

From the CEO

Weighing In on Workers' Compensation Reforms

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When sweeping workers' compensation medical reforms were under consideration in 2002, employers argued that unless unnecessary utilization was brought under control, businesses would suffer serious economic harm which, in turn, would weaken the California economy. Following the 2002 reforms included in AB 227, SB 228 was passed in 2003 and resulted in changes to the physician fee schedule, and raised the issue of converting the existing Official Medical Fee Schedule to an RBRVS-based fee schedule. Four years after enactment, the effects of the reforms are emerging and have resulted in savings to employers far greater than ever projected.

The Primary Changes Affecting Medical Care for Injured Workers

- Mandatory utilization review and 24-visit limit on physical therapy and chiropractic services;
- A 5 percent reduction in payments to physicians;
- Utilization controls with medical treatment guidelines for other medical services;
- Development of Medical Provider Networks, modeled after PPOs for purposes of workers' compensation treatment. (Generally, MPNs can be created by insurers and self-insured employers, but not physician groups.)

SB 228 mandated that the OMFS remain in place until 2006, that physician payments be reduced by 5 percent, and that the Administrative Director of the Division of Workers Compensation monitor the OMFS to ensure that payments do not fall below Medicare rates. In addition, the law mentions a level of 120 percent of Medicare as a possible benchmark for setting payment rates.

OMFS Conversion to RBRVS

Many physicians and other stakeholders interpreted SB 228 to mandate that the physician fee schedule be converted to the RBRVS format by 2006. Now,

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midway into the year, the OMFS remains in effect, but the DWC has confirmed that in the foreseeable future it will adopt the RBRVS methodology.

There is an important distinction between the RBRVS and the Medicare fee schedule. RBRVS' procedure codes come from the AMA's *Current Procedural Terminology* and are updated annually. The anesthesia section of the CPT is developed and updated by the ASA, as are the basic unit values in the RBRVS fee schedule. From that standpoint, the anesthesia section coding and base units would remain unchanged upon adoption of the RBRVS fee schedule. The remainder of the fee schedule would change, including the addition of many procedure codes and unit values for pain management and invasive monitoring codes commonly used by anesthesiologists.

While anesthesiologists would continue to use the same codes and base units, adoption of a conversion factor at 120 percent of Medicare would have disastrous consequences. The workers' compensation conversion factor for anesthesia services is now 32.78 and a CF of 120 percent of Medicare would decrease it to approximately 22.46 (based on an average of the Medicare CFs in California), a reduction of about 31 percent.

How Access Could Affect Physician Payments

With unprecedented savings derived from the reforms, a reasonable argument can be made that physician payments should be increased from 1989 levels. Despite the fact that rates have not increased in close to 20 years, insurers and employers would welcome a Medicare + payment methodology that would lower payments for many medical services. To successfully obtain an increase, additional evidence of need is necessary.

A significant concern among physicians and other stakeholders is that the aggressive reforms could result in reduced access to needed medical care. Increased frustration in obtaining approvals and appealing denials, combined with stagnant payments, can tip the scales in a physician's choice to participate or not in the workers' compensation program. Studies conducted by the California Medical Association and the California Workers' Compensation Institute, the trade association for workers' compensation insurers, have yielded differing early results.

Not surprisingly, the CMA study cited access problems in the form of improper denials and delays of care caused by inappropriate application of medical treatment guidelines and decisions by medical reviewers lacking necessary clinical training. In addition, bureaucratic hassles, incorrect payments, and demands by MPNs for deep discounts resulted in almost two-thirds of those

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surveyed, reporting that they will limit the number of workers' comp patients they treat or will quit the system altogether.

On the other hand, a recent CWCI claims-based review concludes that there is no clear evidence of an access crisis but concedes that more study is needed. The CWCI study examined geographic proximity of treating physicians (per the Labor Code's definition of physician, which includes chiropractors and acupuncturists) to injured workers' home addresses. It notes that in nearly all counties, at least three primary care providers were within 15 miles and three specialists or occupational health physicians were within 30 miles of the injured workers. The data were not analyzed by proximity of the injured worker to his own treating physician or if the specialists in close proximity were in the specialty needed by the worker.

Independent Study of Access Underway

To address access concerns, the Division of Workers' Compensation is required to contract with an independent consulting firm to perform an annual study of access to medical treatment for injured workers. The survey is conducted under the UCLA Center for Health Policy and will be mailed to about 1,200 physicians and injured workers. Researchers will then follow up by phone and interview injured workers about the medical care they received for their injuries. The interview includes questions about doctor visits, ease of getting health care and satisfaction with care.

"It's vital that injured workers and physicians selected for the study participate because their responses will help us make decisions on important issues."

—Dr. Anne Searcy, Executive Medical Director, DWC

Selected physicians who currently treat workers' compensation patients, or who stopped treating workers' comp patients after 2001, are being surveyed on their opinions about—and experiences with—providing workers' compensation care in California. Questions will include the scope of the physician's workers' compensation practice, reasons for any changes in that practice and experiences providing care in the workers' compensation system. Participants will also be asked to suggest ways to encourage providers to continue to treat work-related injuries and illnesses.

Data collection from physicians began in April and from injured workers in May. The final report for the first year will be completed in the fall of 2006. The study findings will serve as a baseline for ongoing monitoring and tracking of

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trends in access to quality medical care in workers' compensation cases, and it will provide necessary information in development of regulations.

"The information we gather will tell us whether workers injured in California have access to quality care," said DWC Executive Medical Director Dr. Anne Searcy. "It's vital that injured workers and physicians selected for the study participate because their responses will help us make decisions on important issues."

Any CSA member who is contacted to participate in the DWC survey is strongly urged to participate. Physician input regarding their experiences in treating patients since the reforms and continued participation in the program is critical to correcting the negative outcomes of the reforms. Fair physician payment is another element in maintaining access to medical care. If asked, please weigh in on these important issues.

References

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