

Workers' Compensation Elements in Different Jurisdictions in the United States

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Over the decades, the workers' compensation system has provided many injured workers with a significant guarantee of both medical and financial support when they have been injured on the job. To be effective, workers' compensation systems at a minimum should include principles that require the addressing of medical causation, determination of an individual's functional ability both pre- and post-injury to include activity restrictions, return-to-work capability and disability, meeting jurisdiction-specific reporting requirements of the workers' compensation reporting requirements, and having knowledge of other perspectives of the various authorities and jurisdictions present in the United States. ACOEM lays out a description of various aspects of workers' compensations systems in the United States, with recommendations for minimal standards and best practices. This paper limits itself to the discussion of jurisdictions within the United States and ACOEM strongly recommends that providers consult directly with the states in which they are working as there are state variations in workers' compensation.

PURPOSE

The association between work and injury or illness has been long recognized as a critical part of medical care, not only for the many unique conditions present, but also because of the economic impact on

society. This led to a "grand bargain" that created workers' compensation (WC) systems a century ago, trading workers' rights to bring tort lawsuits against employers for work injuries in exchange for access to medical care with disability compensation.

This document addresses WC systems in the United States (US). Mandated in every jurisdiction, WC falls under administrative law and each state has its own WC insurance program and laws.¹ The federal government offers WC insurance for federal employees both military and civilian: the four major federal programs are the Federal Employee's Compensation Program, Longshore and Harbor Workers' Compensation Program, Energy Employees Occupational Illness Compensation Program, and the Federal Black Lung Program.¹ But, most employers are not part of a federal system and have programs that are determined, run, and managed by individual states, territories, and the District of Columbia (referred to in this paper as "states"). With the passage of time and the advent of insurance systems, the increased involvement of legal representation, emergence of electronic health records (EHRs), advances in knowledge about genetic susceptibilities and associated testing, as well as layers of privacy concerns, the current landscape differs from when WC systems were created.

The American College of Occupational and Environmental Medicine (ACOEM) believes any WC system should include the same fundamental principles regardless of jurisdiction. To be effective, WC systems should at a minimum include principles that require addressing of medical causation, determination of an individual's functional ability both pre- and post-injury to include activity restrictions, return-to-work capability and disability, meeting jurisdiction-specific WC reporting requirements, and having knowledge of other perspectives of the various authorities and jurisdictions present in the US. This is not meant to be an exhaustive list, but an affirmation of the basic requirements and recommendations (Exhibit A) for all systems. ACOEM is uniquely positioned to offer an authoritative analysis of these

issues from a neutral, scientific, results-oriented perspective, and to propose standards regarding fundamentals of how these systems should be structured and implemented. This paper limits itself to the discussion of US jurisdictions; providers are strongly recommended to consult directly with the states in which they work due to state variations in WC.

INTRODUCTION

In the era before WC, employees injured at work had the opportunity to sue their employer. The lawsuit could involve unlimited damages, but at the same time there was no guarantee that worker medical costs would be covered. The employee would not be paid for disability unless and until a suit was won. The WC system was developed as a compromise between labor and business owners. If a worker was injured during and as a result of employment, the employer would cover the medical expenses and provide replacement wages that would normally be paid to the individual during their medical treatment and convalescence. It is also understood that the WC system would compensate both temporary and permanent disability resulting from work-related illness or injury. Over the decades, the system has provided many injured workers with a significant guarantee of both medical and financial support when they have been injured on the job.

Modifications of the WC system affect costs for both employee and employer. Interjected into the interaction between those parties is the potential for controversy over the injury, treatment, and other aspects of care. The medical-legal system that has evolved to deal with this includes lawyers and judges specializing in WC (and regulations that specifically address WC), and other individuals such as case managers, claims adjusters, and others who have become involved in the management of this large complex system.

In most states, WC benefits are administered by a combination of self-insured entities and competing private insurers. In a minority of states, WC benefits are exclusively administered by state government.

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Monopolistic state-run examples are those of Washington and Ohio. While the overall WC principles apply regardless of the entity administering benefits, monopolistic states have more control over all aspects of the system. Variability of WC systems among jurisdictions includes parameters such as thresholds and mechanisms for determining if an injury is work-related, control over choice of treating providers, compensation to injured workers for lost wages, rules for provider treatments, compensation to providers, rules for legal representation, appeals rights of various kinds, and many others.

ACOEM believes that certain core principles should apply to these complicated systems. Specifically, causation should be determined insofar as possible by scientifically valid criteria; injured workers should be protected against economic harm due to work injuries; employers should be incentivized to protect workers from injury and to provide alternate job assignments to minimize lost time after injury; providers should be incentivized to provide appropriate care by adequate compensation, and minimal barriers from system requirements; quality of care should be assessed by a fair and scientifically valid protocol that is available to all parties in selecting treating providers as well as for determining appropriate treatment; and the ultimate goal of treatment should be to maximize functional outcomes. Clinical quality assurance should be an integral part of WC systems, with adequate feedback to stakeholders and continuing quality improvement wherever possible.

Due to the large amount of documentation that is generally required from multiple parties, WC systems should be built around robust information technology (IT) systems to minimize inefficiency, maximize confidentiality, standardize reporting, and make elements of a WC case easily available to all appropriate stakeholders in a transparent fashion, also giving state regulators the ability to gather and analyze data for the system as a whole. This paper presents a description of various aspects of WC systems in the US, with recommendations for minimal standards and best practices.

FUNCTIONALITY AND WORKERS' COMPENSATION

WC is a unique health insurance system in the US in that it focuses on both functional outcomes in addition to clinical processes. Functional ability is increasingly recognized as an important measure of health. Roughly 10% of workers incur injuries or illnesses that ultimately lead to prolonged or permanent withdrawal from the workforce, which can be as a result of both work-related, as well as, non-work-related injuries and illnesses.²

Workers may have a loss of physical ability and limitations in their routine activities. Functional impairment has significant financial and societal costs and often WC does not fully cover financial loss to injured workers, further contributing to overall decreased productivity. One strategy proposed to decrease overall disability trends, as well as associated costs, is a new emphasis on functional ability as a quality health-care metric that would be integrated into the clinical processes.² Occupational and environmental medicine (OEM) physicians have long placed a strong emphasis on measuring functional outcomes in its approach to patient treatment. OEM physicians are often retained by WC systems to address work-related injuries and illnesses and recommend evidence-based treatment plans that facilitate performance improvement and functionality.²

Functionally based care complements clinical process measures by adding a strong emphasis on longer-term outcomes and seeking to return employees to work and normal functioning as quickly as possible to the benefit of all parties involved, that is, patients, providers, employers, insurers, as well as the economy and society at large.² The overall goal for providers should be improving value for patients and systems.

