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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Labor and Election Process Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

SB 474

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Senate Committee on Labor and Election Process Reform
Senator Tom Reynolds, Chair

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations

DATE: January 25, 2006

RE: Wisconsin's Worker's Compensation Care

On behalf of the nearly 11,000 members of the Wisconsin Medical Society, thank you for this opportunity to share information related to Wisconsin's Worker's Compensation (WC) system. Simply put, Wisconsin has a lot to be proud of for our innovative and successful Worker's Compensation program. One of those success stories is the quality of care workers receive from physicians and other WC providers, and how that quality of care leads to a quicker return to work and fewer returns to the physician's office.

The independent, not-for-profit Workers Compensation Research Institute recently released a report comparing and analyzing WC claims in 13 different states (Wisconsin, Indiana, Arkansas, Pennsylvania, Maryland, North Carolina, Tennessee, Illinois, Louisiana, Florida, Texas and California). Among the major findings (PowerPoint presentation attached to this cover memo):

Wisconsin had the lowest adjusted total cost per claim among the 13 states (under $4,000).
While Wisconsin's medical prices are higher, these were offset by lower utilization. Workers also return to work sooner than in other states, and enjoy less litigation – only 8 percent of Wisconsin cases involved defense attorneys, while that involvement balloons to 30 percent in California and more than 30 percent in Florida. Wisconsin also had lower medical cost containment expenses, and the cost of delivering benefits was among the lowest in the 13 states studied. The above figures are all adjusted to reflect the states' different characteristics.

Wisconsin worker outcomes ranked among the best in all categories.
Workers reported better recoveries, highest percent with substantial return to work, high satisfaction levels and fewer problems accessing care. In fact, more workers in Wisconsin were "very satisfied" with their care than any other state – over 60 percent.

WCRI's database was powerful, with a robust sample of 20 million claims, examining data from accident years 1995-2003. The database was representative with data from a variety of sources.

As you debate any changes to Wisconsin's Worker's Compensation law, please keep the above success stories in mind – heath care in this state is good for Wisconsin's workers and employers. If you have any further questions or need additional information, please feel free to contact Mark Grapentine at markg@wismed.org or (608) 442.3800.

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org •
Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

Wisconsin Workers' Compensation System Outcomes

January 24, 2006
Madison, Wisconsin

WCRI

About WCRI

- Independent, not-for-profit research organization
- Has diverse membership support
- Studies are peer-reviewed
- Resource for public officials and stakeholders
  - Published over 150 studies on WC
  - Content-rich website: www.wcrinet.org

WCRI

WCRI Approach

- Mission: "Be a catalyst for improving WC systems by providing the public with high-quality, credible information on important public policy issues"
- Studies focus on benefit delivery system
- Not make recommendations nor take positions on issues

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Key Value Proposition For Workers' Compensation Systems

- Costs to employers should be directly related to the outcomes received by workers
  - States with higher costs should deliver better outcomes to workers
  - Increases in employers' costs should produce improved outcomes for workers

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WCRI Benchmark Tools

- CompScope™ Multistate Benchmarks
- Anatomy of Workers' Compensation Medical Costs and Utilization
- Outcomes of Injured Workers
- Fee Schedule Benchmarks

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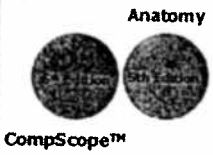
WCRI's Benchmarking Tools

CompScope™

- Benefit amounts
- Timeliness
- Medical costs
- Disability duration
- Attorney involvement
- Vocational rehabilitation use
- Benefit delivery expenses
- Annual report

WCRI

WCRI's Benchmarking Tools



- Medical costs
- Medical prices
- Utilization of services
- By provider type
- By type of service
- Annual report

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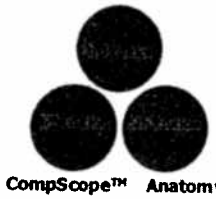
WCRI's Benchmarking Tools



- Access to health care
- Recovery of health and functioning
- Return to work
  - Yes or no
  - Speed
  - Sustainability
  - Earnings recovery
- Satisfaction with health care
- Periodic report

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Today's Briefing Outline

- How does WI workers' comp system compare to other study states
- Key drivers of medical costs
- Workers outcomes
- Recent trends in medical costs

WCRI

Major Findings From WCRI Benchmark Studies

- Total cost per claim among lowest of 13 states
- Workers returned to work sooner; less litigation
- Higher medical prices offset by lower utilization
- WI worker outcomes ranked among the best in all categories
- Medical costs per claim increasing at rapid pace due to increasing medical prices

WCRI

How Does WI Compare? Findings From CompScope™, 6th Edition

- Cost per claim among lowest of 13 states
- Workers returned to work sooner
- Fewer workers received PPD/lump-sum payments and lower payment per case
- Lower litigation
- Lower medical cost containment expenses
- Medical cost per claim at lower end of middle group

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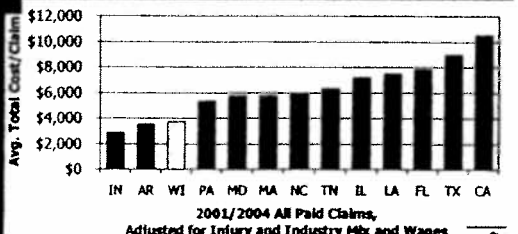
WI Total Cost Per Claim Among Lowest Of 13 Study States



2001/2004 All Paid Claims, Adjusted for Injury and Industry Mix and Wages

WCRI

DBE: Powerful Database And Strategic Asset For State Policy Issues

- Robust sample
  - 20 million claims
  - Accident years 1995-2003, as of 2004
  - 40-64% of claims in each state (44% in WI)
  - States represent > 70% of U.S. WC benefits
- Representative
  - Voluntary and residual market
  - Self-insured employers
  - State funds

WCRI

Methods To Enhance Comparability Across States

- Standard definitions across states
- Focus on claims > 7 days of lost time
- Similar mix of claims in each state (industry, injury, wage)
- Remaining differences explained by system features, culture, and behavior

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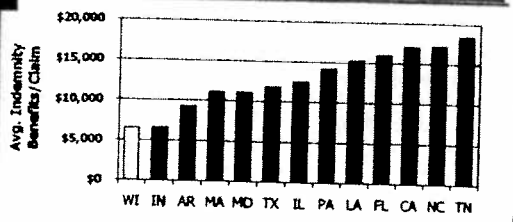
WI Indemnity Benefits Per Claim Lowest Among 13 Study States



2001/2004 Claims with > 7 Days Lost Time, Adjusted for Injury and Industry Mix and Wages

