California State Auditor

BUREAU OF STATE AUDITS

California's Workers' Compensation Program:

The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care

August 2003
2003-108.1

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CALIFORNIA STATE AUDITOR

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August 27, 2003 2003-108.1

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the rising cost of medical services in California's workers' compensation system.

This report concludes that rising costs of medical services and products are contributing to the increasing costs of the workers' compensation system—costs that California's employers are required to pay. These medical costs are rising, in part, because the State has not taken the necessary steps to ensure that the cost of treating injured workers is within reasonable limits. A lack of action to address these and other issues by the Department of Industrial Relations' Workers' Compensation Division (division), budget reductions, and restrictions placed on the system by past legislation, have contributed to the inadequate controls over medical costs. Despite mandates to update existing fee schedules for medical services and products, and statutory authority to develop fees for services not covered under existing schedules, the division has not maintained or fully developed the medical payment system. The medical payment system also lacks a process for using consistent medical treatment guidelines to determine necessary medical treatment and resolve disputes between insurers or claims administrators and medical professionals—a key feature in controlling costs and discouraging the under- or overutilization of medical services.

Proposed improvements for controlling costs of the medical payment system entail the use of fee schedules developed by other entities, such as Medicare. To satisfy the needs of California's workers' compensation system, these fee schedules may need to be modified and there is no universal standard for what adjustments may be needed. As a result, policymakers will need to determine the suitability of any adjustments to those fees while considering the effects those decisions may have on injured workers' access to quality care. However, the division does not currently have a data collection system that will produce the information necessary to monitor medical costs, the effect of system reforms, and the accessibility of care for injured workers.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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Response to the Audit

SUMMARY

Audit Highlights . . .

Our review of the workers' compensation medical payments system revealed that:

- ☑ *Rising medical costs are contributing to the increasing costs of the workers' compensation system—costs California's employers are required to pay.*
- ☑ *Despite numerous warnings from research experts, the Division of Workers' Compensation (division) has done little to respond to the problems in the workers' compensation medical payment system.*
- ☑ *Fee schedules intended to control the amounts paid for medical services and products are outdated or nonexistent.*
- ☑ *The medical payment system lacks enforceable treatment guidelines that can help contain medical costs and streamline the delivery of medical care to injured workers. Researchers point to inadequate control over treatment utilization as a primary cause of escalating costs in the workers' compensation system.*

continued . . .

RESULTS IN BRIEF

Established in 1911, the California workers' compensation system requires that employers pay the costs to treat workers who are injured on the job and partially compensate them for lost wages. The Workers' Compensation Insurance Rating Bureau (rating bureau) reported that the workers' compensation total system costs for employers that purchase workers' compensation insurance were more than $17.9 billion in 2002, with medical costs, including pharmaceuticals, representing approximately $4.1 billion, or 23 percent. Using a commonly accepted factor of 1.4 to convert costs for insured employers to include the costs for all self-insured employers in the State, we estimate the total workers' compensation cost for the system in 2002 to be approximately $25.1 billion, about $5.7 billion of which was paid for medical costs.

A recent survey reveals a widespread belief among California's businesses that workers' compensation costs are the biggest single cost issue facing businesses today. The costs of the State's workers' compensation program to employers are spiraling upward, and numerous studies point to the rising medical costs of treating injured workers as a major contributor to the problem. The rating bureau reported that the average total estimated medical cost per workers' compensation claim involving lost work time increased by 254 percent from 1992 to 2002. The insurance premiums charged to employers to provide workers' compensation coverage increased from $5.8 billion to $14.7 billion between 1995 and 2002.

Unpredictably rising costs may have also affected the insurance companies that sell workers' compensation policies. According to the insurance commissioner, 27 of those insurers have become bankrupt, and the State Compensation Insurance Fund (state fund), with 50 percent of the California market, is in serious financial condition. The insurance commissioner predicts that the system will collapse if legislative reforms are not enacted to control the costs related to providing medical treatment to injured workers.

- ☑ *Although the division could adopt fee schedules developed by other entities, such as Medicare, it would first have to decide on how to adjust those fee schedules to best meet the needs of the workers' compensation system.*
- ☑ *The division lacks a data collection system that allows it to monitor medical costs and measure the effectiveness of reforms made to the system.*

The medical costs of the workers' compensation system are rising in part because the State has not taken the necessary steps to ensure that the costs of treating injured workers are within reasonable limits. According to a study conducted by the Commission on Health and Safety and Workers' Compensation (commission), the system for administering medical payments (medical payment system) is unnecessarily complex, costly, and difficult to manage. The administrative director of the Department of Industrial Relations' (Industrial Relations) Division of Workers' Compensation (division) is responsible for administering and monitoring the workers' compensation system. However, the administrative director has not maintained or fully developed the medical payment system. Despite mandates to biennially update the medical fee schedules for professional services, inpatient hospital facilities, and for medical products—such as pharmaceuticals and durable medical equipment—other than for minor adjustments, these schedules have not been updated since 1999, and they are essentially a patchwork of prior fee schedules.

In addition, costs for services performed at facilities such as outpatient surgical centers and emergency rooms are not covered by fee schedules but are paid on the basis of what are known as usual, customary, and reasonable charges for such services. Health care experts consider this basis for payment to be inflationary, and thus these charges may be contributing to the escalating costs in the workers' compensation system.

The system also lacks a process that would allow doctors to use a uniform set of treatment guidelines as a standard for treating similar workplace injuries and illnesses. Researchers point to inadequate controls over treatment utilization as a primary cause of escalating costs in the workers' compensation system. Overall, they report that in the area of professional medical services, California's average payment amount per claim is typical of other states, but the number of treatments per claim provided to injured workers is far above the average. A study of workers' compensation claims by the Workers' Compensation Research Institute revealed that overall utilization is 71 percent higher in California than in the other states profiled and that injured workers in California have 49 percent more visits with physicians and 105 percent more chiropractor visits. These conclusions align with analyses we conducted of medical claims data we obtained from the state fund, which shows that the

recent increases in medical costs stem more from the increase in the number of medical services rendered than from the increase in the prices paid for medical services.

The Industrial Medical Council (medical council) has developed treatment guidelines and it recently voted to review the medical evidence on treatment and utilization and to update its guidelines. The medical council's executive medical director stated that the medical council's guidelines have an advantage in that they cover all physician groups that practice in the workers' compensation system. However, the law requires that the medical council be made up of members of the medical community that would be subject to the treatment guidelines and maintain liaisons with the medical, osteopathic, psychological, and podiatric professions. As such, we question whether the medical council is the entity that can most effectively develop treatment guidelines without giving the appearance that it could be influenced by the extent to which the guidelines might adversely affect the financial interests of the medical community.

Despite the research pointing out the absence of utilization controls, California's system is without an effective process that would make treatment utilization review standards consistent among insurers. As a result, according to a study conducted by the division, there is little consistency in the processes or criteria used by insurers and claims administrators to determine the necessity of treatments proposed by physicians. In fact, one-third of the claims administrators included in the study reported using more than one set of criteria but did not provide a methodology for selecting which one they used for a particular case.

A primary cause of the lack of effective utilization controls is that under the current law, utilization reviews are usually not admissible in judicial proceedings to resolve disputes between medical providers and claims administrators. To be admissible as evidence, a decision reached through a utilization review would need to be supported by a report from a physician performing an examination of the injured worker—a level of review not typically used by insurers and claims administrators when approving payment for treatment. Therefore, utilization reviews prepared by claims administrators have no weight in judicial proceedings.

The absence of an effective utilization control process leads to disagreements between medical providers and claims administrators over proposed treatments for injured workers. However, the system does not have an effective process for resolving those disputes. Under the current dispute resolution structure, unresolved disagreements are finally settled by the Workers' Compensation Appeals Board after going through the judicial process within the workers' compensation system. Lacking a more efficient intermediary process, nearly 20 percent of the workers' compensation cases end up going through this judicial process. This lengthy process of resolving disputes can prolong the duration of workers' compensation cases.

Numerous studies have pointed to opportunities to improve cost control in the system; however, the division has not built upon those studies to implement corrective actions. The division's administrative director states that the division has not been able to dedicate more effort to improving the medical payment system due in part to staff reductions, indicating that he has lost almost 17 percent of his authorized positions and 19 percent of his filled positions since fiscal year 1999–2000. He added that when he was appointed in 1999, he was instructed to place a greater priority on improving the workers' compensation judicial process. In addition, he said that he does not believe that the law provides him with the authority to address cost controls by compelling insurers to adhere to standardized treatment guidelines.

Further, the Legislature and administration have sometimes responded to the needs of the system with measures that impede improvement, such as requiring the use of data not currently being collected to develop a new fee schedule for outpatient surgical facility charges and reducing the funding for tasks critical to improving cost control.

While the Legislature is currently studying options for improving the workers' compensation medical payment system, the administrative director and the commission have presented two different proposals for improving medical cost controls using variations of Medicare-based fee schedules. The Medicare payment system for physician services is founded on a valuation of the resources needed to provide each service. This system is known as the resource-based relative value scale (RBRVS) system. The administrative director expects to complete a study of implementing an RBRVS-based fee schedule only for physician services by September or October 2003, with plans

to actually implement a new schedule for physician services by July 2004. However, according to the administrative director, the implementation of a fee schedule to better control the costs of services provided by outpatient surgical facilities is on hold because the law requires the fee schedule be developed using data to be collected by the Office of Statewide Health Planning and Development—a data collection project that may not be completed for several years.

The commission has proposed a total conversion to a payment system based on the Medicare payment system for medical services and products, and a Medi-Cal-based payment system for pharmaceuticals. The commission estimates that this conversion would save the State's workers' compensation system at least $964 million in 2004, with increasing savings in the following two years. However, its estimates are based on assumptions and projections that use findings from other research studies. We could not independently verify the commission's estimates because the commission's researcher did not maintain the source data to calculate the savings. Therefore, we offer no opinion on the validity of the commission's estimated savings from implementing its proposed medical payment system.

Basing part or all of the workers' compensation system on the Medicare RBRVS system would have several advantages, among them the values on which payments are based would be derived from the amount of resources needed to perform services, rather than on customary charges. In addition, Medicare updates its schedules regularly, and so the values would remain current. Health policy experts believe resource-based systems to be less inflationary than charge-based ones. However, because the payments are resource based, it is projected that for some medical specialties, such as surgery and anesthesia, the payment amounts would be reduced from the traditional charge-based payments, and payments for evaluation and management services would be increased. This redistributive effect of the RBRVS system is a major point of controversy among providers of these affected medical specialties, in spite of the RBRVS system's ability to contain costs.

More work is needed to ensure that injured workers have access to quality care at reasonable costs to employers. If the State adopts a payment system that is based on indexed values, such as the RBRVS, it will need to determine how to adjust the RBRVS to arrive at payments that will meet this objective. There is no universal way to make these adjustments. Other states that

have implemented a payment system based on the RBRVS have used a variety of approaches in adapting the system to fit their needs. Some considerations the State must weigh include the need to balance adequate access to care against overutilization and whether a transition strategy may be needed to mitigate the effects of the payment redistribution that would be caused by an RBRVS payment system.

Once these decisions have been made, the division will need to monitor the effect of these policy decisions on the quality and availability of care to injured workers. However, the division does not currently have a data collection system that will allow it to perform the necessary research. Although legislation that took effect in 1993 mandated the development of a data collection system, the Workers' Compensation Information System (WCIS) is still incomplete. According to the division, intense opposition to data collection from insurers, a shortage of knowledgeable and experienced staff, and technical difficulties in installing the proper hardware and software infrastructure have delayed the implementation of the WCIS. The division still has not identified a projected completion date for the system.

The WCIS consists of three components: two are used to collect information on the nature and duration of workplace injuries, and the third collects data on medical treatments and payments. The first two components are complete and operational, but the division is still working to identify the types of medical data it needs to collect to provide useful information for monitoring the performance of the medical payment system. However, the division has not provided us with any assurance that the medical data it collects will generate the information required to meet the statutory objectives for the system. According to the administrative director, identification of the needed medical data has been slow due in part to the effort required to work through the concerns the insurers have about the cost of reporting the data.

RECOMMENDATIONS

Regardless of how the State modifies its workers' compensation medical payment system, it will need to improve its controls to allow it to better administer the system. As part of this effort, it will need to monitor the effects of policy changes so that it can respond more quickly to changing conditions in the system,

including pressures on the costs of providing medical services and injured workers' access to care. Therefore, the administrative director and the Legislature should consider the following:

- Because rising medical costs in workers' compensation contribute to increased costs to California's employers, greater importance should be placed on more closely managing the costs of providing medical care to injured workers. As such, the administrative director should take the steps necessary to identify the organization and level of resources needed to effectively administer the workers' compensation medical payment system and should work with the Department of Finance and the Legislature to obtain those resources.

- Medical treatment guidelines that provide standards for the treatment reasonably required to relieve the effects of workers' injuries, and that are presumed correct unless medical opinion establishes the need for a departure from those guidelines, can serve to ensure that injured workers receive the care they need to return to work, control medical costs, and increase the efficiency of the delivery of those medical services. The administrative director, in coordination with the medical council, should adopt a standardized set of treatment utilization guidelines, based on clinical evidence, to deter over- or underutilization of physician services and other professional medical services and products. The administrative director should consider, to the extent possible, adopting treatment guidelines that are developed by independent entities and that are updated with adequate frequency to reflect advancing technology and changes in professional practice. If the administrative director adopts treatment guidelines developed by the medical council, he should take the steps necessary to ensure that those guidelines are developed without the appearance of undue influence from any group that participates in the State's workers' compensation system.

- To ensure that the treatment guidelines can serve as an authoritative standard for the treatment of workers' injuries, the administrative director should seek the changes necessary in the Labor Code to ensure that all insurers and claims administrators are required to follow the standardized treatment guidelines and that treatment guidelines are accepted for use in judicial proceedings.

- After obtaining any needed amendments to the law, the administrative director should amend the division's regulations to reflect those changes to the law. Specifically, the division's regulations should require that insurers and claims administrators adhere to the standardized treatment guidelines and should clearly define the role of treatment guidelines in determining treatment and in judicial proceedings.

- The administrative director should identify the appropriate transition strategy, if needed, to mitigate any significant adverse affects on access to care that a new payment system may have on certain groups of medical service providers.

- As part of an effort to more closely manage the medical payment system, the administrative director should more aggressively pursue corrective action needed to address issues identified in research reports, such as those from the commission, the medical council, the California Workers' Compensation Institute, and the Workers' Compensation Research Institute, as well as any issues raised by internal studies conducted by Industrial Relations.

- The administrative director needs an adequate level of timely information on medical costs and medical service delivery to monitor the performance of the workers' compensation system in delivering quality care to injured workers at reasonable costs to employers and to track the effect of policy changes on the system's performance. Now that the division's budget contains employer user fees and a spending augmentation the administrative director asserts is needed to complete the division's WCIS, he should place the WCIS implementation project on a timeline to facilitate its completion as quickly as possible. In addition, the administrative director should exercise the authority necessary to ensure that the data collected in the WCIS will provide the information needed to adequately monitor medical costs and services.

- To ensure that legislation does not contain any unintended impediments to the improvement of the workers' compensation system, the administrative director should be proactive in working with the Legislature to identify and amend any provisions that would adversely affect the administrative director's ability to effect changes. An example would include the requirement to develop an outpatient

surgical facility fee schedule using data that is not yet being collected, effectively delaying the implementation of this fee schedule.

When determining the future structure of the workers' compensation medical payment system, the administrative director should consider the costs and practicalities of maintaining such a complex system and should give consideration to adopting a payment system that is based on models that are maintained by other entities, such as a variation of the RBRVS maintained by the federal Centers for Medicare and Medicaid Services, as he has done with his current proposal for modifying the physician fee schedule. If the administrative director decides to continue modifying the current workers' compensation payment system, he should consider pursuing a variety of activities, including the following:

- Continue his efforts to identify the adjustments needed to ensure that payments for services in the proposed modified physician fee schedule are high enough to encourage participation by physicians and other professionals in order to provide adequate access to care for injured workers.

- Seek the needed resources to develop and maintain fee schedules for the remaining medical services and products, such as outpatient surgical facilities, pharmaceuticals, emergency rooms, durable medical equipment, and home health care.

One proposal to improve California's workers' compensation payment system requires converting the entire system to a combination system that would use a variation of the Medicare payment system for medical services, facilities, and products, and the Medi-Cal payment system for pharmaceuticals. If this proposal is adopted, the administrative director should consider the following steps:

- Develop adjustments to the fee schedule for physician services and other professional services so as to mitigate any effects on access to care caused by adopting a resource-based relative value payment system that results in redistributing payment amounts away from medical specialties, such as surgery, and in increasing payments for evaluation and management services.

- Monitor the medical payment system to determine whether a reasonable standard of care can be achieved at the capped prices for services and products contained in the proposal.

- To fully benefit from adopting the Medi-Cal payment system for pharmaceuticals, in addition to adopting the Medi-Cal fee schedule, the administrative director should also study the feasibility of establishing a process to secure rebates from drug manufacturers like the supplemental rebates enjoyed by the Department of Health Services in its Medi-Cal pharmaceuticals purchase program.

- Because there are no universally successful formulas for determining payments for medical services and products, the administrative director should consult with other states that have adopted Medicare-based payment systems and consider any measures they have employed to secure quality care at reasonable prices.

AGENCY COMMENTS

The undersecretary and acting secretary for the Labor and Workforce Development Agency believes that our report, with its extensive analysis of options for reducing workers' compensation medical costs, provides an important framework for the legislative conference committee on workers' compensation to use as it undertakes the difficult task of examining ways to significantly reduce system costs while still providing access to care and high quality benefits to injured workers. ■

INTRODUCTION

BACKGROUND

California adopted its workers' compensation program in 1911. The California Constitution authorizes the Legislature to create and enforce a system that requires employers to compensate workers for work-related injuries and illnesses. Injured workers are entitled to receive all medical care that is reasonably required to cure or relieve the effects of the disability. Additionally, workers who are unable to return to work within three days are entitled to receive disability benefits to partially replace lost wages. Injured workers who are permanently disabled or who are unable to return to the same line of work due to the nature of the injury incurred are entitled to receive vocational rehabilitation services and, in some cases, a permanent disability benefit. Vocational rehabilitation services are provided for injured workers who are unable to return to their former type of work if these services can reasonably be expected to return the worker to suitable gainful employment. In exchange for these no-fault insurance benefits, the law designates the limited workers' compensation benefits as the exclusive remedy for injured employees against their employers, even if the injury is due to employer negligence.

Unlike most social insurance programs, such as social security or unemployment compensation, workers' compensation in California is not administered by a single government or private agency. Rather, employers, insurers, claims administrators, medical service providers, and others all have roles in the workers' compensation system to process workers' claims for benefits.

EMPLOYER-FINANCED BENEFITS TO INJURED WORKERS

The workers' compensation system is premised on a trade-off between workers and employers and comprises several interlocking components. When an injury occurs, medical providers are expected to treat the injured worker promptly to ensure a quick return to work. The incentive for providing prompt, quality care for an injured worker is that the quicker the employee returns to work, the lower the cost of the medical benefits and the indemnity benefits, or lost wages, paid by insurers and reflected in the workers' compensation insurance premiums charged to employers. The incentive for the injured

worker is that indemnity benefits only partially replace lost wages, and so the quicker the worker can return to work, the sooner full pay will be restored.

The workers' compensation system provides benefits to injured workers and requires employers to pay the costs of workers' compensation benefits through a financing system that includes the following three methods:

- **Self-insurance:** Most large, stable employers and most government agencies are self-insured for workers' compensation. To become self-insured, employers must obtain a certificate from the Department of Industrial Relations (Industrial Relations). Private employers must post security as a condition of receiving this certificate.

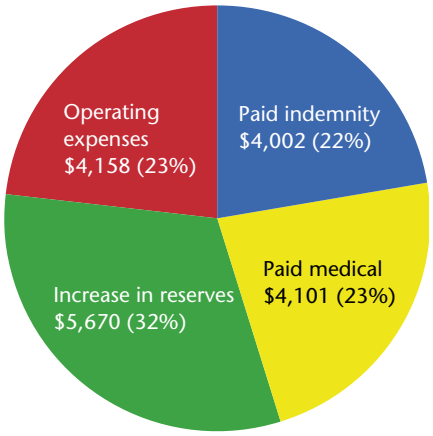
- **Private insurance:** Employers may purchase insurance from any of the private insurance companies (insurers) that are licensed by the Department of Insurance to offer workers' compensation insurance in California. Although approximately 300 companies are licensed to sell workers' compensation insurance, only one-third of that number actually sold workers' compensation insurance to employers in 2002. Insurers can price this insurance at a level they estimate is appropriate for the risk covered and service provided.

- **State insurance:** Employers may also purchase insurance from the State Compensation Insurance Fund (state fund), a state-operated entity that exists solely to provide workers' compensation insurance on a nonprofit basis. It actively competes with private insurers for business, and it also operates as the assigned risk pool for workers' compensation insurance.

The Workers' Compensation Insurance Rating Bureau (rating bureau) reported that the workers' compensation total system costs for employers that purchase workers' compensation insurance were more than $17.9 billion in 2002, with medical costs, including pharmaceuticals, representing approximately $4.1 billion, or 23 percent. Using a commonly accepted factor of 1.4 to convert costs for insured employers to include the costs for all self-insured employers in the State, we estimate that the total workers' compensation costs for the system in 2002 were $25.1 billion, about $5.7 billion of which was paid for medical costs. Figures 1 and 2 show the proportionate costs of the workers' compensation program incurred by insurance companies. Our audit focuses on workers' compensation medical costs.

FIGURE 1

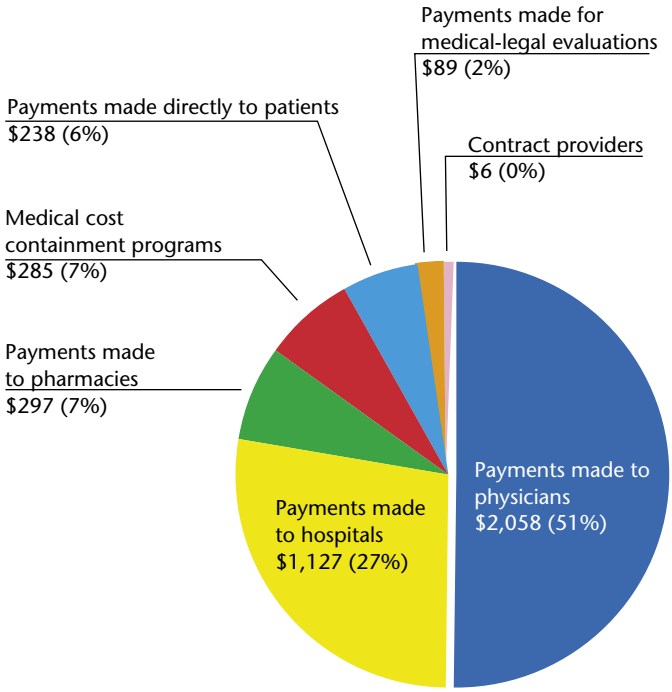
Total California's Workers' Compensation Costs Paid in 2002 by Insurance Companies (Not Including Self-Insured Employers) (Dollars in Millions)



Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

FIGURE 2

Workers' Compensation Medical Costs Paid in 2002 by Insurance Companies (Not Including Self-Insured Employers) (Dollars in Millions)



Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

When medical service providers and payers (insurers or claims administrators) disagree on benefits, payments, or necessary medical services for injured workers, the disputes are settled by the workers' compensation judicial process. The dissatisfied parties apply to administrative law judges for adjudication of their dispute. These judges initially adjudicate claims disputes and approve proposed settlements. The administrative law judges have 30 days from the time of application to hold an initial conference and up to 75 days to conduct a hearing, if necessary. These delays can extend the period that an injured worker is off work. Decisions from the administrative law judges can be appealed to the Workers' Compensation Appeals Board (appeals board) for review. These decisions can be further appealed to California's Court of Appeals and ultimately to its Supreme Court.

The vast majority of workers' compensation claims are handled expeditiously and are administered without dispute or litigation. These are, for the most part, the smaller claims, such as those in which only medical care is provided and those in which the injured worker is disabled for only a few days. These smaller claims account for more than three-fourths of all workers' compensation claims filed each year. The remaining claims include those involving significant periods of disability or permanent disability. These more extensive claims account for most of the costs and litigation.

FEE SCHEDULES USED IN THE CALIFORNIA WORKERS' COMPENSATION MEDICAL PAYMENT SYSTEM

California's current workers' compensation medical payment system consists of a combination of fee schedules, payment formulas, and payments to medical service providers based on their usual, customary, and reasonable charges for medical services. The current payment system uses the Official Medical Fee Schedule (OMFS) to determine reimbursement rates for some medical services provided under the workers' compensation program. Maintaining the OMFS is the responsibility of the administrative director of Industrial Relations' Division of Workers' Compensation (division). The OMFS, however, does not include all the services covered under other payment systems, such as Medicare. Under the OMFS and other fee schedules maintained by the division, payments are generally set for the following services:

- Physician and nonphysician professional services

- Inpatient hospital services
- Pharmaceuticals
- Durable medical equipment
- Medical-legal services
- Orthotics and prosthetic devices
- Interpreters

Medical services not covered by fee schedules but paid based on usual, customary, and reasonable charges include the following categories of services and products:

- Services at hospital outpatient facilities
- Services at ambulatory surgical centers
- Home health care services
- Ambulance services
- Emergency room services

In the workers' compensation system, the number and types of treatments provided to an injured worker (utilization), as well as fees for medical services, are major contributors to the costs of providing workers' compensation benefits.

OTHER PAYMENT SYSTEMS

The federal Medicare program and some other states' workers' compensation programs use payment systems that are based on resource-based fee schedules. In simplified terms, under these systems, payments to physicians and nonphysician professionals, such as physical therapists, are determined using a schedule that indexes each medical service as a value in relation to the value of a common service that is used as a baseline. Because these values are determined based on the resources considered necessary to provide the medical services, the values are known as relative value units (RVUs). The entire collection of RVUs is known as the resource-based relative value scale (RBRVS). The payment for a specific service in the Medicare program is calculated by multiplying the RVU by a geographic adjustment factor to compensate for the varying costs of providing medical services in different geographical zones and then applying a single dollar amount conversion factor. Because

these payments are derived from the perceived resources required to provide the services, they are tied more to the cost to provide them than to the amounts customarily charged by providers, and they are intended to control payment inflation.

As we discuss in Chapter 2, under Medicare, payments to hospitals are determined using the Hospital Inpatient Prospective Payment System. This system categorizes each injury into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources needed to treat a patient in that group, and hospitals are paid a set fee, determined by the DRG, for treating each patient. Additional adjustments are made for hospitals serving a disproportionate share of low-income patients, teaching facilities, and complicated cases with unusually high treatment costs, known as cost outlier cases.

Facility fees paid for surgeries that do not include an overnight stay (outpatient surgeries) are paid under two systems: the Hospital Outpatient Prospective Payment System (outpatient payment system) and the Ambulatory Surgical Center rates. Like the inpatient payment system, the outpatient payment system groups services into categories that are clinically similar and require a similar level of resources.

In addition to the major fee schedules and payment systems just discussed, Medicare also uses fee schedules and payment systems for a variety of other services and products, including ambulance services, clinical laboratory diagnostic services, durable medical equipment, prosthetics/orthotics devices, and medical supplies.

GOVERNANCE OF CALIFORNIA'S WORKERS' COMPENSATION PROGRAM

Although the State does not administer the payment of workers' compensation claims, several state governmental entities do have oversight roles. Industrial Relations, which oversees most of the State's labor programs, is responsible for enforcing California's workers' compensation laws and adjudicating workers' compensation insurance claim disputes using administrative law judges. A division within Industrial Relations, the Division of Workers' Compensation, is headed by the administrative director, who monitors the administration of workers' compensation claims and provides administrative and judicial services to assist in resolving disputes that arise in

connection with claims for workers' compensation benefits. Although the division is organized under Industrial Relations, the administrative director is appointed by the governor, with the advice and consent of the Senate, and holds office at the pleasure of the governor.

When disputed claims cannot be settled using the division's administrative and judicial services, the disputes can be taken to the appeals board for resolution. The appeals board is a seven-member judicial body appointed by the governor and confirmed by the Senate. In addition to reviewing petitions for reconsideration of decisions made by workers' compensation administrative law judges, the appeals board regulates the adjudication process by adopting rules of practice and procedure.

The Industrial Medical Council (medical council), which advises the administrative director, is a body that consists of 20 voting members appointed by the governor, the Senate Committee on Rules, and the Speaker of the Assembly. The medical council has 11 medical doctors, two osteopaths, two chiropractors, one psychologist, one physical therapist, one acupuncturist, one podiatrist, and one medical economist. The medical council examines and appoints physicians to be qualified medical evaluators known as medical examiners. Medical examiners perform the examinations of injured workers that help determine the level of benefits the workers will receive. The medical council has developed evaluation guidelines to be used for these examinations for some types of injuries. It has also created treatment guidelines for physicians to use as they consider various treatment options for injuries that occurred at work. However, as we discuss in Chapter 1, physicians, insurers, and claims administrators are not required to follow these treatment guidelines when determining the necessary treatment for injured workers. In addition, the medical council advises the administrative director on issues affecting physicians and other providers in the workers' compensation system and undertakes studies of current medical care issues.

The Commission on Health and Safety and Workers' Compensation (commission), which also advises the administrative director, is a body comprising representatives of labor and management created by the workers' compensation reform legislation of 1993. Its members are appointed by the governor and members of the Senate and Assembly. The commission is charged with overseeing the health and safety of workers and the workers' compensation system in California

and recommending administrative or legislative modifications needed to improve its operation. The commission conducts a continuing examination of the workers' compensation system and of the State's activities to prevent industrial injuries and occupational diseases, as well as examining those programs in other states to provide a more effective and efficient workers' compensation system in California.

Self Insurance Plans (SIP), a program within Industrial Relations, is responsible for certifying public and private self-insured employers as well as the third-party administrators and claims adjusters who administer workers' compensation benefits on behalf of self-insured employers. SIP also audits the entities involved in the self-insurance program and ensures that those self-insured employers post annually adjusted security deposits, if required, to cover incurred liabilities.

The Department of Insurance is responsible for overseeing the insurance industry and protecting the State's insurance consumers. The Department of Insurance licenses, regulates, investigates, and audits insurance companies in the California market to ensure they remain solvent and meet their obligations to insurance policyholders. Therefore, the Department of Insurance licenses and regulates insurers that wish to provide workers' compensation coverage within California. It also maintains a fraud investigation unit that works in concert with local district attorneys to investigate and prosecute workers' compensation fraud.

The rating bureau is a licensed rating organization. The rating bureau is an unincorporated, nonprofit association made up of more than 300 companies licensed to provide workers' compensation insurance in California. It is funded primarily by membership fees and assessments. As the designated statistical agent for California's insurance commissioner, the rating bureau serves as a source of information about workers' compensation and performs a number of functions, including collecting premium and loss data on workers' compensation policies to aid the insurance commissioner and insurers in recommending changes in premium rates.

Finally, the state fund is a state-operated entity that exists in order to offer workers' compensation insurance on a nonprofit basis. The state fund competes with private

insurance companies for business and serves as the insurer of last resort if other insurers are not willing to offer workers' compensation insurance to a business entity. The state fund writes approximately 50 percent of the insurance premiums for workers' compensation in California, up from 22 percent in 1999.

Because the workers' compensation program is not solely administered by any one state agency, there is no single repository of claims data for injured workers. Therefore, obtaining programwide statistical data is problematic. Currently, the division is developing the Workers' Compensation Information System (WCIS) that was mandated by law in 1993. SIP, within Industrial Relations, collects high-level data from self-insured employers. Public employers report to SIP on a fiscal year basis, while private self-insured employers report on a calendar year basis. Although the Department of Insurance's fraud division maintains data on claims involved in fraud investigations, the department itself relies on the rating bureau to recommend rate changes. The rating bureau bases its rate recommendations on high-level data submitted by insurance companies licensed to sell workers' compensation insurance in California. The California Workers' Compensation Institute (CWCI), a private nonprofit organization of insurers and self-insured employers, collects workers' compensation data, but it views the data as proprietary information furnished on a voluntary basis by its membership, and it makes only selected data available to requestors. Finally, the Office of Statewide Health Planning and Development (OSHPD) is responsible for collecting, analyzing, and disseminating information about hospitals, nursing homes, clinics, and home health agencies licensed in California. However, it collects only patient-specific data about hospitals' discharged inpatients and does not collect data regarding hospital outpatient surgeries or data from ambulatory surgical centers.

