MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON LABOR & EMPLOYMENT RELATIONS

Call to Order: By Sen. Bill Wilson, on February 16, 1993, at 1:00 P.M.

ROLL CALL

Members Present:
Sen. Bill Wilson, Vice Chair (D)
Sen. Gary Aklestad (R)
Sen. Chet Blaylock (D)
Sen. Jim Burnett (R)
Sen. Tom Keating (R)
Sen. J.D. Lynch (D)

Members Excused: Sen. Tom Towe(D)

Members Absent: None.

Staff Present: Eddye McClure, Legislative Council
Patricia Brooke, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: SB 274, SB 347
Executive Action: None

HEARING ON SB 274

Opening Statement by Sponsor:
Sen. Keating, Senate District 44, introduced SB 274 to the Committee by stating the Bill deals with tips that are not considered wages and are over and above the portion of income that is taxed. He stated SB 274 will exempt the employer from having to pay unemployment insurance premiums and workers' compensation premiums on those tips not a part of the payroll. Sen. Keating said SB 274 does not affect workers who would still be covered with unemployment insurance and workers compensation. He stated SB 274 relieves the restaurant owner and the employer, from a few additional dollars in premiums. Sen. Keating stated SB 274 is beneficial and will help save some jobs.

Proponents' Testimony:

Leon Stalkup, Montana Restaurant Association, submitted an amendment to SB 274 in order to comply with Federal law(Exhibit #1). Mr. Stalkup reported SB 274 encourages service for tips to continue. He stated that under current law the employer is burdened with paying additional taxes. Mr. Stalkup stated Montana taxes do not classify tips as wages and therefore the employer should not have to pay premiums. Mr. Stalkup handed out a flyer and a speech by George McGovern to further his point(Exhibits #2 and #3).

Opponents' Testimony:
Veronica Brown, President, Hotel and Restaurant Employees Union, submitted written testimony(Exhibit #4) and handed out a fact sheet about employees who receive tips.(Exhibit #5).

Terry Dolan, representing self, Missoula, stated she is a single mother of three and a waitress. Ms. Dolman informed the Committee that when she has applied for loans or food stamps her tips have always been considered her wages and if she applied for unemployment or workers compensation she would report her tips as wages.

Barbara Downing, waitress, Billings, submitted written testimony(Exhibit #6).

Cindy Polinsky, Local 427, read a statement on behalf of Margaret Olson, a disabled restaurant employee. Ms. Olson informed the Committee her temporary total benefits are reduced because of a technicality in reporting tips. Ms. Olson urged the Committee to defeat SB 274.

Don Judge, Montana State AFL-CIO, pointed out that the Federal government requires taxes to be paid on tips and requires contributions be paid to the Unemployment Trust Account. Mr. Judge stated employers in the state would be penalized if they complied with SB 274. Mr. Judge stated that if the IRS and the Federal Unemployment Department classify tips as taxable wages then there is no reason whatsoever to believe they are not taxable wages.

Questions From Committee Members and Responses:
None

Closing by Sponsor:
Sen. Keating closed the hearing by stating SB 274 would be good for Montana's economy.

HEARING ON SB 347

Opening Statement by Sponsor:
Sen. Harp, Senate District 4, introduced SB 347 to the Committee by stating it represents the first comprehensive revision of the medical delivery system under the Workers' Compensation Act. He stated the Workers' Comp Act requires the State to cover an

injured worker for a reasonable medical expense. He added SB 347 would afford the legislature the opportunity to determine what are reasonable medical services. Sen. Harp stated SB 347 is built upon the principle of cost containment and it would provide timely and quality service for the injured. SB 347 adopts a managed care system. Sen. Harp stated SB 347 will be a protection for the injured worker by involving a third party, the Department of Labor. SB 347 would restrict travel by the insured unless requested by the insurer. Sen. Harp stated SB 347 is designed to contain costs and to ensure an injured worker is taken through a managed care system from the time he/she is injured to when he/she is returned to work.

Proponents' Testimony:
Terry Mittin, Workers' Comp Coalition, stated that the Coalition he represents was formed last fall and has about 200 members who employ about 50,000 people in Montana. Mr. Mittin stated his strong support of SB 347 and added that, if passed, SB 347 will benefit Montana's economy a great deal. Mr. Mittin highlighted sections of SB 347 he felt were crucial improvements to Montana's workers' comp system: 1) domicile care reform, 2) compliance with medical care, 3) reduction of costs for prescription drugs, 4) independent doctor and hospital/insurers contracts, 5) control of referrals for profit.

Rick Hill, Governor's Office, stated workers' compensation premiums are increasing at a rate the Montana economy cannot afford. He stated SB 347 will bring cost containment to the medical care while protecting the needs of the injured.

John Guy, President, St. Peter's Community Hospital, stated the elimination of fraud and abuse of the system and duplication of services are the right way to go. He added managed care will help contain costs. Mr. Guy stated his concerns with SB 347, specifically the proposal to pay out-patient services using a non-hospital fee schedule. Mr. Guy concluded hospitals generally support SB 347.

Bob Olsen, Montana Hospital Association, submitted written testimony(Exhibit #7).

Pat Sweeney, State Fund, stated the State Fund spent almost $37 million on medical expenses in fiscal year 1992. He stated medical expenses account for over half of the 20% rate increase the State Fund experienced at the beginning of fiscal year 1993. Mr. Sweeney stated medical cost containment is essential to managing workers' comp.

Pete Strizich, State Insurance Department, handed out statistics(Exhibit #8) and explained that they illustrate the cost to the workers' comp system of medical costs.

Bill Shaw, physician, submitted written testimony(Exhibit #9).

Rose Hughes, Executive Director, Montana Health Care Association, stated her support of SB 347.

Dr. Terry Jackson, physician, stated his support of SB 347.

Harlee Thompson, Intermountain Trust, submitted written testimony(Exhibit #9a).

Cal Winslow, Deaconess Medical Center, Billings, stated his support of SB 347.

Dr. John Diggs, Bozeman, stated his support of SB 347.

Riley Johnson, National Federation of Independent Business, stated his organization's support of SB 347.

Jacquline Lenmark, American Insurance Association, stated her organization's support of SB 347.

Chuck Hunter, Department of Labor and Industry, stated SB 347 provides the Department with significant new responsibilities and regulatory requirements. The intent is for the Department to provide input to the process.

Jerry Loendorf, Montana Medical Association, stated his organization's support of SB 347.

George Wood, Executive Secretary, Montana Self-Insurers Association, stated his support of SB 347.

Opponents' Testimony:
Don Hecht, chiropractor, stated the benefits of chiropractic practices to the health care delivery system. Mr. Hecht stated the costs in Montana for total chiropractic costs in work comp is at $1.8 million which is less than 1% of the budget. Mr. Hecht passed out a study on chiropractic treatment(Exhibit #10).

Bonnie Tippy, Montana Chiropractors Association, submitted amendments to the Committee(Exhibit #11) and stated the Association wants to be part of the solution and not part of the problem. Ms. Tippy also passed out history of House Bill 33 enacted in the 51st Legislative Session(Exhibit #12). Ms. Tippy stated she has some concern about SB 347 regarding the fact that consulting physician is defined as a medical physician only and the Bill lacks a statement of intent. Ms. Tippy urged the Committee to amend the Bill.

Mark Staples, urged the Committee to amend SB 347 and to look at and adopt the amendments submitted by the Montana Chiropractor Association.

Charles Brown, chiropractor, Billings, submitted an article which addresses self-referral by physicians(Exhibit #13) and urged the Committee to view chiropractic care as a very cost-effective

means of treatment.

Jerry Connolly, physical therapist, Billings, submitted written testimony and suggested amendments(Exhibit #14).

Russell Hill, Montana Trial Lawyer Association, submitted written testimony(Exhibit #15).

Don Judge, Montana State AFL-CIO, stated he would like to work with the Committee on amendments to SB 347. Mr. Judge said he was concerned that SB 347 would limit a worker's ability to work and receive quality treatment if injured. Mr. Judge feels the burden is on the worker to prove the effect of the injury. Mr. Judge stated there are many good aspects of SB 347 but there is an awful side to it as well.

Greg Loushin, pharmacist, Butte, submitted amendments on behalf of the Montana State Pharmaceutical Association(Exhibit #16).

Gary Lusin, physical therapist, Bozeman submitted written testimony(Exhibit #17).

Roger Tippy, Montana State Pharmaceutical Association, urged the Committee to adopt the amendments submitted by the Pharmaceutical Association.

Richard Smith, physical therapist, submitted written testimony(Exhibit #18).

Gail Wheatley, President, Montana Physical Therapy Association, urged the Committee to allow physical therapist to participate in the managed care system.

Kirk Hanson, Montana Association of Private Practice Physical Therapists, Helena, encouraged the Committee to amend SB 347 to include physical therapists.

Lorin Wright, Physical Therapy Association, Red Lodge, submitted written testimony(Exhibit #19).

Ann Lawson, physical therapist, submitted written testimony(Exhibit #20).

Mike Pardis, physical therapist, stated his support for amendments to SB 347.

Wayne Jacobsmeyer, chiropractor, Columbia Falls, urged the Committee to amend SB 347.

Questions From Committee Members and Responses:

Sen. Lynch asked Sen. Harp how the PPO would work. He asked if it would be a bidding process. Sen. Harp answered the PPO could be done independently or as a part of a managed care organization.

Sen. Lynch asked Sen. Harp why HMO's are not in SB 347. Sen. Harp replied they are not included in SB 347 because the Bill is all-inclusive. He said he would be willing to look at including them.

Sen. Lynch asked Sen. Harp if he thought chiropractic care is valid as a method of treatment. Sen. Harp replied it is a valid form of care and the cost to the state is minimal. He said the problem is the large costs incurred by the hospitals.

Sen. Blaylock asked Sen. Harp if he has examined any of the amendments. Sen. Harp replied he has worked with the chiropractors.

Sen. Blaylock asked Leon Stalkup why the chiropractors and physical therapists are opposed to SB 347. Mr. Stalkup replied they are opposed to their clients being pulled away from them to a managed care system. Mr. Stalkup said chiropractors are also unhappy about being excluded from the impairment rating process.

Sen. Lynch asked Sen. Harp what parts of SB 347 he will not compromise on. Sen. Harp responded he will not compromise on freedom of choice and willing provider.

Closing by Sponsor:
Sen. Harp closed the hearing on SB 347 by saying he speaks for employers and employees across Montana He stated he hopes the system is allowed to pass a reform measure that means something for the public.

ADJOURNMENT

Adjournment: 3:05

SEN. TOM TOWE, Chair

PATRICIA BROOKE, Secretary

TET/pmb

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ROLL CALL

SENATE COMMITTEE Labor & Employment Relations DATE 1/20/93

NAME	PRESENT	ABSENT	EXCUSED
Sen. Towe			X
Sen. Wilson	X		
Sen. Akelstad	X		
Sen. Blaylock	X		
Sen. Keating	X		
Sen. Lynch	X		
Sen. Burnett	X		

F08

Attach to each day's minutes

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. Exhibit #1
DATE 2/16/93
BILL NO. SB 274

CHANGES TO SB 274

PAGE 7 LINE 9

set forth in department rules; ~~or~~

PAGE 7 LINE 10

~~iv tips and other gratuities received by the employee.~~

SENATE LABOR & EMPLOYMENT
EXHIBIT #2
DATE 2/16/93
BILL NO. SB 274

NEW DINNER MENU!

AVAILABLE AFTER 4:00 PM

NEW TABLE SERVICE!

AVAILABLE DURING DINNER HOURS

NO TIPPING!
SOFT DRINK REFILLS!
POPCORN!

Garnishes

A Politician's Dream is a Businessman's Nightmare

By George McGovern

Wisdom too often never comes, and so one ought not to reject it merely because it comes late.

—Justice Felix Frankfurter

It's been 11 years since I left the U.S. Senate, after serving 24 years in high public office. After leaving a career in politics, I devoted much of my time to public lectures that took me into every state in the union and much of Europe, Asia, the Middle East and Latin America.

In 1988, I invested most of the earnings from this lecture circuit acquiring the leasehold on Connecticut's Stratford Inn. Hotels, inns and restaurants have always held a special fascination for me. The Stratford Inn promised the realization of a longtime dream to own a combination hotel, restaurant and public conference facility — complete with an experienced manager and staff.

In retrospect, I wish I had known more about the hazards and difficulties of such a business, especially during a recession of the kind that hit New England just as I was acquiring the inn's 43-year leasehold. I also wish that during the years I was in public office, I had had this firsthand experience about the difficulties business people face every day. That knowledge would have made me a better U.S. senator and a more understanding presidential contender.

Today we are much closer to a general acknowledgment that government must encourage business to expand and grow. Bill Clinton, Paul Tsongas, Bob Kerrey and others have, I believe, changed the debate of our party. We intuitively know that to create job opportunities we need entrepreneurs who will risk their capital against an unexpected payoff. Too often, however, public policy does not consider whether we are choking off those opportunities.

My own business perspective has been limited to that small hotel and restaurant in Stratford, Conn., with an especially difficult lease and a severe recession. But my business associates and I also lived with federal, state and local rules that were all passed with the objective of helping employees, protecting the environment, raising tax dollars for schools, protecting our customers from fire hazards, etc. While I never have doubted the worthiness of any of these goals, the concept that most often eludes legislators is: "Can we make consumers pay the higher prices for the increased operating costs that accompany public regulation and government reporting requirements with reams of red tape." It is a simple concern that is nonetheless often ignored by legislators.

For example, the papers today are filled with stories about businesses dropping health coverage for employees. We provided a substantial package for our staff at the Stratford Inn. However, were we operating today, those costs would exceed $150,000 a year for health care on top of salaries and other benefits. There would have been no reasonable way for us to absorb or pass on these costs.

Some of the escalation in the cost of health care is attributed to patients suing doctors. While one cannot assess the merit of all these claims, I've also witnessed firsthand the explosion in blame-shifting and scapegoating for every negative experience in life.

Today, despite bankruptcy, we are still dealing with litigation from individuals who fell in or near our restaurant. Despite these injuries, not every misstep is the fault of someone else. Not every such incident should be viewed as a lawsuit instead of an unfortunate accident. And while the business owner may prevail in the end, the endless exposure to frivolous claims and high legal fees is frightening.

Our Connecticut hotel, along with many others, went bankrupt for a variety of reasons, the general economy in the Northeast being a significant cause. But that reason masks the variety of other challenges we faced that drive operating costs and financing charges beyond what a small business can handle.

It is clear that some businesses have products that can be priced at almost any level. The price of raw materials (e.g., steel and glass) and life-saving drugs and medical care are not easily substituted by consumers. It is only competition or antitrust that tempers price increases. Consumers may delay purchases, but they have little choice when faced with higher prices.

In services, however, consumers do have a choice when faced with higher prices. You may have to stay in a hotel while on vacation, but you can stay fewer days. You can eat in restaurants fewer times per month, or forgo a number of services from car washes to shoeshines. Every such decision eventually results in job losses for someone. And often these are the people without the skills to help themselves — the people I've spent a lifetime trying to help.

In short, "one-size-fits-all" rules for business ignore the reality of the marketplace. And setting thresholds for regulatory guidelines at artificial levels — e.g., 50 employees or more, $500,000 in sales — takes no account of other realities, such as profit margins, labor intensive vs. capital intensive businesses, and local market economics.

The problem we face as legislators is: Where do we set the bar so that it is not too high to clear? I don't have the answer. I do know that we need to start raising these questions more often.

Editor's note: This essay by Mr. McGovern, a U.S. Senator from South Dakota from 1963 to 1981 and the 1972 Democratic presidential candidate, appeared in the June 1, 1992, Wall Street Journal. *Considering the subjects the* Washington Weekly *often finds itself covering — e.g., today's p. 1 story on the FICA tax on tips — we found Mr. McGovern's thoughts particularly interesting.*

MONTANA STATE COUNCIL OF HERE&B
530 South 27th Street
Billings, Montana 59101

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 4
DATE 2/16/93
BILL NO. SB 274

Good afternoon Mr. Chairman and members of the committee. My name is Veronica Brown and I am the President of the Montana State Council of Hotel Employees, Restaurant Employers and Bartenders; but more importantly I am a 4th generation restaurant worker and I am here to ask your opposition to SB 274.

A large percentage of tipped employees are single women with dependant children, who struggle day to day to make ends meet. The loss of a job or the advent of an injury to these people is a major catastrophe; most of these people are but 1 weeks pay from being put out on the street. Even under the system current, tipped employees who are injured or lose their jobs often can not survive on what they receive from Workers Compensation or from Unemployment Insurance and must look toward our welfare system or other social service agencies to survive.

The Restaurant Association would have you believe that waitresses make $100.00 a day in tips, and yes, some do, but that is very rare and is not the norm. The Restaurant Association would also have you believe that if a waitress gives good service she will receive good tips, but that is not always true either. There are many variables such as menu prices, how busy the restaurant is, quality of food, and staffing levels; these things are all beyond the tipped employees control.

The Restaurant Association claims that it is not fair for employers to have to pay taxes on money that doesn't pass through their pockets. Employers constantly use the argument of tips to forgo paying a living wage. We believe that employers are already getting a free ride to begin with, if they don't have to pay Workers Compensation and Unemployment Insurance taxes on tips they are getting a free ride a second time at the expense of their workers. And under federal law, tips are considered part of wages.

The reality of this situation is that the restaurant owner pays tipped employees $4.25 per hour and expects you, the consumer, to make up the shortfall between $4.25 per hour and a living wage.

You as a lawmaker are not going to be able to right all the wrongs and make everything fair. We know that, but please don't make life more difficult than it already is for a group of hard working, low-income wage earners, who are already being exploited by their employers. Please vote no on SB 274.

Thank you,

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 5
DATE 2/16/93
BILL NO. SB 274

TIPPED EMPLOYEES FACT SHEET

A few points to ponder before we investigate the hard numbers.

***Contrary to the examples we site, few tipped employees actually work 40 hour weeks. Most tipped employees work about 20-30 hours per week. They are brought in to work lunch, sent home, and brought back for dinner. For instance, at the Windbag Saloon, tipped workers average 20 hours per week.

***The amount of tips varies from day to day, season to season, and shift to shift. For instance, last week on an eight hour graveyard shift at the 4B's the waitress made $8 in tips. In low cost, family restaurants a tipped employee working an eight hour shift averages about $20-$25 per shift.

***Montana is not Chicago or New York. Tipped employees make less because food costs are cheaper and customers don't tip as well. Tipped workers in Montana are not - contrary to popular opinion - bringing home a $100 a day. If they were, tipped workers would be able to afford new cars, new houses, and health care.

***Tipped employees are usually women. These women are often single mothers trying to provide for children, students paying for college, or seniors supplementing social security. A tip job is one of the few blue collar jobs for women that allows them to earn more than $4.25 per hour.

***Attacking the benefits these workers receive is one sure-fire way of guaranteeing that women and children will fall even further below the poverty line. It certainly won't salvage the work comp system or save an already failing restaurant.

***Most tipped employees earn $4.25 an hour as a wage. The workers pay federal taxes on these tips, which often reduces the size of the actual paycheck. THE FEDERAL GOVERNMENT CONSIDERS TIPS AS WAGES IN ADDITION TO THE ACTUAL SALARY.

***Most tipped employees don't have access to other benefits like health insurance. In fact, many do not receive paid sick days, paid vacations, or even paid breaks.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 5a
DATE 2/16/93
BILL NO. SB 274

WORK COMP STATS FOR TIPPED WORKERS

Rate - $5.12 per $100 of wages

Tipped workers rate with tips of $2.75 per hour for a wage of $7 per hour at a rate of 40 hours per week.

Weekly Salary - $280
Employer pays - $14.34
Injured worker receives - $184.80 per week

Tipped workers rate based on wages of $4.25 per hour at 40 hours per week.

Weekly Salary - $170
Employer pays - $8.70
Injured worker receives - $170

Difference for employer - $5.64 per week
$25.38 per month (4.5 weeks)

Difference to worker - $14.80 per week
$66.60 per month

$66.60 per month could mean a new pair of shoes for a 5-year old, food on the table for the family, or a monthly power bill.

UNEMPLOYMENT STATS FOR TIPPED WORKER

Rate - 2.2 percent of monthly income

Tipped worker rate with tips of $2.75 per hour for a wage of $7 per hour at an average of 40 hours per week.

Monthly Salary (4.5 weeks) - $1,260
Employer pays per month - $27.72
Laid-off worker receives - $140/week

Tipped worker rate based on wages of $4.25 per hour at at 40 hours per week

Monthly Salary (4.5 weeks) - $765
Employer pays per month - $16.83
Laid-off worker receives - $85/week

Difference for employer - $10.89 per month
Difference to worker - $55 per week or
$247.50 per month

$247.50 per month could pay rent, buy food and clothing for children, and pay utility bills.

Good afternoon Mr. Chairman and members of the Committee, my name is Barbara Downing from Billings. I have been a waitress for 33 years and have been employed by the Radisson Northern Hotel for the last 14 years.

Approximately a year and a half ago, I fell in the kitchen and fractured by spine. Ultimately I underwent surgery and continue intensive physical therapy.

During the last year that I worked, I worked 32 hours a week and made $6018.00 in wages and $1867.20 in tips, for a grand total of $7885.20. Based on that income my current weekly Workers Compensation benefit is 119.34; from this I must pay for my health insurance and provide my cab fair to and from physical therapy. Do you really believe that a person can live on this paltry sum?

The misconception that waitress make $15.00 an hour is exactly that. I never made $15.00 an hour and I worked at one of the nicest restaurants in Billings.

My current compensation checks are calculated on my tips. I can't even begin to image my Workers Compensation being even less than it is. If SB 274 is passed, future accidents in the workplace suffered by tipped employees will only lead them to the welfare lines and eminent disaster. Please, I urge you, vote no on SB274.

Barbara Downing
355 Naylor
Billings, Montana 59101

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 6
DATE 2/16/93
BILL NO. SB 274

MHA MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. # 7
DATE 2/16/93
BILL NO. SB 347

TESTIMONY OF THE MONTANA HOSPITAL ASSOCIATION

SENATE BILL 347

WORKER'S COMPENSATION MEDICAL COST CONTAINMENT

MHA generally supports the provisions of Senate Bill 347 which call for managed care, case management and preferred provider organizations for worker's comp. Hospitals have long urged the State Fund to develop controls on the utilization of health services by injured workers.

Much of the discussion about the problems of worker's compensation deal with the overuse of expensive medical care, lack of coordination of services and concerns about the effectiveness of treatment provided to injured workers. It is not surprising that directing injured workers to seek medical treatment on their own, without any limits, results in high utilization, doctor shopping and longer periods of unemployment. Hospitals believe that careful coordination of medical services by managed care organizations or insurers will result in savings to the insurers, and improve the effectiveness of treatment.

There are some provisions of SB 347 that concern hospitals that should be called to the attention of the committee.

Section 3, page 10 This part describes the services an insurer must provide to an injured worker. North Valley Hospital in Whitefish suggests that the bill be amended to require the physician to assess the "functional capacity" of the injured worker. Physicians would be required to determine what the injured person could do, rather than focus on what the injured person is unable to do. A functional capacity assessment would help employers with "early return to work" programs.

A functional capacity assessment would also help employers comply with the Americans with Disabilities Act. The ADA requires that employers make reasonable accommodations in employing disabled workers. The bill could also link a workers willingness to participate in early return to work with receipt of benefits.

Page 12, line 17 MHA would advise the committee that SRS has similar restriction in Medicaid program which the Department of Labor should adopt. SRS relies on determinations made by the Health Care Financing Administration and the Food and Drug Administration regarding medical treatment.

MCA 39-71-704(3) MHA is concerned that this section of the law will be amended again this session. As you can see, this section of the law has been amended every session, and most special sessions, since 1986. This section of the law has worked to reduce payments to hospitals every year. Hospitals now receive, on average, only 62 cents for each dollar of care delivered to injured workers. This ratio is getting worse every year. In 1992, hospitals provided a $9 million subsidy to the state fund alone. A similar discount is provided to private insurers.

Another problem with this statute is the unfair treatment of hospitals located in Montana. Even though this bill provides no exemptions, insurers apply the payment limits only to hospitals located inside Montana. Hospitals outside Montana are paid full charges. This causes a terrible disadvantage for Montanans, and creates an incentive to refer patients outside the state.

This law also is applied to every service offered by a hospital. That means if a hospital operates a home health agency, that agency is limited by this statute. But if the agency is not operated by a hospital, no limit is applied. The same goes for any clinic, nursing home or other medical service.

Finally, legislators are never advised by insurers about the impact of this law on their rates. We all here about increasing health care costs. But you probably didn't know that the state fund actually paid hospitals less money in 1991 than in 1990. According to state fund data, hospitals were paid 73 percent of charges, or a total of $11.8 million in 1990, but only 66 percent of charges, or $11.3 million in 1991. Hospitals were paid 62 percent of charges, or $13.9 million in 1992.

Specific sections of the bill MHA wants to call your attention to include:

Page 12, line 21-22 MHA opposes adoption of fee schedule payments for outpatient hospital services. Fee schedules do not reflect the hospitals costs, differences in staffing and intensity of service. Fee schedules reflect the cost of the personal service offered by physician or other provider, and the office expense. Hospitals, unlike non-hospital providers, treat all patients regardless of their ability to pay, meet strict facility standards, are open 24 hours per day, every day, and therefore incur higher costs. HB 347 should not arbitrarily reduce payments to hospitals in this fashion.

