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There is no printed version at this time; all Texas state agencies have been asked to re-evaluate upcoming budget commitments, and we will be relying on our website and e-mail capabilities to disseminate our informational materials for the remainder of this fiscal year. We appreciate your patience during this time.

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Early Results of Changes to the Impairment Rating Process for Injured Workers in Texas

by Joseph Shields and Xiaohua Lu

Impairment ratings in the Texas workers' compensation system measure an injured employee's permanent level of disability, and control the employee's long-term eligibility for income benefits. As such, accurate impairment ratings are a critical aspect of the system. The determination of an impairment rating is made at the time the injured employee reaches maximum medical improvement (MMI), which is the point at which further medical improvement is not reasonably expected or 104 weeks from the date that income benefits begin to accrue (also known as "statutory MMI"), whichever comes first.[1]

In late 2001 and early 2002, the Texas workers' compensation system implemented significant changes related to the certification of MMI and the assignment of permanent impairment ratings. One of those changes was the result of 1999 legislation and rule changes by the Texas Workers' Compensation Commission (TWCC) to implement this legislation (i.e., a change in the version of the guidelines used to rate permanent impairment). Others were the result of TWCC reaction to decisions made in Texas courts. However, some of the most significant changes to the IR process are a direct result of Article 5 of House Bill (HB) 2600, which was passed by the 77th Texas Legislature in 2001.

Key changes to the MMI/IR process are as follows:

1) Article 5 of HB 2600 established a new process for Required Medical Examinations of injured employees concerning IR and MMI issues. In cases in which an insurance carrier questions an impairment rating or MMI date, injured workers are directed first to independent, TWCC-designated doctors (instead of being directed to an insurance carrier-selected doctor, as the process previously prescribed).[2] The new law applies to all MMI and IR-related requests for medical

exams received on or after January 1, 2002. This new IR process is designed to allow for a speedier, more independent determination on MMI and IR issues.[3] Under this change, at either the injured worker's or insurance carrier's request, the employee is directed to a TWCC designated doctor for an MMI or IR exam.

2) Article 5 of HB 2600 also revised the designated doctor appointment criteria to allow a doctor with a different licensure who is "trained and experienced" with medical issues involved in the case to be appointed as the designated doctor. This new criteria replaces a "same licensure" requirement previously in place and also applied to all requests for a medical exam received on or after January 1, 2002.
3) By TWCC rule, the system shifted from the 3rd to the 4th edition of the *AMA Guides to the Evaluation of Permanent Impairment* (AMA Guides). This change, allowed by legislation from the 76th Session in 1999, became effective for all IRs assigned on or after October 15, 2001.
4) TWCC's repeal of Rule 130.5(e) (i.e., the "90 Day Rule") may impact how insurance carriers and injured workers approach the MMI/IR medical evaluation process. The "90 Day Rule" made the *first assessment* of MMI and/or the assigned IR final if the determination of MMI or the IR was not disputed within 90 days. The 3rd Court of Appeals in Austin issued an opinion on April 12, 2001 (in *Fulton v. Associated Indemnity Corporation*) that TWCC had no statutory authority to place a timeframe on IR disputes, and stated "Rule 130.5(e) is invalid to the extent that it prevents reassessment of MMI certification because the impairment rating or MMI was not disputed within 90 days." In response to the Court's decision, TWCC repealed the 90-day provision of the amended rule effective January 2, 2002.[4]
5) TWCC's designated doctor monitoring program, required by Article 1 of HB 2600, may also have an impact on IRs assigned by designated doctors. TWCC began conducting peer reviews of designated doctors in 2002, and the review process may hold designated doctors more accountable for their ratings and result in more accurate evaluations of permanent impairment for injured workers.

It is likely that all five of these changes to the workers' compensation system have had an impact on various system measures (i.e., the duration of temporary income benefit payments, the timing of MMI/IR exams) related to MMI and IRs assigned to injured workers. Three main areas are addressed in this *Texas Monitor* article: 1) changes in the number of MMI/IR-related medical exams, and what types of doctors (e.g., an injured worker's treating doctor, TWCC designated doctor, or carrier- selected doctor) are conducting those exams; 2) changes in the average IRs assigned to injured workers for various injury types; and 3) changes to the proportion of disputes related to MMI and IR issues as a percentage of all disputes filed with TWCC.

Research Methodology

This early analysis of the impact of the changes made to the MMI and IR-related medical exam process is based on an analysis of a total of 76,010 workers' compensation claims. These claims are classified into three time-period groups, based on the date of the first MMI/IR exam (i.e., TWCC-69 form filed with TWCC):

1) Group 1 includes 26,394 claims in which the first MMI/IR exam was conducted between March 1, 2000 and June 30, 2000 (i.e., Pre-HB 2600 IR Process, "90 Day Rule" in Effect, 3rd edition of *AMA Guides*);
2) Group 2 includes 31,024 claims in which the first MMI/IR exam was conducted between March 1, 2001 and June 30, 2001 (i.e., Pre-HB 2600 IR Process, "90 Day Rule" Struck Down by 3rd Court of Appeals,[5] 3rd edition of *AMA Guides*); and

3) Group 3 includes 18,592 claims in which the first MMI/IR exam was conducted between March 1, 2002 and June 30, 2002 (i.e., Post-HB 2600 IR Process, "90 Day Rule" Repealed by TWCC, 4th edition of *AMA Guides*).

In order to make each of the three groups as comparable as possible, medical examinations, impairment ratings, and dispute activity for each claim are tracked for exactly 180 days from the date of the first MMI/IR exam. This ensures that each claim included in the analysis, regardless of when the injury occurred, will have the same amount of time (from date of first MMI/IR exam) for claim activity to be evaluated.

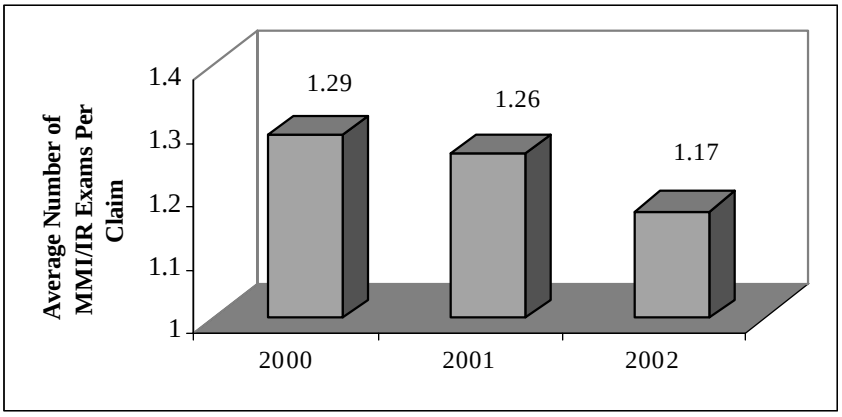
It is important to note that the findings presented in this article represent events that occurred during or immediately after the implementation of a number of important changes to the system. It will be critical to continue to monitor key system metrics to determine if the early changes observed in the new process are sustained, and if impacts not immediately discernible (e.g., duration of temporary income benefits) emerge as the system modifications have more time to mature and system participants have more time to adjust to the statutory and rule changes.

Total Number of MMI/IR Exams Conducted

On average, 1.17 MMI/IR-related medical exams per claim were conducted for injured workers under the revised IR process in 2002.[6] This represents a decline from the pre-HB 2600 IR process, which yielded an average of 1.29 exams per claim in 2000 and 1.26 exams per claim in 2001 (see Figure 1).

