REPORT OF THE
VIRGINIA WORKERS' COMPENSATION
COMMISSION ON

MEDICAL CARE COSTS CONTAINMENT PROPOSALS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 14

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

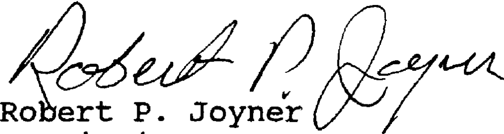
November 17, 1994

TO: The Honorable George F. Allen, Governor of Virginia, and Members of the General Assembly

Senate Joint Resolution 92 was enacted by the General Assembly at the 1994 Session. This resolution directed the Workers' Compensation Commission to study proposals for medical cost containment in workers' compensation cases and to recommend appropriate plans for containing these costs.

The Commission appointed a study committee made up of representatives of management, labor, the insurance industry, physicians, and hospitals. The committee held several meetings and conducted a public hearing at the Capitol on October 7, 1994. This report is a compilation of various recommendations presented to the committee and their report on those recommendations.

Respectfully submitted,



Robert P. Joyner
Commissioner

PREFACE

Senate Joint Resolution 92,[1] enacted at the 1994 Session of the General Assembly, directed the Workers' Compensation Commission to study means of containing the medical costs associated with workers' compensation cases.

The Commission appointed representatives of the various interest groups to comprise a committee to study this subject. Dr. Robert T. C. Cone, Vice President of Operations, Trigon Administrators, was selected as the employer representative; Mr. Daniel G. LeBlanc, President of the Virginia AFL-CIO, represented employees; Ms. Marie Kinietz, Director at the National Council on Compensation Insurance (NCCI), represented the insurance industry; Dr. Clarke Russ, orthopedist, represented the Virginia Medical Society; and Ms. Katharine M. Webb, Senior Vice President at the Virginia Hospital Association, represented hospitals. The Commission was represented by the three Commissioners.

The committee met on several occasions to review studies by NCCI, the American Insurance Association (AIA), and the AFL-CIO. Various recommendations by interested parties and groups were also reviewed. A public hearing was conducted on this subject in House Room C of the General Assembly Building in Richmond, Virginia, on October 7, 1994. Following that hearing, the committee concluded its work and reached the conclusions set forth in this report.

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[1] Appendix A

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EXECUTIVE SUMMARY

In response to Senate Joint Resolution 92, from the 1994 Session, the Workers' Compensation Commission undertook the study of various means of controlling medical costs in workers' compensation cases without interfering with the physician/patient relationship.

The resolution pointed out the unprecedented increases in medical costs in these cases in recent years and the trend towards cost containment in health care coverage outside the workers' compensation system. It was noted that the use of managed care, care utilization review, or peer review is an effective strategy and that there was no such strategy formalized within the workers' compensation system.

The Commission initially met informally with representatives of the Virginia Manufacturers Association, the Virginia Retail Merchants Association, labor, and the insurance industry to discuss the organization and staffing of a study committee. It was decided that one representative of each interest group would be designated by that group to represent its interests on the study committee. The study committee was subsequently assembled consisting of Dr. Robert T. C. Cone, Vice President of Operations, Trigon Administrators, for the employers; Mr. Daniel G. LeBlanc, President of the Virginia AFL-CIO, for the employees; Ms. Marie Kinietz, Director at the National Council on Compensation Insurance (NCCI), for the insurance industry; Dr. Clarke Russ, orthopedist, Virginia Medical Society, for physicians; and Ms. Katharine M. Webb, Senior

Vice President, Virginia Hospital Association, for hospitals. The three members of the Workers' Compensation Commission represented the agency.

Three meetings were held at the Commission offices to review the various studies on this subject currently available. These consisted primarily of an exhaustive "worst-case" study by NCCI and a somewhat shorter study by the American Insurance Association (AIA). In addition, a review of various studies nationwide was presented by the AFL-CIO.

