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Methodology Disclosure

Researchers are expected to precisely outline the methodology involved in drawing conclusions from a body of evidence. When the study involves an analysis of the existing research, the methodology typically includes such items as the specific body of literature reviewed; how studies were extracted, reviewed and rated; and the inclusion/exclusion criteria utilized in determining the final literature relied upon. An explanation of how the conclusions were fairly and accurately drawn from the final sampling of research must also be presented. Done properly, this full disclosure should enable subsequent researchers to independently generate the same literature pool. Failure to comply with these basic dictates of research analysis raises doubts about the credibility of the derivative process and the resultant deductions. Respected medical/scientific journals reject studies that fail to disclose this information.[3]

The requirement to fully disclose the "pathway to conclusions" is even more critical in the formation and dissemination of health care guidelines. This heightened demand springs from the potential for physical, emotional and financial harm that may result from the application of "unsound" practices derived in an unscientific manner. Accordingly, one would expect the ACOEM Guidelines to include a full delineation of the methodology used to arrive at its conclusions. This omission occurs in both the first and second editions of the ACOEM Guidelines, and is also lacking on its Web site. Furthermore, it was not provided when the primary author of the current analysis requested it via e-mail and written correspondence.[4]

Since the preface to the second edition of the Guidelines references the Loss Work Data Institute (WLDI) of Encinitas, CA, this organization was contacted for clarification of the methodology issue. Written and verbal communication from WLDI's members disclosed that only extracted research on selected topics was provided by their organization to ACOEM. The precise methodology of this process in relationship to what was given to ACOEM was not revealed. Assurance was given, however, by an employee of the WLDI that the same standard protocol outlined on its Web site (www.worklossdata.com) was used for its part of the research process.[5] Another WLDI representative recommended that ACOEM be contacted for additional clarification. This was done, but once again, there was no reply.

Helm[6] noted that the ACOEM Guidelines demonstrated a significant lack of compliance with the standards for guidelines generation put forth by Shaneyfelt, et al.[7] in the *Journal of the American Medical Association*. In fact, the ACOEM Guidelines only met 12 of the 25 recognized key elements of guideline development.[6] By contrast, the Evidenced-based Guidelines for Interventional Techniques in the Management of Chronic Spinal Pain by the American Society of Interventional Pain Physicians[8] complied with 23 out of 25. This disparity means that the ACOEM's Guidelines had a nearly 50% poorer compliance rate than did a similar type of publication on medical protocols.[6]

♦ **Recommendation:** Future editions of the ACOEM Guidelines should fully disclose the research methodology. ACOEM should also provide an addendum to the second edition of its Guidelines detailing the construction methodology.

Footnotes to References

Another deficient research protocol is the failure of the ACOEM Guidelines to relate each recommendation made to specific studies supporting that position. This is most commonly accomplished with the use of footnotes and is standard practice in most scholarly literature. Failure to specify these associations in a clear manner complicates the process of substantiating the opinions expressed. According to WLDI, ACOEM was provided with the data in a footnoted format, but elected to follow the same nonstandard protocol as used in the first edition of the ACOEM Guidelines.[1] Simply listing references in a bibliographic fashion, alphabetically by primary author, is inefficient and may contribute to doubts about the validity of the conclusions.

♦ **Recommendation:** Future editions of the ACOEM Guidelines should adopt a footnote reference system with itemization of not only the strength of evidence, but also the specific studies alluded to from which the recommendations were made. When statements are made regarding evaluation and/or treatment without any reference to the strength of the evidence or to specific studies, these statements should be considered the opinions of the lead author of that particular chapter, and not grounds for any parameter of practice.

Internal Inconsistencies

No publication of the magnitude of the ACOEM Guidelines can be compiled without errors. Errors of internal consistency regarding specific recommendations, however, raise credibility questions. For example, page 181 of the Guidelines, the Summary of Evidence and Recommendations for the neck and upper back complaints, states that traction, TENS, and other modalities are "Not Recommended." Contrast that statement with the narrative in the same chapter on pages 173-4 that these physical modalities "may be used on a trial basis, but should be monitored closely." With two widely different perspectives, which recommendation would an insurance representative be more likely to adopt in a cost-containment environment?

The same pattern of inconsistency occurs again in chapter 12 on low-back complaints. Page 308 states "corset for treatment" is "Not Recommended," but the narrative on page 301 states that "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." One can reasonably infer from this statement that there is some temporary benefit during the acute phase of the injury from the use of these supports. Unfortunately, the Summary of Evidence and Recommendations does not reflect this direct inference.

This same chapter contains at least one other example of this inconsistency problem. Physical modalities including massage, diathermy, cutaneous laser treatment, ultrasound, TENS units, and PENS units are described on page 300 as possibly having "some value in the short term if used in conjunction with functional restoration." When one compares this statement with the Summary of Evidence and Recommendations on page 308, it is clear that this message failed to make its way into this table of information.

Such inconsistencies as those noted above are likely to mislead and/or confuse the insurance reviewer relying on the ACOEM Guidelines in the authorization process.

♦ **Recommendation:** The ACOEM Guidelines should be immediately reviewed for internal consistency. An addendum with any corrections should be made available to all concerned. Waiting years for a third edition of the Guidelines to rectify these errors is unacceptable, especially in an environment that already has many complaints about the misinterpretation of its recommendations.

Classification Problems

The ACOEM Guidelines utilize an apparently straightforward approach to classification of its recommendations, including: "Recommended," "Optional," and "Not Recommended." Health care workers electing to use a "Not Recommended" evaluation or treatment procedure in a setting where the ACOEM Guidelines are utilized place themselves in a position of increased likelihood of reimbursement denial. It could even be argued that a health care worker in this situation is more likely to be accused of being outside the standard of care, opening the door for malpractice allegations. Thus, the "Not Recommended" classification should only be used when the procedure is likely to be ineffective or harmful according to the evidence. To automatically classify a procedure as "Not Recommended" simply because there is *insufficient* evidence to support its efficacy/safety is misleading. If there is insufficient evidence, the consensus process should be used by polling only experts in that particular field to determine the appropriate classification. If there is no reasonable consensus, an additional classification should be created and labeled something to the effect of "Unable to Determine." There are considerable differences between "Not Recommended" and "Unable to Determine."

♦ **Recommendation:** Add a category to the classification system to account for the "Unable to Determine" procedures. The "Not Recommended" classification should only be used when the procedure is likely to be ineffective or harmful according to the available evidence.

Not Diagnosis Specific

Most of the recommendations for treatment in the ACOEM Guidelines focus on injuries to general regions of the body. This restriction is most likely the result of the lack of sufficient studies on specific diagnoses and that specific diagnoses are often difficult to

determine with any degree of accuracy. Unfortunately, the health care profession demands specific ICD-9 (International Classification of Diseases, Ninth Revision) codes for billing purposes. To apply the Guidelines, an insurance reviewer must force a specific ICD-9 code into a generalized category, yielding a very narrow set of protocols for a large variety of diagnoses. Unless the literature can be shown to support this approach, the use of the ACOEM Guidelines for insurance review should be severely restricted.

♦ **Recommendation:** The ACOEM Guidelines should clearly state that they are not diagnosis-specific with regard to treatment recommendations. Their usefulness in utilization review, therefore, may be severely limited.

Not Severity Specific

Some guidelines reference the severity of a given injury using terms like slight, moderate, and severe.[9,10,11] This breakdown is in keeping with standard clinical practice and is often used in conjunction with the descriptors accompanying ICD-9 diagnoses. Sub-classifying injuries in this manner requires a consensus process because research does not typically incorporate these variables into the investigation. This may explain why some research findings, as well as the guidelines based on that research, sometimes appear inconsistent with clinical experience.

♦ **Recommendation:** Provide an amendment to the second edition of the ACOEM Guidelines indicating that certain diagnostic and treatment recommendations may need to be modified depending on the severity of the injury. Future editions of the Guidelines should account for a grading of injury severity.

Inadequate Handling of Risk/Complicating Factors

A number of factors may be clinically associated with a delayed recovery. Examples include the physical demands of a job, prior episodes of the condition, abnormal structural anatomy, and certain pathologies. The authors of the Mercy Document recognized this need and provided multipliers to modify their recommended treatment and frequency duration.[10 (pg. 124)] Since atypical cases are more likely to be problematic in terms of cost, time loss, and frustration, guidelines should account for complicating factors in a clinically useful way. Simply stating that "delayed recovery" has been identified in cohort or cross-sectional studies (ACOEM Guidelines, page 84) is of little clinical value. This ambiguity may also inadequately represent to insurance reviewers the need for continuing care.

♦ **Recommendation:** Future editions of the Guidelines should account more completely for factors likely to require a greater duration of care, even if the evidence is simply consensus-based.

Inadequate Handling of Chronic Conditions

The ACOEM Guidelines admittedly focus on acute and subacute evaluation/care. There is one chapter that briefly discusses chronic pain, but it fails to utilize the same development protocols (as inadequate as they may be) found in the remainder of the ACOEM Guidelines. The chapter presents no algorithms or organized recommendation for evaluation and treatment. At best, it is a generic overview with opinions on work injuries that extend beyond the subacute phase of healing.

- **Recommendation:** Clearly specify in a published addendum to the ACOEM Guidelines that the guidelines are not intended for the evaluation and treatment in chronic cases. Future editions should either account for chronic conditions in a consistent, evidence-based manner, or clearly state that they are not intended for use after the subacute phase.

Inadequate Handling of Recurrent/Flare-up Conditions

Virtually all experienced manual practitioners have seen patients with musculoskeletal injuries that recur. Sometimes the duration between recurrences is months, sometimes it is a matter of days or weeks. If the recurrence happens 3 to 4 weeks subsequent to the onset of care and after apparent resolution, the ACOEM Guidelines are unclear on how to handle this situation. Should this event be treated as a new injury, even though it is the same problem revisited? Or if the problem flares up before acceptable resolution is achieved, do the same treatment recommendations apply as with a new onset date? The ACOEM Guidelines are inadequate in this regard and should not be applied to recurrences or flare-ups.

- **Recommendation:** Modify future editions of the ACOEM Guidelines to fully accommodate recurrent and flare-up conditions with specific recommendations and clearly specify in a published addendum that the current guidelines are not intended to be used for the evaluation and treatment of such conditions.

Ambiguity Issues

Certain treatment modalities are poorly described and may be misinterpreted. This misinterpretation is especially likely if the ACOEM Guidelines are read by a lay person without a thorough understanding of the subtleties of the health care profession. For example, the Summary of Evidence and Recommendations for the low-back complaints in the Guidelines lists traction as "Not Recommended." The literature on the subject, however, typically refers only to long-axis traction, not intersegmental traction, manual traction or flexion-distraction traction. Thus, confusion may arise for those using the ACOEM Guidelines when all forms of traction are classified as if they were the same modality.

- **Recommendation:** Have *relevant* national health care associations review the ACOEM Guidelines before finalization so that areas needing clarification can be brought to light and corrected.

Divergent Interpretation of the Medical Literature

Ideally, if any widely used guideline relies upon an interpretation of the current available literature, one would expect the conclusions to be reasonably similar on the same issues. So how to explain divergent opinions on a given topic based on essentially the same literature? For example, the Official Disability Guidelines—Treatment in Workers' Compensation,[9] based on data from WLDI, states that "massage has some proven efficacy in the treatment of acute low-back symptoms, based on quality studies, and there is substantial anecdotal evidence." Conversely, page 300 of the Guidelines lists massage as having "no proven benefit efficacy in treating acute low back symptoms."

- **Recommendation:** Protocol should be established detailing how the literature would be monitored and updated. The full text of the available literature should be carefully reviewed in a recognized and documented manner by multiple research experts in the field of study and precisely summarized for the decision-making personnel. Once recommendations are generated, expert researchers should analyze the accuracy of literature-based recommendations and report discrepancies.

Need for More Frequent Updates

New medical research of special relevance to practice guidelines is published on a relatively frequent basis; practice guidelines are not. Thus, it is inevitable that certain aspects of the recommended protocols will be rendered obsolete by more current evidence. When seven years elapse between the first and second editions of any guidelines (as with the ACOEM Guidelines), the likelihood of problems expands. A seven-year gap means that improper recommendations will most likely have been made for years, potentially adversely affecting thousands of patients and health care practitioners. The RAND Corporation, in its analysis of guidelines for medical treatment, defined "Current Guidelines" as having been "developed, updated, or reviewed during the last three years."[12]

- **Recommendation:** The medical literature should be regularly monitored for potentially protocol-influencing research. If found, this research should be closely reviewed and, if deemed likely to alter/modify recommendations, amended ACOEM updates should be made available on a timely basis.

Extent of the Disclaimer

The disclaimer on page *ii* of the ACOEM Guidelines reads as follows:

"The American College of Occupational and Environmental Medicine provides this segment of the guidelines for practitioners and notes that decisions to adopt particular courses of action must be made by trained practitioners on the basis of available resources and the particular circumstances presented by the individual patient. Accordingly, the American College of Occupational and Environmental Medicine and OEM Health Information, Inc., disclaim responsibility for any injury or damage resulting from actions taken by practitioners after considering these guidelines."

This disclaimer appears to be primarily directed at protecting the makers of the Guidelines from lawsuits that may result if the Guidelines are utilized and liability issues arise.

Other practice guidelines provide examples of what a full and proper disclaimer should contain. *The Guidelines for Chiropractic Quality Assurance and Practice Parameters*, although somewhat outdated by new research, contains a more complete and useful disclaimer.[10] This disclaimer contains the following statements, which are quite similar to those found in another comprehensive set of guidelines.[13]

"These guidelines, which may need to be modified, are intended to be flexible. They are not standards of care. Adherence to them is voluntary. The Commission understands that alternative practices are possible and may be preferable under certain clinical conditions. The ultimate judgment regarding the propriety of any specific procedure must be made by the practitioner in light of the individual circumstances presented by each patient."

"This document may provide some assistance to third-party payers in the evaluation of care, but is not by itself a proper basis for evaluation of care. Many factors must be considered in determining clinical or medical necessity."

The creators of the Mercy Document also insist that the following disclaimer be used when quoting an extracted portion of the practice parameters:

"The reader is warned that the following is an extract or part only of a major publication suggesting guidelines for the practice of chiropractic. Any part of the publication is likely to be confusing and/or misinterpreted unless read in the context of the full document, which includes detailed commentary, definitions, and explanation of rating systems used."

Without thorough disclaimers, the door to misuse of any guidelines is left wide open in the med-legal and insurance review arenas. Proper disclaimers should assure all parties that the recommendations contained therein are not a "cookbook" for evaluation/treatment and that a host of factors must be considered in deciding appropriate care. Even under ideal conditions, evidence-based guidelines deal with generalities made for the entire population and not a specific individual. The wide range of individual differences further justifies the need for thorough disclaimers.

Dr. Glass, the chairperson of the ACOEM Practice Guidelines Committee, has reportedly stated that the Guidelines were not intended for utilization review or for retrospective analysis of care.[14] Unfortunately, the disclaimer in the ACOEM Guidelines does not make this clear. This failure is baffling, especially when the organization has published two guidelines editions, both of which fail to specify these limitations.

- **Recommendation:** Future editions of the ACOEM Guidelines should contain a more thorough disclaimer as outlined above. Additionally, ACOEM should provide this modified disclaimer to current users of its guidelines.

Concerns Regarding Chiropractic and Manipulation

Chiropractic treatment warrants special attention because signs of bias against this profession and its prime modality, manipulation, seem to exist the ACOEM Guidelines. Historically, the chiropractic profession has been the focus of discrimination by the medical profession, most notably demonstrated by the American Medical Association. As indicated in the Wilk v. American Medical Association lawsuit,[15] a permanent injunction was needed because of a long-term conspiracy to eliminate the chiropractic profession through suppression of scientific information, the publication of false and misleading documents, the denial of chiropractic referrals to hospitals, and rules discouraging medical doctors from associating with chiropractors. This bias extends to the research arena, as well. In 2001, Terrett[16] pointed out numerous examples where "medical organizations, medical authors, respected peer-reviewed and indexed journals, and medical-legal journalists have on numerous occasions, misrepresented the facts regarding the identity of a practitioner of SMT associated with patient injury (i.e., classified a non-chiropractic injury, regardless of the presence or absence of professional training of the person involved, as being a result of chiropractic and/or a chiropractor." Such errors, especially on such a widespread basis, appear to fit the definition of professional bias and border on fraudulent misrepresentation.

Unfortunately, there appear to be signs of bias against chiropractic in the ACOEM Guidelines, as well. Several examples are listed below, with recommendations.

Consensus Procedure

Much of what constitutes evidenced-based protocols in health care are, by necessity, actually consensus-based protocols. This is the result of a generalized paucity of quality research. Useful research, with wide applicability, is often expensive, time consuming, and a challenge to execute properly.

Without sufficient useful research in a given area, those constructing guidelines typically turn to their "best and brightest" minds for feedback based upon their years of clinical experience. It should be obvious that those selected for the consensus group need to be

specialists in that specific area. Thus, one does not turn to doctors of chiropractic to render opinions concerning the most appropriate grounds for surgery—nor would one expect medical doctors not extremely well practiced in osseous manual therapy to be part of a consensus team providing opinions on the recommended duration for a course of spinal manipulative therapy. This, however, is exactly the approach that ACOEM allowed. A review of the roster of health care workers listed in the formation of the guidelines specifies only one doctor of chiropractic. This sole DC, though a respected member of the profession, no longer actively practices as a treating doctor. Furthermore, no national or state chiropractic association is listed as having been consulted for feedback. Representatives of the American Chiropractic Association, the nation's largest chiropractic group, were not invited to provide feedback on any portion of the ACOEM Guidelines.[17] Paradoxically, these guidelines list a variety of *other* types of health care associations that were contacted for input.

- **Recommendation:** The next edition of the ACOEM Guidelines should seek to raise its credibility by using *only specialists in each area of consideration* for any consensus-based protocols. Additionally, feedback should be solicited from the *representative* national associations before publication. If widely divergent opinions are obtained in this solicitation process, they should be noted in the ACOEM Guidelines.

