V. MEDICAL AND VOCATIONAL REHABILITATION

Professor Solomon Axelrod, of the University of Michigan School of Public Health, is one of the country's foremost authorities on the medical aspects of workers' compensation. He was kind enough to provide me, as a **pro bono** contribution to my project, with the following appraisal of the extraordinarily important effort to contain medical costs in the rehabilitation of injured workers. With some minor editing by myself, this is what Professor Axelrod had to say:

A. Medical Care Cost Containment

1. **Background.** Medical care is an important component of workers' compensation in Michigan, accounting for about one-fourth of all expenditures in recent years.

Eligibility for medical benefits conforms to requirements of eligibility for cash benefits ("lost time cases"). In addition, medical benefits are provided for employees with work-related illnesses and injuries who are not entitled to cash benefits because the duration of their lost time is less than seven days ("non-compensable medical cases"). Only about a quarter of all reported cases are "lost time cases," but because of their relative severity — about 20 percent receive hospital care -- "lost time cases" account for about 80 percent of all medical expenditures.

The Act requires that the employer or the employer's insurance carrier furnish an employee injured in the course of employment reasonable medical, surgical, and hospital services, drugs, "or other attendance or treatment recognized by the laws of this state as legal, when they are needed." Dental service, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other applicances necessary to cure, so far as reasonably possible, and relief from the effects of the injury, are specifically cited. Appliances such as corsets, splints, braces, walkers, and wheelchairs are also included. The injured worker is entitled to vocational rehabilitation services which include retraining and job placement necessary to restore useful employment. Vocational rehabilitation is limited to 52 weeks except by special review.

Medical benefits are provided in a wide variety of settings -- a private physician's office, an industrial clinic, a hospital emergency room or inpatient facility — by providers who are designated by the employer or the employer's insurance carrier and who are reimbursed for their services by them. After ten days from the inception of medical care, the employee may change the designated source of care and select a provider of his own choosing.

There are estimated to be about 800 entities, private insurance carriers, and self-insurers, involved in making arrangements for medical care under workers' compensation in Michigan. Most of them, about 70 percent, are self-insurers; the rest are private insurance carriers. There is a high degree of concentration in this arena both with respect to the number of employees covered, the number receiving medical benefits, and the amounts paid out for claims. For example, in 1981, the ten highest ranking private insurance carriers paid out about 38 percent of total medical benefit expenditures; the ten highest ranking self-insurers, about 31 percent.

Medical benefit expenditures in 1981 were estimated to be about $139 million, a figure which may be understated by as much as $50 million. Slightly over half of these expenditures (54%) were made by private insurance carriers; slightly less than half (46%), by self-insurers. Costs per case receiving medical benefits vary widely depending on type of insurance and cash compensation status. Thus, in 1981, available data indicate that average cost per case varied as shown below:

Type of Insurance	Average Cost/Case
Self-insured	$ 54.43
Private carrier	434.36
Compensation status	
Non-compensable	29.13
Compensable	1,569.08

Administrative responsibility for the medical care aspects of workers' compensation resided in the Bureau of Workers' Disability Compensation, Michigan Department of Labor until 1981, when the 1969 Compensation Act was amended. The 1981 amendments to the Act mandated medical care cost containment responsibilities. MCL § 418.315. Statutory authority for implementing these responsibilities was transferred to the Department of Management and Budget, Office of Health and Medical Affairs, by Executive Reorganization Order No. 2-1982.

Until such time as new regulations are put in place, information bearing on the medical care component of workers' compensation is derived from two required reports, Employer's Basic Report of Injury, Form 100, and a semi-annual report on the total number of cases receiving medical benefits and the total amount spent on such cases, Form 109.

An annual report, **Compensable Occupational Injury and Illness Report**, is published by the Bureau of Safety and Regulation, Michigan Department of Labor. It is based on an analysis of the Form 100 reports. A federal-state cooperative Supplementary Data System (SDS) furnishes data on reported cases in regard to injury and illness characteristics, their nature and sources, parts of body affected, and types of accident or exposure. This report provides information for the development of educational and training

materials for employers and employees and should assist them in the planning of accident and disease prevention activities. The number of reported compensable injury and illness cases has been declining in Michigan during the past few years.