DIRECTING CARE

Rules regarding the choice of treating physician vary widely by jurisdiction. Either the employee or employer may choose the physician. In some jurisdictions, employers may direct medical care if they are part of a managed health care system. If an employer participates in a state monopoly WC system, for example, the employee may choose the provider.³

Rules can be complex. In Arkansas, the employer has the initial choice of physician from among those associated with managed care entities certified by the commission. In California, employees who have not pre-designated a physician before the time of injury, may change to a treating physician of their choice 30 days after the injury (the employer directs medical treatment for first 30 days). But if the employer utilizes a state-approved medical provider network that choice can only be within the network. In Colorado, the employer has the initial choice. In Connecticut, the employee chooses from a state list. In New Jersey, the employer chooses the physician.³

Currently, 25 states allow the choice of care to be directed by the employee; 18 states leave the choice of physician to the employers' direction; six states have a mixture of employee and employer choice; and two states have the employer/insurer determining how health care is directed. Due to

specific wording regarding provider assignment and managed care models, it is strongly recommended that providers consult directly with the states in which they are working as statutory and regulatory requirements change frequently.

States have tried a number of models to try to reach a balance between providing high-quality health care and rehabilitative services to an injured worker while avoiding excessive costs overall. In one scenario, the employee has the choice of physicians, but the employer has set up relationships typically with an occupational health clinic or a particular provider and tends to refer the care to that provider. There is a voluntary agreement by the employee to see the employer's preferred health care provider.

In a state where employees choose the provider, there are a limited number of checks and balances for the employer to manage cost. The first check in that system is to maintain a good relationship with the injured worker.⁴ An employer who disregards an injured worker, providing no contact or any indication of concern typically has a suboptimal financial outcome compared with an employer that supports the employee. This has consequences in all states as it can lead to litigation and delayed recovery including in states where employees do not have complete choice. For example, human resource may show concern for the injured worker which is a relatively inexpensive intervention in terms of limiting subsequent WC cost. This reflects on the culture of the employer's organization.

MODIFIED DUTY

It is essential that employers offer a modified duty option for injured workers to maintain them in the workplace. It is well known that the longer an employee remains out of work, the likelihood that they will return to work diminishes precipitously.^{5,6} Therefore, a return-to-work specialist is a valuable option, and a workplace that is willing to accommodate a wide variety of work restrictions will have a better outcome. The move toward providing alternative jobs or light duty is an important management strategy.

CLAIMS ADJUSTERS AND NURSE CASE MANAGERS

A WC claims adjuster or examiner reviews claims and ensures that all entities follow proper guidelines and WC laws. Individuals who adjust claims vary widely in terms of their medical knowledge and expertise. Claims adjusters may have as little as a high school education, or they may be medically trained individuals. Claims adjusters may have influence in the course of treatment as part of a multi-disciplinary team, such as accepting the

treating physician's recommended treatment or questioning the treatment plan and obtaining independent assessments such as independent medical examinations (IMEs) by third-party medical providers to help make decisions in the care of the individual.

A higher level of control for some claims is the use of a nurse case manager. A nurse case manager is a liaison among the medical provider, the employer, and the injured worker.⁷ A nurse case manager may work for the WC carrier and may play an integral role in the coordination of medical treatment and the stay-at-work/return-to-work process.⁷ Nurse case managers may also be hired by an employer representative, and their most significant charge is to make care more efficient and to limit the cost of care. The nurse case manager can ensure the claims adjuster is aware of the injured worker's medical needs so they can assist in expediting access to prescriptions, medical tests, and therapy as ordered by the treating physician.⁷ A nurse case manager may provide information that speeds up the process of returning the injured worker to work, as well as, their recovery from the workplace injury.⁷ In addition to nurse case managers, WC carriers or employers often have nurses on staff to help interact with workers and to aid in the interpretation of medical issues.

ROLE OF ATTORNEYS IN WORKERS' COMPENSATION

WC attorneys represent parties, including both workers and their employers, involved in legal disputes regarding injuries sustained on the job. The attorneys negotiate settlements and ensure funds awarded by the courts are actually paid. These attorneys may be called upon to argue on behalf of an injured worker or may defend employers. In addition to their role in trial advocacy, they may also provide legal advice to determine whether or not to go to court and whether to engage in negotiations if a settlement is possible.^{8,9}

In an undisputed claim, where an injured worker is fully compensated and is satisfied with their WC benefits, the worker may not choose to engage an attorney. However, there are examples where an injured worker may benefit from qualified representation (eg, if there is a high probability of future medical care being needed).⁸

An employer also has a level of control through hiring a lawyer. The lawyer may negotiate with the other parties directly to try to reach conclusions regarding reasonable benefits. This is particularly true in more catastrophic injuries in which the costs may be quite significant.

INDEPENDENT MEDICAL EXAMINATIONS (IMEs)

IMEs may sometimes be needed to review the medical care and medical records that are available and to provide clarification for the claim adjuster. Depending on state regulations, IMEs may be requested by the employer representative (eg, WC carrier), the worker, or an administrative law judge. In some IMEs, the issue may be one of causality in the course of employment. Each state may have a different nomenclature for these IMEs and the physicians who perform them.

The IME may be obtained to determine the course of treatment and may help to limit unnecessary and extensive costs that do not give value to the care of the injured worker as well as explore fraudulent activities. In some states with state-funded medical examiners, the medical evaluation may be a function of the WC board and provide an independent review for the administrative law judge involved.