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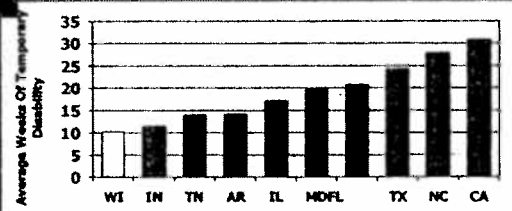
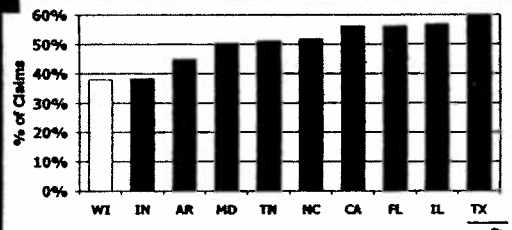
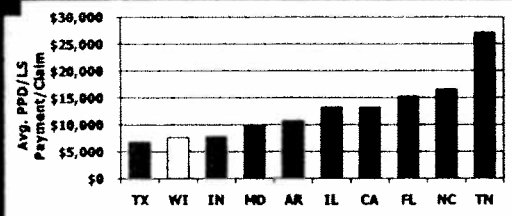
WI Duration Shorter: Injured Workers Returned To Work Faster



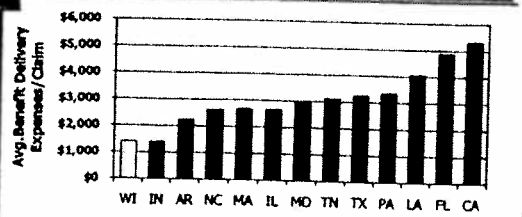
Fewer Claims Received PPD or Lump-sum Payments In Wisconsin



WI PPD/Lump-Sum Payment Per PPD/Lump-Sum Claim Among Lowest



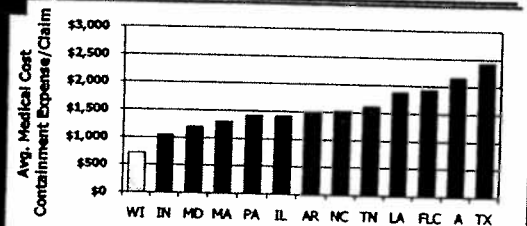
WI Expenses Of Delivering Benefits Among Lowest Of 13 Study States



2001/2004 Claims with > 7 Days Lost Time with Expenses, Adjusted for Injury and Industry Mix

WCRI

Medical Cost Containment Expenses Per Claim Lowest In Wisconsin



2001/2004 Claims with > 7 Days Lost Time with MCC Expenses, Adjusted for Injury and Industry Mix

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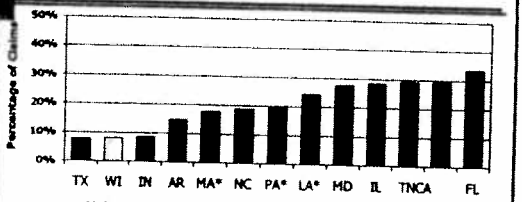
Less Frequent Involvement Of Defense Attorneys In Wisconsin



Claims with Defense Attorney Payments as Percentage of 2001/2004 Claims with > 7 Days Lost Time, Adjusted for Injury and Industry Mix

* Wage-loss States

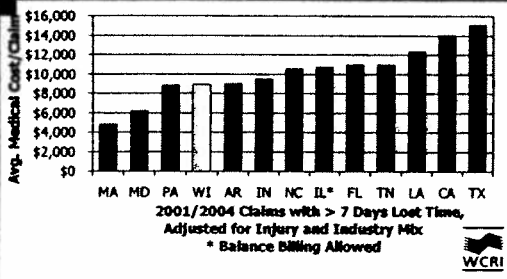
WCRI

Findings From Other WCRI Studies

- System features encourage RTW and reduce litigation
  - Ballantyne and Telles, 1992
  - Boden, 1988
- Earning replacement rate varied by duration of temporary disability (Boden and Galizzi, 1998)

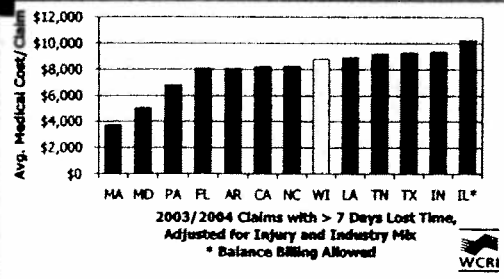
WCRI

WI Medical Cost Per Claim Was Lower, For More Mature Claims



WCRI

Medical Cost Per Claim Slightly Higher In WI Among Less Mature Claims



WCRI

WI Medical Costs Per Claim: Higher Prices; Lower Utilization

- Non-hospital prices highest among 12 study states
- Prices higher for some hospital outpatient services
- Lower utilization:
  - Fewer cases involve specialty services
  - Fewer visits per claim and services/visit
- Chiropractors involved in more claims; PT/OTs in fewer claims compared to median state
- Costs of outpatient surgery higher; inpatient lower compared to other states

WCRI

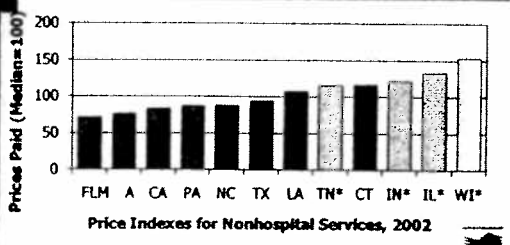
Utilization Lower, Prices Paid Higher In Wisconsin For Nonhospital Providers

Nonhospital Providers	WI	12-State Median	% Diff
Payment/Claim	$3,971	$4,230	-6%
Visits/Claim	13.3	17.5	-24%
Services/Visit	2.0	2.5	-18%
Average Price/Service	--	--	+53%

2002/2003 Claims with > 7 Days Lost Time (Injury/Industry Mix Adjusted)

WCRI

WI Prices 53% Higher Than 12 State Median (Nonhospital Providers)

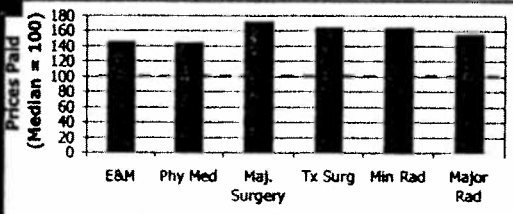


Price Indexes for Nonhospital Services, 2002

* No Fee Schedule

WCRI

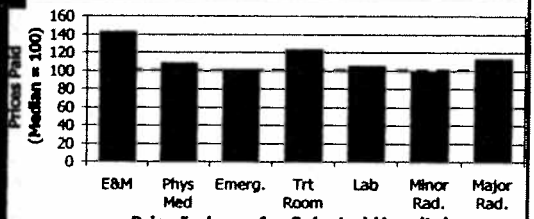
WI's Prices Paid Substantially Higher For All Nonhospital Services



Price Indexes for Selected Nonhospital Services, 2002

WCRI

Prices Higher For Outpatient E&M, Operating Room, And Major Radiology



Price Indexes for Selected Hospital Outpatient Services, 2002

WCRI

WI Medical Costs Per Claim: Higher Prices; Lower Utilization

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WCRI

Fewer Claims Involve Specialty Services

% Claims with services (>7 days lost time)	WI	12-State Median	% Point Diff
Minor radiology	65%	71%	-6
Major radiology	28%	40%	-12
Neurological testing	10%	14%	-4
Treatment surgery	29%	36%	-7
Major surgery	27%	29%	-2
Physical medicine	43%	54%	-11

