

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

Presentation by
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This presentation document is only intended to outline selected portions of Report 2003-108.1, *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). For a more complete explanation of the points outlined in this document, refer to the report.

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AUDIT HIGHLIGHTS

- ◆ Rising medical costs are contributing to the overall increase in the workers' compensation system.
- ◆ 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- ◆ Fee schedules intended to control the amounts paid for medical services and products are outdated or nonexistent.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 costs and streamline the delivery of care to injured workers.
- ◆ Inadequate controls over treatment utilization are a primary cause of escalating costs in the workers' compensation system.
- ◆ Prior to adopting fee schedules developed by other entities such as Medicare, the division 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 will allow it to monitor the medical costs and measure the effectiveness of reforms made to the system.

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

Workers' Compensation Medical Costs and Workers' Compensation Insurance Premiums Are Rising

Workers' compensation insurance premiums have risen from \$5.8 billion to \$14.7 billion, or 153 percent, between 1995 and 2002. **(Figure 3)**

Uncontrolled and unpredictable inflation of workers' compensation medical costs is one of the primary drivers and a central cause of escalating workers' compensation premiums in the State.

The average estimated medical costs per indemnity claim in the workers' compensation system rose dramatically from \$8,781 in 1992 to \$31,120 in 2002, a 254 percent increase. In contrast, the national Medical Services Consumer Price Index (CPI), a measure of medical prices nationally, increased only 49 percent over the same time period. **(Figure 4)**

Because the medical cost increases include the effects of both price and utilization increases and the National Medical Services CPI only includes price increases, the steep rise in the workers' compensation medical costs can be attributed to utilization.

From 1995 through 2002 actual paid medical costs increased sharply. Paid medical costs include cost of services provided by physicians, hospitals, and pharmacies. **(Figure 6)** Medical costs have increased in almost all categories reported.

- ✓ Payments to physicians increased from \$1.1 billion in 1995 to \$2.1 billion in 2002.
- ✓ Hospital costs increased 132 percent from \$485 million in 1995 to \$1.1 billion in 2002.
- ✓ Payments for pharmaceuticals increased 188 percent, from \$103 million to \$297 million.
- ✓ Payments to chiropractors increased 126 percent, from \$104 million to \$235 million.

Our Review of Data From the State Compensation Insurance Fund Reveals Significant Characteristics of Medical Costs

Medical payment data from 1999 through 2002 reveals that increasing medical costs appear to primarily result from the increasing number of workers' compensation claims.

Payments for claims filed from as far back as the 1940s are a significant cost to the State Compensation Insurance Fund (state fund), however, they have remained relatively stable and do not appear to be contributing to the upward spiral in medical costs.

Our review of paid medical claims data from the state 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. (Based on medical claim payment data from the employers insured by the state fund in both 1999 to 2002.)

Between 1999 and 2002 total medical payments associated with the claims we identified increased 104 percent from \$329.5 million to \$673.4 million while at the same time the number of claims increased 50 percent from 145,996 to 218,687.

In 1999, \$89.1 million was paid for 67,401 claims for workers' injuries occurring in that year; however, for injuries occurring in 2002, \$173.3 million was paid for 96,943 claims. These increases of 94 percent in cost and 44 percent in number of claims indicate that newer claims may be a primary cause of increased medical costs.

As **Table 3** shows, the volume of services and not their price were a major cause of the overall increase in medical costs, regardless of the year the injury occurred. The number of medical services for which payments were made increased from 4.4 million in 1999 to 8.7 million in 2002. Of the \$343.9 million increase in medical payments, \$327.8 million represents an increase in the number of medical services rendered, and only \$16.1 million can be attributed to a higher price per medical service.

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

The failure to control costs includes using outdated fee schedules and formulas for physician, hospital inpatient, and pharmaceutical fees. In addition, for outpatient surgical facilities, no fee schedules or formulas exist.

The State has not facilitated a system of uniform treatment guidelines that can be used as a standard for treating the same types of injuries and illnesses.

Reports issued in 2003 by the Commission on Health and Safety and Workers' Compensation (commission) and the California Workers' Compensation Institute (CWCI) stated that using up-to-date fee schedules and utilization controls can be effective in containing costs. The two studies pointed out that savings could be achieved through the implementation of cost control measures.

