Workers' Compensation Medical Care in California: **Access to Care** (2006 UPDATE)

FACT SHEET

Obtaining Care Following a Workplace Injury

California workers are entitled to receive medical services needed to cure or relieve the effects of a job-related injury or illness. These services are provided through workers' compensation (WC) insurance, which is paid for by the injured worker's employer. The system is designed to be "no-fault," so workers can receive needed care promptly, without having to establish the employer's legal responsibility in court.

To obtain initial care following a workplace injury, a worker notifies his or her employer, who files a workers' compensation claim with the WC insurer, or (in the case of a self-insured employer), with the employer's insurance administrator. The claims administrator is required to accept or deny the claim within 90 days after the claim is filed. Employees may appeal insurers' denial of the claim. Employers must authorize payment for up to $10,000 for initial medical payment before the claim is accepted, so long as the treatment conforms to the state's authorized medical utilization schedule.

Under California's WC law, the employer and its insurance administrator generally have the right to determine which medical provider the worker uses during the first 30 days of care following an injury. Thereafter, employees are free to select their own primary treating physician. Legislation enacted in 2005 allows employers to establish a medical provider network (MPN), which the employee must use throughout the course of WC treatment. In a MPN, the employer or its insurer can select the worker's initial treating provider. -After the first visit, the worker may select a different medical provider, so long as that provider is in the network. The legislation also established procedures whereby an injured worker can obtain a second or third opinion within a MPN, and, if necessary, seek treatment outside the network if there is still a dispute about the care to be provided after getting those opinions.

California's system for WC medical care presupposes that a designated health care provider will act as the injured worker's primary treating physician. Besides conventional medical doctors, the law allows chiropractors, osteopaths, psychologists, licensed nurse practitioners, and other specified kinds of practitioners to serve as the worker's "primary treating physician."

NUMBER 3
October 2006

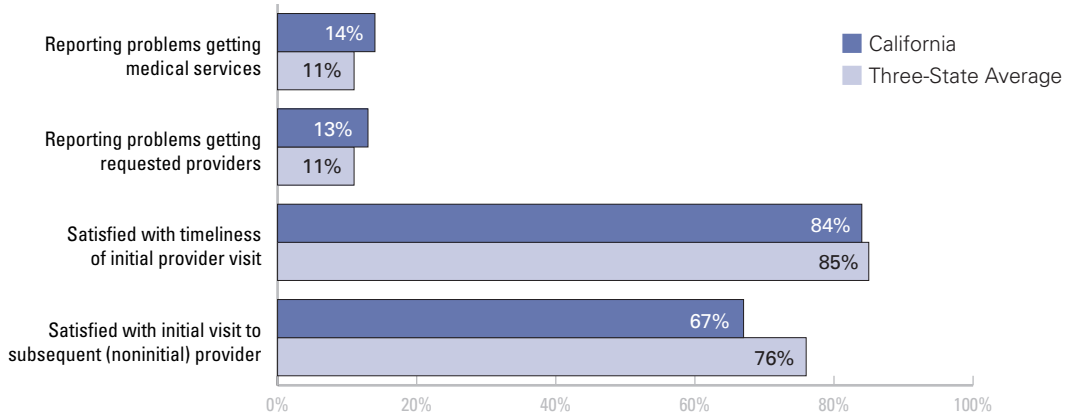
Potential Barriers to Obtaining Care

Evidence suggests that some injured workers in California face obstacles in accessing appropriate and timely care despite the basic financial protection afforded under WC insurance. For example, a recent survey conducted by the California Division of Workers' Compensation (DWC) found that about 13 percent of injured workers in California reported "some or a lot of trouble getting medical care."[1] A survey of injured workers in four states (California, Texas, Massachusetts, and Pennsylvania) conducted by the Workers' Compensation Research Institute found that only a small proportion of injured California workers (14 percent) reported problems in getting medical services for their job injuries.[2] However, compared to the other three states, the California workers were slightly more likely to report problems accessing initial medical care and expressed lower satisfaction with their initial visits (Figure 1).

Other potential barriers workers have reported in accessing WC medical care include employer disincentives to reporting of WC claims, lack of information provided to employees by employers about how to file claims, employers' failure to carry WC insurance, insurer denial of care, utilization review decisions to deny payment for particular services, and out-of-pocket payments needed for some services (e.g., pharmaceutical) prior to reimbursement through WC.[3] Nearly one-quarter (23.1 percent) of respondents to the 2002 California DWC injured worker survey reported that they incurred unreimbursed expenses for WC medical care, despite the fact that they are fully covered under their employers' WC insurance.[4] The need to pay expenses out-of-pocket can discourage some workers (particularly low-wage employees) from obtaining needed care. Since WC only covers medical care for conditions determined to be work-related, problems in accessing care also can arise as the result of delays in administering (or getting payment for) the various diagnostic tests needed to establish that a patient's condition is work-related.

Low-wage, immigrant, and minority workers are especially likely to experience difficulties in obtaining appropriate WC medical care. A survey conducted by

Figure 1. Comparison of Injured Workers' Survey* Responses Regarding Access to Care: California vs. Three-State Average (Texas, Massachusetts, and Pennsylvania)



*Survey conducted in 2003 (Texas) and 2003 (other states) for injuries that occurred in 1998 (Texas) and 1999 (other states).

Source: Victor R, Barth P, Liu T. Workers' Compensation Research Institute (WCRI). *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas.* Cambridge, MA: WCRI. December, 2003.

