Three-Member Panel Biennial Report

2011 Edition

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Chapter 1
Introduction and Background

The Florida Legislature enacted Senate Bill 108 in 2002, including an explicit charge in section 440.13(12)(e), Florida Statutes, that the Three-Member Panel (hereinafter referred to as the "3MP" or the "Panel") assess the adequacy of medical reimbursement, access to care, and other aspects of the health care delivery system in the Florida Workers' Compensation program. The Panel is comprised of Florida's Chief Financial Officer (CFO) or the CFO's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate. At present, the two appointed Panel members are Jorge Durand (Employee Representative) and Terry Morrow (Employer Representative) while Insurance Commissioner, Kevin McCarty sits on the Panel as the CFO's designee.

In accordance with its statutory mandate, the 3MP issued its initial Biennial Report in January 2003 and it has issued succeeding reports biennially to the President of the Senate and the Speaker of the House of Representatives on methods for improving Florida's workers' compensation health care delivery system.

The Panel's initial report foreshadowed many of the medically related reforms enacted during the 2003 legislative session; these reforms were contained in Senate Bill 50A (SB 50A). To further improve the health care delivery system, the 3MP made the following recommendation to the Legislature in January 2005:

- Support and Clarify the SB 50A reform initiatives[1];
- Transfer the Agency for Health Care Administration's (Agency), Workers' Compensation Medical Services Unit (now referred to as the Office of Medical Services) to the Department of Financial Services, Division of Workers' Compensation (DFS-DWC);
- Grant the Division of Workers' Compensation (Division) statutory authority to enforce healthcare provider compliance, including the form DFS-F5-DWC-25 (DWC-25) requirement; and,
- Provide an alternate dispute resolution system to manage medical disputes.

The 2005 Biennial Report primarily discussed the inefficiencies in the administration of the medical services program. The cause for the then existing administrative inefficiencies were stated to be "structural in nature, while other causes were couched as being a matter of divergent priorities and management issues" resulting from two different agencies sharing responsibility for one program. As a result of the Panel's

[1] Workers' compensation reforms under SB 50A include (1) revisions to the medical fee schedule, (2) increased limits on chiropractic services, (3) redefined eligibility standards for permanent total disability (PTD) benefits, (4) revisions to permanent partial disability (PPD) benefit amounts, (5) limitation on the number of independent medical examinations (IMEs) allowed, and (6) reduced amounts of plaintiff attorney fees.

recommendation, the Agency for Health Care Administration's Workers' Compensation Medical Services Unit was transferred, by means of an interagency agreement, to the DFS-DWC in November 2005.

The Panel's 2007 Biennial Report (its most comprehensive to date) carried forward the discussion of the difficulties in the administration of the medical services program under the tenuous auspices of the interagency agreement. On July 1, 2008, Florida's Legislature officially transferred the Medical Services Unit to the DFS-DWC, fulfilling the Panel's standing recommendation since its 2005 Biennial Report. The 2009 Biennial Report generally reaffirmed several of the Panel's earlier recommendations and proposed a wait and see posture to future comprehensive reform initiatives.

The 2011 Biennial Report presents four primary topics. The topics, which set the foundation for the *conclusions and recommendations* that comprise the last chapter of this report, are Electronic Medical Billing (E-billing); Prescription Medications, Physician Dispensing, and Drug Repackaging; Practice Parameters and Protocols of Treatment; and, the Florida Uniform Permanent Impairment Rating Schedule. The ensuing discussion on these topics is not intended to be exhaustive. However, it is intended that the material will provide sufficient information to update the Legislature on each topic within the context of this, 2011 Biennial Report.

In addition to the four topics listed above, the penultimate chapter of this Biennial Report provides a brief look at some of the provisions contained in the substantial and sweeping health care reform legislation enacted at the federal level. Some reform initiatives raise interesting questions about the potential impact the reform legislation might have on state workers' compensation systems generally, and on Florida's workers' compensation system specifically. A portion of this text will posit how the provisions might impact Florida's workers' compensation system.

Chapter 2
Electronic Medical Billing (E-billing)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) laid the groundwork for much needed efficiency in medical billing and payments for a broad spectrum of health insurance. The HIPAA administrative rules included a mandate that all payers use a common electronic bill and acknowledgement. It also standardized codes to describe medical bills and required provider identification numbers. It should be noted that electronic billing entails more than the submission of the medical bill. It entails all communication between a health care provider and an insurer necessary to adjudicate a medical bill. In this context, electronic communication includes, but is not limited to, the electronic transmission of medical records, treatment plans, functional restrictions and limitations, dates of maximum medical improvement, and permanent impairment ratings.

Today, more than $200 billion is being spent on health care administration and over half of this total is associated with payment processes.[2] Physicians, hospitals and health plans

[2] This is according to the National Health Expenditure data compiled by the Centers for Medicare and Medicaid Services.

expend these costs as they carry out their respective roles in the multifarious process of coding, submitting, receiving, paying and posting medical claims, checking patient eligibility and resolving denials.

While the HIPAA mandates for electronic transactions are not binding on state workers' compensation programs, Texas, in 2008, moved forward with an electronic medical billing system designed to free its workers' compensation program from paper and to take advantage of efficiencies that accumulate to the benefit of general health insurance. While Texas was blazing a trail, California, Minnesota[3], and Oregon also implemented medical e-billing initiatives. With the perpetual goal of reducing system expenses (to include medical costs) an increasing number of workers' compensation administrative agencies are exploring the efficiencies that can be gained by more fully utilizing electronic medical billing.

As part of its 2007 Biennial Report, the Panel recommended that, "[t]he Division [of Workers' Compensation] should evaluate and analyze the results from Texas and California regarding the outcomes of their respective mandates, and determine what, if any, benefits such a mandate would have on the Florida workers' compensation system.[4]

In Texas, providers and payers have been required to have the capability to receive medical bills electronically and to remit electronic payment advisements since January 1, 2008. However, to alleviate initial compliance burdens, providers and payers have been allowed to receive e-billing waivers and to utilize various e-billing "clearinghouses" or vendors. To drive better system compliance, the Texas Division of Workers' Compensation (TDWC) recently published proposed changes to existing e-billing rule requirements that will:

- Replace "must be capable**"** (of receiving and remitting) language, with "shall submit and shall remit**"** language, thereby making e-billing the exclusive format.[5]
- Revise required formats for e-billing, in anticipation of HIPAA-related changes to ANSI/ASC 837 and NCPDP (National Council for Prescription Drug Programs) formats.
- Require providers and payers to show good cause for perpetual e-billing waivers.
- Prohibit carriers from charging health-care providers to use closed, proprietary, or "clearinghouse" e-billing systems.

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[3] The Minnesota Department of Public Health mandated e-bill transmittal as of July 15, 2009 and remittance as of December 15, 2009. The regulations cover bills for almost all health transactions including workers compensation and auto. According to Lisa Wichterman, Medical Policy Specialist with the Workers' Compensation Division of Minnesota's Department of Labor and Industry, health care providers and payers both think they are set-up and ready to send and receive electronic bills but the clearinghouses won't transmit the data to each other for various reasons. Additional challenges that have been identified include electronic attachment of medical records and some healthcare providers still clinging to paper bills.

[4] See "Three Member Panel Biennial Report, 2007 Edition", page 14.

[5] According to Allen McDonald, of the Texas Division of Workers' Compensation, providers who treat less than 32 injured workers per year will still be able to bill on paper claims. According to their analysis, 80 percent of all treatment is rendered by providers who treat 32 or more injured workers per year.

The outcomes in Texas, for the most part, have been very positive from providers and payers who have adopted e-billing. They report of fewer errors, improved payment cycles, fewer resubmissions due to incomplete bills or missing attachments, and fewer disputes. However, the feedback from both stakeholders has reportedly been a desire to be able to utilize e-billing across the board, to the broadest possible extent. It has been reported that one of the largest payers in Texas (Texas Mutual Insurance Company) has observed a 33% reduction in the time necessary to accomplish reimbursement, with significant positive impacts to resubmissions[6].

In terms of regulatory compliance, the numbers in Texas vary between payers, from around 1% to approximately 20-30%. There are a few carriers that may in fact report higher numbers (one payer is reportedly above 50%). The primary factor in this regard is who the payer selects as its contracted entity (to provide connectivity solutions). Some contracted entities have not yet deployed a workers' compensation solution for their provider clients. In such instances, the provider is allowed to submit a paper claim.

Meanwhile, California has released proposed rules that have been reviewed and commented on. However, it has not yet released final rules. California's aspiration is to establish e-billing as the exclusive billing format for its workers' compensation system participants. California had initially planned an 18 month compliance window; it is not clear if this provision will remain part of its final rule.

These mixed results suggest that, while e-billing is intended to streamline and modernize medical claims processing systems, implementation does present challenges and opportunities. The efforts of Texas, California, Minnesota and Oregon should only encourage Florida as it continues to consider the appropriateness and the timing for mandated use of electronic medical billing by all providers that participate in its workers' compensation system[7].

The International Association of Industrial Accidents Boards and Commissions (IAIABC)[8] is a tremendous resource in terms of its initiatives to support state efforts to mandate electronic systems for workers' compensation medical billing. The IAIABC EDI Provider to Payer (Pro-Pay) Subcommittee and Medical EDI Committees have been working collaboratively with standards setting organizations to establish a set of national workers compensation EDI guidelines. The Pro-Pay group recently completed the following two significant work products:

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[6] This information was furnished by Don St. Jacques, Senior Vice President and Chief Operating Officer for Jopari, Inc.

[7] Florida currently mandates carriers to electronically submit medical claims data to the Division of Workers' Compensation directly or through the use of a third party submitter. Florida's efforts in this regard are extensively detailed in the Three Member Panel Biennial Report, 2007 Edition.

[8] Founded in 1914, the IAIABC is the world's oldest trade association dedicated to promoting the advancement of workers' compensation systems throughout the world through education, research, and resource management. It is a not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories.

• A model law for states to use in implementing electronic billing and payment standards. This law is patterned after the Texas legislation, which has been in effect since January 1, 2008, and legislative language from California.

• A "Companion Guide" to assist medical providers in understanding workers' compensation requirements when using electronic standards. This guide is proposed for use in states that have mandated or are in the process of mandating electronic billing and payment for workers' compensation, such as Texas, Minnesota, California, and Oregon.