These studies reviewed managed care or preferred provider organizations in various states. Utilization review, treatment protocols for various specific injuries, and the use of pain clinics were discussed. The possibility of developing a medical fee schedule was considered.

The committee also considered recommending a pilot project in Virginia which would direct injured employees to a managed care group or facility or a preferred provider organization in lieu of, or in addition to, the current panel of physicians provided by the employer. The committee reviewed the Joint Legislative Audit and Review Committee (JLARC) study of the Commission conducted in 1989, as it pertained to medical costs, and the report by the Governor's Commission on Workers' Compensation, 1993.

The committee also reviewed a managed care program being operated by Trigon Administrators (formerly Consolidated Risk Management). In addition, the committee received a report from the Lynchburg Health Care Coalition. Each of these proposals was

discussed in detail and the concerns of the various interest groups reviewed.

The committee then conducted a public hearing on Friday, October 7, 1994, at the General Assembly Building. Approximately 35 people attended this hearing, including 15 people who registered and spoke. Several speakers presented written proposals and reports for review by the committee.

COMMITTEE FINDINGS

The Committee first reviewed a study of this subject by NCCI issued October 26, 1993 ("Managed Care in Workers Compensation: Current Practices and Considerations for Future Policy"). This study reflected the steady annual increase in medical costs nationwide. It then focused on those states in which a formal managed care program had been established, a review of those programs, and the results.

The elusive definition of the term "managed care" was discussed at some length by the committee. No specific working definition was developed by the committee; however, the members understood it to mean medical care that was regulated or controlled in some fashion by the employer or its insurance carrier. These include health maintenance organizations (HMOs) and preferred provider organizations (PPOs), as well as other plans.

This NCCI report reviewed workers' compensation claims in New Hampshire, Florida, and Oregon. New Hampshire adopted a pilot project of managed care that included the appointment of a state care manager who established a network of care providers to which

participating employees would be directed. The care manager would also implement time guidelines for the duration of disability and medical treatment for specific diagnoses. In addition, there is peer review of medical treatment and approval for certain surgical procedures. No results from this program were available at the time the report was written. However, it was noted that the plan had shown "promising signs that, with proper controls and appropriate incentives, costs can be controlled" (NCCI report, p. 12).

Florida also instituted a pilot program in 1991 reported to be "virtually identical" to the New Hampshire plan.

Oregon made substantial revisions in its workers' compensation laws in 1990 at a time when its medical expenses exceeded the national average by 235 percent. Oregon required certification of managed care organizations. Physician members of such organizations could treat an employee without further approval. Non-member physicians were required to obtain authorization, either from the employer or the director of the managed care organization, if authorized medical treatment was to continue beyond 12 treatments or 30 days, whichever occurred first. The employers or their insurance carriers were authorized to contract with managed care organizations. "Authorization" apparently applies to financial responsibility for treatment under the Oregon statutes.

At the time this report was prepared, the pilot projects in the three states had not been in operation long enough to produce significant statistical data. From the limited experience in each

state, it was anticipated that these plans would result in some reduction in costs. However, it should be pointed out that none of the states studied had the statutory provision found in Virginia which permits the employer to select the initial three-member panel of physicians. Under Virginia law, the initial choice of physicians lies with the employer, and the employee then selects the treating physician from the panel provided by the employer (§ 65.2-603). Indeed, this feature of Virginia law distinguishes our state from most of the other states of the union, particularly those states in which medical costs have escalated substantially, such as Oregon.

We also note that each of these states experimented with various pilot projects. The committee considered whether such an approach might be feasible in Virginia. However, the committee decided against recommending a pilot project because there are several currently underway in Virginia by private insurers, including Trigon. The consensus was that these pilot projects should be followed and the results studied.