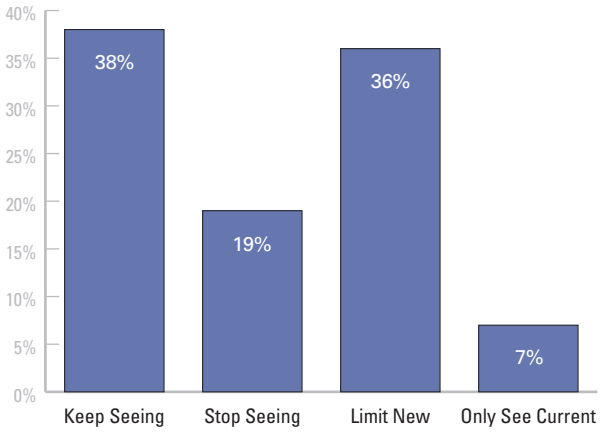
University of California, San Francisco researchers found that nearly one-third of garment workers with work-related musculoskeletal injuries were never seen by a health care provider, and only 3 percent filed a WC claim.[5] The most frequently cited barriers to accessing medical care for these workers were language (46 percent) and the cost of care (40 percent). Ten percent of them were afraid to seek care because of potential job loss or other employer reprisals.

Physician Reluctance to See WC Patients

A 2005 survey of California physicians conducted by the California Medical Association (CMA) reported widespread physician dissatisfaction with the WC system, including delays in getting responses from utilization review companies, frequent denials of service authorization requests, underpayments, and slow payments for services.[6] The CMA report concluded that the process for assuring compliance with the ACOEM Guidelines in the state is "inadequately developed and improperly implemented," thereby "depriving workers of timely and necessary medical care." Sixty-three percent of the physician respondents to this survey indicated that they intend to leave or reduce participation in WC care because of these problems (Figure 2).

In August 2006, the California Workers' Compensation Institute (CWCI), representing WC insurers and self-insured employers, issued a report challenging CMA's contention that problems in the WC system were discouraging physicians from accepting WC cases.[7] The CWCI compared data before (1993–1998) and after (2004–2005) the legislative reforms to show that the implementation of managed care controls under the reforms was not associated with a material change in access to a choice of medical providers. The CWCI

Figure 2. California Physicians' Intentions to Continue Seeing WC Patients, 2005



Source: California Medical Association (CMA). *Hostile to Physicians, Harmful to Patients: the Workers' Compensation . . .Reform?* Sacramento: CMA, June 2005.

study found that both before and after the reforms, at least 95 percent of all injured workers in California had a choice of at least three primary care physicians within 15 miles of their residence, and a choice of three specialty providers within 30 miles, in conformity to the minimum access standards for MPNs specified by the DWC. However, the CWCI study also showed that access to primary care and specialty physicians differed markedly by region, with considerably lower availability in some rural counties. Moreover, the average distance to WC primary care and specialist providers was found to have increased in 2005 compared to 2004 among all provider categories, possibly indicating the kind of physician disengagement from WC that had been predicted by the CMA report (Table 1). DWC is conducting a statewide survey of providers and injured workers, scheduled to be completed in late 2006, that will shed new light on access to care and the adequacy of physician reimbursement rates.

Table 1. Average Distance to the Three Closest WC Medical Providers

	MILES			
	1996	1998	2004	2005
Primary Care Physicians	3.2	3.0	2.7	3.0
Specialty Physicians	2.7	2.3	2.3	3.9
Chiropractic	3.7	3.1	2.9	3.6
Orthopedics	6.9	5.2	5.3	7.8
Neurosurgery	16.7	10.1	11.9	16.6
Internal Medicine	5.8	5.1	5.6	6.9

Source: Swedlow, A. *California Workers' Compensation Medical Care Reform & Access to Medical Care.* Oakland: California Workers' Compensation Institute (CWCI). August 2006.

Improving Access to Workers' Compensation Medical Care

Employers, workers, insurers, medical providers, health care systems, and state officials will need to work together to ensure that injured workers can easily access needed medical care. Injured workers should be provided with essential information on how to locate and use available services. This will become more important as an increasing number of workers receive care within MPNs. Systems are needed to ensure that MPNs meet their regulatory requirements for providing employees adequate facilities, medical personnel, and information on accessing care.

Expectations should be established for how quickly providers respond to requests for medical care, the geographical distribution of providers, staffing levels needed to ensure the availability of specialists and ancillary services, and periodic patient surveys to monitor satisfaction with access to care. Special approaches to help minority and disadvantaged workers obtain appropriate care include multi-lingual and culturally diverse providers and staff, trained medical interpreters, and translated versions of medical literature and applicable forms. Ensuring timely access to appropriate WC medical care ultimately is in everyone's interest, reducing costs for employers and insurers, boosting workplace productivity, minimizing disability for injured workers, and enhancing providers' ability to deliver high quality care.

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Workers' Compensation Medical Care in California: **Costs** (2006 UPDATE)

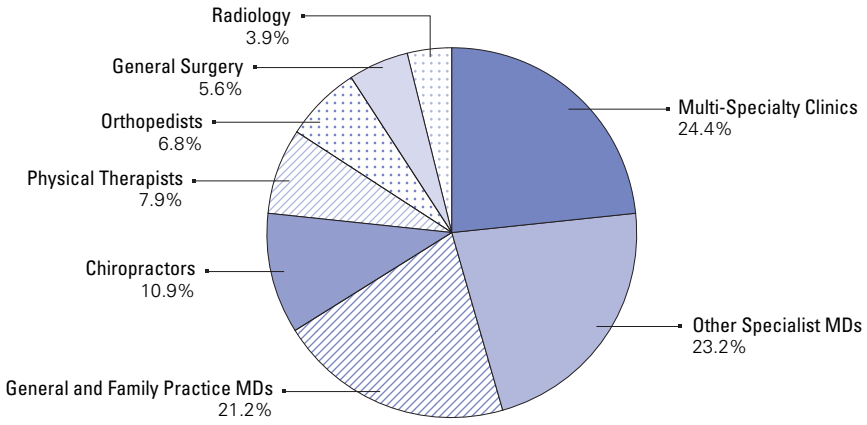
FACT SHEET

System Medical Costs

The total costs of California's workers' compensation (WC) system were estimated to be about $21 billion in 2005, consisting of medical care payments and wage replacement ("indemnity') benefits to injured workers, along with administrative expenses and adjustments to reserves.[1] Based on data from 2003 and 2004 for claims with more than seven work days, the Workers' Compensation Research Institute (WCRI) estimates that the median medical payment per claim was $8,211.[2] For California employers, WC insurance represents an average WC premium expenditure of $3.75 per $100 of payroll, as of March 2006.[3] That translates into an average annual premium of $1,580 per worker.[4]