PROVIDER NETWORKS

The most common models that are outside the pure employee choice scenario include the formation of a managed care organization (MCO) or a preferred provider organization (PPO) in which networks are established that limit the physicians and give employers the options to work with certain individuals. There are some intermediate options available. For example, New York State has an option for a negotiated network between the labor union and an employer. This is done through collective bargaining. There is also a form called a C3.1, maintained by the employer, offered by the New York State Workers' Compensation Board which is completed by an injured employee when the employer who is not part of a PPO wishes to recommend a network and facilitate treatment. Individual states may have state specific programs which may further define or expand the network-based options available for the employer or the employee. The resources for WC MCO and PPO are state specific. Specific data looking at the benefit analysis of managed care options on a national basis or quantitative data on a state level was not uncovered and these authors defer to each state legislated program.¹⁰

Legislation in some states allows for an organization to form a network of providers that are certified by the state to provide WC care. This is to identify those providers who offer the highest quality care with more efficiency, thereby decreasing waste in the system and increasing return-to-work efficiencies. Depending on how the network is originated, the organizing network provider may have a

mechanism in place to monitor the care provided by network providers to injured workers and may add value to the network by mechanisms which encourage care to be given by the best performers in the system. The network may also have a mechanism to eliminate care being given by poor outcome providers. However, the parameters used to manage an outcome-based network remain quite difficult given the variability of circumstance and patient populations.

There is a requirement to maintain surveillance and document the proper credentials of the network providers. Most states require a minimum number of entry providers for the injured worker in each county certified, as well as specialists and facilities sufficient to allow for rapid care and choice. States may also require accessibility to a health care provider in the WC network within a certain timeframe.

In most situations, there is a period during which the employer has control after which the employee can opt out and seek care on their own. The idea was to have a network of the best providers providing the most efficient care with the integration of nurse case managers. Theoretically, this could be quite a valuable system, but the outcome comparison data has been limited and the value, in terms of cost savings and employee return to work parameters, remains unquantified.

For the treating physician, the PPO will often reduce the reimbursement rate by utilizing a reduced fee schedule. Another area of concern is that the PPO model may attract high volume, low-quality WC care. PPOs frequently depend on volume as an adjustment for the decrease in revenue and may not provide the highest quality care as the number of services provided, rather than the quality of service, determines overall compensation. The mechanism and methodology by which providers are added or removed from the network by the network manager remains poorly defined.

MANAGED CARE ORGANIZATION

In the MCO model, a private company selected by the employer medically manages the WC claims. Certain states, but not all, have authorized the use of WC in MCOs. This offers an alternative to the traditional WC care approach by allowing employers to take advantage of a network of providers designated to provide care to the injured worker, and this is often offered at a reduced premium. Depending on the network, its performance may be monitored by the state agencies, the carriers providing or utilizing the network, or be accredited by independent agencies such as the Utilization Review Accreditation Commission

(URAC), National Committee for Quality Assurance (NCQA), etc.

The inclusion of the many stakeholders creates significant stress on a traditional health care provider network model, like a health maintenance organization (HMO) and while “universal health care models” incorporating WC into other health care services has been tried, to date, it has not been utilized as a standard mechanism to provide network based care. In the WC MCO model, the organization remains responsible to many customers; not just the patient but also the employer, the lawyers, the WC board, claims adjusters, and case managers. It is a complex system and does not fit easily into an HMO model. The MCO model does have some advantages over the PPO model including the fact that in the MCO model, the health care organization does have an incentive to identify inefficiencies and expedite care beyond just providing a list of network providers.

There are incentives to provide medical services to an employee in order to facilitate return to work in the least amount of time possible with the best quality care. MCOs have some control and management over the health care provider network, and this system provides some control. In addition, negotiated services, such as radiological services and durable goods costs may result in additional savings for the payor.

REIMBURSEMENT AND QUALITY OF CARE

Another area of interest is the reimbursement schemes. One such scheme—outcome-based reimbursement system—has been attempted in Ohio. The Bureau of Workers' Compensation Group experience rating programs or group retrospective rating programs are available in the Ohio Workers' Compensation System. In this results-oriented approach a consultant analyzes a hospital's experience data and helps to determine the WC premium saving program for each organization.

In the group retrospective rating hospitals or in premium rebates, assessments are based on the level of claims incurred. In 2016, Ohio reported that 13% of employers had implemented value-based care in their WC systems, 53% reported no plans to implement value-based care, but 40% of commercial group health entities had adopted the value-based model and Medicare was tying 85% of payments to quality-care results.¹¹ Macy's also applied a similar model in California and replaced its fragmented fee-for-service system with an outcome-based integrated fee for value system utilizing Kaiser on the job. They found that the program drastically reduced the medical and pharmaceutical costs as well as litigation rates. Total costs remained low and they

found that there was a 41% lower total cost per claim, 45% lower direct medical cost per claim, 59% lower average pharmacy cost, 64% fewer claims involving litigation, 42% lower medical cost for low back injuries, and 73% lower cost for shoulder and upper arm injuries per claim.¹¹

The lessons learned included that building an outcome-based network as a single payer employer and multiple states is extremely difficult and resource intensive. Further analytics are needed in order to build the network which is not as advanced in the system as it needs to be. The easiest place to start was with industrial clinics where many of the specialty doctors may not maintain enough provider data. Other considerations included outcomes-based networks reducing utilization review (UR) volume, utilization of opioids, and measurement of return on investment (ROI).¹¹

It may be difficult to determine who are the best providers within the network of providers. Medical directors for the state regulatory system or within provider systems may be useful. Experienced nurse case managers and claims adjusters can also be helpful. Not all providers are knowledgeable about the return to function and work process.

There is currently no good way to judge the value of particular providers within the system. Furthermore, part of the difficulty is that the best quality providers may be responsible particularly in the subspecialty areas for the most challenging cases and their outcomes may be skewed to poorer return to work values than physicians that take on the more straightforward cases. An MCO system does have some value, but it is difficult for traditional HMOs and health care networks to integrate a WC model.