Although legislation that took effect in 2002 authorized the development of a fee schedule for outpatient surgical facilities, the data necessary to develop the schedule is not currently collected. Moreover, the data will not be available until mid- to late-2005.

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.

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 current OMFS does not represent current or comprehensive medical services or products, and does not ensure that payments to providers are fair and equitable.

The division last updated the procedural codes and relative values of the OMFS for services rendered on or after April 1, 1999. Some of the values in the current OMFS are based on a 1974 value scale study.

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.

The cost outlier threshold is currently \$14,500. In contrast, the Centers for Medicare and Medicaid Services increased the federal threshold for 2003 from \$21,025 to \$33,560. The result of the low cost outlier threshold in California is that more cases qualify for outlier payment status, increasing total medical costs.

According to a 2003 study by the commission, updating the cost outlier threshold will reduce the percentage of outlier payments from 11 percent of all 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 plans, and other states' workers' compensation systems.

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 drug prices.

The generic fee formula in OMFS provides a premium of \$7.50 for dispensing generic drugs in addition to paying 140 percent of the average wholesale price (AWP). For brand name drugs, the dispensing fee is \$4 and the payment for the drugs is 110 percent of the AWP.

In contrast, Medi-Cal pays a single dispensing fee of \$4.05 regardless of whether the drug is brand name or generic, and it pays the lowest of three predetermined reimbursement rates, usually AWP minus 10 percent. In addition, Medi-Cal negotiates supplemental rebates from drug manufacturers.

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

According to the administrative director, efforts to update the fee schedules have been hampered by resource shortages at the division, and he cited staff reductions of 25 percent over the past three years.

In addition, the administrative director states that efforts to fill authorized positions have been stalled by the hiring freezes.

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. However, the 2003-04 Budget Act includes an augmentation of just over \$8 million to implement the legislation.

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

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.

Providers are entitled to charge amounts that are considered usual, customary, and reasonable. Research indicates that these types of charges are inflationary and inequitable and that such a payment method distorts the relationship between the resources used to provide the services and the payment for those services.

The absence of a fee schedule also has created the unintended consequence of increased administrative costs as a result of case-by-case negotiations between payers and providers for each procedure.

A LACK OF EFFECTIVE UTILIZATION CONTROLS LEADS TO HIGHER MEDICAL COSTS

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 study of 1999 and 2000 claims with more than seven days of lost work found that while California's average medical payment per claim was typical for the 12 states in the study, the average price paid per service was 44 percent lower than the 12-state median, but the number of visits was 71 percent higher. **(Table 4)**

One way to control utilization is to adopt clinical treatment guidelines. Researchers agree that evidence-based treatment guidelines would be effective in streamlining care and containing costs for injured workers.

The Workers' Compensation Research Institute's (WCRI) 2003 12-state study found that injured California workers who missed more than seven days of work were visiting physicians, chiropractors, and physical or occupational therapists substantially more times than the 12-state median. **(Table 5)**

Despite lower average prices per service, chiropractors in California receive higher average payments per claim than the 12-state median. **(Figure 7)**

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

Little consistency exists in the methods used by insurers and claims administrators in reviewing proposed medical treatments for injured workers.

A 2001 study by the division revealed that 20 of 22 payers reported using a total of eight different utilization review criteria. Nearly one-third of the insurers and claims administrators reported that they use 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.

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

The Current Legal and Regulatory Structure for Utilization Review Is Ineffective

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.

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 to provide review standards and it requires all insurers to comply with these protocols.

However, the regulations adopted do not establish utilization review standards based on utilization protocols, but instead allows insurers to establish their own unique utilization review plans so long as they maintain and make available written summaries of the plans that describe the review processes, criteria used, and qualifications of the personnel who develop and review the criteria.

The administrative director stated that he does not believe he has the statutory authority to make utilization reviews mandatory for insurers.

Enacted Legislation Requires a Study of Utilization Controls

Legislation enacted in 2002 requires the administrative director, in consultation with the commission and the medical council, to conduct a study of medical treatment provided to injured workers who have sustained industrial injuries. The 2003-04 Budget Act provides funding for the study.