RECENT AND PENDING LEGISLATION AFFECTING WORKERS' COMPENSATION

During 2001 and 2002, the Legislature passed, and the governor signed into law, many bills that affected the workers' compensation system in some way. Two enacted bills that

significantly affect medical costs are Chapter 6, Statutes of 2002, and Chapter 252, Statutes of 2001. Included in their provisions are the following:

- Eliminate the presumption that treating physicians are correct in their proposed treatment plans, except when a worker has predesignated a personal physician or chiropractor.
- Require the use of generic drugs.
- Require the adoption of a pharmaceutical fee schedule.
- Outline the conditions for the development of an outpatient surgical facility fee schedule.
- Require the administrative director to study medical cost controls and treatment provided to injured workers.
- Allow a medical services provider to contract with an employer, insurer, or other payer for reimbursement rates that are different from the rates contained in the OMFS.

During the current legislative session, 20 bills addressing workers' compensation issues have passed out of their house of origin. The issues covered in these bills include medical fee schedules, treatment utilization, and insurance market regulation. According to a July 9, 2003, Assembly bill analysis, while the interested parties agree that the workers' compensation system is in need of repair, they disagree as to what the real, systemic problems are and how to fix them without diminishing the benefits to injured workers. Legislative leaders and the authors of the bills have agreed to submit the bills to a joint conference committee to ensure comprehensive workers' compensation reform.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested that we review the medical costs related to the workers' compensation insurance system and the extent to which the payment structure has resulted in unacceptably high reimbursement rates. The audit committee specifically requested that we focus on medical services provided by hospitals and outpatient surgical facilities and paid for by workers' compensation insurers.

To gain an understanding of the governance structure of the workers' compensation system, we reviewed the relevant sections of the California Labor Code, Insurance Code, and Health and Safety Code, as well as the California Code of Regulations. To gain an understanding of the roles and responsibilities of state departments that are responsible for different aspects of the workers' compensation system, we interviewed key management staff of Industrial Relations and the Department of Insurance. We also worked with state and other entities that provide support or advice to the workers' compensation program—the commission, the medical council, the rating bureau, and the OSHPD.

To further understand the issues surrounding medical payments in the workers' compensation system, we interviewed representatives from the California Society of Industrial Medicine and Surgery, a legislative advocate for physicians, and the California Medical Association. In addition, we interviewed representatives from the community of workers' compensation insurers, such as CWCI and the state fund. Further, we met with representatives from an occupational health physicians' group who provide services in the workers' compensation system and with representatives of the UC DATA Survey Research Center at the University of California, Berkeley. Lastly, we reviewed numerous research reports on workers' compensation in California and other states, released by the commission, the medical council, the CWCI, the Workers' Compensation Research Institute, and the UCLA Center for Health Policy Research.

To identify sources of available workers' compensation billing and payment data, we interviewed representatives and reviewed documents from various entities that collect such data. State entities we contacted include the OSHPD, Industrial Relations, the Department of Insurance, and the state fund. In addition, we contacted the CWCI and the rating bureau.

The data from each of these entities have their own limitations to their usefulness in conducting studies of claims payments, especially with respect to identifying outpatient facility charges. The OSHPD is responsible for collecting, analyzing, and disseminating information about hospitals, nursing homes, clinics, and home health agencies licensed in California. However, it collects only patient-specific data about hospitals' discharged inpatients and does not collect data regarding hospital outpatient surgeries or surgeries performed at ambulatory surgical centers. Further, this data includes only the

amounts billed, not the amounts paid. Industrial Relations is still developing its capability to collect medical payment data; it currently collects none. The Department of Insurance collects only data for the workers' compensation fraud investigations it conducts. The state fund collects medical payment data on the claims it pays or administers, but it represents only about 47 percent of the claims filed with insurers in the workers' compensation system. The CWCI, a nonprofit organization made up of insurers, claims administrators, and self-insured employers, collects medical payment data on a voluntary basis from its membership, which consists of insurers and claims administrators who handle about 70 percent of the total claims in the system. However, the CWCI considers this data proprietary; it does not share many identifying characteristics of the data and provides the data only on loan. In addition, these data do not identify outpatient surgeries performed in ambulatory surgical centers. Finally, the rating bureau collects its claims data only from insurers (it collects no information from self-insurers), and the data are at a high level of detail that does not include specific procedure codes needed to identify individual costs or the frequency of treatment utilization.

We obtained medical claims data from the state fund and attempted to determine the extent to which increases in workers' compensation medical costs were being driven by increases in the average price per service or by the cost of the increased number of services performed. We also attempted to determine the reasonableness of the cost savings projected in a study the commission performed, which estimated that $370 million could be saved in workers' compensation pharmacy costs from adopting Medi-Cal's fee schedule for pharmaceutical reimbursements. Finally, we attempted to determine and analyze the amounts paid for outpatient surgical facility fees to both hospitals and ambulatory surgical centers since neither is covered by a fee schedule. Although the state fund provided the data we needed to successfully complete our first objective, it did not provide the information we needed to perform analyses of payments for outpatient surgical facility fees and pharmaceuticals in time to present the results in this report. As a result, we will issue a subsequent report on the results of those analyses after we have received and analyzed additional information and data from the state fund.

We also conducted a survey of 10 other states that had implemented workers' compensation payment systems patterned on the RBRVS, to gain an understanding of their

successes and challenges in implementing their respective systems. Eight of the states participated in our survey, which focused on whether the states had achieved their goals with respect to implementing and maintaining an RBRVS system and whether implementing the system had resulted in any adverse effects on access to quality care. We also asked them about the data they collect and how they monitor their systems. ■

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CHAPTER 1

California's Workers' Compensation Medical Payment System Does Not Adequately Control the Costs of Treating Injured Workers

CHAPTER SUMMARY

The cost of medical payments under California's workers' compensation program is increasing at a rate much higher than a national index of general health care costs. The result affects California businesses that must pay for those increased costs, in part through higher insurance premiums. According to a recent survey conducted by the California Chamber of Commerce and the California Business Roundtable, there is a widespread belief in the business community that workers' compensation insurance is the largest single cost problem associated with doing business in the State.

These escalating costs have affected the workers' compensation insurance industry as well. The commissioner for the Department of Insurance (insurance commissioner) reports that 27 workers' compensation insurance companies (insurers) have gone bankrupt and that the State Compensation Insurance Fund (state fund), which now insures approximately 50 percent of the California market, is in serious financial condition. The insurance commissioner predicts that the system will collapse if legislative reforms are not enacted to control the costs related to providing medical treatment to injured workers.

Medical costs are rising in the workers' compensation system because the State has done a poor job of containing costs in a system in which employers have no choice but to pay those costs. For example, the State's system lacks adequate cost controls, such as current fee schedules and procedures to control treatment utilization, both important cost drivers in the system. A lack of uniform treatment guidelines that providers and insurers are required to follow increases the cost of workers' compensation claims by contributing to an already inefficient judicial process for resolving disagreements regarding treatment for injured workers.

Since 1999 various researchers have conducted studies that touch on issues such as how costs can be contained through the use of fee schedules and utilization controls. The studies point out that costs for medical services and pharmaceuticals are escalating and that savings could be achieved through the implementation of cost control measures. Some of these studies' findings parallel analyses we conducted using the state fund's medical claims data and indicate the recent rise in medical costs is more attributable to the increase in the number of medical services provided than to increases in the prices of medical services. These reports should have served as an early warning, prompting further investigation and leading to a strategy to better contain costs and improve the system.

In spite of abundant available research, the State has not taken steps to ensure that injured workers have access to quality care at a reasonable cost to employers. According to the administrative director of the workers' compensation system, he has not implemented improvements to better control and monitor the system for administering medical payments (medical payment system) due to budget constraints and because he was instructed to address other priorities upon his appointment in 1999. In addition, the administrative director does not believe the law gives him the authority to mandate that insurers use uniform utilization review procedures.

WORKERS' COMPENSATION MEDICAL COSTS AND WORKERS' COMPENSATION INSURANCE PREMIUMS ARE RISING

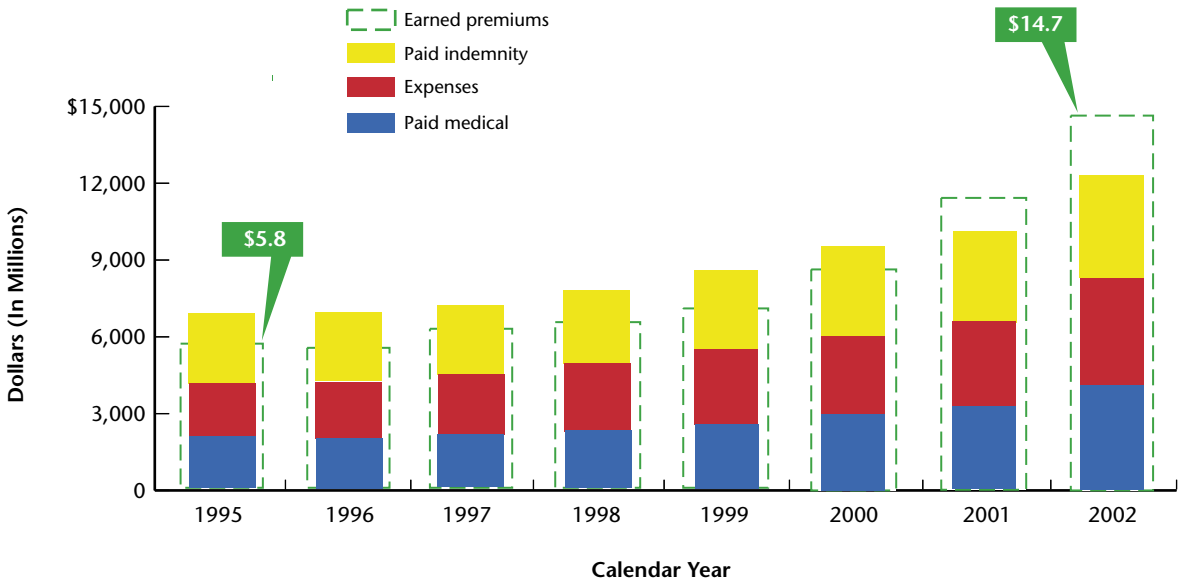
Workers' compensation insurance premiums have risen by almost $9 billion, or 153 percent between 1995 and 2002.

The Thirteenth Annual Business Climate Survey, released on May 1, 2002, by the California Chamber of Commerce and the California Business Roundtable, indicated a widespread belief that the cost of workers' compensation insurance is the single largest cost problem facing businesses in the State. Businesses bear the burden of the workers' compensation program because they are required to pay for the system's benefits to injured workers, in part through the payment of workers' compensation insurance premiums. In its June 2003 report, the Workers' Compensation Insurance Rating Bureau (rating bureau) reported that insurance premiums increased from $5.8 billion to $14.7 billion, or 153 percent, between 1995 and 2002, as shown in Figure 3. Effective July 1, 2003, the insurance commissioner approved a proposed premium rate increase of 7.2 percent to keep pace with rising medical costs. Insurers must not only

charge a sufficient premium to pay the current medical costs to treat injured workers, but also must charge enough to build a sufficient reserve of funds to pay for any estimated future costs of claims.

FIGURE 3

Workers' Compensation Insurance Premiums and Costs 1995 Through 2002



Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

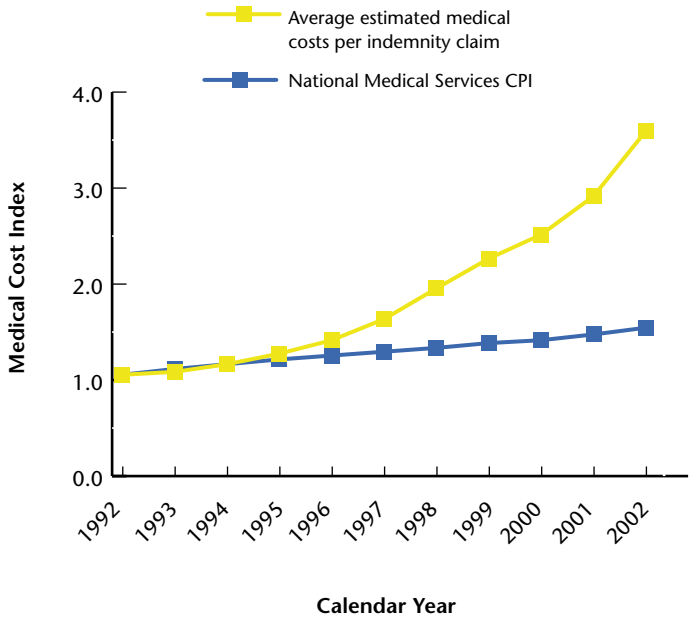
The insurance commissioner has identified medical cost containment as a priority because he believes that the uncontrolled and unpredictable inflation of workers' compensation medical costs is one of the system's primary cost drivers and a central cause of escalating workers' compensation premiums in the State. The unpredictable nature of medical costs also affects the ability of insurers to accurately predict the amount of reserves to set aside to meet the future needs of injured workers, causing instability in the workers' compensation insurance market. In a May 21, 2003, press release, the insurance commissioner reported that 27 workers' compensation insurers have gone bankrupt and that the state fund, which covers about 50 percent of the California market, is in serious financial condition. The insurance commissioner stated that California is heading for a collapse of the system unless the Legislature acts to pass laws that control these cost drivers.

Average estimated medical costs per indemnity claim rose 254 percent from 1992 to 2002, while the National Medical Services CPI rose only 49 percent during the same period.

The rating bureau reports that the average estimated medical costs per indemnity claim (a claim that includes compensated time off from work) in California's workers' compensation system rose dramatically from $8,781 in 1992 to $31,120 in 2002, an increase of 254 percent. These costs are considered estimates because they include amounts already paid for workers' compensation claims as well as the estimated future amounts required to finish providing benefits and close the cases for injured workers. In contrast, the rating bureau reported that the National Medical Services Consumer Price Index (National Medical Services CPI), a measure of increases in medical prices nationally, has increased only 49 percent over the same period, as shown in Figure 4. Since the cost increases include the effects of both price increases and utilization increases and the National Medical Services CPI increase includes only price increases, a portion of the steep rise in workers' compensation medical costs can be attributed to increases in utilization.

FIGURE 4

Index of Workers' Compensation Medical Costs Per Indemnity Claim Compared to the National Medical Services CPI 1992 Through 2002

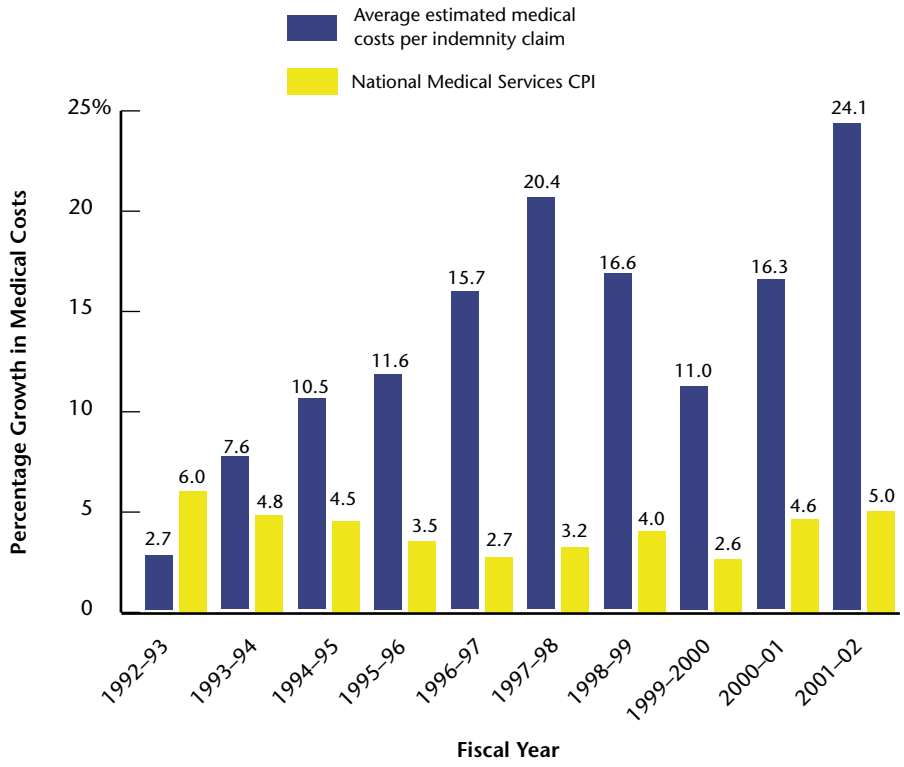


Source: Workers' Compensation Insurance Rating Bureau.

As shown in Figure 5, the growth in the average estimated workers' compensation medical cost per indemnity claim in fiscal year 2001–02 alone was more than 24 percent, while the National Medical Services CPI rose by only 5 percent. These medical cost statistics reported by the rating bureau include only the claims administered by insurers. Employers that elect to self-insure their workers' compensation expenses, such as large companies or government entities, are not required to report their statistics to the rating bureau.

FIGURE 5

Annual Growth in Workers' Compensation Medical Costs Per Indemnity Claim Compared to the National Medical Services CPI Fiscal Years 1992–93 Through 2001–02



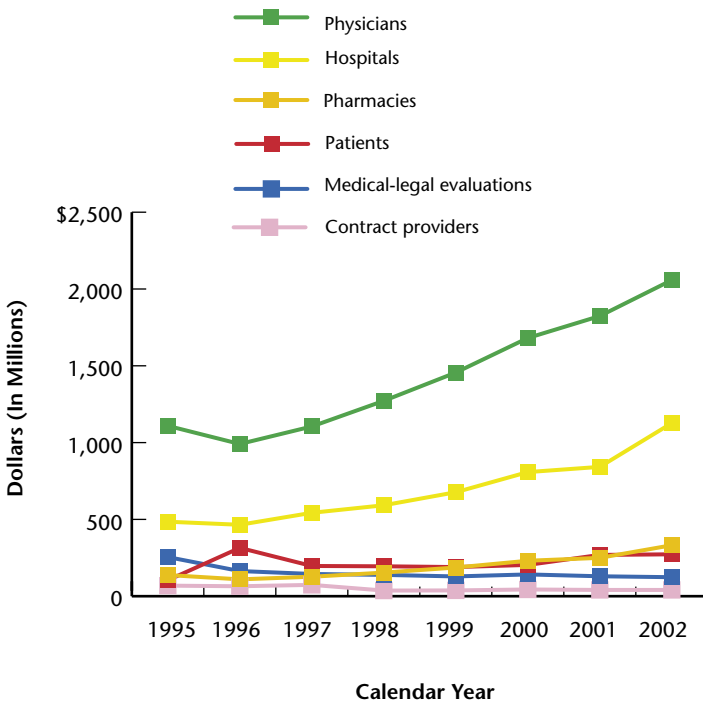
Source: Workers' Compensation Insurance Rating Bureau.

In addition to large increases in the estimated total medical costs per claim, the rating bureau also reported that actual paid medical costs increased sharply from 1995 through 2002. In its latest annual report on insurers' aggregate paid costs for calendar year 2002, the rating bureau reported that insurers paid $4.1 billion for medical expenses. These paid medical costs,

as shown in Figure 6, include the cost of services provided by physicians, hospitals, and pharmacies and direct payments made to compensate some injured workers in lieu of future workers' compensation benefits.

FIGURE 6

Types of Medical Costs Paid*



Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

* Figure 6 excludes $285 million, the cost of medical cost containment programs reported in 2002, because 2002 was the first year insurers began separately reporting these costs to the rating bureau.

Medical costs have increased in almost all categories reported. For example, the rating bureau reports that insurers paid physicians almost $2.1 billion for services rendered to injured workers in 2002, compared to $1.1 billion in 1995, an 86 percent increase. Hospitals were paid $1.1 billion for services in 2002, a 132 percent increase over the $485 million paid in 1995. For other types of costs, such as pharmaceuticals, payments more than doubled, while the payments made directly to patients tripled. Only one cost category—the costs associated with medical-legal evaluations—decreased between 1995 and 2002, with a decline of 60 percent.

One area where costs have risen particularly rapidly is for chiropractic treatments. Payments to chiropractors increased by 126 percent, from $104 million in 1995 to $235 million in 2002, outpacing the growth rate for total medical payments. A study published in 2003 by the Workers' Compensation Research Institute (WCRI) that compared the costs for chiropractic treatment for workers' injuries during 1999 and 2000 reported that a chiropractor treating workers injured in California received an average payment of $2,066 per claim, the second highest among the 12 states reviewed. This cost is based on injuries received in 1999 having an average case history of 12 months. In addition to increases in costs for chiropractors, payments to general and family practice physicians have increased dramatically in recent years. Payments to these physicians increased by 75 percent between 1995 and 2002, with an initial drop followed by a steep increase of 155 percent from 1999 to 2002.

While payments for almost all medical services increased from 1995 through 2002, the increases were particularly dramatic for payments going to chiropractors (126 percent increase) and payments for pharmaceuticals (188 percent increase).

A 2000 study by the Commission on Health and Safety and Workers' Compensation (commission) concluded that pharmaceutical costs were rising faster than overall medical costs at the time, resulting in reimbursement rates that were higher than in other health care systems, such as Medicare or Medicaid. The rating bureau's annual report for calendar year 2002 shows a 188 percent increase in pharmaceutical costs between 1995 and 2002, with the amount paid rising from $103 million to $297 million.

In its most recent annual report on workers' compensation losses and expenses, the rating bureau reported that paid medical costs have increased a little more than 28 percent in just the last year, from $3.2 billion in 2001 to $4.1 billion in 2002.

OUR REVIEW OF SELECT DATA REVEALS SIGNIFICANT CHARACTERISTICS OF MEDICAL COSTS

Our review of medical payment data from the state fund for workers' compensation claims from 1999 to 2002 reveals that increasing medical costs appear to primarily result from the increasing number of new workers' compensation claims. Although long-tailed claims—claims with payments that were filed by injured workers as far back as the 1940s through 1994—are a significant cost to the state fund, they have remained relatively stable and do not appear to be contributing to the upward

spiral in medical costs. While it is important to contain medical costs for services, the recent rise in overall medical costs paid by the state fund stems more from the increase in the number of medical services provided to injured workers than from the rise in prices for medical services.

Our review of paid medical claims data from the State Compensation Insurance Fund indicates the recent increase in overall medical costs is more the result of the increase in the number of medical services provided to workers than increases in the price of medical services.

As we further discuss in Chapter 3, the division currently does not have its Workers' Compensation Information System (WCIS) developed to the point that it contains data on medical treatments or payments. Therefore, we obtained detailed paid medical claims data from the state fund, currently the largest workers' compensation insurer in the State. We do not know, however, how closely workers' injuries and costs in the state fund data represent the claims data maintained by other workers' compensation insurers or self-insured employers.

Nevertheless, using this data, we attempted to determine the extent to which increases in workers' compensation medical costs were being driven by an increase in the number of claims, an increase in the number of medical services, or an increase in the prices of the medical services. Since the state fund represented approximately 22 percent of workers' compensation insurance premiums in 1999 but grew to handle more than 49 percent of those premiums in 2002, we identified the universe of employers insured by the state fund in both 1999 and 2002, using its paid claims data files, so that the increase in the state fund's market share would not affect our analysis of the growth in medical costs. This resulted in a universe of medical payments for 2002 of $673 million, or 16 percent of the total workers' compensation medical payments for insurers reported by the rating bureau for that year.

The first analysis we performed determined the extent to which new claims were driving the increase in total medical costs. We found that between 1999 and 2002, the total medical payments associated with these claims increased from $329.5 million to $673.4 million, an increase of $343.9 million, or 104 percent. During this same time period, the total number of claims for which the state fund made medical payments increased from 145,996 to 218,687, an increase of 72,691 claims, or 50 percent.

We further determined the extent to which recent claims were driving the increase in costs, by year of injury. As shown in Table 1, in 1999, $89.1 million was paid for 67,401 claims related to injuries occurring in that year. However, by 2002, $173.3 million was paid for 96,943 claims related to injuries sustained in that year. These increases of 94 percent in cost

and 44 percent in the number of claims indicate that newer claims may be a primary cause for the increase in medical costs. Although the claims data we reviewed related to employers that the state fund insured in both 1999 and 2002, we do not have any data on the number of employees working for these employers or on how their number may have changed over time. A significant increase in the number of workers employed by these companies, corresponding to an increase in the rate of sustained injuries, could conceivably explain some or all of the increase in new claims.

Table 1 also illustrates that when the claims payment data from calendar years 1999 and 2002 are compared, it is evident that in 2002 the state fund had more claims with payments, and the average medical cost per claim was higher, than in 1999. For example, the state fund's claims with payments increased by almost 72,700 from 1999 to 2002, and its average cost per claim rose from $2,257 to $3,079 during that period.

According to the state fund's claims/rehabilitation manager, the data files the state fund provided to us only contain medical payments that were processed through its medical bill review system. The most common examples of payments not included in these data files are reimbursements paid directly to an injured

TABLE 1

Comparison of Workers' Compensation Medical Payments in 1999 and 2000, by Year of Injury (Dollars in Millions)

Number of Years Between Injury and Payment	Calendar Year 1999		Calendar Year 2002		Increases		Average Cost Per Claim	
	Amount Paid	Number of Claims With Payments	Amount Paid	Number of Claims With Payments	Amount Paid	Number of Claims With Payments	Calendar Year 1999	Calendar Year 2002
0	$ 89.1	67,401	$173.3	96,943	$ 84.2	29,542	$1,322	$1,788
1	108.2	40,260	235.0	67,198	126.8	26,938	2,688	3,497
2	36.9	12,384	81.0	18,750	44.1	6,366	2,980	4,320
3	20.7	5,824	44.9	9,479	24.2	3,655	3,554	4,737
4	13.4	3,783	31.7	6,335	18.3	2,552	3,542	5,004
5	9.8	2,636	19.4	3,822	9.6	1,186	3,718	5,076
>5	51.4	13,708	88.1	16,160	36.7	2,452	3,750	5,452
Totals	**$329.5**	**145,996**	**$673.4**	**218,687**	**$343.9**	**72,691**	**$2,257**	**$3,079**

Source: State Compensation Insurance Fund.

Note: The table reflects employers insured by the state fund in both 1999 and 2002.

worker and payments for medical cost containment reviews and activities. According to the claims/rehabilitation manager, these additional payments increase the average payments per claim to $2,784 for 1999 and $3,367 for 2002. However, the fact that the state fund did not provide the data for these types of payments does not alter our analyses aimed at identifying the causes of the overall increase in payments to medical service providers.

We next analyzed medical costs to determine the extent to which a base of medical costs for payments to workers who sustained injuries during the 55-year period from 1940 to 1994 were contributing to overall medical costs. As shown in Table 2, the medical payments that the state fund made for injuries related to this time period, while not appearing to contribute to the upward spiral in medical costs because they remained relatively stable, do represent a substantial amount, at more than $60 million a year.

TABLE 2

Medical Payments in 1999 and 2002 for Injuries Occurring During the 55-Year Period From 1940 to 1994

	Calendar Year 1999			Calendar Year 2002		
Decade Claim Originated	Total Medical Cost	Number of Services	Average Cost Per Service	Total Medical Cost	Number of Services	Average Cost Per Service
1940s	$ 60,289	394	$153	$ 163,332	333	$490
1950s	328,559	1,776	185	472,243	1,524	310
1960s	2,938,304	22,069	133	2,786,569	22,951	121
1970s	8,658,582	76,860	113	10,313,452	76,896	134
1980s	16,905,512	180,856	93	18,424,451	175,233	105
1990–1994	32,202,180	362,815	89	30,911,591	292,533	106
Totals	**$61,093,426**	**644,770**	**$ 95**	**$63,071,638**	**569,470**	**$111**

Source: State Compensation Insurance Fund.

Note: The table reflects employers insured by the state fund in both 1999 and 2002.

The third analysis we performed was to determine whether the increase in medical costs is the result of an increase in the number of medical services provided or an increase in the prices paid for medical services. As Table 3 shows, the volume of services, and not their price, was the major cause of the overall increase in medical costs, regardless of the year the injury occurred. For this analysis, we determined the number of medical services and the dollar amount of the services for

calendar years 1999 and 2002. The number of medical services for which payments were made increased from 4.4 million in 1999 to 8.7 million in 2002, while the amount paid for those services increased from $329.5 million in 1999 to $673.4 million in 2002. This represented a volume increase of 98 percent and a cost increase of 104 percent. However, as shown in Table 3, of the $343.9 million in increased medical costs, $16.1 million can be attributed to a higher price per medical service, while the remaining $327.8 million represents an increase in the number of medical services rendered.

TABLE 3

Variance in Price and Volume of Medical Services Between 1999 and 2002, by Year of Injury (Dollars in Millions)

Number of Years Between Injury and Payment	Price Variance	Volume Variance	Total Variance
0	$ 6.5	$ 77.7	$ 84.2
1	-4.0	130.9	126.9
2	2.8	41.3	44.1
3	1.8	22.3	24.1
4	1.7	16.6	18.3
5	1.0	8.6	9.6
>5	6.3	30.4	36.7
Totals	**$16.1**	**$327.8**	**$343.9**

Source: State Compensation Insurance Fund.

Note: The table reflects employers insured by the state fund in both 1999 and 2002.

DESPITE NUMEROUS WARNINGS, THE STATE HAS NOT ADEQUATELY RESPONDED TO THE PROBLEMS IN THE WORKERS' COMPENSATION SYSTEM

Medical costs in the workers' compensation system are rising because the State has done a poor job of containing costs in a system where employers have no choice but to pay these costs. The State has not taken the steps necessary to ensure that injured workers receive quality care at a reasonable cost to employers. This failure to control costs includes using outdated

fee schedules and formulas for physician, hospital inpatient, and pharmaceutical fees that do not reflect current medical costs. For outpatient surgical facilities, no fee schedules or formulas exist.

In addition, the State has not facilitated a system, through legislation and regulation, of uniform treatment guidelines that can be used as a standard for treating the same types of injuries and illnesses. Such treatment guidelines could not only serve to ensure that injured workers receive adequate treatment, but could also help in dispute resolution proceedings. This lack of standardized treatment guidelines has contributed to an inefficient process for resolving disputes over medical treatment that arise between injured workers' medical providers and the insurers and claims administrators who approve the proposed treatments for payment. A study by the commission on the workers' compensation medical payment system concluded that the system is unnecessarily complex, costly, and difficult to administer.

The State has not taken the steps necessary to ensure that injured workers receive quality care at reasonable prices, and has not been effective in correcting problems in the workers' compensation system that have been identified by researchers and experts in the field.

Moreover, the State has not been effective in correcting problems in the workers' compensation system that have been identified by researchers and experts in the field. Since 1999, various studies have centered on issues such as the cost containment that could be obtained through the implementation of fee schedules and utilization controls. One study focused on whether the system meets the needs of injured workers, medical providers, insurers, and employers within the system. Still other studies compared various aspects of the workers' compensation system in a sample of states that includes California. These research entities include the commission, the Industrial Medical Council (medical council), the California Workers' Compensation Institute (CWCI), the rating bureau, and the WCRI. Reports issued in 2003 by the commission and CWCI stated that using up-to-date fee schedules and utilization controls can be effective in containing medical costs, and two reports released in 2001 by the Public Health Institute and the Department of Industrial Relations' (Industrial Relations) Division of Workers' Compensation (division) identified inconsistencies in the treatment utilization reviews used by insurance administrators and found significant dissatisfaction with the system's ability to deliver prompt, quality care to injured workers.

Although two of the studies did not contain recommendations for improving the system, they did point out that costs were escalating for medical services and pharmaceuticals and that

savings could be achieved through the implementation of cost control measures. For example, reports analyzing 1999 and 2000 claims data from the WCRI revealed that the average medical payments per workers' compensation claim in California are higher than similar costs in other states.

