

**Commission on Health and Safety and Workers' Compensation**

**MINUTES OF MEETING**

**June 26, 2008**

**Elihu M. Harris State Building  
Oakland, California**

In Attendance

Chair Angie Wei

Commissioners Catherine Aguilar, Allen Davenport, Sean McNally, Kristen Schwenkmeyer,  
Darrel "Shorty" Thacker

Executive Officer Christine Baker

Not in Attendance

Commissioner Steinberg

**Call to Order**

Angie Wei, 2008 CHSWC Chair, called the meeting to order at 10:05 a.m.

**Minutes from the February 28, 2008 CHSWC Meeting**

Chair Wei requested a vote on the Minutes of the previous meeting.

*CHSWC Vote*

Commissioner Thacker moved to approve the Minutes of the February 28, 2008 meeting, and Commissioner Aguilar seconded. The motion passed unanimously.

**The Capture-Recapture Estimates of Workplace Injury Underreporting in California  
"How Often do Workplace Injuries go Uncompensated?"**

Les Boden, Boston University School of Public Health

Background

Christine Baker stated that this study was commissioned as part of a series of studies on potential fraud issues. Injuries that go uncompensated or underreported were one of the areas identified by an advisory group that should be explored as a potential area of fraud.

Les Boden stated that workers' compensation is the main source of replacement for lost earnings for injured workers. If the reported number of work-related injuries and the cost of work-related injuries decline, while real injury rates do not decline or do not decline as rapidly, prevention will seem less important. He stated that good workers' compensation data can help set priorities as well as be used to evaluate the success of prevention programs. He stated that at the Federal level, Congressman Miller recently held a hearing on underreporting of on-the-job injuries and

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

illnesses as part of the Committee on Education and Labor of the House of Representatives.

Methodology of the Study

Mr. Boden stated that the study used individual workplace injury reports from the State's workers' compensation information systems and from the Bureau of Labor Statistics (BLS) Annual Survey of Workplace Injuries and Illnesses to measure underreporting. Those injury reports provide the name of the worker and the type and date of injury. The two data sets were linked at each step to make conservative assumptions to get a lower-bound measure of underreporting. States participating in the study were California, Minnesota, New Mexico, Oregon, Washington, West Virginia, and Wisconsin. The focus was on lost-time injuries, not medical-only cases, because different definitions for non-lost-time injuries make it difficult to match BLS and workers' compensation data sets.

Mr. Boden stated that the California study looked at two timetables: injuries that occurred in 2003; and injuries that occurred in the one-year period of July 1, 2004, through June 30, 2005. Those periods were chosen because there was concern that the 2004 reforms might have an effect on injury and illness reporting. The study found that at least 25% of lost-time injuries were not reported in the earlier period as opposed to 25% than in the earlier period. This is probably due to an extra year of experience with a system that started in 2000. These estimates are the most conservative estimates that could be made and assume independence of reporting. Mr. Boden stated that assuming independence of reporting between the two systems makes the estimates more optimistic than if there is dependence between the two systems.

Mr. Boden then stated that the amount of underreporting of lost-time injuries in California is in the middle of the states studied. He also stated that there are probably a substantial number of cases where indemnity benefits are being paid even if cases are not reported to WCIS.

Mr. Boden stated that there are two other reporting issues: delayed reporting; and very incomplete reporting of the Federal Employer Identification Number (EIN). Between 2.25 years and 3.25 years following injury, there were 43,000 new cases reported, and there were more than 32,000 new lost-time cases. This indicates that there is very slow reporting. The second issue, incomplete federal EIN numbers, is significant because it is more difficult to identify which employers have the most injuries.

Conclusions

Mr. Boden stated that conclusions from the study include: (1) under the most conservative assumptions, 21% to 25% of lost-time cases are not reported; with less conservative assumptions, 29% to 49% of lost-time cases are not reported; (2) California is not atypical of the other states in the study, but that does not mean that it is doing a good job of reporting; (3) most unreported injuries are not being compensated and benefit adequacy is zero and therefore less good; (4) policies based on workers' compensation data may be flawed because of incomplete data; (5) program evaluations can be flawed; (5) employer safety incentives are reduced; and (6) priority on injury and illness prevention is reduced.

Recommendations

Mr. Boden stated that recommendations from the study include:

- CHSWC could consider leading the formation of a task force on underreporting that

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

would include relevant agencies, including the Division of Workers' Compensation (DWC), California Department of Public Health (CDPH), Department of Labor Standards and Research (DLSR), and Cal/OSHA.

- Identify details about underreporting by using: (1) Medical Information Reporting in California (MIRCAL) data, which is the mandatory reporting of all emergency department visits, ambulatory surgery and hospital in-patient stays; it has information about the person being treated and whether the expected payor has workers' compensation insurance, which potentially could be linked to information in WCIS; (2) CDPH data on physicians, including specific information on occupational conditions; and (3) DLSR doctors First Reports of Injury, which have a lot of useful information but are available only on paper. These are cases that should be in WCIS, so it would be even more valuable data if automated.
- Identify a way to work with the Emergency Services agency in California which is in the process of establishing a state trauma registry that would collect information on all cases of trauma; if this information were linked to workers' compensation data, it could be an important source of information on the kinds of cases where there is likely to be little dispute about whether a person has been injured and whether or not the injury is work-related.
- Explore the relationship between unreported and misreported payroll as that could be a link to unreported injuries.
- Require correct federal EINs in WCIS. It might take some minor legislation to give the Department of Industrial Relations (DIR) the authority to do this.
- Add the State Employer Account Number (EAN), the number used by state agencies to identify employers, to data in WCIS.
- Use the annual Behavioral Risk Factors Surveillance Survey (BRFSS) as another source to check about injuries and how that data relate to WCIS data.
- Discuss the possibility of instituting penalties for not reporting or for late reporting, as well as publicizing those cases to communicate that it is important to report injuries and to report them in a timely manner.

Acknowledgements

Mr. Boden thanked the Commission for funding the study.

*Questions from Commissioners*

Commissioner Davenport stated that based on the workers that he represents, there is probably 75% to 80% unreported injuries and that the underreporting that he sees most often is in offices where people choose to report lost time as sick time. He asked if there is any reason to see if the system is underinsured because it is not covering serious injuries to the degree that they occur. Mr. Boden replied that if people are not frequently being compensated for injuries, then this is equivalent to being underinsured or having a policy that does not give the benefits it should.