OTHER WORKERS' COMPENSATION REIMBURSEMENT CONSIDERATIONS

Medicare influences WC medical cost containment in several ways. Medicare reimbursement rates influence prices paid for medical services, including medical services for WC.¹² Many states base their WC medical fee schedules on the Medicare physician reimbursement schedules.¹² Some states control costs for services provided by facilities through systems based on either Medicare's Diagnosis Related Group (DRG) system for hospital stays or Medicare's system for ambulatory services.¹²

In states that base their WC medical fee schedules on the Medicare physician reimbursement schedule, WC medical costs are affected by changes to Medicare reimbursement rates.¹² Failures to account for changes to Medicare's methodology or for

trends in how Medicare reimburses physicians in the various medical specialties might have reduced the effectiveness of some WC physician fee schedules.¹² States with fee schedules based on resource-based relative value scale (RBRVS) show less variability and a tendency toward lower percentages relative to Medicare than states that do not base their fee schedules on the RBRVS.¹² States with the lowest percentages to Medicare base their schedules on the RBRVS, while four of the five states with the largest percentages do not.¹²

The Workers' Compensation Research Institute (WCRI) produced a series of studies that express WC fee schedule as percentages of the corresponding Medicare rate.¹² Most states that use the RBRVS either specify the maximum allowable reimbursement (MAR) as a percentage of the Medicare rate or use the Medicare relative value unit (RVU) and replace the Medicare conversion factor (CF) with state-customized values.¹² WC fee schedules often differ from Medicare by having multiple CFs.¹² One reason that states have multiple CFs is to counteract Medicare's reimbursement of specialty care at a lower rate relative to market rates than Medicare's reimbursement of primary care services.¹² The percentage of WC medical reimbursement that falls subject to physician fee schedules has been steadily declining.¹² Systems frequently price their fee schedule at some defined percentage above Medicare but Medicare is still usually the base. Medicare does not reward occupational medicine physicians for extra time spent in consultation and communication efforts proven to facilitate effective return to work including education and assessment of increasing functional activity as well as communication with employers and case managers for instance. Systems in WC usually have to create new codes for additional much needed services, for example, in Washington State and Colorado.

Choosing the right physicians to take care of workers with work-related injuries is essential, but the process can be challenging. Physicians who provide high-value services produce the same or better results at comparatively lower overall costs per injury episode than other physicians do.¹³ Finding the best physician will require balancing many factors.¹³ It is important to seek out those who deliver high-value services, and in doing so help to upgrade the WC system overall by rewarding the physicians who provide the best medical services and outcomes at competitive cost within the system.¹³

VOCATIONAL REHABILITATION

Vocational rehabilitation is a collection of processes, tools, and resources including trained specialists who address

injured workers deemed unable to perform the regular duties of their jobs, but who retain the potential to develop other job skills which can lead to gainful employment options. There are often employees who can no longer perform their job but have significant work capacity remaining. Vocational rehabilitation is of benefit to offer aggressive assessment and retraining of workers who have lost earning capacity, but who still retain some earning capability. Vermont is the one state that attempted to have an employer fund a vocational rehabilitation program available for injured workers.

Vocational rehabilitation assessment is an area of discussion in terms of education and placement. Integration with the Americans with Disability Act (ADA) and various other employee benefits including the Family Medical Leave Act (FMLA) is also an area for debate. Vocational rehabilitation recognizes that an employee unable to perform within his/her job description does not automatically need to be removed from the workforce and may be capable of significant job skills which can result in wage-earning in the job market.

Vocational rehabilitation includes activities such as:

- Developing a personalized job accommodation to allow for the performance of a job duty (ie, a variable height workstation for back injuries), within the guidelines put forth by the ADA.
- Assessment of job skills by a trained vocational rehabilitation specialist, including an analysis of educational levels, psychosocial issues, functional capacity, past jobs, and skill sets, as well as prior training.
- A survey of the job market based upon current skills and potential trainable skills with the identification of jobs and employers.
- Education and training programs to increase skill sets and employability.
- Counseling on interviewing skills and assistance with job search.
- Subsidized incentives for employers to utilize employees with prior disabling conditions.

Vocational rehabilitation may include placement within the operation of the employer at the time of the injury or may be directed towards new job placement with a new employer or in a self-employed status. The resulting employment may result in work activities and lower or higher wage-earning capacity depending on the original job skills and any obtained through the rehabilitation process. There are problematic issues concerning older workers and less educated workers. However, there are quite a few workers that would be able

to return to some work capacity where there is a robust vocational rehabilitation program in place.

The ability to return an impaired employee to the workforce is of benefit to all involved. There is a strong incentive to all levels of government to diminish the level of disability in the workforce. Programs that are designed to work with injured employees out of the workforce due to impairment are highly desirable. Some employers take on the task of providing vocational rehabilitation by employing or contracting with vocational rehabilitation specialists and acting upon their recommendations. All 50 states have vocational rehabilitation resources that offer the services discussed above. However, these are generally underfunded by state resources. Employer-funded vocational rehabilitation resource as part of the WC system has been attempted but has been met with little support by the business community.

The US Department of Education offers block grant awards to states for vocational rehabilitation services under the State Vocational Rehabilitation Services Program. Details regarding the modifications and status of these grants can be found at <https://www2.ed.gov/programs/rsabvrs/legislation.html>. Funds are utilized for vocational limitations due to impairment of all origins and are not limited to workplace acquired disability. This includes services for the blind and those with developmental disabilities. Further, individual educational grants may be authorized.

Returning a worker with impairment to the workforce utilizing the many services and options available through vocational rehabilitation is a beneficial proposition for all parties. The restoration of normalcy for the worker, the availability of a trained and capable worker to the workforce, and the decreased need for support services improves society overall. It is recommended that states take full advantage of federal grant funding for vocational rehabilitation services and that the injured worker is considered high priority within the program, particularly given the limited timeframe needed to restore a worker to the workforce.

Incentives are present for employers to incorporate or contract with trained vocational rehabilitation specialists on their human resources team. ACOEM recommends that each state's WC system consider a formal vocational rehabilitation resource to be made available to the employees who are deemed disabled. The development of a legal and fair formula for dividing the cost of the program between federal, state and specific funding may be built into an employer's costs of WC

coverage. This may be perceived as an additional cost to employers, but the benefit in reducing disability rates for injured workers who are returned to the workforce, and the availability of skilled and trained workers, provided through this system, will more than pay for the cost of funding this program. Vocational rehabilitation does not have to be covered by the state; it can also be covered by self-insured programs or private insurers which is already done in the face of permanent total disability.