Failure to Account for Special Needs for the Application of Spinal Manipulation

Admittedly, minimal literature supports the use of some physical modalities for use in certain musculoskeletal conditions. When the ACOEM Guidelines classified them as "Not Recommended," however, this is likely to inspire an insurance adjustor to deny their reimbursement under any circumstance. Clinically speaking, this could be unwise. Passive therapies are often useful prior to manipulative procedures to reduce associated muscle rigidity that may accompany spinal dysfunction. Denying all passive therapies, regardless of whether or not they are required as a *preparatory mechanism* for the application of spinal manipulation, fails to take into account the safety and comfort of the patient. If greater manipulative force is required because of regional rigidity due to spasm or inflammation, the patient may experience unnecessary discomfort and be at greater risk for an adverse event. The lack of such preparative therapy could also decrease the overall effectiveness of the spinal manipulation due to counteractive effects of regional spasm or trigger points. This clinical perspective is obvious to those health care professionals regularly using spinal manipulation, but is left unaccounted for when legitimate chiropractic feedback for the ACOEM Guidelines is not obtained prior to publication.

- **Recommendation:** Since doctors of chiropractic are the primary proponents and providers of osseous manipulation, ACOEM needs to incorporate more chiropractic feedback into its recommendation development process regarding this therapy.

Misinterpreting/Misrepresenting Literature Regarding Manipulation

The following is not intended to represent an all-inclusive list of identified misrepresentations of the literature regarding manipulation:

A. Page 181 of the ACOEM Guidelines states that manipulation is an "Optional" choice for treatment, rather than a "Recommended" one. This procedure is so classified despite the fact that the strength of the evidence presented in the ACOEM Guidelines for manipulation is at a "B" level. No other treatment listed in the "Recommended" section of the Summary of Evidence and Recommendations for neck and upper-back complaints has a higher level of evidence rating. In fact, most other "Recommended" treatments have a "D" level of classification. Since there is no medical literature proving that NSAIDs are more effective than spinal manipulation for the treatment of acute neck pain,[18] one would reasonably expect to compare the relative safety of each procedure as a means of assessing which one should be recommended. Research has shown that spinal manipulation is safer by as much as a factor of several hundred times compared to the use of NSAIDs.[18]

Even when listed under the "Optional" classification, manipulation is limited in duration with the phrase "for neck pain early in care only." What if the manipulative therapy continues to be effective in assisting the progression toward a cure, but there is incomplete resolution within this poorly defined "early phase"? Should the practitioner stop treating? Additionally, if the literature[19] shows that manipulation is effective beyond the acute phase of care, why would this limiting clause be warranted?

♦ **Recommendation:** Immediately reclassify manipulation into the "Recommended" category for neck and upper-back complaints. Remove the limiting clause as indicated above. This correction should be made available in an addendum to the ACOEM Guidelines and distributed.

B. Page 265 of the ACOEM Guidelines states that manipulation has not proven effective for patients with pain in the hand, wrist, or forearm. Actually, the study listed in this chapter's bibliography reveals that carpal tunnel syndrome showed "significant improvement in perceived comfort and function, nerve conduction and finger sensation overall" after 9 weeks of treatment with manipulation and passive care.[20] This result was statistically the same as the medication group. If the ACOEM Guidelines listed acetaminophen and NSAIDs as "Recommended," shouldn't manipulation be listed as "Optional" under the Summary of Evidence and Recommendation for forearm, wrist, and hand complaints? Isn't this reclassification especially necessary for those patients who cannot take or who refuse to take medication?

♦ **Recommendation:** Immediately reclassify manipulation from being unlisted to at least an "Optional" status. This correction should be made available in an addendum to the ACOEM Guidelines and distributed.

C. Page 308 of the ACOEM Guidelines states that manipulation is "Not Recommended" beyond 4 weeks. The strength of evidence for this opinion is "D," which is defined as the "Panel interpretation of information not meeting inclusion criteria for research-based evidence." This appears to mean that the recommendation is based on either poor research or the opinions of the panel. Again, the single DC on the panel can be easily outvoted.

Not only is this consensus-based recommendation suspect, it would appear to contradict the literature showing that manipulation is effective for low-back complaints in the acute through chronic phase of care. Paradoxically, the study that provides evidence for this position is listed on pages 318-9 in this chapter's bibliography of the ACOEM Guidelines.[21] This study included individuals with acute, subacute, and chronic low-back pain. Twenty-five randomly controlled studies were reviewed. The researchers concluded that manipulation appeared to be more effective than other interventions for treatment of low-back pain, both short- and long-term. So if manipulation has been shown to be effective over a period of greater than "4 weeks," why would the ACOEM Guidelines state "Not Recommended" longer than 4 weeks? Why was the evidence rating on this point listed as a "D" level when ACOEM's own bibliography contained this reference? One can only assume that the opinions of non-chiropractic physicians on the panel were allowed to override the research.

♦ **Recommendation:** Immediately remove the qualifier not recommending manipulation for low-back complaints beyond 4 weeks of care. This correction should be made available in an addendum to the ACOEM Guidelines and distributed.

Unreasonably Restrictive Recommendations

As stated above, in the Summary of Evidence and Recommendations for low-back complaints on page 308, manipulation is listed as "Not Recommended" beyond 4 weeks. Even if there was not a single study supporting the efficacy of chiropractic care past 4 weeks, this ACOEM Guidelines restriction could still be considered unreasonable. For example, if the patient is making a documented positive response over a course of 30 days of manipulative therapy, what happens on day 31 if the patient's condition is incompletely resolved? Does the treating doctor stop providing care? Should he/she refer out to another specialist? Even with referral as the appropriate course of action, what happens during the days or weeks that are typically required to obtain a referral? Obviously, good clinical judgment must prevail, not a "cookbook" approach to health care.

On the same page of the ACOEM Guidelines, manipulation for patients with "undiagnosed neurologic deficits" is "Not Recommended. A sizable percentage of patients with radiculopathy, however, have some form of "neurologic deficit." The ACOEM Guidelines statement appears to preclude this sub-population of patients from manipulative therapy without special testing to more precisely isolate the cause of the deficit. Strangely enough, special testing for non-red flag conditions is deemed as "not

helpful in the first 4-6 weeks" (algorithm page 311 of the Guidelines). Thus, manipulation is essentially precluded by the Guidelines for at least the first 30 days in this subgroup of patients with radiculopathy. More realistically, it is the progressive neurologic deficit with motor loss that warrants special attention, and not a slight decrease of a deep tendon reflex or a minor sensation loss.

♦ **Recommendation:** Enlist a more thorough chiropractic review of the ACOEM Guidelines prior to publication. Issue an amended addendum correcting such unreasonable restrictions as those outlined above.

Chiropractic Status in ACOEM

ACOEM's website (www.acoem.org) lists various classifications for admittance of different types of health care workers to its organization. Medical doctors and osteopaths are classified under the heading "Regular Active Membership." Non-physicians with a doctorate level are classified under the heading "Associate Membership." "Affiliate Membership" is reserved for non-physicians with a master's level degree, certified physician assistants, or licensed nurse practitioners. Though not specifically identified on the Web site, an e-mail communication did disclose that doctors of chiropractic are classified under the "Affiliate Membership" heading.[22] Such classification defies reason and all sense of fairness. DCs are doctors with a similar training level to MDs and osteopaths, but are not allowed in the same category. There is no doubt that the "D" in DC stands for "doctor," but DCs are not allowed at the doctorate level, either. With no offense intended toward those with a master's degree, doctors of chiropractic go through a longer education process and warrant a higher level of classification. Further inquiry on this classification issue from ACOEM yielded no response. This misclassification appears to reflect a strong bias against doctors of chiropractic by ACOEM.

♦ **Recommendation:** Immediately amend its admittance classification to allow doctors of chiropractic into the same membership category as that reserved for medical doctors and osteopaths, or the category for those with a doctorate-level degree. By allowing a higher level of admittance, as opposed to the current "Affiliate Membership" level, ACOEM will demonstrate a movement away from the current bias shown toward the chiropractic profession. In doing so, ACOEM will follow the lead of other multidisciplinary organizations, such as the American Academy of Pain Management.[23]

Conclusions

Based on the preceding analysis, there are numerous reasons why health care practitioners, insurance providers, the med-legal profession, and the public should not rely on the ACOEM Guidelines' treatment recommendations, especially with regard to chiropractic care. The mandated use of these guidelines in the California Workers' Compensation system is the result of political pressure, not solid, scientific investigation nor a consensus of those likely to be affected by its implementation. As outlined in this

analysis, these guidelines require significant modification to reach the goals outlined by the ACOEM itself.

The ACOEM Guidelines do not currently represent an unbiased and comprehensive means of evaluating care rendered to injured workers and should immediately be substantially modified or rejected.

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An Independent AGREE Evaluation of the *Occupational Medicine Practice Guidelines*

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Executive Summary

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Introduction: Health care professionals need to critically evaluate guidelines to understand whether they are well constructed. In this instance the authors selected and used the AGREE instrument to evaluate the *Occupational Medicine Practice Guidelines* 2nd Ed., published by the American College of Occupational and Environmental Medicine

Methods: Four appraisers with prior guideline evaluation experience volunteered to evaluate the ACOEM guidelines. The AGREE guideline evaluation instrument was selected as it has been assessed as reliable and valid for the purpose of guideline evaluation. The instrument is widely used across Europe and has recently been utilized in Canada. The AGREE instrument is arguably the world standard for guideline evaluation.

Chapters 8 – 16 of the ACOEM Guidelines were identified as appropriate for review and assessment. Each of the nine guideline chapters was assessed individually across six domains. Each item of each domain was rated on a 4-point Likert scale which measured the extent to which a criterion (item) had been fulfilled. Standardized guideline domain scores were calculated by summing all the scores of individual items in a domain and standardizing the total as a percentage of the maximum possible score for that domain. A global assessment was also rendered for each chapter by each reviewer. "Strongly recommend" guidelines generally score above 60% in the majority of domains and indicates high overall quality. Those "recommended with proviso" generally score between 30% and 60% on the majority of domains. Such a rating indicates that the guideline is of moderate overall quality. Guidelines in this category could still be considered for use in practice when no other guidelines on the same clinical topic are available so long as provisos or alterations are made. Those guidelines assessed as "not recommended for use in practice" generally score below 30% in the majority of domains and indicate that the guideline has a low overall quality and serious shortcomings.

Results:

DOMAIN 1 - SCOPE AND PURPOSE: All the reviewers strongly agreed that the overall objectives of the guidelines were specifically described. The reviewers agreed that the clinical questions covered by the guideline were specifically described. The reviewers agreed that the patients to whom the guidelines are meant to apply were specifically described. (See Table 1)

DOMAIN 2 - STAKEHOLDER INVOLVEMENT: While the majority of reviewers strongly agreed that the guideline development group included individuals from all relevant professional groups and that the target users of the guideline were clearly defined; they unanimously reported that there was no indication that either patients views or preferences had been sought or that the guidelines had been piloted.

DOMAIN 3 - RIGOUR OF DEVELOPMENT: The reviewers were unanimous in their strong assessment that the guidelines failed to document the systematic methods used to search for evidence. The reviewers agreed that the guidelines failed to clearly describe the criteria for selecting evidence, and to clearly document the method used for formulating the recommendations. The reviewers unanimously agreed that the health benefits, side effects, and risks had been considered in formulating the recommendations. The reviewers found no explicit link between the recommendations and the supporting evidence, no external review by experts prior to publication, and no procedure for updating the guidelines.

DOMAIN 4 - CLARITY AND PRESENTATION: The reviewers strongly agreed that the recommendations were specific and unambiguous and that the key recommendations were easily identifiable. The reviews agreed that different options for management of the condition were clearly presented and that the guideline is supported with tools for application.

DOMAIN 5 - APPLICATION: The reviews found no documentation that the potential organizational barriers in applying the recommendations had been discussed. The reviewers had mixed scores assessing the cost implications of applying the recommendations and whether or not the guideline presented key review criteria for monitoring and/or audit purposes.

DOMAIN 6 - EDITORIAL INDEPENDENCE: There was general agreement that the guideline was editorially independent from the funding body. There was unanimous agreement that the guidelines did not address possible conflicts of interest.

GLOBAL ASSESSMENT: The chapters of the ACOEM Guidelines are uniform and all reviewers provided the same global assessment of "recommended for use with some modification or proviso" across all chapters.

Reviewer provisos: The reader acknowledges that although the recommendations are consistent with generally accepted clinical practice, they may not be valid due to possible evidence selection deficiencies. The reader should consider the flaws and limitations of the document when using the guideline, and consider utilizing guidelines of higher quality when possible.

Discussion: The ACOEM Guideline scored the lowest in "rigors of development", which included reporting of search methods, selection criteria of evidence, and methods used for formulating recommendation. There was also poor reporting of the link between the recommendations and evidence, any external review and any process to update the guideline.

The guidelines did not score well in the area of "editorial independence" as potential conflicts of interest were not reported. In guideline application domain, auditing, cost implications and organizational barriers were the major problems in the areas. Problems in the domain of stakeholder involvement included poor process in seeking patient preferences and failure to pilot the guidelines.

The ACOEM Guidelines lack transparency that would allow readers to link citations and data to the specific opinions and recommendation contained in the document. The literature review is poorly described and the grading of evidence is poor. This makes it impossible for the reader to follow data from the recommendation to the source data or assess/consider the amount and quality of the research supporting the given recommendations. The patient identification specificity, with respect to patient age, clinical co-morbidities and chronicity and treatment recommendations for such variants are disappointing. Stahl et al used the AGREE instrument to review the first edition of the ACOEM Guidelines and documented similar problems.

The guidelines strong points were seen in the domains of scope and purpose and clarity and presentation. The patients, objectives, and clinical questions were specifically described. The recommendations were specific and unambiguous with key recommendations easily identifiable. The document clearly provided different management options and there were tools to support the application of the recommendations.

There are limits to this study and the instrument employed. The AGREE instrument evaluates the quality of a guideline's construction process and not the validity of a guideline's content.

Conclusions: The ACOEM Guidelines appear to have content consistent with their stated objectives, but the reporting of the guidelines construction process, particularly the rigor of recommendation development, is markedly flawed, and the recommendations may not be valid due to possible evidence selection deficiencies. The reader should consider these flaws and limitations when using the guideline. The reader should consider utilizing guidelines of higher quality when possible.

The AGREE instrument should be adopted by the United States as the preferred method of guideline process assessment.

Averaged AGREE Domain Scores by Chapter

Chapter	Domain 1 Scope & purpose	Domain 2 Stakeholder involvement	Domain 3 Rigor of development	Domain 4 Clarity & presentation	Domain 5 Application	Domain 6 Editorial independence
8 - Neck	80.56	45.83	26.19	89.58	30.56	29.17
9 - Shoulder	80.56	45.83	26.19	89.58	33.33	29.17
10 - Elbow	80.56	45.83	26.19	89.58	30.56	29.17
11 - Wrist	80.56	45.83	26.19	89.58	30.56	29.17
12 - Back	80.56	47.92	29.76	91.67	36.11	29.17
13 - Knee	80.56	45.83	26.19	89.58	30.56	29.17
14 - Ankle	80.56	45.83	26.19	89.58	30.56	29.17
15 - Stress	77.78	45.83	26.19	62.50	30.56	29.17
16 - Eye	75.00	45.83	26.19	89.58	30.56	29.17
Mean Domain Score	**79.63**	**46.06**	**26.59**	**86.81**	**31.48**	**29.17**

Table 1

AMERICAN COLLEGE OF
OCCUPATIONAL AND
ENVIRONMENTAL MEDICINE

Comments to the Alaska Senate Labor and Commerce Committee
Senate Bill 130
March, 2005

The American College of Occupational and Environmental Medicine (ACOEM) appreciates this opportunity to comment on Senate Bill 130 – specifically the role of evidence-based treatment guidelines in workers compensation.

ACOEM Practice Guidelines

The Second Version of ACOEM's the Occupational Medicine Practice Guidelines was published in 2003. The ACOEM guidelines were developed based on the best practices of evidence-based medicine to assist providers in treating injuries and illnesses due to occupational accidents or exposures.

The Practice Guidelines and evidence based medicine focus on the need for health care providers to rely on a critical appraisal of available scientific evidence rather than clinical opinion or anecdotal reports in reaching decisions regarding diagnosis, treatment, causation, and other aspects of health care decision making in workers compensation.

California's Experience

The ACOEM Practice Guidelines presently are being implemented in the State of California where, by statute, the guidelines are presumptively correct on the issue of extent and scope of medical treatment.

Legislation – The legislation incorporating the Practice Guidelines was enacted by the California Legislature in September of 2003, with the support of the California Medical Association.

Regulations – The California Division of Workers Compensation will shortly propose regulations adopting the ACOEM Practice Guidelines as the treatment utilization schedule for the state.

Cost Savings – In a study done for the California Commission on Health and Safety and Workers Compensation, the cost savings to the workers compensation system from adoption of the Practice Guidelines were estimated at $3.1 million. [1]

Use of Multiple Guidelines – A new study by the California Workers Compensation Institute looks at how guidelines are used in California's mandatory medical care utilization review process and examines the potential impact of incorporating multiple guidelines into the treatment utilization schedule by comparing ACOEM and AAOS recommendations for five types of medical services (X-rays, CT scans and MRIs, chiropractic manipulation, physical medicine, and

back surgery) used to treat low back soft tissue and low back nerve involvement injuries. The study also compares the evidence used to support each recommendation. The study documents wide disparities in recommended treatments between the two sets of guidelines, and a lack of high-grade evidence supporting many of the AAOS recommendations.

The study concludes that adoption of multiple, often-conflicting guidelines would likely compromise quality of care for injured workers as well as increase administrative disputes and litigation.[2]

The Future

We want to assure you that we are committed to working with the State of Alaska to improve and evolve the concepts embodied in the evidence-based approach to a medical treatment utilization schedule; as that schedule must be applicable and meaningful to many audiences – such as physicians in other specialties who also treat workers compensation patients, claims processors, claims reviewers, claims adjudicators, patient advocates and judges.

Accordingly, we recognize that the Guidelines are only the first step in this process and that ACOEM is committed to moving to the next level.

We have learned that there are enhancements that need to be made to reflect the administrative and regulatory requirements of the workers compensation system in which guidelines must apply. These enhancements go well beyond the intent and scope of the original work we have produced.

Our challenge will be to ensure the integrity of the process, to maintain the principles of evidence-based medicine, while incorporating the knowledge base being assembled; and to ensure that the results of the process

ACOEM Initiatives

We have several initiatives underway.

- **Utilization Management** – Although the Guidelines were not developed as a tool for utilization review, the information needed for utilization review can directly be extracted from the Guidelines in a manner that will facilitate UR to be consistent with the Guidelines.

  This new work, the Utilization Management Tool (UMT), has a unique coding system, and accompanying set of precise descriptors that together will provide a common meaning for physician and payer alike as to the precise protocol and/or patient circumstances under which a particular service was provided. With this communication available, administrative burdens on both providers and payers will be substantially reduced, and the uniformity in the application of payment policies can be significantly improved.

