Compendium on Workmen's Compensation

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NATIONAL COMMISSION ON STATE WORKMEN'S COMPENSATION LAWS

WASHINGTON, D.C.

1973

Chapter 10

Medical Care Benefits

Over the years, medical care has been recognized increasingly as an important part of workmen's compensation. The early laws, as part of their legacy from the era of common law and employers' liability remedies, showed little concern with medical care for the injured worker. Dollar allowances for care were quite limited. State commissions did not play an active part in supervising the delivery of care.[1] Since then, emphasis has shifted from cash benefits toward restoring the worker to full physical function. Consequently, it has become important to the achievement of the goals of workmen's compensation that the medical care provided to injured workers be adequate in amount, of good quality, and promptly delivered.

What constitutes adequate, prompt, and good quality care differs with the type of injury. Most work injuries are relatively minor: about 80 percent of all compensation cases do not miss enough work to qualify for income benefits.[2] The most common injuries are sprains and strains, bruises, contusions, and abrasions, and cuts and lacerations.[3] These generally are treated quickly and leave no permanent disability. Fractures are another common injury. Again, emergency care and followup are sufficient in many fracture cases and permanent disability is rare. Treatment and convalescence for the more serious of such injuries may, of course, require extended absence from work.

For the less common serious injury or disease, medical treatment can be long and complex. Emergency care may not be enough; medical rehabilitation services also may be necessary. For about 5 percent of all impaired workers [4] there will be some residual effect. If the residual impairment is serious, both medical and vocational rehabilitation will be necessary, e.g. for workers who lose a limb.

Medical care benefits under workmen's compensation amounted to $1 billion in 1970,[5] more than one-third of all benefits paid out under the various State programs. As all compensation cases receive medical benefits, medical care is the most important benefit provided by workmen's compensation in respect to the numbers of people affected. All workers who come into contact with the system have an interest in the amount of medical benefits, the ease or difficulty of obtaining those benefits, and the effect of the system on the services provided and their quality, as observed in the various States.

STATUTORY BENEFITS

Limits on Employer's Liability

The workmen's compensation laws generally specify that the employer shall be responsible for providing medical care to the injured worker but sometimes limit the employer's liability. According to their medical provisions, State laws fall into three general classes:

(1) Those with no arbitrary restrictions on the duration or dollar amount of medical benefits;
(2) Those with initial restrictions as to dollar amount or duration, with provisions for unlimited extension of benefits beyond initial limits; and
(3) Those with a definite upper limit on the amount or duration of care.

Where limits exist, they do not prohibit the insurer or employer from providing more care but relieve them only of legal obligation.

Table 10.1 shows the statutory provisions for medical care in 2 years, 1972 and 1962, by State. The trend has been toward the removal of arbitrary limits. Of the 15 jurisdictions with definite

limits in 1962, six had moved into the categories of unlimited benefits or unlimited extension of benefits by 1972. (Because of its very restrictive test for the extension of benefits, Pennsylvania is classified by the U.S. Department of Labor as having limited benefits. That classification is used here.)

TABLE 10.1.—LIMITS ON MEDICAL BENEFITS IN WORKMEN'S COMPENSATION BY JURISDICATION, 1972 AND 1962

	1972		1962	
	Initial limits	Limits on extension	Initial limits	Limits on extension
Alabama	3 years per $17,500.	No extension	1 year per $1,800.	No extension.
Alaska	2 years	None	2 years	None.
Arizona	None		None*	
Arkansas	None [1] *		6 months*	Do.
California	None		None	
Colorado	$7,500	None [2]	6 months per $1,500*	No extension.
Connecticut	None		None	
Delaware	do		do	
District of Columbia.	do		do	
Florida	do		$1,000	None.
Georgia	$5,000	None	10 weeks per $1,125*.	$1,500.
Hawaii	None		None	
Idaho	do		do	
Illinois	None*		None*	
Indiana	None		180 days	(3).
Iowa	$7,500	None	$1,000 medical to $2,000 hospital.	$5,000 total.
Kansas	$10,500*	No extension	120 days per $4,000.*	$4,000.
Kentucky	$3,500	None	$2,500	$3,500.
Louisiana	$12,500	$25,000	$2,500	No extension.
Maine	None		30 days per $100.*	500 weeks.
Maryland	do		None	
Massachusetts	do		do	
Michigan	do		6 months	(4).
Minnesota	do		None	
Mississippi	do		None*	
Missouri	180 days	None	90 days	None.
Montana	3 years*	No extension	3 years per $2,500.*	(5).
Nebraska	None		None	
Nevada	6 months*	None	6 months	(4).
New Hampshire.	None		90 days	341 weeks.[6]
New Jersey	$50 medical to $50 hospital.	None	$50	None.
New Mexico	$25,000	No extension	5 years per $1,500.*	$15,000.
New York	None		None	
North Carolina	10 weeks*	(7)	10 weeks*	(7).
North Dakota	None		None	
Ohio	None*		None*	
Oklahoma	60 days	None	60 days	None.
Oregon	None		None	
Pennsylvania	1 year	(8)	6 months per $450 plus 6 months hospital.	
Puerto Rico	None		None	

See footnotes at end of table.

TABLE 10.1.—LIMITS ON MEDICAL BENEFITS IN WORKMEN'S COMPENSATION BY JURISDICTION, 1972 AND 1962—Continued.

	1972		1962	
	Initial limits	Limits on extension	Initial limits	Limits on extension
Rhode Island	do		$600 to $1,200	Do.
South Carolina	10 weeks	None	10 weeks	Do.[9]
South Dakota	6 years per $175,000.	No extension	20 weeks per $300 medical $700 hospital.	$2,000 total.
Tennessee	2 years	do	1 year per $1,800.	No extension.
Texas	None		None*	
Utah	None*		$1,283.38*	None.
Vermont	do		None*	
Virginia	3 years [10]	No extension	60 days	2 years.
Washington	None		None	
West Virginia	$3,000	None [11]	$2,400*	$3,200.[11]
Wisconsin	None		None	
Wyoming	$385 medical to $495 hospital.	None	$385 medical to $330 hospital.*	None.
Federal Employees Compensation Act.	None		None	
Longshoremen's Act.	do		do	
Guam	do		Not available	Not available.

[1] 6-month initial limit on medical care nullified by State supreme court decision.

[2] The commission assesses the claimant's disability for purposes of compensation when the carrier discontinues medical benefits. As a result, carriers generally do not stop at the limit.

[3] Additional care would reduce disability or impairment.

[4] Can be extended for 6-month periods indefinitely.

[5] Additional hospital expense is allowable in total disability cases.

[6] In unusual cases, care may be extended beyond 341 weeks.

[7] Additional medical care would tend to lessen period of disability. In 1962 it was also necessary to show that the claimant was unable to work.

[8] Additional care would substantially restore the worker's earning power.

[9] Commission automatically extends unless employer can prove at hearing that further treatment would not lessen disability or give relief.

[10] Unlimited in cases of injury to brain or spinal cord.

[11] Additional benefits come from a special commission fund and are not chargeable to employer's account.

* Special limits on benefits apply to occupational disease. See table 10.3.

Source: Questionnaire completed by the State Commissions, January 1972; Earl F. Cheit, "Medical Care Under Workmen's Compensation."

Table 10.2 shows that 19.1 percent of all covered workers were subject to limited benefits in 1962. By 1972, only 13.8 percent of all covered workers were subject to limited benefits.

Not all of the improvements are reflected in the shifts from one group to another. Most of the States with arbitrary limits have liberalized their limits on medical benefits since 1962. Montana and Tennessee have dropped their rather low limits on the dollar amount of care and retained only time limits: 3 years and 2 years, respectively. South Dakota has increased its dollar limit from $2,000 to $175,000. As medical care prices have risen 50 percent since 1962,[6] dollar allowances have

Table 10.2.—NUMBER OF JURISDICTIONS AND PERCENTAGE OF WORKERS WITH LIMITS ON MEDICAL CARE IN WORKMEN'S COMPENSATION, 1962 AND 1972.

