

**EXPERIENCES OF DOCTORS  
WHO PRACTICE IN THE TEXAS  
WORKERS' COMPENSATION SYSTEM:  
1998 Survey**

**Research and Oversight Council  
on Workers' Compensation**

October 1998

## ACKNOWLEDGMENTS

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Appendix A: Survey Questionnaire

## Executive Summary

The Texas Workers' Compensation Act provides that injured workers are entitled to lifetime medical care reasonably required by the nature and severity of their injury.<sup>1</sup> However, testimony provided to the House Subcommittee on Workers' Compensation Insurance Carrier Practices indicates that effective delivery of medical benefits may be compromised due to difficulties that some doctors experience in their dealings with insurance carriers.

This survey of Texas doctors was designed to determine whether some of the medical care problems identified in testimony before the subcommittee are pervasive within the workers' compensation system as a whole. The design of the present survey also allowed direct comparisons to be made to a benchmark survey of Texas doctors conducted by the Research and Oversight Council in 1996.<sup>2</sup>

The results of the present survey reveal that overall, doctors in the Texas workers' compensation system experience many of the same problems identified by doctors who testified before the subcommittee. Key findings included:

- Doctors experience several problems with inefficient processing of preauthorization requests by insurance carriers.
- Although the vast majority of doctors felt that preauthorization decisions should not be anonymous, more than a third rarely, if ever, receive the name of the carrier's preauthorization decision-maker.
- The vast majority of doctors agreed that preauthorization decisions should be made by the same type of medical professional who recommended the original course of treatment. Nearly half of the doctors also felt that only a Texas-licensed physician should be allowed to deny a preauthorization request.
- Most of the doctors rarely, if ever, receive a reasonable, written justification from an insurance carrier when a request for preauthorization is denied.

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<sup>1</sup> Texas Labor Code, §§ 408.021(a), 410.256(c)(2).

<sup>2</sup> See *Survey of Texas Doctors Who Participate in the Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 1996.

- Although nearly three-fourths of doctors felt that the trend in medical review and bill payments is toward more disputes, only a quarter felt the medical dispute resolution process was fair. More than a third felt the process was unfair.
- Nearly half of the doctors responded that insurance carriers often down-code or reduce fees for services without providing written justification. Another quarter responded that this sometimes occurs.
- More than half of the doctors felt that the length of the medical dispute resolution process discourages doctor participation. The top reasons for low participation were that it is not cost-effective (amount recoverable not worth the effort), and that it requires too much paperwork.
- Nearly half of the doctors responded that they rarely, if ever, challenge a carrier's denial of medical treatment after the carrier pronounces the treatment as not medically necessary.
- Three-fourths of the doctors felt that the prevailing party in a treatment dispute or medical fee dispute should be allowed to recover the expenses associated with an appeal.
- Over half of the doctors agreed that required medical examination (RME) doctors are objective in their evaluation of injured workers. Most also agreed that a treating doctor does not need to be present at an RME to ensure a thorough, objective evaluation of an injured worker.
- Most doctors agreed that RME doctors spend an adequate amount of time examining injured workers and all relevant medical documentation to evaluate the diagnosis, course of treatment, and/or condition of the injured worker.
- Despite the general perception of objectivity and thoroughness on the part of doctors conducting RMEs, nearly two-thirds of doctors felt that insurance carriers should not be allowed to deny treatment or prescriptions based on an RME doctor's evaluation of an injured worker.

- The time and expense of processing paperwork continues to burden doctors. At least a portion of this burden appears to arise out of redundant or unnecessary requests for medical documentation from insurance carriers or their agents.
- Half the doctors responded that they have few problems with prompt payment by insurance companies for undisputed medical treatment, while slightly less than half indicated that they have many problems with late payments.
- Most doctors have experienced an insurance carrier's refusal to pay for treatment of a work-related peripheral condition that was part of the injured worker's overall treatment plan.

## SECTION I: INTRODUCTION

Following the 75th Legislative Session in 1997, the Speaker of the Texas House of Representatives, James E. “Pete” Laney, assigned the House Business and Industry Committee with the following interim charge: “Review workers' compensation insurance carriers' payments and denials of medical benefits and supplemental income benefits. Determine whether carriers' actions are reasonable and consistent with the overall design of the law.”

In response, Representative Kim Brimer, Chairman of the Business and Industry Committee, appointed a subcommittee to study this charge. The subcommittee held four public hearings at which participants from all aspects of the workers' compensation community, including doctors, were given the opportunity to testify.

At several of the subcommittee's public hearings, doctors and injured workers testified regarding problems they had encountered within the workers' compensation system. Injured workers felt that they were not receiving adequate and timely medical treatment for their injuries, while doctors expressed frustration with system controls that they perceive as interfering with their ability to treat injured worker patients.<sup>3</sup>

In order to better understand and quantify some of these concerns, the Research and Oversight Council on Workers' Compensation (ROC) conducted a survey of 794 doctors who practice in the area of workers' compensation. This study is based on a similar 1996 ROC report entitled *Survey of Texas Doctors Who Participate in the Workers' Compensation System*. The current project presented an opportunity to examine new issues raised in testimony before the Business and Industry Subcommittee, to more thoroughly examine issues raised in the 1996 survey, and to make meaningful comparisons with the 1996 survey responses. For this reason, the ROC utilized the same sampling of doctors used to conduct the 1996 survey.

### **Data and Methodology**

A sample of 794 doctors, proportionally stratified by geographic region, was drawn for this

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<sup>3</sup> To put this testimony in a larger context, a recent survey conducted by the Research and Oversight Council found that 79 percent of injured workers felt that they received adequate medical care that met their needs. However, 46 percent felt that the insurance carrier had tried to delay or deny some needed medical treatments. See *An Examination of Strengths and Weaknesses of the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, August 1998.

project. The doctor sample was drawn from the Texas Workers' Compensation Commission's (TWCC) database and included doctors from all parts of the state. To ensure that the doctors were versed in the requirements of the Texas workers' compensation system, the sample of 794 was drawn from the group of approximately 4200 doctors who had given twenty-five or more impairment ratings in workers' compensation cases.

A mail survey was sent to the doctors included in the sample. The results presented in this report are based on a total of 273 completed interviews with doctors who participate in the Texas workers' compensation system. The response rate for this project was 34 percent.

### **Profile of Doctors Who Responded to the Survey**

Virtually all (96.4 percent) of the doctors who responded said that they currently accept workers' compensation cases, while 3.6 percent responded that they did not currently take cases.

The largest group of respondents (49.3 percent) were orthopedists. Of those doctors remaining, 15.5 percent were in family or general practice, 9.2 percent practiced in physical medicine and rehabilitation/sports medicine; 7.7 percent practiced in occupational/industrial medicine; 2.2 percent were neurologists; and 16 percent practiced in other areas.

As in the 1996 survey, doctors in the 1998 survey were asked to identify whether they practiced in the workers' compensation system primarily as a treating doctor (i.e., claimant's doctor), an insurance doctor (i.e., examines injured worker on behalf of insurance carrier), or a designated doctor (i.e., doctor selected by mutual agreement or chosen by the TWCC to settle a medical dispute). Additionally, the 1998 survey added a new classification for referral doctor (i.e., examines injured worker on behalf of treating doctor).

In the 1998 survey, 65.3 percent of the doctors classified themselves as treating doctors while 30.3 percent considered themselves referral doctors. Only 2.9 percent of the doctors considered themselves insurance company doctors while 1.4 percent identified themselves as designated doctors. In the 1996 survey, 92.6 percent of the doctors identified themselves as treating doctors, while 6.2 percent identified themselves as insurance doctors, and 17.8 percent listed themselves as designated doctors.



## SECTION II: PREAUTHORIZATION OF MEDICAL TREATMENTS

### **Overview of the Preauthorization Process<sup>4</sup>**

Currently, there are sixteen medical treatments and services that require preauthorization from the insurance carrier before they can be administered to an injured worker including: pain clinics; repeat baseline diagnostic tests greater than \$350; physical therapy beyond eight weeks of treatment; and all non-emergency hospitalizations; among others.<sup>5</sup> Before these treatments can be administered, the injured worker or the injured worker's treating doctor must first notify the insurance carrier of the proposed treatment and be prepared to show documentation explaining why the treatment is medically necessary, if requested. Once this request for preauthorization is made, the insurance carrier reviews the necessity of the medical treatment and either approves or denies preauthorization within three working days. For all but the sixteen medical treatments requiring preauthorization, the carrier is required to review the bill for the treatment already provided and provide payment for all reasonable and necessary care.<sup>6</sup>

### **Experience with the Preauthorization Process**

Many of the doctors surveyed have had experience with the current preauthorization process. On average, doctors said they request preauthorization for medical services 28 times per month. When asked about denials, 20 percent said they "always" or "often" receive denials from the insurance carrier, 47 percent said they "sometimes" receive preauthorization denials, and 33 percent said they "rarely" or "never" receive carrier denials.

### **Problems with the Preauthorization Process**

According to the 1996 survey of Texas doctors, most doctors (53 percent) felt that preauthorization requirements are necessary to avoid abuse, overuse and duplication of services. Doctors who felt that preauthorization requirements were unnecessary, however, said that the treating doctor should be able to decide proper treatment for the injured worker, and that medical decisions should not be made by people with little or no knowledge of the case.

