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ANNUAL REPORT + RESEARCH REVIEW

WORKERS COMPENSATION RESEARCH INSTITUTE

A catalyst for significant improvements in workers' compensation systems

WCRI Annual Report

The Institute

The Workers Compensation Research Institute is an independent, not-for-profit research organization providing high-quality, objective information about public policy issues involving workers' compensation systems.

The Institute's work helps those interested in improving workers' compensation systems by providing much-needed data and analyses that help answer the following questions:

- How are workers' compensation systems performing?
- How do various state systems compare?
- How can systems better meet workers' needs?
- What factors are driving costs?
- What is the impact of legislative change on system outcomes?
- What are the possible consequences of proposed system changes? Are there alternative solutions that merit consideration? What are their consequences?

Those who benefit from the Institute's work include public officials, insurers, employers, injured workers, organized labor, and others affected by workers' compensation systems across the United States and around the world.

Organized in late 1983, the Institute is independent, not controlled by any industry or trade group. The Institute does not take positions on the issues it researches; rather, it provides information obtained through studies and data-collection efforts that conform to recognized scientific methods, with objectivity further ensured through rigorous, unbiased quality control procedures.

The Institute's work takes several forms:

- *Original research studies of major issues* confronting workers' compensation systems (for example, permanent partial disability, litigiousness, and medical management)
- *Studies of individual state systems* where policymakers have shown an interest in change and where there is an unmet need for objective information
- *Studies of states that have undergone major legislative changes* to measure the impact of those changes and draw possible lessons for other states
- *Studies to identify those system features* that are associated with positive and negative outcomes
- *Presentations* on research findings to legislators, workers' compensation administrators, industry groups, and others interested in workers' compensation issues

"The research done by WCRI has been a pivotal tool for public policymakers for decades. Both as a labor leader and as a lifelong advocate in the fight against substance abuse, their research has helped guide my work. WCRI's study of injured workers and their reliance on opiates helped shed light on the significance of this epidemic in Massachusetts. Their data is an invaluable tool for all those who wish to improve the lives of injured workers and our workers' compensation system."

Steve A. Tolman, President of the Massachusetts AFL-CIO

The Need

The reports and testimony of WCRI act as a catalyst for constructive change in improving workers' compensation systems throughout the U.S. and internationally. Too often, public policies are shaped by anecdote and emotion, not by objective evidence about current system performance or the consequences of proposed changes. As a result of WCRI research, policymakers and stakeholders can make information-based decisions that prove to be more enduring because they are more efficient, more equitable, and better designed to meet the needs of workers and employers.

Specifically, WCRI research meets the following important stakeholder needs:

- *Measuring system results* to encourage continuous improvement and move the system away from the historic cycle of crisis-reform-crisis that has frequently characterized workers' compensation in the past.
- *Examining disability and medical management* by evaluating and measuring the outcomes of medical care. These studies provide regulators with information about managing workplace injuries, what regulatory barriers are unnecessary or counterproductive, and what regulatory protections are needed for injured workers to assure quality outcomes. These studies also help guide business decisions.
- *Identifying system features that improve performance* or drive costs and quantifying their impact on system performance. These studies focus attention on system strengths and opportunities for improvement. They also provide lessons from successful states that other states may adopt.

The Workers Compensation Research Institute provides reliable information to legislators, governors, state (provincial) and federal administrators, task forces and study commissions, industry groups, labor organizations, and others interested in improving workers' compensation systems. The Institute's research addresses the major issues confronting these systems today. Its public policy studies are disseminated to all interested parties.

"WCRI is the 'Joe Friday' of workers' compensation research. By providing 'just the facts, ma'am,' WCRI assists stakeholders in making educated and objective decisions for the direction of the workers' compensation system. In many ways, their research helps frame the discussion and identifies ways of improving outcomes for injured workers."

Wes Hataway, former Director of the Louisiana Office of Workers' Compensation

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The Impact

Improvement in workers' compensation systems is a product of many factors. WCRI's research is one important factor. Policymakers continue to look to the Institute as a source of objective information to help them make informed decisions about legislation and administrative changes.

For over thirty years, Institute studies have helped public officials and stakeholders better understand how to improve system performance, what the impacts of proposed legislative changes are, and what the consequences of proposed solutions are. These studies provide much-needed, objective information on which to base decisions.

- WCRI's opioid and physician-dispensing studies identified substantial issues in many states having to do with usage, abuse, cost, and prescribing methods. These studies had and continue to have impact throughout the country. The following are some recent examples:
  - House Bill 1846, which was signed into law by Pennsylvania Governor Tom Corbett, caps the prices paid for physician-dispensed drugs and limits days of supply for drugs, including narcotics, dispensed by physicians. WCRI was invited to testify before the House Committee on Labor & Industry when the legislation was first introduced, and our research was actively used throughout the debate on the legislation.
  - Senate Bill 744, which was signed into law by North Carolina Governor Pat McCrory, limits the reimbursement amount for drugs dispensed by physicians to 95 percent of the average wholesale price and prohibits doctors from dispensing more than a five-day supply of narcotics to injured workers. WCRI's research was actively used during the debate on the legislation. The Industrial Commission also requested that WCRI help monitor the impact of the legislation.
  - The Michigan Workers' Compensation Agency (MWCA) announced amendments to the Workers' Compensation Health Care Services rules and fee schedule to address the problem of long-term use of opioids by injured workers and to reduce medical costs in the system. The amendments, which went into effect December 26, 2014, address reimbursements for opioid treatment beyond 90 days for non-cancer-related chronic pain. They also amend the fee schedule by adopting more recent Medicare-based schedules. The MWCA said WCRI's research was critical in the development and drafting of these amendments.
  - The medical director of the Tennessee Division of Workers' Compensation contacted WCRI to ask about follow-up research to *The Prevalence and Costs of Physician-Dispensed Drugs* study, in order to gauge the impact of earlier reforms that limit the maximum reimbursement amount of physician-dispensed repackaged drugs to the average wholesale price of the original drug product used in the repackaging process.

"WCRI provides valuable information regarding the impact of system change across the national workers' compensation environment. WCRI's research enables policymakers to compare approaches and learn from other states' experiences, increasing the likelihood that system changes will have the intended effect. I look forward to WCRI's reports and annual meeting as WCRI is one of a very few sources for credible workers' compensation research."

Vern Steiner, President and CEO of the California State Compensation Insurance Fund

- The WCRI medical fee schedule studies, which quantified the large differences among states in workers' compensation medical fee schedules, are well-used by public officials to evaluate their own fee regulations. The following are some recent examples:
  - WCRI briefed Florida State Senator Alan Hays regarding our research comparing workers' compensation and group health outpatient payments. The following day he used the information in his testimony before the Florida Senate Health Policy Committee about a new fee schedule.
  - Following testimony by WCRI to the Workers' Compensation Task Force in Delaware, State Representative Bryon Short, a member of the task force, filed legislation (House Bill 373) to create a new medical fee schedule for the state with provider reimbursements capped as a percentage of Medicare rates. The legislation was signed into law by the governor. In addition, Rep. Short said the following about WCRI's research at a task force meeting: "We had been looking at our numbers for years, but really, just looking at our little world. The WCRI stuff was eye-opening, giving us a perspective of where we are compared to other states, just how out of line we are…for workmen's comp costs. That's what drove me to say we need to make a radical change to how we're doing this stuff."
  - WCRI's work was used extensively by legislators and other stakeholders in Wisconsin during policy debates about whether to implement a medical fee schedule based on group health prices.
  - The New Hampshire Insurance Department was charged with leading a commission to study workers' compensation medical costs in the state and to make a recommendation to the governor on December 1, 2014. The Institute was invited to present to the commission and shared findings from various WCRI studies. The final report that was sent to the governor included a copy of WCRI's presentation along with several findings from WCRI studies relating to fee schedules.
  - Hospitals and employers are working with the Louisiana Office of Workers' Compensation to modify the state's hospital fee schedule, which is currently set at 90 percent of billed charges. WCRI's research helped shape the issue and is actively being used in the negotiations.
- CompScope™ Benchmarks studies, published annually, examine the impact of legislative changes and quantify differences in key metrics among study states. They continue to help policymakers identify key leverage points in their systems. The following are some recent examples:
  - The Illinois Workers' Compensation Medical Fee Advisory Board met in July to discuss increasing fees for office visits in response to findings from three WCRI studies: *Early Insights on the 2011 Reforms in Illinois: CompScope™ Medical Benchmarks, 14th Edition*; *Medical Price Index for Workers' Compensation (MPI-WC), Fifth Edition*; and *The Effect of Reducing the Illinois Fee Schedule*. WCRI research was referenced in the meeting minutes.
  - The former commissioner of the Texas Division of Workers' Compensation cited our research regarding trends in medical costs in testimony before the Texas House Business & Industry Committee.