Hospitals would also find it difficult to comply with this requirement. First, the bill only limits those services available in non-hospital settings. Does this mean available in the community, or available anywhere? How will an insurer know when a service was available or not? Services are provided through the emergency room that could be provided by the community except those providers are closed. Would these be limited? What about those circumstances where a provider in the community limits the number of worker's comp cases they see? Would the service be considered "available" then?

Page 13, line 9 MHA is concerned that the Department is charged with development

of a per diem or DRG system. MHA, along with insurers, Department staff and state fund staff, met last summer to discuss this issue. This group concluded that development of DRGs for worker's comp would not be wise. The system would be expensive to develop and administer, the problems would far outweigh the advantages of DRGs. Likewise, per diem payments are simple, but unfair to hospitals. A day of care in a hospital differs greatly depending on whether it is rehabilitation or a crushed chest. A per diem simply does not account for the differences.

MHA agreed to support the call for managed care and utilization control in return for sharing the savings with providers through improved rates. This bill takes the savings, but leaves the providers out. So much for working with the State Fund.

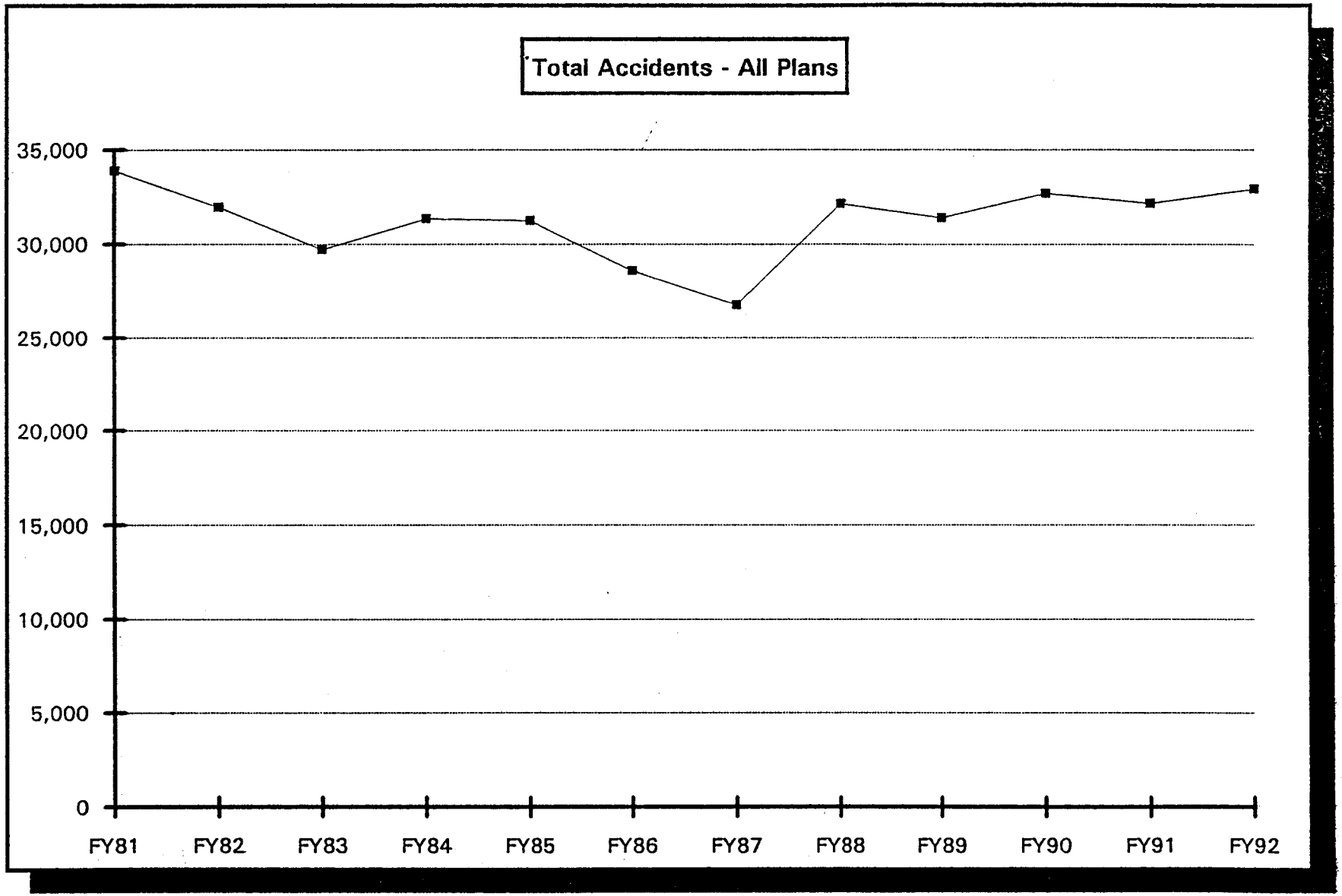
Page 14, line 22 Again, MHA objects to this language.

Sections 6 - 10 MHA supports the development of managed care arrangements in concept. We don't know if the proposed language gets this job done. It appears, however, to greatly increase the bureaucracy of getting services provided. MHA is concerned the rules and regulations required will work to reduce the number of physicians and hospitals willing to craft agreements.

Finally, MHA believes the fiscal note underestimates the cost to develop these payment mechanisms. SRS recently spent $200,000 just to study the Medicaid DRG system, and is requesting another $300,000 for the computer work to update the DRG system they already have. Similar activities will cost the State fund and the Department of Labor more than their estimates in the fiscal notes.

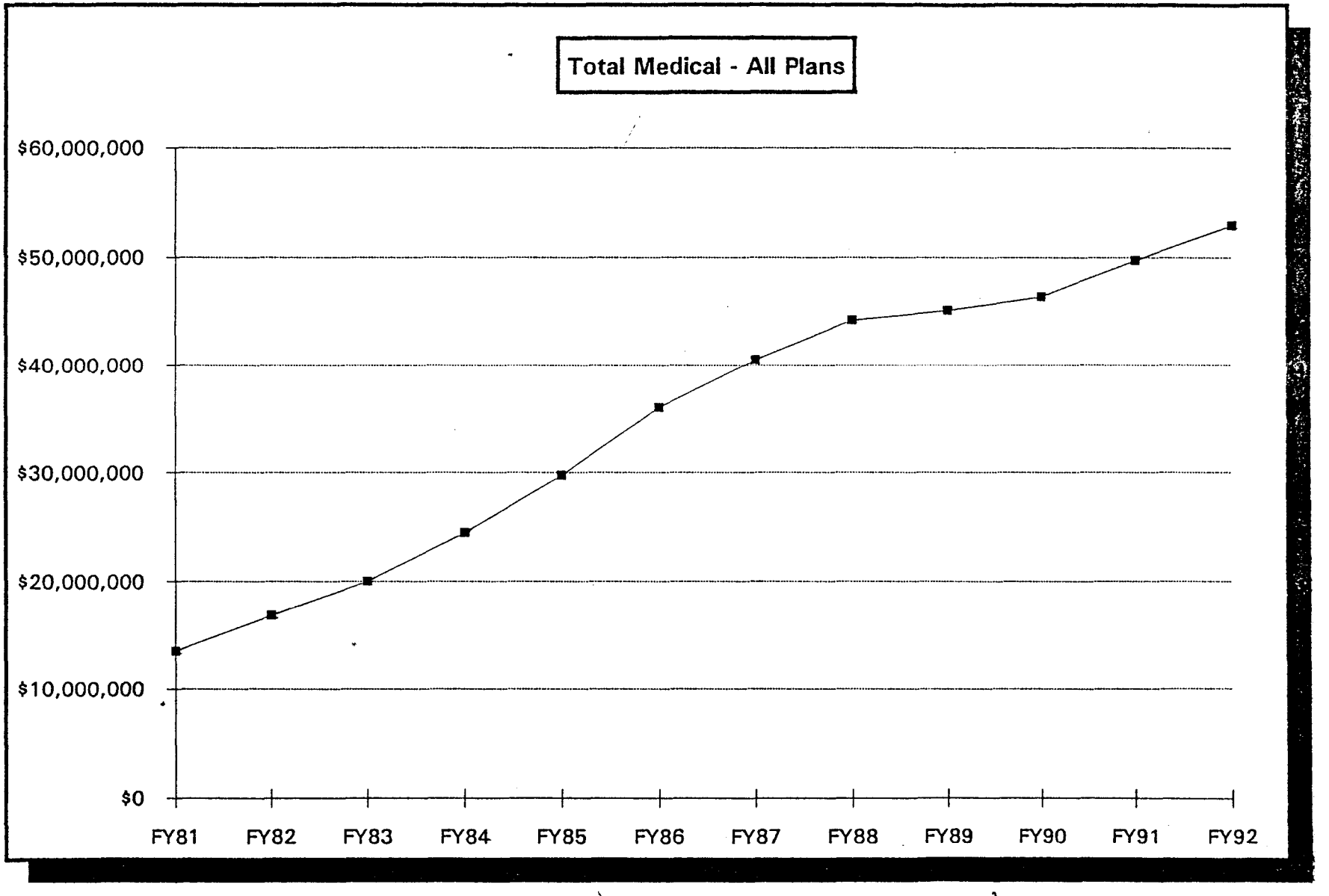
Thank you for your attention, and the opportunity to testify on this bill.

EXHIBIT 7
DATE 2-16-93
SB 347



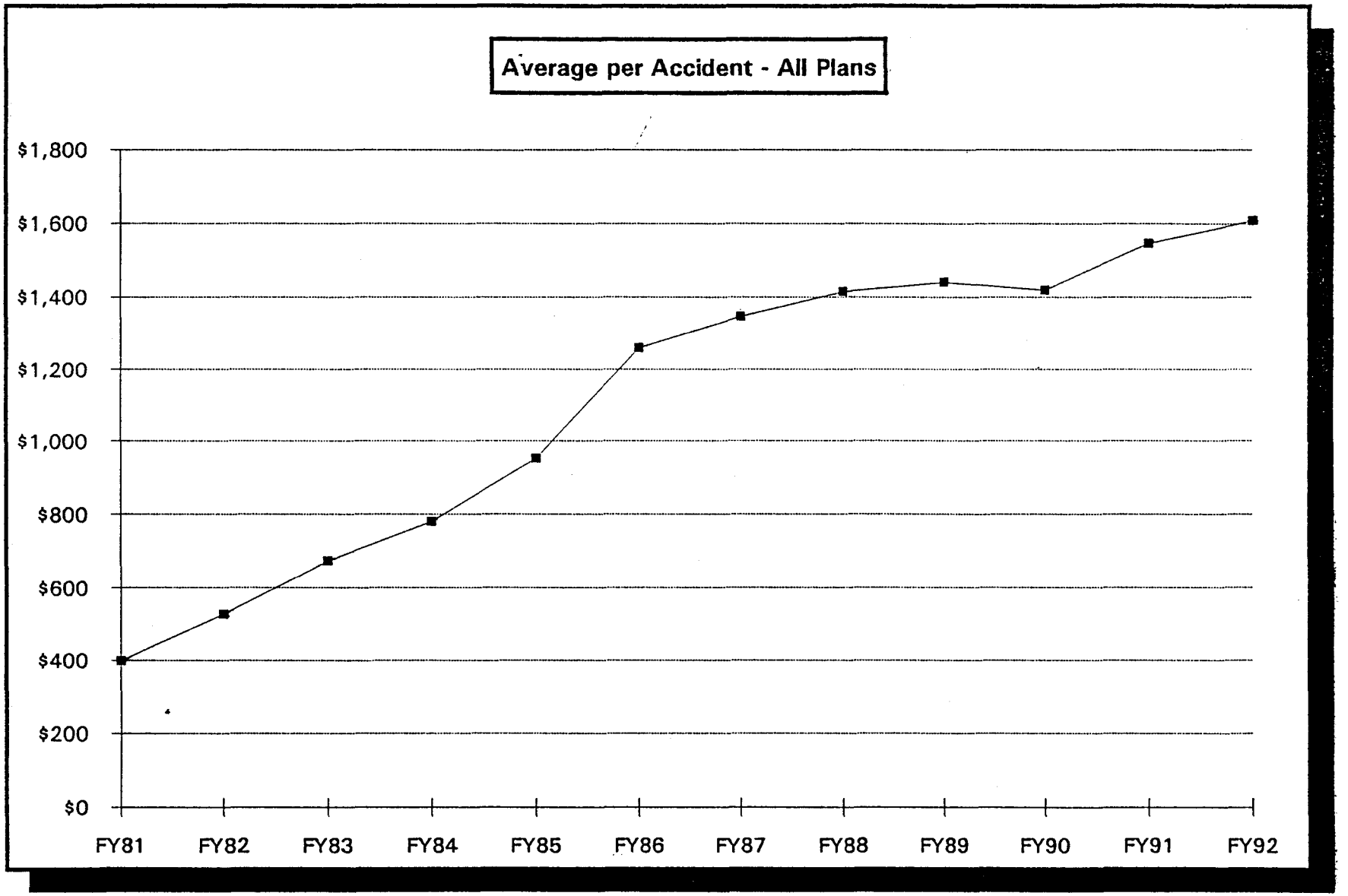
Reflects total # of injuries

EXHIBIT NO. 8
DATE 2/16/93
BILL NO. SB 347



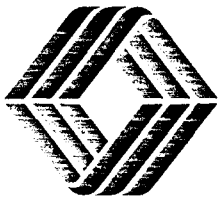
SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 8
DATE 2/16
BI[illegible] SB 347

Total Med Benefits Pd



SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 8
DATE 2/16
BILL NO. SB 347

Average Cost/Accident



BILLINGS CLINIC

WRITTEN TESTIMONY
ON
WORKERS' COMPENSATION LEGISLATION
BEFORE THE
MONTANA STATE LEGISLATURE

Presented by
WILLIAM S. SHAW, M.D.
BILLINGS CLINIC
BILLINGS, MT
1-800-332-7156 (X2710)

February 16, 1993

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 9
DATE 2/16/93
BILL NO. SB 347

ALLERGY
Kathleen C. Davis, M.D.

DERMATOLOGY
Thomas P. Gormley, M.D.
Albert C. Reynaud, M.D.
J. Michael Wentzell, M.D.

FAMILY PRACTICE
Daniel L. Gall, M.D. - West
William J. George, M.D.-Red Lodge
James F. Girolami, M.D.-Heights
Lawrence A. Hemmer, M.D.-West
David M. Kane, M.D.-Columbus
J. Emmett King, M.D.-West
Richard K. Klee, M.D.-Columbus
Larry W. Sonnenberg, M.D.-Red Lodge
Brian C. Weitz, M.D.-Heights
Jeffrey S. Zavala, M.D.-Red Lodge

SAME DAY CARE
Gene V. Holden, M.D.
Ann B. Oglesby, M.D.
Andrew M. Seddon, M.D.

INTERNAL MEDICINE
F. Douglas Carr, M.D.
John J. Fina, M.D.
Steven J. Gerstner, M.D.
Paul V. Hoyer, M.D.
Lucinda M. Husby, M.D.
Elaine S. Samuel, M.D.

CARDIOLOGY
Michael W. Brennan, M.D.
John R. Burg, M.D.
Walter C. Degnan, M.D.
David M. Gonzalez, M.D.
Herman D. Sorensen, M.D.

GASTROENTEROLOGY
John C. Ficke, M.D.
Mark C. Rumans, M.D.

HEMATOLOGY/ONCOLOGY
Warren D. Bowman, Jr., M.D.
Wilderness and Mountain Medicine
Roger G. Santala, M.D.
Donald I. Twito, M.D.

INFECTIOUS DISEASES
David L. Calhoun, M.D.
[illegible], M.D.

NEPHROLOGY
Donald L. Hicks, M.D.
James D. Knostman, M.D.

PULMONARY AND CRITICAL CARE MEDICINE
Walter R. Fairfax, M.D.
Robert K. Merchant, M.D.
R. James Rollins, M.D.
Nicholas J. Wolter, M.D.

RHEUMATOLOGY
Susan C. English, M.D.
Phillip E. Griffin, Jr., M.D.

NEUROSCIENCES

NEUROLOGY, ELECTROMYOGRAPHY & ELECTROENCEPHALOGRAPHY
Patrick J. Cahill, M.D.
Mary D. Gaddy, M.D.
Dale M. Peterson, M.D.
Roger S. Williams, M.D.

NEUROLOGICAL SURGERY
Eugen J. Dolan, M.D.
Lashman W. Soriya, M.D.
Robert C. Wood, M.D.

OBSTETRICS AND GYNECOLOGY
James R. Harris, M.D.
Douglas A. Neuhoff, M.D.
Thomas C. Olson, M.D., P.C.
Mark E. Randak, M.D.

OCCUPATIONAL AND PREVENTIVE MEDICINE
William S. Shaw, M.D.

OPHTHALMOLOGY
James S. Good, M.D., P.C.
J. Thomas Priddy, M.D.
Mark P. Reynolds, O.D.

ORTHOPEDICS
Willard J. Hull, M.D.
Whitney S. Robinson, M.D.
Robert S. Schultz, M.D.
James E. Scott, M.D., P.C.
Curtis R. Settergren, M.D.

OTOLARYNGOLOGY - HEAD AND NECK SURGERY

FACIAL, PLASTIC AND RECONSTRUCTIVE SURGERY
Stephen A. Kramer, M.D.
Sheri L. Rolf, M.D.

PEDIATRICS
Fred E. Gunville, M.D.
Allen P. Hartman, M.D.
Linda R. Johnson, M.D.
Paul H. Kelker, M.D.
Patrick Sauer, M.D.

PHYSICAL MEDICINE & REHABILITATION
W. Michael Breland, M.D.
Gregg L. Singer, M.D.

GENERAL, THORACIC, CARDIAC AND VASCULAR SURGERY
Hewes D. Agnew, M.D.
Dennistoun K. Brown, M.D.
John R. Gregory, M.D.
Paul F. Grmoljez, M.D., P.C.
John W. Heizer, M.D., P.C.
Robert N. Hurd, M.D.
C. Adrian Johnson, M.D., P.C.
J. Scott Millikan, M.D.
Jeffrey L. Stone, M.D. - Red Lodge
Robert J. Wilmouth, M.D.

UROLOGY
Lawrence W. Klee, M.D.
Richard B. Melzer, M.D.
C. Dale Vermillion, M.D.

MEDICAL DIRECTOR
[illegible]

ADMINISTRATION
[illegible]
[illegible]
[illegible]

My name is William Shaw. I am a physician living in Billings and practicing at the Billings Clinic. I appreciate the opportunity to provide testimony to this legislature on an area of some concern and knowlege to me: the Workers' Compensation system.

My specialty is Occupational Medicine. Occupational Medicine is that specialty of medicine which studies hazards in the workplace, how conditions effect people in their work, prevention of injury and illness, and rehabilitation of workers back to gainful employment. For several years, I was the only physician in Montana certified in this specialty. Even now, there is only one other Occupational Medicine physician in the state, Dr. Headapohl who practices in Missoula.

My practice is such that essentially all of the ill or injured patients I see and care for are on Workers' Compensation. Accordingly, I have, from the medical viewpoint, been nearly immersed in the system since 1984. If is from this perspective that I speak with you today.

I would like to make some general observations and then offer some specific comments on the bill before you.

* In my experience, overt and intentional fraud is uncommon.

* Though indemnity costs for the system are considerably more than medical ones, the decisions that physicians are called on to make can have a major impact on both medical and indemnity costs.

* Medical management of the patient on Workers' Compensation is often different from an individual with an identical diagnosis whose condition is not work related. A variety of non medical factors must be considered as the physician seeks to care for a work related condition.

* There are a variety of medical conditions, such a low back pain, which are very poorly understood from a scientific point of view. This can make definitive decisions made in "black and white" quite difficult.

* There is often a poor correlation between objective findings, diagnosis, causation, and symptoms. Presence or absence of "objective findings" is often a poor predictor of an individual's status. These findings are important ONLY when they correlate to the remainder of the clinical presentation.

* Successful outcome from a work related condition requires the cooperative efforts of many parties including the physician, injured worker, employer, vocational rehabilitation counselor and insurer.

* There must be in place incentives for all parties involved in order to promote cooperation for the common goal: successful return to productive work. A mechanism to ensure complicance on the part of ALL parties would be useful. This would include requirements for patients to participate in appropriate treatement plans.

* The entire Workers' Compensation system is riddled with biases. That is, there are few who approach the system with an indifferent mind. And, as we all know, biases introduce a systematic error into the system resulting in a distorted outcome.

Given these observations, I would make the following comments and recommendations:

As I think about the Worker's Compensation system, I believe that the key lies in where constraints on services are placed. This recognizes that the system cannot provide all services for all workers. Simplistically, this means that controls must be placed either on a worker's access into the system, or limitations must be placed on the services rendered to all workers who have gained access to the system.

I would approach this dilemma using the following premises:

1. Access to medical care should be relatively easy.

2. Indemnity payments and services should be reserved for those who are truly injured as a result of their job.

3. Disability settlements should be consistent and relevant to the loss incurred and provided to people who are clearly and truly injured.

Indemnity Coverage (IC) would be provided to a select group who meet certain criteria:

1. The worker's medical problem clearly arises out of an incident, injury, exposure or event (either singular or over an extended period of time) which is clearly and rationally definable (Causation), is scientifically based, and is probably (more likely than not) related to the event.

2. The causative event must provide for a mechanism of injury commensurate with the pathology noted.

3. The causative incident must have some relation to the nature of the work performed and not some normal event which could have just as reasonably occurred off the job (e.g. sneeze, pick up paper from ground, etc.).

4. Subsequent covered diagnoses remote from the initial site of pathology must, on a more likely than not basis, have a clear and medically recognized correlation to the initial problem or be a recognized complication to the treatment required (e.g., vocal cord paralysis following Cloward procedure qualifies, but migratory pains from "walking funny" does not).

Apportionment should be applied to all IC claims. Apportionment would not be calculated by exact percentage but semi quantitatively instead. For example:

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Approximate Percentage	Category	% Indemnity Paid
< 50%	Possible contributor	40%
51% - 70%	Probable contributor	66%
71% - 90%	Predominant Contributor	85%
>90%	Sole Contributor	100%

PPD settlements should be based on Disability. The law must recognize that disability is not synonymous with an impairment rating. It should be specifically noted that disability can be either greater OR less than an impairment rating. The model of the 1991 law for PPD may be an appropriate model.

Return to work guidelines should be consistent with the Americans with Disability Act (ADA). This will place the state law in concord with federal statute covering individuals with disabilities. By definition, any worker who received a PPD settlement would qualify under ADA. Under ADA, an individual qualifies for protection under the law if they are PERCEIVED to have a disability.

Under ADA, employability must be based on the functional ability of an individual to perform the essential functions of a job, and not a worker's symptoms or diagnosis. If clearly definable risk is present, it is relevant only if there is a direct threat to self or others. Once again, direct threat is defined by ADA. The following exact wording from the Technical Assistance Manual is instructive.

"In order to meet the very specific and stringent requirements to establish that direct threat exists, it must be shown that there is:

"A significant risk of substantial harm;

"The specific risk must be identified;

"It must be a current risk, not one this is speculative or remote;

"The assessment of risk must be based on objective medical or other factual evidence regarding a particular individual and;

"Even if a genuine significant risk of substantial harm exists, the employer must consider whether the risk can be eliminated or reduced below the level of a "direct threat" by reasonable accommodation."

Return to work should require from both employer and employee the same reasonable accommodation provisions outlined in ADA. It is important to understand that it is the obligation of the employee to ask for, and the employer to explore with that employee what accommodations might be possible in order for this worker to perform those essential job functions.

ADA also provides that best medical information available should be criteria for decision making. Given this, medical disagreements regarding diagnosis, prognosis, impairment, functional capacity, and appropriate accommodations should be settled by medical systems and not legal ones. For example, the treating physician may not be the best source of medical information.

Obviously, incentives designed to promote safety and prevention of injury are highly appropriate. As well, incentives to return workers who may be limited in some way is critical. The present mentality of many employers is one of "you have to be 100% or don't come back." This attitude may be based in perceived operational needs or liability risks. In either case it is clearly counterproductive. Why pay a worker to sit home and nurture frustration and disability. It is a rare business which cannot find, with a bit of thought and creativity, some productive activity at least temporarily for an injured worker. Furthermore, the liability risks are much higher for prolonged disability by keeping workers away from work than by returning them to the workplace.

I certainly concur with the concept of managing these cases in an organized and efficient manner. However, "managed care" is not a panacea. Several years ago, the SCIF contracted with an organization, HCX, to do just that without the desired results. To be effective, management of care must entail an efficient "shepherding" of individuals through the complexities of the system. An escort has a chance of helping; an overseer trained in the Simon Lagree School of Management Techniques will be counterproductive.

I have several specific comments about the Bill at hearing today.

As noted earlier, it is exceedingly difficult for me as a physician to differentiate between "Primary" and "Secondary" treatements. Defining Maximum Medical Improvement (MMI) as occurring when primary medical treatment has done all that it can might reasonably lead me to conclude that MMI has been reached when the surgical scar has healed and the stitches removed.

Physician Assistants should be able to practice in accordance with their legally authorized treatment plans. The present wording seems to authorize PA-Cs caring for Workers' Compensation patients only in remote settings, where their supervising MDs are not on site.