Limits on medical benefits	1972		1962	
	Number of jurisdictions	Percent of covered workers	Number of jurisdictions	Percent of covered workers
None	32	70.0	24	59.9
Unlimited authority to extend	13	16.2	15	22.0
Money or time limits	9	13.8	15	19.1
Total[1]	54	100.0	54	100.0

[1] Excludes American Samoa, Guam, and the Virgin Islands.

Source: Table 1, percentage of covered workers for 1962 from Cheit, Medical Care Under Workmen's Compensation; for 1972, derived from Alfred M. Skolnik and Daniel N. Price, "Another Look at Workmen's Compensation," Social Security Bulletin, October 1970.

Note.—Because of its very restrictive interpretation of its test for the extension of benefits, Pennsylvania is classified by the U.S. Department of Labor as having limited benefits. That classification is used here.

had to increase at least 50 percent simply to maintain the level of real benefits. Generally speaking, however, most of the States which retain benefit limits have raised the real level of benefits considerably.

In 1962, 18 States placed more severe dollar or duration limits on medical care for occupational disease than for accidental injury (table 10.3). Some limits were specific to certain diseases; others applied to all covered occupational diseases. Ten States had dropped such special limits by 1972. Eight others retained special limits of some kind and a few left the 1962 limits unchanged, imposing a considerable reduction in real benefits. North Carolina's $1,000 in benefits for silicosis and asbestosis could buy only about two-thirds as much care in 1972 as in 1962.

The changes in medical benefits have been accelerated in the last year. Two States added full medical care for accidental injuries in 1971; eight added full coverage of occupational diseases; and five extended full medical care to occupational diseases.

Full coverage of occupational diseases means that any disease is compensable which can be shown to have a causal connection with the work of the claimant. Schedule coverage of occupational disease means that only the diseases enumerated in the law are compensable. Nine jurisdictions report they still limit coverage of occupational disease to scheduled diseases: Arizona, Colorado, Kansas, Louisiana, New Mexico, Oklahoma, Tennessee, Vermont, and Wyoming.

Table 10.3.—SPECIAL LIMITS ON MEDICAL BENEFITS FOR OCCUPATIONAL DISEASES IN WORKMEN'S COMPENSATION BY STATE, 1962 AND 1972

State	1972	1962
Arizona	None	$1,000.
Arkansas	For silicosis cases, 180 days from date of disablement.	For silicosis cases, 180 days from date of disablement.
Colorado	None	$2,500. Commission may add $1,000 if necessary to alleviate and cure. No time limit.
Georgia	do	$500.
Illinois	For silicosis and asbestosis cases, 2 years from date of disablement.	For silicosis and asbestosis cases, 6 months from date of disablement.
Kansas	In silicosis cases, 120 days/$10,500. Can extend to 210 days.	In silicosis cases, 120 days/$4,000. Can extend to 210 days.
Maine	None	In silicosis cases, $1,000.
Mississippi	do	No medical benefits for occupational disease.
Montana	$2,500. May be extended for total disability, $1,000 if employee able to continue work during treatment. No time limit.	$1,000 if employee able to continue work during treatment. No time limit.
Nevada	In silicosis cases, $50 per month.	In silicosis cases, $50 per month.
New Mexico	None	$700, initial limit. No limit. on extension.
North Carolina	In silicosis and asbestosis cases, 3 years/$1,000 per year.	In silicosis and asbestosis cases, 3 years/$1,000 per year.
Ohio	In silicosis cases, no benefits unless total disability or a change in occupation.	In silicosis cases, no medical benefits unless total disability or a change in occupation.
Texas	None	In silicosis and asbestosis cases, 91 days.
Utah	do	Limited to total diasbility. $1,283.33, with extension to $1,925.01 in cases of prolonged hospitalization.
Vermont[1]	In silicosis and asbestosis cases, 3 years/$1,000.	In silicosis and asbestosis cases, 3 years/$1,000.
West Virginia	None	In silicosis cases, no medical benefits.
Wyoming	do	No medical benefits for occupational disease.

[1] This limit applies only to workers who were first exposed to the hazards of silicosis and asbestosis prior to 1939. Workers whose first exposure occurred after 1939 have full medical coverage.

Sources: Questionnaire completed by the State commissions, January 1972; Cheit, Medical Care Under Workmen's Compensation.

Vermont provided for full coverage of occupational diseases effective July 1, 1972.

Types of Services Provided

Most States place no significant restrictions on the types of medical services: The statutory language frequently refer to "all reasonable and necessary medical, surgical, and hospital care." Specific interpretation of the phrase is left to the commission. In general, commissions interpret medical care services broadly and employ guide-

lines used by other public programs; for example, any services prescribed and supervised by a licensed physician are usually covered.

State commissions were asked to indicate whether compensation would pay for the services of 14 types of practitioners and four types of institutions. The practitioners listed were doctors of medicine (except psychiatrists), psychiatrists, osteopaths, dentists, registered nurses, licensed practical nurses, psychologists, optometrists, chiropodists, physical therapists, occupational therapists, chiropractors, naturopaths, and Christian Science practitioners. The institutions: hospitals, extended-care facilities, home health programs, and rehabilitation centers.

Table 10.4 shows which States reported that compensation did not pay for one or more of these medical services, with the exceptions of naturopaths and Christian Science practitioners. Naturopaths and Christian Science practitioners are covered in fewer than half of the jurisdictions. In a few States the use of a Christian Science practitioner is dependent upon mutual agreement between the employee and his employer. The material presented in Table 10.4 represents medical services that the insurer is not obligated to pay for, but nothing prevents him from paying for them if he wants to.

Table 10.4—MEDICAL SERVICES THAT WORKMEN'S COMPENSATION WILL NOT PAY FOR, BY STATE, JANUARY 1972

State	Services that compensation will not pay for [1]
Alabama	Osteopaths, psychologists, optometrists, chiropodists, occupational therapists.
Arkansas	Home health programs.
Georgia	Optometrists, occupational therapists,[2] home health programs.[2]
Idaho	Occupational therapists.
Illinois	Optometrists, occupational therapists, home health programs, rehabilitation centers.
Kansas	Home health programs, rehabilitation centers.
Kentucky	Chiropractors.
Louisiana	Psychiatrists, osteopaths, registered nurses, licensed practical nurses, psychologists, optometrists, chiropodists, physical therapists, occupational therapists, extended-care facilities, home health programs, rehabilitation centers, chiropractors.
New York	Psychologists, occupational therapists, chiropractors.[3]
Ohio	Psychologists.[4]
Oklahoma	Rehabilitation centers.
Oregon	Occupational therapists.
Pennsylvania	Extended-care facilities, home health programs.
Puerto Rico	Osteopaths, optometrists, chiropodists, chiropractors.
South Carolina	Extended-care facilities,[5] home health programs.[5]
South Dakota	Psychologists, occupational therapists, home health programs.
Utah	Do.
Wyoming	Occupational therapists.

[1] Naturopaths and Christian Science practitioners excepted. A majority of the States exclude these practitioners from payment.
[2] Not aware of any such services.
[3] Unless supervised by an M.D.
[4] Generally.
[5] Commission reports that South Carolina does not have such services.

Only Alabama, Louisiana, and Puerto Rico do not cover the services of a licensed doctor of osteopathy. The District of Columbia and Massachusetts pointed out that they paid for osteopathic services only when given under the supervision of a doctor of medicine. By implication, the treating physician in all other States may be either an M.D. or a D.O. Louisiana stands out as an exception to the general tendency to include a broad range of medical services under compensation. Of 14 types of medical practitioners, it will pay for only doctors of medicine (except psychiatrists) and dentists; of the four types of institutions it covers, only hospitals.

Adequacy and Certainty

The preceding sections have described the legal provisions for medical care in the various jurisdictions. In most States, the compensation laws make generous provision for medical care. Only nine still place arbitrary restrictions on the dollar amount or duration. The adequacy of these benefits in individual cases and the certainty with which an injured worker can obtain them, however, may depend not only on the statute but on the realities behind it: The resources and administration which influence medical benefits.

