act [Chapter 51, Article 1 NMSA 1978], unless the context otherwise requires, "injury by accident arising out of and in the course of employment" shall include accidental injuries to workers and death resulting from accidental injury as a result of their employment and while at work in any place where their employer's business requires their presence but shall not include injuries to any worker occurring while on his way to assume the duties of his employment or after leaving such duties, the proximate cause of which is not the employer's negligence.	<i>N.M.S.A. 1978 52-3-43:</i> Where an occupational disease is aggravated by any other disease or infirmity not itself compensable, or where disablement or death from any other cause not itself compensable is aggravated, prolonged, accelerated or in any wise contributed to by an occupational disease, the compensation payable under this act shall be reduced and limited to such proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disablement or death, as such occupational disease as a causative factor bears to all the causes of such disablement or death, such reduction to be effected by reducing the number of weekly payments.	<i>N.M.S.A. 1978 52-1-47 (D):</i> The compensation benefits payable by reason of disability caused by accidental injury shall be reduced by the compensation benefits paid or payable on account of any prior injury suffered by the worker if compensation benefits in both instances are for injury to the same member or function or different parts of the same member or function or for disfigurement and if the compensation benefits payable on account of the subsequent injury would, in whole or in part, duplicate the benefits paid or payable on account of such prior injury.

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New York	<p><i>McKinney's Workers' Compensation law § 3</i>: Lists occupations that are covered under the system as well as occupational diseases. What case law has stated is that a pre-existing condition does not bar award for occupational disease if there is a link between employment and disease. <i>Hollander v. Valor Clothers, Inc.</i> 457 N.Y.S.2d 1002: Workers compensation is not payable for aggravation of previous active condition; to be compensable, pre-existing condition must be dormant and non-disabling and some distinctive feature of employment must cause disability by activating condition. <i>Detenbeck v GMC</i>, 132 N.E.2d 840: o The rule regarding occupational diseases differs from that concerning industrial accident, in that an accident resulting in disability is compensable even though it would not have occurred unless the employee had been predisposed to it through some pre-existing physical defect. Predisposition of an employee to an occupational disease does not prevent him from having benefits of workmen's compensation if he develops what would ordinarily be an occupational disease. WCL § 3. The test of what is an "occupational disease" is the same whether employee is decrepit or in normal health; there must be some recognizable link between disease and some distinctive feature of claimant's job.</p>	No statutory definition pertaining to subsequent non-work related conditions.	Awards may be made against, and payments of compensation or death benefits or medical or other expenses shall be paid out of such special fund for all compensation or death benefits due to an excess of disability found to have been caused to an employee by reason of a pre-existing disability found to have existed at the time of a subsequent injury, after all compensation that would have resulted from such subsequent injury, if no previous disability had existed, has been paid by the employer or his insurance carrier. All expenses authorized in advance by the industrial commissioner, and all reasonable charges for medical treatment and care, nursing and hospitalization, medicines and drugs, necessitated by reason of the injury after the termination of the liability of the employer, shall be paid out of such special fund.

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North Carolina	<p><i>N.C. Gen. Stat. § 97-2: “injury and personal injury” shall mean only injury by accident arising out of and in the course of employment...With respect to back injuries, however, where injury to the back arises out of and in the course of the employment and is the direct result of a specific traumatic incident of the work assigned, “injury by accident” shall be construed to include any disabling physical injury to the back arising out of and causally related to such incident. N.C. Gen. Stat 97-52: Disablement or death of an employee resulting from an occupational disease described in G.S. 97-53 shall be treated as the happening of an injury by accident within the meaning of the North Carolina Workers' Compensation Act and the procedure and practice and compensation and other benefits provided by said act shall apply in all such cases except as hereinafter otherwise provided. The word "accident," as used in the Workers' Compensation Act, shall not be construed to mean a series of events in employment, of a similar or like nature, occurring regularly, continuously or at frequent intervals in the course of such employment, over extended periods of time, whether such events may or may not be attributable to fault of the employer and disease attributable to such causes shall be compensable only if culminating in an occupational disease mentioned in and compensable under this Article.</i></p>	<p><i>N.C. Gen. Stat. 97-35: If an employee has previously incurred permanent partial disability through the loss of a hand, arm, foot, leg, or eye, and by subsequent accident incurs total permanent disability through the loss of another member, the employer's liability is for the subsequent injury only.</i></p>	<p><i>N.C. Gen. Stat. 97-35: If an employee has previously incurred permanent partial disability through the loss of a hand, arm, foot, leg, or eye, and by subsequent accident incurs total permanent disability through the loss of another member, the employer's liability is for the subsequent injury only.</i></p>

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Ohio	<p><i>Ohio Rev Statutes Annotated, Section 4123.01(C):</i> “Injury” includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. “Injury” does not include injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of the body, A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury. Such a substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of such a substantial aggravation. However, subjective complaints without objective diagnostic findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation. “Occupational disease” means a disease contracted in the course of employment, which by its causes and the characteristics of its manifestation or the condition of the employment results in a hazard which distinguishes the employment in character from employment generally, and the employment creates a risk of contracting the disease in greater degree and in a different manner from the public in general.</p>	<p>No compensation shall be awarded on account of disability or death from disease suffered by an employee who, at the time of entering into the employment from which the disease is claimed to have resulted, willfully and falsely represented himself as not having previously suffered from such disease. Compensation shall not be awarded on account of both injury and disease, except when the disability is caused by a disease and an injury, in which event the administrator of workers’ compensation may apportion the payment of compensation provided for in sections 4123.56 to 4123.59 of the Revised Code between the funds as in his judgment seems just and proper. If an employee is suffering from both occupational disease and an injury, and the administrator can determine which is causing his disability, the administrator shall pay compensation therefore from the proper fund.</p>	<p>No compensation shall be awarded on account of disability or death from disease suffered by an employee who, at the time of entering into the employment from which the disease is claimed to have resulted, willfully and falsely represented himself as not having previously suffered from such disease. Compensation shall not be awarded on account of both injury and disease, except when the disability is caused by a disease and an injury, in which event the administrator of workers’ compensation may apportion the payment of compensation provided for in sections 4123.56 to 4123.59 of the Revised Code between the funds as in his judgment seems just and proper. If an employee is suffering from both occupational disease and an injury, and the administrator can determine which is causing his disability, the administrator shall pay compensation therefore from the proper fund.</p>

