# WORKERS' COMPENSATION REVIEW COMMITTE

North Dakota Century Code (NDCC) Section 54-35-22 established the Workers' Compensation Review Committee. The committee is directed to review workers' compensation claims brought to the committee and determine whether changes should be made to the workers' compensation laws. NDCC Section 54-35-22 provides for a six-member committee comprised of two members of the Senate appointed by the Senate Majority Leader, one member of the Senate appointed by the Senate Minority Leader, two members of the House of Representatives appointed by the House Majority Leader, and one member of the House of Representatives appointed by the House Minority Leader. In addition to the directive to review workers' compensation claims, NDCC Section 65-02-30 requires the committee to select up to four of the elements to be included in the quadrennial performance evaluation (performance evaluation) of Workforce Safety and Insurance (WSI). NDCC Section 65-02-30 also requires the committee to receive the performance evaluation report and review any actions taken resulting from the performance evaluation report.

The Workers' Compensation Review Committee is charged, under 2013 House Bill No. 1051, with studying the WSI preferred provider program created under NDCC Sections 65-05-28.1 and 65-05-28.2 and the Legislative Management charged the committee with receiving three reports:

1. A biennial report from WSI regarding compiled data relating to safety grants issued under NDCC Chapter 65-03 (NDCC Section 65-03-05).
2. An annual report from WSI which includes reports on pilot programs to assess alternative methods of providing rehabilitation services (NDCC Section 65-05.1-06.3).
3. A report from WSI on recommendations based on a biennial safety review of Roughrider Industries work programs and a biennial performance review of the program of modified workers' compensation coverage by WSI (NDCC Section 65-06.2-09).

Committee members were Senators Lonnie J. Laffen (Chairman), Tom Campbell, George B. Sinner and Representatives Bill Amerman, Curtiss Kreun, and Gary R. Sukut.

## CLAIM REVIEW

### General Background

Workers' compensation laws in North Dakota are found primarily in NDCC Title 65. The administrative rules adopted by WSI are found in North Dakota Administrative Code (NDAC) Title 92. Article X, Section 12, of the Constitution of North Dakota, specifically addresses the state's workers' compensation agency, providing for a constitutional continuing appropriation of the workers' compensation fund for the purpose of paying workers' compensation benefits.

North Dakota Century Code Section 54-35-22 established the Worker's Compensation Committee effective August 1, 2005, and the law was originally set to expire August 1, 2007. The expiration clause was repealed in 2007. The law requires the committee to meet once each calendar quarter unless there is no claim to review. The committee operates according to the laws and procedures governing the operation of Legislative Management interim committees.

### Interim History

The following is a history of the committee's activities relating to claim reviews conducted under NDCC Section 54-35-22 and legislative recommendations made:

| Interim | Claims Reviewed | Bill Drafts Recommended |
|---|---|---|
| 2005-06 | 11 | 3 |
| 2007-08 | 15 | 9 |
| 2009-10 | 4 | 7 |
| 2011-12 | 2 | 4 |

### Claims Review Procedure

The committee began the interim by establishing a procedure and protocol for conducting its charge of reviewing claim, based on the protocol and application packet used during the 2011-12 interim. The revised application packet included a cover letter explaining the application process and eligibility requirements, a copy of NDCC Section 54-35-22, a "Release of Information and Authorization" form, and a "Review Issue Summary" form.

In order to notify the public of the committee's activities and to solicit injured employees to submit their claims for review, the committee published the application packet on the legislative branch website. The committee adopted the following procedure, which was used during previous interims to determine eligibility for a claim review and prepare the injured employee for the committee meeting at which the claim is reviewed:

1. An injured employee would submit to the Legislative Council office a complete "Release of Information and Authorization" form. In addition, the applicant could submit a "Review Issue Summary" form on which the applicant could summarize the issues the applicant wanted the committee to review.
2. Upon receipt of a completed application, the Legislative Council staff forwarded a copy of the application information to an assigned ombudsman at WSI, who reviewed the application to make a recommendation regarding whether:
   a. The applicant was an injured employee or the survivor of an injured employee;
   b. The workers' compensation claim was final; and
   c. All of the administrative and judicial appeals were exhausted or the period for appeal had expired.
3. Following this review, the ombudsman contacted the Legislative Council staff to provide a recommendation regarding eligibility for review. Upon receipt of this recommendation, the Legislative Council staff contacted the committee Chairman to make a determination of eligibility.
4. Upon a determination of eligibility, the Legislative Council staff contacted the injured employee and the ombudsman to begin the case preparation.
5. Regardless of whether the injured employee accepted the assistance of the ombudsman, the ombudsman prepared a summary of the case to present at the committee meeting.
6. At the injured employee's discretion, the ombudsman assisted the applicant in organizing the issues for review.
7. The ombudsman prepared a case review packet and included this in a binder of information prepared for each committee member, Legislative Council staff, and the WSI representative. Although these binders were distributed at each committee meeting, they remained the property of WSI and were returned at the completion of each committee meeting.
8. Before each committee meeting at which a claim was to be reviewed, the ombudsman met with Legislative Council staff to review the case summary and workers' compensation issues being raised.
9. Upon receipt of these workers' compensation issues, Legislative Council staff notified a WSI representative of the identity of the injured employee who would be appearing before the committee for a case review, and, as appropriate, the basic issues being raised by the injured employee.

The committee established the following committee meeting procedure, which was followed for the claim reviewed by the committee:

1. Committee members had an opportunity before and during the committee meeting to review the binder of claim review information and to review the injured employee's WSI electronic records.
2. The ombudsman summarized the injured employee's case.
3. The injured employee presented the workers' compensation issues brought forward for review. At the discretion of the injured employee, these issues were presented by the injured employee, a representative of the injured employee, or both of these individuals.
4. One or more representatives of WSI commented on the workers' compensation issues raised.
5. Interested persons were invited to comment on the workers' compensation issues raised as part of the claim review.
6. The committee members had an opportunity to discuss the issues raised.

The claim reviewed was allocated a half day--either the morning or afternoon portion of a committee meeting--during which the initial review was conducted. Following the initial review, the committee retained the authority to continue to discuss issues raised as part of the review. The committee may request additional information on specific issues and reviews this information at one or more future meetings. During a committee meeting at which a claim is reviewed, a WSI representative is available to electronically access the injured employee's WSI records.

## Reconsideration of Procedure

The committee received a letter from two North Dakota attorneys who practice in the area of workers' compensation law which stated that there is a root problem in the state's workers' compensation system in that there is an irreconcilable conflict of interest in having the same agency that is responsible for the health of the fund also adjudicate the claims of injured employees. The letter recommends a full-scale study of the current system with an eye toward separating the functions of protection of the fund versus adjudication of claims.

In addition, the letter identifies the following four areas of suggested changes to the state's workers' compensation laws:

1. The committee should recommend legislation that unequivocally requires WSI to follow the opinion of the treating physician of the injured employee unless WSI meets its burden of proof that a preponderance of the evidence does not support the opinion of the treating physician.
2. The committee should recommend legislation to change the preexisting condition law, to require that "the employer take the employee as he finds him" instead of the current law that allows wholesale denial of claims simply because the injured employee had a preexisting injury or condition, even if that condition is completely asymptomatic before the work injury.
3. The committee should recommend legislation that provides for a study to improve vocational rehabilitation services to return vocational rehabilitation to its workable and stated purpose to ensure that injured employees receive services to assist the employee and the employee's family in the adjustments required by the injury to the end that the employee receives comprehensive rehabilitation services, including medical, psychological, economic, and social rehabilitation.
4. The committee should recommend legislation that removes the arbitrary caps on disability benefits--two years for total disability and five years for partial disability. The injured employee should receive disability benefits for as long as the injured employee is disabled.