During testimony provided to the subcommittee, several doctors stated that they experienced problems with the preauthorization process. For this reason, the 1998 survey asked doctors to identify what problems, if any, they encountered with the current preauthorization process. In

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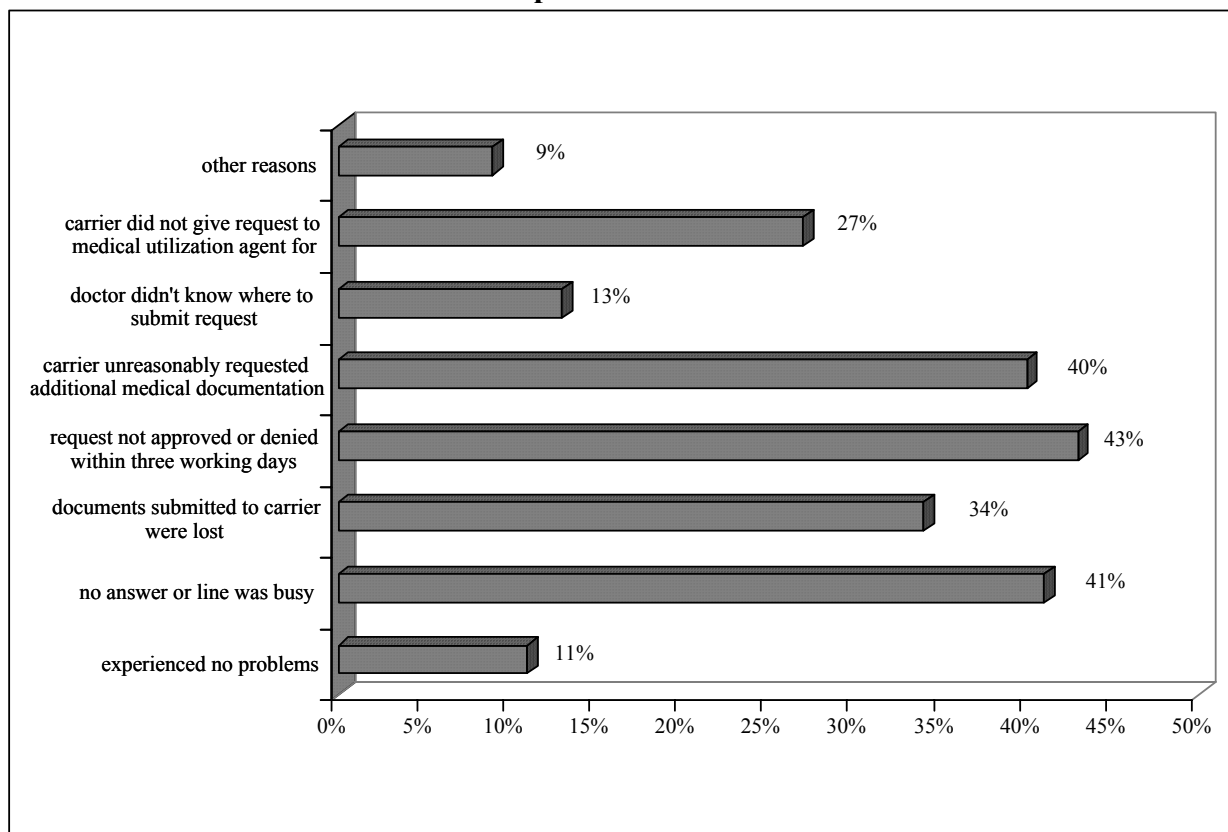
<sup>4</sup> See *Experiences of Injured Workers Part 2: Texas Workers Who Are Denied Medical Treatment through the Preauthorization Process*, Research and Oversight Council on Workers' Compensation, 1997.

<sup>5</sup> See TWCC Rule 134.600. Services preauthorized are statutorily deemed to be reasonable and necessary.

<sup>6</sup> Spinal surgery is another treatment that has a separate preauthorization process.

response, 43 percent said that their request was not approved or denied within the three day time limit, and 41 percent responded that when they attempted to call the carrier for a preauthorization request, there was no answer or the line was busy.<sup>7</sup> A similar number of doctors (40 percent) responded that when preauthorization was requested, the carrier unreasonably requested additional medical documentation (see Figure 1).<sup>8</sup>

**Figure 1**  
**What problems, if any, have you encountered with the current preauthorization process for workers' compensation medical treatments?**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

<sup>7</sup> On August 31, 1998, the Commissioner of the Texas Department of Insurance (TDI) adopted rules that regulate utilization review agents (URA) within the workers' compensation system. See 28 *Texas Administrative Code* §§19.2001-19.2021. Carriers contract with URAs to, among other things, review requests for preauthorization. The rules require URAs to make themselves accessible to injured workers, their representatives, and healthcare providers by toll-free telephone during normal business hours. See 28 TAC §19.2004(f)(4).

<sup>8</sup> The new rules state that URAs may only require medical information necessary to complete a utilization review. See 28 TAC §19.2008(c). The rules also limit the amount of medical documentation that a URA may request from a healthcare provider to that needed to determine whether the healthcare requested is medically reasonable and necessary. See 28 TAC §19.2008(c)(2). In order to prevent duplicate requests for information, the rules require that the URA share pertinent clinical and demographic information among its various divisions. See 28 TAC §19.2008(e). Finally, unless precluded or modified by contract, the rules require the insurance carrier to reimburse the healthcare provider for the reasonable costs of providing written medical information, including the costs of copying and transmitting the injured employee's records. See 28 TAC §19.2008(b).

### **Anonymity in Preauthorization Denials**

The subcommittee received testimony that in some cases, insurance carriers or their utilization review agents denied a request for preauthorization without providing the name of the individual recommending denial. Furthermore, doctors testified that many preauthorization disputes could be avoided if the treating doctors simply had the opportunity to speak with the utilization review doctors about the proposed treatment. Although the vast majority of doctors (87 percent) surveyed for this report felt that preauthorization decisions should not be anonymous, less than half (42 percent) said they “often” or “always” receive the name of the decision-maker. Virtually the same number of doctors (41 percent) responded that insurance carriers “rarely” or “never” provide the name of the individual making a preauthorization decision.<sup>9</sup>

### **Justification for Preauthorization Denials**

Testimony was also provided to the subcommittee that insurance carriers rarely provide a written justification when denying a request for preauthorization. Most of the doctors (55 percent) who responded to our survey confirmed that they “rarely,” or “never,” receive a reasonable, written justification from an insurance carrier when a request for preauthorization is denied.<sup>10</sup>

The vast majority of doctors surveyed (88 percent) also agreed with the assertion that preauthorization decisions should be made by the same type of medical professional who recommended the original course of treatment. When doctors were asked who should be allowed to deny a preauthorization request, nearly half (49 percent) felt that only a Texas-licensed physician should be allowed to deny a preauthorization request; 17 percent said a licensed workers’ compensation adjuster should be allowed to deny a request; and 16 percent said that a registered nurse should be allowed to deny a request with approval from a licensed

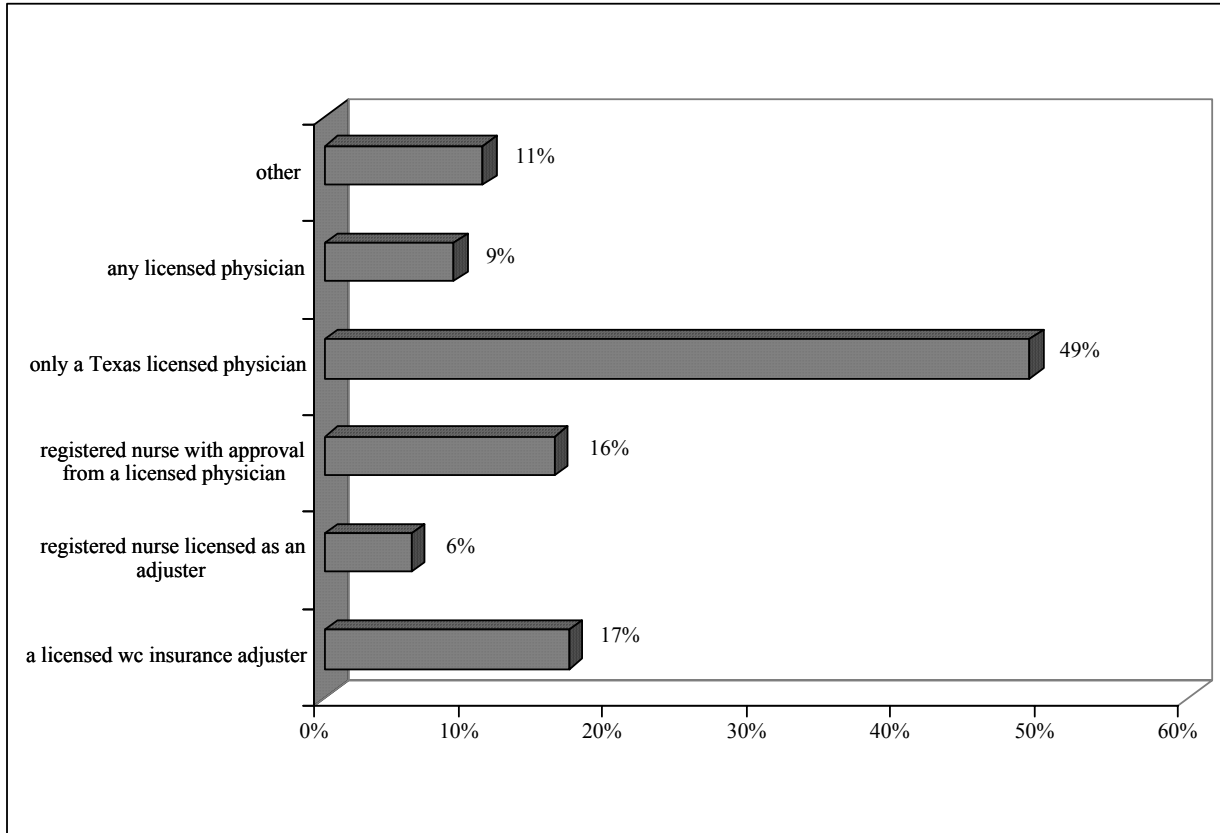
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<sup>9</sup> Under the new utilization review rules adopted by the TDI, URAs are required to be under the direction of a physician licensed to practice medicine (in any state). See 28 TAC §19.2006(d). Furthermore, the rules require URAs to refer proposed preauthorization denials to an appropriate doctor or other healthcare provider for a determination of whether the healthcare requested is medically reasonable and necessary. See 28 TAC §19.2005(3). Under the rules, before a URA can make preauthorization denial, the healthcare provider requesting preauthorization must be given the opportunity to discuss the proposed treatment with doctor or healthcare provider who performed the review. See 28 TAC §19.2011.