"Our industry has the responsibility to continually improve the workers' compensation process for all parties involved. An important component of successfully meeting this goal is having accurate and relevant data to rely on. The information provided by WCRI impressively fulfills this role."

Steve Perroots, Vice President of Global Claims at Marriott International, Inc.

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– The North Carolina Industrial Commission began the rule-making process for fee schedule revisions that base reimbursement for hospital and nonhospital services on Medicare payment methodologies (required under House Bill 92 in 2013). Various WCRI studies were actively used in the negotiations that led to the proposed rules. In the formal notice of the proposed rules, CompScope™ Medical Benchmarks, 15th Edition was cited as a data source reviewed by the Commission in determining the applicable fee schedule rates.

To support our research programs, WCRI has developed the largest, most comprehensive, most representative claims database in use today. The Detailed Benchmark/Evaluation (DBE) database contains over 30 million claims from insurers, state funds, and self-insurers and represents nearly 75 percent of the workers' compensation benefits paid nationwide. This resource is a unique asset for WCRI and the workers' compensation community and allows WCRI to respond quickly to requests from public officials and other stakeholder groups with detailed, timely analysis of important issues.

Membership

To sustain and strengthen its impact, WCRI continues to expand its active and diverse membership, which elects the board of directors and is the source of representatives serving on key governance committees. Over one hundred fifty organizations support the Institute in 2015. (A list of members and associate members appears on the inside back cover of this report.)

Organizations may join the Institute as members or associate members.

Membership in the Institute is open to insured and self-insured employers, insurers, reinsurers, national trade and professional associations, national labor organizations, universities, insurance brokers, third-party administrators, managed care organizations, other service providers, and law firms. Members have electronic access to key research findings from WCRI studies on WCRI's web site. They also receive all publications from the Institute, preferred rates for registration to WCRI's acclaimed Annual Issues & Research Conference, and preferential invitations to other WCRI briefings. Member representatives participate in the governance of the Institute.

Associate members have electronic access to key research findings from WCRI studies on WCRI's web site. They also receive all publications from the Institute and preferred rates for registration to WCRI's Annual Issues & Research Conference and to other WCRI briefings. Associate memberships are available in several categories:

- *Associate member—public sector:* available to state workers' compensation agencies (except state funds), insurance commissioners, labor departments, and foreign entities
- *Associate member—labor association:* available to state labor organizations
- *Associate member—rating organization:* available to rating organizations

Governance

The responsibility for policymaking rests with the Institute's board of directors—a representative group of members who are elected by the membership for staggered, three-year terms and meet three times a year. (A list of 2015 board members and officers appears on the inside front cover of this report.)

Operating responsibility is vested in the executive director by the board, with direction from the board and advice from committees established by the board.

The research committee, composed of representatives of member companies, gives the executive director guidance on the Institute's research program.

Project advisory committees assist the research staff in the formulation and conduct of specific studies. These committees are made up of representatives of member companies, public officials, academic researchers, and others knowledgeable about the specific topics before them.

RESEARCH COMMITTEE/2015

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The Research Program

THE INSTITUTE'S RESEARCH PROGRAM FOCUSES ON THE MAJOR PUBLIC POLICY ISSUES CONFRONTING WORKERS' COMPENSATION SYSTEMS. OUR RESEARCH MEASURES SYSTEM PERFORMANCE, IDENTIFIES COST DRIVERS, QUANTIFIES OUTCOMES RECEIVED BY INJURED WORKERS, EVALUATES THE IMPACT OF ALTERNATIVE SOLUTIONS, AND HIGHLIGHTS EMERGING TRENDS. THE LESSONS FROM WCRI STUDIES ARE USED TO FACILITATE ACTION-ORIENTED DECISIONS BY PUBLIC OFFICIALS, EMPLOYERS, INSURERS, WORKER REPRESENTATIVES, AND OTHERS AFFECTED BY WORKERS' COMPENSATION, BOTH NATIONALLY AND INTERNATIONALLY.

Our current research programs are:

CompScope™ Benchmarks Research Program

System Evaluation Research Program

Disability and Medical Management Research Program

COMPSCOPE™ BENCHMARKS RESEARCH PROGRAM

CompScope™, WCRI's multistate benchmarking program, measures and benchmarks the performance of a growing number of state workers' compensation systems. Each year, CompScope™ studies quantify performance trends, benchmark improvement opportunities, and assess the effectiveness of policy changes. Using CompScope™, stakeholders and public officials can better manage change and avoid the historic pattern of crisis-reform-crisis that has frequently characterized workers' compensation in the past.

Using special statistical methods, the Institute has created performance measures and interstate comparisons that are comparable across otherwise diverse states. By identifying either incremental or sudden large changes in system performance—trends that may signal either improvement or possible deterioration in system performance—goals for system performance can be set, improvements accomplished, and crises avoided.

The CompScope™ program is funded by employers, state governments, rating organizations, and insurers seeking to help achieve a more cost-efficient, stable, and equitable workers' compensation system. To achieve the ambitious goals outlined above, continued, broad support and expanded funding are needed.

Among the diverse organizations that have provided funding for this important program are the following:

ACE USA
Advocate Health Care
AIG
Archer Daniels Midland Company
AT&T
Chevron Corporation
CNA Foundation
Compensation Advisory Organization of Michigan
Costco Wholesale
Country Insurance & Financial Services
Florida Department of Insurance
Ford Motor Company
Gallagher Bassett Services, Inc.
Georgia State Board of Workers' Compensation
The Hartford Insurance Group
Indiana Compensation Rating Bureau
International Truck and Engine Corporation
Levi Strauss & Co.
Liberty Mutual Group
Louisiana Department of Insurance
Louisiana Department of Labor, Office of Workers' Compensation Administration
Marriott International, Inc.
Massachusetts Workers' Compensation Rating and Inspection Board
Minnesota Workers' Compensation Insurers' Association, Inc.
Mitsubishi Motors North America, Inc.
Molloy Consulting, Inc.
New Jersey Compensation Rating & Inspection Bureau
Nordstrom, Inc.
North Carolina Rate Bureau
Pennsylvania Compensation Rating Bureau
Pubic Policy Institute of California
Safeway, Inc.
Sedgwick Claims Management Services, Inc.
State of Maryland Workers' Compensation Commission
Target Corporation
Tennessee Department of Labor and Workforce Development
Texas Department of Insurance
The Travelers Companies, Inc.
United Airlines, Inc.
United Parcel Service
Virginia Workers' Compensation Commission
The Walt Disney Company
Wisconsin Compensation Rating Bureau
Zenith Insurance Company
Zurich North America

SYSTEM EVALUATION RESEARCH PROGRAM

The System Evaluation Research Program focuses on the major current public policy issues and long-term challenges confronting workers' compensation systems. The breadth and diversity of this research adds significantly to the base of knowledge about workers' compensation systems.