2002/2003 Claims with > 7 Days Lost Time
(Injury/Industry Mix Adjusted)

WCRI

Fewer Visits Per Claim When Service Involved

Visits per Claim (>7 days lost time)	WI	12-State Median	% Diff
Minor Radiology	2.1	2.4	-12%
Major radiology	1.3	1.4	-7%
Neurological testing	1.4	1.5	-10%
Treatment surgery	1.6	1.8	-9%
Physical medicine	16.1	18.5	-13%

2002/2003 Claims with > 7 Days Lost Time
(Injury/Industry Mix Adjusted)

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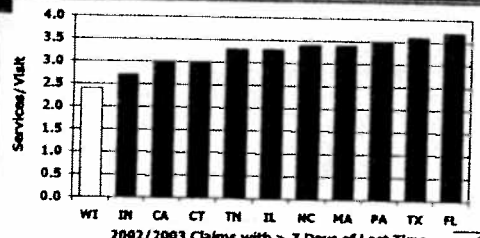
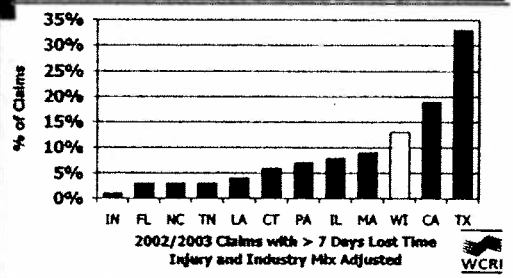
..And WI Had Fewest Services Per Visit For Physical Medicine



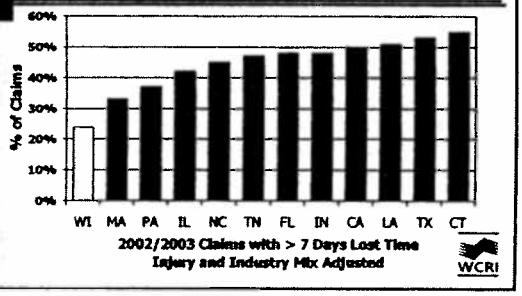
2002/2003 Claims with > 7 Days of Lost Time
Injury and Industry Mix Adjusted

WCRI

Chiropractors Involved In More Claims Than Typical State



Physical/Occupational Therapists Involved In Fewer Claims Than Typical



WI Hospital Inpatient Services Compared To Study States

- WI had typical % of claims with inpatient care
- For similar neuropathic back injuries
  - Typical surgery rate;
  - Higher proportion done on outpatient vs inpatient basis
  - Lower costs of inpatient surgery and higher costs of outpatient surgery, compared to other states

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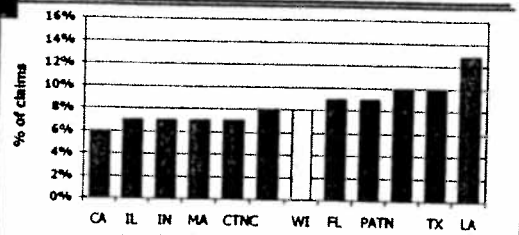
8% Of Claims With Inpatient Care In Wisconsin, Typical Of 12 States



2001/2003 Claims with > 7 Days of Lost Time
Injury and Industry Mix Adjusted

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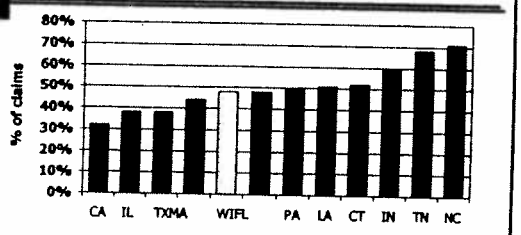
Typical Percent Of Neuropathic Back Claims With Surgery



2001/2003 Claims with > 7 Days of Lost Time
Injury and Industry Mix Adjusted

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Fewer Inpatient Surgeries; Higher Outpatient Costs

Neuropathic Back Claims w/Surgery	WI	12-State Median	% (Point) Diff
% inpatient surgery	55%	62%	-7%
Avg. cost/claim with inpatient surgery	$18,004	$20,007	-10%
Avg. cost/claim with outpatient surgery	$14,401	$11,591	+24%

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WI Medical Costs Per Claim: Higher Prices; Lower Utilization

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How Workers Outcomes In WI Compares? Findings From Workers Outcome Study

- Employers pay less for medical care in MA, PA, and WI, compared to CA, FL, TN, TX
- WI worker outcomes ranked the best or among the best in all categories
  - Workers report better recoveries
  - Highest percent with substantial RTW
  - High levels of satisfaction
  - Fewer problems accessing care

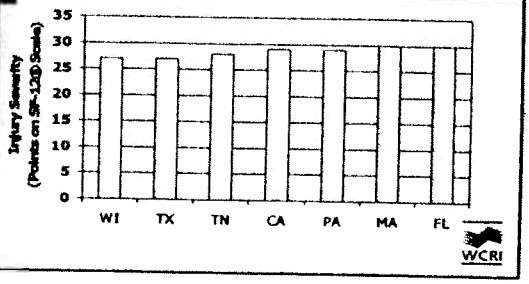
WCRI

Core Outcomes Measures

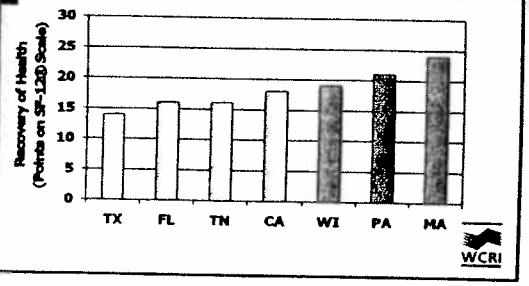
- Recovery of health and functioning
- Return to work
  - Rates of return to work
  - Speed of initial return to work
  - Sustainability of return to work
- Access to health care
- Satisfaction with health care

WCRI

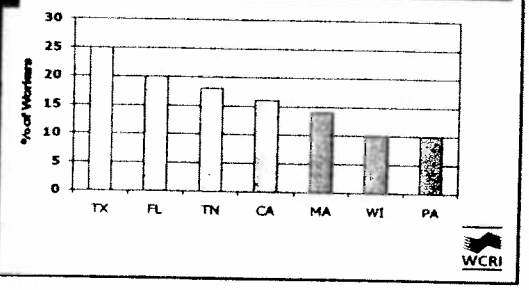
Perceived Injury Severity Similar In All Seven States



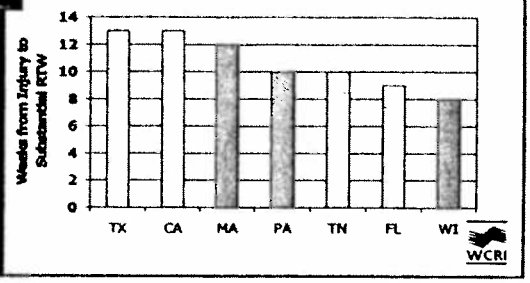
Workers In Wisconsin Report Better Physical Recoveries