About half of all WC benefit payments in California are for medical care expenses, with the majority of the remainder for indemnity benefits. In calendar year 2005, commercial WC insurers in California paid out $3.8 billion for medical care benefits (this does not include payments by self-insured employers, or reserves for future year payments).[5] Half (49.6 percent) of these outlays were for payments to physicians and other medical providers, with lesser amounts, proportionately, paid for hospital charges (27.3 percent), pharmaceuticals (11.4 percent), medical-legal evaluations (4.8 percent), and other medical services. Figure 1 shows the distribution of WC physician payments by specialty.

Figure 1. Distribution of WC Physician Costs, by Physician Specialty, 2005



Source: Workers' Compensation Insurance Rating Bureau (WCIRB), *2005 California Workers' Compensation Losses and Expenses,* June 2006.

NUMBER 2
October 2006

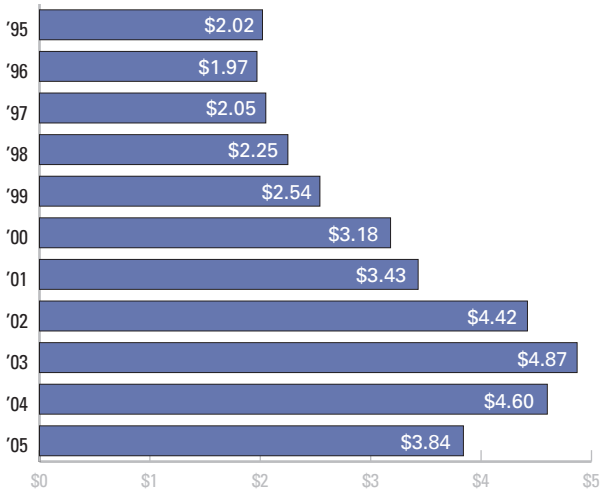
Recent Cost Trends

California WC costs increased sharply between the mid-1990s and the early 2000s. For example, total annual medical expenditures more than doubled between 1995 to 2002, growing from $2.6 billion to $5.3 billion during that period.[6] Likewise, the average ultimate medical loss per lost-time claim rose from $9,041 in 1993 to $25,560 in 2002, a rise of 283 percent in 9 years.[7] There were many factors contributing to the precipitous rise in costs experienced during those years including: substantial increases in prices for medical services; increased use of some services, especially chiropractic, physical therapy, and other physical medicine services; growth in outpatient surgery facility fees; and steep increases in use of pharmaceutical services and their associated costs.

The dramatic cost escalation in the late 1990s and early 2000s prompted reform legislation to be enacted between 2002 and 2004 that incorporated significant cost-containment provisions. Most notably, the new legislation repealed the treating physician's presumption of correctness for legal disputes involving WC claims and required that all care must conform to a utilization schedule to be developed by the California Division of Workers' Compensation (DWC). The DWC, as an interim measure, adopted the treatment guidelines established by the American College of Occupational and Environmental Medicine as the basis for its utilization schedule. That schedule became the accepted presumptively correct criterion for adjudicating WC medical disputes. In addition, the new legislation allowed employers to restrict care for injured employees to designated Medical Provider Networks (MPNs). To control utilization of services, legislation was passed that capped allowable chiropractic, physical, and occupational therapy visits to no more than 24 visits each during the life of any claim. Other provisions in the new legislation established an outpatient surgical fee schedule, required the use of generic drugs whenever possible, reduced reimbursement rates for physician services, allowed employers to obtain second opinions before authorization of spinal surgery, prohibited physician self-referrals to surgical centers in which the physician had a financial interest, and required physicians to use guidelines established by the American Medical Association for evaluating the extent of permanent impairment among injured workers.

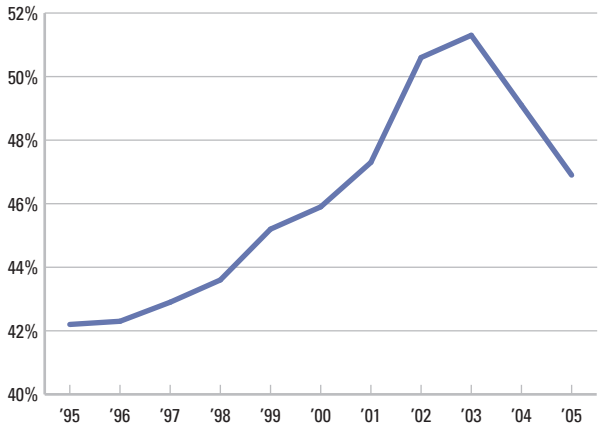
The net effect of these measures was to substantially curtail the rise in medical care expenses within the California WC system. As a result of the enactment of cost-containment legislation in 2002 and 2003, there has been a noticeable drop both in annual WC medical care payments (Figure 2) and medical payments as a percentage of all WC payments (Figure 3).[8] WC payments to California medical providers fell 10 percent to $0.93 per $100 of payroll from $1.03 per $100 pf payroll in 2004.[9]

Figure 2: Annual WC Medical Payments for Insured Employers, 1995–2005 (in billions)



Source: Workers' Compensation Insurance Rating Bureau (WCIRB). *Annual Reports of Losses and Expenses,* San Francisco: WCIRB, 1999–2005.

Figure 3: California WC Medical Payments as a Percentage of All WC Payments, 1995–2005



Source: Workers' Compensation Insurance Rating Bureau (WCIRB). *Annual Reports of Losses and Expenses,* San Francisco: WCIRB, 1999–2005.