Despite the abundance of available research, the administrative director has done little to build on these studies to understand the extent of the problems identified and develop a strategy for solving them. He maintains that he has not dedicated more effort to improving the medical payment system because he has been constrained by staff reductions and other priorities. When the governor appointed him in 1999, the administrative director was instructed to focus on improving the workers' compensation judicial process, and he stated that 87 percent of the current division staff are assigned to the judicial process. The administrative director indicated that he has focused on that priority and that, as he lost staff, he made a conscious decision to direct the remaining staff toward increasing the efficiency of the judicial process. According to the administrative director, the division has lost almost 17 percent of its authorized positions and 19 percent of its filled positions between fiscal year 1999–2000 and July 1, 2002.

The administrative director also does not believe that the law gives him the authority to require insurers and claims administrators to comply with cost control measures such as utilization reviews. Further, the administrative director stated that he has not pursued changes in the law that will facilitate more controls over utilization because he does not sponsor legislation. He stated that the governor's office works with stakeholders in the system and identifies any changes in policy or practice that need to be effected through legislation.

Although legislation authorizes the development of a fee schedule for outpatient surgical facilities, the data necessary to develop such a schedule is not currently collected. Moreover, the data will not be available until mid- to late-2005.

Moreover, some of the legislation that has been enacted to improve the system contains provisions that have impeded such efforts. For example, one of the provisions of legislation that took effect in 2002 gave the administrative director the authority to develop a fee schedule for outpatient surgical facilities. That same legislation required the administrative director to use one year's worth of data maintained by the Office of Statewide Health Planning and Development (OSHPD). However, the OSHPD does not currently collect such data. It estimates that it may begin collecting the data by the end of 2004 or early 2005, with initial data available in mid- to late-2005. The 2002 statute also charged the administrative

director with other tasks, including developing a fee schedule for pharmaceuticals and conducting a study to improve utilization and quality of care for injured workers. However, funding for implementing the requirements of this legislation was eliminated from the administrative director's final budget.

THE WORKERS' COMPENSATION PROGRAM'S MEDICAL PAYMENT SYSTEM HAS NOT BEEN WELL MAINTAINED OR FULLY DEVELOPED

The division does not regularly update the fee schedules to keep them current, as required by law.

Workers' compensation medical costs are determined through a payment system that is partially derived through the use of fee schedules that cover some medical services and products, including physician fees, inpatient hospital facility fees, pharmaceuticals, and medical-legal fees. However, the division does not regularly update the fee schedules to keep them current, as required by law. Payments for other services and products, such as outpatient surgical facility charges and home care, are not covered under fee schedules, and so payments to these providers are determined using criteria that are based on usual and reasonable charges. Payment systems that are based on charges from providers are widely viewed by health experts and researchers as inflationary. Using a charge-based payment system, a provider has only to increase the amount charged to increase revenues.

The Medical Payment Fee Schedules Are Outdated and Vulnerable to Higher Billings

The workers' compensation system uses the Official Medical Fee Schedule (OMFS) to determine reimbursement rates for a variety of services, including physician fees, inpatient hospital facility charges, and pharmaceuticals. The origins of the OMFS date back to the 1950s. Some of the values in the current OMFS are based on a 1974 value scale study. Others are based on values supplied by a commercial vendor in 1993 and 1999 and were derived from historical charges. Still other values are assigned to the OMFS by the division. Thus, the current OMFS represents an assortment of schedules containing values from disparate sources spanning several decades of medical practice. It does not represent current or comprehensive medical services or products, nor does it ensure that payments made to providers are fair and equitable.

How Payment Amounts Are Calculated

Under the California OMFS, payment for a medical service is calculated by multiplying the relative value unit (RVU) for a particular current procedural terminology (CPT) code by the relevant conversion factor.

Relative value units reflect differences in charges for individual services.

Current procedural terminology is a list of descriptive terms and identifying codes for reporting medical services and procedures in a uniform language.

The **conversion factor** is a dollar amount that converts the RVU for a service into a payment amount.

Under the current OMFS for example, the CPT code for an office visit for a new patient is 99203. The relative value for this procedure is 9.0. The conversion factor for the evaluation and management portion of the office visit is $8.50. Thus, the payment rate is 9.0 x $8.50 = $76.50.

Although required by law to revise the OMFS no less frequently than biennially, the division last updated the procedural codes and relative values of the OMFS for services rendered on or after April 1, 1999. In addition, at that time the inpatient hospital fee schedule was adopted and implemented as part of the overall package of OMFS regulations, with partial revisions adopted in 2001. In 2002, the division made only minor changes to the OMFS to correct technical and typographical errors and to reincorporate a prosthetics fee schedule. The administrative director maintains that the division's failure to update the OMFS according to the law is a result of inadequate resources.

Outdated provisions of the OMFS also make the California's workers' compensation system vulnerable to providers charging more for their services. For example, the fee schedule system provides for the payment of inpatient hospital costs in excess of the standard payment in the OMFS if the treatment involves extraordinary conditions that require more costly treatment than the standard payment for ordinary injuries or illnesses allows. This type of case is known as a cost outlier. Payments for cost outlier cases are designed to compensate providers for treating patients requiring costly treatments and to protect hospitals from large financial losses.

Provisions of the fee schedule for hospital inpatient facility charges that are designed to compensate providers for treating patients requiring costly treatments and to protect hospitals from large financial losses are outdated and leave the workers' compensation system vulnerable to higher charges for those services.

According to 2003 testimony by a health policy expert from RAND, the California workers' compensation system is considered vulnerable to high-cost outlier payments because it is using outdated cost-to-charge ratios and an outdated cost outlier threshold. The OMFS cost-to-charge ratios and the cost outlier threshold have not been updated since 2001. The cost outlier threshold is the amount of the charge for services that a hospital must absorb before it is eligible for an additional payment. It is currently $14,500. In contrast, the Centers for Medicare and Medicaid Services (CMS) increased the federal outlier threshold for 2003 from $21,025 to $33,560 in order to address inappropriate hospital outlier claims. The result of California's low cost outlier threshold is that more workers' compensation inpatient hospital cases qualify for outlier payment status, which increases total medical costs.

According to a 2003 study by the commission, updating the OMFS cost-to-charge ratios and the cost outlier threshold with the most up-to-date Medicare figures would reduce the percentage of outlier payments from 11 percent of all California workers' compensation inpatient hospital payments to 5 percent.

The Workers' Compensation Pharmaceutical Formula Pays Much More Than Other Payment Systems

California's workers' compensation system pays up to 30 percent more for pharmaceuticals than other payment systems, including Medi-Cal, large employer health benefit plans, and other states' workers' compensation systems. According to a 2000 study by the commission, California's pharmaceutical reimbursement rate was the third highest among the 18 states analyzed, and it was up to 30 percent higher than the rate used by the State of Washington. Compared to the Medi-Cal fee schedule, under which California reimburses pharmaceutical providers, providers are being paid approximately one-third more for workers' compensation prescription drugs. As a result, California employers are paying higher pharmaceutical drug costs, but injured workers are not receiving any additional benefits.

Under the current workers' compensation medical payment system, California employers are paying higher pharmaceutical costs than most of the 18 states surveyed and the Medi-Cal payment system, but injured workers are not receiving any additional benefits.

Under the State's workers' compensation pharmaceutical reimbursement system, pharmacies are allowed to charge the lower of their customary charge or the maximum fee established by the formulas in the OMFS. The generic fee formula in the OMFS provides a premium of $7.50 to pharmacists for dispensing generic drugs, in addition to paying 140 percent of the average wholesale price (AWP) of the drugs; drug manufacturers determine the AWP. The formula for brand name drugs pays a $4 dispensing fee plus 110 percent of the AWP. In contrast, Medi-Cal pays a single dispensing fee of $4.05, regardless of whether the drug is a brand name or generic, and it pays the lowest of three predetermined reimbursement rates, usually the AWP less 10 percent. According to the division, the pharmaceutical fee formula contained in the OMFS has not been changed since it became effective on January 1, 1994, despite an increase in the cost of pharmaceuticals in the workers' compensation system.

In addition to paying less for drugs than the workers' compensation system does, Medi-Cal negotiates rebates from drug manufacturers. According to a June 2000 study by the

commission, the federal government estimates that rebates further reduce drug costs by 5 percent to 35 percent, depending on the drug manufacturer, whether the drug is a brand name or generic, and the negotiating process used. The Department of Health Services estimates a potential savings of 7 percent on its generic drug purchases from these manufacturer rebates. We discuss the process the Medi-Cal program uses to negotiate drug prices, as well as the one it uses to obtain manufacturers' rebates for pharmaceuticals, in more detail in Chapter 2.

The division is in the midst of revising the pharmaceutical fee schedule, even though legislation passed in 2002 required this revision to be completed by July 1, 2003. The division plans to spend $50,000 to contract with the University of California at San Francisco (UCSF) to conduct a study of pharmaceutical fees in workers' compensation. UCSF will provide the division with a list of proposed strategies for a new pharmaceutical fee schedule, an assessment of those strategies, and a recommendation for favored pharmaceutical fee schedule options for California. According to the division, preliminary findings should be available in August 2003, and the final report is expected in November 2003.

The Division Claims That Budget Constraints Have Delayed the Process of Updating the Fee Schedules

According to the administrative director, efforts to update the workers' compensation fee schedules have been hampered by resource shortages at the division, citing staff reductions of 25 percent over the past three years, adding that he does not have staff dedicated to developing and updating fee schedules and has been unable to hire new staff to perform this task.

In a January 15, 2003, hearing before the Senate Committee on Labor and Industrial Relations, the administrative director testified that efforts to update the workers' compensation fee schedules have been hampered by resource shortages at the division, and he cited staff reductions of 25 percent over the past three years. Moreover, the administrative director stated that he does not have staff dedicated to developing and updating fee schedules and has been unable to hire new staff to perform this task. Our review of staffing levels at the division indicated that the number of filled positions in the administrative section of the division, the section that is responsible for updating fee schedules, conducting research, developing policy, and drafting legislation, has decreased from 43 to 35, or about 19 percent, from fiscal years 1999–2000 through 2001–02, while the number of authorized positions has declined by approximately 33 percent, from 57 to 38 from fiscal years 1999–2000 to the beginning of fiscal year 2002–03. We asked the administrative director what efforts the division had made to fill its authorized

positions while they were available, whether it had experienced any employee recruitment challenges, and how it had addressed those challenges.

According to the administrative director, the division's efforts to fill authorized positions have been hampered by hiring freezes. During the fall of 2001, the governor issued an executive order imposing a statewide hiring freeze in order to address budget shortfalls. In addition, Industrial Relations has not allowed the division to fill vacant positions due to financial difficulties. However, the administrative director stated that the division has recently worked with Industrial Relations to receive permission to request freeze exemptions to fill critical vacancies. The division has filed freeze exemption requests for 70 positions, but only 17 requests have been approved and only one approved request is for a position in the division's administrative unit.

According to the administrative director, during the past three years, the division held headquarters positions vacant and concentrated on filling field office positions. As various General Fund expenditure reduction efforts were imposed, the division placed an emphasis on filling field positions. Furthermore, the administrative director stated that clerical classifications within the division are particularly vulnerable to turnover and are difficult to fill, and he said that the division has had trouble in recruiting employees in other classifications as well, including research program specialists and research analysts.

Division staff also pointed out that a $5.3 million budget augmentation to implement mandated provisions of legislation that took effect in 2002 was eliminated in the final budget for fiscal year 2002–03.

Division staff also pointed out that a $5.3 million budget augmentation to implement mandated provisions of legislation that took effect in 2002 was eliminated in the final budget for fiscal year 2002–03. The 2003–04 Budget Act includes an augmentation of just over $8 million to implement the legislation. However, if the Legislature and the governor enact reforms to the workers' compensation program that require additional effort to implement, the administrative director may need to reevaluate his staffing requirements and seek additional resources.

Division staff indicated that another reason for the delay in updating the OMFS is the division's proposed plan to migrate to a resource-based relative value scale (RBRVS) system. Staff told us that in light of the considerable work underway to prepare for migration to an RBRVS system, the large amount of staff time needed to accomplish such a transition, and the lack of confidence in the current OMFS methodology, which depends

on purchasing private proprietary data, the division determined that it was preferable to migrate directly to an RBRVS system rather than to expend resources on another OMFS update using the prior flawed methodology.

As we discuss in Chapter 2, the division has placed on its Web site draft proposed rules for some components of the OMFS. According to the division's timeline for revising the OMFS, the schedule should be implemented by July 1, 2004, for physician services provided on or after April 1, 2004. However, the division is not working on several other components of the OMFS, including updating the inpatient hospital fee schedule or developing the outpatient facility fee schedule, as we discuss next, thus jeopardizing the division's ability to meet its mandate for the fee schedule revision.

The Current System Lacks Adequate Containment for the Costs of Facilities That Provide Outpatient Surgical Procedures

Because facility charges for procedures that take place in hospitals, licensed surgical facilities, certified ambulatory surgical centers, and accredited surgical clinics are not covered under the division's official medical fee schedule, providers are entitled to charge amounts that are considered usual, customary, and reasonable for the services they provide.

Payments to facilities that provide a setting for surgical procedures that do not require the injured worker to be admitted to a hospital (outpatient surgical facilities) are not currently covered under the OMFS. The law allows facilities such as hospitals, licensed surgical facilities, certified ambulatory surgical centers, and accredited surgical clinics to charge and collect a facility fee for the use of their emergency or operating rooms. Because these facilities' services are not covered under the OMFS, providers are entitled to charge amounts that are considered usual, customary, and reasonable. In a December 5, 2002, decision, the Workers' Compensation Appeals Board (appeals board) concluded that in order to find that a provider's facility fee is usual, customary, and reasonable, consideration may be given to the provider's usual fee, the usual fee of other medical providers in the geographic area, other aspects of the medical provider's practice that are relevant, and any unusual circumstances. The appeals board further stated that the term "usual fee" means the fee that is usually accepted by providers, rather than the fee that is usually charged.

While the appeals board's establishment of criteria for determining whether a fee is usual, customary, and reasonable is a step in the right direction, we believe the criteria are still too subjective for such fees to be an effective cost control. Without a fee schedule that sets the maximum for reimbursements, the payers are forced to pay what the provider considers usual,

customary, and reasonable; try to negotiate with the provider for a fair and reasonable fee; or have the fee adjudicated. A study conducted by the University of California, Los Angeles, Center for Health Policy Research, reported that policymakers and researchers view usual, customary, and reasonable charges as inflationary and inequitable, and that such a payment method distorts the relationship between the resources used to provide services and the payment for those services.

According to an April 2003 study conducted by RAND, facility fee payments represent approximately 16 percent of the State's total medical costs for the workers' compensation system. When there is not a contract in place with the provider, the facility charges are used as a starting point for determining payments. RAND further states that since charges have been increasing more rapidly than costs, the system is vulnerable to higher charges.

Another study conducted in April 2003 by the commission recommends instituting new fee schedules for those areas that are not currently regulated, such as outpatient facility fees. The lack of fee schedules for certain medical services, along with the delays in updating other fee schedules, creates administrative inefficiencies and higher costs. The commission cited California's lack of a fee schedule for outpatient facility fees as the area in which the State is most vulnerable to runaway costs.

According to a study conducted by the commission, the lack of a fee schedule for outpatient surgical facilities has resulted in payers and providers attempting to negotiate "fair and reasonable" prices to cover outpatient surgical facility costs, which has created the unintended consequence of increasing administrative costs.

According to another study conducted by the commission, the lack of a fee schedule for outpatient surgery has resulted in payers and providers attempting to negotiate a "fair and reasonable" price to cover outpatient surgical costs. The study's recommendations indicated that although the intent of ambulatory surgical centers was to leverage advances in medical technology and clinical technique as an alternative to time-consuming, high-cost inpatient stays in the hospital, the State's workers' compensation system has yet to realize the financial and administrative gains from this alternative because the system lacks a stable method of paying for facility fees. The commission's report concluded that the inefficiency of the system can be seen in the variation in the amounts billed and paid for similar services sampled in the study. It stated that the lack of a fee schedule has created the unintended consequence of increased administrative costs as a result of case-by-case

negotiations between payers and providers for each procedure. Further, smaller employers and payers lack the buying power to negotiate for competitive rates.

The Labor Code authorizes only the administrative director to develop an outpatient facility fee schedule, and it sets out process requirements for developing the fee schedule, but it does not specify when the schedule should be completed. The administrative director has placed the development of a fee schedule for outpatient surgical facilities on hold, stating that the Labor Code also places restrictions on the type of data to be used in developing the outpatient surgical facility fee schedule that further delays its implementation by several years.

A LACK OF EFFECTIVE UTILIZATION CONTROLS LEADS TO HIGHER MEDICAL COSTS

The workers' compensation payment system lacks an efficient process to ensure that workers receive necessary and appropriate treatment for their workplace injuries. According to the division, utilization control involves an effort to discourage the use of unnecessary or inappropriate medical services without jeopardizing necessary high-quality care. Researchers in California believe that total medical costs are driven more by the frequency and duration of treatment regimes than by the amounts billed for individual goods or services. A 12-state study published by the WCRI in April 2003, with a follow-up in June, supports that belief. The study examined claims in 1999 and 2000 with more than seven days of lost work time and found that while California's average medical payment per claim was typical for the states in the WCRI's study, the average price paid per service was 44 percent lower than the 12-state median and the number of visits per claim was 71 percent higher than the 12-state median, as shown in Table 4 on the following page.

Researchers in California believe that total medical costs are driven more by the frequency and duration of treatment regimes than by the amounts billed for individual goods or services.

One of the problems cited by the insurance commissioner as part of his proposed legislative package to reform the workers' compensation system is the lack of utilization control. One way to provide this control is to adopt clinical treatment guidelines. The insurance commissioner noted that clinical treatments are determined to be effective based on the results of controlled medical and scientific studies. Using these scientific studies as a basis, the U.S. Agency for Health Care Policy and Research (HCPR), in partnership with the American Medical Association and the American Association of Health Plans, has developed

TABLE 4

Anatomy of California's Workers' Compensation Claims in 1999 and 2000 Compared to a 12-State Median

	California	12-State Median	Percent Difference
Average payment per claim	$5,667	$5,786	-2%
Services per visit	3.6	3.2	13
Visits per claim	29.7	17.4	71
Average price per service	$57	$101	-44

Source: Workers' Compensation Research Institute, *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996–2000,* April 2003.

Note: Claims in 1999 and 2000 with more than seven days of lost work time (injury/industry mix adjusted).

evidence-based clinical treatment guidelines. According to the insurance commissioner, the HCPR guidelines are well respected and are used in group health care. He stated that these clinical treatment guidelines should be the standard for determining what treatments and procedures are supported by the workers' compensation system, because such evidence-based practices or treatments have been proven to produce the best outcome for patients. The insurance commissioner also noted, as has the governor, the importance of including an independent medical review process for evaluating treatments that go beyond the guidelines.

Although we have not evaluated the treatment guidelines suggested by the insurance commissioner, researchers agree that evidence-based treatment guidelines would be effective in streamlining care and containing costs for injured workers. Other studies point to a lack of effective treatment utilization controls as a cause of the significant rise in medical costs in California's workers' compensation system. For example, in its 2003 report on changes in the utilization of chiropractic care, the CWCI stated, "With claim frequency down, little change in the unit price for chiropractic services, and negligible shifts in case mix, it appears that growing utilization has been a key factor behind the dramatic increase in workers' compensation payments for chiropractic care." Moreover, the WCRI's 2003 12-state study found that injured California workers were visiting physicians, chiropractors, and physical or occupational therapists substantially more times per claim than the 12-state median, as illustrated in Table 5.

TABLE 5

Visits Per Claim in California in 1999 and 2000 Compared to a 12-State Median

	California	12-State Median	Percent Difference
Physician	11.6	7.8	49%
Chiropractor	34.1	16.6	105
Physical or occupational therapist	17.0	12.2	39

Source: Workers' Compensation Research Institute, *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996–2000,* April 2003.

Note: Claims in 1999 and 2000 with more than seven days of lost work time (injury/industry mix adjusted).

Reductions in fee amounts do not necessarily reduce total medical costs. For example, WCRI's study shows that although California has lower fees than most other states in its study, it has a higher incidence of treatments or visits. The study demonstrated that seemingly typical payments per claim to physical or occupational therapists in California tend to mask more frequent visits and lower per-service prices, as shown in Table 6.

TABLE 6

Breakdown of California's Payments and Visits Per Claim for Physical Therapists and Occupational Therapists in 1999 and 2000 Compared to a 12-State Median

	California	12-State Median	Percent Difference
Average payment per claim	$1,298	$1,290	0.6%
Visits per claim	17	12.2	39.0
Average price per service	$25	$35	-29.0

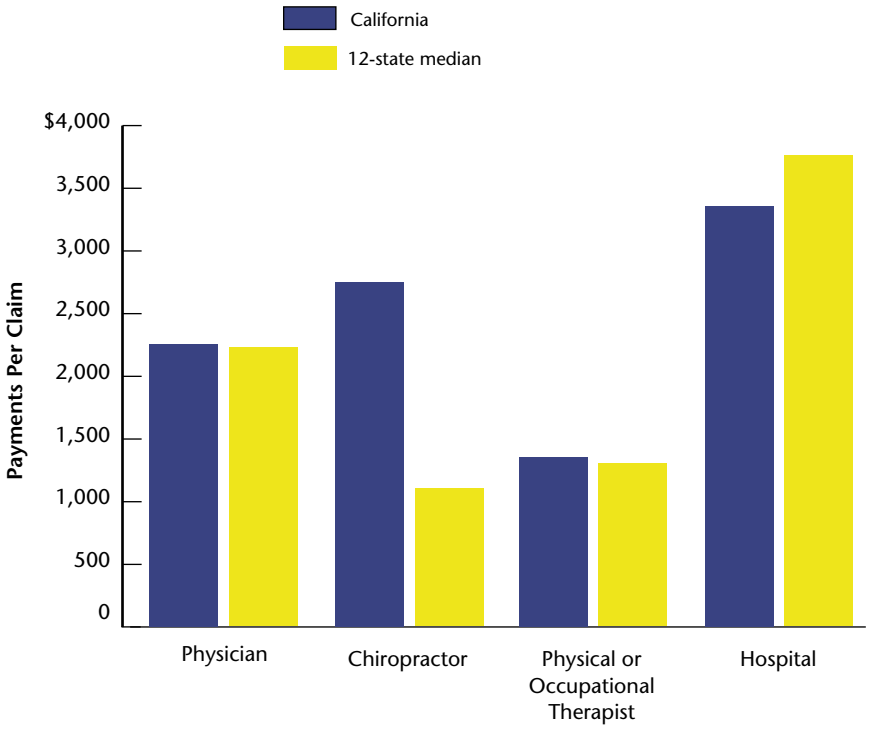
Source: Workers' Compensation Research Institute, *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 1996–2000,* April 2003.

Note: Claims in 1999 and 2000 with more than seven days of lost work time (injury/industry mix adjusted).

Demonstrating that frequency and appropriateness of care (utilization), as well as the cost per service or treatment, drive total costs, Figure 7 shows that chiropractors in California receive higher payments per claim than in other states.

FIGURE 7

Payments Per Claim in 1999 and 2000 Compared to a 12-State Median



Source: Workers' Compensation Research Institute, *How California's Medical Costs and Utilization Compare to Other States, Preliminary Results.*

Note: Claims in 1999 and 2000 with more than seven days of lost work time (injury/industry mix adjusted).

Research Sponsored by the Administrative Director Reveals the Weaknesses in the System's Utilization Controls

During 2001, the division released two reports that revealed inefficiencies and ineffectiveness in the system's processes for controlling treatment utilization. The first report, *Utilization Review in California's Workers' Compensation System: A Preliminary Assessment*, found that the utilization reviews that insurers and claims administrators perform to approve payment for the treatment of injured workers are inconsistent. The study analyzed utilization review plan summaries submitted

by 22 insurers and claims administrators, but it did not examine the actual operational practices of utilization review organizations, provide extensive detail on their policies or procedures, or measure the actual impact of utilization review on the outcomes of treatment. The division, along with the Public Health Institute, analyzed the utilization review plan summaries to learn more about utilization review practices in California's workers' compensation system.

This July 2001 study found little consistency in the methods used by insurers and claims administrators in reviewing proposed medical treatments for injured workers. For example, the study revealed that 20 of 22 payers reported using a total of eight different utilization review criteria developed by utilization review organizations, and one payer did not identify which criteria it used to judge the medical necessity of proposed treatments of injured workers. Almost one-third of the insurers and claims administrators responding to the study reported that they used more than one set of criteria but did not specify their methodology for selecting which criteria to use in a particular case.

The lack of consistency in utilization reviews has led to confusion and difficulty among medical providers, insurers, and claims administrators over the appropriate medical treatment for injured workers. For example, the researchers asked presiding judges in three division district offices to pull cases in which expedited hearings had been requested in the previous several months. In certain circumstances, the parties involved in a dispute over workers' compensation cases can request that the local workers' compensation court decide their case in an expedited manner—that is, with priority over other cases—to facilitate prompt resolution of disagreements over the different aspects of a case, such as the amount of disability indemnity payments or type of medical treatment. The researchers reviewed 64 such cases and found that for 77 percent the parties had requested an expedited hearing because of disputes over medical treatment. However, according to the commission's annual report for fiscal year 2001–02, no local workers' compensation court hearings, including expedited hearings, occurred within the statutorily required time frame. These facts illustrate the magnitude of the opportunities for, and the delays in resolving, disagreements over necessary medical treatment for injured workers in the absence of standardized utilization guidelines.

The lack of consistency in utilization reviews has led to confusion and difficulty among medical providers, insurers, and claims administrators over the appropriate medical treatment for injured workers.

In November 2001, the division and the Public Health Institute released a report on a focus group study aimed at improving the quality of care for injured workers. This report was based on interviews with participants in the system, including injured workers, employers, physicians, nurse case managers, claims administrators, attorneys, and workers' compensation administrative law judges. The report anecdotally described problems these participants had encountered with the workers' compensation program, including issues related to treatment utilization guidelines. For example, claims administrators and employers were most often troubled by ongoing treatment, especially chiropractic care and procedures performed without the active participation of the therapist, such as traction or electrical stimulation, in light of minimal improvement in a worker's health status or work function. On the other hand, the groups were also concerned about the underutilization of appropriate care. The overuse of narcotic medication was also a special concern of the focus groups.

Physicians, workers, attorneys, judges, and nurse case managers all complained of problems with the utilization review process for authorization of recommended treatment, specialist referrals, or diagnostic testing. While physicians said that the utilization review process affords some protections, they felt that the process is often ignored by claims administrators who continue to insert themselves into the authorization process in spite of regulatory requirements for physician review. Physicians and workers also reported that weeks sometimes pass before a response is received for a treatment authorization request. Physicians, nurse case managers, and attorneys also perceived difficulties with denial of referrals for psychological or psychiatric treatment for depression. They claimed that even when physicians recognize that such referrals may significantly improve the outcome of a case, claims administrators often seem reluctant to approve them for fear of accepting liability for a stress claim.

Physicians, workers, attorneys, judges, and nurse case managers all complained of problems with the utilization review process for authorization of recommended treatment, specialist referrals, or diagnostic testing.

Employers, claims administrators, and nurse case managers who participated in the focus group study saw few remedies available for inappropriate or prolonged treatment. They were skeptical of the usefulness of seeking recourse through the appeals board. Some judges included in the study indicated that they feel uncomfortable about making medical treatment decisions because of their lack of medical knowledge and training. Some thought it would be helpful if judges received medical training or had access to a medical information system

from which they could retrieve basic medical information about procedures to help them make informed decisions. The judges stated that they currently just rely on the treating physicians or look for weaknesses in the medical reports presented. Claims administrators were also unhappy that the utilization review record is not admissible before the appeals board, so that even an evidence-based decision on utilization review may not influence a judge's determination. We discuss this issue further in the next section. The focus groups also complained about physicians who are unfamiliar with the workers' compensation system and acknowledged the need for more training in this area.

The Current Legal and Regulatory Structure for Utilization Review Is Ineffective

Treatment utilization reviews are currently ineffective in promoting prompt delivery of necessary treatment and aiding in the quick resolution of disputes over necessary medical treatment. There are two primary reasons for this ineffectiveness. The most important one is that under current law, utilization reviews performed by insurers or claims administrators are generally not admissible as evidence in cases brought before the workers' compensation judicial system. To be admissible as evidence, a decision reached through a utilization review would need to be supported by a report from a physician performing an examination of the injured worker—a level of review not typically used by insurers and claims administrators when approving payment for treatment. As such, utilization reviews are given little weight in disagreements between providers and payers over proposed treatment of injured workers, and they are given no weight should the dispute go to the workers' compensation judicial system for resolution.

To be admissible as evidence, a decision reached through a utilization review would need to be supported by a report from a physician performing an examination of the injured worker—a level of review not typically used by insurers and claims administrators when approving payment for treatment.

Another provision of the law requires that the administrative director provide standards for utilization review. Specifically, the law requires the medical council, in coordination with the administrative director, to adopt guidelines for the treatment of common industrial injuries. The law also requires the administrative director to adopt model utilization protocols in order to provide utilization review standards, and it requires all insurers to comply with these protocols. However, the regulations adopted by the former administrative director do not establish utilization review standards based on utilization protocols but instead allow insurers to establish their own unique utilization review plans so long as they maintain, and

We believe that the division's regulations fail to achieve the objective of using utilization reviews to contain medical costs.

make available, written summaries of the plans that describe the review processes, criteria used, and qualifications of the personnel who develop and review criteria. The regulations also require insurers that implement or maintain a utilization review system to advise the administrative director of the date the system will be operational. If the administrative director discovers that an insurer has implemented or maintained a system that does not comply with these regulations, the administrative director is to notify the insurer in writing of the finding and allow the insurer up to 90 days to correct the deficiency. We believe that the regulations fail to achieve the objective of using utilization reviews to contain medical costs.

According to the administrative director, the adoption of treatment guidelines by the medical council is not directly linked to his adoption of utilization review protocols. The administrative director interprets the statute to mean that those insurers performing utilization reviews must comply with the division's regulations on utilization review standards, but it does not mandate that all carriers conduct utilization reviews. In addition, the administrative director stated that he does not believe he has the statutory authority to make utilization reviews mandatory for insurers.

Moreover, beyond merely adopting treatment guidelines as called for in the law, according to its executive medical director, the medical council has developed treatment guidelines and has recently voted to review the medical evidence on treatment and utilization and to update its guidelines, an enormous task that will consume significant resources. The executive medical director stated that the medical council's treatment guidelines have an advantage in that they cover all physician groups that practice in California's workers' compensation system. However, the law does not charge the medical council with developing treatment guidelines, but rather it states that it should measure and monitor changes in the cost and frequency of the most common medical services and, in coordination with the administrative director, adopt treatment guidelines for the most common industrial injuries. Currently, there are various private and public entities that develop treatment guidelines that might be a viable option to developing the State's guidelines.

The medical council's executive medical director stated that she is not aware of any existing treatment guidelines that cover all physician groups that practice in California's workers' compensation system. She further stated that independent

agencies have not kept their guidelines current and cannot be directed to update guidelines on a regular basis. Although we did not verify how current or complete they are, our brief search identified two independent sources of treatment guidelines, with one indicating that it updates its guidelines annually, in addition to the seven sources of treatment guidelines identified as being used by workers' compensation insurers by the Public Health Institute in its July 2001 report on the utilization review practices.

We question whether the medical council is the entity that can most effectively develop treatment guidelines without giving the appearance that it could be influenced by the extent to which the guidelines may adversely affect the financial interests of the medical community.

Given its membership, we question whether the medical council is the entity that can most effectively develop treatment guidelines. Currently, the law requires that the medical council be made up of members of the medical community that would be subject to the treatment guidelines, and the members maintain liaisons with the medical, osteopathic, chiropractic, psychological, and podiatric professions. Thus, it would be difficult for the medical council to avoid the appearance that it was being influenced by the extent to which the guidelines may adversely affect the financial interests of the medical community.