During the summer of 2009, the Medical Electronic Data Interchange Committee (EDI), a standing committee within the IAIABC, completed work developing electronic billing and payment national companion guides based on ASC X12 004010 and NCPDP 5.1.[9] As of June 1, 2010, the IAIABC's Executive Committee has approved the Model Rule for electronic medical billing for jurisdictional use. The model guides are customizable and are designed to hasten and support multiple state jurisdictions considering regulation for electronic filing of medical data between health care providers and insurers.

It is the Panel's recommendation that the Division continue its current practice of permitting health care providers to electronically submit medical bills to insurers, provided the insurer agrees to accept the submission of electronic medical bills.[10] In addition, the Panel is recommending that the Division develop an action plan with the goal of determining whether to mandate electronic billing no later than 2015.

Chapter 3
Prescription Medications, Physician Dispensing, and Drug Repackaging

For roughly the past decade, medical costs have been and continue to be the leading cost driver of workers' compensation expenditures in Florida's workers' compensation system. Payments associated with dispensed medications have become an ever growing component of the workers' compensation medical expenditures. Prescribing and dispensing of medicinal drugs is controlled at both the federal and state level. The Florida Pharmacy Practice Act[11] establishes the procedures and requirements that pharmacists and other professionals must comply with whenever dispensing drugs.

Florida's injured employees are afforded free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under the State's workers' compensation law.[12]

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[9] The group published IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.1, dated July 1, 2009 and IAIABC Workers' Compensation Electronic Billing and Payment National Companion Guides based on ASC X12 004010 and NCPDP 5.1, Release 1.0, dated June 2, 2009.
[10] Florida Workers' Compensation Medical Services, Billing, Filing, and Reporting Rule, at 69L-7.602(4)(a)(6), Florida Administrative Code.
[11] Chapter 465, Florida Statutes.
[12] Subsection 440.13(3)(j), Florida Statutes.

The Florida workers' compensation statute does not address whether or not this absolute choice by the employee includes the right to have prescriptions filled by licensed dispensing practitioners.[13] However, the relevant portion of Florida's workers' compensation statute[14] does not restrict reimbursement for dispensed medications to only pharmacists. In addition, the Florida Workers' Compensation Health Care Provider Reimbursement Manual has historically allowed payment to both licensed pharmacists and to licensed practitioners for dispensing medications.

Traditionally, and it is still the case today, most injured employees elect to have their prescriptions for medications filled and dispensed by a licensed pharmacist. However, over the course of the past several years, the number of prescription medications dispensed by physicians has increased. According to medical bill data submitted to the Florida Division of Workers' Compensation, pharmacies dispensed 1,253,595 prescriptions in Calendar Year 2007, while physicians dispensed 423,983 prescriptions, which represented 25% of the total amount prescriptions. In Calendar Year 2009, the physician dispensing percentage increased to 31% with 466,185 prescriptions dispensed by physicians and 1,017,276 dispensed by pharmacies (a graphic of this is provided in Appendix A). Prescription medications, dispensed either by a licensed practitioner or pharmacist, are reimbursed pursuant to section 440.13(12)(c), Florida Statutes, which states:

> *As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee.*

It is important to note that the term "average wholesale price" is not defined in statute nor is there a singular, national adopted definition of "average wholesale price". The original manufacturer of a drug sets the drug's "average wholesale price" and obtains a National Drug Code (NDC)[15] for each drug it manufactures. The original manufacturer can sell the drug directly to a physician, a pharmacy, or a drug repackager.[16]

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[13] "Licensed Dispensing Practitioner" is a status that the physician must make application for and have conferred by the Florida Department of Health pursuant to Chapter 465.0278, Florida Statutes, and by adopted companion rules.

[14] Subsection 440.13(12)(c), Florida Statutes.

[15] The FDA mandates that drug products be identified and reported using a unique NDC; it is a universal product identifier for human drugs. This number identifies the product, manufacturer and packaging, including the quantity of the drug contained in the packaging.

[16] Although disparate reimbursement for dispensed medications is the focus of this section, broader policy and legislative considerations regarding the merits of allowing physicians to dispense to workers' compensation patients are appropriate.

A drug repackager does not alter the drug, but sells the drug in different quantities to a physician or pharmacy. Because the drug repackagers alter the quantity of the drug in the packaging, they are able to obtain a new NDC, and thus have the ability to establish a new average wholesale price. Studies performed by the National Council of Compensation Insurance, Inc. (NCCI) and the Workers' Compensation Research Institute, Inc., (WCRI) have shown that the costs of physician dispensed drugs and repackaged drugs are higher and in some cases up to three to four times higher than if the same prescription had been filled at a pharmacy within the state. According to the WCRI study of prescription drugs, the average payment per claim for prescription drugs in Florida is 38 percent higher than the median of the other 16 states in its study. The study further indicated that physician dispensing of repackaged medications is the primary cause for the increased costs for prescription drugs and that the practice has become common in Florida. The executive summaries of the WCRI studies are provided in Appendix B[17] while the NCCI study is provided in Appendix C.

Consistent with these findings, medical bill data submitted to the Florida Division of Workers' Compensation reflects that the average reimbursement per prescription for dispensing practitioners increased 62.4% from $85 per prescription in Calendar Year 2007 to $138 per prescription in Calendar Year 2009. During that same period, the average reimbursement per prescription to pharmacies increased 8.3% from $109 per prescription item to $118 per prescription (Appendix A).

House Bill 5603 was passed during the last days of the 2010 Florida legislative session; however, Governor Crist subsequently vetoed the bill[18]. One provision of the bill would have amended section 440.13(12)(c), Florida Statutes as follows:

> *As to reimbursement for a prescription medication, regardless of the location or provider from which the claimant receives the prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee, except when ~~where~~ the carrier has contracted for a lower amount. The reimbursement amount for a drug that has been repackaged or relabeled shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug, which shall not be the manufacturer of the repackaged or relabeled drug, plus a $4.18 dispensing fee, except when the carrier has contracted for a lower amount. In no case shall the repackaged or relabeled drug price exceed the amount otherwise payable had the drug not been repackaged or relabeled. Fees for pharmaceuticals and pharmaceutical services*

[17] The Division received permission from WCRI to include the executive summaries.

[18] Governor Crist provided the following explanation for his veto of HB 5603 in a May 28, 2010 letter to Dawn K. Roberts, Interim Secretary for Florida's Department of State: "House Bill 5603 contains several provisions that I support that would help control the state's risk management and workers' compensation costs. However, the bill was amended during the budget conference process to include a provision that limits the amount that may be charged for repackaged drugs provided to workers' compensation claimants. While limiting reimbursement rates for relabeled and repackaged prescription drugs sounds like a reasonable way to control costs, this is a complicated issue that was not fully vetted during the legislative process. I am concerned that implementing this bill without additional review could result in numerous unintended consequences that could ultimately adversely impact injured workers."

shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee.

The goal of the statutory amendment is to create price symmetry for the reimbursement of repackaged drugs as compared to the price of the drug as set by its original manufacturer.[19] NCCI estimated that the proposed reimbursement methodology for repackaged drugs would reduce total workers' compensation costs by 1.1%, which equates to $34 million in savings to Florida employers in one year alone (Appendix F). Chief Financial Officer Sink and the Division of Workers' Compensation supported House Bill 5603.

The Panel recommends that the Legislature consider addressing the reimbursement amount for prescription drugs, including repackaged drugs, while providing the opportunity for any interested party to provide input on the subject during the legislative process. The Panel also recommends that the Legislature consider amending the workers' compensation statute to address whether physicians should dispense medications to workers' compensation patients.

Chapter 4
Practice Parameters and Protocols of Treatment

Enacted in 2003, Senate Bill 50A (supra) included language adopting practice parameters and protocols of treatment for medical care. Explicitly, section 440.13(15), Florida Statutes, states "The practice parameters and protocols mandated under this chapter shall be the practice parameters and protocols adopted by the United States Agency for Healthcare Research and Quality (AHRQ) in effect on January 1, 2003." AHRQ maintains a data base called the National Guideline Clearinghouse (NGC) where it provides a listing and access to the practice guidelines it adopts. The NGC can be accessed at http://www.guideline.gov/.

By it's enactment of SB 50A, the Legislature revealed an acute understanding of the need to combat system costs (to include escalating medical costs) that, at the time, threatened to make workers' compensation insurance premiums unaffordable for many employers. Even now, in the most recent workers' compensation rate hearing, the National Council on Compensation Insurance, Inc. (NCCI) data showed that medical costs comprise 68.6 percent of Florida's total workers' compensation expenditures. While it may be appropriate to debate the proper ratio of medical costs with respect to the total of workers' compensation expenditures, the fact remains that any significant future workers' compensation cost savings and efficiencies must be realized by reducing medical costs.

[19] The repackaging provision would continue to allow physicians to dispense medication, but the reimbursement amount would be limited to the average wholesale price of the original manufacturer of the medication plus a $4.18 dispensing fee.

As was extensively detailed in the Panel's 2007 Biennial Report, section 440.13(15), Florida Statutes, (Practice Parameters and Protocols of Treatment) has fallen short of its legislative intent of providing clear, authoritative, and comprehensive treatment guidelines due to several inherent deficiencies. For example, one of the most challenging aspects of section 440.13(15), Florida Statutes, is the fact that there were few if any relevant practice guidelines adopted AHRQ and listed on the NGC website as of January 1, 2003. To further refine the issue, apart from of the January 1, 2003 date limitation concern, the adoption of practice guidelines and protocols by AHRQ does not automatically ensure the quality or validity of the practice guidelines. If it is the intent of future policy makers and workers' compensation stakeholders to contain medical costs, promote better utilization controls, and, ensure high quality medical care to injured workers, the Panel respectfully recommends that the legislature give serious consideration to repealing section 440.13(15), Florida Statutes, and replacing it with an alternative that effectively translates the mandates of section 440.13(16), Florida Statutes, (Standards of Care) into meaningful treatment guidelines.

