1999 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1422

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1422

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 1-25-99

Tape Number	Side A	Side B	Meter #
1		x	36.6 - 53.0
2	x		0 - 49.1
Committee Clerk Signature	Lisa Horner		

Minutes:

HB 1422 Relating to workers' Compensation Benefits for Permanent Impairment and the Prohibition Against Assignment of Claims; and to provide and effective Date.

Chairman Berg opened the hearing on the bill.

Mr. Regan Pufall, Counsel for Workers Compensation Bureau, testified in support of the bill. (see attached written testimony)

Rep. Kempenich questioned the fiscal impact on the reserve and how much funding will be required for the bill at a later time.

Pufall said there will be an impact and it will be 7 - 8 million greater but appears necessary to offer coverage for employees. The bureau has improved the reserve by 382 million improvement and it is not a concern at the present.

Rep. Lemieux asked about changes pp. line 6 and wanted it explained.

Pufall explained the language is used because of current law. A listing of qualified doctors is kept for later use.

Rep. Ekstrom asked about 15 % impairment meaning.

Pufall said the difference may depend on ex-rays or other evidence used to determine level of disability.

Rep. Keiser asked for examples of PDI award.

Pufall said a 5% impairment may be 7% impairment later on and the bureau may change the evaluation along with the award.

Mr. Steve Latham, ND Trial Lawyers, testified in opposition to the bill. His group believes that this legislation eliminates workers with serious back injuries. This appears to be a time when injured workers need greater benefits because of good progress made by the bureau programs in the past. There are instances when ND Workers Comp. benefits are not better than other states. There is nothing for chronic pain which is difficult to identify and ask for no changes for chronic pain.

They believe that the bureau can go further to take care of injured workers and is, however, appreciative of the benefits offered.

Rep. Stefonowicz asked about page 9 with a new addition and what it meant.

Pufall said the bureau intended to clarify what attorneys can do for injured workers. But it appears that attorneys are limited as what they can do for their clients.

Ms. Chris Runge, ND Public Employees Association. They are opposed to the bill because of elimination of chronic pain coverage. She went on to say there are specialists that can address this issue and allow for protection for chronic pain.

Mr. Dave Kemnitz, NDAFL-CIO, testified in opposition to the bill. They believe that the attempt to increase benefits and protection is not great enough. Most people in the area of 0 - 50% injures are in need of help.

Berg said this bill was not intended to deal with per cent ages. Berg wanted a clarification on what Kemnitz's position was on the bill.

Kemnitz said his group was involved in early stages of the legislation. A lower per cent of threshold needs to be applied to help injured workers with more common injuries because that is where the need is. The chronic pain threshold should be left in. The one time award is not adequate and should be looked at. The attorney client relationship should be better because of low representation.

Rep. Koppang asked about pain and if it was included in coverage if pain was include early in the injury.

Kemnitz said the issue was argued before and this will eliminate the coverage of chronic pain.

Ms. Shelly Seaburg testified that her husband was hurt in an accident while working. Fingers were amputated and he had various problems from the accident. He was a machinist and the bill that is proposed would compensate him only $600 per finger. Her family suffered greatly from the accident and went into detail how worker injuries would not be covered fairly with this bill.

Berg suggested getting a release from her case so the committee can better understand this issue.

Seaburg ended with adding that this bill eliminates chronic pain for coverage and her husband would not be protected for his pain he is experiencing.

Mr. Sebald Vetter, C.A.R.E., testified in opposition to the bill. It is not right to take away from one area and give to another area.

Mr. Loranine Ketterling, self, testified in opposition to the bill. She has pain and can not work and can not enjoy a decent life style because of her past injuries. She went on to say that everything is denied by the bureau and complained in detail that the bureau is very inefficient.

Mr. Bud Wedwick, I.D.F.S., Minot, testified in opposition to the bill. He agrees with what Ms. Ketterling is saying. He said if people have an injury in lower back, that injury will affect many other parts of the their body and lifestyle. He encouraged to forget about less important items and take care of injured workers.

Chairman Berg closed the hearing on the bill.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HBO 1422

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 2-3-99

Tape Number	Side A	Side B	Meter #
2		x	16.6
Committee Clerk Signature	Lisa Homer		

Minutes:

HBO 1422

Chairman Berg opened the meeting on the bill.

Mr. Dave Thiele, Litigation Counsel, Workers Compensation Bureau, spoke about past testimony and concerns from various people. He discussed the amendment purpose which indicates only 1 injury award. This allows a worker to get a necessary increase in the award. The statute states that an award may not be received solely on pain. Because of this, the language in the bill is being taken out by amendment. 40 % of weekly wage will be used in place of 1/3rd of weekly wage as currently stated. Various statistics on past claims paid were discussed.

Representative Kempenich moved do pass on amendment, Second by Representative Glassheim

By voice vote, all voting yes, 0 no, motion carried.

Moved by Kempenich do pass as amended, Second by Kleine

by roll vote, 15 yes, 0 no, motion carried

Representative Kempenich will carry.

FISCAL NOTE

(Return original and 10 copies)

Resolution No.: _____ Amendment to: Eng. HB 1422

Requested by Legislative Council Date of Request: 4-9-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   See attached.

2. State fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:						

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: _____
   b. For the 1999-2001 biennium: _____
   c. For the 2001-03 biennium: _____

4. County, City, and School District fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

If additional space is needed, attach a supplemental sheet.

Signed J. Patrick Traynor

Typed Name J. Patrick Traynor

Department Workers Compensation Bureau

Date Prepared: 4-9-99

Phone Number 328-3856

NORTH DAKOTA WORKERS COMPENSATION BUREAU
1999 LEGISLATION
SUMMARY OF ACTUARIAL INFORMATION

BILL DESCRIPTION: **Permanent Partial Impairment**

BILL NO: **Engrossed HB 1422**

SUMMARY OF ACTUARIAL INFORMATION: The Workers Compensation Bureau, with the assistance of its Actuary, Glenn Evans of Pacific Actuarial Consultants, has reviewed the legislation proposed in this bill in conformance with Section 54-03-25 of the North Dakota Century Code.

The bill increases the number of weeks awarded for impairments falling between 15% and 27% and requires the Bureau to conduct a study during the 1999-2000 interim of awards provided to injured employees with permanent impairments caused by compensable work injuries and report its findings to an interim legislative committee.

FISCAL IMPACT:

Rate Level Impact: It is anticipated the bill will generate an increase in the rate level for Fiscal Year 1999-2000 of approximately **1.0%** from the level that would otherwise be required.

Reserve Level Impact: It is anticipated the retroactive nature of the bill will increase required reserve levels for injuries occurring prior to the effective date of the law. The actuary's calculations suggest that the increase in discounted reserves could fall in a range between **$5 million and $6 million.**

AMENDMENT: The proposed amendment increases the value of PPI Awards for impairments greater than or equal to 50%; removes the language relating to limitations on multiple awards; and requires the PPI Awards Study to include input from labor, employers, medical providers, and organizations representing those constituencies.

FISCAL IMPACT:

Rate Level Impact: It is anticipated the bill with the proposed amendment will generate an increase in the rate level for Fiscal Year 1999-2000 of approximately **1.5%** from the level that would otherwise be required.

Reserve Level Impact: It is anticipated the retroactive nature of the engrossed bill with the proposed amendment will increase required reserve levels for injuries occurring prior to the effective date of the law. The actuary's calculations suggest that the increase in discounted reserves could fall in a range between **$7 million and $9 million.**

DATE: **4-9-99**

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: _____ Amendment to: HB 1422

Requested by Legislative Council Date of Request: 2-9-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   See attached.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:						

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: _____
   b. For the 1999-2001 biennium: _____
   c. For the 2001-03 biennium: _____

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

If additional space is needed, attach a supplemental sheet.

Signed J. Patrick Traynor

Typed Name J. Patrick Traynor

Date Prepared: 02-09-99

Department Workers Compensation Bureau

Phone Number 328-3856

NORTH DAKOTA WORKERS COMPENSATION BUREAU
1999 LEGISLATION
SUMMARY OF ACTUARIAL INFORMATION

BILL DESCRIPTION: **Permanent Partial Impairment**

BILL NO: **HB 1422**

SUMMARY OF ACTUARIAL INFORMATION: The Workers Compensation Bureau, with the assistance of its Actuary, Glenn Evans of Pacific Actuarial Consultants, has reviewed the legislation proposed in this bill in conformance with Section 54-03-25 of the North Dakota Century Code.

The proposed bill increases awards for all injured workers with qualifying permanent impairments; bases awards on the average weekly wage at the time of evaluation; requires the Bureau to implement an impairment rating system by administrative rule making it possible to use up-to-date evaluation techniques; provides for a single award at the time of overall maximum medical improvement for the impairment caused by the work injury; clarifies the consideration of pain in impairment evaluations; and enhances dispute resolution through independent medical review, preventing unnecessary litigation.

FISCAL IMPACT:

Rate Level Impact: It is anticipated the proposed bill will generate an increase in the rate level for Fiscal Year 1999-00 of approximately **1.5%** from the level that would otherwise be required.

Reserve Level Impact: It is anticipated the retroactive nature of the proposed change will increase required reserve levels for injuries occurring prior to the effective date of the law. The actuary's calculations suggest that the increase in discounted reserves could fall in a range between **$7 million and $8 million.**

AMENDMENT: The proposed amendment restores 33 1/3% as the ratio of the SAWW used to determine the value of one week of permanent partial impairment benefits; clarifies that an injured employee may be entitled to one additional award if the impairment is at least ten percent whole body greater than the initial impairment for which payment was awarded; removes the language clarifying the consideration of pain in impairment evaluations; increases the number of weeks awarded for impairments falling between 15% and 27%; and requires the Bureau to conduct a study during the 1999-2000 interim of awards provided to injured employees with permanent impairments caused by compensable work injuries and report its findings to an interim legislative committee.

FISCAL IMPACT:

Rate Level Impact: It is anticipated the proposed bill with the amendment will generate an increase in the rate level for Fiscal Year 1999-00 of approximately **1.0%** from the level that would otherwise be required.

Reserve Level Impact: It is anticipated the retroactive nature of the proposed change will increase required reserve levels for injuries occurring prior to the effective date of the law. The actuary's calculations suggest that the increase in discounted reserves could fall in a range between **$5 million and $6 million.**

DATE: **2-4-99**

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: HB 1422 Amendment to: _____

Requested by Legislative Council Date of Request: 1-20-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   See attached.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:						

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: _____
   b. For the 1999-2001 biennium: _____
   c. For the 2001-03 biennium: _____

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

If additional space is needed, attach a supplemental sheet.

Signed J. Patrick Traynor

Typed Name J. Patrick Traynor

Date Prepared: 01-22-99

Department Workers Compensation Bureau

Phone Number 328-3856

NORTH DAKOTA WORKERS COMPENSATION BUREAU
1999 LEGISLATION
SUMMARY OF ACTUARIAL INFORMATION

BILL DESCRIPTION: **Permanent Partial Impairment**

BILL NO: **HB 1422**

SUMMARY OF ACTUARIAL INFORMATION: The Workers Compensation Bureau, with the assistance of its Actuary, Glenn Evans of Pacific Actuarial Consultants, has reviewed the legislation proposed in this bill in conformance with Section 54-03-25 of the North Dakota Century Code.