The NCCI report also contained a brief summary of managed care, if any, in each of the 50 states. The report noted that there is no provision in Virginia for managed care but that the Statewide Coordinating Committee is charged with the responsibility of establishing a statewide peer review program, as well as regional peer review committees, within each of the health systems in the area to monitor services rendered by physicians. This has

been implemented and has been in operation for several years (§ 65.2-1300, et seq.).

The Statewide Coordinating Committee is also charged with developing a utilization review program in each health system area. It attempted to do this at one time but was unsuccessful because of the difficulty of establishing broad guidelines for treatment protocols for particular injuries or diseases. It was felt by the physicians that such protocols interfered with the physician/patient relationship to some extent and that each case should be treated individually. The Statewide Committee pointed out that the regional peer review committees were available for review of treatment and charges in individual cases and that this was their sole function. Finally, the Statewide Committee pointed out that legislation was introduced at the 1993 Session of the General Assembly (SB 1038)[2] to authorize an employer or its insurer to provide medical care for the industrially injured through a managed care arrangement. This measure did not pass.

The NCCI report is the most in-depth report available to the study committee. The report, in summary, pointed out that the cost of medical care has escalated sharply in those states in which the employer is not involved in the initial choice of the treating physician. This situation has never existed in Virginia. For a number of years, the employer had absolute control of the choice of the treating physician through its statutory authority to designate that physician. That provision was amended in 1968 to provide that

[2]Appendix B

the employer would designate a panel of no less than three physicians from which the employee could select a treating physician. However, the employer continues to maintain control of the treating physicians through its statutory authority to designate the panel.

The NCCI report concluded that the cost of medical treatment for the industrially injured has increased in Virginia between five and ten percent each year for the past ten years. This rate approximates or slightly exceeds the inflation rate. However, the average overall premium cost for compensation per $100 of payroll has declined from an average cost of 95 cents per $100 in 1982 to 76 cents per $100 in 1991; a decrease of 20 percent. Therefore, while the cost of the medical component of workers' compensation cases, which is approximately 50 percent of the total cost, has increased, the overall net cost of workers' compensation has decreased to the point that Virginia is one of the lowest of the 50 states. At the same time, Virginia ranks in the top one-half of the states in wage indemnity benefits.

The American Insurance Association (AIA) also prepared a report in 1993 reviewing the statutory provisions in 31 of the 50 states as they pertain to the initial choice of physicians. No purpose would be served in reviewing that report in detail here. Suffice it to say that the AIA report on the statutory provisions was essentially the same as that set forth in the NCCI report. Virginia, however, was not included in this report.

The AIA also provided a four-page report on "Managed Care in Workers' Compensation" dated March 1994. This report notes the escalating costs in those states which permit unrestricted employee choice of provider; a problem which does not exist in Virginia, as noted above. This report also notes that the states are about evenly divided between employer and employee choice, but that in many "employee choice" states, laws have recently been enacted providing for the choice from within a managed care plan offered by the employer, such as an HMO or PPO. However, this approach is fairly recent in all states, and data establishing savings is not yet available, although results appear to be positive. Other reports by AIA of disability management, managed care, and medical cost containment in workers' compensation were also reviewed.

Dr. Cone, a committee member, presented a report prepared by Trigon Administrators on its managed care pilot project. Under this plan, an injured employee is followed closely from the time of the injury. Trigon also follows the "paperwork" required of the employer, such as the filing of an Employer's First Report of Accident and medical reports. The medical treatment is also monitored closely and the prospective treatment plan reviewed. This project, however, has been in effect for approximately one year, and the difficulty of evaluating its results was noted. This problem results because there is no control group against which the results from a managed care group can be measured. The end result may be a reduction in medical costs in particular cases, but the reduction attributable to a particular program is difficult

to establish. However, this program is being evaluated statistically, particularly in terms of what the anticipated cost of certain treatment would have been had some controls not been in place. We note that this program involves the use of physicians and hospitals who are part of the Trigon network. Finally, it is noted that this program will likely result in some cost advantage and should be followed closely.