As a predicate to this recommendation, the 3MP and the Division of Workers' Compensation reached out to an external resource in the form of Christopher J. Wolfkiel, PhD, Director of Practice Guidelines, for the American College of Occupational and Environmental Medicine (ACOEM). While Dr. Wolfkiel authored the ensuing material which offers the reader a look at the state of workers' compensation practice guidelines and presents possible alternatives to Florida's existing practice parameters and protocols, there are other individuals who represent entities (several of which are mentioned herein) that also develop practice guides, that could certainly have provided substantially comparable material, if presented with the opportunity. Therefore, it should not be construed that the Panel or the Division has a preference in this regard.

Practice Patterns Standards

To place this issue into its proper context, national workers compensation guidelines options were limited at the time SB 50A was enacted and only California's demand, in 2004, for high quality, comprehensive guidelines that could be designated as "presumed correct" resulted in the establishment of a baseline for comparison. The result of California's efforts, documented in a study conducted by the RAND Corporation[20] identified ACOEM's *Occupational Medicine Practice Guidelines Second Edition* as the preferred solution (for California), but by no means a standout compared to guidelines from Official Disabilities Guidelines (ODG), American Academy of Orthopedic Surgeons (AAOS) and McKesson. Since then, a greater emphasis on evidence-based medicine has been the rule for development of higher quality guidelines, preferably in transparent, multi-disciplinary process.

Practicing evidence-based medicine (EBM), "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (BMJ 1996; 312 : 71, Editorial, Evidence based medicine: what it is and what it isn't. David L Sackett, et al) is a laudable goal for providers, but as evidence expands at

[20] Evaluating Medical Treatment Guideline Sets for Injured Workers In California, Nuckols et al, Published 2005 by the RAND Corporation

geometric rates and as practitioner's time per patient decreases, EBM is impractical in many settings. However the concept of applying an *a prioi* systematic evidence review process to generalized clinical questions as a surrogate for the individual practice of EBM is a widely accepted methodology to produce guidelines. This model produces results within a wide spectrum of quality; at one end are Cochrane Reviews (http://www.cochrane.org/cochrane-reviews) which produce consistently high quality results to specific clinical questions. At the other end of the spectrum are documents that are better characterized as "marketing" in scientific terminology. Hallmarks of high quality guidelines are original, comprehensive systematic reviews, the lack of reliance on external systematic review of the literature, attention to conflict of interest, and commitment to transparency.

Unfortunately, the AHRQ Guidelines Clearinghouse now tracks almost 3000 guidelines with little effort at identifying or resolving conflicts. The threshold for inclusion is so low that the Institute of Medicine recently convened a special roundtable which will result in a report that will include recommendations including how to identify "trustworthy" guidelines. These facts make updating the time stamp of AHRQ inclusion from 2003 to the present time a poor choice for Florida in updating practice patterns.

Recently many states have realized that a state wide standard is needed to establish minimum standards for injured worker access to care as well as curb the trend towards unnecessary care that plagues health care. These standards are nationally based, adapted or locally developed. Statutorily, standards of evidence based medicine can be specified including:

- Original, occupational medicine systematic review of the literature
- Transparently developed
- Multi-disciplinary, minimized conflict of interest
- Adaptable and available

A good example of an effort to minimize potential conflict of interest is the recent "code" developed by the Council on Medical Specialty Societies which details standards of guideline participants' interactions with industry (http://cmss.org/codeforinteractions.aspx).

States' Experiences

Approximately 28 states have some guideline designation, ranging from legislative to state fund use and as state authored, adapted or national guideline adoption.

State	Guideline Status	State	Guideline Status
Alaska	Considering, may be part of 2011 legislative sessions	**New York**	State Adapted CO, ACOEM, WA (Low Back, Neck, Shoulder, Knee)
California	Adopted ACOEM 2nd ed (SB228/2003) added CO Acupuncture guidelines in 2007, ODG for pain management 2010	**North Dakota**	ODG, ACOEM others used by state administration
Colorado	Own state guidelines	**Ohio**	BWC and its MCOs utilize the Work Loss Data Institute's Official Disability Guidelines (ODG): Treatment in Workers' Compensation and other Guidelines
Delaware	May be considering updating own	**Oklahoma**	Own, state developed
Florida	By statute, Florida uses the AHRQ practice parameters and protocols	**Oregon**	Limited technology compensation recommendations
Georgia	May be considering	**Rhode Island**	The Board has promulgated thirty-seven (37) protocols and standards of treatment since its inception.
Kansas	ODG has been adopted as the standard of reference but not mandated or required	**South Dakota**	Treatment standards are written for general physical medicine
Kentucky	Have considered in the past	**Tennessee**	Has considered
Louisiana	Adapting CO	**Texas**	ODG for Out of Network Providers
Maine	Adopted AHRQ low back in 1991, no longer a standard for clinical practice	**Utah**	State fund coverage recommendations
Massachusetts	Own state developed (may be updating, allows use of national guidelines)	**Washington**	Own, state developed
Minnesota	Own, state developed	**West Virginia**	Own, state developed
Montana	In development, Colorado Primary ACOEM Secondary	**Wisconsin**	Own, state developed
Nevada	ACOEM	**Wyoming**	Own, state developed

National Guidelines for Workers Compensation

There are two non-jurisdictional guidelines, ACOEM and ODG and two state guidelines, Colorado and Washington that are often reviewed by states considering guidelines adoption. ACOEM, ODG, and Colorado contains 1000's of recommendations, Washington significantly less, all produced via different evidence based methodologies.

ACOEM – From the American College of Occupational and Environmental Medicine, *ACOEM's Occupational Medicine Practice Guidelines* were first published in 1997 and now are in their Third Edition covering thousands of strength of evidence weighted recommendations. Mandated in total or part in California, New York, Nevada, and Montana and recognized for use in many more states, the ACOEM Guidelines are the most extensively documented evidence based recommendations.

ODG – *ODG Treatment in Workers Comp*, in its 8th edition, from the Work Loss Data Institute, publishers of the *Official Disabilities Guidelines* is a private publisher and independent of any medical specialty group. The ODG Guidelines, mandated in Kansas and for non-network providers in Texas as well as by the State Fund in Ohio, are widely accepted by the insurance industry.

Colorado – The first state to develop evidence-based workers' compensation practice guidelines in 1992 and most recently updated in 2005. Colorado is the basis for guidelines in New York and Montana. Rated better than its peers for its less restrictive nature (in terms of treat modalities), Colorado combines an evidence based development process with state wide provider review that many find an acceptable balance.

Washington - In 1988 an inpatient utilization review (UR) program was established and the Department of Labor and Industry published its first guideline to establish admission criteria for the inpatient non-surgical treatment of back pain. In 2005, a new process that uses the best available scientific evidence and expert consensus was adopted resulting in seven updated guidelines in 2009-2010.

State Authored Guidelines
Many other states have developed treatment guidelines for workers compensation including MA, OK, RI and others, usually through local ad-hoc development boards.

Adapted Guidelines
States have adapted guidelines via a patchwork/hybrid approach (combining from multiple sources) and/or customizing a national standard or hybrid:

California – California adopted the ACOEM Second Edition as presumed correct in 2004 amongst other reforms. As part of the reform effort, the Administrative Director was given authority to supplement and adapt the guidelines to establish California's Medical Treatment Utilization Schedule (MTUS) with input from the MEEAC (Medical Evidence Evaluation Advisory Committee). In the succeeding years the MTUS has been changing to include:

- Post-surgical recommendations developed by the MEEAC
- Acupuncture recommendations from Colorado
- Chronic Pain recommendation from ODG
- Updated Elbow Recommendations from ACOEM

Montana – In 2010 the state, after many months of research and analysis, decided to establish a set of Montana Guidelines defined by Colorado as a primary source and ACOEM as a secondary source (to be included where Colorado was silent). Part of this development process is the creation of a public access website by ACOEM to allow all stakeholders equal access to the Montana Utilization and Treatment Guidelines.

New York – In 2007, New York, by a gubernatorial reform assignment began development of New York Medical Treatment Guidelines as adapted version of body part chapters from ACOEM and Colorado, Washington state guidelines

were also consulted. Scheduled for adoption Dec 1, 2010, the goal of these guidelines were to develop mandated minimal standards of care for injured workers whose access had deteriorated due to artificially low fee schedules from the 1990s. Of note, the Workers Compensation Board exempted all recommended procedures from pre-authorization with the 12 exceptions corresponding to invasive/risky procedures.

Louisiana – In 2010, the state sought to establish meaningful guidelines for the treatment of injured workers, which resulted in adapting Colorado guidelines by an advisory committee.

Variances and Appeals

"Practice guides", cannot be expected to cover all clinical scenarios. Exceptions are to be expected and as such, non-recommended treatments should occur if other recommended treatments have proven ineffectual. As such carriers, payers, and third party administrators should encompass procedures so that these outcomes can occur without additional costs to providers or injured workers. For example, in addition to the standards outlined for resolving disputes, the Department should also allow for appropriate risk-benefit determinations that may be in the injured workers' interest that are beyond established practice guidelines.

Educational Aspects

The establishment of Statewide Guidelines has to be viewed as change management on a very large scale. Many stakeholders will be impacted, including providers, payers, legal and judiciary as well as employers and injured workers. An "osmotic process" proved to be un-stabling in California; as a result payers were largely educational agents resulting in a pattern of over denial and increased utilization review costs. States, such as New York and Montana, have recognized that the most effective implementation of guidelines will occur when provider's behavior conforms leading to minimal denials and reimbursement issues. The best scale and scope of education programs has not been determined, but a multi-stakeholder approach appears to be preferred.

Technological Considerations

Until recently, treatment guidelines were not thought of in terms of the ease with which they could be incorporated into the technological requirements of any number of entities. However, health care reform has produced a mandate for quality driven patient care. Due in part to this mandate, treatment guidelines that can be readily integrated into modern electronic medical records (EMRs) software and decision support systems will be looked at for adoption for this reason as much as for their adherence to quality development standards.

Florida Practice Guidelines

In summary, Florida's current practice guidelines are ineffective due to the reasons stated earlier in this Chapter. Therefore, the Panel respectfully recommends that the Legislature conduct or commission an analysis of the various types and sources of available practice guidelines to determine which is most appropriate for Florida and determine how it should be developed and implemented.

Chapter 5
The Florida Uniform Permanent Impairment Rating Schedule

The 1996 Florida Uniform Permanent Impairment Rating Schedule (FUPIRS) is used by doctors who participate in Florida's workers' compensation program to assign an impairment rating to an injured worker in order to determine the workers' impairment benefits. This rating system, upon which Florida has relied since 1996, is detailed in section 440.15(3)(b), Florida Statutes.

