To: Jerry Keck, Administrator September 8, 2009

From: Ann Clayton, Consultant
Diana Ferriter, Claims Assistance Bureau Chief

Re: Use of Medical Panels in Resolving Workers' Compensation Medical Disputes
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There is a history of the use of medical panels to assist in resolving workers' compensation medical disputes in a number of jurisdictions; however, according to the most recent addition of *Workers' Compensation Medical Cost Containment: A National Inventory*, published by the WCRI, only two states used them as of January 1, 2008. Those are the states of South Carolina and Texas.

According to the survey that was done for the *National Inventory*, most of the states use the same dispute resolution system for medical disputes as they do for all other workers' compensation disputes. In the states of Arkansas, Colorado, Georgia, Idaho, Iowa, Kansas, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, South Carolina, Texas, Virginia, and Wyoming, they sometimes use an informal administrative mechanism for medical issues (and sometimes other disputes also). Most of these involve mediation or an administrative review of submitted information by specially trained staffs who are not physicians. Only the states of Colorado, Georgia, and Virginia even use "peer review" processes as an initial level of review and even then, if not voluntarily or administratively resolved after peer review, the case goes into their regular dispute resolution process.

South Carolina has a "statutory medical review board" according to the above reference. Ann called and spoke with Al McCutcheon, director of their insurance and medical services section. Al said that **although they may call their process a medical review board, it is actually done by administrative agency personnel specially trained for this purpose who are not physicians.** The provider or payer can file a request for an informal decision and have the agency's medical review section actually make a decision on the facts submitted by both parties. He says this works pretty well in that they had 600 requests last year and none appear to have been appealed to the commissioners for review and a formal hearing. Attached is some additional explanation from him.

Texas appears to be the only state that uses an Independent Review Organization (IRO) for medical disputes. To learn more about that, Ann reviewed their rules (133.305 through 133.309, copy attached). Please note that in their rules, Texas reserves quite a bit of authority for agency personnel to make certain decisions without a dispute going to an IRO and also allows the parties to request a hearing directly without going through the informal procedure (or the IRO) if the medical amounts in dispute are over $2000. They also allow these proceedings to be delayed when there is a dispute over the compensability of the injury that must be heard first. An Independent Review Organization must be "certified" by the Department of Insurance and must use specialists licensed to practice in Texas. An IRO request must be made by the "requestor" within 45

days of the denial of payment or authorization for services and the IRO must issue a decision within 8 days of receipt if the condition is "life threatening"; by the 20th day if it is for preauthorization and concurrent medical necessity disputes; and by the 30th day of the receipt of a retrospective medical dispute. There is a fee for the IRO (which must be covered in the fee schedule provisions as it is not covered in this portion of the statute). It appears the carrier always pays the fee in within network disputes; the carrier pays in a non-network preauthorization, concurrent or retrospective medical necessity disputes when they win; and the "requestor" pays in a non-network retrospective medical necessity dispute initially and then once a decision is made, the non-prevailing party becomes responsible for the fee. It appears the employee is never required to pay for the IRO. Any appeal from these decisions goes through the regular contested case procedure that all other disputes go through in Texas. However, for disputes involving minor amounts, they have a separate Alternate Medical Necessity Dispute Resolution (ADMR) process which is an exclusive process that is not appealable and involves the department appointing a case medical reviewer to make a final administrative decision.

We found no other states that use medical panels for medical disputes as of January of 2008. We do know that other states have (Minnesota and Montana for example) used them in the past. Here is some information about the Minnesota history of the use of medical panels:

In 1984, Minnesota implemented what was called "The Medical Services Review Board" under section 176.103, Subd. 3 of their workers' compensation statute (this was before Ann was asst. commissioner). Their purpose was both to resolve medical disputes upon appeal by an administrative decision by the agency and to assist in setting medical policy in the area of workers compensation. Their responsibilities for resolving disputes only lasted two years and were eliminated in the 1986 legislative session. Ann spoke with Brian Zaidman of the Minnesota Department of Labor and Industry's Research and Statistics section and he indicated the reason he understood for the elimination was they became totally overwhelmed with their duties to resolve disputes and decisions were not being made timely in spite of the fact that the 13 members were working almost full time on dispute resolution (an outcome they had not envisioned). A copy of the statute in effect at the time specifying the powers and composition of the MSRB is attached. It appears they could not handle the volume of disputes. Ann also knows by experience with these that the process was not liked by stakeholders as the disputes became "bifurcated" with medical disputes having to go to the MSRB and the other disputes going to a compensation judge. So many of the medical disputes are related to indemnity decisions, they evidently found that it was very inefficient not to have all the decisions decided at the same time in the same forum. If you would like additional information on the history of this in Minnesota, let us know and Ann will have a discussion with Dr. Bill Lohman, who is the Minnesota medical director and was there during this time, he could give us more history. However, suffice it to say that the medical panel approach tried in Minnesota appears not to have been successful and they abandoned it after only two years.