If injured workers are to be excluded from coverage under Workers' Compensation, as outlined in various places in HB 361 (e.g. injury not the major contributing cause, subsequent nonwork-related, etc.), provisions for coverage under 3rd party carrier must be made. Otherwise, preexisting condition exclusions will leave injured individuals with no medical coverage at all.

Finally, I believe that the unique nature of the Workers' Compensation patient makes for a feeling among many medical providers that some form of managed care in the Workers' Compensation arena is appropriate.

The special challenges including complex questions of causality, duration of disability, extent of disability, and functional capacity are routinely addressed to the treating physician. Discomfort in responding to these necessary questions has led significant numbers of providers to avoid caring for these patients. At other times, patients have sometimes been treated by clinicians for longer than may be appropriate or with modalities which may have limited efficacy.

The managed care model allows for the greater likelihood of optimum care provided in a timely fashion with a minimum of duplicated services. Judicious selection of consultants and specialized often

costly testing can be accomplished in a managed care setting. Consistency in assessment of impairment rating as well as estimation of functional capacity would also seem fairer to all parties involved in this complex system.

All in all, the basic concept of managed care seems an appropriate direction to pursue as an integral part of a broader effort to rework the system which now has many dysfunctional aspects to it.

In any system of managed care, certain critical issues must necessarily be addressed. These include:

1. Clear delineation of criteria for determination of effectiveness. Distinction must be drawn between quality of care effectiveness and cost effectiveness since they are not necessarily the same. As providers, we must always take the position that quality of care takes priority over cost.

2. Standards of care are appropriate, and often useful so long as they reflect the necessary flexibility to accommodate the variability of the human condition. It is unrealistic to expect that all medical services or all possible conditions can be forcast and addressed through such standards. The role, authority, responsibility as well as the administrative and financial support of any Medical Advisory Committee must be clearly delineated.

3. The administrative requirements of developing, operating, and maintaining a managed care organization are extensive. One has only to look at the guidelines set forth in "New Section 5" of the Medical Bill covering application and certification to get a fuller understanding of how onerous these requirements might be. The costs of implementing such services are significant. It is not likely that these management costs would be offset by increased volume of patients. Efficiencies of scale are difficult to achieve when individualized attention to detail is required.

4. Financial incentives are required under New Section 5-4(b). It is important that there be incentives for both insurer AND provider. When reimbursement is provided through a tightly regulated fee-for-service schedule, (as set forth in the upcoming Labor and Industry Rules Hearing I - XVII scheduled for February 18, 1993) incentives are absent for the provider "to reduce service costs and utilization."

5. Quality assessment and peer review requires evaluation of individual providers with exclusion from participation of those deemed to be providing excessive of inappropriate treatment. Such exclusionary practices are fraught with risks and liabilities. No organization can hope to carry out such practices without some protection from legal recourse.

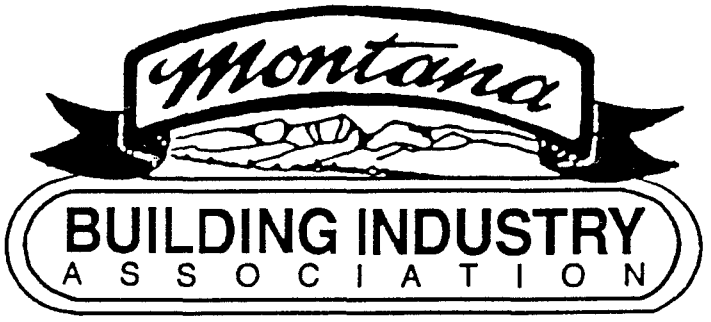
In summary, the concept of managed care of the Workers' Compensation patient population has much in its favor so long as the important issues of quality of care and appropriate financial incentives can be addressed.

I would be glad to respond to questions if there are any.

Homebuilders Assoc. of Billings
252-7533

S.W. Montana Home Builders Assoc.
585-8181

Great Falls Homebuilders Assoc.
452-HOME



Flathead Home Builders A
752-2522

Missoula Chapter of NAHB
273-0314

Helena Chapter of NAHB
449-7275

Exhibit #9

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

SB 347
Worker's Comp Medical Cost Containment

Recommend:
Do Pass

Mr. Chairman, Ladies & Gentlemen of the Committee:

I am Harlee Thompson, manager of Intermountain Truss, and a delegate from the Montana Building Industry Association to the Coalition for Work Comp System Improvement (CWCSI).

No one usually argues that one of the major problems in the Worker's Comp system is the lack of specific injury definition. This has left the matter to the jurisdiction of medical practitioners who tend to over treat to avoid liability; lawyers who are anxious to ask the court for an interpretation of the injury; and confused claims examiners who deal with a variety of diverse court interpretations.

The Coalition for Work Comp System Improvement believes that the creation of stricter injury definitions will not limit benefits--only provide clear instructions for all, whether they be claimants, medical providers, employers or insurers.

The definitions of injuries contained in SB 347 gained bipartisan support during the recent election and are an important step in eliminating costly vagueness in current law.

We urge a do pass committee recommendation.

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Exhibit #10

MANDATED HEALTH INSURANCE COVERAGE FOR CHIROPRACTIC TREATMENT: AN ECONOMIC ASSESSMENT, WITH IMPLICATIONS FOR THE COMMONWEALTH OF VIRGINIA

by

Leonard G. Schifrin
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The College of William and Mary
Williamsburg, Virginia

and

Clinical Professor of Preventive Medicine
Medical College of Virginia
Richmond, Virginia

January 1992

MANDATED HEALTH INSURANCE COVERAGE FOR CHIROPRACTIC TREATMENT: AN ECONOMIC ASSESSMENT, WITH IMPLICATIONS FOR THE COMMONWEALTH OF VIRGINIA

EXECUTIVE SUMMARY

1. MANDATED HEALTH INSURANCE COVERAGE, AND THE INCLUSION OF CHIROPRACTIC COVERAGE, ARE THE USUAL CASE.

All states have health insurance mandates, ranging from a low of five (including both benefit and provider mandates) in Delaware, Idaho, and Vermont, to a high of 37 in Maryland. Virginia is above the 50-states average with 19, tieing for tenth place. In all, 37 states have mandated the inclusion of the services of chiropractors. Mandates exist to provide a more socially optimal package of insurance coverage than would emerge from the private decisions of individual insurers, employers, and households.

2. MANDATED CHIROPRACTIC COVERAGE HAS MINIMAL COST-INCREASING EFFECTS ON INSURANCE, AND MAY EVEN REDUCE INSURANCE COSTS.

Mandates increase insurance costs by bringing under the insurance "umbrella" health care services that otherwise would have been paid for out-of-pocket or not purchased because patients were unable or unwilling to pay their full market prices. In either case, the effect is to increase insurance costs. On the other hand, mandates that promote disease or disability prevention reduce insurance costs, and so, too, do those that provide lower cost substitutes for more costly treatment. Before the fact, mandates neither increase nor decrease the costs of insurance. Using three statistical methods, the "claims based," "actuarial," and "hedonic price" approaches, health insurance mandates as a whole have been estimated to account for 20 percent or more of health insurance outpayments, but there is little evidence, using any of these methods, that chiropractic services increase gross outpayments by more than one percent. Considering that [1] many plans included chiropractic care before it was mandated, or would have offered it later without the mandate to do so, and [2] chiropractic offers itself as a substitute for more costly treatment of lower back pain by medical physicians, surgeons, and hospitals, the actual net cost effect of the chiropractic mandate appears to be lower than one percent, perhaps approaching zero or even being cost reducing.

3. THE LOW COST IMPACT OF CHIROPRACTIC IS DUE NOT TO ITS LOW RATE OF USE, BUT TO ITS APPARENTLY OFFSETTING IMPACTS ON COSTS IN THE FACE OF HIGH RATES OF UTILIZATION. CHIROPRACTIC IS A GROWING COMPONENT OF THE HEALTH CARE SECTOR, AND IT IS WIDELY USED BY THE POPULATION.

In the past several decades, the supply of chiropractors has increased absolutely and also in relation to medical doctors and osteopaths. There are an estimated 47,500 chiropractors in the United States. In 1960, for every new chiropractic graduate there were 11 new doctors of medicine. Despite the subsequent great growth of the annual number of new M.D.s, by 1990 there were only six new medical graduates for every new chiropractor. Between 1971 and 1991, the number of

licenses issued each year to chiropractors new to the Commonwealth of Virginia increased tenfold.

Utilization rates provide different estimates of the proportion of the population under chiropractic care. Employing lower level estimates that four percent currently use chiropractic and that 7.5 percent will use it within a three to five year period, the current chiropractic patient population numbers nine to ten million persons, and will include about twice that number over the next few years. In 1977, the last year for which such data are available, $606 million was spent for chiropractic treatment. Even if we assume that chiropractic has not grown relative to other sources of care and thus expenditures for it have only kept pace with other health care costs, the current level of spending for the services of chiropractors would exceed $2 billion. Other studies indicate that chiropractic is widely recognized by non-users as well as users; that users are representative of the population as a whole, though perhaps somewhat older and more rural; that chiropractic patients view the quality of care and their relationships with chiropractors favorably; and that heavy users of chiropractic also are heavy users of physicians' services. The picture that emerges is one in which chiropractic is a widely relied on and important form of treatment, with which patients have a high level of satisfaction.

4. FORMAL STUDIES OF THE COST, EFFECTIVENESS, OR BOTH OF CHIROPRACTIC, USUALLY MEASURED AGAINST OTHER FORMS OF TREATMENT, SHOW IT TO COMPARE FAVORABLY WITH THEM.

Twenty two studies and one "inquiry," covering many years, 14 states, and two foreign countries, have examined, in total, eight different dimensions of the cost and efficacy of chiropractic treatment of low back pain. The cost measures have included total case costs, total provider payments, total worker compensation for injury-induced wage loss, and treatment frequency. The efficacy or outcome measures include the duration of work loss, period of disability, pain relief, and patient satisfaction with treatment. In 14 state studies in the period before 1980, only in one dimension in one study does chiropractic not rank more favorably than medical treatment of low back pain. In about 35 other comparisons in these 14 studies and two general surveys, the cost and effectiveness results of chiropractic treatment are superior to those of medical treatment.

In five state studies after 1980, chiropractic also fares well, though not quite so unanimously. Except for one study, in West Virginia, the earlier generalizations about chiropractic cost and efficacy are borne out: chiropractic effectiveness often surpasses that of medical care; and, although payment to chiropractors may exceed that to M.D.s, total case costs are lower when treatment is provided by chiropractors. Other studies, in New Zealand and Great Britain, provide further evidence of the valuable role of chiropractic in the provision of care for low back injuries, in comparison with other types of treatment.

5. BY EVERY TEST OF COST AND EFFECTIVENESS, THE GENERAL WEIGHT OF EVIDENCE SHOWS CHIROPRACTIC TO PROVIDE IMPORTANT THERAPEUTIC BENEFITS, AT ECONOMICAL COSTS. ADDITIONALLY, THESE BENEFITS ARE ACHIEVED WITH APPARENTLY MINIMAL, EVEN NEGLIGIBLE IMPACTS ON THE COSTS OF HEALTH INSURANCE.

Leonard G Schifrin

6. THE CONCLUSION OF THIS ANALYSIS IS THAT CHIROPRACTIC MANDATES HELP MAKE AVAILABLE HEALTH CARE THAT IS WIDELY USED BY THE AMERICAN PUBLIC AND HAS PROVEN TO BE COST-EFFECTIVE.

The Effectiveness and Cost Efficiency of Chiropractic Care for Injured Workers

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iropractic: (Greek: treatment by hand) is
the third largest primary health care profession
e western world after medicine and dentistry.
here are approximately 36,000 chiropractors
e United States.

iropractic has had an interesting emergence, arising as a separate profession
e 1890s. In that era of heroic medicine, many alternative disciplines emerged—
practic has been the strongest survivor. The profession has always presented
as a natural and conservative source of health care, offering an alternative
edication and surgery. Accordingly, it makes no use of drugs or surgery.
profession's central interest always has been the relationship between
ired movement of spinal vertebrae and the nervous system, and the effect
this on health. Its principal treatment is joint adjustment or manipulation.
is supplemented by a wide range of physical therapy modalities.

Montana, chiropractors have been licensed for over 50 years, and that
sure was granted through public referendum. Educational requirements in this
e include a minimum of two full academic years of college or university work
m an institution acceptable to the board of regents of higher education, and
ss than four school years, of not less than 9 months each, from a college
iropractic approved by the state board. In other words, chiropractors in
ontana have a minimum of six years of higher education.

opractors are an integral part of our overall health care system, with an
growing number of patients who have benefitted enormously from chiro-
actic care. More and more definitive research findings show that chiropractic
is very effective, particularly in low back injury cases.

iropractic Care and Workers' Injuries

ccording to the latest information from the Washington-based National Safety
ncil, occupational back injuries account for at least 20 percent of all
pational injury cases. According to the Council study, about 400,000
abling back injuries occur each year at work.

use such a large share of workers injuries are back related, chiropractors
and do play a very large role in the treatment of injured workers. Yet, back
uries are particularly problematic, because there oftentimes is no 100% cure,
pain relief and ongoing care are essential in order to get a person back to
and keep them working.

ith a workers' compensation system spiraling out of control, and no statistically
iable answers in sight, there is now a proposal circulating that would, in
t, cut off chiropractic care for injured workers. While a brief glance at such
proposal may lead one to believe that such an act would cut medical costs,
ct it would really serve to do two things:

- Increase direct costs for medical care to the patient . . . if someone is in
pain, they will go somewhere, and
- Keep people from working for longer periods of time. In fact, wage claims
be a more serious drain to the workers' compensation insurance system
n medical costs, and it would take many chiropractic visits indeed to cost as

The Montana Chiropractic Association is the professional organization representing over 75% of the practicing chiropractors in the state. Its membership represents chiropractors from all geographic areas of the state. The main mission of the organization is to promote and enhance the chiropractic profession through a strong ethics program, communications, education and government affairs.

For further questions, please call or write:

THE MONTANA CHIROPRACTIC ASSOCIATION
P.O. Box 6276
Helena, Montana, 59604 406-442-7275

Research Studies

RAND

The newest scientific study, published in 1992, is from the Rand Corporation, one of the nation's most prestigious centers for research in public policy, science and technology applications. The following data is from parts One and Two of a four-part study, "The Appropriateness of Spinal Manipulation for Low Back Pain":

⇨ Back pain occurs in up to 80% of adults at some point in their lives and is one of the leading causes of visits to physicians. It is appropriate for most persons with back pain to undergo an initial course of conservative therapy. Spinal manipulation is the most commonly used conservative treatment for low-back pain for which reimbursement is sought.

⇨ Even though the 9-member panel is interdisciplinary, the concensus among the panel is greater than previous panels from just one discipline have been. The spinal manipulation panel contained members from three different philosophies; chiropractic, osteopathic, and allopathic.

RAND CONCLUDES THAT SUPPORT IS CONSISTENT FOR THE USE OF SPINAL MANIPULATION AS A TREATMENT FOR PATIENTS WITH ACUTE LOW-BACK PAIN.

BRITISH MRC TRIAL

The British Medical Council's 10 year, multicentre trial compared chiropractic and hospital outpatient management of patients with acute (short term) and chronic (long term) mechanical low-back pain was published in the British Medical Journal (June 2, 1990). The conclusions reported in the Journal are as follows:

⇨ Chiropractic treatment was significantly more effective, particularly for patients with chronic (long term) and severe pain.

⇨ Results were long term; "the benefit of chiropractic treatment became more evident throughout the follow-up period of two years."

⇨ "The potential economic, resource, and policy implications of our results are extensive."

⇨ "Of those with jobs, 21% of patients given chiropractic treatment had time off work because of back pain compared with 35% of hospital patients . . . Between 1 and 2 years the frequency and duration of absence from work were less in those treated by chiropractic."

⇨ The study shows a savings in excess of 10 million pounds per year in Britain by having hospital outpatients with back pain treated by chiropractors.

Studies demonstrate the cost effectiveness of chiropractic care

Today, there is more evidence of the effectiveness of spinal manipulation—the primary treatment mode of a chiropractor—than any other treatment approach for back pain.

Numerous workers' compensation studies demonstrate a 45 to 50 percent savings in costs—both in treatment and in compensation for lost time—when chiropractic is compared to medical treatment. The most thorough studies were conducted in California (1972), Wisconsin (1978) and Florida (1988).

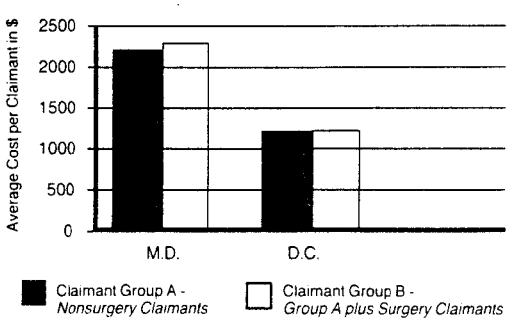
FLORIDA WORKERS COMP

⇨ The duration of temporary total disability for claimants was 48.7% shorter for chiropractic patients.

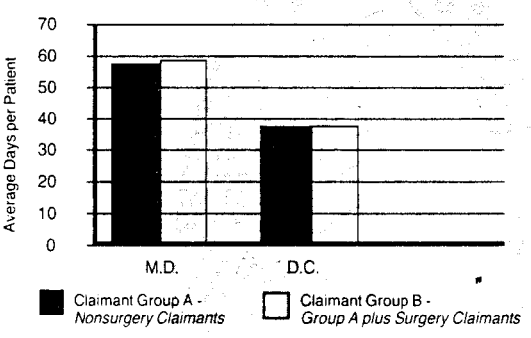
⇨ The average cost of chiropractic services and prescribed procedures was over 50% less than that of medical doctors.

⇨ 51.3% of the claimants treated by medical doctors were hospitalized while only 20.3% of the chiropractic patients were hospitalized.

This study found that:



ESTIMATED TOTAL COST OF CARE



LENGTH OF COMPENSATION PERIOD

TERN

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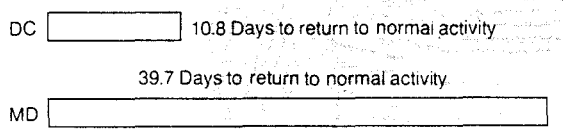
This study concluded that:

⇨ Medical doctors return patients to work in 39.7 days while chiropractors return them to work in 10.8 days.

⇨ Patients of chiropractors were three times as likely as patients of family physicians to report that they were very satisfied with the care they received for low back pain.

Comparison of Patient Satisfaction of DC and MD Care

Comparison of Patient Disability Days of DCs and MDs



TMON

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This study, "Mandated Health Insurance Coverage for Chiropractic Treatment: An Economic Assessment, with Implications for the Commonwealth of Virginia," was done by Leonard G. Schifrin, Chancellor Professor of Economics, The College of William and Mary, Williamsburg, Virginia and Clinical Professor of Preventive Medicine, Medical College of Virginia, Richmond, Virginia in 1992. This study concludes that:

⇨ Mandated chiropractic coverage has minimal cost-increasing effects on insurance and may even reduce insurance costs.

⇨ The low cost impact of chiropractic is due not to its low rate of use, but to its apparently offsetting impacts on costs in the face of high rates of utilization.

⇨ Formal studies of the cost, effectiveness, or both of chiropractic usually measured against other forms of treatment, show it to compare favorably with them.

⇨ By every test of cost and effectiveness, the general weight of evidence shows chiropractic to provide important therapeutic benefits, at economical costs. These benefits are achieved with apparently minimal, even negligible impacts on the costs of health insurance.

EXHIBIT 10
DATE 2-16-93
SB 347

Conclusion

spite of all this and even more available evidence, iropractic is being singled out in Montana by a group of insurers who want to severely limit or eliminate payments r this type of care for injured workers. Why? It is believed the profession that this strong push by insurers represents e newest wrinkle in a 100 year old turf battle between medical doctors and chiropractors. Much of the prejudice ainst chiropractic stems from a concerted effort by e AMA to destroy the chiropractic profession, as found by a federal judge and affirmed by the U.S. Supreme court the case of Wilk vs. AMA. In this case, it was ruled after 11 year legal battle that the AMA had violated the Sherman Antitrust laws by organizing a national boycott of chiropractors by medical physicians and hospitals.

Since this decision, the turf battle between chiropractors and traditional medical care providers is being conducted in a new arena, that of insurance benefits, and it is both subtle and devastating. The chiropractic profession of Montana will use the facts to push back this newest onslaught on their profession and the injured workers they serve. These facts show with no doubt that chiropractic provides injured workers with real help . . . help to relieve their symptoms, help to return them to work, help in restoring them to fully functioning individuals.

pg 3

one has any easy answers to the problem of back injuries; health care ns an art as well as a science in this area. Is the answer to arbitrarily cut d workers off from perhaps the best possible care they can have for their ticular injury?

BSOLUTELY NOT; IN MANY BACK-RELATED INJURIES, NOT ONLY HIROPRACTIC CARE A MORE EFFECTIVE MEANS OF TREATMENT, BUT IS ALSO MORE COST EFFECTIVE THAN TRADITIONAL MEDICAL CARE.

Chiropractic Care Works

Exhibit #11

Montana Chiropractic Association
Senate Bill 347 Amendments and Discussion Points
Submitted to the Senate Labor and Employment Relations Committee
February 16, 1993

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 11
DATE 2/16/93
BILL NO. SB 347

1) ISSUE OF CHARGING FOR EVERY OFFICE VISIT

SECTION 3, Page 14, Subsection 7, line 9
Delete: $10
Insert: "10% of the cost of the visit but not to exceed $10

DISCUSSION: $10 will be a discriminatorily high percentage of the less expensive visit, i.e. chiropractor. We suggest that this language be changed to "10% but not to exceed $10 per visit.

2) CONSISTENCY OF WHO IS A PRIMARY CARE PROVIDER

SECTION 2, Page 8, subsection (21), line 1
Following: "Surgical"
Insert: "Chiropractic"

DISCUSSION: Primary medical services should include chiropractic, these changes simply make the language consistent with the fact that a chiropractor is a treating physician. Failure to include chiropractic in this section has exclusionary ramifications for elsewhere in the bill. If there is no intent to exclude chiropractic from participation in worker's comp, then this addition should pose no problem.

3) PRIMARY CARE PHYSICIAN SHOULD INCLUDE CHIROPRACTOR

SECTION 10, Page 23, line 9
Following: "general practitioner"
Insert: "chiropractor"

DISCUSSION: Primary care physician should include chiropractor as it does elsewhere in the bill. A chiropractor is listed as a treating physician and language here just needs to be clarified to make sure that

"practitioner" designations do not exclude chiropractic.

4) MANAGED CARE NOT TO "YANK" PATIENTS FROM TREATING PHYSICIANS UNLESS PROGRESS IS NOT BEING MADE

SECTION 6, PAGE 17, Subsection (3), line 23
Following: "required"
Insert: New sub subsection (e)
Insert: "Notwithstanding sub subsections a through d, authorization for a treating physician to continue to treat outside of the managed care organization shall not be unreasonably withheld if demonstrable progress towards recovery is being made as specified by the utilization guidelines in Section 3, subsection 2 and determined by the medical advisory committees."

DISCUSSION: It has been the repeatedly stated position of the persons involved in formulating managed care that it should only "kick in" when the claimant is making no progress toward work return with the initial treating physician. This position makes sense both in terms of efficiency and cost since insertion into managed care does add a new layer of decision making and may well involve heightened referral costs. This being the philosophy of managed care, this language simply gives guidelines so that claimants are not prematurely or peremptorily taken to managed care, and if the patient is making progress towards getting back to work, he should stay with the treating physician who is aiding that progress.

5) MANAGED CARE TO BE "INCLUSIVE" OF PHYSICIANS RATHER THAN "EXCLUSIVE"

SECTION 8, Page 19, line 21
Following: "workers"
Insert: New subsection (4)
Following: New subsection
Insert: "Any managed care organization shall allow participation of any treating physician who is licensed by and in good standing with their professional state board."

DISCUSSION: Again, assurances have been given by most of the

individuals in work comp reform that they acknowledge the place of chiropractic as an effective and cost effective treatment for injured workers. As such, we should make every effort to make sure they are included in managed care organizations. Without this type of language, there is every reason to believe they would not be included, because certification criteria could be adopted during rulemaking that made their participation impossible, or left it totally at the will of other treating physicians who have historically sought to discriminate against D.C.s. (Again, if the intent is not to exclude chiropractors, this suggestion should pose no problem, as it does not "gore anybody elses ox.")

6) PREFERRED PROVIDER SHOULD NOT KICK IN AT THE INITIAL VISIT, BUT RATHER AFTER MANAGED CARE BEGINS

SECTION 7, Page 19, line 8
Following: "providers"
Insert: "New subsection (1)
Following: New subsection (1)
Insert: "Nothing in this section should be read to eliminate the choice of the initial treating physician provided to the claimant in Section 6."

DISCUSSION: Overall freedom of choice has already been conceded to reform in section 1. However, freedom of choice by the claimant of the initial treating physician has been specifically preserved in section 6. If preferred provider was to apply at that point, then that choice really is not a choice, or at best a severely limited one. This amendment gives dignity to what choice remains for the claimant in section 6.