- The objectives of this program are to
  - evaluate workers' compensation systems and identify best practices;
  - identify leverage points and quantify opportunities for system improvement;
  - measure outcomes experienced by injured workers;
  - provide comprehensive reference books to help understand key system features; and
  - measure the impact of reform.

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- The current research agenda includes the following topics:
  - Predictors of worker outcomes
  - Provider choice
  - Pain management
  - Medical cost containment
- Recently published studies include the following:
  - *Monitoring Trends in the New York Workers' Compensation System*
  - *WCRI Medical Price Index for Workers' Compensation, Sixth Edition (MPI-WC)*
  - *Comparing Payments to Ambulatory Surgery Centers and Hospital Outpatient Departments*
  - *Payments to Ambulatory Surgery Centers*
  - *Predictors of Worker Outcomes*

The research in this program is funded by members and associate members of the Institute. Representatives of member organizations serve on the board of directors and on key governance committees. A list of current members and associate members appears on the inside back cover of this report.

DISABILITY AND MEDICAL MANAGEMENT RESEARCH PROGRAM

As the cost of medical care continues to rise rapidly, many are asking how to identify high-cost medical care that may be delivering less than optimal benefits. The innovative Disability and Medical Management Research Program provides funds and establishes priorities for objective research that will improve public policy decisions about the management of work injuries.

The following are among the current topics for evaluation:

- Impact of physician dispensing and ban on opioids
- Impact of provider choice

Examples of studies published in the program include the following:

- *Early Impact of Tennessee Reforms on Physician Dispensing*
- *Physician Dispensing in Pennsylvania, 2nd Edition*
- *Impact of a Texas-Like Formulary in Other States*
- *Interstate Variations in Use of Narcotics, 2nd Edition*
- *Longer-Term Use of Opioids, 2nd Edition*

Funding for this program comes from organizations committed to improving public policies on disability and medical management to help policymakers and others make more informed decisions about managing work injuries. Research priorities are established by a program advisory board that is composed of leaders in their fields.

PROGRAM ADVISORY BOARD / 2014

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Visit us at www.wcrinet.org to learn more about the work of the Institute and to quickly access over 400 WCRI studies using a powerful key word search. WCRI's web site is the most content-rich workers' compensation research web site.

VISIT OUR WEBSITE: www.wcrinet.org

For all visitors:

- Powerful key word search of research studies
- Abstracts of over 400 research studies
- WCRI benchmarks of system performance
- WCRI benchmarks of medical cost and utilization
- Press releases
- Conference and seminar information
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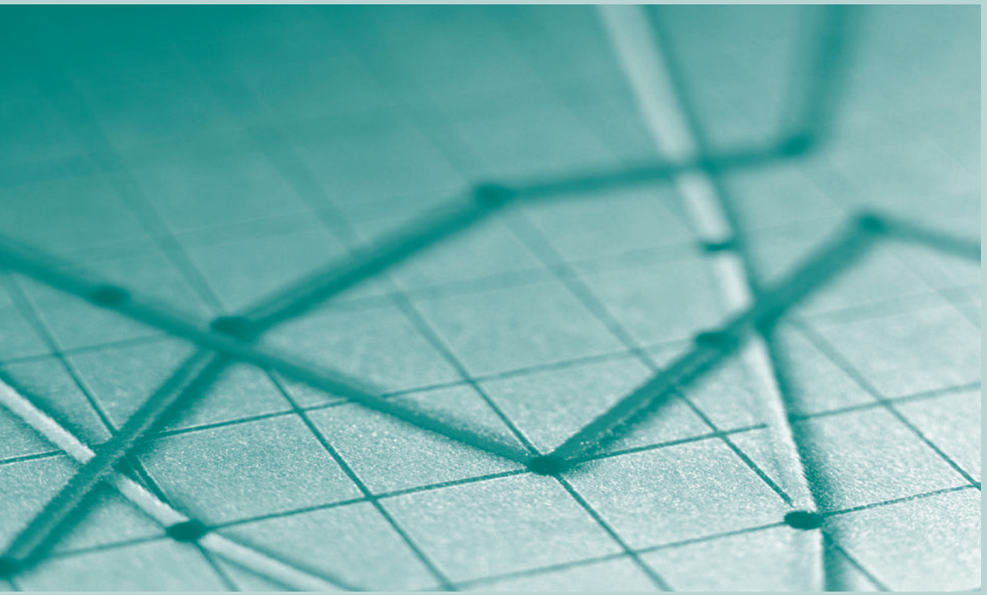
For members only:

- Detailed WCRI benchmarks of system performance and medical use
- Executive summaries of research reports
- Key tables and charts from research reports
- Slide presentations



In its 31st year, the Institute published 48 major studies on a broad range of topics. This brings the Institute's total to over 500 books on a wide variety of important workers' compensation issues affecting a growing number of states.

DISABILITY AND MEDICAL MANAGEMENT

THE IMPACT OF PHYSICIAN DISPENSING ON OPIOID USE

This study found evidence that physician dispensing encourages some physicians to unnecessarily prescribe strong opioids. The study examined changes in physician prescribing and dispensing of opioids for newly injured workers after the implementation of a ban on physician dispensing of Schedule II and Schedule III controlled substances in Florida, which went into effect on July 1, 2011.

The author of the study expected little change in the percentage of patients getting strong opioids—only a change from physician-dispensed to pharmacy-dispensed. Instead of finding an increase in pharmacy-dispensed strong opioids, the study found no material change. Rather, there was an increase in the percentage of patients receiving physician-dispensed weaker pain medications—specifically, nonsteroidal anti-inflammatory medications (e.g., ibuprofen)—from 24.1 percent to 25.8 percent, and the percentage of weaker (not banned) opioids increased from 9.1 percent to 10.1 percent.

The study found there was a high level of compliance with the ban by physician-dispensers. Prior to the reforms, 3.9 percent of injured workers received strong opioids dispensed by physicians during the first six months after their injuries. After the ban, only 0.5 percent of patients with new injuries received physician-dispensed strong opioids. If the pre-ban strong opioids were necessary, researchers would expect that workers who received these weaker physician-dispensed pain medications after the ban would later need strong opioids (that can be dispensed only at a pharmacy). But only 2 percent of those with weaker physician-dispensed pain medications in the first six months after the ban received strong opioids at a pharmacy in the next six months.

According to the study, the policy debate in a growing number of states has been focused on the much higher prices charged by physician-dispensers than pharmacies for the same medications. The debate has recently begun to focus on whether the economic incentives attendant to physician dispensing (like any form of physician self-referral) lead to prescribing and dispensing of unnecessary medications. Over the past 10 years, 18 states have modified reimbursement rules to reduce the prices paid for physician-dispensed drugs. Until recently, few of these states also limited the use of physician dispensing. The findings of this study raise the question of whether policymakers should consider reforms that limit the use of physician dispensing of certain medications in addition to reforms aimed at limiting the prices of physician-dispensed drugs.

This study analyzed data on the medications dispensed for injured workers covered by the Florida workers' compensation program. It included both open and closed Florida claims. The claims were divided into two groups: pre-reform, with dates of injury from January 1, 2010, to June 30, 2010 (prior to the July 1, 2011, effective date of the ban) and

post-reform, with dates of injury from July 1, 2011, to December 30, 2011 (immediately after the ban). The data included 24,567 claims with 59,564 prescriptions in the pre-reform group and 21,625 claims with 52,747 prescriptions in the post-reform group.

The Impact of Physician Dispensing on Opioid Use. Vennela Thumula. December 2014. WC-14-56.

HOSPITAL OUTPATIENT COST INDEX FOR WORKERS' COMPENSATION, 3RD EDITION

Rising hospital costs have been a concern and focus of recent public policy debates in many states. This study assists policymakers and business decision makers in managing this growth by allowing them to compare hospital outpatient costs across states, identify key cost drivers, and evaluate the impact of reforms.