- **APG Insights** – The first issue of APG Insights has been published and is attached. It will assist users in understanding and adapting the Guidelines into their daily practice. Published four times each year, issues will contain questions from users of the Guidelines; supplemental material from the medical literature; topics that provide an in-depth, updated analysis of interventions discussed in the Guidelines; and explanations and interpretations to the guidelines. In APG Insights, new information will be brought forward that will be responsive to the more complex set of needs and requirements that have been legislated.

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[1] UNIVERSITY OF CALIFORNIA, BERKELEY SANTA BARBARA SANTA CRUZ FRANK NEUHAUSER, Project Director UC DATA/Survey Research Center, *http://www.dir.ca.gov/chswc/acoemguideline.doc*

[2] http://www.cwci.org/newsroom/News_Detail.cfm?ReleaseID=142

Fall 2004

Evidence-based Medicine: The Organizing Principle Behind the Development of ACOEM's Occupational Medicine Practice Guidelines

Late last year, the American College of Occupational and Environmental Medicine (ACOEM) released the second edition of its *Occupational Medicine Practice Guidelines*. These guidelines were developed using the principles of evidence-based medicine (EBM). The College chose EBM as the organizing methodology for its *Practice Guidelines* because this concept is widely accepted within the medical community as the approach to guideline development that is most likely to provide the best information to physicians and the best possible care to patients.

EBM began to develop as a methodology approximately 30 years ago, when studies started to demonstrate wide, unexplained variation in the use of resources for treatment of similar health problems. Increasing focus began to be placed on "the use of subjective or random treatments creating random outcomes" that "compromised quality of care and increased costs to the individual and overall health care system."[1]

Dr. D. L. Sackett, an early proponent of EBM, described the methodology as the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" the practice of which requires "integrating individual clinical expertise with the best available clinical evidence from systematic research."[2] Other definitions found in the literature are similar, describing EBM as "the concept of formalizing the scientific approach to the practice of medicine for identification of "evidence" to support our clinical decisions,"[3] or the "ability to track down, critically appraise, and incorporate evidence into clinical practice."[4]

Implicit in all of these definitions is the understanding that while evaluation of the scientific evidence is a necessary component of EBM, it must occur within the context of current clinical practice standards. Accordingly, the appendix to the ACOEM *Guidelines* explicitly states "it is possible to develop guidelines or conclusions regarding treatment and causation that are truly based on the scientific evidence" only "to the extent that the literature has adequate high-quality studies of a given topic."[5] In the absence of high-grade evidence, available scientific information must be analyzed in the context of current clinical practice in order to determine the "value" of accepting a given intervention or causal hypothesis.

Thus the assessment of "value" is inherent in any set of evidence-based guidelines, including those developed by ACOEM. Value may be determined by generally considering the current standards regarding treatments or tests, and more specifically based upon an analysis of the benefit or potential benefit of an intervention, weighed against the cost.

Costs may be measured in both monetary and non-monetary terms. Examples of non-monetary terms range from the direct risk of harm that might result from unnecessary surgery or other invasive procedures, to the chance of addiction or side-effects from unnecessary medication, to the risk of untoward dependency upon a passive palliative treatment or relationship with a provider that is not leading to any improvement in overall functional status.

Continued on next page

Evidence-based Medicine: The Organizing Principle Behind the Development of ACOEM's Occupational Medicine Practice Guidelines, continued from page 1 . . .

Assessing benefit is equally complex, as this requires knowledge of the usual natural history of the problem that is being addressed in the absence of intervention, as well as reasonable estimates that intervention will improve as opposed to worsen clinical outcomes. The difficulty and complexity of these types of assessments is precisely the reason that evidence-based guidelines are developed by national recognized medical specialty societies, with as much interprofessional and interdisciplinary input as is available and appropriate.

The practice of EBM entails:

- Deciding what treatment, test, or theory regarding prevention or causation needs to be evaluated.
- Gathering the evidence (from the medical literature) that addresses the topic.
- Assessing the quality (based upon standard criteria for ranking studies based upon their design and statistical rigor) of available scientific evidence.
- Comparing this evidence to other forms of "evidence" such as consensus-based norms and other commonly accepted or promoted "standards" (all of which are the foundations of the "clinical expertise" with which the scientific evidence must be integrated).
- Deciding, in cases when available high-quality scientific literature *supports* current clinical consensus, whether there is a need for any further scientific analysis of the topic.
- Determining, in the absence of support in the scientific literature for a given intervention or hypothesis, whether it should be:
  - Adopted (until proven as invalid) due a high likelihood of clinical benefit.
  - Adopted (until proven as invalid) due to possible clinical benefit in the context of a low risk of adverse effects and/or relatively low dollar cost.
  - Neither uniformly adopted nor rejected due to an inability to determine (especially for an individual patient) whether potential clinical benefit warrants potential monetary or non-monetary cost.
  - Rejected due to the likelihood that the clinical benefit of adopting the procedure, test, or hypothesis most likely does not justify the monetary cost.
  - Rejected due to the possibility that potential harm (a non-monetary cost) will outweigh the likelihood of benefit.
  - Rejected due to the likelihood that potential harm, or other significant potential costs, will exceed potential benefit.
- Soliciting input regarding the aforementioned conclusions from practitioners who are knowledgeable regarding the tests, treatments, or hypotheses under evaluation and considered representative of their specialty.

Continued on next page

Evidence-based Medicine: The Organizing Principle Behind Development of ACOEM's Occupational Medicine Practice Guidelines, continued from page 2 . . .

- Designing a methodology for periodically reviewing the literature to update the fund of available scientific evidence. This should include a mechanism for receiving, reviewing, and commenting upon literature submitted by parties who disagree with the initial evidence-based recommendations.
- Amending practice guidelines or other evidence-based statements to reflect any changes that occur due to the development of an improved foundation of quality scientific literature (as a result of soliciting input from knowledgeable practitioners and designing an appropriate methodology).

This is essentially the process that was followed in the production of both the first and second editions of the ACOEM *Occupational Medicine Practice Guidelines*. Continued relevance of the *Guidelines* to the practice of occupational medicine will depend upon ongoing review of the updated literature (both identified by ACOEM and submitted by other parties), development of new statements or recommendations that reflect the integration of information in this literature with clinical expertise, and – when necessary – the development of additional evidence-based guidelines to address topics that were either intentionally omitted initially or reflect a need to address new pathologic processes or technology.

APG Insights will periodically review the literature basis regarding specific diagnostic or therapeutic interventions in order to provide summaries that cover the application of the intervention to the field of occupational medicine as a whole (as a supplement instead of focusing on individual body parts as is done in the *Guidelines*). With this first issue of *APG Insights*, parties who wish to see specific interventions or pathologic processes addressed (or reviewed) are invited to provide input to ACOEM.

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[1] Harris JH, Swedlow A. Evidence-based medicine and the California Workers' Compensation System: a report to the industry. California Workers' Compensation Institute. January 2004. www.cwci.org/ebmstudy.pdf.

[2] Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ*. 1996;312(7023):71-2.

[3] Williams JK. Understanding evidence-based medicine: a primer. *Amer J Obstet Gynecol*. 2001;185(2):275-8.

[4] Rosenberg WM, Sackett DL. On the need for evidence-based medicine. *Therapie*. 1996;51(3):212-7.

[5] Genovese E. Evidence-based medicine: what does it mean? Why do we care. In: *Occupational Medicine Practice Guidelines*. 2nd ed. Beverly Farms, Mass: OEM Press;2003:Appendix.

Why Are Guidelines Necessary?

Why do well-trained health care professionals need guidelines for handling workers' compensation cases? Quite simply, practice guidelines, based on the best available medical evidence, are necessary to ensure that workers receive the best medical care as quickly as possible, in the most cost-effective manner possible. Quality practice guidelines can help physicians quickly determine what care is most likely to help their injured patients. When that happens, patients improve faster, employers save money, and the entire workers' compensation system benefits.

Given that the *Guidelines* address conditions that commonly occur as the result of workplace injuries, it would seem that treatment consensus would be equally common. Unfortunately, that is not the case. The more discussion there is over what constitutes optimal care, the more variation in care is likely to occur. Hence, there is a compelling argument for having guidelines that are fundamentally based on clinical evidence. Consider these contrasting examples. There is little debate as to how to treat a patient with appendicitis – most physicians would agree that the appendix should be removed. This is a condition for which there is widespread treatment agreement. Now, consider the worker whose non-radiating low-back pain does not respond to treatment (acetaminophen use, job modification, physical therapy, etc.). Some physicians might feel that the patient should be offered spinal fusion, while others might take the stance that fusion of any type was wrong. A third group might disagree with both approaches. The breadth of opinion – from "do major surgery" to "do no surgery" – may manifest in an enormous variation in terms of short-term risk, long-term outcome, and in costs.

Because worker health and safety are of paramount concern, it is important to identify treatments that are most likely to benefit injured workers. Guidelines fill the gap between the use of certain treatments which may be as yet unproven and the quiet certainty of conclusive scientific proof. Between those ends of the information spectrum, guidelines can provide recommendations that reflect the best practices that have been currently shown to benefit patients.

Guidelines: Recommendations or Requirements?

Everyone who uses the *Guidelines* – whether they be physicians, insurers, or administrators – must understand the following:

- The *Guidelines* are recommendations. They are not requirements nor are they mandates or standards; they provide advice.
- The *Guidelines* are intended to help those who make health care decisions regarding the care of injured workers understand what care will most likely benefit those workers.

Because they are intended to function as advice, there will be times when a health care provider's recommendation is appropriate for the care of the patient, but inconsistent with the *Guidelines*. When this happens, the health care provider should be given an opportunity to explain why there is a compelling medical reason to depart from the *Guidelines* in making a final determination regarding the case. To do otherwise would treat the *Guidelines* as mandates and that is contrary to their intent.

Guidelines: It's about Doing What's Best

Before payment requests for evaluation or treatment are denied, communication with the health care provider should take place and the focus of the communication should be on the medical issue involved. It can be deceptively easy to miscast the issues in such a discussion, with potentially unfortunate consequences. Consider the following examples of concern as expressed by an insurance company representative to a physician:

- Doctor, your request is inconsistent with our guidelines. I'm sorry, but as things stand, I am going to have to deny your request for payment.
- Doctor, the guidelines we follow do not advocate the type of care you are recommending for your patient. Is there a compelling medical justification for departing from those guidelines in this case?

The way the communication is phrased in the first example transforms a medical issue into a legal issue. When an issue underlying an insurer's decision is outside the scope of a physician's expertise, the resolution of the issue may well involve attorneys. In the first example, the physician has no special expertise to address the issue of the insurance company's proposed action. That is not a topic covered in any medical school class, but one to which many hours are devoted in law school curricula.

The communication with the physician in the second example is done in a manner that is most likely to keep the discussion medical in nature. The doctor has been offered the opportunity to provide medical input into the decision-making process. If the doctor offers a compelling and supportable rationale for departing from the guidelines' recommendations, no issue arises, assuming that the insurance company accepts the rationale. Besides keeping the discussion focused on what is likely to be best for the injured worker, the communication in the second example maximizes the opportunity for all the parties involved to understand the underlying medical issue.

Communications should be structured in such a manner as to maximize the focus upon the medical issues that require resolution. Such communications have the greatest chance to result in the care most likely to benefit injured workers, and thereby most quickly resolve the medical issues in workers' compensation cases. Rapid resolution of such issues meets the common needs of injured workers, employers, providers, and insurance companies.

Erratum for Chapter 4

One of our *Guidelines* readers identified a typographical error on page 56 of Chapter 4 – "Work Relatedness." The last sentence of the first paragraph under "Definitions of Causation and Related Terms" reads as follows:

> Such language is not reflective of the scientific basis upon which such opinions should rest, and does provide adequate support for conclusions that must be made regarding financial and legal responsibility.

The typographical error is the absence of the word "not." The corrected sentence should read:

> Such language is not reflective of the scientific basis upon which such opinions should rest, and does **NOT** provide adequate support for conclusions that must be made regarding financial and legal responsibility."

What Happens After 90 Days? Acute v. Chronic Treatment

The ACOEM *Guidelines* mostly focus on the first 90 days following a workplace injury because approximately 90 percent of such injuries are resolved in this time period. In fact, in the absence of complicating factors, most common occupational health problems resolve in less than 30 days. In addition, scientific studies tend to address the presence or absence of tissue pathology during the first 90 days. Finally, injured workers are most likely to return to health and function if they receive proper care as soon after the injury as possible. The further from the date of injury, the more likely it is that other factors will complicate treatment.

But, are the *Guidelines* applicable if more than 90 days have elapsed from the date of injury? The answer, for multiple important reasons, is unequivocally "yes."

The first seven chapters of the *Guidelines* touch upon many fundamentals of occupational medicine – the assessment, treatment, and return to work of injured workers. These basic components remain constant, regardless of whether they are applied immediately after an injury or late in the life of a claim. The considerations that underlie the choice of medications will often be the same no matter when in the life of the claim the medications are prescribed.

In addition, Chapter 6 deals extensively with chronic pain. Almost by definition, the issue of chronic pain arises in cases that are more than 90 days from the date of injury. Similarly, the issues of stress that are addressed in Chapter 15 often arise in cases that do not involve physical injury, and often relate to long-standing conditions. Criteria for imaging and other procedures are generally not dependent on time from injury, but on the presence of specific conditions under which the tests or procedures would be appropriate. For example, an MRI is generally appropriate in order to clarify the anatomy prior to surgery, but is not appropriate as screening test, regardless of the time elapsed from injury. As another example, in the absence of contraindications, laminectomies should be performed to relieve compression of a nerve root and, after appropriate conservative treatment, again performed regardless of the time frame.

It is critically important to understand that the treatment of workers with occupational injuries necessarily involves health care providers in ways that are different than in other areas of medicine. Treating injured workers requires often intense and prolonged involvement with return-to-work issues. Those issues often require that health care providers deal with insurers in ways that are fundamentally different than the types of interactions with payers that occur in group medical situations.

Occupational health providers must interface with claim managers, attorneys, vocational counselors, and others on a routine basis. The ACOEM *Guidelines* provide foundational information about the care of patients with occupational injuries, whether the care is provided during the first 90 days or at some later point.

That the *Guidelines* mostly focus on the first critical 90 days following injury should in no way be interpreted to mean that issues outside of that range are not addressed. The *Guidelines* apply at any point following an injury that the principles it espouses, or the information it includes, are applicable to the care of an injured worker.

Disability Duration Tables: Development and Use

Several *Guidelines* users have inquired about how the disability duration tables found in Chapters 8 through 14 were developed and how they should be used. The disability duration tables contain data from two very different sources. One set of data in each of tables was developed by expert consensus. The remaining set of data was derived from the National Health Interview Survey (NHIS).

The data reflects the expert consensus thinking of those who participated in the development of the *Guidelines*. The development of the NHIS data was more mathematical. This survey, conducted every three years under the auspices of the Centers for Disease Control and Prevention (CDC), randomly interviews residents of the various states regarding numerous aspects of their health history. The survey results in a large amount of data that reflects the recollections and understandings of those interviewed.

It is not possible to determine from the NHIS data as it is currently being collected, whether a reported musculoskeletal condition is work related. The understanding is that an unknown, but presumably small percentage – probably in the area of 15 percent – of the conditions in the NHIS data had work-related etiologies. For the conditions in each chapter of the *Guidelines*, NHIS data was obtained and processed by the company contracted to provide medical literature research assistance for the *Guidelines'* development. The NHIS-based data now in the disability duration tables reflects: 1) the median number of days that NHIS interviewees who reported having the listed condition within the last year said they missed work for that condition during that year; and 2) the percentage of NHIS interviewees who reported missing work because of such conditions.

The purpose in presenting consensus and NHIS data within the *Guidelines* is to provide physicians who treat injured workers for those conditions covered by the *Guidelines* with counsel as to the normal duration of disability associated with such conditions. An injured worker whose disability extends beyond an expected time frame may have a condition different from the one diagnosed, a condition in addition to the one diagnosed, or other factors that may be contributing to delayed recovery. It is important for treating physicians to have a "ballpark" estimation of the time that a condition might be expected to keep workers away from employment, in order to make informed decisions about the progress of their patients.

As with all data, there are strengths and weaknesses to each type. Consensus data reflects the thinking of the experts available on any given topic, yet may lack a reproducible evidentiary basis. NHIS data is based on information collected through a nationally standardized survey processes, but the quality depends to some degree upon the understandings and recollections of those being interviewed. Nevertheless, both types of data can be helpful, if they are used strictly for the purposes for which they are intended.

The disability duration data as presented are of most value when they are used to assist in making determinations as to whether a given patient is making expected progress toward recovery. It is not recommended that these data be used for other purposes. It is understood that there are other data sources that provide useful information. Readers are encouraged to provide input regarding the type of data that is required or helpful when the *Guidelines* are used in particular administration and review settings.

TENS – Medical Literature Analysis and Recommendations

Recently, a user asked whether the *Guidelines* were inconsistent and too restrictive in their recommendations regarding the use of transcutaneous electrical nerve stimulation (TENS) for the treatment of musculoskeletal pain. In response to that question, and in recognition that high-grade studies may have been published since the development of the second edition of the *Guidelines*, the editors went back to look for new and review existing medical literature regarding TENS as a treatment for musculoskeletal pain, once again giving the greatest weight to high-grade medical studies and to meta-analyses of such studies.

TENS is a treatment technique for managing acute and chronic pain by providing an electronic stimulus transmitted through electrodes on the skin to relieve pain by modulating stimulus transmission. Short duration, low-voltage electrical pulses are used to stimulate the large, myelinated peripheral nerve fibers. There are several types of TENS applications, each differing in intensity and electrical characteristics. Advocates for the procedure note that the use of TENS avoids the need for narcotics, the side effects of which can include respiratory depression, sedation, nausea, and vomiting. Complications are minimal. One study reported that electrical artifacts from a TENS machine triggered shocks from an implanted cardiac defibrillator.[1] Another reported that contact dermatitis may result from TENS. This may be resolved by changing the electrode type or location.[2] The *Guideline's* present recommendations regarding TENS are in accord with the Philadelphia Panel guidelines and reflect the current understanding of the effectiveness of TENS. In 2002, the Philadelphia Panel representing the American Physical Therapy Association convened to create evidence-based guidelines for conservative, rehabilitation interventions for low back, knee, neck, and shoulder problems.