The proposed bill increases awards for all injured workers with qualifying permanent impairments; bases awards on the average weekly wage at the time of evaluation; requires the Bureau to implement an impairment rating system by administrative rule making it possible to use up-to-date evaluation techniques; provides for a single award at the time of overall maximum medical improvement for the impairment caused by the work injury; clarifies the consideration of pain in impairment evaluations; and enhances dispute resolution through independent medical review, preventing unnecessary litigation.

FISCAL IMPACT:

Rate Level Impact: It is anticipated the proposed bill will generate an increase in the rate level for Fiscal Year 1999-00 of approximately **1.5%** from the level that would otherwise be required.

Reserve Level Impact: It is anticipated the retroactive nature of the proposed change will increase required reserve levels for injuries occurring prior to the effective date of the law. The actuary's calculations suggest that the increase in discounted reserves could fall in a range between **$7 million and $8 million.**

DATE: **1-21-99**

90763.01 – 1st draft amendments

PROPOSED AMENDMENTS TO 1999 HOUSE BILL NO. 1422

Page 1, line 1, replace "sections" with "section"

Page 1, line 2, remove "and 65-02-29"

Page 1, line 3, replace "benefits" with "awards", and replace "and the prohibition against assignment of claims" with "; to provide for a study of workers' compensation permanent impairment awards"

Page 2, line 11, remove the overstrike over "~~thirty-three and one-third~~" and remove "forty"

Page 2, line 27, after the period insert "An injured employee is entitled to one additional award but only if a subsequent evaluation establishes that the impairment caused by the compensable injury is at least ten percent whole body greater than the initial impairment for which payment was awarded."

Page 4, line 23, remove the overstrike over "~~An injured employee is not entitled to a~~", remove "A", and remove the overstrike over "~~due solely~~"

Page 4, line 24, remove the overstrike over "~~to~~", remove "may not include a rating for chronic", and remove "syndrome or for pain beyond that pain"

Page 4, remove line 25

Page 4, line 26, remove "that condition"

Page 5, line 12, overstrike "5" and insert immediately thereafter "10"

Page 5, line13, overstrike "5" and insert immediately thereafter "10"

Page 5, line 14, overstrike "10" and insert immediately thereafter "15"

Page 5, line 15, overstrike "10" and insert immediately thereafter "15"

Page 5, line 16, overstrike "15" and insert immediately thereafter "20"

Page 5, line 17, overstrike "15" and insert immediately thereafter "20"

Page 5, line 18, overstrike "20" and insert immediately thereafter "25"

Page 5, line 19, overstrike "20" and insert immediately thereafter "25"

Page 5, line 20, overstrike "20" and insert immediately thereafter "30"

Page 5, line 21, overstrike "25" and insert immediately thereafter "30"

Page 5, line 22, overstrike "30" and insert immediately thereafter "35"

Page 8, line 30, remove the overstrike over "~~A permanent~~"

Page 9, remove the overstrike over lines 1 and 2

Page 9, line 3, replace "**AMENDMENT.** Section 65-05-29 of the North Dakota Century Code is" with:

"**PERMANENT IMPAIRMENT AWARDS STUDY.** During the 1999-2000 interim, the bureau shall study the awards provided to injured employees with permanent impairments caused by compensable work injuries. The study must identify the advantages and disadvantages of the current system and of any proposed alternate system. The study must include recommendations on whether changes are needed and the cost of any proposed changes. Before the 2001 legislative session, the bureau shall report the results of the study to an interim committee identified by the legislative council."

Page 9, remove lines 4 through 28

Page 9, remove line 31

Renumber accordingly

Date: 2-3-99
Roll Call Vote #: _____

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1422

House Industry, Business and Labor Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken do pass as amended

Motion Made By Kempenich Seconded By Klein

Representatives	Yes	No	Representatives	Yes	No
Chair - Berg	✓		Rep. Thorpe	✓	
Vice Chair - Kempenich	✓				
Rep. Brekke	✓				
Rep. Eckstrom	✓				
Rep. Froseth	✓				
Rep. Glassheim	✓				
Rep. Johnson	✓				
Rep. Keiser	✓				
Rep. Klein	✓				
Rep. Koppang	✓				
Rep. Lemieux	✓				
Rep. Martinson	✓				
Rep. Severson	✓				
Rep. Stefonowicz	✓				

Total (Yes) 15 No 0

Absent _____

Floor Assignment Kempenich

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1422: Industry, Business and Labor Committee (Rep. Berg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (15 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1422 was placed on the Sixth order on the calendar.

Page 1, line 1, replace "sections" with "section"

Page 1, line 2, remove "and 65-05-29"

Page 1, line 3, replace "benefits" with "awards" and replace "and the prohibition against assignment of claims" with "; to provide for a study of workers' compensation permanent impairment awards"

Page 2, line 11, remove the overstrike over "~~thirty-three and one-third~~" and remove "forty"

Page 2, line 27, after the period insert "An injured employee is entitled to one additional award if a subsequent evaluation establishes that the impairment caused by the compensable injury is at least ten percent whole body greater than the initial impairment for which payment was awarded."

Page 4, line 23, remove the overstrike over "~~An injured employee is not entitled to a~~", remove "A", and remove the overstrike over "~~due solely~~"

Page 4, line 24, remove the overstrike over "~~to~~", remove "may not include a rating for chronic", and remove "syndrome or for pain beyond that pain"

Page 4, remove line 25

Page 4, line 26, remove "that condition"

Page 5, line 12, overstrike "5" and insert immediately thereafter "10"

Page 5, line 13, overstrike "5" and insert immediately thereafter "10"

Page 5, line 14, overstrike "10" and insert immediately thereafter "15"

Page 5, line 15, overstrike "10" and insert immediately thereafter "15"

Page 5, line 16, overstrike "15" and insert immediately thereafter "20"

Page 5, line 17, overstrike "15" and insert immediately thereafter "20"

Page 5, line 18, overstrike "20" and insert immediately thereafter "25"

Page 5, line 19, overstrike "20" and insert immediately thereafter "25"

Page 5, line 20, overstrike "20" and insert immediately thereafter "30"

Page 5, line 21, overstrike "25" and insert immediately thereafter "30"

Page 5, line 22, overstrike "30" and insert immediately thereafter "35"

Page 8, line 30, remove the overstrike over "~~A permanent~~"

Page 9, remove the overstrike over lines 1 and 2

Page 9, replace lines 3 through 28 with:

"**SECTION 3. PERMANENT IMPAIRMENT AWARDS STUDY.** During the 1999-2000 interim, the bureau shall study the awards provided to injured employees with permanent impairments caused by compensable work injuries. The study must identify the advantages and disadvantages of the current system and of any proposed alternate system. The study must include recommendations on whether changes are needed and the cost of any proposed changes. Before the 2001 legislative session, the bureau shall report the results of the study to an interim committee identified by the legislative council."

Page 9, remove line 31

Renumber accordingly

1999 SENATE INDUSTRY, BUSINESS AND LABOR

HB 1422

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1422

Senate Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date March 2, 1999

Tape Number	Side A	Side B	Meter #
Committee Clerk Signature			

Minutes:

Senator Mutch opened the hearing on HB1422. All senators were present.

Reagan Puffal introduced the bill to the committee. His testimony is included.

Senator Thompson asked Mr. Puffal if there was flexibility for worsening cases. He said that the best example for that is a back injury. Under the current law you receive treatment and you have the healing process of time and so forth. At sometime the physician will decide that you are at maximum medical improvement. At that point, if you have a permanent impairment of 16% or more, you can get an award. In most states that is the only payment that they will ever receive. In North Dakota, if the impairment gets worse, as most will in time, the individual can keep coming back and receiving more awards with no numerical limit in it at all. Mr. Puffal said that this bill, as it is currently structured to do, would say that at maximum medical improvement you

will get your award and that will be the only award, unless your impairment percentage gets at least 10% worse. This will take care of the people who really do need a supplemental award.

Senator Heitkamp asked him if other states try to put a years reserve away. Mr. Puffal said that it is the current policy to do so. However, the policies can very from state to state.

Senator Krebsbach asked Mr. Puffal what the percentage of cost of administration on the bureau. He told her that they spend about 12% of their premium income in administrative overhead.

Senator Klein asked Mr. Puffal what the bureau paid last year in lost wage benefits to employees. He said that he would have to get back to him on the figure.

Senator Klein asked him if this bill would increase the liability. Mr. Puffal said that they will increase the amount that they spend on permanent impairment awards and the increase will be enough that it wil have a 1% upward impact on rates into the future. He said that about 64% of employees that receive permanent impairment awards will see a benefit increase with this legislation.

Terry Crow testified on HB1422. He said that they are not totally in favor of this bill.

Chris Runge, Executive Director of the North Dakota Public Employees Association and Secretary/ Treasurer of the North Dakota AFL CIO, testified in opposition to HB1422. Her testimony is included.

Steve Lathum, North Dakota Trial Lawyers Association, testified in a neutral position. He said that they understand that the raising of impairment benefits for the injured worker is a political

decision and it will be a decision that this body is going to have to make. He said that if 1422 is the best that this body can do then they will support that.

Serald Vetter, CARE, testified in opposition to HB1422.

Senator Mutch closed the hearing on HB1422.

Senator Thompson introduced some amendments to the committee. Senator Heitkamp motioned that the committee adopt the amendments. Senator Thompson seconded his motion. The motion was unsuccessful with a 3-4-0 vote.

Senator Sand motioned for a do pass committee recommendation on HB1422. Senator Krebsbach seconded his motion. The motion was successful with a 5-2-0 vote.

Senator Krebsbach will second the motion.

90763.0201
Title.

Prepared by the Legislative Council staff for
Senator Thompson
March 3, 1999

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1422

Page 2, line 24, remove the overstrike over "~~compensation for~~" and remove "a single"

Page 2, line 25, remove "award", remove "and", and remove the overstrike over "~~that~~"

Page 2, line 26, remove "at the time of the impairment evaluation which"

Page 2, line 27, remove "An injured employee is entitled to one"

Page 2, remove lines 28 and 29

Page 2, line 30, remove "the initial impairment for which payment was awarded."

Page 3, line 1, remove ", even if these conditions were"

Page 3, line 2, remove ", and regardless of whether section 65-05-15 applies to"

Page 3, line 3, remove "the claim"

Renumber accordingly

Date: 3/16
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB

Senate INDUSTRY, BUSINESS AND LABOR COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken AMEND (THOMPSON)

Motion Made By HEITKAMP Seconded By THOMPSON

Senators	Yes	No	Senators	Yes	No
Senator Mutch		X			
Senator Sand		X			
Senator Krebsbach		X			
Senator Klein		X			
Senator Mathern	X				
Senator Heitkamp	X				
Senator Thompson	X				

Total (Yes) 3 No 4

Absent 0

Floor Assignment _____

SR3/5557

Date: 3/16
Roll Call Vote #: 2

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HOUSE HB2

Senate INDUSTRY, BUSINESS AND LABOR COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Sand Seconded By ~~Second~~ Krebsbach

Senators	Yes	No	Senators	Yes	No
Senator Mutch	X				
Senator Sand	X				
Senator Krebsbach	X				
Senator Klein	X				
Senator Mathern	X				
Senator Heitkamp		X			
Senator Thompson		X			

Total (Yes) 5 No 2

Absent 0

Floor Assignment ~~Krebsbach~~

REPORT OF STANDING COMMITTEE (410)
March 25, 1999 9:10 a.m.

