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Medical Care Provided Under California's Workers' Compensation Program

Effects of the Reforms and Additional
Opportunities to Improve the Quality and
Efficiency of Care

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Prepared for the Commission on Health and Safety and Workers' Compensation



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Summary

California's WC system was at the center of intense debate and legislative activity during the period leading up to reforms in 2003 and 2004. High rates of growth in medical care expenditures stimulated a series of reform efforts to control medical-treatment expenses for injured workers and to improve program efficiency. CHSWC asked RAND to examine the impact that such policy changes could have on the medical care provided to injured workers. This monograph focuses on policies and incentives in the postreform period that affected the use and costs of care and recommends policy changes that would improve the quality and efficiency of care.

Key Reform Provisions

The most-important new policies affecting the medical treatment provided to injured workers were the following:

- Adopt medical-treatment guidelines as presumptively correct medical treatment. Previously, the medical decisions of the primary treating physician were presumptively correct.
- Limit chiropractic, physical therapy, and occupational therapy services to 24 visits per industrial injury.
- Require that injured workers of employers with medical provider networks (MPNs) use network providers throughout the course of their treatment. If the employer does not have an MPN, the prior rules remain in effect that allow the employer to control provider choice for the first 30 days and permit the injured worker to choose the primary treating physician after 30 days.
- Establish new standards for utilization review (UR) processes.
- Create a second-opinion program for spinal surgery.
- Revise the Official Medical Fee Schedule (OMFS) to do the following:
 - Include additional inpatient hospital services facility and facility fees for outpatient surgery and emergency services, and provide for annual updates for inflation and other changes based on 120 percent of Medicare fee-schedule amounts.
 - Lower allowable fees for pharmaceuticals to Medi-Cal rates, and require generic drugs.
 - Reduce physician fees 5 percent, and authorize the administrative director (AD) of the Division of Workers' Compensation (DWC) to implement a new fee schedule for physician services.

Purpose and Approach

Our purpose in this study was to analyze the effects that these new policies had on access to medically appropriate care and efficiency of service delivery. We also recommend additional changes that might increase both quality and efficiency of care in California's WC system. We were unable to obtain access to longitudinal claim-level data spanning the prepost reform periods that are needed to analyze fully the legislative changes' impacts on medical treatment provided to injured workers. As a result, we focused on how the reforms affect access to medically appropriate care and its quality and efficiency. Specifically, we addressed the following questions:

- What has been the reform provisions' impact on overall medical expenditures and on the use and payments for major types of services? Would additional policy changes improve the quality or efficiency of care, reduce administrative burden, or improve program oversight?
- What has been the experience to date with medical provider networks? Should additional policy changes be considered to improve the performance of medical provider networks?
- What has been the reform provisions' impact on medical cost-containment expenses and selected activities, i.e., UR and resolving medical-necessity disputes? Would additional policy changes increase administrative efficiency?
- Is it feasible to use the WC information system (WCIS) to establish an ongoing system for monitoring access to medically appropriate care? What are its limitations, and how might they be addressed?

To address these questions, we pursued several approaches. We conducted interviews with knowledgeable individuals involved in the WC medical-treatment system from different perspectives: self-insured employers, payers, providers, applicants' attorneys, state regulators, WC appeals judges, and researchers. We also conducted a literature review of pertinent reports and regulations involving WC in California and other states. And we analyzed two kinds of administrative data: data from California's Office of Statewide Health Planning and Development on inpatient hospital services, ambulatory surgery facility services, and emergency room services provided to WC patients; and medical-service data for services provided in 2007 by WCIS, the first full calendar year for which data have been submitted.

We summarize here what we learned about the reforms' effect on the utilization and costs of care, medical provider networks, and administrative processes and expenses.

Utilization and Costs of Care

Our examination of overall changes in annual medical expenditures for WC medical care shows the following:

- Total annual paid medical losses fell sharply following implementation of the reform provisions but have been rising since 2008. These aggregate losses have been affected not only by the medical-reform provisions but also by significant reductions in the number of WC claims.

