STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

INVESTIGATORY HEARING REPORT ON WORKERS' COMPENSATION MEDICAL COST DRIVERS

Addendum to Proposed Decision
July 1, 2009 Workers' Compensation Claims Cost Benchmark
And Pure Premium Rates
July 7, 2009

File Number REG-2009-00015

On June 8, 2009 the Insurance Commissioner heard from three panels of participants requested by the Department to testify on the issues of increasing medical costs in the California workers' compensation system. The purpose of this proceeding was to investigate further into the request by the Workers' Compensation Insurance Rating Bureau for the Insurance Commissioner to approve an increase of 23.7% in the Claims Cost Benchmark, of which 16.9% is due to medical treatment cost increases.

The first panel consisted of representatives of insurance companies, the second panel consisted of self-insured employers, and the final panel consisted of representatives of medical providers. The panels were questioned regarding the current state of the worker's compensation medical treatment system and the issues concerning cost and cost control. The primary focus of inquiry was upon the effectiveness of the workers' compensation reforms in controlling medical costs and effectively delivering appropriate medical treatment.

The panels had many points of agreement and disagreement on what is working and what are problem areas in the delivery of medical treatment to injured workers. Throughout the hearing, common subject areas of concern developed that directly bear upon the medical costs in the workers' compensation system. Those concerns, summarized below, need to be further examined, re-evaluated, and their problems addressed directly by the stakeholders in the system and the governmental agencies responsible for the system's oversight. Also, the Legislature may need to take action to address the short-comings of the workers' compensation reforms enacted almost five years ago.

The Insurance Commissioner and his Department of Insurance have limited authority over the workers' compensation system. Specifically, the Commissioner oversees insurance company financial requirements and solvency as well as reviewing insurance company rates. As part of that authority, the Commissioner reviews the costs in the workers' compensation system and recommends a benchmark for rate filing and solvency purposes. It is through this authority that this investigatory hearing is necessary to inquire into and determine what are driving the costs of medical treatment. However, the Commissioner has no authority over those medical benefit costs or the requirements on how those benefits are delivered. That authority lies with the Division of Workers'

Compensation as the regulator, the Workers' Compensation Appeals Board as the judicial body overseeing workers' compensation benefits, and the Legislature in setting up the workers' compensation system. This investigation will inform those who do have the authority to effect the medical costs what may need to done to address the problems.

This hearing also provided a contrast between the handling of workers' compensation claims between insurers and self-insured employers. It is clear that self-insured employers have a vested interest in the handling and outcome of their workers' compensation claims due to the fact that any cost savings directly affect the employer's bottom line. The insurance companies did not have the same approach or conviction, complaining more and acquiescing to the systems deficiencies rather than providing solutions or alternatives, such as the use of pharmacy networks or focusing more on monitoring and measuring outcomes of medical providers as the self-insured employers testified to doing.

The points made by the medical providers did present many questions as to whether or not the cost containment tools were effective in aiding injured workers to recover and return to work as quickly and efficiently as possible. Again, there were agreements and disagreements on how to deal specifically with the issues, such as physicians dispensing pharmaceuticals.

The general subject areas of concern over workers' compensation medical treatment and possible recommendations on dealing with them are the following:

Medical Provider Networks

Medical Provider Networks (MPN) appears to have the greatest potential for effective delivery of occupational medical care and cost savings. However, insurers are not utilizing MPN as effectively as self-insured employers and may actually be using MPN to their disadvantage.

Two of the self-insured entities that testified actually do not use formal MPN. Rather they use various ways of working closely with their medical providers, similar to the way a MPN should work, to efficiently and effectively work towards proper medical treatment for the injured worker and focus on returning the injured workers back to work. The third self-insured entity, Safeway, has both a MPN and pharmacy network that are closely controlled and monitored by its staff and integrated with its bill review and utilization review to know what is happening for effective medical treatment and cost control.

The medical provider panel was very critical of the way insurers are utilizing MPN. In general, they stated that insurers appear to be more concerned with the lowest cost that can be obtained through use of a network contract rather than quality medical treatment that avoids the use of costly bill review and utilization review. One of the specific complaints leveled at insurers, as compared to self-insured employers, is the failure to

communicate directly with physicians and be closely involved in the injured worker's medical treatment.

Self-insured employers testified as to how they go to great lengths to communicate with the physicians that treat their injured workers. As noted above, some self-insured employers do not need to establish networks due to the close working relationships with their physicians. In comparison, insurers appear to not be utilizing the MPN to its full capability. There was very little information offered by insurers on their communication with medical providers, and it appears insurers have relied upon off-the-shelf, large medical networks that may not facilitate communication.

