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*Access, Quality and Outcomes of Health Care in the California Workers' Compensation System 2008: Review & Commentary*

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## Access, Quality and Outcomes of Health Care in the California Workers' Compensation System 2008: Review & Commentary

“Access, Quality and Outcomes of Health Care in the California Workers' Compensation System – 2008”

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A Review and Commentary Presented by The California Society of Industrial Medicine and Surgery

NOTE: The California Society of Industrial Medicine and Surgery (CSIMS) presents the following commentary and review of the California Division of Workers' Compensation's latest medical treatment access study as a catalyst for action by the Division to publicly analyze all the data presented by University of Washington and more important, as a catalyst for sure, efficient and swift steps to bolster fundamental and costly access issues that had already begun to manifest in the workers sampled for this study who were injured between June 2007 and April 2008. The results of this study – released a month ago, on May 11, 2010 after being delivered to the DWC in 2009 – describe access issues that began between 18 and 24 months ago.

As a result of separate Public Records Act requests from the California Society of Industrial Medicine and Surgery (CSIMS) and the Honorable Jose Solorio, Chairman of the Assembly Insurance Committee, the Administration allowed the Division of Workers' Compensation (DWC) to release only the second of what is supposed to be a series of annual studies of medical access and quality pursuant to [Labor Code 5307.2](#) which was enacted in 2003 by SB 228 (Alarcón) and later modified in 2008 by AB 2091 (Fuentes).

[Labor Code Section 5307.2](#) requires the administrative director to contract for an annual study of access to medical treatment for injured workers. Based on these yearly studies, if the administrative director determines there is insufficient access or substantial problems with access to quality health care for injured workers, he/she may adjust fees to re-establish appropriate access and quality.

The DWC *Newsline* headline announcing release of the study performed by the University of Washington read, in part, “Study shows injured workers getting the care they need and suggests continued improvements.” Within the first paragraph of the release, the Division further states that the study “shows four out of five injured workers are satisfied with their care, and the level of access to quality care appears unchanged from a similar study done in 2006.” To its credit, the Division did acknowledge that improvements were needed, but only scratched the surface regarding study data that clearly indicate emerging deterioration in access to care and significant system costs as a result.

Why the Administration embargoed the University of Washington's work and, more importantly, why the Division took no action in the face of obvious problems, can be left to another discussion. However, it is vital that the community look closely at the results of this study - look closely at deteriorating access and its cause, the systemic issues that are un-mistakenly a result of “reforms” enacted earlier this century and their resulting costs.

The sky is not falling, but the cloud cover is dropping fast.

Readers are encouraged to make their own decisions regarding the DWC's 2008 Access Study and should inspect it for

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### **ALL INJURY SURVEY - Summary of Results**

More than 80% of respondents received their health care through a MPN. Thus, one can conclude that the majority of the access problems described in this study occurred within the MPN environment.

#### 1. Access

a. Researchers found that 89% of the injured workers obtained initial care for their injury within three days of advising their employer. This question is based on the relatively lenient standard found in [CCR Title 8, Section 9767.5](#)  that states, "For non-emergency services, the MPN (emphasis added)...shall ensure that an appointment for initial treatment is available within 3 business days..." of receipt of a request for treatment within the MPN.

i. This was the wrong question. [Labor Code Section 5402 \(c\)](#)  requires the employer to provide treatment within one working day of notice.

ii. To "provide treatment" is a higher and significantly more active standard than simply ensuring that an appointment is available. MPNs stand in the shoes of the employer and a study of their performance should follow the employers' standards.

iii. The better question would be how many of the 89% were provided treatment within 24 hours? How many within 48 hours and so on until the complete data set was developed.

b. The study found that 83% to 86% of injured workers did not travel further to their appointments than the MPN travel standard of 30 miles or one hour.

i. As a truer indicator of access, data should also be gathered to show the number of days from the date of the referral to the date of the appointment.

ii. For the 14% to 17% who had to travel farther than the MPN standard, added specialist information would be helpful, i.e.: what specific specialties were involved when the standard wasn't met and the number of days until the injured worker was seen.

c. Almost half (47%) of the injured workers reported one or more access barriers at some point during their treatment.

i. Data regarding the type of specialist(s) involved and the specific nature of the barriers experienced would be extremely helpful.

#### 2. Satisfaction, Quality, Recovery and Other Outcomes

One might question how "quality" is defined when:

a. Over half (54%) of the sample failed to recover fully at 10 – 12 months post injury.

b. 12% reported no improvement and 21% reported their injury was still having a big affect on their life.

c. 24% of the sample reported missing more than 30 days of work.

i. An important corollary would be to develop data on the spectrum of days reported by the sample and to compare the data for those within and outside of an MPN.

### **BACK INJURY SURVEY - Summary of Results**

More than 85% of respondents received their health care through a MPN. Thus, one can conclude that the majority of the access problems described in this study occurred within the MPN environment.

 [The Lawyer's Guide to the AMA Guides and California Workers' Compensation, 2014 Edition](#)

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1. Access

a. 90% received care within three days of notice.

i. Again, this is the wrong question and does not provide any data regarding how long an injured worker waited to actually receive the health care they needed.

b. 83% to 86% did not travel to appointments further than the MPN standard.

i. Data regarding timeliness and the specific specialties (within the category of MD) involved for the 14% to 17% who had to travel outside the MPN access standard is important.

c. Of the injured workers needing prescription medications, physical or occupational therapy or specialist care, 10% to 27% reported encountering some problem accessing these services.

i. The specific nature and circumstances surrounding these access problems is vital to understand and analyze.