The relevance of FUPIRS should be examined as Florida's workers' compensation system approaches the fifteenth year of its use. The principal question the Legislature needs to address is, "should a workers' compensation injury that occurs in 2011 and beyond be evaluated under an impairment rating system which is based on medical science and concepts that have been in place for as long as twenty years?" The FUPIRS is comprised of components of the Second, Third, and Fourth Editions of the American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment (AMA *Guides*™). The Fifth and Sixth Editions of the AMA Guides™ have been published subsequent to Florida's adoption of its current uniform permanent impairment rating schedule.

To provide a proper comparison of the more recently developed AMA *Guides*™ to Florida's current impairment rating guide, the Division of Workers' Compensation commissioned Impairment Resources, LLC to conduct a comparative analysis of 75 randomly selected cases from a group of 200 cases previously rated with the Fourth, Fifth, and Sixth Editions of the AMA *Guides*™.

The study observed a modest difference between the average whole person permanent impairment values obtained with the *FUPIRS* compared to the Sixth Edition of the AMA *Guides*™ and concluded that the change is not statistically significant. However, the authors did acknowledge that the limited range of impairment values in the study might have contributed to the lack of statistical significance when comparing group means[21]. The authors further disclosed that the insignificant changes in whole person impairment values with the Sixth Edition were anticipated and principally due to the recognition that:

- *FUPIRS* employed methodologies present in earlier Editions of the AMA *Guides* that are no longer considered appropriate;
- Surgery and all therapeutic endeavors should improve function and therefore should not routinely increase impairment, and;
- Certain common conditions that resulted in functional deficits and no ratable impairment in the *FUPIRS* and prior Editions of the AMA *Guides* should be ratable.

The authors further conclude that in the event that Florida adopts the AMA *Guides to the Evaluation of Permanent Impairment,* Sixth Edition, its workers' compensation program

[21] It was noted that 84% of the cases represented a rating of 10% whole person impairment or less.

would be using the most medically current impairment rating system available and would be able to depart from the old methodologies used within *FUPIRS*. The Impairment Resources, LLC study along with an additional bit of narrative (provided by the American Medical Association) on the AMA *Guides*™, are provided in Appendix D and E, respectively.

It is the Panel's recommendation that the Legislature consider authorizing an interim study to determine whether to retain, update, amend, or replace the Florida Uniform Impairment Rating Schedule.

Chapter 6
Federal Health Care Reform: What Does It Mean for Workers' Compensation?

As a prerequisite to offering conclusions and making recommendations, it is structurally appropriate to engage in a broader look at the changed landscape in which health care will be provided and to attempt to identify some specific areas where new opportunities for improvement might exist or where latent impediments might lurk. In this penultimate chapter of the 2011 Biennial Report, we take an abbreviated look at some of the key provisions of H.R.3590 - *Patient Protection and Affordable Care Act (PPACA) and of H.R.* 4872 - *Health Care and Education Reconciliation Act of 2010.* These sweeping federal health care reform bills did not directly address workers' compensation or implicate its medical benefit structure or payment models. Nonetheless, these federal health care reform bills (referred to as PPACA) will usher in a number of changes that, once implemented[22], have the potential to impact workers' compensation generally and Florida's workers' compensation program specifically.

The first thing to note is that there is no language in the health care reform law that would directly and explicitly affect workers' compensation. The PPACA references workers' compensation twice:

- Section 2401, in connection with a mandate to have certain community health service agencies carry workers' compensation insurance; and
- Section 10109, which calls for the Secretary of Health and Human Resources to develop rules that will facilitate the exchange of financial and administrative transactions for the purpose improving the operation of the health care system and administrative costs.

This second provision warrants watching because it encourages comments to the Secretary of the Department of Health and Human Resources on whether the implementing rule should include property and casualty insurance, including workers' compensation.

[22] At the time this report was prepared at least 20 states, including Florida, have filled legal challenges to PPACA. In addition, the United States Congress is contemplating amending or repealing some provisions of PPACA. There are also ongoing discussions about repealing PPACA in its entirety. This report only addresses the legislation as it currently exists.

One of the more intriguing aspects of the federal health care reform law is the way it will incent doctors and hospitals to start to use electronic means of transmitting bills and records. According to the New England Journal of Medicine:

> *Beginning in 2011, Medicare and Medicaid will provide financial incentives over multiple years of up to $40,000 to $65,000 per eligible physician and up to $11 million per hospital for "meaningful" use of health information technology, such as the electronic exchange of data and reporting of clinical quality measures. Starting in 2015, physicians and hospitals that do not use certified products in a meaningful way will be penalized. The Congressional Budget Office (CBO) projects that the incentives will boost the proportions of physicians and hospitals adopting comprehensive electronic health records by 2019 to 90% and 70%, respectively, from the 65% and 45% that would be expected to do so anyway.*[23]

The expected increased ability by doctors and hospitals to send and receive electronic records aligns well the current International Association of Industrial Accidents Boards and Commissions (IAIABC) initiative to support state efforts to mandate electronic systems for workers' compensation medical billing[24]. Allen McDonald, Chair of the IAIABC ProPay Working Group opined "[t]his new federal initiative can only add impetus to the IAIABC ProPay Working Group efforts."

Under another provision of the federal health care reform the pre-existing medical condition exclusion, which currently applies to many group health plans, will fade away from these plans in 2014. Some analysts believe that this provision will diminish the incentive for employees to claim, as work related, long standing "wear and tear" conditions. There may also be much greater demand on employers for workplace and job accommodations leading to new exposures and safety issues.

In another development resulting from the federal health care reform, the Center for Medicare and Medicaid Services (CMS) and Highmark Medicare Services (one of its contractors) have awarded two health information technology contracts to create and maintain systems and applications that support claims payments[25].

Electronic health records (EHR), or electronic medical records (EMR), are considered a key component in controlling health costs. By investing in new technology (some

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[23] *Health Care 2009, published at www.nejm.org, February 17, 2009 (10.1056/NEJMp0900665)*

[24] The anticipation of greater acceptance and use of electronic medical records by the provider communities is yet another reason why the Panel has targeted 2015 as an appropriate point at which to mandate e-billing.

[25] Companion Data Services (CDS) a data storage firm has been awarded a five year contract of unstated value from Highmark Medicare Services to provide data warehousing in support of Highmark's contract to administer emergency healthcare claims processing for undocumented immigrants (according to a news release by CDS). CDS is a subsidiary of Blue Cross and Blue Shield of South Carolina (one of the largest Medicare contractors in the country. In addition, CSC, out of Falls Church, Virginia, received a task order, with a potential value of 230 million dollars, to design and develop a health IT architecture that will consolidate three CMS application groups: the standard data-processing system, the value-based purchasing system and the end-stage renal disease system, according to a CSC news release. The task order has a six-month base period and six one-year extension options.

providers are using federal stimulus dollars to upgrade their records systems, including billing, payroll and patient records) the workers' compensation community may be able to leverage advances in the standardization, collection and use of medical data.

Chapter 7
Conclusions and Recommendations

In summary, this report recognizes the positive impact of past reform initiatives and discusses current issues that warrant study and consideration by this Legislature. To that end, the following recommendations are presented for your consideration:

Electronic Medical Billing (E-billing)
It is the Panel's recommendation that the Division continue its current practice of permitting health care providers to electronically submit medical bills to insurers, provided the insurer agrees to accept the submission of electronic medical bills.[26] In addition, the Panel is recommending that the Division develop an action plan with the goal of determining whether to mandate electronic billing no later than 2015.

Prescription Medications, Physician Dispensing, and Drug Repackaging
The Panel recommends that the Legislature consider addressing the reimbursement amount for prescription drugs, including repackaged drugs, while providing the opportunity for any interested party to provide input on the subject during the legislative process. The Panel also recommends that the Legislature consider amending the workers' compensation statute to address whether physicians should dispense medications to workers' compensation patients.

Practice Parameters and Protocols of Treatment
The Panel recommends that the Legislature give serious consideration to repealing section 440.13(15), Florida Statutes, and replacing it with an alternative that effectively translates the mandates of section 440.13(16), Florida Statutes, (Standards of Care) into meaningful treatment guidelines.

As a foundation for the above recommendation, the Panel recommends that the Legislature conduct or commission an analysis of the various types and sources of available practice guidelines to determine which is most appropriate for Florida and determine how it should be developed and implemented.

The Florida Uniform Permanent Impairment Rating Schedule
It is the Panel's recommendation that the Legislature consider authorizing an interim study to determine whether to retain, update, amend, or replace the Florida Uniform Impairment Rating Schedule.

[26] Florida Workers' Compensation Medical Services, Billing, Filing, and Reporting Rule, at 69L-7.602(4)(a)(6), Florida Administrative Code.