Ms. Baker asked if there is any indication of the number of people going to Emergency Rooms to

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

be taken care of medically. Mr. Boden replied that that information might be available through MIRCAL. Another question is who is paying for the Emergency Room care: whether it is being publicly subsidized, whether the hospital Emergency Room is absorbing the costs, or whether the worker, friends and/or relatives are paying for that care. Commissioner Davenport responded “yes” to Mr. Boden’s comments

Commissioner Aguilar asked which entity in California does the BRFSS. Mr. Boden replied that that is a national survey and that states get to add their own questions. Comments from the public added that the survey is done through the state health departments and that the State pays the cost for it. A number of questions were added to the California survey, including whether a person had been injured within the past year and had applied for workers’ compensation and whether he/she had gotten it and if he/she did not apply, why not. Mr. Boden stated that if those questions were asked on an ongoing basis, it would indicate something about time trends around reporting. He stated that there has been a study looking at Emergency Room discharges nationwide that asks about work-relatedness. He added that Emergency Rooms have not seen the same decline in injury rates that have been seen elsewhere.

Chair Wei stated that claims in California have fallen in the double digits each year for at least a decade. She asked how much of that drop in claims can be attributed to not reporting claims. Mr. Boden replied that that is an important question that has not yet been addressed. He thought that the drop in the 1990’s in BLS-reported injuries was related to changes in workers’ compensation law that made it more difficult to be compensated. He stated that information from a number of sources would have to be used to address this issue.

Chair Wei stated that this study looks only at lost-time underreported claims; she stated that for medical-only cases, she believes that those who have group health are turning to that insurance, even if that means that they are paying for their care. Mr. Boden agreed that that might be correct.

Commissioner Aguilar stated that there is confusion about medical-only claims and first aid claims. First aid claims allow for two visits under the guidelines that employers can and do pay for. Mr. Boden agreed that there are definitional issues around this, and people can be confused.

*Public Comment*

Debby Nosowsky, DJN Consulting, asked about the difference between BLS and WCIS reporting, since in most instances, employers report to BLS and insurers and self-insured employers report to WCIS and how this affects the information. Mr. Boden replied that if the employer is directly reporting, as with BLS reporting, it is less likely that cases will not be reported. He added, however, that there are limitations to BLS reporting, basically, that anything discovered after the reporting date (typically two to three months after the injury year) does not get reported to BLS.

Ms. Nosowsky asked what percentage of late reporting was due to the data reporting problems by the entity required to report, and what percentage were being paid benefits but the reports were not accurate. Mr. Boden replied that this is hard to tell with existing information.

Barbara Materna from the Occupational Health Branch of the California Department of Public Health stated that the branch has been using limited funding from the National Institute of

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Occupational Safety and Health (NIOSH) to look at selected conditions such as asthma cases and comparing what turns up in the doctors' first reports and what turns up in WCIS, and they have found about one-third underreporting. She stated that the branch is adding different data sources now and would like to recommend that more resources at the state level be identified to do this type of work.

*CHSWC Vote*

Commissioner Aguilar moved to approve for feedback and public comment the CHSW report on The Capture-Recapture Estimates of Workplace Injury Underreporting in California: "How Often do Workplace Injuries go Uncompensated?", and Commissioners Thacker and Davenport seconded. The motion passed unanimously.

**Workers' Compensation Medical Payment Accuracy Study (Fraud Study)**

Paula Douglass, Navigant Consulting

Background

Christine Baker stated that the study was the result of a joint effort between the Department of Insurance Fraud Assessment Commission (FAC) and CHSWC. She stated that they entered into an MOU at the request of the FAC to assist them in carrying out the study with the Navigant Consulting team. This was identified as a part of the studies developed by an advisory group that was needed or required to evaluate the extent of fraud in the workers' compensation system. The payment accuracy was one study, the underreporting was another, and the misclassification (of workers) and premium fraud was a third.

Purpose of Study

Paula Douglass stated that the purpose of the study was to estimate the extent of overpayment and underpayment in medical payments in workers' compensation in California. The impetus for the study came from a State Bureau of Audits (BSA) Report that recommended that the Department of Insurance undertake this research to estimate the level of medical payment fraud in workers' compensation.

Methodology

Ms. Douglass stated that the design of the study that the Department of Insurance, CHSWC and other state agencies adopted is based on a methodology for medical payment accuracy developed by Malcolm Sparrow of the John F. Kennedy School of Government at Harvard University, an expert in medical fraud, and his approach has become a widely accepted, sample-based method for measuring the level of payment accuracy and error in health care programs and identifying areas of potential fraud. Ms. Douglass stated that this methodology does not directly measure the level of fraud in medical payments in workers' compensation. Rather, it measures the level of medical payment error. Identifying fraud requires establishing criminal intent and involves the

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

criminal justice system. Therefore, it is beyond the scope of the study to identify which of the errors could be fraud.

Ms. Douglass stated that there are study findings for three different samples. Navigant Consulting selected a sample of 761 medical bills to review, and this was one bill for 761 injured workers. The dates of injury for these injured workers were from 2001 through the first six months of 2006, but they all had medical bills paid during a 12-month period from October 1, 2005, through September 30, 2006. Navigant Consulting did reviews on the sample bills from three different perspectives and addressed three different issues. The first review, the medical review, examined the supporting medical documentation to determine whether that documentation supported the services that the medical provider billed and the insurer paid. The second review was a survey of injured workers in order to give the workers an opportunity to verify or deny that they actually received the services that the medical provider billed to the insurer. The third review, the processing review, reviewed whether the provider submitted the bill in accordance with policies and whether the insurer processed that bill and paid it correctly according to policy.

Ms. Douglass stated that in an ideal situation, all three reviews would have been on all the bills. However, for practical reasons, it was not possible. She stated that Table 1 in the Executive Summary of the Report presents a summary of the bills for which Navigant Consulting was able to conduct the three different reviews. She then stated that three different sets of findings are reported. Ninety-seven bills were examined using all three reviews, and those were the most rigorous findings. Also, in terms of the validity of estimating the level of payment error and the value of the potential payment error in California workers' compensation, those are the most reliable.

Summary of Findings

Ms. Douglass summarized the findings. Navigant Consulting found that 21.9% of the sample dollars were paid in error for the sample that included the three reviews. She stated that looking at the larger sample set of 373 medical reviews on 373 bills; the error rate was 27.4% of the sample. The processing review was a sample of over 38,000 bill lines for all bills paid for the sample injured workers over a 12-month period and a 4.5% error rate was found. She stated that this was consistent with their expectations because it involved only one review. Based on these sample error rates, they estimate that the potential medical payment error rate in the California workers' compensation system ranges from \$494 million to \$1.37 billion for the three combined reviews; from \$822 million to \$1.5 billion for the medical review-only sample; and from \$122 million to \$261 million for the electronic processing review only. She emphasized that even though the sample size is relatively small, this is a statistically valid estimate of the error rate in the California worker's compensation system, although the small sample size does make the confidence interval level quite wide.