2. Effect of access on work disability

a. The University of Washington researchers found that access barriers increased the duration of compensated lost time by approximately 60%.

i. As a result, researchers estimated 3.8 million potentially avoidable lost days

ii. Researchers, using an estimated rate of \$92 per day, calculated that avoidable access barriers cost the California's workers' compensation system approximately \$349 million within the first year after injury.[FN1]

b. Presumably, between 80% and 85% of these costs occurred within the current MPN environment.

**PROVIDER SURVEY**

Providers were contacted by mail between April 2008 and December 2008. It is reasonable to presume that any issues and trends (in provider attrition for instance), left unaddressed in the interim, have continued unabated since that time.

1. Almost 96% of providers who described the frequency of their workers' compensation patients' delays or denials of care as "sometimes" or "more often (than sometimes)," felt these delays or denials were a cause of interference with recovery at least sometimes. A corollary would be that only 4% of the physicians reporting delays or denials felt that the problems were of no consequence.

a. This finding is largely corroborated by the injured worker surveys.

2. Delays and denials resulting from utilization review (UR) and the related administrative paperwork burden, consistently rated as the most important barriers.

3. Fully 66 (out of the total sample of 809) or 8% of providers surveyed, no longer treated injured workers.

4. 32% of the respondents reported that they intended to decrease workers' compensation patient volume or quit treating.

a. 51% of orthopedic surgeons were found to be in this category.

b. 45% of psychologists were found to be in this category.

5. **Based on the data[FN2], fully 37% of the sample had quit work comp, intended to reduce their exposure or intended to quit.**

a. Using data from the "All Injury" and "Back Disability" survey, it is reasonable to conclude that between 80% and 85% of this attrition and deterioration is likely occurring within MPN contracted providers. However, specific data regarding MPN affiliation(s) would make this conclusion more accurate.

- b. All of the reported deterioration/attrition is occurring under the existing OMFS.

### RECOMMENDATIONS

The University of Washington researchers provided the following recommendations more than one year ago:

#### 1. Functioning of utilization review

- a. Delays and the administrative burden must be relieved.
- b. Better and more detailed information about the functioning of utilization review must be determined regarding:
  - i. The efficiency (or lack thereof) of the review process.
  - ii. The frequency and timing of utilization review appeals.
- c. Researchers concluded that, "Prospective UR, which typically reviews all requests for a given procedure, is inefficient and often engenders widespread opposition...**Further; it does little to advance the goal of quality improvement.**"[FN3] (emphasis added)
- d. Creation of a waiver of utilization review based on "provider targeted approach."
  - i. The DWC needs new authority to formalize a waiver program.
  - ii. "Provider targeted plans" are already in the marketplace, but custom networks, comprised of highly selected providers, is an easy concept to controvert and can easily make problems worse rather than solve them.

#### 2. Provider Administrative Burden

- a. Researchers wrote, "...there also appears to be broader dissatisfaction with the general level of administrative burden imposed on providers. **Physicians function under an intolerable paperwork burden, largely imposed by payors.**" (emphasis added)

#### 3. Language Barriers

- a. MPNs should be required to provide access to language assistance services.
  - i. New legislation could mandate access to language services as a requirement of MPN certification and as a paid benefit of the system.
  - ii. Recommend that language capabilities of providers be sought when contracting with providers – reimburse the physician's office for this capability.
    1. CSIMS would recommend that reimbursement for language services account for the higher overhead costs necessary to employ competent, bilingual staff.

#### 4. Quality Improvement within MPNs

- a. Researchers suggested that MPNs have the potential to serve as an organizational locus for improving both quality and injury prevention in the WC system.
  - i. CSIMS understands this intuitive notion. However, under current statute and without new and dynamic audits and enforcement, to place more responsibilities for health care delivery within an MPN would be irresponsible.
- b. Researchers observed there needs to be a strong commitment and leadership from the marketplace (claims administrators that buy MPNs/PPO networks).
- c. This would require legislation and a very pro-active audit and penalty system.
- d. CSIMS observes that these recommendations are more in alignment with current HCO regulations ([CCR Title 8, Section 9770](#) et seq.) that include:

- i. Regular, periodic recertification.
  - ii. Concurrent assessment of HCO operation by DWC Medical Unit staff.
  - iii. Substantial penalty (loss of certification) based on DWC concurrent assessment. Current statute and regulation anticipate action by the DWC based only on a notice of possible violation from the Workers' Compensation Appeals Board, an extremely rare occurrence.
  - iv. There is no natural profit motive under the current PPOs/MPNs business model to take on these responsibilities.
- e. Quality Improvement Research and Policy Agenda
- i. More resources should be directed to the DWC's Workers' Compensation Information System (WCIS)
  - ii. An alternative to the current industry-owned database is imperative.

CSIMS applauds the work of the University of Washington researchers. Their insights and frank presentation of what are now two-year-old access issues and other problems is long overdue.

CSIMS encourages the Division of Workers' Compensation to establish annual surveys under the authority of [Labor Code Section 5307.2](#). A positive return on citizens' tax dollars is assured as such independent research uncovers unnecessary costs and waste such as the estimated \$348 million dollars directly caused by already existing, but unquantified, delays and barriers to quality health care. To delay bringing to light such issues or to make policy decisions that do not focus on elimination of these problems is unconscionable and an affront to California's injured workers.

#### Footnotes

1. Summary of Results, Page xiv.
2. Provider Survey, Results, Pages 79 and 95.
3. Recommendations, Page 126.

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