Physician Reporting Requirements for Injured Workers in California

A Review of Reporting Processes and Payment Policies

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Preface

California's workers' compensation (WC) program provides medical care and wage-replacement benefits to workers who suffer on-the-job injuries and illnesses. Individuals who are injured on the job are entitled to receive the medical care they need to relieve the effects of their injury with no deductibles or copayments. Physicians who treat and provide care to injured workers are required to file reports with the WC payer that address the worker's treatment, medical progress, and work-related issues. California's Division of Workers' Compensation (DWC) asked RAND to review the reporting process and pricing structure of WC-required reports to ensure that the policies are consistent with efficient program administration. This report provides a framework for understanding the current processes for filing WC-required reports in California and establishes a baseline for comparison with other state systems. The objective of this report is to provide an assessment of WC-required reports, including the structure and content, level of effort, allowances, and to compare the elements and processes with other systems to inform potential improvements and further refinements to California's reporting requirements and policies. The report should be of general interest to stakeholders in California's WC system and in other WC programs.

This research was undertaken for the Department of Industrial Relations under contract 41336064. It was conducted under the umbrella of RAND's Justice Policy Program.

RAND Justice Policy

The research reported here was conducted in the RAND Justice Policy Program, which spans both criminal and civil justice system issues with such topics as public safety, effective policing, police–community relations, drug policy and enforcement, corrections policy, use of technology in law enforcement, tort reform, catastrophe and mass-injury compensation, court resourcing, and insurance regulation. Program research is supported by government agencies, foundations, and the private sector.

This program is part of RAND Justice, Infrastructure, and Environment, a division of the RAND Corporation dedicated to improving policy- and decision-making in a wide range of policy domains, including civil and criminal justice, infrastructure protection and homeland security, transportation and energy policy, and environmental and natural resource policy.

This report also drew on the expertise in RAND Health, one of the most trusted sources of objective health policy research in the world.

Questions or comments about this report should be sent to the project leader, Barbara O. Wynn (Barbara_Wynn@rand.org) or Denise D. Quigley (Quigley@rand.org). For more information on RAND research on workers' compensation, see https://www.rand.org/topics/workers-compensation.html.

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California's workers' compensation (WC) program provides medical care and wage-replacement benefits to workers who suffer on-the-job injuries and illnesses. Injured workers are entitled to receive all medical care reasonably required to cure or relieve the effects of their injury with no deductibles or copayments. Physicians caring for injured workers are required to file reports with the WC payer (insurer or self-insured employer) that address the employee's treatment, medical progress, and work-related issues. California's Division of Workers' Compensation (DWC) asked RAND to review the reporting process and the pricing structure of the WC-required reports to ensure that the policies are consistent with efficient program administration.

Project Objectives and Methods

Our review and assessment of WC-required reports had several objectives:

- To characterize the current processes for filing WC-required reports in California. This included the level of effort involved, timelines, and allowances for the various reports.
- To compare the reporting requirements and processes in California to those of other populous states. This part of the study was designed to analyze how California's required reports differ from those of other states and assess whether other state systems could inform potential improvements to California's reporting requirements and payment policies.
- To identify attributes of high-quality reports, as perceived by physicians and users of WC-required reports. Characteristics of quality reporting could help to identify needs for further refinement and circumstances under which reporting can be most effective.
- To identify reporting and payment issues and explore potential opportunities for improvement in policies related to WC-required reports.

The research team conducted three main tasks to evaluate the California WC-required reports. We first conducted an environmental scan of the 20 most populous states' WC-required reports (other than California) and compared them to California's along several dimensions: intended purpose, reporting requirements (by whom, when, and to whom), filing processes (format, mode, and deadlines), data elements, and fee schedule policy. The environmental scan included informal interviews with WC agency staff in other states to confirm our findings. Second, we conducted exploratory semistructured interviews with physicians and users of WC reports in California to validate the gathered information on the processing and filing of reports, to uncover any inconsistencies or areas of confusion, and to understand the issues with each of the WC-required reports. We followed our exploratory interviews with a set of discussions with physicians and users to review and better understand what we had learned about each of the reports and discussed potential options for improvement. Third, we compared the

allowances for the WC-required reports under the Official Medical Fee Schedule (OMFS) with the allowances for other services that require comparable physician activities and estimated the impact of any changes in the fee schedule allowances on medical expenditures.

Our research was completed prior to the enactment of Senate Bill (SB) 1160 (Mendoza) on September 30, 2016. This legislation amended the Labor Code to require that the Doctor's First Report of Occupational Injury or Illness (DFR) be filed electronically with DWC. In addition, the Labor Code was revised to require DWC to develop a system for electronic reporting by employers of documents related to utilization review.

Overview of Reporting Requirements

Table S.1 provides an overview of California's current reporting requirements and any fee schedule allowances that have been established for each report. The reporting forms and time frames are applicable unless the payer and provider mutually agree to an alternative format or time frame. Similarly, the fee schedule allowances apply unless the payer and provider contractually agree to a different amount.

Table S.1. Summary of California Reporting Requirements, Frequency, and Fee Schedule Amount

Doctor's First Report of Occupational Injury or Illness (DFR)	
Timeline	Required within 5 days after initial examination of the injured worker
Frequency	One-time requirement
2016 Allowance	No separate allowance
Primary Treating Physician's Progress Report (PR-2)	
Timeline	Required every 45 days or more frequently
Frequency	Multiple; every 45 days or more frequently when warranted
2016 Allowance	Separate allowance of $12.14 per report
Request for Authorization (RFA)	
Timeline	Required with each request for treatment
Frequency	Multiple; required with each request for treatment
2016 Allowance	No separate allowance
Permanent and Stationary (P&S) Report (PR-3 or PR-4)	
Timeline	Required once the injured worker's condition has become permanent and stationary
Frequency	One-time requirement
2016 Allowance	The PR-3 and PR-4 are separately payable with a maximum allowable amount of $39.42 for the first page, and $24.25 for each additional page. The PR-3 and PR-4 are limited to six and seven pages, respectively, unless the payer and provider agree to a longer report.
Physician's Return-to-Work (RTW) and Voucher Report	
Timeline	Required once the injured worker's condition has become permanent and stationary, and due within 20 days of patient's last examination
Frequency	One-time requirement
2016 Allowance	No separate allowance

Potential Improvements in Physician Reporting Requirements

The reports required from physicians treating injured workers are intended to facilitate claims management in both managing the patient's medical care and monitoring the patient's progression toward maximal medical improvement and return to work. Within this overall framework, the reporting requirements should be designed to provide information needed for claims management and care coordination while imposing minimal administrative burden on treating physicians. The reporting cycle and data elements should be evaluated based on whether they add value to the claims management process. The fee schedule should account for reporting burden that is not otherwise incorporated into the allowance for the related medical care, and any separate allowances should be designed to encourage high-quality reporting in a timely manner.

We identified three overarching refinement objectives during our evaluation of the individual WC-required reports: reduce administrative burden, facilitate care coordination, and align fee schedule policies with reporting objectives. We found opportunities for improvement in each area. After reviewing potential options, we recommend that DWC consider the following policy refinements to further these objectives:

- To reduce administrative burden:
  - Require a DFR only from the first primary treating physician and, if applicable, the first physician who examines the worker following a work-related incident who will not continue to treat the patient (e.g., a physician providing first aid or an emergency room physician). Eliminate the requirement that a new primary treating physician file a DFR. We found that additional DFRs did not add value to the claims management process.
  - Combine the PR-2 and the RFA into a single form that clearly indicates when treatment authorization is being requested. There are redundancies and duplication of effort that could be eliminated with a single form.
  - Eliminate the redundancies between the P&S report and the RTW and Voucher report. The reports are filed together but contain overlapping information on the worker's functional status.
  - Investigate whether to require electronic reporting for all WC-required reports and related documentation. This recommendation expands on the SB 1160 provisions because it would include all medical reports that the physician is required to submit to the claims administrator. Electronic transmission should improve the efficiency of the utilization review and claims management processes and provide opportunities for enhanced care coordination between primary and secondary treating physicians.[1]

[1] For the purposes of this report, electronic submissions include any of the following modes: online reporting system submission, uploaded PDF submission, and printed, scanned, or emailed submission. Consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of electronic transmissions, it does not include transmission of a paper form via facsimile (U.S. Department of Health and Human Services, 2013).

- To facilitate care coordination:
  - Clarify that secondary treating physicians should submit RFAs for proposed treatment related to their services but that the primary treating physician should be copied on the requests. With electronic submissions, this could be done without additional administrative burden.
  - Develop an abbreviated, combined PR-2/RFA for secondary physicians to use when requesting or modifying treatment that would be filed directly with the claims administrator with a copy to the primary treating physician. This would enable the primary treating physician to engage with the secondary physician as needed and reduce the burden on the primary treating physician in compiling progress reports.
- To align fee schedule policies with reporting objectives:
  - Pay for a fully completed DFR filed timely by the first primary treating physician at the same rate as the PR-2. The estimated impact on annual medical expenditures at 2017 PR-2 allowances would be $8.2 million, but if the PR-2 allowance were increased, the impact would be proportionately higher. The DFR is a WC-specific report that requires at least as much effort as the PR-2, which is separately payable.
  - Increase the allowance for a fully completed PR-2 filed by a primary treating physician to be comparable with resource-based relative value system (RBRVS) allowances for similar services (approximately $30 per report). Full compliance with the reporting requirements would increase annual expenditures for the PR-2 by approximately $40 million. The actual impact depends on the completeness of current reports, the rate of improvement in report completeness, and the administrative savings from receiving timely and complete progress reports.
  - Consider restructuring the allowance for a P&S report.
    - Establish a combined allowance for the P&S evaluation, any related prolonged services, and the report that accounts for differences in case complexity. The evaluation and report are integrally related, and some activities, such as extensive medical record review and determination of the impairment level, could be performed either as part of the evaluation or in completing the report. Because there is ambiguity concerning how much record review is already accounted for in the OMFS allowances for the evaluation and report, the separate allowance for prolonged services creates the potential for duplicate payments.
    - After the medical-legal fee schedule has been evaluated for reasonableness in relation to RBRVS allowances, use the findings to determine a reasonable allowance for the primary treating physician's impairment evaluation and report. The combined allowances for the P&S evaluation and report are undervalued in relation to similar services paid under the RBRVS and substantially lower than the allowances under the medical-legal fee schedule.
    - Give the primary treating physician the option of not evaluating the impairment level and completing the P&S report. Incomplete or inaccurate

reports submitted by a physician who either has little experience with the American Medical Association (AMA) guides or little inclination to prepare a high-quality report do not add value and slow claim closure, and the requirement for the P&S report may deter physicians from becoming primary treating physicians for injured workers.

- Use the allowance for the DFR and any increases in the allowances for other reports to incentivize timely electronic submissions of high-quality WC-required reports.

If implemented, our recommendations will result in substantial increases in expenditures for WC-required reports. However, if the allowance for the DFR and any increases in the allowances for other reports are used to incentivize the timely filing of high-quality WC-required reports, there will be savings from greater efficiencies in the claims management process. In addition, eliminating unnecessary administrative burden on providers, providing a choice regarding the completion of the P&S report, and establishing reasonable allowances that recognize the effort involved in filing the WC-required reports may encourage more physicians to treat California's injured workers.

Acknowledgments

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Abbreviations

AMA	American Medical Association
AME	agreed medical evaluator
CCR	California Code of Regulations
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DFR	Doctor's First Report of Occupational Injury or Illness
DWC	Division of Workers' Compensation
E&M	evaluation and management
EAMS	Electronic Adjudication Management System
EMR	electronic medical record
FROI	First Report of Injury (employer)
GAF	geographic adjustment factor
HCPCS	Healthcare Common Procedure Coding System
ICD-9	International Classification of Diseases, Ninth Revision
ML	Medical-Legal
MMI	maximal medical improvement
OMFS	Official Medical Fee Schedule
P&S	Permanent and Stationary
PE	practice expense
PR-2	Primary Treating Physician's Progress Report
PR-3	Primary Treating Physician's Permanent and Stationary Report (for ratings under the 1997 Permanent Disability Rating Schedule)
PR-4	Primary Treating Physician's Permanent and Stationary Report (for ratings under the 2005 Permanent Disability Rating Schedule and AMA guide)
PTP	primary treating physician
QME	qualified medical examiner
RBRVS	resource-based relative value system
RFA	Request for Authorization
RTW	Return-to-Work
RVU	relative value unit
SB	Senate Bill
UR	utilization review
WC	workers' compensation
WCIS	Workers' Compensation Information System

Chapter One: Introduction

California's workers' compensation (WC) program provides medical care and wage-replacement benefits to workers who suffer on-the-job injuries and illnesses. Injured workers are entitled to receive all medical care reasonably required to cure or relieve the effects of their injury with no deductibles or copayments. The WC program requires the following reports from treating physicians that address work-related issues:

- Doctor's First Report of Occupational Injury or Illness (DFR)
- Primary Treating Physician's Progress Report (PR-2)
- Request for Authorization (RFA)
- Primary Treating Physician's Permanent and Stationary (P&S) Report (PR-3 or PR-4)
- Physician's Return-to-Work (RTW) and Voucher report

These reports, and the maximum allowable fees established for providers completing them under the Official Medical Fee Schedule (OMFS), have not changed for a number of years.

Purpose

The Division of Workers' Compensation (DWC) in the Department of Industrial Relations, which administers California's WC program, asked RAND to review the utility of the WC-required reports and the pricing structure to ensure that the policies are consistent with efficient program administration within the context of policy changes resulting from the 2012 enactment of Senate Bill (SB) 863.[1] The payments and processes applicable to WC-required reports have not been reviewed comprehensively since the implementation of the SB 863 provisions. The goal of this study was to understand whether the post–SB 863 environment for medical care provided to injured workers necessitates any changes to the current reporting requirements and fee schedule for required reports. To do so, we explored the value added in submitting required reports, the burden associated with completing each of the required reports, and changes that could be made to the reporting system to improve efficiency within the WC system.

[1] SB 863, which was enacted on September 18, 2012, contained a number of provisions that touch on different aspects of the medical care system. The intent is to constrain the rate of increase in medical expenses through a combination of measures designed to improve the quality, efficiency, and timeliness of medical care provided to injured workers through improvements in the fee schedules and dispute resolution processes and increased accountability and oversight. This report does not address concerns related to the medical dispute resolution process or medical-legal evaluations.

Our review and assessment of WC-required reports had several aims:

- To characterize the current processes for filing WC-required reports in California. This included the level of effort involved, timelines, and allowances for the various reports.
- To compare the reporting requirements and processes in California to those of other populous states. This part of the study was designed to analyze how the required reports in California differ from those of other states and assess whether other state systems could inform potential improvements to California's reporting requirements and payment policies.
- To identify attributes of high-quality reports, as perceived by physicians and users of WC-required reports. Characteristics of quality reporting could help to identify needs for further refinement and circumstances under which reporting can be most effective.
- To identify reporting and payment issues and explore potential opportunities for improvement in policies related to WC-required reports.

Overview of Required Reports in California

This section provides an overview of the reporting requirements and allowances for WC-required reports submitted by physicians treating injured workers. Our focus was on the following required reports: DFR, PR-2, RFA, P&S report, and RTW and Voucher report. This section briefly describes the purpose of each report, the frequency and time frame for submitting each report, and any fee schedule allowance for submitting the report (which are summarized in Table 1.1). More detail is found in the respective chapters evaluating each report and in Appendix D.

Doctor's First Report of Occupational Injury or Illness

California law requires that any physician attending an injured worker file a DFR (DLSR 5021) within five days of an initial examination of an injured worker. This form is used to document the nature of an injury or illness, how it occurred, which body parts were injured, subjective complaints, objective findings, treatment rendered, diagnosis, and work status of the injured worker. The treating physician submits the report to the employer's WC insurance carrier or the self-insured employer (collectively referred to as "the payer"). Under the current medical fee schedule, the report is not separately payable but rather is included within the allowance for the underlying evaluation and management (E&M) visit.

Primary Treating Physician's Progress Report

Over the course of treatment for a WC claimant, primary treating physicians file the PR-2 every 45 days, or earlier if there is a change in the injured worker's treatment plan or work status. This form is used to update and record the patient's progress with respect to his or her subjective complaints; the primary treating physician's objective findings, diagnoses, and treatment plan, including treatment rendered to date; and the patient's work status. The report is

Table 1.1. Summary of California Reporting Requirements, Frequency, and Fee Schedule Amount

DFR	
Timeline	Required within 5 days after initial examination of the injured worker
Frequency	One-time requirement
2016 Allowance	No separate allowance
PR-2	
Timeline	Required every 45 days or more frequently
Frequency	Multiple; every 45 days or more frequently when warranted
2016 Allowance	Separate allowance of $12.14 per report
RFA	
Timeline	Required with each request for treatment
Frequency	Multiple; required with each request for treatment
2016 Allowance	No separate allowance
P&S Report (PR-3 or PR-4)	
Timeline	Required once the injured worker's condition has become permanent and stationary
Frequency	One-time requirement
2016 Allowance	Separately payable with a maximum allowable amount of $39.42 for the first page, and $24.25 for each additional page. The PR-3 and PR-4 are limited to six and seven pages, respectively, unless the payer and provider agree to a longer report.
RTW and Voucher Report	
Timeline	Required once the injured worker's condition has become permanent and stationary, and due within 20 days of patient's last examination
Frequency	One-time requirement
2016 Allowance	No separate allowance

typically billed along with an E&M visit and was separately payable at the rate of $12.14 per report in 2016.

Request for Authorization

DWC utilization review[2] rules provide that a treating physician should send the claims administrator an RFA for a specific course of proposed medical treatment. The form facilitates timely identification of prospective authorization requests by a claims administrator for purposes of initiating utilization review. The RFA must be accompanied by one of the following: a DFR, a PR-2, or an equivalent narrative report substantiating the requested treatment. The treating physician must indicate each specific requested medical service or treatment substantiated by the injured worker's diagnosis, including the diagnosis code, procedure code, and the frequency, quantity, and duration of the requested treatment. Under the medical fee schedule, the RFA is not separately payable.

[2] All issues related to utilization review will be addressed in a separate RAND study examining the impact of the SB 863 provisions. The report is currently being reviewed and cannot be cited.

Permanent and Stationary Report

The P&S report (PR-3, PR-4)[3] is designed for use by the primary treating physician to report the initial evaluation of permanent impairment to the claims administrator once the patient's medical condition has stabilized and if the patient has residual effects from the injury or may require future medical care. The report requires the physician to address impairment rating, apportionment, causation, functional capacity, and future medical treatment. The physician submits the P&S report within 20 days of examination. P&S reports are separately payable with 2016 fee schedule allowances of $39.42 for the first page and $24.25 for each additional page. A maximum of six pages is allowed absent mutual agreement for the PR-3, and up to seven pages absent mutual agreement for the PR-4 report. The examination is separately paid as an E&M visit.

Physician's Return-to-Work and Voucher Report

The RTW and Voucher report is used to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The report is required once the injured worker's condition has become permanent and stationary, and it is due within 20 days of the patient's last examination. The data on the form is for informational purposes and is not considered in any permanent impairment rating or any permanent disability indemnity. The primary treating physician who files the P&S report is responsible for including this report with the P&S report submission. There is no separate fee schedule allowance for the RTW and Voucher report.

Modes for Submitting Workers' Compensation–Required Reports

All WC-required reports may be submitted to the claims administrator by U.S. mail or by facsimile. DWC does not maintain an electronic management system for WC-required reports, nor has it adopted standards for electronic submission of the reports to payers.[4] Payers establish

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[3] The PR-3 is used for injuries occurring before 2005, and the PR-4 is used for injuries occurring in 2005 and later and for pre-2005 injuries that are subject to the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment*. The AMA guide is applicable to pre-2005 injuries if there has been no comprehensive medical-legal report or no primary treating physician report indicating the existence of a permanent disability. A physician may choose not to use the appropriate form as long as his or her report contains all the information required by 8CCR §10606.

[4] In contrast, DWC maintains two electronic record systems for other claims transactions. The Workers' Compensation Information System (WCIS) uses the standards adopted by the International Association of Industrial Accident Boards and Commissions for mandatory reporting of claims (Release 1.0) and medical data (Release 2.0). Provider use of e-billing (Release 2.0) is voluntary, but payers must be able to accept e-billing. The Electronic Adjudication Management System (EAMS) supports electronic filing and management of forms and attachments used in the WC court system and to record case information such as case participants, hearing dates, lien filings, etc. Common forms may be completed online and submitted on the EAMS website individually through a secure portal. Alternatively, large-volume form filers may use an electronic filing method that allows system-to-system filing of multiple documents in one filing. OCR paper versions of the forms may be sent to DWC for scanning and uploading into the EAMS.

their own policies on whether reports may be submitted electronically and the protocols for doing so. For example, one payer may have a secure website that receives uploaded PDF versions, another may accept PDF versions submitted via encrypted email, and a third may accept only facsimiles or paper versions.[5] Similarly, the extent to which claims information is maintained by payers in an electronic database varies across payers.

SB 1160 (Mendoza) was enacted on September 30, 2016. This legislation amended the Labor Code to require that the DFR be filed electronically with both DWC and the employer. In addition, it revises the Labor Code to require DWC to develop and administer a system for mandatory electronic reporting by the employer of documents related to utilization review. The legislative history suggests that one of the purposes of this provision is to facilitate DWC audit of claims administrator compliance with required utilization review time frames and procedures.

Overview of the Fee Schedule for Physician Services

The OMFS sets the maximum allowable fee for services furnished to injured workers unless the provider and payer agree to a different contractual amount.

The OMFS for physician services is based on Medicare's rates under a resource-based relative value system (RBRVS) fee schedule. The RBRVS has relative value units (RVUs) for each medical service based on the resources (costs) associated with the physician's work (the time and skill required for the procedure), practice expenses (the staff time and costs of maintaining an office), and malpractice expenses. The RVUs compare the resources required for one service to those required for other services. SB 863 required DWC to phase in the RBRVS system over a four-year transition period beginning January 1, 2014. Relative to the pre-RBRVS fee schedule, the RBRVS fee schedule increased the overall allowances for E&M visits and for medicine and decreased the allowances for surgery, radiology, pathology, and anesthesia. The RBRVS bundles values for some services that used to be paid separately under the OMFS into the allowance for E&M visits, including supplies and reports. At the time our interviews were conducted, the allowance for prolonged services that are provided beyond the usual services was also bundled. Effective March 15, 2017, prolonged services will be separately payable. In the aggregate, total OMFS allowances in 2017 (when the RBRVS is fully implemented) will be based on 120 percent of Medicare allowances for comparable medical services. The additional 20 percent is intended to compensate for additional time and resources required for WC patients relative to Medicare patients. A 2003 study by the Lewin Group (Dobson et al., 2003) estimated

[5] Workers' compensation programs are exempt from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, which requires entities that accept personal health information sent electronically to have procedures to control access to the information and protect its integrity. DWC's instructions for the PR-2 explicitly indicate email submission is an option; however, physicians are likely to not use this submission mode unless they believe the medical information is appropriately safeguarded. Many physicians who provide services to WC patients are in small practices that do not use electronic medical records and have limited tools to prepare and submit reports electronically through a website portal.

that WC patients required on average 28 percent more physician work than other patients for E&M visits. The estimate included any reports that are taken into account in the allowance for the E&M visit (such as the DFR and RFA) but excluded any WC-required reports that are separately paid (such as the PR-2 and P&S report) and relates only to RVUs for physician work (and not practice expenses).