Continued on next page

TENS – Medical Literature Analysis and Recommendations, continued from page 6 . . .

The Philadelphia Panel concluded that data demonstrated no clinically important benefit (<15% from control) of TENS with regard to lower back pain (LBP), and thus, there is poor evidence to include or exclude TENS alone as an intervention for chronic LBP (>12 weeks) or for acute LBP. The Panel concluded that there is presently a lack of evidence regarding whether TENS should be included or excluded in the treatment of neck pain. The Panel also found that there was insufficient clinical information to allow a recommendation for the use of TENS in the treatment of shoulder pain.[5]

The ACOEM *Guidelines* variously state that: 1) TENS is not recommended as an initial treatment; 2) the absence of high-grade evidence prevents recommending TENS for neck and upper back pain; and 3) TENS may be helpful for shoulder pain and chronic knee pain, but not for acute hand, wrist, forearm, knee, ankle, or foot pain. After reviewing the evidence, several studies were found to have been conducted to examine the efficacy of TENS for the treatment of non-cancer, musculoskeletal pain. High-grade medical literature studies, or meta-analyses of such studies, support the following statements:

Chronic low back pain – Active TENS showed a trend toward greater pain reduction compared to placebo, but the difference was not statistically significant. Statistically significant improvement in function was not shown in two studies that measured functional improvement at one month of treatment.[4,5] Researchers concluded from the above that there is poor evidence to include or to exclude TENS alone as an intervention for chronic LBP because no consistent benefit was shown on clinically relevant outcomes.

Subacute low back pain – One study showed that rehabilitation combined with TENS compared to rehabilitation alone enhanced return to work at 5 weeks.[6,7]

Acute low back pain – There is poor evidence to include or exclude TENS alone as an intervention for acute low back pain.

Neck pain – There is poor evidence to include or exclude TENS alone as an intervention for neck pain.

Shoulder pain – There is poor evidence to include or exclude TENS alone as an intervention for shoulder pain.

Knee pain – High-grade evidence supports the use of TENS in the treatment of osteoarthritis of the knee.

Post-operative pain – Eleven trials reported a mean-weighted difference in the reduction of analgesic consumption that was 35.5 percent better in TENS groups than in the placebo group. The 10 trials that used non-optimal TENS treatment showed an insignificant 4.1 percent mean weighted difference in analgesic consumption between active TENS and placebo TENS.[8]

The evaluation and treatment of injured workers should be guided by high-grade scientific evidence when possible. The discussions concerning the appropriateness of any form of treatment should focus on what is likely to be safe and effective in returning injured workers to improved health and better function. In this regard:

- TENS is safe when used as intended.
- There is abundant medical literature of reasonable quality that addresses TENS-related issues, but which has been excluded from meta-analyses because of inclusion or exclusion criteria.
- In some studies, technical issues such as amplitude of the stimulus or the frequency of the electronic pulse may have caused negative outcomes, when other settings may have produced positive outcomes.
- There is considerable controversy in the medical literature surrounding issues of the effectiveness of TENS.

Because TENS does not expose injured workers to risks of harm and since high-grade scientific evidence is not consistently available to provide guidance, a reasonable (e.g., 10- 30 days) trial of TENS may be appropriate to determine whether, in a particular patient, TENS is capable of producing objectively measurable improvement in health or function. (By way of examples, such improvements should include reduction in the consumption of analgesic medications; improved standing, sitting, lifting or carrying tolerances; and other similarly quantifiable measurements of health and function.) Decisions regarding continuation of treatment beyond the 30-day trial period should include considerations of the nature and extent of the quantified benefits resulting from TENS treatment.

Continued on next page

TENS – Medical Literature Analysis and Recommendations, continued from page 7 . . .

In conclusion, the *Guidelines* recommendations regarding the use of TENS for the treatment of musculoskeletal pain reflect the findings of high-grade medical studies and meta-analyses of such studies, and therefore, are not inconsistent nor too restrictive regarding the use of TENS. As always, regarding the benefits of any treatment, the absence of evidence is not evidence of absence.

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California Medical Association
Physicians dedicated to the health of Californians

January 6, 2005

Ms. Andrea Hoch
Administrative Director
Division of Workers' Compensation
455 Golden Gate Avenue
San Francisco, CA 94102

Dear Ms. Hoch:

As promised, here is a comprehensive list of the national specialty society guidelines that meet the current labor code requirements for treatment/utilization guidelines. We strongly urge you to adopt these guidelines in conjunction with the ACOEM guidelines. Each of the national specialty societies listed below are American Board of Medical Specialties (ABMS) or Medical Board of California (MBC) recognized specialties.

The American Society of Anesthesiologists
http://www.asahq.org/publicationsAndServices/practiceparam.htm

- chronic pain: www.asahq.org/publicationsAndServices/chronic_pain.html
- treating cancer pain: www.asahq.org/publicationsAndServices/cancer.html
- treating perioperative pain: www.asahq.org/publicationsAndServices/pain.pdf

American College of Emergency Physicians
Clinical policies and guidelines: http://www.acep.org/1,18,0.html

American Academy of Neurology
http://www.aan.com/professionals/practice/guideline/index.cfm

The Society of Nuclear Medicine
http://interactive.snm.org/index.cfm?PageID=1377&RPID=969

American Academy of Ophthalmology
http://www.aao.org/aao/education/library/upload/Summary-Benchmarks-2002.pdf

American Academy of Orthopaedic Surgeons
http://www.aaos.org/wordhtml/research/guidelin/guide.htm

American Osteopathic Association
Protocols For Osteopathic Manipulative Treatment (OMT)

American Academy of Pain Medicine
Wisconsin Medical Society -Chronic Pain
http://www.wisconsinmedicalsociety.org/uploads/wmi/pain_manageguides.pdf

AHCPR Guideline - Acute Pain
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.chapter.8991

AHCPR Guideline - Acute Low Back Pain
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.chapter.25870

AHCPR Guideline - Cancer Pain Link below
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.chapter.18803

(The documents listed below were previously forwarded to the DWC, CHSWC and RAND.)

Acute Pain and Cancer Pain – A position statement

AAPM – Basic Principles of Ethics for the Practice of Pain Medicine

AAPM – Long-term Controlled Substances Therapy for Chronic Pain Sample Agreement

AAPM – Federal Criminal Penalties for Illegal Trafficking of Prescription Drugs

AAPM – Definitions Related to the Use of Opioids for the Treatment of Pain

AAPM – The Necessity for Early Evaluation and Treatment of the Chronic Pain Patient

AAPM – Consent for Chronic Opioid Therapy

AAPM and American Pain Society

The Use of Opioids for the Treatment of Chronic Pain

AAPM – A Pledge

AAPM – Quality Care at the End of Life

AAPM – Undergraduate Medical Education on Pain Management, End-of-Life Care, and Palliative Care

AAPM, Amer. Pain Society and Amer. Society of Addition Medicine Public Policy Statement on the Rights and Responsibilities of Healthcare Professionals in the use of Opioids for the Treatment of Pain

American Academy of Physical Medicine and Rehabilitation
http://www.aapmr.org/hpl/pracguide/resource.htm#"Clinical%20Practice%20Guidelines:%20The%20Management%20of%20Chronic%20Pain%20in%20Older%20Persons"

American Psychiatric Association
http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

American Thoracic Society

- ATS Guide – Asthma
  http://www.thoracic.org/adobe/statements/eval1-6.pdf
- ATS Standards - Pulmonology Disease (see attached)
  http://www.thoracic.org/adobe/statements/copd1-45.pdf

We appreciate your consideration of these treatment guidelines. The CMA contact is Elizabeth McNeil 415-882-3376; emcneil@cmanet.org.

Sincerely,

RE Hertzka MD

Robert E. Hertzka, MD
President

cc: Ann Searcy, MD, DWC
Executive Committee
Workers' Compensation Committee

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California Medical Association
Physicians dedicated to the health of Californians

December 12, 2004

Andrea Hoch
Administrative Director
Division of Workers' Compensation
455 Golden Gate Avenue
San Francisco, CA 94102

Dear Ms. Hoch:

The California Medical Association appreciates the opportunity to comment on the RAND report, "Evaluating Medical Treatment Guideline Sets for Injured Workers In California," and the Commission on Health and Safety and Workers' Compensation's recommendations regarding the Workers' Compensation Utilization Schedule. In general, we support the recommendations with a few additions. Our comments are specifically outlined below.

CMA Opposes Adoption of Commercial Proprietary Guidelines

CMA continues to oppose the adoption of commercial proprietary guidelines because they are developed solely for cost containment purposes and do not take quality outcomes into consideration. Moreover, physicians do not have the opportunity to provide input into the development of such guidelines. Please see the attached October 14, 2004 letter in which CMA commented on this issue in great detail.

CMA Supports the Adoption of the ACOEM Guidelines

CMA supports the permanent adoption of the ACOEM Guidelines. These are appropriate, comprehensive guidelines written by occupational physicians dedicated to workplace injury. Moreover, ACOEM is developing support software that will assist both physicians and payers in interpreting the guidelines.

CMA Supports the Adoption of the AAOS Guidelines for Spinal Surgery

CMA endorses the adoption of the American Academy of Orthopaedic Surgeons Guidelines for spinal surgery as recommended by RAND and CHSWC. However, we also support the adoption of all national specialty society guidelines. Please see the discussion below.

CMA Urges the Adoption of the National Specialty Society Guidelines

The physician reviewers used by RAND stated that they preferred the national specialty society guidelines to ACOEM and the other Commercial Guidelines they were asked to review. Unfortunately, the physician reviewers were never asked to review the other national specialty guidelines because the staff at RAND had disqualified the specialty society guidelines on the grounds they were not "comprehensive" – meaning they were too specialty specific. CMA emphatically agrees with the assessment of the RAND physician reviewers. We strongly urge the DWC to adopt all American Board of Medical Specialties (ABMS) and Medical Board of California (MBC) recognized medical specialties who have developed treatment guidelines applicable to workers' compensation cases. We are currently working with the specialty societies to submit a consolidated list of their applicable guidelines to you.

Physicians appropriately seek and follow the guidelines adopted by their national specialty societies. The national specialties provide the most respected clinical guidance to physicians in this country either through evidence-based guidelines developed by the most respected physicians in the specialty or by making the latest literature available to their members. These guidelines attempt to provide physicians with a thoughtful course of treatment based on the most current knowledge and available resources. However, while grounded in science, the practice of medicine is an art. The variety and complexity of the human condition makes it impossible to always reach the correct diagnosis or to predict the response to treatment with precision. Therefore, the sole purpose of guidelines is to assist physicians who are using their reasonable judgment to develop an accurate diagnosis and successful treatment. Therefore, if any guideline is adopted for the workers' compensation system, it should be the professional standard of care that respected physicians in each specialty work to achieve. That professional standard of care, in part, comes from the national specialty guidelines.

The national specialty guidelines will also address some of the gaps and weaknesses in the ACOEM guidelines. The physician reviewers used by RAND already identified the AAOS guidelines as being superior to ACOEM in the area of spinal surgery. Further, ACOEM is admittedly silent in the areas of psychiatry and pain medicine. Those specialty society guidelines should be adopted immediately.

There has been some concern expressed that the payers won't be able to manage multiple sets of guidelines. It should be noted that during the RAND stakeholder meeting prior to the release of the RAND report, two health plans, that also provide private health care, reported that they currently use multiple sets of guidelines and they do not think it to be inordinately difficult to manage. In fact, they thought it was extremely helpful to be able to use all potential evidence-based guidelines in determining the appropriateness of care.

The importance of adopting national specialty society guidelines, in addition to ACOEM, is that they would then carry the "presumption of correctness." Most physicians treating workers' compensation patients will eventually use their specialty society guidelines to justify a course of treatment that may differ from ACOEM. It is inefficient utilization management and inappropriate to not presume a physician is correct if they are adhering to their national specialty society guidelines. Not adopting the specialty guidelines in addition to ACOEM will force physicians to appeal more payer decisions and backlog the already backlogged utilization review system. Therefore, we strongly urge you to adopt the ACOEM guidelines and the national specialty society guidelines and presume them both to be correct. It will create the most effective utilization schedule in the long term.

Finally, ACOEM is attempting to work more collaboratively with the other national specialty societies to develop a consensus set of guidelines. We believe this collaboration will result in a more consolidated set of workers' compensation guidelines that could eventually be adopted by the DWC. But in the meantime, the only solution is to adopt all of the applicable ABMS or MBC-recognized specialty societies' guidelines.

CMA Urges A Prior Authorization System for the Physical Modalities

The RAND reviewers also identified major weaknesses in the ACOEM guidelines related to the physical modalities, such as physical therapy, chiropractic care and acupuncture. CMA certainly does not oppose the adoption of evidenced-based guidelines in these areas, such as the new NIH guidelines on acupuncture that will be released in the near future. However, we believe in the absence of appropriate guidelines, the adoption of a prior authorization system is preferable as long as it is clinically-based and performed in a timely manner.

Moreover, CMA would like to propose that we work with you to develop a system that identifies the 10 most common diagnoses that are also the major cost drivers in the worker's compensation system. The high risk diagnoses should also be included. For these 10 diagnoses, we would propose that a specific number of visits in a specific time period be automatically authorized for initial treatment. Any requests for subsequent treatments would need to be authorized by the payer in a timely way based on the patient's functional improvement. This kind of prior authorization system is successfully applied in all well-managed health care systems today.

However, in order for this system to work, the payers will need to significantly improve the way they are conducting utilization review. Physicians report to CMA that payers are currently taking 5, 10 and sometimes 30 days to approve treatments. The workers' comp community needs the DWC's utilization review regulations to be promulgated as soon as possible. We need a formal process to file complaints with the DWC and most importantly, we need enforcement action against the payers who do not comply with the utilization review timelines, appropriate utilization review procedures and the guidelines that are adopted. We also need to require that under certain circumstances only a physician within the same specialty as the treating physician may deny care.

CMA Urges that the Treating Physician Be Presumed Correct For Treatments That Are Not Addressed in the Guidelines

A. If a physician deviates from the guidelines, CMA believes that the burden should be on the physician to demonstrate to the payer why the treatment is medically necessary and appropriate.

B. Where there are gaps in the guidelines, CMA urges the DWC to adopt the following amendment. Current law states that adherence to the ACOEM guidelines is presumed to be correct. However, the law goes on to say that where ACOEM is silent, physicians must rely on other evidence-based guidelines. However, 80% of the services physicians provide their patients are not addressed in treatment guidelines – and certainly not evidence-based treatment guidelines Therefore, CMA proposes the following language as a balanced approach to allow the judgment of the treating physician to be presumed correct within certain parameters – when there is no guiding evidence-based treatment protocol. Two major health plans have adopted this CMA language as part of our RICO lawsuit settlement agreements.

To cure and relieve shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative services or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in the relevant clinical areas and any other relevant factors.

C. In conjunction with the amendment set forth above, CMA urges the DWC to adopt a hierarchy of evidence that should be used by both physicians and the payers when justifying treatment or payment decisions. The following hierarchy was enacted for the Knox-Keene health plans in California for independent medical review.

i. Scientific-Evidence Based Guidelines
ii. Professional Standards of Care
iii. Expert Opinion

CMA Urges the DWC To Adopt Best Practices for Chronic Care

As outlined in the attached October 1 2004 letter, CMA urges the DWC to establish a physician advisory committee to assist the DWC in developing "best practices" for chronic care which is an area that is not addressed in any of the guidelines under your consideration and in desperate need of attention. We believe this project would provide the most meaningful utilization management tool to control the cases that are the real cost drivers in the workers' compensation system. Such treatment protocols would also help guide physicians in providing better care to patients whose conditions have become chronic.

We appreciate your consideration of these positions related to the treatment guidelines. The CMA contact is Elizabeth McNeil 415-882-3376; emcneil@cmanet.org.

Sincerely,

RE Hertzka MD

Robert E. Hertzka, MD
President

cc: Ann Searcy, MD, DWC
Executive Committee
Workers' Compensation Committee

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 130
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected:
Title: Workers' Compensation
BRU: Alaska Court System
Component: Appellate Courts
Sponsor: Senate Rules Committee
Requester: Governor
Component No.:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	193.7	193.7	193.7	193.7	193.7	193.7
Travel						
Contractual						
Supplies	25.3	4.2	4.2	4.2	4.2	4.2
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**219.0**	**197.9**	**197.9**	**197.9**	**197.9**	**197.9**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	219.0	197.9	197.9	197.9	197.9	197.9
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**219.0**	**197.9**	**197.9**	**197.9**	**197.9**	**197.9**

Estimate of any current year (FY2005) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Senaate Bill 130 makes several changes to the way the Department of Labor and Workforce Development (the agency) and the Alaska Court System resolve workers' compensation disputes and appeals. Most important for purposes of the court's fiscal note is that appeals from the newly-created Workers' Compensation Appeals Commission (commission) will bypass the superior court and go directly to the supreme court.

The court system does not believe that the creation of the new commission will result in a decrease in the number of workers' compensation cases that are appealed to the court system each year. However, bypassing the superior court will lead to a significant increase in the number of these appeals that go to the supreme court. This is because the superior court resolves about 75% of the workers' compensation cases appealed to the court system.

Prepared by: Doug Wooliver, Administrative Attorney
Phone 907-463-4 50
Division: Alaska Court System
Date/Time 3/8/05 8:05 AM
Approved by: Doug Wooliver for Stephanie Cole, Administrative Director
Date 3/8/2005
Agency: Alaska Court System

ANALYSIS CONTINUATION

Of the yearly average of 36 appeals filed with the superior court, only 9 (25%) are further appealed to the supreme court. Because the bill bypasses the superior court the supreme court anticipates that it will see all 36 cases.

Although the removal of these cases from the superior court will ease the workload of that court, the reduction is only slightly more than an average of one case a year per judge. Although this will allow judges some additional time to focus on other cases, it is not a significant enough reduction to produce a cost savings. However, an additional 27 cases a year for the supreme court would represent a greater than 10% increase in its civil caseload.

In order to mitigate the impact of these additional cases the court will hire a central staff attorney with expertise in workers' compensation law to research the record and the legal issues associated with each of the workers' compensation cases. This assistance should reduce the time required to resolve these cases and lessen the impact they will have on other matters before the court.

Additionally, this note reflects the costs of an administrative assistant to assist the attorney and an additional clerical position to handle the increased paper work and to interact with the agency in the preparation of the records on appeal.

This note conservatively assumes that the number of cases appealed to the court system will not grow above the current average of 36 cases a year. Should that average increase the court system may be back before the legislature with a request for additional funding.