Module No: SR-54-5557
Carrier: Krebsbach
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1422, as engrossed: Industry, Business and Labor Committee (Sen. Mutch, Chairman) recommends **DO PASS** (5 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1422 was placed on the Fourteenth order on the calendar.

1999 TESTIMONY

HB 1422

House Bill No. 1422

Fifty-sixth Legislative Assembly
Before the House Industry, Business, and Labor Committee
January 25, 1999
Testimony of Reagan Pufall
Regarding Permanent Impairment Awards

Mr. Chairman, Members of the Committee:

My name is Reagan Pufall. I am the Chief Operating Officer and General Counsel for the Workers Compensation Bureau and I am here to testify in support of 1999 House Bill No. 1422.

1. BACKGROUND

A. Other Benefits

The workers compensation system provides a number of benefits in addition to permanent partial impairment (PPI) awards. These include:

1. Medical benefits – Payment for medical treatment of work injuries with no deductible, no co-pays, and no maximum cap on total costs.
2. Wage-loss (disability) benefits – Tax free benefits equal to two thirds of the injured worker's gross wage before the injury, which is generally about 90% of the pre-injury take home pay. Supplemental benefits are provided to injured workers with dependent children.
3. Death benefits – Provides a monthly benefit equivalent to total disability to the surviving spouse and dependent children, as well as benefits to cover the cost of the funeral and initial incidental expenses. Also makes scholarships available to the surviving spouse and dependent children.
4. Vocational Rehabilitation – A vocational rehabilitation specialist works with the injured worker to identify the best option for a safe return to employment. When necessary, full payment for tuition is provided for up to two years of retraining, along with a living allowance.

B. North Dakota's Unusual System

North Dakota is unusual, in that the PPI award in this state does not have any connection to lost wages, and has become a separate, additional award that is paid in addition to wage loss benefits. Most states have what is called a PPD award, meaning permanent partial disability. A PPD award is generally just one component of wage loss benefits, rather than being a separate, additional award.

Benefit systems vary from state, but the general approach is as follows: Temporary total or partial disability benefits are paid until the injured worker reaches "maximum medical improvement," which means the worker has received medical treatment and

recovered as much as possible from the injury. If the worker is left with a permanent physical impairment, at that point the PPD award is calculated, generally by using a formula that includes the worker's physical disability and the wages the worker was earning before the injury. Once the PPD award is made, disability benefits end. In other words, the PPD award is used to close out the monthly temporary disability benefit. The PPD award is supposed to compensate for all future wage loss after maximum medical improvement.

However, in North Dakota, since the 1974 decision of the North Dakota Supreme Court in the Buechler case, claimants can receive a PPI award and continue to receive monthly disability benefits. In Buechler, the court held that a claimant who was receiving permanent total disability benefits could also receive an award for permanent partial disability. As a result, **North Dakota is one of only seven states that continue to pay disability benefits after the claimant has received a PPI award.**

C. 1989 Legislation

Another turning point for PPI awards in North Dakota came in 1989. **In 1989, legislation was enacted almost doubling the dollar value of PPI awards.** This substantial increase, coming in the same year that the Bureau's massive unfunded liability was discovered, proved to have disastrous consequences for years to come.

The impact of the 1989 increase can be seen in the following table:

Fiscal Year	# of PPI Awards	$ Awarded
87-88	294	876,568.50
88-89	415	1,232,444.10
89-90	487	2,656,242.30
90-91	789	4,779,835.52
91-92	807	6,213,863.01
92-93	1,038	7,872,455.64
93-94	1,360	9,084,313.90
94-95	1,391	7,746,750.24
95-96	1,436	8,558,917.07
96-97	764	3,977,235.54
97-98	292	816,435.50

The dramatic growth in PPI awards following the 1989 legislation was one of the main causes of the financial crisis facing the workers compensation fund in the early 1990's. As the charts attached to this testimony reflect, the discovery and growth of a massive unfunded liability led to years of double digit premium rate increases. These premium rate increases, totaling more than 300% over a five year period, hit North Dakota employers hard. The unfunded liability also made it necessary for restrictions to be placed on certain workers compensation benefits in the 1993 and 1995 legislative sessions.

D. 1995 Legislation

One of the bills enacted 1995 completely overhauled the system for awarding PPI benefits. The 1995 law increased PPI awards for the more severe impairments of greater than a 50% whole body impairment, reduced awards for impairments under 50%, and provided that no award would be paid for an impairment of 15% or lower. The table above reflects the impact of the 1995 law, in reducing the number and the dollar value of PPI awards. It should be noted, however, that the 1995 law has only returned PPI awards to the level that existed prior to the 1989 legislation that almost doubled the value of the awards.

The 1995 law was referred to the voters of North Dakota, who affirmed the new law by a vote of 72,207 to 37,346 on June 11, 1996. Under Article III, section 8 of the North Dakota Constitution, a law approved upon referral cannot be repealed or amended for 7 years except by two-thirds votes in both the House and the Senate. Therefore, **HB 1422 will require a two-thirds vote in both legislative chambers in order to be enacted.**

E. Why the Bureau Has Prepared HB 1422

The workers compensation fund is now in much better financial health than was true several years ago. After many years of operating with an unfunded liability, the fund is now solvent, ending fiscal year 1998 with a $27 million surplus and a contingency reserve of $115 million. That amounts to a $382 million improvement in the fund's financial status since fiscal year 1993, when the fund was burdened with a $240 million unfunded liability and had no contingency reserve.

However, while these hard-won achievements represent a dramatic improvement in the fund's financial condition, further improvement is vital to the long-term health of the fund. It is vital that workers be assured of a sound fund that will be there to protect them in the event of injuries, and that employers be assured that there will not be another financial crisis leading to skyrocketing premium rates.

Currently, the Bureau discounts its future liabilities by 6% when calculating its reserves. In other words, it is assumed that the Bureau's financial assets will earn 6% each year into the future. Generally in the insurance industry, future liabilities are not discounted, and in addition, insurers carry a capital and surplus account based on a percentage of their annual premium income. The Bureau believes it should meet private industry standards. As an example, for the Bureau to achieve fund solvency without discounting, plus establish a reserve equal to 100% of its annual premium income, the Bureau would have to further improve its current financial position by approximately $376 million.

Therefore, now that the fund is no longer in a state of financial crisis, the Bureau will pursue a strategy in which future improvements in its financial condition will be allocated to three areas:

1. Continue to build up the fund's financial reserves;
2. Grant further premium rate decreases to employers;
3. Propose legislation containing targeted increases in benefits for injured workers.

Any decreases in premium rates, and any increases in benefits, must be done prudently and carefully, to avoid re-creating the financial crisis of the early 1990's. HB 1422 is a prudent increase in the value of PPI awards, that will provide substantial additional assistance to injured workers while not jeopardizing the future financial health of the fund.

There are also a number of issues regarding the current law that must be addressed to ensure the future smooth and efficient operation of the PPI award system. This bill addresses those issues, as is outlined below.

2. WHAT HB 1422 DOES

This bill makes a number of changes to section 65-05-12.2 of the Century Code, to accomplish goals in three areas: First, to increase PPI awards for injured workers; Second, to resolve current issues in order to make the system work better for everyone; and Third, to ensure that PPI costs are controlled to avoid rapid unintended growth. This summary highlights the major changes, some minor changes are not noted:

A. Increases PPI Awards for Injured Workers

Provides increased awards for all qualifying impairments, by increasing the underlying dollar value for each "week" that is awarded for each level of impairment. Currently, each week is valued at 33 1/3% of the state's average weekly wage, which is $139 at this time. This bill would increase that to 40% of the state's average weekly wage, which would be $166.80. This dollar value will increase each year as the state's average wage increases, pursuant to the survey done by Job Service each summer. This approach provides significant across-the-board increases for all awards, with the dollar value of the increase rising in proportion to the seriousness of the impairment. This benefit increase is outlined in the table attached to this testimony.

Makes the new, higher value of the awards available to all injured workers, including those who were injured before July 31, 1995. Under current law, workers injured before that date receive a lower value for any PPI awards they may receive in the future.

B. Resolves Issues to Make the System Work Better for Everyone

Clarifies the procedure for requesting an award. When the Bureau receives a medical record showing an injured worker has reached maximum medical improvement, the claims analyst writes the treating doctor, asking if there is any permanent impairment, and whether it could be as high 16%. If so, a letter is sent to the claimant asking whether the claimant would like to be evaluated for a potential award. The claimant has

six months to reply. If the claimant wishes to pursue an evaluation, one is scheduled with a doctor in the appropriate specialty who is familiar with the American Medical Association's Guides to the Evaluation of Permanent Impairment (the Guides), which contains the procedures for evaluating impairments. The Bureau audits all evaluation reports to ensure the procedures were correctly followed. If the evaluation shows an impairment higher than 15% caused by the work injury, an award is paid.

The North Dakota Supreme Court ruled in the McCabe case that the Bureau cannot use newer, updated versions of the Guides as they are published. The Court ruled that it would be improper for the Legislature to direct the Bureau to use new editions as the AMA issues them. The Bureau must continue to use whatever version of the Guides were in place when the PPI law was most recently amended, even if new editions make substantial improvements. To solve this problem, this bill would require the Bureau to adopt administrative rules governing the evaluation of impairments. That way, when a new edition of the Guides is issued, the Bureau can amend the rules to incorporate the improvements made.

Because the Bureau will be able to keep the evaluation process up-to-date through rulemaking, a number of provisions that "micromanage" the evaluation process are removed by this bill, so they will not be on the books when they become outdated with the passage of time.

This bill would make it easier for injured workers to resolve disputes regarding impairment awards. Any dispute would be reviewed by one or more doctors, and the resulting opinion would be binding on the Bureau absent clear and convincing evidence to the contrary.

C. Prevents Rapid Unintended Growth

This bill provides that claimants would receive a single permanent impairment award at the time of maximum medical improvement. This is how PPI awards are generally handled in other states. At some point in North Dakota, the practice arose of allowing claimants who have already received an award return for additional awards. About one quarter of claimants receiving awards have received more than one award. Bringing North Dakota in line with the industry practice in this area will help keep PPI costs under control.