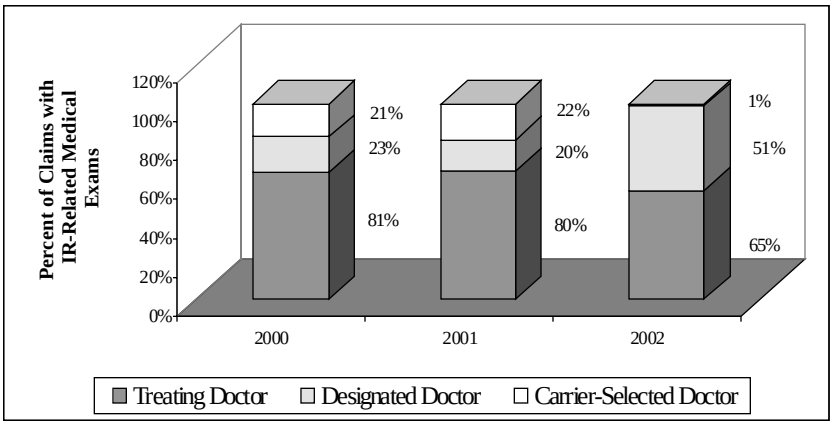
While the reduction in the number of exams per claim may seem modest, it translates into a significant annual cost savings for the system in examination expenses alone. Assuming the number of claims with impairment rating exams remains constant at approximately 58,400 per year,[7] the reduction in exams per claim from 1.26 to 1.17 results in an annual savings of approximately $1.86 million to the workers' compensation system.[8] It is important to note that due to the increase in the number of designated doctor assignments that TWCC staff must make, an increase in state administrative costs may offset

Figure 1
Average Number of MMI/IR-Related Medical Exams Per Claim, 2000 – 2002



Source: Research and Oversight Council on Workers' Compensation and the Texas Workers' Compensation Commission, Administrative Claims Data, 2003.

Figure 2
Percentage of Claims with IR-Related Medical Exams by Specific Doctor Types, 2000 – 2002



Source: Research and Oversight Council on Workers' Compensation, and the Texas Workers' Compensation Commission, Administrative Claims Data, 2003.

a small portion of the savings realized.[9]

Figure 2 shows the percentage of claims with MMI/IR-related medical exam conducted by each of the three primary doctor types (i.e., treating, designated, and carrier-selected) for each of the three periods (2000, 2001, and 2002) included in the analysis. Under the previous IR process, injured employees were evaluated more often for MMI and/or extent of impairment by treating doctors and insurance carrier-selected doctors, in required medical exams (RMEs). However, under the revised IR process in 2002, the proportion of claims with a treating doctor rating has dropped, the percentage of claims that involved designated doctor exams has risen dramatically, and exams by carrier-selected doctors have been nearly eliminated.

Table 1 shows the most common medical exam/doctor mix patterns for the three time periods under analysis. In 2000 and 2001, it was much more common for there to be one and only one exam by a treating doctor or a carrier-selected doctor than under the revised IR process. Another common scenario in 2000 and 2001 was for there to be an exam by a carrier-selected doctor followed by a designated doctor's exam. In contrast, 2002 claims are much more likely to involve a single MMI/IR-related exam by a designated doctor. Only 1 percent of the claims processed in 2000 and 2001 had a single MMI/IR exam performed by a designated doctor,[10] however; over one-third (34 percent) of the claims processed under the revised IR process in 2002 had a single medical exam performed by a TWCC-appointed designated doctor.

While the "insurance doctor exam/designated doctor exam" pattern accounted for approximately 7 percent of the claims under the prior IR process, this pattern was basically nonexistent in 2002. Also, though they generally don't account for many claims during any period, claims involving multiple treating doctor exams were cut in half under the revised IR process.[11]

Key Findings: Impairment Rating Assignments

Several of the factors mentioned at the beginning of this article may have had a significant impact on impairment ratings assigned to injured workers in Texas, particularly the shift from the 3rd to the 4th edition of the *AMA Guides*, the change in the designated doctor assignment criteria, and the change in the IR process.

Overall Impairment Ratings

Overall, the average impairment rating assigned to injured workers was higher in 2002 under the revised IR process and the 4th edition of the *AMA Guides* than in either 2000 or 2001. When all MMI/IR-related examinations are considered (i.e., those conducted by treating doctors, designated doctors, carrier-selected doctors, and commission-assigned doctors), the average rating assigned increased from 5.38 percent in 2000 and 4.82 percent in 2001

Table 1
MMI/IR Exam Patterns: 2000 – 2002

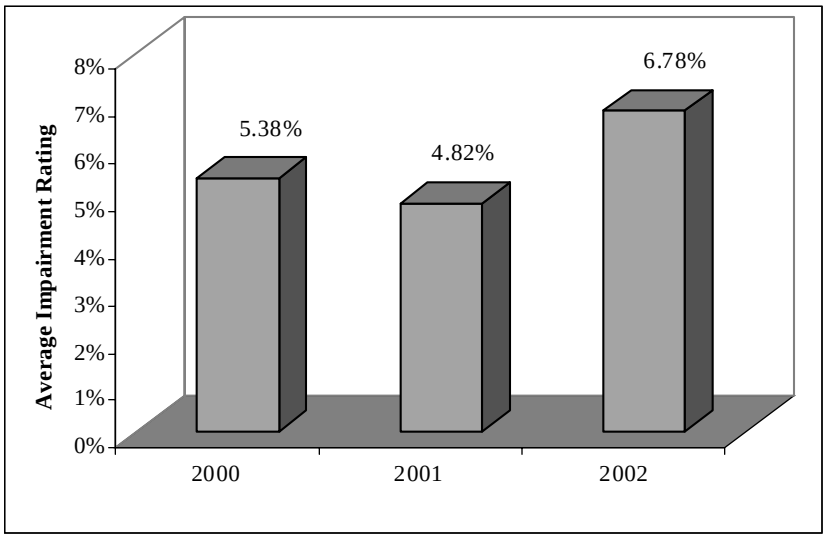
MMI-IR Exam Patterns	2000	2001	2002
Treating Doctor Only	63%	65%	49%
Insurance Doctor Only	10%	11%	0%
Designated Doctor Only	1%	1%	34%
Treating Doctor Exam Followed by Designated Doctor Exam	13%	10%	12%
Insurance Doctor Exam Followed by Designated Doctor Exam	7%	7%	0%
Designated Doctor Exam Followed by a Treating Doctor Exam	0%	0%	2%
Multiple Treating Doctor Exams	2%	2%	1%

Source: Research and Oversight Council on Workers' Compensation, and the Texas Workers' Compensation Commission, Administrative Claims Data, 2003.
Note: "Other" MMI/IR exam patterns account for 4 percent of the 2000 and 2001 patterns and 2 percent of the 2002 patterns.

(using the 3rd edition of the *AMA Guides*) to 6.78 percent in 2002 (when the new IR process was in place and the 4th edition of the *AMA Guides* was utilized) – see Figure 3.

It is clear from closer examination of the distributions of IRs for the three years that a significantly higher percentage of non-zero ratings in 2002 (under the 4th edition of the *AMA Guides*) is driving the increase in the average IR. In 2002, IRs were much more likely to be clustered at 5 percent and 10 percent than was the case in 2000 and 2001 under the 3rd edition of the *AMA Guides*.[12]

Figure 3
Average Impairment Rating Assigned: All Providers
2000 – 2002



Source: Research and Oversight Council on Workers' Compensation, and the Texas Workers' Compensation Commission, Administrative Claims Data, 2003.