<sup>10</sup> Under the TDI’s new utilization review rules, when a URA makes a preauthorization decision, the URA will be required to notify the injured worker, their representative, and the treating doctor or the treating doctor’s representative. See 28 TAC §19.2010(a). Additionally, when a preauthorization denial occurs, the rules require the notification to include the principal reasons for the adverse decision, the clinical basis for the decision, a description of the source of the criteria used in making the decision, and a description of the procedure for filing a complaint regarding the decision. See 28 TAC §19.2010(c).

physician (see Figure 2).<sup>11</sup>

**Figure 2**  
**Who should be allowed to deny a preauthorization request?**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

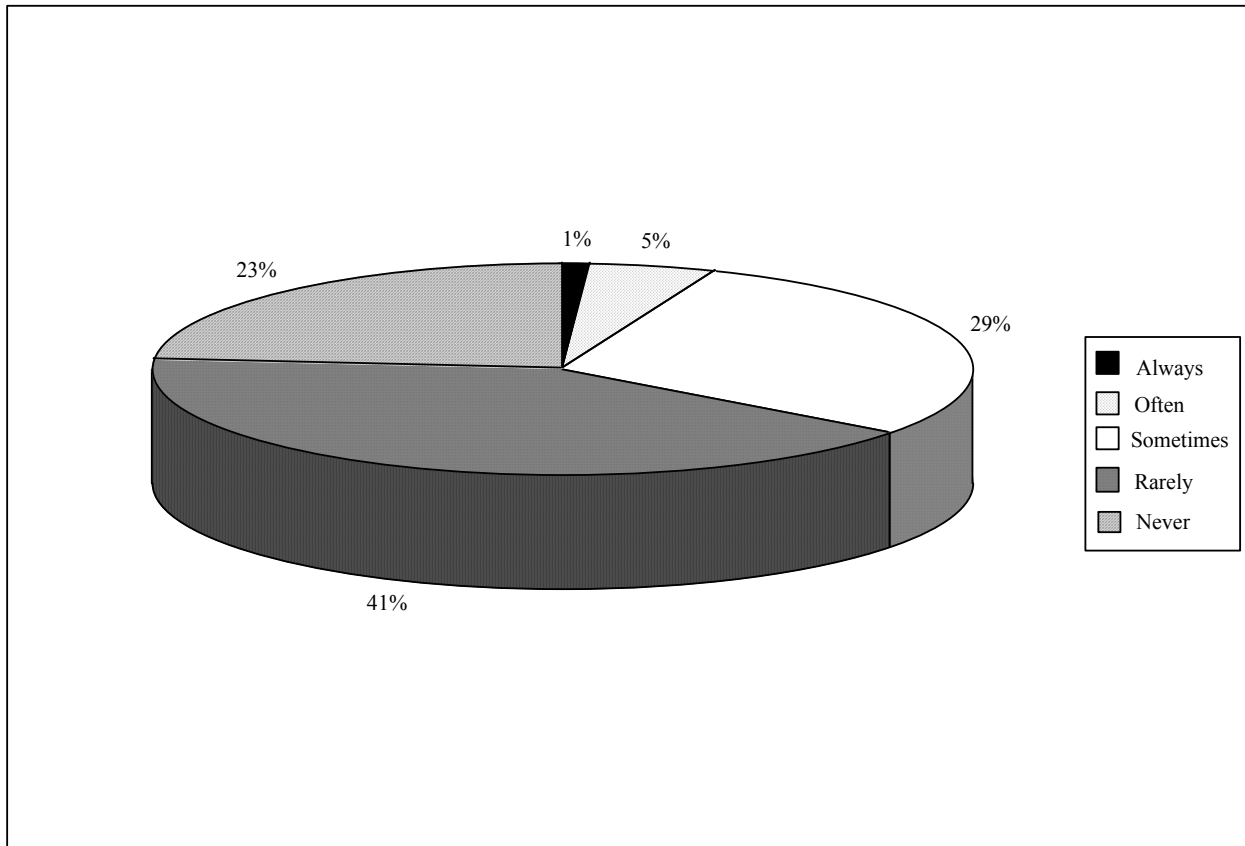
Note: These responses do not add up to 100 percent because respondents were allowed to choose more than one answer to this question.

Testimony was also provided to the subcommittee that medical treatments are sometimes approved by a carrier's utilization review agent only to be subsequently revoked by an adjuster. The majority of doctors surveyed (64 percent), however, responded that this “rarely,” or “never,” occurs, though nearly a third of doctors (29 percent) responded that this “sometimes” occurs (see Figure 3). It is not clear why such seemingly inconsistent actions on the part of the carrier would occur, except that some degree of inconsistency may be inevitable given the fragmentation of services between bill review and adjusting functions.

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<sup>11</sup> Under the TDI's new utilization review rules, a URA must be under the direction of a physician who is licensed to practice medicine by a state licensing agency in the United States. See 28 TAC §19.2006(d). However, the rules allow either a doctor or other appropriate healthcare provider to conduct utilization review. See 28 TAC 19.2005(3).

**Figure 3**  
**How often, if ever, have you received preauthorization from an insurance carrier's utilization review agent and subsequently had that preauthorization revoked by the adjuster handling the case?**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

## SECTION III: MEDICAL DISPUTE RESOLUTION

### **Overview of the Texas Medical Dispute Resolution Process**

Medical dispute resolution is an informal process administered by the Texas Workers' Compensation Commission (TWCC) to resolve medical disputes. Under the current medical dispute resolution process, three types of disputes may arise.<sup>12</sup> Preauthorization disputes can occur when a healthcare provider's request for preauthorization (as described in Section II) is denied by an insurance carrier. General fee disputes can occur when a healthcare provider's fees are reduced or denied by a carrier. Medical necessity disputes can occur in situations where payment for services is denied by a carrier on grounds that the service was not medically necessary.

If the healthcare provider and carrier are unable to resolve one of these three types of disputes among themselves, either party may request medical dispute resolution through the TWCC Medical Review Division. Once a decision is made by the Medical Review Division, any party may appeal the outcome to the State Office of Administrative Hearings (SOAH) under the Administrative Procedures Act for a full hearing. After the SOAH issues a decision, either party may then appeal to district court.

### **Length of Time it Takes to Resolve a Medical Dispute**

Doctors testified before the subcommittee that the TWCC medical dispute resolution process takes too long and is not cost-effective. Doctors testified that, for this reason, they will sometimes “write off” medical bills rather than appealing the denial to the TWCC.

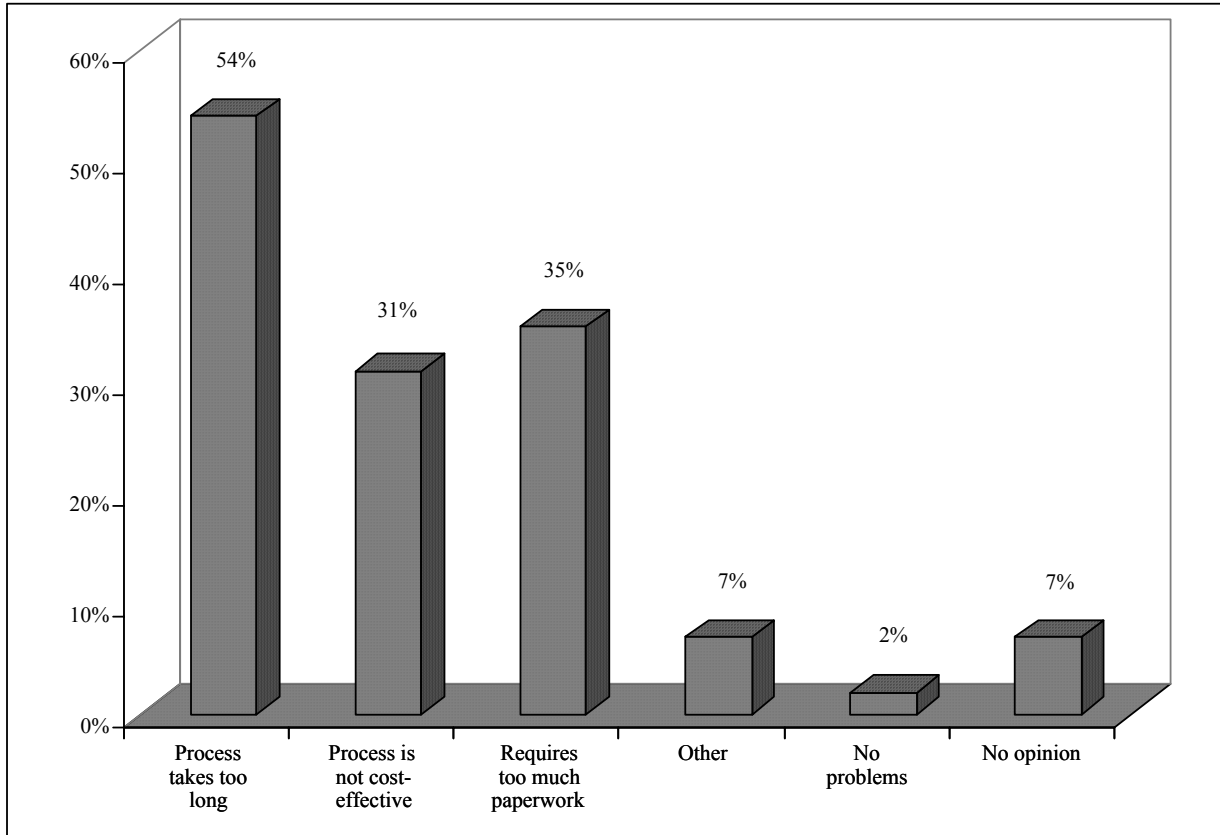
When doctors were surveyed for this report, more than half (54 percent) indicated that the length of the medical dispute resolution process discourages healthcare providers from pursuing disputes. Nearly a third (31 percent) felt the process discouraged participation because it is not cost-effective (i.e., amount recoverable not worth the effort), while more than a third (35 percent) thought it discouraged participation by requiring too much paperwork. Another recent study by the ROC found that both insurance carriers and healthcare providers feel that the amount of time it takes to resolve a medical dispute is unreasonable.<sup>13</sup>

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<sup>12</sup> Texas Labor Code, Section 413.031.