No changes were made in the OMFS payment policies for WC-required reports when the RBRVS fee schedule was implemented. The allowance for the DFR is included in the allowance for the physician's initial examination, and separate payment amounts are allowed for the PR-2 and P&S report (PR-3 or PR-4). No separate allowance is made for RFAs or the RTW and Voucher report. The allowances for these reports are bundled into the payment for the associated E&M visit. The assumption was that the 20 percent add-on was sufficient to compensate for any WC-specific requirements for the bundled reports relative to the documentation and reporting requirements for the typical non-WC patient. The PR-2 and P&S report were viewed as atypical, WC-specific reporting requirements, and separate allowances were continued at pre-RBRVS levels but with regular updates. The separate allowances are not included in the 120-percent limitation on aggregate allowances. A motivating factor for this study was to investigate whether changes should be made in the payment policies for WC-required reports within the RBRVS context.

Summary of Methods

The research team employed a variety of methods to evaluate the California WC-required reports. First we cataloged the California WC-required reports along several dimensions: intended purpose, reporting requirements (by whom, when, and to whom), data elements, fee schedule policy, estimated volume, and allowances for these reports in 2014.

To further our understanding of reporting issues in California, we conducted exploratory semistructured interviews with users of the WC-required reports (both reporters [e.g., primary treating physicians] and recipients of the reports [e.g., claims administrators and attorneys]) to determine how the reports and specific data elements are used, whether alternate sources for the information exist, and whether there are opportunities for process improvements in the reporting required of physicians, as well as to identify the attributes of a high-quality report and potential incentives to increase reporting quality.

To inform our assessment of WC-required reporting issues, we also conducted an environmental scan of other states' reporting requirements. To do this, we compiled information on reports that are required under other state programs in the 20 most populated states (exclusive of California). We did this via a web search, followed by interviews to validate the information we found. We collected information on the reporting processes; forms and requirements (e.g., filing requirements and mode of filing), including the experiences of states that have introduced electronic reporting; and payment policies for WC-required reports. We then assessed for the

three main reports—the DFR, PR-2, and P&S report—which states required an analogous report and which states had similar data content within the report. This allowed us to identify states with processes similar to the California WC process, by report. In Table 1.2, we provide a summary of the 20 states included in our environmental scan and indicate which states require an equivalent DFR, PR-2, and P&S report. The states with data designated in bold are those with comparable data elements; these states are described in more detail in subsequent chapters. For a comprehensive summary of reporting requirements, reporting frequencies, mode or format, and allowances per report by state, refer to Appendix Table E.1.

Table 1.2. Summary of Physician Reporting Requirements Across California and the 20 States in Environmental Scan

	DFR	PR-2	P&S Report
Arizona	Required	Required	Required
California	**Required**	**Required**	**Required**
Florida	Required	**Required**	**Required**
Georgia	Not required (optional)	Not required	**Required**
Illinois	Not required	Not required	Required
Indiana	Not required (optional)	Not required	Not required (optional)
Maryland	Not required (optional)	Not required	Not required (optional)
Massachusetts	Not required	Not required	Not required
Michigan	Not required (optional)	Not required	Not required
Minnesota	Required	Required	Required
Missouri	Not required (optional)	Not required	Not required (optional)
New Jersey	Not required	Not required	Not required
New York	**Required**	**Required**	**Required**
North Carolina	Not required	Not required	Not required
Ohio	Not required	Not required	Not required
Pennsylvania	Not required (optional)	Not required (optional)	Not required (optional)
Tennessee	Not required (optional)	Not required	Required
Texas	**Required**	**Required**	Required
Virginia	Not required	Not required	Not required
Washington	**Required**	**Required**	**Required**
Wisconsin	Not required (optional)	Not required	Required

Using our findings from the background research and interviews described here, we convened two expert discussions to review the findings and discuss current reporting requirements in California and potential refinements. The participants in these discussions were providers and report users. Refer to Appendices A–C for a complete description of the methodology and approaches used in this study.

We used the Centers for Medicare and Medicaid Services (CMS) rulemaking files for the Medicare physician fee schedule to benchmark the allowances for WC-required reports to the OMFS allowances for comparable services. Finally, we analyzed 2014 data from the California Workers' Compensation Information System (WCIS) to estimate current expenditures and the cost of any changes in fee schedule policies for WC-required reports. The WCIS collects transaction-level administrative data on medical care provided to California's injured workers.

Organization of This Report

In this chapter, we have provided an overview of the purpose of our report and provided a brief summary of each WC-required report. The remainder of the report is organized as follows:

- Chapter Two describes the DFR in greater detail and summarizes the findings from our interviews and review of state practices.
- Chapter Three describes the PR-2 and RFA in greater detail and summarizes the findings from our interviews and review of state practices.
- Chapter Four describes the P&S report and the RTW and Voucher report in greater detail and summarizes the findings from our interviews and review of state practices for these reports.
- Chapter Five analyzes the allowances for WC-required reports and compares them to the OMFS allowances for comparable services.
- Chapter Six summarizes our findings and potential refinements that might be made in the reporting requirements and reporting policies to improve the quality of reporting in a timely and efficient manner.

In addition, we have included several appendices that provide additional information on our study approach and findings.

- Appendix A provides a more in-depth explanation of the methods used to conduct the study.
- Appendix B contains the interview protocol guide that we used to conduct stakeholder interviews with physicians and users of WC-required reports.
- Appendix C contains the interview protocol guide that we used to conduct interviews with staff in other states regarding their reporting requirements and processes for WC reports.
- Appendix D contains detailed information on the domains and data elements covered in each of California's WC-required reports.
- Appendix E compares key characteristics of the WC-required reports in selected states to California's WC-required reports.

Chapter Two: Doctor's First Report of Occupational Injury or Illness

In this chapter, we first provide an overview of the DFR and then describe our findings regarding the current process for completing and filing the report, attributes of a quality report, reporting requirements in other states, and reporting issues and potential refinements identified in our interviews and discussions with stakeholders. In Chapter Five, we examine the extent to which the OMFS allowances for new patient visits account for the resources required to complete the DFR.

Overview of California's Reporting Requirements

California Labor Code §6409 requires that any physician (which includes allopathic and osteopathic physicians, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners) who "attends" an injured worker file a DFR (DLSR 5021), also referred to as the "First Report of Injury" or a "Doctor's First Report," within five days of the initial examination. This form is used to document the nature of an injury or illness, how it occurred, which body parts were injured, subjective complaints, objective findings, treatment rendered, diagnosis, and work status of the injured worker. Refer to Appendix D for a detailed summary of the domains and data elements contained in the DFR.

The physician submits two copies of the DFR to the employer's WC insurance carrier or the self-insured employer (collectively referred to as "the payer").[1] Under the current medical fee schedule, the DFR is not separately payable but rather is included within the allowance for the underlying examination. The California WC system allows physicians to access the form on the DWC website and submit the DFR in hard copy. In addition, the payer and provider may mutually agree to submitting comparable information in another format and reporting mode. SB 1160 (Mendoza) amended the Labor Code in September 2016 to require that the DFR be filed electronically with DWC and the employer.[2]

Because separate bills are not submitted for DFRs and the DFRs have not been compiled in an electronic file, we are unable to determine how often they are being filed under various circumstances (such as instances in which the physician provides first-aid treatment only or care is provided by an emergency room physician or subsequent treating physician). This information would be needed to inform a cost estimate if a separate allowance were to be considered for the

[1] In the case of diagnosed or suspected pesticide poisoning, the physician also submits a copy to the Department of Industrial Relations. Otherwise, the payer is responsible for providing copies to the Department of Industrial Relations and other interested parties (employer, employee, employee's representative, etc.).

[2] The provision did not contain an implementation date. As of January 2017, DWC had not initiated rulemaking to implement the provision.

DFR. DWC statistics on First Reports of Injury (FROIs) indicate that 607,000 injuries and illnesses were reported by claims administrators for injuries occurring in 2015. This is an underestimate of expected DFRs because it does not include "first aid only" claims involving physician services and DFRs may be filed multiple times for a single claim.[3] In another study being conducted for the Commission on Health and Safety and Workers' Compensation (Mulcahy et al., 2017 forthcoming), RAND researchers found that nearly 10 percent of initial encounters following a 2013 injury occurred in an emergency department. Assuming that these patients were subsequently seen by a primary treating physician, at least 668,000 DFRs were potentially filed for 2015 injuries if at least emergency room physicians and the first primary treating physician complied with DFR reporting requirements.[4] Data are not readily available to estimate how many additional DFRs were potentially filed by subsequent primary treating physicians or secondary physicians.

Reporting Requirements in Other States

In addition to the FROI form that is required by employers to document a work-related injury, several states require that the injured worker's treating physician complete a DFR. Six of the 20 most populated states require a DFR. These states are Arizona, Florida, Minnesota, New York, Texas, and Washington. The deadline to submit this form within these states ranges from 48 hours to 10 days after the treating physician sees or treats the patient for the first time post-injury or post-illness. The mechanism for filing a DFR varies across the selected states. Nearly all states requiring a DFR permit the form to be submitted electronically[5] and also have a print-format version of the form to be completed manually and submitted as a hard copy via mail, fax, or hand delivery.

Among the six states that require a DFR, we compared the burden of completing and filing the report by comparing the data elements captured on the DFR. Of the six states, three states have moderately to highly similar data elements in their DFR as compared to California. These

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[3] An employer is not required to file an Employer's Report of Occupational Injury or Illness (Form 5020) for a first-aid-only claim that does not involve days lost from work; therefore, information on these incidents is not captured in the DWC administrative system. 8CCR §9780 states, "First aid is any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care." The employer is not required to file an Employer's Report of Injury, but the physician is required to file a DFR. The payer is responsible for submitting a copy to the Department of Industrial Relations, Division of Labor Statistics and Research.

[4] Mulcahy et al., 2017 (forthcoming) found that 17 percent of workers injured in 2014 saw multiple primary care physicians during the first 12 months following date of injury, and on average 1.21 primary care physicians treated workers injured in 2012 during the first 12 months. This suggests that just for a single calendar year, the actual number of DFRs filed could be substantially higher than our 668,000 estimate.

[5] For the purposes of this report, electronic submissions include any of the following modes: online reporting system submission, uploaded PDF submission, and printed, scanned, or emailed submission. Consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of electronic transmissions, it does not include transmission of a paper form via facsimile (U.S. Department of Health and Human Services, 2013).

states are New York, Texas, and Washington. Refer to Table 2.1 for a comparison of reporting requirements and characteristics of the DFR for California and these states. The reporting requirements for the other three states (Arizona, Florida, and Minnesota) are described in Appendix E.

Table 2.1. Features of DFR for California and Identified Comparison States

Report Characteristics	California	New York	Texas	Washington
Form title	Doctor's First Report (DFR)	Doctor's Initial Report (C-4)	Work Status Report (DWC Form-073)	Report of Accident (Form 242-243-000)
Reporting deadline	5 days	48 hours	2 days	5 days
Format	Fillable PDF, read-only PDF	Fillable PDF, read-only PDF	Read-only PDF	Fillable PDF, read-only PDF, Word file
Reporting mode	Mail, fax, email, or electronic (if payer and provider agree)	Electronic submission (online portal), mail	Mail, fax, email	Electronic submission (online portal FileFast), mail, fax, email
Recipient	DWC, insurer, employee, employee's representative	WC board, employer, insurer (only board gets electronic submission through portal)	Insurer, employer, employee	Department of Labor and Industries (single-payer state)
Fee schedule allowance[a]	No separate allowance; bundled into the initial E&M visit allowance	No separate allowance; bundled into the initial E&M visit allowance	Yes, $15 for Work Status report, when carrier requests it or when it is required	Yes, separately payable with amount ranging from $39.10 for timely submission to $19.10 for submission after 9 days or more after initial treatment; late submission may result in a penalty of $250

[a] The Workers' Compensation Research Institute publishes an interstate comparison of WC fee schedules in 31 states. A comparison of the fee schedule allowances for E&M services provides additional context for interpreting the DFR allowances. Relative to the 31-state median price for E&M visits in 2015, prices for E&M visits were lower in New York (66 percent of the median price) and California (91 percent). Prices were higher in Texas (120 percent) (Yang and Fomenko, 2016). Washington was not included in the comparison, but its fee schedule allowance for a new patient comprehensive office visit (CPT 99205) as of July 1, 2015, was $305.28, compared to $251.69 under the OMFS (or about 21 percent higher).

Among the three states requiring a DFR with similar data elements to those of California, Washington and Texas pay separately for a DFR. Texas's DWC fee schedule allows payment of up to $15 for the DFR, and Washington pays $39.10 for timely filing of the Report of Accident (Washington's DFR) within five business days after the initial treatment. Washington's payment policies are unique, as payment amounts align with timeliness requirements. Physicians who submit DFRs within six to eight business days after the initial treatment are paid $29.10, while physicians who do not submit the DFR until nine days or more after the initial treatment are paid $19.10. Late submission of the initial provider's report may result in payment penalties of up to

$250.[6] Similar to California, New York does not have a separate allowance for completing and submitting a DFR but considers the report included in the allowance for the initial examination.

In our interviews with state WC officials, we learned that the physicians in New York (where the allowance for completion of the report is included in the E&M allowance, as is the case in California) believe that the allowance for the E&M visit does not appropriately compensate the provider for filing a DFR. In Texas, where the DFR is paid at a flat rate, physician compliance with submitting the report is not an issue. In Washington, where the DFR payment is linked to the timeliness of the submission, the WC staff indicated that whoever files the DFR, primarily the injured worker's first health care provider contact post-injury or post-illness, becomes the primary treating physician (though the injured worker may later select a different primary treating physician). Physicians are paid separately (using a scaled payment level to encourage timeliness) and also have incentives tied to electronic submission.

Given that SB 1160 requires electronic filing of the DFR, we also reviewed other states' practices regarding electronic filing of the DFR and found that they varied across the selected states. Three states (Minnesota, New York, and Washington) have an online portal or electronic data interchange, which allows physicians to log in, complete the DFR online, and submit the report within the portal. Florida's DFR is available as a fillable PDF that allows the physician to complete the form online and submit it via email. The DFR in Arizona and Texas is available online as a standard PDF. Physicians are instructed to download and print the report, and to submit the report either electronically (by scanning and emailing it) or by mailing or faxing it to the required recipients.

Overview of Current Reporting Process

The exploratory interviews with physicians and users of the California DFR indicated that while there is variation in the process used to complete the DFR across physician practices, the typical process for filing includes steps conducted by the staff and the physician's evaluation of the injured worker.

Before the physician sees the patient, the interviewees indicated that the following steps are required of the office staff:

- Register the patient and enter patient information into a patient's electronic medical record (EMR) if applicable. The patient provides the medical history and any work-related information.
- Obtain authorizations and gather medical records.
- Obtain a translator if necessary.

[6] Failure to file the DFR-comparable report in Washington within five days from the date of treatment may result in a penalty of up to $250 in accordance with RCW 51.48.060. This applies to the provider's initial report (PIR), which is only required for patients insured through a self-insured employer (providers are required to submit a Report of Industrial Injury or Occupational Disease [ROA] for patients insured through WA Labor and Industries [L&I], which is the report we used for comparison to the California DFR).

When the physician sees and examines the patient, he or she performs the following steps, which are considered part of the E&M visit:

- Review the patient's history and the patient's account of the injury and how it happened.
- Record subjective complaints, comprehensive history, and objective findings.
- Determine whether further diagnostic testing is needed.
- Review treatment with the patient.
- Determine next steps.

After the patient is examined, the treating physician and staff are involved in several steps to process and file the DFR.

Treating Physician:

- Determine whether the patient's account of the injury or illness aligns with the doctor's objective findings, accounting for any prior injuries or illness.
- Draft the DFR, including doctor and visit notes.
- Review and sign the DFR.

Office Staff:

- Type up, input, or generate the DFR.
- Send the signed form to the employer representative or claims administrator.

We found that the DFR reporting format varies. Sometimes the DFR is completed using a form with checkboxes. Sometimes it is completed using dictation or the doctor's notes. Other times, it is embedded into the EMR so that it is automatically generated from the patient visit. The format depends on the provider or practice. Interviewees indicated that the DFR is typically completed less than 48 hours after the patient visit, which is well within the five-day deadline.

Physicians also indicated that a higher level of effort is needed to complete the DFR if

- multiple body parts are affected (i.e., it is a more complicated case),
- no medical records are available at the time of examination,
- the patient arrives without authorization, or
- the DFR is not embedded in the EMR.

Attributes of High-Quality Reports

In our exploratory interviews with physicians and users, they indicated that the following were attributes of a high-quality DFR:

- Provides thorough documentation of the injured or exposed body part(s), with clear indication of the relevant body parts and whether cumulative trauma is involved
- Provides clear descriptions of
  - How and when the injury or illness occurred
  - The frequency, duration, and severity of the injury and the expected time frame for recovery
  - The patient's subjective complaints
  - Objective evidence

- Includes medical history or prior issues and indicates whether the physician has treated that patient previously
- Indicates whether the patient's condition (objective findings of the physician and subjective complaints of the patient) aligns with the patient's account of the work-related incident
- Considers impairment and appropriate treatment
- Gives a concise yet detailed report
- Is typed (e.g., not hand-written)

Users noted that it is critical that the DFR be completed thoroughly, as it is referenced throughout the life of the claim.

Reporting Issues and Potential Improvements

During the interviews with California physicians and users, several issues were raised concerning the DFR. Physicians and users alike indicated that there is a lack of clarity on which physicians are required to complete a DFR, and whether it is required from every physician who sees a WC patient for the first time or only from the primary treating physician. Consistent with the Labor Code, 8CCR (California Code of Regulations) §14003 requires that any physician who "attends" an injured worker complete and file a DFR. The completion of this report is required of the initial attending physician, including any emergency and urgent care physicians rendering care in a treatment facility, and all subsequent physicians who attend the injured worker. However, the term "attends" is not defined, and 8CCR §9785 explicitly lists the DFR as a reporting requirement for *primary* treating physicians, leading to inconsistent practices among WC physicians regarding who should complete the DFR.[7]

We heard in our interviews with physicians a range of understanding regarding when a DFR is to be filed:

- Only the first doctor who sees and attends to the patient after the injury has occurred completes the DFR. This would include any emergency and urgent care physicians. No subsequent physicians would be required to complete a DFR.
- The first doctor who sees and attends to the patient after the injury has occurred completes the DFR. In addition, the first primary treating physician after treatment in an emergency situation files a DFR.
- Any time a new physician assumes the role of primary treating physician (e.g., the patient has been referred to the physician), a DFR is completed. Any secondary treating physician providing consultative or ancillary services only would not complete a DFR.
- Any physician who sees an injured worker for the first time, including all emergency care physicians, primary treating physicians, and secondary treating or ancillary physicians, completes and files a DFR.

[7] 8CCR §9785 defines the *primary* treating physician as "the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter." A *secondary* physician is defined as "any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee."

Users offered different perspectives on this issue. Some thought that multiple DFRs add confusion to the medical record and are unnecessary. On the other hand, information on a DFR completed by an emergency physician is often not consistent with or as comprehensive as the information on subsequent DFRs. Some payer interviewees indicated that the DFR serves to alert the payer that there has been a change in primary treating physician.

In terms of the reporting quality, users expressed concern that DFRs often do not accurately record the patient's subjective complaints. The form allows for the physician to describe the patient's perception of pain levels and to provide an assessment of how the injury or illness occurred, but these items are frequently omitted.

With the aim of increasing the timeliness and completion of high-quality DFR reporting, the following potential options were proposed:

- Provide guidelines or a set of screening questions on the first page of the DFR instructions.
- Add a checkbox to the DFR that indicates whether the ER treating doctor, a primary treating physician, or a subsequent physician is submitting the DFR.
- Provide a template with guidelines for the DFR if formats other than the DFR form are used.

With the aim of reducing duplication of DFRs in the medical record, suggestions were made for DWC to review and accept the primary treating physician's DFR as long as it met certain criteria. After the DFR is accepted, the primary treating physician's office would add the DFR to the medical record. No other DFR on the same claim would be accepted.

There were also suggestions to provide a separate allowance for the DFR. The suggested options included linking the allowance to the timeliness of the reporting (and allowing the deadline for submitting the DFR to be extended for good cause), paying only a primary treating physician, and paying for submitting an electronic version of the DFR.

Summary

The DFR serves primarily as a notice that the injured worker has been seen by a physician, and it describes the first diagnosis based on the initial physical examination. The DFR provides the framework for documenting the injury and notifies the carrier of the nature of the injury or illness and medical status of the patient. A quality DFR is legible, thorough (e.g., describes the injury, contains subjective and objective findings, and documents the patient's history), and detailed (e.g., documents the comprehensive physical exam and describes the patient's account of what happened), and it considers impairment and appropriate treatment.

The main issue with the DFR in California, according to physicians and users, is the lack of clarity on when a DFR is required, which results in variation among providers regarding when they submit a DFR. There were differences among the interviewees concerning what the appropriate reporting requirement should be; however, there was general agreement that DFRs

filed after that of the initial primary treating physician are not needed to manage the claim, other than as a potential mechanism to alert the claims administrator that a change of primary treating physician has occurred.

Physicians believe that bundling the report into the allowance for the examination does not appropriately compensate them for completing and filing the reports. Among the states with similar reports, New York does not allow a separate allowance, but Texas ($15) and Washington ($19.10–$39.19, depending on timeliness) do. Suggested options for paying for the report included using the allowance to incentivize the timely completion of high-quality reports and electronic filing.

Chapter Three: Primary Treating Physician Progress Report and Request for Authorization

In this chapter, we first provide an overview of two reports that are often filed together: the Primary Treating Physician's Progress Report (PR-2) and the Request for Authorization (RFA). We then discuss our findings by report regarding the current process for completing and filing the reports, attributes of a good-quality report, reporting requirements in other states, and reporting issues and potential refinements identified in our interviews and discussions with stakeholders. In Chapter Five, we benchmark the allowances for the PR-2 to the OMFS allowances for comparable services.

Overview of California's Reporting Requirements

Progress Report

When continuing medical treatment is provided to a WC claimant, 8CCR §9785 requires a primary treating physician to file a periodic PR-2 at least every 45 days, or if any of the following necessitates an updated submission of the PR-2: an unexpected significant change in the employee's condition, a significant change in the treatment plan, a change in work status or work restrictions or modifications, or the release of the patient from care without a permanent impairment. The form should be filed within 20 days of an examination or an event triggering the filing of the report. The PR-2 is used to update and record the patient's progress with respect to his or her subjective complaints; the primary treating physician's objective findings, diagnoses, and treatment plan, including treatment rendered to date; and the patient's work status. Refer to Appendix D for a detailed summary of the domains and data elements contained in the PR-2. The PR-2, its narrative equivalent, or the report in letter format is typically billed along with an E&M visit and is separately payable at the rate of $12.14 per report. The PR-2 is available on the DWC website as an online fillable Adobe Acrobat PDF form that can be completed and submitted electronically to the claims administrator or can be downloaded and submitted as a hard-copy report.

Table 3.1 summarizes WCIS data on the number of PR-2s and payments in 2013 and 2014. The number of and payments for reports in 2014 declined relative to 2013 levels. In total, an estimated 1.4 million reports were filed that resulted in more than $15 million in medical expenditures in 2014. Because of WCIS underreporting, these estimates understate total volume

and spending. Payments for PR-2s were nearly 1 percent of total WCIS reported payments for physician services.[1]

Table 3.1. Spending for PR-2 Progress Reports Filed in 2013 and 2014

Service Year	Number of Reports (Millions)	Spending ($Millions)	% of Total WCIS Spending for Physician Services
2013	1.62	17.80	0.79
2014	1.36	15.15	0.95

SOURCE: RAND analysis of WCIS data.