The letter states that the lack of injured employees applying to the committee to have their claims reviewed is not a reflection of satisfaction with the system, but is a reflection of the inability of the committee to change the outcome of the injured employees' claims.

The committee recognizes that preexisting conditions and independent medical examinations (IMEs) are ongoing issues that the committee has tried to address over the years. Although the issue of IMEs was addressed during the 2013 legislative session, the performance evaluation also addresses this issue. In addition to the WSI performance evaluation recommendations regarding IMEs, as part of status reports from WSI the committee received information regarding the issue of IMEs.

## Review

The committee reviewed one workers' compensation claim.

**Case Summary**

The following is a summary of events of the inured employee's workers' compensation case:

- The injured employee sustained an injury to his lumbar and thoracic spine on December 11, 2012. At the time of injury, the injured employee worked as a truck driver in the oilfields of North Dakota. The injured employee received medical treatment on the date of injury.
- On January 16, 2013, the injured employee's WSI claims adjuster had a telephone conversation with the employer, which indicated the employer offered the injured employee a dispatch position beginning January 15, 2013, and that the injured employee declined the position indicating his injury prevented him from sitting. The employer reported the injured employee's last day worked was December 13, 2012. The employer reported the injured employee voiced concerns regarding reduction of pay with the dispatching job along with the high cost of living in North Dakota, making it difficult to accept and perform the job of dispatcher.
- On January 17, 2013, WSI issued a Notice of Decision Accepting Claim and Awarding Benefits. Workforce Safety and Insurance accepted liability for contusion of back, thoracic sprain and strain, and lumbar sprain and strain. The injured employee's physician released him to return to light-duty work, which did not include truck driving.
- On March 8, 2013, WSI issued a Notice of Intention to Discontinue/Reduce Benefits effective January 15, 2013, indicating, "You have been released to return to employment by Erin Pirkl, PA-C beginning 12/12/2012. On 12/13/12 you were put on light duty/desk work restrictions and your employer offered you a position within those restrictions on 1/15/13 and you declined it, therefore, self-limiting your income."
- On March 20, 2013, the injured employee requested reconsideration of WSI's Notice of Decision, indicating he was unable to work because of restrictions related to the December 11, 2012, work injury.
- On May 22, 2013, WSI issued an order stating "Claimant is not entitled to disability or vocational rehabilitation benefits while he voluntarily limits his income."
- On May 29, 2013, the injured employee requested the assistance of the WSI Decision Review Office (DRO), and on June 12, 2013, DRO issued its certificate of completion without a change in the decision of the order.

- On June 20, 2013, the injured employee requested a hearing on the May 22, 2013, order.
- On December 5, 2013, a hearing was held before an administrative law judge (ALJ).
- On December 11, 2013, the ALJ issued Findings of Fact and Conclusions of Law and Order, finding that the injured employee's employer offered the injured employee light-duty office employment and he declined to accept that offer. Additionally, the ALJ found there were no medical restrictions preventing the injured employee from doing light-duty employment. As a result, the ALJ found the refusal to accept the offered employment was a voluntary limitation of income pursuant to NDCC Section 65-05-08, and this action disqualified the injured employee from receiving disability benefits for wage loss. The WSI order was affirmed.
- The injured employee did not appeal the ALJ's order, and the decision became final.

The committee was informed that if the injured employee had accepted a job, WSI would have considered the difference in pay between the old job and the new job in calculating wage loss benefits. Additionally, if there had been an unsuccessful work attempt, the injured employee may have had his wage loss benefits reinstated. However, neither of these things occurred and the injured employee's wage loss benefits were terminated.

**Issues for Review**

The injured employee's wife provided the following information to the committee:

- Many errors were made in her husband's workers' compensation claim, including evidentiary errors.
- Her husband was not allowed time to appeal the ALJ's order, in part because of mistakes on WSI's website which were relied on by her husband to his detriment.
- The claimed job offer did not occur. The evidence in the WSI records does not support a finding that the job was offered. There are notepad entries missing in the WSI records. The job claimed to have been offered was more than her husband could handle, it was for less pay, and it was for longer hours.
- The administrative hearing was problematic.

  The injured employee did not fully understand the process, whereas WSI is very experienced and knowledgeable about the entire process, resulting in an unfair outcome. Workforce Safety and Insurance has access to legal counsel and the employer has access to legal counsel, but the injured employee does not have access to legal counsel. Not only was the injured employee unable to afford legal counsel, but there are so few attorneys in the state willing to represent injured employees that he would not have been able to find an attorney even if he had been able to afford one. If the injured employee is not required to have legal counsel and it is nearly impossible to find legal counsel, the system should be designed to look out for the injured employee and do what is right for the injured employee.

  WSI limited the information presented at the administrative hearing, failing to admit evidence that would have supported her husband's position.

  The injured employee did not have access to a recording of the administrative hearing.
- The appeal from the administrative hearing was problematic.

  After the administrative hearing was held and the order was issued, the injured employee provided the ALJ with additional information and the ALJ stated he would treat this as a petition for reconsideration under NDCC Section 28-32-40. Workforce Safety and Insurance and the employer opposed the motion for reconsideration. On January 10, 2014, the ALJ issued an Order Denying Request for Reconsideration.

  The injured employee did not understand when his time for appeal expired. Not only was the information on the WSI website incorrect regarding when an order becomes final (and this error has since been corrected), but he thought his time for appeal may have run before the ALJ ruled on the petition for reconsideration.

The injured employee's wife requests that WSI exercise its continuing jurisdiction and reopen her husband's claim to address the issues she raised and reverse its decision. Workforce Safety and Insurance chose to not exercise continuing jurisdiction to address the issues raised by the injured employee in this claim review.

**Workforce Safety and Insurance Response**

The WSI representative summarized the law relating to appeal times and clarified that the order issued by the ALJ states the appeal process. The representative of WSI testified that although the law can be complicated, the law needs to be followed in order for the system to work correctly.

**Committee Considerations**

The committee identified the following primary issued raised on behalf of the injured employee in the claim review:

- The job offer;
- Lack of legal counsel;
- Appeal timeframe;
- Administrative hearing recordings; and
- WSI notepad entries.

The committee received testimony from the injured employee's wife that it would have helped if the employer's job offer had been in writing and by registered mail. The committee received testimony from a representative of WSI that it would be the best practice to have an employer's job offer in writing, but it is not known whether a statutory requirement that the job offer be in writing would have a positive, significant impact on injured employees.

The committee considered the length of time allowed for appeal and found if the period for appeal is lengthened, it will have the effect of slowing down an injured employee's ability to seek relief.

A member of the committee stressed the importance of legal representation, voicing concern that an injured employee may not always fully appreciate the consequences of the injured employee's decisions and the WSI notices can be confusing to a layperson.

A committee member recognized it is a reoccurring issue for injured employees to be dissatisfied with claims adjusters, and questioned whether it might help if claims adjusters had smaller caseloads in order to provide better customer service. A committee member stressed the importance of keeping things in perspective as perhaps the number of complaints is very small given the number of client contacts for each claims adjuster.