Lastly, we became aware just recently of a "super IME" process used in Tennessee for disputes over medical issues (mostly involving PPD ratings). Evidently, if the plaintiff and defense physicians cannot agree, the DOL offers a listing of three physicians who are on their registry of doctors qualified to do these ratings and each party strikes one, the remaining doctor's report is presumed to be correct (a rebuttable presumption). This may be another option for Montana to discuss in disputes over what treatment is reasonable and necessary and in compliance with the treatment guidelines when they are implemented, but we would encourage Montana to consider other options first as this would delay decisions since the employee would have to be examined by a "registry physician" if you followed this type of approach.

MONTANA'S CURRENT MEDICAL DISPUTE PROCESS:

A treating physician renders opinion on causation or further treatment needs. The Insurer/MCO asks contracted/employer doctor to review. If the dispute is not resolved, then insurer may arrange an IME or ask the Department to order an IME. If the dispute is not resolved, the issue goes to mediation and if not resolved, goes to Workers' Compensation Court and is appealable to MT Supreme Court.

MONTANA'S PREVIOUS MEDICAL PANELS:

Impairment Rating Dispute Resolution Process – 39-71-711, MCA:

As part of the 1987 major reforms in Montana's workers' compensation system, 39-71-711, MCA, was adopted to provide for independent medical evaluations and reviews of disputed impairment ratings. The insurer or claimant or both could obtain an impairment rating. If disputed, the Department directed the claimant to an evaluator for a rating. If still disputed, the Department directed the claimant to a second evaluator. If still disputed, the Department arranged for a third evaluator to review the first and second evaluators' ratings and state the final impairment rating. The 3rd rating was presumed correct. Disputes of the 3rd rating went to the Workers' Compensation Court and appealable to the Supreme Court.

On July 1, 1991, the procedure above was repealed because of the extended delay in resolving disputes over impairment ratings and the additional expense to the parties paying for the additional impairment evaluations.

Occupational Disease Medical Panel – 39-72-601 and 39-72-602, MCA:

The Department developed a list of medical examiners to be part of this panel and process from 1977 to 1997. If an insurer denied liability for an OD claim, the Department directed the claimant to an evaluator to render an opinion about the causation of the claimant's medical condition. If either party disputed this opinion, then the Department directed the claimant to a second evaluation. If either party disputed this opinion, then a third medical panel member reviewed both opinions and rendered a

recommendation whether or not the claimant met the proximate causation for an OD. The Department then issued an order determining whether or not the claimant was entitled to OD benefits. If a dispute arose over the order, then the dispute went to a Contested Case Hearing, then to the Workers' Compensation Court and then the Supreme Court.

In 1999, the process was changed to one Department directed evaluation and then the medical panel member's report was forwarded to the parties for their review. If a dispute arose, then the dispute went to mediation then the Work Comp Court and then the Supreme Court. The reason for the change was the extended delay in the decision of whether or not the claimant suffered from an OD, the increased costs of the evaluations, and the difficulty in finding doctors that would agree to be part of the medical panel. Disputes were sent first to mediation and then the Work Comp Court because of the long delays in getting a final Contested Case order.

In 2005, the OD Act was repealed and portions of it were melded into the Worker' Compensation Act. The Department medical panel and process was repealed because it was part of the legislative efforts to streamline the workers' compensation act and provide for consistent processes for dispute resolution.

Also, there is the current use of the Montana board of Medical Examiners for opinions on what are current approved medical procedures. Here is the process currently in use:

> An insurer, third party administrator, medical provider, attorney or claimant may request that a medical procedure be reviewed to determine if it is unscientific, unproven, outmoded or experimental. When the Department receives a request, a current literature review is conducted by a registered nurse on the procedure. The results of the literature review are then forwarded to the Montana Board of Medical Examiners for review. The Board provides their opinion and based upon their findings, the procedure is either approved for reimbursement, or is determined to be unscientific, unproven, outmoded or experimental and is only paid upon prior approval from the insurer. A list of Unproven Medical Procedures and Treatments is published on the Department's Medical Regulations webpage.

Ann's Recommendation

In my opinion the use of any kind of medical panel in Montana really depends on the problem you are trying to solve. Right now, your dispute resolution system seems to be handling the volume in a timely and fair manner given the information Diana has given me on the average time to mediation, the volume going to the WC Court for decisions and the fact that stakeholders are not filing complaints about the process. Once the U&T Guideline committee makes some decisions about the scope and intensity of the guidelines they will adopt, we may have a better idea of the volume of additional disputes and that would be a good time to discuss the need for any revised or specialized process to resolve disputes over consistency with or exceptions to the treatment guidelines.