SORM
State Office of Risk Management

Annual Report on Cost Containment

Fiscal Year 2017

February 28, 2018

Table of Contents

I. Introduction 3

II. Summary of Cost Containment Savings 4

III. Cost Containment Measures 5

A. Medical Bill Audits 5

B. Workers' Compensation Health Care Network 6

C. Preauthorization of Medical Services 7

D. Pharmacy Benefits Management 7

E. Timely Payment of Medical and Pharmacy Bills 8

F. Provider Refund Requests 9

G. Coordination and Outreach to Employers 9

H. Timely Payment of Indemnity Benefits 9

I. Recoupment of Indemnity Overpayments 10

J. Impairment Ratings Reviews 10

K. Peer Reviews and Required Medical Examinations 11

L. Subrogation Recoveries 11

M. Subsequent Injury Fund 11

N. Fraud Detection and Investigation 11

O. Risk Assessment and Loss Prevention Services 12

IV. Proposed Additional Measures 12

A. Cloud-Based Case Management System 12

I. Introduction

The State Office of Risk Management is administratively attached to the Office of the Attorney General and is governed by a five-member Board. The Office is charged by law to administer the enterprise risk and insurance management programs, continuity of government operations program, and self-insured workers' compensation program for the State of Texas. Its mission is to enable State of Texas agencies to protect their employees, the general public, and the State's physical and financial assets by reducing and controlling risk in the most efficient and cost-effective manner.

The Office is financed wholly through interagency contracts with other state agencies. The funding program allocates an assessment, similar to a premium, to all participating agencies based on risk profile and other relevant factors identified by the Board.

The State of Texas self-insures for the purposes of workers' compensation. Excluding workers' compensation, there are no other statutory retention programs. The Office administers workers' compensation claims for state entities identified in Labor Code Chapter 501. The state employee workers' compensation program covers 143 state entities, which includes courts and institutions of higher education as well as Windham School District within the Department of Criminal Justice, and 122 community supervision and corrections departments, encompassing approximately 190,000 individual employees. There are also situations in which certain non-state employees are covered by workers' compensation through the Office.

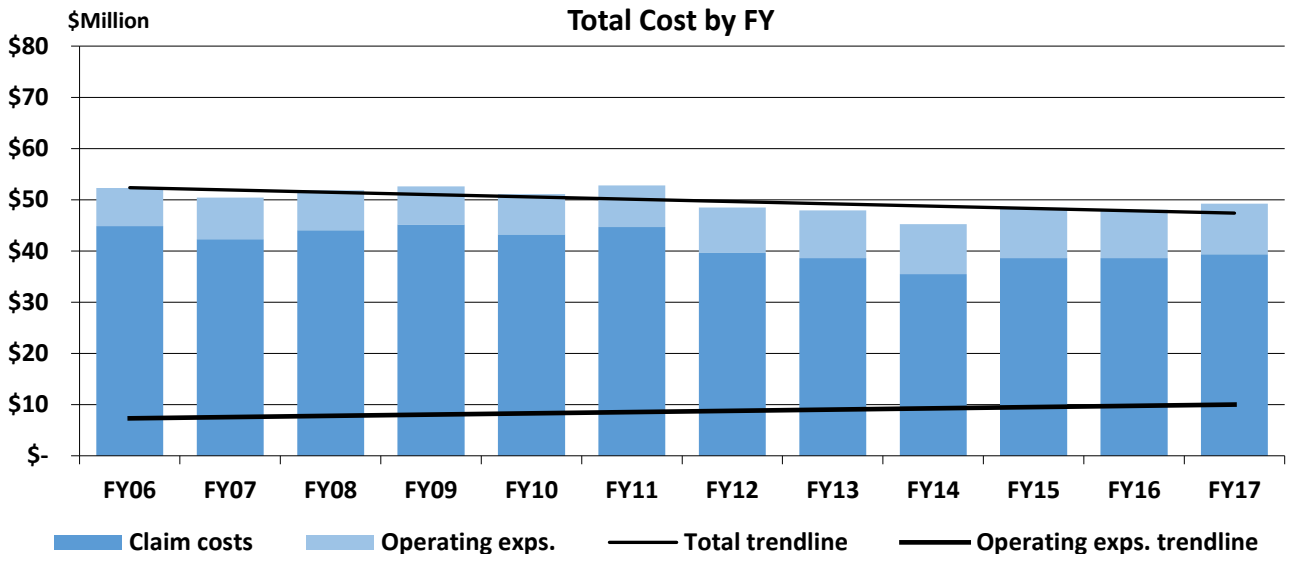
A&M, UT, and TXDOT are exempted from the Office's workers' compensation program and operate their own individual workers' compensation programs.