## Workforce Safety and Insurance Status Updates

To keep apprised of current events at WSI, at each committee meeting the committee received status updates on timely topics and topics raised as part of the claim review process.

**Attorney's Fees and Post Decision Review Office Consultation**

In response to issues raised during the claim review, the committee received information regarding how WSI sets attorney's fees for attorneys of injured employees, the attorney's fee rates WSI pays its contracted legal counsel, and the post-DRO consultation funds.

A representative of WSI reported NDAC Section 92-01-02-11.1 sets the hourly rate for attorney's fees for injured employees at $140, and WSI uses this same rate for its contracts with attorneys to represent WSI at administrative hearings. Workforce Safety and Insurance is able to amend its administrative rules as necessary to change the hourly rates in response to the needs of the market.

A representative of WSI reported on the use of the post-DRO attorney consultation available under NDCC Section 65-02-35, which was enacted in 2009 as a result of recommendations of the Workers' Compensation Review Committee. The maximum of $500 for attorney's fees and maximum of $150 for costs are codified, and WSI reported that now that the program is up and running, WSI pays out approximately $100,000 per year under the program. Although a change in the amount of payment allowed under the program would require legislation, the rates were set in 2009 and testimony from WSI indicated these rates do not require updating at this time.

**Independent Medical Examinations**

In response to issues raised by attorneys representing injured employees and recommendations included in the 2010 and 2014 performance evaluations, the committee received background information regarding IMEs. The committee received an overview of 2013 Senate Bill No. 2298, regarding the weight given conflicting medical opinions; the committee reviewed the IME recommendations in the 2010 and 2014 performance evaluations; and the committee received material regarding the three most recent independent studies, evaluations, and reports regarding IMEs:

- February 1, 2007, "Independent Medical Examination Audit Report" performed by DA Dronen Consulting;
- October 8, 2008, "2008 Performance Evaluation Report" performed by Berry, Dunn, McNeil, and Parker; and
- August 2010 "Workforce Safety & Insurance Independent Medical Exam Study" performed by Trean Corporation.

Upon receipt of the information relating to recent legislative action regarding IMEs, the three prior IME studies, and the performance evaluations recommendations, the committee took this issue under advisement and did not make any recommendations at this time. The committee will continue to receive reports from WSI on the implementation of the performance evaluations, including the IME recommendations.

**Preexisting Conditions**

In response to issues raised by attorneys representing injured employees, the committee reviewed the topic of preexisting conditions. The 2010 performance evaluation included an element that provided for a comparison of other states' workers' compensation laws, including laws relating to prior injuries, preexisting conditions, triggers or chronic conditions, and aggravations. The committee reviewed 2010 performance evaluation material providing a state-by-state comparison with respect to workers' compensation treatment of prior injuries, preexisting conditions, and degenerative conditions. The 2010 performance evaluation included five recommendations regarding this element, and WSI reported all five of the recommendations are closed, which means each of the recommendations was fully implemented, partially implemented, or WSI did not concur with the recommendation and that WSI is no longer taking actions to address the five recommendations. The committee took this issue under advisement and did not make any recommendations at this time.

**Vocational Rehabilitation**

To stay abreast of current events at WSI, the committee reviewed the status of WSI's vocational rehabilitation services. The committee received data regarding WSI's vocational rehabilitation services provided during the period July 1, 2011, through June 30, 2014, and regarding WSI's vocational rehabilitation services expenses during the period July 1, 2009, through December 31, 2013. In addition to the receipt of this information, the 2014 performance evaluation included an element addressing vocational rehabilitation services, and the committee received the related recommendations. The committee did not make any recommendations regarding this matter.

**Employment Trends**

The committee received periodic updates on employment trends in the state, including the increase in WSI's book of business as the economy continues to grow, the increase in the number of out-of-state businesses entering the state, the state's employment mix moving to heavier industry and the associated higher risk of this employment, and personnel steps WSI has taken to stay abreast of this increasing workload. The committee recognized as a result of this growth in the state's economy, WSI is facing increasing personnel needs and WSI may need to request legislative approval for additional full-time equivalent (FTE) positions to address these personnel needs.

**2010 WSI Performance Evaluation**

The committee received updates on the status of WSI's implementation of the 2010 performance evaluation recommendations. A representative of WSI reported of the 50 recommendations made in the 2010 performance evaluation, WSI has closed out 45 recommendations and WSI is still working on 5 of the recommendations.

## PERFORMANCE EVALUATION

### Elements

In accordance with NDCC Section 65-02-30, at the beginning of the interim, the committee selected four elements to be included in the performance evaluation and the State Auditor selected four elements to be included in the performance evaluation. The State Auditor selected the following four elements to be included in the performance evaluation: IMEs, fraud investigations, the claims process, and vocational rehabilitation. The committee considered the elements WSI proposed be included, and the committee selected the following four elements to be included in the performance evaluation: the preferred provider program, cost of living adjustments, narcotic usage, and posttraumatic stress disorder. By selecting the preferred provider program as an element of the WSI performance evaluation, the committee fulfilled its charge of studying WSI's preferred provider program as provided for under 2013 House Bill No. 1051.

### Elements

The State Auditor awarded the contract for the performance evaluation to Sedgwick Claims Management Services, Inc. (Sedgwick). The WSI performance evaluation request for proposals (RFP) provided the following eight elements be addressed:

1. Independent medical examinations.
   a. Review the entire IME process, with a comparison to Sedgwick's IME national best practices developed in 2012.
   b. Conduct an analytical review of the overall number of "lost time" claims.

c. Review a sample of a minimum of 75 "lost time" claims that included the use of an IME during the evaluation period (calendar years 2011, 2012, and 2013). An evaluation of each of the sample items to determine:

(1) If the use of an IME and the process used to assign the IME physician complied with all applicable laws, rules, regulations, and WSI policies and procedures.

(2) The percentage of times the IME physician disagreed with the opinion of the claimant's treating physician.

(3) How this percentage compares with similarly calculated percentages in at least five comparable workers' compensation systems and analyze the reasons for significant differences. In addition, compare this percentage to national statistics.

(4) If the specialty of the IME physician was either the same as the claimant's treating physician or was a specialty better versed in the specific injury.

(5) If the use of an IME significantly delayed resolution of the claim.

d. Analyze the percentage of times an IME was used for "lost time" claims processed by WSI for each year covered by the performance evaluation, and a comparison of this percentage to the percentage of times an IME was used for "lost time" claims in at least five comparable workers' compensation systems.

e. Review the total costs for the use of IME physicians and any other third parties related to IMEs for each of the calendar years covered by the performance evaluation, including relevant travel expenses for the IME physician and the claimant and WSI's costs of using other organizations to locate or recruit physicians to conduct IMEs.

f. Review the process WSI follows to locate or recruit IME physicians. Determine if the agency is following relevant state statutes, administrative code, and WSI policies and procedures, including preference for an IME physician licensed in the state in which the employee resides in accordance with NDCC Section 65-05-28. Also, a determination of whether five comparable workers' compensation systems, at a minimum, use more effective or efficient processes to locate and recruit in-state physicians.

g. Review the percentage of times the IMEs for calendar years 2011, 2012, and 2013 were conducted by North Dakota physicians, and a comparison of this percentage to at least five comparable workers' compensation systems, and if available, national data.

h. In the context of this element, Sedgwick also addressed how WSI has implemented recommendations 1.3, 5.1, and 5.4 of the 2010 performance evaluation.