Dr. Michael A. Spinelli, Associate Professor of Management Science at Virginia Commonwealth University, prepared a report on medical fee schedules. This subject was thoroughly reviewed by the committee, and the consensus was that fee schedules are usually counterproductive. Schedules discourage physicians from agreeing to be members of a medical panel. Thus, medical treatment for the industrially injured is not available from these physicians. Moreover, those physicians who do treat the industrially injured are aware that their fee for services is limited, and in some cases, there could be a corresponding reduction in the quantity or quality of the medical care. Finally, the development of a fee schedule which is fair to physicians, even in a restricted geographical area, is difficult, if not impossible, to develop. The results from those states which have attempted this approach are mixed, at best. Virginia's "community rate" basis appears to be far preferable to a fixed medical fee schedule, particularly in light of the medical peer review program in this state. The Workers Compensation Research Institute (WCRI) also recommended against this approach.

Dr. Russ, a committee member, presented a position paper on the cost containment study prepared by the Medical Society of Virginia. This paper pointed out Virginia's low standing in the cost of compensation insurance per $100 of payroll. It recommended that the Lynchburg voluntary program, which will be commented on below, be followed in detail, rather than a pilot program utilizing HMOs or PPOs, which was commented on above. The Medical Society paper concluded that the existing workers' compensation system in Virginia provides cost-efficient and effective medical care for the industrially injured.

The committee also reviewed the results of the 1989 JLARC study of the Commission. JLARC made no specific recommendations regarding medical cost containment. However, their report pointed out that the medical peer review program was not being utilized to its full potential. The Governor's Advisory Commission on Workers' Compensation, which met several times during 1993, also considered this issue. A recommendation was made to that commission that employees should be permitted to select a treating physician from the employer's managed care network, i.e., an HMO or PPO, as an alternative to selecting a physician from a specific panel. This question was thoroughly discussed by the Governor's Advisory Commission, but no formal recommendation was made, except that the legislature should examine this proposal further. Other recommendations by that commission were acted on at the 1994 Session of the General Assembly, and some recommendations were

carried over to the 1995 Session. None, however, bear directly on the subject of this study.

The AFL-CIO also presented a paper, reviewing managed care in workers' compensation cases throughout the 50 states. This paper pointed out the many variations in the definition of "managed care." It expressed labor's strong reservations about managed care in that it limited the employee's choice of the treating physician by giving this choice to the employer. The three-member panel provision in our current law was the result of a compromise arrived at between labor and management at the time of its enactment in 1968.[3] Some states have also implemented a co-payment provision. However, the Virginia statute specifically prohibits this.

These studies were made available to the general public, together with the committee's comments, prior to the public hearing on October 7, 1994. At that hearing, some 17 speakers preregistered, 15 of which appeared and commented on the existing studies and some made additional recommendations.

Mr. Keith Cheatham, Public Policy Manager for the Virginia Chamber of Commerce, reported on the ongoing study of this subject by the Business Coalition on Workers' Compensation which may have its work completed by late-October 1994.

Dr. J. Lawrence Colley, Trigon Vice President for Corporate Medical Policy, made several recommendations. Dr. Colley first pointed out the difficulty in defining the term "community" and

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[3]Labor's position continues to be that the employee should have a free choice of the treating physician.

determining the appropriate level of charges for medical treatment. Code § 65.2-605[4] provides, in part, that:

> . . . The pecuniary liability of the employer for medical, surgical, and hospital service herein required . . . shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person . . .

Dr. Colley recommended a statutory definition of the term "community" as a regional peer review area or a state planning district. This approach has been used in other states, as set forth in a study from Harvard University which Dr. Colley presented for the committee's consideration.