The hospital outpatient cost indices compare payments paid for common outpatient surgical episodes under workers' compensation from state to state in each study year and compare the trends within each state from 2005 to 2012.

The following is a sample of the key lessons from the report:

- Payments to hospitals for outpatient surgical episodes for knee and shoulder surgeries were highest in study states with percent-of-charge-based fee regulations or no fee schedules. In particular, states with percent-of-charge-based fee regulations had substantially higher hospital outpatient payments per surgical episode than states with fixed-amount fee schedules—33 to 203 percent higher than the median of the study states with fixed-amount fee schedules in 2012.
- In terms of growth, the study found most states with percent-of-charge-based fee regulations or no fee schedules experienced more rapid growth in hospital outpatient payments per episode. More specifically, in most non-fee schedule states, growth in hospital outpatient payments per episode was at least 90 percent higher and as much as 160 percent higher than in the median fixed-amount fee schedule state over the study period.

This study covers 33 large states representing nearly 90 percent of the workers' compensation benefits paid in the United States. Nine study states had substantial changes in their hospital outpatient fee regulations from 2005 to 2012, and this study monitors changes in hospital outpatient payments per episode around the policy changes.

The states included in this study are Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.

Hospital Outpatient Cost Index for Workers' Compensation, 3rd Edition. Olesya Fomenko and Rui Yang. December 2014. WC-14-66.

Research Review

DISABILITY AND MEDICAL MANAGEMENT, CONT.

WORKERS' COMPENSATION MEDICAL COST CONTAINMENT: A NATIONAL INVENTORY, 2013

As the cost of medical care for injured workers continues to grow, this study provides policymakers and system stakeholders with an inventory of the cost containment initiatives employed by 51 jurisdictions. This study updates the tables from the previous edition with the statutory provisions, administrative rules, and administrative procedures as of January 2013. However, it does not provide written explanations of the initiatives in use by each state.

The report contains key features of each state's cost containment initiatives, including

- medical fee schedules;
- regulation of hospital charges;
- choice of provider;
- treatment guidelines;
- utilization review/management;
- managed care;
- pharmaceutical regulations;
- urgent care and ambulatory surgical center fee schedules; and
- medical dispute regulations.

These initiatives aim to curb the cost of a particular service or to reduce the amount of services provided. Cost containment regulatory initiatives entail a balancing act of limiting the cost of services and inappropriate or unnecessary treatment without negatively affecting the quality of treatment or access to care for injured workers. The 2013 edition includes new information about ability to settle costs of future medical care and whether there is a finite period of time for medical care.

Workers' Compensation Medical Cost Containment: A National Inventory, 2013. Ramona P. Tanabe. February 2013. WC-13-02.

IMPACT OF A TEXAS-LIKE FORMULARY IN OTHER STATES

As policymakers and other system stakeholders seek to contain medical costs, part of the focus is on prescription drug costs. This new study examines how a Texas-like closed drug formulary might affect the prevalence and costs of drugs in 23 other state workers' compensation systems that do not currently have a drug formulary. With an evidence-based closed formulary, states have the potential to contain pharmaceutical costs while encouraging evidence-based care.

According to the study, physicians in the other 23 states may have similar or different responses to the closed formulary from Texas physicians. A Texas-like closed formulary limits access to some drugs by requiring prior-authorization for drugs not included in the formulary. The study provides multiple scenarios to the readers to illustrate the impact of the formulary based on how physicians respond.

One of the scenarios finds if physicians in the 23 other study states were to change their prescribing patterns like physicians in Texas, they could reduce their total prescription costs by an estimated 14–29 percent. Non-formulary drug prevalence is estimated to drop from 10–17 percent to 3–5 percent of all prescriptions. Larger effects can be expected in Connecticut, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, and Virginia.

The study found non-formulary drugs were as prevalent in the 23 study states as they were in pre-reform Texas. They accounted for 10–17 percent of all prescriptions and 18–37 percent of total prescription costs. The comparable numbers for pre-reform Texas were 11 percent and 22 percent, respectively. Non-formulary drugs were most common in New York (17 percent) and Louisiana (16 percent). The most commonly prescribed non-formulary drugs in the majority of study states were Lidoderm®, OxyContin®, Soma®, Valium®, and Voltaren®.

The data for the study are based on utilization and costs of non-formulary drugs among newly injured workers in Texas and 23 other states that represent over 70 percent of workers' compensation benefits in the United States. The study looks at prescription utilization for injuries arising from October 1, 2010, to September 30, 2011, with prescriptions filled through March 31, 2012, and paid for by a workers' compensation payor. The data reflect an average 12 months of experience for claims included in the analysis.

The 23 states included in this study are Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Virginia, and Wisconsin.

Impact of a Texas-Like Formulary in Other States. Vennela Thumula and Te-Chun Liu. June 2014. WC-14-31.

INTERSTATE VARIATIONS IN USE OF NARCOTICS, 2ND EDITION

The dangers of narcotic misuse resulting in death and addiction constitute a top priority public health problem in the United States and are shared by the workers' compensation community. This study gives public officials, employers, worker advocates, and other stakeholders the ability to see how the use and prescribing of narcotics in their state compares with others.

The study examines interstate variations and trends in the use of narcotics and prescribing patterns of pain medications in the workers' compensation system across 25 states. The study found that the amount of narcotics used by an average injured worker in Louisiana and New York was striking.

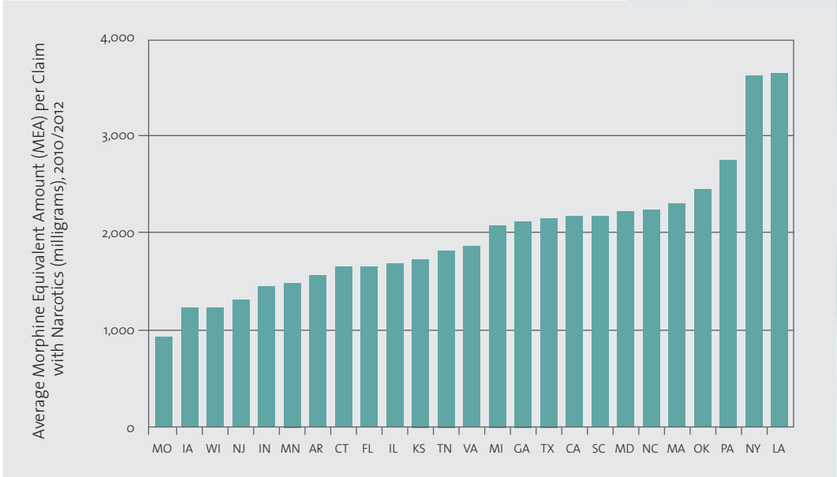
According to the study, the average injured worker in New York and Louisiana received over 3,600 milligrams of morphine equivalent narcotics per claim (double the number in the typical state). To illustrate, this amount is equivalent to an injured worker taking a 5-milligram Vicodin® tablet every four hours for four months continuously, or a 120-milligram morphine equivalent daily dose for an entire month.

Research Review

DISABILITY AND MEDICAL MANAGEMENT, CONT.

Besides New York and Louisiana, the amount of narcotics per claim was also higher in Pennsylvania and Oklahoma (32–48 percent higher than the typical state). Michigan had the highest amount of narcotics per claim among the Midwest states included in this study. It is worth noting that Michigan was among the states with lower use of narcotics per claim compared with the typical state in 2008/2010.

The study found that narcotics are frequently used in the workers' compensation system. In 2010/2012, about 65 to 85 percent of injured workers with pain medications received narcotics for pain relief in most states. A slightly higher proportion of injured workers with pain medications in Arkansas (88 percent) and Louisiana (87 percent) received narcotics. The study also reported a small reduction in the percentage of claims with pain medications that received narcotics in several study states, between 2008/2010 and 2010/2012.