Request for Authorization

DWC utilization review rules (8CCR §9792.6.1(t)) require that a treating physician file a written RFA for a specific course of proposed medical treatment. The form facilitates a payer's timely identification of proposed treatment that is subject to regulatory time frames for completing prospective utilization review.[2] There are inconsistencies across the WC system regarding who files the RFA. 8CCR §9792.6.1(t) anticipates that the RFA is completed by the "treating physician," yet the form is specified in §9785.5, which pertains to reporting requirements for *primary* treating physicians. Furthermore, the RFA must be accompanied by one of the following: a DFR, a PR-2, or an equivalent narrative report substantiating the requested treatment. The RFA form can be submitted when making an initial request for new treatment or procedures and resubmitted due to any change in the material facts or to confirm a prior oral request. The treating physician must indicate each specific requested medical service or treatment substantiated by the injured worker's diagnosis, including the diagnosis code, procedure code, and the frequency, quantity, and duration of the requested treatment. Additionally, the bill for any services that have been provided without prospective authorization should be accompanied by supporting documentation in the form of an RFA sufficient to support the level of service or code that has been billed. Refer to Appendix D for a detailed summary of the domains and data elements contained in the RFA. The RFA is available on the DWC website as an online fillable Adobe Acrobat PDF form that can be completed and downloaded for submission to the claims administrator (or utilization review organization) in hard copy, as a facsimile, or via email as a PDF. Under the current medical fee schedule, there is no separate allowance for the RFA.

[1] Although not enforced, penalty statutes existed prior to SB 1160. Enactment of SB 1160 resulted in raising the penalty for noncompliance from $5,000 to $10,000.

[2] All issues related to utilization review will be addressed in a separate RAND report.

Reporting Requirements in Other States

Progress Reports

Of the 20 most populated states, 6 states require the primary treating physician and, in some instances, any ancillary physician to complete and file progress reports throughout the life of a WC claim. These states are Arizona, Florida, Minnesota, New York, Texas, and Washington. The remaining 14 states do not require filing of progress reports, though several states provide the option.

States vary in their requirements for the primary treating physician to monitor and assess the progress of the injured worker. Most states require a routine E&M visit every 30–45 days during the course of a WC claim. Some states allow more time to elapse between visits, requiring E&M visits at least every 90 days, while other states allow more frequent visits (e.g., every two weeks) if medically necessary. The deadline to submit progress reports after each E&M visit for these six states ranges from one business day to ten days after the patient visit.

We compared the data elements for the six states requiring a progress report and found that three states have similar data elements to those of the required PR-2 form in California: Florida, New York, and Texas. Progress reports required in Washington are submitted in narrative format along with chart notes, and they must follow the SOAPER format: subjective complaints, objective findings, doctor's assessment, plan (treatment), employment capacity, and restrictions (temporary or permanent physical limitations). While we cannot compare the data elements that are specifically captured in Washington's progress reports because they are submitted in narrative form, the SOAPER format covers similar content to that of the California physician PR-2s. Refer to Table 3.2 for a comparison of reporting requirements and characteristics of the PR-2 for California and these states. The two other states that require progress reports are not as comparable.

Among the states that require progress reports and have similar data elements to California's, Texas has a flat rate of $15 per report. The Washington narrative progress reports are separately paid a maximum of $44.96 (limit of one payable report per 60 days). Florida and New York do not separately pay for submission of progress reports and consider the reports included in the allowance for the E&M office visit.

In our interviews with WC staff in other state programs, we learned that the main issue in Florida is that physicians do not submit progress reports for all claims. No separate allowance is made for the report and unless the insurance carrier requests the report, it is often not submitted. In Texas, where a $15 allowance is made, the issue is different because there is no periodic reporting requirement. After the treating physician's initial patient examination and filing of the Work Status Report (similar to a DFR), another report is not required unless there is a change in the injured worker's work status or work restrictions or the carrier has established a reporting schedule based on the worker's scheduled appointments with the primary treating physician.

Table 3.2. Features of PR-2 for California and Identified Comparison States

Report Characteristics	California	Florida	New York	Texas	Washington
Form title	PR-2	Uniform Medical Treatment/ Status Reporting Form	Doctor's Progress Report (C-4.2)	Work Status Report (DWC Form-073)	Progress Report—60-day Narrative Report
Separate report	Yes	No—also used for DFR and P&S report	Yes	No—also used for DFR	Yes
Reporting frequency	45 days (or more frequently when there is actionable change)	30 days (or more frequently if there is an actionable event)	90 days (or more frequently as needed)	Upon request, or if there are changes to work status or activity restrictions	60 days
Deadline	Within 20 days of the examination triggering the report	1 business day	15 days after each visit	2 business days after date of exam	N/A; every 60 days
Format	Fillable PDF, printable PDF	Fillable PDF, printable PDF, Excel file, Word file	Fillable PDF, printable PDF	Printable PDF	Narrative (no form), fillable PDF, printable PDF
Reporting mode	Email, mail, fax	Email, fax	Electronic submission (online portal), mail	Fax, email	Mail, fax
Recipient	DWC, insurer, employee, employee's representative	Insurer and employer upon request	WC board, employer, insurer (only board gets submission through portal)	Insurer, employer, employee	Department of Labor and Industries (single payer)
Fee schedule allowance	Yes, separate allowance—$12.14/report	No, report is included in the E&M visit	No	Yes, $15	Yes, separately payable (maximum $44.96)

The Texas WC program staff indicated that often the second report is not filed until the injured worker is P&S and, as a result, the Work Status Report often does not function as a progress report describing any changes in the worker's treatment or medical condition. The New York WC program staff did not mention any issues with the progress report, despite the lack of a separate allowance for the report.

Request for Authorization

States vary in the extent to which treating physicians are required to request prospective authorization from the payer before ordering medical treatment or services for the injured

worker.[3] For example, New York requires prospective authorization for specific procedures and any treatments costing $1,000 or more that are not addressed by their treatment guidelines. Washington requires prospective authorization for higher-risk modalities, such as large joint or spinal surgeries. If the carrier does not authorize the requested treatment or service, they are not obligated to pay for the treatment.

At least eight of the most populated states require prospective authorization for at least some treatments or services. These states are Florida, Indiana, Minnesota, New York, North Carolina, Ohio, Texas, and Washington. Six of these states have a separate form. Florida embeds the treatment requests in the same form used to report findings related to the worker's injury and progress. Several states, including Minnesota, allow the request to be made orally. Washington has a separate RFA form but also allows the request to be submitted in narrative form or as part of a chart note. While several states do not require prospective authorization, some states, such as Georgia, provide a request of authorization of treatment form that can be used by the treating physician when making a request for a treatment or service.

For the states that require a separate RFA form to be submitted for treatment requests, we compared the data elements captured on the report form and found that most states follow a similar structure. In Florida, Indiana, Minnesota, New York, North Carolina, Ohio, Texas, and Washington, the RFA form served a similar purpose, specified the requested treatment or service, and included the diagnosis, the procedure code, the frequency and duration of the treatment, and the requesting physician's information and signature.

While the requirements to submit an RFA vary across our selected states, none of the selected states separately pay for submitting an RFA form. Payment for the requested service may be negotiated with the insurance carrier or claims adjuster, but no separate fee schedule rates were observed across our selected states.

Overview of Current Reporting Process

Progress Report

In our exploratory interviews, physicians and users of the PR-2 indicated that the main purpose of the report is to communicate and document whether a patient remains in active treatment. The main audience is attorneys, the patient, the payer, and the employer or employer representative.

The primary treating physician has several options in deciding treatment for the patient: (1) exclusively treat the patient; (2) refer the patient to a specialist for treatment or for a

[3] California UR regulations refer to this as "prospective review." We use the term in this report but note that the more commonly used term is "prior authorization." In California, "prior authorization" refers to services a payer has preapproved that do not require an RFA.

consultation; or (3) refer the patient to other services (i.e., physical therapy). As outlined in 8CCR §9785, the PR-2 should involve communicating with all treating clinicians and incorporating their findings and observations with respect to the patient's progress, treatment, and work status under the supervision of the primary treating physician.

After a patient visit, the primary treating physician reviews and incorporates his or her observations and findings from the recent visit and any secondary or specialty treating physician reports. Then, the physician has options on how to generate and complete the PR-2. The physician can complete the PR-2 from his or her own dictation or from the EMR or complete either a narrative report or a hybrid report (which is partially narrative and partially checkbox format). Since the PR-2 can be generated from an EMR, several physicians indicated that developing an electronic version of the PR-2 could help to streamline the process of preparing, processing, and submitting the report. However, we also heard that generating the PR-2 from the EMR often does not thoroughly document the change in the injured worker's progress throughout recovery and while being treated by the primary treating physician. The PR-2 can also be crafted individually after each visit, every 45 days, or when a change occurs, and it can be customized to the patient's treatment and recovery process. The PR-2 is typically submitted with the primary treating physician's signature, along with a bill for the visit and the report and, if relevant, an RFA form with any proposed treatment or medication.

In the interviews, the primary treating physicians estimated that completing the PR-2 from their own dictation took 20–30 minutes, a PR-2 form generated from an EMR took 5–10 minutes, and a narrative or hybrid progress report took 20–30 minutes of their personal time.

We also queried whether the circumstances requiring a PR-2 were appropriate, including the maximum of 45 days between PR-2s and the 20-day time frame for filing the PR-2. For nearly all claims, physicians indicated the requirements were appropriate, particularly when the physician has the worker's records and it is a relatively straightforward case with efficient coordination of care among the primary treating physician and any secondary physicians. At the outset of the claim, physicians prefer to see their patients in a shorter time frame so that they can monitor their cases closely and determine any changes that may be needed in medications, treatments, or work status. Physicians also noted that when there is a need to coordinate with specialists, 45 days may not be sufficient to make the referral to a specialist, have the consultation take place, receive the report from the consultant, and incorporate the results into the PR-2. Users noted that there may be less medical status change in older claims regarding patients with chronic conditions. Visits as frequently as every 45 days may not be medically necessary, and the report remains relatively constant with each submission. In this regard, physicians noted the importance of having authorization for the visits and noted that depending on the authorization, it would be appropriate to see the patient more or less frequently than 45 days.

Request for Authorization

According to our interviews held with physicians and users, the primary purpose of the RFA is to request authorization for a recommended treatment, medication, procedure, or consultation with a specialist. An RFA is required for each proposed medication or treatment unless the payer has adopted a prior authorization policy that waives prospective review. The form does not include the progress of the patient, as this information is documented in one of the reports that must accompany the RFA: a DFR, PR-2, or comparable narrative report. However, the RFA does need to identify clearly the specific course of proposed medical treatment that the treating physician is requesting and substantiate its medical necessity.

The process for completing and submitting an RFA aligns with the process involved in filing a DFR or PR-2. Assuming that the proposed treatment is for services that will be provided by the primary treating physician or by a secondary physician through referral, the primary treating physician first examines the patient, conducts an assessment, constructs a treatment plan, and completes the DFR or PR-2. The primary treating physician will then complete an RFA to request a specific prescription or treatment for the injured worker and submit it to the claims administrator. The primary treating physician needs to monitor which requests have been approved or denied when treating a patient. Once the request for a service has been authorized, the physician's office will notify the patient that the requested treatment, procedure, or service request has been approved. In the case of ancillary services, the physician's office will also send the authorized RFA to the appropriate facility (a radiology imaging facility, for example).

However, there is some variation in whether the RFA is prepared and submitted by the primary treating physician or a secondary physician who will be providing the proposed treatment or is prepared by the secondary physician but submitted by the primary treating physician. For instance, the primary treating physician will submit an RFA for a specialty consultation. Often, the specialist will then receive a referral from the primary treating physician about a potential request for treatment or diagnostic procedure and must then determine if the procedure is an appropriate and needed course of treatment. If it is determined that the procedure is necessary, the specialist will complete and submit the RFA to provide the service. Alternatively, the primary treating physician may submit an RFA that has been completed by the specialist. One primary treating physician stated that it is important that the secondary treating physician complete his or her own RFA to allow the expert to document the medical reasons for specific medication or procedural requests, and that only in instances in which there is a significant delay will the primary treating physician submit the RFA on behalf of the specialist.

The level of effort required to complete a request for authorization varies, and it was not consistent across our interviews with the physicians submitting the RFAs. While the majority of respondents noted that completing the RFA requires a high level of duplicative work, several respondents indicated that it does not necessarily involve a high level of effort, especially if it is generated automatically by an EMR. Typical practices allow the office staff to generate the RFA

form, which generally takes an average of 15–20 minutes. The treating physician will then complete, review, and sign the RFA, requiring an additional 20–30 minutes. Last, the office staff will submit the RFA and are responsible for monitoring the outcome for each request. Several physicians and users of the RFA relayed that monitoring the RFAs requires a significant amount of office resources. Typically, offices have fewer than two full-time employees devoted to administrative facilitative work such as supporting the documentation involved with each patient visit and completing the relevant forms.

Interview respondents indicated that the RFA accompanies a PR-2 approximately 80 percent of the time, and that roughly 70 percent of the content on the RFA is duplicative of the content contained on the PR-2. Additionally, this duplication increases the level of effort for the primary treating physician, as they must account for each approval or denial and determine how that affects the course of treatment for the patient on the two forms. Furthermore, the level of effort varies depending on the timing of the determination, which is often related to the severity or urgency of the request. While decisions on some RFAs are made immediately, other requests can take a week or more, adding unnecessary delays in the treatment of the patient.

Attributes of High-Quality Reports

Progress Reports

We heard from our exploratory interviews with physicians and users that the following were attributes of a high-quality PR-2:

- Documents the following:
  - The patient's past medical history
  - Which treatments and medications were effective or not effective
  - Changes in the worker's symptoms and overall condition
  - The functionality of the worker
  - The patient's test results or pending tests
  - Objective or subjective findings
  - Whether the patient remains in active treatment
- Justifies the treatment plan and all decisions regarding the patient's recovery and return to work
- Communicates the following clearly and concisely:
  - Any change in the injured worker's work status
  - Any change in treatment
  - Any change or development in recovery or healing
  - Any delays or issues with the patient's progress

Users indicated that the progress report should provide a comprehensive and thorough description of the patient's progress and response to treatment. It should be focused on the

patient's status and future treatment plan: target symptoms, recovery goals, current functionality, and ability to return to work.

Request for Authorization

Our interviewees identified several attributes of a high-quality RFA. First, physicians indicated that the RFA should list each specific requested medical service or item and its associated diagnosis and procedure code. If a medical report is attached to the treatment request, the physician should indicate the specific page number on which the requested treatment can be found. RFA users noted that it is important to list all requests on the same RFA form to reduce paperwork burden and expedite the review process. The form has space to list up to five requests, and it instructs the user to list additional requests on a separate sheet if the space provided on the form is inadequate. Our interviews with claims adjusters and administrators suggest that many physicians submit RFAs for each individual treatment proposed for the same patient, and that this practice adds unnecessary review time and increases the level of effort involved in processing the request.

Second, interviewees noted that it is very important to include objective evidence in the report to substantiate the requested treatment. Physicians especially pointed to the need to be as explicit as possible about the nature of the request to increase the probability of approval. This includes specifying the frequency, duration, and dosage or measurement of the treatment to encourage the authorization of multiple sessions or doses as needed. Last, respondents indicated that because the RFA and PR-2 are codependent reports, a high-quality RFA is one that is supported by a high-quality PR-2. Since the PR-2 contains information pertaining to the nature of the injury, the subjective and objective findings, and the progress of the patient to date, the RFA can effectively refer the reviewer to a high-quality PR-2 to justify the need for the request.

Respondents also noted that certain insurance carriers are more familiar with particular providers (individuals or groups) and recognize that these providers do not overutilize treatment or request unnecessary medication. These insurance carriers may expedite the authorization process based on the standing history with that provider.

We heard that the following were attributes of a high-quality RFA:

- Lists each specific requested medical service, good, or item with objective evidence to substantiate the request, including specifying the following:
  - The associated diagnosis and procedure code for each treatment
  - The frequency, duration, and dosage or measurement of the treatment requested
- Indicates the page number on which the requested treatment can be found (if a medical report is attached to the form)
- Is consistent with the treatment plan
- Combines all treatments on the same RFA (rather than multiple forms for multiple concurrent requests)

There is no separate OMFS allowance for the RFA. Among health insurance programs generally (including the other WC programs that we reviewed), RFAs are considered an administrative cost that is bundled into the payment for the services. One difference between the California WC program and other programs is how often the RFAs are required. The California WC program requires prospective authorization for proposed treatment unless the payer has waived the requirement. The more common practice among health insurance programs is to require authorization for selected services. When recent legislation is implemented that is intended to reduce the frequency of utilization review for drugs and for initial treatment following an injury, the frequency of RFAs should be reduced.[4]

Reporting Issues and Potential Improvements

Progress Reports

First, respondents reported that practices surrounding the PR-2 are inconsistent. Many reports do not adequately incorporate information from secondary treating physicians, and in some cases, the existence of multiple reports documenting the care, treatment, and progress from multiple providers causes confusion. The regulations specify that the primary treating physician is the authority on the progress of the WC case, which requires communication across all treating and consulting physicians involved in the case. Due to inconsistencies in reporting and incomplete information, claims administrators reported that they accept PR-2s from multiple providers in order to fill gaps in the claim. However, they also noted that accepting PR-2s from multiple providers can promote noncoordination of care. Primary treating physicians also emphasized the need to channel all case-related information through one provider to support care coordination.

Second, a significant number of respondents pointed to the amount of redundancy between RFAs and PR-2s. Several physicians expressed their frustration with regard to the amount of duplicative information required across the reports. Because the PR-2 can be generated efficiently from an EMR, several users claimed that insufficient effort is applied toward customizing each report to reflect the progress of the patient between reporting periods. Several physicians also indicated that the required timeline for producing the report does not always correspond to the treatment timeline and that it is often not necessary to see the patient as frequently as every 45 days. In such instances, the content of the PR-2 may not differ across reports since the primary treating physician would have no updates.

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[4] Assembly Bill 1124 (Perea) requires DWC to implement a drug formulary by July 1, 2017. DWC is proposing to designate a list of exempt drugs that will not require prospective review when prescribed consistent with medical treatment guidelines applicable to California injured workers. SB 1160 streamlines the UR process by eliminating prospective UR for selected services that are furnished within the first 30 days following an injury.

Our interviews suggest that external delays are another factor impeding the production of high-quality, timely PR-2s. According to the primary treating physicians, delays in submitting a PR-2 largely result from delays in receiving the patient's medical records from secondary physicians, especially when records are not received until after the patient's physical examination.

The final issue identified pertaining to the PR-2 is the submission of incomplete reports. Claims administrators suggest that the most useful PR-2s contain an update on current recommendations, comprehensive information about how the worker is responding to treatment or medication, the patient's test results, and how those test results are incorporated into the treatment plan, but that too many PR-2s do not contain this information.

During our interviews with physicians and users of the PR-2, several areas and opportunities to improve the quality and efficiency of filing PR-2s were identified. Potential options that were proposed included the following:

- Provide incentives for electronic submission of the PR-2. This could reduce the burden of duplicative information contained in the PR-2, RFA, prescriptions, or special reports.
- Include a template or sample of a high-quality PR-2 or provide guidelines or an instruction page to promote the provision of accurate and complete information on the PR-2.
- Include checkboxes and provide space for narrative text to allow the physician to provide information needed to make accurate utilization review determinations.
- Implement graduated allowances to align with timely submission of required PR-2s. (For instance, reduce the allowance a specified number of days past the filing deadline.)
- Provide space on the PR-2 for the primary treating physician to incorporate information and relevant notes from secondary providers. This could reduce confusion across reports and promote better care coordination.
- Ask the physician to highlight differences in the status of the injured worker since the last PR-2 was submitted. This could improve customization of each PR-2 that is submitted.
- Include a section in the PR-2 that serves as an RFA. This could reduce duplicative information contained across the PR-2 and RFA, and it would allow the diagnosis, treatment plan, rationale for the treatment plan, and information on the requested treatment or service to be located in one place.
- Allow for modified timelines for submission of PR-2s to align with the patient's treatment timeline and to correspond with what is medically necessary in the injured worker's case. (Current rules already allow the claims administrator and provider to agree on a different reporting schedule and format.)

Request for Authorization

During the interviews with physicians and users, several issues were raised concerning the RFAs. In terms of reporting requirements, the main concern was the redundancy of content with the PR-2.[5] In addition to the suggestions noted in the preceding section to eliminate the

[5] Other issues concerned how the RFAs are used in the UR process and the UR process in general. These issues are addressed in a forthcoming RAND report evaluating the impact of the SB 863 legislation.

redundancy, other ideas raised in the interviews regarding potential opportunities to improve the quality and efficiency of the reporting process included the following:

- Require a signature from the primary treating physician any time an RFA is submitted from a secondary treating physician, therapist, or other specialist. This could promote better communication and care coordination among multiple providers and larger care teams with regard to the treatment plan and medication management.
- Provide an incentive for care coordination among the provider team, such as paying separately when extra time is taken to communicate with secondary treating physicians.

Summary

The PR-2 serves primarily as a mechanism of notice that the injured worker has been seen by a physician and requires additional treatment. Additionally, it documents the functionality of the patient over the course of treatment. A good PR-2 is one that is thorough (e.g., description of patient progress, response to treatment, symptoms, change in condition, past history, medications, and test results), is detailed (e.g., includes recovery goals, target symptoms, and current functionality), considers the patient's ability to return to work, and documents the reason for the PR-2. During the interviews with physicians and users, several issues were raised concerning the PR-2. The first issue related to inconsistencies among users in whether they accepted progress reports from secondary treating physicians. Some accepted reports that were submitted by any treating physician, while others accepted reports only from the primary treating physician. These users thought that accepting reports from multiple providers introduces the risk of noncoordination of care. A related issue concerned delays in primary treating physicians receiving medical records or full charts from secondary physicians, which results in insufficient time to review the records before the patient is seen or delays in submitting the PR-2. Finally, the quality of progress reports needs improvement. The physicians and users noted that the reports often do not reflect the continuity or timeliness of care and need clearer descriptions of treatment goals, symptoms, and changes or progress in the patient's recovery.

The RFA serves primarily as a notice that the injured worker needs additional treatment, which must be authorized; therefore, it has a high level of specificity and should contain the rationale for the requested treatment. A quality RFA is one that lists each specific requested medical service or item (including frequency, duration, and dosage or measurement of treatment) with the associated diagnosis and procedure codes, refers clearly to any attachments (such as a medical report or PR-2), and provides objective evidence to substantiate all treatment requests for the patient on one RFA form. The main issues are the redundancy of the information on the RFA and the PR-2 and the lack of clarity regarding who should submit the RFA.

Chapter Four: Permanent and Stationary Report and Return-to-Work and Voucher Report

In this chapter, we first provide an overview of two reports that are filed together: the P&S report and the RTW and Voucher report. We then discuss our findings regarding the current process for completing and filing the P&S reports, the attributes of a quality report, reporting requirements in other states, and reporting issues and potential refinements identified in our interviews with stakeholders. In Chapter Five, we compare the allowances for these reports to those for comparable services.

Overview of California's Reporting Requirements

Permanent and Stationary Report

The P&S report (PR-3, PR-4) is designed for use by the primary treating physician to report the initial evaluation of permanent impairment to the claims administrator once the patient's medical condition has stabilized and if the patient has residual effects from the injury or may require future medical care. The report requires the physician to address impairment rating, apportionment, causation, functional capacity, and future medical treatment. The physician is required to submit the report within 20 days of examination and attach the RTW and Voucher report (discussed later). The P&S report is separately payable at the 2016 rate of $39.42 for the first page and $24.25 for each additional page. Absent mutual agreement, a maximum of six pages is allowed for the PR-3 (up to $160.69) and seven pages for the PR-4 report (up to $184.94). The examination is separately paid as an E&M visit. Refer to Appendix D for a detailed summary of the domains and data elements contained in the P&S Report. This report is available on the DWC website as an online fillable Adobe Acrobat PDF form that can be completed and submitted electronically or can be downloaded and submitted in hard copy. The primary treating physician may substitute or append a narrative report to accompany or replace the form to report adequately on the topics contained in the form.