<sup>13</sup> According to a 1998 survey of system participants, two-thirds of insurance carriers and healthcare providers felt that the length of time it takes to resolve a medical dispute is unreasonable; 90 percent felt that a dispute should be resolved within one to three months. See *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, 1998.

**Figure 4**  
**What problems, if any, have you encountered with the current medical dispute resolution process?**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

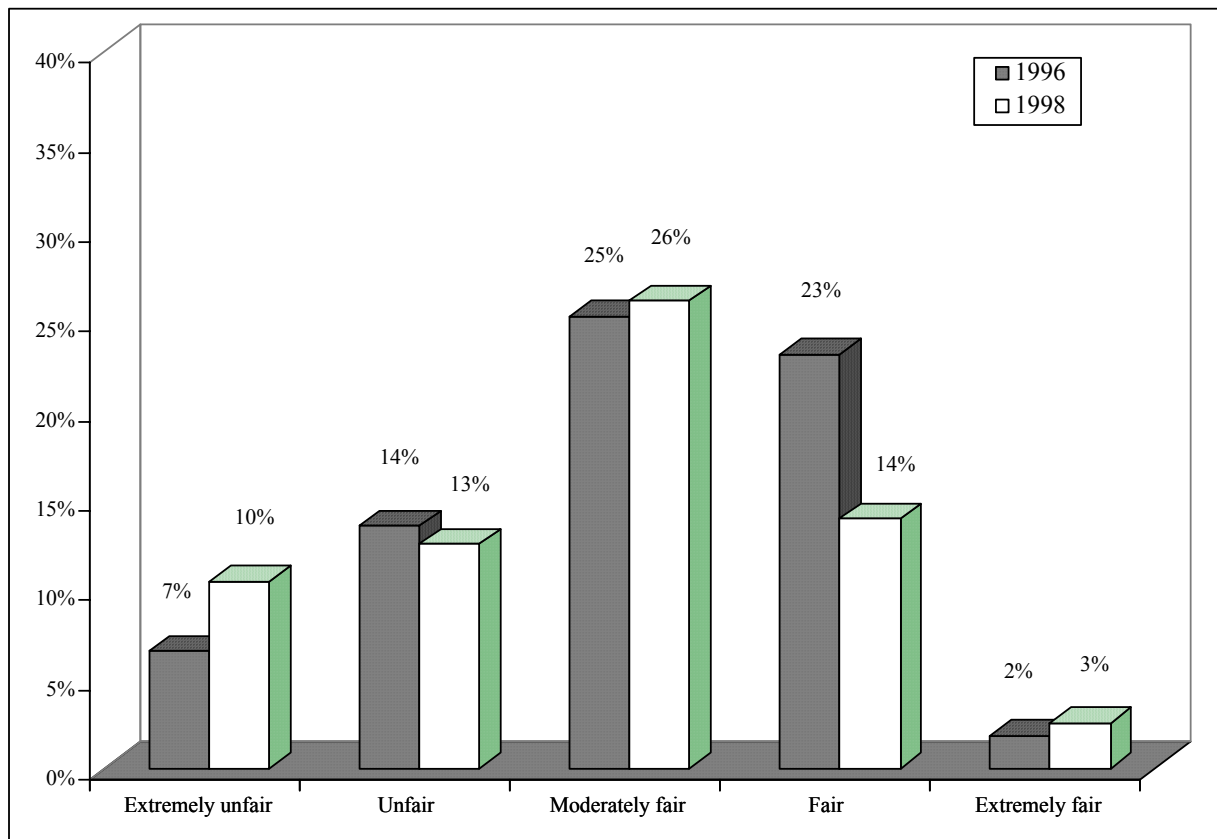
Nearly half of the doctors surveyed (47 percent) responded that insurance carriers “sometimes” deny reimbursement for the treatment of an injured worker on the grounds that the treatment was not medically necessary. Nearly a quarter (24 percent) responded that insurance carriers “often” or “always” deny reimbursement for this reason. Despite this, nearly half of the doctors surveyed (48 percent) responded that they “rarely,” or “never,” use the medical dispute resolution process when a carrier denies reimbursement due to a challenge of medical necessity.

**Fairness of Medical Disputes**

Doctors testified that the current medical dispute resolution process is unfair because it allows insurance carriers to deny or reduce a medical bill without sufficient explanation and place the burden of raising a dispute on the treating doctor. Furthermore, doctors testified that insurance carriers have no disincentive to dispute a request for preauthorization or a request for medical fee reimbursement.

Although nearly three-fourths of doctors (74 percent) felt that the trend in medical review and bill payments is toward more disputes, only 17 percent felt that the medical dispute resolution process was either “fair” or “extremely fair.” This is down from 25 percent in 1996 (see Figure 5).

**Figure 5**  
**Comparison of Doctor’s Ratings of Fairness**  
**of the Medical Dispute Resolution Process**  
**1996 and 1998 Results**



Source: Research and Oversight Council on Workers’ Compensation, Survey of Texas Doctors, 1998, and Survey of Texas Doctors, 1996.

Note: Thirty percent of doctors in 1996 and 35 percent in 1998 expressed no opinion on this question.

More than half (54 percent) of the doctors responded that insurance carriers “often” or “always” down-code or reduce fees for services without providing written justification. For example, the coding for “office visit, extensive” may be down-coded to “office visit, brief,” which is reimbursable at a lower fee.

Furthermore, three-fourths of the doctors (75 percent) felt that the prevailing party in a treatment



or medical fee dispute should be able to recover the expenses associated with the appeal.

## SECTION IV: CARRIER REQUIRED MEDICAL EXAMS

### Overview of Carrier Required Medical Exams

The TWCC may require an injured worker to undergo an additional medical examination outside of the treatment given by the injured worker's treating doctor if there is a question about:

- the medical necessity of the course of treatment given to the injured worker;
- the extent of the injured worker's physical impairment; or
- whether the worker had reached maximum medical improvement.

Usually, these requests for a "required medical exam" (RME) come from the insurance carrier rather than TWCC. Until September 1, 1997, the insurance carrier was allowed to request one required medical exam of the injured worker every 180 days. Recent legislation has amended this requirement to allow for up to three required medical exams every 180 days.<sup>14</sup>

### Objectivity of Carrier Required Medical Exams

According to testimony provided to the subcommittee, some doctors who examine injured workers on behalf of an insurance carrier provide the carrier with inaccurate medical reports that enable the carrier to terminate benefits. Injured workers testified that these RME doctors in some cases generated medical reports without examining the injured worker, or after conducting an insufficient examination of the injured worker.

A little over half of the doctors surveyed, however, (54 percent) felt that RME doctors are objective in their evaluation of injured workers. A similar percentage of doctors (56 percent) also agreed that a treating doctor does not need to be present at an RME to ensure a thorough, objective evaluation of an injured worker.

Half of the doctors agreed that RME doctors spend an adequate amount of time examining injured workers (51 percent) and all relevant medical documentation (58 percent) to evaluate the diagnosis, course of treatment, and/or condition of the injured worker.

Despite the perceived objectivity and thoroughness on the part of doctors conducting RMEs,

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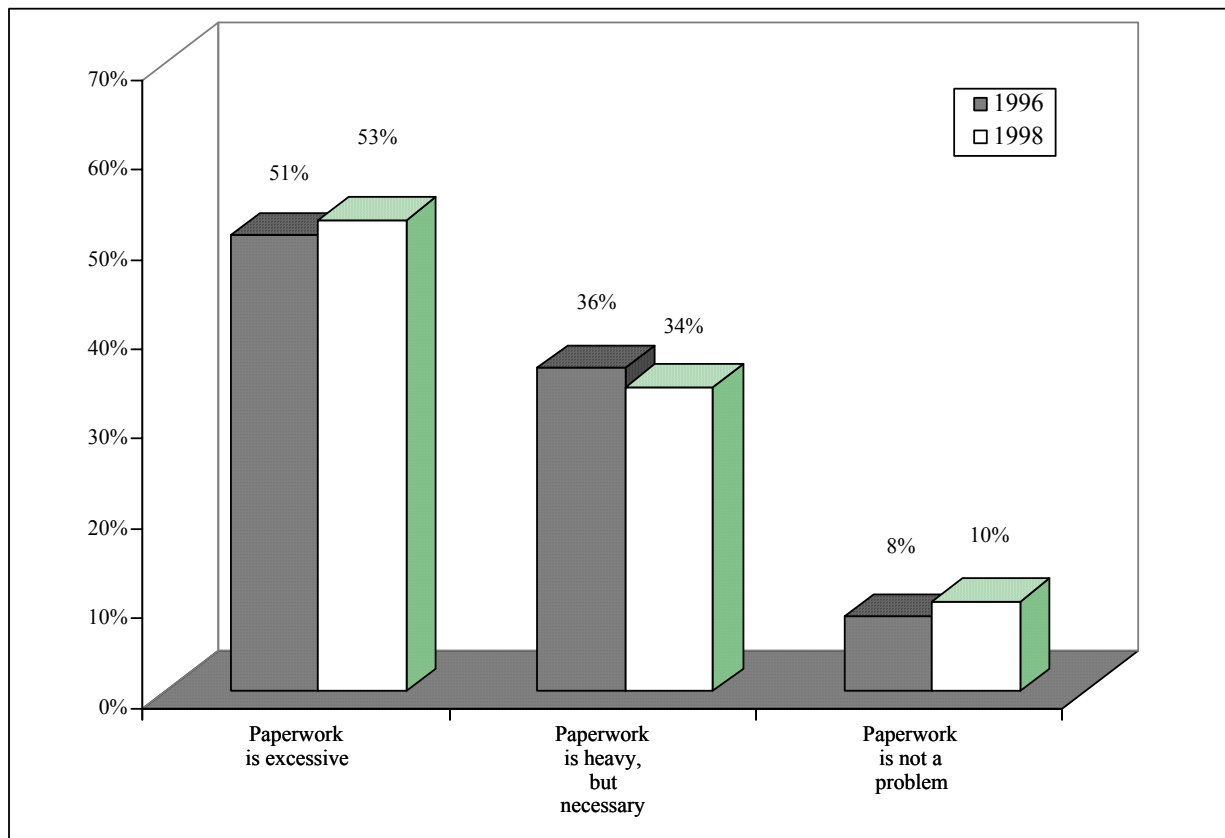
<sup>14</sup> The insurance carrier must have attempted and failed to receive permission from the injured worker to go to a required medical examination before the TWCC can require that an injured worker attend the examination. Currently, for injuries after September 1, 1997, an insurance carrier must show good cause for why more than one required medical examination needs to take place within 180 days. Additional examinations can be used to determine whether there has been a change in the worker's condition; whether the initial diagnosis should be altered; or whether treatment should be extended to another body part or system. See *Texas Labor Code*, Section 408.004.