Major organizations concerned with medical care under workmen's compensation have long advocated that medical care should be available for all occupational injuries and diseases without arbitrary limits.[7] These organizations include the IAIABC, The American College of Surgeons, the American Medical Association, the Council of State Governments, and the AFL–CIO.

States with arbitrary limits.—Clearly, States with arbitrary limits on the dollar amount or duration of care run the risk of providing inadequate medical benefits to some workers, even though insurers sometimes provide additional expenditure on medical care, especially if extra care will reduce expenditure on income benefits. In nine States, a few workers every year may find either that they must pay the bills for continued care themselves or that they must discontinue or curtail their medical care. Table 10.5 presents some rough estimates, for those States with dollar limits, of the numbers

Table 10.5—ESTIMATES OF PERCENTAGE AND NUMBERS OF WORKERS WHO EXHAUST THEIR MEDICAL BENEFITS IN STATES WITH LIMITATIONS ON WORKMEN'S COMPENSATION, 1972

State	Dollar limit (January 72)	Estimated percentage [1]	Estimated number [2]	Year
Alabama	$17,500	0.1	11	1970
Kansas	10,500	.3	[3] 21–32	1969
Louisiana	12,500	.2	[3] 33–50	1968
New Mexico	25,000	.1	6	1969

[1] Derived from a comparison of the dollar limit in each State, with a distribution of compensation cases by amount of medical payment, provided by the NCCI for the policy period centered on 1969.

[2] Based on number of compensable cases for year given.

[3] Lower estimate based on NCCI data for private insurers. Upper estimate reflects an adjustment for self-insurers.

of injured workers who may exhaust their benefits each year. The table shows that only a few exceed the dollar limits in these four States; a few more probably exceed the duration limits set in other States. In all, a handful of workers each year may have their medical benefits cut off, at a negligible savings in compensation insurance premiums. Arbitrary limits seem to be both inequitable and ineffective in controlling compensation medical costs.

States permitting extension of limits.—Less clear-cut are the procedures in 15 States which permit extension of benefits beyond initially specified limits (table 10.6).

Table 10.6.—PROCEDURES FOR EXTENSION OF MEDICAL BENEFITS IN WORKMEN'S COMPENSATION IN STATES WITH INITIAL LIMITS ON BENEFITS, 1972

State and who may apply for extension?	Procedure	Showing necessary to qualify
Alaska: The employee or someone on his behalf.	Authorization by the commission.	Continued treatment or care necessary for recovery.
Colorado: Employee, employer or carrier may apply to the major medical insurance fund.	File application with Director	Expenditure will promote recovery, alleviate pain, or reduce disability.
Georgia: Either party	Simple request	Further medical attention is reasonable and necessary to effect a cure or give relief.
Iowa: Claimant or employer.	File for review. In almost all cases insurance company will pay additional benefits without formal hearing.	Reasonable proof that additional medical is necessary.
Kentucky: Employer, employee or physician.	Application	Need.
Louisiana: Employee	Employee must appear in court.	Services are necessary and, unless same are provided by employer, employee will suffer undue and unusual hardships.
Missouri: Employee	Application to division or commission.	Additional care is necessary.
Nevada: Normally, the claims examiner supervising the care. The claimant or his physician could also initiate a request.	3 commissioners must approve.	Additional medical care is required.
New Jersey	The employer is obligated to furnish unlimited medical care of whatsoever character is necessary. Disputes are resolved in the division through the hearing process.	
North Carolina: Insurers extend automatically without request.	No procedure	
Oklahoma: The claimant or anyone on his behalf.	A request to the insurance carrier or employer.	Medical attention is reasonably necessary.
Pennsylvania: Injured claimant.	Further medical petition after 1 year, filed with the Workmen's Compensation Board.	Further medical care will result in restoring earning power to a substantial degree.
South Carolina: In most cases, it is not necessary for either party to make a request.	The carrier may continue to pay or the employee can make a request.	Disability can be reduced by additional medical treatment.
West Virginia	No formal procedure. Bills for services beyond the $3,000 limit are sent in and paid out of a special fund which is appropriated as part of the Commission funds. Payment is at the discretion of the Commissioner but all have been paid. Self-insurers are not eligible for the fund and may not be legally obligated to pay more that $3,000, but none of them have ever challenged that obligation.	
Wyoming: The employee or someone on his behalf.	Application in writing to the court, hearing, signature of court order by district judge; every 6 months, a routine matter.	Extended treatment is "essential."

Source: Questionnaire completed by the State commissions, January 1972.

The procedures necessary to obtain an extension vary. In some States, extension is so automatic that the procedure requires no initiative by the worker. In West Virginia, for example, bills above the $3,000 limit are simply sent to the commission and are paid out of a special fund. As they are no longer the employer-carrier's responsibility, no formal application for additional benefits is required. By contrast, in court-administered States like Louisiana and Wyoming, the extension procedure requires that the applicant appear in court.

The difficulty of the procedure (or lack of knowledge about the possibility of an extension) may influence some claimants against requesting additional care even though they are entitled. This is likely to occur especially if a request for extension necessitates a court appearance. On the other hand, an extension may present no problem at all if there is no required formal procedure or if the commission itself initiates the request. As an exclusive fund State, Nevada performs the functions that many private insurers perform in other States: the claims examiners supervise each case closely and request extensions when necessary.

An additional difficulty may arise if the test of the need for additional care is restrictive. Of the five States which provided statistics (Georgia, Nevada, Pennsylvania, South Carolina, and Wyoming), four indicated no problem: all requests are granted. The Pennsylvania Commission, however, must apply a strict test: additional care must substantially restore the earning power of the worker. As a result, of 136 requests for extensions in the first 11 months of 1971, only 56 were approved.

The degree of control over the case exercised by the insurer may influence the provision of benefits. Where the insurer has some control, as is usually in States where the employer-insurer has the right to choose the treating physician, he may restrict the types or amounts of care. Proponents of insurer control argue that it improves the care given because the insurer is acquainted with the best procedures and medical specialists. Historically, however, insurer control has been much criticised. In 1933, a New York study committee charged that insurer control had resulted in many abuses and recommended that the employee be given the right to choose his own physician.[8] A subsequent committee summarized their findings:

They found that some employers and carriers cut rates for medical care and as a probable consequence doctors padded bills and prolonged treatment. They also found that carriers and self-insurers frequently lifted cases so as to obtain more favorable testimony. They found intensive solicitation of business by compensation clinics and inadequate treatment of injured workers needing the services of specialists.[9]

Reed also reports that the committee charged that, because of the low rates paid, the medical care obtained was frequently inadequate.

Insurer control is less possible in States which permit the employee to choose the doctor. Some of these States interpret employee choice as a virtual prohibition against insurer intervention (see below).

Data from a 1959 Michigan study are suggestive about one effect of insurer control. Sixteen percent of the study group receiving weekly benefits, and therefore eligible for medical benefits without arbitrary limit, owed money for medical care connected with their injury at the time of the interview (1957). The authors explain that these bills represent visits to additional doctors of the worker's choice (the employer chooses the doctor in Michigan) or bills for treatments that were not recommended by the insurance company doctors.[10]

Compromise and release settlements.—The subject of the Michigan study, compromise and release settlements, presents another way in which medical benefits may be limited even in those States that provide full benefits. In such settlements the insurer pays the claimant a lump sum in exchange for release from all future liability, including, in most States, the liability for full medical care. If the claimant finds, after the settlement, that his compensable injury or disease requires more care than was estimated, he must pay for such care himself. Unless the need for additional care is the result of a significant change in his condition (a qualification not valid in all States) he has no claim against the insurer for additional benefits.

Some States do not permit compromise lump sum settlements to release the insurer from future liability. In 1966, 11 States, the District of Columbia, and Puerto Rico reported that they did not allow settlements which released the employer from further liability.[11] Others limit their use strictly to cases that reach the appellate level. A few do not permit the medical portion of the claim to be released even though the income portion may be. But, in a substantial number of States, compromise and release settlements are an important method of handling litigated cases. These settlements almost always relate to serious injuries whose medical needs are difficult to estimate before treatment is complete. To suggest the possible magnitude of the problem, table 10.7 shows compromise and release settlements as a percentage of all cases receiving income benefits in five States.

