

Commission on Health and Safety and Workers' Compensation

**MINUTES OF MEETING
February 19, 2016
Elihu M. Harris State Building
Oakland, California**

In Attendance

2016 Chair, Angie Wei

Commissioners Daniel Bagan, Doug Bloch, Christy Bouma, and Martin Brady.

Absent

Commissioners Shelley Kessler, Sean McNally, and Kristen Schwenkmeyer.

At-a-Glance Summary of Voted Decisions from the CHSWC Meeting

Approval of Minutes from December 11, 2015, Meeting	Approved
<i>No other business requiring a vote</i>	<i>N/A</i>

Approval of Minutes from the December 11, 2015, CHSWC Meeting

CHSWC Vote

Commissioner Bouma moved to approve the Minutes of the December 11, 2015, meeting, and Commissioner Bagan seconded. The motion was passed unanimously.

Recognition of Past Administrative Director Destie Overpeck

Chair Wei took a moment to recognize and acknowledge the tremendous work by Destie Overpeck, the past administrative director, in service to the Commission, the DWC, and the State of California.

Division of Workers' Compensation Updates

George Parisotto, Acting Administrative Director, Division of Workers' Compensation

Despite the changeover at the top, the DWC is thoroughly committed to carrying forth the agenda in place and will ensure that the statutory mandates given to it will be followed through. At the end of the day, the primary concern is to ensure that injured workers receive the treatment they are supposed to get under the treatment guidelines and that everyone in the system is treated fairly. Mr. Parisotto thanked the people who work at the DWC; he said that they make a great team, they show up and are mindful of what they do, and they are respectful toward others. He said that when there is a combination of those characteristics, good things usually happen.

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DWC Regulatory Update – what is in place, what is in the works, plus additional issues

- **Proposed DWC Regulations: In Formal Rulemaking Process**

Medical Treatment Utilization Schedule (MTUS): Chronic Pain Medical Treatment Guidelines and Opioids Treatment Guidelines

The DWC staff is currently responding to over 400 public comments; no additional comment periods are anticipated. The DWC intends to adopt the final regulations and submit the rulemaking package to the Office of Administrative Law (OAL) in March 2016.

Home Health-Care Services Fee Schedule

With the enactment of SB 542 on January 1, 2016, which allowed the DWC to consider and utilize the billing procedures of home health-care services fee schedules outside Medicare and the state's In Home Supportive Services program, the DWC has revised the regulations to include relevant billing codes from the Federal Office of Workers' Compensation Programs (OWCP) fee schedule. The first 15-day comment period with the new codes should begin by early March 2016.

Official Medical Fee Schedule: Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule

The rulemaking was initiated to resolve coding inconsistencies in the Centers for Medicare and Medicaid Services (CMS) outpatient fee schedule. The DWC is working with RAND and stakeholders to resolve outstanding problems.

Workers' Compensation Information System (WCIS): Revisions to First Report of Injury (FROI) and Medical Billing Data Requirements

The DWC will submit a rulemaking package to OAL. The anticipated end of the 45-day comment period is March 28, 2016. Revised and robust requirements will allow implementation later in the year of a penalty structure for claims administrators not reporting complete data to the DWC.

- **Proposed DWC Regulations: Rulemaking Process Initiated**

Interpreter Fee Schedule

The schedule will soon be submitted for Labor and Workforce Development Agency (LWDA) review. The fees are based on federal court rates for interpreters, although parties are free to negotiate different rates. This will allow for more consistency in the system.

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Prescription Medication Formulary as part of the MTUS

DIR is currently conducting informational meetings; it held a public stakeholder meeting on February 17th and has contracted with RAND for technical assistance and a report recommending a formulary structure. Formal rulemaking is anticipated to begin in December 2016. The statutory deadline mandate of July 1, 2017, for a formulary for the workers' compensation system is expected to be met.

MTUS Update: Guidelines for Occupational/Work-Related Asthma and Occupational Interstitial Lung Disease, Mental Illness, and Stress Guidelines

Updates are posted on DWC Forums at <http://www.dir.ca.gov/dwc/DWCWCABForum/1.asp>; rulemaking is to begin in summer/fall 2016.