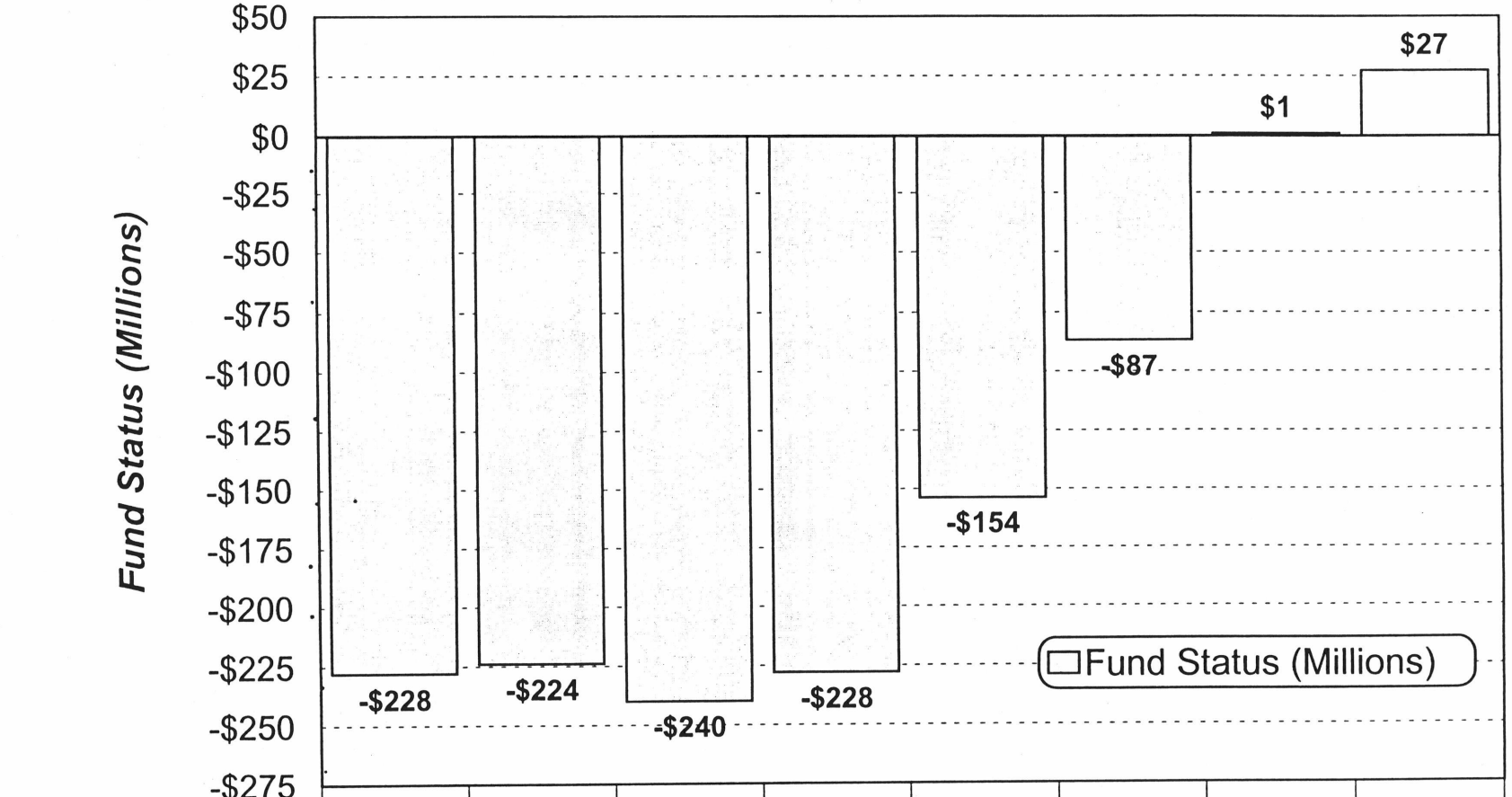
This bill makes it even more clear that there will be no separate awards for chronic pain syndrome, or for pain generally as treated under Chapter 15 of the current Guides. Although current law prohibits any such award, this bill would remove any possible ambiguity that could lead to litigation. The pain that arises from injuries is included in the percentages that are awarded for those conditions under the chapters of the Guides dealing with specific conditions.

3. CONCLUSION

HB 1422 is a balanced bill that offers a package that provides a net advantage for all sides. It will provide significantly increased benefits to injured workers, make the system work better, and guard against unforeseen cost increases. I respectfully request the committee's favorable consideration of this bill.

NDWCB Fund Status

by Fiscal Year

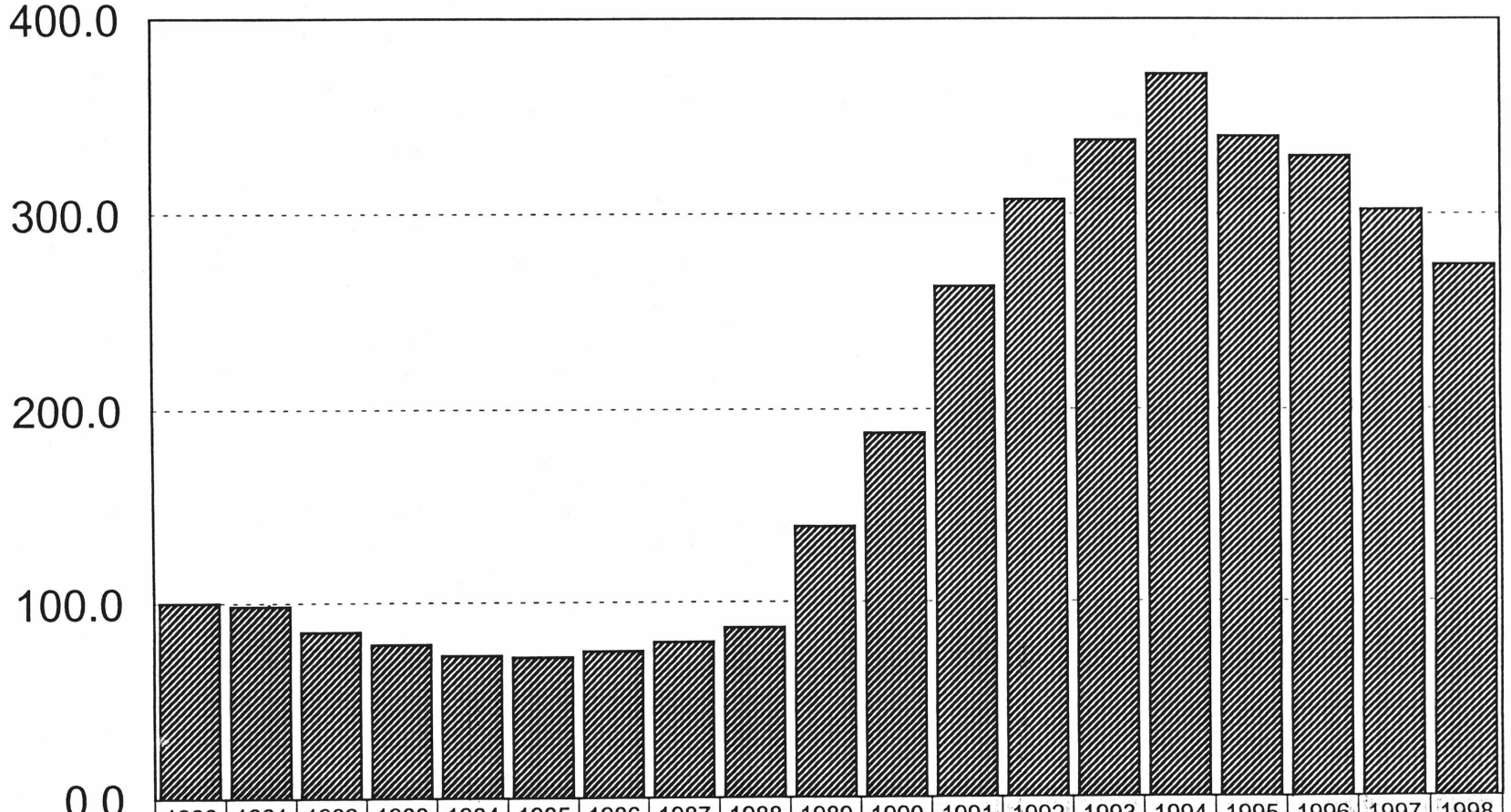


	FYE 1991	FYE 1992	FYE 1993	FYE 1994	FYE 1995	FYE 1996	FYE 1997	FYE 1998*
Fund Status (Millions)	-$228	-$224	-$240	-$228	-$154	-$87	$1	$27

**the fund status as of June 30, 1998 includes a $115 million contingency reserve*

NDWCB

Rate Change History



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Base	100.0	98.3	85.3	78.8	73.3	72.4	75.3	79.8	86.9	139.1	187.8	262.9	307.5	338.3	372.1	340.5	330.3	302.2	273.8
Rate Change		-1.7	-13.2	-7.6	-7.0	-1.3	4.0	6.0	8.9	60.0	35.0	40.0	17.0	10.0	10.0	-8.5	-3.0	-8.5	-9.4

Base Year 1980 = 100

Permanent Partial Impairment

Average Weekly Wage $417	Current PPI Rate $139	40% of Average Weekly Wage $166.80	Difference
16%	$695	$834	$139
20%	$2,085	$2,502	$417
25%	$3,475	$4,170	$695
30%	$6,950	$8,340	$1,390
35%	$13,900	$16,680	$2,780
40%	$20,850	$25,020	$4,170
45%	$27,800	$33,360	$5,560
50%	$34,750	$41,700	$6,950
55%	$45,175	$54,210	$9,035
60%	$55,600	$66,720	$11,120
65%	$66,025	$79,230	$13,205
70%	$76,450	$91,740	$15,290
75%	$86,875	$104,250	$17,375
80%	$97,300	$116,760	$19,460
85%	$107,725	$129,270	$21,545
90% to 100%	$139,000	$166,800	$27,800

American Medical Association
Physicians dedicated to the health of America

Guides to the Evaluation of Permanent Impairment

Fourth Edition

Chapter 15

Pain

Pain is endemic in the United States population, yet knowledge and understanding about this complex entity and its determinants, diagnosis, and treatment are only rudimentary. This is especially true of chronic pain. Thus, any discussion of permanent impairment because of pain will be problematic as well as controversial. The difficulties that physicians experience in dealing with pain are based, in part, on the following characteristics and perceptions.

1. Pain encompasses a multifaceted concept that transcends the traditional medical model of disease based on pathogenesis at the tissue or organ level. A perceptive concept of pain includes consideration of cognitive, behavioral, environmental, and ethnocultural variables as well as pathophysiologic factors.

2. Pain is subjective, and its presence cannot be validated or measured objectively. People tend to view pain complaints with suspicion and disbelief, as with complaints of fatigue. A report of the Social Security Administration in 1987 averred that it is impossible to understand the pain that another person is suffering.[14]

3. Impairment due to pain has not been well defined. No consensus exists about the occurrence of pain in healthy people, nor is there information about its occurrence by age group.

The medical, social, and economic consequences of pain are enormous. A national survey reported in a 1987 Institute of Medicine monograph indicated that about 6% of visits to physicians are for new pain, and a telephone survey disclosed that about 14% of persons 18 to 65 years old have pain for more than 1 month per year.[12] Data from the United States and other nations indicate that at least half of all persons experience moderate pain during their lives.

The federal government has recognized the impact of pain. The Secretary of the US Department of Health and Human Services in 1985 formed a commission on the evaluation of pain, which concluded that chronic pain is not a psychiatric disorder. The commission recommended further study of the subject by the Institute of Medicine.[12] Currently, the Social Security Administration is supporting an investigation to assess the validity of criteria for identifying individuals with chronic pain.