Table 10.7.—COMPROMISE AND RELEASE SETTLEMENTS AS A PERCENTAGE OF ALL CASES RECEIVING INCOME BENEFITS FROM WORKMEN'S COMPENSATION, 1969–70

State	Year	Percent
Illinois	1969	39
Maryland	1970	15
Michigan	1970	27
Missouri	1970	36
Texas	1970	27

Source: Annual reports of the State commissions.

Contested cases.—Litigation gives rise to another medical problem when the insurer's liability is at issue. In most formally contested cases, the issue is the extent of liability rather than the liability itself. Until liability is conceded, the insurer need not pay for medical benefits, although the insurer may elect to pay "without prejudice" to the outcome of the case. If the insurer does not pay, the time it takes to decide the issue becomes important to the claimant and may influence the course of his medical care. A New York study by MacDonald reports that, in cases of contested liability, 77 percent of compensated claimants (the only cases whose postdecision records of care were known) had completed all medical treatment by the date of the final ruling. The median time to a ruling for both compensated and uncompensated cases was 200 days. MacDonald notes that the uncertainty created by the contest ". . . added a psychological burden to the physical one already in existence." [12]

The psychological complications created by litigation have been noted by other authors. The impetus for Kessler's study of compensation back injuries was the observation that the length of disability for compensation cases was far longer than the others. Kessler concluded that confusion and bewilderment caused by the compensation system delayed recovery.[13] Reed, in his study of compensation medical care in New York, states that the compensation process ". . . pits [the worker] as a litigant against maximum recovery." [14]

CHOICE OF PHYSICIAN

Statutory Provisions

Three basic systems of physician choice are used by the States. Currently (Table 10.8), 24 jurisdictions allow the injured worker to choose his own physician. Included among these is New York which limits the employee's choice to a State-approved panel which includes 91 percent of the State's physicians and five other jurisdictions which permit employees to choose from a panel. Twenty-five jurisdictions give the employer-carrier the right to choose the physician. Table 10.9 provides greater detail on the operation of panel selection in the six jurisdictions with panels.

There is some difficulty in classifying States regarding the question of choice. As we shall see, in many States actual practice does not jibe with the statutory language. More important, some State laws do not specify who shall choose the physician.

Table 10.8.—STATUTORY PROVISIONS RELATING TO INITIAL CHOICE OF PHYSICIAN AND CHANGE OF PHYSICIAN IN WORKMEN'S COMPENSATION, 1972

State	(1) Statutory provision on choice of doctor*	(2) Can employee change from initial doctor?**	(3) Can employer change initial physician?**
Alabama	Insurer	Yes †	Yes.
Alaska	Employee	Yes	No.
Arizona	do	Yes	Yes.
Arkansas	Insurer	Yes	Yes.
California	do	Yes	Yes.
Colorado	do	No	Yes.
Connecticut	Panel	Yes	Yes.
Delaware	Employee	Yes	No.
District of Columbia.	Panel	Yes	No.
Florida	Insurer	Yes	Yes.
Georgia	do	Yes	Yes.
Hawaii	Employee	Yes	No.
Idaho	Insurer	Yes [1]	Yes.
Illinois	do	No	Yes.
Indiana	do	No	Yes.
Iowa	do	Yes	Yes.
Kansas	do	No [2]	Yes.
Kentucky	Employee	Yes	Yes.
Louisiana	Insurer	Yes	Yes.
Maine	Employee	Yes	Yes.
Maryland	do	Yes	Yes.
Massachusetts	do	Yes	No.
Michigan	Insurer	Yes	Yes.
Minnesota	Employee	No [3]	No.
Mississippi	Insurer	Yes [8]	Yes. [8]
Missouri	do	No	Yes.
Montana	Employee	Yes	Yes.
Nebraska	Panel	Yes [4]	No.
Nevada	Employee	Yes	No.
New Hampshire	do	Yes	?
New Jersey	Insurer	Yes [5]	Yes.
New Mexico	do	No	Yes.
New York	Panel	Yes	Yes.
North Carolina	Insurer	Yes [6]	Yes.
North Dakota	Employee	Yes	No.
Ohio	do	Yes	No.
Oklahoma	Insurer	No	Yes.
Oregon	Employee	Yes	No.
Pennsylvania	Insurer	No	Yes.
Puerto Rico	do	No	No.
Rhode Island	Employee	Yes	No.
South Carolina	Insurer	Yes [9]	Yes.
South Daota	do	No	Yes.

See footnotes at end of table.

TABLE 10.8.—STATUTORY PROVISIONS RELATING TO INTIAL CHOICE OF PHYSICIAN AND CHANGE OF PHYSICIAN IN WORKMEN'S COMPENSATION, 1972—Continued

State	(1) Statutory provision on choice of doctor*	(2) Can employee change from initial doctor?**	(3) Can employer chan initial physician?**
Tennessee	Panel	Yes[10]	Don't know.
Texas	Insurer	Yes	Yes.
Utah	do	Yes	No.
Vermont	do	Yes	Yes.
Virginia	Employee	Yes	Yes.
Washington	do	Yes	No.
West Virginia	do	Yes[7]	No.
Wisconsin	Panel	Yes	No.
Wyoming	Employee	Yes	No.

[1] With permission of employer or insurer.
[2] Unless employer agrees. It happens frequently.
[3] By mutual consent or order of the Commission. See Minn. Stat. 176.135, Subd. 2. An employee may be authorized to change treating physicians.
[4] Employee may make second choice from panel without permission.
[5] Employer has the right to change with request. Employee must approach employer or carrier for authorization. Commission has nothing to do with change.
[6] With approval of insurer.
[7] With approval of Commissioner.
[8] With Commission's approval.
[9] By request.
[10] Within the panel.

* Source: 1971 Data from Bureau of Labor Statistics, Bureau of Employment Security.
** Source: Questionnaires completed by the State commissions, January 1972.
† In some cases.

Table 10.9.—COMPOSITION AND REGULATION OF PHYSICIAN PANELS FOR WORKMEN'S COMPENSATION, 1972

State	Panel selection	Number of physicians
Connecticut	Compensation agency	Not stated.
District of Columbia	Employer	Minimum of 3.
Nebraska	do	Not stated.
New York	Workmen's compensation Board.	91 percent of State physician's (80,000 plus) approved by board.
Tennessee	Employer	3.
Wisconsin	Employer, insurer, and local medical sometimes.	Reasonable number.

Typical statutory language such as "The employer shall furnish all medical, hospital, etc., care as is necessary," is construed to mean employer choice in some States and worker choice in others. In Nevada and Utah, this phrase has been interpreted in opposite ways. The legislative trend is toward employee choice. Six States (Connecticut, Kentucky, Maine, Nebraska, Nevada, and Virginia), have revised their laws in the last 10 years, taking initial physician choice from the insurer/employer and giving it to the worker.

Choice of Physician in Practice

Although State laws prescribe that only one party, the worker or the employer-insurer, has the right to choose the initial physician, few States are limited in practice to one method of physician selection. Nearly every jurisdiction uses at least two methods of physician selection. Our questionnaire to the State commissions asked them to estimate the percentages of cases in which the employee made the initial choice, in which the employer made the initial choice, and in which the choice was made from a panel.

Table 10.10 shows the response. The States are separated into employee-choice and insurer-choice groups. As expected, the table shows that the percentage of employee-choice cases is higher in employee-choice States than in insurer-choice States. But the table demonstrates a substantial overlap between the two types. Some insurer-choice States have percentages as high or higher than some employee-choice States. It needs to be stressed, however, that these numbers are for the most part estimates without solid statistical support.