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

According to a 2003 study by RAND, nearly 20 percent of workers' compensation claims filed in California result in disputes that enter the judicial process.

The study also found that the time it takes to hold a settlement conference or convene a trial following the initial request is much longer than the period allowed by law, as illustrated in **Figure 8**.

RAND reported that the Workers' Compensation Appeals Board (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.

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

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

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 resource-based relative value scale (RBRVS).

According to an analysis performed for the division by the Lewin Group, this proposal would increase the total payments to physicians and other medical professionals by 7 percent to compensate physicians for the additional evaluation and management work necessary for workers' compensation cases, and to reflect the migration from the OMFS to a resource-based fee schedule.

The Lewin Group claimed that the 7 percent increase would not adversely affect payments to other medical specialties; however, the redistribution of payments that would occur is a major barrier in gaining support from the physician community. **Table 7** shows how the conversion to an RBRVS-based fee schedule will redistribute payments among physician treatment specialties.

Other considerations in the administrative director's proposal include using a conversion factor to keep total payments at the same level as those under the current OMFS. 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.

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

The commission proposes linking the entire workers' compensation medical payment system to Medicare's fee schedules for medical services, equipment, and products and to Medi-Cal's fee schedule for pharmaceuticals. The commission estimates an overall net savings to the workers' compensation system of \$964 million in 2004.

The maximum fee for medical services, including facility fees and products, would be 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.

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

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.
- Malpractice costs that are allocable for providing the service.

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

Diagnosis-related groups (DRGs) cluster injuries or illnesses together according to similar clinical problems that are expected to require similar amounts of hospital services.

Hospital payments under the inpatient 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 such as cost-of-living and hospitals that serve a disproportionate share of low-income patients.

Medicare makes outlier payments to provide incentives for hospitals to treat complicated and more costly injuries and illnesses. To qualify as an 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.

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

The outpatient payment system was mandated by Congress as part of the Balanced Budget Act of 1997 and went into effect August 1, 2000.

Outpatient procedures performed by hospitals are categorized into procedure groups called Ambulatory Payment Classifications (APCs). 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. APC payment rates are calculated and adjusted nationally for wage differences in different geographic locations. Hospitals receive Medicare payments equal to 80 percent of the APC rate allowed.

For services provided in a nonhospital outpatient setting, there are nine Ambulatory Surgical Center (ASC) categories, each with its own rate. Medical procedures are grouped into these nine categories. The federal Centers for Medicare and Medicaid Services (CMS) determines the

standard ASC payment rates by taking into consideration the costs incurred by ambulatory surgical centers in connection with performing certain procedures. Ambulatory surgical centers receive Medicare payments equal to 80 percent of the rate assigned to each group.

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

One way the Department of Health Services (Health Services) controls the cost of pharmaceuticals under the Medi-Cal program is through the use of a 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.

Medi-Cal pays for drugs using the lowest of three predetermined reimbursement rates. According to Health Services, most of the drugs are paid at the average wholesale price less 10 percent, plus a dispensing fee. In addition, Health Services obtains rebates from the drug manufacturers that seek to have their drugs added to the contract drug list.

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

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

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.

The CMS Updates the RBRVS Regularly

Congress mandated the CMS to update the physician fee schedule annually. The CMS is also charged with conducting a systematic review of the relative values for all physician services every five years.

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.

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

Medicare’s RBRVS underwent extensive national review and scrutiny in the 1990s.

The states we contacted that have implemented the Medicare RBRVS payment system generally report that their objectives for adopting it—to control costs and improve fairness and to simplify administration—have been met.

The RBRVS was not designed to be specific to Medicare, so it can be used with other populations such as the one covered by the workers’ compensation system.

Other Advantages

The formula that determines payment under the RBRVS adjusts for geographic differences in the costs of maintaining a physician practice. Medicare already performs some of the work that would be needed to determine adjustments to payment amounts based on geographic location.

Medicare has access to updated hospital cost data that are not available to the State, which it uses for its inpatient payment system.

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.