Ms. Douglass stated that for the three combined reviews, the vast majority of the payment errors found were due to medical review errors. Navigant Consulting had conducted medical reviews on a larger sample of 373 bills, and tested whether the results of the smaller sample of 97 were different from the larger sample size of 373 medical bills. She stated that they found that the two had comparable error rates, thus substantiating the findings in the smaller data set. She then

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

stated that Tables 2 and 3 of the Executive Summary present the reasons for the payment errors. In Table 2, of the 34 total payment errors, 24 were related to a medical review component, 6 were related to a survey of injured workers where an injured worker denied receiving the service or services from a particular medical provider, and 4 were due to processing review errors.

Commissioner Wei asked how Navigant Consulting determined that the service was not medically necessary. Ms. Douglass replied that it was based on the medical documentation that the insurers provided, the diagnosis and the services provided, when the injury occurred, and information from the patient's history and physical examination. Commissioner Wei asked if that was based on treatment guidelines, and Ms. Douglass replied that they were based on American College of Occupational and Environmental Medicine (ACOEM) guidelines, where applicable. Commissioner Wei then asked about the samples drawn during the period before ACOEM guidelines. Ms. Douglass explained that if a service found to be inconsistent with ACOEM guidelines was provided prior to the date of the adoption of ACOEM guidelines, then the service was not counted as a medical review error in the study. Commissioner Wei asked for confirmation that for all 15 in the sample where the service was not medically necessary in Table 2, that all are post-ACOEM guidelines adoption. Ms. Douglass replied that that was correct.

Ms. Douglass then stated that although, it was beyond the scope of the study to identify which of the reasons for error was fraud, fraud could be within the errors identified, in particular among the survey of injured workers. She stated that the purpose of that component of the review is to identify potential fraudulent services.

Ms. Douglass stated that looking at the electronic processing review in Table 4 and considering the reasons for these types of errors, Navigant Consulting did not label as errors line items where the amounts reported as paid differed from the amounts indicated as appropriate, and the only explanation for how the appropriate amounts were determined was that the services were billed at or priced according to the applicable fee schedule amount. This was because there was no way to determine if the difference was simply due to a preferred provider organization (PPO) network reduction. She stated that these processing errors were due to duplicate paid items, unbundled items where the provider submits a bill for several services on an individual basis when they should be bundled under a global fee. She stated that, again, fraud is not listed, but certainly some of these reasons for processing errors can point to potential fraud, especially duplicate billed items, unbundled services, etc.

Commissioner Aguilar asked for an explanation about Table 4 and the term "Other." Ms. Douglass gave the example of incorrect payment according to the fee schedule for an assisting surgeon in a surgery and explained that the net of these other payment errors was an underpayment.

Ms. Douglass again stated that in regard to the results of the study, the confidence interval is wide, but the estimates are valid. She stated that the sample was randomly selected though it was smaller than Navigant Consulting would have liked to achieve. She stated that the period of study covered a period of time for which there was no centralized resource of medical bill payment data, so it required collection of the data from the insurers and self-insured employers. She stated that the study represents the first attempt in California, as well as in any state as far as

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

is known, to estimate the level of medical payment accuracy for the entire workers' compensation system. It can provide a baseline for subsequent studies as well as for monitoring the success of changes that may be implemented as a result of the study.

Commissioner Aguilar asked whether Navigant Consulting tracked refunds in the case of duplicate bills paid. Ms. Douglass stated that if there was a subsequent bill with a credit for the same service, then it would not have been recorded as a duplicate payment; however, if the provider made a cash refund for a duplicate payment, they had no way of knowing that.

Recommendations

Ms. Douglass stated that Navigant Consulting's recommendations reflect consideration of the many causes of payment errors, some of which are honest errors and some of which are likely fraud. The recommendations address the causes of payment error that Navigant Consulting identified in the study, in addition to the ways to more directly identify potential fraud in workers' compensation in California.

Ms. Douglass stated that the first recommendation is to increase education efforts for providers, insurers and other relevant parties about the appropriate course of care per ACOEM guidelines and other evidence-based medical practices for the most frequent types of injury. The study findings suggest that despite the reforms implemented in 2004 to address the utilization of medical services, it appears that many of the services that are being provided to injured workers are not appropriate for their diagnoses or are not medically necessary. She stated that some of this may be willful on the part of providers, but some may be simply unfamiliarity with ACOEM guidelines. She stated that education efforts are therefore in order for providers, insurers, qualified medical examiners (QMEs), agreed medical examiners (AMEs), and physicians and nurses who do utilization review for insurers and third-party administrators (TPAs).

Ms. Douglass then stated that another recommendation is to data mine the new medical bill data in WCIS. Insurers and claims administrators are now required to report to WCIS all medical bill data for services provided on or after September 22, 2006. Ms. Douglass stated that Navigant Consulting believes this is an important resource for the State's fraud-detection efforts. She stated that another important use of that data is to combine it with Medi-Cal data for data mining purposes. This would allow the State to identify trends in medical bill fraud across two programs, which would provide a more complete view of providers' billing patterns than can be gained by analyzing data from each program in isolation.

Commissioner Davenport asked, given the pace at which WCIS has progressed over the years, when Ms. Douglass thought it would be ready to provide the kind of data that would be of value. Ms. Douglass stated that as of April 2008, WCIS had data for half of the injuries reported in 2007. She stated that one could begin now to analyze the data to become familiar with the information that is there and that in a couple of years, there should be a thorough understanding of the available data; at that time, artificial intelligence-based software could be used to mine that data. She stated that another recommendation of the study is to conduct a later study within three years using the WCIS database. She also stated that using WCIS will make doing such a study much faster and much easier and likely achieve a much larger sample size because the medical

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

bill data collection that Navigant Consulting conducted would not be necessary and the data will be standardized as it goes through rigorous edits to get into WCIS.

Ms. Douglass stated that another recommendation was to expand the statutory authority for the Department of Insurance to have access to the medical records of injured workers. For other payment accuracy studies that Navigant Consulting and others have done, they have obtained the medical records directly from the providers because they were working with a one-payor system, such as the Medicaid program. If the Department of Insurance had such access, it would make the study more rigorous, and it would have other benefits for fraud-detection efforts.