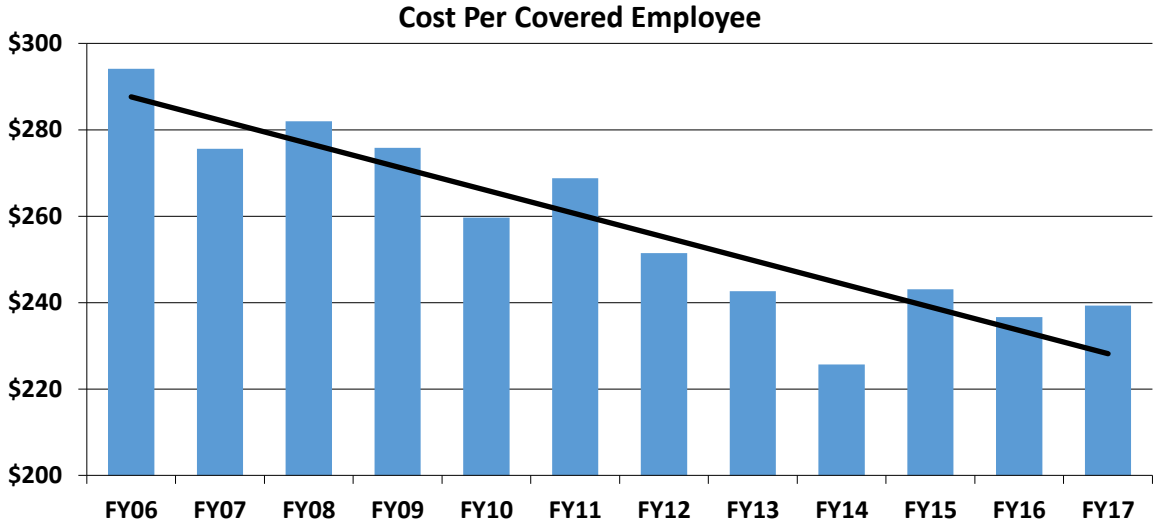
Senate Bill 1, 85th Legislature, RS, requires the Office to submit an annual report detailing the effectiveness of cost containment measures undertaken during the fiscal year and proposing additional measures to reduce workers' compensation payments in future years. This document is the report on cost containment for fiscal year 2017.