The WCIS indicates that more than 50,000 P&S reports were submitted in 2014, with spending totaling more than $5 million (see Table 4.1). Because of WCIS underreporting, this estimate likely understates the total volume and spending for P&S reports.[1]

[1] We do not report the 2013 volume and spending for the reports because we believe the modifier needed to distinguish the P&S reports from other reports was not consistently billed. Beginning in 2014, separate WC-specific codes were established for the PR-3 and PR-4 so that the reports can be identified more reliably in the WCIS data. We estimate the WCIS contains medical data for about 70 percent of claims.

Table 4.1. Volume and Spending for P&S Reports in 2014

	Number of Reports	Spending ($Millions)	% of Total WCIS Spending for Physician Services
PR-3	14,056	1.17	0.07
PR-4	36,460	4.02	0.25
Total	**50,516**	**5.19**	**0.33**

SOURCE: RAND analysis of WCIS data.

Return-to-Work and Voucher Report

The RTW and Voucher report is used to inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The data on the form is for informational purposes and is not considered in any permanent impairment rating or permanent disability indemnity determinations.[2] The first physician who reports that the patient is P&S or has reached maximal medical improvement is responsible for submitting this form along with his or her P&S report. Typically, the primary treating physician files a P&S report, but it could be filed in conjunction with a medical-legal examination. There is no separate allowance for the RTW and Voucher report. Refer to Appendix D for a detailed summary of the domains and data elements contained in the report. The report is available on the DWC website as an online fillable Adobe Acrobat PDF form that can be completed and submitted electronically or can be downloaded and submitted in hard copy. The claims administrator is responsible for transmitting the report to the employer.

We did not specifically ask in the interviews about the process or ideas for improvement for the RTW and Voucher report, largely because our interviewees had little experience to date in completing and filing the newly required report.

Reporting Requirements in Other States

Among the most populated states, nine other states require the P&S report, that is, a final report describing the injured worker's recovery status as P&S and rating the impairment. These are Arizona, Florida, Georgia, Illinois, Minnesota, New York, Tennessee, Texas, and Wisconsin. Washington requires a report from the primary treating physician that the claimant is P&S, but the impairment rating is optional for the primary treating physician. The remaining states do not require a P&S report from the primary treating physician.

[2] However, the form triggers an employer assessment of whether regular modified or alternative work is available. The offer of work must be made within 60 days after receipt of the RTW and Voucher report.

Of the states that require a P&S report, four have reports with a similar form and content to California's P&S report. These are Florida, Georgia, New York, and Washington (with respect to the form used by primary treating physicians electing to determine the impairment rating).[3] While Georgia provides a form for the report, the state also allows the final report to be submitted in letter format. Refer to Table 4.2 for a comparison of reporting requirements and characteristics of the P&S report for California and these states.

Table 4.2. Features of P&S Report for California and Identified Comparison States

Report Characteristics	California	Florida	Georgia	New York	Washington
P&S required?	Yes	Yes	Yes	Yes	Optional
Form title	Permanent and Stationary Report (P&S, PR-4)	Uniform Medical Treatment/Status Reporting Form	Medical Report (Final)	Doctor's Report of MMI/Permanent Impairment	Attending Doctor Rating Report
Separate report (from DFR or PR)	Yes	No	No	Yes	Yes
Frequency	1x; once P&S is determined	1x; once P&S is determined	1x; once P&S is determined	1x; once P&S is determined	1x; once P&S is determined and an impairment evaluation is performed
Reporting deadline	20 days from date of exam (determined P&S)	1 business day (to insurer, employer); 3 days (to injured worker)	10 days	15 days	60 days
Format	Fillable PDF, printable PDF	Fillable PDF, printable PDF, Excel file, Word file	Printable PDF, letter format	Fillable PDF, printable PDF	Narrative (no form)
Reporting mode	Electronic, mail, fax	Electronic, fax	Fax, mail, PDF email	Electronic online portal, mail	Mail, fax
Recipient	DWC, insurer, employee, employee's representative	Insurer, employer, employee	Insurer	WC Board, employer, insurer (only Board gets submission through portal)	Department of Labor and Industries
2016 fee schedule allowance	Yes, separate allowance—$39.42 first page; $24.25 additional pages; max 7 pages ($184.94); PR-4 allowance for established patient comprehensive office visit: $187.76	No separate allowance; CPT code 99455 (work-related disability evaluation) used for the evaluation and report ($90)	No separate allowance; CPT 99455 used for the evaluation and report ($217.22)	No separate allowance; allowance for the evaluation and report set at Level 5 E&M consultation code (CPT 99245)	Yes; allowance is the same amount as for an independent medical examiner: $525.42 for a standard rating and $656.75 for a complex rating

[3] If the primary treating physician elects not to perform an impairment evaluation and rating, a final progress report is filed following the format and pricing schedule discussed in Chapter Three. In California, a final PR-2 is filed only for a claimant who is P&S with no permanent impairment. In Washington, it is also filed for a claimant with a permanent impairment if the physician does not evaluate and rate the impairment.

None of the states with similar data elements to California's pay separately for the examination and report. They include the allowance for the report in the allowance for the examination determining P&S status. The combined maximum allowance in California for an office visit ($187.76) and seven-page PR-4 report ($184.94) is $372.70. In Georgia, documentation of the final work-related examination on the final P&S report has a maximum allowance of $212.74. Florida allows $90 for the examination and report, while the New York allowance for the examination and report is set at the rate for a comprehensive office consultation.[4] Washington pays $525.42 for a standard impairment evaluation and rating and $656.75 for a complex evaluation. Tennessee (which does not have comparable data elements) encourages timely reporting of maximal medical improvement (within 21 days of determining P&S status) by penalizing physicians up to $100 per every 15 days past the due date.

From our interviews with staff in other state WC programs, we learned that there is a problem with the submission of the P&S report in Florida, which does not make a separate allowance for the report. In many cases, the report is not submitted unless the carrier requests that the physician submit it. In Georgia, a physical therapist does any functional capacity evaluation testing requested by the authorized treating physician and reports the results to the physician; together, they determine a permanent partial impairment rating and report it to the Georgia State Board of Workers' Compensation and insurance carrier. The physical therapist bills separately for any testing requested by the authorized treating physician (in 15-minute increments not to exceed $800). The authorized treating physician bills for the impairment evaluation with the same form used to report other medical services using CPT (Current Procedural Terminology) 99455 (work-related or medical disability evaluation services), which includes the report. However, the evaluation often includes medical record review, which does not have an established fee schedule amount and is payable "by report" based on the physician's report describing the services. By default, this makes the payment for the P&S evaluation and report negotiable between the physician and the payer. In New York, there were no issues raised with the P&S report.

Overview of Current Reporting Process

Based on our interviews with treating physicians, the process to compile and complete a P&S report includes conducting the examination that confirms the worker's status as P&S, reviewing medical records, conducting the research needed to calculate an impairment rating, and writing the P&S report. This process takes longer than that of other WC-required reports because the

[4] Consultations are not payable under the RBRVS. Using the values published in the rulemaking documents, an OMFS allowance set at 120 percent of Medicare for an office consultation would be $301.36. The difference between this and the allowance for a comprehensive office visit ($197.13) is $104.23.

primary treating physician needs to consider more information when completing the P&S report. Some content contained in the P&S report is similar to the PR-2 content, but the P&S report also requires that the physician give a comprehensive explanation of how he or she arrived at conclusions pertaining to causation, apportionment, impairment, and future medical care.

For the P&S report, the primary treating physician reviews his or her observations and findings from the examination determining P&S status, all prior examinations, and input from any secondary or specialty physicians who may have been involved throughout the course of the WC claim. The primary treating physician incorporates the notes and recommendations of all specialists and ancillary treating physicians within the final P&S report. The primary treating physician has the latitude to complete the report in a variety of modes. For some practices that have more comprehensive EMR systems, the physician is able to generate the P&S report from the EMR, while other practices have developed system templates to help generate standardized reports. Additionally, physicians have the option to substitute or append a narrative if they require additional space to adequately report on the issues contained in the report.

The level of effort required to complete the P&S report varies widely depending on whether the report is generated from dictation or using an EMR or template. In general, interviewees reported that completion of the P&S report is a significant time burden. While several physicians indicated that using an EMR to generate the report helped to streamline that process, many reported that completion of the P&S report often takes several hours because the physician is required to account for the research involved, provide a report of the evaluation, and calculate the impairment rating based on the AMA guides. We also learned that some practices use a software program to calculate impairment ratings, which helps facilitate and expedite the generation of the P&S report. According to our interviews with primary treating physicians, the average time needed to do a thorough review of the medical records and the average time to determine future medical care are each approximately 60 minutes. The time needed to generate (write or fill out) a P&S report ranges from 15 to 20 minutes using an EMR or template, whereas it takes an average of 60 minutes or more to complete the report based on dictation, according to our interviews. Therefore, the overall level of effort required to produce a P&S report is between 2.5 and 3 hours, exclusive of the examination.

The level of effort involved in completing a P&S report also varies depending on various factors, such as age and type of case. For instance, older cases typically require more effort, as there are more records that need to be reviewed to understand the history, the nature of the injury or illness, and the patient's progress to date. The effort is lessened if the physician has cared for the injured worker throughout the claim and increased if the physician recently became the worker's primary treating physician. Additionally, our interviewees suggested that the level of effort required of primary treating physicians to complete the P&S report is greater in certain cases, such as cases in which multiple providers have been providing care throughout the course of treatment, cases in which the patient has transferred care from a different location, and psychiatric cases. Psychiatric cases tend to be more complicated due to the added volume of

medical records to review, and a higher level of effort is thus required to complete the P&S report.

Standard P&S reports can be completed and submitted within the 20-day time frame. The time frame may be unreasonable when the case is complex or there are delays in obtaining records from secondary providers.

Attributes of High-Quality Reports

Our exploratory interviews with primary treating physicians and users of the P&S report revealed that a high-quality P&S report contains all the information needed to settle the claim and includes evidence to support any rating or final disability determination. The following were described as attributes of a high-quality report:

- Contains the patient's prior history and lists any prior disabilities
- Contains supportive documentation, such as exam test results, or includes specific measurements for range and motion and explains how those measurements were calculated
- Establishes causation, addresses apportionment, and provides a rationale for why the injured worker has been determined to have P&S status
- Describes in detail how the physician arrived at the rating and provides supporting information
- Indicates the percentage of whole person impairment, clearly references the AMA guides, and identifies where the justification for the percentage calculation can be found within the AMA guides, as well as which edition was used[5]

Many primary treating physicians and users of P&S reports prefer to use an electronic version of the report, as it provides more room to describe the physician's assessment, apportionment, rating, and justification for the worker's permanent disability status.

We did not ask about the attributes of a good physician's RTW and Voucher report.

Reporting Issues and Potential Improvements

During the interviews with physicians and users, several specific issues were raised concerning the P&S report, including the following.

Allowance. The adequacy and equity of the allowances were questioned by primary treating physicians and some users. With the implementation of the resource-based fee schedule, physicians can no longer be paid separately for record review. Dictation costs are also not separately billable and can be significant. In the view of the physicians and users we interviewed,

[5] Based on the WC Appeals Board decision in *Almaraz-Guzman*, a physician may rebut the whole person impairment determined using the AMA guide. If a physician takes this approach, the report should set forth the facts, reasoning, and references that support the alternative rating that more accurately reflects the impairment.

dictation and medical record review are time consuming and should be separately payable. The allowance for the examination is insufficient to cover these costs, and there is a disparity between what is payable for a P&S report and a medical-legal examination, leading some primary treating physicians to charge (inappropriately) for a medical-legal examination instead of the P&S report.

Quality. According to users, the P&S reports are often not complete, making it difficult to settle a case without going through the medical-legal process. Some primary treating physicians are not properly trained in using the AMA guides and do not know how to do the impairment ratings. They may not have enough records to do an apportionment determination. Some physicians are not using the PR-4 as it is intended; instead, they are using various narrative forms, PR-2s, and other formats. However, the users still need all the information pertaining to moving the case forward and ultimately settling the case. The use of supplemental reports to provide additional information that should have been in the initial report is increasing.

We also discussed several opportunities to improve the quality and efficiency of filing final P&S reports. The following options were suggested:

- Implement graduated allowances to align with timely submission of required P&S reports. (For instance, reduce the amount of allowance based on the number of days past the due date.)
- Reinstate an allowance for limited record review or a flat rate that is paid when there is medical record review or dictation.
- Eliminate the P&S report. Include a checkbox on the PR-2 to indicate that the report is to be filed as a final P&S report, and modify the PR-2 to include sections to address causation, apportionment, impairment, etc.
- Incentivize completion of quality P&S reports by reducing the allowance for incomplete or insufficient documentation on the report or refusing to accept the report until it is complete.
- Separate the reports of primary treating physicians from the subspecialty of medical-legal evaluations and disability assessments. The knowledge needed for P&S reports is very specialized. The P&S report written by a primary treating physician could focus on the final diagnosis, final commentary on whether the treatment has been effective, and what future medical might be needed. The medical-legal examination could focus on the impairment determination and apportionment.

Summary

Permanent and Stationary Report

The P&S report serves primarily as a notice that the injured worker has reached a stable and permanent status regarding his or her injury, treatment, and recovery. A high-quality P&S report is one that describes the patient's prior history, or any prior disabilities, and provides supporting documentation (e.g., exam test results, specific measurements for range and motion, and a

description of how those measurements were calculated) that clearly establishes causation and apportionment with a clear rationale for why the injured worker has been determined to have P&S status (i.e., has reached maximal medical improvement). It should describe in detail how the physician arrived at the rating and provide supporting information, including the percentage of whole person impairment, with appropriate references and justification.

The main issues that physicians and users identified with the P&S report were related to the quality of the reports and the adequacy of the allowances. Potential refinement options included linking the allowance to the timeliness and quality of reporting and establishing separate allowances for record review and dictation costs. Some suggested that the impairment and apportionment issues should be eliminated from the P&S report and addressed only in medical-legal examinations.

Return-to-Work and Voucher Report

The RTW and Voucher report is a separate report that is required from the first physician who reports that the patient is P&S. It is used to inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The RTW and Voucher report is required for injuries occurring on or after January 1, 2013. We did not address this report with the same depth as other reports, largely because our interviewees had little experience to date in completing and filing the report and did not raise any issues with the report in discussing the P&S reports. However, there is overlap between this report and the P&S report in terms of the assessment of the worker's functional capacity to return to his or her occupation.

Chapter Five: Allowances for Workers' Compensation–Required Reports Within the Resource-Based Relative Value System Context

In this chapter, we examine the assumptions used to establish selected RBRVS values and benchmark the allowances for WC-required reports to the OMFS allowances for comparable services. The comparisons provide a basis for assessing the reasonableness of the current allowances.

Doctor's First Report of Occupational Injury or Illness

One important issue raised in our stakeholder interviews and comparisons to other state policies was whether a separate allowance should be made for the DFR. The pre-RBRVS OMFS bundled the allowance into the allowance for the related E&M service. No change was made when the RBRVS was implemented, based on the assumption that most payers require a similar report when the patient is first seen and that any additional burden entailed in completing the report related to a report for the typical non-WC patient is accounted for in the 20-percent add-on.

The key question is whether the 1.2 multiplier provides adequate recognition for any additional effort required in providing an initial office visit for a new WC patient, including the preparation and filing of the DFR (and related RFAs). To answer this question, we focused on initial office visits for new patients because the DFR filing requirement is most likely to be associated with a new patient visit. We first examined the estimates of physician work for WC patients relative to the typical non-WC patients generated from the 2003 Lewin Group study. We then compared the physician time estimates used to value new patient visits relative to established patient visits in setting the RBRVS relative values.

Table 5.1 shows the WCIS distribution of initial office visits by level of visit, the total RVUs for each visit, and the findings from the Lewin Group report concerning the relationship for a specific E&M code between the physician work RVUs for a WC patient and the work RVUs for a non-WC patient.[1] The work effort for the DFR presumably was included in the comparison as a bundled report. There are five levels of office visits for new patients, ranging from a Level 1 visit involving a problem-focused history and examination and straightforward medical decisionmaking (typically involving ten minutes of physician face-to-face time) to a Level 5 visit

[1] The Lewin study was conducted for the Industrial Medical Council in 2003 before Medicare combined the codes for E&M office visits and E&M consultations. When these codes were combined, the relative values for the E&M office visits were increased. Because the initial DFR is most likely to be filed for an initial office visit, we focus our analysis on the differences between the work RVUs for the WC patient and those for the non-WC patient for initial office visits.

involving a comprehensive history and examination and high-complexity medical decisionmaking. Most WC initial examinations are Level 3 (32.7 percent) and Level 4 (45.0 percent) visits. The estimated additional work for a WC patient in the Lewin study declines as the complexity of the visit increases, but, except for the Level 1 visits, the additional work is at or below the work differential estimated for all visits. This implies that any additional reporting burden is not any greater for new WC patients than for other WC patients and that a separate payment is unnecessary.

Table 5.1. New Patient Office Visits, Distribution, Total and Work RVUs, and Lewin Study Differential

Code	Description	% of Total New Patient Office Visits	2016 Total RVUs	2016 Work RVUs	Lewin Work Differential for WC Patients (%)
99201	Office visit, new patient, Level 1	1.6	1.24	0.48	33
99202	Office visit, new patient, Level 2	6.9	2.11	0.93	28
99203	Office visit, new patient, Level 3	32.7	3.05	1.42	26
99204	Office visit, new patient, Level 4	45.0	4.64	2.43	24
99205	Office visit, new patient, Level 5	13.8	5.82	3.17	24

Another consideration is whether the time estimates for new patient visits provide additional time for postvisit activities such as preparing the DFR. Each visit code has a preservice time, which involves the physician's time spent preparing to see the patient, reviewing records, and communicating with other professionals or the employer. Intraservice time is the physician's face-to-face time spent with the patient in obtaining the patient's history, doing the evaluation, and counseling the patient. The postservice time is the time spent arranging for further services, reviewing results, documenting the visit, and completing reports. It also includes time spent communicating with other professionals or the family. The time assumptions are used as an input into the Medicare rate-setting process that determines work RVUs. The differences in total time between the new and established patient visits largely result from assumptions for intraservice times. The longer time estimates for new patient visits translate into higher RVUs for both the physician work and the practice expense component of new patient visits than for established patients.

Assumptions regarding any additional reporting and documentation effort for a new patient relative to an established patient should be reflected in the estimates for postvisit physician time. When we compare the assumptions by visit level, we find that the estimates for physician time spent in postservice activities for new and established patients are similar for Level 3 through Level 5 visits (Table 5.2). This indicates that the RVUs assume that the reporting burdens on physician work for the two types of visits are similar, which is consistent with Medicare's

administrative requirements. The concept of a primary treating physician is not used in the Medicare fee-for-service program, and a report is not required after a physician sees a new patient. A physician must approve plans of care in limited circumstances, such as when outpatient rehabilitative services are required or the patient is homebound and needs home health services. The plans are typically developed by the health professionals who will deliver the services; the physician documents approval in the patient's medical record but does not submit documentation unless requested by the Medicare contractor who processes bills for medical services, and some services, such as certification of home health care, are separately payable.

For WC, the level of postservice effort for a new patient is higher than for an established patient because the DFR payment is bundled into the allowance for the initial patient visit, while the PR-2 is separately payable in addition to an established patient visit.[2] Arguably, the DFR is likely to require more resources than the PR-2 because the report requires assessment of causation and whether the injury is work related.

Table 5.2. Comparison of Estimated Physician Times Spent During E&M Office and Outpatient Visits

Estimated Minutes for New Patient Visits					Estimated Minutes for Established Patient Visits				
Code	Preservice	Intraservice	Postservice	Total Physician Time	Code	Preservice	Intraservice	Postservice	Total Physician Time
99201	2	10	5	17	99211	0	5	2	7
99202	2	15	5	22	99212	2	10	4	16
99203	4	20	5	29	99213	3	15	5	23
99204	5	30	10	45	99214	5	25	10	40
99205	7	45	15	67	99215	5	35	15	55

SOURCE: CMS Physician Time File, 2017 Final Rule.

Progress Reports

Before the RBRVS, the OMFS allowance for progress reports (PR-2) was set at $11.69 (2.0 RVU × $6.15 conversion factor × .95) and had not been updated since 1999. Under the RBRVS, most reports are bundled into the allowance for office visits. A separate allowance for the progress report was retained on the assumption that comparable reporting is not required for the typical non-WC patient. When the RBRVS was implemented, the underlying pre-RBRVS

[2] The DFR also imposes a reporting burden on the office administrative staff in obtaining information from the patient needed to complete the report on the work-related incident and in filing the report. The rate-setting process allocates indirect costs for administrative staff based on physician work and direct costs. Because physician work and direct costs are higher for new patients, the total RVUs indirectly account for additional administrative staff time for completing and filing the reports.

allowance value for the reports was not changed, but it has been updated annually for inflation. In 2016, it was set at $12.14 per report and increased to $12.29 effective March 15, 2017. Because regular updates are now being provided, the issues identified in our interviews pertain to whether the pre-RBRVS allowance remains appropriate relative to RBRVS allowance levels for other services and whether any special policies for progress reports should be implemented when multiple physicians are providing services to an injured worker. With regard to the second issue, our interviews highlighted both the additional burden on the primary treating physician in gathering reports from secondary physicians and potential inequities for secondary physicians who prepare and send treatment reports to the primary treating physician but receive no payment for the reports.

From our interviews with primary treating physicians, we understand that the completion and filing of the report has three main components: (1) documentation of the patient's medical progress and any changes in the treatment plan, (2) incorporation of any findings from other treating physicians, and (3) assessment of the patient's current functionality and ability to return to work. The estimates of the physician's effort required to complete the report ranged from 5–10 minutes when it is generated from an EMR to 20–30 minutes when it is completed from dictation. For the purposes of this discussion, we assume that the first activity is comparable to medical record documentation for the typical non-WC patient and that it takes an additional 15 minutes to complete the other two activities (i.e., incorporating any findings from other treating physicians and assessing the patient's progress toward a return to work).

A challenge in examining the reasonableness of the allowance for progress reports is our inability to identify RBRVS fee schedule amounts for services that are directly comparable that could be used to benchmark the allowances for the PR-2s. This is because most reports are bundled under the RBRVS and those that are paid separately are priced "by report" based on the physician's description of the effort involved in preparing the report. To address this challenge, we identified other codes that might be used as indicators for the reasonableness of the allowance for progress reports. Codes that include one or more activities related to coordinating with other treating physicians and assessing the patient's progress toward a return to work are shown in Table 5.3. Even though a code is bundled under Medicare rules and therefore not separately payable under the OMFS, Medicare may publish RVUs for the code in its rulemaking documents as a courtesy to the AMA. With the exception of CPT 99490 (chronic care management services), the identified codes were bundled codes in 2016. Effective March 1, 2017, the OMFS also pays for extensive prolonged services that do not involve direct patient contact (such as extensive medical record review or ongoing care management work). The time required for the physician services must be at least 30 minutes beyond the usual service time for the related E&M visit.