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Oklahoma	<p><i>85 Okl. St. Ann. 3(13a):</i> Compensable injury” means any injury or occupational illness, causing internal or external harm to the body, which arises out of and in the course of employment if such employment was the major cause of the specific injury or illness. An injury, other than cumulative trauma, is compensable only if it is caused by a specific incident and is identifiable by time, place and occurrence unless it is otherwise defined as compensable in this title. A compensable injury must be established by objective medical evidence, as defined in this section. <i>85 Okl. St. Ann. 3(13d):</i> “Compensable injury” shall not include the ordinary, gradual deterioration or progressive degeneration caused by the aging process, unless the employment is a major cause of the deterioration or degeneration and is supported by objective medical evidence, as defined in this section; nor shall it include injury incurred while engaging in, performing or as the result of engaging in or performing any recreational or social activities. "Compensable injury" shall not include the ordinary, gradual deterioration or progressive degeneration caused by the aging process, unless the employment is a major cause of the deterioration or degeneration and is supported by objective medical evidence, as defined in this section; nor shall it include injury incurred while engaging in, performing or as the result of engaging in or performing any recreational or social activities. "Cumulative trauma" means a compensable injury, the major cause of which results from employment activities which is repetitive in nature and engaged in over a period of time and which is supported by objective medical evidence as defined in this section.</p>	No statutory definition pertaining to subsequent non-work related conditions.	<p><i>85 Okl. St. Ann. 22(7):</i> The fact that an employee has suffered previous disability or impairment or received compensation therefore shall not preclude the employee from compensation for a later accidental personal injury or occupational disease; but in determining compensation for the later accidental personal injury or occupational disease the employee's average weekly wages shall be such sum as will reasonably represent the employee's earning capacity at the time of the later accidental personal injury or occupational disease. In the event there exists a previous impairment, including a previous non-work-related injury or condition which produced permanent disability and the same is aggravated or accelerated by an accidental personal injury or occupational disease, compensation for permanent disability shall be only for such amount as was caused by such accidental personal injury or occupational disease and no additional compensation shall be allowed for the pre-existing disability or impairment.</p>

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Oregon	<i>O.R.S. 51-656.005(7)(a)</i> : No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition. If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. <i>Wal-Mart Stores, Inc. v. Young, 182 P.3d 298</i> : Once the worker establishes an otherwise compensable injury, the employer shall bear the burden of proof to establish the otherwise compensable injury is not, or is no longer, the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. <i>ORS 656.802</i> : If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to <i>ORS 656.005 (7)</i> , the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.	<i>656.222</i> : Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities.	<i>656.222</i> : Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities.
Pennsylvania	<i>Section 301 C</i> : The terms "injury," "personal injury," and "injury arising in the course of his employment," as used in this act, shall include, unless the context clearly requires otherwise, occupational disease as defined in section 108 of this act: Provided, That whenever occupational disease is the basis for compensation, for disability or death under this act, it shall apply only to disability or death resulting from such disease and occurring within three hundred weeks after the last date of employment in an occupation or industry to which he was exposed to hazards of such disease: And provided further, That if the employee's compensable disability has occurred within such period, his subsequent death as a result of the disease shall likewise be compensable.	<i>Section 306.1</i> : If an employee, who has incurred (through injury or otherwise) permanent partial disability, through the loss, or loss of use of, one hand, one arm, one foot, one leg or one eye, incurs total disability through a subsequent injury, causing loss, or loss of use of, another hand, arm, foot, leg or eye, he shall be entitled to additional compensation via the Second Injury Fund.	<i>Section 306 D</i> : Where, at the time of the injury the employee receives other injuries, separate from these which result in permanent injuries enumerated in clause (c) of this section, the number of weeks for which compensation is specified for the permanent injuries shall begin at the end of the period of temporary total disability which results from the other separate injuries, but in that event the employee shall not receive compensation provided in clause (c) of this section for the specific healing period.

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Rhode Island	<i>R.I. 28-34-2: 28-34-2: Occupational diseases listed as covered.</i>	<i>R.I. 28-34-7: Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable, is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease, the compensation payable shall be the proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as that occupational disease, as a causative factor, bears to all the causes of that disability or death, the reduction in compensation to be effected by reducing the number of weekly payments or the amounts of the payments, as under the circumstances of the particular case may be for the best interests of the claimant or claimants.</i>	<i>R.I. 28-34-7: Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable, is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease, the compensation payable shall be the proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as that occupational disease, as a causative factor, bears to all the causes of that disability or death, the reduction in compensation to be effected by reducing the number of weekly payments or the amounts of the payments, as under the circumstances of the particular case may be for the best interests of the claimant or claimants.</i>