- Reduced payments to providers were the major contributing factor to the initial reductions in annual paid losses. Subsequently, expenses for actual medical care have been rising less rapidly than expenses related to administration of the medical benefit, such as medical cost-containment expenses, medical-legal expenses, and direct payments to workers (which are mostly claim settlements).
- Paid medical losses remain significantly lower than they would have been in the absence of the reform provisions but continue to be higher than those of WC programs in other states.

Since it is unlikely that the reduction in the number of new WC claims is related to implementation of the reform provisions, per-claim measures of medical expenses might be more relevant than the measures of aggregate expenditures. In this regard, one important metric is average paid medical losses by accident year at a common maturity date. For insured claims involving indemnity payments for temporary or permanent disability, the average first 12 months of paid medical losses were at their lowest level in accident year 2005 and subsequently have been increasing 13.1 percent annually. Further research is needed to determine how the decline in WC claims has affected cost trends and the severity of injuries.

Physician and Other Practitioner Services

Physician and other practitioner services were most affected by the changes in medical-treatment policies, especially policies that required the adoption of medical-treatment guidelines and the limitation on chiropractic, physical therapy, and occupational therapy services to 24 visits per industrial injury. Estimated system-wide payments (by insurers and self-insured employers) for physician and practitioner services declined from a high of \$3.7 billion in 2003 to \$2.1 billion in 2009.

Stakeholders interviewed in 2006–2007 believed that the guidelines were well designed for acute conditions but were deficient for not addressing chronic pain, alternative therapies, and use of pharmaceuticals. These concerns have largely been addressed through additional guidelines for acupuncture and chronic pain, although it is too early to assess the impact of these new guidelines.

However, two other concerns expressed by stakeholders might remain applicable. First, concerns were often expressed not about the guidelines per se but that they were being applied too stringently during UR and that insufficient attention was paid to the individual patient's condition that might warrant deviation from the guidelines. Second, there were some concerns that the Labor Code requirement that any medical guidelines to be adopted must be evidence based, nationally recognized, and peer reviewed precluded providing needed guidelines for therapies that do not have a robust evidence base. This issue has most recently arisen with respect to compound drugs and medical foods, for which there is limited evidence on which to establish guidelines.

In 2007, overall utilization of physician and other practitioner services in California during the first 12 months of a claim fell from being about 50 percent more than the median for a multistate comparison group in the prereform period to slightly less than the median. Impact of the changes was greatest on chiropractic care, an estimated 81-percent reduction in total payments between 2003 and 2009 that reflects the imposition of the 24-visit-per-injury limitation and the impact of the American College of Occupational and Environmental Medicine (ACOEM) guidelines. California continues to use substantially more evaluation and

management (E/M) services than other states with about the same number of visits per claim as prereform.

The current fee schedule is outdated and should be replaced by a resource-based fee schedule that creates better incentives to provide appropriate care, by aligning payments with the costs of care. In the aggregate, the allowances for practitioner services are currently about 111 percent of the Medicare fee-schedule rates, which is a lower differential than is allowed for the fee schedules for hospital and ambulatory surgery facility services. Because having high-quality physicians is fundamental to increasing the value of medical care provided under the WC system, paying relatively less for physician services than other services is short sighted. In lieu of across-the-board increases for E/M services, it might be more effective to create payments for activities that are unique to work-related injuries. For example, Washington's quality-improvement initiative reimbursed physicians for calls to employers of injured workers to coordinate return to work and rewarded physicians who filed timely reports (Wickizer, Franklin, et al., 2004).

Inpatient Hospital and Ambulatory Surgery Services

Expenditures for inpatient hospital services declined with the expansion of the OMFS to high-cost inpatient services, such as trauma and burns, but they have since risen above prereform levels because of regular updates for inflation and other factors. We identified two potential inefficiencies: a duplicate payment for hardware implanted during spinal surgery and the inflationary impact of improvements in coding that increase payments without a corresponding increase in the costs of care.

The OMFS was also expanded to cover facility fees for ambulatory surgery services provided by hospitals and freestanding ambulatory surgery centers, which have a lower cost structure than hospitals. Paying a lower rate to freestanding surgery centers would increase the value of those services and reduce the incentive to shift care inappropriately from hospitals and physician offices. The savings from eliminating unnecessary institutional expenditures could be used to reduce employer costs or increase payments to physicians and other practitioners.