Ms. Douglass stated that another recommendation is for the State to develop a medical benefits administration best practices checklist for employers to evaluate how effective their insurance carriers or their TPAs are in terms of ensuring the payment accuracy and fraud detection, including understanding ACOEM guidelines and asking insurance carriers and TPAs to demonstrate how they apply those guidelines in their utilization review processes, as well as to demonstrate how effective they are in negotiating network payment rates and processing bills.

Ms. Douglass then stated that another recommendation is that the State consider requiring insurers and TPAs to send Explanation of Benefits notices to injured workers, because this is a way of involving the injured workers in the front line of fraud detection. Still another recommendation is for the State to require medical providers who participate in workers' compensation to register with the State. To make this effective, the State would have to develop participation rules in much the same way as the Medicare and Medicaid programs have provider participation rules that require adherence on the part of providers to billing standards and utilization criteria such as ACOEM guidelines. If those rules were combined with mandatory education and periodic audits, that they would be even more effective.

Commissioner Davenport asked Executive Officer Christine Baker whether there was a Board or Commission to oversee providers that was eliminated by the State because it was not effective. Ms. Baker replied that the function is now located in DWC and that DWC's Medical Director, Dr. Anne Searcy, is doing a terrific job of trying to put together an evaluation of what is going on in the system. She stated that the Industrial Medical Council (IMC) no longer exists. Commissioner Davenport stated that his concern with such a recommendation is that the last time it was tried, it became a self-serving bureaucracy without much of a function. Ms. Douglass stated that it would not be effective unless it were enforced with rules and regulations.

Acknowledgements

Ms. Douglass stated that there were many people to thank for their assistance in the study and they are listed in the report. She stated that she wanted to especially thank Christine Baker and Bill Zachry with the Fraud Assessment Commission (FAC), who were co-project directors in the study, as well as several people in the Department of Insurance, particularly Hung Le, as well as Judge Lach Taylor of DIR. She stated that Navigant Consulting also had tremendous cooperation from insurance carriers and self-insured employers and TPAs even though it was a challenging data collection effort.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

*Questions from Commissioners*

Commissioner Wei asked where the “big money” was. Ms. Douglas replied that the findings suggest that they are in the medical area, as there are services that are not appropriate for the diagnosis or are simply not medically necessary, for example, services that are provided beyond the time period for which they would have any effect. Commissioner Wei stated that she was reviewing Tables 2, 3 and 4 and was having a hard time comparing them and asked whether they were “apples-to-apples” comparisons across the tables. For example, in Table 4, the processing side, the big ticket item is “incorrect or invalid procedure codes,” which constitutes more than half of the total net dollars. She asked how much the services not medically necessary would be. Ms. Douglass replied that that would be much bigger dollars. She stated that in the processing reviews, Navigant Consulting did not find a high level of error, only 4.5% percent, in a large longitudinal data set used; she stated that it was consistent with other similar studies of, for example, the State Medicaid agencies. The majority of errors are not in the electronic processing but in the medical review area.

Commissioner Wei asked if there is a break-down of who the providers are, whether hospitals, doctors, surgery centers, etc. Ms. Douglass stated that the tables in the report show that the vast majority of the sample bills were from the category physician and other practitioners, which includes chiropractors and physical therapists, etc., and that that is where most of the dollars are spent and not surprisingly, where most of the errors were found. There were some medical review errors in hospitals, but they had the fewest medical review errors, and there were some pharmacies, but the pharmacy sample was fairly small.

Commissioner McNally asked about the recommendation that providers register with the State in order to be eligible to participate and how Navigant Consulting saw that functioning and why that would be effective. Ms. Douglass replied that it would require providers to agree to rules of participation, and it would allow the insurers and self-insured employers to have more legal protection in excluding providers from their networks who do not adhere to those rules. One of the reforms was to allow insurers to use Medical Provider Networks (MPNs), but many of the insurance companies and self-insured employers that Navigant Consulting interviewed stated that they do not feel that they have sufficient legal protection to exclude providers that they believe are abusing the system. This is not accusing these providers of fraud necessarily, but it is simply stating that they do not adhere to the network rules. Ms. Douglass stated that this has been observed in other fraud focus groups that Ms. Baker has led for the Department of Insurance. Ms. Douglass then stated that if there were a State body establishing those rules and registering those providers, that would provide more legal protection, plus it would codify and make clearer what the rules of participation are.

Commissioner McNally asked whether it would make sense to put those in the MPN regulations, so that if providers are to be part of a provider network, that they agree to a certain set of standards, and so the insurer or the self-insured employer would then be able to analyze those standards. Ms. Douglass replied that that might be a good direction to go in, but that it would be important that the rules be standardized and that an individual insurer would not be allowed have its own rules that would be different from other insurers. She stated that it would be beneficial for all parties involved to have one set of rules and regulations to adhere to.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Commissioner Aguilar stated that there is something similar in place for QMEs, but that in her opinion, it is not working. QMEs are being told what they are supposed to do, and they are not complying with those rules. This raises the question of what to do when they do not comply, such as removing them from the workers' compensation system in California.

Commissioner McNally stated that that he thinks that it works better on the private side, whether it is a Blue Cross contract physician or a Kaiser contract physician, because the rules and the utilization process are clear; if providers are not following the rules, they are going to get caught and they are going to suffer financial consequences. He also stated that QME rules are not working the way they are supposed to, so if these kinds of standards are put in statutes that govern MPNs, then you might be able to have more direct financial consequences and get the attention of the providers that are abusing the system.

Commissioner Wei asked Commissioner McNally whether new standards are needed. She stated that the employer could remove the provider from the MPN network if there is a pattern and practice of non-compliance. Commissioner McNally stated that it is not that simple. For example, his company is in a rural area. There are certain requirements of MPNs to have certain types of doctors, and doctors have some leverage in that respect and they know that. He stated that his company has very experienced industrial providers who are seeing a loss in income and they are gaming some of the utilization requirements. He stated that the company is talking with the physicians, and there is a quiet threat that if the company pushes too hard, then the physicians simply will not do business with them anymore. If physicians do not do business with the company, then they will not have an MPN that meets the requirements of the State of California. There is no meaningful leverage to say that this is part of the contract you signed to be part of our network. Commissioner Aguilar stated her agreement about this and that her district is also rural and they do not have enough doctors to remove them from the MPN.

Commissioner Wei stated that this presentation was not an action item, rather the delivery of the final report. She then stated that the Commission would be interested in hearing public comment.