- **Revision and Updating of the Medical-Legal Fee Schedule Are Anticipated**

This schedule has not been substantially changed since 2007 and needs to be updated.

Additional Issues:

- **Online QME Panel in represented cases:** The system is working well. Panels for represented cases are issued immediately. Unrepresented panels are issued within three days of submission. Other panel requests are issued within ten days. The Medical Unit performs this work.
- **Electronic Billing:** DWC contractor Maximus will demonstrate its new independent medical review (IMR) online portal for more timely decisions at the DWC Educational Conference on February 25th and 26th in Los Angeles and on March 3rd and 4th in Oakland. The DWC is interested in moving to an online IMR application and the prospects of doing so seem good.
- **Physician's Guide:** The guide is in its final editing stages and will be ready for publication soon. Educating physicians in the treatment guidelines is an essential component to ensuring that treatment is rendered in a timely fashion.

Comments by Commissioners

Commissioner Bloch asked why the number of payments from the Return to Work (RTW) fund is much lower than projected. Acting Administrative Director Parisotto replied that he did not know the answer, but it is important that people get information about the RTW fund, and the DWC has revised its Supplemental Job Displacement Benefits (SJDB) form so that people know it is available. The DWC is reaching out to claims administrators so that anyone eligible will

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receive a notice about the RTW fund. The DWC does not collect data on how many vouchers are in the system.

Commissioner Bloch stated that, instead of \$5,000, people should get \$10,000 because employers have realized cost savings from the Senate Bill 863 reforms, and workers should reap the benefit. Director Baker responded that RTW is a revolving fund, and it is still early in the process; so workers are just becoming Permanent and Stationary (P&S) from the date of injury in January 2013. It is early in the RTW fund process, and there is an upward projection of workers who will become eligible to receive funds.

Commissioner Bloch asked whether the unspent money in the fund stays in the fund. Director Baker replied that the fund is replenished to a balance of \$120 million each year.

Commissioner Wei stated that she wanted to track the total number of vouchers issued to date to find out how many people have not tapped into the RTW fund, and data should be collected for that. Director Baker agreed.

Update on DWC Medical Issues

Dr. Ray Meister, Acting Executive Medical Director, Division of Workers' Compensation

Dr. Meister gave an update on IMR, independent bill review (IBR), and health-care provider education:

IMR decisions are filed for between 1% and 2% of treatment requests. IMR decisions are timely and are issued in less than 30 days after receiving completed medical records. Overturned decisions comprise 11% of the total.

The largest category of IMR requests is for medications:

- Approximately 50% involve pharmaceuticals, followed by rehabilitation and diagnostic testing, and 32% of pharmaceutical IMRs are for opioid treatment. The three categories make up to 75% of the requests.
 - The rate of pharmaceutical decisions upheld is very close to the average of 88%.
- The top five pharmaceuticals include opioids, muscle relaxants, and nonsteroidal anti-inflammatories like Motrin, topical analgesics, and proton pump inhibitors.
- There is a new feature in the IMR decisions web page: a search function will allow people to search IMR decisions by the date of injury or the specialty of the IMR reviewing physician.
- Supporting data:
 - Between 500,000 and 600,000 new workers' compensation claims are filed each year that require medical treatment.
 - In 2014, 31.5 million treatment request bills were reported to the WCIS. Approximately 300,000 went through the IMR process.
- IMRs in 2015:
 - The number of IMR decisions issued each month ranged from 11,000 to 15,000, averaging 13,000.

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- Timeline for medical decisions:
 - From July to December 2015 decisions were made between 10 days (July 2015) and 24 days (December 2015) from the time completed medical records were received.
- The average number of issues IMR decisions dealt with was 1.9.
- Many IMR requests originate from Los Angeles and the San Francisco bay area. Both areas have a higher percentage of IMR decisions than workers' compensation claims in other areas in California. The rest of California shows the percentage of IMR decisions is lower than workers' compensation claims.
- Approximately 20,000 IMR applications were received each month in 2015. The total number of IMR applications received in 2015 was approximately 250,000 and, after removing duplicates, 195,000 remained. After eligibility was determined, the number of applications was 166,000.