Outpatient Drugs and Other Pharmaceuticals

Despite the reform provisions affecting outpatient drugs, there has been significant growth in both the average number of prescriptions and the average payment per claim for prescriptions (Swedlow, Ireland, and Gardner, 2009). One cause for the increase is physician-dispensed compound drugs, and convenience packaging of drugs and medical foods (co-packs). Another important contributing factor has been a growing use of Schedule II medications (drugs with accepted medical use that have a high potential for abuse or addiction). Both issues were addressed to some extent in the medical-treatment guidelines that were issued in 2007 for chronic pain. It is too early to know how effectively the guidelines will address the pharmaceutical overuse issues, but it appears that that additional guidelines are needed to address compound drugs and medical foods and that OMFS changes are needed to ensure that allowances for these products are reasonable. However, the experience with earlier attempts to address pharmaceutical overuse suggests that the benefits gained from making these policy changes are likely to be temporary unless greater attention is given to improving the overall physician incentives.

Medical Provider Networks

Under the reform provisions, a self-insured employer or insurer may establish an MPN to provide care to injured workers throughout their course of medical treatment. Unless a worker has predesignated a personal physician as his or her primary-care physician prior to his or her injury, the employer assigns the worker to a network physician for initial medical treatment. The worker is free to choose another provider within the network after the first visit but has very limited rights to receive out-of-network care.

As of March 2011, there are 1,401 active MPNs. The MPN penetration rate is uncertain, but it appears that most care is provided under either an MPN contract or another type of contract. The combined proportion of payments made under MPNs and other contracts for accident year (AY) 2007 is 59 percent and lower for older claims. Currently, most MPNs are broad panels selected primarily to meet access requirements and provide fee-discounting opportunities. A few payers—most notably, some self-insured employers—have contracted selectively with providers.

With a few notable exceptions, another administrative entity usually forms the MPN and contracted directly with network physicians. The payer contracts with that administrative entity to “lease” the provider network and does not directly contract with the physicians. The administrative entity leases the same network to multiple payers, resulting in different payers applying for MPN approval for the same group of providers. This creates unnecessary administrative burden and makes it difficult to assess the performance of individual MPNs. As a practical matter, accountability for network performance is not clearly established, and information needed to assess adequacy of network coverage is not obtained. Reapproval is required when there is a material modification (including a 10-percent change in network providers), but there is no recertification process, and the AD has no intermediate sanctions for poor performance—termination is the only recourse for MPNs that fail to meet the required standards.

These shortcomings could be remedied through changes in the Labor Code. The most important change would be to change the definition of the applicant for MPN approval to be the group of providers or entity that establishes the MPN (employer, insurer, or other administrative entity). This would streamline the approval process and better align legal accountability with operational accountability for meeting MPN standards.

Other issues that were identified during our interviews and potential changes to address them include the following:

- The employer or insurer has the exclusive right to determine the members of its network but is not explicitly relieved of the burden of proving that due process was used in the provider selection process. The Labor Code provision that allows the payer to be selective in provider contracting could be strengthened.
- When provider networks are leased, a provider might not be aware of its responsibilities as an MPN provider. A written agreement could be required between the MPN and network physician outlining the physician’s responsibilities as a network provider.
- Most workers either are not aware of the right to predesignate or do not anticipate that they will have an injury that they would like to have treated by their personal physician. The Labor Code could be revised to allow an injured worker to designate his or her per-

sonal physician as primary treating physician after an injury occurs if the physician agrees to abide by the MPN rules and refer only to the MPN.

Medical Cost-Containment Expenses and Activities

Medical cost-containment activities are payer actions to monitor and manage the price, use, and volume of medical services and products based on clinical efficiency and need. The expenses for these activities have risen rapidly since the implementation of the reform provisions. Because the categories of expenses are not reported separately, it is difficult to determine the reasons for the increases, although it appears that major factors are expenses incurred for leasing MPNs and costs associated with medical-necessity determinations.