7) IMPAIRMENT EVALUATIONS

SECTION 4, Page 14-15
Delete: Entire Section

DISCUSSION: Simply stated, this is a blatant targeting of the chiropractic profession. Any effect on the overall thrust of this bill would be so minimal as to be imperceptible, while at the same time being grossly discriminatory and flying in the face of legislative intent that

originally enacted this section. And that is the best case intrepretation of this section. At worst, it could be seen to take the area of worker's comp where the most fairness should be emphasized (Given that the evaluation ultimately determines compensation) and put it into a realm of "company doctor" as it would if impairment ratings could only be given by the managed care organization. In that scenario, the worker gives up the most fundamental privilege of any medical patient...a second opinion.

8) HOW NARROW IS PREFERRED PROVIDER? DOES UNBRIDLED RULEMAKING AUTHORITY LEAVE THE DEPARTMENT DIRECTIONLESS?

Following: "organizations"
Insert: "any provider agreeing to practice under standards set in the utilization guidelines as defined in Section 2, subsection (2), and agreeing to follow other guidelines as set by the Department, shall be allowed to participate as a preferred provider."

DISCUSSION: Some may believe that this language is not necessary, as they assure us that "sole" provider is neither the intent of the Department nor the effect of this section. With the unfettered rulemaking authority given the Department, however, there are simply not the slightest assurances that these intrepretations will be those adopted. The only possible rationale for "sole provider" or, shall we say "exclusive providers", whereby a few select pharmacies, therapists, M.D.s, chiropractors, or whatever, are contracted with to the exclusion of all others, is for cost containment and volume discounts. Yet, we have been told over and over again that those "select" providers would be paid even more to "play ball." If we are really just going to choose "favorites", who will always take the insurers' side over that of the claimant, we are proceeding unconscionably in the name of reform. If not, then this type of language should serve as no threat.

9) CONTINUED TREATMENT UNDER "PALLIATIVE CARE"

DISCUSSION: This legislation recognizes in Section 3, page 12, subsection "g", that oftentimes "palliative care" keeps workers on the job. "Palliative care is defined as "treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms." The problem with

section "g" on page 12 is that it sets up a panel to review the case. We believe that from the time the insurer denies continued treatment to a full panel reviewing the case, a great deal of time can elapse during which the injured worker is in "limbo". We believe, in fact, that this provision can wind up costing more money, since the worker's condition may have degenerated to a state where they are not working. We suggest that instead of a panel, the following amendment be adopted:

SECTION 3, page 12, sub subsection (g), line 8
Following: "treatment"
Delete: Line 8-13
Insert: "If approval is not granted, then the treating physician may request approval from the department, which shall appoint a treating physician in the area of specialty from which the injured worker is being treated who shall review the treatment plan, determine its appropriateness, and make a final recommendation."

10) THE TERM "CONSULTING PHYSICIAN"

DISCUSSION: Section 2, subsection (7), page 4, defines "consulting physician', yet nowhere in the bill is this language used. If the intent of this language is to eliminate the possibility that chiropractors can review utilization of chiropractic care in worker's compensation, then it poses definite problems in the area of chiropractic care. Because M.D.s know little about chiropractic, they are simply not equipped to consult in this area. We suggest that either this definition is deleted from the bill or that it be amended to include "treating physician", not just M.D.s with hospital admitting privileges.

11) MEDICAL ADVISORY COMMITTEES

DISCUSSION: In section 14, the bill talks about "medical advisory committees" which will be made up of various providers. However, in present language the individuals who sit on these committees are left solely to the discretion of the department. We suggest the following amendment to rectify this problem:

SECTION 14, page 26, line 7
Following: "groups"
Insert: "as recommended by the state board governing these providers"

EXHIBIT 12
DATE 2-16-93
SB 347

QUESTIONS & ANSWERS
HOUSE BILL 33

1. Have chiropractors been allowed to do impairment ratings in the past?

Yes, Just a few years ago, chiropractors were able to do impairment ratings in Montana. However, the laws and rules were vague, and a few years ago worker's compensation Judge Reardon ruled testimony regarding impairment rating from a chiropractor as inadmissable. MCA took this case to court, but the ruling was upheld, based, in part, on the new workers compensation laws enacted in 1987 which specifically allowed only medical doctors to do impairment ratings.

2. Will this law start to open this process up to other types of health care providers?

No. The law specifically states "treating physician." or " Doctor of Chiropractic." Other health care providers are not physicians or Chiropractors.

3. How long have chiropractors been licensed to practice in Montana?

Over fifty years ago, chiropractors were licensed to practice through a public initiative. There are over 245 chiropractors licensed to practice in the state. The educational requirements to become a Doctor of Chiropractic are stiff in Montana. The doctor must have completed 4 years of an accredited chiropractic college (chiropractic colleges are accredited by the department of Health, Education and Welfare), and at least two years of an accredited university with an emphasis on the sciences. Doctors are also required to fulfill a minimum of 12 hours of continuing education per year.

4. Why does the law specifically require that if the treating physician is a chiropractor the first impairment evaluation must be done by a chiropractor?

Simply put, other types of physicians know very little about chiropractic, and therefore do not understand the patient's method of treatment. A fellow chiropractor understands the treatment and can make a fairer evaluation of the patient's prognosis.

5. Is there any room for a conflict of interst?

Absolutely not. The treating physician cannot do an impairment rating in any case. It must be another physician or Dr. of Chiropracitic.

6. Are there provisions for proper knowledge and experience on the part of the chiropractor doing the evaluation?

Yes! The bill provides that certification rules be enacted by the State Board of Chiropractic. All chiropractors wishing to do impairment ratings must be board certified. HB 33's statement intent provides that these rules should take into account a doctors experience in treating industrial accident cases as well as academic qualifications.

7. Do other states allow chiropractors to do impairment ratings? Yes. In a survey of surrounding states, we discovered that Minnesota, Idaho, Oregon, South Dakota, Washington and Wyoming all allow this. There have been court cases in several other states which have found that chiropractors can do ratings. Most recent is Nebraska, *Rogers vs Sparks, Citation 228, Neb. 191, 421, NW2nd Series 785 (1988).* In this case, a court found testimony from a chiropractor as inadmissable and the case was brought before the Nebraska Supreme Court, which ruled in favor of the chiropractor. Chiropractors can now do permanent impairment ratings in Nebraska. This case was decided, in part, on case law from many other states, including Arizona.

EXHIBIT 12
DATE 2-16-93
SB 347

TESTIMONY
HOUSE BILL 33
SUBMITTED BY: THE MONTANA CHIROPRACTIC ASSOCIATION
March 1, 1989

An impairment evaluation is defined as "An appraisal of the nature and extent of the patients illness or injuries as they affect his personal efficiency in one or more of the activities of daily living." An impairment rating is performed after a patient has, in the judgement of the treating physician, reached maximum rehabilitation of his injuries. Impairment ratings range from 0 to 35 or 40 percent, and are a definition of permanent disabilities due to injuries.

Why do Montana chiropractors wish to do these evaluations? The number one reason is that we are the primary treating physicians in many worker's compensation cases. A large percentage of long-term work related injuries are back related, and chiropractors have demonstrated throughout the country their ability to cost effectively treat these cases and get people back to work. Several studies of the effectiveness of chiropractic treatment in worker's compensation have been conducted throughout the country, and all show the same conclusion: chiropractic care costs less than care from medical doctors. In particular, a recent study conducted in Florida by the Foundation for Chiropractic Education and Research and the Florida Worker's Compensation Division shows that, "the duration of temporary total disability represented by the average length of the compensation period, and the indemnity payments for work days lost, were substantially less for claimants treated by chiropractors compared with those treated by medical doctors". In the group of claimants that excluded surgery patients, the period of disability was 48.7% shorter for chiropractic patients; for the claimant group that included patients who underwent surgery, the duration of disability was 51.3% shorter for chiropractic patients. The average cost of chiropractic services and prescribed procedures was significantly less than the corresponding cost for medical doctors. In both claimant groups, one which had surgery, the other not, the cost of chiropractors' services and prescribed procedures was over 50% less than that of medical doctors. The costs for medical patients without surgery was 83.8% higher than chiropractic care, and for those undergoing surgery, the cost was 95.3% higher. These statistics, representing the total treatment costs of managing a work-related back injury, more accurately reflect the cost-effectiveness of chiropractic care over standard medical care. We are providing for your information a copy of the Executive Summary of this study.

Chiropractors have been active in treating workers compensation injuries for many years in Montana. As the treating physicians, prior to the early 1980s, they were allowed to do impairment ratings for their patients. It was and still is important to patients of chiropractors that a chiropractor do that rating, simply because that person is their primary treating physician, and a chiropractor has different methods of treating than does a medical doctor.

However, the laws and rules regarding the impairment rating process were vague, and and a few years ago Worker's Compensation Judge Reardon ruled testimony regarding impairment rating from a chiropractor as inadmissable. In 1987-88, the Montana Chiropractic Association challenged the rule in court, unsuccessfully in part because of new laws enacted in 1987 regarding impairment evaluations. That is why we are here today. It is the task

of this legislature to set public policy, and we believe that it should be public policy that chiropractors are allowed to do these ratings. Chiropractors now have to send their patients to medical doctors who have no knowledge or history of the case in order to get their impairment rating. That is not in the best interest of the injured worker, and the Montana Chiropractic Association feels that a change in the law is necessary. We wish to permanently clarify that, should a treating physician be a chiropractor, then a chiropractor can do the impairment rating for their patient.

One of our first steps in studying this problem was to study how other states handle this situation. We personally contacted the surrounding states of Minnesota, Idaho, Oregon, South Dakota, Wyoming and Washington. All of these states allow chiropractors to do permanent impairment ratings, and we know of no other state in the country that does not allow it. As a matter of fact, there is quite a bit of case law on the subject, including Rogers vs Sparks, a Nebraska case. In Nebraska, a court found testimony from a chiropractor as inadmissable and the case was brought before the Nebrtaska Supreme Court, which ruled in favor of the chiropractor. Chiropractors can now do permanent impairment ratings in Nebraska. This case was decided, in part, on case law from many other states, including Arizona. Why Montana should have a policy in direct contradiction to other states is questionable, especially since it is obvious that the state funds of states allowing chiropractors to do these ratings are in no worse condition than Montana's.

Two of the arguments that have been used against Chiropractors doing these ratings are: one, that it is a purely "medical" determination, and, two, that they must rate the "whole man." We would submit to this body that "medical" is a generic term, not one that belongs exclusively to medical doctors. The Merriam-Webster Dictionary defines medical as: "of or relating to the science or practice of medicine or the treatment of disease." The term medicine is defined as: "a science or art dealing with the prevention or cure of disease." No where in these definitions does it say that these terms relate strictly to medical doctors, nor do they denote "ownership" of the terms to any specific health care provider. In addition, even workers compensation uses the term "medical" in a generic sense. Just one example is their newest form that chiropractors fill out entitled "General Medical Continued Billing."

The arguement of a chiropractor not being able to evaluate the "whole man" is also not a convincing one. Number one, chiropractors have extensive training in the health care field, and then specialize in chiropractic. We are providing for the committee copies of the graduation standards for one chiropractic college. In Montana, the licensure requirements for a chiropractor are very strict; The doctor must have completed four years at an accredited chiropractic college (chiropractic colleges are accredited by the Department of Health, Education and Welfare), and at least two years of an accredited university with an emphasis on the sciences. Montana doctors are also required to fulfill a minimum of 12 hours of technical continuing education per year. We argue that chiropractors are well able to evaluate impairments in their field of expertise. Making a statement that a chiropractor is less able to rate a back-related injury than an M.D. specializing in Neurology or Cardiology is ludicrous, but that is the way our current law reads. Any medical doctor, regardless of specialty, can rate impairments.

In addition to the background and training that chiropractors already have, our bill provides that only chiropractors who are certified by the State Board of Chiropractic in impairment will be allowed to rate. This is a much greater

requirement than any imposed upon medical doctors. In fact, all medical doctors have to do in order to rate any type of impairment is to be medical doctors.

The law requires that impairment evaluators use strict guidelines developed by the AMA, "Guides to Evaluation for Permanent Impairment." Chiropractors are trained and able to use these guides, and the portion of our bill that requires board certification will guarantee that any chiropractor doing evaluations is well trained to do them–a standard much stricter than any imposed upon M.D.s.

In summary, an impairment rating is a scientific evaluation, an evaluation that permanently sets percentage of disability. As primary health care providers in workers compensation cases, chiropractors should be allowed to perform this function for their patients. This bill is a fair one, and mirrors policy in every other state of the union that we are aware of, most specifically all of our surrounding states. Chiropractors have been licensed to practice in the state of Montana for over fifty years, and they obtained this licensure by public initiative. They are an ever-growing field of alternative health care, and as any of you who has utilized their services can attest, chiropractic works. That is why so many people in Montana seek chiropractic care.

We urge that this committee make this important public policy. We ask that you give HB33 a do pass recommendation.

Michael Pardis, D.C., President, MCA
Lee Hudson, D.C., Vice-President, MCA
Gary Blom, D.C., Past President, MCA
Bonnie Tippy, Executive Secretary, MCA
350 North Last Chance Gulch, Suite 312
Helena, Montana 59601
(406)442-7275

EXHIBIT 12
DATE 2-16-93
SB 347

Exhibit #12

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 12
DATE 2/16/93
BILL NO. SB 347

MONTANA HOUSE OF REPRESENTATIVES
51ST LEGISLATURE 1989
REGULAR SESSION
VOTE TABULATION

DATE: JANUARY 12, 1989
TIME: 1:46 PM

SEQ. NO: 5.0
BILL NO: HB 33
BILL SP: PAVLOVICH

ORDER OF BUSINESS 7 SECOND READING
AMD-1 SIMON D/PASS

AYES: AAFEDT, ADDY, BACHINI, BARDANOUVE, BLOTKAMP, BOHARSKI, BRADLEY, BROOKE, BROWN J, CAMPBELL, CLARK, COBB, COCCHIARELLA, CODY, COHEN, COMPTON, CONNELLY, DAILY, DARKO, DAVIS, DeBRUYCKER, DeMARS, DRISCOLL, ELLIOTT, ELLISON, EUDAILY, GERVAIS, GIACOMETTO, GILBERT, GLASER, GOOD, GOULD, GRADY, GRINDE, GUTHRIE, HANNAH, HANSEN S, HANSON M, HARPER, HARRINGTON, HAYNE, HOFFMAN, JOHNSON, KADAS, KASTEN, KELLER, KILPATRICK, KIMBERLEY, KNAPP, OEHNKE, LEE, MARKS, McCORMICK, McDONOUGH, MENAHAN, MERCER, MOORE, NELSON L, NELSON R, NELSON T, NISBET, O'KEEFE, OWENS, PATTERSON, PAVLOVICH, PECK, PETERSON, PHILLIPS, QUILICI, RAMIREZ, RANEY, REAM, REHBERG, RICE, ROTH, RUSSELL, SCHYE, SIMON, SIMPKINS, SMITH, SPAETH, SPRING, SQUIRES, STANG, STICKNEY, STRIZICH, SWIFT, SWYSGOOD, THOFT, THOMAS, WALLIN, WESTLAKE, WHALEN, WYATT, ZOOK, MR. SPEAKER.
TOTAL 96

NOES: NONE.
TOTAL 0

EXCUSED: BROWN D, IVERSON, O'CONNELL.
TOTAL 3

ABSENT OR NOT VOTING: STEPPLER.
TOTAL 1

PAIRED: NONE.

IN THE CHAIR: STANG.

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 33 concurred in by the following vote:

Ayes: Abrams, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 47

Noes: Aklestad, Mazurek, Tveit.
Total 3

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 60 concurred in by the following vote:

Ayes: Abrams, Anderson, Beck, Bengtson, Bishop, Blaylock, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Hofman, Jacobson, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail.
Total 43

Noes: Aklestad, Boylan, Himsl, Jenkins, Nathe, Mr. President.
Total 6

Excused: None.
Total 0

Absent or not voting: Severson.
Total 1

HB 80 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 50

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 87 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 50

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 89 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 50

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 121 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Harding, Harp, Himsl, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 47

Noes: Hammond, Hofman, Mazurek.
Total 3

Excused: None.
Total 0

Absent or not voting: None.
Total 0

EXHIBIT 12
DATE 2-16-93
SB 347

HB 33

Exhibit #13

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 13
DATE 2/16/93
BILL NO. SB 347

apta

American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314-1488
703/684-2782
703/684-7343 Fax

Eliminate Referral for Profit

The American Physical Therapy Association (APTA) urges Congress and the State legislatures to eliminate situations which we characterize as referral for profit. An increasing body of evidence is documenting the fact that huge amounts of money are unnecessarily being added to America's already bloated tab for health care. These unnecessary outlays are the result of situations in which health care practitioners invest in health care services and then profit by referring their patients to these services in which they have an investment interest.

These schemes assume various forms. Health care practitioners may become a limited partner in a physical therapy clinic, or they may form a joint venture with a physical therapist, or they might simply imply a physical therapist to whom they then refer their patients for physical therapy care. Regardless of the form the scheme assumes, the results are the same: referring practitioners position themselves to profit from the use of this authority to refer patients to other health care practitioners. Patients themselves can no longer assume that their well-being is the referring practitioner's motivation for ordering these additional services. Are they being referred simply because they need the services or might the referring practitioners' judgement be influenced by this opportunity to profit from these additional services?

A study conducted by the State of Florida's Health Care Cost Containment Board found that physician-owned physical therapy facilities provided 43% more visits per patient than did nonjoint venture physical therapy facilities. These additional visits generated 31% more revenue per patient. Subsequently, a study of this Florida data conducted by the Center for Health Policy Studies found that the estimated 1991 cost impact of physician joint ventures for imaging services, clinical laboratory tests and physical therapy services was a staggering $500.8 million.

Similar results were found across the country in a study of California's Workers' Compensation program. William M. Mercer, Inc. found that if an injured worker received initial treatment from a provider with an ownership interest in physical therapy, that patient received a referral to physical therapy 66% of the time contrasted to 32% of the time when the initial provider had no ownership interest in physical therapy. The conclusion was that this self interest generated approximately $233 million in physical therapy services delivered for economic rather than clinical reasons.

The problem of referral for profit was recognized in a bipartisan manner during the 102nd Congress. Initiatives to restrict it were included in H.R. 5502, the health care reform legislation introduced by Rep. Pete Stark and House Majority Leader Richard Gephardt and in H.R. 5325, the house Republican Leadership health reform bill. Separate legislation, S. 3186, was also introduced by Senator Brock Adams. These initiatives died with the adjournment of Congress.

The APTA urges Congress resume its attention to this issue in 1993. The potential for abuse in these situations is high and the tremendous costs added to health care is completely unnecessary.

11/6/92

APTA
San Antonio
COMBINED SECTIONS MEETING
FEB. 3 - 7, 1993

INCREASED COSTS AND RATES OF USE IN THE CALIFORNIA WORKERS' COMPENSATION SYSTEM AS A RESULT OF SELF-REFERRAL BY PHYSICIANS

ALEX SWEDLOW, M.H.S.A., GREGORY JOHNSON, PH.D., NEIL SMITHLINE, M.D., AND ARNOLD MILSTEIN, M.D., M.P.H.

Abstract *Background.* There is widespread concern that ownership by physicians of testing or treatment facilities to which they refer patients leads to overuse of such facilities. We determined the patterns of use of three services — physical therapy, psychiatric evaluation, and magnetic resonance imaging (MRI) — among physicians treating patients whose care was covered under workers' compensation. We then compared the rates of use among physicians who referred patients to facilities of which they were owners (self-referral group) with the rates among physicians who referred patients to independent facilities (independent-referral group).

Methods. We used a large data base to analyze claims under workers' compensation in California from October 1, 1990, through June 30, 1991, to determine the frequency and cost of these three selected services and determined whether the referring physicians were practicing self-referral or independent referral. We evaluated the cost per case for all three services, measured the frequency with which physical therapy was initiated, and evaluated the medical appropriateness of MRI.

Results. We found that physical therapy was initiated 2.3 times more often by the physicians in the self-referral group (68 percent) than by those in the independent-referral group (30 percent; $P<0.01$). The mean cost per case for physical therapy was significantly lower in the self-referral group ($404±102) than in the independent-referral group ($440±167; $P<0.01$).

The mean cost of psychiatric evaluation services was significantly higher in the self-referral group than in the independent-referral group (psychometric testing, $1,165±728 vs. $870±482; $P<0.01$; psychiatric evaluation reports, $2,056±1,063 vs. $1,680±578; $P<0.01$). The total cost per case of psychiatric evaluation services was 26.3 percent higher in the self-referral group ($3,222±1,451) than in the independent-referral group ($2,550±742; $P<0.01$).

Of all the MRI scans requested by the self-referring physicians, 38 percent were found to be medically inappropriate, as compared with 28 percent of those requested by physicians in the independent-referral group ($P<0.05$). There was no significant difference in the cost per case between the two groups.

Conclusions. This study demonstrates that self-referral increases the cost of medical care covered by workers' compensation for each of the three types of service studied. (N Engl J Med 1992;327:1502-6.)

THERE is growing concern about conflict of interest in medicine in the United States.[1-6] Recent studies have focused on whether physicians' ownership of testing or treatment centers increases the number of tests and services performed.[7-10] Research in Florida indicates that physician-owned facilities generate significantly higher rates of use and costs than independently owned facilities.[7,8] Studies of physician ownership in California have found that the higher concentration of physician-owned magnetic resonance imaging (MRI) facilities in California has increased rates of use between 34 percent and 56 percent above the rates for the rest of the country.[5] The study by Hillman et al. of diagnostic imaging demonstrated that physicians who referred patients to facilities of which they were owners (those who practiced self-referral) charged 4.4 to 7.5 times more per episode of care than other physicians.[10] In response to these findings, the states of Florida, Michigan, and New Jersey have enacted legislation that restricts self-referral by physicians.

The American Medical Association (AMA) Council on Ethical and Judicial Affairs stated in December 1991: "In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility."[11] In June 1992, however, the AMA's House of Delegates adopted a new policy that allows doctors to make such referrals if patients are informed of the doctor's financial interest in the facility and of any available alternatives.[12] This reversal on the part of the AMA reflects the lack of consensus within organized medicine about physicians' ownership of medical facilities. There have also been two recent efforts by the federal government to limit self-referral on the part of physicians. Since January 1992, physicians have been prohibited from referring patients to clinical laboratories in which they have an ownership interest. In addition, the "safe harbor" regulations published in the *Federal Register* defined more clearly the investment, ownership, and reimbursement arrangements in which physicians may participate without fear of violating anti-kickback provisions of Medicare and Medicaid.[13]

To our knowledge, the effects of physician self-referral within the workers' compensation system have not been systematically analyzed. To investigate this issue, we evaluated a total of 6581 California workers' compensation cases for which claims were filed with a large workers' compensation insurance company during a nine-month period in 1990 and 1991. We analyzed the effect of physicians' self-referral on three high-cost medical services covered under workers' compensation: physical therapy, psychiatric evaluation, and MRI. We evaluated the cost per case for all three services, measured the frequen-

From the National Medical Audit unit, William Mercer, Inc., San Francisco (A.S., G.J., A.M.); and Current Health Concepts, Sausalito, Calif. (N.S.). Address reprint requests to Dr. Johnson at William Mercer, Inc., 3 Embarcadero Ctr., Suite 1250, San Francisco, CA 94111.

cy with which physical therapy was initiated, and prospectively analyzed the medical appropriateness of MRI.

Methods

This study was designed to compare the patterns of use of three services — physical therapy, psychiatric evaluation, and MRI — among physicians who refer patients to facilities of which they are owners (self-referral group) and physicians who refer patients to independent facilities (independent-referral group).

Since differences in case mix between physicians in the self-referral and independent-referral groups might account for differences in rates of use or cost, we classified all cases according to the Ambulatory Visit Groups (AVG) classification scheme,[14] which we have modified for workers' compensation cases.[15] The AVG system is analogous to the system of diagnosis-related groups currently used by Medicare to reimburse acute care hospitals. On the basis of the patient's diagnosis (the diagnostic code from the *International Classification of Diseases, 9th Revision, Clinical Modification*) and the medical-procedure codes of the California Relative Value Studies and *Current Procedural Terminology* for outpatient services in each case, the AVG system is used to assign that case to 1 (and only 1) of 571 groups.

Type of Referral

Throughout the study, self-referral was defined as a referral for a medical service made by a physician or clinic to an entity owned entirely or in part by the referring physician or clinic. Self-referral was defined by either of the following two patterns: referral services were provided under the same tax identification number as the primary service, or referral services were provided under a different tax identification number from the primary service, but one or more owners were common to both entities.

When services were delivered under different tax identification numbers, we searched commercially available data bases that list officers, stockholders, and partners of facilities (the California Fictitious Business Name Listing, the Executive Business Listing, and other state and national data bases on corporations and limited partnerships available from Information America, Atlanta). If this search failed to identify common ownership, we then directly telephoned the referring physician's office and inquired about common ownership.

Physical-Therapy and Psychiatric-Evaluation Services

We used one of California's largest data bases on workers' compensation claims (that of the Industrial Indemnity Co., San Francisco) to analyze the frequency and cost of physical-therapy and psychiatric-evaluation services provided to injured workers. The data base was selected because it was complete and contained information on a large number of patients distributed throughout California. Information about each case was stored longitudinally; thus, the data base contained claims information for all services provided to the injured worker during the entire nine-month period of the study.