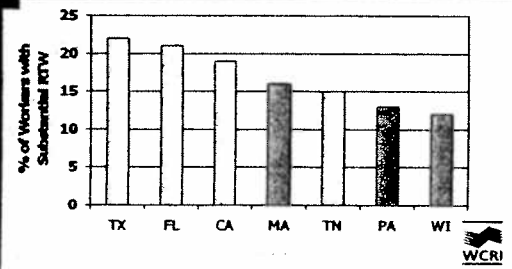
Workers In Wisconsin More Likely To Report A Substantial RTW



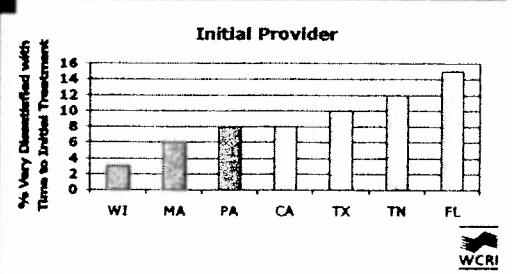
Speed Of Return To Work Fastest In WI



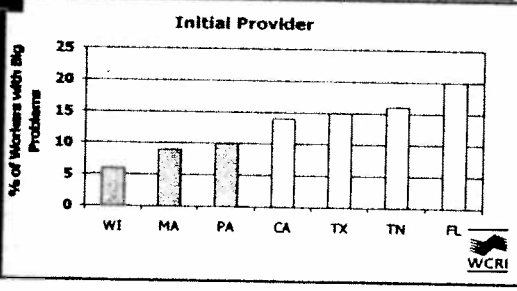
PA And WI: Fewer Second Absences Than TX, FL, And CA



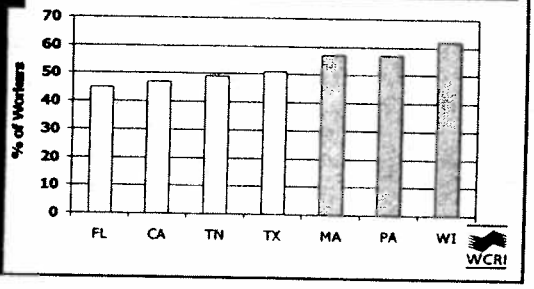
Fewer Wisconsin Workers Dissatisfied With Time To First Treatment



Fewest "Big Problems" With Access To Desired Care In Wisconsin



More Wisconsin Workers "Very Satisfied" With Care



How Workers Outcomes In WI Compare? Findings From Workers Outcome Study

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  - High levels of satisfaction
  - Fewer problems accessing care

WCRI

What Is The Trend In Wisconsin?

- Rapid growth in cost per claim continues
- Sustained double digit medical cost growth, unlike in most states
- Major driver: high & rising medical prices

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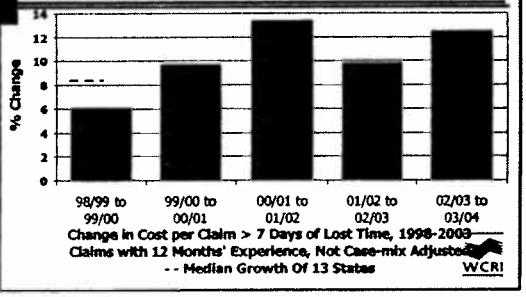
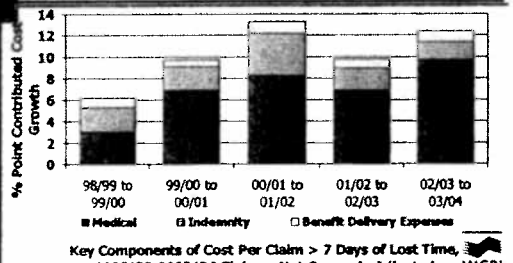
WI Total Cost Per Claim Continued To Grow Rapidly In Most Recent Year



Change in Cost per Claim > 7 Days of Lost Time, 1998-2003 Claims with 12 Months' Experience, Not Case-mix Adjusted
- - Median Growth Of 13 States

WCRI

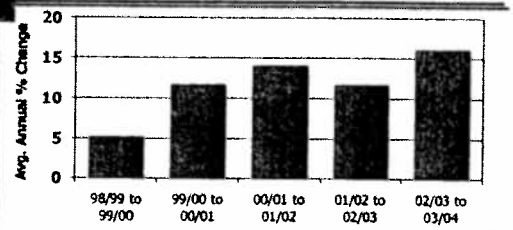
Rapid Growth Of Medical Costs Main Driver To Wisconsin's Cost Growth



Key Components of Cost Per Claim > 7 Days of Lost Time, 1998/99-2003/04 Claims , Not Case-mix Adjusted

WCRI

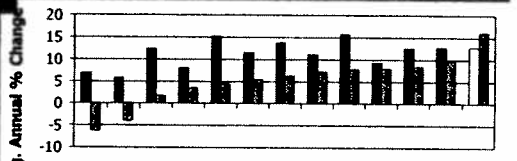
Double-Digit Growth In Medical Cost Per Claim In 4th Consecutive Year



Change in Average Medical Cost Per Claim with > 7 Days of Lost Time, 1998-2003, Not Case-mix Adjusted

WCRI

Rapid Growth Continued In WI While It Slowed In Most Study States



Medical Payment Per Claims, 1998/99-2003/04
Claims with > 7 Days Of Lost Time, Not Case-mix Adjusted

■ 2000/2001-2002/2003 ■ 2002/2003-2003/2004

WCRI

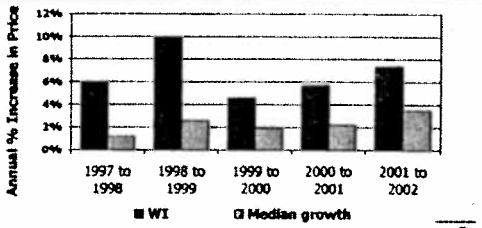
Increase In Nonhospital Payments Driven By Increasing Prices

	2000/2001	2002/2003	AAPC
Nonhospital Providers			
Payment/claim	$3,385	$4,110	+10.0%
Visits/claim	13.2	13.8	+2.1%
Services/visit	2.1	2.0	-1.0%
Average price/service	--	--	+6.5%

2000/2001 and 2002/2003 Claims with > 7 Days Lost Time, Not Adjusted for Injury and IndustryMix

WCRI

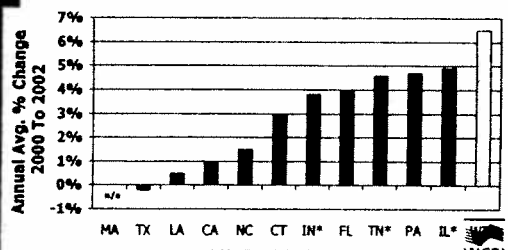
WI Price Growth Highest, Far Outpacing Growth In Median State