Enacted Legislation Requires a Study of Utilization Controls

Legislation enacted in 2002 (Chapter 6, Statutes of 2002), requires the administrative director, in consultation with the commission and the medical council, to conduct a study of medical treatment provided to workers who have sustained industrial injuries. The study is to focus on issues such as physician utilization, quality of care, and outcome measurement data. According to the law, the study is to begin no later than July 1, 2003, with a report and recommendations due to the Legislature by July 1, 2004. The administrative director indicated that the study will begin when the funds required to pay for it are appropriated through the annual budget process. Once funding is provided, the commission estimates that it will take up to three months to consult with the other involved parties, health care experts, and researchers to determine what information needs to be captured and analyzed, and at least another year to gather information and conduct adequate research. The 2003–04 Budget Act provides funding for the study.

The commission favors a survey and evaluation of existing medical treatment utilization standards in other states, at the national level, and in other medical benefit systems, leading to recommendations to the administrative director for the

The commission believes that in judicial proceedings the treatment standards should be the treatment presumed to be correct for workers' injuries. However, that presumption would be rebuttable if the weight of medical opinion was that a departure from the standards was necessary to provide treatment reasonably required by the injured worker.

adoption of a medical treatment utilization schedule. The treatment utilization schedule should address, at a minimum, the frequency, duration, level, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases, and the elements of the current standards of care. The commission also believes that in judicial proceedings the treatment standards should be the treatment presumed to be correct for workers' injuries; however, that presumption would be rebuttable if the weight of medical opinion was that a departure from the standards was necessary to provide treatment reasonably required by the injured worker.

The Lack of Standardized Treatment Guidelines Contributes to an Inefficient Dispute Resolution Process

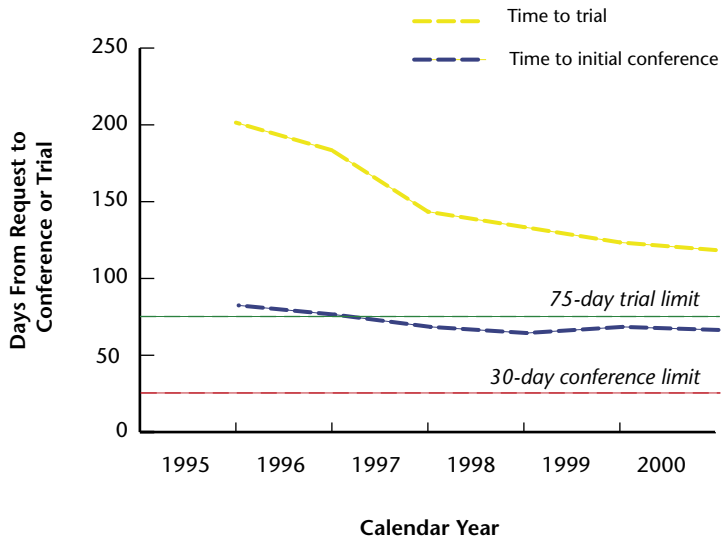
A lack of effective utilization controls can lead to disputes between medical service providers and the insurers and claims administrators who approve the payments for those services. However, the system does not have an expedient process for resolving disputes. Currently, disputes between the providers of medical services and the insurers or claims administrators (payers) are resolved by reaching a consensus as to what medical procedures are necessary to treat injured workers. However, as we discussed previously, payers can employ utilization review criteria from a variety of sources, and the workers' compensation system does not have an efficient process to reconcile those differences in judgments regarding the treatment required for an injured worker.

When providers and payers cannot agree on the proper medical treatment, the dissatisfied parties can take their case through several progressions to attempt to resolve the dispute. After negotiations and necessary paperwork, the first step is a mandatory settlement conference conducted by the workers' compensation judicial process. If the conference is not successful, the second step is a trial conducted by a workers' compensation administrative law judge. The last step in resolving a dispute would be to take it to the appeals board. This lengthy dispute resolution process results in delays in providing treatment to workers and prolongs the time that workers remain on disability. According to a 2003 study conducted by RAND's Institute of Civil Justice, nearly 20 percent of workers' compensation claims filed in California result in disputes that enter the judicial process.

California state law requires the courts to adhere to two specific time limits within the dispute resolution process: to hold an initial mandatory settlement conference within 30 days from the time a party asks to have the case placed on the trial track for dispute resolution, and to hold the trial within 75 days of the party's request. However, RAND's study found that the time it takes to hold the settlement conference and convene the trial following the initial request is much longer than the period allowed by law, as demonstrated in Figure 8.

FIGURE 8

Average Time to Settlement Conference and Trial 1995 Through 2000



Source: RAND Institute for Civil Justice, *Improving Dispute Resolution for California's Injured Workers,* 2003.

The study found wide variation in judicial actions prior to trial, including the standards used to decide whether proposed settlements comply with the law. Often there was no clear or unambiguous guidance on the proper course of action in a case. RAND reported that the appeals board procedures throughout the State are not consistent, partly because the laws governing the appeals board are so complex, and there are numerous delays in resolving disputes. RAND concluded that although the number of days to trial has improved since 1995, the reason for that improvement is primarily a decline in the number of new case filings from the peak numbers reached in the early 1990s, rather than more efficient practices. ■

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CHAPTER 2

Proposed Changes to the Medical Payment System May Control Fees for Medical Services and Products but Do Not Ensure Lower Overall Medical Costs

CHAPTER SUMMARY

Currently, there are at least two proposals for improving the controls over medical costs in the workers' compensation system. The administrative director of the Department of Industrial Relations' (Industrial Relations) Division of Workers' Compensation (division) has posted on the division's Web site for public comment a draft proposal to implement a fee schedule only for physician services that is based on the resource-based relative value scale (RBRVS) used and maintained by the federal Centers for Medicare and Medicaid Services (CMS), after changes in practice are identified by the American Medical Association (AMA). The administrative director's draft proposal is to compensate physicians for the additional work involved in evaluating and managing workers' compensation cases by applying adjustment factors to the relative value units (RVU) established by the CMS. The administrative director plans to implement the new fee schedule by July 1, 2004.

The Commission on Health and Safety and Workers' Compensation (commission) favors a medical payment system that is based on the Medicare and Medi-Cal fee schedules and updates (Medicare/Medi-Cal type payment system) for all medical services and products needed to treat injured workers. In its April 2003 report, the commission proposed fee schedules that are 120 percent of the Medicare fee schedules for medical services and products and a fee schedule for pharmaceuticals that is 100 percent of the Medi-Cal fee schedule for pharmaceuticals.

Converting to a Medicare-based payment system, in whole or in part, has advantages and disadvantages. The Medicare fee schedule for physician services is based on the resources needed to provide those services and, as such, is viewed by health care

researchers as much more effective in containing medical costs than a fee schedule that is based on the amounts charged for services. An added beneficial feature of the fee schedules used in the Medicare program, including the one for physician services, is that the CMS regularly updates the schedules to reflect new procedures and changes in medical technology and practice. In addition, the Medicare payment system has already been exposed to public scrutiny and validation through the process used to design and update the relative value scales that are the basis of the physician services fee schedule part of the system.

However, a conversion from the current payment system, which is based on historical charges, to one that is based in part on a scale of the relative values of various physician services creates controversy among those providers who might be negatively affected by the changes in the fee amounts.

The commission has estimated that the workers' compensation system would save at least $964 million in 2004 if it implemented its proposed Medicare/Medi-Cal type payment system. The commission calculated these savings using estimates of the costs necessary to satisfy current and future claims. However, the estimates are based on assumptions and projections using findings from other research studies, and we could not independently verify the estimates because the commission does not maintain the source data used to calculate the savings. Therefore, we offer no opinion on the validity of the commission's estimated savings from implementing its proposed Medicare/Medi-Cal type payment system.

Moreover, numerous studies have indicated that fee schedules alone do not ensure effective containment for medical costs. In fact, these studies have shown that some states with relatively low fees for services have some of the highest average medical costs per claim. According to the research, control over treatment utilization is essential to controlling total medical costs. In addition, adopting all of Medicare's ground rules may increase the administrative costs of California's workers' compensation system, and some of the ground rules may not be applicable in a workers' compensation setting.

THE ADMINISTRATIVE DIRECTOR IS PROPOSING A PAYMENT SCHEDULE FOR PHYSICIAN SERVICES THAT IS BASED ON A VARIATION OF THE MEDICARE PAYMENT SYSTEM

The division's administrative director is proposing to convert the current payment system for physician services, part of the Official Medical Fee Schedule (OMFS), to one that is based on a variation of the federal Medicare payment system. As we discuss later in this chapter, the Medicare payment system for physician services is based on an index determined by the estimated resources needed to provide various services relative to a common service that is used as a baseline. This index is known as the RBRVS. The value for each service in the RBRVS is multiplied by a determined dollar amount (conversion factor) to arrive at the fee for that service. The administrative director's proposal would affect only the physician fee schedule, without altering the schedules for other services and products such as hospital inpatient services or pharmaceuticals. According to an analysis performed for the division by the Lewin Group, this proposal would raise the total payments to physicians and other medical professionals by 7 percent to compensate physicians for the additional evaluation and management work identified by the Lewin Group as necessary for workers' compensation cases. This increase would be the equivalent of 123 percent of Medicare's payments for similar services, based on calculations performed by the commission.

Key Components of Evaluation and Management Services

- Patient history
- Physical examination
- Medical decision making
- Coordination of care
- Nature of presenting medical problem
- Duration of treatment

In May 2003, the division posted on its Web site proposed draft rules for the OMFS revision involving the transition of the physician services fee schedule to a schedule using relative values. According to the division, the draft proposed rules are the first formal step in the OMFS revision, which is due to become effective on July 1, 2004, for services occurring on or after April 1, 2004. The act of posting the draft proposed rules on the division's Web site is designed to solicit opinions and feedback from the public. According to the division's timeline, once public input has been gathered, the OMFS rules will be redrafted and posted for additional comment beginning in August 2003, to be followed by a further analysis of the economic effects of migrating to the RBRVS.

The Industrial Medical Council (medical council) began exploring the feasibility of using the RBRVS for workers' compensation in the late 1990s, when it commissioned a report

by researchers from the University of California, Los Angeles, *The Use of Relative Value Scales for Provider Reimbursement in State Workers' Compensation Programs*. After the report was published in August 1999, the medical council hired a health care consultant, the Lewin Group, to conduct a series of studies to analyze how the relative values that determine the fees for different medical specialty services in Medicare's RBRVS payment system would have to be adjusted to accommodate the needs of the workers' compensation system and to analyze the economic effects of adopting the RBRVS in California.

The Lewin Group has determined that evaluation and management services for workers' compensation patients require 28 percent more resources than are assigned under Medicare's payment system for physician services.

In its reports, the Lewin Group determined that evaluation and management services for workers' compensation patients require 28 percent more resources than are assigned under Medicare's RBRVS. They reported that these services are central to the physician-patient relationship and include key components of the care provided by the physician. The Lewin Group also calculated the increases needed in the fees for evaluation and management services to compensate for the additional work involved in providing these services to injured workers. They determined that a budget-neutral move from the current OMFS to the RBRVS would increase total evaluation and management fees by 23 percent. After adjusting the RBRVS for the additional physician work and practice expense associated with workers' compensation cases, the Lewin Group calculated that an additional 29 percent increase would be needed in evaluation and management fees, resulting in an overall increase in payments to physicians of 7 percent.

As we describe later in this chapter, one main objection from some physicians to converting to an RBRVS-based payment system is the fact that the RBRVS distributes payments differently among medical specialty groups than the traditional charge-based payment systems do. That is, some groups, such as general and family practice, would receive higher payments than they have historically enjoyed, while others, including certain types of surgeons, would experience large decreases in payments. In its May 2003 preliminary report, the Lewin Group calculated relative values that it claims will increase payments for the additional physician work and practice expense associated with evaluation and management services required to treat injured workers without adversely affecting reimbursements for other services.

In spite of the Lewin Group's claim that a projected 7 percent increase in overall payments to physicians would not adversely affect payments to other medical specialties, the redistribution of payments that would occur is a major barrier in gaining support from the physician community for a system which measures the resources needed to provide medical services.

In spite of its claim that a projected 7 percent increase in overall payments to physicians would not adversely affect payments to other medical specialties, the redistribution of payments that would occur under an RBRVS payment system is a major barrier in gaining support for the RBRVS system from the physician community. In fact, responses to the division's posting of the proposal on the division's Web site have expressed dissatisfaction and predictions of decreased access to care from some of the medical specialists who will receive decreased payments for their services under the proposed payment system. Moreover, the administrative director stated that he does not know whether the fees in the proposed schedule will be adequate to ensure access to quality care, and he added that the providers, such as surgeons, who will experience a drop in payments will not think the fees are adequate. Table 7 on the following page shows how the Lewin Group projects that a conversion to an RBRVS-based physician fee schedule will redistribute payments among physician treatment specialties.

Other components of the administrative director's proposed draft rules for the OMFS include a discussion of the conversion factor needed for the RBRVS physician fee schedule to keep total payments at the same level as those under the current OMFS. The division says that it intends to adopt a single conversion factor. It is also considering whether to adopt a transition period in which to migrate from the OMFS to the RBRVS, to ease the financial impact of the redistribution effect, recognizing that a transitional period also entails possible administrative burdens and increased complexity. The division is seeking public input about the advisability of having a transition period and what its length should be. Finally, the proposed rules consider and ask for public input on whether to adopt an automatic annual update of the conversion factor to reflect inflation in costs, and for input on the index to be used in such a process.

THE COMMISSION PROPOSES LINKING WORKERS' COMPENSATION FEE SCHEDULES TO MEDICARE AND MEDI-CAL FEE SCHEDULES

In contrast to the administrative director's proposal to convert only the fee schedule for physicians to a variation of the Medicare physician fee schedule, the commission has recommended that California consider linking its entire workers' compensation medical payment system to Medicare's fee schedules for medical services, equipment, and products and to

TABLE 7

Impact of a Conversion to the RBRVS on Physicians by Specialty, Assuming an Adjustment for Evaluation and Management Services

Specialty	Amount Paid Under OMFS (October 2002)	Amount Paid Under Adjusted RBRVS	Estimated Impact of Adjusted RBRVS
Clinics, groups, associations	$48,092,856	$54,644,517	13.6%
General practice	25,590,462	27,463,633	7.3
Chiropractors	25,131,738	24,962,606	-0.7
Orthopedic surgery	16,679,373	17,428,149	4.5
Hospitals (nursing homes/convalesence)	14,208,676	15,595,664	9.8
Physiotherapists	13,435,777	13,330,294	-0.8
Radiology x-rays	10,765,802	10,860,977	0.9
Anesthesiology	6,828,515	6,690,744	-2.0
Physical medicine and rehabilitation	6,747,566	7,009,024	3.9
Psychologists	2,963,704	3,675,626	24.0
Occupational medicine	2,195,562	2,636,903	20.1
Neurology	1,741,355	1,586,706	-8.9
Neurological surgery	1,345,492	1,045,370	-22.3
Acupuncture	942,635	968,748	2.8
Psychiatry	900,744	1,090,768	21.1
General surgery	793,163	791,129	-0.3
Dermatology	792,190	845,614	6.7
Cardiovascular disease	755,983	691,768	-8.5
Internal medicine	584,372	628,510	7.6
Otorhinolaryngology	474,017	386,261	-18.5
Laboratories	448,350	513,222	14.5
Osteopathy	413,877	515,277	24.5
Family practice	380,803	511,099	34.2
Hand surgery	376,176	427,682	13.7

Source: Lewin Group study prepared for the Industrial Medical Council: *Study of the Practice Expenses Associated With the Provision of Evaluation and Management Services,* (draft) May 2003.

Note: Based on a sample of 116,548 workers' compensation claims for calendar year 2000.

Medi-Cal's fee schedule for pharmaceuticals. In an April 2003 report, the commission proposed a change to the workers' compensation medical payment system that is intended to simplify the system and provide administrative efficiency, stating that the current system is unnecessarily complex, costly, and difficult to administer. The report stated that linking

The commission's April 2003 report proposed a change to the workers' compensation medical payment system intended to simplify it and provide administrative efficiency, stating that the current system is unnecessarily complex, costly, and difficult to administer.

existing workers' compensation fee schedules in this way and instituting new fee schedules for those medical services that are not currently regulated would reduce medical costs and increase savings to employers in the State. The projected savings in the commission's report would result from setting the maximum fee for medical services, including facility fees and products, at a maximum of 120 percent of the applicable Medicare fee schedule, except for pharmaceuticals, for which the maximum would be set at 100 percent of the fees allowed under the Medi-Cal system.

THE MEDICARE PAYMENT SYSTEM CONTROLS THE PAYMENTS FOR MEDICAL SERVICES THROUGH THE USE OF FEE SCHEDULES AND PAYMENT SYSTEMS

The federal Centers for Medicare and Medicaid Services (CMS) administer the federal Medicare program. Medicare covers nearly 40 million Americans and costs just under $200 billion per year. It provides health insurance to people 65 and older, to some people with disabilities under age 65, and to people with permanent kidney failure requiring dialysis or a transplant. Payments for Medicare services are determined by fee schedules and prospective payment systems. In particular, payments to physicians are determined using the Medicare Physician Fee Schedule, and hospitals are paid for services to inpatients and outpatients in a hospital setting using the Hospital Inpatient Prospective Payment System (inpatient payment system) and the Hospital Outpatient Prospective Payment System (outpatient payment system), respectively. In addition to these fee schedules and payment systems, Medicare uses the Ambulatory Surgical Center Fee Schedule to set rates for nonhospital outpatient surgical facilities.

Medicare also has fee schedules and payment systems that cover a variety of other services, including, but not limited to, ambulance service, home health care, and skilled nursing facilities. Because payments to physicians, hospitals, outpatient surgical facilities, and pharmaceuticals make up the majority of California's workers' compensation medical costs, we limit our discussion to these groups.

Medicare's Physician Fee Schedule Is Based on the Resources Required to Provide Services Rather Than Amounts Charged

Prior to 1992, Medicare reimbursed physicians according to usual, customary, or reasonable charges. Physician payments were the lower of (1) the physician's actual charge, (2) the

Responding to concerns that payments based on usual, customary, and reasonable charges were inflationary, Congress provided funding to Harvard's School of Public Health to conduct a study to establish an objective basis from which physician fees could be determined—the result was the resource-based relative value scale (RBRVS), which measures the resources needed to provide medical services.

physician's customary charge, or (3) the prevailing charge in the area for similar services. However, concern from policymakers and researchers in the 1970s and 1980s that this payment method was inflationary because it was based on how much medical providers charged for their services prompted Congress to provide funding to Harvard's School of Public Health to conduct a study of physician payments. The goal of this research was to establish an objective basis from which physician fees could be determined. As a result, a team of researchers developed the RBRVS, which measures the resources needed to provide medical services. In 1989, Congress passed the Omnibus Budget Reconciliation Act, which created a fee schedule that applies this scale to physician services. In 1992, the CMS began phasing in the Medicare Physician Fee Schedule (physician fee schedule), based on the RBRVS. Payments under the physician fee schedule are made up of three components: the level of effort required by a physician to perform a specific service, the indirect operating cost or overhead of the physician's practice, and malpractice costs that are allocable to providing the service. For a detailed discussion of how the RBRVS was developed, see Appendix A.

The Medicare Payment System for Inpatient Services Uses Diagnosis-Related Groups to Determine Payment Rates

Medicare reimburses hospitals for the cost for inpatient services using the inpatient payment system. Inpatient services are the facilities and care provided to workers whose injuries or illnesses are severe enough that the worker must be admitted to a hospital for treatment. Under the inpatient payment system, cases are categorized into diagnosis-related groups (DRGs) that cluster injuries or illnesses together according to similar clinical problems that are expected to require similar amounts of hospital services. Hospitals are paid predetermined rates for treating patients, according to the DRG to which the injury or illness is assigned. Each DRG has a payment weight assigned to it, based on the average resources needed to treat patients in that particular DRG.

Hospital payments under the inpatient payment system are determined using a base payment rate for each DRG, consisting of a standardized amount that is made up of labor and nonlabor components. These components are adjusted by a variety of factors. For example, the labor component is adjusted to reflect the prevailing wages in the area in which

the hospital is located. The nonlabor component is also adjusted by a cost-of-living factor if the hospital is located in Hawaii or Alaska. The hospital's payment is then determined by multiplying the DRG's relative weight by the base rate. Medicare makes additional adjustments for hospitals that serve a disproportionate share of low-income patients, for teaching hospitals, and for cost outlier cases.

Medicare makes outlier payments to provide incentives for hospitals to treat complicated and more costly injuries and illnesses. It identifies cost outlier cases by comparing the estimated costs for a case against the standard payment for the service plus a fixed loss threshold known as the cost outlier threshold. To qualify as a cost outlier case in federal fiscal year 2003, a hospital's charges for a case must exceed the payment rate for the DRG by the cost outlier threshold of $33,560. In such cases, Medicare pays the hospital 80 percent of the difference between the hospital's estimated cost for the stay and the sum of the standard DRG payment and the outlier threshold amount. To determine the estimated costs for the case, Medicare's fiscal intermediaries multiply a hospital's charges by a percentage that is intended to represent the hospital's costs to provide the services—the cost-to-charge ratio. The cost-to-charge ratios are derived from cost reports provided by the hospital; either the most recently settled cost report or the most recent tentatively settled cost report.

To qualify as a Medicare cost outlier case in federal fiscal year 2003, a hospital's charges for a case must exceed the payment rate for the diagnosis-related group by the cost outlier threshold of $33,560.

The Medicare Payment System for Outpatient Services Uses Ambulatory Payment Classifications and Ambulatory Surgical Center Rates

Medicare uses the outpatient payment system and Ambulatory Surgical Center (ASC) rates to determine reimbursement amounts for facilities that treat patients on an outpatient basis. Patients are treated on an outpatient basis when their injuries or illnesses are not so severe that they must be admitted to a hospital for treatment. The outpatient payment system was mandated by Congress as part of the Balanced Budget Act of 1997 and went into effect August 1, 2000. According to the CMS, prior to August 1, 2000, Medicare used a number of different methods to determine payment for services performed in a hospital outpatient setting. However, for most services, Medicare paid 80 percent of allowed charges, which were based on historical cost data.

Outpatient procedures performed by hospitals are categorized by the outpatient payment system into 569 procedure groups, called Ambulatory Payment Classifications (APC). Services that are grouped within the same APC are similar and require a similar level of resources. In 2003, the APC rates are being set for the first time using actual data from claims submitted by hospitals. In addition, the CMS has increased the percentage of claims used to set the relative weights for APCs from roughly 40 percent in 2002 to more than 80 percent in 2003.

Under the outpatient payment system, the CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC is assigned a payment weight. An APC's weight represents the median hospital cost of the services included in that APC relative to the median hospital costs of the services included in a base APC—the one for mid-level clinic visits. The APC weights are scaled to this APC because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting. The APC payment rates are calculated and adjusted nationally for wage differences in different geographic locations. The federal Balanced Budget Refinement Act of 1999 requires annual updates of the APC payment weights, rates, payment adjustments, and APC groups.

The CMS pays for services provided by a nonhospital outpatient surgical center or other nonhospital setting using its ASC rate. There are nine ASC categories, each with its own rate. Medical procedures are grouped into these nine categories. The Social Security Act requires that the list of approved procedures be reviewed and updated at least every two years.

Under Medicare, the standard payments for medical procedures provided in ambulatory service centers takes into account the cost of each procedure. Standard payments have been established for nine categories of medical procedures.

The CMS determines the standard ASC payment rates by taking into consideration the costs incurred by ambulatory surgical centers in connection with performing certain procedures. In order to estimate the amounts, the CMS surveys the audited costs incurred by a representative sample of facilities in connection with a representative sample of procedures every five years. Ambulatory surgical centers receive Medicare payments equal to 80 percent of the rate assigned to each group. Part of the federal Benefit Improvement and Protection Act requires that payment rates effective January 2003 be based on a survey of ambulatory surgical centers conducted after 1999. The CMS has therefore developed an ASC survey instrument. However, the CMS states that completion of the survey, followed by an audit of the data reported by ambulatory surgical centers

and the compilation of cost data upon which to base ASC payment rates, will take at least two years. The CMS recognizes that it is not in compliance with the federal act.

THE MEDI-CAL REIMBURSEMENT SYSTEM USES VARIOUS MEANS TO CONTROL THE COST OF PHARMACEUTICALS

Proposed changes to the workers' compensation medical payment system involve the use of the Medi-Cal payment system for pharmacy services and drugs. California's Medicaid program, Medi-Cal, pays for a variety of medical services for children and adults with limited income and resources. The program is supported by both federal and state funds. In addition to the basic services provided by Medicaid, states may opt to receive federal funding if they elect to provide other optional services. Those services include payments for prescription drugs.

One of the ways Health Services controls the cost of pharmaceuticals under the Medi-Cal program is through the use of its drug formulary—a list of drugs, known as the contract drug list, that a physician can prescribe and for which a pharmacy can seek reimbursement without first obtaining approval from Health Services.

The Department of Health Services (Health Services) is responsible for administering the Medi-Cal program, and as part of that program, it has chosen to provide prescription drug benefits. One of the ways Health Services controls the cost of pharmaceuticals under the Medi-Cal program is through the use of its drug formulary—a list of drugs, known as the contract drug list, that a physician can prescribe and for which a pharmacy can seek reimbursement without first obtaining approval from Health Services.

The law also directs Health Services to contract with drug manufacturers and to negotiate to obtain discount prices that are at least comparable to the prices offered to other high-volume purchasers of drugs. One aspect of negotiating lower prices is obtaining rebates from drug manufacturers that seek to have their drugs added to the State's contract drug list. This type of discount from drug manufacturers is known as a supplemental rebate. When determining whether to place a drug on the Medi-Cal contract drug list, Health Services evaluates the drug using five criteria: safety, efficacy, essential need, potential for misuse, and cost of the proposed drug. Once Health Services decides to place a drug on the contract drug list, Medi-Cal pays for the drug using the lowest of three predetermined reimbursement rates. According to Health Services, Medi-Cal pays for most of the drugs at the average wholesale price less 10 percent, plus a dispensing fee and less

any rebates from the drug's manufacturer. The average wholesale price is the price assigned to the drug by its manufacturer and is compiled by commercial organizations such as First DataBank.

USING MEDICARE PAYMENT SYSTEMS FOR WORKERS' COMPENSATION HAS ADVANTAGES AND DISADVANTAGES

Many entities have studied the effects of implementing an RBRVS-based payment system in California's workers' compensation system.

Due to the varying interests of the physicians, employers, insurers, and injured workers that participate in the workers' compensation system, there will always be advantages and disadvantages, proponents and opponents, to any payment system for a mandatory program such as this one. Many entities have studied the effects of implementing an RBRVS-based payment system in California's worker's compensation system. For example, the medical council and the commission have engaged research groups to study various aspects of workers' compensation. These research groups include the Lewin Group and the University of California, Los Angeles (UCLA), Center for Health Policy Research, which reported on the potential effect an RBRVS-based payment system might have on California's workers' compensation system. The commission hired a health policy expert from RAND to analyze how implementing the Medicare payment system would affect the workers' compensation system. In addition, the Workers' Compensation Research Institute (WCRI), an independent research organization, has conducted national studies on policy issues involving a number of states' workers' compensation systems.

Researchers Have Identified Advantages to Implementing an RBRVS-Based Payment System

Studies conducted by the Lewin Group, the UCLA Center for Health Policy Research, RAND, and the WCRI address the advantages and disadvantages of adopting Medicare's RBRVS-based physician fee schedule for California's workers' compensation system. These studies found several advantages to adopting a fee schedule for workers' compensation based on Medicare's RBRVS system, as discussed in the sections that follow.

The RBRVS Is Based on the Resources Required to Provide Medical Services

One advantage identified by researchers is that the RBRVS reflects the cost of providing a given medical service. According to the Lewin Group, the RVUs of the RBRVS are intended to

reflect the amount of resources required to perform a medical procedure relative to a typical or average procedure. In contrast, the RVUs used in the California OMFS may not be representative of providers' relative costs because they are based on multiple sources, many of which are charge based.

The RBRVS tends to provide lower relative values for surgical procedures and higher relative values for medical practice evaluation and management services than fee schedules based on historical charging practices (such as the current OMFS). The Medicare RBRVS was designed to provide neutral financial incentives for providing different types of services by linking reimbursements to provider costs, eliminating what was thought to be an excessive incentive for providers of more costly surgical services relative to primary care services.

States that participated in the UCLA study reported that they adopted fee schedules based on relative value scales for two common reasons: to control costs and improve fairness by eliminating reimbursements based on billed charges, and to simplify the administration of workers' compensation by establishing a more rational, uniform system of billing and payment consistent with other major payers.

UCLA's Center for Health Policy Research contended that charge-based fee schedules are inflationary and provide an incentive for physicians to increase their charges. States that participated in the UCLA study reported that they adopted fee schedules based on relative value scales for two common reasons: to control costs and improve fairness by eliminating reimbursements based on billed charges, and to simplify the administration of workers' compensation by establishing a more rational, uniform system of billing and payment consistent with other major payers.

The Federal Centers for Medicare and Medicaid Services Updates the RBRVS Regularly

Congress mandated the CMS to update the physician fee schedule annually. Additions or changes to the Current Procedure Terminology codes that are adopted by the AMA prompt the CMS to update this schedule. The CMS is also charged with conducting a systematic review of the relative values for all physician services once every five years. The updates to the schedule are vetted by representatives from the medical community and Medicare staff in a public process.

These mandated updates are another major advantage of adopting Medicare's RBRVS fee schedule, according to the Lewin Group, UCLA's Center for Health Policy Research, and RAND. Specifically, RAND stated that having an established system for updates and maintenance for the RBRVS-based physician fee schedule is a major advantage. Much of the maintenance of the physician fee schedule is performed by the Medicare system,

Much of the maintenance of the physician fee schedule is performed by the Medicare system, and therefore other medical programs that choose to implement the Medicare physician fee schedule do not have to perform these updates.

and therefore other medical programs that choose to implement the Medicare physician fee schedule do not have to perform these updates.

In contrast, in payment systems such as those used in California's workers' compensation system, all maintenance of the fee schedules is borne by the administering agency. As we discussed in Chapter 1, the administrative director cited a lack of resources as the primary reason that the fee schedules making up the OMFS are outdated.

Medicare's RBRVS-Based System Was Exposed to Extensive Public Scrutiny and Validation and Is Adaptable to Other Systems

According to the Lewin Group, one of the benefits of the Medicare RBRVS is that it has gone through an extensive validation and public rule-making process. UCLA's Center for Health Policy Research stated that Medicare's RBRVS underwent extensive national review and scrutiny during the 1990s, with hundreds of published articles evaluating various aspects of the methodology. At the time of UCLA's 1999 study, 12 states had implemented physician fee schedules based on the RBRVS. Since then, the commission reported that an additional five states and the District of Columbia have implemented an RBRVS fee schedule. Texas adopted an RBRVS fee schedule in April 2002 and is in the implementation phase. As we discuss in Chapter 3, the states we contacted that have implemented the Medicare RBRVS payment system generally report that their objectives for adopting it have been met, although most report some challenges in implementing and administering the system.

The RBRVS was not designed to be Medicare-specific, so it can be used for other populations, such as the one covered by the workers' compensation system, according to the Lewin Group. The WCRI also stated that there is no indication that the RBRVS was designed or intended to apply only to the Medicare population.

A Payment System Based on the Medicare System Has Other Advantages as Well

The Lewin Group, UCLA's Center for Health Policy Research, RAND, and the WCRI all cited other advantages of adopting a payment system patterned after the one used by Medicare. The WCRI indicated that adopting Medicare's RBRVS-based physician fee schedule would provide administrative simplicity. According to UCLA's Center for Health Policy Research, one of the reasons that surveyed states adopted the RBRVS fee

schedules was to simplify the administration of their workers' compensation systems by establishing a more rational, uniform system of billing and payment consistent with those used by other major payers.

In addition, the formula that determines payment under the RBRVS adjusts for geographic differences in the costs of maintaining a physician practice. The Lewin Group and RAND indicated that California has nine different localities under Medicare, and thus Medicare already performs some of the work that would be needed to determine adjustments to payment amounts based on geographic location.