The use of a MPN to maximize the highest reduction in what is paid for medical treatment may actually have a negative effect on effective medical outcomes and true cost savings. One way to deal with this issue is to work out fair and cost-effective agreements with medical providers in a network on how the providers will be paid for the work they will do treating injured workers and dealing with reporting requirements. It is another thing to utilize a general medical care network, purchased off the shelf, and use low-cost payment contracts that are insufficient to adequately compensate medical providers and to expect quality, cost-effective occupational medical care. In other words, insurers appear, from the testimony provided, to be penny-wise and pound-foolish as the old adage goes. The likely result may be what we see in the data provided by WCIRB and CWCI, namely more treatment, more procedures, more visits, and with no explanation as to what is causing it.

Finally, there is need for adequate system measurements of network and physician outcomes to determine what works or does not work and to reward cost-effective results. Self-insured employers are striving to do this. Insurers have only just begun five years after using networks and may have a long way to go.

One point made clear from the testimony, from both insurers and self-insured employers, is that further cost-savings can be obtained through networks. The insurer representatives specifically made the point that networks are an ongoing process and that there are unrealized savings and improvements to be made. It can then to be expected that insurers will be able maintain or even increase their medical treatment savings by properly using MPN and managing them.

Recommendations for MPN:

- Statutes and regulations appear to promote non-occupational medicine and perceived concerns with access rather than the use of occupational medicine and returning injured workers to their jobs as quickly as possible. The focus needs to be changed.
- Regulatory requirements and insurer use of general medical networks as MPN may also promote the second guessing and delay of medical treatment through additional utilization review. Such networks appear to be merely preferred provider lists from health insurance companies. These types of MPN focus on the lowest cost by contract rather than effective treatment.

- Insurers must develop methods to measure injured worker return to work outcomes and the cost-effectiveness of MPN and to use those measurements to create quality MPN.
- Changes in regulations or statutes on notice requirements and procedures are necessary to allow the continued use of networks by an insurer despite the insured employer changing insurance companies. The focus needs to be that it is the insurer at the time of injury that is responsible for the care of the injured worker rather than the employer.
- A review of how MPN are certified is needed. Should the insurer be certified or is it best to certify the network itself? There appear to be problems with the portability of networks when employers change insurers, as noted above, and insurers concentrating on cost rather than quality. These issues may be addressed by certifying the networks themselves as separate entities that meet occupational medicine standards.
- One must question whether a MPN is necessary in all circumstances. Insurers can look to the examples of some of the self-insured employers that have established better relationships with medical providers rather than black and white contracts.

Pharmaceuticals

Pharmaceuticals are a major cost driver in the workers' compensation system. The use and cost of extremely powerful and dangerous pain narcotics is increasing. Steps are necessary to change this for the safety of injured workers and cost savings.

It is clear that that lack of regulations to implement pharmacy networks are hindering effective control of pharmaceutical costs. Safeway has been able to implement its own pharmacy network with dramatic cost savings to reign in the problems noted by many who testified. The Division of Workers' Compensation needs to evaluate this issue immediately and implement those regulations as soon as possible to control the cost increases and abuse of pharmaceutical prescribing. In addition, insurers should not wait for the regulations and implement pharmacy networks to the extent possible, as has been done by Safeway.

There is strong agreement that pharmaceutical guidelines or a drug formulary is needed as soon as possible along with the general use of generics. This will also aid in controlling what was described as the use of off-label medications or in eliminating the compounding of drugs for purposes of taking advantage of the system, The Division of Workers' Compensation should pursue this.

Recommendations for Pharmaceuticals

- Implement the regulations provided for in AB 749 for pharmacy networks
- All insurers should implement pharmacy networks with or without regulations based upon the example set by Safeway and the fact that the provisions of Labor Code Section 4600.2 do not require regulations as a prerequisite.

- Regulations should be implemented regarding physician dispensing of pharmaceuticals. Does a conflict of interest exist? Legislation may be necessary to deal with this.
- Require the prescribing and/or dispensing of generic drug equivalents.
- A drug formulary should be implemented under the provisions of either creating a pharmacy network and/or treatment guidelines.

Effective Utilization Review

Based upon the testimony provided by the panels, one must question the usefulness of utilization review. The best intentions of having physicians involved with the denial or modification of medical treatment requests, in addition to continuing an additional layer of medical-legal evaluations, has led to increased medical cost containment expenses and delay in getting injured workers necessary and timely treatment.

The origins of utilization review for workers' compensation exist in the insurance code and managed healthcare, where disputes concerning medical treatment requests are within already established coverage limits in health insurance policies and health maintenance organizations and are the exception rather than the rule. The utilization review system may not fit well in the adversarial and litigious system of workers' compensation. This is born out by the fact that some insurers are now realizing that savings and efficiency can be gained through use of a well managed and monitored network providing proper medical treatment and eliminating utilization review all together.