Table 5.3. Potential Benchmarking Codes for Assessing the Reasonableness of PR-2 Allowance

Code	Description	OMFS Allowable?	Physician Work RVUs	Total RVUs in Nonfacility Setting	Equivalent Total RVUs for 15 Minutes of Work[a]	Estimated Allowance Without Multiplier[b]	Estimated Allowance with Multiplier
99358	Prolonged service without patient contact, first hour	Bundled	2.10	3.16	0.79	30.78	36.94
99359	Prolonged service without patient contact, each additional 30 minutes	Bundled	1.00	1.52	0.76	29.65	35.58
99374	Home health care supervision, 15–29 minutes	Bundled	1.1	1.98	1.02	39.28	47.13
99490	Chronic care management services, 20 minutes	Yes	0.61	1.19	0.86	35.61	42.73
G0179	MD recertification home health agency patient	Yes	0.45	1.17	1.10	44.55	53.46
G0180	MD certification home health agency patient	Yes	0.67	1.52	0.99	39.88	47.86
G0181	Home health care supervision	Yes	1.73	3.05	0.80	31.74	38.09

SOURCE: CMS, 2017.

[a] Calculated as the product of the total RVUs and the ratio of 15 minutes to the maximum number of minutes covered by the code. For G0179–G0181, we used the ratio of 15 minutes to the estimated time in the Medicare physician time file (G0179 = 16 minutes; G0180 = 23 minutes; G0181 = 57 minutes).

[b] Calculated as (work RVUs x work GAF + PE (nonfacility) RVUs x PE GAF + malpractice RVUs x MP GAF) x 40.8451 ÷ 1.2 x 1.0812 x ratio of 15 minutes to maximum minutes covered by the code, where GAF = the applicable geographic adjustment factor, 40.8451= the unadjusted 2017 conversion factor, and 1.0933 = the 2016 cumulative adjustment factor.

For each code, we have separately listed the physician work RVUs and the total RVUs. Because these are time-based codes, we converted the total RVUs for the code into the proportion that would be attributable to a 15-minute service. For example, CPT 99358 is defined as one hour of prolonged service related to an E&M visit without patient contact. Assuming the allowance was for 60 minutes, we calculated the equivalent RVUs at 25 percent of total RVUs. The last columns of the table show the product of the equivalent RVUs, geographic adjustment factors, and the 2017 OMFS conversion factor with and without the 1.20 multiplier. In our view, the 1.2 multiplier is unnecessary because these are time-based codes used for complex cases. The

estimated OMFS allowances across the codes range from $28.62 to $38.68, compared to the current $12.29 allowance.

Our objective was to identify codes that might be used to assess the reasonableness of the OMFS allowance for progress reports and not to suggest that the code actually be used to bill for a progress report. The codes do not identify conditions that would describe the filing and completion of the progress report. Each code has particular strengths and weaknesses as an indicator for an appropriate allowance for progress reports, but all suggest that the current OMFS allowance undervalues the service.

- CPT 99358 and 99359 are intended for non-face-to-face prolonged services that are beyond the usual physician care related to an E&M visit. This code is typically used when none of the other codes on the list apply. The values for this code might be most applicable to the effort required to complete relatively straightforward progress reports.
- CPT 99374 is one of several codes that apply to oversight of care plans for patients who are receiving home health care, hospice, or nursing home care that requires complex and multidisciplinary care involving regular development or revision of care plans and regular communication for assessment or care decisions with other health care professionals, family members, or key caregivers. The values for this code may be more appropriate for cases involving secondary treating physicians, although the situations in which it applies may involve more complex patients than the typical WC patient with secondary treating physicians. This is a time-based code that is not used by Medicare. Instead, Medicare uses G0181.
- CPT 99490 (Chronic care management services) is an alternative; however, the Medicare requirements for billing this service (CMS, 2015) with respect to both the definition of chronic care conditions and the care management requirements (including use of electronic medical records and 24/7 access) are unlikely to be met by the typical primary treating physician practice caring for a WC patient with secondary treating physicians. At the same time, the value established for the code would compensate the primary treating physician for the additional effort required of both the treating physician and the clinical staff to manage a complex WC case involving secondary physicians. It would account for not only the effort required to complete the report but also the effort involved in managing the patient between progress reports.
- G0181 is billable in a given month if the physician spends at least 30 minutes in the month coordinating the home health care provided to a Medicare patient that involves complex or multidisciplinary modalities. Staff time does not count toward the 30 minutes. The types of activities that are counted toward the 30 minutes are similar to those reported under CPT 99374: communication with other health professionals involved with the patient's care; coordination of services; review of charts, reports, and test results outside the initial patient review; and documentation of the services provided. These activities are not unlike those that a primary treating physician might perform for a WC patient whose care involves multiple physicians.

- G0179 and G0180 are two other Medicare-established codes that describe activities related to home health care that might have relevancy. As is the case with G0181, these are not time-based codes. The codes are related to initial certification of a plan of care and recertification of it at least every 60 days for a Medicare patient. The certifications, which must be documented in the patient's medical record, confirm the patient's homebound status and need for skilled nursing services (prerequisites for Medicare-covered home health services) and verify that the plan of care has been reviewed and approved by the physician. The home health plan of care and certification are not routinely submitted to the Medicare contractor but should be documented in the patient's medical record and available upon request.[3]

The pre-RBRVS fee schedule undervalued E&M services relative to most other services. Because the current OMFS allowance for the PR-2 is based on the pre-RBRVS values, a finding that the current allowance does not account adequately for the physician time and resources required to produce high-quality progress reports is not unexpected. When the RBRVS was implemented, the allowances at 120 percent of Medicare for E&M services were projected to be 39.5 percent higher than allowances under the pre-OMFS before accounting for bundling policies (Wynn et al., 2014). When estimated billings for supplies and consultation reports under pre-RBRVS policies are accounted for, the estimated increase is 26.9 percent. Raising the 2017 allowance 26.9 percent, or to $15.59, would maintain the relationship between the PR-2 allowance and allowances for E&M services.

Permanent and Stationary Reports

Interviewees expressed concern over both the quality of the P&S reports and the adequacy of the allowance post-RBRVS. The latter could be construed as an issue regarding the adequacy of the allowance to conduct the examination and determine the impairment rating, including any medical record review. Both activities are integrally related, and an assessment of the adequacy of the allowance for the report needs to be considered in concert with the allowance for the disability evaluation. In this regard, none of the states that we identified with comparable data elements for their P&S report paid separately for the report but rather included the allowance for the report in the allowance for the examination to determine the disability rating.

With the implementation of the RBRVS schedule, the OMFS allowance for the E&M evaluation increased, but no change occurred in allowance for the report (which is based on the number of pages) and, perhaps most importantly, separate allowances for extended record review were no longer paid separately but rather bundled into the allowance for the E&M visit. The issue of dropping the separate allowance for extended record review was frequently raised by

[3] CMS has developed a form (CMS-485) that home health agencies may use to document the plan of care and physician certification. The form is not mandatory but fulfills the regulatory requirements and may be submitted if the services are targeted for medical review. The data elements are similar to those that one might expect in a PR-2: diagnoses, treatment goals, and frequency and duration of services.

both providers and payers, particularly with respect to older claims with extensive medical records. Effective March 1, 2017, extended record review may be separately payable for the time spent by the physician (but not time spent by the physician's staff) in conjunction with the E&M visit.

As discussed in Chapter Four, some content of the P&S report is similar to the PR-2 content, but the P&S report also requires that the physician give a comprehensive explanation of how he or she arrived at conclusions pertaining to causation, apportionment, impairment, and future medical care. The level of effort varies widely based on case complexity, whether the report is generated from the EMR, and whether a software program is used to calculate the impairment rating. The primary treating physicians estimated that it takes about 2.5–3 hours to complete the report (including thorough medical record review but excluding the E&M visit).

The Medicare fee schedule file does not have relative values for the work-related or medical disability evaluation services (CPT 99455) performed by the treating physician. Table 5.4 shows potential codes that might be considered in an assessment of the reasonableness of the allowances. If a physician determines that an injured worker has reached maximal medical improvement with no impairment, a final PR-2 is filed indicating that the patient is P&S. Effective March 1, 2017, the combined allowance for the E&M visit (assuming a CPT 99215–established patient visit is billed) and the final PR-2 is $209.42 (line 1 in the table). If the injured worker is determined to be P&S with permanent impairment, the same E&M allowance applies, but a P&S report is filed instead of a final PR-2. The average OMFS allowance for PR-4s in 2014 was $102.55. After adjusting this average for inflation to 2017 ($105.74), the estimated total OMFS allowance is $302.87 (line 2). The difference in the total allowances indicates that about $93 is being paid to develop the impairment rating and complete the P&S report. For comparison, the hourly rate for CPT 99358 (Prolonged service without patient contact) is $123.12 (exclusive of the 1.2 modifier).

Table 5.4. Potential Benchmarking Codes for Assessing the Reasonableness of P&S Allowances

	Evaluation Allowance ($)	Average Report Allowance ($)	Total Allowance ($)
1. CPT 99215 E&M established patient office visit + PR-2	197.13	12.29	209.42
2. CPT 99215 E&M established patient office visit + PR-4	197.13	105.74	302.87
3. ML 102 Basic comprehensive ML evaluation + report			625.00
4. ML 103 Complex comprehensive ML evaluation + report			938.00

Other potential benchmarks are the medical-legal (ML) codes. The ML allowances are based on a $250 hourly rate, about twice the rate provided by CPT 99358. The assumption underlying ML 102 (Basic comprehensive medical-legal evaluation) is that it requires on average 2.5 hours

of physician effort, including the examination. The code is currently valued at $625 (line 3), while an ML 103 (Complex comprehensive medical-legal examination) is valued at $938 based on an estimated average of 3.75 hours per examination (line 4). Presumably, because the primary treating physician is familiar with the injured worker's medical history, the completion of the examination, determination of the impairment rating, and documentation of the findings should take less time than an independent medical evaluator would require. While our interviewees indicated the level of effort varies depending on a number of factors, the overall level of effort required to produce a P&S report was estimated to be on average between 2.5 and 3 hours, exclusive of the examination. These estimates are longer than might be expected based on the assumptions for the ML 102 and 103 codes, which include both the examination and the report. In addition to these two ML codes, ML 104 (Comprehensive medical-legal evaluation involving extraordinary circumstances) is a time-based code that is to be used for unusually complex, resource-intensive evaluations.

Summary

The analyses in this chapter provided benchmarks to gauge the reasonableness of the allowances for WC-required reports with post-RBRVS allowances for similar services under the OMFS. Under the RBRVS, reports are bundled, so we did not find codes that describe the actual activities involved in completing the DFR and PR-2; instead, we identified codes that appear to describe comparable activities. For the P&S, we expanded our comparison to include the fee schedule allowances for medical-legal evaluations.

There are two RBRVS-related issues in assessing the reasonableness of bundling the allowance for the DFR. The first is whether the activities required by the reports are covered by the OMFS 20-percent add-on to the Medicare fee schedule amounts. The second is whether the allowance is reasonable relative to the OMFS allowance for other services.

Our findings are mixed with regard to the lack of an allowance for the DFR. The results from the Lewin study imply that the additional reporting burden is not any greater for new WC patients than for established WC patients and that, to the extent that the 20-percent add-on is intended to compensate for the additional resources required to care for WC patients, a separate allowance is not necessary. However, our review of the allowances for other services suggests that a separate payment for the DFR might be appropriate. Medicare does not require a comparable report when care is initiated for a new patient (and the fee schedule does not assume additional postservice time for a new patient), and the DFR is likely to require at least as much time as the PR-2, which is separately payable.

The OMFS provides a separate allowance for the PR-2 based on an assumption that this is a work-related activity that is not accounted for by the RBRVS. Our review of the RBRVS and Medicare rules support this assumption. CMS does not routinely require progress reports from physicians caring for Medicare patients, and most activities that are similar to those required to

complete a progress report are separately payable. The codes for similar activities are payable either as a time-based code (e.g., prolonged services) or for a specific activity (e.g., supervision of complex home health care). When we compared what is payable for the average PR-2 with the amount that would be payable under the benchmark codes for a comparable level of effort, we found that the PR-2 is undervalued.

We compared the allowance for the examination and PR-2 filed when an injured worker has reached P&S without permanent impairment to the allowance for the examination when there is permanent impairment and a PR-3 or PR-4 is required. We found that the additional allowance for the impairment rating is about $93 before any additional allowance is provided for prolonged record review or other services that are not accounted for in the allowance for the evaluation and report. The combined allowance is substantially lower than the current allowances for basic and complex comprehensive medical-legal evaluations (ML 102 and ML 103), but, effective March 1, 2017, an additional allowance may be payable for the examination or report when prolonged services are involved.

Chapter Six: Summary of Findings, Discussion, and Recommendations

In this chapter, we first summarize the main findings from our stakeholder interviews, comparison to other state reporting requirements, and assessment of the adequacy of the allowances for WC-required reports. We then discuss and recommend potential refinements in the reporting policies and processes for WC-required reports.

Summary of Reporting Requirements, Processes, and Issues

Doctor's First Report

The DFR serves primarily as a notice that the injured worker has been seen by a physician and describes the first diagnosis based on the initial physical examination. The DFR provides the framework for documenting the injury and notifies the carrier of the nature of the injury or illness and medical status of the patient. A good DFR is one that is legible, thorough (e.g., includes a description of the injury, subjective and objective findings, and patient history), and detailed (e.g., provides an account of a comprehensive physical exam and a descriptive patient account of what happened), and it considers impairment and appropriate treatment.

The main issue with the DFR in California, according to physicians and users, is the lack of clarity on when a DFR is required and the resulting variation among providers regarding when they submit a DFR. There were differences among the interviewees concerning what the appropriate reporting requirement should be; however, there was general agreement that DFRs filed after that of the initial primary treating physician are not needed to manage the claim other than as a potential mechanism to alert the claims administrator that a change of primary treating physician has occurred.

Physicians believe that bundling the report into the allowance for the examination does not appropriately compensate them for completing and filing the reports. Among the states with similar reports, New York does not have a separate allowance, but Texas ($15) and Washington ($19.10–$39.19, depending on timeliness) do. Texas and Washington also pay more generously for E&M visits than either California or New York. Suggested options for paying for the report included using the allowance to incentivize the timely completion of high-quality reports and electronic filing (which is now required by SB 1160).

There are two RBRVS-related issues in assessing the reasonableness of bundling the allowance for the DFR. The first is whether the activities required by the reports are covered by the OMFS 20-percent add-on to the Medicare fee schedule amounts. The second is whether the allowance is reasonable relative to the OMFS allowance for other services. Our findings are

mixed with regard to the lack of an allowance for the DFR. The results from the Lewin study imply that the additional reporting burden is not any greater for new WC patients than for other WC patients and that, to the extent that the 20-percent add-on is intended to compensate for the additional resources required to care for WC patients, a separate allowance is not necessary. However, our review of the allowances for other services suggests that it would be more equitable to provide a separate payment for the DFR. Medicare does not require a comparable report when care is initiated for a new patient (and the fee schedule does not assume additional postservice time for a new patient), and the DFR is likely to require at least as much time as the PR-2, which is separately payable.

Progress Report

The PR-2 serves primarily as a mechanism to report that the injured worker has been seen by a physician and requires additional treatment. It documents the functionality of the patient along his or her course of treatment. A good PR-2 is one that is thorough (e.g., provides descriptions of patient progress, response to treatment, symptoms, change in condition, past history, medications, and test results) and detailed (e.g., includes recovery goals, target symptoms, and current functionality), and it considers the patient's ability to return to work and documents the reason for the PR-2.

During the interviews with physicians and users, several issues were raised concerning the PR-2. The first issue related to inconsistencies among users is whether they accepted progress reports from secondary treating physicians. Some accepted reports that were submitted by any treating physician, while others accepted reports only from the primary treating physician. A related issue concerned delays in primary treating physicians receiving medical records or full charts from secondary physicians, which result in insufficient time to review the records before the patient is seen or delays in submitting the PR-2. Finally, the quality of progress reports needs improvement. The physicians and users noted the reports often do not reflect the continuity or timeliness of care and need clearer descriptions of treatment goals, symptoms, and changes or progress in the patient's recovery.

Among the states that require progress reports with similar data elements to California's, Texas has a flat rate of $15 per report. The Washington narrative progress reports are separately paid a maximum of $44.96 (limit of one payable report per 60 days). Florida and New York (which also have relatively low payment rates for E&M visits) do not separately pay for submission of progress reports and consider the reports included in the allowance for the E&M office visit.

Our review of the RBRVS and Medicare rules supports the assumption that the PR-2 is a work-related activity that is not accounted for by the RBRVS. CMS does not routinely require progress reports from physicians caring for Medicare patients, and most activities performed for Medicare patients that are similar to those required to complete a progress report are separately payable. When we compared what is payable for the average PR-2 with the amount that would

be payable under the benchmark codes for a comparable level of effort, we found that the PR-2 2017 allowance of $12.49 is undervalued.

Request for Authorization

The RFA serves primarily as a notice that the injured worker needs additional treatment, which must be authorized; therefore, it has a high level of specificity and should contain the rationale for the requested treatment. A good RFA is one that lists each specific requested medical service or item (including frequency, duration, and dosage or measurement of treatment) with the associated diagnosis and procedure codes, refers clearly to any attachments (such as a medical report or PR-2), and provides objective evidence to substantiate all treatment requests for the patient on one RFA form. The main issues are the redundancy of the information on the RFA and the PR-2 and the lack of clarity regarding who should submit the RFA. California and the other WC states do not pay separately for the RFA, and time required to obtain authorization for a service is considered bundled into the payment for the related service. For selected services (rather than all proposed treatment), Medicare requires authorization and does not pay an additional amount for submitting the supporting documentation.

Permanent and Stationary Report

The P&S report serves primarily as a notice that the injured worker has reached a stable and permanent status regarding his or her injury, treatment, and recovery. A high-quality P&S report is one that describes the patient's prior history, or any prior disabilities, with supporting documentation (e.g., exam test results, specific measurements for range and motion, and a description of how those measurements were calculated) that establishes causation and apportionment with a clear rationale for why the injured worker has been determined to have P&S status or to have reached maximal medical improvement. It should describe in detail how the physician arrived at the impairment rating and provide supporting information, including the percentage of whole person impairment, with appropriate references and justification.

The main issues that physicians and users identified with the P&S report related to the quality of the reports and the adequacy of the allowance. Potential refinement options included linking the allowance to the timeliness and quality of reporting and paying for record review and dictation costs. (Under RBRVS rules effective with the 2017 update, prolonged services personally furnished by the physician—but not staff—may be separately payable.) Some interviewees suggested that the impairment and apportionment issues should be eliminated from the P&S report and addressed only in medical-legal examinations.

The states with similar data elements to California's include the allowance for the report in the allowance for the examination determining P&S status. In Georgia, documentation of the final work-related examination on the final P&S report has a maximum allowance of $212.74. Florida allows $90 for the examination and report, while New York's allowance for the examination and report is set at the rate for a comprehensive office consultation (which is about

$104 more than a comprehensive office visit). Washington pays $525.42 for a standard impairment rating and $656.75 for a complex rating by either the primary treating physician or an independent medical examiner.

When we compared the combined allowance for the examination and PR-2 filed when an injured worker has reached maximal medical improvement without permanent impairment to the allowance for the examination when there is permanent impairment and a PR-3 or PR-4 is required, we found that the additional allowance for the impairment rating is about $93. This suggests that the report is considerably undervalued if it is intended to cover the 2.5–3 hours estimated by our physician interviewees as the time required to complete the report. For comparison, the hourly rate for CPT 99358 (prolonged service without patient contact) is $123.12, exclusive of the 1.2 modifier. However, this assessment does not include any additional allowance effective March 1, 2017, for prolonged record review or other services that are not accounted for in the allowance for the evaluation and report. Absent an additional allowance for prolonged services, the combined allowance is also substantially lower than the current allowances for basic and complex comprehensive medical-legal evaluations (ML 102 and ML 103), both of which combine the evaluation and report into a single payment at an assumed $250 hourly rate. Because the ML fee schedule has not been revised since 2007, the current allowances for the ML codes should not be used as a benchmark until they are reviewed in the post-RBRVS environment for reasonableness.

Discussion

The reports required from physicians treating injured workers are intended to facilitate claims management both in terms of managing the patient's medical care and in monitoring the patient's progress toward maximal medical improvement and a return to work. Within this overall framework, the reporting requirements should be designed to provide information needed for claims management (including medical-legal processes) and care coordination while imposing the least administrative burden on treating physicians. The reporting cycle and data elements should be evaluated based on whether they add value to the claims management process. The fee schedule should account for reporting burden that is not otherwise incorporated into the allowance for the related medical care, and any separate allowances should be designed to encourage high-quality reporting in a timely manner. The remainder of this section discusses three overarching refinement objectives that we identified during our evaluation of the individual WC-required reports: reduce administrative burden, facilitate care coordination, and align fee schedule policies with reporting objectives.

Reduce Administrative Burden

We identified several opportunities to eliminate unnecessary WC-required reports. The first concerns the DFR and the existing confusion regarding who is required to submit it. However,

the more important question is when the report should be required. There is a general consensus that, at a minimum, the report should be required from the first physician who examines the patient following a work-related incident. The report notifies the appropriate parties that a physician has treated the injured worker, gets the injured worker into the WC system, and provides the information needed for monitoring workplace injuries and public health issues. The question is whether additional DFRs add value to the management of the claim. Our interviews suggest that requiring the DFR from only the first physician who treats an injured worker may not be sufficient. The physician providing first aid or treating the patient in the emergency room may not obtain complete information from the worker and the plan of treatment may not be comprehensive. This suggests that also requiring the DFR from the first primary treating physician would add value. The interviews also suggest that requiring a DFR from subsequent primary treating physicians does not facilitate claims management, except as a way to notify the claims administrator that there has been a change in primary treating physician. Using the PR-2 to track changes in the primary treating physician would be less burdensome and avoid the issues involved in having inconsistent DFRs from multiple physicians in a claims file.

The elimination of the redundancies between the PR-2 and the RFA represents another opportunity to reduce reporting burden for physicians. From our interviews, we understand that the RFA form was developed so that claims administrators would be able to easily recognize treatment requests for the purposes of utilization review and to route the PR-2 to the claims adjuster and the RFA (either before or after claims adjuster review) to utilization review. However, it imposes an unnecessary burden on the physician, particularly if the RFA is not used to authorize treatment. According to a report by the California Workers' Compensation Institute that examines utilization review practices (David et al., 2015) only 15 percent (range = 9–19 percent) of WC medical services in a study sample were requested in RFAs that underwent utilization review.[1] Because DWC rules anticipate physicians will submit RFAs and our review of utilization review plans indicates that the use of prior authorization (which waives the RFA) is not widespread, their finding implies that a significant percentage of RFAs were not used in a medical necessity determination. Combining the two forms into a single form with a checkbox at the top to indicate whether the form includes a request for treatment authorization has several benefits. It would eliminate duplication of effort for the primary treating physician, it would increase the likelihood that the treatment request is reviewed within the context of the patient's condition as outlined in the progress report, and it could reduce unnecessarily elevating proposed treatment for utilization review by clinical staff. In the subsection that discusses coordination of care, we will address the appropriate roles of primary and secondary treating physicians in requesting treatment.

[1] Their estimate may be sensitive to how UR is defined, the composition of the study sample (third-party administrators were not included), and how adjustments were made to make the units of service in the treatment request comparable to those used to report paid medical services. The report did not break down the RFA submission rates by type of service.

The RTW and Voucher report is required for injuries occurring on or after January 1, 2013. We did not address this report with the same depth as other reports, in part because our interviewees had little experience to date in completing and filing the report. However, there is overlap between this report and the P&S report in terms of the assessment of the worker's functional capacity to return to his or her occupation. The questions are similar but not identical, which only adds to the effort required to complete the report. Because the information is not used in the permanent impairment rating, it should be eliminated from the P&S report. Alternatively, the RTW and Voucher report could be eliminated as a separate report and incorporated into the P&S report. Having a single form that obtains all information may ensure better reporting compliance but may complicate the transmission of the necessary information to the employer.