The study is based on approximately 264,000 workers' compensation claims and 1.5 million prescriptions associated with those claims from 25 states. The claims represent injuries arising from October 1, 2007, to September 30, 2010, with prescriptions filled up to March 31, 2012. The underlying data reflect an average of 24 months of experience.

The following states are included in this study: Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

Interstate Variations in Use of Narcotics, 2nd Edition. Vennela Thumula, Dongchun Wang, and Te-Chun Liu. May 2014. WC-14-18.

Research Review

LONGER-TERM USE OF OPIOIDS, 2ND EDITION

The issue this study addresses is very serious, which is how often doctors followed recommended treatment guidelines for monitoring injured workers who are longer-term users of opioids. It helps public officials, employers, and other stakeholders understand as well as balance providing appropriate care to injured workers while reducing unnecessary risks to patients and costs to employers.

According to the study, there has been little reduction in the prevalence of longer-term opioid use in most states studied. In most states, the percentage of claims with opioids that received opioids on a longer-term basis changed little, within 2 percentage points, between 2008/2010 and 2010/2012.

The study examined the prevalence of longer-term use of opioids in 25 states and how often the services recommended by medical treatment guidelines were used for monitoring and managing chronic opioid therapy. The recommended services include drug testing and psychological evaluations and treatment, which may help prevent opioid misuse resulting in addiction and even overdose deaths.

The study found a sizable increase across states in the use of drug testing over the study period. However, in some states, the percentage of longer-term opioid users who received these services was still low. The study also reported low use of psychological evaluations, which remained low over the study period.

The study found longer-term opioid use was most prevalent in Louisiana, where 1 in 6 injured workers with opioids were identified as having longer-term use of opioids in 2010/2012. The numbers were 1 in 8 or 9 in New York, Pennsylvania, and pre-reform Texas. By contrast, fewer than 1 in 20 injured workers with opioids received opioids on a longer-term basis in several Midwest states (Indiana, Missouri, and Wisconsin) and New Jersey.

The study is based on approximately 264,000 workers' compensation claims and 1.5 million prescriptions associated with those claims from 25 states. The claims represent injuries arising from October 1, 2007, to September 30, 2010, with prescriptions filled up to March 31, 2012. The underlying data reflect an average of 24 months of experience.

The following states are included in this study: Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

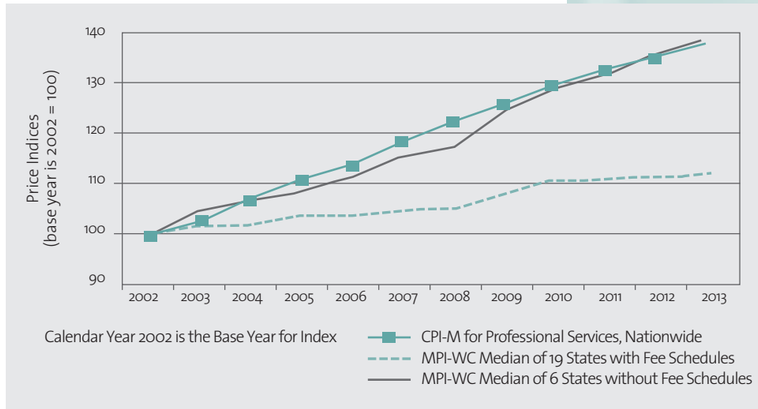
Longer-Term Use of Opioids, 2nd Edition. Dongchun Wang. May 2014. WC-14-19.

WCRI MEDICAL PRICE INDEX FOR WORKERS' COMPENSATION, SIXTH EDITION (MPI-WC)

This annual study helps public policymakers and system stakeholders understand how prices paid for medical professional services for injured workers in their state compare with other states and know if prices in their state are rising rapidly or relatively slowly. They can also learn if the reason for price growth in their state is part of a national phenomenon or whether the causes are unique to their state and, hence, subject to local management or reform.

The study tracks medical prices paid in 25 large states from calendar year 2002 through June 2013 for nonhospital, nonfacility services billed by physicians, physical therapists, and chiropractors. The medical services fall into eight major groups: evaluation and management, physical medicine, surgery, major radiology, minor radiology, neurological and neuromuscular testing, pain management injections, and emergency care.

The 25 states included in the MPI-WC, which represent nearly 80 percent of the workers' compensation benefits paid in the United States, are Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.



WCRI Medical Price Index for Workers' Compensation, Sixth Edition (MPI-WC). Rui Yang and Olesya Fomenko. July 2014. WC-14-34.

COMPSCOPE™ MEDICAL BENCHMARKS, 15TH EDITION

The cost drivers of medical care in state workers' compensation systems; the effects of legislative and regulatory changes on medical costs; and trends in payments, prices, and utilization of medical care for injured workers are examined in the 15th edition of CompScope™ Medical Benchmarks.

The studies examine 16 different state workers' compensation systems and provide a baseline of current medical costs and trends by documenting how medical payments per claim and their cost components compare over time with other states. The time period covered is 2007 to 2012, with claims' experience up through March 2013.

The reports are designed to help policymakers and others benchmark state system performance or a company's workers' compensation program and provide an excellent baseline for tracking system performance in the aftermath of policy changes and identifying important trends.

They are indispensable for identifying where changes in treatment patterns may be occurring; where medical payments per claim or utilization may be atypical compared with other study states; or where, because of underutilization of medical services, there may be concerns about restrictions on access to care.

The 16 states in the study—Arkansas, California, Florida, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas,

Virginia, and Wisconsin—represent more than 60 percent of the nation's workers' compensation benefit payments. There are individual reports for all states except Arkansas and Iowa.

The following is a sample of the key findings found in the studies:

- Illinois: Medical payments per claim in Illinois fell 20 percent between 2010 and 2012, likely due to a reduction in the fee schedule rates.
- Texas: Overall medical costs per claim in Texas increased less than in many states from 2007 to 2012, reflecting 2005 reforms that took the state's costs from the highest of the states that WCRI studied to one of the lowest.
- North Carolina: Hospital costs per claim in North Carolina remained higher than in most states, despite 2009 outpatient fee schedule changes that attempted to control those costs.
- Michigan: Medical costs per claim in Michigan grew more slowly than in the median of the 16 states WCRI studied. From 2007 to 2012, medical payments per claim grew 11.5 percent annually in Michigan, compared with 24.6 percent in the typical state.

CompScope™ Medical Benchmarks, 15th Edition. Sharon E. Belton, Roman Dolinschi, Evelina Radeva, Karen Rothkin, Bogdan Savych, Carol A. Telles, and Rui Yang. October 2014. WC-14-35 to 48.

COMPSCOPE™ BENCHMARKS, 14TH EDITION

This comprehensive reference report measures the performance of 16 different state workers' compensation systems, how they compare with each other, and how they have changed over time.

The report is designed to help policymakers and others benchmark state system performance or a company's workers' compensation program. The benchmarks also provide an excellent baseline for tracking the effectiveness of policy changes and identifying important trends.

The study examines how income benefits, overall medical payments, costs, use of benefits, duration of disability, litigiousness, benefit delivery expenses, timeliness of payment, and other metrics and system performance have changed per claim from 2007 to 2012.

The 16 states in the study—Arkansas, California, Florida, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin—represent nearly 60 percent of the nation's workers' compensation benefit payments. Separate state reports are available for 14 of the 16 study states.

Among the major findings are the following:

- Medical payments per claim in Illinois declined, likely due to a reduction in the fee schedule rates.
- Costs per claim in Louisiana were higher than in most states and growing rapidly, mainly due to longer and increasing duration of temporary disability and higher and growing hospital payments.
- Overall costs per claim declined in Texas following reforms aimed at containing medical costs.
- Growth in total costs per claim moderated in Pennsylvania after rising in prior years.