Note: The averages expressed in Figure 3 are based on the most recent, or last, rating provided (i.e., 180 days from the first MMI/IR exam for the claim). Valid IRs include all exams with an MMI date and a rating between 0 and 99 percent. IRs of 100 percent were viewed as suspect and removed from the analysis.

Impairment Ratings by Injury Type

Twelve categories of injuries were also analyzed to determine if the change in the average impairment rating assigned to injured workers was consistent across all injury types. ICD-9 codes were used to group injuries into "diagnostic buckets" for analytic purposes.[13] The average IR assigned in 2002 is higher than the ratings assigned in 2000 and 2001 for 8 of the 12 diagnostic groups included in the analysis, including the two most frequent injury types ("soft tissue injuries" and "other injuries/symptoms"), which together account for approximately two-thirds of the claims.

Average impairment ratings for the third most common injury type, neurological problems, remained stable over the 2000 to 2002 period, with little observable change in the mean impairment rating of just under 9 percent. Three injury types (internal derangement, degenerative disease, and disc displacement) received lower impairment ratings, on average, in 2002 than in 2000 and 2001, when they were rated with the 3rd edition of the *AMA Guides*. Table 2 provides average impairment ratings for the three periods of analysis, stratified by diagnostic groups (i.e., injury type).

Impairment Ratings by Doctor Type

It was previously shown that overall average IRs have increased since the revised, post-HB 2600 IR process was implemented and doctors began using the 4th edition of the *AMA Guides* to evaluate injured workers for permanent impairment. Interestingly, the average IRs assigned by injured workers' treating doctors increased in 2002 using the 4th edition of the *AMA Guides* (from 4.17 percent in 2000 and 3.47 percent in 2001 to 5.89 percent in 2002), while the average impairment rating issued by TWCC-appointed designated doctors declined from 9.4 in 2000 and 9.6 percent in 2001, to 7.8 percent in 2002. It is likely that the overall increase in IRs is being driven by the change to the 4th edition of the *AMA Guides*. Not surprisingly, the average IRs issued by designated doctors are higher than the average ratings as-

Table 2
Average Impairment Ratings By Diagnostic Group: 2000 – 2002

Diagnostic Group	2000 (3rd Edition of AMA Guides)	2001 (3rd Edition of AMA Guides)	2002 (4th Edition of AMA Guides)
Soft Tissue Injury	4.90% (N=11,770)	4.32% (N=14,393)	6.19% (N=8,737)
Neurological Problems	8.84% (N=2,783)	8.90% (N=2,895)	8.78% (N=2,484)
Superficial Injuries	1.17% (N=1,698)	0.99% (N=3,123)	3.73% (N=778)
Skeletal Trauma	3.60% (N=1,545)	3.57% (N=1,686)	5.27% (N=1,106)
Internal Derangement	5.99% (N=1,132)	5.49% (N=1,352)	4.97% (N=1,004)
Degenerative Disease	9.92% (N=528)	10.84% (N=435)	8.80% (N=388)
Superficial Injuries	1.17% (N=1,698)	0.99% (N=3,123)	3.73% (N=778)
Disc Displacement	14.22% (N=528)	14.28% (N=296)	11.69% (N=315)
Amputation or Crush	5.80% (N=422)	4.95% (N=439)	6.68% (N=292)
Myelopathy	12.34% (N=214)	11.43% (N=221)	13.04% (N=165)
Hernia	2.20% (N=190)	1.57% (N=164)	5.06% (N=51)
Burns	3.07% (N=58)	1.28% (N=123)	4.03% (N=30)
Other Injuries/Symptoms	5.17% (N=5,786)	5.25% (N=5,897)	7.67% (3,242)

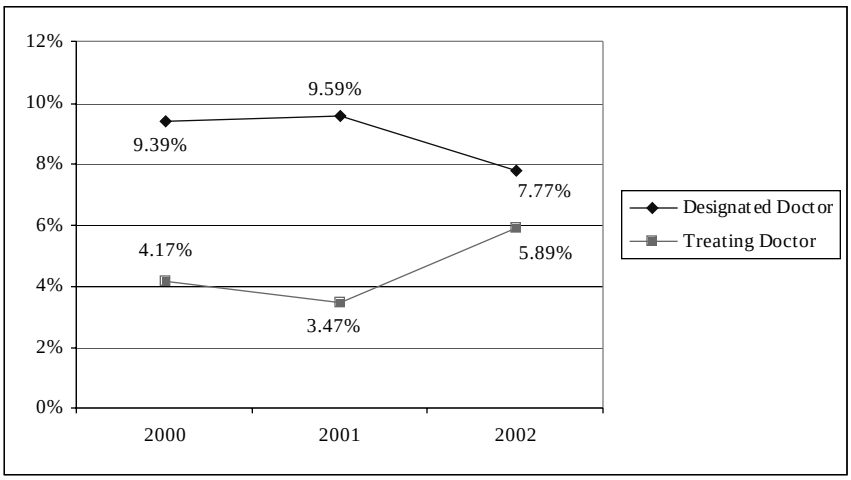
Source: Research and Oversight Council on Workers' Compensation, and the Texas Workers' Compensation Commission, Administrative Claims Data, 2003.
Notes: Neurological problems include neuropathy and nerve compression disorders. The number of IRs assigned for each diagnostic group is noted in parentheses.

signed by treating doctors. This is to be expected because injuries that are more severe and that require more complicated medical services are much more likely to involve a designated doctor to resolve differences of opinion over MMI and IR issues (see Figure 4).[14]

There are several factors that may be contributing to the patterns shown in Figure 4. Since insurance carriers are now allowed to request a designated doctor exam without a previous exam (and have to wait only 60 days for a follow-up designated doctor exam if necessary), it is likely that the mix of injuries rated by designated doctors in 2002 is less severe in nature than in previous years. The fact that a much higher proportion of designated doctors have received training on the use of the 4th edition of the *AMA Guides* than treating doctors and that the ratings calculated by designated doctors are being reviewed more thoroughly by TWCC through its doctor monitoring program may also be contributing to the decline in designated doctor ratings.

Another factor contributing to the decline in average impairment ratings assigned by designated doctors in 2002 is that the mix of medical providers may have become more conservative due to more doctors who have traditionally performed exams for insurance carriers acting as designated doctors under the revised IR process. "Insurance carrier doctors" are defined as doctors who performed more MMI/IR evaluations under the previous IR process in 2000 and 2001 as an insurance carrier selected doctor than as either a designated doctor or a treating doctor. Doctors classified as insurance doctors using the definition above (on average) issued significantly lower impairment ratings (7.0 percent) when they served as designated doctors, than the overall average for all designated doctors (9.35 percent). In 2001, prior to the implementation of the revised IR process (which involved a near elimination of MMI/IR exams conducted by carrier-se-

Figure 4
Average Impairment Rating Assigned by Doctor Type
2000 – 2002



Source: Research and Oversight Council on Workers' Compensation, and the Texas Workers' Compensation Commission, Administrative Claims Data, 2003.