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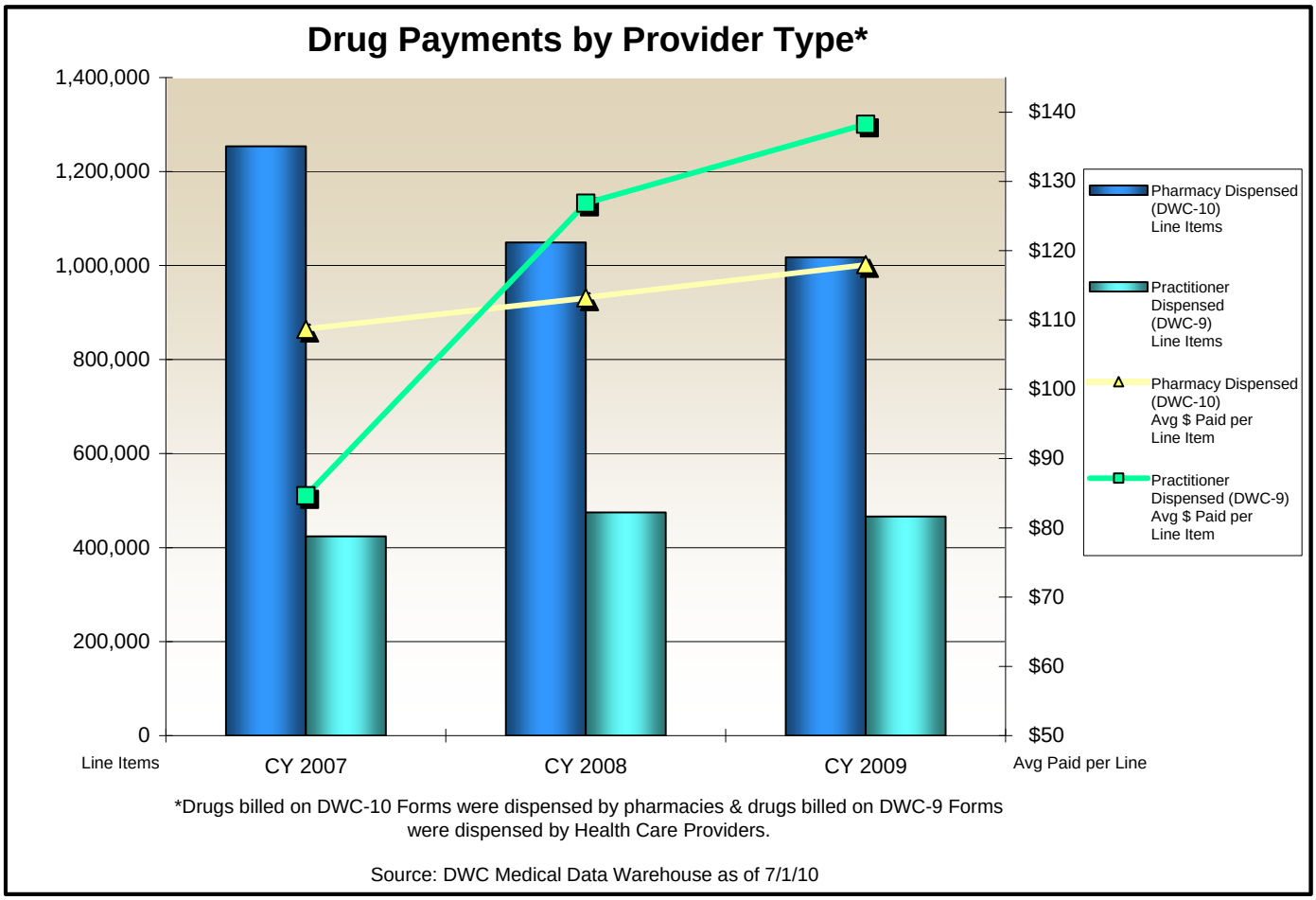
Appendix A



*Drugs billed on DWC-10 Forms were dispensed by pharmacies & drugs billed on DWC-9 Forms were dispensed by Health Care Providers.

Source: DWC Medical Data Warehouse as of 7/1/10

Appendix B Executive Summaries

Prescription Benchmarks for Florida

Summary of Major Findings for Florida

Among claims with prescriptions paid under workers' compensation, the average payment per claim for prescription drugs in Florida was $565, 38 percent higher than the median of the 16 states in our study. The main reason for higher than average prescription costs in Florida was that some physicians wrote prescriptions and dispensed them directly to the patient at their offices. When physicians dispensed, they often were paid much more than pharmacies for the same prescription. Some physicians also wrote prescriptions for certain drugs that were especially profitable, but not used as often as in other states. This helps explain why Florida had higher utilization of prescriptions. Prices paid to Florida pharmacies were similar to the prices paid to pharmacies in the median state, largely due to Florida's pharmacy fee schedule that is set at levels that are typical of many states.

Physician dispensing was common in Florida. We observed that California physicians engaged in similar practices. In 2007, the California legislature took actions to equalize the prices paid for physician-dispensed and pharmacy-dispensed prescriptions.

Advocates for physician dispensing note its advantages. First, for some patients, it may mean greater compliance with the doctors' instructions to take the medications prescribed, since not all prescriptions get filled by patients. Second, it saves the patient time—especially for patients who live in remote areas that are long distances from the nearest pharmacy. Finally, it maximizes the benefit of prompt treatment, since some medications (e.g., antibiotics in some cases) should be taken as soon as possible. The public policy question is what premium should be paid in order to realize these benefits and in what types of cases.

Physician Dispensing in Florida Was Common

Physicians in Florida dispensed prescription drugs in 51 percent of claims with any prescriptions, representing 30 percent of all prescriptions paid under workers' compensation over the study period (Table 3.1). When physicians dispensed prescription drugs, they received an average of $427 per claim for those prescriptions.

Table 3.1 Percentage of All Prescriptions That Were Dispensed by Physicians

TX[a]	NY[a,b]	MA[a]	WI	NC	LA	IA	TN	NJ	IN	PA	IL	MD	MI	FL	CA[c]
0%	0%	0%	7%	9%	9%	9%	11%	14%	14%	15%	22%	24%	27%	30%	60%

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

[a] Physician dispensing was not permitted in Massachusetts, New York, and Texas over the study period.

[b] Data for New York include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

[c] In 2007, the legislature in California enacted reforms specially aimed at reducing the unusual amount of physician dispensing. Data for California include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

Key: Rx = prescriptions.

Physicians were Paid Higher Prices Than Pharmacies for the Same Prescription

When physicians dispensed prescription drugs at their offices, the average price paid per pill was often much higher than that for the same prescriptions filled at retail pharmacies. Table 3.2 compares the average prices paid per pill between physician- and pharmacy-dispensed prescriptions for specific medications that were commonly used in treating injured workers in Florida. As can be seen, the prices paid to physicians were often much higher for common drugs. The most striking examples are Ranitidine HCL (more than double what pharmacies were paid),[1] Carisoprodol (five times higher), Hydrocodone-Acetaminophen (double what the pharmacy was paid), and Oxycodone-Acetaminophen (one and a half times higher). For most of the other common drugs, physicians were paid 35–60 percent more than pharmacies for the same prescription.

Table 3.2 Comparing Prices Paid for Same Drugs between Physician- and Pharmacy-Dispensed Prescriptions in Florida

Drug Name (Brand Name)	% of Claims with Rx That Had Specific Drug	% of Rx for the Drug That Was Dispensed by Physicians	Average Price Paid per Pill		
			Physician-Dispensed Rx	Pharmacy-Dispensed Rx	% Difference
Hydrocodone-Acetaminophen (Vicodin®)	48%	12%	$0.96	$0.46	109%
Ibuprofen (Motrin®)	29%	47%	$0.49	$0.34	44%
Oxycodone w/Acetaminophen (Percocet®)	27%	4%	$2.22	$0.87	155%
Tramadol HCL (Ultram®)	23%	56%	$1.25	$1.25	0%
Cyclobenzaprine HCL (Flexeril®)	21%	33%	$1.33	$1.19	12%
Naproxen (Aleve®)	21%	49%	$1.58	$1.17	35%
Propoxyphene-N w/APAP (Darvocet-N®)	18%	19%	$1.00	$0.63	59%
Carisoprodol (Soma®)	11%	54%	$3.05	$0.62	392%
Ranitidine HCL (Zantac®)[a]	7%	95%	$3.15	$1.46	116%

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

[a] This drug is also available over-the-counter at the pharmacy for 35 cents per pill (*Source:* Walgreens.com, October 28, 2009, bottle of 24 pills of Zantac® 150mg).

Key: Rx = prescriptions.

Physician Dispensing: Higher Utilization of Certain Drugs

On average, Florida physicians wrote more prescriptions for more pills per claim than physicians in the median state. The average number of prescriptions per claim in Florida was 17 percent higher than in the median state. Similar results can be seen on the average number of pills per claim.

This was largely due to the use of certain medications that were often dispensed by physicians in Florida and that physicians in other states prescribed much less frequently. Among the most common drugs used for Florida injured workers, the leading examples include Carisoprodol (i.e., Soma® a muscle relaxant) and Ranitidine HCL (i.e., Zantac® for acid reflux). Carisoprodol was much more commonly used in states where physician dispensing was common. As Table 3.3 shows, about 1 in 10 injured workers received this drug in Florida and Louisiana, [2] but only about 1 in 20 or fewer in most other states studied.

The average injured worker with prescriptions for Carisoprodol filled (or refilled) their prescriptions 2.9 times for 173 pills per claim in Florida, compared to 2.7 times for 124 pills per claim in the median state (Table 3.4).

Ranitidine HCL was also much more commonly used in states where physician dispensing was common. As Table 3.5 shows, seven percent of injured workers received this drug in Florida (six percent in Maryland and 14 percent in California) while in most states, the number was only one percent or less.

Table 3.3 Percentage of Claims with Rx That Had Rx for Carisoprodol

WI	IA	NJ	MI	IL	NY[a, b]	PA	NC	MA[a]	IN	TN	MD	TX[a]	FL	LA	CA[c]
1%	1%	2%	2%	3%	3%	4%	4%	4%	5%	6%	8%	8%	11%	12%	21%

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

[a] Physician dispensing was not permitted in Massachusetts, New York, and Texas over the study period.

[b] Data for New York include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

[c] In 2007, the legislature in California enacted reforms specially aimed at reducing the unusual amount of physician dispensing. Data for California include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

Key: Rx = prescriptions.

The average injured worker with prescriptions for Ranitidine HCL filled (or refilled) the prescriptions 2.6 times for 141 pills per claim in Florida, compared to 1.5 times for 74 pills per claim in the median state (Table 3.4).

Table 3.4 Utilization of Most Common Medications: Comparing Florida to the Median State

Drug Name (Brand Name)	% of Claims with Rx That Had Specific Drug	Average Number of Pills for Specific Drug per Claim with the Drug			Average Number of Rx for Specific Drug per Claim with the Drug		
		Florida	16-State Median	% Difference	Florida	16-State Median	% Difference
Hydrocodone-Acetaminophen (Vicodin®)	48%	125	132	-5%	3.2	3.3	-2%
Ibuprofen (Motrin®)	29%	77	84	-9%	1.9	1.8	3%
Oxycodone w/Acetaminophen (Percocet®)	27%	103	107	-3%	2.3	2.3	0%
Tramadol HCL (Ultram®)	23%	118	105	12%	2.4	2.1	11%
Cyclobenzaprine HCL (Flexeril®)	21%	71	67	6%	2.1	2.0	4%
Naproxen (Aleve®)	21%	71	74	-4%	1.9	1.8	4%
Propoxyphene-N w/APAP (Darvocet-N®)	18%	75	76	-1%	2.0	2.0	0%
Carisoprodol (Soma®)	11%	173	124	40%	2.9	2.7	7%
Ranitidine HCL (Zantac®)	7%	141	74	91%	2.6	1.5	71%

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

Key: Rx = prescriptions.