Program efficiency could be increased through electronic reporting of all WC-required reports and related documentation. Implementation of the SB 1160 provision requiring electronic reporting of the DFR should reduce the time required to open a WC claim and initiate treatment. If claims administrators have the infrastructure to receive progress reports and RFAs electronically and make them accessible to the appropriate people, the elapsed time to process RFAs could be reduced. Depending on how it is implemented, electronic reporting could provide a platform for communications between the primary treating physician, secondary treating physicians, and the claims administrator. If properly designed, it could reduce provider time spent in completing reports by auto-filling standard information requested on each form concerning the patient, claims administrator, employer, and treating physician. For a PR-2, it could provide the prior report and ask targeted questions on changes in the patient's condition and treatment plan. If there is an appeal on an adverse utilization review decision, the case documentation could be transmitted electronically to the independent medical review organization.

While electronic reporting has distinct advantages over the current system, it is important to recognize that physician practices providing services to WC patients have different levels of health information technology capabilities. Electronic reporting poses an administrative burden unless the provider has the capacity to generate the report from an EMR. Any requirements for electronic reporting would need to take this into account by providing alternative modes for submission.[2]

[2] The use of health information technology has increased rapidly in recent years. In 2015, 76.5 percent of California physicians reported possessing a certified electronic health record (including 73.5 percent in small practices). Forty-seven percent of physicians reported sharing patient health information electronically, with 39 percent sharing patient health information electronically with outside providers (Office of the National Coordinator, 2017). Providers caring for Medicare or Medicaid patients are likely to have higher usage rates than providers with high WC patient loads because the Medicare and Medicaid programs have financial incentive programs to promote the meaningful use of electronic health records.

Facilitate Care Coordination

Care coordination issues become prominent when secondary physicians are involved in treating an injured worker. The main issue is whether the conception of the primary treating physician as a "gatekeeper" who coordinates the worker's medical care should continue to be preserved by requiring that the primary treating physician submit all progress reports and RFAs or whether the secondary physician should submit the RFA for treatment he or she proposes to furnish and potentially a progress report. The main rationale for requiring the primary treating physician to submit the reports is to facilitate care coordination. However, there are downsides as well. First, the secondary physician is in the best position to describe why the proposed treatment is medically necessary and to respond to questions that may arise during the medical necessity review process, yet the communication is between the reviewer and the primary treating physician. Second, utilization review decisions, appeal requests for independent medical review, and independent medical review decisions are also communicated to the requesting physician. If the requesting physician is the primary treating physician, the secondary physician may not even be aware of approval or denial determinations on treatments that the secondary physician is proposing. If the secondary physician is aware of an adverse utilization review decision, the physician has an opportunity to consider alternative treatments, request informal review, and support the appeal request when appropriate. Third, the timeline for requesting authorization for the proposed treatment and the timeline for a progress report may not be aligned. We assume that an RFA for referral to a specialist would be submitted by the primary treating physician in conjunction with a progress report that is filed following an E&M visit; however, there is no direct tie between when the specialist conducts an evaluation and determines any proposed treatment and the 45-day time frame for the next progress report. Either the visit to the specialist precipitates RFA/PR-2 filings that are independent of the patient's next scheduled visit to the primary treating physician or the RFA submission is deferred until the next visit occurs. If the PR-2 is submitted independently of the next visit with the primary treating physician, the secondary treating physician expends effort on completing what is needed for the RFA, but the primary treating physician receives a payment by filing the PR-2. Deferring the RFA/PR-2 filings until the next scheduled visit with the primary treating physician creates a delay in providing medically necessary care.

Primary treating physicians indicated that obtaining and compiling the reports from secondary physicians was time-consuming and can create delays in filing progress reports. Other states with similar reporting requirements do not require that the RFA be submitted with a primary treating physician progress report and provide that the physician who would be ordering or prescribing the treatment submit the RFA. As discussed previously, electronic reporting can facilitate communication between the primary treating physician and any secondary treating physicians. One option would be to break the link between the PR-2 and the RFA for services provided by the secondary physician. The PR-2 would include any RFAs associated with the

care provided by the primary treating physician, including referrals to secondary physicians but not any care resulting from the referral to the secondary physician. The secondary treating physician would submit a separate RFA with a copy to the primary treating physician. This way, the primary treating physician would be apprised of the secondary physician's proposed treatment and could intervene if appropriate. There would be no delays in treatment. Both the primary and secondary physicians should be advised of any related utilization review or independent medical review actions. In sum, the main channel of communication throughout the medical necessity determination and dispute-resolution process would be with the secondary physician who is proposing the treatment, but the primary treating physician would also be apprised of any proposed treatments and adverse utilization review decisions and associated appeals.

Requiring a secondary treating physician to submit the RFA raises an issue of whether the physician should also file a PR-2. Primary treating physicians noted difficulties in receiving reports from secondary treating physicians. We are unsure whether this issue has been exacerbated by the elimination of separate allowances for reports associated with E&M visits and consultations. In the previous section, we suggested that the PR-2 and RFA should be combined into a single form. An abbreviated form might be considered for secondary treating physicians that covers the proposed treatments, the treatment objectives, and progress in meeting them for the services that the secondary treating physician provides.

Align Fee Schedule Policies with Reporting Objectives

As noted earlier, the fee schedule should account for reporting burden that is not otherwise incorporated into the allowance for the related medical care, and any separate allowances should be designed to encourage high-quality reporting in a timely manner. These objectives raise two questions: (1) Do current OMFS policies provide reasonable remuneration for the time and resources required to comply with WC reporting requirements relative to the allowances for other services? and (2) Should incentives be considered to encourage timely filing of high-quality WC-required reports or electronic filing of reports?

Doctor's First Report of Occupational Injury or Illness

As noted earlier, our findings are mixed with regard to the lack of an allowance for the DFR. The results from the Lewin study imply that a separate allowance for the DFR is not necessary in addition to the 20-percent add-on to Medicare's rate. On the other hand, the DFR is unique to WC; Medicare does not require a comparable report, and its fee schedule does not account for additional postservice time for a new patient relative to an established patient. On equity grounds, the DFR is likely to require at least as much time as the separately payable PR-2.

SB 1160 (Mendoza) amended Section 6409 of the Labor Code to require that the DFR be filed electronically with DWC and the payer (with no change in the five-day time frame).[3] DWC decisions on the electronic filing requirements could affect a physician's administrative burden in filing the DFR. Completing and filing the report through a website portal is likely to be more burdensome than scanning and uploading a completed document. Either method involves additional steps that are not currently required to file a DFR. Sending the document via encrypted email is likely to be the least burdensome method relative to the current filing methods.

Our mixed findings regarding the lack of a separate payment for the DFR suggest a range of options that might be considered: (1) make no change in current policy on the assumption the 20-percent add-on accounts for the additional time and resources required to complete and file a DFR, (2) make an additional payment for all DFRs because the report is unique to WC, and make separate payments for the PR-2, and (3) selectively pay for the DFR to incentivize timely filing of the report using electronic modes that facilitate maintenance of a claims management system.

As discussed in Chapter Three, because no bills are submitted for DFRs, we are unable to determine how often they are being filed under various circumstances. Estimating the number of DFRs that are required from physicians providing first aid, urgent, or emergency care is particularly problematic.[4] DWC does not maintain an electronic file that can be analyzed to review DFRs that are reported for first aid services, so we are unable to take these DFRs into account in our estimates. Our analysis of the WCIS 2015 data suggests that other than DFRs for first-aid services, potentially 668,000 DFRs would have been filed by emergency room physicians for initial care following injury and by the initial primary treating physician. If payment for the DFR were made at the current rate for the PR-2, establishing an allowance for the DFR would increase medical expenses for WC-required reports by an estimated $8.2 million before consideration of payments for DFRs filed for first-aid services immediately following injury. If, as discussed later, the allowance for the PR-2 were increased, the expenses for the DFR would increase proportionately.

In lieu of establishing an allowance for all DFRs, the allowance could be used as an incentive payment for timely filing in the preferred electronic mode. Only providers that comply with the reporting requirements would receive an equitable allowance for filing the DFR. A rationale for this approach would be to recognize that timely reporting improves the efficiency of the claims

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[3] In the case of treatment for pesticide poisoning, a DFR must also be filed with the local health office by facsimile or other means within one day. Unless the physician certifies that the report has been filed, no payment is to be made for initial treatment for pesticide poisoning.

[4] In the past, first-aid-only claims have been underreported to the Workers' Compensation Insurance Rating Bureau, but the extent of the underreporting has not been determined. The bureau's rules effective for 2017 filings clarify that insurers must report the cost of all claims for which any medical care is provided. First-aid-only claims will be not be distinguished from other "medical only" claims, so it will still be problematic to estimate the number of DFRs that would be generated for these claims and the percentage that would also involve subsequent care from a primary treating physician.

management functions and increases the timeliness of recommended care. It would also recognize that electronic reporting through a secure portal creates a platform for improved claims management but also imposes additional administrative burden on physicians, particularly those who do not maintain an EMR. Because total expenses under this option depend on the compliance rates, we are unable to estimate what the additional allowances would be. Large WC practices that are designated as an initial Medical Provider Network provider are already likely to generate the DFR from their EMR and submit DFRs in a timely manner. Therefore, we are uncertain whether the efficiency gains from improved reporting compliance are likely to offset the allowances for the DFR.

Primary Treating Physician's Progress Report

When the RBRVS was implemented, provision was made for regular updating of the allowance for the PR-2. However, the underlying value was not reexamined for consistency with the RBRVS allowances. One major effect of the RBRVS was to increase the allowances for E&M services, which had been undervalued before the RBRVS. Our review described in Chapter Five found that the PR-2 is undervalued relative to other services that involve comparable activities.

We identified several approaches that might be considered for bringing the allowances in line with comparable services under the RBRVS. The first approach maintains the pre-RBRVS relationship between the PR-2 allowance and overall E&M payment levels. It assumes that the PR-2 allowance was reasonable in relation to average allowances for pre-RBRVS E&M services and increases the allowance 26.9 percent to maintain that relationship under the RBRVS. The 2017 allowance would be $15.59. Total expenditures for the PR-2 would increase by an estimated $7.5 million, assuming no change in PR-2 filing behavior.[5]

A different approach would be to benchmark the PR-2 to an E&M service that involves similar physician activities, such as CPT 99358/99359 (prolonged services without face-to-face contact). Based on an assumption that 15 minutes is required to complete the WC-specific portions of the report, the allowance would be increased to about $30 per report, without the 1.2 multiplier. Because the benchmark is based on an estimate of the physician's time spent completing the PR-2, we do not believe the multiplier is appropriate. A $30 allowance would be a substantial increase (144 percent) over the current allowance. Total expenditures for the PR-2 would increase by an estimated $40 million, assuming no change in PR-2 filing behavior.[6]

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[5] Our estimates for changes in the PR-2 are based on the 1.6 million reports filed in 2014, adjusted for an estimated 30 percent underreporting to the WCIS and the increase in the allowance per report. For the first approach, we calculated the estimate as 1.6 million ÷ 0.7 × (15.59 – 12.29). Changes in the number of new WC claims between 2014 and 2017 are not accounted for because data are not available for 2017.

[6] Our estimate is based on the 1.6 million reports filed in 2014, adjusted for an estimated 30 percent underreporting to the WCIS and the increase in the allowance per report. We calculated the estimate as 1.6 million ÷ 0.7 × (30.00 – 12.29). Changes in the number of new WC claims between 2014 and 2017 are not accounted for because data are not available for 2017.

However, the higher payment might create an incentive for claims administrators to customize the frequency of the reporting on the injured worker's medical status and eliminate the practice of reporting more frequently than necessary. This would reduce the volume of PR-2s and eliminate unnecessary reporting burden on providers.

While a $30 allowance would create a substantial increase in medical expenditures, it still might not be sufficient to account for the effort required to coordinate with secondary physicians and synthesize their reports into the PR-2. As discussed in Chapter Five, benchmark services that require coordination with other health care professions have higher values under the RBRVS than prolonged services without patient contact.

In contrast, a $30 allowance would overvalue the effort a secondary physician would expend in submitting the streamlined PR-2/RFA discussed previously as a potential mechanism to facilitate care coordination. A rule of thumb in considering a reasonable allowance for the streamlined report is the extent to which the report requires WC-specific information. If the required information were similar to what is recorded in the injured worker's medical record and submitted with an RFA, the WC-specific burden on the physician would be minimal. Nevertheless, some allowance (e.g., the current allowance of $12.49) still might be appropriate to encourage care coordination and reduce the burden on the primary treating physician in collecting progress reports from secondary physicians.

A modification to the second approach would be to pay the higher allowance to the primary treating physician for the PR-2 only if the PR-2 is complete and addresses all components of the report. In our interviews, we heard concerns from claims administrators regarding the quality of the PR-2s. The rationale for this approach is that the increase in the allowance is based on an estimate of the additional physician time required to complete the WC-specific portions of the report (incorporating any findings from other treating physicians and assessing the patient's progress toward a return to work) and is justified only if those portions of the report are appropriately completed. The plan of care and treatment objectives are similar to what should be recorded in the injured worker's medical record, and reporting this information should not entail significant physician effort. This approach would create incentives for more complete and higher-quality reporting; however, it could also create potential friction between the claims administrator and the provider over the adequacy of the report. The cost impact of this approach depends on the completeness of current reports, the rate of improvement in report completeness, and the administrative savings from receiving timely and complete progress reports. We do not have sufficient information to estimate the impact.

Permanent and Stationary Report

We identified several issues that should be addressed in evaluating whether any changes should be made in the pricing for the P&S report. The main issue that RAND was asked to address was the reasonableness of the allowances relative to other allowances under the RBRVS. The P&S (PR-3 and PR-4) allowances should reflect the additional reporting effort required

when there is permanent impairment relative to when the claimant does not have a permanent impairment and a PR-2 is filed. Based on the current PR-2 allowance of $12.29, an additional $93 is allowed for the P&S report (Table 5.4). The reasonableness of this allowance hinges on what it is intended to cover. If it is intended to cover all activities related to completion of the report, the allowance is inadequate, assuming 2.5–3 hours is required to review the medical record, determine the impairment rating, consider future medical needs, and write the report. If it is intended to cover the report writing but not the other activities, the allowance may be adequate.

Separate billing for prolonged services is permitted under the RBRVS effective March 1, 2017, for both care involving patient contact and care without patient contact. The CPT 99358/9 codes are used for prolonged services not involving direct care that are beyond the usual non-face-to-face component of physician service time. However, there is ambiguity concerning how much record review is expected and already accounted for in the allowances for the OMFS E&M evaluation (which has the 1.20 multiplier) and P&S report. Without further clarification, the prolonged service codes could lead to duplicate payments. Close monitoring of the use of the codes will be required to identify any abusive billing practices.

A related issue is whether the current structure appropriately accounts for differences in case complexity. Arguably, both the current allowance per page and the prolonged service codes account for differences in case complexity, with more complex cases requiring more extensive medical record review and more detailed and lengthy explanations in the P&S report. While they provide an incentive to fully address the required issues, they also create an incentive to pad the report with unnecessary documentation or otherwise be inefficient in completing the report. A complexity definition could be based on objective rather than subjective case characteristics, such as whether multiple body parts are involved and the maturity of the claim, and could be independent of the actual amount of time required to complete the evaluation and report. This would avoid the “coding creep” that often occurs with time-based codes.

Our review also raises the question of how the allowances for the evaluation and report should be structured. The fee schedules for the other states that we examined and the California medical-legal fee schedule combine the allowance for the evaluation and report. In our view, there is little rationale for maintaining separate allowances since some activities, such as medical record review and determination of the impairment level, could be performed either as part of the E&M evaluation or in writing the report. The two activities are integrally related and should be payable as a combined service with a higher allowance for more complex cases.

Another issue raised in our interviews was whether the impairment rating component of the report should be mandatory for the primary treating physician. The quality of the P&S report is affected by the physician’s familiarity with the AMA guides, and those who do not have a high WC caseload may not be equipped to determine an impairment rating without considerable effort. Making the P&S a mandatory filing requirement may deter some physicians from treating injured workers as a primary treating physician. There are benefits to having the primary treating

physician, who is most familiar with the injured worker, complete the impairment rating. Also, a quality P&S report can expedite claim closure relative to a medical-legal evaluation. However, incomplete or inaccurate reports submitted by the physician slow claim closure and do not add value. The Washington approach—which makes an impairment rating by the primary treating physician optional—offers a potential model. One question is whether the claims administrator should authorize the primary treating physician's impairment evaluation and rating, as is done in Washington, or whether the primary treating physician can independently choose to perform the rating.

Potential Improvements in Physician Reporting Requirements

As discussed previously, we identified three overarching refinement objectives during our evaluation of the individual WC-required reports: reduce administrative burden, facilitate care coordination, and align fee schedule policies with reporting objectives. We recommend that DWC consider the following policy refinements that would further these objectives:

- To reduce administrative burden:
  - Require a DFR only from the first primary treating physician and, if applicable, the first physician who examines the worker following a work-related incident who will not continue to treat the patient (e.g., a physician providing first aid or an emergency room physician). Eliminate the requirement that a new primary treating physician file a DFR.
  - Combine the PR-2 and the RFA into a single form that clearly indicates when treatment authorization is being requested.
  - Eliminate the redundancies between the P&S report and the RTW and Voucher report.
  - Investigate whether to require electronic reporting for all WC-required reports and related documentation.
- To facilitate care coordination:
  - Clarify that secondary treating physicians should submit RFAs for proposed treatment related to their services but that the primary treating physician should be copied on the requests. With electronic submissions, this could be done without additional administrative burden.
  - Develop an abbreviated, combined PR-2/RFA for secondary physicians to use when requesting or modifying treatment that would be filed directly with the claims administrator with a copy to the primary treating physician.
- To align fee schedule policies with reporting objectives:
  - Pay for a timely, fully completed DFR filed by the first primary treating physician at the same rate as the PR-2.
  - Increase the allowance for a fully completed PR-2 filed by a primary treating physician to be more in line with RBRVS allowances for similar services (approximately $30).

- Consider restructuring the allowance for a P&S report.
    - Establish combined allowances for the P&S evaluation, any related prolonged services, and the report that account for differences in case complexity.
    - After the medical-legal fee schedule has been evaluated for reasonableness in relation to RBRVS allowances, use the findings to determine a reasonable allowance for the primary treating physician's impairment examination and report.
    - Give the primary treating physician the option of not evaluating the impairment level and completing the P&S report. A primary treating physician who elects not to do so would file a PR-2 indicating that the worker is P&S and likely has a permanent impairment. The impairment rating would be determined using the medical-legal evaluation process.
- Use the allowance for the DFR and any increases in the allowances for other reports to incentivize timely electronic submissions of high-quality WC-required reports.

Our research was completed prior to the enactment of SB 1160 (Mendoza) on September 30, 2016. This legislation amended the Labor Code to require that the DFR be filed electronically with DWC in addition to the employer. It also revises the Labor Code to require DWC to develop and administer a system for mandatory electronic reporting of documents related to utilization review. Our recommendation to consider requiring electronic transmission of WC-related reports and related documentation expands on these legislative changes. Expanded use of electronic reporting should improve the efficiency of the claims management and medical necessity dispute-resolution processes and provide opportunities for enhanced care coordination between primary and secondary treating physicians.

If implemented, our recommendations will result in substantial increases in expenditures for WC-required reports. However, if the allowance for the DFR and any increases in the allowances for other reports are used to incentivize timely electronic submissions of high-quality WC-required reports, there will be savings from greater efficiencies in the claims management process, including the medical necessity dispute-resolution process. In addition, eliminating unnecessary administrative burden on providers, providing a choice regarding the completion of the P&S report, and establishing reasonable allowances that recognize the effort involved in completing the WC-required reports may encourage more physicians to treat California's injured workers.

Appendix A: Methods

Environmental Scan

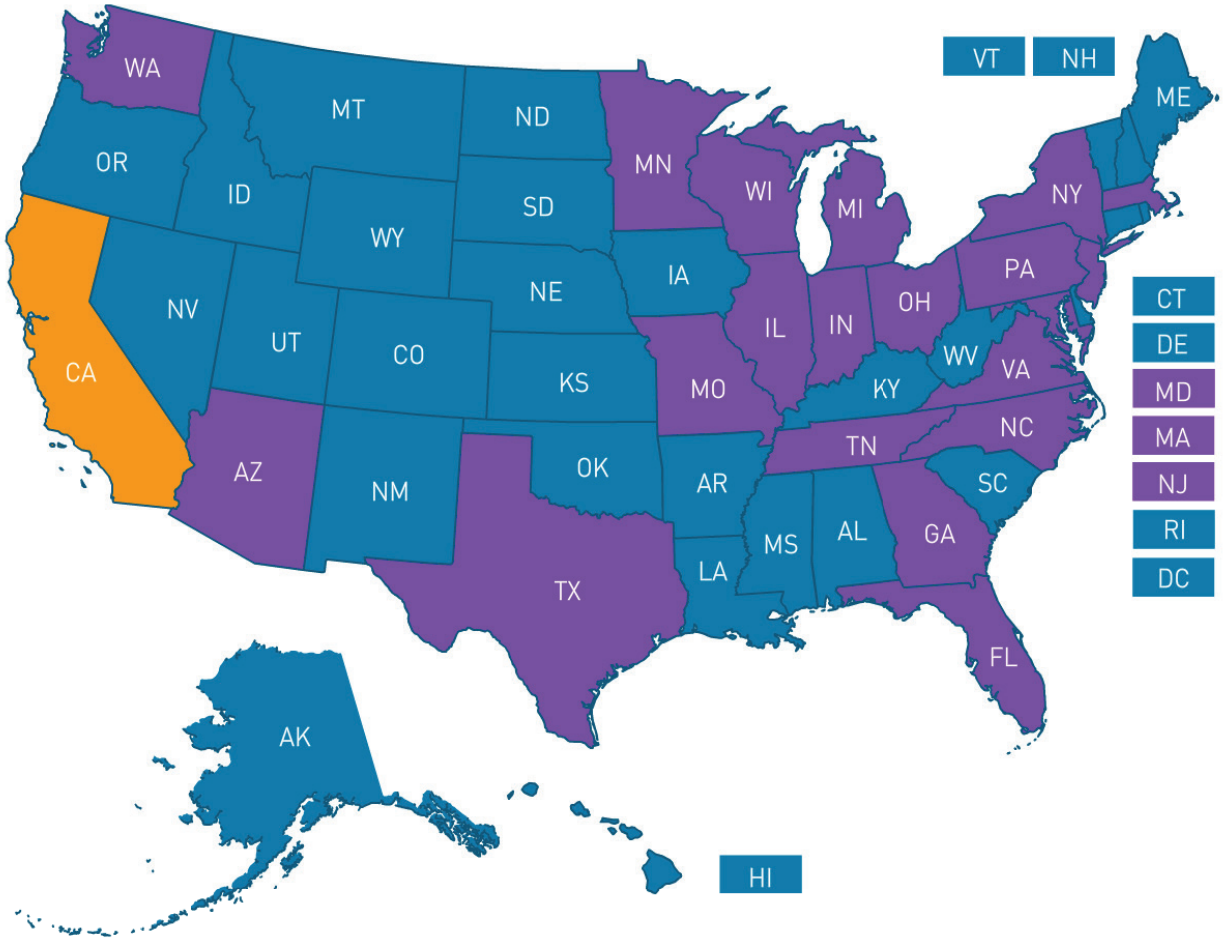
The research team conducted an environmental scan of other states' workers' compensation systems to inform our understanding of the role and value of required reports in California's WC system. The primary purpose of the environmental scan was to capture the comparability of reporting requirements in other states, identify intersecting data elements in those required reports, understand other states' reporting structures and processes, and compare payment policies and other financial incentives related to completing WC-required reports. In identifying comparable reporting requirements in other states, the research team looked to other state WC systems for best practices in level of effort, burden, timeliness, quality, and payment methodology that may be applicable to or serve as guidance for California's DWC.