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
South Carolina	<i>S.C. 42-1-60</i> : "Injury" and "personal injury" mean only injury by accident arising out of and in the course of employment and shall not include a disease in any form, except when it results naturally and unavoidably from the accident and except such diseases as are compensable under the provisions of Chapter 11 of this title. In medically complex cases, an employee shall establish by medical evidence that the injury arose in the course of employment. For purposes of this subsection, "medically complex cases" means sophisticated cases requiring highly scientific procedures or techniques for diagnosis or treatment excluding MRIs, CAT scans, x-rays, or other similar diagnostic techniques. <i>S.C. 42-11-10</i> : Occupational disease" means a disease arising out of and in the course of employment that is due to hazards in excess of those ordinarily incident to employment and is peculiar to the occupation in which the employee is engaged. A disease is considered an occupational disease only if caused by a hazard recognized as peculiar to a particular trade, process, occupation, or employment as a direct result of continuous exposure to the normal working conditions of that particular trade, process, occupation, or employment. In a claim for an occupational disease, the employee shall establish that the occupational disease arose directly and naturally from exposure in this State to the hazards peculiar to the particular employment by a preponderance of the evidence.	<i>SC Code 42-11-90</i> : No compensation is payable or the degree of disability resulting from non-compensable causes.	<i>SC Code 42-11-90</i> : When an occupational disease prolongs, accelerates or aggravates or is prolonged, accelerated or aggravated by any other cause or infirmity not otherwise compensable, the compensation payable for disability or death shall be limited to the disability which would have resulted solely from the occupational disease if there were no other such cause or infirmity and shall be computed by the proportion which the disability from occupational disease bears to the entire disability. No compensation is payable or the degree of disability resulting from non-compensable causes.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
South Dakota	<i>S.D.C.L. 62-1-1(7):</i> “Injury” or “personal injury,” only injury arising out of and in the course of the employment, and does not include a disease in any form except as it results from the injury. An injury is compensable only if it is established by medical evidence. (a) No injury is compensable unless the employment or employment related activities are a major contributing cause of the condition complained of; or (b) If the injury combines with a preexisting disease or condition to cause or prolong disability, impairment, or need for treatment, the condition complained of is compensable if the employment or employment related injury is and remains a major contributing cause of the disability, impairment, or need for treatment. (c) If the injury combines with a preexisting work related compensable injury, disability, or impairment, the subsequent injury is compensable if the subsequent employment or subsequent employment related activities contributed independently to the disability, impairment, or need for treatment.	<i>S.D. 62-4-29:</i> Apportionment of compensation for subsequent injury. As to an employee who before the accident for which the employee claims compensation was disabled and drawing compensation under the terms of this title, the compensation for each subsequent injury shall be apportioned according to the proportion of incapacity and disability caused by the respective injuries which the employee may have suffered.	<i>S.D. 62-4-29:</i> Apportionment of compensation for subsequent injury. As to an employee who before the accident for which the employee claims compensation was disabled and drawing compensation under the terms of this title, the compensation for each subsequent injury shall be apportioned according to the proportion of incapacity and disability caused by the respective injuries which the employee may have suffered.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Tennessee	<i>TN 50-6-102.12:</i> “Injury” and “personal injury” mean an injury by accident arising out of and in the course of employment that causes either disablement or death of the employee and shall include occupational diseases arising out of and in the course of employment that cause either disablement or death of the employee and shall include a mental injury arising out of and in the course of employment.	<i>TN 50-6-208 a.1-2:</i> If an employee has previously sustained a permanent physical disability from any cause or origin and becomes permanently and totally disabled through a subsequent injury, the employee shall be entitled to compensation from the employee's employer or the employer's insurance company only for the disability that would have resulted from the subsequent injury, and the previous injury shall not be considered in estimating the compensation to which the employee may be entitled under this chapter from the employer or the employer's insurance company; provided, that in addition to the compensation for a subsequent injury, and after completion of the payments for the subsequent injury, then the employee shall be paid the remainder of the compensation that would be due for the permanent total disability out of a special fund to be known as the second injury fund. To receive benefits from the second injury fund, the injured employee must be the employee of an employer who has properly insured the employer's workers' compensation liability or has qualified to operate this chapter as a self-insurer, and the employer must establish that the employer had actual knowledge of the permanent and preexisting disability at the time that the employee was hired or at the time that the employee was retained in employment after the employer acquired knowledge, but in all cases prior to the subsequent injury.	<i>TN 50-6-208 a.1-2:</i> If an employee has previously sustained a permanent physical disability from any cause or origin and becomes permanently and totally disabled through a subsequent injury, the employee shall be entitled to compensation from the employee's employer or the employer's insurance company only for the disability that would have resulted from the subsequent injury, and the previous injury shall not be considered in estimating the compensation to which the employee may be entitled under this chapter from the employer or the employer's insurance company; provided, that in addition to the compensation for a subsequent injury, and after completion of the payments for the subsequent injury, then the employee shall be paid the remainder of the compensation that would be due for the permanent total disability out of a special fund to be known as the second injury fund. To receive benefits from the second injury fund, the injured employee must be the employee of an employer who has properly insured the employer's workers' compensation liability or has qualified to operate this chapter as a self-insurer, and the employer must establish that the employer had actual knowledge of the permanent and preexisting disability at the time that the employee was hired or at the time that the employee was retained in employment after the employer acquired knowledge, but in all cases prior to the subsequent injury.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Texas	<i>State Office of Risk Mgmt vs. Escalante, 162 S.W.3d. 619:</i> Even if Claimant had a pre-existing condition affecting his lower back, the aggravation of a pre-existing condition is a compensable injury. No statutory definition pertaining to pre-existing conditions.	<i>TX Sec. 408.162:</i> If a subsequent compensable injury, with the effects of a previous injury, results in a condition for which the injured employee is entitled to lifetime income benefits, the insurance carrier is liable for the payment of benefits for the subsequent injury only to the extent that the subsequent injury would have entitled the employee to benefits had the previous injury not existed. The subsequent injury fund shall compensate the employee for the remainder of the lifetime income benefits to which the employee is entitled.	<i>TX Sec. 408.084:</i> At the request of the insurance carrier, the commissioner may order that impairment income benefits and supplemental income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries. The commissioner shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section; if the combination of the compensable injuries results in an injury compensable under Section 408.161, the benefits for that injury shall be paid as provided by Section 408.162.
Utah	<i>U.C.A. 34A-3-103:</i> For purposes of this chapter, a compensable occupational disease means any disease or illness that arises out of and in the course of employment and is medically caused or aggravated by that employment.	<i>U.C.A. 34A-3-110:</i> The compensation payable under this chapter shall be reduced and limited to the proportion of the compensation that would be payable if the occupational disease were the sole cause of disability or death, as the occupational disease as a causative factor bears to all the causes of the disability or death when the occupational disease, or any part of the disease: is causally related to employment with a non-Utah employer not subject to commission jurisdiction; is of a character to which the employee may have had substantial exposure outside of employment or to which the general public is commonly exposed or is aggravated by any other disease or infirmity not itself compensable; or when disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease.	<i>U.C.A. 34A-3-110:</i> The compensation payable under this chapter shall be reduced and limited to the proportion of the compensation that would be payable if the occupational disease were the sole cause of disability or death, as the occupational disease as a causative factor bears to all the causes of the disability or death when the occupational disease, or any part of the disease: is causally related to employment with a non-Utah employer not subject to commission jurisdiction; is of a character to which the employee may have had substantial exposure outside of employment or to which the general public is commonly exposed or, is aggravated by any other disease or infirmity not itself compensable; or when disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Vermont	VT ST T. 21 601: "Injury" and "personal injury" includes occupational diseases, death resulting from injury within two years and includes injury to and cost of acquiring and replacement of prosthetic devices, hearing aids and eye glasses. "Occupational disease" means a disease that results from causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and to which an employee is not ordinarily subjected or exposed outside or away from the employment and arises out of and in the course of the employment. <i>Marsigli Estate v. Granite City Auto Sales, Inc.</i> , 124 Vt. 95, 103, 197 A.2d 799, 805; <i>Laird v. State Highway Department</i> , <i>supra</i> , 112 Vt. at 86, 20A.2d at 565; <i>Morrill v. Charles Bianchi & Sons, Inc.</i> , 107 Vt. 80, 87-88, 176 A. 416, 419-20: The aggravation or acceleration of a pre-existing condition can constitute a personal injury by accident under the Act.	No statutory definition pertaining to subsequent non-work related conditions.	VT ST T. 21 633: The commissioner shall, from time to time, apportion such compensation between any and all dependents named in section 632 of this title in such manner as he deems best and in making such apportionment he shall, insofar as it is possible, apportion such sum so that each dependent shall be self-supporting.