nearly two-thirds of doctors (64 percent) disagreed with the assertion that insurance carriers should be allowed to deny treatment or prescriptions based on an RME doctor's evaluation of an injured worker. Some doctors noted that the required medical examiner should not be able to negate the treating doctor's prescribed treatment after only one visit. Other doctors stated that if the required medical examiner's decision is used as a basis for denying medical care, the required medical examiner should have some liability for making those decisions. Additionally, some doctors felt that before a required medical examiner's exam could be used as a basis for changing the treating doctor's prescribed course of treatment, the treating doctor should be given the opportunity to discuss the exam findings with the examiner to ensure that all the proper documentation was utilized. Recently adopted rules for preauthorization address this issue (see footnote 6).

## SECTION V: PAPERWORK

Excessive paperwork continues to be a problem for doctors in the workers' compensation system. When asked to rate the administrative duties required under the workers' compensation system, the majority (53 percent) of doctors responded that paperwork is excessive. When asked the same question as part of the 1996 survey, a similar majority (51 percent) of doctors responded that paperwork was onerous (see Figure 6).

**Figure 6**  
**Comparison of Paperwork Necessity**  
**1996 and 1998 Results**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998, and Survey of Texas Doctors, 1996.

Note: 5 percent of doctors in 1996 and 4 percent in 1998 had no opinion on this question.

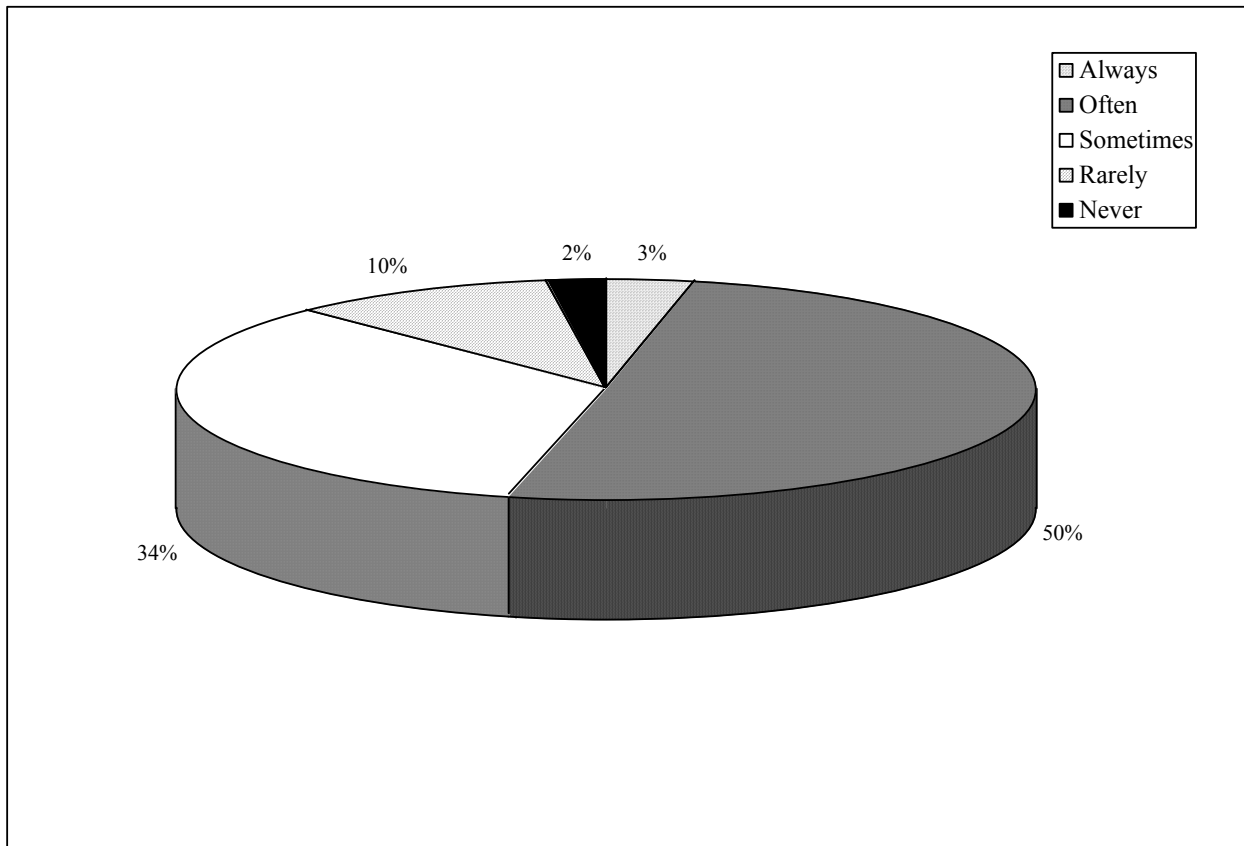
According to testimony provided by doctors to the Business and Industry Subcommittee on Insurance Carrier Practices, excessive paperwork results from unnecessary or redundant requests for medical documentation made by insurance carriers and their utilization review agents. Survey responses support this testimony.

### Medical Documentation Required by Carriers

Doctors testified before the subcommittee that insurance carriers require more documentation than is needed from treating doctors to support the proposed course of treatment for an injured worker. Of those doctors surveyed, a clear majority (79 percent) agreed with this assertion; only 7 percent disagreed.<sup>15</sup>

Another assertion raised by doctors during testimony before the subcommittee was that, in some cases, medical documentation had to be resubmitted due to mistakes made by insurance carriers. When asked how frequently this occurs, half of the doctors (50 percent) responded “often” while more than a third (34 percent) answered “sometimes” (see Figure 7).

**Figure 7**  
**How often, if ever, do you have to resubmit the same medical documentation to an insurance carrier because of a mistake made by the carrier?**



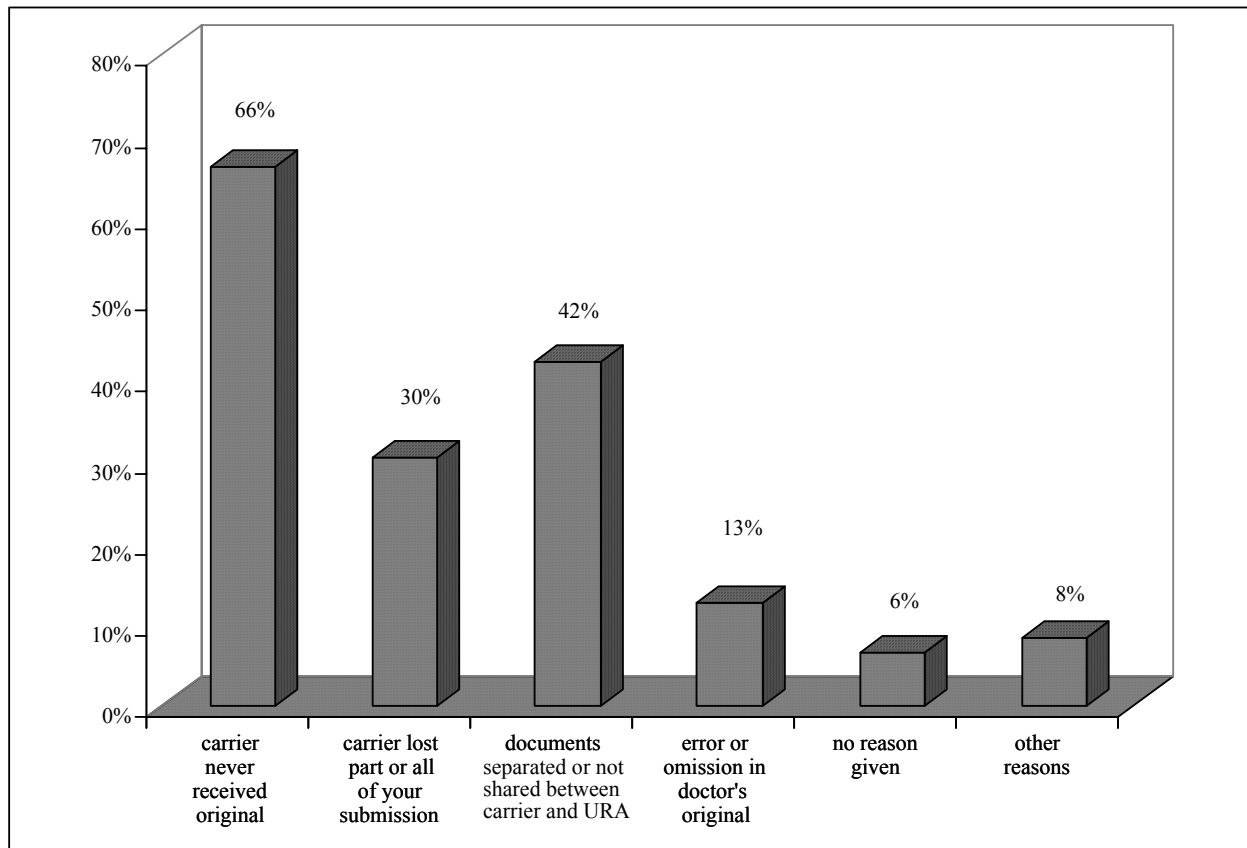
Source: Research and Oversight Council on Workers’ Compensation, Survey of Texas Doctors, 1998.