Adopting the Medicare’s outpatient payment system would shift the administrative burden of maintaining and updating an outpatient fee schedule from the State to the CMS.

One of the reasons states cite for adopting the RBRVS fee schedule was to simplify the administration of their workers’ compensation systems.

DISADVANTAGES

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

There will be a need to mitigate the possible restrictions to access to services that the RBRVS system might have because of redistributing payments for services across the different medical specialties. **(Tables 8 and 9)**

Other Disadvantages

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.

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

Physician and Hospital Inpatient Fees Are Estimated to Increase

The commission concluded that 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 a geographic adjustment factor, will increase overall payments to physicians by \$281 million in 2004 rising to \$345 million in 2006.

The commission also estimated that total hospital inpatient payments would increase more than 8 percent for ordinary admissions, increasing from \$340 million to \$367 million. Payments for cost outliers would decline by \$19.5 million.

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

Currently, outpatient surgical facility fees for the California workers' compensation system are unregulated, and adopting Medicare's APC and capping rates at 120 percent, the commission estimates would save \$834 million in 2004.

The commission's study estimates the workers' compensation system could save 37 percent annually by adopting the Medi-Cal pharmaceutical fee schedule, or an estimated \$370 million in 2004.

The commission also concluded that linking the fee schedules to Medicare/Medi-Cal and the updating processes should enable the workers' compensation system to reduce administrative costs by an estimated \$70 million.

We could not verify any of the commission's estimates because the underlying data was not available.

MEDICAL FEE SCHEDULES ALONE WILL NOT CONTROL TOTAL MEDICAL COSTS

Research studies agree that lack of effective utilization controls is a major driver of total medical costs in California's workers' compensation system.

Studies of other states 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.

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

According to the executive director of the medical council, adopting all the Medicare ground rules would add significant administrative complexity to the 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 carriers or fiscal intermediaries.

Medicare's ground rules do not have any number assigned to them for easy location or identification and they are geared toward a 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.

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

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

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.

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

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.

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

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.

Policymakers need to consider the effects that lower fees may have on providing incentives for increased utilization when making decisions on fee schedules.

Conversion Factors May Be Needed to Increase Medicare Fee Amounts

Workers' compensation patients may require more administrative effort and present more complicating issues that could require more time and medical expertise to treat.

Medicare payment levels have been affected by federal budgetary constraints that do not apply to states' workers' compensation programs.

A 2001-2002 study by 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.

Significant Changes in Fee Amounts May Require a Transition Strategy

The Lewin Group identified three approaches to lessening the effect of a significant decrease in payments on medical providers caused by adopting a resource-based OMFS:

- ✓ Blend the old and new relative value units for computing payments.
- ✓ Moderate the effect on particular medical specialties during a set period by limiting the change in fee schedule amounts under the RBRVS.
- ✓ Use multiple conversion factors.

RAND identified four different policies that other programs have used to phase in payment changes:

- ✓ Establish floors and ceilings on maximum annual changes that would be needed in service-specific conversion factors.
- ✓ Blend conversion factors. Cost-neutral conversion factors are gradually blended with the new conversion factor over time.
- ✓ Establish 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.
- ✓ Base the transition payment amount on the payment for specific procedures rather than on service groups.

CALIFORNIA CAN BENEFIT FROM THE EXPERIENCES OF OTHER STATES

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

WCRI found that among the 40 states it studied, some have fee levels that are higher and some have fee levels that are lower than the Medicare levels, even though the objectives for the fee schedules are similar. States cited that objectives of the fee schedule include:

- ✓ Containing the growth of medical costs.
- ✓ Equalizing profit margins across different types of providers without limiting access to quality care.
- ✓ Simplifying administration.

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

All of the states we surveyed based their fee schedules on Medicare's RBRVS. Most of the states we queried believed that 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 different.

Every state we surveyed applies relative value units from Medicare in some fashion to determine their fee amounts. **Table 10** shows that the conversion factors used by the states vary significantly.

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.

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

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'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 factors to maintain desired spending levels.

In January 2003, Massachusetts implemented a compensation review system to monitor and review the insurance agents responsible for following state-mandated treatment guidelines.

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.