2. Fraud.

a. Review WSI processes, procedures, and policies as they relate to claims handler functions to identify suspicious claims. Analyze fraud personnel procedures to review, determine, document, and investigate suspicious claim activity in all facets of the workers' compensation system. Compare state policies and procedures to those of WSI.

b. Determine the areas of responsibility within the department to appropriately and effectively investigate suspicious claims in the three specific areas of workers' compensation fraud: employee, employer, and provider. Review workloads and workflows to determine if WSI has the necessary resources to address these specific areas and if the resources are being utilized appropriately.

c. Review the current software being utilized by the fraud unit to identify potential fraud in all aspects of the workers' compensation system. Determine if the software has impacted the identification of fraud and if those programs are sufficient to properly identify fraud. Through the review of the comparable workers' compensation investigation departments, determine possible enhancements to technology programs to enhance the effectiveness of fraud identification.

d. Review current training documents of claim handlers and fraud investigators to determine if the training program provides the necessary knowledge and skills to identify and investigate fraudulent claims in all areas of the workers' compensation system.

e. Analyze all suspicious claim investigation undertaken by the fraud unit for 2011, 2012, and 2013. Determine and categorize investigations by party (i.e. employee, employer, or provider fraud). Review those claims by category and determine financial outcomes of each claim to include recoveries and cost avoidance.

f. Evaluate current WSI performance indicators and metrics to determine if those performance objectives are appropriate in properly evaluating the fraud unit's personnel in the identification and investigation of suspicious claims.

g. Determine WSI's mechanism for capturing and tracking return on investment data and provide an analysis of that data as it relates to the comparable state's fraud investigation program.

3. Aspects of the claim process.

a. Review the appeals process available to claimants to include a comparison of this process to five other states and any "best practices" that may exist pertaining to the appeals process.

b. Analyze denied claims submitted to the DRO during calendar years 2011 through 2013 with an analysis of the number of times a decision was modified and whether the denials were supported by state law, administrative code, and WSI's policies and procedures.

c. Review the denial rate calculation process, including review of the rationale and accuracy for denial rate adjustments, the rate of denials in calendar years 2011 through 2013, and how these rates compare to national norms and the averages of five comparable states.

d. Analyze claims filed trends over the performance evaluation period, recognizing that claims filed year over year within the evaluation period and considering how that has influenced WSI's staffing and claim processes.

e. Review the appeal system as managed by the Office of Administrative Hearings (OAH) and whether alternative forms of dispute resolution could enhance the process from a timing and cost perspective.

4. Vocational rehabilitation.

a. Determine whether WSI has sufficient policies and procedures established to guide the staff and to establish protocol to ensure consistent, quality services for the return-to-work of injured employees.

b. Evaluate whether WSI has performance measures in place to adequately evaluate the performance of the vocational rehabilitation division.

c. Compare, to the extent data is available, WSI performance measures to those measures used in at least five other states.

d. Determine whether WSI surveys claimants who used return-to-work services or if any other means are utilized to determine claimant satisfaction and provide an analysis of those results.

e. Review 75 claims in which vocational rehabilitation services were provided to assess how policies and procedures are followed as well as assess compliance with various Century Code sections that define vocational obligations.

f. Determine how WSI compares with at least five other comparable workers' compensation systems in returning injured employees to the work force.

g. To the extent national benchmarks may be available, compare how WSI is returning employees to the workforce against those benchmarks.

5. Preferred provider program.

a. Conduct a complete and thorough review of the program including the legislative history of 2013 House Bill No. 1051, comparing the claims results and outcomes to the intended results in the bill to determine the success of the program.

b. Perform a thorough review and audit of the credentialing policies and procedures as well as the provider quality assurance program to ascertain whether the qualifications of the selected providers are appropriate for the program.

c. Compare the previous claims outcomes to the current program outcomes to demonstrate the benefits to the employees and employers and to measure the overall effectiveness of the program.

d. Review the administrative costs of operating the program.

e. Compare the current WSI opt-out policy to other states to determine the overall effectiveness of the WSI opt-out, including consideration of eliminating the policy.

f. Send questionnaires to and utilize online surveys for employers and employees to evaluate their understanding of the program.

6. Narcotic utilization.

   a. Review WSI policies and procedures relating to the use of narcotics.

   b. Evaluate North Dakota's narcotic utilization trends with a comparison to at least five comparable workers' compensation systems (when adjusted for North Dakota's labor force and age of the claims).

   c. Evaluate and compare utilization trends among localities and medical specialties within North Dakota.

   d. Analyze potential causes for variations with at least five other comparable workers' compensation systems as well as within the localities and medical specialties within North Dakota.

   e. In the context of this element, Sedgwick also addressed how WSI implemented recommendations 6.1 through 6.6 and 6.9 of the 2010 performance evaluation. An evaluation of narcotic utilization was also part of that evaluation and these prior recommendations tie in, and in some cases overlap with areas of interest in this WSI performance evaluation.

7. Cost-of-living adjustments.

   a. Review the process for determining the annual cost-of-living adjustments (COLAs) provided to certain benefit recipients after three consecutive years of disability.

   b. Compare the process for determining the annual COLA with at least five comparable workers' compensation systems providing for a COLA, including comparing and contrasting eligibility requirements to qualify for COLA as well as the basis used to determine COLAs.

   c. Identify national best practices, if available for this area and compare to North Dakota's processes and determination of COLAs.

8. Posttraumatic stress disorders.

   a. Evaluate posttraumatic stress disorder (PTSD) in five comparable workers' compensation systems, including an identification of any trends in coverage along with eligibility requirements for receiving coverage in each of the systems selected.

   b. Determine the economic impact on WSI of providing coverage for PTSD for any type of compensable injury.

   c. Consider the pros and cons of providing PTSD coverage and the various conditions associated with eligibility requirements.

   d. Within the original RFP on this project, there had been a provision suggesting that if national data were available relating to coverage of PTSD that Sedgwick provide that information. National data in the workers' compensation community is not available and is also difficult to obtain on a state-by-state basis. The RFP further suggested that if national data is not available that the consultant work with the State Auditor's office to estimate a cost to survey states so national trends could be identified. Following the issuance of the RFP, Sedgwick worked with the State Auditor's office and indirectly with the committee to scale this element to specific types of PTSD circumstances and to forecast potential costs in keeping with those criteria.

## Performance Evaluation Recommendations

For the eight elements of the performance evaluation, the report prepared by Sedgwick included recommendations identified by priority level, WSI's response to the recommendations, and Sedgwick's replies to WSI's responses. The material in this report is limited to the recommendations and does not include WSI's responses or Sedgwick's replies.

**Independent Medical Examinations**

**Recommendation 1.1: High Priority.** Sedgwick recommends when a new claim is filed, the WSI claim system be reviewed for all prior claims filed under the claimant's social security number to identify prior claims already in the WSI claim system. A synopsis of related body part injuries and medical conditions should be documented in the notepad, along with the name and location of any prior treating physicians, and the location of any diagnostic testing for the related body part or parts in questions. This recommendation would allow claims examiners the ability to identify and review all prior notes, medical records, and claims decisions made on prior work related injuries that were WSI's liability. This recommendation would also assist the staff with requesting prior medical records and diagnostic test results (lab, x-rays, scans, etc.) for treating physician and potential future IME review. Special medical releases may need to be sent to the claimant to obtain medical evidence from states other than North Dakota.