Average Price Per Service For Nonhospital Providers, 1997-2002

WCRI

WI's Prices Increased At Fastest Rate Among Study States



* No Fee Schedule

WCRI

Prices For Nonhospital Services Increased 5-11% Each Year

Nonhospital Prices	2000	2002	AAPC
Minor radiology	$73	$81	+4.9%
Major radiology	$800	$960	+9.5%
Neurological testing	$156	$191	+10.5%
Treatment surgery	$270	$302	+5.8%
Major surgery	$1,900	$2,077	+4.6%
Physical medicine	$38	$44	+6.7%

WCRI

Hospital Payments /Claim Increased 12% Each Year In Recent Two Years

Hospital Payment/Claim	AAPC 2000/01 to 2002/03
All hospital	12.0%
Hospital outpatient	15.5%
Hospital Inpatient	6.7%

2000/2001 and 2002/2003 Claims with >7 Days of Lost Time, Not Adjusted for Injury and Industry Mix

WCRI

Increase In Hospital Outpatient Payments Due To Increasing Prices

Hospital Outpatient	AAPC 2000/2001 to 2002/2003
Payment/claim	12.0%
Prices	12.2%
Utilization	
# visits/claim	8.3%
# services/visit	-7.4%
Service mix intensity	-0.3%

2000/2001 and 2002/2003 Claims with >7 Days of Lost Time, Not Adjusted for Injury and Industry Mix

WCRI

Prices For Hospital Outpatient Services Increased 4-17% Annually

	2000	2002	AAPC
Laboratory	$41	$47	+6.5%
Minor radiology	$135	$166	+11.0%
Major radiology	$912	$1,149	+12.2%
Operating/recovery/ treatment room	$774	$1,061	+17.1%
Physical medicine	$76	$83	+4.0%

2000 and 2002 Calendar Year Price

WCRI

What Is The Trend In Wisconsin?

- Rapid growth in cost per claim continues
- Sustained, double-digit medical cost growth, unlike in most states
- Major driver: high & rising medical prices

WCRI

Major Findings From WCRI Benchmark Studies

- Total cost per claim among lowest of 13 states
- Workers returned to work sooner; less litigation
- Higher medical prices offset by lower utilization
- WI worker outcomes ranked among the best in all categories
- Medical costs per claim increasing at rapid pace due to increasing medical prices

WCRI

Wisconsin Workers' Compensation System Outcomes

January 24, 2006

Madison, Wisconsin

Stacey Eccleston
617-661-9274 ext. 237
seccleston@wcrinet.org

WCRI

Dongchun Wang
617-661-9274 ext. 284
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FORWARD
E PLURIBUS UNUM

REPRESENTING WISCONSIN BUSINESS

Wisconsin Manufacturers & Commerce

Memo

TO: Members of the Wisconsin State Senate Committee on Labor and Election Process Reform

FROM: James A. Buchen, Vice President, Government Relations

DATE: January 25, 2006

RE: **Support SB 474**– Worker's Compensation Reform Legislation

The Wisconsin Worker's Compensation Advisory Council (WCAC) recently proposed SB 474, legislation making various modifications to Wisconsin's Worker's Compensation program under Chapter 102 of the Wisconsin statutes. Wisconsin Manufacturers & Commerce strongly supports the package of reforms recommended by the WCAC embodied in Senate Bill 474.

Background on the WCAC

The proposed legislation was developed over the last 18 months by the WCAC. The Council has 10 members, 5 representing large and small employers, and 5 representing labor. The Council was created in 1913 when Wisconsin first established its worker's compensation program. The idea underlying the WCAC is to have the parties directly affected – injured workers who may be eligible to receive health or disability benefits, and employers who purchase worker's compensation insurance, or who self insure for worker's compensation purposes – develop jointly any proposed reforms to the Wisconsin Worker's Compensation program. Over nearly a century, the Legislature has adopted the recommendations of the Council without substantive amendment, recognizing that the bill is the product of a great deal of research, analysis, negotiation and compromise.

We strongly believe that over the long term, this Council has proven to be a very successful method of public policy making in the complex area of worker's compensation. The program has avoided the wide policy swings seen in other states that result from the changing political make-up of the Legislature or the Governor's office. The predictable and stable policy making environment within the UIAC has produced one of the most efficient and effective worker's compensation programs in the country – one that is widely regarded as a model for the nation.

SIGNIFICANT PROVISIONS IN SB 474

Health Care Costs

The Wisconsin Worker's Compensation Division will adopt Health Care Treatment Guidelines, modeled on the Minnesota Worker's Compensation program's treatment guidelines that are currently in effect. The Guidelines will be adopted as the basis for determining the appropriateness and necessity of treatment for compensable injuries under the Wisconsin Worker's compensation Act. An Advisory Panel of Wisconsin Health Care Practitioners will be created to assist in implementing the guidelines.

Employee Misconduct

Where an employee is not available for light duty employment, due to a violation of an employer's drug policy or due to illegal activity related to the employment, the employee will not be eligible for disability benefits.

501 East Washington Avenue
Madison, WI 53703-2944
P.O. Box 352
Madison, WI 53701-0352
Phone: (608) 258-3400
Fax: (608) 258-3413
www.wmc.org

Permanent Total Disability
Increase the compensation rate for Permanent Total Disability Claims in two (2) stages. The first stage is for injuries occurring between May 13, 1980 and January 1, 1986 (approximately a five and one-half year period) to the rate in effect on January 1, 1986. The increases in the first stage will be effective January 1, 2006. The second stage is for injuries occurring between January 1, 1986 and January 1, 1988 (a two year period) to the rate in effect on January 1, 1988. The second stage will be effective January 1, 2007. Funding for these increased benefits will be paid from the Worker's Compensation Supplemental Benefit Fund.

Death and Dismemberment Assessments
Employers' assessments for death and dismemberment claims, payable to the Work Injury Supplemental Benefit Fund, will increase as of January 1, 2006 from $10,000 per occurrence to $20,000 per occurrence and will be used to pay for the supplements to Permanent Total Disability claims outlined above.

Bad Faith Penalty
The penalty for "bad faith" by an insurer or self insured employer in the administration of a claim will increase to the lesser of 200% of total compensation due or $30,000. The prior penalty was the lesser of 200% of total compensation due or $15,000. This amount has not increased since 1981. Claimants will no longer be permitted to "stack" delay of payment penalties in addition to bad faith penalties. In addition, interest claims per Wi Stat 648.46 are excluded.

PEO Notice of Coverage
When a Professional Employer Organization (PEO) terminates the professional employer agreement with a client company, the PEO must notify the worker's compensation insurance carrier as well as the Department of Workforce Development to alert them that the client company's worker's compensation insurance coverage has terminated.

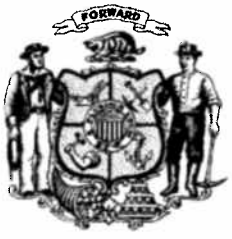
Areas for Further Study
The Worker's Compensation Advisory Council will continue to study avenues to fund supplemental benefits for three (3) additional years for permanently totally disabled workers whose injuries occurred after January 1, 1988, to January 1, 1991.