ISSUES OF FUNCTIONAL OUTCOMES AND RETURN-TO-WORK

WC directly impacts both medical costs and disability; while related, most systems tend to treat these two issues separately. The medical components approach WC through fee schedules, prior authorization, guidelines to help decrease medical costs while the disability component is addressed via caps on disability payments. Most WC guidelines emphasize continual assessment of function, both to assist in return to work and as a measure to determine when treatment will be approved.

Washington State has shown that occupational medicine models can significantly improve outcomes, that is, Centers of Occupational Health and Education (COHE), which combine medical care with immediate access to return to work coordinators and incentivize reimbursement to providers based on a return-to-work focus. The COHE model is now the focus of a major grant initiative from the US government. Washington State found that this model not only improves outcomes but also results in higher provider satisfaction with care.¹⁴ An integrated model like this allows the provider to spend time working with the patient and a coordinator to use the return to work restrictions and making sure a position can be found. Also, the provider is paid for their time creating the work restrictions.

WC models which compartmentalize medical and disability components merely confound the issues that already exist in the general health care system and do nothing to prevent disability. Reasons cited by many providers for not wanting to be in the WC system include difficulty getting paid, time spent completing forms or working with employers that are not compensated, too much litigation, and patients with chronic pain that they are not sure how to handle.

Administrative reforms and fee issues that states can put in place to alleviate some of these challenges are one consideration. Modifications that can assist providers in understanding and working with the return to work issues, as well as, how the use of specialized providers or

clinics focused on the return to function and work can improve outcomes.

Other ideas include the use of prior authorization only for areas outside of guidelines and payment required for any treatment within the guidelines. There could be a mechanism in place to penalize insurers who do not follow these rules which in turn delay care and increases overall costs by paying third-party administrators and increasing provider staff time. Providers should be incentivized to adopt a functionally based system when providing care, thus assisting the return to work and limiting treatment when function is not achieved. There should be access to specialized integrated care models when disability or functionally limiting pain is present (Colorado is an example where these ideas have been successfully incorporated).

THE MEDICAL PROVIDER

Provider Training and Education

The majority of WC care in the US is delivered by providers with little or no formal training in occupational medicine. The care is also delivered in a variety of settings, some which foster less thorough evaluations than others. Based on this premise, there is a need to establish minimum desirable provider qualifications to deliver competent WC care effectively. To achieve provider quality, at least two major requirements must be addressed: the development of WC specific competencies, and provider training in WC.

Often the medical care delivered is adequate no matter who does it but what is lacking is critical thinking, understanding the unique requirement inherent in occupational medicine. The focus of care in the WC system is not exclusively on the patient as it is in general medical care. Although top quality patient care is essential, the provider must take into consideration the employer, as well as the insurance carrier, and governmental agencies. This is a developed skill and requires a different focus and mindset than is traditionally learned in medical school, residency, or other formal training. Obtaining the critical skills in managing work-related injuries has been generally acquired from hands-on experience.

Competencies specific to WC medical services should focus on the unique skills required in occupational medicine. Taking an occupational history is different from a general medical history and is reviewed in detail below. Additional competencies include, understanding the role of UR; the important legal aspects, which include the insurance company's role in managing the claim as well as state and/or local jurisdictional requirements; and the focus upon functional recovery and return to work.

Providers education should be addressed by programs that can provide training and preferably certification in WC practice. To this end, ACOEM has developed basic occupational medicine courses and its Western Occupational and Environmental Medicine Association offers a WC certificate course at its annual meeting. Both supply the practitioner with basic, solid training for successful management of WC patients, and encompasses the discussed competencies. Although the same essential skills are required regardless of who sees the patient, physician assistants' (PAs) and nurse practitioners' (NPs) depth of medical knowledge is not as extensive as that of physicians and needs to be considered in educational planning.

Continued quality improvement and educational advancement is also an important consideration. Additional advanced certification programs within ACOEM for expertise in the field of occupational medicine have been developed. ACOEM's Utilization Review Subcommittee recently completed work on a certificate of training in UR both for providers and UR physicians. Additional training in WC may also be developed by other professional organizations that can focus more directly on the impact of WC care to their particular specialty. Furthermore, ACOEM can reach out to and partner with affiliated professional organizations such as physician assistants and nurse practitioners to develop a specialty in occupational medicine. Such a program would then require recertification and continuous training.

Who Are the Providers?

As previously discussed, most medical providers have no formal training in occupational medicine, though some of the primary care specialties (including family practice) are now offering occupational medicine courses. Most medical providers who provide occupational service but are not trained in occupational medicine generally belong to specialties such as family practice, emergency medicine, or internal medicine. Physicians who specialize in urgent care treatment predominantly come from these specialties as well. There are a variety of educational opportunities that could be provided. Partnership with the respective organizations is essential. Whether it is the offering of speakers, sponsoring courses at their conventions, offering an enticement to participate in an ACOEM's conference or one of its component society meetings, these possibilities should be considered.

Development of a curriculum for the essentials of treating the injured worker is critical (as discussed above). Traditionally many of the educational goals routinely

taught have been focused on specific types of injury and how to treat them. This information is universal, no matter the source of training. The missing portion in most curricula is the nuance of managing multiple stakeholders around an injury claim. The coordination that is required to return an individual to work is critical to the success of the case. It is essential to make the right diagnosis or to clarify the diagnosis, as any delay in treatment that extends the life of the claim makes things more difficult and costlier.

Certification for all providers, with learned competency in managing WC, should be promoted. This additional certification should then be utilized to select providers, giving preferences to those certified. Other possibilities include the development of preferred providers being allowed to bypass UR, at least on specific issues (this has been tried but should be more formalized and objective) and the possibility of being reimbursed at a higher rate to provide an incentive to obtain additional training.

Specialty Care

Specialty care is an essential part of the practice of occupational medical care. There are opportunities to develop an educational partnership in the practice of occupational medicine with other specialty organizations, for example, that of orthopedics, and physical medicine and rehabilitation (PM&R). The goal is for the specialist to have a basic understanding of how the WC system(s) functions and what are the critical parameters of care (including disability, return to work, and medical causation components) and what is the role of the primary treating physician (which can vary), and when to defer care to the primary treating provider. This is, of course, a dynamic that is different from treating (or operating) on a patient and then just releasing them. This is especially true for return to work issues and work modifications.