Virginia	Va. Code Ann. 65.2-101: "Injury" means only injury by accident arising out of and in the course of the employment or occupational disease as defined in Chapter 4 (§ 65.2-400 et seq.) of this title and does not include a disease in any form, except when it results naturally and unavoidably from either of the foregoing causes. Va. Code Ann. 65.2-400. "Occupational disease" defined as used in this title, unless the context clearly indicates otherwise, the term "occupational disease" means a disease arising out of and in the course of employment, but not an ordinary disease of life to which the general public is exposed outside of the employment. B. A disease shall be deemed to arise out of the employment only if there is apparent to the rational mind, upon consideration of all the circumstances: 1. A direct causal connection between the conditions under which work is performed and the occupational disease; 2. It can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; 3. It can be fairly traced to the employment as the proximate cause; 4. It is neither a disease to which an employee may have had substantial exposure outside of the employment, nor any condition of the neck, back or	Va. Code Ann. 65.2-505: Except for hearing or vision loss that has not reached a compensable level of disability, if an employee has a permanent disability or has sustained a permanent injury in service to his employer and receives a subsequent permanent injury by accident, such as specified in 65.2-503, he shall be entitled to compensation only for the degree of incapacity which would have resulted from the later accident if the earlier disability or injury had not existed.	Va. Code Ann. 65.2-505: Except for hearing or vision loss that has not reached a compensable level of disability, if an employee has a permanent disability or has sustained a permanent injury in service in the armed forces of the United States or in another employment other than that in which he receives a subsequent permanent injury by accident, such as specified in 65.2-503, he shall be entitled to compensation only for the degree of incapacity which would have resulted from the later accident if the earlier disability or injury had not existed.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Virginia (Cont'd)	spinal column; 5. It is incidental to the character of the business and not independent of the relation of employer and employee; and 6. It had its origin in a risk connected with the employment and flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction.		
Washington	<i>RCW 51.32.100</i> : If it is determined that an injured worker had, at the time of his or her injury, a preexisting disease and that such disease delays or prevents complete recovery from such injury, it shall be ascertained, as nearly as possible, the period over which the injury would have caused disability were it not for the diseased condition and the extent of permanent partial disability which the injury would have caused were it not for the disease, and compensation shall be awarded only therefore. <i>RCW 51.32.180</i> : Every worker who suffers disability from an occupational disease in the course of employment under the mandatory or elective adoption provisions of this title, or his or her family and dependents in case of death of the worker from such disease or infection, shall receive the same compensation benefits and medical, surgical and hospital care and treatment as would be paid and provided for a worker injured or killed in employment under this title, except as follows: (a) This section and RCW 51.16.040 shall not apply where the last exposure to the hazards of the disease or infection occurred prior to January 1, 1937; and (b) for claims filed on or after July 1, 1988, the rate of compensation for occupational diseases shall be established as of the date the disease requires medical treatment or becomes totally or partially disabling, whichever occurs first, and without regard to the date of the contraction of the disease or the date of filing the claim.	No statutory definition pertaining to subsequent non-work related conditions.	<i>RCW 51.32.160 (1)(a)</i> : If aggravation, diminution, or termination of disability takes place, the director may, upon the application of the beneficiary, made within seven years from the date the first closing order becomes final, or at any time upon his or her own motion, readjust the rate of compensation in accordance with the rules in this section provided for the same, or in a proper case terminate the payment: PROVIDED, That the director may, upon application of the worker made at any time, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. The department shall promptly mail a copy of the application to the employer at the employer's last known address as shown by the records of the department.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Washington DC	<i>Title 32 Chap 5 Sec. 32-1501: "Injury" means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury, and includes an injury caused by the willful act of third persons directed against an employee because of his employment.</i>	<i>Title 32 Chap 5 Sec. 32-1501 (6)(A): If an employee receives an injury, which combined with a previous occupational or non-occupational disability or physical impairment causes substantially greater disability or death, the liability of the employer shall be as if the subsequent injury alone caused the subsequent amount of disability and shall be the payment of: (i) All medical expenses; (ii) All monetary benefits for temporary total or partial injuries; and (iii) Monetary benefits for permanent total or partial injuries up to 104 weeks.</i>	<i>Title 32 Chap 5 Sec. 32-1501 (6)(A): If an employee receives an injury, which combined with a previous occupational or non-occupational disability or physical impairment causes substantially greater disability or death, the liability of the employer shall be as if the subsequent injury alone caused the subsequent amount of disability and shall be the payment of: (i) All medical expenses; (ii) All monetary benefits for temporary total or partial injuries; and (iii) Monetary benefits for permanent total or partial injuries up to 104 weeks.</i>
West Virginia	<i>W.V. Reg Chapter 3 Article 4 Sec. 23-4-(f) For the purposes of this chapter, occupational disease means a disease incurred in the course of and resulting from employment. No ordinary disease of life to which the general public is exposed outside of the employment is compensable except when it follows as an incident of occupational disease as defined in this chapter. W.V. Reg Chapter 3 Article 4 Sec. 23-4-(1f): For the purposes of this chapter, no alleged injury or disease shall be recognized as a compensable injury or disease which was solely caused by nonphysical means and which did not result in any physical injury or disease to the person claiming benefits. It is the purpose of this section to clarify that so-called mental-mental claims are not compensable under this chapter.</i>	<i>W.V. Reg Chapter 3 Article 4 Sec.23-4-9b:Where an employee has a definitely ascertainable impairment resulting from an occupational or a non-occupational injury, disease or any other cause, whether or not disabling, and the employee thereafter receives an injury in the course of and resulting from his or her employment, unless the subsequent injury results in total permanent disability within the meaning of section one, article three of this chapter, the prior injury, and the effect of the prior injury, and an aggravation, shall not be taken into consideration in fixing the amount of compensation allowed by reason of the subsequent injury. Compensation shall be awarded only in the amount that would have been allowable had the employee not had the preexisting impairment. Nothing in this section requires that the degree of the preexisting impairment be definitely ascertained or rated prior to the injury received in the course of and resulting from the employee's employment or that benefits must have</i>	<i>W.V. Reg Chapter 3 Article 4 Sec.23-4-9b:Where an employee has a definitely ascertainable impairment resulting from an occupational or a non-occupational injury, disease or any other cause, whether or not disabling, and the employee thereafter receives an injury in the course of and resulting from his or her employment, unless the subsequent injury results in total permanent disability within the meaning of section one, article three of this chapter, the prior injury, and the effect of the prior injury, and an aggravation, shall not be taken into consideration in fixing the amount of compensation allowed by reason of the subsequent injury. Compensation shall be awarded only in the amount that would have been allowable had the employee not had the preexisting impairment. Nothing in this section requires that the degree of the preexisting impairment be definitely ascertained or rated prior to the injury received in the course of and resulting from the employee's employment or that benefits must have</i>

