WORKING
PAPER

Medical Care Provided California's Injured Workers

An Overview of the Issues

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SUMMARY

BACKGROUND

California's workers' compensation (WC) system has been the center of intense debate and legislative activity over the past several years. The California Commission on Health and Safety and Workers' Compensation (CHSWC) and the California Division of Workers' Compensation (DWC) asked RAND to examine the cost and quality issues affecting medical care provided to California's injured workers and to assess strategies to improve the quality and efficiency of that care. The study involved several interrelated tasks, the first of which was to identify the most important utilization and cost drivers and quality-related issues. This paper discusses our findings from this task, which are based on a review of the literature and interviews with stakeholders regarding their perceptions of the program and the likely impact of recent legislative changes on the access, cost, and quality of medical care. The paper also contains the product of a second task, which was to develop a conceptual framework for an ongoing monitoring system. Other publications deal with other aspects of the study.

RECENT LEGISLATIVE CHANGES AFFECTING MEDICAL TREATMENT

Rising costs stimulated a series of reform efforts between 2002 and 2004 to control medical treatment costs for injured workers and improve program efficiency. The most important changes affecting medical treatment for California's injured workers were to repeal the primary treating physician (PTP) presumption on medical issues; adopt medical treatment guidelines as presumptively correct medical treatment; limit the number of chiropractic, physical therapy, and occupational therapy visits per claim; require that injured workers of employers with medical provider networks use network providers throughout the course of their treatment; require employers to authorize up to $10,000 in medical treatment before the compensability determination is made; and expand the Official Medical Fee Schedule (OMFS) to include facility fees for ambulatory surgery, ambulance services, and other Medicare-covered services (all limited to 120 percent of Medicare fees). Physician

services remain under the former fee schedule until a new fee schedule is implemented but were reduced 5 percent (with Medicare as a floor).

Cost and Utilization Drivers

In 2003, medical expenses accounted for 51 percent of total WC program expenditures. Three broad categories of costs accounted for 90 percent of expenditures for medical care in 2003: professional services, hospital services, and pharmaceuticals.[1] Over the study period (1997 to 2003), payments to physicians and practitioners increased 157 percent, most of which was attributable to utilization because, with the exception of a 1999 increase in allowable fees for evaluation and management (E/M) services, the fee schedule for these services was frozen. Comparative analyses by the Workers' Compensation Research Institute (WCRI) of claim data for accidents occurring in 1999 for 12 states generally found that California had higher utilization rates but lower prices than average (Eccleston, Zhao, and Watson, 2003).

Payments for hospital and ambulatory surgery center (ASC) facility services comprise the second-largest component of medical expenditures after professional fees. Between 1997 and 2003, hospital and ASC facility payments grew 168 percent. Several studies have concluded that the inpatient facility fees are higher than needed to provide injured workers with access to inpatient hospital care and may create incentives for unnecessary utilization (Kominski and Gardner, 2001; Wynn, 2004). Payments for ambulatory surgery conducted prior to 2004 were not subject to a fee schedule and were substantially higher than the amounts paid by group health insurance and the amounts that would be payable under Medicare (Kominski and Gardner, 2001). However, the WCRI 12-state comparison suggests that California's high total costs for facility services were due more to a high utilization of services per claim than to high payments per service (Eccleston, Zhao, and Watson, 2003).

Although payments for pharmaceuticals were only 9 percent of total medical costs in 2003, they grew 356 percent over the 1997–2003 study period. Increases in utilization (particularly for pain medications) and

1 The other categories are medical-legal evaluations, payments made directly to patients, capitated medical payments, and cost-containment expenses.

price, coupled with the frequent use of brand-name drugs over generic equivalents, were all factors in the rising costs.