This deviation between the letter of the law and actual practice has a number of explanations. Sometimes, the company doctor may be nearest

Table 10.10.—PERCENTAGE OF CASES IN WHICH THE EMPLOYEE CHOSE THE INITIAL PHYSICIAN IN WORKMEN'S COMPENSATION, 1972

	States
Employee choice:	
Less than 5 percent	
5 to 9 percent	
10 to 24 percent	Maryland, District of Columbia.[1]
25 to 49 percent	Kentucky, Nevada, Virginia.[1]
50 to 74 percent	Connecticut, Delaware, Massachusetts, Montana, Wisconsin.[1]
75 to 89 percent	Arizona.
90 to 94 percent	Rhode Island.
More than 95 percent	Alaska, Hawaii, Nebraska, New Hampshire, New York, North Dakota, Ohio, Oregon, Washington, West Virginia, Wyoming, Vermont.
Insurer choice:	
Less than 5 percent	Colorado, Georgia, Illinois, Mississippi, Pennsylvania, Puerto Rico, South Dakota.
5 to 9 percent	Iowa, Missouri, Oklahoma, South Carolina, Guam.
10 to 24 percent	Arkansas, California, Florida, Kansas, Michigan, New Jersey, New Mexico, Texas.
25 to 49 percent	
50 to 74 percent	Alabama, Idaho, North Carolina.
75 to 89 percent	Utah.
90 to 94 percent	
More than 95 percent	Vermont.

[1] In all other cases, the employee selects a physician from a panel.
Source; Estimates provided by the State commissions in answer to a questionnaire, January 1972. Indiana, Louisiana, Maine, and Minnesota did not supply estimates. Tennessee, Federal Employees, and Longshore reported that all physician selections were made from a panel.

and the employee may be quite satisfied to accept his care. In rural areas, with few physicians, there is no real choice. In insurer choice jurisdictions which are lenient in permitting employees to change physicians if they are dissatisfied, insurers may give employees greater freedom to choose in the first place. Finally, past practice may change slowly when the law is changed to give the choice to the employee. Four of the States that have recently changed their laws to permit employee choice (Connecticut, Kentucky, Nevada, and Virginia) fall towards the low end of the estimates for employee-choice States.

Change of Initial Physician

In the event that a patient is not satisfied with the care he is receiving, no one's interest is particularly well served by mandating that treatment be continued with the same physician.[15] On the other hand, insurers are interested in avoiding capricious change of physician. Further, the insurer may not be satisfied with a particular physician's treatment of a patient. "Generally, carriers have recognized the long run savings gained from prescribing the best medical care at first treatment." This opinion, offered by an official of Employers' Mutual-Wausau, explains why carriers feel it important that they can effect a change of physician. To accommodate misgivings on all sides, State statutes provide machinery for changing physicians.

Columns 2 and 3 of Table 10.8 show whether the employee or employer-insurer is permitted to change the initial physician. Usually, such changes require the approval of the State commission, at least for that party who is not permitted to make the initial choice. The table shows that nine jurisdictions do not permit the employee to change physicians unless, of course, the employer-insurer consents. In 18 jurisdictions, the employer may not request a change in physician; virtually all of these are employee-choice jurisdictions.

The Debate Over Physician Choice

The debate over employee-choice versus insurer-choice focuses on three major questions. First, which system costs less? Second, which system provides better quality care? Third, what are the legal interests of each side in the selection of a physician?

Cost of medical care.—Employers, insurers and some union officials believe that the designation of the physician by the insurer is necessary to minimize the cost of insurance.[16] Insurers believe that physicians chosen by the employee tend to "overtreat," thus increasing costs. They argue also that costs are minimized in many instances by the use of retained or salaried physicians. Many insurer-appointed "company doctors" are reimbursed for their compensation work in some manner other than the common fee-for-service method.

The costs of providing services have not been documented well. Table 10.11 shows several interesting variables related to the cost of providing medical care under insurer-choice and employee-choice systems. These data are for the 17 States participating in the BLS Work-Injury Survey. In column 3 is the average medical payment to workmen's compensation cases as gathered by the NCCI. The average payment in employee-choice States ($109.78) is $1.55 more than the payment in insurer-choice States ($108.23).

While this difference does not appear to be significant, it is interesting to speculate on why the

Table 10.11.—COMPARISON BY STATE OF MEDICAL COSTS, FREQUENCY RATES, AND SEVERITY RATES BY SYSTEM OF PHYSICIAN SELECTION FOR WORKMEN'S COMPENSATION IN 17 STATES, 1969

State	System of physician selection[1]	Average medical payment per case (various years)	Frequency rate 1968–69	Severity rate 1968–69
Alabama	IC	96.83	14.8	1,200
Arkansas	IC	123.76	25.5	1,845
Connecticut	FC	127.70	12.2	404
Florida	IC	150.17	19.3	1,359
Georgia	IC	93.41	19.5	1,472
Indiana	IC	79.16	15.2	860
Iowa	IC	92.49	19.0	700
Maine	FC	92.66	21.6	1,064
Michigan	IC	116.94	11.4	470
New Jersey	IC	124.68	14.2	684
New York	FC	132.35	13.4	548
Pennsylvania	IC	93.48	13.9	651
South Carolina	IC	93.07	7.5	NA
Texas	IC	126.56	NA	NA
Virginia	FC	99.71	12.8	793
Wisconsin	FC	96.51	20.9	839
Wyoming	FC	NA	30.6	2,295
Averages:				
Insurer choice	11	$108.23	16.0	1,026
Free choice	6	$109.78	18.5	990

[1] IC=Insurer choice. FC=Free choice.

Sources: NCCI data, 1968–69, 5th report, for medical payments. "Injury Rates by Industry," 1969. BLS report No. 389.

cost of medical care is higher in employee-choice States. One hypothesis is that the accidents occurring in free choice States are more serious, and therefore require more medical care than those occurring in insurer-choice States. However, severity rates, figured as ratio of total charges (in days) per 1,000,000 man-hours, in (column 5) are slightly lower in the employee-choice States than in the employer-insurer-choice States. Without a more detailed study of medical costs by diagnosis in employer-choice and employee-choice States, it is not possible to come to a definite conclusion. This simple comparison of average medical costs indicates that there are no significant differences between medical costs in different States on the basis of their methods of physician choice.

Quality of care.—The second issue concerning physician choice, closely allied with the problem of costs, is the quality of care. The arguments advanced by proponents of each system center on three factors: (1) speed or delay in providing initial medical care; (2) competence of practioners under either plans; and (3) the incentives to provide the highest quality care.

Employers and insurers contend that insurer-choice speeds the assignment of the injured worker to a physician and prompt treatment results in reduced disability limits, more speedy recovery, and less time away from the job.[17] Opponents of insurer-choice argue that workers are sufficiently well informed to select a doctor with little delay. Further, they cite examples of "company doctors," out of concern for production or minimal loss of time, ordering patients back to work while they are still recovering from their injuries.

Insurers believe that their experience makes it possible for them to assign patients to the appropriate specialists, physicians who deal consistently with patients from the same industrial background and thus offer higher quality care. They charge that "general practitioners have a lamentable record in making critically important referrals." [18] On the other hand, proponents of free choice feel that the physician initially consulted by the employee is usually the family doctor who is intimately familiar with the patient's medical background and who furnishes personalized care, a dimension thought by many to be the most important element of quality medical care. Regarding incentives, insurers argue that it is to their advantage to provide the best care possible since an investment in quality will often return disproportionate savings by reducing or even preventing permanent disability.

No studies compare the quality of care provided to compensation patients under each method of selection. In the absence of anything more definitive, something may be gleaned from a study of the medical resources available to workers in each State. Table 10.12 shows the numbers of all specialists and of several types of specialists of particular importance to victims of industrial accidents, expressed as rates per 100,000 nonagricultural workers.

The average number of all specialists per 100,000 workers is 10 percent higher in employee-choice States (including New York, the average is 261) than in insurer-choice States (235). Similarly, the physician/worker ratios for each of the individual specialties—orthopedic surgeons, neurological surgeons, occupational medicine specialists, and physical medicine and rehabilitation specialists—are higher in employee-choice than in insurer-choice States. It thus seems that, for whatever reasons, a greater number and variety of specialists are available to injured workers in employee-choice States.