15.1 Basic Assumptions

The *Guides* is intended to provide a standard method of analysis for evaluation of impairing conditions. Fundamental to the *Guides* is that it applies only to *permanent* impairments, which are defined as those that are stable and unlikely to change in future months because of medical or surgical therapy. Permanent impairments are considered further in Chapter 1 and the Glossary (p. 315).

In general, the impairment percents given in the tables and figures applicable to permanent impairments of the various organ systems include allowances for the pain that may occur with those impairments.

In considering pain, it is prudent to list the following assumptions.

1. Pain evaluation does not lend itself to strict laboratory standards of sensitivity, specificity, and other scientific criteria.

2. Chronic pain is not measurable or detectable on the basis of the classic, tissue-oriented disease model.

3. Pain evaluation requires acknowledging and understanding a multifaceted, biopsychosocial model that transcends the usual, more limited disease model.

4. Pain impairment estimates are based on the physician's training, experience, skill, and thoroughness. As with most medical care, the physician's judgment about pain represents a blend of the art and science of medicine, and the judgment must be characterized not so much by scientific accuracy as by procedural regularity.

The important task of evaluating impairment due to pain is difficult but not impossible. Physicians initially may feel uncomfortable evaluating pain, but they regularly employ similar methods and approaches in arriving at diagnostic and therapeutic judgments. Physicians generally are comfortable making decisions on the basis of probabilities backed up by experience and stated in terms of reasonable medical certainty. Pain should be evaluated by physicians who are conversant with the disorder.

15.2 Definitions

Pain is ubiquitous. Pain is usually regarded as a warning signal that alerts the organism to potential tissue damage. Indeed, life without pain is hardly conceivable and would result in irrevocable harm. Yet, strangely, there is no consensus as to a meaningful definition of pain.

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience with actual or potential tissue damage [that is] described in terms of such damage." The Commission on the Evaluation of Pain defines pain as a "complex experience, embracing physical, mental, social and behavioral processes, which comprises the quality of life of many individuals." Another definition views pain as an unpleasant subjective perception in the context of tissue damage.

Embodied in the definitions above are the following concepts. Pain is subjective and cannot be measured objectively. Pain evokes negative psychologic reactions, such as fear, anxiety, and depression. Pain is perceived consciously and is evaluated in the light of past experiences. People usually regard pain as an indicator of physical harm, despite the fact that pain can exist without tissue damage, and tissue damage can exist without pain.

15.3 Pain, Impairment, and Disability

The *Guides* defines impairment as the loss, loss of use, or derangement of any body part, system, or function. Thus, impairment is defined on an anatomic, physiologic, or psychological basis. This definition operates at the organ level and presumes a disease model that involves endogenous systems and generally is independent of the external milieu. In this narrow context, it would be difficult to consider pain an impairment.

But the *Guides* interprets the definition of impairment to involve also interfering with the individual's performance of daily activities (see Glossary). In this broader context, impairment is at the level of the individual, is based on an illness model, and is viewed as being dependent on personal needs and the demands of the external milieu. In this context, pain may be viewed as an impairment that should be assessed according to the individual's residual functional capacity. Chronic pain and pain-related behavior are not, per se, impairments, but they should trigger assessments with regard to ability to function and carry out daily activities.

These concepts and definitions are blurred by the operational definitions and demands in different venues dealing with pain, impairment, and disability. The Social Security Administration, for instance, gives credence to pain only insofar as it relates to an underlying physical or mental impairment (see Glossary). Workers' compensation programs vary from state to state in their constraints and procedures. The US Department of Veterans Affairs generally does not consider pain, except as a manifestation of a physical or mental impairment. Private disability insurance programs tend to recognize pain as an exacerbating factor, if there is an underlying physical or mental impairment.

Related Concepts

Disease: This is a pathologic process or disorder at the tissue or organ system level.

Illness: This is an adverse, unhealthy process or disorder that affects the individual. An illness must be viewed in the context of both the external and internal milieu and transcends pathogenicity at the tissue level.

Nociception: This is the perception of pain resulting from a noxious stimulus to a nociceptor. Complex neurochemical and neuroelectrical processes transmit pain impulses from the site of injury along the peripheral, autonomic, and central nervous systems.

Modulation: Transmission of pain impulses along multisynaptic pathways can result in significant alteration of the quality and intensity of the stimulus. Modulation occurs in the central nervous system.

Perception: Conscious awareness or recognition of pain is governed by the cerebral cortex. The pain impulse is evaluated through association pathways, and it may be identified as "suffering." The emotional content of the evaluation depends on such factors as the individual's personality characteristics and value system, cognitive awareness, experiences, education, and ethnocultural background. Pain is viewed as an unpleasant experience, and the emotional content frequently consists of feelings of fear, anxiety, frustration, and depression. The fear of pain may be more devastating than the pain itself.

Response: The individual's response to perceived pain depends on multiple factors in the internal and external milieu. The response involves the central nervous system and the autonomic nervous system, is involuntary as well as voluntary, and may be appropriate or inappropriate. Before the pain response, the pain experience of the individual is unknown to others. The pain response provides a "window" through which others can discern and evaluate the individual's pain experience.

Suffering: This is a state of severe distress associated with events that threaten the individual's intactness. Suffering may or may not be associated with pain. Suffering and pain are distinct entities.

Malingering: This is the conscious and deliberate feigning of an illness or disability. Malingering is discussed in the *Guides* chapter on mental and behavioral disorders (p. 291).

Functional capacity evaluation: This involves examining an individual as the individual performs activities in a structured setting. It does not necessarily reflect what the individual *should be able* to do, but rather what the individual *can* do or *is willing* to do at a given time. Functional capacity depends especially on motivation, cognitive awareness, behavioral factors, and sincerity of effort, and these characteristics have a major impact on the functional capacity assessment (FCA).

The functional capacity assessment, which is performed by or under the supervision of the physician, varies according to the physician's training, experience, skill, competence, and understanding of the assessment processes. A great need exists for a valid, accurate, reliable, and relevant instrument for performing the FCA, one that is based on the full range of abilities and activities of normal persons.

15.4 Classification and Models

Classifying pain in a multiaxial context is important from both a conceptual and an operational perspective. Several models are proposed: a functional classification depending on neuropsychiatric considerations; a clinical classification depending on pathogenesis; and an operational or interactive classification depending upon a biopsychosocial concept. The models are not necessarily mutually exclusive: a patient seen in the office or clinic might have pain encompassing aspects of several of the models.

Neuropsychiatric Model

Nociceptive or somatic pain results from actual or impending tissue damage. This pain represents the usual and most frequent acute pain experience. Pain arising from peripheral or visceral tissues is defined within established neuroanatomic and neurophysiologic

processes. Usually the pain is limited, easily diagnosed, short-lived, and readily treated. This type of pain occurs with a fractured bone, skin laceration or angina pectoris.

Neurogenic or central pain encompasses neuropathic and deafferentation pain. This pain results from spontaneous excitation within the central, peripheral, or autonomic nervous system and in the absence of any specific noxious painful stimuli. Making the diagnosis and evaluating this type of pain may be difficult, and the pain may be persistent and refractory to effective treatment. Examples include peripheral neuropathy, trigeminal neuralgia, and phantom limb pain.

Psychogenic pain is a psychiatric disorder that is part of such conditions as somatization disorder, thought disorder, mood disorder, and hypochondriasis.[1] Psychogenic pain should not be confused with chronic pain syndrome, which is *not* considered to be a mental disorder. Confusion arises because the chronic pain syndrome often is associated with emotional problems, such as depression and anxiety, which occur frequently in mental disorders.

Significant mind-body interrelationships exist with both the chronic pain syndrome and psychogenic pain. A useful diagnostic test is to ask the question, "Would the individual have pain if the mental disorder were absent?"

Pathogenesis Model

Primary pain is related to tissue trauma or physiologic disruption, either nociceptive or neurogenic. The link between the stimulus generating the pain and the resulting perception of pain is direct. The pain usually is acute and self-limiting. Examples include pain resulting from an acute sprain or renal lithiasis.

Secondary pain usually is the result of adverse pain behavior or ineffective medical treatment (iatrogenesis). Secondary pain arises not from the primary pain stimulus, but as the patient's reaction to the result of the primary pain problem. Secondary pain is likely to be persistent and difficult to manage. Examples of secondary pain include pain resulting from the treatment of a malignant neoplasm with surgery, radiation, or chemotherapy; pain resulting from substance abuse and dependency; and pain resulting from prolonged inactivity and deconditioning.

Biopsychosocial Model

Acute pain serves as an alerting mechanism that protects the individual. Acute pain usually is nociceptive, primary, and short-lived, and its psychosocial consequences are minimal. The perception of the pain and the individual's behavior and capability after the episode generally are commensurate with the noxious stimulus. The pain abates as healing occurs. Usually, acute pain is associated with conditions that are short-lived and self-limiting; thus, estimates of permanent impairment according to *Guides* criteria are not indicated.

Recurrent acute pain is a more complex subject than acute pain. This category involves the episodic painful sensations that occur in chronic disorders, such as the arthritides, trigeminal neuralgia, and some types of headache. Recurrent acute pain may be nociceptive or neurogenic, primary or secondary. Recurrent acute pain should not be confused with chronic pain, because the determinants are greatly different, especially the pathophysiologic ones.

The significance, evaluation, and medical management of recurrent acute pain are basically the same as for acute pain. However, the emphasis is on palliation and management and not on cure. Prognosis depends on the availability of effective treatment for the underlying pathologic process. Impairment is a function of the underlying disease process as modified by the superimposed pain and the patient's makeup.

Cancer-related pain, which frequently is referred to as chronic, intractable pain, represents one of the broadest syntheses of pain models because of the nature of the causative process. The pain may be nociceptive or neurogenic; primary or secondary; acute, recurrent, or chronic. Combinations of these varieties may occur. Understandably, significant psychological states often are at play in individuals with cancer. Fear, anxiety, depression, anger, denial, and other manifestations add dramatically to the patient's perception and interpretation of the pain experience.

In patients with cancer who have pain, the diagnosis and treatment usually have been accomplished as well as is possible. The goal of pain management is to provide a comfortable and dignified life. The basis of treatment includes the use of opioid and nonopioid analgesics, other pharmaceuticals, surgical intervention, and behavior modification techniques, including biofeedback, hypnosis, and relaxation therapy.

Chronic pain represents the nidus of the chronic pain syndrome. Chronic pain may be referred to as "chronic benign pain" to differentiate it from the pain related to a malignant neoplasm. Pain of long duration is properly referred to as "persistent pain," with the term "chronic pain" being reserved for the devastating and recalcitrant type with major psychosocial consequences. In this chapter, the term "chronic pain" is synonymous with "chronic pain syndrome." Under the *Guides* definitions, persistent pain may exist in the absence of chronic pain, but chronic pain always presumes the presence of persistent pain.