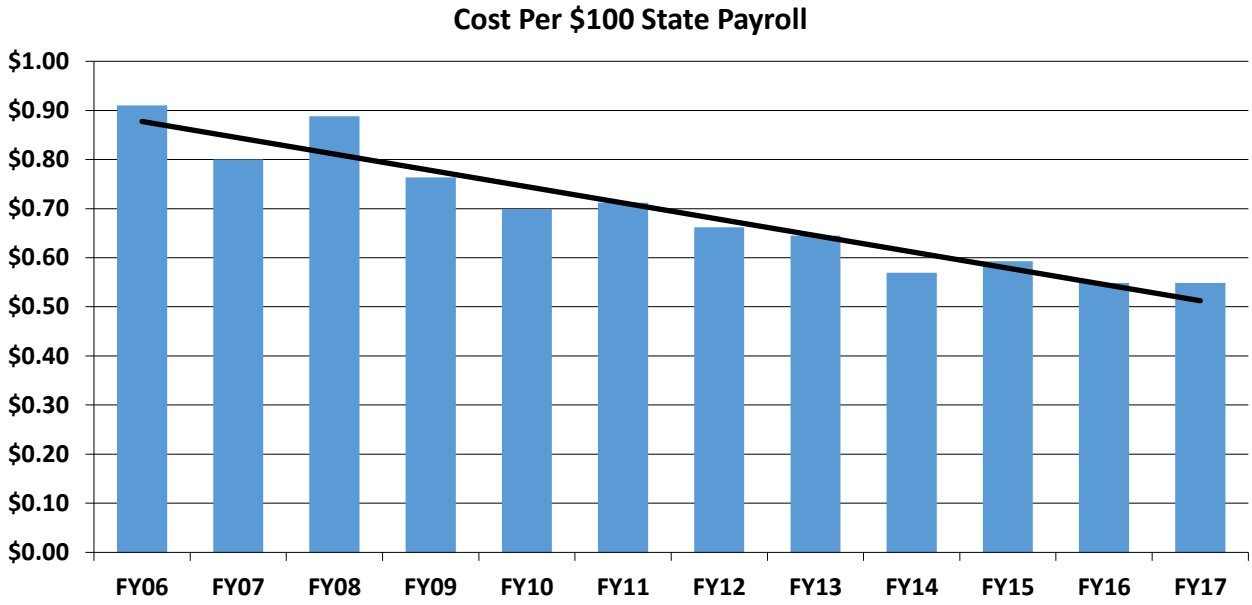
II. Summary of Cost Containment Savings

One of the Office's core statutory missions is to provide covered injured employees with access to prompt, high-quality medical care within the framework established by the Workers' Compensation Act. The Office must also ensure it provides appropriate income benefits and medical benefits in a manner that is timely and cost-effective.

The following charts show workers' compensation costs have declined and costs have stabilized:







III. Cost Containment Measures

The Office is consistently placed in the High Performer category by the Division of Workers' Compensation. The Office works to reduce overall medical and indemnity costs through improved claim handling practices, education, and training. The Office continuously evaluates its policies and processes and implements change as needed to meet internal and external needs.

The following discussion summarizes the cost containment measures utilized by the Office during fiscal year 2017.

A. Medical Bill Audits

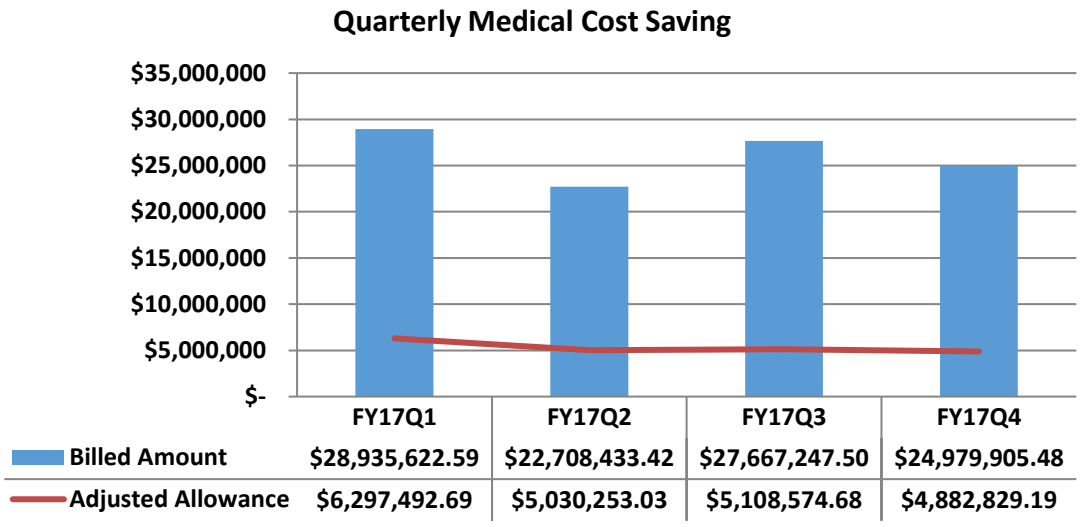
Workers' compensation benefits include medically necessary treatment related to the compensable injury. The Division of Workers' Compensation sets the amount of reimbursement for health care treatment in non-network claims.