Data on all patients covered by workers' compensation in California who received physical-therapy or psychiatric-evaluation services from October 1, 1990, through June 30, 1991, were analyzed. Our analysis compared the rates of use and costs of physical-therapy and psychiatric-evaluation services for physicians in the self-referral and independent-referral groups.

Since musculoskeletal injuries make up the majority of all workers' compensation medical cases, we were able to limit our evaluation of physical therapy to providers with substantial experience in treating industrial musculoskeletal injuries. We defined this degree of experience as the treatment of 10 or more cases of musculoskeletal injury during the study period. There were 76 providers who met this criterion; they treated 1257 cases of musculoskeletal injury. Using the method described above, we were able to determine in all instances whether the referring providers were in the self-referral group or the independent-referral group.

In California, patients covered by workers' compensation are most frequently referred for psychiatric-evaluation services to document a claim of "stress." This evaluation virtually always includes both psychometric testing and a psychiatric-evaluation report. (We documented this fact in a preliminary analysis of our data base.) We therefore limited our analysis of psychiatric-evaluation services to cases in which there was both psychometric testing and a psychiatric-evaluation report. Altogether, 1751 (39 percent) of the cases within the data base met this criterion. A random sample of 220 cases (13 percent) was selected for analysis of ownership. We were able to determine ownership and self-referral or independent-referral status in each of these cases.

MRI

We also compared the cost and appropriateness of MRI scans in the self-referral and independent-referral groups. Appropriateness of referral for an MRI scan was determined under a prospective precertification program. All physicians' requests for MRI scans (regardless of the body part to be examined) were referred by Industrial Indemnity to a national, independent utilization-review firm for precertification review of medical appropriateness. The firm's criteria for appropriateness were established by a panel of board-certified specialists in orthopedics, industrial medicine, and radiology. After initial development by an independent board-certified radiologist and the medical directors of the utilization-review firm and its parent (one of the three largest companies managing health maintenance organizations in the United States), the criteria were reviewed and revised by a panel of independent, practicing experts in managed care who were all board-certified in orthopedics, neurology, neurosurgery, or radiology.

On the basis of medical documentation of the patient's injuries and conversations with the physician who requested the MRI, the review firm gave an opinion on the medical appropriateness of the procedure before it was performed. The reviewers were blinded to the physician's relation with the MRI center.

The classification of a procedure as medically inappropriate could be appealed. To be certain that the reviewer's decision did not merely defer an appropriate scan to another date, cases in which the MRI was categorized as medically inappropriate were followed for an additional six months. In all cases in which a scan was approved within six months after the original request, the MRI was considered to be medically appropriate.

All 864 requests for MRI scans from January 1, 1991, through June 30, 1991, were evaluated. We were able to determine whether the physician had an ownership interest in the facility in 502 (58 percent) of these cases.

Statistical Analysis

Continuous variables are presented as means ±SD and were compared by two-tailed t-tests. The proportion of cases in each group was assessed by the chi-square test. For all analyses, a P value of less than 0.05 was considered to indicate statistical significance. Results were analyzed with use of the Crunch4 Statistical Package (Oakland, Calif.).

Results

Physical Therapy

Table 1 shows the 1257 cases of musculoskeletal injury (whether or not the patients received physical therapy) according to AVG and type of provider (whether the provider practiced self-referral or independent referral). Four AVGs account for 92 percent of all cases; there was no significant difference in the distribution of AVGs between the self-referral and independent-referral groups.

As shown in Table 2, physical therapy was initiated more than twice as often by physicians in the self-referral group (in 68 percent of the cases) as by those

in the independent-referral group (30 percent; P<0.01). The mean cost per case for physical therapy in the self-referral group ($404±102) was significantly lower than that in the independent-referral group ($440±167; P<0.01).

Table 1. Distribution of AVGs and Mean Cost per Case in the Self-Referral and Independent-Referral Groups.*

AVG Code and Category	Cases		Cost per Case	
	Self-Referral	Independent Referral	Self-Referral	Independent Referral
	No. (%)		Mean ±SD ($)	
Physical therapy				
824 Medical back problems†	632 (62)	135 (56)	406±98	448±131
825 Tendonitis	162 (16)	43 (18)	384±119	451±177
829 Strain of arm or shoulder	87 (9)	18 (8)	413±88	360±234
826 Wound or fracture of arm or shoulder	58 (6)	18 (8)	381±122	401±188
828 Trauma to fingers or toes†	42 (4)	12 (5)	416±95	261±200
Other‡	36 (4)	14 (6)	444±111	789±1
Total‡	1017 (100)	240 (100)	404±102	440±167
Psychiatric services				
824 Medical back problems‡	61 (39)	24 (37)	3,230±1,493	2,340±697
2120 Minor wounds and injuries	58 (37)	18 (28)	3,215±1,420	2,887±743
1941 Individual supportive therapy	14 (9)	8 (12)	3,114±1,465	2,214±626
1945 Unscheduled crisis	10 (6)	3 (5)	2,929±1,153	2,314±929
1923 Other mental disturbances	6 (4)	7 (11)	4,372±1,967	2,744±748
Other	6 (4)	5 (8)	2,780±1,091	2,751±736
Total‡	155 (100)	65 (100)	3,222±1,450	2,549±742
MRI				
824 Medical back problems	273 (87)	165 (88)	981±231	994±171
829 Strain of arm or shoulder	30 (10)	14 (7)	936±179	874±79
Other	12 (4)	8 (4)	964±199	1,103±180
Total	315 (100)	187 (100)	976±226	990±170

*AVG designates the Ambulatory Visit Groups classification.[14] There were no significant differences in the distribution of AVGs for physical therapy, psychiatric-evaluation services, or MRI between the self-referral group and the independent-referral group, by the chi-square test. Percentages do not always total 100, because of rounding.

†Differences in cost between the self-referral and independent-referral groups were significant (P<0.05) by t-test.

‡Differences in cost between the self-referral and independent-referral groups were significant (P<0.01) by t-test.

Psychiatric-Evaluation Services

Table 1 classifies the random sample of 220 cases in which patients received both psychometric testing and psychiatric-evaluation services, according to AVG and provider type. There was no significant difference in the distribution of AVGs between the two types of providers. As Table 2 shows, the mean cost per case for psychiatric-evaluation services was 26 percent higher in the self-referral group ($3,222±1,451) than in the independent-referral group ($2,550±742; P<0.01). This difference was due to the higher cost of psychometric testing ($1,165±728 vs. $870±482; P<0.01) and the greater number of tests per case and to the higher costs of psychiatric-evaluation reports ($2,056±1,063 vs. $1,680±578; P<0.01) (since psychometric tests are reimbursed according to the California Official Medical Fee Schedule, which pays the same amount for each psychometric test regardless of the test, the cost per case for these reports is directly proportional to the number of tests performed).

MRI Scans

Tables 1 and 2 show the results of our study of the medical appropriateness of MRI scans. A total of 502 requests for precertification were received from imaging centers in which ownership could be identified. In Table 1, these cases are classified according to AVG and provider type. There was no significant difference in the distribution of cases between the self-referral and independent-referral groups.

As shown in Table 2, 38 percent of the scans requested by physicians in the self-referral group were found to be medically inappropriate, as compared with 28 percent of those requested by physicians in the independent-referral group (P<0.05). There was no significant difference in cost per MRI procedure between the two groups.

Discussion

This study demonstrates that self-referral increases the cost of medical care under workers' compensation for each of the three types of service studied, but by a different mechanism in each instance: by substantially increasing the percentage of injured workers who receive physical therapy (which more than offsets the slight decrease in cost per case); by increasing the number of psychometric tests and the cost of psychiatric-evaluation reports; and by increasing the frequency of requests for clinically inappropriate MRI scans. These higher rates of use and higher costs have important implications for workers' compensation expenditures, since self-referral is the predominant form of referral for these services.

Physical Therapy

According to the California Workers' Compensation Institute (CWCI) 1990 Medical Fee Survey of 39 private and public insurers, physical therapy represents 56 percent of all outpatient procedures and 34 percent of all outpatient costs for the treatment of injured workers in California.[16] This represents an increase of 31 percent in the volume of services in relation to other outpatient procedures since the CWCI's 1988 study.[16]

Injured workers usually receive a prescription for treatment from a physician (an orthopedic specialist or physician at an industrial medical or multispecialty clinic) to the physical therapist for specific treatment. Over the years, many physicians and clinics that treat patients covered by workers' compensation have established physical-therapy departments within their general operations or have established separate phys-

Table 2. Frequency of Use of Services and Cost per Case in the Self-Referral and Independent-Referral Groups.

Variable	Cases			Cost per Case		
	Self-Referral	Independent Referral	Self/Independent Ratio*	Self-Referral	Independent Referral	Self/Independent Ratio*
	no. (%)			mean ±SD ($)		
Physical therapy						
No. of musculoskeletal injuries	1017 (100)	240 (100)	—	—	—	—
Cases with physical therapy	690 (68)†	71 (30)	2.3	404±102‡	440±167	0.9
Psychiatric services						
Cases with psychiatric-evaluation reports	155 (100)	65 (100)	—	2,056±1,063‡	1,680±578	1.2
Cases with psychometric testing	155 (100)	65 (100)	—	1,165±728‡	870±482	1.3
Cost of total evaluation	—	—	—	3,222±1,451‡	2,550±742	1.3
MRI						
Requests for scans	315 (100)	187 (100)	—	—	—	—
Scans found medically inappropriate	121 (38)§	52 (28)	1.4	976±226	990±170	1.0

*The ratio of the number of cases or the cost per case in the self-referral group to that in the independent-referral group.

†The proportion of cases in which physical therapy was ordered in the self-referral and independent-referral groups differed significantly ($P<0.01$), by the chi-square test.

‡The mean cost per case differed significantly between the self-referral group and the independent-referral group ($P<0.01$), by t-test.

§The proportion of cases in which MRI scans were found to be medically inappropriate differed significantly between the self-referral group and the independent-referral group ($P<0.05$), by the chi-square test.

ical-therapy facilities that they own but that are operated as distinct financial entities.

In Florida, Mitchel and Scott recently found that 40 percent of physical-therapy facilities were owned by physicians.[7] Our study focused on California physicians who treat large numbers of musculoskeletal injuries and found that 91 percent of all physical therapy was performed by providers who engage in self-referral (Table 2), and the frequency with which physical therapy was initiated was 2.3 times greater in the self-referral group than the independent-referral group. The cost per case of physical therapy, however, was about 10 percent higher in the independent-referral group.

In this study, there was no significant difference in case mix between the self-referral and independent-referral groups (Table 1). In the absence of measures of severity of illness among outpatients, it is therefore impossible to determine whether the lower cost per case in the self-referral group reflects more efficient care or the provision of physical therapy to patients with less severe injuries, since self-referring practitioners initiate physical therapy at more than twice the rate of independent providers.

Regardless of which hypothesis is correct, this small difference in cost per case is more than offset by the dramatically greater frequency with which self-referring providers initiate physical therapy. As Table 3 shows, for every 1000 workers with musculoskeletal injuries, the costs incurred by the California workers' compensation system would be $143,672 (110 percent) higher if these injured workers were evaluated by self-referring rather than independently referring practitioners.

Psychiatric-Evaluation Services

The CWCI estimates that approximately 6 percent of the total medical payments under workers' compensation were for psychiatric services in 1991.[16] California state law defines a valid claim of work-related stress as one in which the work environment contributes 10 percent or more to a worker's total stress level. Some argue that this definition of compensable workplace stress has created a referral environment that encourages excessive evaluation and testing.

We found that 70 percent of all psychiatric-evaluation services were requested by providers who had an ownership interest in the entity that provided both psychometric testing and psychiatric-evaluation reports (Table 2). Furthermore, evaluation costs were 26 percent higher when this ownership relation existed.

As indicated above, a referral for evaluation virtually always results in charges for two services: psychometric testing and a psychiatric-evaluation report that synthesizes the findings of the psychometric tests with the findings from the psychiatric history and examination. Therefore, if a provider with an economic interest in a facility were motivated more by monetary incentives than one without such an economic interest, we would expect this to be reflected in greater use and higher costs of psychometric testing, as well as a more extensive and therefore more costly evaluation report, which would be required to integrate the results of more extensive testing. As shown in Table 2, the cost of each psychiatric service and the mean cost per case were significantly higher in the self-referral group than the independent-referral group; the differences in cost were as follows: psychometric testing, 34 percent; psychiatric evaluation reports, 22 percent; and total evaluation, 26 percent.

As Table 3 shows, for every 1000 workers receiving psychiatric-evaluation services, the costs incurred by the California workers' compensation system would be $672,000 (26 percent) higher if these workers were treated by physicians in the self-referral group rather than the independent-referral group.

MRI Scans

MRI has gained prominence as the diagnostic imaging tool of choice in the assessment and documentation of specific types of injuries. California cur-

Table 3. Additional Cost Incurred by the California Workers' Compensation System for Each 1000 Injuries Treated at Self-Referral Rather Than Independent-Referral Rates.

Service	Self-Referral	Independent Referral
Physical therapy		
No. of musculoskeletal injuries	1000	1000
Rate of referral for physical therapy	× .678	× .296
No. of cases with physical therapy	678	296
Cost per case	× $404	× $440
Total cost of physical therapy	$273,912	$130,240
Additional cost per 1000 cases (%)	$143,672 (110)	
Psychiatric services		
No. of cases with psychiatric-evaluation services	1000	1000
Cost per case	× $3,222	× $2,550
Total cost of psychiatric-evaluation services	$3,222,000	$2,550,000
Additional cost per 1000 cases (%)	$672,000 (26)	
MRI		
No. of requests for MRI	1000	1000
Rate of inappropriate scans	× .384	× .278
No. of inappropriate scans	384	278
Cost per case	× $976	× $990
Cost of inappropriate MRI	$374,784	$275,220
Cost differential for appropriate scans*	—	$10,108
Total cost of MRI scans	$374,784	$285,328
Additional cost per 1000 cases (%)	$89,456 (31)	

*Additional cost ($14 per case) of the 722 approved MRI procedures.

rently has approximately 400 MRI machines (Mitchel J: personal communication). Recent studies have shown that such a concentration of imaging centers is associated with higher rates of use. After adjustment for the characteristics of the population, Californians undergo 51 percent more MRI procedures than the national average.[9] Leape et al. similarly concluded that an increased concentration of providers increases rates of use.[17] In their study, regions with a high rate of carotid endarterectomy had twice as many surgeons performing the operation as regions where the rate was low.

We found MRI scans to be medically inappropriate 38 percent more often when ordered by self-referring physicians, suggesting increased rates of use in this group. The higher rate of inappropriateness in the self-referral group may help explain the Florida study's finding that rates of use in these physician-owned facilities were 14 to 65 percent higher than in a control area.[7]

Table 3 illustrates the effects of these requests for medically inappropriate scans. For every 1000 requests for MRI scans, the costs incurred by the California workers' compensation system would be $89,456 (31 percent) higher if these requests were made by self-referring physicians rather than by physicians in the independent-referral group.

We are indebted to Mr. Will B. Murphey for his support and encouragement in this project.

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EXHIBIT 13
2-16-93
SB 347

SPECIAL ARTICLES

CONSEQUENCES OF PHYSICIANS' OWNERSHIP OF HEALTH CARE FACILITIES — JOINT VENTURES IN RADIATION THERAPY

JEAN M. MITCHELL, PH.D., AND JONATHAN H. SUNSHINE, PH.D.

Abstract *Background.* Physicians are increasingly the owners of health care facilities to which they refer patients for services but at which they do *not* practice. We studied such ownership arrangements, known as "joint ventures," in the field of radiation therapy, examining their effects on access, use of services, costs, and quality.

Methods. Because 44 percent of free-standing facilities providing radiation therapy in Florida in 1989 were joint ventures, as compared with 7 percent elsewhere (95 percent confidence interval, 3 to 10 percent), we compared data for Florida with comparable data for the remainder of the United States. We also compared radiation-therapy facilities in Florida that were established as joint ventures with those that were *not*. Since most data were derived from entire populations rather than from samples, any differences found were of necessity statistically significant.

Results. No joint-venture facilities providing radiation therapy were located in inner-city neighborhoods or rural areas, but 11 percent of other free-standing facilities and hospital-based facilities were located in such areas. Among free-standing facilities, joint ventures received 39 percent of their revenues from patients with well-paying insurance coverage, as compared with 31 percent for facilities that were not joint ventures ($P<0.01$). The frequency and costs of radiation-therapy treatments at free-standing centers were 40 to 60 percent higher in Florida than in the rest of the United States; there was no below-average use of radiation therapy at hospitals or higher cancer rates that explained the higher rates of use or higher costs in Florida. Radiation physicists at joint-venture facilities (the principal personnel involved in quality control other than physicians) spent 18 percent less time with each patient over the course of treatment than did their counterparts at free-standing facilities that were not joint ventures ($P<0.05$). Mortality among patients with cancer in Florida was not lower than the U.S. average, even though joint ventures are much more common in that state.

Conclusions. Joint ventures in radiation therapy appear to have adverse effects on patients' access to care. They also appear to increase the use of services and costs substantially. Some indicators show that joint ventures cause either no improvement in quality or a decline. Our results add to the evidence indicating that physicians' self-referral generally has negative consequences. We recommend legislation to ban ownership of joint ventures by referring physicians. Such legislation needs to be carefully designed in order to achieve its objectives and forestall new, financially abusive arrangements. (N Engl J Med 1992;327:1497-501.)

UNDER federal law, it is illegal for physicians to receive kickbacks for referrals of Medicare and Medicaid patients. Thirty-six states also have anti-kickback laws of various types that apply to both publicly and privately insured patients. General prohibitions of referrals to facilities in which physicians have a financial interest are uncommon, however.[1,2] Nonetheless, in recent years physicians have come to own nearly every type of health care business to which they make referrals, but at which they do not directly provide services.[3] Some critics argue that such arrangements, known as "joint ventures," have proliferated because they are lucrative investments from which the referring physicians are able to earn disguised kickbacks.[4]

Critics contend that the financial incentives for referring physicians that are created by joint ventures lead to overuse of services, increased costs to consumers, reduced access for the poor, and service of diminished quality.[5-8] Proponents claim that joint ventures may increase access to care for persons in medically underserved areas, may provide needed financing, and may allow physicians to improve the quality of the services provided to their patients.[9,10] Despite intense debate, there is little empirical evidence of the effects of joint ventures involving physicians.

This study uses recent data, principally from Florida, to examine the effects of joint ventures in radiation therapy. Previous research on the effects of physicians' financial interests has concentrated on use of services and costs.[11-15] We examine a broader range of effects, including those on access and (to a more limited extent) quality, in accordance with a recent study conducted by one of us.[16] The examination of data from Florida is particularly appropriate, because a large proportion of the free-standing radiation-therapy centers there are owned by referring physicians. In contrast, joint-venture centers providing radiation therapy were rare elsewhere before 1991. Thus, comparing the situation in Florida with that in other states constitutes something of a natural experiment.

METHODS

All free-standing facilities providing radiation therapy and all acute care general hospitals in Florida were sent questionnaires as part of a comprehensive study of health care facilities commissioned by the Florida legislature.[16] Twenty-three of the 52 free-standing facilities (72 percent) provided information on ownership, staffing, and revenue according to category of payer; facilities that

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did not respond were contacted by telephone for information about their ownership. Over 95 percent of the 238 acute care licensed hospitals returned the surveys, from which we identified 39 hospital-based departments providing radiation therapy.

The free-standing facilities were classified according to ownership status as either joint ventures or non-joint ventures. The term "joint venture" was defined to indicate any ownership or investment interest between a referring physician (or other health care professional making referrals) and a business providing radiation-therapy services. Because radiation oncologists are consultative physicians who receive and treat patients referred by other physicians, radiation-therapy centers owned solely by such specialists are not joint ventures. Joint ventures located outside Florida that provided radiation therapy were identified by tabulating data from the 1989 Group Practice Survey of the American College of Radiology.[17]

Access

We compared joint ventures with other facilities providing radiation-therapy services in Florida in order to evaluate geographic access — that is, whether any facilities were located in inner-city neighborhoods or outside urban areas. In accordance with the practice of Florida's Department of Health and Rehabilitative Services, we defined urban areas to include metropolitan statistical areas (as designated by the U.S. Census Bureau) and counties with a population in excess of 100,000 persons.

We also evaluated economic access by comparing the percentage of revenues derived from well-paying sources with that derived from poorly paying sources. Managed care payers, Blue Cross, and commercial insurers were classified as well-paying sources, because during 1989 these payers reimbursed, on average, about 90 percent of the submitted charges. In contrast, during 1989 Medicaid reimbursements for radiation-therapy services averaged between 5 and 10 percent of the full charges, Medicare reimbursements averaged approximately 70 percent, and patients nominally paying their own bills were typically recipients of charity care. These were classified as poorly paying revenue sources.

Use of Services

Radiation therapy for cancer has become somewhat standardized as a result of the Patterns of Care study.[18-20] Hence, any variations in use associated with joint ventures are likely to result more from different numbers of patients receiving treatment than from changes in the number of services per patient treated. Radiation therapy thus offers an interesting contrast to clinical laboratory services, in which investors who are referring physicians can easily increase the use of services not only by ordering tests for more of their patients, but also by ordering more tests per patient.

We evaluated the effects of joint ventures on the use of services by taking a market-area approach.[21,22] Specifically, we measured the use of radiation-therapy services per Medicare beneficiary in Florida and compared these figures with corresponding data for the rest of the United States. Such ratios of use to population take into account differences both in the percentage of patients receiving treatment and in the number of services provided to each such patient.

An analysis of Medicare data is particularly appropriate in the case of radiation-therapy services because cancer, the disease that is treated by radiation therapy, is very much a disease of the elderly (persons 65 years of age or older). The source of data used to study use of services and costs was the procedure file of Part B Medicare Annual Data for 1989. This file contains data on all physicians' services provided under Medicare, including the number of services, the charges submitted, and the amounts paid according to procedure, locality and state, and place of service (i.e., hospital or nonhospital), and other variables.

Two measures of use were employed: the number of radiation-therapy services per 1000 Medicare enrollees and the number of relative-value units for radiation therapy per 1000 Medicare enrollees. To standardize the count of services, each "weekly treatment management" service (codes 77420 to 77430 of *Current Procedural Terminology*, fourth revision [CPT-4]) was counted as five services, in accordance with Medicare's definition of weekly treatment management.[23] The Medicare relative-value scale for radiation-therapy services was developed by radiation oncologists. A relative-value scale recognizes the amount of work involved in providing each individual service and thus represents a more refined measure of use than a simple count of services.[24] The use of hospital-based facilities, which may serve as a substitute for the use of free-standing centers, was measured in the same two ways.

We also compared both the incidence of cancer and mortality from cancer in the Florida elderly population in 1989 with the corresponding statistics for the entire United States, since these factors could underlie differences in service use. Data on cancer in Florida were obtained from the Florida Department of Health and Rehabilitative Services. National data were obtained from the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute, with the incidence data for 1984 through 1988 extrapolated to 1989,[25] and from the National Center for Health Statistics (for 1989 death rates). With respect to age and sex, the composition of the Florida elderly population was almost identical to that of the overall U.S. elderly population, so no adjustments for age or sex were made to the data on use of services or cancer rates.

Costs

We compared the Medicare Part B data on submitted charges and amounts reimbursed by Medicare (the so-called "allowed charges") for all radiation-therapy procedures rendered in free-standing facilities in Florida with the corresponding figures for the rest of the United States. Free-standing facilities charge a global fee that includes both the physician's "professional component" and the technical or facility component. Submitted charges and payments for radiation-therapy procedures performed in hospitals were not analyzed, because the Medicare Part B file contains only the physician's professional component.

Quality

We evaluated the use of time by radiation physicists, the nonphysician personnel most responsible for quality control. Specifically, we compared joint ventures and non-joint ventures with respect to physicists' hours of work per patient treated in free-standing facilities. We also compared outcomes of cancer in Florida with those in the United States as a whole. The outcome measure was an approximation of the cancer lethality rate, calculated as the number of cancer deaths in 1989 divided by the 1989 incidence rate for cancer. Since outcomes of cancer differ according to age and sex, and this measure may be sensitive to very small differences, we adjusted the U.S. nationwide data to the age- and sex-related mix of Florida's elderly population before computing the U.S. lethality rate. The statistic we used was not a strict case fatality rate. For example, some of the 1989 cancer deaths involved patients who were first given their diagnoses in earlier years. However, since incidence and death rates change slowly, a comparison of our statistic across geographic areas provides a reasonable measure of relative outcomes.

Statistical Analysis

Percentages of revenue derived from high-paying sources and physicists' time spent per patient were compared by two-tailed t-tests. Since the sample of radiation-therapy facilities represented a large percentage of the total number, we applied the usual finite-population correction factor to adjust the standard errors of these variables. The Medicare data represented the entire population, rather than a sample. In such cases, the usual view of statisticians is that tests of significance are not required, because all differences found are real.[26]

Results

During 1989, 14 of the 32 free-standing radiation-therapy facilities in Florida (44 percent) were joint ventures. Tabulations from the 1989 Group Practice Survey of the American College of Radiology show that elsewhere in the United States, 7 percent of such

centers (95 percent confidence interval, 3 to 10 percent) were joint ventures.

Access

None of the joint ventures among the free-standing radiation-therapy centers in Florida were located in a rural county or an inner-city neighborhood. In contrast, 1 of the 18 free-standing centers that were not joint ventures (6 percent) was located in a rural county, and 5 of the 39 hospital-based facilities (13 percent) were situated in inner-city neighborhoods.