Note: The averages expressed in Figure 4 are based on 5,874 valid designated doctor ratings assigned in 2000, 6,081 valid designated doctor ratings assigned in 2001, and 8,705 valid designated doctor ratings assigned in 2002; and 17,307 valid treating doctor ratings assigned in 2000; 20,902 valid treating doctor ratings assigned in 2001, and 9,646 valid treating doctor ratings assigned in 2002.

lected doctors), insurance carrier doctors conducted approximately 11 percent of the total number of designated doctor evaluations. However, in 2002, these doctors accounted for 22 percent of the designated doctor exams performed under the new IR process.[15] A more detailed analysis of changes in impairment ratings over the 2000 to 2002 period will be the focus of a future *Texas Monitor* article.

Impairment Rating and MMI-Related Disputes

This section of the article reports on any changes (over the 2000 to 2002 periods) in the propensity of insurance carriers and injured workers to request a Benefit Review Conference (BRC)[16] or a Contested Case Hearing (CCH)[17] to resolve a dispute involving one of the following issues:

- Impairment rating (assigned by a treating doctor or carrier-selected doctor);
- Date of MMI (assigned by a treating doctor or carrier-selected doctor);
- Designated doctor's impairment rating; and
- Designated doctor's MMI date.

Calendar year 2000 disputes include all requests for BRCs and CCHs with dates between March 1, 2000 and June 30, 2000. Calendar year 2001 disputes include all requests for BRCs and CCHs with dates between March 1, 2001 and June 30, 2001. These two periods represent disputes made under the previous IR process, which was in effect prior to January 1, 2002. Calendar year 2002 disputes include all requests for BRCs and CCHs with dates between March 1, 2002 and June 30, 2002. This third period represents disputes occurring under the new IR process provided for in HB 2600.

General MMI and IR Disputes

General IR and MMI-date disputes at the BRC level (i.e., those *not related* to a designated doctor's evaluation) account for a very small proportion of all disputes in the Texas workers' compensation system. However, they have been more than cut in half under the revised IR process under HB 2600. In 2000 and 2001, general IR disputes accounted for 1.1 percent of all disputes filed, compared to just to 0.4 percent in 2002. Similarly, in 2000 and 2001, general disputes regarding MMI dates also accounted for 1.1 percent of all disputes filed. In 2002, the number of BRCs requested to resolve general IR disputes dropped to 0.4 percent.

When disputes are not resolved at the BRC level, the dispute can be brought to a more formal proceeding called a CCH. As a proportion of all CCHs requested, general MMI and IR disputes also declined in 2002.[18]

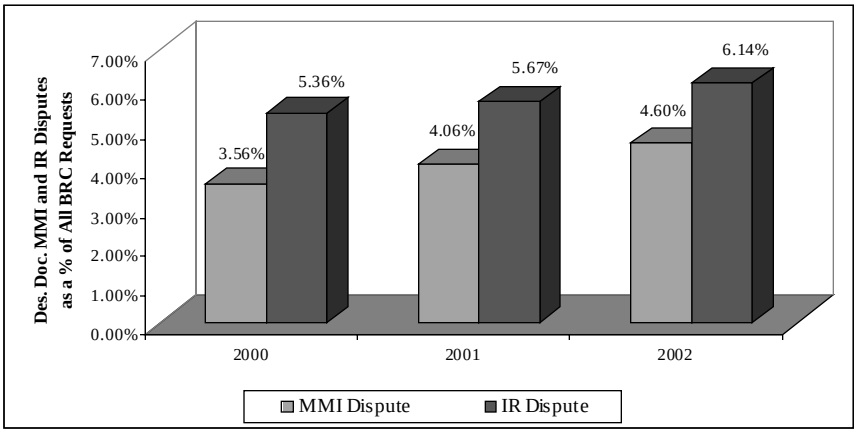
Designated Doctor MMI and IR Disputes

As Figure 5 shows, even though the number of designated doctor exams increased significantly in 2002 under the revised IR process, the proportion of designated doctor MMI and IR disputes at the BRC level have remained fairly stable when compared to 2000 and 2001.

In terms of absolute numbers, the total number of MMI and IR disputes (general and designated doctor-related disputes) filed at the BRC level has remained relatively stable over the 2000 to 2002 period: 2002 MMI/IR-related dispute requests were down just 3 percent from 2000 and approximately the same as 2001.[19] Meanwhile CCH disputes related to general or designated doctor MMI or IR issues were 8 percent lower in 2002 when compared to 2000, and 12 percent lower in 2002, when compared to 2001.[20] If this trend in fewer MMI/IR disputes under the new IR process continues, significant savings in administrative costs, borne by TWCC and the parties involved in the disputes, could be realized.

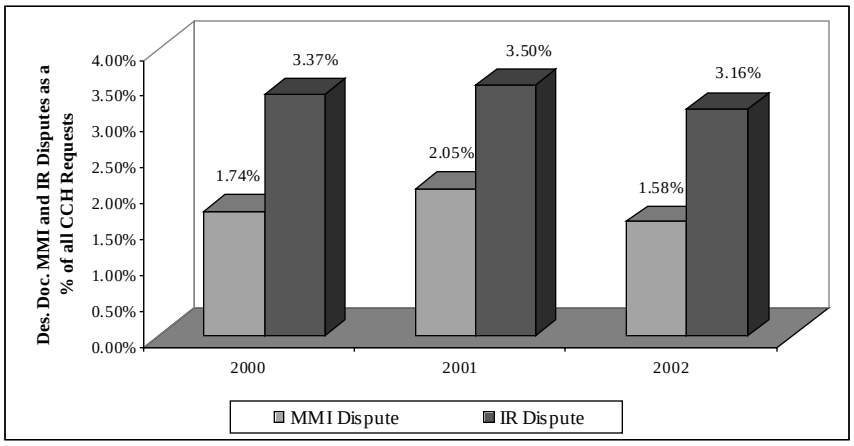
Under the new IR process, disputes over a designated doctor's MMI date and IR have declined slightly as a percentage of all disputes filed at the CCH level (see Figure 6). In addition to the change in the IR process, the repeal of the "90-Day Rule" in 2002, which eliminated the finality of initial IRs, may have had an impact on dispute rates in the workers' compensation system.

Figure 5
Designated Doctor MMI and Impairment Rating Disputes
As a Percentage of All BRC Requests: 2000 – 2002



Source: Research and Oversight Council on Workers' Compensation, 2003, and the Texas Workers' Compensation Commission, Dispute Resolution Information System, 2003.

Figure 6
Designated Doctor MMI and Impairment Rating Disputes
As a Percentage of All CCH Requests: 2000 – 2002



Source: Research and Oversight Council on Workers' Compensation, and the Texas Workers' Compensation Commission, Dispute Resolution Information System, 2003.

Conclusion

It is clear from the findings presented in this early analysis that recent changes in the IR process, the switch from the 3rd edition to the 4th edition of the *AMA Guides*, and the change in the manner in which designated doctors are selected, among other factors, have had a profound impact on a variety of system outcomes.

These system changes have resulted in fewer MMI/IR related medical exams per claim, and a different mix of MMI/IR related exams (i.e., more designated doctor exams, fewer treating doctor exams, near elimination of exams by carrier-selected doctors), with a minimal impact on the number

of disputes filed to resolve MMI and IR issues through TWCC's dispute resolution process.

It appears as though the change to the 4th edition of the *AMA Guides*, among other system changes, has resulted in higher overall impairment ratings assigned to injured workers. IRs assigned by treating doctors rose dramatically in 2002, while ratings by designated doctors dropped in 2002. Both the increase in treating doctor ratings and decline in designated doctor ratings hold across most injury types, including the most commonly rated injury — soft tissue ailments.