For information on medical care in workers' compensation, Form 109 is relied on. This semi-annual report, as indicated above, provides limited medical care information, i.e., aggregate data on the number of cases reported to the self-insured employer and the private insurance carrier, and the amount paid out for medical benefits both for cases which received weekly compensation, and for those on which weekly compensation was not payable. Other information, crucial to an understanding of how this third-party payor system works, and needed for its evaluation in cost containment terms, is not available from the program at this time. Such basic information as number of **claims** submitted (in contrast to number of **cases**), number of services rendered, and billed charges, **by type of provider** would have to be obtained from bills submitted by health care providers to carriers for reimbursement, on a total or sample basis. Although some carriers use a standard government billing form such as required by Medicare, no uniform billing form is required, nor is there a requirement for the provider to use a standard diagnostic code.

Administration of workers' compensation medical benefits can be characterized as exhibiting a "hands-off" posture on the part of the Bureau. Surveillance of the appropriateness of the type and volume of services rendered and the charges for them is left to the approximately 800 entities involved in making arrangements for medical care. Some of them, usually the larger private insurance carriers, use "fee screens" to assess the reasonableness of billed charges. Others have no written guidelines or "fee screens" by which to assess the appropriate charge for a service and their claims review personnel use their "common sense and experience" in making such judgments. Under these circumstances, flagrant discrepancies in charges and numbers of services rendered may be detected, but for the most part the providers' self-determined fees are accepted as reasonable and the hospital's billed charges are paid.

2. **The 1981 amendments.** The 1981 amendments included a number of provisions bearing on the administration of medical benefits under workers' compensation. Briefly summarized, they were as follows (MCL § 418.315):

> All fees or charges for medical services shall be subject to rules promulgated by the Bureau.
>
> The rules shall establish schedules of maximum charges for each service, subject to annual revision.
>
> The facility or provider shall be paid its usual or customary charge for each service or the maximum charge established by the Bureau, whichever is less.

> The rules shall be promulgated not later than one year after the effective date of this subsection [March 31, 1982] and sent to the Legislature for review.

Section 418.315 also provided for the appointment of an Advisory Committee to assist the Bureau in establishing a schedule of maximum charges. The Bureau was further directed to review health care facilities for compliance with established charges and to create a system for utilization review.

As previously mentioned, an Executive Order in 1982 transferred responsibilities for carrying out these responsibilities from the Department of Labor, Bureau of Workers' Disability Compensation, to the Department of Management and Budget, Office of Health and Medical Affairs. A 25-member Health Care Cost Advisory Committee was appointed in early 1983. this committee has been meeting since then to assist in the development of proposed fee schedules and utilization review procedures. The development of a fee schedule which was to have been promulgated no later than April 1, 1982, after being approved by the Joint Legislative Administrative Committee, has been delayed by lack of consensus in the Advisory Committee. The scope and specifics of the proposed utilization review procedures have also been subjected to far-reaching differences of opinion and their promulgation has likewise been delayed.

In brief, rules have been proposed for the establishment of maximum charges for medical benefits, a utilization review process, and a reporting system to permit surveillance of costs and volume of medical benefits provided.

3. **Issues in cost containment.** Although both the overall cost of workers' compensation insurance in Michigan and the number of reported compensable cases have been declining since 1981, there is no reason to assume that medical benefit costs have undergone commensurate reductions. In a period when medical care costs have been increasing at more than twice the rate of inflation, and in the face of what is essentially an open-ended, inadequately controlled third-party payment system, it can reasonably be argued that in fact this is not the case.

In the absence of mechanisms to limit costs or reduce the use of medical services such as fee schedules and utilization review procedures, medical care costs under workers' compensation are subject to the same inflationary forces that affect all medical care costs. **It is therefore important that the cost containment measures mandated in the 1981 amendments be implemented promptly.**

Medical care cost containment must, of course, be balanced against an equally important objective — to ensure that injured workers receive the best medical care possible to maximize recovery from injury. To achieve this goal, consideration should be given to the creation of a professionally

staffed medical unit, such as the Medical Services Division of the Ontario Workers' Compensation Board, to provide professional surveillance over the quality of the care and the medical aspects of vocational rehabilitation.