Chronic pain represents a malevolent and destructive force and generally is considered to be useless. Chronic pain is a self-sustaining, self-reinforcing, and self-regenerating process. It is not a symptom of an underlying acute somatic injury, but rather a destructive illness in its own right. It is an illness of the whole person and not a disease caused by the pathologic state of an organ system. Chronic pain is persistent, long-lived, and progressive. Pain perception is markedly enhanced. Pain-related behavior becomes maladaptive and grossly disproportional to any underlying noxious stimulus, which usually has healed and no longer serves as an underlying pain generator.

Chronic pain that is not recognized and properly treated results in a deterioration of coping mechanisms. Under such circumstances, limitations of functional capacity are apt to occur. The patient's maladaptive behavior may have medical, social, and economic consequences that greatly outweigh any somatic components of the illness. These consequences may include despair, alienation from family and society, loss of job, isolation, invalidism, and suicidal thoughts. Yet, chronic pain is not a psychiatric disorder.

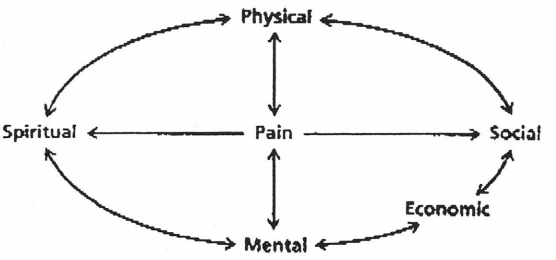
Chronic pain may result from inappropriate management of acute pain. It is not possible to predict the course of a patient's condition from inception of the noxious stimulus to the development of the complete chronic pain syndrome. However, there is some evidence relating the development of chronic pain to emotional abuse, sexual abuse, physical abuse, substance abuse, or abandonment by the primary caregiver. A history of childhood sexual or physical abuse is a common theme among female patients with chronic pain. Early detection and prompt, effective intervention require a high index of suspicion and are essential to effective management.

15.5 Dynamic Interrelationships of Models

It is important to recognize that changing interrelationships exist among the biologic, psychological, and socioeconomic components and modifiers of pain (Fig. 1, at right). The devastating, stultifying economic and social impacts of chronic pain are well known. The psychological impact is manifested by depression, withdrawal, anxiety, and other mood disorders, and the biologic consequences are beginning to be explored. Animal studies demonstrate that neuroendocrine changes related to pain, which involve the thalamic-pituitary axis and the limbic system, can alter behavior. Other experimental studies indicate that persistent pain may result in increased morbidity and mortality.

In considering the various pain classifications and models, it is important to recognize the ascending order: tissue, organ, and organism. Disorders affecting tissues and organ systems result in symptoms and disease, and acute and recurrent pain can be viewed in this context. Disorders affecting the individual as a whole result in illnesses, such as those that characterize chronic pain. Regarding pain and its interrelated determinants, it is wise to consider Dr. William Osler's maxim, "It is not nearly as important what illness a patient has, as what patient has the illness."

Figure 1. Biopsychosocial Modifiers of Pain.



15.6 Clinical Assessment

Assessing the magnitude of the patient's pain and pain-related impairment requires a multidisciplinary approach based on the biopsychosocial model. In general, the assessment calls for the traditional approach of the physician. However, assessing chronic pain is a complex and lengthy process that usually requires hours if not days to complete. In difficult cases, it may be appropriate to enlist the aid of physicians specializing in pain medicine.

The *Guides* Chapter 2 describes in general terms the methods that should be used to evaluate and estimate the extent of impairments. The following steps should guide the examination of a patient with a complex pain problem. Some important information, for instance, that is described in steps 4, 5, and 6 below ideally will be available to the evaluator because of others' examinations and studies. It is the physician's responsibility to ensure that the information, if it is used, is of good quality.

1. Review all available medical records and diagnostic studies. Communication with previous health care providers may be needed.

2. Obtain a complete medical history from the patient, speaking with persons in close contact with the patient as needed. Include a family, work, and social activities history. List affected daily activities (See p. 313).

3. Document all current complaints and the pain history. The pain history should include a description of onset, location, quality, progression, character, intensity, variability, frequency, duration, migration pattern, precipitating and aggravating factors, epiphenomena, treatment, medications, and other interventions used and results.

4. Perform a complete physical and neurologic examination.

5. Arrange appropriate ancillary studies, for instance, roentgenographic, magnetic resonance imaging, and electromyographic studies.

6. Psychological testing is an integral part of evaluating pain. Using the Minnesota Multiphasic Personality Inventory has become standard. Other instruments include the Cornell Medical Index Health Questionnaire, McGill Pain Questionnaire, Beck and Zung Depression Indices, and Westhaven-Yale Multidimensional Pain Inventory.

7. Formulate a diagnostic impression based on the accumulated information. This assessment should refer to the cause and classification of the pain, description of the biopsychosocial impact, and prognosis.

8. Estimate the extent of the pain and impairment using the procedures described in Section 15.9 (p. 311) and other parts of the *Guides* as appropriate.

Diagnostic Characteristics (the Eight *Ds*) of Chronic Pain

The presence of two or more of the following characteristics should be considered to establish a presumptive diagnosis of chronic pain syndrome.

1. *Duration:* In the past, the term "chronic pain" has been applied to pain of greater than 6 months' duration; however, current opinion is that the chronic pain syndrome can be diagnosed as early as 2 to 4 weeks after its onset. Prompt evaluation and treatment are essential.

2. *Dramatization:* Patients with chronic pain display unusual verbal and nonverbal pain behavior. Words used to describe the pain are emotionally charged, affective, and exaggerated. Patients may exhibit maladaptive, theatrical behavior, such as moaning, groaning, gasping, grimacing, posturing, or pantomiming.

3. *Diagnostic Dilemma:* Patients tend to have extensive histories of evaluations by multiple physicians. The patient has undergone repeated diagnostic studies, despite which the clinical impressions tend to be vague, inconsistent, and inaccurate.

4. *Drugs:* Substance dependence and abuse involving drugs and alcohol is a frequent concomitant. Patients are willing recipients of multiple drugs, which may interact adversely. Often they consume excessive amounts of prescribed drugs.

5. *Dependence:* These patients become dependent on their physicians and demand excessive medical care. They expect passive types of physical therapy over long time periods, but these provide no lasting benefit. They become dependent on their spouses and families and relinquish all domestic and social responsibilities.

6. *Depression:* The condition is characterized by emotional upheaval. Patients tend to have psychological test results that suggest depression, hypochondriasis, and hysteria. Cognitive aberrations give way to unhappiness, depression, despair, apprehension, irritability, and hostility. Coping mechanisms are severely impaired. Low self-esteem results in impaired self-reliance and increased dependence on others.

7. *Disuse:* Prolonged, excessive immobilization results in secondary pain of musculoskeletal origin. Self-imposed splinting may be validated by misguided medical directives to be "cautious," and this can result in progressive muscular dysfunction and generalized deconditioning. The secondary pain further aggravates and perpetuates the reverberating pain cycle.

8. *Dysfunction:* Having lost adequate coping skills, patients with chronic pain begin to withdraw from the social milieu. They disengage from work, drop recreational endeavors, tend to alienate friends and family, and become increasingly isolated, eventually restricting their activities to the bare essentials of life. Bereft of social contacts, rebuffed by the medical system, and deprived of adequate financial means, the patient becomes an invalid in the broadest sense: physical, emotional, social, and economic.

The physician should suspect the presence of the chronic pain syndrome if a patient does not respond to appropriate medical care within a reasonable period of time, or if the patient's verbal or nonverbal pain behavior greatly surpasses the usual response to a given noxious stimulus.

15.7 Treatment

Pain, including persistent and chronic pain, need not be a progressive, destructive force. But physicians who specialize in pain medicine consider chronic pain to represent a failure of traditional medical approaches that is characterized by repeated diagnostic studies, excessive use of medicines, prolonged use of passive physical therapy modalities, prolonged immobilization, and unwise surgical intervention. All of these approaches only perpetuate and augment the syndrome.

Nonmedical factors also may have substantial roles in chronic pain conditions. The authoritative commission on pain in 1987 noted that there are many ways to reward illness behavior and provide disincentives for recovery. From the patient's standpoint, pain can provide the rationalization for quitting an unpleasant job or provide a useful attention-getting device. Pain also may lead to expectation of financial gain through an illness-compensation system.

Chronic Pain

Effective treatment of persistent and chronic pain recognizes it as a multifaceted illness, rather than as a localized disease process. The focus of treatment is on management rather than cure. Management requires a multidisciplinary effort that is carried out at a comprehensive pain center on an inpatient or outpatient basis. The goals should be clearly defined and articulated. These include an increase in functional capacity and a decrease in dependencies on medication and medical care providers.

Pain-oriented behavior usually can be decreased. Although pain perception often is not diminished, the significance of pain to the patient can be reduced. Return to the work force is highly desirable, and this can be achieved in about one half of treated patients. A return of the work ethic in the patient with chronic pain depends on many variables, including character traits, personality, ethnic and cultural background, the presence of support systems, motivation, and satisfaction with the position held before the event that gave rise to the condition.

Effective management incorporates the three major pathways indicated below.

Rehabilitation: This includes physical rehabilitation, with mobilization, stretching, and strengthening exercises; and rehabilitation in terms of medical and psychological factors, including those that involve vocation, social relationships, and use of medications.

Behavior modification: This may include operant conditioning and relaxation therapy.

Cognitive therapy: This includes helping the patient understand and revamp thought processes aided by knowledgeable persons in medicine, psychiatry, and psychology. Patients with chronic pain must "take control" again and become responsible for their lives.

15.8 Estimating Impairment

If the patient's pain or pain-related condition is to be evaluated under the criteria of the *Guides*, by definition it must be one that is stable and unlikely to change in the future despite therapy (see Glossary, p. 315). Pain is a subjective perception. Usually no exact relationships exist among the degree of pain, extent of pathologic change, and extent of impairment.

Decreased ability to carry out daily activities may be one result of pain-related impairment. This decreased ability is *not* merely a function of verbal behavior. An individual who complains of constant pain but who has no objectively validated limitations in daily activities has *no* impairment. The proper test is not "Does this daily activity cause pain?" but rather "Can the patient perform this daily activity?"

Evaluating functional capacity (p. 305) is the process of assessing the patient's ability to carry out the activities necessary for daily living. There is no universally accepted standard, method, or instrument for evaluating functional capacity. Rather, functional capacity evaluation depends on medical experience and judgment. The process is a comprehensive, multidimensional assessment of the individual's capabilities, considering biologic, psychological, and social aspects of the individual's condition. This type of evaluation is more complex and difficult than estimating an impairment using anatomic or physiologic measures.

The validity of a functional capacity evaluation depends on the capability of the physician or the trained examiner acting under the physician's purview. The Visual Analogue Scale, a linear scale used to grade pain from 1 to 10 depending on severity, may be useful in determining pain intensity, but it must not be the primary criterion. The physician's judgment must be based on reasonable certainty. The goal should be to achieve precision, replicability, and interobserver agreement, not necessarily absolute accuracy.

Assessment Content

A comprehensive pain assessment includes clinical assessment (Section 15.7, p. 310); classification (Section 15.4, p. 305); and description of the effects of the pain on performing daily activities (functional capacity evaluation). In estimating the extent of pain-related impairment, the following criteria should be observed.