Some states collect data to monitor their workers' compensation system. 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. Because its state fund is the only carrier in the state, Washington has data on all claims that are not self-insured.

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

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.

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

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.

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.

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

In May 2002, the division and an 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. 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.

However, our analysis of the survey results indicates that only seven of the 78 medical data elements are 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.

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.

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

Reporting data to WCIS is currently voluntary for insurers, claims administrators, and self-insured employers, as there are no consequences for not reporting.

The division states that the conditions that make it difficult to commit to a specific date for completing the medical data collection module of the WCIS include research, resources, and rulemaking.

The 2003-04 Budget Act provides both employer user fees and an augmentation to fund certain mandates included in Assembly Bill 749.

RECOMMENDATIONS

The administrative director of the division should:

- Take steps necessary to identify the organization and level of resources needed to effectively administer the medical payment system and work with the Legislature and the Department of Finance to obtain those resources.
- In coordination with the Industrial Medical Council, adopt a standardized set of treatment utilization guidelines, based on clinical evidence, to deter over- or underutilization of physician services or other professional medical services and products.
- Consider 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.
- Take the steps necessary to ensure the treatment guidelines are developed without the appearance of undue influence from any group.
- 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 the treatment guidelines are accepted for use in judicial proceedings.
- After obtaining the changes in the law, amend the division's regulations to reflect those changes.
- Identify the appropriate transition strategy to mitigate any significant adverse affects on access to care that a new payment system may have on certain groups of medical service providers.
- More aggressively pursue corrective action needed to address issues identified in research reports or studies.
- Now that the additional resources are included in the budget act, place the WCIS implementation project on a timeline to facilitate its completion as quickly as possible.

When determining the future structure of the medical payment system, the administrative director should:

- Consider 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.

- Continue his efforts to identify 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 medical professionals.
- Seek resources needed 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.

If the proposal to convert the workers' compensation system to a combination system that would use a variation of the Medicare system for medical services, facilities, and products and the Medi-Cal system for pharmaceuticals is adopted, the administrative director should:

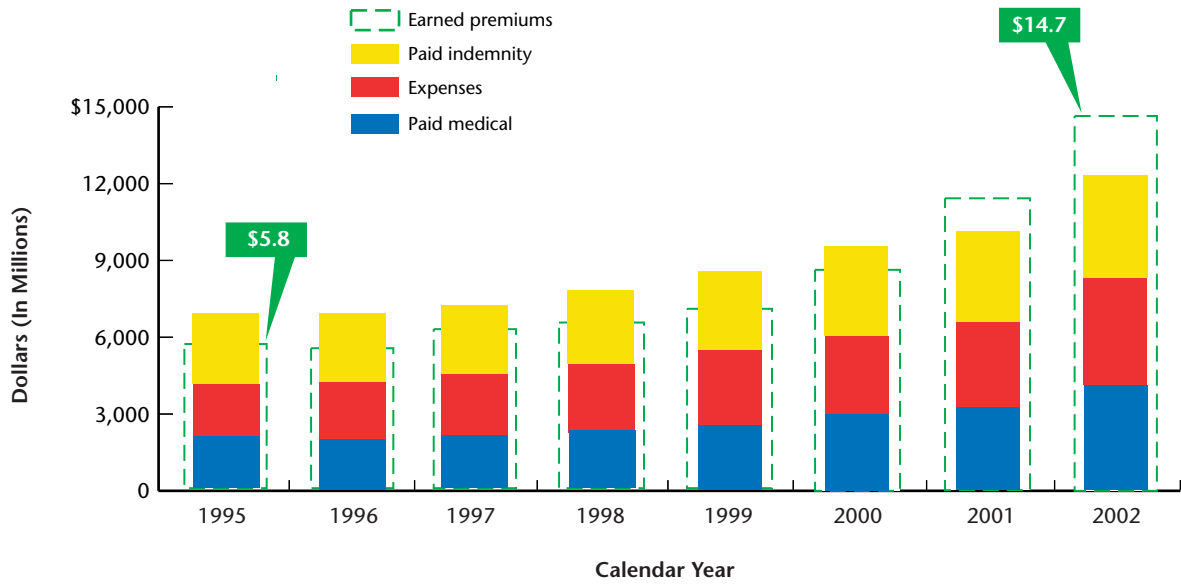
- Develop adjustments to the Medicare fee schedule to mitigate the affect on access to care the Medicare payment system would have in redistributing payment amounts away from medical specialties such as surgery, and in increasing payments for evaluation and management services.
- Monitor the medical payment system to determine whether a reasonable standard of care can be achieved at the capped prices contained in the proposal.
- Study the feasibility of establishing a process to secure rebates from drug manufacturers like the supplemental rebates enjoyed by Health Services in its Medi-Cal pharmaceuticals purchase program.
- Consult with other states that have adopted Medicare-based payment systems and consider other measures they have employed to secure quality care at reasonable prices.