The Worker's Compensation Advisory Council, the Wisconsin Compensation Rating Bureau and the Office of the Commissioner of Insurance will continue to review issues relating to Professional Employer Organizations, including:

- The Definition of PEO's under the Wisconsin Worker's Compensation Act
- The process for experience rating PEO's and their clients for purposes of worker's compensation insurance
- The employer status of PEO's under the Worker's Compensation Act
- The configuration of worker's compensation insurance policies that include PEO's and their clients

Wisconsin Manufacturers & Commerce Strongly Supports the WCAC Process on SB 474
Wisconsin Manufacturers & Commerce strongly supports the WCAC process as well as the package of changes recommended by the WCAC embodied in Senate Bill 474.

WISCONSIN STATE LEGISLATURE



Wisconsin State AFL-CIO ...the voice for working families.

David Newby, President • Sara J. Rogers, Exec. Vice President • Phillip L. Neuenfeldt, Secretary-Treasurer

TO: Senate Labor and Election Process Reform Committee Members

FROM: Paul Welnak, Business Manager, IBEW Local #494, on behalf of the Wisconsin State AFL-CIO and the employee members of the Workers Compensation Advisory Council

DATE: January 25, 2006

RE: **Support for SB 474**

Members of the Committee: thank you for the opportunity to testify in favor of SB 474, which makes modest changes to our Workers Compensation system.

You have already heard the specifics of the bill, but I would like to highlight a few of them for you. We are pleased that the bill includes two $10 increases in the weekly benefit level for those receiving Permanent Partial Disability. These are very modest increases, but they at least help to offset the effect of inflation.

We are also pleased that we were able to agree to increases for some injured workers receiving Permanent Total Disability payments. As you may know, these benefit levels are not indexed for inflation, so absent legislative action they do not change to keep up with increases in the cost of living. SB 474 provides that minimum payments will be those in effect in 1985 this year and 1987 next year.

But while these increases are the largest in many years, they are woefully inadequate. Can you imagine living today on your income level of 1987? Labor members of the Council are absolutely committed to increasing these minimum payments as quickly as possible to raise them to current benefit levels. Permanently disabled workers deserve no less.

We are not particularly happy with the agreement to allow termination of Temporary Total Disability benefits under certain circumstances, since we feel strongly that in a "no fault" system like Workers Compensation all injured workers should receive benefits no matter what unrelated behavior they may exhibit. But that is part of the compromise we agreed to in the spirit of reaching agreement with the management side of the Council. As you know, the "agreed-upon bill" process is one of give and take, and that is precisely what you have before you in SB 474.

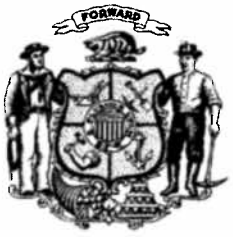
There is an old adage when negotiating a labor agreement that if at the end of the day neither side is happy, it is probably a fair contract. I believe that this was certainly the case with these negotiations.

We strongly urge you to approve SB 474 without amendment as quickly as possible so that these changes can be implemented in a timely fashion.

opeiu#9,afl-cio

6333 West Blue Mound Road • Milwaukee, WI 53213 • 414.771.0700 • Fax 414.771.1715 • www.wisaflcio.org


WISCONSIN STATE LEGISLATURE


FORWARD

SB474

I recommend you all read this document carefully. Don't we have a good lobby faction somewhere that can get this whole thing thrown out?

After a quick scan of these "guidelines," they look like the worst type of bureaucratic regulatory intrusion into your medical practice, specifying even when it is ok to order back X-rays (8 weeks -- except in certain specified circumstances); when to refer backs to a surgeon (may be as early as 8 weeks but not over 12 weeks -- except in certain cases), when a tennis elbow surgical referral is mandated, etc, etc, etc. These "guidelines" will give insurance companies dozens of new reasons not to pay.

While maybe inhibiting some of the worst abuses of Work Comp, this approach creates many new headaches for everyone involved. These "guidelines" once established will only lead to more and stricter "guidelines" over the years.

Richard E. ("Dick") Sturm, MD, MPH
855 N. Westhaven Dr.
Oshkosh, WI 54904
Receptionist: 920-303-8750

I would whole heartedly agree with Dr. Strum, the WC Treatment Guidelines are unlikely to ultimately serve the best interests of our patients. Who ever said that "cookbook" medicine was the way to practice the healing arts. Why do you even need a physician if you don't need their judgment. Are there variations in the practice of medicine? Of course there is, does that mean that quality is substantially different? Not necessarily. For a variety of reasons, including liability and insurance denials, guidelines will become the only standard of care. We have seen this happen in many areas of medicine. This is a back door way of rationing care through the denial of services. Do we really want the worker's comp. system to become an HMO?

I agree that they seem very rigid and unyielding. I am
told the intent was that they would only be used when there are disputes about treatment/payment, but I've also been around long enough to suspect that once they are adopted, the insurance industry will in fact start using them, as Dr. Newgent said, as the standard of care and the basis to deny, deny, deny.

Maja Jurisic, MD
Regional Medical Director
phone: 262-814-2547
fax: 262-814-0603

So the proposed negotiation was for us to cut our own throats by reducing reimbursement or cutting our patients throats by creating a "one size fits

all" guidelines. This brings to mind the words of Tyron Edwards, "Between two evils, choose neither; between two goods, choose both." We should not to be obliged, to choose between the insipid and the atrocious.

Eric Newgent, DO, MS

As I have a little more time to look at these "Guidelines," I see them as very proscriptive and real problem for both patients and providers. The word "must" is in there countless times. How can they be called guidelines when they tell you you must do something. I can't imagine how a treatment provider could be so familiar with them (if they become "law") such that he/she never deviates from them. However, I can imagine how insurance adjusters will become intimately familiar with them in order to deny payment. They're in need of such major revision that you might as well throw them out and start over. Calling them Practice Guidelines might help, but even then I can see insurers using them to deny payment because they don't see them the same way we might.

Bill Scorby, MD, MPH
Gundersen Lutheran Health System

I believe that as a matter of principle the "guidelines" violate the foundation that the WC system was founded. Many years ago a covenant was made between employees and employers. The employee gave up their right to sue for injuries, including compensation for pain and suffering, and the employers agreed to pay all the expenses associated with the injury (medical expenses, lost time, disability, and voc rehab). These guidelines violate that covenant. No longer can an employee get everything their doctor thinks as reasonable, but only what the insurance company thinks is reasonable.

Another concern is the violation of the "any provider" law in Wisconsin. If a provider must comply with a 57 page guidelines or not get reimbursed, many providers will simply get out of the practice of handling WC. We will be left with the WC docs who have mastered the art of working within the guidelines. This is exactly what the insurance companies want, to deal with a handful of docs whom they can control.