When asked why insurance carriers typically request that information be resubmitted, the most

<sup>15</sup> Fourteen percent of doctors were neutral in response to this question.

frequent reason given by doctors (66 percent) was that the carrier claimed never to have received the original submission. The second most frequent reason (42 percent) was that documents contained in the original submission were separated and/or not shared between the carrier and the utilization review agent (see Figure 8). Nearly a third of the doctors (30 percent) responded that resubmission was requested because the carrier lost all or part of the original submission. The TWCC has recently issued an advisory on this topic, and newly adopted rules also address this issue (see footnote 5).

**Figure 8**  
**Why do carriers typically ask that you resubmit information?**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

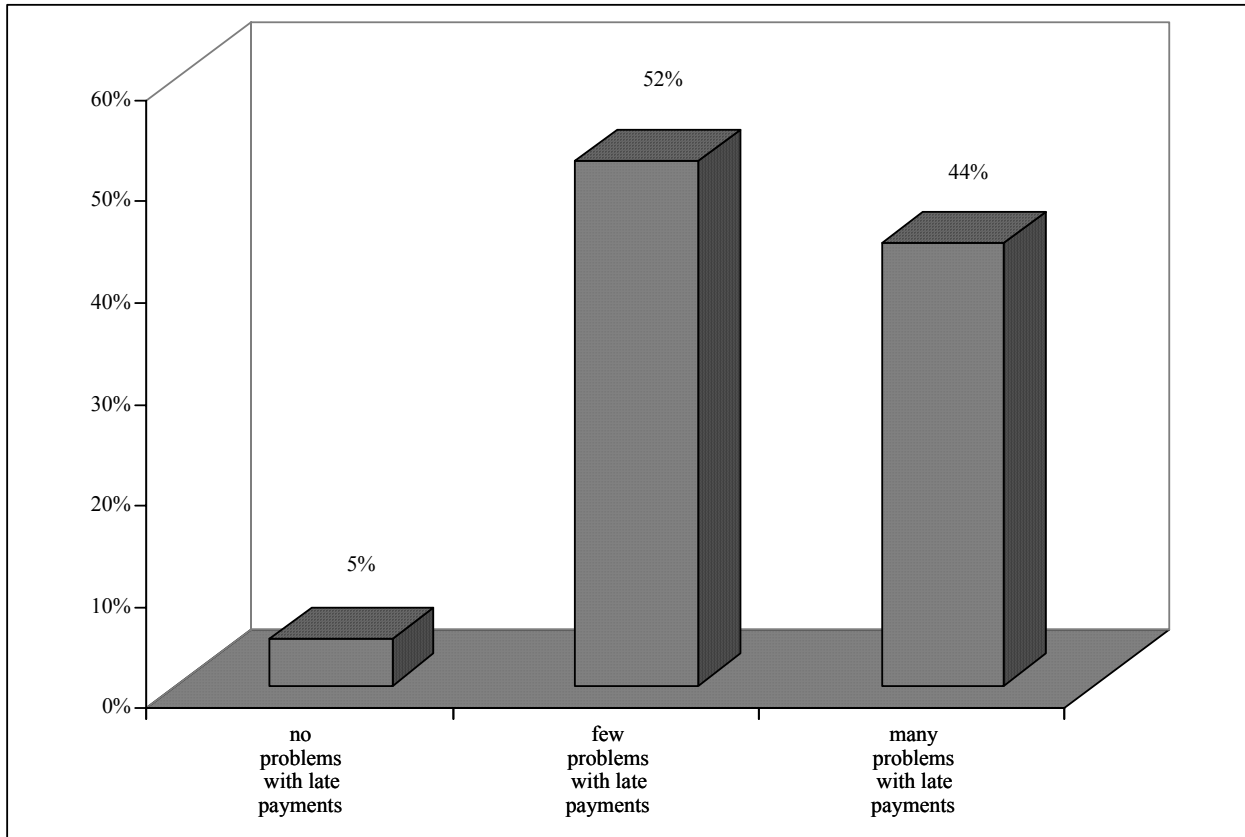
## SECTION VI: OTHER ISSUES

In addition to important issues such as preauthorization of medical treatment and medical dispute resolution, doctors testified before the subcommittee regarding their concerns with prompt payment for their medical services when no medical dispute exists, and payment for peripheral conditions.

### Payment for Medical Services

Outside of the medical dispute resolution process, a little over half of the doctors (52 percent) responded that they have few problems with prompt payment by insurance companies for undisputed medical treatment. A smaller number (44 percent) indicated that they have many problems with late payments (see Figure 9).

**Figure 9**  
**What has been your experience with the promptness of payment by insurance carriers for undisputed medical treatment in workers' compensation cases?**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

Note: In the 1996 survey, 3.1% of doctors responded that they had no problems with late payments; 56.3 percent characterized their problems as "few" and 34.2 percent said they had "many" problems with late payments.

### **Treatment of Peripheral Conditions**

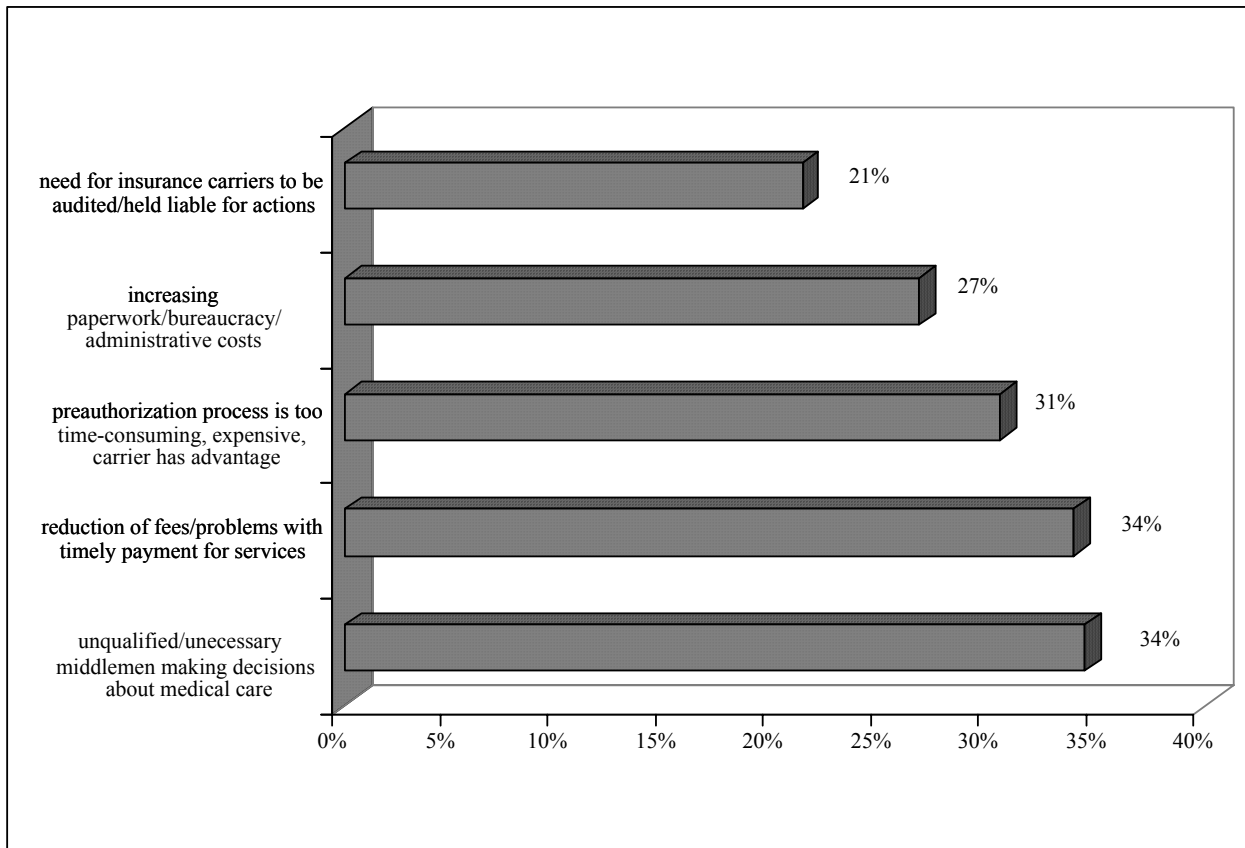
Another topic of concern was the issue of payment for the treatment of a peripheral condition, that is, a general medical condition (such as high blood pressure or diabetes) that is aggravated by the occupational injury or requires medical stabilization before the injury can be treated. When asked whether insurance carriers disapprove payment for the treatment of work-related peripheral conditions, most doctors (54 percent) responded that insurance carriers “always” or “often” disapprove payment for treatment of these conditions. It should be noted that the workers’ compensation system is, by definition, focused on work-related injuries, and it should flag general medical conditions for close scrutiny to determine a clear relationship to the occupational injury.