APPENDIX—Tables and Figures

The following tables and figures appear in the order of the discussion presented in the presentation.

FIGURE 3

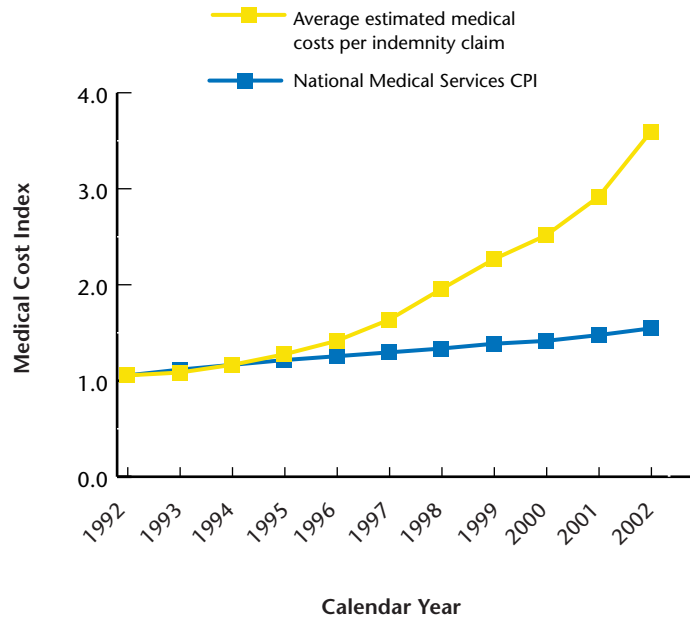
**Workers' Compensation Insurance Premiums and Costs
1995 Through 2002**



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

FIGURE 4

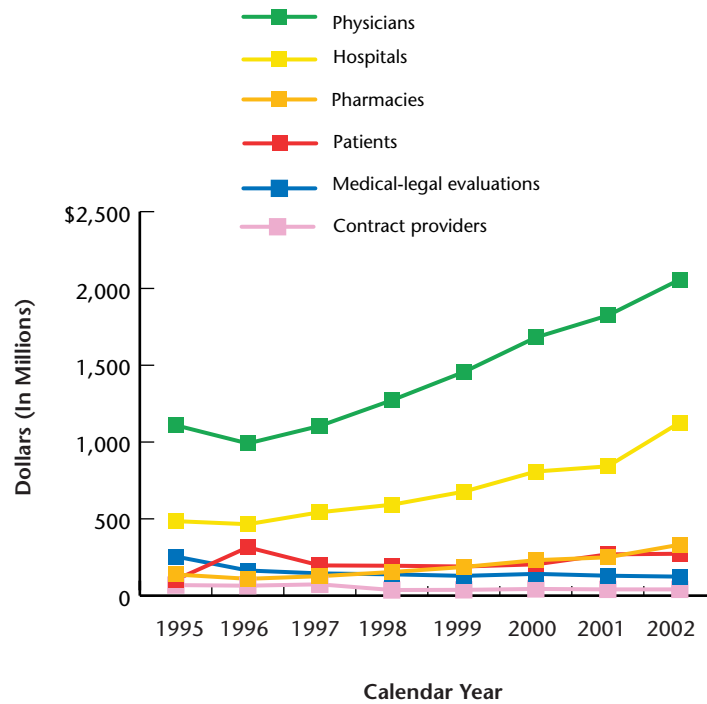
**Index of Workers' Compensation Medical Costs Per Indemnity Claim Compared to the National Medical Services CPI
1992 Through 2002**



Source: Workers' Compensation Insurance Rating Bureau.