LYNDEN

March 3, 2005

6441 South Airpark Place
Anchorage, Alaska 99502-1809
(907) 245-1544
Fax (907) 245-1744

Senator Con Bunde
Chairman, Labor and Commerce Committee
State Capitol
Juneau, Alaska 99801

Dear Senator Bunde:

After reading the recent press coverage of the proposed Worker's Compensation legislation, I would like to encourage you to pursue the legislation this session even though the "ad hoc management/labor committee" only endorsed some of the Governor's proposal.

Please keep focus on the bigger picture – the adverse impact of extremely high worker's compensation insurance rates on the economy of Alaska. While it would have been helpful for the "ad hoc" committee to have come to agreement on a greater number of proposed changes, it is not surprising that their recommendations are somewhat limited as they were operating by consensus. Also, keep in mind that the committee, while extremely useful, does not represent all businesses, all workers nor does it include insurance representatives.

While I understand that this issue is complicated and contentious, it is very important that the Legislature do whatever possible this session to change the system to make it more efficient, more predictable and more affordable. The Governor's bill has many good suggested changes. Even if you don't adopt all of them, please go as far as you reasonable can during the last half of the session.

Thanks.

Sincerely,

Jim Jansen
President

Cc: Ben Stevens, Senate
Greg O'Claray, Commissioner of Labor
Linda Hall, Director of Insurance

Suzanne Mullen

From: Mary Patricia Quin [mquin@earthlink.net]
Sent: Tuesday, February 01, 2005 8:29 AM
To: Sen. Con Bunde
Subject: RE: 2005 Session Priorities

Importance: High

Dear Senator Bunde,
Thank you for this update and best wishes for your health. It looks like a good list of priorities for the 2005 Session. As a new business owner I am pleased to see you are addressing the cost of workers compensation. I opened a new retail store in downtown Anchorage in November and hired my first employee to help me operate the store. I was stunned to find out that the workers compensation insurance premium for this one retail worker is $1,300 per year. According to my insurance agent it makes no difference if the retail employee is handling heavy lumber and equipment in an industrial supply or hardware store or selling towels and cosmetics in my bed and bath boutique. Surely the risk of injury is dramatically different but not the insurance premium. Nor does it make any difference if the employee is a manager who does 10% store work and 90% office work - the premium is based entirely on the much higher retail rate. I want to hire two more employees before the summer season but the insurance cost is making me seriously reconsider how fast to expand my business.
Mary Quin

Alaska Department of Labor and Workforce Development

News Release

Frank H. Murkowski, Governor
Greg O'Claray, Commissioner

P.O. Box 21149
Juneau, Alaska 99802-1149
Telephone: (907) 465-2700
Fax: (907) 465-2784

Press Kit
2005 Workers' Compensation Reform Act

- Press release
- Synopsis of bill
- Five charts
  - "Where Your Workers' Compensation Benefit Dollars Go"
  - "Workers' Comp Annual Premiums Paid - Copy Express"
  - "Workers' Comp Annual Premiums Paid - McGraw's Custom Construction"
  - "Workers' Comp Annual Premiums Paid - Central Peninsula Gen. Hospital
  - "Workers' Comp Annual Premiums Paid - Kodiak Island Borough
- Excerpt from DOLWD Division of Worker's Compensation's 2003 annual report
- Anchorage Daily News clip, 2/9/05, "Labor costs kill downtown La Mex"
- Copy of bill

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: SB 130
(S) Publish Date: 3/3/05

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An act relating to workers' compensation benefits
RDU: Risk Management
Component: Risk Management
Sponsor: Rules
Requester: By request of the Governor
Component No.: 71

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	•	•	•	•	•	•
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	•	•	•	•	•	•

Estimate of any current year (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

As a self insured employer, the state will experience significant savings in future claims costs due to the changes proposed in this comprehensive reform to workers' compensation benefits and adjudication process.

continued page 2

Prepared by: J. Brad Thompson
Phone: 465-5723
Division: Director
Date/Time: 2/24/05 2:28 PM
Approved by: Michael A. Tibbles Deputy Commissioner
Date: 2/24/2005
Agency: Administration

(Revised 9/23/2004 OMB)

COMMITTEE COPY

FISCAL NOTE #4

STATE OF ALASKA **BILL NO. SB 130**
2005 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Many provisions will provide savings to the state's self insured workers' compensation claims...the more significant changes include but are not limited to the following:

workers' compensation appeals commission - streamlining adjudication process thereby reducing expenses presently incurred in resolving disputes in determining claim and benefit obligations.

ability to settle - if claimant is represented by an attorney licensed in Alaska settlements no longer need to be reviewed and approved by the board.

medical fee schedule, generic drug, medical treatment guidelines, and ability to create PPO's - reducing skyrocketing costs in the medical services component of workers' compensation claims expense.

coordination of disability benefits - eliminates present situation where injured employees may receive dual remedies that exceed pre-injury spendable wage.

fraud prevention - increased penalty and prosecution will reduce fraudulent claims and their inherent additional expense

repeal of the second injury fund - delayed implementation until present claims are resolved, future assessments will be eliminated.

If RM was authorized continuing funds for each FY (held in reserve until all outstanding liabilities from that period are paid - as an insurance carrier operates), then immediate reduction of cost of risk assessments to each agency - (a negative fiscal note) could be provided to reflect cost savings expected within these reforms.

However, the state funds its claims costs on a "cash flow" basis (appropriating only the amounts expected to be paid the next fiscal year) collected solely through interagency receipts (cost of risk allocations) assessed each agency based on relative share of exposure (payroll) and experience (past claims).

In time, RM cost of risk allocations will reflect the cost reductions generated by these reform measures as rates are developed from actual claims expenses realized.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 130
(S) Publish Date: 3/3/05

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to a special deposit for workers' compensation and employers' liability insurers..."
RDU CIVIL
Component Labor & State Affairs
Sponsor Rules Committee
Requester Governor
Component Number:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	69.6	69.6	69.6			
Travel	0.2	0.2	0.2			
Contractual	8.2	8.2	8.2			
Supplies	1.1	1.1	1.1			
Equipment	7.1	7.1	7.1			
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**86.2**	**86.2**	**86.2**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	86.2	86.2	86.2			
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**86.2**	**86.2**	**86.2**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2005) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time	1					
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill amends AS 21 and AS 23 in order to increase the efficiency and flexibility of the current workers' compensation system. A significant change proposed in this bill is the creation of an appeal commission specific to workers' compensation rather than the current system in which superior court judges hear appeals on a rotating basis. The bill also increases the responsibility for oversight of the system on the workers' compensation division. Additionally, the bill makes the division responsible for addressing rising medical costs which now make up 60 cents of every workers' compensation dollar paid; and it gives workers and employers greater flexibility over certain portions of the worker's claim. The bill enhances efficiency by expanding workers' access to legal counsel and medical information and it allows the division to contract with a non profit agency to provide legal services to injured workers. Under this proposed legislation employers would no longer be encouraged to hire under conditions of

Prepared by: Kathryn A. Daughhetee, Director
Phone 465-3673
Division Administrative Services Division
Date/Time 2/24/05 2:44 PM
Approved by: K. Daughhetee for Scott Nordstrand, Acting Attorney General
Date 2/24/2005
Agency Department of Law

COMMITTEE COPY

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB 130

ANALYSIS CONTINUATION

the Second Injury fund, instead replacing that out-dated mechanism with contemporary standards in the Americans with Disabilities Act. Finally the bill increases the coordination of benefits between the workers' compensation system and other disability systems

Although difficult to predict, passage of this legislation has the potential to increase the workload of the Labor and State Affairs Section by one half-time attorney needed to assist with revision to statutes that may ensue from the medical cost study and representation of the new commission. The cost associated with a half time attorney is in accordance with the Department of Law's FY 2006 timekeeping and billing rate and includes overhead costs and equipment consistent with the addition of a new attorney position in the Department of Law.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLAT. . E SESSION

Fiscal Note Number: 2
Bill Version: SB 130
(S) Publish Date: 3/3/05

Revision Date/Time (Note if correction):
Dept. Affected: Commerce, Community & Econ. Devel.
Title: Workers' Compensation
RDU: Insurance 116
Component: Insurance
Sponsor: Governor
Requester:
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type–Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
This bill has no fiscal impact on the Division of Insurance

Prepared by: Linda S. Hall, Director
Phone 907-269-7900
Division: Insurance
Date/Time 2/23/05 12:54 PM
Approved by: Edgar Blatchford, Commissioner
Date 2/23/2005
Agency: Commerce, Community & Economic Development

(Revised 12/2003 OMB)

COMMITTEE COPY

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 130
(S) Publish Date: 3/3/05

Revision Date/Time (Note if correction):
Title: "An Act relating to Workers' Compensation...

Department: Labor and Workforce Development
RDU: Workers' Compensation
Component: Workers' Compensation

Sponsor: Rules
Requester: Governor

Component Number: 344

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	209.3	209.3	209.3	209.3	209.3	209.3
Travel	69.8	69.8	36.8	36.8	36.8	36.8
Contractual	418.7	268.7	184.9	184.9	184.9	184.9
Supplies	22.5	12.5	12.5	12.5	12.5	12.5
Equipment	50.0	6.0	6.0	6.0	6.0	6.0
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**770.3**	**566.3**	**449.5**	**449.5**	**449.5**	**449.5**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (1157)	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1157 Workers' Safety Account	770.3	566.3	449.5	449.5	449.5	449.5
TOTAL	**770.3**	**566.3**	**449.5**	**449.5**	**449.5**	**449.5**

Estimate of any current year (FY2005) cost: None

Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time	3	3	3	3	3	3
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

(See attached.)

Prepared by: Paul F. Lisankie, Director
Phone: 465-6059
Division: Workers' Compensation
Date/Time: 2/24/05 3:42 PM

Approved by: Greg O'Claray, Commissioner
Date: 2/24/2005
Agency: Department of Labor and Workforce Development

(Revised 9/23/2004 OMB)

COMMITTEE COPY

ANALYSIS: (continued)

This legislation establishes a Workers' Compensation Appeals Commission within the Alaska Department of Labor & Workforce Development. The Appeals Commission is composed of 4 volunteer members and 3 new positions:

Commission Chair - range 27, will be responsible for general supervision and administrative functions of the Appeals commission.
Administrative Assistant - range 13, will provide administrative support to the commission chair.
Administrative Clerk III - range 10, will maintain and index the administrative decisions and orders of the commission.
Although the Commission doesn't start until September 2005, personal services have been calculated at a full year to allow the commission to be formed and fully operating by the implementation date.

Travel: The Commission will hold its appeal hearings in Anchorage and be staffed in that location. Planned travel includes 3 trips (ANC/JNO) for the commission chair and the division's administrative manager and travel costs and per diem for the volunteer commission members. Travel and per diem is included for the members of the medical review committee for FY06 and FY07 ($33.0).

Contractual: This item includes costs for interagency services, leasing space, etc. as well as the honorariums for the volunteer commission members. To implement section 9 (contracting with a non-profit organization to provide legal representation for employees) $75,000 has been included in FY06 and $50,000 in FY07. There is a one-time cost in FY06 to create the office space for the commission ($50.0). Costs for a consultant and Workers' Compensation board honorariums ($86.3) are included in the first two fiscal years for the medical review committee to study the medical delivery system for workers' compensation (due date 3/1/07).

Supplies and Equipment: There are one-time costs in FY06 to set up the Appeals Commission office; FY07 forward are for on-going supplies and equipment necessary to operate the commission.

New Fees/Fines:

This bill authorizes the Appeals Commission to charge a $100 fee for the filing of an appeal. This is expected to amount to a yearly total of approximately $6,000 payable to the Workers' Safety & Compensation Administration Account.

This bill authorizes the Workers' Compensation Board to impose civil penalties against employers that violate the statutory requirement to insure or properly self-insure their employees for workers' compensation benefits. Penalties may be up to $1000 per employee per day. In FY04 over 150 employers were found without workers' compensation insurance; however, the amount of any penalties cannot be determined. Any penalties assessed will be deposited to the Workers' Compensation Guaranty Fund established by this legislation. The Guaranty Fund will use those funds to pay benefits to workers injured while employed by an uninsured employer. The amount of those benefits is also indeterminate.

2004 Oregon Workers' Compensation Premium Rate Ranking Summary

Department of Consumer & Business Services • December 2004

By Derek Reinke and Mike Manley

Oregon employers in the voluntary market pay, on average, the forty-second highest workers' compensation premium rates in the nation.

Oregon's premium rate index is $2.05 per $100 of payroll. National premium rate indices range from a low of $1.06 in North Dakota to a high of $6.08 in California. Three jurisdictions have an index rating above $4.00; 13 are in the $3.00-$3.99 range; 26 are in the $2.00-$2.99 range; and nine have indices under $2.00. Indices are based on data from 51 jurisdictions, for rates in effect as of January 1, 2004.

Classification codes from the National Council on Compensation Insurance (NCCI) were used in this study. Of the approximately 450 active classes in Oregon, 50 were selected based on relative importance as measured by share of losses in Oregon. To control for differences in industry distributions, each state's rates were weighted by 1998-2000 Oregon payroll to obtain an average manual rate for that state. Listed in Table 1 are Oregon's rankings in the 10 largest (by payroll) of the 50 classifications used.

Table 2 (on the back) contains the premium rate ranking for all 51 jurisdictions.

Figure 1. 2004 Workers' compensation premium rates

Table 1. Oregon's ranking in the top 10 classifications

Occupation	Ranking
Clerical office employees NOC	46
Salespersons - outside	47
College: Professional employees and clerical	44
Physician and clerical	31
Restaurant NOC	37
Store: Retail, NOC	43
Automobile service/repair center and drivers	33
Hospital: Professional employees	29
Trucking: Local and long haul - all employees & drivers	25
Television/radio/telephone/telecommunication device	45

Table 2. Workers' compensation premium rate ranking

2004 Ranking	2002 Ranking	State	Index Rate	Effective Date
1	1	California	6.08	January 1, 2004
2	15	Alaska	4.39	January 1, 2004
3	2	Florida	4.20	October 1, 2003
4	3	Hawaii	3.73	January 1, 2004
5	14	Ohio	3.59	July 1, 2003
6	16	Kentucky	3.48	September 1, 2003
7	4	Delaware	3.44	December 1, 2003
8	10	Montana	3.41	July 1, 2003
9	7	Louisiana	3.37	January 1, 2004
10	17	District of Columbia	3.26	November 1, 2003
11	13	Connecticut	3.23	January 1, 2004
12	18	New Hampshire	3.19	January 1, 2004
13	8	Maine	3.08	January 1, 2004
14	5	Texas	3.08	January 1, 2003
15	19	Oklahoma	3.07	2/1/02 State Fund, 1/1/04 private
16	6	Rhode Island	3.01	November 1, 1998
17	25	Vermont	2.99	April 1, 2003
18	9	New York	2.97	December 1, 2003
19	12	Alabama	2.88	March 1, 2004
20	23	Pennsylvania	2.82	April 1, 2003
[illegible]	22	Minnesota	2.74	January 1, 2004
22	26	Missouri	2.67	January 1, 2004
23	20	Illinois	2.65	January 1, 2004
24	24	West Virginia	2.64	July 1, 2003
25	29	Tennessee	2.62	March 1, 2003
26	11	Nevada	2.58	January 1, 2004
27	36	New Mexico	2.56	January 1, 2004
28	38	Wyoming	2.43	January 1, 2004
29	31	New Jersey	2.38	January 1, 2004
30	30	Michigan	2.34	January 1, 2004
31	21	Colorado	2.33	January 1, 2004
32	34	North Carolina	2.32	August 29, 2003
33	32	Wisconsin	2.27	October 1, 2003
34	27	Idaho	2.25	January 1, 2004
35	45	Washington	2.20	January 1, 2004
36	33	Mississippi	2.19	March 1, 2003
37	28	Georgia	2.14	November 1, 2001
38	39	Nebraska	2.10	February 1, 2003
39	42	South Carolina	2.08	January 1, 2004
40	40	Maryland	2.06	January 1, 2004
41	48	South Dakota	2.05	July 1, 2003
42	**35**	**OREGON**	**2.05**	**January 1, 2004**
43	43	Iowa	1.91	January 1, 2004
44	41	Kansas	1.81	January 1, 2004
45	37	Massachusetts	1.70	September 1, 2003
46	44	Utah	1.63	December 1, 2003
47	49	Virginia	1.57	April 1, 2003
48	47	Arkansas	1.57	July 1, 2001
49	46	Arizona	1.49	October 1, 2003
50	50	Indiana	1.24	January 1, 2004
51	51	North Dakota	1.06	July 1, 2003

Based on updated information, the 2002 ranking has been revised since it was originally published.

Although some states may appear to have the same index rate, the ranking is based on calculations prior to rounding to two decimal places. The index rates reflect appropriate adjustments for the characteristics of each individual state's residual market. Rates vary by classification and insurer in each state. Actual cost to an employer can be adjusted by the employer's experience rating, premium discount, retrospective rating, and dividends.

Employers can reduce their workers' compensation rates through accident prevention, safety training, and by helping injured workers return to work.

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DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Information Management Division
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440-2082 (12/04/COM)

Comparison of Maximum Allowable Rates for Various Medical Procedures

CPT Code (Current Procedural Terminology)	29881	49505	63005	71020	72131	99205	99213
Short Description	Arthroscopy	Repair Initial Inguinal hernia	Laminectomy Lumbar	Radiological exam, chest, 2 views	Scan, lumbar without contrast	Office visit, new patient, comprehensive exam	Office visit, established patient Intermediate exam
Idaho WC 2005	$3,507	$1,824	$6,613	$144	$921	$265	$115
Oregon WC 2005	$1,491	$1,170	$2,624	$65	$528	$315	$97
Alaska WC 2000	$3,283	$1,869	$4,977	$120	$930	$280	$94
Alaska WC 2004	$3,813	$2,204	$5,728	$135	$1,266	$388	$114
Alaska WC 2005	$4,181	$2,295	$5,936	$153	$1,369	$368	$127
% increase in AK WC charges between 2000 and 2005	27%	23%	19%	28%	47%	31%	36%
Current maximum allowable rates for:							
AlaskaCare	$3,873	$2,200	$6,000 *	$140	$1,400 *	$316	$107
Alaska Medicare	$1,015	$781	$1,781	$61	$494	$290	$88
Alaska Medicaid	$893	$678	$1,558	$55	$450	$253	$78

* insufficient data for Alaska; uses National data, adjusted

Prepared by Alaska Department of Labor and Workforce Development, March 2005

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

FRANK H. MURKOWSKI, GOVERNOR

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ANCHORAGE, ALASKA 99501-5903
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March 7, 2005

MEMORANDUM

TO: The Honorable Greg S. O'Claray, Commissioner
Department of Labor and Workforce Development

FROM: Scott J. Nordstrand
Acting Attorney General
By: Kristin S. Knudsen
Assistant Attorney General

RE: Attached Revised Section by Section Analysis of SB 130
Our file: 773-05-0112

Attached is a revised section by section analysis of SB 130, concerning workers' compensation reform. While the actual sectional analysis is not changed, a correction was made in the introduction to replace an erroneous reference with the correct insurance term.