In the testimony, the term utilization review had both broad and narrow meanings. It could be the process of dealing with any request for medical care, even when not disputed, or it could stand for the process of dealing with a questionable medical request only. However the term was used, one self insured employer, Safeway, appears to have developed an effective utilization review.

Safeway's process of dealing with medical treatment requests is done in a holistic manner that involves all aspects of medical cost containment. The entire process is kept in-house to be able to handle the entire aspects of medical treatment requests. This incorporates the network, authorization request, review of the treatment, and final of review of the bill related to the medical treatment. This compares dramatically to the insurer model of utilization review that may be entirely separated from the network and bill review.

Medical providers complained that they have no communication with insurers regarding the treatment they provide in a network setting, and it appears the network is seen as a contractual relationship rather than collaborative process. Denials and delays are the norm and the final outcome is a discussion with an insurer's utilization review physician who may or may not have any detail of the injured worker's case.

The most surprising statistic offered by one insurer is that according to DWC studies of utilization review 75% of 1100 treatment requests were approved after review. Does this represent that 3 out of 4 requests should have been authorized in the first place rather than being disputed and, thereby, save expenses due to utilization review? The general finding from this hearing is that a vast majority of treatment requests went to utilization review and no information can provided as to how effective or cost-savings it was. It appears that the use of utilization review is not managed or proven to be cost effective.

Recommendations on Utilization Review:

- Is utilization review necessary? Insurers need to review and determine if the costs and delays for utilization review are effective. It appears that better medical control and outcomes may be obtained through the use of a proper MPN and communication with physicians.
- Utilization Review needs some utilization review of itself. If a majority of medical requests are going to utilization review and are approved, it is not effective. Utilization review, as it was intended for health care, was for exceptional circumstances.
- Utilization review needs to be properly measured and managed as to its effectiveness and outcomes. Insurers were unable to provide this information.

Liens

Both insurers and self-insured employers believe the filing of liens by medical providers for payment of medical services was both costly and inefficient. An extraordinary amount of resources is expended to deal with liens since they are put into a litigation process that involves third parties and the judicial system.

Surprisingly, the problem with liens appears to be primarily in Southern California rather than throughout the state, which to some degree demonstrates it is institutionalized in Southern California and is not systemic. Therefore, this issue may not be due directly to the practices and procedures of insurers or self-insured employers. If that were the case, the problem would occur throughout the entire state. Rather, it appears to be a problem with medical providers and/or the way such liens are handled by the WCAB in Southern California.

There did not appear to be one cause to the filing of liens, but many. Some liens are filed for services that were provided and prior authorization not sought. They also are filed for billing balances that were denied. Liens were filed long after the services were rendered. In addition, third parties appear to have created an industry that is willing to take liens from medical providers at nominal cost to see how much they can negotiate.

Recommendations for Liens:

- Enforceable fee schedules for medical services to avoid balance billing to the greatest extent.

- Establish proper procedural requirements for prior authorization of medical services as a prerequisite for filing a lien and to allow for utilization review to be used before the medical services are rendered.
- A statute of limitations for filing a lien be implemented to have prompt notice and resolution of billing disputes.
- WCAB standards on dealing with liens should be reviewed and possible alternative dispute resolution procedures to deal with the volume and technical issues of medical lien claims created.
- The WCAB should inquire into why the problem with liens primarily occurs in Southern California. A review of what is happening in northern California with the resolution of medical billing disputes and handling of liens should be done to determine why there exists a difference between the regions and what can be done to have a uniform system throughout the state.

Medical Billing and Fee Schedule

The consensus from all panels was that medical billings should be at fee schedule. In addition, the strong recommendation was that medical services should be paid at fee schedule and not reduced, either due to down-coding or for network contracts.

As noted earlier in the section on Medical Provider Networks, some insurers have taken off-the-shelf, general medical treatment networks and their fee contracts and have used those to provide occupational medicine. This is despite the need to properly compensate physicians for the added responsibility, time, and reporting requirements of the workers' compensation system. This is suspected to be a primary cause of the unexplainable increase in treatment visits and procedures. Therefore, such arrangements should be eliminated and replaced with proper network arrangements and adequate fees.

The self-insured employer panel was consistent with its recommendation that it is fair, proper, and necessary to pay physicians at no less than the fee schedule created by the Division of Workers' Compensation. No testimony was provided from the insurers to support a different finding.

Additionally, many complaints were raised by both insurer and self-insured panels regarding liens. One complaint had to do with unauthorized treatment liens, but another complaint was with balance-billing. Use of a fee schedule to both bill at and pay is fundamental to removing a number of the liens in the system.