The Office has a medical cost containment contract with ISG, LLC (StrataCare) to audit bills submitted by health care providers and reduce billed amounts to the maximum allowable rates under the appropriate fee schedule. Bills are also reviewed for medical necessity and relatedness to the compensable injury. Charges reduced because of such reviews represent savings from the billed amounts. In the case of the state's self-insured workers' compensation program administered by the Office, these savings accrue to the benefit of the state's taxpayers.

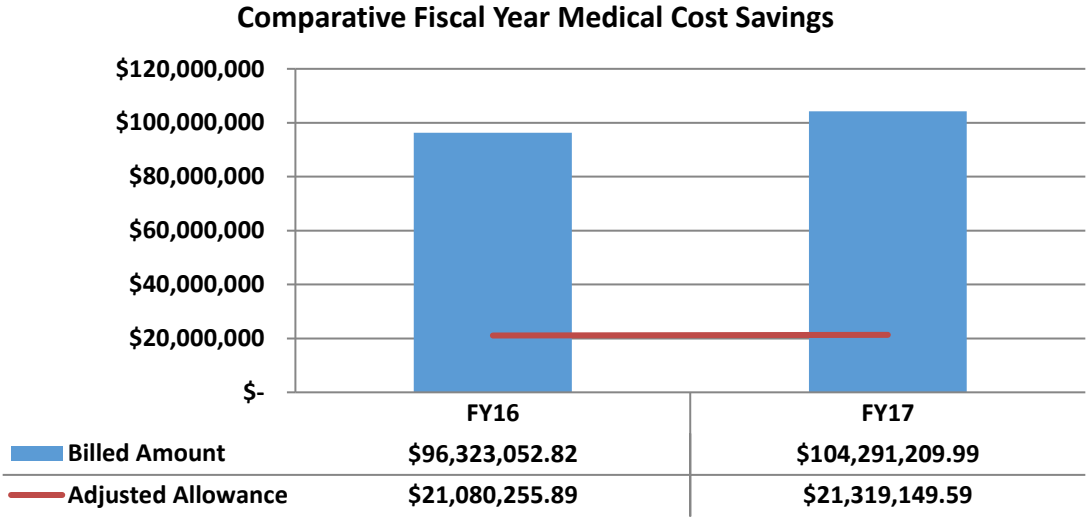
The Office's Medical Quality Assurance unit (MQA) assumed responsibility for approval and denial of medical bills from the Claims Operations department in the third quarter of FY17. This unit is reviewing medical bills that have been re-priced by the Office's medical

bill audit vendor before payment is issued to verify the accuracy of the proposed payment, ensure the medical treatment is related to the compensable injury, confirm services have received preauthorization approval when required, and ensure the bill was timely filed.

The savings realized during FY17 through the application of the medical fee guidelines and network reductions is shown in the following chart:



The chart below shows the medical cost savings for fiscal years FY16 and FY17:



B. Workers' Compensation Health Care Network

The Office has a medical cost containment contract with Injury Management Organization, Inc., which is a certified workers' compensation health care network, to provide state employees with access to health care with primary and specialty medical providers who are familiar with workers' compensation injuries.

The amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider.

C. Preauthorization of Medical Services

The Texas Workers' Compensation Act and the rules adopted by the Division of Workers' Compensation require health care providers to obtain preauthorization of certain medical procedures prior to such services being provided. The health care services must be prospectively reviewed and preauthorized as medically necessary before the service is provided to an injured employee. The preauthorization guidelines can vary between non-network and network claims.

The Office's medical cost containment contract with Injury Management Organization, Inc. also includes utilization review services related to preauthorization requests. Preauthorization savings represent the avoidance of expenses related to unreasonable or unnecessary procedures or services prior to being provided and billed. It should be noted that health care that was not preauthorized may be approved later if there is a change in medical diagnoses or documentation is provided to support the request or alternative treatment may be approved. Under these circumstances "savings" attributable to preauthorization will not accurately reflect the true cost of treatment.