*Public Comment*

Linda Atcherley, on behalf of the California Applicants Attorneys Association, stated that in follow-up to Commissioner Wei's question, the area of medical services that are not medically necessary is the area of greatest abuse. She also stated that retrospective review by Navigant Consulting is not appropriate when treatment is provided outside of ACOEM guidelines which is perfectly appropriate in some cases and has gone through utilization review which has been done pretty rigorously. She stated that as an attorney in workers' compensation, she has hundreds of utilization review documents that come through in a week, and a lot of the procedures are authorized that are not necessarily according to ACOEM guidelines. For example, physical therapy that is outside the 24-cap can be necessary for extraordinary injuries that require physical therapy and chiropractic treatment outside the cap. She stated that she would hate to see this study do anything to impair an adjustor's right to authorize treatment that is medically necessary simply on the cost factor, when the idea is to get the injured worker back to work. She stated that taking a look at the cost of services not medically necessary on Table 2, at \$1,689, and on Table

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

3, at \$6,710, they add up to roughly \$9,000; however, invalid and incorrect procedure codes in Table 4 are \$68,233. It therefore seems that the biggest cost, assuming the study is correct, is incorrect or invalid procedure codes and multipliers, which is perhaps a result of problems with the medical legal fee schedule and with the Current Procedural Terminology (CPT) codes. Therefore, it does not seem that medically inappropriate procedures are actually the big cost in the system.

Ms. Atcherley stated that there are a lot of problems getting medical treatment for injured workers with some very diverse injuries, cases that do not always follow ACOEM guidelines. The person who needs a liver transplant, a very costly procedure, does not follow under ACOEM guidelines. Also, someone who has had a couple of legs amputated, has multiple body parts, has a head injury does not necessarily follow ACOEM guidelines. She stated that it is not appropriate to strictly review these cases and determine that they are not medically appropriate because they do not follow a guideline. She stated that while she understands the necessity of the guidelines and the importance of containing costs, they have to be put in perspective. She stated that she did not want this study to be an excuse to further diminish the ability of the injured worker to get appropriate medical treatment, whether under ACOEM guidelines or not. She also stated that there is effective utilization review in the State, and it is getting better, and it takes time to get to an optimum level so that people should limit critiques about medical treatment until utilization review is firmly in place.

Ms. Atcherley stated that she is concerned about the recommendation to expand statutory authority for access by the Department of Insurance to the injured worker's medical records. She stated it takes an insurance company an authorization or a lawful subpoena to get medical records of an injured worker. There are significant privacy issues with allowing the Department of Insurance to go into the injured worker's record, because they suspect the provider of fraud or they suspect a billing fraud problem or some other problem. She stated that one has to be careful about giving criminal departments open access to innocent patients' medical records. She stated that, therefore, she did not think it was an appropriate recommendation, although she commends the Department of Insurance for the work it has been doing to identify fraud and go after the cost factors in the system.

Ms. Atcherley then stated that there are also problems with doctors leaving the system. There are many MPN regulations; however, employers and insurers are allowed to do economical profiling of doctors in the network, so that if doctors are too costly, they just eliminate those doctors from the network. She stated that there are some doctors who do not follow the regulations and that it is a problem for everyone; she also stated that as an applicants attorney, she needs medical reports or she cannot go to court and enforce a medical award. She stated that the answer is not to regulate MPNs more; the idea of MPNs and utilization review was to provide top-notch medical treatment to return an injured worker to work. If you make it impossible for doctors to participate, they will leave and go to Medicare because Medicare rules are easier to follow and doctors do not have to file a report every time they see a patient. It is important to keep the good providers in the system and look at the regulatory or educational end to see if some minor changes can be made that do not change the quality of care but make it easier to have regularity and consistency between doctors and how they participate in an MPN.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Debby Nosowsky of DJN Consulting stated that she also had a question about Table 4 and considering payment for physical therapy and chiropractic services beyond the cap and equating that to an error. She stated that the statute specifically authorizes claims administrators to pay services beyond the cap. Now, because of allegations that some claims administrators refused to pay, there are rules for physical therapy post-surgery. She stated that she was shocked to see this category in the study as a payment error. She stated that she would like to know the extent that the payment for physical therapy beyond the cap may have spilled over into the other tables under services not medically necessary. She asked if some of those services considered not medically necessary were also payment for physical therapy beyond the cap. Ms. Douglass replied that from the processing review perspective, the point made about the cap acknowledged in the study is a strict application of the cap, and it does not consider whether the insurer approved it. However, it does not affect the medical review findings where there is actual information and medical documentation provided and reviewed to determine whether that should have been approved. Navigant Consulting acknowledges the processing review strict application, but that does not affect the medical review, and those cases are not counted twice.

Ms. Nosowsky asked about the medical review and the documentation required to justify payment beyond the cap. Ms. Douglass stated that it was up to the payors to request the documentation they believe necessary to substantiate that the services were appropriate in order to pay the bill. Navigant Consulting could not go directly to the providers and request documentation; rather, it relied on information that the insurer may have requested and obtained from the provider at the time they were adjudicating the claim. Ms. Nosowsky then asked about cases of partial payment or disputes about the remainder of the bill which sometimes is resolved later and paid. Ms. Douglass stated that Navigant Consulting only looked at paid bills, so if it was paid, it would have been resolved. She also stated that this explains why there were some very old dates of service with a much more recent payment date, probably related to those types of disputes. Ms. Douglass added a clarification that it is important when looking at the dollar value of the error in the sample to look at it as a percent of the total sample dollar value error, so that the processing review was a much larger sample, 38,000 bill lines, and the value of that is much higher. Commissioner Wei stated that it was difficult to make those kinds of comparisons across the three tables.

Steve Cattolica of the California Society of Industrial Medicine and Surgery, US Healthworks and the California Society of Physical Medicine and Rehabilitation stated that providers provide about 25% of the care in California. Mr. Cattolica stated that no one who was consulted was from the medical community, and whatever the intent of the study, this was a huge error. He also stated that notwithstanding Mr. Sparrow's authority and Navigant Consulting's work, not all errors are indeed errors. He stated that other comments have already pointed out that what Navigant Consulting calls errors could have been authorized and could be in fact proper and found at the Workers' Compensation Appeals Board (WCAB) to have been medically necessary and paid after the fact at a later date.