After the new IR process has had more time to mature, a more thorough evaluation of its impact on the Texas workers' compensation system can be conducted. Key measures reported in this article will continue to be tracked and subsequent analyses will include an evaluation of the impact on the duration of temporary disability (i.e., TIBs payments), time to first MMI/IR exam, and other issues that could not be addressed in this early analysis. A full report is due to the Texas Legislature on December 31, 2004.

Notes to pages 1-9

[1] See Texas *Labor Code*, Section 408.123.

[2] A "designated doctor" is a health care professional assigned by TWCC to resolve a dispute over an impairment rating. A designated doctor's decision carries presumptive weight over other decisions. See Texas *Labor Code,* Section 408.0041.

[3] If the carrier disagrees with the designated doctor's evaluation of MMI or degree of permanent impairment, it may still request an examination by a doctor of its choice; however, the designated doctor's evaluation is given presumptive weight in the TWCC dispute resolution process.

[4] See Texas Workers' Compensation Commission, *Advisory 2002-04,* "Status of the Fulton Decision."

[5] It should be noted that, while the *Fulton* decision was issued by the 3rd Court of Appeals on April 12, 2001, TWCC did not repeal Rule 130.5(e) until January 2, 2002 and did not issue an advisory on the Fulton decision and the repeal of the related rule until March 4, 2002. This delayed action by TWCC is likely to have an impact on how insurance carriers and other system participants may have reacted to the April 2001 decision by the 3rd Court of Appeals.

[6] As discussed in the methodology, all references to 2000, 2001 and 2002 refer to claims in which the first MMI/IR exam occurred between March 1 and June 30, and tracked all subsequent activity for the claim for 180 days beyond the first exam.

[7] See Texas Workers' Compensation Commission, *Texas Workers' Compensation System Data Report*, data as of June 30, 2002.

[8] This calculation is based on the average number of claims with impairment rating exams over the 1997 to 2000 period (58,373 claims) times the reduction in the average number of impairment rating exams per claim over the 2001 (prior IR process) to 2002 (revised IR process) period (-.0908 exams per claim) times the estimated cost per impairment rating exam ($350). IR exams are paid for my insurance carriers, and therefore through the employer's workers' compensation premiums.

[9] TWCC estimates that the change in the IR process under HB 2600 has resulted in an annual increase in costs of approximately $106,196 associated with processing more designated doctor requests, and in the implementation of the matrix to assign the appropriate kind of designated doctor to the claim.

[10] This is largely because under the pre-HB 2600 MMI/IR process, a designated doctor exam could not occur until a carrier-selected doctor had conducted an exam.

[11] It is interesting to note that in 2002, instances in which an exam by a carrier-selected doctor accounted for just two-tenths of 1 percent of all 2002 claims involving MMI/IR exams. This percentage was even lower for 2000 and 2001.

[12] It is important to note that this discussion includes the last IR assigned to a claim during the periods of analysis (i.e., 180 days from the first MMI/IR exam conducted) and may not necessarily represent the final rating upon which the injured worker's benefits were paid. However, since most claims here are single-rating claims and 180 days were allowed to capture any subsequent exams, it is likely that the rating included in this analysis represents the final IR for the vast majority of the instances.

[13] The International Classification of Diseases, Ninth Revision (ICD-9), published by the National Center for Health Statistics, is the coding system used to ensure comparability of health data.

[14] Only ratings by designated doctors and treating doctors are included in this analysis due to the small number of carrier-assigned doctor ratings and the great disparity in ratings assigned by carrier selected doctors between the pre- and post-HB 2600 periods. The new MMI/IR process reduced the number of impairment rating exams by carrier-selected doctors nearly to zero, so comparisons to the 2000 and 2001 periods were not feasible.

[15] It should be noted that the change in the manner in which designated doctors are selected (i.e., by training and experience as opposed to licensure) may have resulted in a higher proportion of designated doctor exams being conducted by medical doctors and fewer by chiropractors. This, in turn, may have resulted in an increase in the number of "insurance doctors' conducting designated doctor

exams in 2002, and on the average ratings assigned by designated doctors.

[16] The Benefit Review Conference (BRC) provides an opportunity to resolve disputes through mediation. During the benefit review conference, each person will discuss his or her side of the dispute. A TWCC employee called a Benefit Review Officer facilitates the discussion. Any party can appeal a Benefit Review Officer's recommendation to a Contested Case Hearing (CCH).

[17] The contested case hearing is similar in some ways to a hearing in a court of law. A Commission employee called a hearing officer will preside at the hearing. The hearing officer will examine the evidence and testimony and will issue a decision on the dispute. During the contested case hearing, each side will present its side of the dispute and may question witnesses and introduce evidence to support its case. Usually, only the disputed issues that were discussed at the benefit review conference are discussed at the contested case hearing.

[18] The number of general MMI disputes at the CCH level dropped (as a percentage of all disputes) from 1.1 percent in 2000 and 2001 to 0.45 percent in 2002. Likewise, general IR disputes dropped (as a proportion of all disputes) from 1.1 percent in 2000 and 2001.

[19] The figures that follow consider the three comparable 4-month time periods in 2000, 2001, and 2002. In 2000, there were 191 general MMI disputes, 188 general IR disputes, 616 designated doctor MMI disputes, and 928 designated doctor IR disputes. In 2001, there were 189 general MMI disputes, 185 general IR disputes, 671 designated doctor MMI disputes, and 936 designated doctor IR disputes. In 2002, there were 74 general MMI disputes and 72 general IR disputes, compared to 759 designated doctor MMI disputes and 1,013 designated doctor IR disputes. All of these figures reflect dispute activity at the BRC level.

[20] For the comparable 2000, 2001, and 2002 periods, there were 318 total MMI or IR disputes at the CCH level in 2000, 332 in 2001, and 292 in 2002.

New Chair, Members Appointed to ROC Board

State Representative Helen Giddings has been appointed Chair of the Board of Directors of the Research and Oversight Council on Workers' Compensation (ROC) by Texas Speaker of the House, Tom Craddick. Rep. Giddings replaces outgoing Chair Representative Scott Hochberg. Representatives Lois W. Kolkhorst, and Representative Gary Elkins have also been appointed to the Board of Directors. The appointments take effect immediately.

Representative Giddings represents parts of Dallas County. A graduate of the University of Texas at Arlington, she serves as the Chair of the Business and Industry Committee, and serves on the Higher Education, and House Administration Committee. Representative Giddings was born and raised in North Texas, and owns a beverage and concession business.

Representative Elkins represents parts of Harris County. A native of Houston, he serves as the Vice-Chair for the Business and Industry Committee, and serves on the House Administration and State Affairs Committee. Representative Elkins graduated from Southwestern Assemblies of God University, and is owner and president of Personal Credit Corporation, a small Texas business.

Representative Kolkhorst represents parts of Austin, Grimes, Walker and Washington Counties. A graduate of Texas Christian University, she serves on the Business and Industry, Appropriations, and Local & Consent Calendars Committees. Representative Kolkhorst is a Brenham native, and a business owner.

The ROC is governed by a nine-member board of directors consisting of three state senators, three state representatives, two commissioners from the Texas Workers' Compensation Commission (one representing employers and one representing employees), and the Texas Insurance Commissioner (or person designated by the commissioner). Board leadership changes every two years.