The following chart displays the FY17 cost-avoidance estimates related to preauthorization:

Preauthorization of Medical Services Cost Containment			
Network Status	Requested Cost*	Approved Cost**	Cost Avoidance
Network	$4,227,347.27	$2,976,992.92	$1,326,185.38
Non-Network	$4,575,388.34	$3,160,307.52	$1,412,863.44
	$8,802,735.61	$6,137,300.44	$2,739,048.82

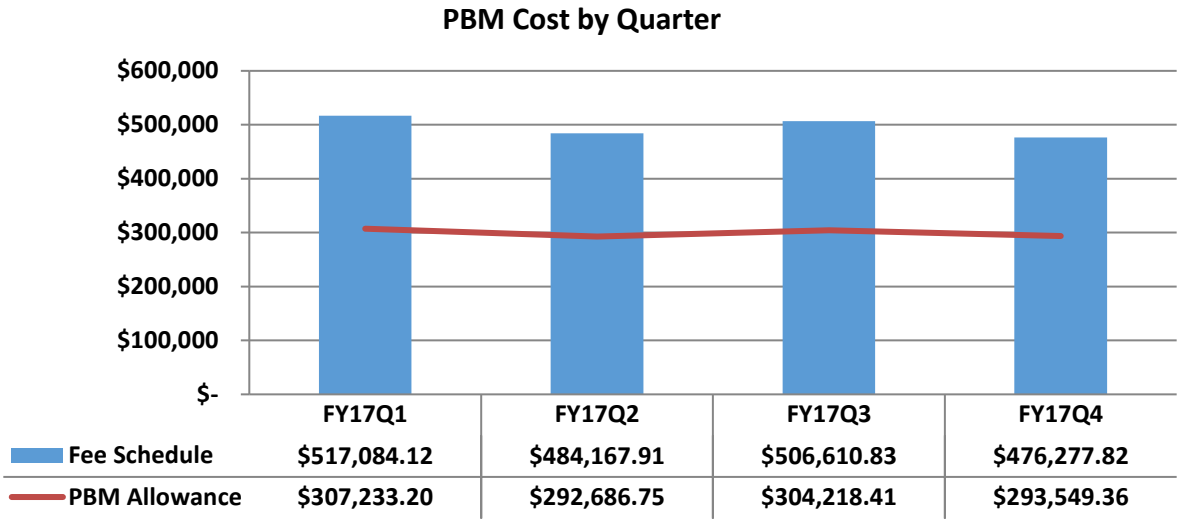
*This represents the value of requested services processed through preauthorization
**This represents the value of requested services that were authorized through preauthorization

D. Pharmacy Benefits Management

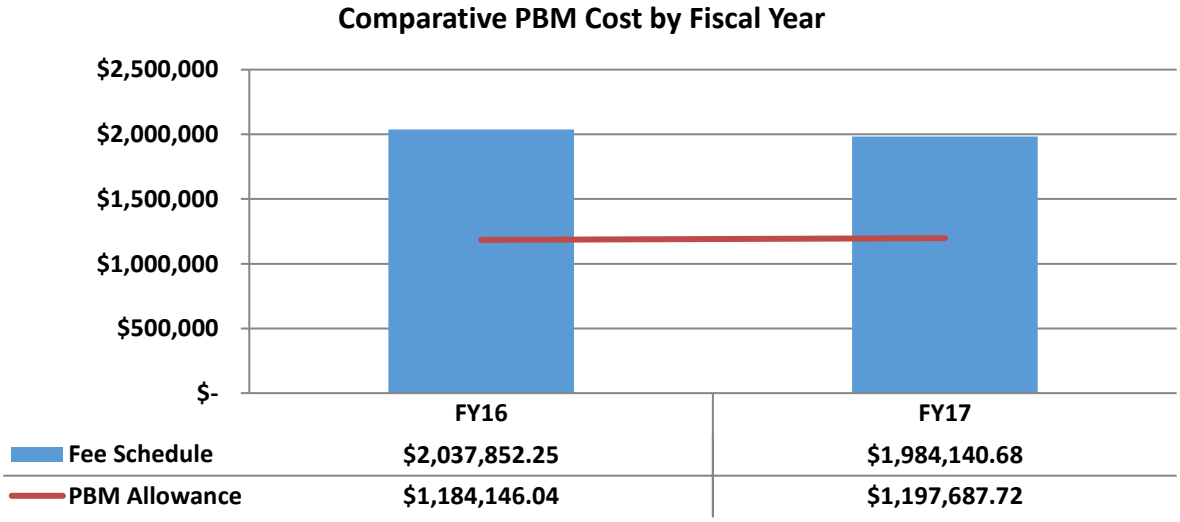
Workers' compensation benefits include medically necessary prescription drugs and over-the-counter medication. The reimbursement fees for prescription drugs are set by the Division of Workers' Compensation.