Reaction to Cost Declines

The Workers' Compensation Insurance Rating Bureau estimates that ultimate WC losses (estimated benefits paid over the life of claims for accidents occurring in a particular calendar year) declined to $7.3 billion in 2005, compared to $10.8 billion in 2003 and $12.4 billion in 2002.[10] The WCIRB reports that the average medical cost of a WC claim (with more than seven days of lost time) increased only 4.4 percent between 2003 and 2002, after rising between 13.1 and 16.5 percent per year during each of the preceding three annual periods.[11] The success of WC reforms in lowering system costs has been touted by the California Chamber of Commerce and other business groups.[12]

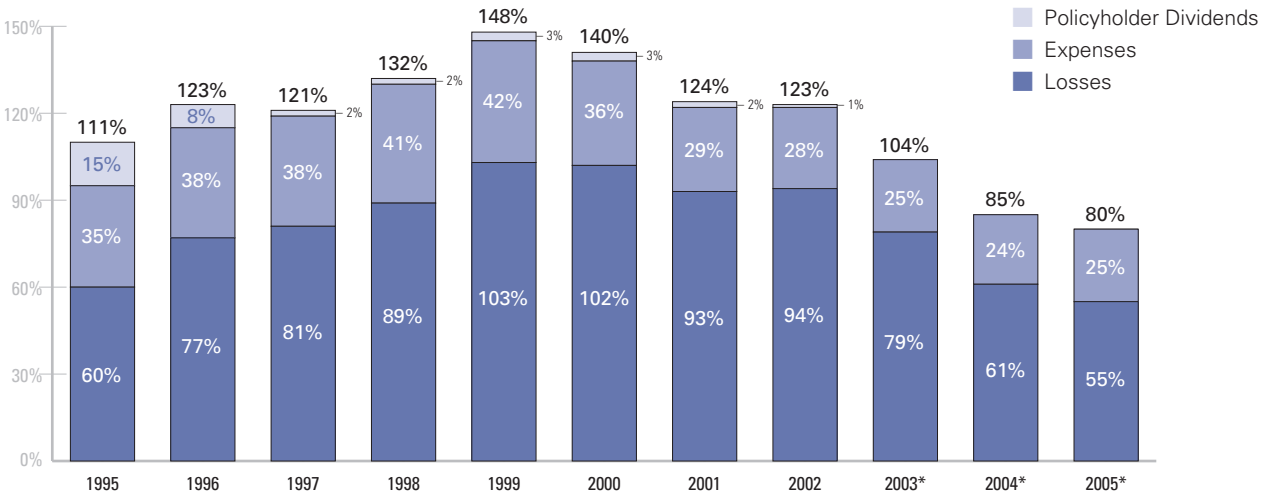
Some commentators believe, however, that the cost containment strategies enacted by recent legislation may be having a detrimental effect on injured workers' ability to obtain needed treatment.[13] Evidence suggests, for example, that some WC insurers and utilization management companies may have interpreted the legislative rules very narrowly, for instance, as a means to disallow payment for any medical services that are not explicitly covered by the American College of Occupational and Environmental Medicine (ACOEM) treatment guidelines.[14] New rules proposed by DWC in July 2006 clarify that "treatment cannot be denied on the sole basis that the condition or injury is not addressed by the ACOEM Practice Guidelines." The proposed rules further specify that treatments not covered by the ACOEM Guidelines should be authorized as long as they are "in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based."[14] The DWC is enacting a Utilization Review Oversight and Medical Survey process to monitor this issue, with substantial fines for non-compliance.

The underwriting experience of California's WC insurers has also dramatically improved since the passage of reform legislation, with loss ratios (loss payouts and expenses as a percentage of premiums paid to the insurer) plummeting from a high of 148 percent in 1999 to 80 percent in 2005 (Figure 4), with actual benefits paid in 2005 representing only 55 percent of premium.[15] This has sparked fears that cost savings derived from tightening eligibility for medical services may be merely increasing insurers' profits at the expense of injured workers and of the employers who pay the premiums.[16]

Future Cost Directions in the California WC System

It is still too early to say what the final effect of reform legislation will be on medical costs in the California WC system. Early evidence suggests that basing reimbursement for care on evidence-based treatment guidelines, capping utilization of high-volume services such as chiropractic manipulation, and restricting care within designated medical provider networks, has been

Figure 4: Trends in WC Insurers' Underwriting Experience in California, 1995–2005



*No policyholder dividends were distributed in these years.

Source: Workers' Compensation Insurance Rating Bureau (WCIRB). *2005 California Workers' Compensation Losses and Expenses.* June 23, 2006, p. 32.

effective in constraining WC medical care costs. A study published in January 2006 prepared by Bickmore Risk Service under contract to the California Department of Industrial Relations found that primarily due to the reform legislation, WC insurance rates have decreased by 46 percent.[17] The study estimates that the cost savings for California's WC system in 2006 owing to the reforms is $8.1 billion in comparison to 2003 and approximately $15 billion in comparison to what 2006 costs might have been absent the reforms. Moreover, the study concluded that 48 percent of the accrued savings are due to medical care initiatives, including the use of the evidence-based utilization schedule (27 percent of the savings), reductions in allowable medical fees (13 percent), and caps on physical medicine services (8 percent).