With respect to economic access, we found that among free-standing facilities in Florida, the joint ventures generated 39 percent of their revenues from high-paying sources. In comparison, free-standing centers that were not joint ventures derived 31 percent of their revenues from such sources ($P<0.01$).

Use of Services

At free-standing centers, the number of radiation-therapy procedures per 1000 Medicare enrollees was 58 percent higher, and the number of relative-value units for radiation therapy 53 percent higher, in Florida than the average in the rest of the United States (Table 1).

The frequency with which radiation therapy was administered in hospital-based facilities, measured by a count both of procedures and of relative-value units, was slightly higher in Florida than in the rest of the United States (Table 2). The higher volume of services performed in hospitals as compared with free-standing centers, both in Florida and nationally, does not imply that hospitals use more resources to treat patients. Instead, it probably indicates that there are more hospital-based facilities than free-standing centers. The incidence of cancer among the elderly in Florida and the mortality rate from cancer were, respectively, 8 and 6 percent below the national average (Table 3).

Costs

For every 1000 Medicare enrollees, the submitted charges for radiation therapy performed in free-standing centers in Florida exceeded the submitted charges for the rest of the United States by 42 percent ($13,290 vs. $9,572) (Table 1). A similar comparison of the amount actually paid by Medicare (the "allowed charges") shows that in Florida, Medicare payments for radiation therapy provided in free-standing centers exceeded the average payments elsewhere by almost 46 percent ($9,572 per 1000 enrollees in Florida vs. $6,556 nationally).

Quality

Among free-standing facilities, the joint ventures used radiation physicists 18 percent less than facilities that were not joint ventures. They averaged 4.78 hours of physicist time per patient treated, as compared with 5.82 hours for free-standing facilities that were not joint ventures ($P<0.05$). Approximately 54 percent of patients with cancer died of their disease in Florida, as compared with 53 percent nationally (Table 3). Adjustments for age and sex made a difference of approximately 0.1 percent in this measure of lethality.

Table 1. Cost and Frequency of Radiation-Therapy Services Provided in 1989 at Free-Standing Centers, per 1000 Medicare Enrollees.

Measure	No. of Procedures	No. of Relative-Value Units	Charges ($)	
			Submitted	Allowed
Florida	139	1165	13,290	9,572
Rest of U.S.	88	762	9,328	6,556
Excess, Florida over rest of U.S. (%)	58	53	42	46

Discussion

Findings in Florida

Our analysis of Florida shows that free-standing radiation-therapy facilities owned by referring physicians provide less access to poorly served populations than other types of radiation-therapy facilities. Geographically, hospitals provide the most ready access for such populations, because a considerable percentage of hospitals are located in inner-city neighborhoods. Economically, joint ventures "skim the cream," because they generate substantially more of their revenues from patients with good insurance than do free-standing centers that are not joint ventures. The disparity we measured would probably have been even greater if we had data on sources of revenue for

Table 2. Frequency of Radiation-Therapy Services Provided in 1989 at Hospitals, per 1000 Medicare Enrollees.

Measure	No. of Procedures	No. of Relative-Value Units
Florida	186	769
Rest of U.S.	182	678
Excess, Florida over rest of U.S. (%)	2	13

Table 3. Cancer Rates among the Elderly in 1989.

Measure	Florida	Entire United States	Difference (%)
	per 1000 elderly		
Incidence	18.82	20.52	−8
Death rate	10.24	10.85	−6
Synthesized lethality rate*	54.4	52.8	+3

*Equals the death rate divided by the incidence rate. For the United States, the rate shown was derived after standardization of the U.S. population to the composition of the elderly population in Florida with regard to age and sex. Without such standardization, the rate for the United States would be 52.9 percent.

hospital-based facilities, many of which are located in inner cities. "Cream skimming" tends to undermine the financial base of facilities that are more willing to treat poorly insured patients.

Since 44 percent of the free-standing facilities in Florida were joint ventures, as compared with 7 percent elsewhere, joint ventures must be regarded as a likely explanation for the high levels of use and costs characteristic of Florida. Moreover, we investigated the two most obvious alternative explanations: that free-standing centers substitute for hospital-based facilities and that cancer is more common in Florida than elsewhere. Our analyses show that neither of these explanations is valid. Indeed, since the use of hospital-based radiation-therapy services was slightly higher in Florida than elsewhere in the United States and the burden of cancer lower, these factors should lead to lower use and costs at free-standing centers in Florida.

A replication of the analysis of use of services with 1988 data showed that rates of use in Florida were at least as far above the U.S. average in 1988 as in 1989. Therefore, the 1989 findings were not a onetime occurrence. Since use of services and costs at free-standing facilities are about equally elevated in Florida, the increase in use is probably the principal cause of the higher costs.

Other evidence supports the contention that joint ventures are responsible for the increase in service use and costs. Several recent studies have found that when physicians gain financially from the provision of services, as is the case with joint ventures, service use and costs are substantially higher.[1,11-14,16] In one case in Florida, a radiation oncologist in an academic center reported that in an area where approximately 80 patients per day had received radiation therapy, the number increased to approximately 110 after the opening of a free-standing facility owned by some 175 referring physicians.[27] Additional case studies of this sort would help resolve the issue of causality more definitively. Currently, Florida's high rate of use of services and costs could possibly be explained by factors other than joint ventures. For example, physicians in the state may provide more services for all kinds of illnesses, with radiation therapy being only an example of this pattern. Nonetheless, joint ventures are extremely common in Florida in many types of health care services,[3] and this might well account for a generally higher use of services.

Our evidence with regard to quality is quite limited. Traditionally, quality has been conceptualized as consisting of a number of factors related to structure, process, and outcome. We measured only one structure variable (staffing with physicists) and one outcome variable (the percentage of patients with cancer who die of their disease). The structural measure suggests that quality is lower in joint ventures. Our outcome measure was probably not particularly sensitive, because many patients with cancer receive no radi- Still, it is clear that mortality from cancer in Florida has not declined substantially, despite the many joint ventures in the state.

Policy Considerations

At its annual meeting in December 1991, the American Medical Association (AMA) adopted new guidelines on joint ventures, specifying that "physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility."[28] An exception was made for facilities established both because there is a demonstrated need in the community and because alternative financing is not available. The AMA emphasized that a physician's professional obligation is to the well-being of the patient and that the financial interest created by joint ventures results in at least the appearance of a conflict of interest.

Our findings documenting the generally negative consequences of joint ventures in radiation therapy, the similar findings of others on the effect of physicians' financial interests,[1,11-14,16] and the conflict of interest inherent in self-referral by physicians all lead us to conclude that joint ventures involving referring physicians should be made illegal. The AMA's repudiation of its strong stance in June 1992 shows that professional guidelines are a weak reed. The existing federal anti-kickback law is in itself not an adequate remedy, if only because most patients are not covered by Medicare or Medicaid, and therefore the federal law does not apply to them. Banning joint ventures should substantially mitigate the continued escalation of health care costs. Such prohibitions have been recommended by President George Bush as part of his comprehensive program of health care reform.[29] Bans on physicians' joint ventures, covering various types of services, were enacted this year in Illinois, Florida, and New York.

For such laws to be effective, they must include a requirement for the reasonably prompt divestiture or dissolution of existing joint ventures. For example, the federal ban on joint ventures involving clinical laboratories allowed two years for divestiture or dissolution.[8] Provisions that allow "grandfathering" over the long or moderately long term only perpetuate deleterious effects. Also, the laws must effectively prevent new forms of abuse. If joint ventures are clearly outlawed and actively prosecuted, we expect to see attempts to achieve the same inappropriate financial gains through legal stratagems intended to make a facility to which a physician refers patients appear to be part of the physician's own practice.

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not detected by current assays may yet be found in both serum and cryoprecipitates.

The possibility that HCV infection is responsible for many or perhaps most cases of Type II and Type III cryoglobulinemia has therapeutic implications. In the past, treatment with plasmapheresis or plasma exchange plus corticosteroids or cytotoxic drugs was reserved for patients with severe manifestations, such as vascular insufficiency, renal failure, and progressive involvement of the peripheral nerves. Combined treatment was often remarkably effective under these circumstances, but it was less effective in patients with smoldering renal or neurologic involvement or painful episodes of cutaneous vasculitis. The favorable results of treatment of mixed cryoglobulinemia with interferon alfa are encouraging[9]; this drug should be subjected to multicenter controlled therapeutic trials to determine its efficacy in mixed cryoglobulinemia due to HCV infection.

Several viruses have also been implicated in the pathogenesis of Sjögren's syndrome,[10] but there is no rigorous proof of an etiologic role for any of them. The finding of HCV RNA in the serum of three of four patients raises this issue anew. Possibly, HCV will prove to be the etiologic agent of Sjögren's syndrome, or perhaps HCV is merely another virus capable of infecting salivary and lacrimal glands to produce a clinical and histologic picture resembling idiopathic Sjögren's syndrome.

Meticulous adherence to the proper methods of collecting and processing samples is essential to the detection of cryoprecipitable substances in serum. At least 20 ml of blood (large amounts enhance the likelihood of detecting small amounts of cryoprecipitate) should be taken from a fasting patient (lipids may interfere with the test by precipitating in the cold). The blood (not treated with an anticoagulant) is placed in tubes in warm water and transported promptly to the laboratory. Once there, it is allowed to clot at 37°C for 1 hour and then separated in a warm centrifuge; the clear serum supernatant is removed and stored at 4°C for 72 hours. The serum is examined daily for cryoprecipitate. If any is detected, the amount of cryoprecipitate (the cryocrit) is determined, and the carefully washed cryoprecipitate is dissolved by warming. Its constituents are then identified by immunodiffusion. Delay in the transport or refrigeration of the sample before processing will lead to the loss of cryoprecipitable substances in the clot, which is discarded when serum is obtained. Hence, in most instances, blood to be examined for cryoprecipitable substances should not be drawn when the laboratory is closed or about to close.

Finally, in view of the demonstration of HCV RNA in the cryoprecipitate from many patients with Type II and Type III cryoglobulinemia, the term "cryoglobulin" no longer accurately describes the cold-precipitable substances recoverable from serum. The phenomenon is once again in search of a name.

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"SELF-REFERRAL" — WHAT'S AT STAKE?

"SELF-REFERRAL" is the term used to describe a physician's referral of patients to an outside facility in which he or she has a financial interest but no professional responsibility. This practice has become particularly prevalent in certain parts of the country, where for-profit imaging centers, diagnostic laboratories, home health care services, radiotherapy centers, physiotherapy units, and other free-standing facilities have been soliciting investments by physicians who can refer patients to them. Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. The contentious and emotional debate that has been waged over this issue reflects the increasing tension between professional and business values in medicine.[1]

In December 1991, the American Medical Association (AMA) seemed finally to have ended years of ambivalence and uncertainty about self-referral when its House of Delegates approved without dissent a report from the Council on Ethical and Judicial Affairs.[2] Taking a strong stand on the side of professional values, the council advised physicians to avoid self-referral, except when there is a demonstrated need in the community for the facility and alternative financing is not available. The council acknowledged the mounting evidence of excessive costs and rates of use in jointly owned for-profit facilities but emphasized that it was primarily concerned about the integrity of the profession. The following passage from the report expresses its essential message:

At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply business people with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than

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even the most ethical business person. . . . There are some activities involving their patients that physicians should avoid whether or not there is evidence of abuse.[2]

This admirable statement supports a position I have repeatedly advocated for more than a decade[3-6] — one that was also strongly recommended by the Institute of Medicine in its 1986 report on for-profit enterprise in health care.[7]

Coming on the heels of recent similar statements on self-referral by such other major medical organizations as the American College of Physicians, the American College of Surgeons, and the American College of Radiology, the council's report and its endorsement by the AMA's House of Delegates seemed to have settled the debate once and for all. Unfortunately, that did not prove to be the case. Six months later, in June of this year, the House of Delegates reversed its position. By a close margin, the delegates approved a new resolution introduced by the New Jersey delegation that declared self-referral to be ethical as long as the patient is fully informed about the physician's financial interest in the facility. Although the vote could not change the council's report, which remains part of the AMA's code of ethics, this sudden about-face reveals the confusion and the conflicting interests that still prevent many physicians from recognizing their professional obligations.

The justification offered for the new resolution was unconvincing. Proponents argued that the policy recommended by the council would limit the access of many patients to necessary health services. They also claimed that the great majority of self-referring physicians, who do not abuse their patients' trust, were being penalized because of concern over the few who did. One delegate from New Jersey was quoted in the press as saying, "Sanctions should be applied [to "overutilizers"] when appropriate. . . . But must we always punish the innocent along with the guilty?"[8]

These arguments are transparently spurious. As already noted, the council's report allows for self-referral if the facility is clearly needed by the community and could not be built without physician-investors. As for distinguishing between physicians who abuse self-referral and those who do not, there would be no way to do that without prohibitively expensive and intrusive surveillance of the private practices of all physicians who practice self-referral. Besides, the argument that self-referring physicians should be trusted unless they can be proved to have abused that trust misses an essential point about fiduciary responsibility: people in important positions of trust should not put themselves in situations that inevitably raise questions about their motives and priorities, regardless of whether they actually behave in accordance with that trust.

Physicians are trusted to act as medical purchasing agents for their patients. A doctor who thinks there should be no concern about self-referral as long as it is disclosed and the referrals are monitored is analogous to a purchasing agent for a large corporation who discloses to the chief executive officer (CEO) that he has a vested interest in certain vendors with whom he does business, and who thinks that this disclosure, plus careful surveillance of his purchases by management, should assuage the CEO's concerns. Obviously, it would not do so. In fact, the CEO would probably fire the purchasing agent on the spot. Why should physicians want to apply a lower standard of fiduciary responsibility to themselves than is generally accepted in business?

Two articles in this issue of the *Journal* add to the growing body of evidence that self-referral leads to the overuse of services and excessive cost.[9,10] In a study of free-standing radiation-therapy facilities in Florida, where at least 40 percent of all practicing physicians are involved in some kind of self-referral,[11] Mitchell and Sunshine[9] report that none of the joint-venture facilities were located in inner-city neighborhoods or rural areas, thus refuting the suggestion that joint ventures often bring needed services to otherwise underserved communities. These authors also found that self-referral in radiation therapy, as already reported for other services, was associated with increased use and costs.[9] The second study, by Swedlow et al.,[10] reports on self-referral to three different kinds of outside services in California's workers' compensation system. They found that self-referral increased the rate of use and the cost per case of physiotherapy and increased the cost per case of psychiatric evaluation. Even more interesting, they report that the inappropriate use of magnetic resonance imaging was more frequent among the patients cared for by self-referring physicians, although there was no difference in the cost per case. None of this new evidence is particularly surprising, but taken together with the results of earlier studies cited in the council report, it convincingly demonstrates that self-referral adds to the cost of medical care.

No wonder that government has begun to take restrictive action. In September 1991 the U.S. Department of Health and Human Services issued so-called safe-harbor regulations, which allow physicians to refer Medicare and Medicaid patients to facilities in which they have a financial interest only under limited conditions.[12] These regulations are new interpretations of a Medicare and Medicaid anti-kickback statute that has been on the books since 1972, but they may soon become moot as a result of new, more comprehensive laws at the federal and state levels. A law passed by Congress in 1989 that took effect this year bans the referral of Medicare and Medicaid patients to clinical laboratories owned by their physicians. There is discussion about extending the ban to other kinds of facilities, a move favored by the Bush administration as a means of restraining Medicare expenses. The Internal Revenue Service, reversing its previous stance, has announced that not-for-profit hospitals may lose their tax-exempt status if they enter into certain types of financial arrangements with physicians, including those that involve self-referral. The Federal Trade Commission, which had formerly en-

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dorsed self-referral as enhancing competitiveness, now thinks the practice may be anticompetitive because it tends to limit the referring physician's choice to the facility in which he or she has invested, and because it keeps prices up. There has also been much activity at the state level. Florida and New Jersey recently banned most self-referrals, and several other states, including California and New York, are considering similar legislation. Thus, it seems evident that still more legislative restrictions are in the offing.

Those who say that ethics cannot and should not be legislated[13] are right, but for government the issue is clearly economic, not ethical. Voluntary ethical guidelines, although essential for the morale of the profession and for its public image and self-image, cannot establish firm national policy. That requires legislation. Some medical organizations oppose legislation because they fear the indiscriminate banning of referrals to all facilities with which the referring physician has any financial connection — even when the arrangement is in the interest of patients and necessary for good medical practice. This concern is legitimate, but the problem can easily be solved if professional groups work constructively with government to develop laws and regulations that are appropriate. Attempts simply to obstruct corrective legislation are, in my opinion, ill advised. They merely strengthen the public's impression that physicians are more interested in pursuing their own economic interests than in preserving their good name or helping to keep costs down. In any case, as recent history has shown, most efforts to prevent legislative action are likely to fail, leaving a residue of public cynicism and ill will toward organized medicine.

The AMA is worried about the erosion of professionalism in a system of medical care that is becoming increasingly commercialized, and its concern is justified. The reputation of medicine as a trusted profession is at stake, as is the profession's own view of its basic values. The AMA has wisely chosen to make the promulgation and enforcement of ethical standards a major strategic goal. It has sought help from state and local organizations in this task and has asked the Federal Trade Commission to allow physicians more flexibility in self-regulation. These initiatives deserve support, but there is still much more to be done in the profession's struggle against commercialization. In addition to self-referral, the AMA should look closely at the sale of drugs by office-based physicians,[14] deals between physicians and the manufacturers of devices and prostheses, and a wide variety of other kinds of joint ventures between physicians and the facilities in which they treat their patients.[5]

It would be a major victory for professional values if the AMA could once again endorse a simple precept that stood as one of the beacons of its pre-1980s ethical code: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."[15] In today's chaotic medical market, doctors need a few clear guidelines. This is one of the best.

It is hard to predict what our health care system will look like in the year 2000, or what the conditions of medical practice will be. What seems clear, however, is that physicians will have little opportunity to help shape the future if they do not retain their public credibility. That is the real importance of the self-referral debate. If physicians choose to act from self-interest, or even if they merely put themselves in positions that suggest self-interest, they risk damaging their most precious possessions — the trust and respect of their patients and the esteem of the general public.

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The Washington Post

AN INDEPENDENT NEWSPAPER

Doctors' Self-Referral

SHOULD DOCTORS invest in for-profit treatment facilities to which they send their own patients? The practice is known as self-referral, and doctors are deeply divided over it. The American Medical Association is debating it hotly in its current meeting in Nashville. It sets up an obvious conflict of interest, opponents argue, and they cite the statistical studies indicating that patients get more tests and more therapy when their doctors have a direct monetary stake in the labs and clinics doing the work. But, defenders reply, if they disclose their investment to their patients, that takes care of the ethical issue. Competition holds down costs, they add, and why should doctors be denied opportunities open to other businessmen?

That's exactly the point. Do doctors want to be regarded as successful businessmen or as something quite different? Treating a serious illness requires difficult judgments, and most patients would doubtless like to think that their doctors approach those choices as more than commercial decisions.

A patient should not be required to take into account the physicians' concern for the profitability of their investments. The AMA's Council on Ethical and Judicial Affairs had it right a year ago when it concluded that the practice of self-referral should be presumed inconsistent with a doctor's duty to the patient, except in the rare case in which a community would otherwise lack an important service.

That advice set off a great uproar that culminated last June in the AMA's House of Delegates, which declared self-referral to be ethical as long as the patient is informed of the doctor's stake. But that didn't end the matter. This week the delegates are debating it again. They now have an opportunity to reverse their unwise June decision and put the country's largest medical organization in the much stronger moral position that its own council recommended.

This dispute, along with the uneasiness it must inevitably generate among patients, is a useful warning regarding national health care reform. Relying heavily on commercial competition to discipline medical practice and hold down costs is a questionable strategy with unattractive side effects. As this country approaches the process of reorganizing health care and the means of financing it, one prominent concept calls for an emphasis on managed competition. While there is certainly a place for competition in the future health system, it will have to be *tightly* managed indeed, and highly regulated, to prevent precisely the kinds of ethical doubts and ambiguities that arise in self-referral.

AMA Decrees 'Self-Referral' Is Unethical

Decision Not Binding On Group's Physicians

By Dana Priest
Washington Post Staff Writer

NASHVILLE, Dec. 8—The American Medical Association today declared it unethical for a physician to refer patients to medical facilities in which the doctor has a financial interest.

In voting on the controversial practice known as "self-referral," the AMA delegates reversed the position they took last year. At that time, the group revolted against a prior decision by the AMA's Council on Ethical and Judicial Affairs that deemed self-referral unethical except in special circumstances.

But today, a strong majority of the AMA's 436-member House of Delegates at the organization's semiannual meeting voted to support the council. Before the voice vote, many members stated their desire to appear "squeaky clean" before a public that has grown critical of the amount of money doctors make.

Describing the debate over self-referral as "lacerating and divisive," AMA chairman Raymond Scalettar said the House of Delegate's decision today has "sent a message that we will always put the interest of the patient before us."

The decision is not legally binding on the AMA's 300,000 members, but carries significant moral weight.

AMA state and county associations are now instructed to help their members divest themselves of involvement in diagnostic labora-

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Doctors Urged to End Financial Interests In Facilities Where They Refer Patients

AMA, From A1

tories and other facilities in which they have a financial interest but where they do not actually provide medical care for people.

An exception is providing such facilities in underserved areas where there is a need and physicians may be the only ones with the money and inclination to provide them.

Opponents of the council's decision argued that doctors could avoid the appearance of impropriety by disclosing their financial interest to patients they refer to such facilities. They said declaring the situation unethical unfairly tarnishes the entire profession because of the unscrupulous actions of a few.

The AMA says that about 7 percent of the 600,000 physicians in this country own medical facilities to which they refer patients, but others say the number is as high as 10 percent. The ethics policy approved today applies only to physicians who do not actually provide medical services at the doctor-owned facilities but only refer patients there.

In other action today, the delegates voted to prohibit AMA's leadership from negotiating with the incoming Clinton administration over the possibility of price controls on health care.

Summing up an apparently widespread desire for a firm AMA stance against price controls of any kind, Dick Van Eldik, a Florida delegate, said his colleagues "don't want the AMA to negotiate from a position of weakness. They want a line drawn in the sand."

Among other measures considered today, the House of Delegates voted to support AMA's participation in a national health advisory board that Clinton might establish to devise and implement various health reform proposals, "except global budgets, expenditure targets or payment determination."

Price controls are expected to be one of the most hotly contested issues in the coming reform debate over how to bring down escalating health care costs.

> *The AMA's decision on physician self-referral "sent a message that we will always put the interest of the patient before us."*
>
> —AMA chairman Raymond Scalettar

The AMA's position is counter to an announcement last week by the leadership of the largest commercial insurance group, the Health Insurance Assocation of America, suggesting that the physicians' organization support some form of price controls.

The AMA's strategy, according to many physicians here, will be to enter any negotiations with a set of items on which the group will not compromise, rather than opening up all areas for discussion.

The AMA, like other health industry blocs, has been sharply divided over health reform, and leaders here called repeatedly for unity. "We must have a single voice," AMA president John L. C... told the group's House of Delegates on Sunday. "If we don't unify behind a basic policy, it will confuse the public. It will put the whole profession in a difficult position with the new administration."

But the details and tenor of the delegates' votes on health care reform frustrated some members, who said foreclosing debate on certain topics will create the impression that physicians are an obstacle to change.

"Ideas such as a national health care budget is not going to be off the table just because the AMA is opposed to it," said Howard B. Shapiro, public policy director of the American College of Physicians. "It sends the message that the AMA knows what it opposes, but has not yet come up with anything that contains strong cost controls."

The AMA's House of Delegates, a body elected by state medical associations and societies of physician specialists, threw its qualified support behind other proposals Clinton is believed to favor.

The delegates expressed approval of "managed competition," a model favored by Clinton, as long as it does not give unfair advantages to managed care, in which a group of physicians works for a corporate entity that scrutinizes and manages the physicians' care of patients. Many health experts believe that the health plans consumers would purchase in a managed competition system would evolve into "super-HMOs," and that it would be hard for physicians in solo or group practice to compete for patients.

Many doctors here also expressed a desire to change the antitrust laws so that physicians would be allowed to band together to negotiate fees with insurers or with hospitals that ... health ... that consumers will buy.

Exhibit #14

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 14
DATE 2/16/93
BILL NO. SB 347

SB 347--Testimony

My name is Jerome Connolly. I am a physical therapist residing in Billings. I am founder and co-owner of First Physical Therapy which is an independent, physical therapist-owned private business employing 24 people and providing services to a wide variety of clientele a portion of which is injured workers in Red Lodge, Laurel and Billings.

First physical Therapy has a 17 + year history of providing effective, low cost, high quality work injury management services. Moreover, FPT is currently working with companies on early return-to-work (ERTW) programs involving the use of the sportsmedicine model in treatment of injured workers or "industrial athletes." Furthermore, has provided effective work injury prevention services to over 50 companies mostly in Montana but also in six other states. The industries served include mining, oil refining, railroad, energy companies, distributors, trucking, manufacturing, hospitality and several small businesses.

I, personally, have been actively involved over the past 13 months through the Billings area Chamber of Commerce and the Coalition for Work Comp System Improvement (CWCSI) in seeking meaningful changes for Montana's worker's compensation system. Changes that will result in a fair and equitable system for employers, workers and providers. Unfortunately, without substantial changes, I cannot support SB 347.