The legal importance of medical testimony.—Underlying the arguments are concerns over contested compensation cases. Over the years, a plaintiff's bar has become a powerful force in the final settlement of compensation cases. Employees, through their attorneys, know that the plaintaiff's ability to choose his doctor is crucial to securing advantageous settlements. Conversely, the defendant insurers or employers know that their costs will be affected by the medical testimony they can present.

Employers and insurers feel generally that discontent on the part of the worker with his physician is motivated by his concern with the potential indemnity.[19] In most employer-choice States, the worker has the option of changing physicians during the course of treatment.[20] Workers, on the other hand, naturally feel that a company-appointed doctor owes his first allegiance to the insurer or the employer and accordingly may attempt to minimize the nature of the disability and give biased advice to his patient concerning the extent and permanence of his disability. Clearly, the conflicting interests make impartial medical testimony important to the equitable operation of the system.

Table 10.12.—SYSTEM OF SELECTION AND NUMBER OF SPECIALISTS BY STATE PER 100,000 NONAGRICULTURAL WORKERS, 1972

State	System of selection	All specialists	Orthopedic surgeons	Neurological surgeons	Occupational medicine specialists	Physical medicine and rehabilitation specialists
Alabama	Insurer	196.4	9.5	2.7	1.9	0.5
Alaska	Employee	135.9	12.0	2.2	0	0
Arizona	do	285.9	11.2	5.0	1.7	2.4
Arkansas	Insurer	181.1	.8	1.9	(1)	.2
California	do	356.9	18.0	4.4	3.2	1.5
Colorado	do	354.9	15.0	3.5	2.2	1.3
Connecticut	Panel	347.2	13.2	4.5	4.4	1.8
Delaware	Employee	238.0	9.1	2.9	8.2	1.4
District of Columbia.	Panel	309.6	8.0	3.5	2.0	1.3
Florida	Insurer	297.2	15.6	3.2	1.3	.7
Georgia	do	219.0	9.5	3.1	1.0	.8
Hawaii	Employee	271.8	11.1	4.2	1.7	1.4
Idaho	Insurer	167.5	.5	1.0	(1)	.5
Illinois	do	232.6	8.1	2.4	3.6	1.1
Indiana	do	163.3	7.7	2.0	3.2	.4
Iowa	do	186.5	8.2	2.0	1.2	.8
Kansas	do	234.4	10.6	2.8	1.0	.6
Kentucky	Employee	217.1	9.8	2.5	1.7	.8
Louisiana	Insurer	280.5	14.7	2.8	2.2	.5
Maine	Employee	193.3	9.1	3.0	1.8	.3
Maryland	do	378.2	10.3	3.9	2.8	.2
Massachusetts	do	355.4	15.1	3.4	8.1	1.2
Michigan	Insurer	261.1	8.9	2.6	4.4	1.4
Minnesota	Employee	285.3	13.6	4.7	1.6	2.9
Mississippi	Insurer	185.5	9.0	.8	.9	0
Missouri	do	252.6	10.1	2.6	3.0	.9
Montana	Employee	205.0	12.4	2.5	1.0	.5
Nebraska	Panel	193.6	8.9	1.5	.6	.2
Nevada	do	169.7	10.0	3.5	1.5	1.0
New Hampshire	do	235.1	10.0	3.5	.8	1.9
New Jersey	Insurer	279.1	11.9	1.8	3.8	1.2
New Mexico	do	258.3	15.2	3.4	2.4	.7
New York	Panel	430.7	12.9	3.3	3.1	4.3
North Carolina	Insurer	203.9	9.2	2.5	1.3	.2
North Dakota	Employee	200.0	11.7	3.1	0	1.8
Ohio	do	246.9	9.4	2.7	2.6	1.2
Oklahoma	Insurer	213.5	11.5	2.4	2.1	.4
Oregon	Employee	272.5	15.5	5.2	1.0	.4
Pennsylvania	Insurer	271.0	9.7	2.6	2.9	1.9
Puerto Rico	do	(2)	(2)	(2)	(2)	(2)
Rhode Island	Employee	315.8	15.2	3.9	.9	1.8
South Carolina	Insurer	173.3	10.1	2.5	2.2	.2
South Dakota	do	160.8	8.5	1.7	0	0
Tennessee	Panel	240.0	12.7	5.0	3.0	.5
Texas	Insurer	228.1	11.4	3.4	2.0	1.2
Utah	do	274.9	15.6	3.1	2.2	.8
Vermont	Employee	355.4	14.2	7.4	2.0	2.0
Virginia	do	254.0	10.4	3.9	2.0	.8
Washington	do	289.7	14.5	3.8	2.3	2.8
West Virginia	do	225.5	11.3	3.7	1.8	.4
Wisconsin	Panel	222.4	9.6	2.5	1.4	1.2
Wyoming	Employee	157.0	9.3	1.9	1.9	.9
Insurer choice States[3]		234.7	10.4	2.6	2.0	.7
Employee choice States[3]		260.8	11.7	3.6	2.2	1.4

[1] Less than 0.5

[2] Not available.

[3] Unweighted averages, panel States and Puerto Rico omitted.

Source: "Distribution of Physicians in the United States 1970," American Medical Association, Chicago, 1971; "Manpower Report of the President," U.S. Department of Labor, April 1971.

REGULATION OF MEDICAL FEES

Several States attempt to regulate the costs of medical care by establishing a schedule of fees for physicians in workmen's compensation. Other medical charges, such as hospital and drugs, also are regulated by some jurisdictions. Table 10.13 shows the types of fee schedules used by the States: 18 regulate the fees of physicians by schedules; 12 use fee schedules for hospital expenses; only a few have schedules for prosthetic devices and drugs.

Table 10.13.—FEE SCHEDULE BY TYPE OF SERVICE FOR WORKMEN'S COMPENSATION, 1972

CNS=Charges not specified. R=Reasonable. P=Prevailing. U=Usual. C=Customary

State	Schedule for physician fees (1)	Schedule for hospital fees (2)	Schedule for drugs (3)	Schedule for prosthetics (4)	Schedule for other (5)
Alabama	P	P	P	P	
Alaska	CNS	CNS	CNS	CNS	
Arizona	Yes	R	CNS	CNS	Nursing service.
Arkansas	CNS	CNS	CNS	CNS	
California	Yes	CNS	CNS	CNS	
Colorado	Yes	Yes	Yes	CNS	
Connecticut	P	Cost to hospital.	R	R	
Delaware	R	R	R	R	
District of Columbia.	CNS	CNS	CNS	CNS	
Florida	Yes	Yes	P	P	
Georgia	UC	UC	UC	UC	
Hawaii	Yes	P	P	P	Radiology and laboratory dental fees.
Idaho	Yes	Yes	CNS	CNS	
Illinois	CNS	CNS	CNS	CNS	
Indiana	CNS	CNS	CNS	CNS	
Iowa	R	R	R	R	
Kansas	Yes	Yes	CNS	CNS	Dental fees.
Kentucky	CNS	CNS	CNS	CNS	
Louisiana					
Maine	R	R	R	R	
Maryland	Yes	Yes	C	C	
Massachusetts	Yes	Yes	CNS	CNS	
Michigan	R	R	R	R	
Minnesota	R	R	R	R	
Mississippi	R	R	R	R	
Missouri	R	R	R	R	
Montana	Yes	Yes	CNS	CNS	Physical therapy chiropractic.
Nebraska	Yes	R	R	R	
Nevada	Yes	Yes	Yes	CNS	
New Hampshire	CNS	CNS	CNS	CNS	
New Jersey	R	R	R	R	
New Mexico	R	R	R	R	
New York	Yes	R	R	R	
North Carolina	Yes	Yes	R	R	
North Dakota	RC	RC	RC	RC	

See footnotes at end of table.