Recent Additions to ROC Staff

The ROC is pleased to welcome Rachel Zardiackas and Andrew Moellmer to its staff. Rachel is a new information specialist/librarian, and joins us from Prosofttraining.com, where she worked to manage the Certified Internet Webmaster (CIW) certification program. Rachel has a Masters degree in Library and Information Science from UT Austin.

Andrew, a new oversight associate, joins the ROC from the private sector, where he worked as an associate economist for Welch Consulting in Santa Monica, CA. He holds an MA degree in political science from Tulane University.

Impact of Initial Changes to the Medical Dispute Resolution Process by HB 2600 (77th Legislature)

by D.C. Campbell and Dana Baroni

The Texas Workers' Compensation Act entitles injured employees to all reasonable and necessary medical care to treat a compensable injury. Sometimes disagreements arise between parties in the system over whether care provided (or proposed to be provided) to injured employees is reasonable and necessary. It has long been a goal of the workers' compensation system to resolve disputes over medical benefits as quickly and expertly as possible, while minimizing costly and lengthy litigation.[1]

A relatively small percentage of medical services in the Texas workers' compensation system are disputed each year. A 1999 study by the Research and Oversight Council on Workers' Compensation (ROC) found that less than 1 percent of the medical services provided to injured workers from 1996 to 1998 resulted in disputes being filed by system participants with the Texas Workers' Compensation Commission (TWCC).[2] However, medical disputes still constitute a significant and growing administrative burden for the system.[3] For example, the 1999 study also showed that the number of medical disputes more than doubled between 1993 and 1998, from approximately 1,200 to nearly 2,800.

As the number of disputes increased, so did dissatisfaction among system participants in the medical dispute resolution process.[4]

- Health care providers' claimed that they were faced with a cost-prohibitive administrative burden when considering a medical dispute;
- Health care providers' perceived that the dispute process was biased in favor of insurance carriers;
- Health care providers' perceived that insurance adjusters (without medical expertise) were making medical decisions in the denial process;
- Health care providers' alleged that insurance carriers frequently denied payment of bills without adequate supporting documentation;
- Insurance carriers' and health care providers' perceived that there was a lack of medical expertise among TWCC staff involved in the medical dispute resolution process;
- Two-thirds of surveyed insurance carriers and health care providers perceived that the time required to resolve medical disputes was too long; and
- The overwhelming majority (90 percent) of surveyed insurance carriers and health care providers held the expectation that all medical disputes should be resolved within three months.[5]

Stakeholder concerns about these and other medical management issues in the workers' compensation system led to the passage of House Bill (HB) 2600 in the 77th Texas Legislature in 2001. Article 6 of HB 2600 made changes to the structure of the medical dispute resolution process by requiring that all workers' compensation medical necessity disputes (both prospective and retrospective) be handled externally by Independent Review Organizations (IROs), instead of by TWCC staff.

An IRO is a certified or licensed professional organization that enlists the services of medical professionals to resolve disputes regarding the appropriateness of medical care rendered to patients. Since the Texas Legislature approved IROs in 1997, Health Maintenance Organization (HMOs) have utilized IROs to render more timely and independent resolution of medical disputes.

Under HB 2600, IROs in workers' compensation resolve

prospective medical necessity disputes (i.e., those based on insurance carriers' denials of the reasonableness or necessity of medical services requiring preauthorization *before* the treatment or service is provided), and *retrospective* medical necessity disputes (i.e., those involving insurance carriers' denials of reasonableness or necessity *after* a treatment or service has been provided).[6] Together, prospective and retrospective medical necessity disputes account for approximately 60 percent of all medical disputes.[7]

Meanwhile, TWCC will continue to process and review fee disputes. Fee disputes – involving the pricing or coding of medical services and other billing issues not directly related to the medical necessity of individual services – account for the remaining 40 percent of all medical disputes.[8] The frequency and outcomes of fee disputes will be addressed in a future ROC report.

Purpose of this Study

The primary objectives of this study are to:

- Describe the new IRO-based Medical Dispute Resolution process under HB 2600; and
- Compare the frequency, durations, and outcomes of medical disputes under the pre-HB 2600 process and during the first six months of the new IRO system.

Description of the Medical Dispute Resolution Process – Post-HB 2600

A medical dispute – whether prospective or retrospective – is initiated by a denial on the part of the insurance carrier. Under HB 2600, prior to filing a medical dispute, the requestor (typically a health care provider, sometimes an injured worker)[9] must first request that the insurance carrier reconsider the denial.[10] If the insurance carrier denies the request for reconsideration, the requestor may ask for an IRO review within 45 calendar days from the date the reconsideration denial is received for a preauthorization request, or within one year from the date the service was delivered in the case of retrospective denial. An insurance carrier's failure to respond to a request for reconsideration within the required timeframes also allows a provider or injured worker access to the IRO process.[11]

Table 1 shows key elements of the pre- and post-HB 2600 medical dispute resolution process.

Non-prevailing parties can appeal after the dispute decision by filing, within 20 days, a written request to TWCC for a hearing before the State Office of Administrative Hearings (SOAH).[12] All appeals are conducted at SOAH, except those involving spinal surgery preauthorization denials, which are considered in a TWCC con-

Table 1
Primary Steps in the Medical Dispute Resolution Process
Pre-HB 2600 and Post HB 2600

	Pre-HB 2600 Before January 1, 2002	Post-HB 2600 After January 1, 2002
Step 1 **Doctor Requests Reconsideration of Denied or Reduced Bill**		
Step 2 **Request for Medical Dispute Resolution After Request for Reconsideration is Denied**	**Form TWCC-60** Submitted by requestor to TWCC. Respondent had 30 days to file a response to TWCC.	**Form TWCC-60** Submitted by requestor to TWCC. Respondent has 7 days to file a response with TWCC for prospective and 14 days for retrospective medical necessity disputes.
Step 3 **Paper Review of Medical Dispute**	TWCC Staff Fee: $41 per hour of TWCC staff time by non-compliant party, only if a party was found to be non-compliant. If non-compliance not found, neither party paid a fee. Resolution Timeframe: None	IRO Doctor Fee: $650 for MD, DO; $460 for other specialties, pre-paid by requestor to IRO for retrospective denials and pre-paid by carrier for prospective denials Resolution Timeframe: 20 days for Preauthorization disputes; 30 days for Retrospective medical necessity disputes
Step 4 **First Appeal**	Decision appeals went to TWCC's Informal Resolution Conference (IRC)	Decision appeals go to State Office of Administrative Hearings (SOAH)
Step 5 **Second Appeal**	Unresolved IRC appeals went to SOAH	SOAH decision appeals go to District Court

Source: Texas Workers' Compensation Commission Rules 133.305, 133.307, and 133.308.

tested case hearing (CCH). Further, HB 2600 requires TWCC to post all IRO and SOAH decisions on TWCC's website, and clarifies that medical disputes can be appealed to district court, a longstanding issue of disagreement between TWCC and insurance carriers.