Mr. Cattolica stated that Ms. Douglass cited 761 claimants, yet the study findings state 761 bills. Ms. Douglass replied that since there was no centralized medical bill data for the time period covered by the study, the sampling had to begin with the doctors' First Reports of Injury, so 761 injured workers were identified, and medical bill data were requested from the respective insurer

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

or self-insured employer. Navigant Consulting received that data and selected one bill from each of those workers. Mr. Cattolica then asked for confirmation that one bill was randomly selected from the array of bills, regardless of whether it was the first injury provider's bill or the specialist downstream, or whomever in between. Ms. Douglass confirmed his understanding and noted that the bill had to have been paid during the 12-month period defined in the study.

Mr. Cattolica stated that he wished to reiterate the comments on ACOEM guidelines. The medical treatment utilization schedule takes in much more than ACOEM. If there was no attempt to reconcile what the utilization review provider or vendor may have authorized versus what was actually done, that is, simply a rote comparison to ACOEM, there are going to be all sorts of errors. The adjusters have the right to make a determination, and in fact, they have their list of doctors who they pay in full, over the fee schedule, simply because of who that physician is; that would be an error, and in some respects, that might be fraud, but there is no reconciliation in the study for that kind of conduct. He also questioned the determination of services that are not medically necessary. The procedure codes in the Official Medical Fee Schedule are based in 1997. Every procedure code between now and then might have been billed, but may not be in the fee schedule and would therefore reflect an error. That is an error that the study should consider.

Mr. Cattolica then stated that in regard to the Explanation of Benefits recommendation, he is aware of the Department of Insurance's Fraud Task Force's introduction of the O'Brien Form. Judge O'Brien was making an effort to try to back track on injured workers and have them help with an effort to identify certain services that were not provided. He stated that he has had discussions with that group, and with the exception of Disney, they have withdrawn that idea because of some of those discussions. He stated that such an effort has so many issues that care would have to be taken if it were put into statute. He then stated that in regard to registration with the State, Labor Code Section 4616 is clear, and notwithstanding geographic issues that have been around for a long time, PPO contracts before MPNs were established reflected the marketplace. You probably could discount in those areas where there were fewer providers than in other areas. Labor Code Section 4616 is quite clear; they do not even need to profile anyone to remove them from a network. They do not need to prove fraud; it can be based on reputation, or if their name is spelled wrong, it does not matter. This is probably one of the hardest areas to administer and probably the least effective. Quantified studies have shown that it has been least effective in states that have adopted a Resource-Based Relative Value Scale (RBRVS) system; medical registration has had the least effect on billing accuracy and physician participation. Mr. Cattolica stated that he would welcome the opportunity to correspond with Navigant Consulting about next steps and the study.

Christine Schultz of the California Chiropractic Association restated concerns of the provider community about using ACOEM guidelines as the standard for determining medical necessity. She stated that the Association recognizes that fraud is a problem and is interested in making things better. The Association has focused on trying to educate providers about billing properly. She asked if there were other things Associations could be doing to address the problems of fraud. Ms. Douglass replied that education efforts are important, including the proper use of ACOEM guidelines, even if there is disagreement. Ms. Schultz stated that while the Association disagrees with the numbers in the study, the Association sees that this is an important issue and is working on ways to solve this problem.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Frank Neuhauser of University of California, Berkeley, and consultant to the Commission stated that he notes Malcolm Sparrow's efforts of focusing on the patient and asking whether they had services and that this has been important in his other studies. He stated that in the survey, approximately 6% of the patients claimed not to have received the treatment, that is, 6 out of 97 or 6.1%, suggesting that between 1% and 11%, but probably closer to 6% of the services in this portion of the study were not delivered to the patient, and he stated that it would be difficult to imagine that it would not be fraud. He asked if Navigant Consulting were confident that the survey was accurate and whether it would be reasonable to assume that between 1% and 11% of the services were not delivered to the patient. Ms. Douglass replied that it would be reasonable to assume that. She stated that Navigant Consulting is not confident that the workers' recall was perfect, but that was not addressed; the survey was constructed to give the injured workers more than one opportunity to verify their answer. She also stated that there were other injured workers who denied receiving services; however, the name of the provider listed by the insurer was in some instances a billing entity rather than the rendering provider; in those circumstances, Navigant Consulting did not count those as errors. Mr. Neuhauser stated that it was a staggering number in any case.

**Project Update: Study Evaluating the Impact of the Recent Reforms: Medical Provider Networks**

Barbara Wynn, RAND

Background

Barbara Wynn stated that she would discuss preliminary findings on medical provider networks (MPNs), part of the ongoing study for the Commission on the impact of the recent workers' compensation reforms. She stated that the findings will be presented in an Interim Report that will be available in the near future. The study addressed MPNs and what the issues and best practices are. The findings are based on key interviews and site visits in 2007, review of rulemaking documents and applications, and other studies done. Ms. Wynn stated that the majority of MPNs were approved within the first six months of the effective date of the regulations. At first, insurers leased existing networks or signed agreements with health care organizations (HCOs). After that time, a number of self-insured employers have come in. The remaining are Joint Powers Authorities (JPAs).

Findings

Ms. Wynn stated that physicians are definitely in multiple networks. MPN websites are not always up-to-date, and it is not always easy to find information. In addition, there are often disclaimers on the websites about the accuracy of the information. From the interviews conducted with key informants, multiple applications for the same MPN are inefficient for all those involved, the networks, employers, payors and DWC. A material modification involves a substantial modification of 10% or more in the size or composition of an MPN. When adding additional physicians, that process may be an unnecessary burden. Employers and payors that lease networks pay a fee, and they rely on the MPN that requirements are being met. There is no

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

requirement for re-approval of MPNs. Ms. Wynn stated that key considerations would include certifying or including the network or allowing the network to apply for approval as opposed to requiring the employer or payor. This clarifies the accountability of the network and facilitates performance monitoring through WCIS. This also reduces system cost. Changing the material modification criteria to focus just on reductions, where the program safeguards are needed to ensure adequate access, would also reduce the administrative burden. In addition, a streamlined re-approval process is recommended.

Ms. Wynn stated that other issues involve questions of access, especially a scarcity of physicians in rural areas, and the need for DWC to provide greater oversight. Many physicians were determined to be ineligible for a number of reasons. Of the respondents to the survey, 42% of physicians stated that they had no contract with an HCO or MPN, even though they were listed as part of the network. Ms. Wynn then stated that satisfaction with care is about the same as the UCLA Survey. DWC has tried to address some of the access issues in MPN regulations: applicants have to confirm that a contractual relationship exists with physicians to provide workers' compensation care, which complies with the regulations; HCOs have to confirm that the network is adequate for the number of covered lines; and there have to be at least three specialists in the network for the most common conditions that meet the access standards. Ms. Wynn stated that DWC is using the complaint process to try to resolve issues, and it is meeting the requirement to do an annual access study.