The research team examined reporting requirements and procedures in the 20 most populous states (after California, according to 2010 U.S. Census). The states in this environmental scan included Arizona, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Virginia, Washington, and Wisconsin. Refer to Table A.1 for the population numbers and Figure A.1 as a visual representation of the states.

Table A.1. 2010 U.S. Population Census, 20 Most Populated States, After California

	California	37,253,956
1	Texas	25,145,561
2	New York	19,378,102
3	Florida	18,801,310
4	Illinois	12,830,632
5	Pennsylvania	12,702,379
6	Ohio	11,536,504
7	Michigan	9,883,640
8	Georgia	9,687,653
9	North Carolina	9,535,483
10	New Jersey	8,791,894
11	Virginia	8,001,024
12	Washington	6,724,540
13	Massachusetts	6,547,629
14	Indiana	6,483,802
15	Arizona	6,392,017
16	Tennessee	6,346,105
17	Missouri	5,988,927
18	Maryland	5,773,552
19	Wisconsin	5,686,986
20	Minnesota	5,303,925

Figure A.1. Map of 20 Most Populated U.S. States, According to 2010 U.S. Population Census



Color Key: Orange represents California; purple represents the top 20 most populated states; blue represents the remaining states.

First, the research team conducted informal, exploratory interviews with staff from the DWC of each of the selected states in March 2015 to collect preliminary information on physician reporting requirements. Staff were identified by contacting each state's DWC or equivalent state entity and requesting to speak with the appropriate staff member capable of responding knowledgeably to questions pertaining to WC reporting requirements, specifically reports required of physicians involved in treating injured workers. The purpose of the exploratory interviews was to gather information on the state reporting requirements and payment policies to determine whether they were comparable to California's, and to estimate the value of conducting a comprehensive environmental scan. The main topics discussed were (1) required reporting for physicians or health care providers involved in the treatment of an injured worker; (2) data elements of any required reports; (3) the structure, processes, and policies of any required reports; and (4) the allowable amount for completion or submission of any required reports.

Responses from these exploratory interviews were transcribed and categorized by state and by report. Refer to Appendix C for exploratory interview questions used with DWC staff for the environmental scan.

Next, the research team conducted a systematic web search of each selected state's DWC website. The research team collected all required reports related to the documentation of the injured worker's case by the treating physician as available, and analyzed the required elements and reporting instructions and guidelines. The web search included downloading and reviewing each state's required reports; documenting the requirements, timelines, and processes; and recording each form's data elements. The web search also included systematically searching state statutes and regulations to better understand rules concerning physician reporting, and reviewing each state's physician fee schedule to determine whether the state separately pays physicians for completing required reports and other payment stipulations for each state's required reports. Each state's required reports were categorized into the following groups: required physician reporting, report customization, data element comparability, and payment policy (whether separate payments are issued for submitted reports). The research team also documented the frequency, format, mode of submission, and recipients for each state's required reports.

To validate the information gleaned from the initial round of exploratory interviews and systematic web search, a second round of semistructured interviews was conducted with staff from the DWC of each of the selected states in December 2015. Refer to Appendix C for semistructured interview protocol used with DWC staff as part of the environmental scan. Interviewees were identified from a list of jurisdictional contacts on medical cost containment regulations taken from the report *Workers' Compensation Medical Cost Containment: A National Inventory, 2015*, compiled by the Workers Compensation Research Institute (Tanabe, 2015). The main topics discussed were (1) required reporting for physicians or health care providers involved in the treatment of an injured worker; (2) data elements of any required reports; (3) the structure, processes, and policies of any required reports; and (4) the allowable amount for completion or submission of any required reports. Responses from these semistructured interviews were transcribed and categorized by state and by report.

Data collected on the reporting requirements and processes from the exploratory and semi-structured interviews and those collected on the data elements and fee schedules from state DWC websites through the systematic web search were evaluated to determine comparability across states. Our systematic search helped to identify comparability across states and determine which states' reporting structures are consistent with California's, by report. States with similar reporting structures or whose reporting policies parallel California's policies were selected for further analysis. The data elements for this smaller selection of states were then compared by report to identify similarities in the documentation and burden of reports required of physicians. States with similar reporting structures and moderate to highly similar data elements (by report) were compared with California.

Limitations of Environmental Scan

The research team conducted the environmental scan as a supplemental step toward better understanding reporting requirements and processes in other states in order to identify valuable aspects of the reporting required of physicians in documenting treatment of injured workers in California. The environmental scan consisted of conducting exploratory, informal interviews with state WC staff, a systematic web search, another round of interviews with state WC jurisdictional contacts, and a comparative analysis of required reports. The web search, interviews, and assessment of required reports have several limitations.

We conducted interviews with staff from state DWCs or the state equivalent entity and staff identified from a list of jurisdictional contacts on medical cost containment regulations. Responses from these interviews reflect themes voiced in December 2015–March 2016 and may not reflect the current WC environment in those states. In the first round of informal, exploratory interviews, participants were selected through contacts available on state WC websites and by contacting state WC entities and asking to speak with staff best positioned to answer and validate information pertaining to WC-related reports and provider requirements. In the validation round of interviews, we interviewed staff that we felt were better positioned to be knowledgeable on reporting requirements and allowances in their state. We relied on responses provided by interviewees, but it is possible that these responses were not comprehensive or accurate. If so, there may be additional states with similar reporting requirements to California's or states with best practices that may not have been captured in the environmental scan.

We also compiled information on reports that are required under state programs in only the 20 most populated states, which may not be representative of physician reporting requirements nationwide. We systematically explored the reporting requirements in the 20 most populous states by searching state WC websites. The data collected from this web search reflect physician reporting requirements in those states as of December 2015, and may not reflect current reporting requirements if changes have occurred since our data-collection phase. To the extent that forms were not equally accessible and requirements were not always clearly described on the state's website or on individual reports, data collection and a comprehensive comparison of data elements were only feasible in a limited number of states. In some cases, we may have failed to identify states that require reports of providers because our environmental scan was limited to capturing information accessible or available on state websites.

Exploratory Interviews with Physicians and Users

In order to understand the process and use of WC-required reports, the research team conducted interviews with physicians and users across California. We specifically sought to understand the current features of the reporting process, the perceived purpose of the reports, the attributes of a good report, what is involved in the filing process, the level of effort required to

complete a report, the reasonableness of the deadlines, and any improvements that could be made.

Each member of the research team conducted interviews with a convenience sample of both physicians and users. We asked the DWC and members of a technical advisory group convened for RAND's broader study evaluating the SB 863 provisions for recommendations of individuals who would have familiarity with the WC-required reports. We also contacted several physician specialty organizations directly for recommendations. We received 15 physicians' names from Southern and Northern California (including specialists in orthopedic, psychiatry, neurology, and occupational medicine) and also the names of 8 users from Southern and Northern California (including applicant attorneys, defense attorneys, claims administrators, and claims examiners) and selected our interviewees from this list.

We developed a semistructured interview guide (see Appendix B for interview protocol for physicians and users). The topics addressed for each of the five required WC reports included the perceived purpose of the report, details of how the report is filed and what is involved in filing, the reasonableness of deadlines, and any recommended changes to reduce the administrative burden of the report or methods to increase utility. A notetaker took contemporaneous notes during the interviews, except for three interviews that were digitally recorded and transcribed. We used a variation of content analysis to summarize stakeholder comments on each interview topic, noting differences by type of stakeholder and by report.

As can be seen in Table A.2, we conducted ten physician interviews (six primary treating physicians and four primary treating physicians who also performed medical-legal examinations) and six user interviews (two lawyers and four claims examiners). The six primary treating physicians included specialists in occupational medicine (two), pain management and rehabilitation (two), neurology (one), and psychiatry (one). The four physicians who performed medical-legal examinations included one orthopedic surgeon, one pain management and rehabilitation physician, and two psychiatry physicians. These physicians also practiced as primary treating physicians and provided information in their interviews about the required reports in California. Data from all ten interviews contributed to the findings. The interviews were conducted in February and March 2015 and lasted from 45 to 75 minutes in length.

Discussions with Physicians and Users

To gain feedback on the validity of the themes we heard in the interviews about the WC-required reports and to discuss potential options, we held two webinars one week apart in August 2015 with the same group of physicians and users. We developed a set of slides to guide the discussions and sent ahead of the webinar a set of background slides with more detail on the background of the reports and the findings from interviews and the environmental scan for participants to review. We discussed the themes and the value added for each of the reports at the two 90-minute webinars.

Table A.2. Exploratory Interviews with Physicians and Users of WC-Required Reports

Type	Specialty/Title	Location (California)
Physicians		
Primary treating physician	Occupational medicine	Southern
Primary treating physician	Primary care; pain management	Northern
Primary treating physician	Occupational medicine	Southern
Primary treating physician	Pain management	Southern
Primary treating physician	Psychiatry; rehabilitation pain medicine	Northern
Primary treating physician	Neurology	Northern
Med-legal examiner/PTP	Psychiatry	Northern
Med-legal examiner/PTP	Rehabilitation pain medicine	Northern
Med-legal examiner	Psychiatry	Northern
Med-legal examiner/PTP	Orthopedic surgery	Northern
Users of WC Reports Required of Physicians		
User of WC reports	Lawyer	Northern
User of WC reports	Lawyer	Northern
User of WC reports	Claims examiner	Northern/Southern
User of WC reports	Claims examiner	Northern/Southern
User of WC reports	Claims examiner	Northern/Southern
User of WC reports	Claims examiner	Northern/Southern

Appendix B: Interview Protocol Guide for Stakeholder Interviews

The following is the interview protocol guide that was used to conduct stakeholder interviews with physicians and users. There is a tailored section for questions posed to physicians and a section tailored for users; the questions asked of both groups are also annotated as such.

Section 1. Introduction

Thank you for your time today. I am [*say first name and last name and introduce any other study staff present (e.g., notetaker or other team member)*].

Facilitate introductions of the interviewee(s).

Review the purpose of the study.

Explain the general purpose and format of the interview and RAND's role in this effort.

1. We are researchers from RAND, a nonprofit research institution.
2. We are doing a research project funded by the California Department of Industrial Relations.
3. The interview is intended to learn about your practice's experiences with WC-required reports and conducting medical-legal examinations.
4. We want to learn from you and your experiences in order to evaluate and improve the current reporting processes and to understand the level of effort required for medical-legal examinations.
5. The discussion should take about 45 minutes. If you need to take a break at any time, please let us know.
6. Data will be reported so that neither you nor your practice can be identified. We will be aggregating the interviews across the workers' compensation experts and reporting the information in aggregate form.
7. Your participation is voluntary, and you can decline to discuss any topic that we raise. We will not be reporting your participation to anyone outside of the research team.
8. We would like to record this discussion for note-taking purposes only. We will destroy the tape as soon as the notes have been completed. You do not have to agree to be taped; you can still participate in this conversation if you do not want to be taped.

May we record this discussion? (Circle: YES NO)

→ Turn on recorder.

Section 2. Background

1. For the record, can you please state your name and that you have consented to the interview?
2. What is your job within [*name of practice*] and what role, if any, do you play in workers' compensation claims?

For the providers/submitters only, confirm specialty and gather other information (for those we do not have):

Specialty:
% of patients who are WC:
Most common conditions treated (for WC):
QME? Estimated number of annual exams:
AME? Estimated number of annual exams:

Section 3. Effort to Submit Required Reports

*(ASK OF **Providers/Submitters ONLY**)*

We want to learn about the reporting requirements when you treat a worker who has been injured on the job.

We know that California law indicates that a physician—which includes physicians, surgeons, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners, is required to file a *First Report of Injury* with 5 days after initial examination. Physicians then file a *Primary Treating Physician's Progress Report* every 45 days. Once a physician determines that the injured worker's condition is permanent and stationary, then the physician submits within 20 days of examination the *Permanent and Stationary Report* and attaches the *Physician's Return-to-Work and Voucher Report*. We will ask you a series of questions about three reports:

(1) *First Report of Injury*,
(2) *Primary Treating Physician's Progress Report*, and
(3) *Permanent and Stationary Report*

After we discuss these, we will ask you some questions about medical-legal examinations.

First Report of Injury

1. We will start with the *First Report of Injury*. In your view, what is the intended purpose of the report?

   Probe: What distinguishes a high-quality report from others?

2. When do you file a report?

   Probe: First time you see any WC patient or only if you are primary treating physician?

3. Can you please tell me the typical process for *preparing, processing, and submitting* a *First Report of Injury*?

   A. Probe: Who is involved?

      Injured worker
      Yourself as the primary care physician or treating physician? (Yes/No)
      Nurse practitioner? (Yes/No)
      Medical assistant? (Yes/No)
      Other staff? Please specify: _____

   B. Probe: What are the roles or tasks of each of these people?

4. What is your level of personal involvement in the processing or submitting of this information? Peripheral? Central? Does this vary by type of injury? Other factors?
5. Apart from the time you spend examining the patient and deciding on a plan of treatment, what is your estimate of how long it takes to document the information in this *First Report of Injury*? (*Probe for time in minutes and for an overall estimate and then for each person* [*e.g., the primary physician and others who collect the information*].)

   Probe: Overall, how much time do you think your staff spends on helping prepare and submit the *First Report of Injury*? Clinical or administrative staff?
   Probe: How much time do you spend on preparing a typical report?

6. Is the 5-day deadline for the submission of the *First Report of Injury* reasonable? If not, what makes it unreasonable?

   Probe: How timely are your report filings?

7. Is there anything unusual about how your practice approaches the preparation and submission of the *First Report of Injury*, compared to how other practices might handle these reports?
8. Are there changes that you would recommend to reduce the administrative burden of completing the *First Report of Injury* or increase its utility?

   Probe: Could the reporting requirements or process be modified to reduce administrative burden?
   Probe: Do you see any confusion or redundancy in the process that could be eliminated?
   For any recommended deletions: Probe about how this information would otherwise be obtained.

Thank you, that was really helpful.

Primary Treating Physician's Progress Report

Now, I would like to talk with you about the *Primary Treating Physician's Progress Report*, or the *Progress Reports*.

9. In your view, what is the purpose of the report? To what extent do you believe this is achieved?
10. I would like to understand a little more about when two health care providers are involved. If there is a secondary care provider who would like to request a change in treatment and needs the request for authorization, who files the progress report and/or the RFA?

    Probe: How is any direct filing coordinated with the primary treating physician?
    Probe: Who is paid for the report?
    Probe: Does the payment policy differ by claims administrator?

11. Can you please tell me your typical process for *preparing, processing, and submitting* the *Progress Reports*?

    A. Probe: Who is involved?

       Yourself as the primary care physician or treating physician? (Yes/No)
       Nurse practitioner? (Yes/No)
       Medical assistant? (Yes/No)
       Other staff? Please specify: _____

    B. Probe: What are the roles or tasks of each person?

12. What is your level of involvement in the processing or submitting of this information? Peripheral? Central?

    Probe: Does your process or involvement differ depending on the reason for the PR-2 or if a Request for Authorization is also involved?

13. Next, I would like to talk about the resources and time it takes your practice to fill out and submit these *Progress Reports*.

    Probe: Overall, how much time do you think your staff spends on helping prepare and submit the *First Report of Injury*? Clinical or administrative staff?

    Probe: How much time do you spend on preparing a typical report? Does this vary by type of injury? How old the claim is? Other factors?

14. The instructions allow a narrative report instead of the form. Which approach do you typically use?
15. The regulations allow the physician to make reports in any manner and form, by mutual agreement between the physician and the claims administrator. In your experience, is this provision being utilized, and if so, by whom? How is the reporting being modified?
16. Is the deadline of 45 days after last report for the submission of the *Primary Treating Physician's Progress Report* reasonable? Are there cases that you can think of for which you feel this is unreasonable?
17. How often are you asked to file a special report?
18. Are there changes that you would recommend to reduce the administrative burden of completing the *Primary Treating Physician's Progress Report* or *Progress Reports*?

    Probe: Could the reporting requirements or process be modified to reduce administrative burden?

    Probe: Do you see any confusion or redundancy in the process that could be eliminated?

19. Is there anything unusual about how your practice approaches the preparation and submission of the *Progress Reports*, compared to how other practices might handle these reports?

Thank you, that was really helpful.

Final Report, a.k.a. Permanent and Stationary Report

20. Now, I would like to talk with you about the final type of report, the *Permanent and Stationary Report*. Can you please tell me what the typical process is for *preparing, processing, and submitting* a *Final Report*, the *Permanent and Stationary Report*?

    A. Probe: Is the report initiated by the claims administrator, or do you decide when to submit?
    B. Probe: Who is involved?

       Yourself as the primary care physician or treating physician? (Yes/No)
       Nurse practitioner? (Yes/No)
       Medical assistant? (Yes/No)
       Other staff? Please specify: _____

    C. Probe: What are the roles or tasks of each person?

21. Apart from the time you spend examining the patient and deciding that the patient is permanent and stationary, what is your estimate of how long it takes to document the information in this *Permanent and Stationary Report*? (*Probe for time in minutes and for an overall estimate and then for each person* [*e.g., the primary physician and others who collect the information*].)

    Probe: How much time do you spend on preparing a typical report? Does this vary by type of injury? Other factors?
    Probe: Overall, how much time do you think your staff spends on helping prepare and submit the *Permanent and Stationary Report*? Clinical or administrative staff?

22. Is the deadline of 20 days after last examination for the submission of the *Permanent and Stationary Report* reasonable? Are there cases that you can think of for which you feel this is unreasonable?

    Probe: Are there specific issues that make it difficult to comply with the 20-day submission deadline?

23. Are there changes that you would recommend to reduce the administrative burden of completing the *Permanent and Stationary Report*?

    Probe: Is there anything that could make this process easier, quicker, or less resource intensive for you (or for your practice)?
    Probe: Could the reporting requirements or process be modified to reduce administrative burden?
    Probe: Do you see any confusion or redundancy in the process that could be eliminated?

24. Is there anything unusual about how your practice approaches the preparation and submission of *Permanent and Stationary Report*, compared to how other practices might handle these reports?

Medical-Legal Examinations

25. Earlier, you estimated the time you spend in preparing a *Permanent and Stationary Report*. How does this compare to preparing a medical-legal examination to determine

permanent disability as a qualified medical examiner (QME)? As an agreed medical evaluator (AME)?

Probe: What are the factors that contribute to the different time requirements?
Probe: How does it compare to a comprehensive consultation visit and report?

26. What are the activities and associated level of effort required to perform a "typical" high-quality, comprehensive medical-legal exam?

    Probe: Does this differ:

    a. By body part(s) and type of injury?
    b. By type of physician (AME, QME) performing the exam?

27. Has the effort required to perform a comprehensive evaluation using the American Medical Association guidelines changed over time, and if so, how and why?
28. A set of factors is used to determine, for payment purposes, whether an examination is a basic comprehensive examination or a complex one.

    Probe: One factor is whether there are more than two hours of face-to-face time with the injured worker. How often does this occur in your medical-legal exams and under what circumstances?

    Probe: A second factor is whether two or more hours of medical research are involved. When medical research is required, do you undertake this personally or does another staff person?

    Probe: A third factor is whether two or more hours of record review are required. Do you have any insights on whether this is an area in which there might be opportunities for an increase in efficiency?

    Probe: A fourth factor is whether medical causation is an issue. Once the employer has agreed that the injury is compensable, are there reasons for reexamining causation?

29. Would you please tell me the typical process for *preparing, processing, and submitting* a medical-legal report?

    A. Probe: Who is involved?

    Yourself as the primary care physician or treating physician? (Yes/No)
    Nurse practitioner? (Yes/No)
    Medical assistant? (Yes/No)
    Other staff? Please specify: _____

    B. Probe: What are the roles or tasks of each of these persons?

30. Are there changes that you would recommend in the pricing structure in order to encourage the efficient production of high-quality reports?

NOW SKIP TO LAST SECTION—DO NOT ASK USERS QUESTIONS

Section 4. Use of Reports

*(ASK OF **Users ONLY**)*

We want to learn about how you use the information that you receive when a worker has been injured on the job.

We know that California law indicates that a physician, which includes physicians, surgeons, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners, is required to file a *First Report of Injury* with 5 days after initial examination. Physicians then file a *Primary Treating Physician's Progress Report* or a *Progress Report* every 45 days. Once a physician determines that the injured worker's condition is permanent and stationary, then the physician submits within 20 days of examination the *Permanent and Stationary Report* and attaches the *Physician's Return-to-Work and Voucher Report*. We would like to ask you a series of questions about each of these three reports:

(1) *First Report of Injury*,
(2) *Primary Treating Physician's Progress Report*, and
(3) *Permanent and Stationary Report*

1. Let's talk for a bit about how you use these three reports. How are you involved in using the information in the reports made by an injured worker or filled out by the treating physician?
2. What would you say are the main uses of the three reports?

[*Fill in the main uses in the columns in the table below.*]

Table B.1. Reports of Interest—Main Uses

First Report of Injury				
Progress Reports				
Permanent and Stationary Report				
Special Reports				

3. Who else in your organization uses the information in these three different reports? For what purpose?

First Report of Injury

4. Do you typically receive a doctor's *First Report of Injury* from any physician who treats a patient or only from the primary treating physician? Are there benefits to having each physician who sees the patient complete the *First Report of Injury*?
5. What are the biggest tasks or challenges that you and your staff face when using this *First Report of Injury* for an injured worker?

6. Are there changes that you would recommend to increase the utility of the *First Report of Injury* to claims administrators and other users?

   Probe: In your view, what are the characteristics of a high-quality report?

7. What distinguishes a high-quality report?

Thank you, that was really helpful.

Second Report of Injury or Primary Treating Physician's Progress Report

8. There seem to be different practices regarding who can submit a progress report and be paid for it. What policy does your organization follow?

   Probe: The regulations require that a Request for Authorization be accompanied by a progress report. What happens when authorization is sought for services provided by a secondary physician?

9. The *Primary Treating Physician's Progress Report* form allows the physician to submit the information in narrative form. In your experience, what percentage of the time is this done? Does this have any effect on the utility of the form?
10. The form allows the claims administrator and physician to agree on a different reporting format. How often do you think this occurs? What would be the motivating reasons?
11. Does the 45-day filing requirement seem reasonable?

    Probe: Under what circumstances do you modify it for a primary treating physician?

12. In your view, what are the characteristics of a high-quality progress report? What percentage of the reports have these characteristics?
13. Are there changes that you would recommend to increase the utility of the *Primary Treating Physician's Progress Report* to claims administrators and other users?

Thank you, that was really helpful.

Final Report—Permanent and Stationary Report

14. We know the last report filed is the *Permanent and Stationary Report.* How do you use this report when the injured worker is unrepresented? Represented?
15. Do you use the report differently when there is also a QME or AME exam on the apportionment or rating issues?
16. In your view, what distinguishes a high-quality report that meets your needs from one that has deficiencies that reduce its usefulness?
17. Are there changes that you would recommend to increase the utility of the *Permanent and Stationary Report* to claims administrators and other users?
18. How often during the course of a typical claim do you need to request a special report? What are the common reasons for needing to do so?

Section 5. Lessons and Advice

*(ASK OF **BOTH Users and Providers/Submitters)***

1. Based on all we have talked about today, are there aspects of the reporting process that you would prefer to be different in order to facilitate the flow of information or use of the information?
2. What advice would you give to another state or practice about the process of requiring and submitting reports on injured workers? What lessons have you learned so far that could be useful for others?
3. Knowing what you know about the risks, legal environment, and privacy issues surrounding injured workers, would you recommend any additional changes to how information is reported or structured for the future?