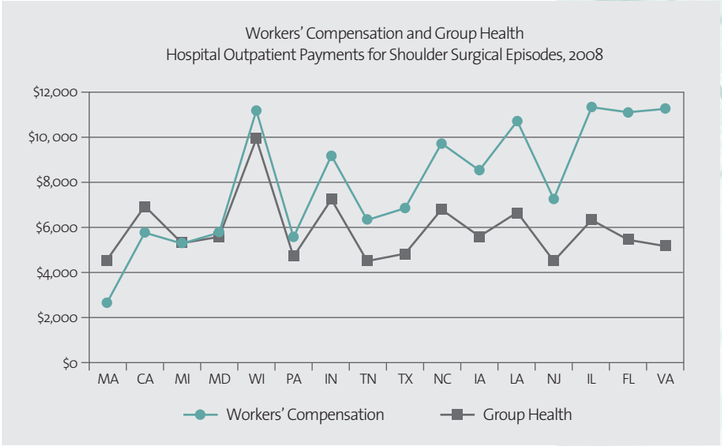
The report presents various measures in several areas, including time from injury to payor notice of injury and first indemnity payment; average total cost per claim, average payment per claim for medical benefits, and average payments per claim for indemnity benefits and components (temporary disability benefits, permanent partial disability benefits, and lump-sum settlements); vocational rehabilitation use and costs; benefit delivery expenses per claim; defense attorney involvement; and duration of temporary disability.

CompScope™ Benchmarks, 14th Edition. Sharon E. Belton, Roman Dolinschi, Evelina Radeva, Karen Rothkin, Bogdan Savych, Carol A. Telles, and Rui Yang. October 2013. WC-13-25 to 38.

COMPARING WORKERS' COMPENSATION AND GROUP HEALTH HOSPITAL OUTPATIENT PAYMENTS

This study compares hospital payments for the same surgical procedure when paid for by group health versus workers' compensation in 16 states. According to this study, in a majority of the study states, workers' compensation incurred substantially higher hospital payments than group health for the same surgical procedure. Some speculate that there is an additional burden associated with taking care of a worker injured on their job, such as uncertainty or delay in payments. If so, the question for policymakers and other stakeholders is, what additional reimbursement is necessary to get quality care for injured workers?

Rising hospital payments have been a focus of recent policy debates in many states. Policymakers and stakeholders have considered various means of cost containment, with special attention devoted to implementation of and updates to workers' compensation fee schedules. To set fee schedule levels, policymakers often seek a reference point or benchmark to which they can tie the state's reimbursement rates.



Increasingly, states rely on Medicare rates as a benchmark, while other states use some form of usual and

customary charges in the area. This study uses group health reimbursement levels as an alternative benchmark. Group health has some important advantages as a benchmark for workers' compensation fee schedules, including being the largest provider of health insurance with the most widely accepted reimbursement rates by medical providers.

Among the study's findings are the following:

- In two thirds of the study states, workers' compensation hospital outpatient payments related to common surgeries were higher than those paid by group health, and, in half of the study states, the workers' compensation and group health difference for shoulder surgeries exceeded $2,000 (or at least 43 percent).
- The workers' compensation payment premiums over group health were highest in the study states with percent-of-charge-based fee regulation or no fee schedule.
- States with high workers' compensation hospital outpatient payments were rarely states with above-typical group health hospital payments.
- The hospital outpatient payments per surgical episode demonstrated substantially greater interstate variation in workers' compensation than in group health.

This study compares hospital outpatient payments incurred by workers' compensation and group health for treatment of similar common surgical cases in 16 large states, which represented 60 percent of the workers' compensation benefits paid in the United States, and covers hospital outpatient services delivered in 2008. Given that most study states, except Illinois, North Carolina, and Texas, did not have substantial changes in their fee schedule regulations after 2008, the interstate comparisons should provide a reasonable approximation for current state rankings in workers' compensation/group health payment differences.

Comparing Workers' Compensation and Group Health Hospital Outpatient Payments. Olesya Fomenko. June 2013. WC-13-18.

PREDICTORS OF WORKER OUTCOMES

Eight new state-specific studies identified new predictors of worker outcomes that can help public officials, payors, and health care providers improve the treatment and communication an injured worker receives after an injury—leading to better outcomes.

Among the study's many findings, trust in the workplace was found to be one of the more important predictors that has not been examined before. To describe the level of trust or mistrust in the work relationship, the studies' interviewers asked workers if they were concerned about being fired as a result of the injury.

The following are some findings from the studies regarding this predictor:

- Workers who were strongly concerned about being fired after the injury experienced poorer return-to-work outcomes than workers without those concerns.
- One in five workers who were concerned about being fired reported that they were not working at the time of the interview. This was double the rate that was observed for workers without such concerns. Among workers who were not concerned about being fired, one in ten workers was not working at the time of the interview.
- Concerns about being fired were associated with a four-week increase in the average duration of disability.

The studies also identified workers with specific comorbid medical conditions (existing simultaneously with and usually independently of another medical condition) by asking whether the worker had received treatment for hypertension, diabetes, and heart problems. The medical condition may have been present at the time of the injury or may have manifested during the recovery period.

Among those findings:

- Workers with hypertension (when compared with workers without hypertension) had a 3 percentage point higher rate of not working at the time of the interview predominantly due to injury.
- Workers with heart problems reported an 8 percentage point higher rate of not working at the time of the interview predominantly due to injury and had disability duration that was four weeks longer.
- Workers with diabetes had a 4 percentage point higher rate of not working at the time of the interview predominantly due to injury than workers without diabetes.

The studies are based on telephone interviews with 3,200 injured workers across eight states. The eight states are Indiana, Massachusetts, Michigan, Minnesota, North Carolina, Pennsylvania, Virginia, and Wisconsin. The studies interviewed workers who suffered a workplace injury in 2010 and received workers' compensation income benefits. The surveys were conducted during February through June 2013—on average, about three years after these workers sustained their injuries.

Predictors of Worker Outcomes. Bogdan Savych, Vennela Thumula, and Richard A. Victor. June 2014. WC-14-20 to 27.

AVOIDING LITIGATION: WHAT CAN EMPLOYERS, INSURERS, AND STATE WORKERS' COMPENSATION AGENCIES DO?

One goal of a workers' compensation program is to deliver necessary medical care and income benefits to workers injured on the job without the uncertainty, delay, and expense of litigation. In many states, however, disputes and attorney involvement in the benefit delivery process are common.

Policy debates about attorney involvement have common themes from state to state. Workers' attorneys argue that they help workers receive benefits that these workers would not be able to obtain themselves, help workers navigate a sometimes complex system, and protect workers from retaliation by the employer or insurer. Advocates for

employers and insurers contend that attorneys are involved more often than necessary, that workers can often receive the benefits they are entitled to without representation, and that attorneys may even reduce the total amount of benefits that workers take home.

Some of the existing attorney involvement is inevitably unnecessary, such as cases where the worker would have received the statutory entitlement without resorting to hiring an attorney. If unnecessary attorney involvement can be avoided, this would be a win-win-win scenario. Workers would receive benefits without the expense of paying an attorney and the delays of dispute resolution; employers and insurers would save the costs of defending the case; and increasingly resource-short state workers' compensation agencies would have smaller caseloads to manage and would have to provide fewer dispute-resolution services.

This study identifies and quantifies some of the more important factors that lead injured workers to seek representation by an attorney, providing some key elements for employers, claims organizations, and state agencies to take away.

Major findings:

The study found that workers were more likely to seek attorneys when they felt threatened. Sources of perceived threats were found in two areas:

- *The employment relationship.* Workers believed they would be fired as a result of the injury, and/or workers perceived that the supervisor did not think the injury was legitimate.
- *The claims process.* The worker perceived that his or her claim had been denied, although it was later paid. This perception may have stemmed from a formal denial, delays in payment, or communications that the worker deemed to be a denial.