KSK:ksk

cc w/enc.: Hon. Ray Matiashoski, Comm'r, Dept. of Administration
Hon. Edgar Blatchford, Comm'r, Dept. of Commerce, Comm., and Econ. Dev.
David Marquez, Acting Deputy Attorney General, Civil Division, and Legislative Liason
Deborah Behr, AAG, Legislation and Regulations
Stephanie J. Cole, Administrative Dir., Alaska Court System
Kevin Jardell, Legislative Liason, Office of the Governor
Cheryl Frasca, Dir., OMB, Office of the Governor

Summary of 2005 Workers' Compensation Reform Act

This legislation's reforms are aimed at lessening the threat to jobs and benefits caused by insurance premiums increasing at intolerable rates. The reforms are consistent with the oft-stated legislative intent of ensuring the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to their employers. The reforms address seven major areas:

Maintaining Medical Benefits While Reducing Costs

- Immediately reduce health care costs by resetting the current maximum reimbursement rates for health care services at the maximum level applied to bills for services rendered in 2000. (By using the Medical Fee Schedule originally adopted by the Alaska Workers' Compensation Board on December 15, 1999.)
- Freeze those maximum reimbursement rates until completion of an appointed medical review committee's comprehensive examination of the workers' compensation health care delivery system. (The committee must report to the Commissioner of Labor & Workforce Development no later than March 1, 2007.)
- Continue to protect workers by providing that they may not be required to pay any fee or charge for health care services provided under the Act.
- Promote injured workers' safe and efficient return to health and function by presuming their injuries require the treatments described in the national, peer-reviewed Occupational Medicine Practice Guidelines of the American College of Occupational and Environmental Medicine. (Other treatments may be justified by a preponderance of the scientific evidence. The Board must also adopt other guidelines for injuries not covered by the ACOEM Guidelines.)
- Take advantage of generic drug cost savings by requiring their use unless a name brand is medically necessary.
- Take advantage of potential cost reductions by requiring the Department Of Labor & Workforce Development to adopt a preferred drug list like that developed by the Department of Health & Social Services. (Department of Labor & Workforce Development must also set procedures for establishing need to depart from list.)
- Remove roadblocks to potential cost savings by allowing employers to develop preferred provider lists and negotiate fee rates. (Workers are not required, and must be informed, that they can choose physicians not on the list.)

Protecting Workers' Benefits and Their Jobs From Uninsured Employers

- Empower the Division Director to immediately shut down an employer upon completion of an investigation confirming lack of required insurance.
- Empower the Board to fine uninsured employers up to $1,000/day/employee and put the fines in a Fund paying benefits to uninsured employers' injured workers.

Summary of 2005 Workers' Compensation Reform Act

Improving Return-to-Work Benefits While Reducing Costs

- Phase out archaic Second Injury Fund, gradually reduce 6% contribution rate to 0.
- Reduce delays in determining reemployment benefits eligibility, and resulting costs, by allowing workers and employers to stipulate to eligibility and by simplifying entitlement to evaluation.
- Encourage utilization of reemployment benefits, and reduce costs, by requiring worker to either choose to begin retraining process within 15 days of eligibility determination or choose to accept cash job dislocation benefits ($5,000-13,500) based upon percentage of permanent partial impairment.

Quicker and More Efficient Resolution of Disputed Benefits Claims

- Legalize private attorneys' receipt of an one-time consultation fee up to $300 to advise injured workers' about benefits matters.
- Allow the Department of Labor & Workforce Development to contract with non-profit organizations to provide information and legal assistance to injured workers unable to obtain private counsel.
- Allow injured workers represented by Alaska-licensed attorneys to settle their claims without review by the Workers' Compensation Board. Focus Board review on settlements of workers who are minors, incompetent, or unrepresented by counsel.
- Formally require use of hearing officers, Board adoption of conflict of interest regulations.

Fair Benefits at Reasonable Employer Cost

- Cap non-resident compensation rates at those paid to Alaskan residents.
- Coordinate private disability and workers' compensation benefits so combined benefits do not exceed worker's take home pay.
- Broaden and strengthen anti-fraud provisions enforced by the Board.
- Improve criminal anti-fraud provisions to facilitate effective prosecution.
- Confirm that Limited Liability Company members need not have workers' compensation coverage but allow Company to add them to its insurance policy if desired.
- Speed processing of medical bills by requiring injury report to include release of medical records for treatment of the injury. Maintain confidentiality of worker's medical and rehabilitation records held by Division or Appeals Commission. Ban the Division from assembling or providing individual records for commercial purposes.

Increasing Speed, Efficiency, and Predictability in Workers' Compensation Appeals

- Replace appeals to the Superior Court, heard by numerous individual judges who are not necessarily experienced in workers' compensation matters and whose decisions do not establish binding legal precedent, with appeals to a single, experienced Workers' Compensation Appeals Commission whose decisions will be legal precedent. Legal precedent will be available years sooner than the current system, which establishes precedent only at the Supreme Court level, greatly increasing predictability of worker entitlements and employer obligations under the Act.

- Permit the Workers' Compensation Division Director to file an appeal where an unsettled question of law is involved and a party is not represented by legal counsel.

- Speed the appeals process by requiring the Commission to issue its decision within 90 days after closing the record.

- Establish consistency in both legal and fact-based conclusions concerning workers' compensation issues by having the Commission review both legal conclusions and factual findings de novo.

- Provide that Board-level determinations of the credibility of hearing witness testimony are binding on the Commission. (To allay concerns about addressing credibility without having seen the witness and possible constitutional issues.)

- Provide for two lay, volunteer members on each Commission panel, one with an employee background and one with an employer background. (To allay concerns about cost and concerns that employee/employer background and understanding would be lost by having panels made up of three attorneys.)

- Continue right of any party to appeal to Supreme Court.

Improving the Workers' Compensation Insurance System

- Provide additional financial protection to injured Alaskan workers, in the event their employer's insurer becomes insolvent, by requiring insurers to make in-state deposits to collateralize the insurer's loss reserves. Upon an insurer's insolvency those deposits will be available for the Insurance Division Director to release to the Alaska Insurance Guaranty Association for payment of benefits claims.

- Establish that all reciprocal insurers, not just those formed by municipalities or non-profit public utilities, are exempt from participation in the assigned risk pool.

and encourage prompt entry into plan development, and, by making the alternative to retraining less attractive, to provide a disincentive to the practice of delaying plan development in hopes of increasing the settlement value of reemployment benefits, or of beginning plans the employee has no real interest or inclination to pursue in order to continue receiving payments. Finally, it provides a small benefit not previously available to those employees who genuinely desire to retire from the active labor market or to pursue plans of their own without direction from the workers' compensation system.

Section 17 amends AS 23.30.041(j) to modernize the language.

Section 18 amends AS 23.30.041(p) to replaces the board with the director as the holder of a public meeting to select a proposed date on which a new edition of the US Department of Labor's Dictionary of Occupational Titles shall be implemented. The department replaces the board as the agency selecting the date proposed and the director replaces the board as the person giving notice of the selected date.

Section 19 amends AS 23.30.041(q) to replace the board with the division as the agency receiving filed waivers of rehabilitation benefits and serving notices of the waivers. The amendment also replaces the board with the director as the agency proscribing or approving the form of such waivers.

Section 20 amends AS 23.30.080(d) regarding proceedings to obtain stop work orders against uninsured employers. The amendment provides that the director may petition the board for a stop work order, replacing the general grant of authority of the board to issue a stop work order. The amendment clarifies the role of the director and the form of procedure to be used - one pursuant to the board's petition process provided in regulation (8 AAC 45.050) instead of one based on a notice of accusation.

Section 21 creates two new statutory provisions relating to penalties against uninsured employers and stop orders. New subsection AS 23.30.080(e) authorizes the director to issue a stop order after an investigation by a department officer reveals substantial evidence that the employer is not insured or has no self-insurance certificate. The director must dissolve the stop order on receipt of proof of insurance or a self-insurance certificate. In addition, the director may petition the board to assess a civil penalty if the employer fails to obey the stop order.

New subsection AS 23.30.080(f) authorizes the division to petition the board for a civil penalty of up to $1,000/day of employment per uninsured employee. New subsection AS 23.30.080(g) permits the director to declare an employer in default if the employer fails to pay a civil penalty under subsection 080(d) (failing to comply with a board stop work order, $1000 per day), subsection 080(e) (failing to comply with a director stop work order,

SB 130

Protecting Rights of Employees and Employers

- Division may petition Board to order uninsured employer to stop work.
- After investigation Department representative may request Director to order uninsured employer to stop work.
- Board may assess fines up to $1,000/day/employee against uninsured employer and Director may seek enforcement of fines in Court.
- Workers' Compensation Benefits Guaranty Fund established to receive uninsured employer fines.
- Injured worker may seek payment from Fund when uninsured employer fails to pay benefits.
- Broadened Board-level anti-fraud provisions.
- Improved criminal anti-fraud provisions.
- Limited Liability Company members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy.
- Coordination of disability and workers' compensation benefits.

Fairness to Alaska Resident Workers

- Non-resident compensation may not exceed that paid to Alaska residents.
- COLA studies every three years.

Modernizing Return to Work Incentives

- Second Injury Fund wind down, no new claims accepted after September 1, 2005.
- All current claims continue to be paid, SIF closed out when Commissioner certifies to Lt. Governor that all SIF claims paid off.

Ad Hoc Bill

Protecting Rights of Employees and Employers

- Division may petition Board to order uninsured employer to stop work.
- After investigation Department representative may request Director to order uninsured employer to stop work.
- Board may assess fines up to $1,000/day/employee against uninsured employer and Director may seek enforcement of fines in Court.
- No provision.

- No provision.

- Broadened Board-level anti-fraud provisions.
- Improved criminal anti-fraud provisions.
- Limited Liability Company members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy.
- No provision.

Fairness to Alaska Resident Workers

- Non-resident compensation may not exceed that paid to Alaska residents.
- COLA studies every three years.

Modernizing Return to Work Incentives

- Second Injury Fund wind down, no new claims accepted after July 1, 2005.
- All current claims continue to be paid, SIF closed out when all existing SIF claims paid off.

Balancing Privacy and Discovery Rights

- Injury report must include release for medical records for the injury or death.
- Medical/rehabilitation records confidential wher held by Division or Appeals Commission.
- Division may not assemble or provide individual records for commercial purposes.

Insurance Improvements

- In-state deposits to collateralize insurers' loss costs.
- Insurance Director may release deposits to Guaranty Association if insurer becomes insolvent.
- Reciprocal insurers exempt from assigned risk pool obligation.

Speeding and Improving Dispute Resolution

- DOL&WD may contract with non-profit organizations to provide information/representation to employees.
- Mandate use of "hearing officer."
- Mandate Board conflict of interest regulations.
- Board credibility findings must be supported by specific findings.
- Settlement forms prescribed by Director, filed with Division.
- Most settlement agreements effective upon filing.
- Claimants who are minors, incompetent, or not represented by Alaska-licensed attorney must have settlement agreements approved by Board.
- One-time attorney consultation fee up to $300 payable without Board approval.

Balancing Privacy and Discovery Rights

- No provision.

- Medical/rehabilitation records confidential when held by Board.
- Individually identifiable information not public records.

Insurance Improvements

- In-state deposits equal basic capital/required surplus.
- Insurance Director may request release of deposits to Guaranty Association if insurer becomes insolvent.
- No provision.

Speeding and Improving Dispute Resolution

- No provision.
- Add three Board hearing panels.
- No provision.
- No provision.
- No provision
- Limited issues heard by designated representative alone.
- No provision.

- No provision.
- All claimants must have settlement agreements approved by Board.

- One-time attorney consultation fee up to $300 payable without Board approval.

Reemployment Benefits Improvements	**Reemployment Benefits Improvements**
• Director hires Reemployment Benefits Administrator (RBA) and authorizes staffing.	• Director hires Reemployment Benefits Administrator (RBA) and authorizes staffing.
• Parties may stipulate to injured worker's reemployment benefits eligibility.	• Parties may stipulate to injured worker's reemployment benefits eligibility.
• 45 continuous days off work require RBA to inform worker of rights.	• No provision.
• After 60 continuous days off worker or employer may request benefits eligibility evaluation.	• §041(k) compensation paid during reemployment process.
• After 90 continuous days off RBA must order evaluation absent an eligibility stipulation.	• No provision.
• Worker ineligible for reemployment benefits if previously declined reemployment benefits, received cash job dislocation benefit, and then returned to work in occupation having physical demands similar to those at time of injury job.	• Wages earned offset during reemployment process.
	• No provision.
	• PPD/PPI lump sum offset before §041(k) compensation paid.
	• No provision.
• Within 15 days after determination of eligibility, worker must elect to use reemployment benefits or decline them and accept cash job dislocation benefit of $5,000 (0-14% PPI), $8,000 (15-29% PPI), or $13,500 (30% or greater PPI).	• No provision.
• Director picks date for implementing use of new SCODRDOT within 90-days already required by Act.	• Director picks date for implementing use of new SCODRDOT within 90-days already required by Act.
• Director prescribes reemployment benefits waiver form then filed with and served by Division.	• No provision.
	• Revised remunerative employability rate calculation.
Controlling Health Benefits Costs	**Controlling Health Benefits Costs**
• Commissioner required to appoint medical services review committee.	• Director may appoint medical services review committee.
• Medical services review committee report to Commissioner no later than March 1, 2007.	• No provision.
• Require use of generic drugs unless brand medically justified.	• Require use of generic drugs unless brand medically justified.

- Department required to establish a preferred drug list.
- American College of Occupational and Environmental Medicine (ACOEM) medical treatment guidelines adopted.
- Treatment under guidelines presumed correct subject to rebuttal by preponderance of scientific evidence.
- Board must adopt other recognized national guidelines for injuries not covered by ACOEM guidelines.
- Medical fee payments may not exceed lesser of usual, customary and reasonable (UCR) rate effective December 15, 1999 or any rate negotiated by the employer.
- Employer may establish a preferred provider list but worker not required to use listed providers and list must clearly so state.
- Employers may negotiate rates with providers.
- A worker still may not be required to pay a fee or charge for treatment provided under Act.

Appeal Process Improvements

- Workers' Compensation Appeals Commission established, decisions are legal precedent.
- Director may appeal if party unrepresented and unsettled question of law.
- Appeals generally based on written record and arguments without new evidence.
- Evidence allowed on stays, attorney's fees/costs, fee waivers, dismissal for failure to prosecute or settlement of appeal.
- Review de novo of legal conclusions and factual findings.
- Commission decision due within 90 days of record closure.
- Decisions appealable to Supreme Court, factual findings reviewed for substantial evidence.

- Advisory Committee helps adopt preferred drug list.
- No provision.

- No provision.

- No provision.
- Worker finds billing discrepancy, gets 25% of recovery.
- Medical fee payments may not exceed lesser of usual, customary and reasonable (UCR) calculated annually, rate paid by general public, or employer-negotiated rate.
- Employer may establish a preferred provider list but worker not required to use listed providers and list must clearly so state.
- Employers may negotiate rates with providers.
- A worker still may not be required to pay a fee or charge for treatment provided under Act.

Appeal Process Improvements

- Policy Panel established within Workers' Compensation Board, decisions are legal precedent.
- No provision.

- No provision.

- No provision.
- Policy Panel reconsiders hearing panel decisions. Hearing panel decisions may still be appealed to Superior Court.
- Review de novo only legal conclusions not factual findings.
- Panel decision due 90 days after hearing panel decision.
- Decisions appealable to Superior Court, factual findings reviewed for substantial evidence, then Supreme Court.

Administrative Improvements

- Board may delegate its administrative authority to Director by regulation.

Administrative Improvements

- Numerous administrative provisions for notices, claims, reports, and similar documents to be filed with, retained by, or served by the Workers' Compensation Board redelegated to the Director, Division, or Department.

Compensation Rate Methodology

- Compensation rate calculation methods revised for workers paid by day/hour/output, seasonal/temporary work, and minors/apprentices/trainees.