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
West Virginia (Cont'd)		<p>been granted or paid for the preexisting impairment. The degree of the preexisting impairment may be established at any time by competent medical or other evidence.</p> <p>Notwithstanding the foregoing provisions of this section, if the definitely ascertainable preexisting impairment resulted from an injury or disease previously held compensable and the impairment had not been rated, benefits for the impairment shall be payable to the claimant by or charged to the employer in whose employ the injury or disease occurred. The employee shall also receive the difference, if any, in the benefit rate applicable in the more recent claim and the prior claim.</p>	the prior claim.

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Wisconsin	"Injury" means any harmful change in the human organism other than normal aging and includes damage to or loss of any artificial replacement and death, arising out of and in the course of employment while at work in or about the premises occupied, used or controlled by the employer and incurred while at work in places where the employer's business requires an employee's presence and which subjects the employee to extra-hazardous duties incident to the business. "Injury" does not include any illness or communicable disease unless the risk of contracting the illness or disease is increased by the nature of the employment; any injury or condition preexisting at the time of employment with the employer against whom a claim is made; any injury resulting primarily from the natural aging process or from the normal activities of day-to-day living, as established by medical evidence supported by objective findings.	<i>WI Reg Chap 102 Sec 102.59:</i> (1) If an employee has at the time of injury permanent disability which if it had resulted from such injury would have entitled him or her to indemnity for 200 weeks and, as a result of such injury, incurs further permanent disability which entitles him or her to indemnity for 200 weeks, the employee shall be paid from the funds provided in this section additional compensation equivalent to the amount which would be payable for said previous disability if it had resulted from such injury or the amount which is payable for said further disability, whichever is the lesser. If said disabilities result in permanent total disability the additional compensation shall be in such amount as will complete the payments which would have been due had said permanent total disability resulted from such injury. This additional compensation accrues from, and may not be paid to any person before, the end of the period for which compensation for permanent disability resulting from such injury is payable by the employer, and shall be subject to s. 102.32 (6), (6m), and (7).	<i>WI Reg Chap 102 Sec 102.59:</i> (1) If an employee has at the time of injury permanent disability which if it had resulted from such injury would have entitled him or her to indemnity for 200 weeks and, as a result of such injury, incurs further permanent disability which entitles him or her to indemnity for 200 weeks, the employee shall be paid from the funds provided in this section additional compensation equivalent to the amount which would be payable for said previous disability if it had resulted from such injury or the amount which is payable for said further disability, whichever is the lesser. If said disabilities result in permanent total disability the additional compensation shall be in such amount as will complete the payments which would have been due had said permanent total disability resulted from such injury. This additional compensation accrues from, and may not be paid to any person before, the end of the period for which compensation for permanent disability resulting from such injury is payable by the employer, and shall be subject to s. 102.32 (6), (6m), and (7).

State	Pre-existing, chronic or degenerative condition worsened by work related injury or occupational disease	Work injury accelerated by subsequent non-work condition	Apportionment
Wyoming	W.W.C.A. Chap 14 Article 1, 27-14-102: "Injury" means any harmful change in the human organism other than normal aging and includes damage to or loss of any artificial replacement and death, arising out of and in the course of employment while at work in or about the premises occupied, used or controlled by the employer and incurred while at work in places where the employer's business requires an employee's presence and which subjects the employee to extra-hazardous duties incident to the business. "Injury" does not include: (F) Any injury or condition preexisting at the time of employment with the employer against whom a claim is made; (G) Any injury resulting primarily from the natural aging process or from the normal activities of day-to-day living, as established by medical evidence supported by objective findings.	No statutory definition pertaining to subsequent non-work related conditions.	W.W.C.A. Chap 14 Article 27-14-105(a) If an employee covered by this act receives an injury under circumstances creating a legal liability in some person other than the employer to pay damages, the employee if engaged in work for his employer at the time of the injury is not deprived of any compensation to which he is entitled under this act.