Table 3.5 Percentage of Claims with Rx That Had Rx for Ranitidine HCL

IA	TX[a]	WI	IN	LA	NY[a, b]	NC	MI	MA[a]	PA	TN	IL	NJ	MD	FL	CA[c]
n/a	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	1%	6%	7%	14%

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

[a] Physician dispensing was not permitted in Massachusetts, New York, and Texas over the study period.

[b] Data for New York include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

[c] In 2007, the legislature in California enacted reforms specially aimed at reducing the unusual amount of physician dispensing. Data for California include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

Key: n/a = not available; Rx = prescriptions.

Prices Paid to Florida Pharmacies Were Similar to the Median State

The average price per pill paid to pharmacies in Florida was at the median of the 16 states ($1.16 per pill on average). We see typical prices paid for almost all medications that were commonly used in treating injured workers in Florida (Table 3.6). Florida has a pharmacy fee schedule which is set at the level of the Average Wholesale Price—typical of many states. This typical pharmacy fee schedule explains why the prices paid to pharmacies were typical in Florida.

Table 3.6 Prices Paid to Pharmacies for Most Common Drugs: Comparing Florida to the Median State

Drug Name (Brand Name)	% of Claims with Rx That Had Specific Drug			Average Price Paid per Pill, Pharmacy-Dispensed Rx		
	Florida	16-State Median	% Point Difference	Florida	16-State Median	% Difference
Hydrocodone-Acetaminophen (Vicodin®)	48%	53%	-5%	$0.46	$0.49	-6%
Ibuprofen (Motrin®)	29%	27%	2%	$0.34	$0.35	-3%
Oxycodone w/Acetaminophen (Percocet®)	27%	23%	4%	$0.87	$0.88	-1%
Tramadol HCL (Ultram®)	23%	14%	9%	$1.25	$1.24	1%
Cyclobenzaprine HCL (Flexeril®)	21%	20%	1%	$1.19	$1.20	< 1%
Naproxen (Aleve®)	21%	16%	5%	$1.17	$1.19	-1%
Propoxyphene-N w/APAP (Darvocet-N®)	18%	16%	2%	$0.63	$0.66	-4%
Carisoprodol (Soma®)	11%	4%	7%	$0.62	$0.68	-9%
Ranitidine HCL (Zantac®)[a]	7%	0%	7%	$1.46	$1.46	0%

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

[a] This drug is also available over-the-counter at the pharmacy for 35 cents per pill (*Source:* Walgreens.com, October 28, 2009, bottle of 24 pills of Zantac® 150mg).

Key: Rx = prescriptions.

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[1] It is interesting to note that on Walgreens.com, the price for the same medication without a prescription was 35 cents (Zantac® 150mg, bottle of 24 pills, October 28, 2009).

[2]One in five injured workers also received this drug in California before the most recent change that addressed the issue of physician dispensing.

Appendix C

FL Repackaged and Nonrepackaged Drugs Dispensed by Physician, Pharmacies and Other - For service year 2008

	Average Unit Price		
	Repackaged Drugs	Nonrepackaged Drugs	Difference in %
	(1)	(2)	(3) = (1)/(2)-1
CARISOPRODOL	4.13	0.58	612.1%
MELOXICAM	6.16	3.26	89.0%
RANITIDINE HCL	3.71	1.49	149.0%
TRAMADOL HCL	1.57	0.79	98.7%
LIDODERM®	12.64	6.64	90.4%
NAPROXEN	2.08	1.09	90.8%
OMEPRAZOLE	7.62	4.04	88.6%
HYDROCODONE-ACETAMINOPHEN	1.23	0.45	173.3%
ETODOLAC	2.78	1.35	105.9%
SKELAXIN®	4.86	3.20	51.9%
OXYCODONE-ACETAMINOPHEN	3.50	0.55	536.4%
CYCLOBENZAPRINE HCL	1.59	1.10	44.5%
CEPHALEXIN	2.73	0.84	225.0%
ZOLPIDEM TARTRATE	6.74	4.00	68.5%
IBUPROFEN	0.65	0.34	91.2%

Appendix D

Comparative Analysis of Impairment Evaluations by the 1996 Florida Uniform Permanent Impairment Rating Schedule (FUPRIS) and the AMA *Guides*, Fourth, Fifth, and Sixth Editions

By Christopher R. Brigham, M.D., Aimee McEntire, and Craig Uejo, M.D., M.P.H.[27]

Background

The Florida workers' compensation system uses the *1996 Florida Uniform Permanent Impairment Rating Schedule* (*FUPIRS*). The FUPIRS was based in part on the Second, Third Revised, and Fourth Editions of the AMA *Guides to the Evaluation of Permanent Impairment*; the Fourth Edition was published in 1993.

Published since 1958, the AMA *Guides to the Evaluation of Permanent Impairment (Guides)* is the recognized national and international standard to determine the medical loss associated with an injury or illness.

In December 2007, the American Medical Association published the most recent Edition, the Sixth Edition[i]. As with other areas of medicine, concepts and approaches are improved with time; for example, in medicine, some prior treatments are founded to be ineffective and newer approaches are adopted – this also occurs with the medical assessment of impairment. With the change in impairment methodology, there will also be changes in impairment values associated with specific conditions.

The Sixth Edition introduced an innovative methodology used to enhance the relevancy of impairment ratings, improve internal consistency, promote greater precision, and simplify the rating process. The approach is based on a modification of the conceptual framework of the International Classification of Functioning, Disability, and Health (ICF)[ii], although many of the fundamental principles underlying the *Guides* remain unchanged.

There have been challenges associated with the use of the *Guides*, including criticisms of the *Guides* themselves, the use of impairment rating numbers, and a high error rate.[iii iv v vi vii viii ix x] These criticisms of the *Guides* could also be applied to the *FUPIRS* since they were based on earlier Editions of the *Guides.* Previous criticisms include:

- Failure to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system.
- Impairment ratings do not adequately or accurately reflect loss of function.
- Numerical ratings are more the representation of “legal fiction than medical reality.”

In response to these criticisms, the following changes were recommended with the Sixth Edition:

- Standardize assessment of Activities of Daily Living (ADL) limitations associated with physical impairments.
- Apply functional assessment tools to validate impairment rating scales.
- Include measures of functional loss in the impairment rating.
- Improve overall intrarater and interrater reliability and internal consistency.

[27] This comparative study was performed by Impairment Resources, LLC (www.impairment.com) at the request of the Division of Workers' Compensation of the Florida Department of Financial Services and based, in part, on study performed for the American Medical Association. Brigham and Associates, Inc., the predecessor of Impairment Resources, LLC, has performed similar studies in the State of California and the State of Colorado.

Studies have demonstrated poor interrater reliability and revealed that many impairment ratings based on earlier Editions of the *Guides* were incorrect and more often than not were rated significantly higher than was appropriate.[xi] There were changes that impacted impairment ratings; for example, impairments for conditions that may result in functional loss previously did not result in ratable impairment (such as non-specific spinal pain and certain soft tissue conditions). This reflects an underlying concept that treatment should be designed to improve functioning and decrease impairment. The focus should be on the diagnosis and final outcome as well as the update of impairment values based on medical advancements (e.g., the outcomes of total knee replacements and carpal tunnel release are improved).

In that the *FUPIRS* are used in Florida to define awards, it is appropriate to determine if change to the AMA *Guides* would result in different impairment ratings and different awards.

Study

To determine the potential impact of changes in ratings with the *FUPIRS* and the AMA *Guides*, a study was performed based on an earlier 2010 study of impairment ratings resulting from the Fourth, Fifth and Sixth Editions.[xii]

The earlier AMA Study involved the assessment of two hundred cases, using the clinical data to determine the resulting whole person permanent impairments by these three editions. If the case reflected more than one diagnosis, each diagnosis was rated and if both extremities were involved, each was rated as a separate diagnosis. The cases analyzed were cases that had been referred in 2009 to Impairment Resources, LLC, by three clients (two based in California and one in Hawaii) who refer all impairment ratings to determine their accuracy. It is probable that these cases are reflective of typical cases resulting in impairment ratings, since the cases were not selectively referred (i.e., the referring client did not refer the case because it was atypical or there was a concern about the rating). All cases had been originally rated by the Fifth Edition. Each case was independently analyzed using the clinical data provided in the case by a professional rater experienced in the use of the Fourth, Fifth, and Sixth Editions. To assure reliability 15% of these cases were blindly reviewed by a separate reviewer; all ratings were within 1% whole person permanent impairment with the exception of one case where there was a 5% whole person permanent impairment difference for the Fifth Edition due to differing interpretations of what spinal impairment was appropriate (using the Diagnosis-Related Estimates approach). There was agreement within 1% whole person permanent impairment for all Sixth Edition ratings.

In this current study, seventy five cases were selected on a random basis (using a random number generator). Each case was analyzed by a professional rater using the *FUPIRS* with ten of these cases being evaluated by a second rater for validation purposes; there was agreement on the *FUPIRS* impairment rating on all cases. Impairments were expressed both as an overall whole person impairment value for the case as well as for each diagnosis.