Occupational Medical Reports

There are a variety of reports required in occupational medicine care and WC systems. The basic purpose of all medical reports is to supply an accurate and current record of the injured worker's treatment and medical status. In addition, there are critical topics that must be addressed for a medical report to be complete and meet legal and administrative requirements.

Many OEM physicians perform IMEs and have performed occupational medical consults as specialists. Thus, they understand the essential points of focus. However, there is a need to develop an outline of what would be considered a good and competent note that, for example, documents a routine visit.

Essential points include the history and mechanism of injury, which, should

always be kept in mind, especially regarding whether or not the injury makes sense, that is, causality. This is often of concern to the carrier as it may be required to determine compensability. Applying Bradford-Hill Causation Criteria is one consideration, but it is also important to include a statement upon analysis by the provider on how this injury could have been prevented or mitigated. The examination should focus on the injured body parts with emphasis on objective findings to monitor, frequently a missing element in reports generated in electronic health records (EHRs).

Addressing the working diagnosis remains an essential feature of all medical reports. Often, the diagnosis is vague and nonspecific and sometimes never changes (inappropriately). This information is critical in the UR process so that treatment decisions are timely. A diagnosis should become more specific with time as symptoms change and the clinical picture becomes more evident. It is important to discard diagnostic considerations that have been proven false. Problems occur when the diagnosis is not progressively clarified.

Treatment progress should include whether or not there has been an improvement. With a lack of progress, it becomes essential to intervene and try to assess why progress is not being made. This information also assists the employer in planning for possible accommodations. Documentation of delayed recovery is necessary and should be identified early. Pain should be addressed especially how it is affecting treatment, return to work, and activities of daily living (ADLs). Pain management by specialty care may be required. Further, providers should be mindful of chronic medical problems and whether they are stable and are being appropriately treated.

Work status is also crucial and whether the individual is working or not is often all that is reported. Sometimes a list of modifications or work restrictions is also included but it may be uncertain whether they are being honored or if the individual is actually at work. A specific section in the medical record should address an assessment of routine ADLs and functional ability assessment. Specialty care is often very important in managing rehabilitation.

Finally, an assessment on the progress towards maximum medical improvement (MMI) should be addressed. This is probably best articulated by assessment of the functional recovery of the injured worker and when they are likely to achieve their pre-injury work capacity. This then helps the carrier and employer plan for either return to regular employment versus developing workplace accommodations or planning vocational retraining.

Effect on OSHA Recordability on Provider Practice in Workers' Compensation

The Occupational Safety and Health Administration (OSHA) revised its rules for tracking and reporting workplace injuries and illnesses in 2015.¹⁵ OSHA implemented a new recordkeeping regulation to improve the quality of workplace injury and illness recording to help reduce underreporting of workplace injuries and illnesses.¹⁵ Accurate recordkeeping increases employer awareness of workplace injuries and illnesses, and assist employers to voluntarily correct workplace hazards.¹⁶ Producing accurate injury and illness data helps measure the magnitude of occupational injury and illness across industry.¹⁶ Recordability does not necessarily equate to WC eligibility.¹⁶ Not all cases recorded in the OSHA system are compensable under the state WC system.¹⁶ Conversely, cases compensable under state WC may exist that do not need to be recorded.¹⁶

Some first-aid treatments and procedures include using a nonprescription medication at nonprescription strength.¹⁷ A recommendation by a physician or other licensed health care professional to use a nonprescription medication at prescription strength is considered medical treatment for recordkeeping purposes. Using wound coverings such as bandages, butterfly bandages, Steri-strips, and Band Aids are considered first aid while other wound closing devices such as sutures, staples, etc., are considered medical treatment.¹⁷ California Labor Code Section 5401 defines "first aid" as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care."¹⁸ Such one-time treatment and follow-up visit for the purpose of observation is considered first aid even though provided by a physician or registered professional personnel.

State differences exist. For example, in California, the Workers' Compensation Insurance Rating Bureau requires all injuries and illnesses receiving medical care to be reported to them, even first aid claims, which is not an OSHA or Cal/OSHA requirement. It is important for physicians to be aware of state specific reporting requirements and physicians are sometimes asked by employers not to report for fear it will impact their loss ratios and costs.

Employers are often concerned regarding the costs associated with WC claims including the extent to which work-related injuries contribute to medical expenditures.¹⁹ Similarly, employers are concerned regarding the potential impact of OSHA recordables on companies in terms of fines, transparency for public

viewing, which may affect future contracts, for example. Employers may pressure providers regarding causality determinations and whether an injury is managed beyond first aid or not. The authors opine that injured workers should receive timely and efficient care in keeping with the standard of care as represented by certain guidelines such as the ACOEM *Practice Guidelines* and reporting requirements adhered to as adjudicated by state and federal reporting requirements.

Confidentiality and Privacy Requirements and Workers' Compensation

Entities such as WC insurers, WC administrative agencies, and employers need access to health information of individuals who are injured on the job or who have work-related illnesses in order to adjudicate claims or coordinate care in WC systems. This health information is obtained from health care providers who treat these individuals and who may be covered by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule which recognizes the legitimate need of insurers and other entities in WC systems to have access to personal health information as authorized by state or other laws.²⁰ Under the Privacy Rule, covered entities can disclose protected health information to insurers, state administrators, employers, and other covered entities in WC systems with or without individual authorization. The minimum necessary expectation is that covered entities reasonably limit the amount of protected health information disclosed to the minimum necessary to accomplish WC purpose.²⁰

HIPAA does not generally apply to entities that are employers, WC insurers, WC administrative agencies, except to the extent they may otherwise be covered entities.²¹ HIPAA does not apply to employers merely because they collect employee health information; rather, HIPAA will affect employers in their processes of obtaining protected health information as it applies to the health care entity from which the employer is attempting to obtain the information.²²

HIPAA emerged in part due to the evolving technology and the digitalization of medical records in an effort to keep up with the demands for patient privacy which in the WC arena means obtaining and securing medical information.²¹ It is felt by some thought leaders that the HIPAA and the HIPAA Privacy and Security Rules should be amended to cover employers.²³