1. Acute pain is not a "permanent impairment."

2. Psychogenic pain is a mental disorder that should be evaluated according to the chapter on mental and behavioral disorders (p. 291).

3. Recurrent acute pain is likely to be classified as primary and nociceptive or neurogenic. Such pain relates clearly to well-defined diseases or pathologic entities.

4. Chronic pain (chronic pain syndrome) is likely to be classified as secondary pain. Chronic pain in the absence of objectively validated diseases or impairments, such as those that are described in the *Guides*, should be evaluated on a multidisciplinary basis by physicians with a special interest and background in pain medicine and considering the effects of the pain on the patient's ability to carry out daily activities. The Pain Intensity-Frequency Grid (Fig. 2, at right) should be used to describe the degree of impairment resulting from this disorder.

Figure 2. Pain Intensity-frequency Grid.

Intensity	Frequency			
	Intermittent	Occasional	Frequent	Constant
Minimal				
Slight				
Moderate				
Marked				

The Pain Intensity-frequency Grid (Fig. 2, above) should be interpreted according to the guidelines below. The physician should indicate in the impairment report in which category of the grid the pain impairment lies. In some instances, an impairment percent applicable to the patient's pain may be determined, if the condition causing the pain can itself be evaluated according to the criteria applicable to a particular organ system as with example 3 (p. 313).

Intensity

Minimal: The pain is annoying, but it has not been documented medically to have caused appreciable diminution in an individual's capacity to carry out daily activities. The pain does not interfere with sleep, and it requires only *occasional* use of nonnarcotic medication.

Slight: The pain is tolerated by the individual but has been documented medically to cause diminution in an individual's capacity to carry out *some* specified daily activities. The pain may interfere with sleep. Nonnarcotic medication may be consumed regularly, and occasional narcotic medication may be required.

Moderate: The pain has been documented medically to result in *extensive diminution* in an individual's capacity to carry out specific activities of daily living. The pain may be tolerable, but it interferes with sleep. It frequently requires use of narcotic medication, or it may require invasive procedures. Recreation and socialization are severely limited.

Marked: The pain precludes carrying out *most* activities of daily living. Sleep is disrupted. Recreation and socialization are impossible. Narcotic medication or invasive procedures are required and may not result in complete pain control.

Frequency

Intermittent: The pain has been documented medically to occur less than one fourth of the time when the individual is awake.

Occasional: The pain has been documented medically to occur between one fourth and one half of the time when the individual is awake.

Frequent: The pain has been documented medically to occur between one half and three fourths of the time when the individual is awake.

Constant: The pain has been documented medically to occur between three fourths and all of the time when the individual is awake.

15.9 Headache

Head, neck, and facial pain disorders, in this section referred to as headache disorders, possess some features that distinguish them from other painful disorders. Generally, however, these common disorders may be considered in terms of the same model.

The *primary headache disorders* include migraine, cluster headache, and tension-type headache. The *secondary headache disorders* are those that are associated with a variety of organic causes and with an identifiable, distinct pathologic process, of which head pain is a symptom. More than 300 organic disorders are capable of producing secondary headaches. However, more than 90% of headaches requiring medical attention are the result of one or more of the primary headache disorders.

Headache may present either in an intermittent, recurring fashion or in a persistent, constant form. Though headaches such as migraine are generally intermittent and periodic, they may evolve or transform to a state of constancy. Similarly, headaches secondary to organic processes may begin intermittently and then evolve to a more constant form.

Pathogenesis

Whereas muscular and vascular disturbance have been considered in the past to be the fundamental physiologic alterations causing primary headache disorders, current concepts of headache pathogenesis hold that these disorders arise from disturbances within the central nervous system. Supporting this neurogenic concept of migraine is the frequent presence of premonitory symptoms suggesting hypothalmic dysfunction; the presence of focal neurologic disturbances that cannot be explained solely by cerebral blood flow alterations; the accompanying features that include autonomic and systemic dysfunction; evidence concerning alteration of serotonin function; encephalographic alterations indicating neuronal disturbances during attacks; and the presence of inflammation within the trigeminal nerve vascular system that is induced by nervous system alterations.

Other evidence of this concept is that the primary headache disorders often improve with the use of pharmaceuticals and other therapeutic approaches that influence serotonin function independent of direct vascular or muscular effects.

Migraine

Migraine embodies an increasing variety of headache presentations, which range from typical, characteristic, periodic attacks to a daily persistent form. There is growing support for a concept suggesting that migraine represents a broad clinical spectrum. At one extreme are patients with an occasional intermittent migraine with aura, and at the other extreme are those with daily persistent pain similar to the traditional types of chronic tension-type headache.

Migraine may be defined as a complex neurophysiologic disorder characterized by episodic and progressive attacks of head pain with numerous neurologic, autonomic, systemic, and psychophysiologic disturbances. There is increasing recognition of migraine's capacity to transform or evolve from intermittent attacks to daily or almost daily head pain. This variant form most recently has been termed transformational migraine, progressive migraine, or pernicious migraine. Migraine is considered to be inherited as an autosomal dominant trait with incomplete penetrance.

Subclassifications of migraine reflect specific migraine syndromes and include ophthalmoplegic migraine, hemiplegic migraine, aphasic migraine, and retinal migraine. Major and sometimes prolonged disturbances of brain-stem function may occur with migraine, including dizziness with or without vertigo and disequilibrium; nausea, vomiting, diarrhea, and anorexia; loss of consciousness; sudden mood change; and dramatic disturbances, such as stupor, confusion, and ataxia.

Tension-type Headache

Many clinicians experienced with headache believe that tension-type headache represents a variant form of migraine. There is a significant overlap between the symptoms of tension-type headache and those of migraine, and a large number of patients with tension-type headache suffer superimposed periodic migraine.

Cluster Headache
Cluster headache is a devastating and painful affliction in which attacks of one-half hour to 1½ hours occur daily for weeks, months, or years at a time. Up to eight or more attacks may occur per day. The term "cluster headache" was originally used to describe the clustering or sequence of bouts of attacks in which the headache cycle occurred for a period of time, usually several months, and then remitted for a quiescent period referred to as the interim. A chronic form of cluster headache without an interim now is recognized.

Primary Headache Frequency Patterns
Three patterns of primary headache occur, as shown below, and these are independent of the specific diagnosis. Complex or mixed forms of headache may occur, in which varying intensities and frequencies of one form occur with superimposed features of another form.

1. Minimal, slight, moderate, and marked headache may occur in intermittent, occasional, frequent, or constant forms.

2. Cycles or episodes of the above may occur, lasting moments, hours, days, weeks, months, or years, which are followed by periods of complete or almost complete remission.

3. Constant and persistent pain of varying intensity may last years, decades, or a lifetime.

Chronic Pain
Chronic, intractable pain embodies a condition in which a malevolent and destructive influence occurs. Headache that evolves into chronic pain is a self-sustaining process and does not reflect an underlying acute somatic injury. Rather, the headache is a disorder in its own right and is chronic, long-lived, and progressive. The patient's pain perception is markedly enhanced, the pain behavior becomes maladaptive and counterproductive, and both behavior and perception are greatly disproportional to any identifiable underlying noxious stimulation.

Clinical Features Distinguishing Headache Illnesses from Other Painful Disorders
Many of the headache illnesses are accompanied by dramatic, often strokelike clinical phenomena that can be even more disruptive and disabling than the pain experience itself. Moreover, functioning in patients with headache syndromes often is compromised by the effects of excessively used sedative medications prescribed or taken to treat the headache.

Many headache symptoms persist beyond the period of pain itself or can occur hours or days in advance of an attack. After the acute episode, a period of *mental dullness, fatigue,* and somnolence occurs, which is similar to that seen in the postictal phase of an epileptic seizure.

Diagnostic and Therapeutic Considerations
Because the presence or suspected presence of a primary headache disorder does not exclude the presence of a separate, comorbid, distinct pathologic process that might be responsible for secondary headache, broad and careful diagnostic measures are required both initially and periodically. Moreover, in the presence of an intense pharmacotherapeutic program, the monitoring of blood levels of the pharmaceutical agent, organ responses, and cardiac status is required for safety. Screening studies are necessary to determine the safety of drug administration, and other measures may be required.

Determining Impairment
Impairment related to headache pain should be estimated according to the procedures described in Section 15.8 (p. 309) for evaluating other types of pain. It is important to remember that assessing *permanent* impairment refers to assessing a condition that is stable and unlikely to change in future months despite medical or surgical therapy. The vast majority of patients with headache will not have permanent impairments.

Examples of Evaluating Pain

Example 1: A 34-year-old man injured his back while lifting a heavy object; this injury was an L4 to L5 disk herniation causing radiculopathy. He had an operation for removal of the disk and had good pain relief for 8 weeks. He then developed constant low-back pain and burning pain radiating down the right leg to the toes. During the succeeding 2 years, he was under the care of a neurosurgeon, an orthopedic surgeon, and a neurologist, and the diagnoses of arachnoiditis and neuritis were made.

The man required the use of narcotics, anti-inflammatory drugs, and antidepressants, but these did not relieve his pain. He could not participate in recreational activities or sit long enough to drive, and he required assistance to put on his shoes and socks.

Diagnosis: Arachnoiditis; neuritis; disk herniation at L4 to L5.

Impairment: 10% whole-person impairment from a herniated disk, DRE lumbosacral category III (p. 110); pain impairment due to frequent pain of moderate intensity.

Comment: The man's pain, which followed the primary insult and a surgical procedure, and his inability to perform some daily living activities established the presence of chronic pain syndrome. Any peripheral nerve impairment other than that due to the L4 to L5 lesion should be determined by referring to criteria in Section 3.1 or 3.2 of Chapter 3 (pp. 15 and 75), and the whole-person impairment percent should be *combined* with the spine impairment percent (Combined Values Chart, p. 322).

Example 2: A 47-year-old woman bumped the dorsum of her right hand as she was stocking shelves at work. Within 24 hours, the hand became swollen and painful. Roentgenograms disclosed no fracture. Within a week of the injury, the hand had become red, swollen, and hot, and she was unable to tolerate stimulation of any kind of the affected part. A physician made the diagnosis of reflex sympathetic dystrophy. The patient underwent a series of stellate ganglion blocks, which did not provide lasting relief.

A year after the injury, the patient had a surgical sympathectomy, which did not relieve the pain. An examination showed that the woman held her right hand in a protected fashion guarded by the left hand. The history indicated that she could not perform domestic tasks and that she had to rely on family members to assist with dressing, hygiene, and most daily activities. She also no longer took part in social activities. She described her pain as being intense and constant and would not allow anyone to touch the affected limb.

Diagnosis: Reflex sympathetic dystrophy; impairment due to constant, marked pain.

Impairment: Impairment due to constant, marked pain.

Comment: The patient became totally focused on her pain, her life was consumed by the pain, and she was incapable of performing most daily activities.

An impairment percent related to the causalgia may be determined according to criteria in Chapter 3, Section 3.1 (p. 15) for impairment of hand and wrist motion and sensation.