	SB 130	Ad Hoc Proposal
	Sec 1: Provides legislative intent to reform Workers' Compensation and to reduce overall cost of Workers' Compensation premiums.	Sec 1: Provides legislative intent to reform Workers' Compensation, give affected parties a voice on the AK Insurance Guaranty Association and reduce overall cost of Workers' Compensation premiums.
21.09.090(e) & (f)	Sec 2: Establishes an in-state deposit, for all insurers of workers' compensation in the state, to collateralize insurers' loss costs	Sec. 2: Establishes an in-state deposit equal to basic capital or required surplus for all insurers of workers' compensation in the state. Allows the Director of Insurance to release those deposits to Guaranty Association if insurer becomes insolvent.
21.24.130(f)	Sec. 3: Insurance Director may release deposits to Guaranty Association if insurer becomes insolvent	
21.39.155(a)	Sec. 4: Exempts all reciprocal insurers from assigned risk pool participation	
21.24.130(d)		Sec. 3: Exempts deposits, subject to the Guaranty Association, from requirement to yield assets to insolvent insurer's conservator.
21.80.050(a)		Sec. 4: Expands Insurance Guaranty Association board membership from 2 public members and 2-7 insurer members to 9 members - 4 representing insurers, 2 each representing labor and employers and 1 member representing licensees.
23.05.067(a)	Sec. 5: Service fee, delete reference to Second Injury Fund (SIF) contributions	Sec. 5: Service fee, refer to Division rather than Board
23.30.001	Sec. 6: Intent language, workers' compensation provisions.	
23.30.005(a)	Sec. 7: Replace designated representative with "hearing officer," mandate Board conflict of interest regulations.	Sec. 6: Adds three additional hearing panels to the Workers' Compensation Board.
23.30.005(b)	Sec. 8: Commissioner's representative chairs full Board meetings, hearing officers chair hearing panels	
23.30.005(f)		Sec. 7: Clarifies Panel quorum acts as full board 'on claims heard'
23.30.005(h)		Sec. 8: Allows department to adopt regulations to allow procedural, discovery, and stipulated matters to be heard by Commissioner's representative instead of Board hearing panel.
23.30.005(m) & (n)	Sec. 9: DOL&WD may contract with non-profit to provide information/representation to employees, Board may delegate its authority to Director	

	SB 130	Ad Hoc Proposal
23.30.007 – 009	Sec. 10: Creates Workers' Compensation Appeals Commission. 5 members to be appointed by Governor, approved by Legislature; members must be Alaskan attorneys with at least 5 years of Alaskan workers' compensation experience. Members will receive $200 per day. Appeals Commission will hear workers' compensation appeals in lieu of the Superior Court.	
23.30.012	Sec. 11: Settlement forms prescribed by Director, filed with Division, some agreements not effective upon filing. Claimants who are minors, incompetent, or not represented by Alaska-licensed attorney must have settlement agreements approved by Board	
23.30.015	Sec. 12: (e) Distribution of third-party recovery, delete SIF contributions reference	Sec. 9: (j) Notice of third-party lawsuit filed with Division rather than Board
23.30.025(a)		Sec. 10: Insurer policy form filed with Division rather than Board
23.30.030(5)		Sec. 11: Insurer policy cancellation notice filed with Division rather than Board.
23.30.040(a)		Sec. 12: Second Injury Fund (SIF) administered by Director rather than Board
23.30.040(d)		Sec. 13: Again, transfers authority from Board to Director for refunding SIF payments
23.30.041(a)	Sec. 13: Has Director hire Reemployment Benefits Administrator (RBA) and authorize staffing rather than Board	Sec. 14: Allows Director to hire Reemployment Benefits Administrator (RBA) and authorize staffing rather than the Board.
23.30.041(c)	Sec. 14: Parties may stipulate to injured worker's reemployment benefits eligibility. After 45 continuous days off work requires RBA to inform worker of rights. After 60 continuous days off either worker or employer may request benefits eligibility evaluation. After 90 continuous days off work RBA must order an evaluation absent an eligibility stipulation.	Sec. 15: Allows employer and employee to stipulate to injured worker's eligibility for reemployment benefits.
23.30.041(f)	Sec. 15: Adds wording stating worker is ineligible for reemployment benefits if previously declined reemployment benefits, received cash job dislocation benefit and then returned to work in occupation having physical demands similar to those at time of previous injury.	

23.30.041(g)	Sec. 16: Adds new language stating: within 15 days after determination of eligibility, worker must elect to use reemployment benefits or decline them and accept cash job dislocation benefit of $5,000 (0-14% PPI), $8,000 (15-29% PPI), or $13,500 (30% or greater PP ,	
23.30.041(j)	Sec. 17: Syntax change.	
23.30..410(k)		Sec. 16: §041(k) compensation paid, and wages earned offset, during reemployment process. Lump sum PPD and PPI payments considered before §041 compensation paid
23.30.041(p)	Sec. 18: Gives authority to DOLWD to pick date for implementing use of new SCODRDOT within time frame required by law (formerly Board).	Sec. 17: Allows Director, rather than Board, to pick and announce date for implementing use of new SCODRDOT within the time frame required by law.
23.30.041(q)	Sec. 19: Director prescribes reemployment benefits waiver form then filed with and served by Division.	
23.30.041(r)		Sec. 18: Revises method for calculating remunerative employability rate
23.30.065		Sec. 19: Allows for Injury report requirements to be set by Division rather than Board.
23.30.070(a)		Sec. 20: Allows Injury report to be filed with Division rather than Board.
23.30.070(b)		Sec. 21: Allows additional reports to be filed with the Division and prescribed by Director rather than Board.
23.30.070(d)		Sec. 22: Allows reports to be mailed to Division rather than Board.
23.30.075		Sec. 23: Allows self-insurance documentation to be provided to Division and for the Division to provide self-insurance certificates rather than Board.
23.30.080(d)	Sec. 20: Division may petition Board to order uninsured employer to stop work	Sec. 24: Division may petition Board to order uninsured employer to stop work (formerly Board issued stop order)
23.30.080	Sec. 21: After investigation Department representative may request Director to order uninsured employer to stop work. Director can dissolve stop order upon evidence insurance has been secured, or petition Board to assess penalty. Board may assess fines up to $1,000/day/ee against uninsured employer and Director may seek enforcement of fines in Court.	Sec. 25: After investigation Department representative may request Director to order uninsured employer to stop work. Director can dissolve stop order upon evidence insurance has been secured, or petition Board to assess penalty. Board may assess fines up to $1,000/day/ee against uninsured employer and Division may seek enforcement of fines in Court.

	SB 130	Ad Hoc Proposal
23.30.082	Sec. 22: Workers' Compensation Benefits Guaranty Fund established, worker may seek payment from Fund when uninsured employer fails to pay benefits	
23.30.085(a)		Sec. 26: Amends to allow Proof of insurance to be filed with Division in form prescribed by Director rather than Board
23.30.095(h)		Sec. 27: Allows Medical reports to be filed with Division rather than Board
23.30.095(j)	Sec. 23: Commissioner required to appoint medical services review committee. Report is due no later than March 1, 2007.	Sec. 28: Allows Medical services review committee to be appointed by Director rather than Board
23.30.095(l)		Sec. 29: Requires use of generic drugs unless brand medically justified
23.30.095(m)		Sec. 30: Establishes Medical policy advisory committee (consisting of 4 Board members, 2 medical professionals & WC director). Committee will assist Division to establish/administer preferred drug list, educate providers about Act, and administer return to work program
23.30.095	Sec. 24: New section requires use of generic drugs unless brand name is medically justified; Department is required to establish a preferred drug list. Sets the American College of Occupational and Environmental Medicine (ACOEM) medical treatment guidelines as the allowed treatment of injuries or illness. Treatment under these guidelines presumed correct subject to rebuttal by preponderance of scientific evidence. Board must adopt other recognized national guidelines for injuries not covered by ACOEM guidelines	
23.30.097	Sec. 25: Adds new section which states medical fee payments may not exceed lesser of usual, customary and reasonable (UCR) rate effective December 15, 1999 or any rate negotiated by the employer. Employer may establish a preferred provider list but worker not required to use listed providers and list must clearly so state. Employers may negotiate rates with providers, an employee may not be required to pay a fee or charge for treatment provided	Sec. 31: Medical fee payments regulated by Board, may not exceed lesser of annual usual, customary and reasonable (UCR) rate, charge to general public, or employer-negotiated rate. Opens law to allow employer to establish a preferred provider list, or to negotiate rates with providers. If employer uses a preferred provider list, worker is not required to use list. Other employee rights regarding obtaining treatment and use of providers remain. Requires copies of bills must be sent to employees. Employees finding billing errors are entitled to a 25% fee if discrepancy found is more than $100 (less if insurer pursues repayment) and insurer did not note discrepancy.

23.30.100(a)		Sec. 32: Allows for Notice of injury to be sent to Division rather than Board.
23.30.100(b)	Sec. 26: Adds authority for Injury report to include a release of medical records for the injury or death.	
23.30.100(c)		Sec. 33: Allows for Notice of injury to be submitted to Division office rather than Board
23.30.107	Sec. 27: Extends confidentiality of Medical/rehabilitation records to those held by Division or Commission.	Sec. 34: Allows for Discovery petitions to be filed with Division rather than Board. Expands confidentiality of division records to include individually identifiable information.
23.30.107	Sec. 28: Prohibits Division from assembling or providing individual records for commercial purposes	
23.30.122	Sec. 29: Gives Board sole power to determine credibility of witness testimony. Requires Board's determination of credibility must be supported by specific findings.	
23.30.125	Sec. 30: Effective date of Board decision, may be appealed to WC Appeals Commission, procedures for stay	
23.30.127	Sec. 31: Sets out procedures for appeals to WCA Commission. Allows Director to appeal if party is unrepresented and there is an unsettled question of law, appeal procedures, filing and transcript fees. Commission hearing panel composition, review de novo of legal conclusions and factual findings. Appeals generally based on written record and arguments without new evidence, evidence allowed on stays, attorney's fees/costs, fee waivers, dismissal for failure to prosecute or settlement of appeal. Commission decision due within 90 days of record closure, decisions appealable to Supreme Court, factual findings reviewed for substantial evidence	Sec. 35: Establishes a Workers' Compensation Board Policy Panel and defines procedures to reconsider hearing panel legal decisions using substitution of judgment standard. The Panel may not reconsider factual findings. Its opinions are binding legal precedent unless reversed by Supreme Court. Board hearing panels may still reconsider their own decisions.
23.30.140		Sec. 36: Allows Director to seek guardianship rather than Board
23.30.145		Sec. 37: Syntax change
23.30.155(a)		Sec. 38: Allows Director to prescribe controversion notice rather than Board.
23.30.155(c)		Sec. 39: Allows Director to prescribe compensation reports and for those reports to be filed with Division (formerly both directed by Board).

23.30.155(d)		Sec. 40: Allows controversion notice to be filed with Division rather than Board; syntax change in attorney's fee provision.
23.30.155(e)		Sec. 41: Clarifies additional compensation "penalty" is payable to person owed compensation without an award rather than employee.
23.30.155(f)		Sec. 42: Clarifies additional compensation "penalty" is payable to person owed compensation under an award rather than employee
23.30.155(i)		Sec. 43: Allows Division to require deposit to secure payment rather than Board
23.30.155(k)		Sec. 44: Allows benefits receipts to be inspected by Director rather than Board.
23.30.155(m)		Sec. 45: Allows Annual reports to be filed on form prescribed by Director and filed with Division, rather than Board. Amends t allow penalty notification by Director rather than Commissioner.
23.30.155(o)		Sec. 46: Allows Director, rather than the Board to notify Division of Insurance of unfair or frivolous controversions.
23.30.175(b)	Sec. 32: Adds language restricting the maximum Non-resident compensation to that paid to Alaska residents.	Sec. 47: Adds language restricting the maximum Non-resident compensation to that paid to Alaska residents.
23.30.175(c)	Sec. 33: Allows for COLA studies every three years rather than annually.	Sec. 48: Allows for COLA studies every three years rather than annually.
23.30.180(a)		Sec. 49: Syntax change
23.30.190(d)		Sec. 50: Allows Director rather than Board to pick and announce date for implementing use of new AMA Guides (rating permanent impairment) within 90-day period allowed by law.
23.30.200(b)		Sec. 51: Syntax change
23.30.205(e)	Sec. 34: Allows SIF notifications to go to Director rather than Commissioner.	Sec. 53: Allows SIF notifications to go to Director rather than Commissioner
23.30.205(f)		Sec. 54: SIF claim notifications to Director rather than Commissioner
23.30.205	Sec. 35: SIF wind down, no new claims may be filed after September 1, 2005 or accepted after July 1, 2006	Sec. 52: SIF wind down, no new claims may be filed after July 1, 2005. Payments will be made on previously filed claims until SIF liabilities for claim are extinguished.

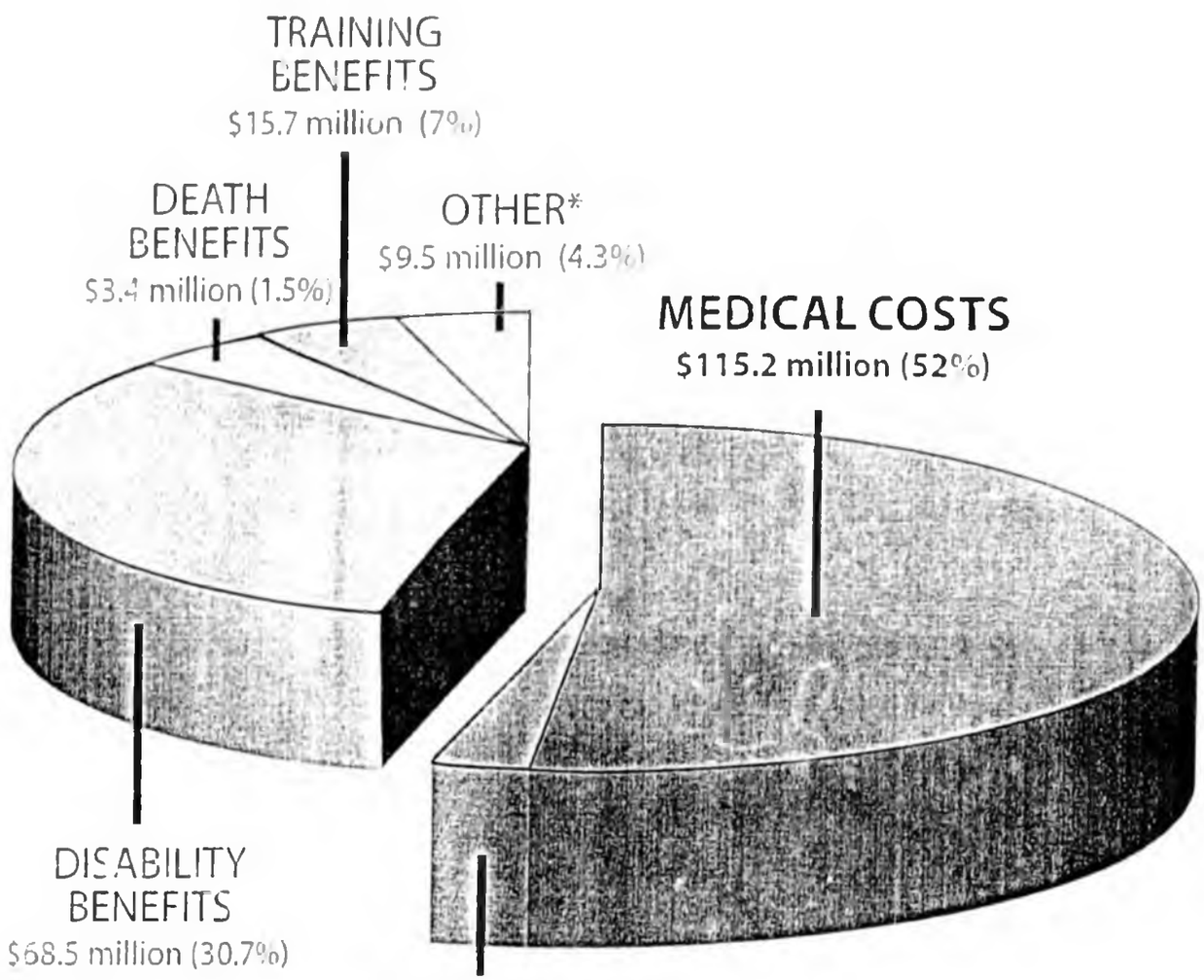
	SB 130	Ad Hoc Proposal
23.30.220(a)		Sec. 55: Amends methods for compensation rate calculations for workers paid by day/hour/output, seasonal/temporary work, and for minors/apprentices/trainees
23.30.224	Sec. 36: Allows for coordination of employer sponsored disability and workers' compensation benefits	
23.30.240	Sec. 37: Allows Corporate officer waivers to be approved by Director (was Commissioner)	Sec. 56: Allows Corporate officer waivers to be approved by Director (was Commissioner). LLC members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy
23.30.240(b)	Sec. 38: Limited Liability Company (LLC) members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy.	
23.30.247(c)	Sec. 39: Delete reference to SIF on employment questionnaires	
23.30.249	Sec. 40: Broadens Board-level anti-fraud provisions. Allows director to investigate fraudulent claims.	
23.30.250	Sec. 41: Improves criminal anti-fraud provisions	Sec. 57: Criminal anti-fraud provision broadened, Board-level anti-fraud provisions expanded to include providers, civil liabilities under both provisions include compensatory damages, punitive damages, and attorney's fees
23.30.260	Sec. 42: **(b)** One-time attorney consultation fee up to $300 payable without Board approval	Sec. 58 & 59: Syntax change in unauthorized attorney's fee and solicitation provisions **(b) (new)** Allows one-time attorney consultation fee up to $300 payable without Board approval
23.30.395	Sec. 43: Adds definitions for Commissioner, Department, Director and Division	Sec. 60: Adds definitions for Director and Division
37.05.146(c)	Sec. 44: Includes Workers' Compensation Benefits Guaranty Fund in Program Receipts list	
39.25.110	Sec. 45: Places Commission chair in exempt service	
39.25.120	Sec. 46: RBA continues in partially exempt service	Sec. 61: RBA continues in partially exempt service
39.50.200	Sec. 47: Requires Appeals Commission members to file financial disclosure forms	
Section 48	Repeals 23.30.095(f), 23.20.095(l), 23.30.095(m)	
Section 49	Repeals (delayed) 23.30.015(c), 23.30.040, 23.30.205, 23.30.395(27), 37.05.146(c)(12).	
Section 50	Sec. 32 (23.30.175(b) amendment) applicable to injuries on/after effective date	Sec. 62: Sec. 32 (23.30.175(b) amendment) applicable to injuries on/after effective date

Section 51	Transition, initial Commission members get staggered appointments under AS 39.05.055	Sec. 63: Transition, initial Commission members get staggered appointments
Section 52	Transition, Division staff may be assigned to Commission for six months	
Section 53	Transition, ongoing activities continued and completed, determinations remain in effect	
Section 54	Transition, DOL&WD, DCCED, and Commission regulations	
Section 55	Transfer of SIF balance upon final repeal	
Section 56	Transition, medical services review committee report to Commissioner no later than March 1, 2007.	
Section 57	Sec. 54(a) (regulations) effective immediately under AS 01.10.070(c).	
Section 58	Sec. 1-4, 32, 56 effective September 1, 2005	
Section 59	Sec. 5, 12, 39, 49, 55 (SIF) effective upon Commissioner certification to Lt. Governor that all SIF claims paid off	
Section 60	Except as provided in Sec. 57-59, Act effective August 1, 2005	Sec. 64: Act takes effect July 1, 2005