The Office has a medical cost containment contract with Matrix Healthcare Services, Inc. (myMatrixx), a pharmacy benefit manager, to ensure cost-savings and prompt service for medically necessary medications. The pharmacy benefits manager (PBM) provides a prescription card to all workers' compensation claimants. Participation in this program is entirely voluntary for injured workers. When the prescription card is presented at a participating pharmacy, the pharmacy can quickly provide the necessary medication to the injured worker.

The Office receives a discount below the pharmaceutical fee guideline on the medication obtained through the PBM. The following chart shows the FY17 savings from the voluntary PBM program:



The following chart shows the cost savings related to the PBM program for fiscal years FY16 and FY17:



E. Timely Payment of Medical and Pharmacy Bills

The Office must take final action on medical and pharmacy bills not later than the 45th day after the complete bill was received. SORM must take final action on a request for reconsideration not later than 30 days after the request was received. If the Office does not comply with the payment deadlines, it must pay interest to the health care provider. The Office could also be subject to an administrative fine.

The following chart shows the Office's medical cost containment vendors' average turnaround time in FY17 to audit medical and pharmacy bills:

Average Turnaround	
Initial Audits	18.4 Days
Appeal Audits	21 Days
PBM Audits*	1 Day

F. Provider Refund Requests

A workers' compensation insurance carrier can request a refund from a health care provider when the carrier determines that inappropriate health care was previously reimbursed or when an overpayment for health care is made. The Office conducts post payment audits of medical bills to identify overpayments. Refund requests must comply with the Division of Workers' Compensation's statutes and rules.

G. Coordination and Outreach to Employers

When SORM receives notice of a claim, an email is automatically generated to the employer's claims coordinator. This email explains the information the employer needs to provide to the Office, which includes information required to accurately calculate average weekly wage. Paying timely and accurate indemnity benefits reduces cost by eliminating interest on late payments, reducing and/or avoiding potentially unrecoupable overpayments, and eliminates potential administrative penalties.

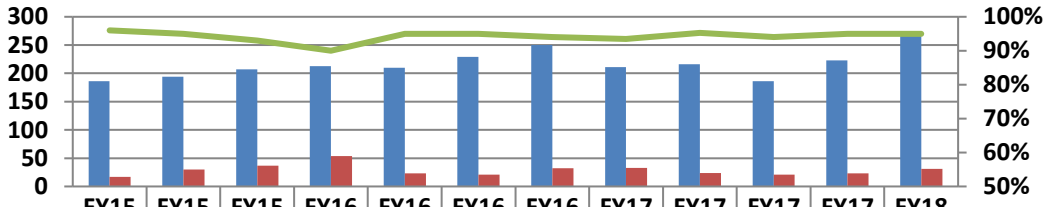
H. Timely Payment of Indemnity Benefits

The Office must initiate temporary income benefits (TIBs) by the 7th day after the date of disability or the 15th day after notice of injury. The Office must initiate Impairment Income Benefits (IIBs) by the 5th day after receiving a Designated Doctor's report indicating the injured employee has reached maximum medical improvement. The Office must pay interest if it fails to initiate indemnity benefits on time.

The Office's Indemnity Quality Assurance Department (IQA) conducts indemnity audits on all claims where the claimant is receiving indemnity benefits. The initial audit occurs when (i) the claimant reaches eight days of disability, (ii) the claimant's accrued leave expires, or (iii) impairment income benefits are owed. The purpose of this audit is to verify the accuracy and timeliness of the initial indemnity payments. Because indemnity benefits can change during the lifetime of the claim, IQA continues to conduct audits to confirm the accuracy of any change(s) to the indemnity benefits.