It is not yet known how these measures have affected the quality of care provided to injured workers or the likelihood for injured workers to recover and resume work successfully without residual symptoms or risk of reinjury. For example, prior to the reforms, some authorities feared that decreasing fees for physician services allowed under the state's official medical fee schedule would discourage some medical providers (especially physician specialists) from accepting WC cases. To date, there is little evidence to suggest that this has happened. Proposals are currently being considered to develop enhanced monitoring systems to ensure that that cost-containment measures do not compromise the quality of care provide to injured workers.[18]

Many of the factors that affect costs in workers compensation medical care are similar to those affecting costs in general (non-WC) medical care, for instance, the high cost of pharmaceuticals and the increased use of sophisticated diagnostic and therapeutic technologies. Thus, effective strategies to contain WC costs must consider and be coordinated with general care. As cost escalation continues in the general medical setting, initiatives will likely continue to be explored for more closely integrating or combining medical care delivery under WC and non-WC plans as a way of achieving better efficiencies in care delivery and further controlling costs. Recent legislation has been enacted in California to allow for pilot programs in so-called

"twenty-four hour" integrated (WC and non-WC) plans in some industries.[18]

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Workers' Compensation Medical Care in California: **System Overview** (2006 UPDATE)

FACT SHEET

Workers' Compensation Insurance Coverage

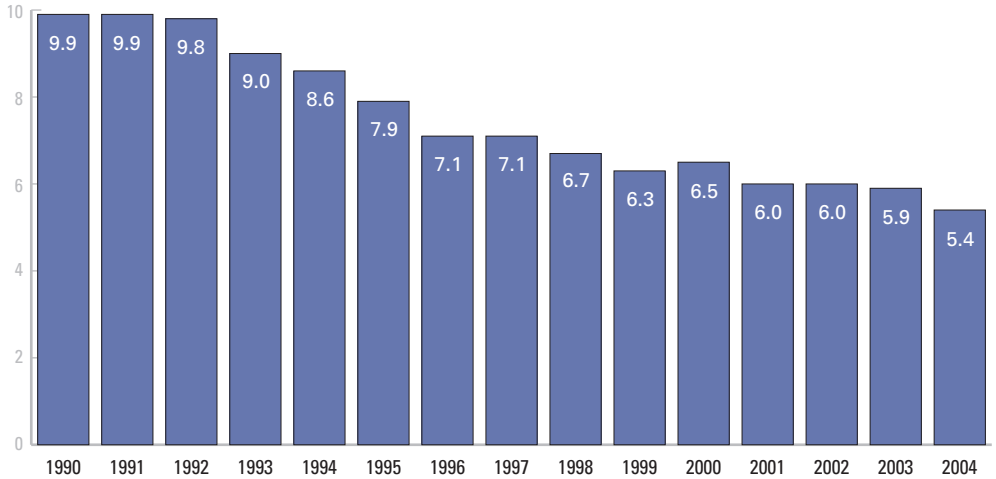
In California, workers' compensation (WC) insurance provides medical care, wage replacement ("indemnity"), and other benefits to workers who suffer job-related injuries and illnesses. Employers pay the entire cost of WC insurance, without deductibles, copayments, or premium contributions by employees. Workers' compensation medical care covers all diagnostic and therapeutic services reasonably required as a result of a work-related injury or illness, which can include specialist care, hospital services, surgery, physical therapy, laboratory tests, x-rays, and pharmaceuticals. WC insurance is intended to ensure that workers with job-related disorders can receive prompt and appropriate medical care without having to prove negligence on the part of the employer.

The delivery of WC medical care to injured workers is governed by the California Labor Code (Division 4) and by rules and regulations adopted by the Division of Workers' Compensation (DWC) of the California Department of Industrial Relations (DIR).

Recent System Trends

The California workers' compensation system is the largest of any state in the nation, covering approximately 14.7 million workers as of 2004, representing 11.7 percent of all covered American workers.[1] Employer WC premiums in California totaled $21 billion in

Figure 1. Incidence Rate of Reported Occupational Injuries and Illnesses in California, per 100 workers, 1990–2004



Source: California Division of Labor Statistics and Research.

NUMBER 1
October 2006

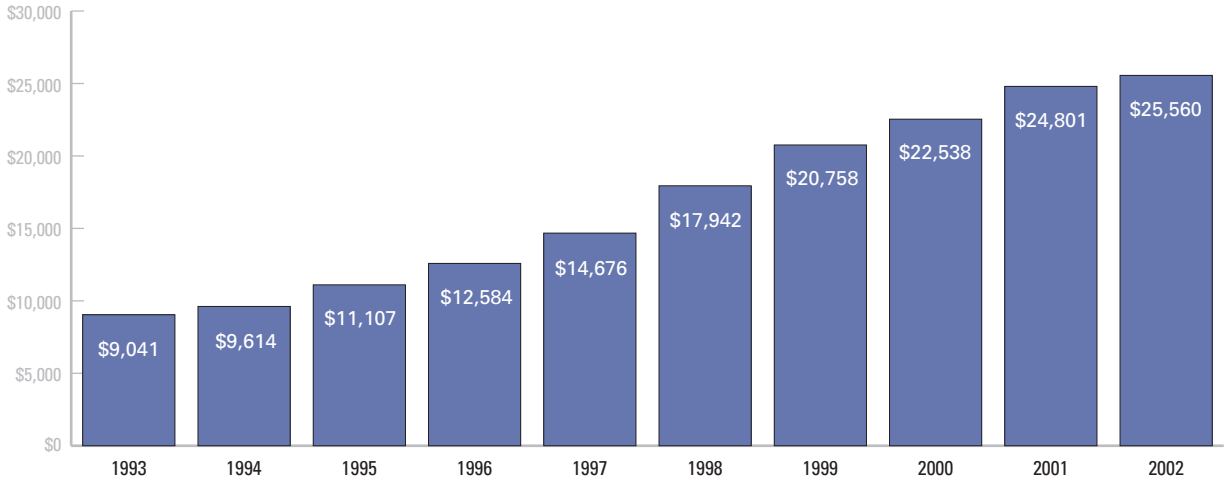
2005[2] and benefit payments made that year were estimated to be about $9.6 billion.[1] Over 600,000 injured workers file WC claims in California annually. The incidence rate of occupational injuries and illnesses in California has declined steadily since 1990 (Figure 1). Potential reasons for this decline include safer workplaces, shifts from high-risk (e.g., manufacturing) to lower-risk (service) industries, aging of the workforce (younger workers generally have higher injury rates), and other factors.