    Probe: What benefits and drawbacks might these changes have?

Section 6. Conclusion/Follow-Up

4. Thinking about all the things you have told us, are there any areas that we failed to cover or important questions that we should have asked?
5. If you were going to summarize the most important points of our discussion today that relate to the efficiency or utility of reporting on injured workers, what would they be?

Thank you for your time.

Appendix C: Interview Questions for Division of Workers' Compensation Staff for Environmental Scan

The following are the interview questions for the exploratory interviews and also the semistructured interview protocol guide that was used to conduct interviews with staff from our selected states' DWCs.

Exploratory Interview Questions for Division of Workers' Compensation Staff

1. Does your state have required reporting for physicians or health providers involved in an injured worker's case?
2. What reports are required?
3. What is the protocol for the reports (if required)? For example, who can file the reports? What are the deadlines? Where do the reports need to be submitted? In what format are the reports?
4. If reports are required, are physicians paid for submission of the reports, and if so, what is the allowable amount in the fee schedule? How are payment amounts determined? And what is the value in that amount paid to physicians?

Semistructured Interview Protocol for Division of Workers' Compensation Staff

1. In our web search, we located a form on the [*state*] website titled "[*name of DFR-equivalent report on state DWC website*]." Is this the form submitted by the treating physician to document the injury or illness required by [*state*] after the initial visit?
2. Are there any forms or reports that are used to document the progress of the injured worker throughout the course of his or her recovery that are to be completed and submitted by the primary or attending treating physician?
3. Is there a form that is used as a final report, indicating when the patient has reached maximal medical improvement and has residual impairment from the work-related injury or illness?
4. Are requests for authorization or preauthorization required when requesting a treatment or service for the injured worker and to ensure that the physician is paid for providing that treatment or service?
5. Do treating physicians complete a return-to-work form that documents under what capacity the injured worker can return to work and perform work duties?
6. [*If yes to any:*] Are any of these forms payable? If so, which ones? What is the allowable amount?
7. We are also exploring opportunities for process improvement in physician reporting. Would you be able to identify any issues or potential opportunities for improvement in physician reporting in your state?

Appendix D: Summary of Domains and Data Elements for California's Workers' Compensation–Required Reports

Doctor's First Report of Occupational Injury or Illness

The DFR is the initial documentation recorded by a treating physician on the extent of the injured worker's illness or injury. The DFR is a one-page form that lists the insurer's and employer's contact information, details the injured worker's personal information and job title, and specifies the time and location of the incident related to the injury or illness onset. The patient is permitted to provide a description of how the accident or exposure occurred. The treating physician completes the remaining domains and elements of the DFR, including the patient's subjective complaints, objective findings (consisting of the physical examination results or X-ray or laboratory results), diagnosis, and treatment rendered. The DFR provides an opportunity for the treating physician to document consistency between the patient's account of the injury or illness with the objective findings, and to identify any co-occurring conditions that may impede or delay the patient's recovery. The treating physician must also document a specified treatment plan and its estimated duration if further treatment is required. The treating physician must also report on the patient's work status, and whether the injured worker is able to return to work under regular or modified conditions. Last, the treating physician must log his or her credentials—including medical license number, tax identification number, and medical degree—and provide his or her contact information and signature.

Primary Treating Physician's Progress Report

The PR-2 is a two-page form that serves a number of purposes during the course of a WC case. Primarily, the PR-2 is used as periodic documentation of the injured worker's progress, including any improvements or relapses in physical rehabilitation or any change in the patient's condition. The PR-2 is also commonly used to document any changes in the injured worker's work status, changes in the treatment plan, and whether the patient has been released from care. The PR-2 also serves as an indication that the patient needs a referral, consultation, surgery, or hospitalization related to the patient's work injury or illness. Lastly, the PR-2 must be submitted in response to specific requests for information, and it should accompany the RFA when new treatment or prescriptions are issued. The form documents the patient's personal and contact information and the employer and claims administrator's contact information. The form then reviews the patient's subjective complaints, objective findings, diagnoses—including International Classification of Diseases, Ninth Revision (ICD-9) codes—and the treatment plan. The treatment plan should include the treatment that has been rendered to date at the time of the

PR-2 submission and the methods, frequency, and duration of any planned treatments. The PR-2 provides the primary treating physician an opportunity to document the injured worker's work status, including whether the patient should remain off work, return to modified work, or return to work with no limitations. Last, the treating physician must log his or her credentials—including medical license number and specialty—contact information, and signature.

Request for Authorization

The RFA is a one-page form that is required to request treatment. The form can be used as a new treatment request or as a resubmission of a previously denied request based on a change in the material facts regarding the injured worker's condition. This form may also be used as a written confirmation of a previous oral request. The form contains a checkbox that can be used to expedite the review of the requested treatment if the injured worker faces an imminent and serious threat to his or her health that necessitates urgent care or an urgent treatment. The form documents the injured worker's personal information, the requesting physician's information, and the claims administrator's information. The requesting physician must complete the "Requested Treatment" section and include each specified requested medical service or procedure, or indicate where in the supporting documentation (e.g., DFR or PR-2) the requested treatment can be found. This section includes space to indicate the diagnosis, relevant ICD-9 code, requested good or service, CPT/HCPCS (Healthcare Common Procedure Coding System) code, and any other known information, such as the frequency, duration, and quantity of the service, treatment, or procedure. The form allows for the claims administrator reviewing the request to provide comments and the result of the request ("approved," "denied or modified," "delay," "requested treatment has been previously denied," or "liability for treatment is disputed").

Permanent and Stationary Report

The P&S report is primarily used to document the initial evaluation of permanent impairment to the claims administrator. The P&S report serves to assist in determining the ratings prepared pursuant to the Permanent Disability Rating Schedule and the AMA guides to the Evaluation of Permanent Impairment. The form documents the contact information for the claims administrator, employer, and treating physician, in addition to the contact and personal information for the injured worker.

The P&S report addresses each facet of the injured worker's injury or illness and describes any residual effects from the injury or illness and the scope of future medical care. First, the report documents the historical aspect of the WC case, such as the date of injury, the last date worked, a description of how the injury or illness occurred, and the relevant medical history. The form provides an opportunity for the primary treating physician to describe the objective findings based on the current and any previous physical examinations, including any specific

measurements of atrophy, range of motion, and strength and a full report of any diagnostic test results, all related diagnoses, and their respective ICD-9 codes. The primary treating physician is expected to report the whole person impairment rating for each impairment using the AMA guides, and to explain how that rating was derived. The primary treating physician must then address two questions on apportionment of the permanent disability: (1) whether the permanent disability was caused by an injury or illness arising from and in the course of employment (yes/no), and (2) whether the permanent disability was caused in whole or in part by other factors besides this industrial injury or illness, including any prior industrial injury or illness (yes/no).

Next, the primary treating physician must address future medical treatment and is expected to describe any continuing treatment related to the injury that should be provided to the patient presently or in the future, including medications, surgery, physical medicine services, and any durable medical equipment. Subsequently, the primary treating physician is required to complete the functional capacity assessment to determine the injured worker's ability to return to his or her usual and customary occupation. This section addresses specific abilities in motion, strength, position, and activity; which abilities are limited; and the ways in which the impaired abilities are restricted. It also addresses any environmental restrictions, such as which environmental conditions the injured worker should reduce his or her exposure to or avoid, and whether the injured worker can return to his or her usual occupation at the time the report is completed.

Last, this report documents all information sources and medical records that were reviewed during the preparation of the report and used to formulate the primary treating physician's medical opinion on the P&S status of the injured worker. The final page of the P&S report has room for the primary treating physician to supply any additional notes on how he or she arrived at the conclusions presented. Finally, the primary treating physician must log his or her credentials—including medical license number and specialty—contact information, and signature.

Physician's Return-to-Work and Voucher Report

The RTW and Voucher report is a one-page form that is used to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. First, the form documents the contact information of the employee, employer, claims administrator, and claims representative. In the next portion of the form, the physician uses one of two checkboxes to indicate whether the injured worker can return to regular work or return to work with restrictions. If the latter option is selected, the physician is asked to indicate the number of hours the worker is restricted to performing specific functions, motions, positions, or activities. The physician must also specify any lift or carry restrictions and any other restrictions or work-related limitations. Independently, the employer or claims administrator has the option to provide the physician with the injured worker's job description depicting the physical requirements of the employee's regular work,

proposed modified work, or alternative work. If a proposed job description is shared with the physician, the physician can evaluate in the RTW and Voucher report whether the work capacities and activity restrictions are compatible with the provided job description. That portion of the form is not required to be completed if the physician has not been supplied with a proposed job description. Last, the physician must record his or her name, role (QME, AME, or primary treating physician), and signature.

Appendix E: Reporting Characteristics for California and the 20 Most Populous States, by Report

Table E.1 displays the states included in the environmental scan and the reporting characteristics for each report within each state. While some states require the treating physician to submit a DFR, PR-2, or equivalent P&S report, several states were not included in our comparisons as the reporting processes or reports' data elements were not comparable to those of the reports required in California. The states that do not require the treating physician to submit any report documenting the initial onset or progress of the injury or illness include Massachusetts, New Jersey, North Carolina, Ohio, and Virginia. Note that the bolding in the table signifies the states with comparable reporting processes or required reports with comparable data elements, as described in previous chapters.

Table E.1. Reporting Characteristics for California and the 20 Most Populous States, by Report

	DFR	PR-2	P&S
California	• **Required** • **Doctor's First Report** • **5-day deadline** • **Fillable PDF, printable PDF** • **Electronic, mail, fax reporting mode** • **Not separately payable; bundled into initial E&M visit**	• **Required** • **Progress Report** • **Separate from DFR** • **45-day frequency** • **20-day deadline (after exam)** • **Fillable PDF, printable PDF** • **Electronic, mail, fax reporting mode** • **Separately payable ($12.14) when submitted as required**	• **Required** • **Permanent and Stationary Report** • **Separate from DFR** • **One-time frequency (once P&S is determined)** • **20-day deadline (from exam determining P&S)** • **Fillable PDF, printable PDF** • **Electronic, mail, fax reporting modes** • **Separately payable ($38.68/first page; $23.80 additional pages; max 7 pages)**
Arizona	• Required • Physician's Report of Injury Form • 8-day deadline • Printable PDF • Mail, fax reporting modes • Not separately payable; bundled into E&M visit	• Required • Progress Report (Narrative) • Separate from DFR • 30-day frequency • Narrative/chart note format • Mail, fax reporting modes • Not separately payable; bundled into E&M visit	• Required • Final Medical Report • Separate from DFR • Deadline not specified • Printable PDF • Mail, fax reporting modes • Not separately payable

Table E.1—Continued

	DFR	PR-2	P&S
Florida	• Required • Uniform Medical Treatment/Status Reporting Form • 3-day deadline • Printable PDF, fillable PDF, Excel file, Word file • Electronic, fax reporting modes • Not separately payable; included in E&M visit	• **Required** • **Uniform Medical Treatment/Status Reporting Form** • **Same form as DFR** • **30-day frequency** • **1-day deadline (after exam)** • **Printable PDF, fillable PDF, Excel file, Word file** • **Electronic, fax reporting modes** • **Not separately payable; included in E&M visit**	• **Required** • **Uniform Medical Treatment/Status Reporting Form** • **Same form as DFR** • **One-time frequency (once P&S is determined)** • **1-day deadline (to employer, insurer); 3-day deadline (to injured worker)** • **Printable PDF, fillable PDF, Excel file, Word file** • **Electronic, fax reporting modes** • **Not separately payable**
Georgia	• Not required (optional) • Medical Report • Printable PDF • Fax, mail, email reporting modes • Not separately payable	• Not required	• **Required** • **Medical Report (final)** • **Same form as DFR** • **One-time frequency (once P&S is determined)** • **10-day deadline** • **Printable PDF or letter format** • **Fax, mail, email reporting modes** • **Not separately payable**
Illinois	• Not required	• Not required	• Required
Indiana	• Not required (optional) • Physician's Report • Printable PDF, fillable PDF • Mail, fax reporting modes • Payment not specified	• Not required	• Not required (optional) • Physician's Report • Same report as DFR (2nd page reserved for permanent impairment) • Printable PDF, fillable PDF • Mail, fax reporting modes • Payment not specified

Table E.1—Continued

	DFR	PR-2	P&S
Maryland	• Not required (optional) • Surgeon's First Report • Printable PDF, fillable PDF • Electronic submission through portal, mail reporting modes • Not separately payable	• Not required	• Not required (optional) • Surgeon's Final Report • Same form as DFR • Printable PDF, fillable PDF • Electronic submission through portal, mail reporting modes • Not separately payable
Massachusetts	• Not required	• Not required	• Not required
Michigan	• Not required (optional) • Provider's Report of Claim and Request for Medical Payment • Printable PDF • Mail reporting mode • Payment not specified	• Not required	• Not required
Minnesota	• Required • Health Care Provider Report • 10-day deadline • Printable PDF, fillable PDF • Electronic Data Interchange (online portal), mail, fax reporting modes • Not separately payable; bundled into E&M visit	• Required • Health Care Provider Report • Same form as DFR • Deadline not specified (due 10 days after request) • Printable PDF, fillable PDF • Electronic Data Interchange (online portal), mail, fax reporting modes • Not separately payable; bundled into E&M visit	• Required • Health Care Provider Report • Same form as DFR • Deadline not specified (due 10 days after request) • Printable PDF, fillable PDF • Electronic Data Interchange (online portal), mail, fax reporting modes • Not separately payable; bundled into E&M visit
Missouri	• Not required (optional) • Medical Treatment Form • Deadline not specified • Printable PDF • Mail, fax, electronic reporting modes • Payment not specified	• Not required	• Not required (optional) • Medical Treatment Form • Same form as DFR (narrative report encouraged with final report) • Printable PDF • Mail, fax, electronic reporting modes • Payment not specified

Table E.1—Continued

	DFR	PR-2	P&S
New Jersey	• Not required	• Not required	• Not required
New York	• **Required** • **Doctor's Initial Report (C-4)** • **48-hour deadline** • **Fillable PDF, printable PDF** • **Electronic submission (online portal); mail reporting mode** • **Not separately payable; bundled into initial E&M visit**	• **Required** • **Doctor's Progress Report (C-4.2)** • **Separate form from DFR** • **90-day frequency** • **15-day deadline** • **Fillable PDF, printable PDF** • **Electronic submission (online portal); mail reporting mode** • **Not separately payable**	• **Required** • **Doctor's Report of Permanent Impairment** • **Separate from DFR** • **One-time frequency (once P&S is determined)** • **15-day deadline** • **Fillable PDF, printable PDF** • **Electronic submission (online portal); mail reporting modes** • **Not separately payable**
North Carolina	• Not required	• Not required	• Not required
Ohio	• Not required	• Not required	• Not required
Pennsylvania	• Not required (optional) • Medical Report Form • 10-day deadline • Printable PDF, fillable PDF (interactive web) • Mail, electronic reporting mode • Not separately payable	• Not required (optional) • Medical Report Form • Same report as DFR • 30-day frequency • Printable PDF, fillable PDF (interactive web) • Mail, electronic reporting mode • Not separately payable	• Not required (optional) • Medical Report Form • Same report as DFR • Printable PDF, fillable PDF (interactive web) • Mail, electronic reporting mode • Not separately payable
Tennessee	• Not required (optional) • Attending Physician's Report • Deadline not specified • Printable PDF • Mail, fax reporting modes • Separately payable (not to exceed $10 for reports 20 pages in length, and 25 cents per page for any additional page after 20)	• Not required	• Required • Final Medical Report • Separate from DFR • 21-day deadline (after MMI is determined) • Printable PDF • Mail, fax reporting modes • Physicians can be paid up to $250 for completing the report (when the rating is >0)

Table E.1—Continued

	DFR	PR-2	P&S
Texas	• **Required** • **Work Status Report** • **2-day deadline** • **Printable PDF** • **Mail, fax, email reporting mode** • **Separately payable ($15) when submitted as required**	• **Required** • **Work Status Report** • **Same form as DFR** • **Submission required upon request or with changes to work status or activity restrictions** • **2-day deadline** • **Printable PDF** • **Mail, fax, email reporting mode** • **Separately payable ($15) when submitted as required**	• Required • Report of Medical Evaluation • Separate from DFR • 7-day deadline (after date of certifying exam) • Printable PDF • Mail, fax, email reporting mode • Not separately payable; bundled into E&M visit
Virginia	• Not required	• Not required	• Not required
Washington	• **Required** • **Report of Accident** • **5-day deadline** • **Fillable PDF, printable PDF, Word file** • **Electronic submission (online portal, "FileFast"), mail, fax, email reporting mode** • **Separately payable ($19–$39) for timely submissions** • **Late submission may result in penalty of $250**	• **Required** • **Progress Report; 60-day Narrative; separate from DFR** • **60-day frequency** • **Deadline not applicable (required every 60 days)** • **Narrative (no form), printable PDF, fillable PDF** • **Mail, fax reporting mode** • **Separately payable**	• **Required** • **Final Report; Narrative Report** • **Separate from DFR** • **One-time frequency (once P&S is determined)** • **60-day deadline** • **Narrative (no form), printable PDF, fillable PDF** • **Mail, fax reporting modes** • **Separately payable**
Wisconsin	• Not required (optional) • Medical Report on Industrial Injury • Required upon request (i.e., deadline not specified) • Printable PDF, fillable Word file • Mail, email, fax reporting modes • Payment not specified	• Not required	• Required • Final Treating Practitioner's Report • Separate from DFR • Deadline not specified (due when temporary disability exceeds 3 weeks or permanent disability results) • Office note, narrative, printable PDF • Separately payable (negotiated amount between physician and carrier for submitting final treating practitioner's report)

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For reference, Table R.1 includes links to workers' compensation websites for the states included in our environmental scan. Data collected from these websites were used to document and categorize reporting requirements, processes, and rules structured around pay for reporting, and to compare data elements among available required reports. Tables R.2–R.5 contain links to the corresponding reports for the states with data elements and reporting requirements comparable to those in California.

Table R.1. Links to State Workers' Compensation Websites

State	State Workers' Compensation Entity and URL
Arizona	Industrial Commission of Arizona http://www.ica.state.az.us
California	Department of Industrial Relations, Division of Workers' Compensation http://www.dir.ca.gov/dwc/
Florida	Department of Financial Services, Division of Workers' Compensation http://www.myfloridacfo.com/division/wc/
Georgia	State Board of Workers' Compensation https://sbwc.georgia.gov
Illinois	Illinois Workers' Compensation Commission http://www.iwcc.il.gov

Table R.1—Continued

State	State Workers' Compensation Entity and URL
Indiana	Workers' Compensation Board of Indiana http://www.in.gov/wcb/
Maryland	MD Workers' Compensation Commission http://www.wcc.state.md.us
Massachusetts	Executive Office of Labor and Workforce Development: Workers' Compensation http://www.mass.gov/lwd/workers-compensation/
Michigan	Department of Licensing and Regulatory Affairs, Workers' Compensation Agency http://www.michigan.gov/wca/
Minnesota	Department of Labor and Industry, Workers' Compensation http://www.dli.mn.gov/workcomp.asp
Missouri	Department of Labor, Division of Workers' Compensation http://labor.mo.gov/dwc
New Jersey	Department of Labor and Workforce Development, Workers' Compensation http://lwd.dol.state.nj.us/labor/wc/wc_index.html
New York	New York State Workers' Compensation Board http://www.wcb.ny.gov
North Carolina	North Carolina Industrial Commission, Workers' Compensation http://www.ic.nc.gov
Ohio	Ohio Bureau of Workers' Compensation https://www.bwc.ohio.gov
Pennsylvania	Department of Labor and Industry, Workers' Compensation http://www.dli.pa.gov/Businesses/Compensation/Pages/default.aspx
Tennessee	Department of Labor and Workforce Development, Bureau of Workers' Compensation https://www.tn.gov/workforce/section/injuries-at-work
Texas	Department of Insurance, Division of Workers' Compensation http://www.tdi.texas.gov/wc/indexwc.html
Virginia	Virginia Workers' Compensation Commission http://www.vwc.state.va.us
Washington	Washington State Department of Labor and Industries, Workers' Compensation http://www.lni.wa.gov/claimsins/claims/
Wisconsin	Wisconsin Department of Workforce Development, Workers' Compensation https://dwd.wisconsin.gov/wc/

Table R.2. Links to States' Doctor's First Report of Injury

State	Report Title and URL
California	Doctor's First Report of Injury (DFR) https://www.dir.ca.gov/OPRL/dlsrform5021.pdf
New York	Doctor's Initial Report (C-4) http://www.wcb.ny.gov/content/main/forms/c4.pdf
Texas	Work Status Report (DWC Form-073) http://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf
Washington	Provider's Initial Report (PIR; F207-028-000) http://www.lni.wa.gov/formpub/Detail.asp?DocID=2467

Table R.3. Links to States' Progress Reports

State	Report Title and URL
California	Primary Treating Physician's Progress Report (PR-2) http://www.dir.ca.gov/t8/FormPR-2.pdf
Florida	Uniform Medical Treatment/Status Reporting Form (DFS-F5-DWC-25) https://www.myfloridacfo.com/division/risk/WorkersCompensation/Documents/06.DWC-25_Uniform_Treatments.pdf
New York	Doctor's Progress Report (C-4.2) http://www.wcb.ny.gov/content/main/forms/c4_2.pdf
Texas	Work Status Report (DWC Form-073) http://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf
Washington	Progress Report—60-day Narrative Report http://www.lni.wa.gov/ClaimsIns/Providers/Claims/DocReport/

Table R.4. Links to States' Request for Authorization

State	Report Title and URL
California	Request for Authorization (DWC Form RFA) https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf
Florida	Uniform Medical Treatment/Status Reporting Form (DFS-F5-DWC-25) https://www.myfloridacfo.com/division/risk/WorkersCompensation/Documents/06.DWC-25_Uniform_Treatments.pdf
Minnesota	Medical Request Form (MN MQ03) http://www.dli.mn.gov/wc/PDF/mq03.pdf
New York	Attending Doctor's Request for Authorization and Carrier's Response (C-4 Auth) http://www.wcb.ny.gov/content/main/forms/c4AUTH.pdf
North Carolina	Request for Preauthorization of Medical Treatment (Form 25PR) http://www.ic.nc.gov/forms/form25pr.pdf
Ohio	Request for Prior Authorization of Medication (MEDCO-31) https://www.bwc.ohio.gov/downloads/blankpdf/MEDCO-31.pdf Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease https://www.bwc.ohio.gov/downloads/blankpdf/C-9.pdf
Texas	Texas Standard Prior Authorization Request Form for Health Care Services http://www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf
Washington	Preauthorization Request for Services for State Fund WC Patients http://www.lni.wa.gov/formpub/Detail.asp?DocID=2566

Table R.5. Links to States' Permanent and Stationary Report

State	Report Title and URL
California	Permanent and Stationary Report (PR-4, or "P&S Report") http://www.dir.ca.gov/dwc/PR-4.pdf
Florida	Uniform Medical Treatment/Status Reporting Form (DFS-F5-DWC-25) https://www.myfloridacfo.com/division/risk/WorkersCompensation/Documents/06.DWC-25_Uniform_Treatments.pdf
Georgia	Final Medical Report (WC-20a) https://sbwc.georgia.gov/sites/sbwc.georgia.gov/files/imported/SBWC/Files/wc020a.pdf
New York	Doctor's Report of MMI/Permanent Impairment (C-4.3) http://www.wcb.ny.gov/content/main/forms/c4_3.pdf
Washington	Final Report—Narrative Report http://www.lni.wa.gov/ClaimsIns/Providers/Claims/DocReport/