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B. Vocational Rehabilitation

Perhaps the greatest tragedy of the workers' compensation system is that it does not put every injured worker back to work. No amount of money can compensate for that. Every self-respecting human being wishes to be self-supporting. That obviously means that any humane system for dealing with employee disabilities must establish as a first priority the restoration of the worker to a full-fledged position in the work force. The medical and vocational rehabilitation of injured workers is espoused by everyone as a primary goal of the workers' compensation system, but in practice it is sadly neglected. Professor Axelrod arranged for Eugenia S. Carpenter, a Research Scientist at the University of Michigan School of Public Health, to assess the existing system of vocational rehabilitation in this State and to make such recommendations for improvement as she thought appropriate. A summary of Ms. Carpenter's study follows:

1. **Summary.** Restoring the employability of the worker has always been a goal of the workers' compensation program. Nevertheless, medical and physical rehabilitation has tended to take precedence over vocational rehabilitation during most of the history of the program. Even today, there is a perception that vocational rehabilitation is an underutilized component of the workers' compensation program.

Section 319 of the Michigan Worker's Disability Compensation Act provides that an injured worker "who is unable to perform work for which he has previous training or experience...shall be entitled to such vocational rehabilitation services, including retraining and job placement, as may be reasonably necessary to restore him to useful employment." The statute entitles a worker to up to 52 weeks of vocational rehabilitation services, and an additional 52 weeks or portion thereof may be authorized by special order of the Director of the Bureau of Workers' Disability Compensation, Department of Labor, if deemed necessary to restore employability.

The statute is predicated on the assumption that vocational services will be voluntarily offered by the employer or carrier and accepted by the injured employee. If this does not occur, the Director may, at the request of the employee, or the employer, or the carrier, or on his own motion, refer the employee to appropriate vocational rehabilitation for evaluation of rehabilitation potential. It is important to note that a worker is not entitled to vocational rehabilitation services while his claim is being contested. In the case of a redemption, the worker waives all rights to rehabilitation services under the workers' compensation program.

Over the past five years, an average of about 3,000 vocational rehabilitation cases have been opened annually. They represented between two and four percent of cases opened for payment in each year. On the average, some 2,700 vocational rehabilitation cases were closed annually between 1980 and 1984. The average success rate during this period, that is, the percentage of workers who returned to work for the same or a new employer or redeemed under an approved self-employment plan, was about 27 percent. By far the majority of successful rehabilitations involved returning to work for the same employer. Vocational rehabilitation experts estimate that the proportion of injured workers who are feasible candidates for vocational rehabilitation services ranges between 0.5 and 5 percent. The Michigan Bureau's Vocational Rehabilitation Division (VRD) staff (three persons) estimates the potential to be between 3 and 5 percent of compensable injury cases. On the average, about 90 percent of injured workers return to work within 120 days and about 94 percent of compensable cases are off compensation within 180 days.

The literature on workers' compensation, the experience of Michigan and other states, and the opinions of experts in the field have identified a number of barriers and disincentives to the realization of the full potential of vocational rehabilitation as a tool to restore injured workers to gainful employment. Some of the problems may be overcome by administrative and statutory changes. Others are not easily solved and may be an inevitable part of the complexity inherent in any system to compensate workers who are injured or disabled in the course of employment. Problems include: lack of understanding of or support for VR services on the part of employers, carriers, and injured workers; skewed economic incentives; the litigious nature of the workers' compensation system; the redemption process; abuses in the provision of VR services; and lack of adequate program evaluation.

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2. **Recommendations.** Ms. Carpenter made a series of specific proposals for improving the vocational rehabilitation program. After careful review, I adopt these recommendations as my own, with one significant modification. Ms. Carpenter would prohibit outright the waiver of rehabilitation rights in cases of benefit redemptions or settlements. In keeping with the language of the National Commission on State Workmen's Compensation Laws (**Report**, Recommendation 6.17, p. 110), I simply say that the Bureau should be "particularly reluctant" to approve such waivers. With that qualification, the recommendations and the justifications for them are as follows:

(a) A system of utilization review for rehabilitation services, analogous to that mandated for medical care under Section 315 of the Act, should be developed and implemented.

Justification: Allegations about abuses by providers of VR services cannot be dealt with adequately until standards for the level and quality of services are developed and applied. The difficulty of accomplishing that

goal is acknowledged. Unlike medical care, standards for appropriateness of vocational rehabilitation services are virtually nonexistent. Nevertheless, until agreement can be reached on criteria for judging whether services are in excess of what are needed, or conversely, inadequate to a client's needs, no effective monitoring of rehabilitation services will be possible. Although difficult to accomplish, the task of defining professionally acceptable standards is one that experts in the field of rehabilitation could assist the state agency in developing. Authorizing legislation would be required to implement this recommendation.