Eric Newgent, DO, MS
Reedsburg Area Medical Center

I would love not to have Guidelines, but the reality of the situation is that we'll probably have to end up with some variant/flavor of them. Dr. John Williams has worked in Colorado and felt the Colorado Guidelines were more reasonable and more workable. Here's a link to them.
Let me know what you think. Do you believe Guidelines more like these would be preferable to the ones Wisconsin is currently proposing to impose?

http://www.coworkforce.com/DWC/Medical%20Topics/MedicalTrtmt.asp

Maja Jurisic, MD
Regional Medical Director
phone: 262-814-2547
fax: 262-814-0603

Hello,
For what it is worth.
I practiced Occupational Medicine under the Minnesota Treatment Guidelines from 1991-2003. My previous faculty colleague on the Regions Hospital (St. Paul) Occupational Medicine Residency, Bill Lohman, a very experienced occupational medicine physician, (and who was also the Residency Director) was the Medical Consultant to the MN Department of Labor during this time and continues to be in this position. I was also on the MN DOL Medical Services Review Board for 3 years, although we didn't do much during my term which was the same time that Jesse Ventura was governor. We had no funding to meet regularly.
>From my practice perspective, the MN Guidelines were not onerous and did not affect my practice or the practice of other occupational medicine practitioners in Minnesota. Probably because they were in place when I started occupational medicine and it is what I grew up with professionally. It was a given that they were going to be developed as was the fact that the occupational medicine community was too small to derail the process. The goal was to develop best practice guidelines through the political process. They were developed with ortho, neurosurgery, PM&R, PT, Chiro, neurology and occupational medicine, as well as labor and business groups. The occupational medicine community generally felt the guidelines represented best practices but political compromise was clearly involved. Occupational medicine was never a major player in developing these as the drivers of medical expense were the surgical specialties, PT, and chiro. These guidelines are very similar but I have not yet had the opportunity to go over them in detail. I will do so.
This is my experience with existing guidelines and my opinion that some guidelines will be instituted and are necessary but I have only been in Wisconsin for 2 1/2 years and am not aware of how the medical/political process works in this state yet. FYI, these guidelines have been modified several times over the years and further modifications have been stalled by the political process in Minnesota.
I am completing my term as President of NCOEM and have asked Bill Lohman to present at our membership meeting on Nov. 17 in the Twin Cities on a treatment guideline update. Beth Baker, who is the present director of the Regions OEM residency and also a trustee on the Minnesota Medical

Association and chair of the Medical Services Review Board will give input from the perspective of organized medicine. I will be glad to report back what the conclusions are.
Steve Kirkhorn

As president of NCOEMA,I had asked William Lohman MD, the medical consultant to provide an overview of how Minnesota's Work Comp treatment parameters were developed and the role of evidence based medicine and what the next steps were at our recent North Central Occupational and Environmental Medicine membership meeting in Minneapolis. The development of the treatment parameters was definitely a political process of multiple stakeholders, including business and labor, medical specialists, chiropractors, PT, and insurers and a political process was used to develop the final language. The available medical studies were reviewed and rated. It was a very time consuming process. There was a very strong component of physician involvement. They were developed as standards rather than guidelines although they aren't uniformly applied by administrative law judges. The treatment parameters were developed because a MN Department of Labor study showed that the medical costs for work comp back cases were 2-3 times higher than non work comp back cases.
The next step for Minnesota's treatment guidelines will address pharmaceuticals and treatment of worker's compensation, including narcotics, as medication costs are significantly increasing.
The Medical Services Review Board (MSRB), chaired by Beth Baker MD, MPH, an OEM physician and Regions Occ Med Residency Director, will be involved in this review. In the first phase of the initial Work comp treatment parameters, the MSRB met for no reimbursement every Thursday for 2 hours for 3 months to review papers and documents. There were two Occ Med physicians and at least one orthopedist on that panel plus others. There is no expectation that physicians will put in that much time in the future in revision or developing new treatment standards in Minnesota although they will review recommendations by the MN Department of Labor.
There should obviously be physician participation in the development of WI treatment guidelines.
I may have missed a previous e-mail, but were the ACOEM practice guidelines considered for Wisconsin, and if so what were the reasons they aren't being adopted or modified?
Steve Kirkhorn
Steven Kirkhorn, MD, MPH
Medical Director
Marshfield Clinic Occupational Health

The ACOEM Guidelines (Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers; 2nd edition: OEM Press 2004) are very well-written and represent the

combined effort of 21 specialty societies and sections with representation and input from chiropractic and podiatric medicine. Having served as an independent reviewer for the Guidelines, I can say they are instructive and have enough latitude that a practitioner can treat a problem in more than one way and still remain within the standard of care. They are not written like a penal code (as the proposed WI guidelines are) and the word "must" does not occur in every sentence (349 times in the proposed guidelines). I do not think that one person's dislike for the ACOEM Guidelines should negate their value. As stated by Dr. Timothy Key, former ACOEM president to the California Division of Workers Compensation:

"The ACOEM Guidelines are intended to provide physicians who treat injured workers with a common knowledge base and recommendations regarding the diagnosis and treatments that are most likely to return workers to health and function as safely and as efficiently as possible. The Guidelines were not expressly developed to meet the needs of payer or regulators."

I would be interested in comments from other members of this e-mail group. I would ask that you read both sets of guidelines first so you can make informed commentary. I would also mention that I have not received and will not receive any compensation from ACOEM or the OEM Press related to the publication of the Guidelines.

John Williams, M.D.

John and Maja,
I would like to emphasize that Minnesota's treatment parameters were standards not guidelines and were developed specifically for Minnesota and were shaped by the political realities in that state. That was to address the rising medical costs of the treatment of WC low back pain. There is one very important caveat to remember before applying these to Wisconsin and that is that they were developed with signficant physician input and for that were reason accepted by the majority of the medical community in Minnesota. I was previously on the Medical Services Review Board after the adoption of the Treatment parameters and was involved in the post adoption discussion. There was a long-standing legal challenge that went before the MN Supreme Court which supported the Treatment Parameters. They were also one of the first formalized guidelines or standards used in the country, predating the AHCPR Acute Low Back guidelines, although they matched up fairly closely with those guidelines....

I agree with John that the ACOEM guidelines should be considered if it isn't too late to do so. I have gone to the sessions on the ACOEM guidelines and also as a member of the ACOEM House of Delegates over the last two years have heard presentations on their use. They aren't perfect and weren't designed to be used for regulatory purposes but are being adopted by at least one state Department of Labor for workers compensation purposes. Very importantly, they are physician developed, which may be why there is hesitation on the part of other involved

parties to look at these.
Steve
Steven Kirkhorn, MD, MPH, FACOEM
Medical Director
Marshfield Clinic Occupational Health

Using the ACOEM Guidelines makes a lot of sense. They were developed by a multidisciplanary group of physicians as true practice "guidelines" as opposed to treatment standards that are much more rigid and what many regulators would like to see. I think the ACOEM guides could be "codified" for Wisconsin with whatever else stakeholders feel is appropriate. I don't think that Wisconsin is so unique that we would have to start from scratch once again to do what many have spent countless hours already developing. I think the guides would serve as true practice guidelines and at the same time reign in the outlier practitioner. This may then obviate the need for many IME's that are primarily obtained to get an opinion on appropriateness of treatment, end of healing/MMI etc.

Bill Scorby, MD, MPH
Chairman
Occupational Services
Gundersen Lutheran Health Systems
La Crosse, WI 54601
608-775-5593

Below, you will find a link to a report from the Stay-at-Work and Return-to-Work Committee of ACOEM. Dr. Vasudevan brought this report to my attention, and I thought it was very well done. It might help us in our dealings with the WC Advisory Council. If you haven't seen this report, I think you'll find it worth your time.