According to RAND, in addition to having an established system for updating and maintaining the physician fee schedule, Medicare has access to updated hospital cost data that are not available to the State, which it uses for its inpatient payment system. In addition, the cost outlier payment policy used in Medicare's outpatient payment system is revised annually to ensure that outlier payments are approximately 2 percent of total estimated payments.

According to RAND, in addition to having an established system for updating and maintaining the physician fee schedule, Medicare has access to updated hospital cost data, that are not available to the State, for its inpatient payment system.

RAND also stated that adopting Medicare's outpatient payment system would shift the administrative burden of maintaining and updating an outpatient fee schedule from the State to the CMS. This study pointed out that the Medicare outpatient payment system is already established and could be adapted for the workers' compensation system with fewer resources and in a shorter time frame than developing a fee schedule from workers' compensation-specific data.

Adopting the RBRVS for Workers' Compensation Also Has Some Disadvantages

Adopting a payment system designed for use in another medical care system also presents some issues that need to be addressed. One is how to mitigate the possible restrictions to access to services that the RBRVS system might create because of redistributing payments for services across the different medical specialties. Other issues include dealing with the complexities of the Medicare payment system so that federal policy issues that may be embedded in the system can be identified and adjusted to make the system better meet the needs of California. When Medicare makes its annual and five-year updates to the payment system, those updates will have to be evaluated to ensure they are appropriate for California's workers' compensation system.

The Relative Values in the Medicare Payment System Redistribute Payment Amounts Across Medical Specialties

Because the Medicare payment system and the Official Medical Fee Schedule currently used by California's workers' compensation system use different underlying approaches to determining payments, implementing the Medicare system will increase the payments to some physician medical specialties while reducing the payments to others.

Because the Medicare payment system and the OMFS currently used by California's workers' compensation system use different underlying approaches to determining payments, implementing the Medicare system will increase the payments to some physician medical specialties while reducing the payments to others. The Lewin Group, UCLA's Center for Health Policy Research, and the WCRI all indicated that adopting a fee schedule based on the RBRVS, without adjustment, would cause payment redistributions. For example, the Lewin Group conducted a study that modeled the OMFS after Medicare's RBRVS and assessed the proposed system's impact on providers while keeping the model budget neutral—that is, without increasing the overall costs to the system.

As shown in Table 8, the Lewin Group reported that among those physician specialty groups with total payments greater than $5 million, orthopedic surgeons, chiropractors, general practitioners, and anesthesiologists would experience the greatest loss in revenue due to a budget-neutral fee schedule based on the RBRVS. Medical clinics, groups, and associations would experience the greatest revenue increase under an RBRVS system.

TABLE 8

Financial Impact on Physician Specialty Groups With Payments Greater Than $5 Million

Specialty	Amount Paid Under OMFS	Amount Paid Under RBRVS	Percent Difference
Clinics, groups, associations	$ 48,092,856	$ 49,858,877	3.70%
General practice	25,590,462	24,839,718	-2.90
Chiropractors	25,131,738	24,339,469	-3.20
Orthopedic surgery	16,679,373	15,825,183	-5.10
Hospitals	14,208,676	14,513,384	2.10
Physiotherapists	13,435,777	13,283,073	-1.10
Radiology x-rays	10,765,802	10,811,919	0.40
Physical medicine and rehabilitation	6,747,566	6,893,501	2.20
Anesthesiology	6,828,515	6,656,046	-2.50
Totals	**$167,480,765**	**$167,021,170**	**-0.30%**

Source: Lewin Group study prepared for the Industrial Medical Council: *California Workers' Compensation RBRVS Study,* October 2002.

The Lewin Group found that physicians who evaluate workers' injuries through a review of their medical history and an examination, decide on a course of treatment, and manage the care the workers receive (evaluation and management services) would experience the largest revenue increase. As shown in Table 9, the researchers estimated that these services would experience a 22.9 percent increase if the physician fee schedule were modeled after the RBRVS. Excluding special OMFS services that are not subject to the RBRVS, surgical services would experience the greatest decrease in payments. The Lewin Group estimated that surgical services would experience a 15.8 percent decrease in payments if the physician fee schedule were modeled after RBRVS.

TABLE 9

Financial Impact of the RBRVS by Procedure Group Using a Single Budget-Neutral Conversion Factor

OMFS Category	Amount Paid Under OMFS	Amount Paid Under RBRVS	Dollar Difference	Percent Difference
Anesthesia	$ 6,145,869	$ 6,145,869	—	—
Evaluation and management	40,935,969	50,316,739	$9,380,770	22.90%
Surgery	42,098,904	35,432,041	(6,666,863)	-15.80
Radiology	24,523,624	24,341,127	(182,497)	-0.70
Pathology and laboratory	1,818,870	2,188,852	369,982	20.30
Medicine	13,155,808	12,375,410	(780,398)	-5.90
Special services (total)*	11,845,046	11,505,896	(339,150)	-2.90
Subject to RBRVS	396,042	56,892	(339,150)	-85.60
Pass throughs	11,449,004	11,449,004	—	0.00
Physical medicine	75,053,599	73,271,755	(1,781,844)	-2.40
Totals	**$215,577,690**	**$215,577,690**	**$ 0**	**0.00%**

Source: Lewin Group study prepared for the Industrial Medical Council: *California Workers' Compensation RBRVS Study,* October 2002.

Note: Estimated payments reported in this table reflect only the procedures included in the California Workers' Compensation Institute database, and are not an estimate of all workers' compensation payments in the State.

* Since most special service codes are paid using codes created by the State for California's workers' compensation services, the Lewin Group assumed payments would remain the same under the RBRVS and categorized them as "pass throughs." Many of those codes that are subject to the RBRVS were bundled into other codes in the Medicare RBRVS, and hence experienced significant payment decreases.

A Fee Schedule Based on the RBRVS Has Other Disadvantages for Workers' Compensation

UCLA's Center for Health Policy Research stated that any reduction in the State's administrative burden that would result from migrating to an RBRVS fee schedule based on the Medicare program would be offset by the increased effort needed to understand the complexity of the federal program and to determine whether federal policy is appropriate at the State level for the workers' compensation system.

UCLA's Center for Health Policy Research stated that any reduction in the State's administrative burden that would result from migrating to an RBRVS fee schedule based on the Medicare program would be offset by the increased effort needed to understand the complexity of the federal program and to determine whether federal policy is appropriate at the State level for the workers' compensation system. As one example of this issue, RAND noted that the Medicare program uses an annual update to adjust its conversion factor to account for inflation and to achieve a sustainable growth rate for aggregate federal expenditures for physician services. When actual prior year expenditures exceed the target for sustainable growth, the conversion factor is reduced. If actual prior year expenditures are less than the target, the conversion factor is increased. Because Medicare's annual update to its conversion factor is intended to control federal expenditures, RAND stated that it does not believe it would be appropriate to use the annual percentage increase in the Medicare conversion factor to update the California workers' compensation system's conversion factor.

In addition, although the CMS conducts annual updates of RVUs, the UCLA study pointed out that these annual updates focus on medical services that are covered by Medicare and are therefore included in the RBRVS. These updates may diminish the appropriateness of RVUs for medical procedures that are performed more commonly for workers' compensation than for Medicare.

For reasons such as these, RAND advised that in adjusting its conversion factor to reflect any annual inflation in the cost of providing medical services, California should ensure that it selects a measure that is appropriate for any underlying policy goals it intends for its workers' compensation system, and does not inadvertently adopt conversion factors that reflect federal policy goals such as controlling total federal expenditures. We discuss how other states deal with these issues in Chapter 3 and Appendix B.

THE COMMISSION PROJECTS SIGNIFICANT SAVINGS IF THE SYSTEM CONVERTS TO MEDICARE-BASED FEE SCHEDULES

A 2003 study by the commission estimated that paying for medical services and products at a rate of 120 percent of Medicare fee schedules and for pharmaceuticals at 100 percent of the Medi-Cal rate will provide at least $964 million in savings to the workers' compensation system in 2004, with increasing savings in the following two years. These savings comprise lower payments for services performed in each year, as well as the projected savings on medical services yet to be provided for existing and new claims in future years. This figure comprises increases in payments to physicians and hospitals for inpatient services and significant savings in pharmaceuticals and payments to outpatient surgical facilities. The commission's study was led by a researcher from the DATA Survey Research Center at the University of California, Berkeley (UC Berkeley). However, the estimates are based on broad assumptions and projections using findings from other research studies, and we could not independently verify the estimates because the commission's researcher does not maintain the source data used to calculate the savings. Therefore, we offer no opinion on the validity of the commission's estimated savings from implementing its proposed medical payment system.

We could not independently verify the estimates because the source data was not available. Therefore, we offer no opinion on the validity of the commission's estimated savings from implementing its proposed medical payment system.

The commission's study arrived at its estimates by comparing projected medical costs under existing workers' compensation fee schedules—for physicians and inpatient hospital fees—to the amount that would be paid for those services at a rate equal to 120 percent of the Medicare fee schedule rates for the same services. Because some medical services, such as those performed at outpatient surgical facilities, are not separately identifiable from the available data, the study relied on the 2001 study by the commission to project current costs for these categories. The study estimated the cost savings of applying a fee schedule capped at 120 percent of Medicare rates to payments for outpatient surgical facility services, which are currently unregulated by fee schedules in the State's workers' compensation system. In addition, the study estimated the cost savings that would result from revising the current workers' compensation pharmaceutical payment system to one that mirrors the Medi-Cal payment system. Finally, the study estimated the administrative savings to the workers' compensation system that would result from changing to a fee schedule patterned on Medicare's fee schedule. Estimated costs and savings are shown in the text box on the following page.

The commission's estimate of savings against added costs in 2004 from converting the workers' compensation payment system to a system based on 120 percent of Medicare medical fees and 100 percent of the Medi-Cal pharmaceutical fee:

Physicians and other professional services	$281 million additional costs
Hospital inpatient facilities	$18 million additional costs
Outpatient surgical facilities	$823 million savings
Pharmaceuticals	$370 million savings
Administrative costs	$70 million savings
Total projected net savings	**$964 million**

The analysis and costs and savings estimates in the commission's 2003 study build upon several earlier studies. These reports include the 2002 *California Workers' Compensation RBRVS Study* by the Lewin Group, a health care and human services consultant; the 2001 *Inpatient Hospital Fee Schedule and Outpatient Surgery Study,* led by an expert from the Center for Health Policy Research at UCLA; and the 2000 *Study of the Cost of Pharmaceuticals in Workers' Compensation,* led by a member of the DATA Survey Research Center at UC Berkeley. The methodologies employed in these analyses served as the basis of the costs and savings estimates in the commission's 2003 study.

In calculating future costs and savings, the commission's study relied on estimated baseline workers' compensation cost figures from the Workers' Compensation Insurance Rating Bureau, and on hospital admissions data from the Office of Statewide Health Planning and Development.

Physician and Hospital Inpatient Fees Are Estimated to Increase

The commission's study estimated that the impact of applying the Medicare payment system to the physician and other providers' fee schedule within the OMFS would be to increase overall payments to physicians by $281 million in 2004, rising to $345 million in 2006.

The commission's study estimated that the impact of applying the Medicare payment system to the physician and other providers' fee schedule within the OMFS would be to increase overall payments to physicians by $281 million in 2004, rising to $345 million in 2006. This estimate is based on revising the physician fee schedule in the OMFS from its current estimated conversion level of 115 percent of Medicare to 120 percent of Medicare, including using a geographic adjustment factor for California.

The commission's study also estimated that updating the inpatient hospital fee schedule with the newest Medicare fee calculation factors, while maintaining a multiplier for California's workers' compensation of 120 percent, would result in an annual increase in total hospital inpatient payments of over 8 percent for ordinary admissions, rising from $340 million to $367 million. This increase is the result of both higher DRG weights for workers' compensation cases and higher composite factors for individual hospitals in California. Hospital composite factors take into consideration operating costs that

result from certain hospitals' characteristics, such as geographic location, teaching activities, and commitment to serving low-income patients.

Within the context of using updated payment calculation factors, the study estimated that payments for cost outliers would decline by $19.5 million. The reduction would result from an increase in the OMFS cost outlier threshold from the current level of $14,500 to Medicare's 2003 level of $33,560, and from updated cost-to-charge ratios. With these updates, the study estimated that the annual percentage of workers' compensation cases paid as outliers would decline by 74 percent (from 6.2 percent to 1.6 percent), while the annual cost of outlier payments would decline by more than 51 percent, from nearly $38 million to $18.5 million.

The Largest Estimated Savings Would Come From Lower Fees Paid for Outpatient Surgical Facilities and Pharmaceuticals

The commission's study estimated that the majority of the savings to the workers' compensation system would come from establishing a fee schedule for services provided by outpatient surgical facilities. Under federal law, such services include those shown in the text box. Currently, outpatient surgical facility fees for the California workers' compensation system are unregulated. According to an earlier commission study published in 2001, California employers are paying between 2.3 and 3.7 times more than Medicare pays for outpatient surgical facility fees, depending on the type of facility and where the services are delivered.

Outpatient surgical facility services include:

- Nursing, technician, and related services.
- Use of the facilities where the surgical procedures are performed.
- Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures.
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
- Administrative, record keeping, and housekeeping items and services.
- Materials for anesthesia.
- Supervision of the services of an anesthetist by the operating surgeon.

Source: Code of Federal Regulations, Title 42, Section 416.61.

The commission's 2003 study analyzed the anticipated payment amounts for the various procedure codes, using each of the two leading prospective payment methodologies for reimbursement of outpatient surgical facility fees: Medicare's Ambulatory Payment Classifications (APC) system and Medicare's Ambulatory Surgical Center (ASC) payment system. The commission estimated outpatient facility savings by applying both the APC and ASC payment methods at 120 percent of Medicare against estimated incurred costs in the California workers' compensation system.

The commission's study estimated that the potential savings from applying the Ambulatory Payment Classification method at 120 percent of Medicare for hospital outpatient surgical facility payments would be as much as $823.4 million in 2004 and more than $1 billion in 2006.

The study estimated that the potential savings from applying the APC payment method at 120 percent of Medicare would be as much as $823.4 million in 2004 and more than $1 billion in 2006. Alternatively, the estimated savings from applying the ASC payment method at 120 percent of Medicare would be nearly $1.3 billion in 2004 and more than $1.6 billion in 2006. The cost savings estimates include the impact of the prevailing wage index, which varies by geographic location in California. The savings differential between the APC and ASC occurs because the APC covers a broader range of services and generally pays a higher reimbursement rate than the ASC.

The commission's estimates of the savings in outpatient surgical facility payments build on a 2001 analysis done for the commission by a health consultant from UCLA's Center for Health Policy Research. This analysis estimated the percentage of savings in outpatient facility costs by comparing amounts actually paid for those services to the fees that would have been paid using the then-current fees for medical services delivered under the APC and ASC payment methods. For the 2003 study, the commission recalculated the percentage of savings using a prevailing wage index and determined that the cost savings would be slightly lower than those the health consultant estimated.

Because of the multiple estimates made when calculating the savings in outpatient surgical facility fees, and because the commission did not have access to the raw data used by the authors of the 2001 report, it is not possible for us to validate the aggregate cost savings. Moreover, the actual distribution of outpatient surgeries by geographic area is unknown because there are no consistent data for these procedures. Therefore, the commission assumed that outpatient surgeries were geographically distributed in a manner similar to inpatient surgeries. Finally, for the purposes of its savings estimates, the commission assumed that outpatient facility costs in 2004 would be 60 percent of estimated hospital costs. Estimating cost savings in outpatient surgical facility fees is an ambitious effort, particularly given the lack of availability of outpatient data. While it is reasonable to assume that the use of a fee schedule for unregulated services will produce savings, and possibly substantial savings, the number of assumptions the commission's study used to support the estimate of outpatient savings makes this estimate susceptible to variation.

The commission's study estimates the workers' compensation system could save 37 percent on drug costs annually by adopting the Medi-Cal pharmaceutical fee schedule.

The commission's 2003 study estimated that the potential savings from adopting the Medi-Cal payment system for pharmaceuticals, rather than continuing to use the payment system in the current OMFS, would be as much as $370 million in 2004 and would increase to nearly $515 million in 2006. The study bases this estimate on the percentage differential in the reimbursement paid by the workers' compensation system compared to that paid by Medi-Cal. In a commission study published in 2000, Medi-Cal's reimbursements were estimated to be approximately two-thirds of the amount paid for pharmaceuticals in the State's workers' compensation system. After recent changes in the Medi-Cal pharmaceutical fee schedule, the 2003 commission study updated the reimbursement differential to 37 percent, meaning that the workers' compensation system could save 37 percent on drug costs annually by adopting the Medi-Cal pharmaceutical fee schedule.

Another factor underlying the estimated pharmaceutical savings is the assumption used in the study of an 18 percent annual growth in pharmaceutical costs for 2002 through 2006. This annual growth estimate, initially established in the commission's 2000 study, was based on a combination of changes in price and in the drug mix (12 percent) and an estimated increase in utilization identified in national systems such as Medicare and group health care (6 percent). The study reported that the estimated annual growth in pharmacy costs is consistent with, or even a little lower than, the recent increases experienced by Medicare and group health care in drug costs of approximately 18 percent to 22 percent annually.

Although the methodology employed to calculate the cost savings resulting from adoption of the Medi-Cal pharmaceutical fee schedule is straightforward and appears reasonable, and we can confirm Medi-Cal's lower fee formula relative to the workers' compensation system, the commission no longer has the data used to develop the pharmaceutical analysis. The data were obtained under specific agreements that they would be returned at the completion of the study project. As a result, we cannot verify the estimated cost savings.

Administrative Savings Are General Estimates

The commission's 2003 study estimated the potential administrative savings to be derived from adopting Medicare/Medi-Cal type payment systems for use in the State's workers' compensation system to be as much as $70 million annually.

The study admits that the administrative savings are difficult to quantify, and it bases the $70 million in savings on interviews conducted with representatives of the workers' compensation community.

These savings are presumed to derive from a variety of sources, including streamlining the division's administration, reducing litigation, simplifying bill review processes, and so on. The study admits that the administrative savings are difficult to quantify, and it bases the $70 million in savings on interviews conducted with representatives of the workers' compensation community.

The commission's research consultant could not provide support for the $70 million figure because he does not have any empirical data about the actual annual administrative costs of the workers' compensation system, or about what savings might be derived from the specific sources indicated in the study. In addition, the study makes no mention of whether linking existing fee schedules and updates to Medicare/Medi-Cal and instituting new fee schedules could possibly increase administrative costs, at least in the short term. It seems reasonable to assume that the fee schedule linkage and updating processes would enable the workers' compensation system to reduce administrative costs. However, since the $70 million estimate is not tied to any baseline figure for administrative costs, we could not substantiate the savings estimate.

Reductions in Insurers' Reserves for Workers' Compensation Claims Depend on How Well Proposed Reforms Work

The commission's study also estimates that adopting a payment system similar to Medicare's, capped at 120 percent of Medicare's rates, and paying for pharmaceuticals at rates that mirror the Medi-Cal fee schedule would provide a one-time savings of approximately $3.35 billion to insurers and self-insured employers, due to a projected decrease in the future costs of existing claims and a corresponding reduction in the amount of reserve funds that insurers and self-insured employers must set aside to pay those claims in the future. The commission's study derived this estimate from savings on past incurred but unpaid liabilities that would result from the proposed changes to the OMFS (approximately $4.3 billion) minus the estimated additional costs for payments to physicians under a revised payment system (approximately $0.95 billion).

The accuracy of the estimate of the reduction in insurers' reserves for workers' compensation claims relies entirely on the overall savings in total workers' compensation costs. If the effort to link workers' compensation fee schedules to Medicare and Medi-Cal does indeed produce at least $964 million in net savings in 2004, the insurers' reserves for past incurred

but unpaid medical costs may in fact be reduced by the commission's estimate. However, since we could not verify the savings estimates in the commission's 2003 study, we also could not validate the estimated reduction in reserves of $3.35 billion. According to a representative from the rating bureau, it does not plan to study the economic impact of changes in the payment system until a final version is adopted.

MEDICAL FEE SCHEDULES ALONE WILL NOT CONTROL TOTAL MEDICAL COSTS

Total medical costs in the workers' compensation system are driven by a number of factors, including medical fee amounts, appropriate treatment for injuries and illnesses, prompt resolution of disputes over workers' injuries and treatments, and the length and magnitude of workers' disabilities. As such, implementing medical fee schedules alone will not ensure the containment of total medical costs. Studies such as those from the WCRI have shown that controlling the number and types of treatments provided (treatment utilization) is closely tied to fee amounts when attempting to control total medical costs. The consensus among these studies is that a lack of effective utilization controls is a major driver of total medical costs in California's workers' compensation system.

The consensus among research studies is that a lack of effective utilization controls is a major driver of total medical costs in California's workers' compensation system.

In two separate 2002 studies, the WCRI reviewed workers' compensation claims from 1996 through 1998 for eight states and compared workers' compensation medical fee schedules for 40 states. The WCRI has also issued its preliminary results from a 2003 study of medical costs and utilization in workers' compensation among 12 states.

In its studies, the WCRI reported that states with lower fees are not always the ones with the lowest average medical payments per claim. The studies indicated that a higher number of services per claim result in higher average medical payments. For example, in the WCRI's 2002 comparative study of fee schedules among 40 states, Florida had the lowest fees. However, Florida's medical payments per claim were near the average of eight large states included in the study. The WCRI reported that the average medical payment per claim in Florida increased between 1996 and 1998 because of an increase in the number of services delivered per claim, rather than the prices paid per service.

Similarly, the WCRI reported that Massachusetts' average cost per claim for medical care rose significantly in recent years because of an increase in the number of visits per claim. In January 2001, Texas reported that its workers' compensation medical costs exceeded those in other states and other health care delivery systems, primarily because more medical testing and treatment were provided to injured workers for longer periods of time than were provided to workers with similar injuries in other states' workers' compensation systems or group health plans.

In contrast, according to the WCRI, Connecticut had fees that were higher than 36 other states in the 40-state survey, but its average medical payments per claim were the second lowest among eight large states when comparing average medical payments per claim with more than seven days of lost work time. Connecticut's average number of services per claim for claims with more than seven days of lost work time was also among the lowest of the eight states.

ADOPTING THE STRUCTURE AND RULES OF THE MEDICARE PAYMENT SYSTEM COULD RESULT IN INCREASED ADMINISTRATIVE COSTS

There is concern that adopting the ground rules associated with the Medicare RBRVS will add costs to the workers' compensation system. The executive medical director of the medical council told us that adopting all the Medicare ground rules would add significant administrative complexity to the system. Ground rules define items that are necessary to appropriately interpret and report the procedures and services contained in different sections of the schedule. For example, in the medicine section of the current OMFS, specific ground rules are provided for handling unlisted services or procedures provided by the physician. Ground rules also provide explanations regarding terms that apply only to a particular section of the schedule.

According to the executive medical director of the medical council, adopting all of Medicare's ground rules would involve a number of issues that may cause an administrative burden.

According to the executive medical director of the medical council, adopting all of Medicare's ground rules would involve issues that may cause an administrative burden. For example, the Medicare ground rules are extensive, difficult to locate, are updated frequently, and are unfamiliar to providers and payers in California's workers' compensation system. There is no single source for the Medicare ground rules; they are included in the CMS Medicare Carrier's Manual, Program Memoranda,

and payment rules of the individual Medicare carriers or fiscal intermediaries. In addition to being contained in several places, Medicare's ground rules do not have any number assigned to them for easy location or identification. They are also updated quarterly. Moreover, Medicare's ground rules are geared toward an entirely different population than that of the workers' compensation system. Procedures and controls for Medicare patients are not the same as those for patients in California's workers' compensation system. Therefore, providers and payers in California's workers' compensation system would have to spend a lot of time and effort trying to locate and understand Medicare's ground rules, as well as trying to keep up with the frequent changes and updates that may not apply to the patients they serve.

The executive medical director stated that certain Medicare ground rules are not applicable to California's workers' compensation system.

The executive medical director stated that certain Medicare ground rules are not applicable to California's workers' compensation system. For example, some Medicare ground rules do not allow physicians to charge evaluation and management codes along with other codes. However, combining codes is allowed in California's workers' compensation system. According to the executive medical director, physicians in California's workers' compensation system spend more time and effort providing evaluation and management services than physicians in Medicare do; therefore, these Medicare ground rules do not seem relevant to California's workers' compensation system. Other Medicare ground rules place a dollar limit, rather than a limit on the number of visits, on physical therapy services. An example would be a $1,590 cap on physical therapy treatments that Medicare would pay for in a given year. Representatives at the medical council question whether this ground rule would apply to California's workers' compensation system because California law may not permit such a cap on medical services to injured workers.

Division staff and the proposed draft rules to revise the OMFS indicate an intention to adopt ground rules that are relevant to the California workers' compensation system. The division is seeking public input to help identify which Medicare ground rules should be adopted for the California system. ■

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CHAPTER 3

More Work Is Needed to Ensure That Injured Workers Have Access to Quality Care

CHAPTER SUMMARY

As California considers moving its workers' compensation system toward resource-based fee schedules as a solution to controlling medical costs, the administrative director must make critical decisions regarding the necessary adjustments to the resource-based relative value scale (RBRVS) and other schedules the State may adopt to ensure that the fee amounts provide access to a reasonable standard of service and care for injured workers. Payments for physician services under the RBRVS are determined by multiplying the relative value unit (RVU) assigned to each procedure code by conversion factors. However, there is no universal standard for fee amounts that will ensure access to quality care for injured workers, and therefore policymakers need to determine the extent to which fee schedules developed by external entities must be adjusted to meet this goal. For example, the two proposals to implement Medicare-based fee schedules to contain costs set a ceiling on fees at 123 percent and 120 percent, respectively, of Medicare payment amounts. However, it is uncertain whether fees at those levels will ensure access to a reasonable standard of service and care for injured workers.

To attain the goal of containing medical costs, policymakers must consider the impact of fee schedules on access to care and overutilization of medical services. Fees that are too low may reduce access to quality care and provide incentives to increase utilization. Policymakers will also have to consider the number and dollar amount of conversion factors—factors to apply to RVUs to determine fee amounts—and whether a single conversion factor or multiple conversion factors are optimal for California. Multiple conversion factors, if they are excessively applied, can partially defeat the purpose of a fee schedule based on the resources used to provide a service.

Researchers have concluded that there is not a single level of reimbursement that would satisfy all the groups of providers affected by the workers' compensation system. One consultant

advised that the division, when establishing conversion factors, consider whether there is adequate access to quality care, the current level of the workers' compensation system payment amounts, the current difference between Medicare and private payer fee levels in California, and available information on the cost of providing specific services.

Our survey of eight states using an RBRVS-based payment system found a variety of methods for implementing and maintaining RBRVS fee schedules. Although most states reported that they were successful in reaching their cost containment goals for implementing their RBRVS systems, and some reported overall decreases in costs, most also stated that they did not have specific data to support these assertions. In addition, most of the states we surveyed indicated that they relied on insurers to monitor treatment utilization.

For California to be able to ensure that its policy decisions result in cost containment and adequate access to quality care, it must be able to monitor the effects of policy decisions. To monitor and review the effectiveness of adopting new workers' compensation fee schedules, the State needs an available database to track claims transactions and collect information from providers, employers, and insurers that reflects the cost of individual medical services, the frequency and appropriateness of treatment provided, and the accessibility of quality care. Currently, the State does not have such a system. The administrative director of the Department of Industrial Relations' (Industrial Relations) Division of Workers' Compensation (division) is working on a data collection system, but since 1993 it has been plagued with delays resulting from budget restrictions and technical problems, and the administrative director cannot specify a completion date because of further budget constraints and his need to gain cooperation from the insurers that will submit medical payment data to the system when it is completed.

Two current proposals to control medical costs for physician services use a payment system based on 123 percent and 120 percent of Medicare's fee schedules, respectively. However, it is uncertain whether the proposed fees will be adequate to ensure access to a reasonable standard of services and care for injured workers.

PROPOSED FEE SCHEDULES MAY NOT NECESSARILY PROVIDE THE NECESSARY ACCESS TO QUALITY CARE FOR INJURED WORKERS

Two current proposals to control medical costs for physician services use a payment system based on the Medicare RBRVS system. The proposal from the administrative director and a proposal presented by the Commission on Health and Safety and Workers' Compensation (commission) favor fee schedules

based on 123 percent and 120 percent of Medicare's fee schedules, respectively. However, it is uncertain whether the proposed fees will be adequate to ensure access to a reasonable standard of services and care for injured workers. In fact, although two states use fees for physician services that are less than Medicare's fees, most states that employ a variation of the Medicare fee schedule for physician services reimburse providers at a range of 140 percent to 160 percent of Medicare fees. According to the administrative director, as of June 10, 2003, he had not conducted any analysis to determine whether the proposed payment system will be adequate to ensure access to a reasonable standard of services and care for injured workers. The administrative director added that this is a very complex issue and that he really does not have the staff to devote to it at this time.

Representatives of the Industrial Medical Council (medical council) indicated that if the division goes directly to a fee structure in which the fee for each medical procedure is capped at 120 percent of Medicare, it is reasonable to assume that some doctors whose payments are decreased will reduce or eliminate their workers' compensation practices. The commission, however, does not believe that this ceiling will create problems with injured workers having access to care.

According to a 2001 study on improving the quality of care for California's injured workers, conducted by the administrative director in conjunction with the Public Health Institute and using several focus groups, access to medical care and to specialists is one of five factors necessary for achieving high-quality health care. Some of the focus groups' specific concerns included physicians' lack of familiarity with occupational medicine and return-to-work issues, and access problems, including access to specialty care and to physicians willing to treat injured workers. Timeliness of care, including availability of after-hours care, was also identified as another important aspect of access. In addition, concerns about adequate access to diagnostic services and the failure of primary care physicians to make prompt referrals to specialists were raised. The competence and technical expertise of medical providers were also identified as a critical element in quality care.

Access to health care for injured workers surfaced as a major issue in almost all groups in a study conducted by the administrative director.

Access to health care for injured workers surfaced as a major issue in almost all groups in the study. One particular concern was the possibility that physicians would not be willing to treat workers' compensation patients in some regions of the State,

especially in some medical specialty areas. Workers whose cases are delayed or denied may face difficulties in receiving care because these workers must often find a provider who is willing not only to treat workers' compensation patients, but also to do so without an approval for payment from insurers or claims administrators in advance of treatment, which reduces the pool of available providers. Physicians and others gave a number of reasons for the unwillingness of some providers to participate in the workers' compensation system, such as excessive paperwork, billing disputes, concerns about the legal aspects of workers' compensation, and other problems seen as being worse in the workers' compensation system than in the general managed care environment. The need to have access to medical care 24 hours a day was also raised as a concern.

Physicians and others gave a number of reasons for the unwillingness of some providers to participate in the workers' compensation system, such as excessive paperwork, billing disputes, concerns about the legal aspects of workers' compensation, and other problems seen as being worse in the workers' compensation system than in the general managed care environment.

According to a 2003 RAND study, payment levels should ideally be sufficiently high to ensure that workers' compensation patients have access to high-quality, medically appropriate care, but not so high as to be excessive or to create incentives for inefficient and unnecessary care. According to the study, there is no "gold standard" for determining appropriate payment levels.

A study by the Medicare Advisory Commission (MedPAC), an independent federal body that advises Congress on issues affecting the Medicare program, made the following observations on access to health care. Evaluating access is a complex and difficult task, in part because there is no agreed-upon measure of what constitutes appropriate access. Measuring access requires analysts and policymakers to piece together many types of information to create a balanced picture. There is no simple definition of access because the concept involves questions about both the availability and the actual use of services. A sufficient supply of providers does not guarantee that injured workers will be able to obtain care. Furthermore, knowing that workers are obtaining care does not ensure that they are receiving the right mix of services.

THERE IS NO UNIVERSAL STANDARD FOR CONVERTING MEDICARE RATES TO A WORKERS' COMPENSATION FEE SCHEDULE

In order for policymakers to make informed decisions about California's workers' compensation system, many concerns related to fee schedules will need to be addressed. Studies conducted between August 1999 and April 2003 by the

Lewin Group, the University of California, Los Angeles (UCLA) Center for Health Policy Research, RAND, and the Workers' Compensation Research Institute (WCRI) all point to issues that California will need to consider when adopting a fee schedule based on the RBRVS. The changes in the RVUs for services provided by physicians and other health care professionals could be significant.