Dr. Colley also pointed out that the workers' compensation system in Virginia presents the only unmanaged system in the marketplace. Other systems covered by health and accident insurance use a network of providers. In addition, Dr. Colley recommended more accountability by all parties as to treatment and charges. Dr. Colley noted that the expense of litigating contested medical charges adds to the cost of the workers' compensation system. He also recommended against a pilot project, noting that such projects were in existence. Finally, Dr. Colley pointed out that HMOs or PPOs, in effect, provide "managed care" and in most cases could be substituted for the statutory panel of physicians.

The Virginia Hospital Association (VHA) submitted a written statement noting the unique status of its members, both as

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[4]Appendix C

employers and as providers. Their recommendation is that all health care be consolidated into a single program with the medical services to be delivered by a network of designated providers with a negotiated fixed fee.

Mr. Timothy J. Shean, Vice President, Chemical Products Division, Sandvik Rock Tools, Inc., reported to the committee on the success of the safety committee utilized by his company. Sandvik employs approximately 200 people in its tool and chemical divisions in Virginia. Employees in the tool division have accumulated some 835 days without a lost-time accident. In the chemical division, some 1,557 days have been accumulated. The resulting savings can only be estimated but are thought to be substantial. Mr. Shean urged the committee to make a strong recommendation for safety committees through publicizing the substantial savings realized by employers with such programs. In addition, Mr. Shean recommended that employers with outstanding safety records be recognized publicly and their accomplishments acknowledged. These comments were echoed by Mr. John Gray of Weyerhaeuser Corporation and Mr. Donald McVey of Virginia Fiber Corporation and endorsed enthusiastically by Dr. Anthony Cetrone and by Mr. LeBlanc, a committee member, on behalf of labor.

Mr. Gray, Mr. McVey, and Dr. Jay E. Hopkins, orthopedist, are also members of the Lynchburg Health Care Coalition, which has developed a pilot project in that area. The Coalition is made up of employers, representatives of employees, and the medical profession. Its primary purpose is to educate all interested

parties in the handling of workers' compensation cases. The employees are made aware of their obligations, i.e., notice to the employer, selection of a physician, and following recommended medical treatment. The employers are informed of their obligations, i.e., the providing of a panel of physicians from which the employee may select a treating physician and follow-up thereafter. The physicians are informed as to the reporting requirements and the importance of keeping the employer advised as to the employee's progress. Particular emphasis is placed on finding appropriate light work when a disabled employee is able to engage in such activities.

The details of this plan and its results are set forth in a booklet prepared by the Coalition ("Problem Solving Guide to Handling Workers Compensation Problems") which, apparently, can be made available to interested parties. The speakers were all enthusiastic about this program and its results, which apparently have benefitted all parties involved in workers' compensation cases.

Mr. Gray reported that Weyerhaeuser has in excess of one million man hours without a lost-time accident and that its workers' compensation premiums have been reduced by approximately $100,000 since this program was implemented. Mr. McVey also pointed out the need for panel physicians and hospital personnel to be familiar with workers' compensation cases in order that these claims be processed properly.

Dr. H. W. Trieshmann, a practicing orthopedist from Newport News, Virginia, and Mr. Stephen Schall, a physical therapist, spoke in favor of PPOs and against fee schedules which were unworkable. Both felt that the current Virginia system was functioning satisfactorily. However, Dr. Trieshmann pointed out the additional record keeping required in workers' compensation cases and questioned whether the "community standard" in setting fees in these cases was adequate. The same concern was expressed by every other physician who spoke on this subject, including Dr. Hopkins and Dr. Russ, a committee member.

Mr. T. J. Smith, workers' compensation case manager for Newport News Shipbuilding, suggested that medical fee schedules be avoided and was otherwise complimentary of the current system.

Mr. Herbert DeGroft, Personnel Director of Smithfield Packing, stated his company's satisfaction with the existing system, but recommended greater communication between employers, employees, and medical providers; the point emphasized by the Lynchburg Health Care Coalition.