Exhibit 5.3: Proposed Benefit Changes

North Dakota Workforce Safety and Insurance
Proposed Benefit Change - Elimination of Aggravation Statute

A. Aggravation Claims - as of April 30, 2018

Fiscal Year	(1) Aggravation Count	(2) Medical Paid Since Aggravation	(3) Indemnity Paid Since Aggravation	(4) Total Paid Since Aggravation	(5) Medical Case Reserve	(6) Indemnity Case Reserve	(7) Supplemental Case Reserve	(8) Total Case Reserve
2004-05	41	578,371	253,406	831,778	273,610	1,300,173	704,023	2,277,806
2005-06	58	773,442	442,644	1,216,086	353,246	76,243	0	429,489
2006-07	33	327,603	118,346	445,949	165,664	8,513	0	174,177
2007-08	38	752,057	154,201	906,258	499,382	382,664	0	882,046
2008-09	38	295,540	77,458	372,997	145,781	67,983	0	213,764
	208			3,773,072				3,977,462

B. Estimated Ultimate Losses - ALAE since Aggravation

Fiscal Year	(9) Medical Case Reserve	(10) Medical Case Reserve LDF to Ultimate	(11) Est. Ultimate Medical (2) + (9) x (10)	(12) Indemnity Case Reserve	(13) Indemnity Case Reserve LDF to Ultimate	(14) Est. Ultimate Indemnity (3) + (12) x (13)	(15) Aggravation Ult. Losses (11) + (14) + (7)
2004-05	273,610	4.40%	1,782,811	1,300,173	2.27%	3,205,375	5,662,709
2005-06	353,246	6.00%	3,511,313	76,243	3.37%	700,163	3,311,396
2006-07	165,664	5.43%	1,228,663	8,513	2.87%	142,316	1,371,478
2007-08	499,382	5.38%	3,440,893	382,664	4.52%	1,884,312	5,325,805
2008-09	145,781	5.13%	1,344,332	67,983	5.31%	438,519	1,482,851

C. Additional Losses due to elimination of Aggravation Statute (as a % of Total Losses) - Undiscounted

Fiscal Year	(16) Additional Aggravation Losses	(17) Undiscounted Ultimate Losses	(18) Ultimate Medical Assessments	(19) Ratio: (16) / [(17) - (18)]
2004-05	5,662,709	100,789,000	3,180,076	
2005-06	3,311,396	116,475,000	1,829,533	
2006-07	1,371,478	120,368,000	1,666,650	
2007-08	5,325,805	140,328,000	1,508,959	
2008-09	1,482,851	168,964,000	1,708,755	
	17,114,239	646,914,000	9,903,972	2.7%

Notes:

Col (1) through (8) - supplied by WSI.

Cols (10) and (13) - See Page 2.

Col (17) - PAC's June 30, 2009 Reserve Analysis, Exhibit II, Page 3, Column A.

All benefit types, prices of Medical Assessments.

Col (18) - BWR&B Rate Level Analysis, Exhibit 14, Page 1.

Cols (16) and (19) - Assumes that all aggravation claims are currently paid at 50% of otherwise applicable benefits.



Exhibit 6.1: Express Scripts Narcotic Utilization by State of Jurisdiction: Year 2005

STATE OF JURIS	% NARCOTICS PLAN COST	% NARCOTIC RXS
AK	34.71%	47.09%
AL	30.21%	31.67%
AR	27.19%	30.39%
AZ	40.89%	36.06%
CA	41.09%	34.61%
CO	32.10%	40.86%
CT	33.41%	29.15%
DC	36.23%	27.26%
DE	44.77%	39.04%
FL	29.48%	34.25%
GA	29.19%	32.96%
HI	39.94%	34.32%
IA	20.78%	33.00%
ID	39.24%	34.57%
IL	31.62%	39.96%
IN	51.50%	40.00%
KS	42.23%	44.40%
KY	25.56%	29.52%
LA	31.75%	33.83%
MA	49.75%	42.61%
MD	47.83%	38.58%
ME	50.99%	39.67%
MI	36.06%	38.34%
MN	34.13%	34.69%
MO	27.14%	36.83%
MS	29.09%	38.03%

STATE OF JURIS	% NARCOTICS PLAN COST	% NARCOTIC RXS
MT	34.39%	31.42%
NC	29.57%	33.85%
ND	41.19%	39.99%
NE	32.57%	34.94%
NH	43.07%	40.39%
NJ	53.10%	35.12%
NM	35.41%	36.23%
NV	37.45%	38.40%
NY	40.14%	35.05%
OH	44.96%	37.30%
OK	36.50%	36.29%
OR	39.60%	37.09%
PA	43.26%	37.06%
RI	32.97%	41.61%
SC	35.73%	34.14%
SD	29.65%	34.37%
TN	33.63%	33.04%
TX	33.30%	33.84%
UT	50.33%	36.91%
VA	30.10%	26.54%
VT	39.17%	39.16%
WA	34.59%	45.31%
WI	30.44%	35.26%
WV	19.55%	21.91%
WY	16.00%	15.38%
National	38.44%	35.04%

Exhibit 6.2: Express Scripts Narcotic Utilization by State of Jurisdiction: Year 2006

STATE OF JURIS	% NARCOTIC S PLAN COST	% NARCOTIC RXS
AK	32.61%	39.04%
AL	27.44%	30.25%
AR	33.34%	32.00%
AZ	39.21%	32.64%
CA	42.23%	34.58%
CO	29.73%	40.38%
CT	49.76%	41.06%
DC	39.04%	31.41%
DE	46.34%	39.12%
FL	28.20%	32.71%
GA	31.94%	33.66%
HI	46.24%	34.78%
IA	18.90%	32.08%
ID	38.59%	37.97%
IL	35.12%	40.11%
IN	46.98%	42.29%
KS	40.79%	44.53%
KY	24.96%	28.84%
LA	29.60%	30.05%
MA	49.73%	42.62%
MD	50.01%	39.14%
ME	50.53%	36.13%
MI	32.20%	39.76%
MN	34.49%	35.72%
MO	28.35%	35.35%
MS	23.17%	34.94%