**Recommendation 1.2: High Priority.** Sedgwick recommends WSI utilize more IMEs to facilitate claim resolution and manage claim costs. The standard claim investigation process in the majority of the states is to identify potential issues early in the life of the claim and to get these issues resolved as quickly as possible. This resolution involves

taking statements, requesting medical records at the beginning of the claim, setting baselines, reviewing records for potential cost drivers, and working with the treating physician in managed care strategies. An IME is useful in early stages to set expectations and again at the next juncture at which the specific claim type should have been resolved based upon the nature and severity of the claim, official disability guidelines, and best practices. It is also useful at the time a new condition or body part is migrating into the claim. While not all time-loss cases need an IME, the use of an IME on claims that are open for one year or slightly more is helpful to define what is preventing the claim from closing, which allows the claims organization to begin working more diligently with the treating physician and injured employee at setting goals for claim resolution. Workforce Safety and Insurance's use of IMEs has been very cost-effective, in that appropriate denials associated with IMEs have been very effective at reducing the future cost of the claim files.

**Recommendation 1.3: High Priority.** Sedgwick recommends upon receipt of an internal independent medical records review (IMR) that raises a dispute in compensability which would preclude benefit provision to a claimant, that WSI first solicit concurrence from the treating physician. If the treating physician does not agree with the IMR, or does not respond to the request for concurrence, WSI should proceed with the IME process to resolve the dispute that was created with a records review. This would require that WSI refrain from issuing decision notices without at least two attempts to obtain concurrence from the primary treating physician.

**Recommendation 1.4: High Priority.** Sedgwick recommends WSI immediately resume its attempts to locate North Dakota physicians who will serve as independent medical evaluators to improve the frequency of use of North Dakota physicians in this area. Not one in-state medical provider was utilized to perform an IME for North Dakota constituency in the past three years. Coupled with the fact that the last attempt to generate some interest in this area was made four years ago gives the appearance that this is not an area of great importance. Sedgwick's review of five comparable states found that in-state medical providers were used 79 percent of the time at the very least. In one state, 100 percent of the IMEs used in-state providers. There are most certainly highly qualified physician specialists in the state of North Dakota who are both competent and highly respected for their ability to produce a sound and well-reasoned second opinion on any of the claim-related subject matters that WSI requires. Workforce Safety and Insurance needs to reach out and develop relationships within the state's medical community, offering training and providing incentives to welcome its in-state medical partners into the WSI IME preferred vendor pool.

**Recommendation 1.5: High Priority.** Sedgwick recommends WSI locate space in medical facilities to host IMEs in strategic locations throughout the state of North Dakota to serve its injured North Dakota constituents. Sixty-five percent of the IMEs in the evaluation sample were needed in North Dakota. Conducting IMEs in locations near North Dakota's most populated areas will reduce claimant time loss from work and hotel, meal, and mileage reimbursements. The costs associated with IME travel would be offset by reduced claimant reimbursements.

**Recommendation 1.6: High Priority.** Sedgwick recommends WSI develop and provide web-based training opportunities for North Dakota treating physicians designed to improve communication and help the medical community understand how the workers' compensation system works in North Dakota. The outreach curriculum should include frequently asked questions and links to applicable statutes, codes, and case law citations that are most frequently applied and misunderstood. A more in depth program will need to be developed to provide training to potential IME physicians in North Dakota laws, rules, regulations, and case law.

**Recommendation 1.7: High Priority.** Sedgwick recommends WSI review its IME-related claims procedures in their entirety with current staff, more specifically supervisors, to ensure that the procedures and processes as documented are being followed. Further, claims with IME requests should be sampled regularly by supervisory staff to ensure that all procedures and processes that pertain to claimant advocacy issues have not been overlooked.

**Recommendation 1.8: High Priority.** Sedgwick recommends the claim evaluation process should always begin with inquiries at the treating physician level. If the form letter FL332 in the claim procedure manual is not the vehicle WSI uses to do this, WSI should implement some other appropriate process to fully inform the treating physician of the level of detail that is required to meet the test of "objective medical evidence" that gives the treating physician the opportunity to represent the claimant.

**Fraud Investigations**

**Recommendation 2.1: High Priority.** Sedgwick recommends the WSI fraud unit review the old fraud unit manual, update it according to current fraud unit practice, policy, and procedures, and provide to all fraud unit staff.

**Recommendation 2.2: High Priority.** Sedgwick recommends WSI develop a process in conjunction with its medical vendors (CGI and PMSI Comprehensive Health Care) to review atypical payment trends as a starting point for provider investigation. One component of this process should include an assessment of referral patterns for ancillary medical services in which a treating provider has a financial interest. Information of this sort could be available through state records relating to corporate filings. Another way of obtaining this information would be to require by statute that

providers disclose any financial interest they have in ancillary services if that interest is equal to or greater than 5 percent. Once WSI has this information, WSI can evaluate trends by comparing providers of like specialties treating injuries in the same geographic area.

**Recommendation 2.3: High Priority.** Sedgwick recommends WSI develop techniques in data mining to detect fraud, notably as regards medical providers given the relative lack of provider fraud detected not only in the performance evaluation period but before that as well. Sedgwick is not sure what the data mining results will be but provided two examples. First, within the bill review area WSI could track the frequency with which certain followup office visit codes are used by medical providers in the state. If this is implemented, WSI may learn that many providers use relatively simple or low-level procedure codes when submitting their bills for reimbursement. Other providers may tend to use higher, more complex codes. Workforce Safety and Insurance could then measure these trends and can then filter the results by provider as a way of better understanding individual provider billing practices and validating whether the more complex codes are justified. A broad-based metric tied to this effort would be a report that sorts by billing code and then monitors how trends may change over time. A second approach should be tied to Recommendation 6.4 in the Narcotics Utilization section of this report in which Sedgwick recommends provider profiling. Once prescribing patterns are better understood, something may be gleaned from the analysis which suggests fraud or at least a need to educate providers who are outliers when compared to their peers.

**Recommendation 2.4: High Priority.** Sedgwick recommends upon implementation of Recommendations 2.2 and 2.3 that WSI expand its training of staff in the claims, medical, and policyholder services areas. The training should feature any new fraud detection practices that have been developed as well as information on trends observed through the data mining process. Sedgwick also recommends that when fraud has been detected, particularly in instances when the type of fraud constitutes a unique or new approach, that information be disseminated around the organization to appropriate staff.

**Recommendation 2.5: Medium Priority.** Sedgwick recommends WSI collect information on cases for which restitution is made. To the extent changes occur in restitution expectations, these changes should be tracked so there is a comprehensive means of accounting for expected restitutions and ultimate recoveries. In short, it would be wise to have comprehensive information on what is compromised as well as solid rationale for the reduction of the initial obligation.

**Recommendation 2.6: High Priority.** Sedgwick recommends the fraud unit reassess its method of calculating cost avoidance. When the amounts in outstanding reserves and cost avoidance are drastically different it suggests either reserves are woefully understated or avoided costs are inflated or possibly both. Sedgwick recommends as WSI reassesses its methods for calculating cost avoidance that it consider how medical treatment patterns have changed over time. More recent years of payment activity should be given precedence in the calculation as these years are more reliable predictors of future cost.