Conclusions

Ms. Wynn stated that study conclusions include: data are not obtained to assess the adequacy of MPN capacity during the approval process; there is no sense of how the covered lines can match the geographic locations of the providers; there is no information by the non-HCOs in terms of the locations of the insured employers; DWC annual surveys are a critical tool, but DWC needs other tools and resources to look behind assurances given during the approval process in order to enforce compliance.

Ms. Wynn then stated that MPN best practices include: some MPNs are using geocoding to ensure that there are three physicians in each specialty in the areas where there are covered lines; and at least one MPN is monitoring wait times for appointments. There are a couple of ways of addressing rural access issues: supplemental primary care network contracting or adding supplemental physicians to expand the network; and, as with at least one MPN, allowing payors to use non-member providers. Still another access issue would be paying for evaluation management services.

Ms. Wynn stated that in terms of cost-containment activities, fee discounting is a major source of physician dissatisfaction; most payors are not distinguishing between network and non-network physicians in their utilization review (UR) process. She stated that broad networks were used to quickly establish MPNs, but some self-insured employers have established successfully selective networks, and some payors are beginning to be more selective.

Ms. Wynn stated that best practices which reduce administrative burden and costs for providers and payors alike and increase provider participation rates and access to medically appropriate care

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

include: selectively contracting; profiling, benchmarking and providing feedback to physicians; reducing utilization review prior-authorization requirements; and payors having active continuing education requirements on workers' compensation. Ms. Wynn stated that the new physician fee schedule provides some opportunities to create incentives for quality and access. She also stated that facility fees are better candidates for fee discounting than physician fees. She then stated that Medicare has adopted a severity-adjusted diagnostic related group (DRG) system that now pays more when prosthetic devices are used during in-patient surgery. Medicare has also revised its rules and is now paying ambulatory surgery centers 67% of hospital outpatient payment rates. In addition, surgical services in physician offices are now capped. Some of these best practices are process-type measures and could be implemented in the short-term, and that they warrant some evaluation where they have been used for the long-term.

*Questions from Commissioners*

Commissioner Davenport stated that he was astounded at the findings. He asked if one could guess how many of the networks are not operational. Ms. Wynn replied that the promise of the MPN was creating a network of providers who were required to abide by certain guidelines and rules and giving the employer the right to selectively contract. In return, providers might see an increase in their workers' compensation business and they might achieve improved coordination. There may not be any networks that are fully operational at that level. Many networks were set up to control the life of the claim and to get fee discounts. To move from that to an understanding that the way to get quality and efficiency into the system is to move toward the vision of an MPN. That vision, however, has not been tested or evaluated. Hopefully, through WCIS, information will become available that will make it possible to compare networks on performance. Currently, there is no MPN number, and it might be possible to identify networks by relying on the federal EIN.

Commissioner Davenport asked if Ms. Wynn thought that WCIS were ready and operable. Ms. Wynn replied that lot of data are coming in. WCIS is definitely ready for at least an exploratory analysis with data from reliable sources. To cover the full range of issues will take more time.

Commissioner McNally asked if information on the presentation will be available. He stated that he has a lot of questions but would need to review the information. Ms. Wynn replied that a hard copy of the presentation and the Interim Report will be made available.

Chair Wei asked if it is possible to give a number on discounted fees, such as what percentage of all MPN doctors are facing discounted fees or on average, what is the discount they are being paid. Ms. Wynn replied that she would provide that information. There was some information in the UCLA Access Study, and RAND has done some further analysis for the report. Chair Wei then asked "who is the MPN?" Ms. Wynn replied that requirements are for the physician network, and it is the network that should be seeking certification. In some instances, HCO networks have not known that they were covering workers' compensation; what is happening is that there are multiple applications coming in; the network is performing most of the functions and should go through the approval process, not each employer or each payor.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Commissioner Aguilar stated that discounting existed in preferred provider organizations (PPOs) before there were MPNs. Ms. Wynn replied that the most contentious area was with leased networks where doctors did not even know that they were being pulled into workers' compensation. Commissioner Aguilar stated that most of the doctors have been unaware of certain requirements in the application and that the person registering the application has not adequately explained the agreement. Ms. Wynn replied that that has been true in the final rules, not in the initial rules; however, now, an MPN coming in with a material modification has to meet the rule requiring signing a contract.

*Public Comment*

Steve Cattolica stated that the study has done a wonderful job in identifying most of the pressure points in MPNs. He stated that the organizations he represents have experienced the lack of data integrity in MPN lists. For example, in a recent mailing, over 15% came back with incorrect addresses. He then stated that Ms. Wynn proposed that employers not be responsible for filing, but he stated that it is possible that some sort of re-certification process is necessary. He stated that there have been substantial requirements for HCOs, but an employer-by-employer process is the only way to assess whether injured workers will have the right access within a particular network. This will also be important with small employers. Ms. Wynn replied that at the employer level, even if you can tell that there are providers in the network, you cannot determine what other covered lines are being handled. Matching the totality of the covered lines with the physician network has not yet been done. Mr. Cattolica said that there needs to be a balance between responsibilities of employers covered by the same network, who may have different philosophies with respect to referring out of the network. He also stated that discounting may not have changed since before MPNs were in place, but what has happened is that penetration of those networks has gone up; prior to HCOs and PPOs in general, if there was a network in place, once every other time, there would be a discount. PPOs are getting the greatest amount of profits.

Commissioner McNally stated again that he would like to review the written presentation and context in order to raise questions. Ms. Baker and Ms. Wynn stated that the materials will be available. Ms. Baker also stated that discussion should be held with Commissioner McNally to see where the data do not match his experience. Chair Wei suggested that time on the agenda of a future meeting should be set aside for further discussion.

Debby Nosowsky stated that California is unique in having each self-insured employer and each insurer apply for certification. Other states certify the network and allow contracting with any provider on a state list. She also stated that she does not think that workers' compensation is unique in regard to problems with adequacy of the network of physicians and that this issue is far broader than workers' compensation. Finally, she stated that in group health, virtually every member of an employee base is going to have at least one doctor visit during the year. With workers' compensation, it is important to estimate the percentage of employees statewide that is going to be injured and need to access an MPN.