In our stakeholder interviews, providers raised considerable concern over the UR process. Major concerns included the application of the medical-treatment guidelines as “hard and fast” rules with reluctance to approve any deviations from the guidelines, across-the-board review of all services, and excessive and unreasonable levels of documentation being required to substantiate medical necessity. Results from a University of Washington provider survey found that at least four of the top five barriers to care cited by physicians were related to the UR process and strict application of the medical-treatment guidelines.

It is difficult to analyze decisions made during the UR process because most care is reviewed prospectively and might never enter the bill processing or appeal processes. DWC undertakes routine UR investigations that do inform whether UR procedural requirements are being followed and provide an overview of the types of UR reviews and decisions but do not address the quality of the decisionmaking process. Summary measures are reported for the timeliness of the responses, whether the content of the notice was proper, and whether the notice was distributed to the proper individuals. Most faulty responses involved timeliness of decisions (7.5 percent of cases). Overall, 7.5 percent of decisions involved an untimely response.

In our interviews, some stakeholders expressed concerns about the complexity, timeliness, and appropriateness of the dispute-resolution process for medical-necessity determinations. The current independent medical review process for MPN medical-necessity disputes is not functional because workers may simply keep changing physicians when there is a dispute over appropriate medical care. A large share of expedited hearings and many regular hearings involve medical-necessity issues. When these issues reach hearings, judges make decisions based on their understanding of evidence presented to them, but the rulings on these issues are not decided by medical experts in the medical treatment at issue.

Potentially, external review of medical-necessity issues could reduce the complexity of California's dispute-resolution process, increase the timeliness and appropriateness of medical-necessity appeal determinations, and reduce medical cost-containment expenses. There are various models that use external review organizations in deciding medical-necessity disputes. Timely and impartial independent medical review (IMR) decisions would improve the quality of medical-necessity decisions because such issues would be decided by medical experts instead of judges in an administrative process. To reinforce the use of the IMR process, a limit could be established on the number of times the worker may change physicians within the same specialty without MPN permission (e.g., several states provide that the employee may change initial provider twice and authorized specialist twice). This would encourage resolution

of medical-necessity issues through the dispute-resolution process rather than through switching providers and reduce inefficiencies inherent in changing physicians.

Monitoring System Performance Through the Workers' Compensation Information System

The overarching purpose of performance-measurement systems is to provide information that will enable policymakers and other stakeholders to identify areas in which performance is sub-optimal. This then allows for the prioritization of identified issues, as well as the development of policies and interventions that will facilitate improvements in performance. These same systems can then be used to evaluate the effects of reforms and interventions.

Complete and reliable reporting to the WCIS is key to DWC's ability to monitor performance. Medical data reporting is required for all services provided on or after September 22, 2006. DWC reports that WCIS data are incomplete, with approximately 11–12 percent of claims not reported into the system and further underreporting of medical data (California Department of Industrial Relations, 2011). Section 138.6 of the Labor Code, which sets out the AD's authority with respect to reporting requirements for the WCIS, does not include penalties for the failure of a claim administrator to comply with the electronic data-reporting requirements. Notably, two of the three other states with medical data-reporting requirements (Florida and Texas) both have financial penalties associated with failure to comply with reporting compliance. Texas has very high compliance rates; achieving such rates is likely possible only when requirements are paired with financial penalties for noncompliance. (Like California, Oregon does not have any penalties.)

There are many significant challenges to implementing a performance-monitoring system that focuses on the quality of medical care delivered to injured workers. To date, very few measures assessing the appropriateness of care can be supported using only medical data. These, combined with measures of utilization selected with input from providers and other stakeholders for common types of WC illnesses and injuries, could form the initial efforts to measure performance. These efforts could be enhanced and built upon as new measures become available and the use of electronic medical records becomes common. As more information is reported through other measurement activities, such as the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System, the feasibility and stakeholder receptiveness to the inclusion of data reported to national performance-assessment efforts supported by all-payer data (as opposed to data on WC payers alone) in a WC monitoring system should be assessed.