Dr. John Lofgren spoke for the Virginia Chiropractic Association. Dr. Lofgren pointed out that the most common injury suffered in industrial accidents is to the back. This is the chiropractor's specialty, and their treatment is cost-effective. Reference was made to the "Report of the Special Advisory Commission on Mandated Health Insurance Benefits," Senate Document No. 22, presented at the 1994 Session of the General Assembly. Dr. Lofgren pointed out that chiropractic care is underutilized in

workers' compensation cases and recommended that employers be required to include a chiropractor on its panel of physicians. In addition, treatment protocol for specific injuries should be established, as well as utilization review by other chiropractors.

Brenda Swindell, R.N., with First Hospital Corporation, spoke on behalf of her employer which operates several mental health facilities. It was pointed out that psychiatric treatment is needed in many workers' compensation cases. In such cases, the hospital must work closely with the treating physician in an effort to return the injured worker to full employment as quickly as possible.

Ms. Barbara Fowler, an occupational health nurse with Ingersoll-Rand, recommended board certification for occupational physicians, pointing out that this is a recognized specialty in itself.

CONCLUSIONS

The committee, having considered those matters set forth in this report, reach the following conclusions and make recommendations as indicated:

1) A statutory system of "managed care" is not required in Virginia at the present time.

2) The current system of providing a panel of physicians selected by the employer, from whom the claimant selects the treating physician, has been in place since 1968 and appears to be functioning well.

Labor continues to be of the opinion that the employee should have a free choice in selecting the treating physician. Moreover, in those cases in which an employer has an HMO or equivalent organization, physicians from that group should also be available to the injured employees, in addition to the panel physicians.

3) There are several innovative efforts underway in Virginia utilizing various approaches to "managed care." These efforts should be followed and their results studied. However, no new program is recommended by the committee.

4) Medical fee schedules are not recommended.

5) Treatment protocols are not recommended.

6) Utilization review is not recommended because it is available now through the peer review system currently in place (§ 65.2-1301, <u>et. seq.</u>).

7) Two members of the committee for the employers and the insurance industry, recommend a statutory definition of the term "community" as it applies to the pecuniary liability of the employer for the cost of medical, surgical, and hospital services. The Medical Society of Virginia opposes a statutory definition. Labor and the Virginia Hospital Association abstain on this issue, as does the Commission.

Some consideration should also be given to the intensity of service required of all parties in workers' compensation cases in determining appropriate charges.

8) The committee recommends that educational efforts directed at employers, employees, carriers, and medical providers be

encouraged. The plan developed by the Lynchburg Health Care Coalition received favorable comment in this regard. In addition, the savings realized by employers who utilize safety committees should be publicized. The committee encourages the cooperation of all parties within the workers' compensation community in this project.

9) No statutory mandate as to specialty of panel of physicians is recommended.

10) The committee, on a divided vote, recommends that an HMO or PPO be utilized in lieu of the panel or as part of the panel. This recommendation is supported by the employers, insurance industry, and the Virginia Hospital Association. Labor and the Virginia Medical Society recommend that an HMO or PPO, if part of the employer's medical benefit package, be added as a fourth member of the medical panel. The Commission makes no recommendation on this issue.

1994 SESSION

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SENATE JOINT RESOLUTION NO. 92
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Rules
on February 23, 1994)
(Patron Prior to Substitute—Senator Holland, R.J.)