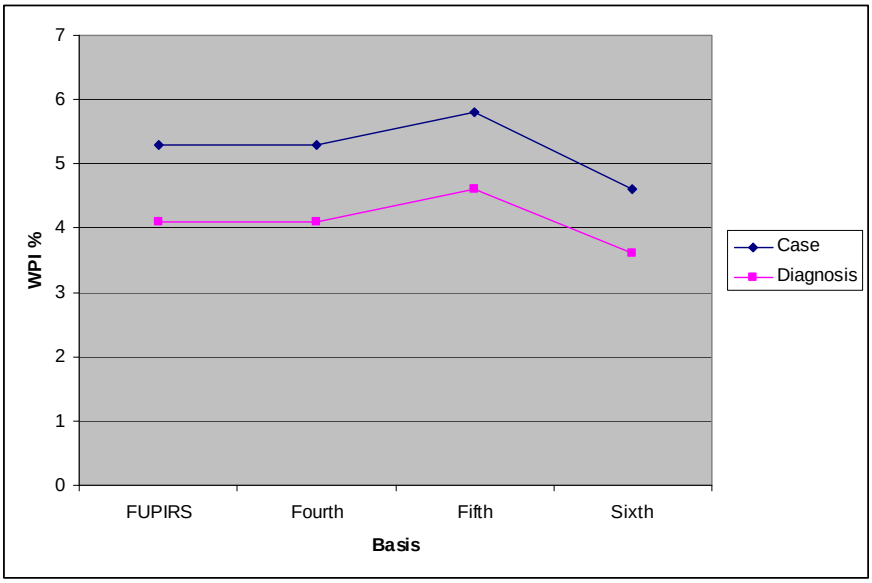
Results

Ninety two diagnoses were associated with these 75 cases; 14 of the cases had more than one ratable diagnosis. Forty percent of these diagnoses involved surgery. Upper extremity diagnoses were most common (43% of the diagnoses), followed by spine (39%) and lower extremity (15%). The average age of the patients was 46 years and the majority were male (57%). The average time between the date of injury and date of the original impairment evaluation was 24 months.
Seventy one percent of the Sixth Edition ratings were based on the Diagnosis-Based Impairment (DBI) approach (including Entrapment). Of the DBI ratings most (78%) were Class 1 (Mild Problem).

The average whole person permanent impairment per case was 5.3% whole person permanent impairment (WPI) per the *FUPIRS*, 5.3% WPI by the Fourth Edition, 5.8% WPI per the Fifth Edition, and 4.6% WPI per the Sixth Edition. The average whole person permanent impairment per diagnosis was 4.1% WPI per the *FUPIRS*, 4.1% WPI by the Fourth Edition, 4.6% WPI per the Fifth Edition, and 3.6% WPI per the Sixth Edition; this is illustrated in Figure 1. The difference between average whole person impairment ratings was tested using a paired sample t-test analysis with an alpha level set at the .05 level of significance. This analysis revealed that the difference between average whole person impairment ratings when

comparing the *FUPIRS* to the Sixth Edition was not statistically significant. The authors acknowledge that the limited range of impairment values in this study might have contributed to the lack of statistical significance when comparing group means (84% of the cases represented a rating of 10% WPI or less).

Figure 1. Comparison of Average Whole Person Permanent Impairment Ratings by Edition



Comparison of average whole person impairment ratings for diagnosis by regions is illustrated in Table 1.

Table 1. Comparison of Average Whole Person Permanent Impairment Ratings by Region

Title	FUPIRS	Fourth Ed.	Fifth Ed.	Sixth Ed.	Diagnoses	Percent
Upper Extremities	3.8%	3.5%	3.9%	3.7%	39	42%
Lower Extremities	5.5%	4.8%	4.8%	3.4%	15	19%
Spine	4.0%	4.6%	5.3%	3.6%	36	39%
					93	

Differences for diagnoses dependent on whether there was surgery is presented in Table 2.

Table 2. Comparison of Average Whole Person Permanent Impairment Ratings by Non-Surgical vs. Surgical Intervention.

Title	FUPIRS	Fourth Ed.	Fifth Ed.	Sixth Ed.	Diagnoses	Percent
Non-Surgical	3.1%	2.8%	3.2%	2.9%	37	40%
Surgical	5.7%	6.1%	6.5%	4.6%	55	60%

Twenty-nine percent of the diagnostic ratings per the *FUPIRS* resulted in no ratable impairment, however of these zero ratings 20 (74% of these zero ratings) had ratable impairment by the Sixth Edition with the average impairment being 1% WPI.

Table 3 illustrates the differences in ratings among editions based on the value of the *FUPIRS* rating.

Table 3. Change in Whole Person Permanent Impairment Ratings Compared to FUPIRS - by Case

WPI% Rating per FUPRIS	Cases	% Case	FUPIRS	Fourth Ed.	Fifth Ed.	Sixth Ed.
0	17	23%	0.0%	0.4%	1.2%	1.3%
1% - 5%	28	37%	3.2%	3.6%	3.8%	3.0%
6% - 10%	18	24%	7.1%	6.7%	7.6%	6.1%
11% - 15%	8	11%	12.8%	12.5%	12.8%	8.4%
16% - 20%	3	4%	17.0%	17.7%	17.7%	14.7%
>20%	1	1%	25.0%	18.0%	18.0%	15.0%

The findings by region, based on diagnosis (including only those regions where there were 4 or more diagnoses rated), are presented in Table 4.

Table 4. Comparison of Average Whole Person Permanent Impairment Ratings by Region and Edition

Region	Diagnoses	FUPIRS	Fourth Ed.	Fifth Ed.	Sixth Ed.
Upper Extremity – Hand	10	3.2%	3.4%	3.4%	3.6%
Upper Extremity – Wrist	4	2.3%	0.5%	0.5%	1.0%
Upper Extremity – Shoulder	15	5.5%	5.5%	5.5%	5.5%
Upper Extremity - Nervous System	8	1.0%	1.1%	2.6%	1.5%
Lower Extremity - Ankle/Foot	4	2.0%	1.3%	1.3%	2.0%
Lower Extremity – Knee	10	6.3%	5.2%	5.2%	3.9%
Spine – Cervical	12	2.2%	2.9%	3.3%	3.0%
Spine – Lumbar	22	5.0%	5.5%	6.4%	3.5%

The most common diagnosis (based on ICD-9 assignment) was backache, followed by shoulder region disease and carpal tunnel syndrome. The impairment values associated with these diagnoses (for diagnoses where there 3 or more ratings) are shown in Table 5.

Table 5. Comparison of Whole Person Permanent Impairment Ratings for Common Diagnoses

ICD-9	Diagnosis	Count	FUPIRS	Fourth Ed.	Fifth Ed.	Sixth Ed.
724.5	Backache NOS	15	4.1%	3.7%	4.6%	2.2%
726.2	Shoulder Region Disease NEC	12	4.0%	4.3%	4.3%	4.4%
354.0	Carpal Tunnel Syndrome	7	1.0%	1.0%	2.7%	1.3%
723.1	Cervicalgia	7	1.9%	1.4%	2.0%	0.9%
722.93	Disc Disease NEC / NOC -Lumbar	6	6.7%	9.2%	10.0%	5.8%
717.5	Derangement Meniscus NEC	5	3.6%	3.2%	3.2%	2.0%
842.10	Sprain Of Hand NOS	5	1.8%	1.8%	1.8%	2.0%
722.91	Disc Disease NEC / NOC -Cervical	4	2.3%	5.0%	5.0%	5.5%
717.9	Internal Derangement Knee NOS	3	6.3%	3.7%	3.7%	3.3%

Summary

The average whole person permanent impairment per case was 5.3% WPI per the *FUPIRS*, 5.3% WPI by the Fourth Edition, 5.8% WPI per the Fifth Edition, and 4.6% WPI per the Sixth Edition. The 0.7% WPI difference between the average whole person permanent impairment values observed with the *FUPIRS* compared to the Sixth Edition is not statistically significant.

The authors acknowledge that the limited range of impairment values in this study might have contributed to the lack of statistical significance when comparing group means (84% of the cases represented a rating of 10% WPI or less).

In conclusion, the observed modest and not statistically significant changes in values with the Sixth Edition were expected and primarily due to the recognition that: 1) the *FUPIRS* used methodologies present in earlier Editions of the AMA *Guides* that are no longer considered appropriate, 2) surgery and all therapeutic endeavors should improve function and therefore should not routinely increase impairment, and 3) certain common conditions that resulted in functional deficits and no ratable impairment in the *FUPIRS* and prior Editions of the AMA *Guides* should be ratable. By adopting the AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition, the state of Florida will be using the most medically current impairment rating system available and be able to move away from the old methodologies used within *FUPIRS*.

Acknowledgments

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Appendix E

The AMA Guides in Florida

The Florida workers' compensation system uses the *1996 Florida Uniform Permanent Impairment Rating Schedule* (*FUPIRS*). The FUPIRS was based in part on the Second, Third Revised and Fourth editions of the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*™).

The AMA *Guides* are already used by the insurance industry within Florida for cases that involve injuries resulting from an automobile casualty or personal injury. As an insured's claims for pain and suffering (as a basis for recovery) are subject to limits outside the automobile no-fault system, the AMA Guides are used to define permanent loss.[1]

By adopting the AMA *Guides to the Evaluation of Permanent Impairment, Sixth Edition* (AMA *Guides Sixth*), Florida will be using the most medically current impairment rating system available. In addition, given that the *FUPIRS* incorporated copyrighted materials from the Second, Third and Fourth Editions of the AMA Guides without permission, adoption of the AMA *Guides Sixth* will alleviate the potential infringement that has existed since *FUPIRS* was published in 1996.

Background: The AMA Guides™

The AMA *Guides* is the most commonly used tool in the United States for rating impairment. The precursor to the AMA *Guides* originated in 1956, when the AMA Board of Trustees created an ad hoc committee on Medical Rating of Physical Impairment to establish a series of practical guidelines for rating impairment of the various organ systems. From 1958 to 1970, the Committee published a series of AMA *Guides* articles in the *Journal of the American Medical Association* (*JAMA*). In 1971, these were published as a single volume, which has since been revised into five subsequent editions in response to new or emerging medical practices, research and stakeholder needs.

With each update to the impairment methodology, there were changes in impairment ratings associated with specific conditions. As clinical medicine evolves and there is increased efficacy of treatment, improved outcomes will reduce impairment previously associated with injury and illness in some cases.[2] In addition, each new edition allows for ratings for some conditions that earlier editions of the AMA *Guides* did not.

[1] Brigham CR, Rondinelli RD, Genovese E, Uejo C, Eskay-Auerbach M. Sixth Edition: the New Standard. *Guides Newsletter* January/February 2008

[2] Brigham CR, Uejo C, McEntire A, Dilbeck L. Comparative Analysis of AMA *Guides* Ratings by the Fourth, Fifth, and Sixth Editions. *Guides Newsletter* January/February 2010

The AMA Guides Sixth: Breaking new ground, building on history

The AMA *Guides Sixth*, published in 2007, introduced a more contemporary terminology and approach and defines a new international standard for impairment assessment. A comprehensive model of disablement—the 2001 International Classification of Functioning, Disability and Health (ICF) developed by the World Health Organization (WHO)—was adopted in place of the previous 1980 terminology of the International Classification of Impairments, Disabilities and Handicaps (ICIDH). This latest model provides evidence-based concepts, terminology, definitions and a conceptual framework. This framework was implemented and applied to each chapter of the AMA *Guides Sixth* with the objective of enhancing the validity, improving internal consistency, standardizing the rating process and improving interrater reliability.