**SECTION VII:  
TOP HEALTHCARE ISSUES  
FOR WORKERS' COMPENSATION**

On the eve of a new legislative session, it is important to take note of the issues that healthcare providers consider important in today's workers' compensation environment. In 1996, the top issues were the reduction of fees by insurance carriers and payment problems; increasing paperwork/bureaucracy/administrative costs; and administrative delays of medical treatment or payment by insurance carriers. Many of these issues remain important to healthcare providers while others have emerged since the last survey as areas that need further policy consideration. Figure 10 below outlines the top five healthcare issues important to doctors in the workers' compensation system.

**Figure 10  
Top Five Health Care Issues in the Workers' Compensation System**



Source: Research and Oversight Council on Workers' Compensation, Survey of Texas Doctors, 1998.

Note: Percentages do not add up to 100 percent because doctors were allowed to give more than one answer to this question.

## **SECTION VIII: CONCLUSION AND POLICY CONSIDERATIONS**

The Texas workers' compensation system was intended to provide appropriate and adequate medical benefits to injured workers in a timely, cost-effective manner. The system was also designed to minimize disputes, but to identify and resolve them promptly and fairly when they arise. Lastly, the system seeks to avoid cost shifting, both into and out of other social programs.

Healthcare providers and injured workers alike testified before the Texas House of Representatives Business and Industry Subcommittee on Workers' Compensation Insurance Carrier Practices regarding problems that exist with the delivery of medical benefits in the Texas workers' compensation system. Much of the testimony focused on problems with the medical dispute resolution process, the preauthorization process, and the use of required medical examinations (RME) by insurance carriers. This survey supports testimony that Texas doctors experience problems with the preauthorization and medical dispute resolution process. Testimony regarding problems with RME doctors is not as strongly supported by the survey.

### **Medical Dispute Resolution**

According to TWCC data, less than one percent of all medical bills processed in the system are disputed each year.<sup>16</sup> Although this suggests that the system is meeting its objective of minimizing disputes, this survey and testimony received by the subcommittee suggest that the low number of disputes may be the result of a medical dispute resolution system that discourages doctor participation. If doctors are simply choosing not to use the system, this could explain the low number of disputes that are filed each year.

Survey results affirmed testimony that doctors are reluctant to participate in the medical dispute resolution process, not necessarily because the system is unfair, but because they cannot justify the required time and expense of pursuing a dispute. When asked whether there were aspects of the process that discouraged participation, most doctors responded that the process takes too long,<sup>17</sup> requires too much paperwork, and is not cost-effective (i.e., the amount they would

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<sup>16</sup> According to the TWCC *System Data Report*, in 1995, 1996 and 1997, less than one percent of all medical billings processed in the system resulted in the filing of a medical dispute.

<sup>17</sup> For the first year such data were collected (6/16/97 – 6/16/98), the TWCC Medical Dispute Resolution Information System (MDRIS) database revealed that preauthorization disputes took an average of 41 days to resolve; medical necessity disputes took an average of 272 days to resolve, and fee disputes took an average of 117 days to resolve.

recover is not worth the effort).

Given the fact that more than half the doctors surveyed said that insurance carriers “always” or “often” down-code or reduce fees for services rendered without giving written justification, it is difficult to otherwise explain why more medical fee disputes are not filed with the TWCC.<sup>18</sup> It is also difficult to otherwise explain why more medical necessity disputes are not filed,<sup>19</sup> given the fact that more than half of doctors surveyed said that insurance carriers “sometimes” or “often” deny medical fee reimbursement on the grounds that a treatment was not medically necessary. The same question can be asked for preauthorization disputes<sup>20</sup> when more than half of the doctors responded that insurance carriers or their utilization review agents “rarely” or “never” provide a reasonable, written justification when denying a request for preauthorization.

A timely, cost-effective medical dispute resolution process is critical to the effective functioning of the system as a whole. If the process discourages participation by doctors, it may encourage carriers to inappropriately deny or reduce medical bills knowing the unlikelihood that a dispute will be raised. Furthermore, if doctors perceive that medical bills will not be appropriately reimbursed, this could result in a chilling effect on their willingness to treat injured workers.

To ensure that doctors with legitimate disputes are not discouraged from using the process, the average length of time to reach a medical dispute resolution must be shortened. Achieving this result may require additional staffing and resources at the TWCC, and/or increased access to medical expertise at the TWCC. Currently, the TWCC does not maintain a licensed physician on staff but may order an examination by a doctor if necessary (which adds time and expense to the case). In addition, the process should be reviewed to ensure that inappropriate bill reductions or denials can be identified and that adequate disincentives are in place to prevent this practice.

### **The Preauthorization Process**

The Texas workers’ compensation system utilizes retrospective review for all medical treatments and services provided to injured workers except for the sixteen listed in the TWCC Preauthorization Rule. Medical services which require preauthorization, if not preauthorized, relieve the carrier of liability for that medical service.

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<sup>18</sup> For the first year such data were collected, the TWCC MDRIS database revealed that 867 medical fee disputes were filed between June 16, 1997 and June 16, 1998.

<sup>19</sup> For the first year such data were collected, the TWCC MDRIS database revealed that 272 medical necessity disputes were filed between June 16, 1997 and June 16, 1998.

<sup>20</sup> For the first year such data were collected, the TWCC MDRIS database revealed that 1040 preauthorization disputes were filed between June 16, 1997 and June 16, 1998.

This survey affirms testimony received by the subcommittee that problems exist with the preauthorization process. The four problems most often identified by doctors include:

- 1) the carrier's failure to comply with the three-day rule;
- 2) the inability to request preauthorization because no one answered the carrier's dedicated preauthorization phone line, or the line was busy;
- 3) the carrier unreasonably requested additional medical documentation; and
- 4) documents submitted by the doctor were lost by the carrier.

In addition, doctors responded that carriers sometimes fail to provide a reasonable, written justification when denying requests for preauthorization, and sometimes fail to provide the name of the individual making a preauthorization decision. Doctors overwhelmingly agreed that preauthorization decisions should be made by the same type of medical professional who recommended the original course of treatment. Looking specifically at denials, most doctors responded that only a Texas-licensed physician should be allowed to deny a request for preauthorization.

The rules adopted by the Texas Department of Insurance (TDI) that regulate utilization review agents (URA) are a first step in resolving some of the medical delivery problems within the workers' compensation system identified through this survey and through testimony received by the subcommittee.

The rules should help to ensure that only qualified personnel make utilization review decisions supervised by a licensed physician. Additionally, the requirements that URAs provide the principal reasons for an adverse determination, the clinical basis for such determinations, and a description or the source of the criteria used in making these determinations, should ensure that treating doctors have a clear understanding of the basis for a preauthorization denial. The requirement that, prior to the issuance of a denial, a doctor requesting preauthorization must be given the opportunity to discuss the proposed treatment with the doctor or healthcare provider who performed the review, should also make sure that each party understands the other's position.

The rules should also aid in opening the channels of communication between treating doctors and URAs by requiring reasonable access during normal business hours. Finally, the rules should help to reduce the amount of medical documentation required of treating doctors, and at the least provide for the recouping of copying costs.

Although the new rules proposed by the TDI are designed to address some of the problems associated with the preauthorization process, the rules must be adequately enforced. For this to happen, adequate resources should be provided to ensure compliance with the new rules, including ongoing monitoring of TDI's implementation efforts.

### **Carrier Required Medical Examinations**

Doctors in this survey were somewhat divided on the role of RME doctors, and thus did not fully support testimony received by the subcommittee that doctors who conduct required medical exams are biased and do not sufficiently examine injured workers. A little over half of the doctors responded that RME doctors are objective in their evaluation of injured workers, spend an adequate amount of time examining injured workers, and examine all relevant medical documentation in evaluating the diagnosis, course of treatment, and/or condition of an injured worker. Interestingly, however, most doctors did not think that insurance carriers should be allowed to deny treatment or prescriptions based on an RME doctor's evaluation of an injured worker. Some doctors testified that if RMEs were used to deny medical care, the doctor performing the RME should have liability for the decision. Currently, under the Act, doctors conducting RMEs are immune from civil liability.<sup>21</sup>

Doctors responded that it was not necessary for the treating doctor to be present during an RME to ensure a thorough, objective evaluation of an injured worker. The Act currently provides that an injured worker is entitled to choose a doctor to attend an RME.<sup>22</sup> Policymakers might want to reconsider the necessity of this provision, or consider alternatives that may be more practical and cost-efficient.

### **Paperwork**

Doctors responded that excessive paperwork continues to be a problem in the system. However, this survey suggests that at least part of the problem is attributable to unnecessary or redundant requests for medical documentation made by insurance carriers. The requirement contained in the new URA rules that insurance carriers reimburse doctors for the reasonable costs of providing written medical information should help to address this problem. However, policymakers could consider the creation of additional mechanisms for reducing the amount of paperwork required by the system including the use of electronic technology for the transmission

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<sup>21</sup> See *Texas Labor Code*, Section 413.054(a).

<sup>22</sup> See *Texas Labor Code*, Section 408.004(d). This provision also requires the carrier to pay a TWCC-established fee to a doctor selected by the employee.

of medical documentation. This would assist in the tracking of the flow of information in the system while, at the same time, establishing a mechanism for identifying abusive practices by system participants. It would also align the Texas medical billing/reporting system with Federal initiatives such as the Health Insurance Portability and Accountability Act to streamline the flow and use of health insurance data through innovative information technologies.

**APPENDIX A: SURVEY QUESTIONNAIRE**  
**SURVEY OF PHYSICIANS**  
**WORKERS' COMPENSATION INSURANCE CARRIER PRACTICES**

**Part 1: GENERAL INFORMATION**

1. Do you currently accept workers' compensation cases? **(circle one)**

- 1 Yes. Please skip to Question 3.
- 2 No. Thank you for participating in our survey. After completing questions 2 and 3, please return this form in the envelope provided, or fax it to the Research and Oversight Council on Workers' Compensation at 512-469-7481.