Comparison of the Frequency of Medical Disputes, Pre- and Post-HB 2600 (1997-2002)

The IRO process designed to handle medical necessity disputes went into effect in January 2002, and the data analyzed in this study represent a snapshot of the first six months of this new process. While this early data may provide limited conclusions, the ROC plans to reexamine medical dispute trends in 2004-2005 as part of an agency-wide review of TWCC.[13]

In the years prior to HB 2600 (from 1997 to 2001), TWCC considered and processed a total of approximately 11,500 prospective and retrospective medical necessity disputes. This included 5,500 prospective (preauthorization) and 5,900 retrospective medical necessity disputes. Both types of disputes increased dramatically during the first part of this time period. A 1999 study by the ROC suggested that the overall rise may have been a response to significant reductions in the time it took TWCC to resolve disputes.[14]

Preauthorization disputes fell sharply in 2001, while retrospective disputes continued to experience significant increases (from approximately 1,600 in 2000 to more than 3,100 in 2001). It is unclear why preauthorization disputes declined in 2001, but two factors may have contributed to the recent surge in the number of retrospective medical necessity disputes: requestor anticipation that system changes from HB 2600 might reduce their future chances to prevail in disputes, and the fact that the HB 2600 medical dispute processes would require the non-prevailing party in a retrospective dispute to pay the cost of the dispute. The ROC plans to reexamine these recent dispute trends in FY 2004-2005.

Table 2 shows the number of disputes assigned to the three IROs certified for the first six months of the new IRO process and the closure rates of the dispute types.[15] The total monthly assignments grew from 58 disputes in January 2002 to 170 in June 2002. As of the end of the period under analysis (June 2002), a total of 803 disputes had been assigned to IROs, and 496 had been decided.

During the first six months of the HB 2600-mandated medical dispute processes in 2002 (January to June), IROs processed and closed 292 prospective and 204 retrospective medical necessity disputes, at an average of approximately 80 disputes per month (see Table 3). In comparison, during the first six months in 2001, TWCC processed and closed 417 prospective and 1751 and retrospective medical necessity disputes, at an average of approximately 360 per month.

Table 2
Total Number of Assignments and Decisions for Prospective and Retrospective Medical Necessity Disputes, January – June 2002 (New Process)

Month	Prospective (Preauthorization) Disputes			Retrospective Medical Necessity Disputes		
	Disputes Assigned	IRO Decisions	Percent Closed	Disputes Assigned	IRO Decisions	Percent Closed
January	23	20	87 %	35	21	60 %
February	30	25	83 %	86	44	51 %
March	73	60	82 %	78	38	49 %
April	65	46	71 %	57	33	58 %
May	114	86	75 %	72	34	47 %
June	92	55	60 %	78	34	44 %
Totals	**397**	**292**	**74 %**	**406**	**204**	**50 %**

Source: Texas Workers' Compensation Commission's Independent Review Organization Dispute Database and Research and Oversight Council on Workers' Compensation, 2002.

Table 3
Total Number of TWCC Disputes Pre-HB 2600
Preauthorization and Retrospective Medical Necessity Disputes
1997 to 2001

Month Disputes Received	Preauthorization Disputes		Retrospective Disputes	
	TWCC 2001	IRO 2002	TWCC 2001	IRO 2002
January	115	20	284	21
February	51	25	303	44
March	52	60	319	38
April	65	46	305	33
May	64	86	347	34
June	70	55	193	34
Totals	**417**	**292**	**1751**	**204**

Source: Texas Workers' Compensation Commission's Medical Dispute Resolution Information System (MDRIS), 2002.

The lower numbers for IROs may simply reflect a "startup" period for the new process. Looking beyond the six-month period covered in this analysis, in July 2002 the IROs were up to 200 medical necessity disputes closed for the month. By November 2002, the number of certified IROs doubled from three to six, and it thus appears that the new process has achieved the capacity necessary to manage the pre-HB 2600 levels of requests for retrospective and prospective medical necessity disputes.

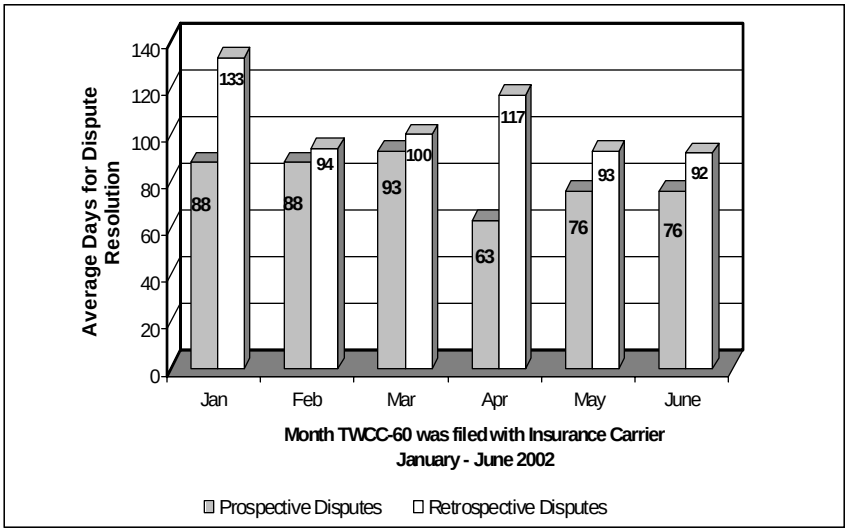
Comparison of the Duration of Medical Disputes, Pre- and Post-HB 2600

A key measure of how well the new medical dispute resolution process is working is the number of days that elapse between the date a dispute request is submitted to TWCC and the date a decision is rendered by the IRO. This measure reflects all aspects of the process – the time it takes TWCC to assign the case to the IRO, the time it takes the IRO to receive the required documentation and fee, and the time it takes the IRO to analyze the information and render a decision on the dispute.

Figure 1 illustrates that progress has been made in total dispute resolution processing time for retrospective disputes. The average processing time was 133 days for disputes submitted in January 2002 compared to 92 days for disputes submitted in June 2002, an almost thirty percent drop. This compares favorably to TWCC's dispute processing duration of 141 days under the old process in 2001. The dispute resolution duration for preauthorization has experienced moderate improvements, falling from 88 days in January to 76 days in June, significantly higher than TWCC's duration of 40 days in 2001.

A key measure for the new IRO process is the amount of

Figure 1
Average Duration from Submission of TWCC-60
to Date of IRO Decision



Source: Texas Workers' Compensation Commission's Independent Review Organization Dispute Database and Research and Oversight Council on Workers' Compensation, 2002.

time it takes TWCC to process incoming TWCC-60s and to assign the disputes to the proper dispute track. TWCC's processing time includes categorizing and assigning medical necessity and preauthorization disputes to IROs, and in assigning fee disputes to TWCC staff.

TWCC's average processing time for IRO disputes experienced measurable improvements during the first six months of the new process. The average processing time for retrospective medical necessity disputes fell from 66 days for January disputes to 42 days for June disputes, while the average processing time for prospective medical necessity disputes fell from 40 days for January disputes to 22 days for June disputes. It may be possible to further reduce this processing time as TWCC's staff adjust to the new process and internal procedures are fine-tuned.

Another important component of the duration is the time it takes the IRO to review a dispute, which begins once it receives payment and ends with a decision. The IROs averaged 32 days to resolve a retrospective medical necessity dispute (two more days than the mandated 30 days under HB 2600) and 42 days to review preauthorization disputes (22 more days than the 20 days mandated by HB 2600).

Comparison of Medical Dispute Outcomes, Pre- and Post HB-2600

The prevailing party in a medical dispute is typically either an insurance carrier or a health care provider.[16] Therefore, for the purpose of this study, medical dispute outcomes will be measured by the "prevailing ratio" (i.e., the percentage of disputes in which insurance carriers prevail versus the percentage of disputes in which health care providers prevail).

Table 4 illustrates the prevailing ratios at TWCC for preauthorization and retrospective medical necessity disputes between insurance carriers and health care providers from 1997 to 2001, as compared to IRO decisions from January to June 2002. Of note is the fact that insurance carriers are prevailing more often under the IRO system than under the previous TWCC administrative dispute process.