Access, Quality, and Outcome Issues

When looking specifically at WC, value-based care should translate into good access to appropriate, high-quality care, high patient satisfaction, good long-term health outcomes, and return to sustained employment for as many injured workers as possible. Studies predating the legislative changes documented shortcomings in each of these areas. We made a preliminary assessment of the likely implications of the new legislation on access, quality, and outcomes through a review of the literature and interviews with various stakeholders and observers of the California WC medical treatment system.

Findings from the Key Informant Interviews

We conducted a series of interviews with stakeholders involved in the medical care provided to injured workers to obtain information on the likely impact of the legislative changes on access, cost, and quality. We conducted the interviews from June 2004 to October 2004, so the findings reflect early experiences with the reform legislation, and some comments may be less relevant as workers and their representatives, providers, employers, and payors alike have gained familiarity with the provisions. Respondents expressed general support for the use of evidenced-based guidelines to improve quality of care but also concerns that the guidelines were being applied too stringently without sufficient room for clinical judgment, that they needed to be translated into utilization criteria that include the frequency and duration of care, and that they do not adequately address chronic conditions, particularly pain management.

The experts we interviewed had mixed views on the likely impact of the medical networks. They expressed concerns regarding whether workers would have adequate access to care, how selective the employers would be in establishing the networks, and whether fee discounting would be used.

In addition, our interviewees emphasized that the recent reforms had not solved two salient problems in the California WC system:

- The first is the sheer complexity of the system—the rules differ depending on whether the employer has a medical network and whether the employee has predesignated a physician.
- The second is the high level of distrust and contention within the system. The challenge is to find ways to reduce the opportunities for dispute while safeguarding the rights of both employers and workers.

Discussion of Potential Impact of Legislative Changes

The way in which the medical network and medical treatment guidelines are implemented will affect whether workers have better access to appropriate care. Evidence from previous studies has shown that the use of medical provider networks for WC care can reduce costs within the program. However, study findings also suggest that the cost savings attained through the use of networks may come at the price of reduced worker satisfaction with medical care and with the WC program overall (Victor, 2003). But this is not always the case. For example, Pennsylvania injured workers with access to panel physicians report better access and higher satisfaction than do other injured workers (Pennsylvania Department of Labor and Industry, 2005). While patient choice may be more limited—depending on how selective the network is—it may become easier for an injured worker to find a physician willing to provide care, and there may be improvements in coordination and continuity of care. Potentially, networks can concentrate physician workloads for injured workers and increase treating-physician expertise in occupational health issues and practice guidelines.

Medical treatment guidelines are an important tool for implementing evidence-based medicine and, if appropriately refined and implemented, should increase value-based care. The requirement that payors employ utilization review (UR) criteria that are consistent with medical treatment guidelines should reduce the variability in the criteria for assessing whether care is appropriate (Gray and Field, 1989; Wickizer and Lessler, 2002) and may reduce the level of contention in the system as providers and payors become more familiar with the guidelines.

There are two other important considerations in assessing whether injured workers have access to appropriate care. First, the provision requiring up to $10,000 in payments for medical care before the compensability determination is made should provide injured workers with timelier access to care and improve outcomes. Second, taken together, the changes may negatively affect provider willingness to treat injured workers. The medical-necessity and dispute-resolution provisions have added administrative complexity and burden, and there have been reductions in maximum allowable fees for many professional services and a continued freeze on fees for the remaining services.

EVALUATING THE IMPACT OF THE RECENT REFORMS

Initial Findings

There is evidence from the California Workers' Compensation Insurance Rating Bureau (WCIRB) that the reform measures are having a significant impact on costs. Reflecting the estimated impact of fully implemented legislation, the estimated ultimate medical costs for indemnity claims have decreased from a high of $25,857 on average per claim for accident year 2002 to $20,477 for accident year 2004 (WCIRB,2005b). There is also preliminary evidence from the California Workers' Compensation Institute (CWCI) analyses that there have been significant reductions in utilization (Swedlow, 2005a;Swedlow, 2005b). While there is considerable evidence that the legislation has had the intended effect of decreasing medical costs, there has not been a comprehensive analysis of how the provisions, both individually and jointly, have affected access, quality of care, and outcomes.