Table 10.13.—FEE SCHDULE BY TYPE OF SERVICE FOR WORKMEN'S COMPENSATION, 1972—Continued

State	Schedule for physician fees (1)	Schedule for hospital fees (2)	Schedule for drugs (3)	Schedule for prosthetics (4)	Schedule for other (5)
Ohio	CNS	Rates based on costs.	Shine system.	Yes	
Oklahoma	RP	RP	RP	RP	
Oregon	U	U	U	U	
Pennsylvania	CNS	CNS	CNS	CNS	
Puerto Rico	CNS	CNS	R	R	
Rhode Island	R	R	R	R	
South Carolina	Yes	R	R	R	
South Dakota	CNS	CNS	CNS	CNS	
Tennessee	P	P	P	P	
Texas	R	R	R	R	
Utah	Yes	Yes	CNS	Yes	
Vermont	P	P	P	P	
Virginia	P	P	P	P	
Washington	Yes	Yes	CNS	CNS	
West Virginia	P	Hospital cost.	P	P	
Wisconsin	RN	RN	RN	RN	
Wyoming	Yes	Yes	CNS	CNS	Physical therapy chiropractice.
Federal Employees Compensation Act.	UC	UC	UC	UC	
Longshoremen's Act.	P	P	P	P	
Guam	CNS	CNS	CNS	CNS	

Source: Responses by agencies to Commission questionnaire.

The fee schedules are usually prescribed by statute and set administratively. Most often the fees are those prevailing in the State and adjusted by agency panels, generally composed of representatives of the State medical society, insurance carriers, and the compensation agency.

Several agencies employ a relative value scale for fees. First developed in California, the relative value scale attempts to price various procedures according to their demand on the physician's time. A sample of physicians is asked to indicate the average amount of time required to treat and the average fee charged for a list of procedures. From these replies, a cost per unit of physician's time is derived as the basis of the relative value scale. This scale, in effect, prices one procedure relative to another. The fee setting agency then applies a dollar "multiplier" to the values given in the relative value scale to derive a series of fees. Fees can be raised by raising the multiplier.

Where fee schedules are used, they are reviewed generally on an annual or biennial basis. South Carolina's 5-year review is an exception. States not employing fee schedules usually permit physicians to charge fees which are "reasonable and customary," "usual," or "prevailing in the community."

The effective enforcement of compensation agency regulated fees is often performed by reviewing physician charges. Ten States regularly review physician charges. The remaining States apparently feel there is no need to police physician fees or the law does not provide for this. In addition to the efforts by the compensation agencies to control medical costs, private insurers police medical charges, in general, in a uniform fashion. In States with fee schedules, the insurer will pay only the fee posted. Elsewhere, the insurers have developed profiles by geographic regions of the usual and customary fees for procedures. They adjust doctors' bills to meet this profile. An official of Employers' Mutual-Wausau notes that the carrier makes adjustments to the customary and usual profile in telephone conversation with the physician in States without fee schedules.

If charges are in dispute, the compensation agencies often intervene to seek a settlement between the parties. Commissions in most States provide arbitration of fees on application in disputes where the parties seek this solution. In some States, this arbitration function is shared with a medical advisory committee. In a few jurisdictions, the medical advisory committee takes sole responsibility for fee arbitration.

SUPERVISION BY STATE COMMISSIONS

As medical evidence is often crucial in settling contested compensation claims, it is important to have good medical records as evidence. The medical reporting systems of many compensation commissions are still oriented toward this need for medical evidence and impartial evaluations in contested cases.

Many students of compensation have argued that the commissions should take responsibility for continuing supervision of the medical care of all compensation cases, whether or not disputes occur.[21] They argue that compensation care should be the best available and that impartial supervision by experienced commission staff can assure that care is up to expectations. Further, Cheit points out that States which restrict the em-

ployee's freedom to choose a doctor have done so on the grounds that the employee lacks the knowledge to select the best care; he concludes that this line is justifiable only if the commissions then take responsibility for insuring that carriers and employers provide care that is better than could be obtained through employee-choice.[22] On the other hand, given sufficient records in employee-choice States, the commission can guard against serious errors in treatment that may arise because the employee chooses poorly. Finally, the commission can guard against abuse of the system.

The U.S. Department of Labor has published a recommended standard that State compensation agencies supervise the medical care provided injured workers in order to achieve maximum restoration with a minimum of delay. In carrying out this responsibility the agencies are urged to consult with appropriate medical advisory bodies.[23] According to the Department, 26 States met this standard as of January 1972: Alaska, Arizona, California, Connecticut, Florida, Georgia, Hawai, Idaho, Maryland, Michigan, Minnesota, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

Effective supervision requires: (1) sufficient information on the medical care given to individual cases; (2) a staff competent to assess this information; and (3) the power to initiate changes in treatment if changes are necessary. All jurisdictions can and do request medical reports, as needed, in court contests or hearings. The questionnaire asked whether the commissions regularly receive reports from physicians for each case, the types of reports received, the use made of these reports, and the extent to which the commissions take an active part in supervising care.

Treatment Reports

Treatment reports are probably most important for purposes of supervision. In these, the physician generally describes the patient's condition, the care given, and the prognosis. Table 10.14 shows the answers given by commissions to a question asking whether they reecived treatment reports. Because the question did not emphasize the distinction between receiving and requiring reports, or between requiring them for all or merely some cases, the answers do not show clearly which States currently have the information base necessary for a comprehensive supervision of medical care. The answers given by Alabama and Minnesota illustrate the different interpretations put on the question.

Some States clarified their answers in response to a question asking how the requirements for phy-

Table 10.14.—JURISDICTIONS THAT RECEIVE TREATMENT REPORTS FOR WORKMEN'S COMPENSATION AND REQUIRED TIME OF FILING, 1972

Alabama	No, except on request.
Alaska [1]	Yes, varies with seriousness of injury.
Arizona	No.
Arkansas [1]	Yes, no set time.
California	No.
Colorado	Yes, as required.
Connecticut	No.
Delaware	No.
District of Columbia	Yes, within 10 days.
Florida [1]	Yes, completion of treatment.
Georgia [1]	Yes, periodic.
Hawaii [1]	Yes, every 21 days.
Idaho	Yes, not required.
Illinois	No.
Indiana	No.
Iowa	Yes, many received, but not required.
Kansas	No.
Kentucky	Yes, reasonable.
Louisiana	No, commission.
Maine	Yes, no occasion.
Maryland	Yes, varies.
Massachusetts	Yes, periodically.
Michigan [1]	Yes, required for all disabilities of more than 13 weeks.
Minnesota	Yes, upon request.
Mississippi	Yes, as rendered.
Missouri	Yes, no time specified.
Montana [1]	Yes, as indicated.
Nebraska	No.
Nevada [1 2]	Yes, every 30 days.
New Hampshire	Yes, as requested.
New Jersey	No.
New Mexico	Yes, not required.
New York [1]	Yes, every 21 days.
North Carolina [1]	Yes, no time specified.
North Dakota [1 2]	Yes, every 30 days.
Ohio [1 2]	Yes, as soon as available from physician.
Oklahoma	No.
Oregon [1]	Yes, within 10 days of treatment.
Pennsylvania	No.
Puerto Rico [2]	No.
Rhode Island	No.
South Carolina	Yes, periodically.
South Dakota [1]	Yes, within approximately 7 days.
Tennessee [1]	Yes, no time specified.
Texas [1]	Do.
Utah	Yes, as required.
Vermont	Do.
Virginia [1]	Yes, within a reasonable time.
Washington [1 2]	Yes, every 30 days.
West Virginia [1 2]	Yes, every 90 days.
Wisconsin	No.
Wyoming [1 2]	Yes, every 30 days.
Federal Employees Compensation Act.[1]	Do.
Longshoremen's Act [1]	Yes, no time specified.
Guam [1]	Do.

[1] Treatment reports may be required for all cases, contested and noncontested.
[2] Exclusive fund States.

sicians' reports were enforced (table 10.15). Where the State does not receive treatment reports, but does show penalties in table 10.15, these are for failure to file other physicians' reports, such as first injury and discharge reports. Answers such as those given by Missouri indicate that some commissions were still thinking of requirements for litigated cases rather than for supervision.