Where Your Workers' Compensation Benefit Dollars Go

2003 Paid Costs/Benefits = $223 million

Source: Workers' Compensation 2003 Annual Report



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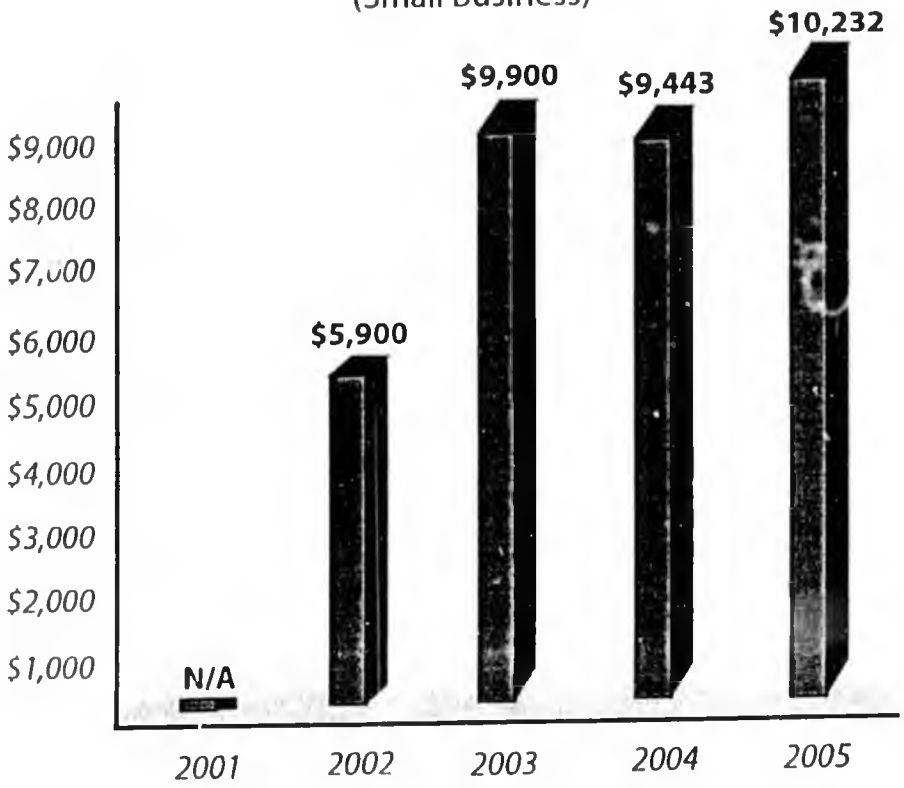
ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

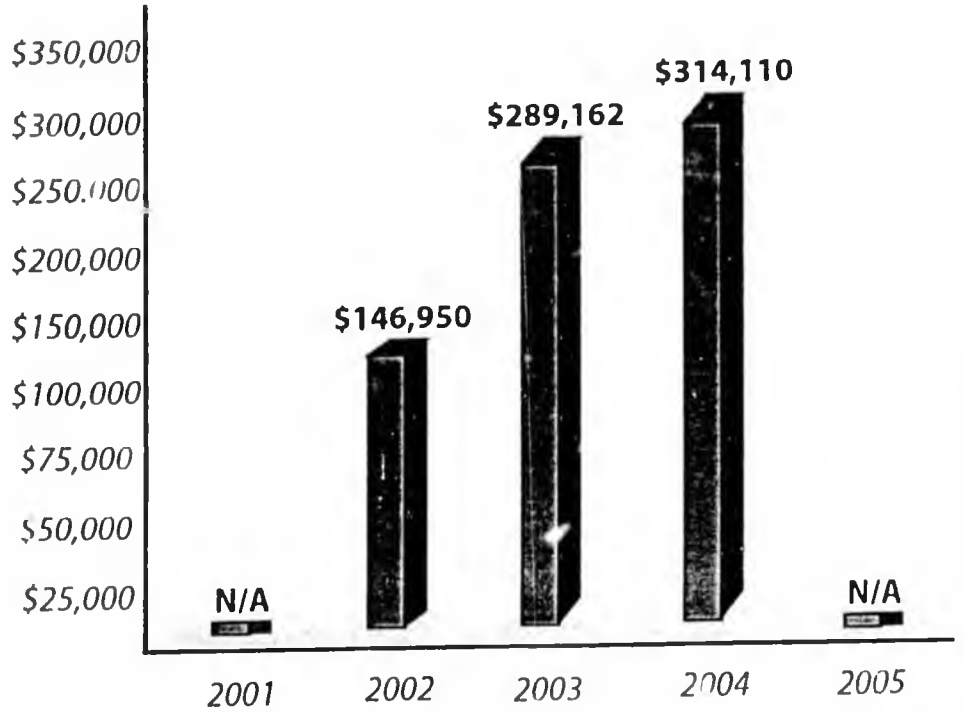
* Interest, Second Injury Fund, etc.

Workers' Compensation Insurance Annual Premiums Paid

Copy Express
(Small Business)



McGraw's Custom Construction
(General Contractor)



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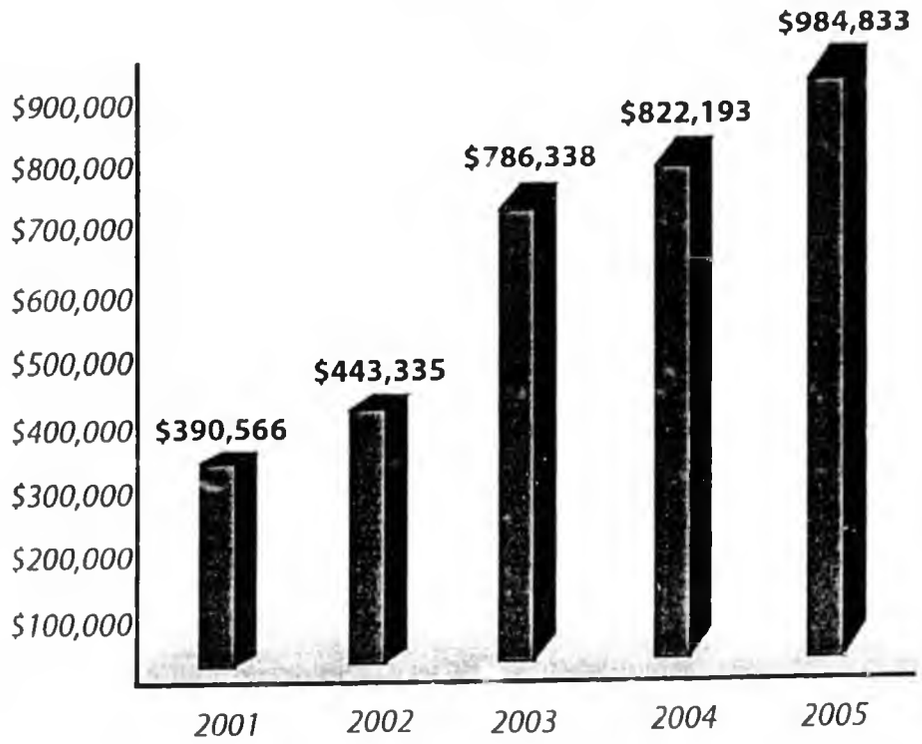
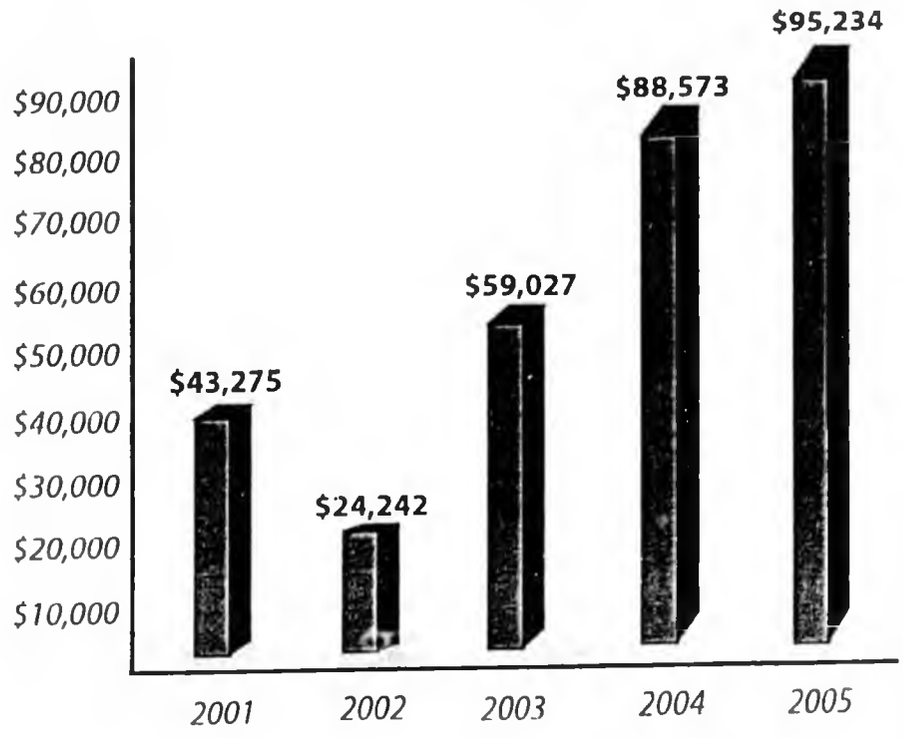
ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

Workers' Compensation Insurance Annual Premiums Paid

Central Peninsula General Hospital
(Health Care)



Kodiak Island Borough
(Government)



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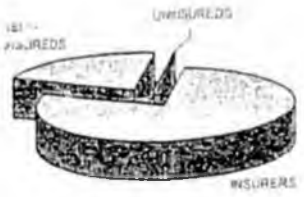
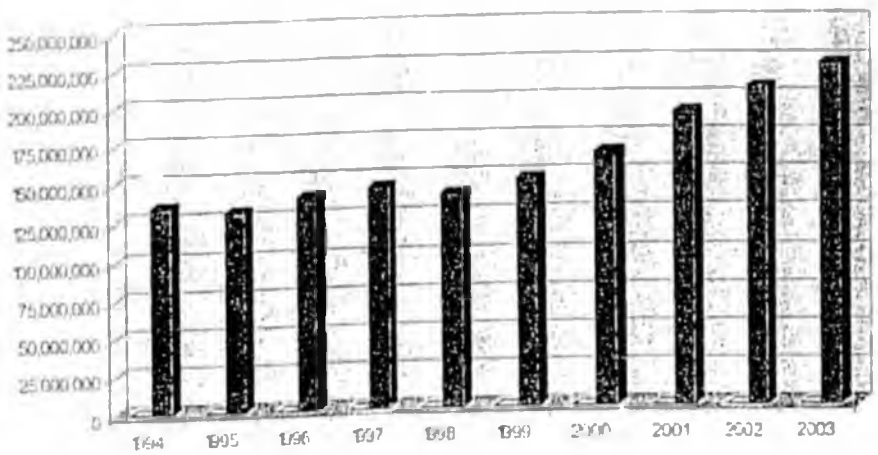
ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

WORKERS' COMPENSATION
2003 ANNUAL REPORT

A total of $223.0 million was paid in workers' compensation benefits during calendar year 2003. This is an increase of 7.01% over 2002's total of $208.4 million.

Of this amount, $174.4 million, 78.22%, was paid by insurance companies, and $48.6 million, 21.78%, was paid by self-insured employers.



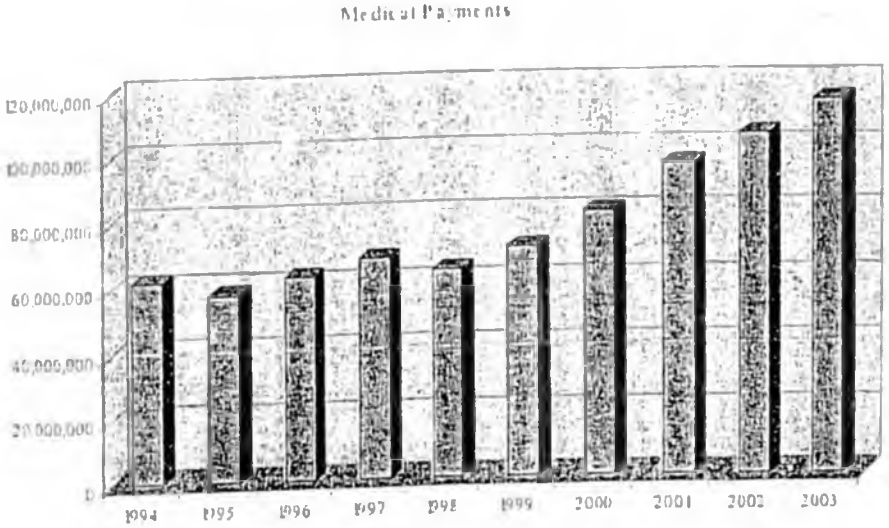


This compares to $162.1 million, 77.7%, paid by insurance companies and $46.4 million, 22.27%, paid by self-insured employers in 2002. Benefits reported by uninsured employers in 2003 totaled $24,891, compared to $33,123 in 2002.

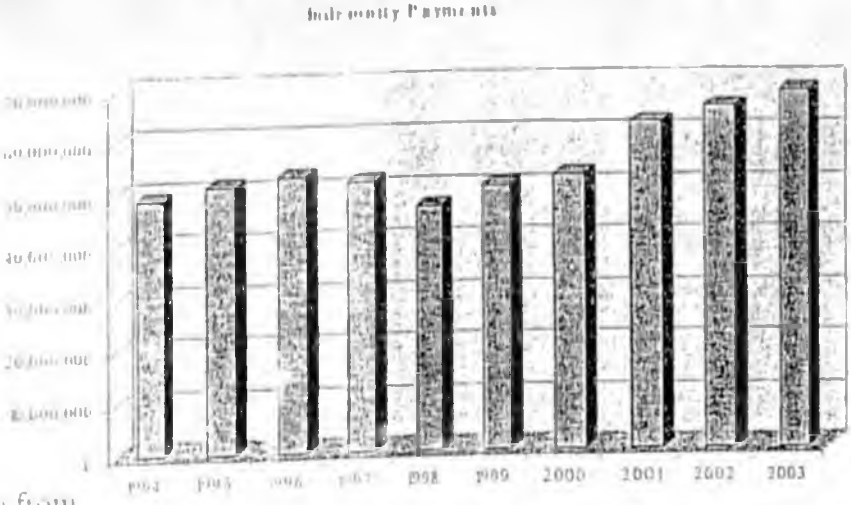
In the past 10 years $1.63 billion has been paid out in workers' compensation benefits. Of this amount, benefits by insurance companies totaled $1.27 billion or 78.12% of total benefits paid, while self-insured employers paid $355.3 million, or 27.97% of total benefits paid. Benefits reported by Uninsured Employers totaled $521,062, or 0.15% of total benefits paid.

MEDICAL BENEFITS

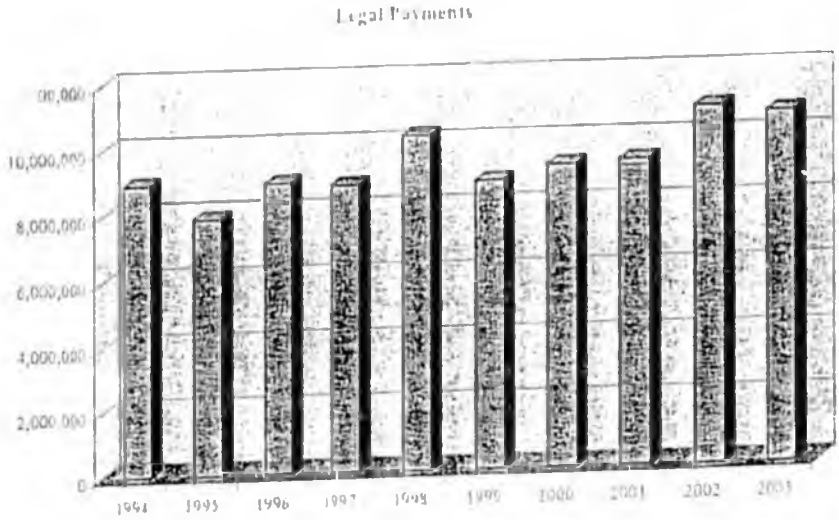
In 2003, medical benefits totaled $115.2 million, up 8.1% from $106.6 million in 2002. Medical benefits were 51.65% of total benefits paid, compared to 50.08% in 2002.



INDEMNITY BENEFITS

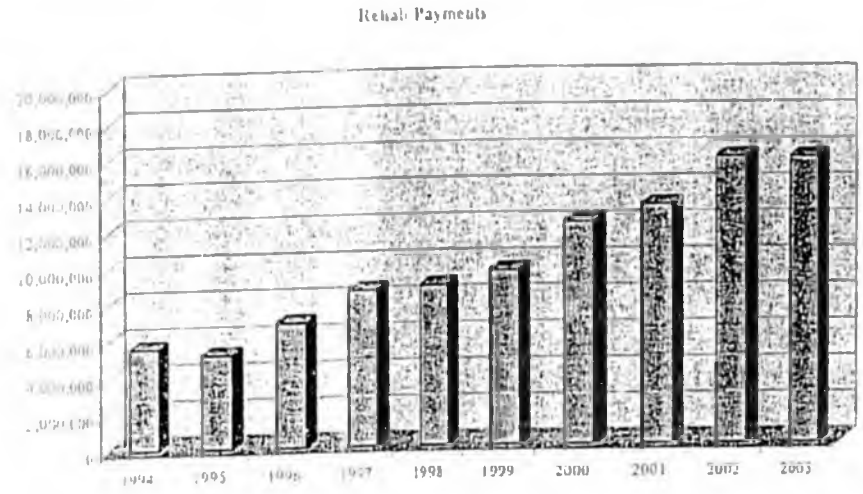


Year 2003 indemnity benefits (TTD, TPD, PPI, and PTD) totaled $68.5 million, up 4.95% from $65.3 million in 2002. TTD benefits increased 4.23% to $38.2 million from $36.7 million in 2002; TPD benefits decreased 3.72% to $1.43 million from $1.49 million in 2002; PPI benefits increased 5.95% to $23.7 million from $22.4 million in 2002; and PTD benefits increased 8.58% to $5.1 million from $4.7 million in 2002.



LEGAL EXPENSES

Legal expenses decrease l 1.94%, to $10.7 million in 2003 from $11.0 million in 2002. Employee attorney fees decreased 10.34% to $2.4 million from $2.7 million; employer attorney fees rose 1.98%, to $7.2 million from $7.1 million; and litigation costs decreased 6.21%, to $1.1 million from $1.2 million.



REEMPLOYMENT BENEFITS

Reemployment benefit payments decreased .2% in 2003, to $15.71 million from $15.75 million in 2002. Wages paid while under rehabilitation, 041K wages, were the largest rehabilitation expense. 041K wages decreased 3.31%, from $10.7 million in 2002 to $10.3 million in 2003. Employee evaluation costs decreased 24.4%, to $1.3 million from $1.7 million. Rehabilitation specialist fees increased 36.8%, to