Recommendations

The medical-treatment system for WC is complex and multifaceted. We have limited our review to selected aspects of the system that were affected by the reform provisions and areas in which we believe further policy changes would improve system performance. The following recommendations would improve the incentives for providing medically appropriate care efficiently, increase accountability for performance, facilitate DWC monitoring and oversight, and reduce administrative burden.

Create Incentives for Providing Medically Appropriate Care Efficiently

The value of medical treatment would be improved by doing the following:

- Implement a resource-based fee schedule that provides for regular updates and equitable payment levels.
- Create nonmonetary incentives for providing medically appropriate care. Within the MPN context, incentives could be created through more-selective contracting with providers and reducing UR and prior-authorization requirements for high-performing physicians.
- Reduce unnecessary expenditures for inpatient hospital care by eliminating the duplicate payment for spinal hardware and the inflationary impact of coding improvement.
- Reduce unnecessary expenditures for ambulatory surgery by reducing the OMFS multiplier for procedures performed in freestanding ambulatory surgery centers.
- Reduce the incentives for inappropriate prescribing practices by curtailing in-office physician dispensing.
- Implement the pharmacy benefit network provisions.

Increase Accountability for Performance

Accountability for performance could be increased by making the following revisions in the Labor Code:

- Revise the MPN certification process to place accountability for meeting MPN standards on the entity contracting with the physician network.
- Strengthen DWC authorities to do the following:
 - Provide intermediate sanctions for failure to comply with MPN requirements.
 - Provide penalties for the failure of a claim administrator to comply with the data-reporting requirements.
- Modify the Labor Code to remove payers and MPNs from the definition of *individually identifiable data* so that performance on key measures can be publicly available.

Facilitate Monitoring and Oversight

Program oversight activities could be facilitated by the following:

- Provide DWC with more flexibility to add needed data elements to medical data reporting, e.g., revise the WCIS reporting requirements to require a unique identifier for each MPN.
- Require that medical cost-containment expenses be reported by category of cost (e.g., bill review, network leasing, UR, case management).
- Compile information on the types of medical services that are subject to UR denials and expedited hearings.
- Expand ongoing monitoring of system performance.

Increase Administrative Efficiency

Efficiency in the administration of medical benefits could be increased by the following:

- Use an external medical review organization to review medical-necessity determinations. A separate dispute-resolution process for medical-necessity determinations also creates a mechanism to monitor the quality of payer decisions and to identify areas in which expansions or revisions in the MTUS are needed.
- Explore best practices of other WC programs and health programs in carrying out medical cost-containment activities.

Issues Needing Additional Research

There are several aspects of the medical-treatment system that warrant additional investigation.

Cost of Care. An increased understanding of the reasons behind the postreform changes in the costs of medical care is needed. This could be done by decomposing the WC cost experience into various components: price, utilization, claim volume and mix (industry and type of injury), and benchmarking the results to relevant WC and other health program experience. In the short run, this type of comparison will help explain the factors contributing to the changes in annual paid losses. In the long run, the methods developed to do so could be incorporated into a performance-monitoring system.

Quality of Care. With regard to quality of care, there are many significant challenges to developing appropriate measures for a performance-monitoring system. To date, very few measures assessing the appropriateness of care can be supported using only medical data. These, combined with utilization measures selected with input from providers and other stakeholders for common types of WC illnesses and injuries, could form the initial efforts to measure performance. These efforts could be enhanced and built upon as new measures become available and the use of electronic medical records becomes common. As more information is reported through other measurement activities, such as the CMS Physician Quality Reporting System, the feasibility and stakeholder receptiveness to the inclusion of data reported to national performance-assessment efforts supported by all-payer data in a WC monitoring system should be assessed.

Work-Related Outcomes of Care. The literature concerning the impact of the reform provisions has focused on changes in the use and costs of medical services. Additional work is needed to understand how work-related outcomes, such as days lost from work and return to work, are affected by differences in patterns of service. This type of analysis will require linking transaction-level medical data with other administrative data sets.

Comparative Performance. On the basis of our stakeholder interviews, we identified selective contracting as an MPN best practice. Further research is needed to compare the pattern and costs of care under different contracting arrangements and to assess whether the narrow WC networks have better outcomes and cost-efficiency than broad networks.