At the same time that workplace injury rates were declining in California, costs in the state's WC system rose dramatically. Employers' WC premiums in California skyrocketed from $5.8 million in 1995 to $20.2 billion in 2003—a 348 percent rise.[2] Medical costs were responsible for much of this increase, with the ultimate medical cost per indemnity claim rising from $9,041 in 1993 to $25,560 in 2002 (Figure 2).[3] The medical cost increases were due to a variety of factors, including high utilization rates for some medical services, such as chiropractic and physical therapy, escalating costs for pharmaceuticals, and other factors.

Legislative Reforms

In response to the rapidly growing WC system costs during this period, the California legislature passed reforms between 2002 and 2004 that have significantly changed the way that WC medical care is provided in the state. Some major implications of these new laws for WC medical care are summarized in Table 1. California employers and their insurers have traditionally been allowed to determine which medical providers the injured worker must use during the first 30 days of care following a workplace injury. The new legislation expanded employer control by allowing employers to restrict care within designated Medical Provider Networks (MPNs) throughout the course of treatment. In addition, to be eligible for payment under WC, the treatment must be in accordance to a "medical utilization schedule" established by the state. At least initially, the state DWC adopted the American College of Occupational and Environmental Medicine's occupational practice guidelines (ACOEM Guidelines) as the basis for the utilization schedule. Treatments not addressed in the ACOEM Guidelines can also be paid

Figure 2. Average Ultimate Medical Payments per Indemnity Claim, 1993–2002



Source: Workers' Compensation Insurance Rating Bureau.

Table 1. Major Changes to WC Medical Care from Reform Legislation in California, 2002–2004

AB 749 AND AB 486 signed into law 9/15/2002	AB 227 AND SB 228 signed into law 9/30/2003	SB 899 signed into law 4/19/2004
• Eliminated the treating physician's presumption of correctness, except when an employee had predesignated a personal physician. • Streamlined requirements for employer use of certified health care organizations (HCOs). Expanded employer choice of physician within HCOs to 180 days. • Mandated adoption of pharmaceutical fee schedule and required pharmacies to offer generic drug equivalents when available. • Gave DWC authority to adopt an outpatient surgical fee schedule. • Limited disclosure of WC medical information to third parties. • Provided for electronic medical billing and a standardized billing form. • Required the DWC to develop educational materials for physicians.	• Limited chiropractic and physical therapy to no more than 24 visits. • Abolished the Industrial Medical Council (IMC). • Directed employers to develop a utilization review process and DWC to establish a medical treatment utilization schedule, which would be considered presumptively correct for legal purposes. Adopted the ACOEM Guidelines until the DWC development of the final utilization schedule. • Mandated establishment of a new official medical fee schedule (OMFS). Imposed an immediate reduction of 5 percent in fee rates for physician services. • Allowed employers to obtain second opinions for spinal surgery. • Prohibited self-referrals by physicians to outpatient surgical centers. • Expanded the requirement for generic drug alternatives for all dispensers . • Required payment of medical bills to be made within 45 working days.	• Authorized the formation and use of Medical Provider Networks (MPNs). • Allowed employees in MPNs to change physicians, obtain second and third medical opinions, and request an Independent Medical Review if there was still a disagreement after the third opinion. • Strengthened and clarified requirements for WC treatment to be evidence-based and to conform with the DWC's utilization schedule or (until the schedule is developed) the ACOEM Guidelines. • Required employers to authorize payment of up to $10,000 for initial care prior to formal claim acceptance. • Extended the 24 visit cap to visits for occupational therapy. • Clarified the medical-legal dispute resolution process involving examinations by AMEs and QMEs. • Specified that physicians determine the level of permanent disability based on AMA Guidelines. • Specified that indemnity awards will be based on a medical determination of the proportion of disability that is attributable to a specific work injury. • Allowed for the establishment of 24-hour care plans within unionized industries.

for under WC if they conform to other nationally recognized evidence-based practice guidelines.

The new legislation also provided for reductions in reimbursement rates for particular services, allowed employees to obtain a second medical opinion before authorization of spinal surgery, and adopted new fee schedules for outpatient surgery and pharmaceuticals. In addition, to control excessive utilization of physical medicine services, the number of allowable physical therapy, occupational therapy, and chiropractic visits was capped at a maximum of 24 visits each over the life of a particular WC claim. The reforms also imposed new requirements for resolution of medical disputes and specified that the medical determination of permanent disability must be based on guidelines for impairment rating established by the American Medical Association. The rise in WC medical has slowed significantly, and in many cases begun to decline, since the enactment of the new legislation.

Current Issues in WC Medical Care in California

The ability of California's WC system to move ahead successfully depends on several key issues that are now facing decision-makers in the state:

Medical Treatment Guidelines. An analysis of California's approach to medical practice guidelines in WC was conducted by the RAND Corporation in 2005.[4] The study concluded that although the ACOEM Guidelines seemed to be the best available, they are not completely comprehensive nor valid as a basis for the state's utilization schedule. RAND recommended that additional efforts are necessary to supplement or amend the existing guidelines and that a process should be undertaken in the state towards that end. That recommendation is currently under consideration.

System for Monitoring the Quality of WC Care. Concerns have been expressed that recent efforts to constrain costs in the California WC system and limit employee choice of provider could potentially jeopardize access, quality, and effectiveness of care received by injured workers. Although recent legislation and regulatory actions have established requirements for Medical Provider Networks and Certified Health Care Organizations, there is, at present, no comprehensive data collection or reporting system in place by which the state can monitor the quality of care and thereby assure that cost containment measures do not have a detrimental effect. RAND and other organizations have recommended that a quality-of-care monitoring system be developed.[5] A new statewide WC database (the WC Information System) that is now beginning to collect information on WC claims and medical bills may be useful in this regard.