The Lewin Group found that California's current fee schedule uses some procedure codes that have not been updated since 1994 and others that have remained unchanged since 1997. Moreover, the RVUs for the current Official Medical Fee Schedule (OMFS) are based on multiple sources, such as the 1974 California Relative Value Study, updates supplied by private vendors, and values assigned by the State. The UCLA study stated that the RVUs contained in the OMFS should be updated because they are based on multiple sources from various time periods, while the RAND study concluded that California needs to address the procedures that currently do not have an assigned RVU.

The Lewin Group also indicated that California should consider making adjustments in the OMFS to recognize cost differences associated with various geographical locations throughout the State. Under the current OMFS, no such adjustments are made for geographic cost differences, whereas the Medicare payment system divides California into nine geographic cost localities. In addition, Medicare reimbursement policies in general provide that a physician payment is lower if the service is furnished in a facility that is eligible for separate payments under Medicare fee schedules (hospitals and outpatient surgical centers). California's current OMFS pays the same amount regardless of where the service is furnished.

Decisions regarding the level of fees involve setting a conversion factor for California's workers' compensation system that balances access to care against overutilization of medical services.

Inappropriate Fee Schedules Could Adversely Affect Access to Care or Cause Potential Overutilization of Medical Services

Decisions regarding the level of fees involve setting a conversion factor for California's workers' compensation system that balances access to care against overutilization of medical services. In making recommendations regarding Medicare payment policies, MedPAC advised that if payments are set too low, providers may not want to participate in the program and Medicare beneficiaries may not have access to quality care. If payments are too high, taxpayers will bear too large a burden. This advice would also seem to apply to the State's workers'

compensation system. Regarding access to physician services, MedPAC concluded that there were no widespread problems in beneficiaries' access to care. Although physicians are more selective about accepting patients from a number of payers than in the past, MedPAC found that the vast majority are still accepting at least some new Medicare patients.

The effects that lower fees may have on providing incentives for increased utilization will need to be considered when making decisions on fee schedules.

As we discussed in Chapter 1, a 2003 WCRI study indicated that, relative to other states, California has more claims representing injuries in which workers lost more than seven days of work. Policymakers need to consider the effects that lower fees may have on providing incentives for increased utilization when making decisions on fee schedules.

The Number and Dollar Amount of Conversion Factors Vary Significantly Across the Country

Because RVUs are merely a method of calculating the value of medical services relative to the value of other medical services, Medicare applies a dollar amount multiplier, or conversion factor, to each procedure's RVU code to determine a maximum payment amount for the service. RAND offered three basic options for establishing the conversion factor. The first is to use a budget-neutral single conversion factor. This option ensures that total payments for medical services remain the same, but it allows for the redistribution of payments based on their relative values across specialties and services. The second option involves applying a single multiplier to the Medicare conversion factor that approximates the conversion factor needed to achieve specific policy objectives. The third option is to develop "cost-neutral" conversion factors by type of service. This option is intended to maintain the current payment levels for certain types of medical services and to reduce the redistribution that would otherwise occur in adopting the Medicare RBRVS. The RAND study stated that this third option is not consistent with the goal of aligning payments with resource requirements, and it did not recommend this option because it perpetuates the existing discrepancies between payments and the actual resources required to provide services.

Conversion Factors May Be Needed to Increase Medicare Fee Amounts

According to the WCRI, a premium over Medicare payments may be needed to ensure that injured workers have access to medically appropriate care. The 2002 WCRI study reasoned

Another reason the WCRI study offered in support of paying a premium above Medicare fee amounts is that the Medicare payment levels have been affected by federal budgetary constraints that do not apply to states' workers' compensation programs.

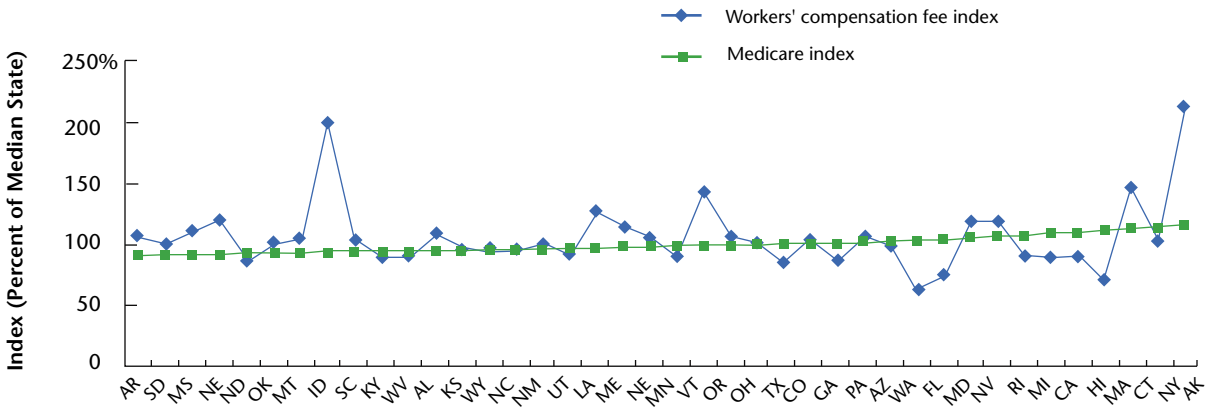
that workers' compensation patients may require more administrative effort and present other complicating issues that could require more time and medical expertise to treat. Another reason the WCRI study offered in support of a premium is that the Medicare payment levels have been affected by federal budgetary constraints that do not apply to states' workers' compensation programs. The WCRI study estimated that the overall OMFS for California was 12 percent higher than Medicare payments in 2001 and required a 1.15 multiplier to be cost neutral after accounting for the reduction in the Medicare conversion factor between 2001 and 2003.

Using a slightly different mix of physician services than the Lewin Group's 2002 study, RAND, in its 2003 study, concluded that adopting the RBRVS for California's workers' compensation system would reduce fees for surgical services by almost 15 percent and would reduce fees for anesthesia services by 39.1 percent. The RAND study stated that a reduction this large could reduce access unless it is accompanied by a multiyear transition. RAND advised that, when establishing a conversion factor, the division should consider whether there is adequate access to quality care, the current level of the workers' compensation system payment amounts, the current difference between Medicare and private payer fee levels in California, and available information on the cost of providing specific services.

Studies conducted by the WCRI and RAND indicated that there is no single level of reimbursement that will satisfy all the groups affected by the workers' compensation system. In its study titled *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2001–2002*, the WCRI noted that the level of fees paid to providers varies widely among the 40 states studied, from more than triple the Medicare rates in Idaho to fees that are 17 percent and 13 percent lower than Medicare in Florida and Massachusetts, respectively. The study also indicated that the differences in fee levels from state to state are due to more than just the differences in the costs to deliver medical services. Because Medicare fees are adjusted to reflect the differences in the cost of delivering medical services in different regions across the country, the Medicare fees can be used as an indicator of the cost to deliver workers' compensation in one state relative to another. By comparing the Medicare fee levels to workers' compensation fee levels, the WCRI found that there is a low correlation between the cost of providing medical services for workers' compensation and workers' compensation fees, as shown in Figure 9 on the following page.

FIGURE 9

States' Workers' Compensation Fee Indices Compared to the Medicare Indices



Source: Workers' Compensation Research Institute.

Note: The values in the workers' compensation fee index are determined by comparing each state's workers' compensation level to the median workers' compensation fee level for the 40 states included in the study. The values in the Medicare index are determined by comparing each state's Medicare fee level to the median Medicare fee level for the 40 states included in the study.

Significant Changes in Fee Amounts May Require a Transition Strategy

As we discussed in Chapter 2, according to the Lewin Group, adopting a resource-based OMFS could result in a redistribution of payments across various types of medical providers. The Lewin Group's study identified three approaches to lessening the effect of a significant decrease in payments on medical providers. The first approach would blend the old and new RVUs for computing payments. This blending approach would ease the impact of adopting the RBRVS by providing an opportunity for affected medical providers to adjust to the new payment system. A second approach would moderate the effect on particular medical specialties during a set period by limiting the change in fee schedule amounts under the RBRVS. This approach would offer temporary protection for specific medical procedure codes for which payments under the new system would be significantly reduced. The Lewin Group stated that this approach is unlikely to be budget neutral and advised that, under the new fee schedule, those medical procedures for which payments decrease less than the established change limit could be implemented without a transition period. The third approach the Lewin Group identified uses multiple conversion factors. The study pointed out that to use this approach, the State would need to determine how many conversion factors are appropriate

and how to apply them to the OMFS. Each conversion factor could protect specific groups of codes from significant changes in payments. However, the study cautioned that the impact of the RBRVS could still be significant for some medical procedure codes, and that an RBRVS-based system that uses multiple conversion factors would not be fully resource based.

According to RAND, the impact of significant increases or decreases in payment levels could be softened through transitional payment policies that limit the annual amount of change in payment.

According to RAND, the impact of significant increases or decreases in payment levels could be softened through transitional payment policies that limit the annual amount of change in payment. RAND identified four different policies that other programs have used to phase in payment changes. The first three options are based on a comparison of the service-specific conversion factors with the conversion factors under a new payment system. The fourth option makes payment comparisons on a procedure-specific basis.

The first option establishes floors and ceilings on maximum annual changes that would be needed in service-specific conversion factors. This option limits the maximum percentage increase or decrease in the conversion factor in a given year. The second option uses blended conversion factors. Cost-neutral conversion factors are gradually blended with the new conversion factor over time. For example, if a transition were to occur over four years, in year one, the old conversion factor would make up 75 percent of the rate, while the new conversion factor would make up 25 percent of the rate. In year two, the old and new conversion factors would each make up 50 percent of the rate. At the end of year four, the new conversion factor would make up 100 percent of the rate.

The third option establishes a policy that would avoid a reduction in the first few years of the transition, only to be followed by an increase in subsequent years. This "hold-harmless" policy means that there is no reduction in a payment amount if the new payment amount is lower than the old payment amount. Instead, the current payment amount is frozen until the new payment amount catches up. Hold-harmless policies increase program expenditures during the periods that the payment amount is frozen at the higher rate. The fourth option bases the transition payment amount on the payment for specific procedures rather than on service groups. This transition option is similar to the three other transition policies, except that the policy applies to single procedures instead of to categories of procedures.

CALIFORNIA CAN BENEFIT FROM THE EXPERIENCES OF OTHER STATES

The California workers' compensation system can benefit from other states' experiences in implementing systems to contain medical costs and monitor the provision of services to injured workers. In addition to reviewing research on other states' efforts, we conducted a survey of 10 other states that use RBRVSs to calculate payments for workers' compensation medical care, and eight chose to participate in the survey.

Recent Research Reveals a Wide Variety in the Fees Other States Pay for Medical Services

In 2002, the WCRI conducted studies to identify benchmarks for designing workers' compensation fee schedules and workers' compensation trends for medical costs and utilization. The WCRI found that among the 40 states it studied, some have fee levels for workers' compensation that are higher than the Medicare fee levels and some have fee levels that are lower than the Medicare levels, even though the objectives for the fee schedules are similar. Specifically, states indicated that their objectives for a fee schedule are to (1) contain the growth of medical costs, (2) equalize profit margins across different types of providers without limiting access to quality care, and (3) simplify administration.

The WCRI found that among the 40 states it studied, some have fee levels for workers' compensation that are higher than the Medicare fee levels and some have ones that are lower than the Medicare levels, even though the objectives for the fee schedules are similar.

In its 2003 preliminary study results for a comparison of workers' compensation medical costs among 12 states, the WCRI compared the states' average medical payments per claim. Massachusetts and Texas had the lowest and highest average medical payments per claim, respectively. Florida, with the lowest fee level among the 40 states included in its benchmarks study, had higher average medical payments than seven of the 12 states included in its trends study.

In addition to the different levels of fees, states also use different relative value scales. The scales they use include the Medicare RBRVS, the relative value scales for California and other states, and relative value scales from private entities such as Blue Cross/Blue Shield, McGraw Hill, and St. Anthony Press. Several other states rely on usual, customary, reasonable, and prevailing rates and thus have no relative values.

In its 1999 study of relative value scales, UCLA found that many states have implemented a resource-based payment system and that their fees vary widely for services that are similar in nature. UCLA identified 12 states that use the RBRVS system as the basis for developing their physician reimbursement fee schedules for workers' compensation, but there were differences among the states for six general medical service groupings. As one example, the conversion factor for general medicine ranged from $33 to $89.43. Also, among the 12 states that use the RBRVS as a basis for their fee schedules, eight use dollar conversion factors. The conversion factors used for the medical specialty areas of medicine and surgery varied among all eight states that used dollar amounts as conversion factors. The four remaining states express their conversion factors as a percentage of Medicare or as falling within a certain percentile.

Our Survey of Other States Identified Diverse Approaches to Implementing Controls Over the Costs of Workers' Compensation Programs

We conducted a survey of eight states that use resource-based fee schedules for their workers' compensation systems to learn how they handled the challenges that accompanied converting their charge-for-services-based workers' compensation payment systems to a resource-based system. We asked about each state's goals for implementing a fee schedule based on resources and about the fee schedule's impact on utilization and access, as well as about each state's data collection and utilization review methods. Finally, we asked about any barriers to successfully implementing the fee schedule and the fee schedule's effect on overall system costs.

Most of the states we queried believed they had met their goals for implementing a resource-based payment system, even though their approaches for adjusting the Medicare fee schedules to determine payment amounts were very different.

From our survey, we concluded that controls over the costs of workers' compensation programs could be applied in a variety of ways. All of the states we surveyed based their fee schedules on Medicare's RBRVS. Most of the states we queried believed they had met their goals for implementing a resource-based payment system, even though their approaches for adjusting the Medicare fee schedules to determine payment amounts were very different. Moreover, most states reported that they do not monitor access to quality care and that they rely on insurers to perform utilization reviews. We present the full results of our survey in Appendix B.

The states we surveyed reported varying goals in implementing a fee schedule based on the RBRVS. Washington, North Carolina, and Hawaii hoped that a fee schedule based on resources would provide a fairer payment system. Massachusetts and Mississippi indicated that Medicare's regularly updated fee schedules were an established, reliable, defensible standard. Texas adopted the RBRVS in hopes of moving toward fees that are based on resources rather than charges. Michigan and Mississippi stated that they hoped to contain increasing medical and system costs. Minnesota stated that it adopted the RBRVS to address problems with administrative ease, coverage of services, and cost control in their previous charge-based fee schedule.

For the most part, the states indicated that they have achieved the goal of a fairer payment system. Washington stated that providers were involved in every step of the implementation and update process and that the payment system is viewed as fair. North Carolina and Hawaii also indicated that the fee schedules were viewed as fair by interested parties or the state, respectively. Massachusetts indicated that it had wanted to adopt a fee schedule that was valid and universal in terms of what people understood. The Medicare RBRVS payment system fit with these goals because people understand it and because it went through public scrutiny. Michigan responded that its costs per case were lower when comparing against the WCRI's 12-state study. Therefore, Michigan indicated that its goals have been met. Related to its goals of cost containment, Mississippi communicated that its overall system costs appear to have stabilized, but it added that it lacks the data to support this conclusion.

Every state we surveyed applies relative value units from Medicare in some fashion to determine their fee amounts.

Every state we surveyed applies RVUs from Medicare in some fashion to determine their fee amounts. Michigan uses RVUs from the 2002 Medicare Physician Fee Schedule (physician fee schedule) and applies a conversion factor. Mississippi uses RVUs taken from Medicare and applies conversion factors purchased from a private vendor. Our survey also shows a range of conversion factors being used for similar services. As Table 10 shows, the conversion factors used by the surveyed states vary significantly. For example, Hawaii's conversion factor for physicians' evaluation and management services is $33.54, whereas Minnesota's conversion factor for these same services is $75.18.

The states we surveyed indicated that they base updates to their respective fee schedules on Medicare's updates of RVUs in some way. North Carolina, Massachusetts, and Hawaii all

TABLE 10

Conversion Factors Used by the Surveyed States

State	Evaluation and Management	Medicine	Surgery	Radiology	Pathology
Medicare 2003	**$36.79**	**$36.79**	**$36.79**	**$36.79**	**$36.79**
Hawaii	33.54	33.54	33.54	33.54	33.54
Massachusetts	36.20	36.20	36.20	36.20	36.20
Michigan	47.01	47.01	47.01	47.01	47.01
Minnesota*	75.18	75.18	75.18	75.18	75.18
Mississippi	50.30	60.50	75.60	62.00	60.50
Washington†	50.51	50.51	50.51	50.51	50.51
Texas under RBRVS	45.98	45.98	45.98	45.98	45.98
North Carolina	See note.				

Source: Medicare 2003 conversion factor, effective between March 2003 and December 2003, published in the Federal Register on February 28, 2003.

Conversion factors for other states taken from survey responses from: Hawaii, Massachusetts, Michigan, Minnesota, Mississippi, Washington, Texas, and North Carolina.

Note: North Carolina applies its own multipliers to the product of a Medicare conversion factor and RVU in order to determine payment under the state's workers' compensation program. The Medicare conversion factor used is based upon the year the RVUs are initiated or modified. The multiplier for evaluation and management, medicine, and pathology is 1.58. The multiplier for surgery is 2.06. The multiplier for radiology is 1.96.

* For Minnesota, scaling factors are used to reduce the fees for physical medicine, pathology/laboratory and chiropractic services. The scaling factors are 0.867 for physical medicine RVUs, 0.835 for pathology/laboratory RVUs and 0.541 for chiropractic RVUs.

† Washington's proposed conversion factor, effective for dates of service on or after August 1, 2003, is $50.58 for all RBRVS services except anesthesia. The proposed anesthesia conversion factor for all such services on or after August 1, 2003, is $2.80 per minute.

Medicare used a different scale of RVUs for anesthesia services and a conversion factor of $17.05. State conversion factors for anesthesia services range from $18.34 to $75.18, with some states using a per-minute rate.

indicated that updates of their RVU schedules follow Medicare's adoption of RVUs. Washington indicated that it occasionally also takes into consideration the recommendations from the American Medical Association along with Medicare's adopted RVUs. Mississippi reviews the RVUs annually but revises the fee schedule only as needed. Texas intends to adopt Medicare's annual updates to the RVUs. Michigan stated that it last updated its relative values in 2003 to reflect the 2002 Medicare RVUs. Michigan last updated its conversion factor in 2002 to reflect a move from three conversion factors to a single conversion factor.

The Surveyed States Employ a Variety of Payment Systems for Other Medical Services and Products

Because the Medicare physician fee schedule applies only to physician services, the states we surveyed use a variety of methods to determine payments for other medical services and products, including hospital inpatient facility services, outpatient surgical facility services, and pharmaceuticals. For example, Michigan calculates fees for hospitals for certain services, such as emergency room services, inpatient services, outpatient surgery, physical medicine services, and laboratory services, using a cost-to-charge ratio methodology. The reimbursement equals the charge times the cost-to-charge ratio times 1.07. It pays for pharmaceuticals at the average wholesale price plus a $4 dispensing fee. In contrast, Washington pays hospital inpatient facility fees using one of three options: (1) Washington's diagnosis-related groups (DRGs), (2) statewide per diem rates for low-volume DRGs, or (3) a percentage of allowed charges. Payments for hospital outpatient facility services are based on Medicare's outpatient payment system with modifications. Most pharmaceuticals are reimbursed at the average wholesale price minus 10 percent plus a $4.50 dispensing fee.

Because the Medicare physician fee schedule applies only to physician services, the states we surveyed use a variety of methods to determine payments for other medical services and products, including hospital inpatient facility services, outpatient surgical facility services, and pharmaceuticals.

The States We Surveyed Do Not Monitor Costs or Utilization Changes Resulting From Fee Schedules

The effect that fee schedules had on workers' compensation costs in other states is unknown. Although various states classified costs as increasing, stabilized, or decreasing, most states indicated that they either did not have sufficient data to determine the extent to which fee schedules contributed to these changes or had the data but had not performed the analysis. Texas gathered the data, analyzed it, and concluded that its rising costs were not controlled by a fee schedule because injured workers in Texas receive more medical testing and treatment for longer periods of time than do workers with similar injuries in other state workers' compensation systems and group health plans.

However, not all states require insurers and claims administrators to follow these fee schedules. Our interview with a representative from Massachusetts indicated that medical providers and insurance carriers in the state are free to negotiate contracts outside the fee schedule. In a study conducted by the

Not all states require insurers and claims administrators to follow their fee schedules.

UCLA Center for Health Policy Research in 1999, responses from Florida indicated that insurance companies there also negotiate outside the fee schedule since they are not required to follow it.

We asked the states we surveyed about the monitoring efforts they have in place to determine the fee schedule's impact on utilization. In general, the states indicated that they do not monitor treatment utilization, and some reported that they rely on insurance carriers to monitor utilization. Washington stated that it could do a better job of monitoring utilization. Washington's workers' compensation insurance policies are all written by its state fund, and the state collects claims data on these insured claims. After reviewing the utilization patterns from these claims, the state adjusts the conversion factor to maintain desired spending levels. In Texas, although insurance carriers are responsible for monitoring utilization, the state uses retroactive reviews of claims to monitor the system, as well as preauthorization for some services. Texas reported that separate studies conducted by the WCRI and the Texas Research and Oversight Council on Workers' Compensation concluded that utilization was the driver for the increasing medical costs in that state. Although in Chapter 2 we discuss that California does not plan to adopt all of Medicare's ground rules, Texas hopes that adopting Medicare's ground rules will limit services that are not medically necessary. Massachusetts indicated that it had not studied or measured the fee schedule's impact on utilization prior to 2003. In January 2003, the state implemented a compensation review system to monitor and review the insurance agents responsible for following state-mandated treatment guidelines. Hawaii indicated that while utilization has increased since it implemented the fee schedule, its utilization levels are still within the rules set by the state.

Some states rely on insurance carriers to conduct utilization reviews. North Carolina, Massachusetts, Hawaii, Michigan, and Mississippi all rely on carriers to conduct utilization reviews. Hawaii indicated that injured workers are allowed a set number of treatments under state law, after which treating physicians must provide compelling reasons for extending treatments. Mississippi does not have a set number of treatments specified by law, but it does have utilization guidelines. Massachusetts has implemented a compensation review system to determine whether utilization review agents are following the treatment guidelines set by the state for the maximum number of treatments or services allowed for a particular injury. Studies in Texas concluded that overutilization was the reason for

increasing costs. The state relies on insurance carriers to conduct utilization reviews to determine the medical necessity of a service. According to Texas, many believe that the adoption of Medicare's ground rules will serve as a de facto treatment guideline, allowing carriers to more consistently deny services that are not medically necessary.

Some states collect data to monitor their workers' compensation system, while others do not. In Massachusetts, Michigan, Hawaii, and Mississippi, insurance carriers report to the state the amount of claims paid. North Carolina indicated that the state currently processes inpatient claims while insurance carriers process outpatient claims. Therefore, the state has data on all inpatient claims, while carriers have data on all outpatient claims. Washington, because its state fund is the only carrier in the state for workers' compensation, has data on all claims that are not self-insured. For self-insured claims, it has limited data. In Texas, all medical bills submitted to insurance carriers are required to be reported to the Texas Workers' Compensation Commission.

Although the states indicated that insurance carriers collect data on workers' compensation claims, some states collect data required to monitor their workers' compensation system, while others do not.

Many States Reported Some Barriers to Success

Many states reported barriers to success in implementing their resource-based fee schedules. Both North Carolina and Hawaii indicated that they encountered challenges stemming from understanding, or keeping up with, how changes in the Medicare program rules should affect their workers' compensation programs. Texas experienced legal problems arising from the use of fee schedules. Michigan reported that it had trouble getting information out to physicians about the state's switch to the fee schedule. Washington's respondent was unaware of any significant barriers at the time the fee schedule was implemented. This may have been because the state kept physicians involved in the implementation and update process.

THE DIVISION LACKS A DATA COLLECTION SYSTEM THAT IS ADEQUATE TO MONITOR THE WORKERS' COMPENSATION SYSTEM

One of the most critical needs of the workers' compensation system is useful and accessible data that can assist with overseeing the system and making necessary policy changes. However, the system that is intended to provide these data, the Workers' Compensation Information System (WCIS), has been

Although the Workers' Compensation Information System (WCIS) concept appears to have promise as a useful research and monitoring tool, according to the division, the WCIS has suffered extensive delays because of slow implementation, inadequate resources, and technical hurdles.

under development for years and is currently unable to facilitate evaluation of the workers' compensation system and measure the adequacy of benefits for injured workers or provide statistical data for research necessary to guide policy decisions. Although the WCIS concept appears to have promise as a useful research and monitoring tool, according to the division, the WCIS has suffered extensive delays because of slow implementation, inadequate resources, and technical hurdles. Further, the administrative director has not set a projected completion date for the system. As a result, the WCIS is not available to assist the administrative director in isolating the factors causing the increases in medical costs in the workers' compensation system or in monitoring the effects of the policy changes regarding fee schedules for medical services that the administrative director is currently contemplating.

The Data Collection System Is Not Ready to Monitor Changes in the Workers' Compensation Medical Payment System

An important consequence of the slow pace of the WCIS development is that the division will not have the medical payment information it needs to effectively monitor the proposed transition from the current charge-based medical fee schedule to an RBRVS-based fee schedule or to monitor the effect of other recent or pending changes to the system. The division is currently considering whether to implement the changes in the OMFS during an undefined transitional period, rather than through a comprehensive and immediate change. Although the decision about a transition is pending, monitoring the outcomes of the change is considered extremely important by workers' compensation researchers.

Given the likelihood that some types of medical provider specialties could be affected by the proposed changes to the OMFS, it will be particularly important to monitor trends in the system in order to gauge the economic impact, if any, on specific medical service providers and any resulting effect on workers' access to quality care. However, in the absence of a monitoring system that contains adequate, relevant, and timely data, it will be difficult for effective monitoring to occur once the division begins to migrate to the RBRVS approach. The division admits that the WCIS will not adequately serve the monitoring function during the transition to the RBRVS and is considering gathering additional information items.

Development of the WCIS Has Been Delayed by a Variety of Factors

Mandated by workers' compensation reform legislation enacted in 1993, the WCIS is designed to store data received from workers' compensation insurers, self-insured employers, and third-party claims administrators (claims administrators) through an electronic data interchange process, using standards developed by the International Association of Industrial Accidents Boards and Commissions (IAIABC). The WCIS project formally began in July 1997 and comprises three administrative data modules: the first report of injury (first report data), the subsequent report of injury (subsequent report data), and medical billing/payment data (medical data). Although legislation mandated the development of the WCIS in 1993, the division did not begin collecting first report data until September 1999, did not collect subsequent report data until July 2000, and is still working to complete the medical data module.

Purpose and Elements of the First Report of Injury and the Subsequent Report of Injury

The *first report of injury* is used to make the initial report of worker injury and includes the name of the insurer, nature and cause of the injury, and any physical restrictions.

The *subsequent report of injury* is used to report when indemnity benefits of a particular type and amount are started, changed, suspended, stopped, delayed, or denied, when a claim is closed or reopened, or when an employee changes attorneys.

According to the division, the delay experienced in developing the WCIS was due to a variety of factors, including a conscious decision to move slowly on the project. According to the division, the WCIS was mandated in 1993 after the Legislature recognized the need for a state-maintained database containing workers' compensation claims information. At that time, California had few databases containing workers' compensation claims and cost data. Those that did exist were proprietary, and the entities that owned them were selective in allowing access to the data. Nationwide, state workers' compensation agencies were working with claims administrators through the IAIABC to define national standards for data transmission and collection of workers' compensation claims data, to avoid problems caused by different state standards that added to claims administrators' and insurers' costs. The initial intense opposition to the WCIS from insurers and claims administrators affected the pace of development and has persisted throughout the life of the project. The division moved slowly at first because of this intense resistance and opposition.

According to the division, at the time the project was initiated, there were no existing models for designing a statewide system capable of handling the volume of cases and data that existed in California's workers' compensation system. Once the feasibility

study report was approved by the Department of Finance in 1998, an outside vendor began work on designing the system. However, the chief architect of the design died suddenly, leaving a void in knowledge and expertise among the contractor's staff and delaying system development. The system design was complex. To conform to IAIABC standards for collecting and transmitting data, and to enable workers' compensation insurers and claims administrators maximum flexibility in their methods of transmitting the required data to the WCIS, the division contracted with another vendor to develop additional software. However, the first attempt to incorporate the additional software in the system was not successful. According to the current research director, when he began working for the division in 2001, the WCIS was collapsing because of technical difficulties and backlogs of data from insurers and claims administrators. He went on to say that the system is now refined and the division has the in-house capacity to maintain and further develop the WCIS as needs change.

The Division Has Not Provided Assurance That Its Data Collection System Will Provide the Information Needed to Meet Its System Oversight Responsibilities

The next major phase in the WCIS implementation process is to collect detailed medical billing information pertaining to individual workers' compensation claims. Although the division has identified the medical billing data elements that it believes it needs to monitor the medical payment system and conduct research, it is still working with insurers and claims administrators before requiring that they submit the data elements to the WCIS. In May 2002, the division and the WCIS Advisory Committee (advisory committee) selected 78 medical data elements and surveyed a sample of seven insurers to obtain input on the practicality of collecting the data elements selected. Membership in the advisory committee comprises a cross section of the workers' compensation community, including representatives of claims administrators.

Although the division has identified the medical billing data elements that it believes it needs to monitor the medical payment system and conduct research, it is still working with insurers and claims administrators before requiring that they submit the data elements to the Workers' Compensation Information System.

By January 2003, the division had gathered the results of its survey and concluded that the sampled insurers could provide most of the medical data elements that the division had proposed to collect. However, we question whether the collection of this data will be sufficient to meet the statutory objectives for the WCIS because of the inconsistency in the data reported as being collected. Our analysis of the survey results indicates that only seven of the 78 medical data elements are

According to the division, as of July 2003, it is still working with the insurers and claims administrators to identify and refine the list of medical data elements of most value for analyzing medical treatments and monitoring the costs in the system.

being collected by all of the insurers in the sample. In addition, the survey respondents reported mixed collection efforts for other important medical data elements. For example, only five of seven respondents sampled reported that they collect data that identify a worker's injury or illness, the DRG code. Furthermore, only four of seven respondents reported that they collect data regarding facility codes. The division defines the facility code as indicating the type of facility where medical treatment was provided and states that these data are useful in utilization reviews, audits, and statistical analysis; for determining whether treatment was provided in an inpatient or outpatient facility; and for tracking differences in costs between inpatient and outpatient facilities for similar procedures.

According to the division, as of July 2003, it is still working with the insurers and claims administrators to identify and refine the list of medical data elements of most value for analyzing medical treatments and monitoring the costs in the system. For example, insurers and claims administrators and the division are discussing issues related to the cost-effectiveness of gathering and reporting medical data and the trade-offs between data collection and the ability to address important public policy issues within the workers' compensation system. The division did not indicate how it plans to ensure that it collects the medical data it has determined it needs.

The Workers' Compensation Information System is intended to do the following:

- Assist the department in managing the workers' compensation system in an efficient and effective manner.
- Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.
- Assist in measuring how adequately the system indemnifies injured workers and their families.
- Provide statistical data for research into specific aspects of the workers' compensation system.

Source: Labor Code, Section 138.6.

We asked the division how it will ensure that the data it collects will provide the information on the medical payment system necessary to meet the statutory purpose of the WCIS. However, the division responded with vague information that was silent on medical payment data and, therefore, gave us no basis to believe that the WCIS will achieve its four statutory objectives. Specifically, the division indicated that about one million first reports of injury are submitted in California each year and that the division currently collects first report data from 75 percent to 80 percent of them. The division also indicated that about one-third of the claims reported in first reports become indemnity claims each year, but it did not specify how many of those claims are included in the data it collects. The division further stated that, with the WCIS's ability to receive, store, and report information gleaned from first report data and subsequent report data, it has met the

existing statutory objectives for the system. However, we believe that meeting the statutory objectives for the WCIS will involve collecting more information than is currently collected in the first report data. Moreover, the division's response did not speak to its current progress in collecting subsequent report data, nor did it indicate how it will ensure that it meets the additional reporting requirements for its third data module, which will collect and incorporate medical payment data into the WCIS.