IRO decision ratios (January to June 2002) suggest a slight increase in the prevailing ratio for insurance carriers in preauthorization disputes, from 60 percent to 65 percent. How-

Table 4
Prevailing Ratios, 1997 to 2002
TWCC Medical Dispute Resolution Process and IRO Process

Year	Prospective (Preauth.) Disputes Prevailing Ratios		Retrospective Disputes Prevailing Ratios	
	Insurance Carriers	Health Care Providers	Insurance Carriers	Health Care Providers
1997 (TWCC)	62%	38%	43%	57%
1998 (TWCC)	61%	39%	40%	60%
1999 (TWCC)	67%	33%	29%	71%
2000 (TWCC)	64%	36%	23%	77%
2001 (TWCC)	43%	57%	39%	61%
1997-2001 Average*	**60%**	**40%**	**34%**	**66%**
2002 ** (IRO)	**65%**	**35%**	**66%**	**34%**

Source: Texas Workers' Compensation Commission's Independent Review Organization Dispute Database and MDRIS Database and the Research and Oversight Council on Workers' Compensation, 2002.

Note: Prevailing ratios for preauthorization disputes experienced a significant shift in 2001, counter to the pattern established from 1997 to 2000. A possible explanation is carrier reaction to a 2000 ROC report, which noted that insurance carriers and their utilization review agents could be more active in challening preauthorization requests (see *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*, pages 77-79).

* Medical Dispute Resolution (MDR) decisions at TWCC, 1997 – 2001.

** IRO decisions rendered from January to June 2002.

ever, the prevailing ratio for retrospective medical necessity disputes experienced a reversal under the IRO process. While health care providers prevailed in an average of 66 percent of the retrospective medical necessity disputes at TWCC over the five-year period, they prevailed in 34 percent of the IRO decisions, with insurance carriers now prevailing in 66 percent of those disputes.

This prevailing ratio under the IRO process shows some major shifts in the decision patterns as compared to the decision patterns from earlier years under the pre-HB 2600 process. The shift may be explained in part by a switch from TWCC staff-determined decisions to doctor-determined decisions. The shift may also be a function of the mix of disputes and the corresponding merits of those disputes filed before and after the HB 2600 changes. However, it is too early in the new process to draw firm conclusions about the apparent shift. ROC will re-examine these trends in FY 2004-2005 when more data are available.

Conclusion

HB 2600 modified the medical dispute resolution process at TWCC in an effort to address system participants' concerns, including the lack of medical expertise in the former process and the length of time to resolve disputes.

Under HB 2600, medical doctors in Independent Review Organizations (IROs) now review all medical necessity disputes, which include both prospective (preauthorization) and retrospective disputes. Fee disputes are still handled by TWCC.

A six-month "snapshot" review shows that fewer medical necessity disputes have been filed under the new process, though it is too early to tell whether this trend will continue. The certification of additional IROs since the six month review suggests that the new process will have the capacity to handle the volume of disputes even as it increases.

Duration times to dispute resolution under the new IRO process showed marked improvement over the six month review period for both preauthorization and retrospective disputes. However, durations are still significantly longer than the statutory requirements. Furthermore, while retrospective disputes are already resolved faster than under the old process, preauthorization disputes are taking longer to resolve under the new IRO process.

A notable change under the new process that warrants continued examination is a shift in the prevailing ratios for retrospective disputes. Formerly, health care providers prevailed more often than insurance carriers (in 60 percent of the cases), but under the new IRO process, carriers are prevailing more often. Carriers also prevailed more often in preauthorization disputes, both under the old process and under the new process. Reasons for the shift in retrospective disputes are unclear; however, continuation of this trend could mean cost savings for the system. Since overutilization of medical care has been a particular problem in the Texas workers' compensation system (and was one of the main issues addressed by HB 2600), early results of the new process suggest that the use of IROs could be an effective tool to control some medical overutilization. Further research is needed to confirm long-term trends and examine related issues. For example, the new fee structure may work as a disincentive for health care providers on low cost disputes. The charge for the IRO review ($650 to $460 depending on the doctor type doing the review) may be cost-prohibitive for some health care providers in cases where the disputed amount is less than the IRO fee.

TWCC continues in its efforts to implement changes to the medical dispute resolution process. This includes the posting of IRO dispute resolution results on its website, to meet statutory requirements, an important educational tool for system participants.

The IRO process appears to be making progress in addressing the major concerns of system participants. More comprehensive research is planned by ROC in the future as more data are available.

Notes to pages 11-16

[1] Medical disputes fall into three categories: 1. Disputes over the medical necessity of services that have been provided (i.e., a "retrospective" dispute); 2. Disputes over the medical necessity of ser-

vices requiring preauthorization before treatment is rendered (i.e., a "prospective" dispute); and 3. Disputes over fees charged for medical services.

[2] See Research and Oversight Council on Workers' Compensation, *An Examination of the Medical Dispute Resolution Process in Texas (1999).*

[3] See Research and Oversight Council on Workers' Compensation, *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Workers' Compensation System* (2002)

[4] Many of these concerns have been identified in previous studies by the ROC: see Research and Oversight Council on Workers' Compensation, *Experiences of Doctors Who Practice in the Texas Workers' Compensation System* (1998); and *Survey of Texas Doctors Who Participate in the Workers' Compensation System* (1996).

[5] See Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System* (1998).

[6] A complete list of services requiring preauthorization from insurance carriers, most recently revised in November 2001, is provided in TWCC Rule 134.600. Generally, medical services that are not on the preauthorization list are subject to retrospective review by the insurance carrier.

[7] Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System (MDRIS), 2002 and the Research and Oversight Council on Workers' Compensation.

[8] It should be noted that Article 6 of HB 2600 also made changes to the resolution of fee disputes by requiring that TWCC staff render a decision in fee disputes rather than simply mediating a resolution between the parties.

[9] Injured workers can file preauthorization disputes and retrospective disputes if the worker paid for these services out of pocket and was denied reimbursement. However, in practice, relatively few injured workers file medical disputes.

[10] TWCC Rule 134.600(g)(1) allows a party 15 working days from the receipt of a written denial to request reconsideration in a case involving a preauthorization or concurrent review denial. There is no specific statutory or rule timeframe for filing a request for reconsideration of a retrospective denial, although a failure to do so within a certain timeframe may limit the requestor's access to dispute resolution.

[11] See TWCC Rule 133.304(m)(2), which allows access to medical dispute resolution if the insurance carrier has not responded to a request for reconsideration by the 28th day after the date the request was sent.

[12] This deadline remained unchanged with the passage of HB 2600.

[13] All Texas state agencies are subject to a periodic review known as "Sunset Review" to ascertain operational effectiveness and continued usefulness to the state. TWCC's Sunset review is scheduled for 2005.

[14] See Research and Oversight Council on Workers' Compensation, *An Examination of the Medical Dispute Resolution Process in Texas (1999).*

[15] A dispute is determined closed on the date the IRO renders a decision. Closed disputes in this study include disputes submitted during the January through June 2002 timeframe, but closed after June.

[16] While injured workers can file preauthorization and some medical necessity disputes, relatively few do. Injured workers prevailed in 141 fee and medical disputes from 1997 to 2001, less than two percent of the 8,334 disputes in which either health care providers prevailed (5,280 disputes) or insurance carriers prevailed (3,074 disputes) over the same period.

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