Commissioner Wei asked about the number of requests going to IMR. Dr. Meister replied that about 1% or 2% of the treatment requested in the system end in an IMR decision. If there were approximately 30 million individual treatment requests, close to 1%, or 300,000, result in an IMR decision.

Commissioner Bouma asked about the 1.9 statistic. Dr. Meister replied that, for each IMR, two treatment requests are usually contested.

Commissioner Bloch asked what proportion of decisions is deemed ineligible, and Dr. Meister responded it is 15%. Dr. Meister added that if a contested body part is involved, then the application is deemed ineligible until the body part issue is resolved.

Commissioner Bloch asked if applications are deemed ineligible, what is being done so that people in the system know the bureaucratic details so that they are not ineligible for treatment for bureaucratic reasons, such as timeliness and missing signatures on applications.

Commissioner Bouma stated that when injured workers receive a notice that they are ineligible for IMR, they may incorrectly think that they are not allowed to apply for IMR because of misinformation. Clarification about the reasons for ineligibility will help injured workers apply for IMR.

Dr. Meister stated that the two important timelines in IMR are: the number of days it takes to issue a decision from the acceptance of the IMR application and the number of days it takes to receive a decision after the complete medical records are received, averages between 10 and 30 days.

Commissioner Bagan asked what proportion of requests has incomplete medical records. Dr. Meister stated that he did not know.

Independent Bill Review (IBR) Highlights

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- 15% increase in filings from 2014
 - 2,310 applications filed
 - 2,167 decisions issued
- 75% of IBR determinations result in at least a partial overturn of a disputed billing denial (note: an IBR request likely has more than one billing item in it—or is made up of more than one billing item—so a partial overturn is an overturn of at least one of the disputed billing items.)
- In December 2015, IBR determinations were completed in an average 4.8 days
- ~50% of determinations involve physician services

Note: for detailed charts and graphs from the presentation, consult the presentation at http://www.dir.ca.gov/chswc/Meetings/2016/IMR_IBR_ProviderEd.pdf

Commissioner Wei asked about the total number of bills. Dr. Meister said that the 30 million cited earlier are the treatment requests associated with the bills. Commissioner Wei asked for confirmation that less than 3,000 bills of 30 million are contested. Dr. Meister confirmed.

Commissioner Bouma asked for confirmation that it would actually be less than 30 million because although the treatment is requested, it is not actually delivered and would not generate a bill. Dr. Meister confirmed.

Commissioner Wei said that while it is not an equivalent comparison, she wished that they had similar data on requests, turnaround times, and overturn rates for IMR. Dr. Meister agreed but referred to the IMR decision timeline slide to indicate that one could easily see that August 2015 was the best month for timeliness. He added that obtaining medical records is one of the potential delays in the process.

Health-Care Provider Education

- Physician's Guide: —the first update since 2007
- QME CE Course Evaluations: reviewing/updating as necessary
- Online CME modules: online modules for health-care providers, MTUS, principles of evidence-based medicine, and using MTUS; others will follow
- Education for Pharmaceutical Formulary

Commissioner Bloch asked about the Physician's Guide and whether IMR physicians would be part of this education. Dr. Meister confirmed and added that another important group that will use the guide is QMEs. Director Baker added that another group is UR doctors.

Commissioner Bagan asked for some explanation of the Physician's Guide and whether it will help providers follow the MTUS. Dr. Meister explained that it is a comprehensive document to help health-care providers find answers as they care for patients. It also helps doctors as they prepare the P&S status report.

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Commissioner Bloch asked whether a system is being created that doctors may not want to participate in. He recognizes the challenges but has met many doctors who are in the system because they care about the workers. He asked whether the DWC tracks the number of doctors in the system. Dr. Meister stated that an estimated 30,000 in the state are in it. They certainly know the number of QMEs as a subset. Director Baker said that overall the workers' compensation fee schedule is at 120% of Medicare; group health is at about 80% of Medicare. Therefore, workers' compensation compensates fairly well. She said access studies are going on to ensure they know they do not have a problem; she cited the most recent study being conducted by RAND, the results would inform any needed fee schedule adjustments.