6 *Requesting the Virginia Workers' Compensation Commission to study medical care cost*
7 *containment proposals for the workers' compensation system in Virginia.*
8 WHEREAS, the purpose of worker's compensation insurance is to compensate injured
9 workers for job-related injuries and diseases; and
10 WHEREAS, the integrity of the Commonwealth's workers' compensation system has been
11 profoundly challenged by unprecedented increases in medical costs associated with the care
12 and treatment of injured workers; and
13 WHEREAS, while health care coverage trends outside the workers' compensation system
14 are toward cost containment through managed care systems and care utilization review, no
15 such cost reduction strategies are formalized within the workers' compensation system; and
16 WHEREAS, the workers' compensation system could realize enormous benefits from
17 adopting such strategies if properly implemented with due regard to the importance of
18 proper medical care for injured workers; now, therefore, be it
19 RESOLVED by the Senate, the House of Delegates concurring, That the Virginia
20 Workers' Compensation Commission be requested to study medical care cost containment
21 proposals for the workers' compensation system in Virginia. The Commission is requested to
22 review and assess the feasibility of such proposals, including managed care and utilization
23 review, and recommend appropriate alternatives for containing medical care costs in the
24 workers' compensation system.
25 The Commission shall complete its work in time to submit its findings and
26 recommendations to the Governor and the 1995 Session of the General Assembly as
27 provided in the procedures of the Division of Legislative Automated Systems for the
28 processing of legislative documents.
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Official Use By Clerks

Agreed to By The Senate		**Agreed to By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: ______		Date: ______	
Clerk of the Senate		Clerk of the House of Delegates	

1993 SESSION

LD7897681

1 SENATE BILL NO. 1038
2 Offered January 26, 1993
3 *A BILL to amend and reenact § 65.2-603 of the Code of Virginia, relating to workers'*
4 *compensation; medical attention; managed care.*
5 ———
6 Patrons—Chichester, Barry, Russell, Saslaw and Schewel; Delegates: Bennett, Brickley,
7 Giesen and Watkins
8 ———
9 Referred to the Committee on Commerce and Labor
10 ———
11 Be it enacted by the General Assembly of Virginia:
12 1. That § 65.2-603 of the Code of Virginia is amended and reenacted as follows:
13 § 65.2-603. Duty to furnish medical attention, etc., and vocational rehabilitation; effect of
14 refusal of employee to accept.—A. 1. As long as necessary after an accident, the employer
15 shall furnish or cause to be furnished, free of charge to the injured employee, a physician
16 chosen by the injured employee from a panel of at least three physicians selected by the
17 employer and such other necessary medical attention. Where such accident results in the
18 amputation of an arm, hand, leg, or foot or the enucleation of an eye or the loss of any
19 natural teeth or loss of hearing, the employer shall furnish prosthetic or orthotic
20 appliances, proper fitting thereof, and training in the use thereof, as the nature of the
21 injury may require. In awards entered for incapacity for work, under this title, upon
22 determination by the treating physician and the Commission that the same is medically
23 necessary, the Commission may require that the employer furnish and maintain
24 wheelchairs, bedside lifts, adjustable beds, and modification of the employee's principal
25 home consisting of ramps, handrails, or any appliances prescribed by the treating physician
26 and doorway alterations, provided that the aggregate cost of all such items and
27 modifications required to be furnished on account of any one accident shall not exceed
28 $25,000. The employee shall accept the attending physician, unless otherwise ordered by the
29 Commission, and in addition, such surgical and hospital service and supplies as may be
30 deemed necessary by the attending physician or the Commission.
31 2. The employer shall repair, if repairable, or replace dentures, artificial limbs, or
32 other prosthetic or orthotic devices damaged in an accident otherwise compensable under
33 workers' compensation, and furnish proper fitting thereof.
34 3. The employer shall also furnish or cause to be furnished, at the direction of the
35 Commission, reasonable and necessary vocational rehabilitation services. Vocational
36 rehabilitation services may include vocational evaluation, counseling, job coaching, job
37 development, job placement, on-the-job training, education, and retraining. In the event a
38 dispute arises, any party may request a hearing and seek the approval of the Commission
39 for the proposed services. Such services shall take into account the employee's preinjury
40 job and wage classifications; his age, aptitude, and level of education; the likelihood of
41 success in the new vocation; and the relative costs and benefits to be derived from such
42 services.
43 B. The unjustified refusal of the employee to accept such medical service or vocational
44 rehabilitation services when provided by the employer shall bar the employee from further
45 compensation until such refusal ceases and no compensation shall at any time be paid for
46 the period of suspension unless, in the opinion of the Commission, the circumstances
47 justified the refusal. In any such case the Commission may order a change in the medical
48 or hospital service or vocational rehabilitation services.
49 C. If in an emergency or on account of the employer's failure to provide the medical
50 care during the period herein specified, or for other good reasons, a physician other than
51 provided by the employer is called to treat the injured employee, during such period, the
52 reasonable cost of such service shall be paid by the employer if ordered so to do by the
53 Commission.
54 D. As used in this section and in § 65.2-604, the terms "medical attention," "medical