Employers may obtain employees' medical records. In some states, workers sign an authorization for release of medical

information before the beginning of employment while in other states, this authorization can only be obtained after an injury. Employers may process the medical information obtained for various purposes including WC. The question is under what circumstances is it lawful for employers to obtain medical information, and what are they allowed to do with the information.²³

HIPAA's Privacy Rule permits employers, WC insurers, and third-party administrators to obtain the necessary medical information to manage WC claims. Laws regarding disclosure of medical information vary from state to state, and in some states, a medical release is not needed while in other states it is required. The Privacy Rule for Workers' Compensation is designed to provide the minimum necessary information to manage a claim. State laws allow for subpoenas to obtain full medical records as is needed.²⁴

WC carriers and administrators send authorization release forms to injured employees upon receipt and setting up of a WC claim to ensure that they are in full compliance with HIPAA and state laws.²⁵ All states have WC laws that require employers to report workplace injuries and compensate employees for them. OSHA reporting requirements overlap with the state and affect how employers report workplace injuries. However, in order to determine the appropriate compensation, WC insurers ask injured employees to produce medical documentation or sign a medical records release form. If the employer is self-insured for WC purposes, medical documentation about injured workers is disclosed directly to the employer.²³

Relevant state laws govern disclosure of EHRs to employers. State statutes augment federal mandates that prohibit discrimination and protect the privacy of employees. WC statutes establish requirements for medical disclosures in particular circumstances. All 50 states have their own disability rights statutes which vary in scope and coverage, and many do not discuss or limit medical inquiries.²³

In summary, all health care providers should realize that because neither employers nor WC insurers are covered under HIPAA, the final responsibility for record release remains legally on their shoulders. If a record is released that includes unnecessary information and that information goes to an employer, possibly from the non-covered insurer who can legally release it because they are not covered by HIPAA, any untoward consequences will be the legal responsibility of the provider. In some states, the WC law releases all records to the employer and in that case the provider would not be responsible because they are

covered by the state law. In other states, only information pertinent to the claim are releasable to the employer. Thus, the provider would need a signed release from the patient to send more extensive medical records to either the insurer or the employer. In these states, release of information not directly material to the claim (such as obstetrical history or previous addiction treatment), without a full release from the patient, can cause the provider to be in violation of HIPAA.

GINA—Genetic Information Nondiscrimination Act

With advances in genetic testing, a federal anti-discrimination statute—the Genetic Information Nondiscrimination Act of 2008 (GINA)—took effect in 2009. Genetic information pertains to disease in the employee and their family members. GINA prohibits an employer from using this information to make employability decisions and further prevents employers from obtaining genetic information deliberately.²⁶

In a WC claim, if an insurer or employer is requesting medical information, GINA strongly recommends an appropriate disclaimer on any medical authorization or release form. There are state laws and HIPAA rules that are constantly being amended; however, each governs who can receive medical information on an injured worker's claim, also what information can be received and when. For employers, it is recommended that the information received is limited to avoid violation of HIPAA and state laws.²⁶ In the context of EHRs, GINA prohibits employers from requesting genetic information about employees or their family members.²³ In some instances, GINA may have the unintended consequence of interfering with good medical care if a provider avoids asking about genetic information in a WC case.

Electronic Health Records (EHRs)

EHRs have had a profound impact on the workplace and affect pre-placement medical inquiries, employers' storage of health data, business costs, and the work habits of health care providers.²³ EHRs often require users to enter elaborate data creating excessively voluminous records due to cut and paste capabilities allowing providers to copy large portions of prior clinical notes into current updates. However, this exacerbates information overload and can bury relevant content and produce errors if not carefully edited. In addition, EHRs suffer from fragmentation and other display problems which may result in employers receiving unwarranted information in response to medical inquiries.²³

EHR platforms are primarily built for general medical care, not WC cases,

and as such are often ill-suited for WC systems. They are often suboptimal for capturing information for work injuries and illnesses, most notably important functionality measurement parameters which are important to compare from one visit to the next and which are not built into most platforms. Other critical components to WC injury management that are lacking in EHR platforms and would be helpful include addressing components of injury mechanism, causation, treatment progress, work status and whether work modifications are being accommodated, and assessment of ADLs and documentation of delayed recovery.

EHRs were initially a mechanism to maximize reimbursement and have continued to be used primarily for that purpose. Automation enhances billing opportunities for providers and increases charges.²³ These costs may be passed on to employers and those that contract with third-party insurers may be subject to higher premiums.²³ EHR systems also impact medical costs with regard to their purchase as implementation and maintenance is expensive, costing tens of thousands of dollars per physician.²³

EHRs may not create an accurate reflection of the patient encounter and may have a negative impact on interpersonal relationships and have contributed to physician burnout due to the clerical burden. Employers involved in litigation relating to worker injuries or disabilities will in the future encounter EHRs rather than traditional medical files in discovery. However, employers might be able to determine easily whether a patient had a pre-existing condition that affected a claimed workplace injury.²³ Rather than obtaining general authorizations for release of all medical records, employers should be permitted to pose only narrowly tailored queries that are designed in the adjudication of work injury claims or in fitness for duty evaluations.²³

Employers will need to develop standardized methods to formulate their medical inquiries. Such standardization may allow EHR vendors to incorporate search and retrieval mechanisms into EHRs that will facilitate standardized modes of response to employer queries. The less burdensome the task of extracting information is for providers, the more likely it is that they will be able to furnish precise and meaningful responses and adhere to the HIPAA Privacy Rule principle of limiting disclosures to the minimum necessary for the employer's purposes.²³

Workers' Compensation Billing

WC provides coverage for medical treatment, wage replacement benefits, vocational rehabilitation, and other benefits to workers who are injured at work or who

acquire an occupational illness. WC is a unique hybrid insurance dealing concomitantly with health as well as disability. State and federal laws require that employers maintain WC coverage to meet minimum standards. Costs are borne almost entirely by employers. Private insurance companies dispense the majority of WC benefits, although certain employers are self-insured.

WC billing differs from state to state and knowing state regulations will ensure practice compliance. The state commission establishes the regulations pertaining to WC billing at the state level. However, there is general information that helps keep WC billing uniform.