A separate project task was to provide technical assistance on various fee-schedule issues. Our work on this task found that the implementation of the fee schedule was relatively smooth but that one area warrants further attention: the pass-through payment for hardware and instrumentation used during complex spinal surgery (Wynn and Bergamo, 2005b). The administrative director (AD) has authority to take further action on setting the maximum allowable fee. In addition, the AD still needs to implement a fee schedule for rehabilitation hospitals and other specialty hospitals and to establish a new fee schedule for

physician services. Further, there is a need to determine whether the new fee-schedule provisions, along with the other changes that have occurred, have affected provider participation rates, access to services, and the site where services are delivered.

BUILDING AN INFRASTRUCTURE FOR FUTURE EVALUATIONS

Improving the Knowledge Base

A general challenge to evaluating WC reforms is the relative scarcity of evidence and information on effective and efficient care practices.

There may be merit in establishing a national clearinghouse to make what is known about medical treatment for common injured-worker conditions readily available and to provide measures for monitoring access, cost, and quality. While there is a growing body of literature on these topics, there is no single place that interested parties can go for high-quality, evidence-based information. A national clearinghouse would help drive rational and evidence-based decisions for all WC programs.

Improving Access to Data

Having a limited amount of available data presents a major obstacle to evaluation of the reforms. There is no single database that combines medical claim data from payors and self-insured employers. Further, there is no unified source of data on all aspects of WC care; instead, the information has to be pieced together from different entities, often with different conditions for data use and with differences in sampling and time periods. Progress is being made in this regard in that DWC has implemented reporting requirements for the submission of medical claim data for injured workers, but much work needs to be done. Providers and employers need to be held accountable for furnishing timely and accurate data. There also need to be links between the medical claim data and other administrative data, such as appeal history and indemnity payments, so that total system performance can be evaluated. Finally, public use files are needed that can be used for program evaluation and research purposes.

Developing Performance Measures

It is a major task to go from collecting data to providing useful information. Standard and accepted measures are needed to gauge system performance and to benchmark both within California and with other WC systems. Substantial development efforts will be necessary to meet this requirement. Quality measurement for the most common conditions in WC care is an underdeveloped field in spite of its great policy importance. Indicators should be developed that make optimal use of administrative data that are collected on an ongoing basis and require as little dedicated data collection as possible.

PRIORITIES FOR FUTURE REFORMS

Our interviewees highlighted two policy issues for future consideration: the complexity of the rules and the contentious nature of the system. In addition, we identified two major priorities for future reform efforts: the implementation of a performance-monitoring system and the introduction of financial incentives to reward performance.

Implementation of a Performance-Monitoring System

Improving the knowledge base, access to data, and measurement science in WC care will not only facilitate future evaluation but will also form the basis for a performance-monitoring system, which would provide actionable information to various stakeholders on a routine basis. This system could be used by policymakers to monitor trends and track the impact of reforms, by purchasers to inform selection decisions regarding individual providers and networks and contract negotiations, and by health care organizations and providers for quality improvement activities. Availability of objective data would also help to reduce the system's contentiousness that is commonly fed by irrational fears and unfounded assumptions.

Experimentation with Performance-Based Payment

Performance monitoring will have its greatest impact if the results are tied to financial incentives for reporting reliable data and for providing appropriate care. Because the current WC system is primarily on a fee-for-service basis, physicians have had no financial incentive to provide efficient care and little accountability for the quality of

care and outcomes. Now that employers can establish medical networks and control which providers care for an injured worker, there may be greater opportunity to measure performance and use financial incentives to reward providers who deliver high-quality care. A better understanding is needed of the strategies aimed at providers or medical networks that an individual employer, payors, or DWC could *plausibly* adopt to stimulate quality improvement (Dudley et al., 2004).