The Division Has Not Identified a Target Date for Completing Its Data Collection System

The division has not identified a target date for completing the WCIS. It is reluctant to specify a target date for completing the next data module for the WCIS for several reasons. The research director pointed out that the WCIS will continue to evolve as policy questions change, and those changes will require changes in the data elements being collected. The research director also stated that technically, data collection for module one (first report data) and module two (subsequent report data) has been completed, and that the framework has been completed for adding the module for medical data. In addition, he stated that the system is capable of producing 26 reports, but that until the data "matures," some of the reports will have limited value for predicting real trends in the system. The division acknowledges that the WCIS's ability to produce any additional reports, beyond the 26 it is currently capable of, is directly related to staffing in the division's research unit and the information technology unit for Industrial Relations. It pointed to two factors that threaten the pace of further changes and improvements in the existing WCIS system: budget uncertainties and staffing, and the need to elicit cooperation from insurers and claims administrators so that needed medical data are reported.

The division pointed to two factors that threaten the pace of further changes and improvements in the existing WCIS system: budget uncertainties and staffing, and the need to elicit cooperation from insurers and claims administrators so that needed medical data is reported.

The division stated that reporting data to WCIS is currently "voluntary" for insurers, claims administrators, and self-insured employers, as there are currently no consequences for not reporting. According to the division, obtaining medical data from all these parties will mean a significant increase in the volume of data transactions collected. The division explained that it had arranged a pilot project with two insurers to transmit medical data on a trial basis as a test of current system functionality, but the insurers had recently decided to defer participation because they need to reduce costs. The division has since begun working with the State Compensation Insurance

Fund (state fund) in an effort to have it submit aggregate medical data to model the module for medical data collection and reporting. The division stated that the state fund wants to cooperate, but that it has yet to respond to the request sent in May 2003.

According to the division, the conditions that make it difficult to commit to a specific target date for completing the medical data collection module of the WCIS expansion include the following:

- **Resources**—The division's research unit currently has only one staff person, the research director, and the information technology unit for Industrial Relations may lose some staff through layoffs. If the governor's budget proposal for the division is funded, either through employer user fees or by restoring General Fund dollars, the division will be able to restore some research unit positions and will be able to pursue the collection of more medical data. The pace of programming work by the information technology staff will depend on the final staffing of the unit.

- **Research**—The division, by working with insurers and claims administrators, has identified most of the medical data elements to be collected. These insurers and claims administrators are reviewing whether supplying the identified medical data will involve excessive cost.

- **Rulemaking**—Once the list of medical data elements is finalized, rulemaking—the establishment of regulations through a public process—generally takes about six months.

If resources permit, the division plans to continue to work with the two insurers in its pilot to test transmission of medical data elements.

However, if resources permit, the division plans to continue to work with the two insurers in its pilot project to test transmission of medical data elements. The value in this, while the list is being finalized, is that the division can test the system's functionality before receiving data transmissions in real time from all insurers. One of the insurers that deferred participation said it could be ready in September. The state fund is also considering participating in the pilot project.

Another benefit of the pilot project cited by the division, beyond checking the ability to transmit and receive medical data elements, which have a much higher volume of data than first report data and subsequent report data transmissions do, is that it provides a trial period to check the linking of those data

to particular first report data and subsequent report data on a specific claim, and the chance to test the types of reports that can then be generated to address various policy questions.

Finally, the division stated that, if its funding is stabilized by passage of a state budget that includes employer user fees or sufficient General Fund moneys, and if the proposed funding augmentation for Assembly Bill 749 mandates is made, it will identify a timeline for completing the medical data collection module of the WCIS expansion. The 2003–04 Budget Act includes both employer user fees and an augmentation to fund Assembly Bill 749 mandates. ■

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CHAPTER 4

California Needs to Improve the Controls Over Workers' Compensation Medical Costs

CHAPTER SUMMARY

The costs to California's employers to support the workers' compensation system are accelerating, and medical costs are a major contributor to this increase. The current system lacks the cost controls that come from a system of updated and complete fee schedules to cover the payments for needed medical services and products, and it also lacks effective controls over the number and types of treatments (treatment utilization) to ensure that injured workers receive quality care at a reasonable cost to employers. According to the administrative director of the Department of Industrial Relations' (Industrial Relations) Division of Workers' Compensation (division), he has been unable to effect meaningful improvements to the medical payment system because of budget constraints and competing priorities.

Although the Legislature is still searching for the solution to rising medical costs, two proposals have been introduced by state entities for modifying the outdated payment system currently in use. One proposal from the division involves updating the current fee schedule for physician services to one that is resource-based, and the other proposal from the Commission on Health and Safety and Workers' Compensation (commission) calls for converting the entire payment system to one based on a combination of the Medicare payment system for medical services and products and the Medi-Cal payment system for pharmaceuticals. However, because the fee schedules in these proposals were not specifically designed for California's workers' compensation system, adjustments to the payments in the fee schedules may be required to ensure sufficient access to quality care. Moreover, the administrative director does not currently have an information system that collects the necessary data to monitor and improve the performance of the workers' compensation system.

RECOMMENDATIONS

Regardless of how the State modifies its workers' compensation medical payment system, it will need to improve its controls to allow it to better administer the system. As part of this effort, it will need to monitor the effects of policy changes so that it can respond more quickly to changing conditions in the system, including pressures on the costs of providing medical services and injured workers' access to care. Therefore, the administrative director and the Legislature should consider the following:

- Because rising costs in the workers' compensation system contribute to increased costs to California's employers, greater importance should be placed on more closely managing the components of the workers' compensation system, especially the costs of providing medical care to injured workers. As such, the administrative director should take the steps necessary to identify the organization and level of resources needed to effectively administer the workers' compensation medical payment system and should work with the Department of Finance and the Legislature to obtain those resources.

- Medical treatment guidelines that provide standards for the treatment reasonably required to relieve the effects of workers' injuries, and that are presumed correct unless medical opinion establishes the need for a departure from those guidelines, can serve to ensure that injured workers receive the care they need to return to work, control medical costs, and increase the efficiency of the delivery of those medical services. The administrative director, in coordination with the Industrial Medical Council (medical council), should adopt a standardized set of treatment utilization guidelines, based on clinical evidence, to deter over- or underutilization of physician services and other professional medical services and products. The administrative director should consider, to the extent possible, adopting treatment guidelines that are developed by independent entities and that are updated with adequate frequency to reflect advancing technology and changes in professional practice. If the administrative director adopts treatment guidelines developed by the medical council, he should take the steps necessary to ensure that those guidelines are developed without the appearance of undue influence from any group that participates in the State's workers' compensation system.

- To ensure that the treatment guidelines can serve as an authoritative standard for the treatment of workers' injuries, the administrative director should seek the changes necessary in the Labor Code to ensure that all insurers and claims administrators are required to follow the standardized treatment guidelines and that treatment guidelines are accepted in judicial proceedings.

- After obtaining any needed amendments to the law, the administrative director should amend the division's regulations to reflect those changes to the law. Specifically, the division's regulations should require that insurers and claims administrators adhere to the standardized treatment guidelines and should clearly define the role of treatment guidelines in determining treatment and in judicial proceedings.

- The administrative director should identify the appropriate transition strategy, if needed, to mitigate any significant adverse affects on access to care that a new payment system may have on certain groups of medical service providers.

- As part of an effort to more closely manage the medical payment system, the administrative director should more aggressively pursue corrective action needed to address issues identified in research reports, such as those from the commission, the medical council, the California Workers' Compensation Institute, and the Workers' Compensation Research Institute, as well as any issues raised by internal studies conducted by Industrial Relations.

- The administrative director needs an adequate level of timely information on medical costs and medical service delivery to monitor the performance of the workers' compensation system in delivering quality care to injured workers at reasonable costs to employers and to track the effect of policy changes on the system's performance. Now that the division's budget contains the employer user fees and a spending augmentation the administrative director asserts is needed to complete the division's Workers' Compensation Information System (WCIS), he should place the WCIS implementation project on a timeline to facilitate its completion as quickly as possible. In addition, the administrative director should take the steps necessary to ensure that the data collected in the WCIS will provide the information needed to adequately monitor medical costs and services.

- To ensure that legislation does not contain any unintended impediments to the improvement of the workers' compensation system, the administrative director should be more proactive in working with the Legislature to identify and amend any provisions that would adversely affect the administrative director's ability to effect changes. An example would include the requirement to develop an outpatient fee schedule using data that is not yet collected, effectively delaying the implementation of this fee schedule.

When determining the future structure of the workers' compensation medical payment system, the administrative director should consider the costs and practicalities of maintaining such a complex system and should give consideration to adopting a payment system that is based on structures that are maintained by other entities, such as a variation of the resource-based relative value scales (RBRVS) maintained by the federal Centers for Medicare and Medicaid Services, as he has done with his proposal for modifying the physician fee schedule. If the administrative director decides to continue modifying the current medical payment system, he should consider pursuing a variety of activities, including the following:

- Continue his efforts to identify the adjustments needed to ensure that payments for services in the proposed modified physician fee schedule are high enough to encourage participation by physicians and other professionals in order to provide adequate access to care for injured workers.

- Seek the needed resources to develop and maintain fee schedules for the remaining medical services and products, such as outpatient surgical facilities, pharmaceuticals, emergency rooms, durable medical equipment, and home health care.

One proposal to improve California's workers' compensation payment system requires converting the entire system to a combination system that would use a variation of the Medicare payment system for medical services, facilities, and products, and the Medi-Cal payment system for pharmaceuticals. If this proposal becomes effective, the administrative director should consider the following steps:

- Develop adjustments to the fee schedule for physician services and other professional services so as to mitigate any adverse effects on access to care the RBRVS payment system would

have in redistributing payment amounts away from medical specialties, such as surgery, and in increasing payments for evaluation and management services.

- Monitor the medical payment system to determine whether a reasonable standard of care can be achieved at the capped prices for services and products contained in the proposal.

- To fully benefit from adopting the Medi-Cal payment system for pharmaceuticals, in addition to adopting the Medi-Cal fee schedule, the administrative director should also study the feasibility of establishing a process to secure rebates from drug manufacturers like the supplemental rebates enjoyed by the Department of Health Services in its Medi-Cal pharmaceuticals purchase program.

- Because there are no universally successful formulas for determining payments for medical services and products, the administrative director should consult with other states that have adopted Medicare-based payment systems and consider any measures they have employed to secure quality care at reasonable prices.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: August 27, 2003

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APPENDIX A

The Resource-Based Relative Value Scale Represents Physicians' Level of Effort and Resources in Providing Services

Under the Medicare Physician Fee Schedule (physician fee schedule), the level of effort and resources required by physicians to perform medical services is primarily based on a relative value scale, known as the resource-based relative value scale (RBRVS) that was developed over the course of several years by a research team from Harvard's School of Public Health. This project was completed in three phases and was aided by practicing physicians, the American Medical Association (AMA), and the Medicare Payment Advisory Commission (MedPAC) (formerly known as the Physician Payment Review Commission). The AMA represents about 260,000 physicians in the United States. The House of Delegates is the principal policy-making body of the AMA. The House of Delegates comprises physician delegates representing nearly 100 national medical specialty societies; federal service agencies; and six sections representing hospital and clinical staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. The AMA's work includes developing and promoting standards in medical practices, research, and education; pursuing a strong advocacy agenda on behalf of patients and physicians; and providing timely information on matters important to the health of Americans. The MedPAC comprises health professionals and financial experts who advise Congress on issues affecting Medicare.

The first phase of the RBRVS project centered on choosing and testing methods to measure a physician's work for a sample of 400 medical services that ranged across 18 medical and surgical specialties and developed descriptions of roughly 25 services for each of the specialties. These descriptions were intended to represent medical conditions prevalent in the general population and were not specific to the Medicare population. Physicians were asked to rate the level of effort needed to provide these services within their area of expertise. Researchers placed the average results from different specialties on a common scale. A common service was designated as a baseline and assigned a value of 1.0. In other words, within each medical

specialty, each service was assigned a value that was based on the level of effort to provide that service relative to the effort required to provide the baseline service. These values formed the initial relative value units (RVUs) used within the RBRVS.

The results of the first phase were reviewed by a spectrum of medical specialty societies, the AMA, the Centers for Medicare and Medicaid Services (CMS), and MedPAC. These groups came to a consensus that it was possible to develop reliable and valid measures of physicians' work.

During the second and third phases of the project, most of the physician services included in the current procedural terminology (CPT), developed by the AMA, were surveyed through either national random samples or small physician groups. The CPT contains a listing of descriptions of medical services and procedures and serves to standardize the description of medical, surgical, and diagnostic services. According to the CMS, the research team was able to provide it with RVUs for approximately 5,000 physician services delivered by 32 different physician specialties. The RVUs that resulted from this project were subjected to review and validation from different sources, such as MedPAC and the AMA.

To calculate a payment for a medical service, the CMS multiplies the RVU assigned to the procedure by a conversion factor and adjusts it to account for the differences in the cost of providing services in different geographic locations. Effective between March 1 and December 31, 2003, the universal conversion factor for the physician fee schedule is $36.79. The RVU assigned to a procedure reflects components for a physician's work, practice expense, and malpractice expense. The CMS updates the physician fee schedule conversion factor each year by the percentage change in the Medicare Economic Index, which measures the change in the weighted average price for various inputs involved with providing physician services. It is also adjusted by a performance adjustment factor determined by a statutory formula that compares actual and target expenditures.

THE CMS REGULARLY UPDATES ITS RBRVS FOR PHYSICIAN SERVICES

The CMS is required to update the RVUs that comprise the RBRVS fee schedule annually to reflect the changes in CPT coding for physician services. In addition, Congress has mandated the CMS to examine the entire RBRVS no less than every five years.

Annual updates of the components of the RBRVS (physician work, practice expense, and malpractice expense) to reflect coding changes for physician services involve different groups of professionals working together. The CMS, representatives from the medical community, and the general public work collaboratively to update the RVUs. According to the AMA, in 1991, the AMA and national specialty societies formed the AMA/Specialty RVS Update Committee (update committee) to make recommendations to the CMS on relative values for new or revised procedure codes in the CPT. The update committee is composed of 29 members. Twenty-three are appointed by major national specialty societies, including three rotating seats whose membership changes every two years and two reserved seats—one for an internal medicine subspecialty and the other for any other type of specialty. The chair of the update committee; the chair of the Practice Expense Advisory Committee; the co-chair of the Health Care Professional Advisory Committee (HCPAC); and representatives of the AMA, the American Osteopathic Association, and the CPT Editorial Panel hold the remaining six seats.

The process of updating the RBRVS begins when the AMA receives proposed changes to procedure codes from its CPT Editorial Panel (panel). The panel consists of 16 members, 11 of whom are nominated by the AMA. The remaining membership is made up of one member each from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the CMS, the American Hospital Association, and the co-chair of the HCPAC. The panel's list of new and revised procedure codes is sent to the update committee, which prepares a summary of the codes. The AMA's specialty societies then have the opportunity to make recommendations on the procedure changes.

Members of the update committee's advisory committee review the summaries and indicate their specialty societies' interest in developing RVU recommendations. The specialty societies can participate in one of four ways: (1) survey their members

to obtain data on the amount of work involved in a service and develop a recommendation based on their survey results, (2) comment in writing on recommendations from other societies, (3) decide that the procedure coding does not need to be changed, (4) take no action because the codes are not used by physicians in their specialty. The update committee decides whether or not to adopt a specialty society's recommendation, refer it back to the specialty society, or modify it before submitting it to the CMS. Recommendations to the CMS require a two-thirds vote by update committee members.

The update committee forwards its recommendations to the CMS each May. The CMS reviews the recommendations by convening a multispecialty panel of physicians and internal staff, which evaluates the reasonableness of the proposed RVUs by comparing them to a reference set of RVUs for comparable services. The outcome of these panel evaluations is a list of the RVUs proposed by the CMS for update and is published in the *Federal Register.* Specialty societies and the general public have 60 days from the publication in the *Federal Register* to submit comments on the RVUs. At the end of the comment period, the CMS reviews the comments and makes a final determination on the RVUs to be added or revised during the annual update to the RBRVS. The comments and responses are also published in the *Federal Register.*

In addition to the annual updates of RVUs for new and revised CPT codes, Congress mandated that the CMS conduct a comprehensive review of the entire RBRVS at least once every five years. During the five-year review, the CMS seeks public comments on all procedures and their respective assigned relative values. In contrast, the annual updates review only the procedure codes that are affected by the CPT Editorial Panel's proposals to change or add procedure codes in the CPT.

Public comments all follow the same format. They include the CPT code, a clinical description of the service, and a discussion of the ways in which the work is similar to one or more of the reference services that the CMS uses in its evaluation of the RVUs. Public commenters are asked to provide data that would be nationally representative of the average work involved in providing the service and not to focus on cases that are extreme either in terms of time or intensity. The CMS's medical staff review these comments and then forward the codes to the update committee for its review. From this point, the five-year review follows the same process described previously for

the annual RVU update to evaluate proposed changes to the RVUs. The results of the first five-year review were published in the *Federal Register* on November 22, 1996. The final rule resulting from the second five-year review was published in the *Federal Register* on November 1, 2001, effective for procedures beginning January 1, 2002.

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APPENDIX B

A Survey of Other States' Experiences in Implementing Medical Service Fee Schedules

This appendix contains the results of our survey of other states' experiences with converting to resource-based payment systems for their workers' compensation programs. Our survey questions included the states' goals for implementing a fee schedule based on resources, the fee schedule's impact on utilization and access to care, the fee schedule's effect on overall system cost, and the data collection and monitoring methods used by the state. Finally, we asked about any barriers to successfully implementing the fee schedule, as well as for any advice the state might have regarding implementing a resource-based relative value system (RBRVS) fee schedule.

We selected five states that were included in an interstate survey by the Workers' Compensation Research Institute (WCRI) of workers' compensation programs that had adopted RBRVS fee schedules. The WCRI survey was of 12 large states with workers' compensation programs that collectively pay more than 50 percent of the nation's workers' compensation benefits. The five states we selected were Florida, Massachusetts, Pennsylvania, North Carolina, and Texas. Two states, Florida and Pennsylvania, did not wish to participate in our survey.

We also selected five states using RBRVS-based fee schedules that were cited in a study by the University of California, Los Angeles, Center for Health Policy Research, as representing a range of workers' compensation fee levels—both higher than and lower than the Medicare fee levels. The five states we selected were Hawaii, Michigan, Washington, Minnesota, and Mississippi.

HAWAII

Goals	Hawaii wanted to establish fair and reasonable fees for physician services. It was also concerned with rising medical and overall system costs.
Overall costs	After implementing the fee schedule in 1995, Hawaii reported that workers' compensation medical costs had dropped to 35 percent of total costs. However, since then, it is again experiencing rising medical costs that currently make up approximately 40 percent of total costs. System cost increases have been attributed primarily to increases in temporary total disability cases and increases in medical costs.
Updates	Hawaii updates its relative value units (RVUs) and conversion factor to coincide with updates of Medicare's RVUs and conversion factor, but it uses a 110 percent multiplier.
Utilization controls	Hawaii has utilization rules that set limits on the number of services.
RBRVS impact on utilization	Utilization of services has increased since Hawaii implemented the RBRVS fee schedule but is still within the limits set by the state.
RBRVS impact on access	Hawaii has no indication that access to physicians is a problem.
Monitoring—utilization	Hawaii relies on insurance carriers to determine the appropriateness of services for an injured worker. Insurance carriers employ independent medical examiners to make decisions regarding the appropriateness of the treatment or service.
Monitoring—access	Hawaii does not monitor access to services.
Data collection	Insurance carriers are responsible for reporting to the state the amount of paid medical costs.
Other payment systems	Physician services not included in the Medicare Physician Fee Schedule are reimbursed at usual and customary charges.
Barriers	Updates and maintenance continue to be difficult for the state because Medicare's program policies are not intended for workers' compensation. Therefore, Hawaii needs to keep up with the updates and ground rule changes to determine whether they are applicable to its workers' compensation system.
Advice	The respondent indicated that there should be uniformity in fees, regardless of the program. There should not be a difference between fees for workers' compensation and for other payers, because the service performed to treat an injury should be the same.

ADDITIONAL COMMENTS

Goals

- Reasonable fees are necessary to ensure access and quality of care. Medical costs were increasing and represented 43 percent of total costs prior to implementing the Medicare Physician Fee Schedule.

- Hawaii considers its current fee schedule, which is 110 percent of Medicare, to be fair and reasonable.

Updates to the Fee Schedule

- Hawaii uses the RVUs and the conversion factor from Medicare. However, it also applies a 10 percent increase to the Medicare fee levels for its workers' compensation program.

- The state updates its fee schedule using the same geographic adjustment factors used by Medicare.

- Although Hawaii still needs to keep up with Medicare's changes and ground rules, updates and maintenance are more convenient because Medicare has a more complete database of information than the state does. In addition, Hawaii lacks the resources to maintain an independent system.

Ground Rules

Hawaii adopted Medicare's ground rules because it views Medicare as having extensive information on payment systems and the resources to update the system. The respondent to our survey indicated that the state does not have the resources necessary to be able to maintain the system.

Utilization

- Hawaii has rules for utilization. An injured worker is allowed 15 treatments within the first 60 days. After the first 60-day period, the treating physician submits a treatment plan for the next 120 days. During the next 120 days, the injured worker may not exceed 15 treatments. For special circumstances, the treating physician must provide compelling reasons for extended treatment. Utilization has increased since implementation of the fee schedule but is within the limits set in the state's utilization rules.

- Hawaii conducts hearings to resolve disagreements on the treatment or services provided.

Access

- The state does not monitor access and quality of care.

- Hawaii has no indication that access and quality of care are a problem. Injured workers have not indicated difficulty in finding providers to treat their injuries, nor have they complained of poor quality of care.

Data Collection

Insurance carriers report to the state the amount of paid medical costs on each claim.

Providers

- There is no indication that injured workers are being denied services.

- Providers may request an adjustment to the fee schedule. When an adjustment is requested, Hawaii surveys the medical specialty discipline that requested the adjustment and makes changes accordingly. Adjustments are added to a supplemental fee schedule.

Other Fee Schedules

- Not all services are covered under the Medicare Physician Fee Schedule, and adjusted services are included in a supplemental fee schedule.

- For the services not covered under the Medicare Physician Fee Schedule, fees are determined by usual and customary charges. There are no conversion factors or RVUs for these fees.

- Pharmaceuticals are reimbursed at the average wholesale price plus 40 percent.

Advice

The respondent believes that providers would not be distracted by the different fees for different programs if there were uniform fees.

MASSACHUSETTS

Goals	Massachusetts wanted to adopt a fee schedule that was well accepted and universal in terms of what people understood. The Medicare Physician Fee Schedule was a good fit because people understood the Medicare payment system.
Overall costs	The Division of Health Care Finance and Policy (HCFP) and the Department of Industrial Accidents (DIA) do not currently collect cost data.
Updates	Massachusetts will take RVUs from the annual updates to the Medicare Physician Fee Schedule. The state has multiple conversion factors. Its fee schedule was implemented in December 1, 2002, so no updates have occurred.
Utilization controls	Utilization review is mandated for all compensable workers' compensation claims. Massachusetts has mandated treatment guidelines that set the maximum number of services for an injury. A 14-member medical advisory body determines treatment guidelines.
RBRVS impact on utilization	Massachusetts has not studied or measured the impact the fee schedule has had on utilization.
RBRVS impact on access	Massachusetts has not studied or measured the impact the fee schedule has had on access.
Monitoring—utilization	In January 2003, the Compensation Review System (CRS) was implemented. The goals of the CRS include reviewing compliance with treatment guidelines, patterns of care, and utilization of medical services and trends in medical care.
Monitoring—access	Data requirements in the CRS will enable the state to monitor an injured worker's access to medical services.
Data collection	The DIA is currently collecting data for the CRS. The CRS will measure the quality, necessity, and effectiveness of medical care, as well as the best practices. The HCFP does not currently collect data.
Other payment systems	Payments to outpatient surgical centers are based on Medicare's Ambulatory Surgical Center rates. Massachusetts pays the lower of multiple formulas for pharmaceuticals.
Barriers	The HCFP is responsible for setting fees in the fee schedule but does not currently collect claims data.
Advice	Massachusetts was able to gather support from different groups that were affected by changes in fees.

ADDITIONAL COMMENTS

Background

The HCFP is responsible for setting fees, while the DIA is responsible for other aspects of the program.

Goals

The Medicare system underwent public scrutiny; therefore it would be well accepted.

Updates to the Fee Schedule

- Changes to the fee schedule are introduced as regulations. This alone is a 90-day process.

- Updates have not been done because the fee schedule has been in place for less than one year.

- In the current fee schedule, there are multiple conversion factors that pertain only to provider types. For example, psychologists and psychiatrists use the same procedure code but different conversion factors.

- The conversion factors that are different from those used by Medicare have no relationship to Medicare.

- The conversion factors were developed to reflect smaller increases in 2002 over the existing fees in 2000 for the various specialties and provider types. It was not felt at the time that a move for all provider types to Medicare levels would be affordable or necessarily advisable.

Ground Rules

The state developed ground rules that were specific to Massachusetts because the volume of Medicare ground rules would be cumbersome to update. However, the state did adopt some of Medicare's basic payment structure.

Utilization

- The Health Care Services Board (HCSB) continually reviews and develops medical treatment guidelines.

- State-mandated treatment guidelines set the maximum number of visits for an injury. When utilization review agents review claims, they make decisions based on the treatment guidelines. Implemented in 2003, the CRS monitors utilization review to determine whether utilization review agents are following the treatment guidelines.

- After an employer reports an injury to its insurance carrier, the carrier is required to conduct a utilization review, either through in-house staff or through third-party contracts.

- In order to be able to conduct utilization reviews on workers' compensation claims, utilization review agents must be approved by the state. Massachusetts requires utilization review agents to be licensed professionals. Utilization review agents review workers' compensation claims for medical necessity and appropriateness of care.

- Utilization review groups are generally made up of nurses and medical directors.

- Massachusetts has not yet studied or measured the impact the fee schedule has had on utilization.

Access

As part of the CRS, insurers are required to report the date of injury and the date of treatment. This enables the state to determine whether injured workers are having problems gaining access to medical services.

Data Collection

The DIA collects data to monitor the services delivered to injured workers and to compare the data to the HCSB's treatment guidelines.

Providers

- Providers are generally satisfied because the fee schedule was an increase to the previous fee schedule.

- Providers and insurance carriers can negotiate outside the fee schedule. Massachusetts does not monitor negotiated contracts.

Other Fee Schedules

- Hospital inpatient facility fees are based on a payment on account factor (PAF) that is hospital-specific. The PAF reflects the private sector discount rate that is applied to hospital charges.

- Pharmaceuticals are based on Massachusetts' Medicaid drug reimbursements. The current formula for brand name drugs is the lower of the estimated acquisition cost (EAC) or usual and customary charges. For generic drugs, it is the lower of the federal upper limit, the Massachusetts upper limit, the EAC,

or usual and customary charges. The current definition of the EAC is the wholesale acquisition cost (WAC) plus 6 percent. A dispensing fee of $3.50 for brand name drugs and $5 for generics is added. There is currently a proposal to lower the EAC to the WAC plus 5 percent.

Advice

The state developed support for this project by gaining backing from the Legislature and other stakeholders, such as the Massachusetts Medical Society, the Department of Industrial Relations, the Division of Insurance, the Massachusetts Workers' Compensation Insurance Rating Bureau, and physician and provider groups. With any change to rates, the potential impact on utilization is an extremely delicate matter. Therefore, leave ample opportunity to review and offer testimony, data, and objections to any planned regulatory change. While it is not simple, it is an open and public process.

MICHIGAN

Goals	Michigan's goals for implementing a fee schedule for workers' compensation were cost containment, an updated system, and budget neutrality.
Overall costs	The respondent reported that overall system costs have gone up. However, increases in system costs cannot be attributed solely to the RBRVS fee schedule. According to the respondent, utilization plays the largest part in overall costs, but Michigan does not monitor utilization. The respondent reported that 100 percent of insurance carriers submitted data to the state this past year. These data include the amount paid per claim. Therefore, increases in overall system costs could be due to receiving better data. The respondent reported that the number of claims has gone down.
Updates	Michigan updates the RVUs by using the updates to the Medicare Physician Fee Schedule. In October 2000, the state added all of the current procedural terminology (CPT) codes to the fee schedule.
Utilization controls	The state relies on insurance carriers to control utilization. Insurance carriers determine whether a procedure or treatment is reasonable and necessary.
RBRVS impact on utilization	Michigan does not have treatment guidelines for insurance carriers to follow. The respondent indicated that she felt the state has high utilization compared to other states.
RBRVS impact on access	The respondent reported that Michigan has no indication that access to medical services is a problem.

Monitoring—utilization	Insurance carriers are responsible for determining whether treatment is reasonable and necessary for the injured worker. However, Michigan does not have treatment guidelines for insurance carriers to follow. The respondent stated that, many times, insurance carriers choose not to look closely at actual utilization of services, instead depending on discounts from provider-carrier agreements.
Monitoring—access	The respondent indicated that if access to service was a problem, injured workers would lobby or make complaints to the state.
Data collection	Insurance carriers report the amount paid per claim to the state annually. Michigan does not collect utilization data.
Other payment systems	Pharmaceuticals are reimbursed at the average wholesale price plus a $4 dispensing fee. Dental services are determined by usual and customary charges. Cost-to-charge ratios are used in determining hospital reimbursements. The ratio is calculated by using the hospital's most recent year-end information submitted to the Department of Community Health. This reimbursement rate reflects a 7 percent premium above charges.
Barriers	Michigan initially had trouble getting the information regarding the conversion to the fee schedule out to physicians.
Advice	The respondent reported that updates to the conversion factor and the RVUs should be done at the same time rather than separately.

ADDITIONAL COMMENTS

Background

- A fee schedule was put into place beginning in 1989. Michigan switched to an RBRVS fee schedule beginning in 1996.

- The initial version of the RBRVS fee schedule did not include all the procedure codes contained in the American Medical Association's CPT.

- Payments for procedures that are not assigned an RVU are based on usual and customary charges.

Updates to the Fee Schedule

- In 1996, Michigan adopted Medicare's 1995 RVUs. In 2000, all procedure codes contained in the CPT, along with their RVUs, were added to the state's fee schedule.

- RVUs were last updated in March 2003 to reflect the Medicare 2002 RVUs.

- Michigan moved from three conversion factors to one conversion factor between October 2000 and January 2002. The current conversion factor for all services is $47.01.

Geographic Adjustments

The state is separated into two geographic areas for Medicare: Detroit and the rest of Michigan. For workers' compensation, Michigan melds the two areas together.

Ground Rules

Because of the complexity and frequent updates to the Medicare ground rules, Michigan adopted only Medicare's basic payment rules.

Utilization

The state does not monitor utilization.

Access

- Mediation services are provided by the state if there are disagreements with access or quality of care.

- Insurance carriers try to get injured workers back to work at full capacity or at least on a restricted duty status. Insurance carriers continue to pay for necessary and reasonable medical services even after the worker returns to work.

- The insurance carrier supplements injured workers' wages with a partial payment in order to return the wage to preinjury levels if the injured worker returns to work on restricted duty.

Data Collection

Insurance carriers report the amount paid per claim annually to the state. The state includes this information in Michigan's workers' compensation annual report.

Providers

Providers who complained that there would be access problems and threatened to leave the state prior to the initial rules in 1989 and again when the state adopted the RBRVS system in 1996, are

still treating workers' compensation patients today. Over the last three to four years, providers appear to be accepting the workers' compensation fee schedule without complaint.

Other Fee Schedules

- Michigan's fee schedule covers all medical services, devices, apparatus, and attendant care.

- Supplies and durable medical equipment are reimbursed at the average wholesale price plus a markup of not more than 50 percent.

- Dental services and other ancillary services such as vision and hearing services are reimbursed at the provider's usual and customary charge or reasonable charge, whichever is less.