Potential implications for employers, claims organizations, and state agencies:

It is possible that attorney involvement can be decreased if employers, claims organizations, and state agencies reduce or eliminate *unnecessary actions* that workers interpret as threats. The suggested actions below, while logical implications of this study, are not themselves the findings of the empirical research:

- *Train supervisors.* Help supervisors create timely communications that focus on trust, job security, and entitlement to medical care and income benefits.
- *Create state agency education materials and help lines.* Provide written materials and an accessible help line that answers workers' questions to help ease feelings of vulnerability and uncertainty.
- *Communicate in a clear and timely fashion about the status of the claim.* Prevent misunderstandings through unambiguous, timely communication from the claims manager so the worker does not mistakenly conclude that the claim has been denied.
- *Eliminate system features that encourage denials or payment delays.* Eliminating system features that discourage timely payments may help prevent a worker's misconstruing a delay as a denial.

Research Review

OTHER STUDIES BY WCRI, CONT.

Avoiding Litigation: What Can Employers, Insurers, and State Workers' Compensation Agencies Do? Richard A. Victor and Bogdan Savych. July 2010. WC-10-18.

MONITORING TRENDS IN THE NEW YORK WORKERS' COMPENSATION SYSTEM

This is the seventh annual report to regularly track key metrics of the performance of the state's workers' compensation system following the implementation of the 2007 reforms. The study helps policymakers and system stakeholders focus on objectives that are being met, objectives that are not being met, and any unintended consequences that have emerged.

The key reform measures increased maximum statutory benefits, limited the number of weeks of permanent partial disability (PPD), created medical treatment guidelines, adopted a fee schedule for pharmaceuticals, established networks for diagnostic services and thresholds for preauthorization, and enacted administrative changes to increase speed of case resolution.

The report noted that the changes have various effective dates and have been instituted over time. As a result, it will be several more years before the full impact of the reforms will be realized.

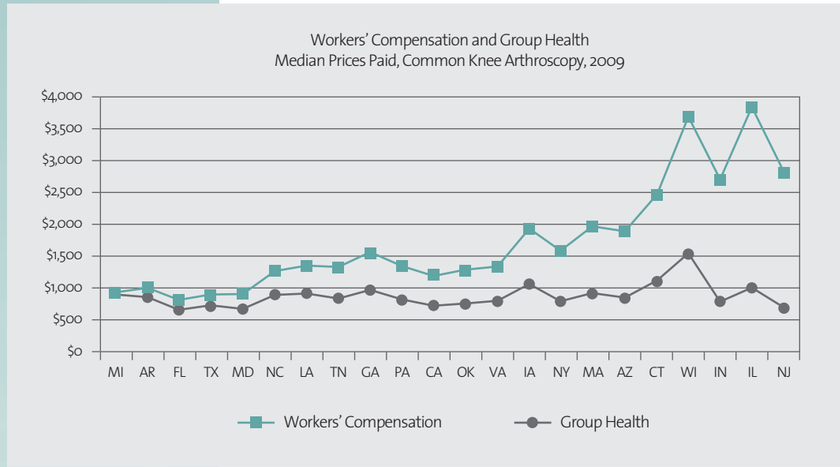
The following are among the study's key findings:

- In 2011 claims evaluated in 2012 (reflecting 16 months of experience under the treatment guidelines), the number of visits per indemnity claim decreased notably for chiropractors and physical/occupational therapists compared with the prior year. There was a smaller decrease for physicians.
- From 2007 to 2010, for PPD/lump-sum cases at an average 24 months of experience, there was a nearly 15 percentage point decrease in cases that received PPD payments only (with no lump-sum payment) and a nearly 12 percentage point increase in cases with a lump-sum settlement only (with no PPD payments).
- From 2007 to 2011 (for claims at an average 12 months of experience), there was a 4 percent increase in the number of visits for major radiology services by nonhospital providers. The percentage of indemnity claims with major radiology services also grew over that same period, from 45 percent to 52 percent.
- There was little change in the average defense attorney payment per claim from 2009 to 2010, but an increase of nearly 9 percent in 2011.

The study uses open and closed indemnity and medical-only claims with dates of injury from October 2005 through September 2011, with experience as of March 2012. The data are representative of the New York system.

Monitoring Trends in the New York Workers' Compensation System. Carol A. Telles and Ramona P. Tanabe. September 2014. WC-14-33.

A NEW BENCHMARK FOR WORKERS' COMPENSATION FEE SCHEDULES: PRICES PAID BY COMMERCIAL INSURERS?



In a typical year, 5 to 10 states have significant public policy debates about enacting new fee schedules or making major revisions to existing ones to regulate prices paid in workers' compensation. Often, the central question debated is what price level is too low—that is, at which point good health care providers will not provide timely treatment to injured workers. In making such decisions, providers consider what they are paid by other payors. Prices paid by Medicare and commercial insurers are plausible benchmarks for policymakers to use since they are usually the largest payors in a given state.

This study provides the basic comparative data that policymakers can use to ground the debate. For example, if the maximum prices proposed were double those paid by commercial insurers, policymakers might be skeptical of testimony by providers that they would stop treating injured workers if the maximum fees were lowered by a modest amount. Similarly, if the maximum workers' compensation fees were lower than what commercial insurers are paying, policymakers might be skeptical of testimony of payor representatives that the prices are too high and can be lowered without adversely affecting access to care for injured workers.

Sample of major findings:

- Workers' compensation prices are very much shaped by the state fee schedules or their absence. In states with higher (lower) fee schedules, workers' compensation prices paid were typically higher (lower). In states without fee schedules, prices paid were generally higher. States without fee schedules in this study include Indiana, Iowa, New Jersey, Virginia, and Wisconsin.
- For common surgeries performed on injured workers, the prices paid under workers' compensation were higher than the prices paid by group health insurers for the same surgery in almost all study states. In some states, the workers' compensation prices paid were 2–4 times higher than the prices paid by group health insurers in the same state.
- For office visits, the prices paid under workers' compensation were typically within 30 percent of the prices paid by group health insurers. In nearly half of the states studied, the prices paid under workers' compensation were within 15 percent of the group health price.

This study focuses on the median nonhospital price paid for five common surgeries and four common established patient office visits in 22 large states for services delivered in 2009. These are the prices actually paid for professional services billed under a specific Current Procedural Terminology (CPT) code. This study also discusses how to generalize these results to later years.

The 22 states included in this study are Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, and Wisconsin.

A New Benchmark for Workers' Compensation Fee Schedules: Prices Paid by Commercial Insurers? Olesya Fomenko and Richard A. Victor. June 2013. WC-13-17.

WORKERS' COMPENSATION LAWS AS OF JANUARY 2014

An essential tool for researching and understanding the distinctions among workers' compensation laws in all U.S. states and certain Canadian provinces is done as a joint venture of the International Association of Industrial Accident Boards and Commissions (IAIABC) and the Workers Compensation Research Institute (WCRI).

This report is a key resource for policymakers and other stakeholders to identify the similarities and distinctions between workers' compensation regulations and benefit levels in multiple jurisdictions in effect as of January 1, 2014.

The publication is best used to understand macro-level differences and general tendencies across jurisdictions:

- How many states/provinces allow individual or group self insurance?
- How do the maximum and minimum payments for temporary and permanent total disability benefits vary?
- How many states cover mental stress claims, hearing loss, and cumulative trauma?
- How many jurisdictions allow the worker to choose the treating physician and how many allow the employer to do so?

In Canada and the United States, workers' compensation is entirely under the control of sub-national legislative bodies and administrative agencies. As a result, it is easy to misunderstand subtle differences between jurisdictional laws and regulations. This survey gives you the ability to understand those differences.

Workers' Compensation Laws as of January 2014. April 2014. WC-14-28.