Table 10.15.—HOW STATES ENFORCE REQUIREMENTS FOR PHYSICIANS' REPORTS IN WORKMEN'S COMPENSATION

Alabama	No reports required.
Alaska	Payment may be withheld or denied.
Arizona	Any violation of the provisions or requirements of the law is a misdemeanor punishable by a fine of $50 to $1,000 and $100 to $5,000 for each subsequent offense. It has seldom been necessary to impose a fine.
Arkansas	By calling or writing the insurance carrier or doctor.
California	Failure to file is a misdemeanor but prosecutions are unnecessary. Carrier may withhold payment of doctor's bill.
Colorado	By request.
Connecticut	No provisions.
Delaware	Not applicable.
District of Columbia	Employer is subject to civil penalty not to exceed $500 for each such failure or refusal.
Florida	Initial report must be filed within 10 days or fees can be denied.
Georgia	No physicians' fees shall be paid until all reports required have been filed.
Hawaii	No statutory provisions; requests, exercise of subpena powers, and persuasion.
Idaho	No report requirements.
Illinois	Not applicable.
Indiana	Do.
Iowa	By request.
Kansas	Not applicable.
Kentucky	No enforcement.
Louisiana	No commission.
Maine	No provision.
Maryland	If doctor fails or refuses to file reports, he is subpenaed.
Massachusetts	Little effective means of enforcement, except at time of a conference or hearing before a member of the Board; however, reports of employer's or insurer clinics must be provided employee or his attorney upon request; failure to so provide upon request could bar the admission into evidence.
Michigan	Physician must appear before commission.
Minnesota	Fine of $50 for each failure.
Mississippi	No manner of enforcement.
Missouri	Testimony of physician is not admissable in evidence if medical report is not available to all parties.
Montana	Constant file review.
Nebraska	Have authority for fines and penalties and may request State insurance department to suspend or revoke insurer's license.
Nevada	May fine employer; have not found it necessary.
New Hampshire	Payment may be delayed.
New Jersey	No routine filing. Specific requests always honored. Insurers do not pay unless report received.
New Mexico	No reports required.
New York	Physician may not be paid. Chairman may suspend or revoke physician's authority to treat claimants.
North Carolina	No report, no payment.
North Dakota	Request reports by phone or letter; if not received, request another doctor.
Ohio	Not applicable.
Oklahoma	No reports required.
Oregon	(1) Refer case medical director of Board; (2) Medical director may refer case to peer review committee.
Pennsylvania	Not applicable.
Puerto Rico	Resolution after medical or public hearings.
Rhode Island	Not applicable.
South Carolina	Penalty of $25 on insurer or employer.
South Dakota	Statutory authority to impose fine on those responsible for report.
Tennessee	Payment may be withheld.
Texas	Carrier forwards reports as received.
Utah	Refusal to file constitutes misdemeanor.
Vermont	No provision.
Virginia	Deny payment of physician's bill; subpena physician; exercise persuasion by letter or phone.
Washington	May refuse to pay physician for services rendered during period for which no report has been submitted. In chronic cases of failure to submit reports the department may deny the doctor the privilege of treating industrial cases.
West Virginia	May withhold or discontinue payment of medical bills.
Wisconsin	Agreement with State medical society. On referral, they solicit reports. Can call doctor in before their committee, would probably be removed from panel.
Wyoming	Infrequently, bills are disallowed for tardy filing; unused misdemeanor provision is available.
Federal Employees Compensation Act.	Payment may be withheld.
Longshoremen's Act	Act provides for a $500 civil penalty for failure to file reports.
Guam	Invalidate claim for services.

Source: Mail questionnaire complete by the State commissions, January 1972.

The coverage of the reporting is indicated by filing intervals cited by the commissions: 11 jurisdictions say treatment reports are due every 21, 30, or 90 days or within some time interval after the treatment is given. These data suggest that the reports are required for cases that require continued treatment whether or not they are subject to a contest. Other States gave answers which, though not specific, indicated that reports are a regular requirement, expected for all cases, as in Alaska, Florida, Mississippi, and Ohio.

By combining the information in both tables, it is possible to estimate that as many as 24 jurisdictions may have treatment information on most or all of their compensation cases. (For example, when a commission enforces report requirements by denying payment, it seems reasonable to conclude that the reports are a general requirement since it is not always possible to know in advance of payment whether the case is eventually to be contested or not. This group of 24 includes some States, such as Michigan, which receive treatment reports only for cases of more than some specified duration.) Similarly, at least 30 jurisdictions

would appear not to have this base of information. It is not surprising to find all the exclusive State funds, except Puerto Rico, in this group of 24 that require treatment reports on most cases. Because State funds act both as insurer and commission, it is to be expected that they will require the same sorts of information that private insurers do.

Evaluation of Treatment Reports

Once the information is available, supervision of medical care requires a staff competent to evaluate medical information. The commissions were asked if they have medical professionals on their staff and if these or other staff members review physicians' reports to determine whether the treatment is adequate and appropriate. Of the 26 that replied that they have no medical professionals on their staff, one, Colorado, has plans to set up a medical staff in the near future. The remaining jurisdictions have anything from one part-time rehabilitation specialist (New Hampshire) to a large staff of full-time physicians (New York). Only nine jurisdictions have one or more full-time physicians: California, New Jersey, New York, North Dakota, Ohio, Oregon, Puerto Rico, Washington, and Federal Employees. Four of these are exclusive fund jurisdictions. Twelve others have one or more part-time physicians.

In most commissions, the medical staff reviews physicians' reports, but not for the purpose of general case supervision.

Such staffs frequently are asked to determine eligibility for compensation, whether a case should be closed, the accuracy of a disability rating, or other administrative matters. Reed found that doctors on the staffs of insurance companies frequently spent much of their time on administrative matters such as estimating the necessary reserves for serious cases rather than on the general supervision of care.[24] Alaska, Hawaii, Nevada, and Washington (the last two are exclusive fund States) report that cases are reviewed to check on their medical progress. Any desirable changes in treatment could be identified at this point. In Virginia, cases are reviewed to determine the need for special care. California and Nebraska review cases specifically for the need for rehabilitation services.

Power To Initiate Changes in Treatment

Given the information and competence, how much power do States have to initiate changes in treatment and how vigorous is their use of such power? In 17 jurisdictions, the commission cannot initiate a change of physician. Of this number, seven are employee-choice States, two are panel-choice, and nine are employer-insurer choice. Louisiana is excluded from the following discussion. It does not have a commission and did not report what the court is allowed to do in these matters.

This lack of commission power to initiate changes of physician does not appear to be designed especially to favor the insurers or the insured. Where the commission does have the right to initiate a change of physicians, the extent to which that right is used does not seem to depend on whether initial choice of physician is given to the employee or employer. Six commissioners have made no use of this power in the last 2 years.

Forty jurisdictions claim the right to order a change in medical treatment or the use of a consultant (California can do so only in litigated cases) and all but four had exercised that right in the last 2 years.

When asked whether the commission ever advised the treating physician or suggested a change in treatment or use of a consultant, 29 jurisdictions answered that they never do so. Of the remaining 25 jurisdictions, 12 do so in fewer than 1 percent of the cases. Thirteen others have made wider use of this possibility in the last 2 years, with Minnesota, Montana, South Carolina, Texas, and the exclusive-fund States of Nevada, North Dakota, West Virginia reporting that such suggestions and advice had been given in more than 5 percent of all cases.

References to Chapter 10

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16. Cheit, *op. cit.*, p. 43. Data and opinions reported by Cheit were gathered from questionnaires circulated among insurers, employers and organized labor.
17. *Ibid.*, p. 43.
18. *Ibid.*, p. 45.
19. *Ibid.*, p. 37.
20. *Ibid.*, p. 25.
21. *Ibid.*, Ch. 4.
22. *Ibid.*, p. 85.
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24. Reed, *op. cit.*, p. 141.