- A hospital is reimbursed for certain services such as emergency room services, inpatient services, outpatient surgery, physical medicine services, and lab services using a cost-to-charge ratio methodology. The reimbursement equals the charge times the cost-to-charge ratio times 1.07. The ratio is calculated using the hospital's most recent year-end information submitted to the Department of Community Health. This reimbursement reflects a 7 percent premium above charges.

Barriers

- During the mid-1980s when there was talk of using a fee schedule, some specialty providers sued the state for a temporary injunction because they did not want their codes included in the fee schedule. This initial fee schedule was not based on the RBRVS.

- Getting the initial information to the providers about the state changing over to RBRVS fee schedules was a problem because workers' compensation providers are not required to register with the state.

Advice

- The respondent suggests updating the conversion factor and the RVUs at the same time.

- The respondent believes that the fee schedule has made it easier administratively because Medicare develops all the information concerning the RVUs, and the updates already existed.

TEXAS

Goals	The state's previous relative value for physicians (RVP) fee schedule, a charge-based schedule, was not working because of the high costs of the Texas system. The state wanted to move toward a fee schedule that was resource-based and evidence-based and improved consistency among other payers.
Overall costs	Costs under the RVP fee schedule were increasing due to overutilization of medical services. Providers were required to bill using the 1995 CPT codes, which caused medical disputes, since certain providers would bill using more current CPT codes. Many providers and carriers felt that the RVP fee schedule was outdated and was becoming harder to enforce. These concerns led to changes in the statutes in 2001 requiring the state to adopt the RBRVS fee schedule in April 2002 in order to align workers' compensation billing and payment patterns with those in other nationally recognized health care delivery systems.
Updates	Under the RVP-based fee schedule, the state was using a 1996 fee schedule based on 1995 procedure codes. Under the RBRVS, the state intends to automatically follow Medicare's annual updates of RVUs. The conversion factor will be 125 percent of Medicare.
Utilization controls	The state currently relies on insurance carriers to conduct utilization reviews and deny payment for services that are not medically necessary. By rule, the state also preauthorizes some services.
RBRVS impact on utilization	Under the RVP-based fee schedule, utilization was determined to be the primary cost driver for the state's increasing medical costs. The RBRVS-based fee schedule has not been implemented yet, and therefore the impact on utilization is unknown.
RBRVS impact on access	Texas is currently working on a research plan to study issues relating to access to care.
Monitoring—utilization	The state is currently working on a research plan to assess the impact of the new fee schedule on medical costs, utilization of medical services, and access to care.
Monitoring—access	Texas is currently working on a research plan to assess the impact of the new fee schedule on medical costs, utilization of medical services, and access to care. In addition, registration of physicians will enable the state to compare the number of physicians providing medical services to injured workers after implementing the RBRVS fee schedule to the number of physicians providing those services before the change.
Data collection	All injured workers' medical bills that are submitted to insurance carriers must be reported to the Texas Workers' Compensation Commission (commission). The commission collects these data monthly.

Other payment systems	Inpatient hospital services are paid at the lesser of (1) the prenegotiated rate between the hospital and the insurance carriers, (2) the hospital's usual and customary charges, or (3) a predetermined per diem rate. Ambulatory outpatient care and emergency services that do not result in hospital admission are reimbursed at a fair and reasonable rate.
Barriers	Texas was involved in legal proceedings over the methodology used to determine the conversion factor, and it also had problems understanding how to apply the geographic adjustments.
Advice	The state indicated that if utilization is determined to be the main driver of increases in medical costs, states should implement utilization controls first.

ADDITIONAL COMMENTS

Goals

- Texas will be implementing an RBRVS fee schedule within a year. The state wanted to move toward a fee schedule that was resource-based and evidence-based, rather than the charge-based RVP fee schedule currently used. Also, the state wanted to improve its consistency with nonoccupational payers in the state.

- Implementation of the fee schedule was held up because of litigation over the methodology used to determine the workers' compensation conversion factor.

Updates to the Fee Schedule

- Texas statutes require the state to update the fee schedule every two years. However, the state has had trouble updating the fee schedule. Until the adoption of the RBRVS fee schedule in April 2002, the state was using a 1996 fee schedule based on 1995 procedure codes. Problems with updating the fee schedule were attributed to resource constraints and the state not having access to representative billing and payment data from other health plans. Lack of available billing and payment data, including access to proprietary data included in managed care contracts, made it difficult for the commission to calculate a new fee schedule using anything but earlier charge data in the workers' compensation system.

- The state intends to automatically follow Medicare's annual updates of RVUs and the Medicare conversion factor. Texas will apply a multiplier that is 125 percent of Medicare.

- Texas will use the eight Geographic Practice Cost Indices that Medicare uses for the state.

Ground Rules

- Texas had its own ground rules under the old RVP fee guideline. However, there were people who felt that the state's ground rules were too unique to Texas workers' compensation cases and therefore not reflective of best or standard medical practices.

- The state adopted all of Medicare's ground rules for the RBRVS-based fee schedule. Texas statutes allow the commission to make exceptions to Medicare's ground rules by issuing a rule in order to provide some flexibility in situations where the workers' compensation system is indeed unique.

Utilization

- The Workers' Compensation Research Institute and the Texas Research and Oversight Council conducted studies about cost drivers in the state's workers' compensation system. Both studies determined that overutilization was the main cause of the increase in medical costs. The state currently uses a model that relies heavily on insurance carriers to conduct utilization reviews and deny payment for services that are not medically necessary.

- The state plans to continue requiring preauthorization of some services, such as inpatient hospitalization, spinal surgery, and experimental procedures. Many believe that the adoption of Medicare's ground rules will serve as a de facto treatment guideline, allowing carriers to more consistently deny services that are not medically necessary.

Access

- The state is currently working on a research plan to study access to care issues as well as the economic impact of the RBRVS/Medicare structure on medical costs and medical disputes.

- Providers and labor groups have raised some concerns that the Texas workers' compensation multiplier factor is too low (the 1996 fee guideline paid approximately 140 percent of Medicare and the new 2002 fee guideline will be paying 125 percent of Medicare) and as a result of that, providers

will leave the workers' compensation system. In addition to the lower fee schedule, access to care will also be affected by statutory changes passed in the last legislative session that require all doctors to register with the state in order to be workers' compensation providers and receive training on workers' compensation issues.

- Registration of providers will give the state an idea of the number of providers in the system under the new guideline, and this can be compared with the number of providers who billed for medical services under the old fee guideline.

Data Collection

In Texas, every medical bill submitted to a carrier must be reported to the commission monthly. Usually, surveys of injured workers are used to measure perceptions regarding access to care, although additional quantitative analysis will be conducted that will look at the number, type, and geographic location of providers billing under the old fee guideline compared with those billing under the new fee guideline.

Providers

Provider payments, in general, were reduced from 140 percent of Medicare to 125 percent of Medicare. Providers also have to register and receive training in order to be workers' compensation providers. In response to the lower workers' compensation multiplier factor, the Texas Medical Association and the Texas AFL-CIO jointly sued the commission over the validity of the guideline. A district court judge enjoined the guideline until a full hearing could be completed. In the spring of 2003, the judge upheld the commission's guideline. A new implementation date for the RBRVS fee schedule is forthcoming.

Other Fee Schedules

The reimbursement for generic drugs in Texas is the average wholesale price times 1.25 plus a $4 dispensing fee. The reimbursement for brand name drugs is the average wholesale price times 1.09 plus a $4 dispensing fee. The pharmacist receives a $15 fee for combining more than one drug substance in making up a prescription. Language was added to the rules to clarify that reimbursement for over-the-counter drugs will be made at the retail price of the lowest package quantity available.

Barriers

- Litigation over the methodology used to determine the conversion factor delayed implementation. It was anticipated that since overutilization, and not fees, was the primary driver of increased workers' compensation medical costs in Texas, more attention would be placed on implementing the monitoring program for carriers and providers first. As it turned out, however, the fee guideline was tackled first, and when the litigation occurred, it delayed not only the implementation of the guideline but also the monitoring program.

- Technical problems that have occurred include questions about how carriers are supposed to apply Medicare's Geographic Practice Cost Indices when workers' compensation providers do not have provider numbers for each of those indices.

- Another question was whether additional payments should be made to providers in medically underserved areas, since this is a common practice in Medicare.

- Questions still remain about how a provider or an injured worker is supposed to petition the commission for an exception if the doctor or worker believes that a particular service is needed that Medicare currently does not pay for.

Advice

- The state should be more prescriptive in the statute regarding the methodology for calculating the workers' compensation multiplier factor (such as clearly indicating which economic factors to consider or whether an inflationary factor should be systematically applied).

- If utilization, and not price, is the problem causing increased medical costs within a state, then the state should implement the system features designed to control overutilization first. Since Medicare's RBRVS fee schedule and ground rules are considered to be restrictive, it might have been a good idea to move to the RBRVS and leave medical expenditures at their former levels until after the payment policies were fully implemented. Once the fee was lowered, that became the center of controversy and, as a result of the litigation, any benefit the state may have achieved from the implementation of the payment policies was delayed. Also, the litigation delayed the implementation of a monitoring program for utilization.

- The state should consider how the Medicare payment policies would be used or enforced during the dispute resolution process, especially if nonproviders are responsible for resolving disputes.

- The state should also consider how to handle exceptions to the Medicare process that will arise and whether individual exceptions should be allowed or whether a party must petition for a change in the rule.

NORTH CAROLINA

Goals	North Carolina wanted to move away from payments based on the usual, customary, and reasonable criteria and toward a payment system that is fair and equitable.
Overall costs	The respondent believes that overall system costs have gone down but lacks data to support this belief. The state has information on claims, services, and utilization for inpatient bills. All other services are processed through the carrier.
Updates	North Carolina applies multipliers to the dollar amounts determined by the Medicare Physician Fee Schedule for various medical services. There have been no changes to the multipliers.
Utilization controls	The state relies on insurance carriers to conduct utilization reviews that are consistent with statutes. North Carolina's rules regarding utilization review are not strict. Inpatient services are the only services required to be preauthorized.
RBRVS impact on utilization	North Carolina does not monitor the impact on utilization at the state level.
RBRVS impact on access	The state reported that there is no indication providers are opting out of the workers' compensation system.
Monitoring—utilization	North Carolina relies on insurance carriers to monitor and review cases.
Monitoring—access	The state reported that it relies heavily on data collected by the Workers' Compensation Research Institute to monitor access.
Data collection	North Carolina has data on inpatient services. On all other services, it relies on the carriers to provide the information to the state. Insurance carriers provide North Carolina with the amount paid for medical-only claims annually, and they report the amount paid in indemnity costs when the case is closed.

Other payment systems	Outpatient facility fees are based on 95 percent of the usual, customary, and reasonable charges. Inpatient facility fees are based on the diagnosis-related groups (DRGs), but the state sets a floor on these fees of no less than 77.07 percent of charges. Ambulatory surgical centers are reimbursed at 100 percent of usual, customary, and reasonable charges.
Barriers	The major barrier to success was that North Carolina initially was not direct in saying that it was going to adopt Medicare's guidelines with regard to utilization review. Problems also arose when the Medicare program changed some of the dollar amounts in its physician fee schedule.
Advice	A state should be direct in informing stakeholders when it decides to adopt Medicare guidelines.

ADDITIONAL COMMENTS

Updates to the Fee Schedule

- North Carolina applies multipliers to the Medicare Physician Fee Schedule amounts in order to determine payment under the state's workers' compensation program. Payment for each procedure is dependent on the year the procedure code was added to the state's fee schedule.

- The state applies the multiplier to the Medicare conversion factor in place during the year the procedure was added to the state's fee schedule.

- North Carolina uses four multipliers:

  Surgery: 2.06

  Radiology: 1.96

  Physical therapy: 1.3

  All other services: 1.58

- The respondent indicated that the state used 1995 statistical data from the WCRI to determine the multipliers. So far, North Carolina has made no changes to its multipliers. If and when the state decides to update the multipliers, it will most likely contract out for the service.

Geographic Adjustments

North Carolina applies the same rates across the entire state.

Ground Rules

- North Carolina did not adopt Medicare's rules entirely. It did not adopt all of Medicare's ground rules because some Medicare policy issues are not relevant to workers' compensation.

- When the state does review cases, it uses Medicare's ground rules as a guide. North Carolina then makes a judgment on fairness as to whether the rule applies to workers' compensation.

Utilization

- Carriers conduct utilization reviews. The state expects carriers to submit utilization review plans that ensure cost-effectiveness as well as quality care for injured workers. In cases in which the injured worker returns to a limited work assignment, a rehabilitation professional is usually assigned to ensure that the worker is getting the necessary treatment.

- The respondent indicated that utilization review statutes appear to be reducing the treating physician's control over treatment plans.

Access

- The respondent indicated that North Carolina has had some concerns over injured workers' access to care because of a recent influx of preferred provider organization (PPO) networks in the state. These PPO networks require that injured workers know not only which physicians are part of the PPO, but also which physicians within the PPO accept workers' compensation cases.

- The state has no indication that providers are opting out of the workers' compensation program. However, providers are concerned about receiving prompt payment.

Providers

Surgery professionals always scrutinize the fee schedule more than other providers because they are the group that has the most to lose. Physical therapists are relatively patient with the fee schedule. In general, providers feel that the rates are fair.

Other Fee Schedules

In a professional setting, drugs are reimbursed at 20 percent above cost. In nonprofessional settings, such as stand-alone pharmacies or hospitals, drugs are paid in full. In other words, charges are reimbursed at the billed amount unless the payer negotiated a discount. Physicians who bill for pharmaceuticals may have to provide an invoice to the payer, as they would for unlisted supplies. The reimbursement is cost plus 20 percent.

Barriers

North Carolina is in the process of consolidating the state's workers' compensation information. This has proven to be a difficult task because the information on the 1996 codes and RVUs is separate from the subsequent additions of procedure codes and their respective RVUs.

MINNESOTA

Goals	Minnesota reported that the RBRVS was designed to address the following problems with the previous charge-based fee schedule: administrative difficulty, insufficient coverage, and the lack of cost control.
Overall costs	The state reported that the fee schedule has reduced the system cost, but it has not estimated by how much.
Updates	The fee schedule was last updated in 2001, using 1998 RVUs. Physical medicine and chiropractic manipulation services use 1999 RVUs.
Utilization controls	Minnesota relies on insurance carriers to make determinations regarding whether treatment is reasonably required to cure or relieve workers' injuries. Insurance carriers use treatment parameters developed by the state in order to make these determinations.
RBRVS impact on utilization	The state has no indication that the fee schedule has adversely affected utilization.
RBRVS impact on access	Minnesota reports that instances of injured workers having difficulty finding medical care are rare.
Monitoring—utilization	The state is in the process of conducting a study of cost drivers in the workers' compensation system.
Monitoring—access	The Customer Assistance Unit resolves disputes and fields questions from all parties. A medical compliance services specialist investigates complaints about health care providers and certified managed care plans.
Data collection	Minnesota is in the process of conducting a study that will address data collection.
Other payment systems	Payments to hospitals are determined by using a percentage of their usual and customary charges. The percentage depends on whether the hospital has more or fewer than 100 beds.

Barriers	Minnesota reported that the fee schedule is difficult to update and maintain. The Medicare RVUs and procedure codes change annually. Given the volume of the Medicare RBRVS, updates under the Minnesota Administrative Procedures Act are time-consuming and expensive.
Advice	Based on Minnesota's experience with the frequent changes in the Medicare RVUs, the state suggests that the process for making annual updates should be looked at closely. In addition, the initial level of the multiplier factor and the most appropriate factor for annual increases to the multiplier factor should also be considered carefully.

ADDITIONAL COMMENTS

Background

- The original maximum fees for the 1993 RBRVS fee schedule were set to reflect a 15 percent overall reduction from the 1991 charge-based fee schedule. Legislation required that the relative value fee schedule differentiate among health care provider disciplines. Therefore, the 15 percent reduction was applied separately to four provider groups: medical/surgical providers, physical medicine services, chiropractic providers, and pathology/laboratory providers.

- Rather than use a separate multiplier factor for each group, Minnesota calculated one factor for the medical/surgical services, which was to be used for the other provider groups as well. For the other three provider groups, the 15 percent reduction was incorporated into the RVUs through the use of a scaling factor for physical medicine services, chiropractic, and pathology/laboratory. The scaling factors are 0.867 for physical medicine RVUs, 0.541 for chiropractic RVUs, and 0.835 for pathology/laboratory services.

- Scaling factors are used to reduce the Medicare RVUs for physical medicine, chiropractic, and pathology/laboratory services during the update process.

Goals

As stated in Minnesota's Statement of Need and Reasonableness for the RBRVS as adopted in 1993, it was designed to address the following three problems with the previous charge-based fee schedule:

1. **Administrative difficulty**: It was burdensome to obtain statistical charge-based data to update the fee schedule annually. The Medicare RVUs were not expected to change.

2. **Insufficient coverage**: Almost half of charges were not covered by the previous charge-based fee schedule because the statistical criteria for inclusion were not met. The Medicare RBRVS included many more services, so coverage was expected to be more comprehensive.

3. **Lack of cost control**: Medical costs were expected to be more easily controlled because increases would no longer be based on the previous years' charges.

Updates to the Fee Schedule

- Minnesota law permits annual updates by an abbreviated rulemaking process. However, given the volume of codes and services, the need to modify the Medicare fee schedule for consistency with the workers' compensation law, and the requirements of the Minnesota Administrative Procedures Act, updating the fee schedule is still expensive and time-consuming.

- The conversion factor was updated annually by no more than the increase in the statewide average weekly wages until October 2002. Thereafter, it is increased by the change in the producer price index for physician offices.

Geographic Adjustments

The only geographical adjustment that is made to the RVUs is the one assigned to Minnesota by Medicare. The Medicare geographical adjustment is made when the RVUs are updated.

Ground Rules

To the extent possible, Minnesota adopted by rule the Medicare payment policies. However, some of these policies limit coverage that is otherwise payable under the workers' compensation law. Where the Medicare payment policies conflict with the Minnesota workers' compensation law, the state has adopted separate rules.

Utilization

- The workers' compensation law requires that employers provide treatment that is reasonably required to cure and relieve the employee from the effects of the injury. The state relies on insurance carriers to make this determination during their bill review process.

- The state has adopted treatment parameters for common work-related conditions, which insurers use to determine whether treatment of covered conditions is reasonable and necessary.

- The Department of Labor and Industry and compensation judges have authority to make decisions on compensability if there is a dispute about whether a treatment was reasonable and necessary.

- Treatment parameters and fee schedules are components of a unified policy to control costs, in that the treatment parameters limit utilization increases that might otherwise result from the payment limits.

- Legislation passed by Minnesota in 2003 requires the Department of Labor and Industry to convene a working group to study the medical cost drivers in the workers' compensation system, including the growth in workers' compensation medical costs compared to the growth in medical costs in other systems. The working group will also identify and assess the costs that are unique to providing care to injured workers.

Access

- A statutorily created Medical Services Review Board and a medical consultant advise the state about issues related to the medical treatment of injured workers.

- The state is not aware of any reports or complaints about access or quality of care.

Data Collection

Minnesota is in the process of conducting a study that will include data collection.

Providers

- Some providers recently threatened to leave the system in response to a proposal before the workers' compensation advisory council to set the multiplier factor at 129 percent of the Medicare conversion factor. The proposal did not pass. For medical doctors, the multiplier factor is currently at 208 percent of Medicare.

- Chiropractors and physical medicine providers object to the lower payments reflected by the scaling factors applied to those services. Legislation was proposed this year to require the same payment for the same CPT code regardless of the type of provider delivering the service. That legislation did not pass.

Other Fee Schedules

- Minnesota pays for inpatient services at hospitals with more than 100 beds at 85 percent of the hospital's usual and customary charge. Outpatient services at these large hospitals are paid according to the RBRVS fee schedule if the service is in the fee schedule; otherwise the services are paid at 85 percent of the usual and customary charge.

- Inpatient and outpatient services at a small hospital (100 or fewer beds) are paid at 100 percent of the hospital's usual and customary charge.

- Pharmaceutical fees are limited to the average wholesale price plus a dispensing fee of $5.14, or a lower actual retail price for nonprescription medication.

Barriers

The Medicare RVUs and CPT codes change annually, and given the volume of the Medicare RBRVS, updates under the Minnesota Administrative Procedures Act are time-consuming and expensive.

MISSISSIPPI

Goals	Prior to implementation of the fee schedule, Mississippi's insurance carriers were complaining that the cost of servicing workers' compensation claims was rising. The state felt that costs needed to be contained to a reasonable level. Medicare's Physician Fee Schedule appeared to be reliable and defensible.
Overall costs	Overall system costs appear to have stabilized, but the state does not have supporting data. Increases to indemnity payments are dependent on the State Average Weekly Wage.
Updates	Mississippi reviews the fee schedule annually but updates it only when Medicare makes major changes to its RVUs. RVU updates are taken from the Medicare Physician Fee Schedule when the state determines it is necessary. Ingenix (a consultant) developed the state's conversion factors, which are based on usual and customary charges.
Utilization controls	There is no limit to the number of treatments for an injured worker. Mississippi relies on insurance carriers and providers to follow the state's utilization rules. Some insurance carriers contract with other vendors to perform utilization reviews. Insurance carriers require providers to submit a request for treatment or service plan. This control has proven effective in controlling utilization.
Impact on utilization	Mississippi does not have the data to track utilization.
Impact on access	The state reported that there is no indication that access to providers and services is a problem.
Monitoring—utilization	Mississippi relies on insurance carriers to monitor utilization.
Monitoring—access	The state monitors access through complaints.
Data collection	Mississippi contracts with Ingenix to provide conversion factors specific to Mississippi. Insurance carriers report the total amount of paid claims to the state.
Other payment systems	Hospital outpatient facility fees are based on 150 percent of Medicare's Ambulatory Surgical Center (ASC) fee schedule.
Barriers	The respondent was not present during the implementation and therefore is not aware of any barriers.
Advice	It is important to keep the providers and payers involved in the fee schedule process from the beginning. The system must be consistently reviewed, and accurate data must be obtained.

ADDITIONAL COMMENTS

Goals

Mississippi wanted to be able to use Medicare's documented medical information.

Updates to the Fee Schedule

- Mississippi reviews the RVUs annually but updates them only when there is a big change in Medicare RVUs.

- The respondent indicated that updates to the RVUs occurred in 1998 and then again in 2002. The RVUs were reviewed in 1999–2001 but were not updated because of the expense. There were major changes to the American Medical Association (AMA) procedural codes in 2000. Therefore, Mississippi updated the codes and RVUs and completed this effort in 2002.

- There are multiple conversion factors according to medical specialty. To maintain budget neutrality and approximate usual and customary charges, the state applied conversion factors that were above Medicare's conversion factor.

Geographic Adjustments

The state contracted with Ingenix to provide Mississippi-specific conversion factors, which are the same across the state.

Ground Rules

The fee schedule specifically states that if there is a dispute between state and federal laws, federal laws supersede state laws. Medicare's ground rules were not adopted.

Utilization

- There is no limit to the number of treatments for an injured worker.

- Insurance carriers monitor utilization. Mississippi cannot determine whether utilization of services has increased, because it does not have the data to track utilization.

Access

The state has no indication that access is a problem.

Providers

Providers were involved in the process since the very beginning. Public hearings and meetings were held between providers and the workers' compensation commission before publication of the first fee schedule.

Other Fee Schedules

- In Mississippi, generic pharmaceuticals are reimbursed at 110 percent of the average wholesale price plus a $5 dispensing fee. Name brand pharmaceuticals are reimbursed at the average wholesale price plus a $5 dispensing fee.

- Hospital inpatient facility fees are based on per diem rates and outlier reimbursements.

- Hospital outpatient facility fees are based on 150 percent of Medicare's ASC fee schedule.

WASHINGTON

Goals	Washington wanted fair payments for providers that are based on the resources used.
Overall costs	Medical costs are increasing.
Updates	When new codes are added to Medicare's RBRVS, Washington updates its fee schedule by adding those codes with the new RVUs. Based on comments and suggestions from the AMA, the state occasionally diverges from Medicare's RVUs, but those occasions are rare. Washington creates its own conversion factor based on the new RVUs and the state's historic utilization patterns to maintain aggregate payment levels from the current fiscal year after the new RVUs are adopted.
Utilization controls	Washington has utilization review programs for specific inpatient services.
RBRVS impact on utilization	Although the state has data on utilization, it has not monitored the system for utilization as well as it could.
RBRVS impact on access	Washington reported that some orthopedic surgeons left the workers' compensation program, but the number of those physicians treating injured workers has remained relatively stable.
Monitoring—utilization	Washington has utilization programs for specific inpatient services. However, the respondent indicated that the state could do a better job of monitoring utilization. Washington also reviews utilization patterns and adjusts the conversion factor in order to stay within a set budget.
Monitoring—access	In order to treat workers' compensation patients, physicians must apply annually to the state. This enables Washington to monitor whether or not physicians are leaving the system.
Data collection	Washington has a single provider of workers' compensation insurance, the state fund. Therefore, the state has data on all but self-insured employers.

Other payment systems	Hospital facility fees for outpatients are based on Medicare's outpatient payment system, with modifications. For most inpatient fees, Washington determines payment from one of three options: (1) the state's DRGs, (2) a statewide per diem for less common diagnoses, or (3) a percentage of allowed charges.
Barriers	The respondent was not aware of any significant barriers.
Advice	The state suggests that providers be involved in every step of the implementation and update process.

ADDITIONAL COMMENTS

Background

Implementation of the RBRVS fee schedule occurred during the period from 1993 to 1995.

Updates to the Fee Schedule

- RVUs are taken directly from Medicare's RBRVS fee schedule annually. When Medicare adds new CPT codes, Washington adds those codes to the fee schedule with the RVUs. The state does occasionally diverge from Medicare's RVUs, depending on the comments and suggestions from the AMA.

- A state interagency group representing different views gets together to review the RVUs for consistency.

- Washington reviews utilization patterns and adjusts the conversion factor in order to maintain aggregate payment levels. Annual adjustments are also applied to reflect the State Average Weekly Wage.

- Medicare has two geographic adjustment factors for Washington. The state uses one geographic factor for its workers' compensation system. This factor is reviewed and updated annually.

Ground Rules

Washington uses Medicare's ground rules as a guide.

Utilization

- The state could do more with regard to monitoring and controlling utilization.

- As the state fund is the only insurer for workers' compensation in Washington, the state has all data on utilization except for self-insured employers.

Access

In order to be able to treat injured workers, providers need to apply to be workers' compensation providers. This allows Washington to keep track of the number of system providers.

Data Collection

Washington has data on all but self-insured workers' compensation claims because the state is the only insurer. However, it has not conducted studies on or evaluated the data.

Other Fee Schedules

Most pharmaceuticals are reimbursed at the average wholesale price minus 10 percent plus a $4.50 dispensing fee.

Advice

Providers should be involved in every step of the process, including in the update process.

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Agency's comments provided as text only.

California Labor and Workforce Development Agency
801 K Street, Suite 2101
Sacramento, CA 95814

August 11, 2003

Elaine M. Howle, State Auditor
Bureau of State Audits
555 Capitol Mall
Sacramento, CA 95814

Dear Ms. Howle:

The Labor and Workforce Development Agency (Labor Agency) reviewed the draft report of the Bureau of State Audits (BSA) on the medical payment system in the California Workers' Compensation program. This letter contains the Labor Agency's response for inclusion in the final report.

As you are aware, reform of the Workers' Compensation system is one of the most complex and challenging issues facing California's policymakers today. Rising health care costs, coupled with significant administrative and legal expenses, have resulted in increases in employer costs. A legislative conference committee on Workers' Compensation was appointed recently and has begun to examine ways to significantly reduce system costs while still providing access to care and high quality benefits to employees. The BSA report, with its extensive analysis of options for reducing medical costs, provides an important framework for the Conference Committee as it undertakes this difficult task.

Davis Administration Reform Proposal

On May 1, 2003, in recognition of rising costs and a shrinking pool of insurers, Governor Gray Davis, in coordination with Insurance Commissioner John Garamendi, announced a comprehensive package of Workers' Compensation reforms designed to keep jobs in California and curb rising employer costs while maintaining benefits for injured workers. Since the announcement, the Davis Administration has been working with members of the legislature, their staffs, and organizations and individuals who participate in the Workers' Compensation system to find common ground on these very difficult issues. Reform of the system is essential this year.

This plan incorporates new proposals and includes working with legislators on already introduced legislation aimed at easing employer costs. In summary, the proposal includes:

- requiring the development of an outpatient surgery center fee schedule;
- limiting what can be charged under all of the various fee schedules;
- strengthening prompt payment requirements;
- expanding the use of managed care and creating Independent Medical Review;
- making Return to Work credits transferable for employers who help their employees return to work;
- requiring insurance carriers to list their rates on the Internet and expand the posting of insurer audits results, including enforcement data;
- allowing collaboration between the Administration and the Department of Insurance regarding Workers' Compensation fraud and authorizing the Employment Development Department to share information with insurers in an effort to weed out fraud;
- increasing penalties for worst offenders who fail to pay employee claims and reducing penalties for minor delays;
- encouraging the use of generic drugs;
- certifying Medical Bill Review Companies and Claims Adjusters;
- expanding programs for employers and unions that agree to Alternative Dispute Resolutions;
- involving physicians earlier in the Workers' Compensation claims process; and
- promoting small business participation in Workers' Compensation policy making.

Utilization Review, Utilization Management, and Independent Medical Review (IMR)

The BSA points out throughout the audit report that California's rising medical costs are more attributable to frequency and length than what is billed for treatment. In addition, the BSA report also includes a discussion regarding studies that found effective utilization management requirements are lacking in California and are a cause of the rise in medical costs in the state. Further, the BSA correctly states that fee schedules and stronger utilization management are both necessary reforms in order to control costs.

Therefore, it is important to note that a key component of the proposed reform plan outlined above would address one of the very critical issues identified in the report - the need for effective utilization management and expedited dispute resolution to reduce and control medical costs in the system.

The Labor Agency agrees with your assessment that the dispute resolution process is inefficient and strongly supports strengthening requirements for utilization review and utilization management. This is essential in order to help ensure that injured workers get medically necessary care in the most efficient way possible and without delay. Nonetheless, disputes that result in denials and inappropriate delays in medical treatment are likely to still arise even with the strengthening of utilization management requirements and the use of treatment guidelines.

In light of this, the Administration has proposed a new process aimed at resolving costly disputes between treating doctors and insurance companies – Independent Medical Review (IMR) – whereby doctors independent of an insurance company make a decision about what treatments

injured workers ought to receive when proposed medical treatments have been denied or delayed. The addition of IMR for disputes over the necessity and appropriateness of medical treatment should improve medical decision-making and result in higher quality utilization decisions before an IMR would have to be undertaken. The IMR system has been used very successfully in California in since 2001 for consumers who have been denied medical treatments by their HMOs, PPOs and other health insurance plans.

User Funding

The report raises the issue of funding for the administration of the Workers' Compensation program. The Davis Administration first proposed 100 percent user funding of the Workers' Compensation system in the fiscal year 2003/04 Governor's Budget to provide a dedicated and stable fund source. Enactment of 100 percent user funding will remove the Division of Workers' Compensation's reliance on the General Fund and on economic conditions to further ensure the effective administration of the Workers' Compensation system. Furthermore, it is absolutely essential in supporting the significant administrative and legislative reforms recommended in the BSA draft report. We are pleased that the Conference Committee was given the responsibility in the recently enacted state budget for fiscal year 2003/04 to review this important proposal as a part of the discussion of a larger comprehensive reform package.

In addition, the new budget contains funding for the AB 749 reforms that were proposed in the Governor's fiscal year 2003/04 budget and aimed at reducing costs for employers. These include, among others, the creation of an official pharmaceutical fee schedule, limitations on medical liens, and implementation of the Return-to-Work program to provide employers with resources for worksite modifications, wage subsidies and premium rebates.

I wish to commend the BSA staff for their understanding and analysis of this complex issue and thank you for your thoughtful consideration of issues relating to the medical payment system in California's Workers' Compensation program.

Sincerely,

(Signed by: Herb K. Schultz)

Herb K. Schultz
Undersecretary and Acting Secretary
Labor and Workforce Development Agency

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press