Research Review

Publication List

COMPSCOPE™ BENCHMARKS

CompScope™ Benchmarks: Multistate Comparisons, 14th Edition (October 2013) WC-13-25 to WC-13-38, WC-13-41

CompScope™ Benchmarks: Multistate Comparisons, 13th Edition (October 2012) WC-12-25 to WC-12-38

CompScope™ Benchmarks: Multistate Comparisons, 12th Edition (December 2011) WC-11-41 to WC-11-54

CompScope™ Benchmarks: Multistate Comparisons, 11th Edition (January 2011) WC-11-02 to WC-11-16

CompScope™ Benchmarks: Multistate Comparisons, 10th Edition (December 2009) WC-09-32 to WC-09-44

CompScope™ Benchmarks: Multistate Comparisons, 9th Edition (January 2009) WC-09-01 to WC-09-12

CompScope™ Benchmarks: Multistate Comparisons, 8th Edition (January 2008) WC-08-01 to WC-08-11

CompScope™ Benchmarks: Multistate Comparisons, 7th Edition (February/March 2007) WC-07-15 to WC-07-25

CompScope™ Benchmarks: Multistate Comparisons, 6th Edition (February 2006) WC-06-02 to WC-06-11

CompScope™ Benchmarks: Multistate Comparisons, 5th Edition (February 2005) WC-05-01 to WC-05-09

CompScope™ Benchmarks: Multistate Comparisons, 4th Edition (February 2004) WC-04-1

CompScope™ Benchmarks: Multistate Comparisons, 1994–2000 (April 2003) WC-03-2

CompScope™ Benchmarks: Massachusetts, 1994–1999 (January 2002) CS-01-3

CompScope™ Benchmarks: Florida, 1994–1999 (September 2001) CS-01-1

CompScope™ Benchmarks: Multistate Comparisons, 1994–1999 (August 2001) CS-02-2

Benchmarking the Performance of Workers' Compensation Systems: CompScope™ Multistate Comparisons (July 2000) CS-00-1

Benchmarking the Performance of Workers' Compensation Systems: CompScope™Measures for Minnesota (June 2000) CS-00-2

Benchmarking the Performance of Workers' Compensation Systems: CompScope™ Measures for Massachusetts (December 1999) CS-99-3

Benchmarking the Performance of Workers' Compensation Systems: CompScope™ Measures for California (December 1999) CS-99-2

Benchmarking the Performance of Workers' Compensation Systems: CompScope™ Measures for Pennsylvania (November 1999) CS-99-1

DISABILITY AND MEDICAL MANAGEMENT

The Impact of Physician Dispensing on Opioid Use (December 2014) WC-14-56

Hospital Outpatient Cost Index for Workers' Compensation, 3rd Edition (December 2014) WC-14-66

Early Impact of Tennessee Reforms on Physician Dispensing (December 2014) WC-14-55

Early Impact of South Carolina Reforms on Physician Dispensing (November 2014) WC-14-54

Early Impact of Connecticut Reforms on Physician Dispensing (November 2014) WC-14-53

Estimating the Effect of California's Fee Schedule Changes: Lessons from WCRI Studies (October 2014) WC-14-19

CompScope™ Medical Benchmarks, 15th Edition (October 2014) WC-14-35 to WC-14-48

Impact of Physician Dispensing Reform in Georgia, 2nd Edition (September 2014) WC-14-50

Physician Dispensing in Pennsylvania, 2nd Edition (September 2014) WC-14-51

WCRI Medical Price Index for Workers' Compensation, Sixth Edition (MPI-WC) (July 2014) WC-14-34

Impact of a Texas-Like Formulary in Other States (June 2014) WC-14-31

Comparing Payments to Ambulatory Surgery Centers and Hospital Outpatient Departments (June 2014) WC-14-29

Payments to Ambulatory Surgery Centers (June 2014) WC-14-30

Interstate Variations in Use of Narcotics, 2nd Edition (May 2014) WC-14-18

Longer-Term Use of Opioids, 2nd Edition (May 2014) WC-14-19

CompScope™ Medical Benchmarks, 14th Edition (February 2014) WC-14-02 to WC-14-15

The Effect of Reducing the Illinois Fee Schedule (January 2014) WC-14-01

The Prevalence and Costs of Physician-Dispensed Drugs (September 2013) WC-13-39

Physician Dispensing in the Pennsylvania Workers' Compensation System (September 2013) WC-13-23

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Impact of Reform on Physician Dispensing and Prescription Prices in Georgia (July 2013) WC-13-21

Impact of Banning Physician Dispensing of Opioids in Florida (July 2013) WC-13-20

A New Benchmark for Workers' Compensation Fee Schedules: Prices Paid by Commercial Insurers? (June 2013) WC-13-17

WCRI Medical Price Index for Workers' Compensation, Fifth Edition (MPI-WC) (June 2013) WC-13-19

Comparing Workers' Compensation and Group Health Hospital Outpatient Payments (June 2013) WC-13-18

CompScope™ Medical Benchmarks, 13th Edition (February 2013) WC-13-03 to WC-13-16

Workers' Compensation Medical Cost Containment: A National Inventory, 2013 (February 2013) WC-13-02

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(July 2012) WC-12-24

Designing Workers' Compensation Medical Fee Schedules
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(May 2012) WC-12-02 to WC-12-16

Why Surgeon Owners of Ambulatory Surgical Centers Do More Surgery Than Non-Owners
(May 2012) WC-12-17

WCRI Medical Price Index for Workers' Compensation, 4th Edition (MPI-WC)
(March 2012) WC-12-20

Hospital Outpatient Cost Index for Workers' Compensation
(January 2012) WC-12-01

WCRI Medical Price Index for Workers' Compensation, Third Edition (MPI-WC)
(August 2011) WC-11-37

Interstate Variations in Use of Narcotics
(July 2011) WC-11-01

Prescription Benchmarks, 2nd Edition: Trends and Interstate Comparisons
(July 2011) WC-11-31

Prescription Benchmarks for Florida: 2nd Edition
(July 2011) WC-11-32

Prescription Benchmarks for Washington
(July 2011) WC-11-33

Impact of Preauthorization on Medical Care in Texas
(June 2011) WC-11-34

CompScope™ Medical Benchmarks, 11th Edition
(May 2011) WC-11-17 to WC-11-30

Workers' Compensation Medical Cost Containment: A National Inventory, 2011
(April 2011) WC-11-35

Prescription Benchmarks for Minnesota
(October 2010) WC-10-41

CompScope™ Medical Benchmarks, 10th Edition (June 2010)
WC-10-19 to WC-10-13

Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2009
(June 2010) WC-10-32

Prescription Benchmarks
(March 2010) WC-10-05 to WC-10-16

Fee Schedules for Hospitals and Ambulatory Surgical Centers: A Guide for Policymakers
(February 2010) WC-10-01

National Inventory of Workers' Compensation Fee Schedules for Hospitals and Ambulatory Surgical Centers
(February 2010) WC-10-02

CompScope™ Medical Benchmarks, 9th Edition
(June 2009) WC-09-17 to WC-09-28

Workers' Compensation Medical Cost Containment: A National Inventory
(August 2009) WC-09-15

The Anatomy of Workers' Compensation Medical Costs and Utilization, 7th Edition
(January 2009) WC-08-16 to WC-08-26

Interstate Variations in Medical Practice Patterns for Low Back Conditions
(June 2008) WC-08-28

WCRI Medical Price Index for Workers' Compensation: The MPI-WC, Second Edition
(June 2008) WC-08-29

Connecticut Fee Schedule Rates Compared to State Medicare Rates: Common Medical Services Delivered to Injured Workers by Nonhospital Providers
(December 2007) FR-07-04

What Are the Most Important Medical Conditions in Workers' Compensation?—A WCRI FLASHREPORT
(August 2007) FR-07-03

What Are the Most Important Medical Conditions in New York Workers' Compensation?—A WCRI FLASHREPORT
(July 2007) FR-07-02

Analysis of Illustrative Medical Fee Schedules in Wisconsin—A WCRI FLASHREPORT
(March 2007) FR-07-01

The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 6th Edition
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