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.

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.

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).

TABLE 5

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

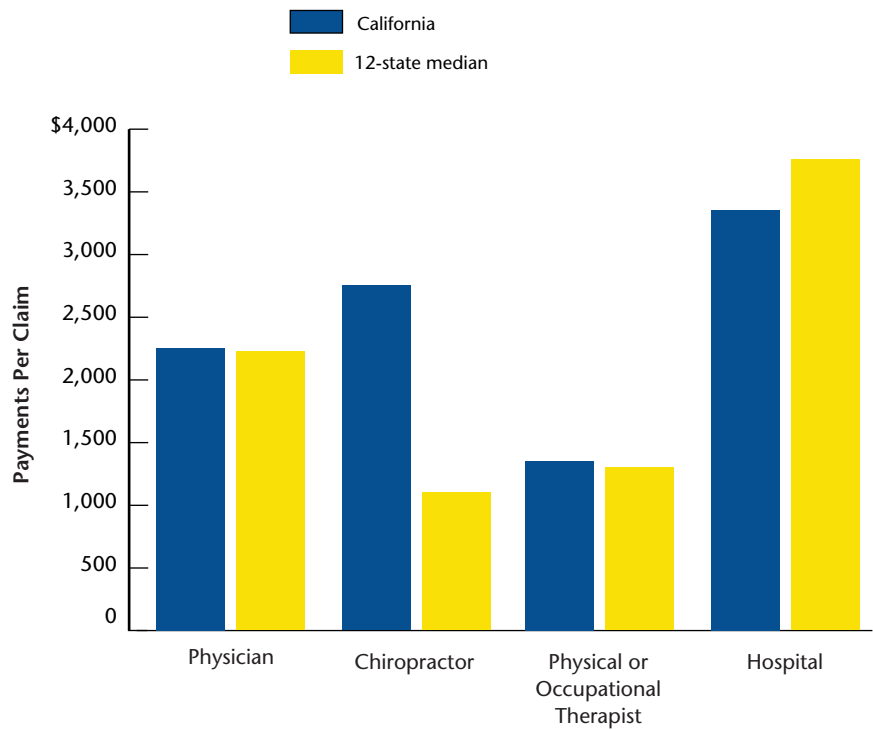
	California	12-State Median	Percent Difference
Physician	11.6	7.8	49%
Chiropractor	34.1	16.6	105
Physical or occupational therapist	17.0	12.2	39

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).

FIGURE 7

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

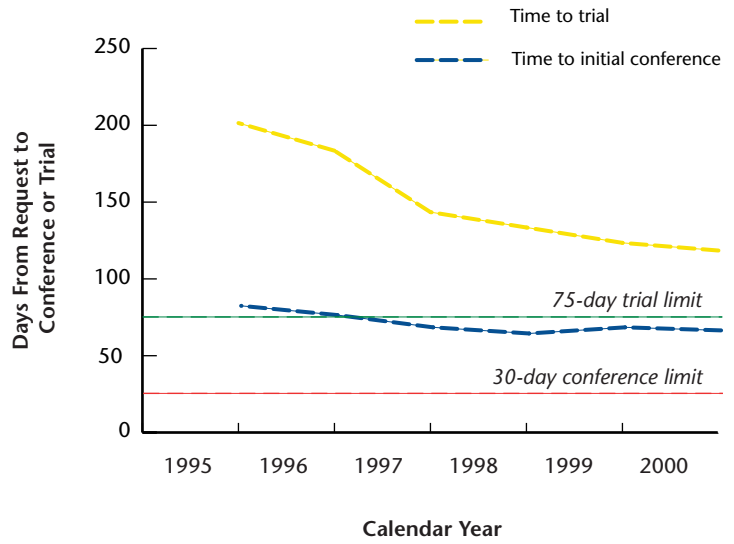


Source: Workers' Compensation Research Institute, *How California's Medical Costs and Utilization Compare to Other States, Preliminary Results*.

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

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.

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/convalescence)	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.

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.

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.

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.