The sentinel effect of a monitoring system cannot be overemphasized. The results of the Vocational Rehabilitation Division's monitoring system in encouraging a sharp rise in voluntary employer referrals to rehabilitation is an outstanding example.

(b) A companion system to establish standard reimbursement levels for rehabilitation services covering both public and private providers should be authorized through amendments to the Act.

Justification: There are no controls at present on the amounts that may be charged for VR services. While some employers and insurance carriers have a perception that these services are too costly, there are no standards for judging whether and by how much costs are excessive. In support of cost containment and restraint, studies in California indicate that the least expensive rehabilitation plans offer the greatest opportunity to return a worker to employment.

The difficulties of establishing reimbursement standards are at least as great as those surrounding utilization review. The experience of the Office of Health and Medical Affairs in developing a system of fee schedules for medical care under Section 315 may provide some guidance in approaches to the problem, including identifying those to be avoided. Because the notion of setting levels for payment for rehabilitation is **terra nova**, there may be greater opportunities for innovative approaches, including perhaps a DRG-type approach to classifying clients for purposes of levels of payment to rehabilitation providers. A fee-for-service system lends itself to abuses and tends to have an escalating effect on outlays for services, judging by the experience of the medical care sector.

(c) Statutory changes should be sought to clarify the authority of the BWCD to approve rehabilitation facilities; approval should be tied to minimally acceptable levels of performance as determined under the utilization review criteria recommended above.

Justification: The decentralization and pluralistic system for providing rehabilitation services needs tighter controls and monitoring, according to a majority of both insurance carriers and rehabilitation facilities responding to a voluntary survey conducted in Michigan in 1984. Monitoring and quality control will be most effective if they focus on the process and outcome of

services provided, rather than on inputs, as is more usual with traditional licensing programs.

(d) Efforts to reduce the time lag in referring potential candidates to vocational rehabilitation need to be increased. These could include requiring employers to notify injured workers of their rights to VR services; encouraging physicians and hospitals to initiate vocational evaluation early in the treatment program through cooperative educational efforts of the medical and rehabilitation communities; including a requirement for vocational rehabilitation evaluation in all work injury cases as a part of the concurrent review standards being developed by Blue Cross/Blue Shield of Michigan.

Justification: Though program experience overwhelmingly demonstrates the critical effect of timing in initiating successful rehabilitation, there continues to be evidence that opportunities to return injured workers to gainful employment are lost because delays in referral exacerbate psychological and other impediments to the process. [**Note by St. Antoine:** Minnesota has been accused by some of "storm trooper" tactics in its promotion of "mandatory" rehabilitation. But Steve Keefe, Minnesota's tireless, crusading director of workers' compensation, has a powerful reply: "You've got to catch disabled workers early. After they start spending time (up to five years in some systems) trying to persuade everyone how disabled they are, they will be disabled."]

(e) Rehabilitation services should be made available to workers whose cases are in litigation, and the Bureau should be particularly reluctant to permit the waiver of rights to rehabilitation in cases of benefit redemptions.

Justification: Evidence from studies in Michigan and other states show high levels of unemployment, low incomes, and dependency among former workers' compensation claimants. In most of these cases, little effort had been made to provide vocational rehabilitation, often because the cases were litigated or settled by a lump-sum payment. Society as well as these individuals bear the cost of this waste of human potential.

(f) Some portion of the newly established Redemption Fund should be earmarked to support data collection, analysis, and program evaluation in vocational rehabilitation of workers' compensation claimants.

Justification: Formulating and implementing good public policy depends upon adequate information. Resources to collect and analyze program data are necessary to ensure efficient and equitable operation of the system. A longitudinal follow-up of a sample of claimants, including successful and unsuccessful rehabilitations, redemptions, and litigated cases, could provide the basis for a rigorous assessment of the cost effectiveness of different approaches to the rehabilitation of injured and disabled workers. Without data from longitudinal follow-up of a representative sample of all types of

cases, cost-effectiveness analysis of VR services cannot be performed. Similarly, assessing administrative efficiency and identifying obstacles to effective program implementation require adequate informational resources.

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