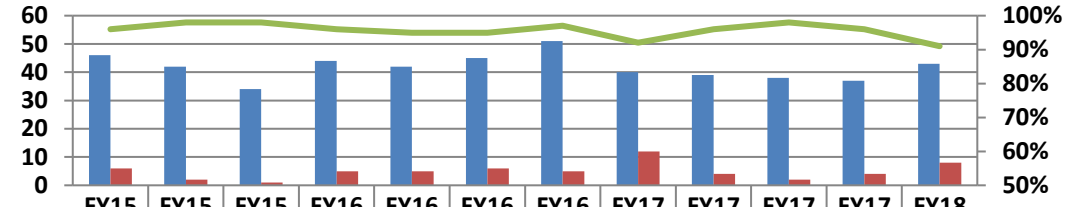
The following charts show the Office's compliance rates with the deadlines to initiate initial temporary indemnity benefits (TIB) and impairment indemnity benefits (IIB):

Initial TIBs Compliance Rate & Late Payments



	FY15 Q2	FY15 Q3	FY15 Q4	FY16 Q1	FY16 Q2	FY16 Q3	FY16 Q4	FY17 Q1	FY17 Q2	FY17 Q3	FY17 Q4	FY18 Q1
Initial TIBs	186	194	207	213	210	229	250	211	216	186	223	266
Late Payments	17	30	37	54	23	21	32	33	24	21	23	31
Compliance	96%	95%	93%	90%	95%	95%	94%	93%	95%	94%	95%	95%

Initial IIBs Compliance Rate and Late Payments



	FY15 Q2	FY15 Q3	FY15 Q4	FY16 Q1	FY16 Q2	FY16 Q3	FY16 Q4	FY17 Q1	FY17 Q2	FY17 Q3	FY17 Q4	FY18 Q1
Initial IIBs	46	42	34	44	42	45	51	40	39	38	37	43
Late Payments	6	2	1	5	5	6	5	12	4	2	4	8
Compliance	96%	98%	98%	96%	95%	95%	97%	92%	96%	98%	96%	91%

I. Recoupment of Indemnity Overpayments

The Office tracks overpayment of indemnity information internally. If IQA identifies an overpayment of indemnity that can be recouped from future indemnity benefits, IQA sends a recommendation on recoupment to the assigned adjuster. Indemnity recoupment must comply with the Division of Workers' Compensation's statutes and rules.

J. Impairment Ratings Reviews

Cost savings are also realized from the review and dispute of incorrect impairment ratings. Under the Workers' Compensation Act, injured employees may be entitled to impairment income benefits (IIBs) determined by a whole-body impairment rating assigned to the injured employee by an examining physician. Both the injured employee and the insurance carrier have the right to dispute an impairment rating. A review of questionable impairment ratings ensures the indemnity benefits paid to injured state employee are accurate and can also reduce overpayment of benefits.

K. Peer Reviews and Required Medical Examinations

The Office utilizes peer reviews of medical services and pharmaceuticals and required medical examinations of injured workers to verify the medical necessity and reasonableness of medical treatments and prescribed pharmaceuticals; to determine whether such treatments and prescriptions are related to compensable injuries; and to ensure that the injured employee receives quality medical care.

These services can be utilized when a determination requires medical expertise beyond what may be expected of a licensed adjuster. The opinions obtained form the basis of actions taken by the Office and establish the factual and medical evidence necessary to defend the Office's determinations through the dispute resolution process. As a result of these opinions more appropriate care is provided to injured workers while delivering savings through the elimination of unnecessary care.

L. Subrogation Recoveries

Subrogation reduces costs in two distinct ways. First, if a workers' compensation claim is based on an injury where a third party's negligence was the primary cause of the injury, the Office can assert a subrogation lien against the third-party liability carrier or payer for the amount that has been paid in workers' compensation benefits on the claim. Any monies recovered through subrogation are used for the payment of workers' compensation benefits to state employees.

An additional feature of a subrogation lien is the avoidance of future expenses in an amount equal to the injured workers' direct recovery from the third-party settlement that exceeds the worker's compensation lien. Workers' compensation insurance carriers have a statutory right to treat the additional settlement amount as an offset against potential future benefits that may be sought by the claimant. Consequently, until the claimant exhausts the third-party settlement, the Office does not have to pay future benefits.