Using the correct forms is crucial and includes the incident report which is completed when the patient first seeks treatment for the work injury. The billing department also submits a claim form along with the provider's documentation to the WC insurance company for reimbursement. The date of injury has to be completed and may be overlooked during billing.²⁷

WC insurance has no copayment or deductible and providers must accept compensation as payment in full. Balance billing of patients is not permitted. The state compensation commission sets the fee schedule and is furnished on individual state websites.²⁷ The coding systems for billing are based on those used in general medicine, including the Centers for Medicare and Medicaid Services (CMS) rules.²⁸ Current coding rules for complexity have little bearing on musculoskeletal work injuries which are most common and do not recognize information important to the adjudication of WC claims such as job description, details of job tasks, workplace exposures, job satisfaction, previous WC claims, and functionality, for example.²⁸

HIPAA privacy rules must be adhered to and illness or injuries unrelated to the workplace should never be billed to the employer.²⁷ Sometimes an employee may present to a provider for a workplace injury wanting to be seen for an unrelated issue. Providers need to be aware of the importance of maintaining separate encounter forms if this occurs. Conversely, a patient may see a provider and fail to inform them that the injury is work related in which case the primary payer will obtain a bill for the services. If subsequently payment is requested from the WC insurance, the primary payer may have already paid. The reimbursement paid by the primary payer must be returned. If the WC claim is denied, an appeal may be initiated.²⁷

Often, coding rules do not succinctly capture or provide adequate incentive for delivery of services that are critical in the WC arena such as addressing causation, functional impact, and return to work

planning. Compensation to medical providers are often based on payment systems designed for other purposes, for example, primary care so the codes may not relate to parameters important in WC.²⁸ Some parameters that are routine in regular health care may be excluded from payment in WC if they do not apply to work-related injury or illness. However, WC providers must also assess factors beyond the patient's immediate health status such as workplace exposure and mechanism of injury to determine causation.²⁸ Further, important communication with employers, rehabilitation providers, or return-to-work coordinators by providers is not captured in the current reimbursement system. Consultation codes have been eliminated from CMS payment.

ACOEM recommends that WC payers adopt improved documentation as a requirement for many of the evaluation and management (E&M) codes and recognition of consultation and case management codes critical to WC.²⁸ Adoption of certain coding ground rules appropriate for WC care would take the functional status, projected recovery and other clinical details that are crucial for successful outcomes in WC cases.²⁸ ACOEM in collaboration with the International Association of Industrial Accident Boards and Commissions highlighted the need to compensate physicians for the additional time and expertise required in assessing medical causation and minimizing disability. In routine primary care encounters, there are no incentives to obtain a thorough occupational history, for example. WC providers require specialized knowledge and training in evaluating injured workers, and make causality determinations and address function, recovery and return to work within evidence-based guidelines hence mitigating disability.²⁸

Washington State has a special fund responsible for its WC system and used to develop the Centers of Occupational Health and Education (COHE) program. This program was designed to implement and evaluate whether disability would be decreased by providing modest financial incentives to providers for engaging in certain occupational best practices including prompt submission of the report of incident, daily calling employees placed off work, prescribing activity at each visit, and assessment of impairment if the employee is not back to work after 4 weeks. The data were analyzed by the University of Washington and revealed that disability days per claim were reduced as were disability costs, and medical costs, disability claims for back injuries were reduced, also the likelihood of 1-year disability was reduced. Further, injured workers are likely to benefit from a coding system that rewards functional assessment and attention to indicators of delayed recovery.²⁸

State compensation boards or commissions establish regulations pertaining to state WC billing as well as approve fee schedules. Current reimbursement systems are based on CMS required documentation which does not align with the needs in WC systems for successful adjudication of claims. Further, current WC payer systems do not reimburse for the actual needs of recommended WC care. Compensation is an important driver of provider behavior and outcomes and new coding rules are needed to facilitate excellent care and service. ACOEM proposes new rules for documenting E&M encounters with decreased emphasis on unneeded elements of the history and physical, increased emphasis on work-related parameters, and functionality hence mitigating the disability risk. ACOEM further proposes recognition of codes for consultation in WC care.

EXHIBIT A

Summary Recommendations for Workers' Compensation Systems

ACOEM supports the following recommendations for WC systems:

1. Choice of provider in the initial, early, and late phases of WC. There should be options for second opinions by appropriate mechanisms.
2. There should be minimum qualifications and training of providers for effective WC care.
3. Assessment of medical causation should be done by providers with training on the topic with special attention to the mechanism of injury, applicable legal standards in the jurisdiction, and utilize evidence-based reasoning.
4. All health care providers should understand the patient's job duties in order to safely return to duty.
5. It is recommended that all systems use scientifically based, functionally oriented medical treatment guidelines that are compliant with the Institute of Medicine's Standards for Developing Trustworthy Clinical Practice Guidelines.²⁹
6. Limit requirements for prior authorization for issues outside of approved guidelines. In such circumstances the best approach may be a cooperative discussion between the peer reviewer and treating provider and such discussions should be effectively incentivized. Regulatory systems

should assure efficient and medically appropriate care and avoid unnecessary requirements for prior authorization whenever possible. Incentives aimed at completion of specific return to work documents, patient-centered assessment, and goal setting may be helpful.

7. Regulatory systems should assure efficient and medically appropriate care where we would create incentives for providers and disincentives to keep payers from denying appropriate care.
8. All health care providers should continually use functional assessment of their patients in order to set treatment goals, determine MMI and assist in early return to work.
9. In permanent partial disability systems where, for example, the American Medical Association's AMA Guides or other state-specific guidelines are used, only trained providers should rate a patient's permanent partial disability. The use of nationally accepted standards is preferred.
10. Additional training of health care professionals on the concept of MMI which is unique to WC. Proper use of this concept can avoid unnecessary care which is not functionally improving the patient.
11. Movement towards an assessment metric to capture progress towards MMI.
12. Administrative reforms that states can put in place to alleviate some of the compartmentalization in WC.
13. Medical authorization/release forms should contain approved HIPAA compliant disclaimer.
14. EHR platforms should include functional assessment, as well as, other components relevant to WC—mechanism of injury, causation, treatment progress, work status, and whether work modifications are being accommodated, assessment of ADLs and documentation of any delayed recovery.
15. Employers should tailor queries instead of obtaining blanket authorizations for release of all medical records.

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