STATE OF JURIS	% NARCOTIC S PLAN COST	% NARCOTIC RXS
MT	40.55%	33.29%
NC	27.62%	31.59%
ND	40.53%	39.18%
NE	33.27%	35.26%
NH	46.25%	42.22%
NJ	56.53%	35.40%
NM	35.74%	36.29%
NV	29.46%	33.86%
NY	39.91%	35.09%
OH	44.83%	35.28%
OK	34.41%	39.64%
OR	39.64%	38.80%
PA	44.50%	36.93%
RI	26.86%	39.30%
SC	34.62%	32.54%
SD	31.90%	34.59%
TN	33.97%	31.74%
TX	33.15%	33.42%
UT	51.64%	35.86%
VA	29.83%	28.82%
VT	39.47%	42.17%
WA	35.87%	45.38%
WI	30.56%	35.48%
WV	18.34%	19.56%
WY	20.10%	18.75%
National	39.23%	35.01%

Exhibit 6.3: Express Scripts Narcotic Utilization by State of Jurisdiction: Year 2007

STATE OF JURIS	% NARCOTIC PLAN COST	% NARCOTIC RXS
AK	33.44%	36.27%
AL	28.53%	31.67%
AR	34.97%	32.73%
AZ	44.73%	35.12%
CA	42.91%	34.80%
CO	31.46%	40.86%
CT	46.45%	40.94%
DC	43.73%	35.04%
DE	53.95%	41.99%
FL	28.73%	32.05%
GA	32.00%	34.67%
HI	43.23%	31.80%
IA	23.89%	30.21%
ID	32.70%	33.02%
IL	41.49%	41.77%
IN	39.15%	40.56%
KS	41.20%	41.61%
KY	26.16%	30.15%
LA	33.56%	33.38%
MA	44.51%	40.03%
MD	50.40%	38.94%
ME	41.86%	37.23%
MI	34.32%	35.46%
MN	35.75%	36.94%
MO	31.68%	37.40%
MS	26.62%	36.87%

STATE OF JURIS	% NARCOTIC PLAN COST	% NARCOTIC RXS
MT	38.82%	35.45%
NC	30.06%	34.79%
ND	41.59%	40.61%
NE	25.94%	35.66%
NH	45.49%	43.79%
NJ	52.65%	36.46%
NM	38.73%	36.78%
NV	28.78%	33.58%
NY	42.13%	35.52%
OH	42.12%	37.92%
OK	35.76%	39.43%
OR	40.12%	40.01%
PA	45.60%	38.14%
RI	33.39%	40.40%
SC	41.45%	33.06%
SD	31.25%	35.15%
TN	34.71%	33.64%
TX	34.62%	34.28%
UT	42.39%	38.16%
VA	30.68%	29.89%
VT	40.24%	42.58%
WA	39.44%	47.00%
WI	37.51%	41.15%
WV	16.85%	19.48%
WY	73.78%	71.95%
National	40.04%	35.48%

Exhibit 6.4: Express Scripts Narcotic Utilization by State of Jurisdiction: Year 2008

STATE OF JURIS	% NARCOTIC PLAN COST	% NARCOTIC RXS
AK	33.47%	36.66%
AL	30.05%	32.41%
AR	27.26%	33.02%
AZ	43.88%	35.83%
CA	40.34%	33.10%
CO	32.06%	40.97%
CT	44.05%	39.86%
DC	39.40%	34.77%
DE	54.05%	43.57%
FL	28.35%	31.95%
GA	31.31%	35.53%
HI	41.27%	33.00%
IA	22.80%	31.58%
ID	29.21%	33.57%
IL	39.62%	42.79%
IN	38.30%	44.66%
KS	39.94%	43.16%
KY	27.00%	31.78%
LA	32.05%	35.71%
MA	40.59%	36.90%
MD	50.72%	39.33%
ME	38.36%	38.47%
MI	30.93%	34.41%
MN	38.22%	37.44%
MO	34.30%	39.23%
MS	27.43%	39.32%

STATE OF JURIS	% NARCOTIC PLAN COST	% NARCOTIC RXS
MT	38.81%	35.92%
NC	30.96%	36.34%
ND	40.90%	41.71%
NE	25.26%	35.49%
NH	49.27%	45.47%
NJ	47.84%	37.33%
NM	36.67%	36.59%
NV	29.64%	34.89%
NY	41.61%	35.59%
OH	38.52%	39.83%
OK	32.63%	40.42%
OR	40.80%	42.77%
PA	44.84%	38.81%
RI	34.21%	39.22%
SC	37.70%	34.87%
SD	32.72%	33.60%
TN	35.45%	36.55%
TX	33.82%	34.72%
UT	41.20%	37.57%
VA	29.13%	30.14%
VT	38.85%	41.47%
WA	37.74%	47.21%
WI	39.50%	44.48%
WV	21.16%	26.35%
WY	27.66%	30.51%
National	38.04%	34.79%

Exhibit 6.5: Express Scripts Narcotic Utilization by State of Jurisdiction: Year 2009

STATE OF JURIS	% NARCOTIC PLAN COST	% NARCOTIC RXS
AK	32.84%	38.97%
AL	30.00%	32.23%
AR	27.38%	34.44%
AZ	46.16%	37.12%
CA	41.61%	32.48%
CO	32.34%	39.76%
CT	42.31%	39.45%
DC	38.80%	37.26%
DE	52.34%	43.67%
FL	29.89%	32.52%
GA	31.47%	36.21%
HI	43.68%	34.81%
IA	23.96%	32.37%
ID	33.95%	34.77%
IL	36.28%	42.51%
IN	38.45%	44.58%
KS	40.45%	43.17%
KY	26.76%	32.02%
LA	29.80%	36.71%
MA	41.51%	37.42%
MD	49.60%	39.93%
ME	41.87%	39.80%
MI	33.14%	34.97%
MN	38.56%	36.96%
MO	32.81%	39.90%
MS	27.59%	38.96%

STATE OF JURIS	% NARCOTIC PLAN COST	% NARCOTIC RXS
MT	41.13%	35.75%
NC	29.78%	36.31%
ND	40.15%	41.13%
NE	33.72%	38.34%
NH	42.62%	43.49%
NJ	47.07%	38.13%
NM	35.44%	36.12%
NV	27.95%	33.42%
NY	41.28%	35.79%
OH	39.69%	40.99%
OK	35.98%	42.28%
OR	39.46%	42.42%
PA	44.31%	38.78%
RI	29.90%	41.24%
SC	32.91%	36.41%
SD	37.41%	33.50%
TN	34.23%	36.81%
TX	33.46%	35.38%
UT	40.91%	36.21%
VA	29.10%	30.51%
VT	36.34%	39.94%
WA	41.00%	47.58%
WI	37.96%	41.08%
WV	21.89%	25.51%
WY	76.36%	64.10%
National	38.53%	34.80%

Exhibit 6.6: Questionnaire to Providers Regarding Narcotics

May 3, 2010

Dear Doctor,

§65-02-30 of the North Dakota Century Code requires a biennial 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 each year about eight or nine 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 the use of narcotics in the treatment of North Dakota employees, who are injured on the job. (We are describing narcotics as opioid agonists, partial agonists or opioid compounds.) This Element requires Sedgwick CMS to evaluate prescribing patterns and trends in North Dakota over the past five years and compare North Dakota's experience with other states around the country.