The collective action the 53rd legislature takes in order to be meaningful reform must produce a healthier climate for businesses while creating a fair and sound system for workers' compensation insurance. One with reasonable benefits and premiums and one that is administered effectively and efficiently. One that is fair to the injured worker, the employer and the health provider involved in the care of these individuals. Unfortunately, heretofore, one cannot say that such is the system that has been in existence.

An effective system must have the following elements:

- An emphasis on early return-to-work;
- Safety incentives and mandates;
- Curbing of abuses;
- Prompt payment of healthcare providers on a reasonable fee schedule.

SB 347 represents some good steps in the right direction and provides the basis for a managed care system that will enable the insurer to limit access to, and expenditures for, health care for injured workers. One of its more progressive features is Section 13 which prohibits physician self-referral.

While SB 347 is a good strong stride in the right direction, there are several areas that need to be strengthened or added in order for this legislation to accomplish the reform intended.

A. To instill an early return-to-work (ERTW) philosophy among the employers as well as workers, the creation of a temporary partial disability classification is necessary. This encourages employers to bring workers back to work before they are 100%. Resistance in this area is one of the most frequently encountered obstacles by health providers. The Coalition for Work Comp System Improvement (CWCSI) recommended this in its deliberations and the proposed language I have submitted to you in an amendments packet.

B. Also from the CWCSI reports, an amendment is needed to create a new section to enable a recognized health care provider to treat an injured worker up to twelve times before referral to a Managed Care Organization (MCO) is required. This change facilitates early intervention that is consistent with the rapid response or what can be termed the "sportsmedicine approach" to treating the injured worker and facilitating early return-to-work.

Our practice is currently working with companies to do just that; setting up rapid response and early intervention protocols to avoid lengthy time-loss conditions. An amendment of this type is a key provision of meaningful reform to allow this type of rapid response to take place. It facilitates care that can prevent a long term disability and instead make it a short term problem.

This would also necessitate a change in Section 1, page 2, line 5 adding "physical therapist".

C. In Section 10 a new subsection is needed that allows an injured worker to elect to receive a health service from a provider of choice ***IF*** the provider is willing to provide the same service as the MCO for an equal or lower cost.

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In addition to those new sections, several clarifying amendments are in order to make this reform meaningful.

1. The definition of maximum healing and medical stability requires clarification. Medical stability and maximum healing are not synonymous terms. Medical stability describes a condition that is controlled, or out of danger; a situation in which the condition is not changing or fluctuating. A patient can be medically stable, for example, when transferred out of intensive care.

Maximum medical healing means being restored to maximum health; freedom from physical disease; reached maximum physical potential; all parts functioning normally.

References: Dorland's and Webster's Medical Dictionaries.

These two terms should be divided as some things are appropriate to be decided following medical stability has been reached but others are not. For example, an evaluation of an injured worker's impairment should be conducted after maximum healing; not after mere stability has been reached. To evaluate after only medically stable would result in findings of considerably more impairment than is necessary and that would be determined after maximum physical potential has been accomplished.

Medical stability can be reached with primary medical treatment; maximum healing usually is not. This is consistent with the definition of primary medical services found in Section 2 (21) page 7.

Clarification of this issue can best be accomplished by deleting in Section 2 (14) (page 5) the term "medical stability" and from line 2 page 6 the term "primary".
A new subsection should then be created defining medical stability as a situation in which the condition is controlled, or the patient is out of danger.

It is appropriate to note that physical therapy can contribute to reaching medical stability especially in early return-to-work (ERTW) programs. To be effective, ERTW must involve early intervention. Using the "sportsmedicine" model, rapid response can stabilize the condition by controlling swelling, resolving the pain/spasm cycle and introducing early mobilization which the medical literature supports as the most effective methodology in treating injury. In order to be effective in this regard, SB 347 must include physical therapy as part of primary care. Please insert "physical therapy" after "nursing" on page 8, line 1, Section 2 (21).

2. It is not appropriate to determine permanent partial disability only after "primary" treatment. Nor is it appropriate or desirable to determine permanent total disability only after "primary" treatment. See pages 5,6,7, Section 2 (14) (18) (19) (21)

3. Physical restoration, physical conditioning, and exercise are integral to, and key components of, attaining maximal healing and are, therefore, part of primary medical services. Please strike these terms from page 8, line 9, Section 2 (25).

4. On page 10, Section 3 (1) (b), lines 22-25 should be deleted. While cost-effectiveness studies would be desirable for any medical service, they are based on outcomes assessment and are among the most sophisticated, costly, time-consuming and difficult to perform of all clinical research. In these type of longitudinal studies it is most important to control or account for multiple variables. This subsection specifically mentions return-to-work. The variables in this regard would include a job that is no longer available or an employer who will not allow a worker to return until s/he is 100%.

This subsection gives the insurer an excuse to deny services in the absence of data that may not be available, may be affected by extenuating circumstances, or the insurer simply may not believe, understand or be willing to accept.

More importantly, this subsection mentions nothing of the injured worker who continues to work.

5. The term "Rehabilitative" should be inserted before "palliative" on page 11, line 19 and page 12, line 3. Section 3 (f) and (g). Injured workers who can be kept working by rehabilitative means are successes for the system. This is also consistent with early return-to-work. (ERTW).

6. The legislative intent is not clear relative to how PPOs are to be established and utilized vis a vis the Managed Care organizations (MCOs).

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7. In Section 10 Managed Care Organizations..."or an entity with a managed care organization" is a term that is not qualified nor defined. Does this allow another insurer (e.g., Blue Cross/Blue Shield) to become "a health care provider to become certified to provide managed care"? The phrase "or an entity with a managed care organization" should be deleted in three places.

8. The criteria for application and certification as a MCO is quite extensive and is likely to be quite bureaucratic and costly. In spite of the extensiveness of criteria stipulated in the bill, the process is still quite ambiguous. For example, "satisfactory evidence of the ability to comply with any financial requirements..." if interpreted to be an annual or periodic audit could be quite prohibitive. Even for smaller entities, audits start at around $10,000 and escalate from there.

These MCO criteria have been lifted from the Oregon law and have little if any applicability in Montana. Managed Care Organizations are not applicable to rural (most of) Montana and exclude single service providers which are lower cost providers.

Furthermore, it is not understood how MCOs in the Billings area might interface with the surrounding rural areas. For example, if an injured worker in Red Lodge sees a primary care physician, will the injured worker be required to drive 120 miles round trip to Billings to receive laboratory, x-ray, physical therapy or other health services from the MCO if the primary care physician orders any of those services?

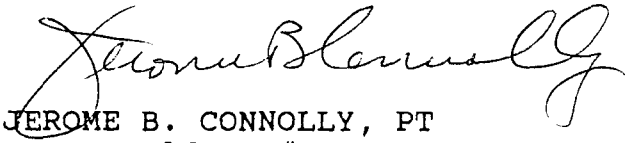
9. Page 24, line 8, Section 11 (3): After "providers", Insert "the employer". The employer is in need of pertinent information relative to status, employability etc., in order to make reasonable accommodation and structure any temporary transitional duty positions or make any return-to-work offers. Since the employer is financially responsible for premiums and modification factors that influence premiums, it is only appropriate that the employer be included in the list of entities to which information should be provided.

10. Another physician in Billings has recently started a "captive" physical therapy practice in his office. Section 13, while a good step, does not preclude this practice of self-referral nor does it allow the insurer to deny payment for services provided in a self-referral situation of this type. Section 13, page 25, line 20, needs amending to cover these kinds of situations.

I have attached a complete list of proposed amendments designed to strengthen SB 347 and make it more equitable. In doing so, these changes continue to pursue the original spirit of the legislation which is to achieve cost-containment, promote early return-to-work and foster fair competition among providers, while maintaining just an element of patient freedom of choice that is consistent with the above.

Please oppose SB 347 as written. I ask you to make the changes as offered in our amendments packet so we all can support this legislation.

Very truly yours,



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Attachments

SENATE LABOR & EMPLOYMENT
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SB 347

Questions

The following is a list of suggested questions that legislators may wish to have answered relative to some of the more specific provisions of SB347 and some of the actual effects of those provisions.

1. In Section 10 Managed Care Organizations...the phrase: "or an entity with a managed care organization" is a term that is not qualified nor defined. Does this allow another insurer (e.g., Blue Cross/Blue Shield) to become "a health care provider to become certified to provide managed care"? I suspect it does.

2. What is meant by primary medical services provider? Is physical therapy included? Page 7, line 21.

3. How is it envisioned that PPOs and MCOs will interface. If a physician is required to either be in an MCO or refer to an MCO what benefit is there for a provider to become a PPO?

4. Extensive criteria are listed for MCOs and statutory authority is given the department to establish more rules to certify MCOs. Yet very little is stipulated relative to PPOs. What certification process, if any, is envisioned?

5. SB347 prohibits an injured worker from going directly to a specialist including orthopedists, rheumatologists, podiatrists, etc. If an injured worker has a back or knee condition for which s/he has seen a specialist, wouldn't it make sense to allow that patient to return to that physician rather than go through the "middle man" and incur additional costs?

6. What in this bill as written provides incentive for the employer to take injured workers back to work?

7. This bill appears to discourage or even prohibit injured workers from obtaining treatment from private sector health care providers. Since **private** practitioners are usually **lower** cost providers and many have dedicated their resources to becoming efficient work injury management providers, why would we want prohibit or discourage the use of their services?

Re: Managed Care

The Oregon Model

What reason does the public have to believe that this managed care system proposed in SB 347 will save money and reduce premium?

Oregon is using almost an identical system. In fact, much of SB 347 was lifted from Oregon law.

On December 17th an Oregon Lobbyist who was instrumental in the Oregon legislative changes, presented at the meeting of MT's Coalition for Work Comp System Improvement (CWCSI) and described problems Oregon is having with managed care.

He stated:

> There is needless duplication between providers and employers;
> No way to serve rural areas;
> It did solve our chiropractor problem;
> Hasn't saved any money;
> Overall, it's been a big disappointment.

He summarized by saying: "I would advise you to look at what Oregon did in regard to managed care and don't do it that way."

On January 15th the head of the critical claims division of the SAIF (the Oregon entity comparable to our SCMIF) testified before the House select subcommittee chaired by Rep Chase Hibbard. She indicated they had no MCOs in rural or eastern Oregon. In fact, they only had two MCOs in the entire state and they were both in heavily urbanized areas. She advised that we not take a law from another state and try to make it work in ours. "You have to find out what works for your situation; each one is unique and characteristically different."

The managed care system proposed in SB 347 doesn't work for Montana. There are too many problems and unanswered questions.

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Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

1. Page 2, line 5, Section 1, after: "optometrist" insert: "licensed physical therapist".

*2. Page 5, line 24, Section 2 (14) strike "medical stability".

*3. Page 6, line 2, Section 2 (14), strike "primary".

*4. Page 6, line 3, Section 2 (14) A new subsection should be created to read: "medical stability means a situation in which the condition is controlled, or the patient is out of danger."

5. Page 8, line 1, Section 2 (21), after: "nursing", insert "physical therapy".

6. Page 8, line 19, Section 2 (25): Strike "physical restoration, physical conditioning, or exercise program".

7. Page 10, lines 22 through 25, Section 3 (1) (b): Strike lines 22-25.

8. Page 11, line 19, Section 3 (f), after "stability", insert "rehabilitative".

Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

9. Page 12, line 2, Section 3 (g), after "that", insert "rehabilitative,".

10. Page 17, line 20, Section 6, insert new subsection (3) and re-number:
"(3) A medical service provider who is not a member of a managed care organization and who is not:
(a) qualified to be an attending physician may provide services to the injured worker for 30 days from the date of injury or for 12 visits, whichever occurs first, without the authorization of an attending physician. thereafter, medical services provided to an injured worker without the written authorization of the insurer in not compensable; or
(b) an attending physician cannot authorize payment of temporary total compensation benefits as provided in 39-71-701. Except as provided in 39-71-711, only the attending physician at the time of medical stability may make findings regarding the worker's impairment for the purpose of evaluating disability pursuant to 39-71-703.
(Reference: CWCSI Report of the Medical Committee adopted 12/17/92)

11. Page 20, line 8, Section 10 (1), strike: "or an entity with a managed care organization".

12. Page 21, line 21, Section 10 (4), strike "or an entity with a managed care organization".

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Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

13. Page 23, line 15, Section 10 (5), strike "or an entity with a managed care organization".

14. Page 20, line 5, Section 9: Insert **New subsection** (2). "(2) Workers who are subject to managed care are allowed to elect to receive a health service ordered by the attending physician, from a provider of choice if the elected provider is willing to provide the same service as the managed care organization at an equal or lower cost."

15. Page 24, line 8, Section 11 (3), after: "providers", insert: "the employer".

16. Page 25, line 20, Section 13, Strike and replace with: "A treating physician may not refer an injured worker to a health care practitioner or a health care facility in which the referring physician has a financial interest, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer is not liable for charges incurred in violation of this section.

17. Page 8, line 22, Section 2, insert **new subsection** (26) and renumber:
(26) "Temporary partial disability" means a condition that results when a worker is medically approved to return to the same, a modified or an alternative employment position that the worker is able and qualified to perform prior to reaching maximum healing, and suffers an actual wage loss as a result of a temporary work restriction.

Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

18. NEW SECTION

(1) If an injured worker is medically approved to return to the same, a modified or an alternative employment position that the worker is able and qualified to perform prior to reaching maximum healing, and suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial compensation.

(2) Weekly compensation benefits for temporary partial disability shall be the difference between the injured worker's hourly wage received at the time of injury, subject to a maximum of forty (40) hours per week, and the actual weekly wages earned during the period for which the claimant is temporarily partially disabled.

(3) Temporary partial disability compensation shall be limited to a total of twenty-six (26) weeks of combined biweekly compensation, or the worker is no longer temporarily partially disabled, whichever occurs first.

(4) The amount of temporary partial disability will be based upon payroll records provided by the employer and calculated on a biweekly basis. The combined wages and compensation benefits shall not exceed the worker's average weekly wage at the time of injury.

(5) Temporary partial disability shall not be considered an element of permanent partial disability, and may not be credited against any permanent impairment, permanent partial disability award, or settlement achieved after the injured worker reaches a point of maximum medical healing.

(Reference: CWCSI Report of the Law Committee adopted 12/17/92)

* ***NOTE***: If Proposed Amendment #5 above is accomplished and "physical therapy" is inserted into primary medical services, (page 8, line 1,), amendments # 2, 3, and 4 are then not necessary.

Exhibit # 15

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February 16, 1993

Sen. Tom Towe, Chair
Senate Labor and Employment Relations Committee
Room 413/415, State Capitol
Helena, MT 59620

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 15
DATE 2/16/93
BILL NO. SB 347

RE: SB 347

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to portions of SB 347, which revises workers compensation law regarding medical benefits. MTLA opposes numerous provisions of SB 347:

1. The bill reflects an underlying assumption that current law guarantees excessive medical benefits to injured workers. That assumption is incorrect. Current law may indeed provide medical benefits to injured workers inefficiently, and MTLA supports efforts to reduce wasteful and duplicative medical services. But instead of repairing problems, SB 347 amputates them with provisions that:

* deny injured workers treatment for pain (i.e., Section 2, page 7, lines 23-25; page 8, lines 15-21; Section 3, page 11, beginning with line 17);
* deny injured workers maintenance care (Section 3, page 11, beginning with line 17);
* deny injured workers domiciliary care (Section 12, pages 24-26); and
* require injured workers to pay for medical treatments (i.e., Section 3, page 14, lines 8-23) without regard to their ability to pay and even when those treatments are ordered by a doctor unilaterally selected by the insurer (i.e., Section 6, pages 17-18).

2. The bill reflects an underlying assumption that workers compensation insurers are trustworthy and deserve virtually unlimited discretion while injured workers and their medical providers use their discretion to exploit the system. For example:

* Section 11 (pages 23-24) authorizes an insurer to terminate any compensation benefits, not just when an injured worker in fact unreasonably refuses to cooperate but also whenever the insurer believes that the worker has unreasonably refused to cooperate.

* Section 12 (pages 24-25) drastically limits the situations in which an insurer must provide domiciliary care and even then requires such care, not from the date when the claimant needs it but from the date when the insurer knows, by a "preponderance of credible medical evidence" and "with a reasonable degree of particularity," that the claimant needs it.

* Section 13 (pages 25-26) declares that insurers are not liable for charges by self-referring medical providers, but it neglects to extend that admittedly reasonable protection to injured workers.

Thank you for considering these comments. If I can provide additional information or assistance, please contact me.

Respectfully,

Russell B. Hill
Executive Director

Exhibit #17

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 16
DATE 2/16/93
BILL NO. SB 347

TESTIMONY
SENATE BILL 347
Submitted by:
The Montana State Pharmaceutical Association
February 16, 1993

It is acknowledged by all that some type of reform in the provision of medical services within the worker's compensation system is needed. While Montana's pharmacists are willing to live with the fee provisions in this bill, which move the structure to "usual and customary" to Average Wholesale Price plus $5.50 for dispensing, we have two large problems with this bill as it is written. They are:

1) The bill has left broad rulemaking authority up to the Department of Labor, and because definitions of "preferred provider" are extremely vague, we could quickly move towards a system of "sole provider." What does this mean to Montana's pharmacists and the pharmacies that provide all Montanans with much needed services? It means that insurers could exclude all but one provider in a given area, and that area may be very large. An example may be that there would be one pharmacy chosen in Billings, to the exclusion of all others, one pharmacy in Libby to the exclusion of others. Another example would be that no rural pharmacies would receive a contract, and that injured workers would have to obtain their pharmaceutical products from a facility located a long ways away from where they live. An absolutely worst case scenario is that insurers would contract with large out-of-state pharmaceutical "warehouses" known as mail order pharmacies, and force the injured worker to get their drugs by mail. Because Section 1 of the bill exempts comp insurers from the Freedom of Choice Act, the problems I have outlined are not just possible, but highly probably. However, we concede that this legislature may have a willingness to exempt workers compensation from the Act, and therefore ask that you adopt amendments to this bill that will rectify potential problems. They are:

a) Section 5, page 16, line 3
Following: "limitations"
Insert: New subsection (1) "Any pharmacy in Montana which agrees to provide such services, products, and prices as designated by the department or the insurer shall be allowed to participate as a preferred provider under the definitions of this legislation. No insurer shall disallow any pharmacy from participating as a preferred provider for any reason whatsoever except that they cannot comply with provisions of preferred provider agreements. In addition, no pharmacy shall be disallowed from participating in any managed care organization.

b) Section 5, page 16
Following: New subsection (1)
Insert: New subsection (2) "An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out of state mail service

pharmacy as defined in Title 37-7-702 without affording the opportunity to obtain the same medications from a pharmacy in this state with no financial penalty to the injured worker."

Renumber: Following subsections

2) In the bill, on page 16, new subsection (5), line 22, pharmacy reimbursement rates have been changed from usual and customary to a fee schedule which is Average Wholesale Price of the product plus a $5.50 dispensing fee. While we are willing to live with the AWP plus a dispensing fee, we believe that to put the fee in statute means that it may stay at that rate for years. We suggest language that will index this fee, so that legislative time will not be wasted with future bills that do nothing but ask for an increase in the fee. We propose the following amendment:

a) Section 5, page 17, line 1

Following: Product

Insert: "The foregoing limitations on dispensing fees shall be multiplied by the inflation factor as defined in 15-30-101 (8) for the year; the resulting figure shall be rounded off to the nearest $.10 increment."

Exhibit #19

BOZEMAN PHYSICAL THERAPY CENTER

300 NORTH WILLSON, SUITE 703G
BOZEMAN, MONTANA 59715

406-587-4501 PHONE
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SERVICES FOR:

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TO: Senate Labor and Employment Relations Committee

FROM: Gary Lusin, MS, ATC, PT

RE: Senate Bill 347

DATE: February 15, 1993

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 17
DATE 2/16/93
BILL NO. SB 347

It is with some reluctance and personal conflict that I must oppose portions of this bill. For the sake of brevity I will comment only on portions that I have concerns or questions on. Over the last four to six years the records will reflect that I, as well as my professional association, have been willing and vocal participants in promoting positive change within the Worker's Compensation System. My intentions continue to be forthright and certainly within the spirit that all of us have to rectify the many problems within the Worker's Compensation System at this time.

SECTION I

I request that the Committee seriously consider including licensed physical therapists under the Freedom of Choice Act. If true Worker's Compensation reform is one of the goals of this legislature the provision for allowing injured workers to see physical therapists directly must be viewed as the initial phase of early return to work. I personally have raised this concept before to the Subcommittee on Early Return to Work, Rehabilitation, and Benefits in the fall of 1992 as well as in discussions with State Fund officials and other Legislators. My experience is that debate on this issue is worthless unless key individuals will seriously listen to our proposal and the benefits it can provide injured workers as well as the Worker's Compensation System.

Nine states currently allow this provision in their Worker's Compensation Law, two of which are Idaho and South Dakota. In this state citizens of Montana have legally been allowed to see a physical therapist without a physician referral since 1987. To my knowledge no complaints or problems have arisen from this provision and it has resulted in savings to insurers and patients.

I am not advocating that injured workers see physical therapists without the medical attention of a physician. I am suggesting that the law appropriately allow physical therapists, as skilled rehabilitation professionals for acute and chronic injuries, to provide early treatment to injured workers when those injuries fall within the scope of physical therapy practice. Rules and guidelines can easily be written to allow injured workers to receive the services of a physical therapist directly, while at the same time scheduling to see their physician, and through the course the initial goals of treatment are to return the injured worker to work as soon as possible and as the injury allows.

I am only requesting that the physical therapists be able to present this concept logically to the Committee or appropriate individuals without the inclusion of outside individuals who have unfounded biases towards this concept. The Legislature, if allowed to decide this issue on their own, may be pleasantly surprised at the benefit licensed physical therapists can provide to the Worker's Compensation System but more importantly to injured workers and their employers.

SECTION 2 (14)

The definitions of "medical stability", "maximum healing", or "maximum medical healing" are vague and may need further definition.

As the physical therapist I see many people who, at least by my understanding of these definitions, are actually medically stable or their injury may be healed, however, their functional status may be the major problem. I am curious if it would be necessary to include the term, along with definition, of functional stability since this may have a relation to language later in the bill under the definitions of permanent partial and permanent total disability with regard to determining the injured worker's physical capability of returning to work.

Many times it is not so much the medical healing that is of question but the functional abilities and deficits a person is left with once the healing has been completed. It may be helpful to have a distinction between maximum medical healing and its relation to maximum functional healing (or a like term).

SECTION 2 (21), (25)

The new language which is included to define "primary medical services" and "secondary medical services" are of considerable concern to me as a physical therapist. It does not state under primary medical services that physical therapy is included although there is historical evidence that we have been included under the medical language in previous laws as well as rules and regulations.

EXHIBIT 17
DATE 2-16-93
SB 347

The items listed under secondary medical services really encompass a large majority of what physical therapy has to offer. Specifically this involves physical restoration, physical conditioning, or exercise programs or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities. Also included is the term work hardening and it is my opinion that perhaps work hardening is appropriately placed in secondary medical services.

However, since so much of the hands on, education, and advise that is involved in rehabilitating an injured worker is covered under language in secondary medical services, I would appreciate clarification as to exactly where physical therapy would fall? Are we to assume we are covered under primary medical services and if so are the exercise programs and physical rehabilitation techniques excluded from primary medical services? If the latter is true what this language does is promote modality based treatment which is simply hot packs, ultrasound, massage, electrical stimulation, and ice which have only a relatively small place in true work injury rehabilitation.

I would appreciate clarification as to where physical therapy as it is currently legally practiced fits in to the definitions of primary medical services versus secondary medical services.

The ramification of these two paragraphs, at least as I read them, can have a profound and significant impact on my physical therapy practice should it be determined that physical therapy is a secondary medical service. My practice currently has approximately 45% of its patient load being injured workers. All of these workers have been referred to us by physicians and I have no control over the types of patients physicians refer to me. Should my services be deemed secondary medical services, and this bill goes through as it is written, it literally puts me, as well as my colleagues, in a situation where insurers could restrict any or all injured workers from being referred to or treated in my practice. I sincerely hope it is not the intent of this legislation to put my business, as well as many other businesses, in jeopardy and that it would be recognized that my practice as well as many other practices are providing an excellent and cost effective service to injured workers and we should be actively sought out to continue that service.

Accurate and valid clarification of this language would be helpful.

SECTION 3 (1), (B)

This language appears to be directly related to work hardening and work conditioning programs or possibly other services that are construed to be very expensive and of long duration. The message behind this language appears very short sighted. While conceptually I agree with this language, in reality this should not be the concern of medical care providers.

What this language is saying is that if an injured worker is injured, and the vast majority of them are legitimally injured, and for some reason they do not have a job to go to then full and appropriate medical treatment is not worth paying for simply because they do not have a job to go to.

This language creates a significant dilemma for injured workers in that it apparently will be determined how much medical care they will receive and to what level of function they will be returned to solely based on whether or not they have a job to return to.

I support some level of demonstration of the cost effectiveness of services in returning an injured worker to an appropriate level of function but whether or not that person actually has a job to return to should not dictate how much medical service he or she is to be provided, nor if the program is effective.