The AMA *Guides Sixth* is currently being used in 13 states in addition to Puerto Rico, the Department of Labor's Division of Federal Employees' Compensation, Hong Kong, Korea, New Zealand, Australia, South Africa, and numerous provinces and territories within Canada. Feedback from users of the AMA *Guides Sixth*—including the Department of Labor which adopted the AMA *Guides Sixth* in May of 2009 through the Federal Employment Compensation Act—indicates that the AMA objectives for this most recent edition were achieved. In addition, trained users report that the AMA *Guides Sixth* is both easier to use and to teach.

The AMA Guides Sixth editorial process: A collaboration of experts

In order to secure greater transparency and input from stakeholders, the AMA implemented a new process for the AMA *Guides Sixth* modeled after pre-established AMA editorial processes. An Editorial Panel, Advisory Committee, contributors and peer reviewers comprised of over 200 individuals had input to this most current edition. The editorial process used an evidence-based foundation when possible and a modified Delphi panel approach to consensus building.

Specifically, over 500 state medical associations and national medical specialty societies were invited to nominate a disability or impairment physician expert to serve as a potential author, content contributor and/or reviewer. Forty-five organizations submitted nominations. Participants were chosen based on their past publications, evidence-based research experience, reputation in their field and the application of scientific methods to problems of impairment evaluation.

The mission of the Advisory Committee was to solicit questions and concerns about previous editions of the AMA *Guides* from their various societies and agencies. The Committee submitted their recommendations to the Editorial Panel for its deliberations and final decision with respect to content for the AMA *Guides Sixth*. The Committee is composed of participants from medical specialty societies and other experts from certification organizations, teaching organizations, and workers' compensation systems.

The Editorial Panel was comprised of 11 participants recognized for their knowledge and application of clinical medicine and science in the field of impairment evaluation. The Editorial Panel outlined a set of recommendations to revise the AMA *Guides Fifth.* The recommendations were disseminated to a group of 16 additional physician participants for review and input. Based

on these recommendations, the Editorial Panel identified a framework and adopted a set of axioms that would form the basis of the AMA *Guides Sixth*. These axioms were:

- Adopt the terminology, definitions and, conceptual framework of disablement of the International Classification of Functioning, Disability and Health (WHO, 2001) in place of the current and antiquated ICIDH terminology (WHO, 1980); Make greater use of evidence-based medicine and methodologies;

- Wherever/whenever evidence-based criteria are lacking, give highest priority to simplicity and ease of application, and follow precedent unless otherwise justified;

- Stress conceptual and methodological congruity within and between organ system ratings; and

- Provide rating percentages that are functionally based whenever possible, unless/until science supports otherwise.

Six of the Editorial Panel members were selected to be Section Editors. The remaining five Editorial Panel members served in a consultative role. Section Editors were charged with developing the AMA *Guides Sixth* in accordance with the axioms identified above. Each Section Editor was assigned to lead the revision of a section consisting of 2-4 related chapters. Contributors and reviewers from the various state and county medical associations and national medical specialty societies were assigned to a section based on his/her specialty and expertise. The Section Editors worked with contributors who wrote the specialty specific chapters. This process assured that each chapter had contributors in that specialty. Chapters in draft form were reviewed by the assigned Section Editor, then by all of the Section Editors. This approach ensured consistency across chapters and uniform adherence to the axioms established by the Editorial Panel. Next, chapters were disseminated for expert peer review including the remaining members of the Editorial Panel.

The six Section Editors met via conference call at least monthly to review questions and issues that required resolution. Section Editors met individually with their author teams to achieve uniformity and consensus on individual chapters. When consensus could not be reached, the issue was brought to the Editorial Panel for resolution.

Using the AMA Guides Sixth

In evaluating the severity of an illness or injury, a physician typically considers four basic points: (1) what is the problem (diagnosis); (2) what symptoms and resulting functional difficulty does the patient report; (3) what are the physical findings pertaining to the problem; and (4) what are the results of clinical studies. These same considerations are used by physicians to evaluate impairment and, therefore, were used as a guiding construct for the AMA *Guides Sixth*. It is designed to encourage attention to—and documentation of—functional consequences of the impairment as a part of each physician's detailed history, to clarify and delineate key physical findings, and to underscore essential clinical test results where applicable.

As previously mentioned, the AMA *Guides Sixth* methodology applies terminology and adopts an analytical framework based on the WHO's ICF model. Diagnosis-based grids were developed for each organ system and these grids arrange diagnoses into five classes of impairment severity, according to the consensus-based dominant criterion. The functionally based history, physical findings, and broadly accepted clinical test results, where applicable, are then integrated to determine severity grade and provide a corresponding impairment value. Ratings are transparent, clearly stated, and reproducible. The template of the diagnosis-based grid is common to each organ system and chapter, leading to improved internal consistency and ease of application when using the new methodology.

Features of the AMA *Guides Sixth* include:

- The most contemporary concepts and terminology based on the ICF model
- A standardized approach across organ systems and chapters
- The latest scientific research and evolving medical opinions of more than 200 nationally and internationally-recognized experts
- Unified methodology that helps physicians calculate impairment ratings through a grid construct and promotes consistent scoring of impairment ratings
- Comprehensive and expanded use of the diagnostic-based approach
- Documentation of functional outcomes, physical findings, and clinical test results, as modifiers of impairment severity
- Increased transparency and precision of the impairment ratings
- Improved internal consistency across body systems
- Increased intra and inter-rater reliability

These features benefit all stakeholders by minimizing conflict and improving decision making. The AMA *Guides Sixth* standardizes the rating process, increases accuracy, and provides a solid basis for future editions of the AMA *Guides*. The goal of the AMA *Guides Sixth* was to develop an impairment rating system that is fair and equitable to all parties.

Appendix F

National Council on Compensation Insurance, Inc.

ANALYSIS OF FLORIDA DRAFT PROPOSAL TO REVISE REIMBRUSEMENT RULES FOR REPACKAGED OR RELABELED PRESCRIPTION DRUGS EFFECTIVE UPON ADOPTION

NCCI estimates that adopting the proposed rules on reimbursement of repackaged or relabeled prescription drugs would result in a decrease of 1.1% ($34M) on overall workers compensation costs in Florida.

Summary of Proposal

The proposal introduces a reimbursement rule for drugs that have been repackaged or relabeled. Under the proposed rule, reimbursements for such drugs are limited to the number of units dispensed times the per unit Average Wholesale Price (AWP) set by the original manufacturer of the drug, plus a $4.18 dispensing fee. This rule does not apply in situations where the carrier has contracted for a lower reimbursement amount.

Currently, prescription drugs are reimbursed at the AWP plus a $4.18 dispensing fee. There are no restrictions on reimbursements for repackaged or relabeled prescription drugs.

Actuarial Analysis

In Florida, drug costs represent 12.8%[1] of workers compensation (WC) medical costs. Repackaged drug costs represent 23.5%[1] of Florida's WC drug costs, or 3.0% (=23.5% x 12.8%) of medical costs.

In order to estimate the cost impact of this proposal, NCCI compared the cost of repackaged drugs to the cost of drugs dispensed in its original packaging from the manufacturer (not repackaged drugs). A repackaged indicator field from First Databank's *National Drug Data File™ (NDDF), Descriptive and Pricing Data*, was used to identify repackaged and not repackaged drugs within the Florida Workers Compensation Data licensed to NCCI.

NCCI has assumed the difference between the current reimbursement for repackaged or relabeled drugs and the current reimbursement for the equivalent of these drugs that are not repackaged, to be a reasonable estimate of the cost impact due to the proposed rule.

The current and proposed reimbursements for each drug brand name were calculated as follows:

Current Reimbursement = Average observed reimbursement for repackaged drug x Total Units of Repackaged Drug

Proposed Reimbursement = Average observed reimbursement for equivalent drug that is not repackaged x Total Units of Drug that is not repackaged

Where:
Average observed reimbursement = Total Paid divided by Total Units
Units = Total number of pills per prescription

[1] Based on Florida Workers Compensation Data licensed to NCCI for service year 2008.

Prepared on 3/15/2010

National Council on Compensation Insurance, Inc.

ANALYSIS OF FLORIDA DRAFT PROPOSAL TO REVISE REIMBRUSEMENT RULES FOR REPACKAGED OR RELABELED PRESCRIPTION DRUGS EFFECTIVE UPON ADOPTION

The current and proposed reimbursement is then summed to obtain total current and total proposed costs. The estimated direct impact due to the proposed rule is the ratio of total proposed costs to total current costs.

Note that the AWP is not subject to any law or regulation. Therefore, there are no requirements for the AWP to reflect the price of any actual sale of drugs by a manufacturer. In addition, since there is a lack of control over the AWP, it may be subject to significant upward pricing pressures (much like the "sticker prices" on automobiles). For these reasons, limiting the reimbursement for repackaged drugs to the AWP set by the manufacturer may result in less savings than anticipated.

The direct impact on prescription drugs is estimated to be -52.8%. This impact is then multiplied by the estimated Florida percentage of medical costs that are for repackaged prescription drugs (3.0%)[1]. The resulting impact on medical costs is then multiplied by the percentage of Florida benefit costs that are medical (68.9%)[2] to yield the impact on Florida overall workers compensation system costs.

The impact due to the proposed rule is summarized in the following table:

		Impact
(1)	Impact on Repackaged Prescription Drug Costs in Florida	-52.8%
(2)	Repackaged Prescription Drug Costs as a Percentage of Medical Costs in Florida[1]	3.0%
(3)	**Impact on Medical Costs in Florida = (1) x (2)**	**-1.6%**
(4)	Medical Costs as a Percentage of Overall Workers Compensation System Costs in Florida[2]	68.9%
(5)	**Total Impact on Overall Workers Compensation System Costs in South Florida = (3) x (4)**	**-1.1%**

[1] Based on Florida Workers Compensation Data licensed to NCCI for service year 2008.
[2] Based on Calendar Years 2007-2008 Financial Call data projected to 9/1/2010. This estimated date is subject to change depending on the date the changes become effective.

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