Sedgwick CMS seeks to learn what factors may enter into prescribing patterns of North Dakota physicians. To do that, we have prepared a short questionnaire seeking your opinions. Answers provided to this 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 providers will be identified by name in the report nor will their identities be revealed in any work papers Sedgwick CMS must provide to the State Auditor's office.

As such, we encourage your participation to assist in the evaluation into the use of narcotics to treat North Dakota employees who sustain injuries at work.

We are providing this questionnaire to you through the North Dakota Medical Association and would ask that you return your replies via e-mail to the address indicated below by June 1, 2010. Should you have any questions, about completion of this questionnaire, please contact Malcolm Dodge, Assistant Vice President – Risk Services Practice; Sedgwick CMS; 701 S. Parker St., Ste. 5000; Orange, CA 92868 or at 714-258-5089. He can also be reached via his e-mail address of malcolm.dodge@sedgwickcms.com, which is where you should return your completed questionnaire. We hope that your responses will help us in our assessment. Thank you for the courtesy of your reply.

Exhibit 6.6: Questionnaire to Providers Regarding Narcotics (Continued)

Your Name (optional) _____ Specialty:

Primary Practice Location (city): _____ Years in Profession: _____

Question 1: Have you observed any changes in your own treatment practices over the last five years insofar as the prescribing of narcotic medicines? Please explain if your answer is yes.

Question 2: To that end, would you say there is anything in medical literature that you have seen over the past five to ten years, notably relating to the management of pain, that has influenced how often you prescribe a narcotic medicine? If so, has this literature resulted in you prescribing narcotics more or less often?

Question 3: Under what general conditions are you apt to prescribe a narcotic for a work-related accident?

Question 4: Are there conditions for which you are apt to prescribe a narcotic following an initial office visit with a patient? If so, could you provide some examples?

Exhibit 6.6: Questionnaire to Providers Regarding Narcotics (Continued)

Question 5: When you prescribe narcotics, would you say that it is your expectation that your patients will not need a narcotic for more than one to two weeks? If so, are you generally able to stick to that plan?

Question 6: For those circumstances where you prescribe beyond your initial plan, what are the reasons for the change in plan?

Question 7: In your own estimation, given all the prescriptions you may write for injured employees, what percentage of those prescriptions would you say are for narcotics?

Question 8: Have you prescribed narcotics because other treatment modalities have not worked? If so, could you provide an example?

Question 9: Have you prescribed narcotics because other treatment modalities have been disallowed by WSI? If so, could you provide an example?

Exhibit 6.6: Questionnaire to Providers Regarding Narcotics (Continued)

Question 10: If you have a situation where you have a concern regarding suspected abuse of a prescribed narcotic, how have you managed that?

Question 11: If applicable in your practice, as part of your treatment of injured workers who may be receiving narcotic medications on a long-term basis, do you conduct blood and urine tests to validate that these medicines are being taken as prescribed? If so, how often are those tests conducted?

Question 12: Would you like to add any closing comment relative to the management of injuries and illnesses in North Dakota insofar as narcotic medicines are concerned?

Exhibit 7.1: Proposed Benefit Changes

North Dakota Workforce Safety and Insurance
Proposed Benefit Change - Permanent Partial Impairment (PPI)
Estimated Effect of Moving from the 5th Edition AMA Guides to the 6th Edition

A. PPI sample rated under both the 6th and 8th Editions - excludes "Pain" component

WPI % Range			Sample Count	Average 5th WPI%	Average 6th WPI%	Average WPI% Chng	Average 5th Award	Average 6th Award	Average Change (\$)	% Change (\$)
10%	to	15%	14	12.6	8.2	-4.4	0	0	0	0.0%
16%	to	20%	11	18.9	10.1	-8.8	3,633	0	-3,633	-100.0%
21%	to	25%	10	22.6	16.7	-5.9	5,550	2,664	-2,886	-52.0%
26%	to	30%	5	29.6	24.2	-5.4	10,656	6,438	-4,218	-39.6%
31%	to	35%	7	32.6	18.7	-13.9	16,809	4,123	-12,686	-75.5%
36%	to	40%	2	36.0	35.5	-0.5	24,420	23,310	-1,110	-4.5%
41%	to	50%	1	49.0	23.0	-26.0	53,280	5,550	-47,730	-89.6%
51%	to	60%	1	56.0	29.0	-27.0	84,360	9,990	-74,370	-88.2%
61%	to	100%	1	96.0	91.0	-5.0	306,360	275,280	-31,080	-10.1%
			14			< 16%				
			28			>= 16%	19,980	11,188	-8,792	-44.0%
			52							

B. Estimated Effect using sample results and 2004 - 2007 distribution of PPI cases by WPI%

WPI % Range			2004 - 2007 actual PPI Claim Count	5th edition Average award at 2009 rates	% change moving from 5th to 6th	6th edition Average award at 2009 rates
Scheduled Injuries			101	7,084	0.0%	7,084
16%	to	20%	110	3,340	-100.0%	0
21%	to	25%	69	5,775	-52.0%	2,772
26%	to	30%	46	9,242	-39.6%	5,584
31%	to	35%	19	16,942	-75.5%	4,156
36%	to	40%	14	28,701	-4.5%	27,397
41%	to	50%	21	45,457	-89.6%	4,735
51%	to	60%	17	75,088	-88.2%	8,892
61%	to	100%	18	245,865	-10.1%	220,922
			415	22,378	-87.0%	14,104

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