For FY17, the Office's subrogation recovery was $633,273.32, which exceeds the target of $567,750.

M. Subsequent Injury Fund

The subsequent injury fund is a dedicated account in the general revenue fund that can be used to reimburse an insurance carrier when it has made an unrecoupable overpayment of benefits based on a decision or order from the Division of Workers' Compensation and the decision or order is later reversed or modified. This type of reimbursement can remove either all, or a large portion of, the expenditures the Office made in certain disputed claims.

N. Fraud Detection and Investigation

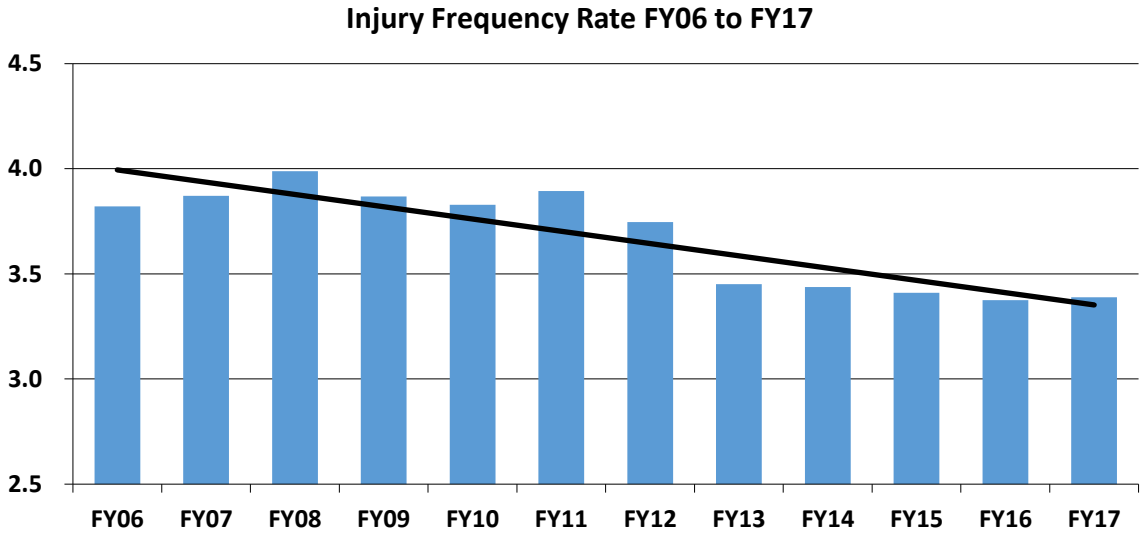
The Office employs two full-time staff members to investigate potential fraud and abuse as a part of the Office's workers' compensation fraud detection program. The Office

investigates both individual and medical provider fraud. The Office has a zero-tolerance policy for fraud and actively pursues administrative and criminal prosecution against those who attempt to receive monies and benefits to which they are not entitled.

O. Risk Assessment and Loss Prevention Services

The Office's risk management specialists serve as consultants to state agencies, conduct risk assessments and assist in developing and implementing risk management programs to prevent and control losses. During risk management program reviews and on-site consultations, particular emphasis is placed on policies, programs, and procedures that promote workplace safety and employee wellness, accident prevention, and loss control.

Direct evidence of the effectiveness and efficiency of the risk management program is the overall decline in the injury frequency rate over time.



IV. Proposed Additional Measures

A. Cloud-Based Case Management System

One of the Office's initiatives is to transition its risk management, insurance, and claims administration services to a cloud-based case management system. For workers' compensation claims administration, most systems utilize the Official Disability Guidelines (ODG) on medical treatment and return to work guidelines to benchmark outcomes in workers' compensation claims. ODG's Reserve Calculator is a statistical modeling program that incorporates unique factors, which may increase claim costs. Adjusters can use risk levels provided by the ODG Reserve Calculator to specifically address high risk claims as well as claims that fall outside the ODG's treatment guidelines, costs, and return to work standards.