Medical Fee Schedules. Evidence suggests that the existing Official Medical Fee Schedule (OMFS) used in California's WC system is not entirely adequate insofar as it does not adequately reflect true costs of delivery care, does not reflect geographical differences within the state, and may be outdated. Proposals are now being considered to revise the OMFS to be based on a resource-based relative value fee schedule basis, as is done in Medicare and other state WC systems.[5]

Additional information about California's WC system can be obtained through the sources indicated in Table 2.

Table 2. Resources on Workers' Compensation Medical Care

California Commission on Health and Safety and Workers' Compensation	www.dir.ca.gov/chswc
California Department of Health Services, Occupational Health Branch	www.dhs.ca.gov/ohb
California Department of Industrial Relations	www.dir.ca.gov/
California Division of Labor Statistics and Research	www.dir.ca.gov/dlsr
California Division of Workers' Compensation	www.dir.ca.gov/dwc
California Workers' Compensation Institute	www.cwci.org
Labor Occupational Health Program	www.lohp.org
National Academy of Social Insurance	www.nasi.org
Workers' Compensation Health Initiative	www.umassmed.edu/workerscomp
Workers' Compensation Insurance Rating Bureau of California	www.wcirbonline.org
Workers' Compensation Research Institute	www.wcrinet.org

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Additional fact sheets on workers' compensation medical care in California are available at either of the above two Web sites.

Workers' Compensation Medical Care in California: **Quality of Care** (2006 UPDATE)

FACT SHEET

Evaluating Quality and Outcomes in WC Medical Care

Recent reforms in California's workers' compensation (WC) system have focused on reducing costs and adopting evidence-based treatment guidelines to control inappropriate care and overuse of medical services. It is not yet known what the ultimate effect of these reforms will be on the outcomes of care for injured workers or on their satisfaction with care. Proposals are now being considered to establish a statewide process for regularly monitoring and evaluating the quality of care provided to injured workers.[1]

Assessing the quality of medical care for injured workers is, in many ways, more difficult than evaluating health care for the general population. Quality of care in workers' compensation involves assessing patients' ability to successfully resume work activities, their risk of suffering reinjury at work, and their experiences with employers and the WC system. The California Division of Workers' Compensation (DWC) conducted surveys of injured workers in 1996 and 2000 to assess their satisfaction with care.[2] Regulations pertaining to quality of care were developed following legislation authorizing the use of Certified Health Care Organizations (CHCOs) in 1994 and Medical Provider Networks in 2005.[3] However, California state agencies currently do not have a system in place to routinely monitor the quality of care in the WC system and few private WC insurers or provider networks systematically assess or report the quality of patients' care or their outcomes following treatment. The California Commission on Health and Safety and Workers' Compensation unanimously voted in 2005 to authorize a feasibility study for the development of such as system.[4]

Reasons for Concern

Evidence from other states indicates that the introduction of managed care controls in WC systems can diminish injured workers' satisfaction with care.[5] Research studies have found that the outcomes of care for job-related injuries treated under workers' compensation are worse than the outcomes for similar conditions treated in the general (non-WC) setting.[6] Because of the connection between workplace injuries and diminished earnings capacity from lost worktime, the outcomes of workplace injuries can have substantial social and economic consequences that must be considered when evaluating the quality of care.[7] California studies have found that the wage replacement (indemnity) benefits available through WC do not fully replace workers' lost earnings resulting from a workplace injury.[8]

NUMBER 4
October 2006

The Workers' Compensation Research Institute evaluated WC care in California and three other states (Texas, Massachusetts, and Pennsylvania) through telephone surveys and insurers' claims data.[9] The study found that injured workers in California and Texas generally had worse outcomes than in Massachusetts and Pennsylvania, with respect to post-injury function and ability to return to work. The average time needed for California workers to return to work was eight weeks, two weeks longer than in all the other states. The WCRI further observed that California workers had worse outcomes in all categories compared to injured workers in Pennsylvania and Massachusetts. The outcome was worse despite receiving, on average, substantially more medical services per claim and incurring significantly higher medical costs per claim. (California's costs per claim were 113 percent higher than in Massachusetts and 32 percent higher than in Pennsylvania). The WCRI findings are consistent with other studies that have not found a significant correlation between the outcomes of care, as measured by indemnity costs and the duration of disability, and the volume or duration of medical care services that are provided to injured workers.[10]

California workers, surveyed an average of eight months after being injured, reported a significant degree of ill health. About one-third of the workers (32.9 percent) indicated that their overall health was worse than before the injury; and nearly a quarter (23.6 percent) said the injury still exerts a negative effect on their lives. Only 30 percent reported that they had fully recovered.[11]

Satisfaction with Care

Surveys of injured California workers conducted by the DWC found that 76.5 percent of workers were either "very satisfied" or "somewhat satisfied" with the medical care received for their job-related injury (Table 1).[12] Most of the surveyed workers expressed satisfaction with their choice of provider (72.5 percent); felt that the provider listened well (77.8 percent); showed them courtesy and respect (73.5 percent); explained care in a way that was understandable (70.3 percent); made a thorough and careful examination (63.7 percent); and developed an appropriate diagnosis and treatment (64.9 percent). Approximately 25 percent of respondents expressed dissatisfaction with overall care and with the choice of provider. Respondents who were younger, Spanish-speaking, non-white, and of lower income or education were more likely to be dissatisfied with care.

Table 1. Overall Satisfaction with Care and Choice of Physicians, Survey of 809 Injured California Workers

LEVEL OF SATISFACTION...	WITH CARE	WITH CHOICE
Very Satisfied	41.9%	38.6%
Somewhat Satisfied	34.6%	33.9%
Somewhat Dissatisfied	14.2%	16.6%
Very Dissatisfied	9.3%	10.9%

Source: Rudolph L, Dervin K, Cheadle A, Maizlish N, Wickizer T. " What do injured workers think about their medical care and outcomes after work injury?" *Journal of Occupational and Environmental Medicine* 44: 425–434, 2002.