Director Baker noted that Dr. Meister has been with the DWC for several years, he was hired by former medical director Rupali Das, and he personally updated the Physician's Guide. Director Baker expressed her pleasure that he is taking over as acting medical director.

Report on the Evaluation of SB 863 Medical Care Reforms Study

Barbara Wynn, RAND

DIR asked RAND to evaluate the impact of the SB 863 medical provisions.

- Comprehensive evaluation of the impacts of the various medical care provisions on access and quality of care and work-related outcomes, volume and mix of services, medical spending, and administrative burden.
 - Final report is due in a year
- Topic for this meeting: Update on their review of the utilization review (UR) portion of the medical necessity dispute resolution process.

The medical necessity determination process involves several components:

- Care should be consistent with the MTUS maintained by the DWC.
- The payer must have a UR process to review the medical appropriateness of requested care.
- An injured worker may request that an adverse UR decision be reviewed by an IMR organization.
- SB 863 added the IMR process, with spillover effects on other aspects of the medical necessity dispute resolution process.

This meeting's update provides new findings from subsequent activities:

- Review of UR plans associated with the 2014 UR investigations
- Review of WC UR policies in states that have both UR and treatment guidelines
- Additional analyses of the UR listings and IMR data

Overview of Prospective UR Decision Process

- Treating physician submits a written Request for Authorization (RFA) for treatment (in writing, accompanied by either a doctor's first report of injury or progress report,

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including medical documentation to substantiate that the request for treatment is appropriate).

- Claims Administrator Reviews RFA
 - Decides whether to handle in-house or refer to an external utilization review organization (URO). If there is an insurer, it may all be handled in-house, but even the largest insurers refer cases to a URO. This claims administrator review is where clinical review occurs at a nurse review level or by a physician. Then there are issues of claim compensability and whether there is need for additional information before a UR decision can be made. If additional information is needed, a request is sent, which extends the timeframe for making a decision. If additional information is requested, a conditional denial is issued within 14 days. If the additional information is received, the request has to be adjudicated, and the decision will be reopened. The problem is that no data is available on these different steps. For example, they cannot answer the question as to the proportion of cases in which a request is made for additional information or the proportion of cases with a conditional denial, which makes the case ineligible for IMR appeal.

Commissioner Wei asked about the proportion of UR-issued conditional denials. Ms. Wynn said that unless a decision is made to furnish the service anyway, it does not show up in the WCIS data. At present, the audit investigations do not collect that information; one of RAND's recommendations is that such information be obtained during the audit investigations.

Commissioner Bagan stated that after a claim goes through UR, it goes to a doctor or a nurse. He asked whether RAND found any UROs that didn't utilize nurses. Ms. Wynn said that it only reviewed 23 plans and that its approach was to find a wide range of services so that it could see the level at which the determination was made and what the decision was. It found a variety of arrangements with in-house nurses, physicians, claims adjusters (CA), and URO nurses and physicians in the position of approving or denying. It found approval rates from 74%-96% in the UR investigation cases.

Commissioner Bloch asked why a claims administrator would decide to refer the case to either a nurse or a physician. Ms. Wynn explained that under UR policies only a physician can deny or modify a request for treatment. All that a claims administrator can do is approve, unless the injured worker has a physician.

Commissioner Bloch asked how long the UR process is supposed to take. Ms. Wynn explained that the answer is found in the statistics generated as part of the audit investigation, and it varies across claims administrators. For a case in which no additional information is needed, the UR request must be acted on within five working days of receipt. If additional information is needed, it must be acted on within 14 days. The request for information needs to go out within five days.

RAND's objective in conducting the study was to identify potential best practices and to inform our estimates of UR denial rates.