2. Why aren't you currently accepting workers' compensation cases?: **(circle all that apply)**

- 1 Not accepting new patients
- 2 Obtaining reimbursement for services too difficult
- 3 Fee schedule reimbursement rate too low
- 4 Workers' compensation system too adversarial
- 5 Too much paperwork
- 6 Other: \_\_\_\_\_

3. What type of medicine do you practice? **(circle one)**

- 1 Orthopedics (spine, hand, foot, etc.)
- 2 Family practice/general practice
- 3 Physical medicine and rehabilitation/sports medicine
- 4 Occupational/industrial medicine
- 5 Osteopathy
- 6 Chiropractic
- 7 Neurology
- 8 Other (please specify): \_\_\_\_\_

4. Approximately what percentage of your practice is devoted to workers' compensation cases? **(circle one)**

- 1 less than 5%
- 2 between 5% and 25%
- 3 between 26% and 50%
- 3 greater than 50%

5. In the **majority** of your workers' compensation cases, were you the: **(circle one)**

- 1 treating doctor (i.e., the injured worker's doctor)

- 2 referral doctor (i.e., injured workers were referred to you by the treating doctor)
- 3 insurance doctor (i.e., injured workers were referred to you by the insurance company)
- 4 designated doctor (i.e., the doctor chosen by a mutual agreement or by the Texas Workers' Compensation Commission to resolve disputes)

**Part 2: PAPERWORK**

6. How would you rate the administrative duties required of you under the workers' compensation system? **(circle one)**

- 1 Paperwork is excessive.
- 2 Paperwork is heavy, but necessary.
- 3 Paperwork is not a problem.

To what extent do you **agree** or **disagree** with the following statement:

7a. Insurance carriers require more documentation than is needed from treating doctors to support the treating doctor's proposed course of treatment for an injured worker. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

7b. Please explain.

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8a. How often, if ever, do you have to resubmit the same medical documentation to an insurance carrier because of a mistake made by the carrier? **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never (Skip to Part 3)

8b. With which insurance carriers do you experience this problem? (Remember, all of your answers are confidential.) \_\_\_\_\_

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9. Why do insurance carriers typically ask that you resubmit information? **(circle all that apply)**

- 1 The carrier claimed to have never received your original submission
- 2 The carrier lost part or all of your original submission
- 3 The documents contained in your original submission were separated and/or not shared by the carrier and its utilization review agent
- 4 Error or omission in doctor's original submission
- 5 Other (please specify): \_\_\_\_\_



6 No reason given

**Part 3: PREAUTHORIZATION OF WORKERS' COMPENSATION MEDICAL TREATMENTS**

10. Approximately how many times do you request preauthorization for treatments or services in a given month? \_\_\_\_\_ (If none, please skip to Part 4).

11. How often are preauthorization requests submitted by your office denied by the insurance carrier?  
**(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/Don't know

12. Which of the following problems, if any, have you encountered with the preauthorization process?  
**(circle all that apply)**

- 1 Experienced no problems
- 2 No answer or line was busy
- 3 Documents submitted were lost
- 4 Request not approved or denied within 3 working days
- 5 Carrier unreasonably requested additional medical documentation
- 6 Didn't know where to submit request or who to contact
- 7 Submitted request to adjuster who did not give to appropriate carrier personnel for approval or denial
- 8 Other (please explain): \_\_\_\_\_

13. To what extent do you **agree** or **disagree** with the following statement:

Insurance carriers apply different standards in reviewing preauthorization requests submitted by treating doctors as opposed to those submitted by insurance doctors (i.e., doctors regularly used by carriers for Required Medical Exams). **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

14. How often, if ever, have you received preauthorization from an insurance carrier's utilization review agent and subsequently had that preauthorization revoked by the adjuster handling the case?  
**(circle one)**

- 1 Always
- 2 Often

- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

15. How often do insurance carriers provide the name of the individual making a preauthorization decision? **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

16. Some assert that anonymity in preauthorization decisions is important because it encourages participation in the process; others see it as a disadvantage because of a lack of professional accountability. What is your opinion? **(circle one)**

- 1 Anonymity is more important
- 2 Preauthorization decisions should not be anonymous
- 3 No opinion

17. In your opinion, who should be allowed to deny a preauthorization request? **(circle all that apply)**

- 1 A licensed workers' compensation adjuster
- 2 A registered nurse, licensed as a workers' compensation insurance adjuster
- 3 A registered nurse initially, with approval from a licensed physician
- 4 Only a Texas licensed physician
- 5 Any licensed physician
- 6 Other: \_\_\_\_\_
- 7 Not applicable/No opinion

18. To what extent do you **agree** or **disagree** with the following statement:

Preauthorization decisions should be made by the same type of medical professional who recommended the original course of treatment (e.g., an orthopedist should preauthorize the treatment plan of another orthopedist). **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

19. How often, if ever, do insurance carriers or their utilization review agents provide a reasonable, written justification when denying a preauthorization request? **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

20. To what extent do you **agree** or **disagree** with the following statement:

Insurance carriers or their utilization review agents should be required to provide a reasonable, written justification when denying a preauthorization request. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

**Part 4: CARRIER PEER REVIEWS**

21. In your opinion, who should be allowed to conduct a peer review of an injured worker's claim file? **(select all that apply)**

- 1 A licensed workers' compensation adjuster
- 2 A registered nurse, licensed as a workers' compensation insurance adjuster
- 3 A registered nurse initially, with approval from a licensed physician
- 4 A Texas licensed physician
- 5 Any licensed physician
- 6 Other: \_\_\_\_\_
- 7 Not applicable/No opinion

22. To what extent do you **agree** or **disagree** with the following statement:

the Peer reviews should be conducted by the same type of medical professional who recommended original course of treatment (e.g., an orthopedist should review the treatment plan of another orthopedist). **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

23. How often do insurance carriers provide the name of the individual conducting a peer review? **(circle one)**

- 1 Always
- 2 Often

- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

24. In conducting peer reviews, do the advantages of anonymity (encouraging participation) outweigh the disadvantages of a potential lack of accountability? **(circle one)**

- 1 Anonymity is more important
- 2 Peer reviews should not be anonymous
- 3 No opinion

**Part 5: MEDICAL DISPUTE RESOLUTION**

25. Have you ever been involved in the TWCC medical dispute resolution process?

- 1 Yes
- 2 No (Skip to Question \_\_\_\_)

26. Approximately how many times have you been involved in the medical dispute resolution process? **(circle one)**

- 1 1 to 10 times
- 2 11 to 25 times
- 3 26 to 50 times
- 4 More than 50 times

27. Which of the following, if any, discourage participation in the medical dispute resolution process? **(circle all that apply)**

- 1 The process takes too long
- 2 The process is not cost effective (amount recoverable not worth the effort)
- 3 The process requires too much paperwork
- 4 Other: \_\_\_\_\_
- 5 None of the above
- 6 Not applicable/No opinion

28. To what degree do you feel the medical dispute process is fair or unfair: **(circle one)**

- 1 Extremely Fair
- 2 Fair
- 3 Moderate
- 4 Unfair
- 5 Extremely Unfair
- 6 Not applicable/No opinion

29. How often, if ever, do insurance carriers refuse to reimburse you for treatment of an injured worker because they say the treatment was not medically necessary (assuming the injury was work-related)? **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never (Skip to Question 31a)
- 6 Not applicable/No opinion

**30.** When a carrier states that your proposed course of treatment is not medically necessary, how often, if ever, do you use the TWCC's medical dispute resolution process to challenge that decision? **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

To what extent do you **agree** or **disagree** with the following statements:

**31a.** The trend in medical utilization review and bill payments is toward more disputes. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

**31b.** A party who prevails should be allowed to recover the expenses associated with an administrative appeal regarding a treatment or medical fee dispute. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

**32.** How often, if ever, do insurance carriers down-code or reduce fees for your services without giving justification. **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

## **Part 6: MEDICAL EXAMINATIONS**

To what extent do you **agree** or **disagree** with the following statements:

**33a.** It is necessary for a treating doctor to be present at a carrier required medical examination (RME) to ensure a thorough, objective evaluation of an injured worker. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

**33b.** Please explain.

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**33c.** Doctors conducting RMEs spend adequate time with injured workers to evaluate the diagnosis, course of treatment, and/or condition of the injured worker. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

**33d.** Doctors conducting RMEs examine all relevant medical documentation when evaluating the diagnosis, course of treatment, and current condition of an injured worker. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

**33e.** Doctors who conduct RMEs are objective in their evaluation of injured workers. **(circle one)**

- 1 Strongly agree
- 2 Somewhat agree
- 3 Not sure/undecided
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 You don't know

**33f.** Insurance carriers should be allowed to deny treatment or prescriptions based on an RME doctor's evaluation of the injured worker. **(circle one)**

- 1 Strongly agree

- 2 Somewhat agree
- 3 Neutral
- 4 Somewhat disagree
- 5 Strongly disagree
- 6 Not applicable/No opinion

33g. Please explain. \_\_\_\_\_  
 \_\_\_\_\_

**Part 7: MISCELLANEOUS**

34. What has been your experience in the promptness of payment by insurance companies for undisputed medical treatment in workers' compensation cases? **(circle one)**

- 1 No problems with late payment
- 2 Few problems with late payment
- 3 Many problems with late payments

35. How often, if ever, do insurance carriers disapprove payment for the treatment of a work-related peripheral condition that is part of the injured worker's overall treatment plan? (These are not pre-existing conditions such as diabetes or high blood pressure, but rather a condition such as depression that is associated with the injury.) **(circle one)**

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never
- 6 Not applicable/No opinion

**Part 8: SUMMARY**

36. Please summarize the three main issues relating to workers' compensation insurance carrier practices that should be examined in order to improve the workers' compensation system?

- 1. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 2. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 3. \_\_\_\_\_  
 \_\_\_\_\_

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**THANK YOU** for taking the time to complete this survey. Please return it in the envelope provided or you can fax it to the Research and Oversight Council on Workers' Compensation at **512-469-7481**.

If you would like a copy of the survey results, please provide your name and mailing address:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_