WCRI compared injured workers' satisfaction with WC medical care in California to satisfaction with WC care in Texas, Pennsylvania, and Massachusetts.[13] Satisfaction was gauged according to overall care, the initial provider, the primary treatment provider, and the desire to change providers because of dissatisfaction (Table 2). On all measures, California workers were generally satisfied with the care received — 80 percent reported that they were "somewhat or very" satisfied with care (consistent with the DWC findings mentioned above); 68 percent were satisfied with the initial non-emergency provider; and 84 percent were satisfied with the primary treating provider. However, on six of the eight measures reported by WCRI, California had the lowest satisfaction ratings of all four states.

Table 2. Comparison of Satisfaction with Care in California and Three Other States (TX, MA, and PA)

WORKERS...	CALIFORNIA	3-STATE AVERAGE
Satisfied (somewhat or very) with their overall care	80%	83%
Very dissatisfied with their overall care	10%	9%
Satisfied (somewhat or very) with their initial provider	68%	80%
Very dissatisfied with their initial provider	19%	12%
Satisfied (somewhat or very) with their primary (noninitial) provider	84%	87%
Very dissatisfied with their primary (noninitial) provider	10%	8%
Ever wanting to change their initial provider due to dissatisfaction	33%	23%
Ever wanting to change their primary (noninitial) provider due to dissatisfaction	18%	18%

Note: Survey conducted in 2003 (Texas) and 2002 (other states) for injuries that occurred in 1998 (Texas) and 1999 (other states).

Source: Victor R, Barth P, Liu T. Workers' Compensation Research Institute (WCRI). *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas.* Cambridge, MA: WCRI. December, 2003.

Surveys of injured California workers have consistently found that many workers are not well informed about what medical benefits are available under WC, or how to obtain the most appropriate care.[14] A significant proportion of injured workers experience delays in accessing care, barriers to care related to claims processing by employers and insurers, and disputes concerning their care. About one third of the respondents to a 1998 DWC injured worker survey indicated they had little or no involvement in making decisions about their medical care. Roughly 30 to 40 percent of survey respondents reported that physicians rarely obtained job descriptions, talked about return to work, or discussed ways of preventing reinjury.[15]

Most of the injured workers who participated in a recent series of California focus groups reported receiving inadequate information from their employers about how to obtain medical care for their injuries. A sizable proportion of the workers expressed feelings of distrust and suspicion regarding their care, or believed that their doctors were oriented "against" injured workers. Several focus group participants commented that the treating physician caused further injury to them, did not know how to treat their particular injuries, or failed to understand the nature of their jobs.[16]

WC Quality of Care Initiatives in California and Other States

It has been suggested that California and other states develop specific quality-of-care performance measures that could constitute the basis for a quality-of-care monitoring and evaluation system. The American Accreditation HealthCare Commission (URAC) disseminated a set of standardized quality and performance measures for WC medical care in 2001. The URAC set contains 46 specific measures grouped into ten domains: access to care, coordination of care, communication, work-related outcomes, health-related outcomes, patient satisfaction, prevention, appropriateness of care, cost of care, and utilization of services (Table 3).[17] A similar set of quality indicators had previously been published by the medical director of the California DWC in 1996.[18]

Table 3. American Accreditation HealthCare Commission (AAHCC)/ URAC Workers' Compensation Medical Care Performance Measures

MEASUREMENT DOMAIN	EXAMPLES OF PERFORMANCE INDICATORS
Access to Care	• Getting needed care • Wait time to get care
Appropriateness of Care	• Work history taken • Job capabilities assessed
Communications	• Provider communicates well • Provider treats worker with respect
Coordination of Services	• Timely referral • Advice given on return to work
Medical Costs	• Medical costs compared to benchmarks • Disability costs compared to benchmarks
Patient Satisfaction	• Satisfaction with overall care • Satisfaction with choice of provider
Prevention	• Injury prevention counseling
Utilization of Services	• Utilization of medical services • Appropriate services provided for specific conditions
Work-related Outcomes	• Time needed to return to work • Ability to perform job after return

Source: American Accreditation HealthCare Commission/URAC (AAHCC/URAC). *Measuring Quality in Workers' Compensation Managed Care Organizations, Technical Manual of Performance Measures.* Washington, DC: AAHCC/URAC, 2001.

With financial support from the Robert Wood Johnson Foundation's Workers' Compensation Health Initiative, the California Department of Industrial Relations conducted initial planning and feasibility studies for the creation of the California Work Injury Resource Center. Activities of the proposed center would include dissemination of quality-of-care information; educational programs for providers and insurers concerning quality of care; data collection and analysis to measure the quality of WC medical care in the state; and technical assistance to health systems, employers, providers, and workers regarding techniques for enhancing the quality of care received by injured workers.[19]

Certification standards were developed in 1994 by the California DWC specifying the quality-of-care program required for health care organizations (HCOs) providing WC medical care.[20] Under these regulations, HCOs must have a quality assurance (QA) program, a QA committee, and an oversight process for monitoring care and access, identifying problems with treatment, and taking corrective action. Regulations adopted in 2005 for WC Medical Provider Networks (MPNs) contain a more limited set of quality-of-care requirements.[21] The regulations mandate that MPNs have an appropriate mix of qualified medical providers, comply with specific access-to-care requirements, ensure continuity and coordination of care, and have a process for allowing patients to change physicians within the network and seek second and third opinions regarding their treatment plan.

Most experts agree that a comprehensive effort to ensure high quality of WC medical care should combine private initiatives by MPNs, WC insurers, and

provider organizations; self-regulation in the form of industry accreditation and review of provider qualifications; and regulatory oversight by state agencies. Components of a comprehensive quality-of-care approach potentially include formal quality assurance and improvement programs, specific quality standards and reporting requirements, patient education and communication, and measures to ensure access to timely and appropriate care. DWC and other state agencies can play an important role in gathering and reporting quality-of-care data and facilitating cooperation among the various stakeholders.

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