**Claim Processes**

**Recommendation 3.1: High Priority.** Sedgwick recommends the operating report provide an appropriate footnote to describe the denial types that are excluded from the adjusted acceptance rate. For instance, when referring to claim technical denials it would be useful to know the kinds of cases that fall into this category.

**Recommendation 3.2: Medium Priority.** Sedgwick recommends that to the extent WSI can develop an informal network of treating doctors who practice out-of-state and who are familiar with and accepting of WSI's requirements, this could help WSI better manage out-of-state claims. Matching might occur by comparing provider zip code to the zip code associated with the injured employee's residence. Adjusters should also be pooled for names of those out-of-state providers with whom they have worked successfully.

**Recommendation 3.3: Medium Priority.** Sedgwick recommends WSI work with OAH to amend the calculations it does on cases so that an average duration from receipt of file to file closure breaks out those cases that proceeded to hearing when the hearing was initially set, and another data set for those cases for which hearings occurred later than originally set. Hearing delays typically occur because one of the parties has requested a delay or continuance and some instances of delay can be weather-related. Workforce Safety and Insurance would be well-served if it can identify all cases that do not meet the 160-day target when hearings occur as initially scheduled. Workforce Safety and Insurance might then publish two rates, with the second rate including the average duration from OAH receipt to OAH closure when delays have occurred because the hearing did not occur on the original hearing date.

**Vocational Rehabilitation**

**Recommendation 4.1: High Priority.** Sedgwick recommends WSI issue its orders pertaining to vocational plans in a timely manner. If the legislature believes an order is issued timely within 60 days of final approval of the vocational manager's report (VCR), Sedgwick suggests the statute be amended to reflect that intent.

**Recommendation 4.2: High Priority.** Sedgwick recommends WSI prepare legislation governing the payment of temporary partial benefits for vocational plan participants to be amended such that the combined value of post-injury earnings and temporary partial disability may not exceed 90 percent of the injured employee's preinjury earnings.

**Recommendation 4.3: High Priority.** Assuming WSI and the injured employee settle a vocational rehabilitation entitlement, Sedgwick recommends the law should be written in such a way that if an employee wishes to return to work in North Dakota in the same or similar position after acceptance of a vocational benefit settlement and the employee claims a worsening of the condition, causing additional disability, that WSI be allowed to take a credit up to the full value of the settlement against future disability benefits. Such a provision would mimic the State of Washington's option 2 language.

**Recommendation 4.4: High Priority.** As a preliminary statement to this recommendation, Sedgwick recognizes WSI is in the midst of a project to create a data collection and reporting environment for rehabilitation and legal services. This environment is functioning to some extent but not yet optimally, so the recommendations are made with the understanding that these metrics should be available as functionality exists in the environment to capture the required elements accurately. Metrics should include:

- Continue the CL0954, 0956, 0958, and 0959 reports.
- Add a column to the CL0958 report so it captures the percentage the average post-injury average weekly wage (AWW) is of the average preinjury AWW as this percentage will show the extent to which injured employees have on average achieved a post-injury wage that is at least equal to 90 percent of their preinjury wage. This percentage can be displayed both on the summary page--page 1 of the report--and throughout the detail portion of the report on each case.
- When closing out a case, build in a data element that identifies whether the post-injury weekly wage is based on earning capacity when the injured employee has not returned to work or actual wages. This particular data element is relevant to Recommendation 4.7 on injured employee surveys.
- For long-term training programs that can by statute run for up to 104 weeks, have a flag to capture those programs that are extended beyond 104 weeks. Use this data to evaluate the reasons for program extensions and whether there is anything WSI and the injured employee could have done to complete the program as originally scheduled.
- For cases on which a functional capacity evaluation (FCE) occurs, track that date. Vocational services often kick into a higher gear once the FCE is completed and the treating physician has signed off on the capabilities identified through the FCE. The FCE approval date from the treating physician should be tracked and then a date set for completion of the VCR should follow. Assuming the injured employee is not in the middle of skills upgrading or obtaining a general education development at the time the FCE is approved, a target date for the VCR should be 45 days unless a long-term training program is to be recommended in which case 75 days could be allowed.
- Track plan options by case manager so the return to work services director can evaluate how effectively they are pursuing the preferred plan options. For instance, if an average case manager has 60 percent of that case manager's cases pursuing options that are among the first four plan types, the director can evaluate a case manager who falls well below that average. Similarly, if someone is more successful, then perhaps that case manager's approach can be evaluated so other case managers can learn from that approach. It might be useful to link this type of data collection to the residence of the injured employee to see if later plan options tend to occur more frequently among those who live in more remote areas.
- Include summary data from the CL0958 report in the quarterly operating report. The values to include would be the number of cases closed, the average preinjury wage, and the average post-injury wage.

**Recommendation 4.5: Medium Priority.** Sedgwick recommends WSI examine the reason for the decline of those in the survey pool when comparing older years to newer ones. Sedgwick recommends that if the underlying pool is roughly the same year over year that the survey pool should in future surveys include more injured employees.

**Recommendation 4.6: Low Priority.** Sedgwick recommends the survey include questions relating to the respondent's education level and whether services were provided during vocational rehabilitation to improve that education level.

**Recommendation 4.7: High Priority.** Sedgwick recommends the survey be expanded to include a sampling of injured employees a second time. This sampling would be limited to employees who were not working at the time of the initial survey and timed to occur one year after the quarter in which they were initially surveyed. The survey should be limited to whether they have returned to work, how long they have been working, what kind of work they are doing, whether they are working part-time or full-time, and what their current earnings are. For those who have returned to

work, injured employees should be asked if they think something could have been done in their vocational rehabilitation experience that they believe could have led to an earlier return-to-work.

**Recommendation 4.8: Medium Priority.** Rather than being required to issue a formal order when injured employees referred for vocational services return to their regular job, Sedgwick recommends WSI issue a notice similar to what it would issue when an employee returns to the employee's regular job following a period of temporary total disability. For cases of this type, there is not a need for WSI to compile a full VCR.

**Preferred Provider Program**

**Recommendation 5.1: High Priority.** Sedgwick recommends WSI develop a designated provider acknowledgement form to be submitted to the provider by the employer.

- The legislative intent identified the purpose of the preferred provider program to be the development of a relationship between the employer and the designated provider in order to improve the quality of care provided to the injured employees. By providing the acknowledgement form to the designated provider, WSI is ensured there is an established communication between the employer and designated provider and the designated provider wants to have the injured employees directed to the designated provider's care.
- The acknowledgement should provide the requirements of the program and the expectation of the designated provider.
- The form should require signature by the designated provider indicating an understanding of the program as well as a willingness to be the designated provider.
- The acknowledgement form should be maintained at the employer's office or facility and be available to WSI upon request.

If the employer elects to change the designated provider, a notice of the termination should be submitted to the current designated provider and the designated provider acknowledgement form should be submitted to the new designated provider.