1 service," "medical care," and "medical report" shall be deemed to include chiropractic
2 service or treatment and, where appropriate, a chiropractic treatment report.
3 E. Whenever an employer furnishes an employee the names of three physicians
4 pursuant to this section, and the employer also assumes all or part of the cost of providing
5 health care coverage for the employee as a self-insured or under a group health insurance
6 policy, health services plan or health care plan, upon the request of an employee, the
7 employer shall also inform the employee whether each physician named is eligible to
8 receive payment under the employee's health care coverage provided by the employer.
9 *F. In meeting its obligations to provide all reasonable and necessary medical care*
10 *under this Act, the employer or, if insured, its insurer, may provide such care through*
11 *managed care arrangements. Such arrangements shall afford all treatment to be provided*
12 *to the injured employee.*
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Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
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with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: ____________________ Date: ____________________

____________________ ____________________
Clerk of the Senate Clerk of the House of Delegates

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice. — The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such. (Code 1950, § 65-86; 1968, c. 660, § 65.1-89; 1991, c. 355.)

November 14, 1994

The Honorable Robert P. Joyner
Commonwealth of Virginia
Workers' Compensation Commission
1000 DMV Drive
Richmond, VA 23220

Dear Commissioner Joyner:

Please excuse my delay in responding to the draft of the report to the Governor as required by SJR 92. In general, I concur with the recommendations presented in this report. However, I have several comments regarding specific recommendations as I do not feel they necessarily represent the majority view on the committee.

Recommendation 6 - The report indicates that utilization review is not required as it is available through the current peer review system. In addition, a wide variety of non-leglislative peer review activities are used in the market today. By and large, these processes work quite effectively. Certainly, peer review under the workers' compensation title represents the area of last resort.

Recommendation 7- I totally concur with the recommendation on the need to define community and the statute. As an addendum to this recommendation, also included was a statement indicating the need to provide consideration to the intensity of service required of all parties in workers' compensation cases in determining appropriate charges. I am in total disagreement with this statement. The American Medical Association in its publication Physicians' Current Procedural Terminology CPT 94 provides a very explicit listing of medical procedures using a basic five-code numbering system which can be expanded through the use of modifiers. Billing using this AMA approved format provides incredible flexibility to medical providers in billing for their services. For example, there are in excess of 35 codes defining various levels of office visits and physician consultations. The AMA CPT definitions of medical procedures provides physicians the ample opportunity to bill for services and have such billing reflect the intensity of medical service provided.

Recommendation 10 - Amend the language to state "recommends at the employer's option, an HMO or PPO be utilized in lieu of the panel of three physicians." This change will make the recommendation consistent with the report.

If possible, I would appreciate these points of clarification be used as a supplement to the SJR 92 report. If this cannot be done, I request that this letter be included as an addendum to the report.

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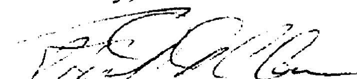
Please accept my personal thanks for providing the leadership which made what could have been a difficult task pleasant both rewarding and productive. I certainly hope that I have the opportunity to work with you in the future.

Sincerely,



Robert T. C. Cone
Vice President - Operations

RTCC:apr