There was also a consensus and agreement to the concept of billing and paying at fee schedule by the medical provider panel. This includes great interest by medical providers in being paid adequately and promptly for the services authorized, and one way to accomplish this is through adherence to the fee schedule.

Medical providers are far ahead insurers in electronic billing capability, which would streamline the payment process. The entire billing process could achieve dramatic cost savings, reduced bill review costs, and reductions in filed liens through fee schedule

billing and payment requirements done through electronic billing. The impediments to electronic billing appear to be lack of regulations implemented by the DWC and lack of initiative from insurers.

Finally, mandating a fee schedule system is only effective if it is broad enough to cover most medical procedures and is updated regularly. The current fee schedule, based upon the testimony, is not properly updated or revised. There is need for action by DWC to update the fee schedule and evaluate how it can be modified to be fair and effective. Some have suggested that the fee schedule be changed to Resource-Based Relative Value Scale (RBRVS) to adequately compensate for the services provided. This should be evaluated along with looking at what other states have done with RBRVS.

Recommendations for medical billing and fee schedule

- Require billing and payment at fee schedule
- DWC should update the fee schedule immediately and continue to do it as an ongoing process.
- Regulations for electronic billing and a standard medical bill form need to be implemented.
- Review and possibly change to an RBRVS medical fee system and/or move away from the Medicare/Medi-Cal fee schedules.

Medical Dispute Resolution and the WCAB

Many of the issues that rose in the testimony involved dispute resolution and how effective and timely it should be. If the dispute resolution process is inefficient and lengthy, injured workers will not be given timely medical treatment to return them to work. At the heart of this is the WCAB, which has exclusive jurisdiction to determine and resolve disputes concerning workers' compensation benefits, including medical care and its costs.

It is expected that there will be differences in what is recommended by a treating physician and what will be agreed to by the employer or its insurer, even if based upon the use of guidelines and review by consulting physicians. However, once a dispute has occurred, prompt and fair resolution is necessary.

Some of the solutions offered by the panels are worth pursuing. First, all parties agreed that direct and ongoing communication with the physician is needed to prevent disputes in the first place. It appears insurers need to improve at this. Once a dispute does occur, alternative ways to resolve the dispute need to be established that could bypass the established adversarial process involving medical-legal evaluations, which are costly and examinations can take months or up to a year to complete. It was recommended and generally agreed among the panelists that an Independent Medical Review (IMR) process is needed.

IMR has been utilized before in different ways. The WCAB, many years ago, used IMR to resolve disputes between medical opinions. However, the panelists were looking more

towards an IMR process that could be used to avoid having to go before the WCAB to implement. This idea needs to be explored further.

As noted above, the handling of liens, particularly in southern California, has created unexpected delays and costs to insurers and employers. New procedures and alternative dispute resolution methods are needed to handle and get control of this lien process, as noted above.

There was much criticism with the inconsistency between what the approved medical treatment guidelines and evidence based medicine findings require and what is being recommended by Qualified Medical Evaluators and Agreed Medical Evaluators and approved by the WCAB. Despite the desire to provide fairness in the system and give injured workers and their physicians what they want, there needs to be rational support based upon the established guidelines and evidence based medicine that is consistent. The WCAB needs to determine if evaluators are adhering to those standards in their examination recommendations and whether its own decisions are in line with those standards. Otherwise, the outcomes in a workers' compensation system are unpredictable and will lead to increasing costs to deal with such unpredictability.

Recommendations for Medical Dispute Resolution and the WCAB:

- IMR alternatives should be explored to determine if they will lead to effective and timely resolution of medical treatment disputes.
- As noted above, medical billing and lien procedures need to be implemented to avoid unnecessary disputes.
- WCAB judges should adhere to the requirements of evidence based medicine and treatment guidelines to have outcomes that are consistent and predictable for all parties.
- The WCAB should look at effective and efficient alternative dispute resolution methods for medical treatment decisions. If statutory changes are necessary, the legislature should review and revise the processes and procedures for resolving medical treatment disputes so as to avoid delays and costs.

Safety, Loss Prevention, and Return-To-Work Programs

Though this topic was not specifically addressed, we were reminded that this is a necessary component to save medical treatment costs. Self-insured employers in the panel have made safety and loss prevention a primary way to create savings in the system and have invested in it. Additionally, self-insured employers have seen the direct savings in having return-to-work programs where the treating physicians are involved. The medical provider panel emphasized the need to communicate with employers and insurers regarding medical treatment and returning employees back to work.

Insurers must focus on the areas of safety and loss prevention with their employer insureds and continue to re-examine whether their networks and utilization review aid or hinder the timely return of injured workers back to work. Through these efforts, medical treatment costs can be reduced.