Two policies were of particular interest to RAND in the study:

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- *Prior authorization* or advanced approval for treatment without requiring a request for authorization from the physician (this avoids the need for an RFA).
- Services that may be approved by a claims adjuster versus those that must be *elevated* for clinical review (or URO review).

Findings: Prior Authorization Is Uncommon

- Only 4 of 23 reviewed UR plans described prior authorization policies
 - Policies were limited to a few payers using the URO (payer-driven policies)
 - URO 1: 50 percent of payers (9)
 - URO 2: less than 5 percent of payers (6)
 - URO 3: standard prior authorization for payers (11)
 - URO 4: tailored plan for a few payers (3)
 - Some payers further limited the policies to specific occupational medicine clinics (e.g., Concentra, Healthworks, or Kaiser) or to initial care following injury

Several payers with prior authorization policies represent a significant portion of the WC market.

Commissioner Wei asked how a physician would know whether a treatment had prior authorization. Ms. Wynn said prior authorization is not common in the URO plans and found that the UROs send letters to the providers to let them know which treatments have prior authorization. However, it is a complication for physicians because payers have different sets of rules that physicians need to understand.

Ms. Wynn explained that a range of services has prior authorization, but this varies widely across payers. The PA services for medical provider network (MPN) physicians are as follows:

- Claims administrator prior authorization policy was limited, and there was a limited number of PT visits.
- The clients of another claims administrator in the same URO had prior authorization up to 24 visits, so there was a range of prior authorizations in the system.
- The initial services that are preauthorized show a pattern of low-cost/low-risk services.

Commissioner Bouma asked whether it is the same URO but different payers that create the variation in the range of services. Ms. Wynn responded yes.

RAND also found wide variation in the services that claims adjusters may approve.

- 10 of the 23 UR plans did not describe which services claims adjusters may approve.
- Three indicated that the payer determines the policies for the claims adjuster-approved services.
- Seven made no mention of claims adjuster-approved services, which could be a defect in the plan, but RAND does not know.
- For the remaining 13 UR plans:
 - Claims adjuster services are low-cost treatments with low medical risk to injured worker
 - Range and variation in services is similar to those with prior authorization
- 8 of the 13 have policies that vary for each individual claims administrator.

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- The burden is not on the physician.
- The timeliness of the approvals can be affected by whether the claims adjuster can approve a wide range of services.
- Study used findings to refine earlier analyses of UR audit listings
 - The DWC audits each claims administrator and URO every three to five years.
 - At the outset of the investigation, the DWC requests a listing of every request for authorization (RFA) received during the preceding three months.
 - RAND used the audit listings that report all RFAs as case studies:
 - Estimate UR approval rates
 - If you do not have the RFAs, then none of the services can be denied.

Commissioner Wei asked whether the approval rates ranged from 74% to 96% for the UR investigation cases that get approved for treatment. Ms. Wynn replied that it is for this set of claims based on the sample that RAND used for this study.

The question is what proportion of denials from UR is actually appealed. It appears that many are not appealed, though the precise percentage is unclear.

- WCIS data provided information on the services that are actually furnished. RAND matched the audit listing denials and used matching logic to the IMR decisions to find out the proportion of denials in the audit listing that match to an IMR decision.
- RAND took as its universe an audit listing and claim number and the date of the UR decision and matched that to the IMR and Maximus data. This method reveals a rate of 33% of denied services that are appealed.

Initial denials may have undergone informal review or may have been overturned. They do not know what happens to claims that have a conditional denial.

Exempting select services from preauthorization would improve the efficiency of the UR process.

- Provider interviews revealed a common perception that formalizing the RFA process increased the volume of services undergoing prospective UR.
- Exempting low-cost services that pose a low risk for injured workers from RFA would reduce the administrative burden for physicians and medical cost containment expenses and increase the timeliness of care.
- The starting point could be the types of services currently preauthorized or claims adjuster-approved services.
 - Could limit care provided within an MPN.
 - Could focus on care provided within one month of injury, e.g., PT/OT, low-cost diagnostics, and Durable Medical Equipment (DME).