**Recommendation 5.2: High Priority.** Sedgwick recommends WSI establish a formal policy not to retroactively seek reimbursement from the injured employee on auto-adjudicated claims when the claim is ultimately denied due to the injured employee not going to the employer's designated provider. The auto-adjudication process does not contemplate the preferred provider program and does not identify whether an injured employee went to the designated provider. To retroactively seek payment because the claim becomes manually reviewed due to additional bills at a later date and denied due to the injured employee selecting a nondesignated provider is not only unjust but would lead to litigation.

**Recommendation 5.3: Low Priority.** Sedgwick recommends WSI post on its website providers that have their license suspended or revoked.

- WSI is not and should not be required to credential preferred provider program designated providers. The employer selects the designated provider and not WSI.
- To require WSI to credential all designated providers would be cost-prohibitive, unduly burdensome, and unnecessary.
- In lieu of credentialing all preferred provider program designated providers, WSI should identify designated providers with suspended or revoked licenses.
- The information could be obtained from the State Board of Medical Examiners.
- This would provide employers easy quality assurance check by providing access to information verifying the license of their selected designated provider.

**Recommendation 5.4: High Priority.** Sedgwick recommends WSI develop a formal policy permitting an injured employee to opt-out if the injured employee's residence is more than a specified distance from the employer's designated provider.

- The legislature will need to establish a fair and reasonable distance from the injured employee's residence to the designated provider's office.
- Most state certified networks and state operated managed care organizations have legislation requiring sufficient provider coverage within a certain geographical distance from the injured employee's residence.

- Developing a formal policy clearly defining the distance from the injured employee's residence will provide uniformity in adjudicating the preferred provider program claims.
- To require an injured employee to travel in excess of 30 miles to obtain treatment is unduly burdensome and cost-prohibitive for the employee.

**Recommendation 5.5: Medium Priority.** Sedgwick recommends WSI simplify and expedite the designated provider 30-day opt-out provisions.

- The 30-day opt-out requirement actually takes 60 days from the date of first treatment to take effect.
- The employer objection provision of the preferred provider program is rarely if ever employed.
- A simple notification in writing by the employee provided to the employer any time after 30 days of treatment would simplify and expedite the process--creating a true opt-out opportunity to the injured employee.
- At the same time the injured employee provides the notice to the employer, the notification could be provided to WSI.

**Recommendation 5.6: High Priority.** Sedgwick recommends WSI contact all employers using the preferred provider program and receive an acknowledgement in writing the employers are aware of the fact they are in the program and they want to remain in the program.

- The employer questionnaire identified a significant number of employers that were unaware of the program.
- The employer questionnaire indicated a significant number of employers were unaware of the requirements of the preferred provider program.
- WSI should create an employer written acknowledgement form that provides the purpose of the program, the requirements of the program, and the employer's consent to continue the program. This will ensure employers using the program understand the program.
- By obtaining an affirmative written acknowledgement from the employers using the program, WSI will confirm the employers are aware of the program, its requirements, and its purpose.
- By obtaining a negative acknowledgement form, WSI will eliminate the employers who have signed up for the program and no longer want to participate in the program.

**Narcotics Utilization**

Sedgwick reviewed the extent to which WSI implemented the 2010 performance evaluation recommendations regarding this element, classifying the implementation as fully implemented, partially implemented, or not implemented. Additionally, Sedgwick made new recommendations regarding the narcotics utilization element.

**Recommendation 6.1: High Priority.** Since WSI's change from using US Script to using PMSI, the new pharmacy benefits manager has not produced the patient utilization report. This report is used to identify patients whose opioid use has continued for at least 90 days. Sedgwick recommends WSI work with PMSI to reinitiate this report.

**Recommendation 6.2: Medium Priority.** When WSI sends out the form letter 423-1, Sedgwick recommends the form letter be accompanied by a form letter to the provider asking the provider to identify a date when the provider believes the patient will be able to discontinue use of opioid treatment. Proportionately few patients receive more than two narcotic prescriptions so addressing those cases with a potential for a third fill seems a reasonably prudent step in opioid management.

**Recommendation 6.3: High Priority.** Sedgwick recommends WSI draft legislation to be considered in the next biennium which seeks to accomplish the following:

- Require the pain management contract be signed by the injured employee and treating physician in all cases for which opioid therapy has extended beyond 90 days.
- For cases of opioid use beyond 90 days, require no less frequently than quarterly that the treating physician address how the current opioid regimen is either decreasing pain or improving function. In those instances where neither is demonstrated, WSI may use IMEs to determine if ongoing opioid therapy is necessary. These IMEs could lead to a decision by WSI to disallow certain opioids, to reduce the dosage, or to allow the treatment to continue as is.
- For cases of opioid therapy beyond 90 days, mandate that appropriate and random drug screens are accomplished to ascertain if medication is being taken as prescribed. Drug screens should occur no less

frequently than semi-annually and may at the treating physician's discretion be conducted more frequently up to four times annually. Failed tests would be considered a breach of the pain management contract and under such circumstances WSI should have the discretion to discontinue payment for opioid therapy.

**Recommendation 6.4: High Priority.** Provider profiling was recommended in the 2010 performance evaluation but the prior pharmacy benefits manager could not accomplish the recommendation. Sedgwick recommends WSI pursue the profiling recommendation made in 2010 with the new pharmacy benefits manager, PMSI. To accomplish the profiling, Sedgwick recommends WSI profile and manage results according to the following criteria:

- Identify those physicians who have prescribed opioid medications over a certain dollar threshold in the past year (consider $20,000 as a starting point to see what the data reveals).
- Create a report that goes to the physicians who hit this threshold which provides for their patients the names of the injured employees, their dates of injury, when they commenced on opioid therapy, the amount prescribed in morphine equivalencies, and a return to work date if one exists.
- Schedule peer-to-peer meetings on cases selected by WSI with these treating physicians to include a review of the current opioid intake, morphine equivalencies, opportunities to reduce or discontinue opioid use, pain level, functional level, urine drug screening outcomes, and the use of generic medications in lieu of brand name.
- Establish goals or revised treatment plan objectives on each case and follow for compliance.
- Pay treating physicians for their time at an appropriate professional hourly rate for participating in these reviews.

**Recommendation 6.5: High Priority.** Sedgwick recommends WSI evaluate its current formulary and build in a prior authorization process for long-acting opioid medications requested within the first three months postinjury.

**Cost-of-Living Adjustments**

Sedgwick considered making a recommendation to implement a cap on supplementary benefits. However, in general, increases in wages are tied to economic prosperity in an area which can also be linked to an increased cost of living. If claimants on a fixed wage are subject to caps that run below the increased cost-of-living experienced in the state, they could be proportionately more affected. Further, the increases in state average weekly wage in 2012 and 2013 appear to be anomalies when compared to the 20-year history of changes in the state average weekly wage.

Sedgwick also considered making a recommendation for changing the requirement for three years of consecutive benefits before being eligible for COLA to a shorter time frame. Given the benefit types--death benefits and permanent total disability benefits--to which COLAs are applied, Sedgwick determined that three years is reasonable and relatively in line with national averages. The lack of a cap means that once COLAs commence recipients will see benefit increases in line with growth in the state average weekly wage. The timing of the first COLA means increases are delayed to some extent by the fact no COLA is paid until three consecutive years of disability benefits have been paid.

Given the review of North Dakota in the context of other states, the methods of benefit calculation, and the timing of COLA increases, Sedgwick makes no recommendations.