The report makes the point that our current system doesn't function very well because we fail to distinguish among the four parallel processes that are important in getting an injured worker back to work. These are:
1) The injured person's coping process
2) The medical care process
3) The benefits administration process
4) The reasonable accommodation process under the ADA

This report points out the fact that rising medical costs won't/can't be controlled optimally by focusing on only one of those processes (limiting medical care), as the WC Advisory Council is trying to do with the Treatment Guidelines.

Maja Jurisic, MD
Regional Medical Director

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http://www.webility.md/pdfs/Preventing%20Needless%20Disability%20-%20final%20pdf%202005-11-30.pdf

Preventing Needless Work Disability by Helping People Stay Employed

A Report from the Stay-at-Work and Return-to-Work Committee of the American College of Occupational & Environmental Medicine

EXECUTIVE SUMMARY

As physicians our fundamental precept is "first, do no harm." However, we see daily the contrast between well- and poorly managed health-related employment situations and the harm that results. Identical medical problems end up having very different impacts on people's lives. The differences in impact cannot be explained by the biology alone. We know that much work disability is not required from a strictly medical point of view. We see devastating psychological, medical, social, and economic effects caused by unnecessarily prolonged work disability and loss of employability. We also see wasted human and financial resources and lost productivity.

Finding better ways of handling key non-medical aspects of the process that determines if an injured or ill person will stay at work or return to work will improve outcomes. Until now, the distinct nature and importance of the stay at work and return to
work process (SAW/RTW) has been overlooked. Improvements to that process will support optimal health and function for more individuals, encourage their continuing contribution to society, help control the growth of disability program costs, and protect the competitive vitality of the North American economy. The first half of our Committee's report provides the groundwork for readers to understand the second half. Most importantly, the first half describes the SAW/RTW process, how it works and how it parallels other related processes. The second half discusses factors that lead to needless work disability and what can be done about them. Sixteen sections with our observations and specific recommendations are grouped under these four general recommendations:

1. Adopt a disability prevention model.
2. Address behavioral and circumstantial realities that create and prolong work disability.
3. Acknowledge the powerful contribution that motivation makes to outcomes

and make changes that improve incentive alignment.
4. Invest in system and infrastructure improvements.

A committee of 21 physicians prepared this report because we feel compelled to speak. The insights we have gleaned about the preventable nature of much work disability must be shared. Our primary goals at this time are to draw attention to the SAW/RTW process and shift the way many people think. Our intent is to open a dialogue between the American College of Occupational and Environmental Medicine (ACOEM) and other stakeholders in the workers' compensation and non-work- related disability benefits systems: employers, unions, working people, the insurance industry, policymakers, the healthcare industry, lawyers, and healthcare professionals, especially all physicians. We invite you to work with us towards solutions.

I attended the ACOEM CME course on ACOEM Practice Guidelines, 12/3/05, presented by Jeff Harris, MD, MPH, who was one of the primary authors. I recommend this course to you. Several states require use of these ACOEM Guidelines for Workers' Comp, including California. I have obtained this book and am starting to use it for peer review and clinical pathway type purposes. Anyone can buy these guidelines from OEM Press.

It strikes me that these ACOEM Practice Guidelines are far more reasonable, insightful, and clinically-based than the Minnesota/proposed Wisconsin practice guidelines, as I interpret them. The ACOEM Guidelines read like a medical textbook.

In contrast, the Minnesota/proposed Wisconsin guidelines seem arbitrary and bureaucratic -- out of touch with the patient care process, in my opinion. They read like a set of traffic laws devised by legal consultants.

The presenters at ACOEM indicated their guidelines can always be altered in practice if there are documented reasons to make exceptions for given patients. Exceptions don't have to require an emergency situation or "red flag," just documentation of the specific clinical reasons. This is not clearly the case with the Minnesota guidelines.

The writing of the ACOEM Guidelines started 10 years ago, and they have gone through one complete revision. They are an accepted professional standard with wider use and acceptance by insurers, managed care companies, etc. than the Minnesota guidelines. Dozens of experts, including all specialties, were consulted in writing and rewriting of the ACOEM guidelines -- they are under constant review. Specific references to the peer reviewed literature are cited, along with assessment of statistical strength of arguments for or against given lines of treatment.

The ACOEM guidelines were accepted and published by the ACOEM board of directors, which is OUR organization. Personally, I doubt any set of guidelines is really going to curtail total Work Comp costs, so the less bureaucratic and intrusive the guidelines are into clinical practice, the better. We should argue for the ACOEM Clinical Practice Guidelines, if any have to be introduced.

Richard Sturm, MD, MPH, MBA
Aurora Occupational Health, Oshkosh
920-303-8750

Dr. Lischak, I am on the SMS Occ Med committee and have significant reservations about Wisconsin's use of the Minnesota guidelines. Primarily, after discussion with Occupational physicians, nurses and corporate executives we find them overtly politicizing the clinical process. These guidelines would become dogmatic and subject to changes by governmental agencies. A complete disconnect from clinical research and national peer review could result in an increased cost for employers and significant increases in injuries to Wisconsin's work force.

The use of the ACOEM Practice Guidelines would be a far more reasonable, insightful, and clinically- based approach than the proposed Minnesota/Wisconsin guidelines. The ACOEM Practice Guidelines read more like a medical textbook. In contrast, the proposed Minnesota/ Wisconsin guidelines seem arbitrary and bureaucratic - out of touch with the patient care process. They read like traffic laws devised by legal consultants.

As I am sure you are aware, the ACOEM Practice Guidelines have been around for 10 years, the educational process to learn about them already exists and the cost of implementation for their use would be minimal. The efforts of national & international researchers keep these Guidelines current and would not necessarily require legislative action to update.

Eventually, not unlike the MRO process, a uniform process for recognizing and treating disability will occur nationally. Tying the State of Wisconsin to an artificial device that limits advancement in our clinical practice and allowing bureaucrats to legislate clinical end points without scientific evidence will hurt all the citizens of the State of Wisconsin.

Thank you for all your time and interest in this process.

Ronald A. Barnes, MD, MPH

Aurora BayCare Occupational Medicine
North Region Medical Director
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Mike Lischak has suggested that our Committee might want to consider proposing a resolution at the Annual Meeting of the Wisconsin Medical Society to establish and support a group to evaluate various WC treatment guidelines. If we asked for a fiscal note to go with this, it might get us some administrative and research support as well. The group could study the various guidelines already out there and determine what they've accomplished or failed to accomplish and thus arrive at a conclusion as to what might serve us best in Wisconsin.

If there is anyone who would like to draft a resolution to this effect, please let me know. I'm attaching a "sample" resolution so you can see the usual form this takes. The attachment is a resolution that the Executive Committee of our section voted on introducing (a resolution to support legislation calling for smoke free workplaces).

(See attached file: smoke free resolution.doc)

Again, please let me know if your talents lie along these lines, or if you'd like to undertake this.

Thanks.

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