Example 3: A 55-year-old executive developed trigeminal neuralgia affecting the maxillary and mandibular branches of the trigeminal nerve. The pain initially diminished with carbamazepine therapy, but after 2 years it recurred. It then became persistent, despite large doses of carbamazepine combined with baclofen and clonazepam and the adjunctive use of acupuncture. Chewing, swallowing, and toothbrushing initiated paroxysms of pain. If the man spoke cautiously, he could avoid pain most of the time. He could not go to work because of the attacks. He was unwilling to submit to surgical intervention.

Diagnosis: Trigeminal neuralgia.

Impairment: Impairment due to intermittent pain of marked severity.

Comment: The man's attacks were infrequent but severe, even though they lasted only a few minutes. The patient believed the attacks prevented his working, which required that he almost continuously converse in person or by telephone.

In this instance, a whole-person impairment percent may be derived by referring to the impairment criteria for cranial nerve V (Chapter 4, p. 139).

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To: Senators Heitkamp
D Mathern
Thompson
For your information.
TMathern

VIA FACSIMILE TRANSMISSION (701-328-3739)

M E M O

To: Honorable Tim Mathern, Senate Democratic Leader
Senate Chambers

From: Mark G. Schneider MGS

Date: March 4, 1999

Re: Engrossed House Bill No. 1422 (Berg)

This bill deals with Workers' Compensation/permanent impairment. It is a bad bill and I urge a caucus position to defeat it. As you know, the Republicans must have Democratic votes in order to get the two-thirds majority required.

The "increase" in PPI benefits under the bill is a "trojan horse" to otherwise serve the Bureau's agenda to dramatically diminish PPI awards. With regard to the "benefits" the "increases" are nominal, at best, i.e., an increase of five "weeks" of benefits which is currently less than $700.00. Also, this will affect only a very small number of injured workers because only 10 percent of the workers are eligible for any PPI award because there is absolutely no benefit to anyone who has 15 percent impairment or less. The Bureau's agenda is at subsection 6 of the bill which would allow the Bureau to "adopt administrative rules governing the evaluation of permanent impairment." This is a "chicken in a hen house" provision and there is no question but that the Bureau will use this authority to further diminish eligibility for PPI awards, particularly in the area of impairments due to "pain."

The Bureau would not be offering any increase, however nominal, unless it was a pretext to further their agenda to continue to diminish benefits to injured workers.

Again, I urge a caucus position on this. Certainly, you could offer an amendment to delete all of the changes in the proposed bill except the additional increase in benefits. Otherwise, this is a bad bill and should be defeated.

February 27 1999.

To: Heidi Heitkamp - Attorney General
Glenn Pomeroy - Insurance Commissioner

Fr: Gary S. Hartquist LPN

Re: ND Workers Compensation Claim # 96 519054 N57

For the sake of brevity and inasmuch as I am seeking guidance and help from both of you, I have decided to address the same letter to you both, rather than embarking on a series of photocopies.

The above captioned claim was accepted by ND Workers Compensation. The claim was initiated on April 17 1996. Since that time, I have encountered every form of obstruction and foot-dragging imaginable. The Bureau, in the person of Pat Traynor, became more actively interested in my claim when I attended a Bureau board meeting, and I was quoted in the Bismarck Tribune, having voiced my concerns openly. Once the 'crisis' was past, it became business as usual.

During my initial conversation with Mr. Traynor, he pridefully pointed out the large number of claims which were accepted by the Bureau. Because of my experiences with the Bureau, I pointed out that accepting a claim and then denying virtually every request for treatment was worse than denying the claim. This is the situation in which I find myself yet again.

I was recently referred by my treating physician, Dr. James Torrance MD, to a neurosurgeon, Dr. M. Syrquin DO. Dr. Syrquin requested authorization for an MRI. The request was denied. This, despite the fact that the Bureau had previously given carte blanche in advance for any testing to one of their approved consultants, if this testing would be useful in denying my claim. A copy of the Bureau's letter to the consultant is attached. It would appear that the Bureau uses its medical management contractor, Encompass, when it suits them, but can and will bypass them as 'needed'.

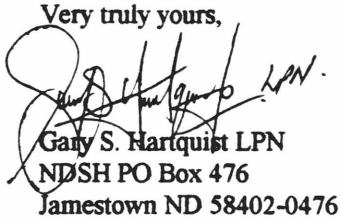
It has been more than two years since I had an MRI. My condition has worsened. I am in constant pain. I have virtually no reflex in my left leg. Because Dr. Syrquin considers me a possible candidate for a newer type of spinal fusion, the MRI is a necessity.

I really do not know where else to turn. I cannot afford an attorney and the Bureau can assemble squads of Special Attorneys General at will. This time, Goliath is beating the heck out of David.

Is the Bureau legally entitled to impede my medical care in this fashion? Can they accept my claim but refuse to authorize appropriate tests and treatments by hiding behind managed care as it suits them?

If there is any guidance or help you can provide to me, I would be eternally grateful.

Very truly yours,



Gary S. Hartquist LPN
NDSH PO Box 476
Jamestown ND 58402-0476 Tel.: 701 251 2853

Copies to: Dr. James Torrance MD, Dakota Clinic Jamestown

Encl: Correspondence WCB to Dr. Melissa Ray DO

GSH/...

Workers Compensation Bureau
500 East Front Avenue
Bismarck, North Dakota 58504-5685

Pat Traynor
Executive Director & CEO

July 10, 1998

Dr Melissa Ray
1087 Rivershyre Dr
Evans GA 30809

RE: Claim No. 96 519054 N57
Gary Hartquist
DOB: 01/12/54

Dear Dr. Ray:

Thank you for agreeing to perform an independent medical evaluation on Mr. Gary Hartquist following his PPI evaluation scheduled on July 29, 1998 in Minot, North Dakota.

The Bureau recently had Mr. Hartquist's medical file reviewed by Dr. Ralph Kilzer, Bureau Medical Consultant. It is Dr. Kilzer's opinion that Mr. Hartquist's complaints of back pain are the result of ongoing progressive degenerative disc disease. I have attached a copy of Dr. Kilzer's comments (memo dated June 27, 1998 to Diane Waliser) for your review. After your review of the attached medical records and examinatio[redacted] Mr. Hartquist, your response to the following questions would be appreciated:

1. Dr. Torrance, Mr. Hartquist's treating physician, has indicated that the Bureau is liable for problems Mr. Hartquist is experiencing with his knees. In your opinion, is there any relationship between the problems Mr. Hartquist is experiencing with his knees and the low back strain sustained on April 17, 1996?

2. Is there any relationship between Mr. Hartquist's diagnosis of degenerative disc disease and the injury he sustained on April 17, 1996?

3. Mr. Hartquist's diagnosis at the time of the injury, April 17, 1996, was a low back strain. Has this low back strain resolved?

4. In your opinion, what is currently causing Mr. Hartquist's low back pain?

5. Do you agree with Dr. Kilzer's opinion that Mr. Hartquist's problems are basically related to his pre-existing ongoing progressive degenerative disc disease, and that the soft tissue component of any strain that he had on April 17, 1996 has resolved?

As indicated in our phone conversation of April 9, 1998 the N.D. Workers Compensation Bureau will pay for any costs incurred for the use of the medical facility in which you complete your examination of Mr. Hartquist.

Thank you again for your assistance in this matter. If you have any questions or need any further information please do not hesitate to contact me at 701-328-3882. Please refer to the above claim number when contacting the Bureau.

Sincerely,

Diane Waliser
Senior Claims Analyst

DW/lm

Enc.

cc: Dr. James Torrance
Medical Arts Clinic
Attention David Dansl

Decline In Workers' Compensation Rates Leaves Insurers With Huge Tab

Dow Jones Business News
March 5, 1999

By Deborah Lohse, Staff Reporter of The Wall Street Journal

A sharp decline in workers' compensation rates is roiling the insurance industry, which now faces at least $1 billion of losses from the coverage, analysts and industry executives said.

Already, the prospect of mounting losses has spawned at least one lawsuit involving major insurers, in a dispute over who would be liable for picking up any tab.

One of the most significant signs of the industry's troubles came late last month when Cologne Re, a reinsurance unit of Berkshire Hathaway Inc., said it would take a $275 million charge to add to reserves to cover claims related to its workers' compensation business.

The charge is related to coverage that was arranged through Unicover Managers Inc., a unit of Delphi Financial Group Inc., Wilmington, Del. Unicover acts as a middleman between primary insurers that sell workers' compensation coverage to the nation's employers, and reinsurers that take on some of the risk from actual workers' injuries and other claims in exchange for a slice of the premiums.

Rates have fallen so far over the past few years that the pools of workers' compensation coverage organized by Unicover, involving many insurers and reinsurers, contain possibly large amounts of unprofitable business, analysts said. Some analysts estimated that the business written through the pools will generate losses and expenses that are as much as $1.25 billion to $2.5 billion greater than the premiums collected in recent years. It isn't immediately clear which insurers and reinsurers beyond the Berkshire Hathaway unit will be affected.

The lower rates, of course, have been good news for the nation's employers, which are generally required to purchase workers' compensation insurance to cover on-the-job injuries. But if losses materialize as the analysts are predicting, employers may find rates creeping upward again. The current turmoil "adds significant incremental pressure for a 'turn' in the workers' compensation market," according to Alice Schroeder, a PaineWebber Inc. insurance analyst.

Delphi stock has been especially hard hit lately. Its shares have dropped more than 30% since late February. Yesterday, Delphi shares closed at $40.375 in New York Stock Exchange composite trading, down 12.5 cents.

Adding to Delphi's problems is criticism from some Wall Street analysts and institutional investors that Delphi allegedly failed to adequately disclose in recent weeks that some key reinsurers in the pools have terminated their relationships with Unicover, said PaineWebber's Ms. Schroeder.

(continued)

Robert Smith, a Delphi spokesman, said its level of disclosure was adequate because Unicover has been negotiating with "a variety of parties" to replace the departing reinsurers, and while new workers' compensation coverage isn't currently being arranged by Unicover, the terminations are immaterial to Delphi's results because they don't "affect current arrangements."

Among the reinsurers that have ended their Unicover dealings are the Berkshire Hathaway life-reinsurance unit, which cited, among other things, regulatory concerns. Analysts said more such terminations could follow; in a bulletin issued last week, Connecticut's insurance commissioner said reinsurers licensed in the state to reinsure life insurance shouldn't be reinsuring workers' compensation coverage, which requires special licensing and expertise. Unicover's reinsurers included life reinsurers besides the Berkshire Hathaway unit.

Delphi's Mr. Smith played down the effect the Connecticut bulletin would have on Unicover.

Meanwhile, in a lawsuit filed last month in New York State Supreme Court, American International Group Inc. alleged that Unicover and ReliaStar Life Insurance Co., a unit of ReliaStar Financial Corp., repudiated reinsurance contracts that would have mitigated AIG's exposure to the business written in the Unicover pools. AIG is seeking enforcement of the contracts and specified monetary damages.

Delphi's Mr. Smith said Unicover disputes that a reinsurance deal was ever in place. ReliaStar also denied the allegations, adding: "We have no reason to believe that the resolution of this matter will result in material losses to ReliaStar."

Anne Colden contributed to this article.