**Posttraumatic Stress Disorder**

**Recommendation 8.1: Low Priority.** If the legislature adopts a statute covering PTSD claims, Sedgwick recommends, that to the extent statutory language currently exists to require injured employees to file their claims within certain time frames, that this language be amended if needed to extend that time frame. The extension should be in keeping with when injured employees knew or should have known they have a PTSD injury and the condition is related to workplace experiences. The reason for this recommendation is to provide statutory relief for timely claim filing in keeping with the period of time that must elapse for the condition to actually manifest itself. Workforce Safety and Insurance may determine NDCC Section 65-05-01 would already achieve this objective, which is why Sedgwick categorizes this recommendation as low.

**Recommendation 8.2: High Priority.** When WSI currently pays for mental or psychological injuries arising out of a physical injury, at least 50 percent of the mental injury must be attributable to the work-related injury given other possible causes. Sedgwick recommends application of the same 50 percent threshold if the legislature adopts statutory language to cover workplace PTSD when no physical injury has occurred.

**Recommendation 8.3: High Priority.** Sedgwick recommends:

- Workforce Safety and Insurance submit legislation to allow mental injury claims under one or more of the three scenarios referenced in the findings. Those scenarios include first responder claims, victims of violent crimes, and employees who experience unusual and extraordinary events. If legislation is submitted to cover employees who experience unusual and extraordinary events as the primary qualifying characteristic, Sedgwick recommends this language include first responders and victims of violent crimes.
- Workforce Safety and Insurance establish a cap on disability benefits in the legislation in a manner that is similar to the law in the state of Arkansas; that is, that temporary total disability benefits will not be paid for more than 26 weeks and no death benefit will be paid if the death occurs more than one year from the date of injury. Vocational rehabilitation services should be provided if as a consequence of the mental injury a return to the usual job is not possible.
- A PTSD diagnosis must be made by a qualified health care professional in the field of mental health before any benefit may be paid.
- Language should be included in new legislation which excludes from coverage any claim that allegedly arises out of normal employer and employee relations.
- A sunset provision should exist of no shorter than two years and no longer than four years during which time WSI should develop measures designed to identify the actual benefit costs to providing coverage for injuries of the types contemplated in the proposed legislation.
- Workforce Safety and Insurance identify as part of its metrics those injured employees whose temporary total disability benefits end because they have exhausted the 26-week cap. This should be part of an overall metric that includes a total claim count and total and average medical and indemnity costs as compared to average costs of other workers' compensation claims in North Dakota.
- If legislation is submitted specifically related to first responders, that legislation should identify and limit coverage to that occupation.
- Claims for PTSD would only be accepted based on an event date the legislation would establish.

**Recommendation 8.4: Medium Priority.** If the legislature adopts legislation to cover mental injury claims, employers that participate in the preferred provider program should include at least one psychologist or psychiatrist as a designated provider.

## REPORTS

### Safety Grants Report

Pursuant to NDCC Section 65-03-05, the committee received the biennial report from WSI regarding compiled data relating to safety grants issued under Chapter 65-03.

### Rehabilitation Services Pilot Program Report

Pursuant to NDCC Section 65-05.1-06.3, the committee received reports on WSI's system of pilot programs to allow WSI to assess alternative methods of providing rehabilitation services. The report indicates WSI has three new rehabilitation services programs in the works. The first new program is in the early stage of development and will provide for a vocational support program that will provide rehabilitation services to assist with psychological, economic, and social elements. If an injured employee participates in this new program, some of the rehabilitation timelines will be relaxed. The second new rehabilitation services program is a scholarship program for retraining students. Under this new scholarship program, WSI makes scholarships available to assist in paying for additional education beyond the traditionally covered associate degree. The third new rehabilitation services program is a rehabilitation grant program for grants to rehabilitation partners.

### Modified Workers' Compensation Program Performance Audit and Roughrider Industries Safety Audit

Pursuant to NDCC Section 65-06.2-09, the committee received a report from WSI regarding the status of the modified workers' compensation program performance audit and the Roughrider Industries safety audit. The modified workers' compensation program was established in 1997 to provide workers' compensation coverage for inmates in prison work programs and to allow Rough Rider Industries to continue receiving federal funding through the prison industry enhancement certification program.

The performance review of the program for modified workers' compensation coverage was conducted by WSI's Internal Audit Department while the safety inspection of Rough Rider Industries' Prison Industry Enhancement

Certification work programs was conducted by a WSI safety consultant. The three objectives of the modified workers' compensation coverage program review are to:

1. Verify excess coverage or reinsurance has been obtained;
2. Identify any claims filed for workers' compensation benefits; and
3. Verify premiums and other costs are being collected.

The report provides that since the beginning of the modified workers' compensation coverage program in 1999, it had been determined that coverage available under the risk management fund and its excess carrier are sufficient to meet the statutory requirements. However, before the 2014 fiscal year, the Risk Management Division and the Department of Corrections and Rehabilitation began reviewing whether the statutory coverage requirements have been interpreted correctly in the past. Workforce Safety and Insurance and the Risk Management Division determined that the excess/reinsurance coverage maintained by WSI's third party is adequate for the purposes of covering Rough Rider Industries at this time, regardless of whether the state's risk management fund is adequate. Workforce Safety and Insurance's current reinsurance coverage is for claims and events in excess of $3 million and up to $30 million. Workforce Safety and Insurance has had excess or reinsurance coverage in place by a third party during calendar years 1999-2002 and 2010 to the present.

The internal audit recommends the Department of Corrections and Rehabilitation work with WSI and the Risk Management Division to make the necessary language changes to all applicable sections of the Century Code and Administrative Rules relating to securing excess or reinsurance coverage under the modified workers' compensation program. If necessary language changes are not made, the Rough Rider Industries prison industry enhancement certification program should be discontinued and the workers' compensation account cancelled if at any point in time the excess or reinsurance coverage is no longer maintained by WSI's third party.

The report provides all claims for workers' compensation coverage benefits must be filed according to NDCC Section 65-05-01. Between the period of July 1, 2012, and June 30, 2014, there were no inmate injury claims filed. Additionally, the report finds WSI billed and Rough Rider Industries paid the necessary workers' compensation premium for the reporting period.

## CONSIDERATIONS

The committee considered a bill draft WSI brought to the committee for consideration which would have expanded the workers' compensation definition of "compensable injury" to include PTSD for full-time employed first responders. The bill draft would have placed time and dollar limitations on the disability benefits and would have expired August 1, 2017. There was mixed committee support for this bill draft--some committee members supported the bill draft, some committee members supported the bill draft but voiced concern regarding what type of precedence the bill draft may be setting for future requests for expanding coverage for mental injuries, and some committee members did not support the bill draft.

## RECOMMENDATIONS

The committee recommends a bill [15.0264.03000] to provide that for workers' compensation wage loss benefits, to establish that an employer made a job offer to an injured employee, the proof of offer of employment must be established by an employer's written offer to the employee by registered mail.

The committee recommends a bill [15.0317.01000] to establish protocols that must be followed as a prerequisite for WSI to cover chronic opioid therapy for injured employees. To qualify for coverage, the chronic opioid therapy must be appropriate and meet specified requirements; the status of the injured employee must meet specified requirements, such as have a diagnosis consistent with chronic pain; and the prescriber of the chronic opioid therapy shall comply with specified requirements, such as complying with documentation requirements and entering treatment agreements with the injured employee.