Increasing transparency in the UR process should improve its performance.

- UR plans are publicly available documents from the DWC Medical Unit.
- Posting UR plans to facilitate understanding of UR review process used by different claims administrators.

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- Revamping the audit process to include new performance measures that will show how well the system works. The complete RFA listings that detail information prior to investigation.
- Consistency is needed between UR plan policies and the levels at which decisions are made.
- Percent of reviews with request for additional information.
- Percent of conditional denials.
- With respect to the average number of days for elevated review, is there enough time for the URO physician to review the case? If there is potential for denial, is there a peer-to-peer conversation?
- Successful peer-to-peer contacts.

Ms. Wynn indicated that there is now an increased reliance on evidence based medicine and more appropriate medical care is being provided to injured workers.

Summary of findings from a review of the UR process.

- Implementation of the IMR provisions had spillover effect on UR processes.
 - Increased reliance on evidence-based medicine
 - Increased administrative burden on providers
- UR practices vary widely and subject providers to payor specific rules
- Improvements in quality and efficiency of UR process should be considered:
 - Streamline the RFA process by combining RFA and progress reports into a single form
 - Electronic submission and processing of RFAs
 - Exempting low-cost/low-risk services from UR
 - Revamping the performance measures for UROs
 - Establishing additional standards for UROs.

Comments by Commissioners

Commissioner Bouma stated that in meetings with her members, it seemed that the focus of their frustration was on IMR and it seems to become more evident that IMR has just made more transparent some of the issues that are not being dealt with in UR.

Commissioner Bloch stated that the system should be streamlined so that services do not have to go to UR and IMR.

Commissioner Brady wanted to know whether 50% of IMR is pharmaceutical, and commented that he was looking forward to having a formulary in place.

A member of the audience asked Ms. Wynn whether other states have pharmaceutical guidelines; Ms. Wynn stated that examples of other states with pharmaceutical guidelines are in the RAND report.

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CHSWC Report

Eduardo Enz, Executive Officer, CHSWC

Executive Officer Enz stated that CHSWC staff is hard at work on a variety of activities:

- Continued monitoring of the progress of ongoing studies, including RAND's Evaluation of SB 863 Medical Care Reforms.
- LOHP's Aging Workforce project is nearing completion, and the staff will soon be turning its attention to the joint LOHP/UC Berkeley Janitorial study that is getting underway.

CHSWC is also planning and holding a number of upcoming meetings together with our partners at LOHP.

- Hosting a Young Worker Partnership meeting in Oakland on February 25.
- The School Action for Safety and Health (SASH) Advisory Committee meeting scheduled on March 22 in Oakland.
- Scheduled the next Worker Occupational Safety and Health Training and Education Program (WOSHTEP) Advisory Board meeting in Oakland on April 14.

CHSWC Vote

Comments by Commissioners

Commissioner Bouma stated that the WCIS data may not have data on the self-insured and asked whether this deficiency can be addressed. Director Baker replied that the public self-insured entities are not reporting as they should and that DIR is having meetings with them to determine how to get consistent reporting and explore other options so that definitions are clear and it can create reports. The work is ongoing. Commissioner Bouma would like to have a report on self-insured data at the next Commission meeting.

Public Comments

Richard Meechan, an applicant attorney and member of California Applicant Attorney Association (CAAA), commented:

- Regarding the RTW fund: Responding to the question of why only \$11 million has been spent, Mr. Meechan said that no regulation requires carriers to give a form to the doctors to state that the person is eligible for the RTW fund. The carriers or insurers have no incentive to pay it, and that is a major problem and why the full \$120 million is not spent.
- Regarding health care: The administrative burden on the treating physician should be reduced; the system is too complex, and that is not creating better outcomes for injured workers.

Other Business

None.

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Adjournment

The meeting was adjourned at 11:40 a.m.

Approved:

A motion to adjourn was offered by Commissioner Bloch, and Commissioner Bagan seconded the motion.

Angie Wei, 2016 Chair

Date

Respectfully submitted:

Eduardo Enz, Executive Officer, CHSWC

Date