If the intent of this particular section is to limit the use of work hardening and work conditioning programs, then it needs to be done based on other parameters than return to actual employment. This is actually an area where physical therapists can be of significant help in not only clarifying the language but providing objective documentation as to a person's functional ability and limitations and could also identify when the person is at a level of function to return to some form of employment. Once they are ready treatment could be terminated. Judging cost effectiveness of these types of programs solely on the fact that the worker actually return to employment is totally unfair to the effectiveness of these programs. This is much more related to the current job situation in Montana and I would almost guarantee that if jobs were available and individuals had them to return to then the cost effectiveness of these programs could be easily demonstrated.

SECTION 3 (7)

In the defense of injured workers I have seen many workers who were injured on minimum wage jobs and who essentially fall into the classification of the "working poor". Having them pay medical providers, $10.00 each visit, may be a significant burden to many legitimally injured workers and their families. I fully support the concept of having injured workers pay for some of their care but I would ask the Committee to evaluate this particular language to see if it truly is in the best interest of the injured worker and their family. There have been many injured workers who it has taken weeks or months for them to get their wage loss checks or even travel checks from State Fund so they can make appointments and provide basic services to them and their families.

I am assuming it would be the responsibility of the medical service provider to collect this money including taking the patient to court or turning them over to a collection agency in the likely event that

they would not pay for these services. Another option would be that medical service providers would require payment in advance on the day of service to see that money is collected. This may influence compliance with treatment.

SECTION 13

I fully support the concept of this language and commend the Committee for including it. There is significant data regarding physician self referral within physical therapy most recently out of California and Florida. The data is compelling that there is an increased cost when treatment is provided in a physician's office or in a facility in which the physician owns the service. Utilization is the primary variable that is increased.

Several states have enacted legislation to prohibit any type of physician self referral for physical therapy services. The AMA currently finds the practice unethical except when it is in an area that does not have access to other services.

I would encourage the Committee to include in this language that physicians may not refer a claimant to a health care facility, including the physician's office practice, particularly in areas where there are already these services being provided.

CONCLUSION

The sections I did not comment on are generally acceptable to me and I will await further clarification regarding the managed care and preferred provider language as that continues to develop.

I hope some of my questions and concerns can be clarified or addressed and I look forward to those responses.

EXHIBIT 17
DATE 2-16-93
SB 347

Exhibit #18

MISSOULA PHYSICAL THERAPY CENTER

Professional Village, Suite 6
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406-543-4890

RICHARD L. SMITH, M.S., P.T. EDIE G. SMITH, P.T.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 18
DATE 2/16/93
BILL NO. SB 347

SENATE BILL 347
TESTIMONY

My name is Richard Smith. I am here representing the Montana Chapter of American Physical Therapy Task Force on Workers Compensation, and myself as a Physical Therapist and Occupational Health Consultant in independent private practice. I have been a therapist for 17 years and for the past 6 years, I have practiced in Missoula where, along with my wife, we have provided rehabilitation, education, and injury prevention services to hundreds of injured workers and employers. Approximately 50% of our business is Workers Compensation related.

I serve on both Montana and national American Physical Therapy Association Task Forces working to solve Workers Compensation problems that deal with physical therapy. I train therapists around the country and have published papers on progressive work rehabilitation. I tell you this only to show that I have a broad experience working in the system.

I have been told my practice does a good job, that I do a good job, when it comes to providing evaluation and rehabilitation services, which fall under this medical bill SB347. I pride myself in the fact that I am independent of any conflicts of interest; I am not owned by, employed by, or controlled by anyone. I receive no kickbacks. I don't split fees with anyone.

I don't lease my equipment or space from referral sources. I receive my referrals from a wide range of sources and try to promote the highest quality of care, generate the most accurate and object data possible, to facilitate early return to work of injured workers.

This would all change under Senate Bill 347. Injured workers would have limited access to my services. Private practice physical therapists cannot provide primary medical services, other than physical therapy, if physical therapy is even included in the definition. You will say I could contract with a managed care organization. Think about that scenario. I understand that large medical clinics and hospitals are ready to become MCO's. Montana's two largest medical clinics have their own physical therapy clinics. Do you think they are going to use private practice physical therapists?

Whether managed care is mandatory or optional, therapists will be at the mercy of the MCO for referrals. The injured worker has little, if any choice, except to go into the managed care system. I compare it to the difference between shopping at large, big-business shopping malls versus your local, small business shop. Where do you get more personal service? Better service? Does quality matter? I ask you, where would you rather shop? If you were injured, where would you prefer to be rehabilitated? Ask the insurers, doctors, employers and injured workers where the

quality of care and best rehabilitation work is done in this state.

The way to decrease costs and increase quality of care is to increase competition, not form monopolies.

I support parts of this bill. For example, Section 13 addresses referral for profit. This is a step in the right direction, but only a small step. Please strengthen or clarify the language to outlaw all referral for profit situations. Physicians and MCO's should not be allowed to refer to physical therapy clinics in which they have a financial investment. The Mercer Work Comp study showed self-referral in California generated $223 million in physical therapy services delivered for economic rather than clinical reasons. (Copy of study attached) If you need stronger language or research documentation of the excessive costs associated with referral for profit, please contact me.

I welcome peer review, utilization review and treatment standards as described in Section 10, Subsection 4c. But I will see workers only when they are referred by the MCO, according to Subsection 4f. I suspect the MCO will use my services as a last resort, if at all. For the first time, I would be forced to align myself, "choose sides", if you will, with specific and limited referral sources. I will be forced to work for the MCO.

EXHIBIT 18
DATE 2-16-93
SB 347

If the purpose of SB 347 is to contain costs, then consider the following: Strong utilization guidelines (pomolgated by Dept of Labor and Industry) may be all we need to add to the current system to deny compensation for unreasonable and unnecessary medical services.

I understand the crisis we face very well. The goal in this bill seems to be to allow the insurer to control the management of claims using a narrow and limited doctor-based MCO.

Theoretically, managed care can work in Montana. But will it? It has not been tried in rural areas. A month ago, here in Helena, we heard from 3 national experts, Gary Anderberg from Conservco, Michelle Graham, from the SAIF Corp., and Brian Rassmussen, from the APTA. All three of them urged caution and flexibility to pick and choose. Perhaps a two year prospective trial of managed care is in order. Prospective studies are controlled research studies to answer specific questions - - in this case, is a managed care system more or less effective than what we currently have?

This bill restricts access to critically needed Independent Physical Therapy and Rehabilitation Services. I support aggressive case management, early intervention, and early return to work. Physical therapists want to be part of the solution to the current crisis, and I believe we can be effective in helping,

if given the opportunity.

Thank you for the opportunity to provide my input.

Respectively submitted,

Richard L. Smith, MS, PT

SUGGESTED LANGUAGE CHANGES

I support Definition 13, "Maintenance Care", but this language can be stronger. I suggest that if treatment is not rehabilitative, and if there is no documentation of improvement, then treatment can be considered maintenance.

Under Section 3, Subsection 2, establishing a fee schedule for hospitals is financially responsible. However, this language is unclear whether the hospital fee schedule will be the same or different from the non-hospital service fee schedule.

I recommend omitting Definition 21, "primary medical services", and Definition 25, "secondary medical services." These definitions discourage, if not preclude the claimant from receiving physical therapy rehabilitation services. Moreover, the definitions are unnecessary overkill because the Department

of Labor and Industry is promogating service rules that will specifically regulate utilization of physical medicine and rehabilitation services. These two terms are used in other sections, such as 3a and 3b where the vagueness of "for those periods as the nature of the injury or the process of recovery requires" and "clear demonstration of cost effectiveness" is very subjective. In the place of these definitions, I recommend language strengthening Section 3, Subsections 3f and 3g, that maintenance care if not compensable. Furthermore, I would recommend under 3g, that matters related to physical therapy be reviewed by physical therapists instead of physicians.

Under Section 3, Subsection 7, the $10 co-payment will not work. The client will simply refuse to pay and walk out.

RLS:slb R:Bill 347.ltr

Exhibit # 19

MONTANA CHAPTER
OF THE
AMERICAN PHYSICAL THERAPY ASSOCIATION

February 14, 1993

To: Senator Tom Towe and Members of the Senate Committee on Labor and Employment Relations

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 19
DATE 2/16/93
BILL NO. SB 347

Re: Senate Bill 347

Dear Senator Towe and Members of the Committee,

I am contacting you regarding this bill due to my grave concern with several sections. Please to not construe from this that I am opposed to cost containment and that I do not think that there are several sections of this bill which I favor.

The most serious of these sections are Section 6 and 8. These two sections will put my clinic out of business along with the other private practice physical therapists in this state. Literally this will put hundreds of people out of work. These will be higher paying jobs which will be forced to leave the state that presently has a shortage of Physical therapists. There is no provision which will allow referral to the private physical therapy provider and it will be impossible for us to join a managed care organization (MCO) as the organizations which can now qualify by being able to provide "all primary medical services" have in their employ physical therapists. Mind you that many private practicing therapists have taken specialized training in treating the injured worker and now provide these services for a less expensive cost that the organizations that may qualify. Therefore you are eliminating the most effective and efficient providers from the system. For clarity sake I have outlined the sections with comments below.

Section 1. Physical Therapists should be included in this section along with the other providers.

Section 2.(14) Medical stability does not mean the same thing as maximum healing. A person could be just out of intensive care and be medically stable but not maximally healed.

Section 2 (21) This must include all physical therapy functions many of which are shifted into Secondary Medical services such as exercise programs, work hardening, physical restoration, and physical conditioning. These activities are critical to restoration of function as well as early return to work.

Section 2 (25) The items of work hardening, physical restoration, physical conditioning, or exercise programs needs to be included in section 2 (21). This includes many of the higher level programs for treatment of the injured worker. To have this out encourages the use of modality based treatments to be done in Primary medical services.

Section 3 (a) What is or will be the definition of "reasonable" primary medical services?

Section 3 (1)(b) There is no mention of maintaining a workers abilities for their employment to keep them on the job in this section, only returning to actual employment is included.

Section 3 (2) This is an excellent section needed for a long time. We have been trying to assist the State Fund and the Department of Labor in setting utilization guidelines for several years.

Section 3 (7)(c) excludes chiropractors who are not treating physicians and does not include all other providers such as ot's. I have had patients who could not have afforded to come in after a work injury if they would have had to pay $10 per visit.

Section 6 This section as I read it would mandate that a worker could choose his physician but if that physician wished to refer to any other medical provider the referral must go to the managed care organization and it also indicates that the insurer has the right to switch the worker to the MCO. Later in the rules in section 10 it indicates that to be an MCO one must have a treating physician, and provide primary and secondary medical services. This would eliminate private pt's from applying and therefore eliminate them unless they could join a MCO but this is highly unlikely or impossible as the MCO's will be hospitals and larger medical clinics who have their own pt departments.

Section 8 Without knowing the criteria now we do not know what a managed care organization will be or become.

Section 10 This section eliminates a private pt unless they have a physician with them who can be a treating physician and only if they can provide all the necessary primary and secondary medical services. No private pt's meet this criteria in this state. This would put many who have even a moderate workers comp. case load OUT OF BUSINESS taking them off the tax rolls and loosing many jobs in the state.

Section (10)(d) pays lip service to early return to work but does not put the emphasis where it belongs and does not provide incentives for employers to get injured workers back early.

Section (10)(f) specifies that a physician who is not in the MCO must refer to the MCO if specialized treatment is needed and then singles out physical therapy. Many of the private practice pt's are specialists in treating the injured workers and provide that service now cheaper than other treating facilities. This looks like a reduction in access to cost effective and the highest quality providers and will require injured workers out of the largest cities to travel to the MCO's which are going to be available only in larger areas. To my knowledge this has not worked in any other rural state. In addition, travel for many injuries has a dramatically negative effect on healing.

Section 13 This is basically a good section but needs to be tightened to eliminate referral by physicians who employ a physical therapist in their office.

COMMENTS IN GENERAL

We have heard from two individuals within the workers compensation system in Oregon from which similar language exists and both have cautioned against MCO in rural settings. They indicate they have used them only in their largest metropolitan areas which are much larger than our largest two cities combined. They simply do not serve the injured workers in rural areas of this state.

With constructive changes to these sections the physical therapists in the state could perhaps support this legislation following review of the changes. We would be more than willing to help with this task in any way. Please do not hesitate to contact me if we can help.

Sincerely,

Lorin R. Wright

Lorin R. Wright, PT
P.O. Box 341
Red Lodge, Mt. 59068
446-1112

EXHIBIT 19
DATE 2-16-93
SB 347

Exhibit #20

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SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 20
DATE 2/16/93
BILL NO. SB 347

Ann Lawson PT
Clinical Director
Don Bestwick PT, ATC
Laura Wyman PT
Kenny Klundt MT
Anita Lavin PT

NORTHERN ROCKIES
THERAPY CENTER, INC.

February 16, 1993

Sen. Tom Towe Labor & Empl. Relations
Chr. Comm. on ~~Business and Industry~~
Capital Building
Helena, MT 59460

Sen. Towe and Committeemembers:

I am writing in opposition to Senate Bill 347 as it is currently written. Having spent considerable time reviewing this bill, I find that it has several areas that need clarification and refinement. In addition, I wish to be perfectly clear that I strongly agree that Montana Worker's Compensation systems needs drastic reform.

I will make specific reference to several areas of this bill that I feel need alteration:
In **Section 2 paragraph 25** which is headed **"Secondary medical services"**: there is a grouping of both active and passive "services" that clearly do not belong in the same classification. For example, the physical conditioning or exercise that is medically necessary to improve a worker's tolerance enable him/her to return to work, is drastically different than "equipment", or a "hot tub". Following general healing of an injured tissue, conditioning/strengthening exercises are in most cases very necessary to avoid re-injury to that same body part. I strongly protest the inclusion of these items as though they are similar.

In **Section 3 paragraph 1b**, the "insurer shall furnish secondary medical services only upon..." speaks about **clear demonstration of cost-effectiveness of the services**. I feel that the intent of this paragraph is good, but I question how it will be reinforced efficiently. I also question how retroactive denial to pay for services already provided, or determining "cost-effectiveness" of treatment in advance of approval can occur! This certainly may create a negative incentive to provide immediate needed followup care to an injured worker when the question of whether it will be reimbursed remains in clear question until the course of treatment is over.

In **Section 3 paragraph 1g** the procedure outlined here could take 3-4 weeks with the present system of staff and efficiency demonstrated at WC. There is well-documented evidence that the earlier an injured worker can be returned to his workplace, a drastic reduction occurs in the likelihood that he will remain "disabled" and out of the workforce. Paragraph 1g, clearly disallows the chance for timely, immediate care of an acutely injured worker. That same worker could beback on the job productively by the time the WC "procedure" as indicated could give approval to begin treatment. Telephone calls, and response from the WC offices is currently quite slow, much slower than private insurers. This added "burden" to an already overloaded system, certainly can't create better services for the injured worker. I suggest that there be a special category for "traumatic, spinal or musculoskeletal" injuries that could be expedited through the procedure of paragraph 1g in order to avoid delay of unnecessary wait time.

In **Section 3 paragraph 7a**, I agree with the worker's obligation to provide a co-payment for services in general. However when a worker is completing their conditioning process, they may be seen 3-5 times per week for a 3-6 week period, depending on their specific needs. The cost of co-pay for such an intense

treatment schedule would be burdensome and not possible for most injured workers. I therefore propose that a "special consideration" section be added to cover a reduced co-pay amount for such circumstances.

Section 11 in its entirety is much needed, long overdue and a welcome addition to the WC laws! I offer no suggestions for change here. I also heartily endorse an end to over-utilization of Physical Therapy services as covered in **Section 13.** I feel that this area alone will cut the cost of WC rehabilitation considerably.

In completion, as an owner of a multi-therapist Physical Therapy clinic in Kalispell, I wish to comment on the impact SB 347 will have on my business. **There is a strong possibility that this bill, as written, will put me out of business.** Care of injured workers represents approximately 60% of my caseload. The impact of this bill as written would have devastating consequences to the ability for us to operate. I implore you as a committee to recognize the excessively stringent measures directed toward Physical Therapy services as a "highlighted" target. I resent this. Workers Compensation is not in the fiscal crisis that it is from just Physical Therapy overutilization.

I challenge you to recognize the professional judgement of licensed, qualified medical professionals in determining what care is appropriate for our worker's and force good documentation of those services. I am deeply dissatisfied with the concept that an insurance claims adjustor is in some way more competent to determine a Physical Therapy plan of care than the professional themself. This is not likely to decrease our disabled workforce, is not proactive, and does not advocate for our injured worker as we should feel charged to do.

Thank you for your consideration of my above comments. I greatly appreciate the hard-working efforts that went into creation of this bill. However, it clearly needs refinement.

Sincerely yours,

Ann L. Lawson PT

SENATE LABOR & EMPLOYMENT
EXHIBIT NO 22
DATE 2/16/93
BILL NO SB 347

NAME Terry L. Jackson MD

ADDRESS 69 Sun River Road Great Falls MT.

HOME PHONE 454-3833 WORK PHONE 771-7557

REPRESENTING Self

APPEARING ON WHICH PROPOSAL? SB 347

DO YOU: SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F11

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 21
DATE 2/16/93
BILL NO. SB 347

FEB 16 '93 11:10AM BEUT P.1

To Tom Towe
Chairman Senate Labor

From Russ Logan Billings Chamber Chair
Workers Compensation committee

Senate Bill 347 (Sen John Harp)

Senate Bill 347 is an accumulation of efforts of many people including the Billings Chamber of Commerce and the Coalition for Work Comp System Improvement

Some of the components of the bill are definitely controversial however if we are going to have improvement we must have change.

The changes in this bill are good for work comp cost Reduction and abuse.

I encourage you to see through the special interests that seek to defeat this bill and make the commitment to future generations of Montanans that we are responsible stewards of Montana's financial affairs

* Please give this bill a favorable recommendation as written.

Pardis Chiropractic Clinic

"Discover Our Gentle Effective Care"

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 23
DATE 2/16/93
BILL NO. SB 347

February 13, 1993

Senator Tom Towe
Capitol Station
Helena, MT 59620

Dear Senator:

My family has been working to provide chiropractic services to people from Montana for over 40 years. Please help us amend senate bill #347 so that injured workers are not denied this safe and effective care.

Sincerely,

James H. Pardis, D.C.

JHP/sw

Dr. James H. Pardis • Director-Owner • 826 10th Ave. S. • Great Falls, MT 59405 • Phone (406) 727-9100

M—M Enterprises
1054 GRANT DRIVE
SUN PRAIRIE VILLAGE
GREAT FALLS, MONTANA 59401
PHONE 965-2280

MELVIN M. MART

KATHLEEN M. MART

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 24
DATE 2/16/93
BILL NO. SB 347

Dear Senators:

I understand the law makers of Montana want to introduce legislation to cut off the use of chiropractic care from the Workers Compensation — this will mean the injured worker in Montana can no longer see a Chiropractor for their injuries the Workers Compensation is in trouble - But cutting off our care will not help the injured worker — Only make it worse.

The injured workers of Montana need more than they are getting they need helps from Chiropractors, Doctors, Surgeris and most of all from our Elected Officials —

Thank You

Melvin M. Mart

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 25
DATE 2/16/93
BILL NO. SB 347

Feb 16, 1993

Dear Senators

I am writing to you today in reguards to Workmans Comp. and the decision to possibly bar Certain doctors from Workmans Comp payments especially Chiropractors.

In light of this new issue I feel it necessary to voice my thought on the matter. I currently suffer from a back injury. I have been to several Medical doctors. Some do not know what to do for my back. aside from perscribing drugs and more drugs and pain killers (which in turn play havoc with my ulcers). I submitted my self to there treatments but to no avail.

The other half of the of the Medical Profession, and I should emphasize all these are orthopedic doctors (experts in their field).

recommend an expensive surgery with no guarantees that it would help.

While you are off work recuperating. this in turn takes a long recovery time.

Need I say more - this is all very costly and unnecessary for Workmans Comp.

I have found that the Chiropractor I have been going to has helped me the most.

I go for treatments and follow it up with exercise and diet. for the first time since seeing [redacted] a medical [redacted] Doctor's. I feel as though my back is getting stronger and I'm making real progress thanks to the Chiropractors and at the fraction of the cost. Perhaps it is the Medical - Doctors procedures that should be scrutinized in stead of the Chiropractors Please Consider my Case when you're making decisions. there are so many more in My situation. thank you for your time and Consideration

Sincerely Edward J Wright

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 26
DATE 2/16/93
BILL NO. SB 347

TO WHOM IT MAY CONCERN:

I am writing this letter in regards to Worker's Comp allowing a patient to seek alternative care verses medical care. When my case with Worker's Comp was settled, I was cut off from chiropractic care. The settlement will, however, allow me to continue to see a medical doctor and will pay for any treatment he feels is necessary. His recommendation was for physical therapy and nonsteroidal drugs.

Now I will be the first to admit that I had my doubts about chiropractic care. When it came to either being doped up to relieve pain or chiropractic care, I chose chiropractic care and have not regretted my choice. I have known to many people who have become addicted to prescription drugs. I did not even want to consider this possibility.

I checked into the costs of physical therapy and non-steroidal drugs. The **average** price of physical therapy is $60 to $70 per session. One injection of a nonsteroidal drug is $75. My chiropractic care was $52 per week. I do not see how Worker's Comp, with the financial trouble it is in, can afford to stop people from seeking alternative care. It makes absolutely no sense to pay a medical doctor two to three times the amount when I can get relief from my chiro-practor.

My working hours are from 8:30 a.m. to 5:30 p.m. The hours that physical therapy is available to patients are from 8:30 a.m. to 5:00 p.m. In order for me to go, I would have to take time off from work. This would put my job in jeopardy. I thought the whole purpose of Worker's Comp was to get people back to work and not to cause them to lose their jobs.

These are just some of my concerns about Worker's Comp. I have many more but that would take many more pages. I am now paying for my chiropractic care out of my own pocket. As far as I am concerned, if you do not allow alternative care for Worker's Comp, you are punishing patients for trying to get the help they think is the best and most cost effective for them.

Sincerely,

Penny C. Stevens

DATE 2/16/93

SENATE COMMITTEE ON Labor

BILLS BEING HEARD TODAY: ~~SB~~ 274, ~~SB~~ 347

page 1 of 3

Name	Representing	Bill No.	Check One Support	Oppose
Dr Wayne E. Jacobsmeyer	Chiropractors	347		X
Dr. L. Jon Perkins	Chiropractor	347		X
Dr K. Vande Tempelde	Chiropractor	347		X
VERONICA BROWN	St. Council HERE	274		X
BARBARA DOWNING	HERE LOCAL 56	274		X
M.N. Pardis	Chiropractor	347		X
Dr Bob Larson	Chiropractic	347		X
CHARLES BROWN	CHIROPRACTIC	347		X
ADOLF D. HOKLIN	CHIROPRACTIC	347		✓
Don Hecht	Chiropractic	347		
Don Judge	MT STATE AFL-CIO	SB 347 SB 274		X
Beth McCaull	HERE	274		X
Heather VanDyke	Here	274		X
Fabrice Abel	Here	274		X
Dr. Jim Pardis	Chiropractic	347		X
DR. MARK HERTENSTEIN	CHIROPRACTIC	347		X
DR GARY E. JIMMERSON	CHIROPRACTIC	347		X
John Hoing	~~VISITOR REGISTER~~	274		

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

DATE 2/16/93

SENATE COMMITTEE ON Labor

BILLS BEING HEARD TODAY: SB 274, SB 347

Name	Representing	Bill No.	Check One: Support	Oppose
Cindy Polinsky	Local 1427	274		✓
[illegible]	[illegible]	347	✓	
John A. Guy	St. Peter's Comm. Hospital	347	✓	
[illegible]		347		✓
James Tutwiler	MT Chamber	347	✓	
Robert Johnson	NFIB	347	X	
Jacqueline Lenmark	AIA	347	w/amdts	
[illegible]	Deaconess Med Ctr	347	✓	
[illegible]	CWCSI	347	X	
George Wood	Mt Self Insurers Assn.	347	✓	
Bruce Reed	Gov. Office	347	✓	
Roger Tippy	MT St Pharmaceutical Assn	347		Amd
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	347	✓	
Mary McCue	MT Association of Acupuncture & Oriental Med	347		✓
Leon Stalcup	MT Rest. Assoc	274	✓	
Greg Gould	Pharmacy			✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

DATE 2-16-93

SENATE COMMITTEE ON Labor

BILLS BEING HEARD TODAY: SB 274 SB 347

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Name	Representing	Bill No.	Check One Support	Oppose
Jackey Fascinde	HERE	274		X
Dr Pamela A Blanchard	Chiropractic	347		X
Robert Olsen	MT Hospital Assoc	347	✓	
Terry Mitts	WORK COMP COALITION	347	✓	
Harley Thompson	MBIA + CWCSI	347	✓	
Dr Richard R Hecht	Chiropractic	347		
Dr Gregory A Hall	Chiropractic	347		
Dr John Francis	Chiropractic	347		
Melissa Case	Hotel Employees & Restaurant	274		X
Richard Smith	Physical Therapy Assoc	347		
Charles E. Brooks	MT Retail Assoc	347	✓	
Lorin Wright	phys. Ther. Assn.	347		✓
[illegible]	Phy Therapy Assc	347		✓
[illegible]	Teamsters	274		✓
[illegible]	MT Chapter American Phys. Therapy Assoc	347		✓
Gail Wheatley	Phys. Therapy Assoc	347		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

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