**Report on the Worker Occupational Safety and Health Training and Education Program (WOSHTEP) and California Partnership for Young Worker Health and Safety**

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Ms. Baker asked whether the Commission would like to hear the briefing on WOSHTEP and the California Partnership for Young Worker Health and Safety activities. Chair Wei asked the Commissioners if in the interest of time, they would like to vote on the 2008-2009 contracts and delay the briefing to another meeting. Commissioners Aguilar and Davenport stated that they were ready to vote on the contracts and were satisfied with the results of the program. Ms. Baker stated that it would be best to move ahead to vote on the contracts and new projects and defer any presentations until the next meeting, as the programs are running very well and products are available for viewing.

*CHSWC Vote*

Commissioners Davenport and Aguilar moved to approve the WOSHTEP and California Partnership for Young Worker Health and Safety proposals, and Commissioner Thacker seconded. The motion passed unanimously.

**Executive Officer Report**

Christine Baker, CHSWC Executive Officer

***Schools IIPP Project***

Ms. Baker stated that there have been Cal/OSHA penalty monies from schools that have been deposited into an account. The Commission took action to encumber those funds through a Budget Change Proposal (BCP). The proposal has been approved by the governor and should be approved through the budget process. This would allow CHSWC to establish and implement a Schools IIPP model program to help schools throughout the statewide to improve their injury and illness prevention practices and resources. Ms. Baker stated that there will be a roundtable tomorrow for this project. Commissioner Aguilar will assist and advise with this program. In addition, Homeland Security has said that it would like to partner and disseminate information at the same time about disaster recovery.

*CHSWC Vote*

Commissioner Davenport moved to approve the proposal to establish and implement a Schools IIPP model program, and Commissioner Aguilar seconded. The motion passed unanimously.

***Proposal on Estimating the Underground Economy***

Ms. Baker stated that a proposal for a study to estimate the underground economy and the impact of fraud on compliant employers and state government was taken to the FAC to see if they were interested in funding it, but the FAC felt that it was out of their scope. She stated that she then took the proposal to the DIR Director, the Labor Commissioner, the Labor Agency and the chief of DOSH. There were concerns about a possible increased workload and whether there is sufficient data to purpose the study. According to the University of California, Berkeley, there is sufficient information to proceed with the study.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Ms. Baker stated that she recommends at least a pilot to identify if it is feasible to look at this issue in the state of California by targeting certain areas and then extrapolating later. If approved and if it appears later that the study is impossible to do, then it would be stopped. The budget is approximately \$300,000 over two years, or \$150,000 each year. It was possible to reduce the budget presented to the FAC by \$100,000 since the Commission does not pay overhead.

Chair Wei stated that she would like to thank Ms. Baker and the staff of the Commission for efforts to partner with the FAC. She stated that there is a difference between resources of the FAC and the Commission, as the FAC has \$44 million in its budget, and the Commission operates on a limited budget of around \$3 million. She stated that she is grateful that the Executive Officer submitted the revised proposal and had it reviewed by Agency.

*Public Comment*

Lori Kammerer stated that on behalf of Small Business California, they are very grateful for the support of the Commission on this issue. She stated that one of the primary issues for Small Business California is the underground economy. Last year, with the help of the Commission, the governor signed Senate Bill (SB) 869 which has established a matching identification program. As a result, 191 employers have been identified as not having workers' compensation coverage out of a sample of 500. Ms. Kammerer stated that Small Business California would be happy to provide support for this study.

Linda Atcherley stated that on behalf of the California Applicants Attorneys Association (CAAA), she wanted to emphasize that uninsured employers provide a real detriment to injured workers. She then stated that the Commission did an important study several years ago on this issue and that DIR is doing great work through Joint Task Force.

*CHSWC Vote*

Commissioner Thacker made a motion to approve the study on "Estimating the Underground Economy: Impact of Fraud on Complying Employers and State Government," and Commissioner Aguilar seconded. The motion passed unanimously.

***Workers' Compensation Insolvencies***

Ms. Baker stated that SB 316 required the Commission to undertake a study to examine the causes of the number of insolvencies among workers' compensation insurers within the past ten years. The study shall be conducted by an independent research organization under the direction of the Commission. Not later than July 1, 2009, the Commission and the Department shall publish the report of the study on its Internet web site and shall inform the Legislature and the Governor of the availability of the report.

Ms. Baker stated that they have gone out to bid and conducted an evaluation. Commissioner McNally sat on the evaluation team with Lach Taylor and herself. Additional non-evaluator observers were present. The bid was awarded to RAND with a sub-contract to Navigant

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Consulting, who were hands down the best vendor. Last week, a two-day intensive discussion with the research team was held to identify data needs and contacts, as well as a detailed prioritization. She stated that she is pleased with the expertise on the team and feels that a good product will come of it. An advisory committee will be established, and the research team will be contacting a number of people in the workers' compensation system.

***Musculoskeletal Project***

Ms. Baker stated that the musculoskeletal project also went out to bid, and Commissioner Aguilar was on the evaluation team. Hands down, again, the project went to RAND, as they had the expertise and familiarity with the issue. Work is in process on details regarding the data needs.

***Roundtables***

Ms. Baker stated that there have been a number of roundtables. One was with the California Manufacturers & Technology Association (CMTA), DIR and the California HealthCare Foundation (CHCF) to discuss integration of care. A key outcome was the recommendation that the public sector would be the ideal setting for a pilot. The next steps, therefore, would be to develop a feasibility study of integration in the public sector, using public sector data. Preliminary meetings have been held with some parties who have indicated they would cooperate. There will be several more roundtable meetings on this topic, including one in September with Labor.

***CHSWC Vote***

Commissioner Aguilar made a motion to approve a feasibility study of integration of care, and Commissioner Davenport seconded. The motion passed unanimously.

***NASI Forum on Integration of Care***

Ms. Baker stated that the National Academy of Social Insurance (NASI) and CHCF would like the Commission to pursue a grant for a forum on integration of care to be held on a national level and would like to partner with them in kind. The Commission would be applying for a grant that would promote the dialogue and share insights on ways to improve both quality and efficiency of medical care for ill or injured workers.

***CHSWC Vote***

Commissioner Davenport moved that the Commission should pursue a grant for a forum on integration of care to be held on a national level, and Commissioner Thacker seconded. The motion passed unanimously.

***Insurance Commissioner's Task Force on Experience Rating***

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

Ms. Baker stated that they were a part of the Commissioner's advisory task force on insurance fraud, and the task force report came out recently. Some of the recommendations are re-affirming recommendations that CHSWC has had, particularly in the area of proof of coverage. She stated that she will send copies of the report to the Commissioners.

Ms. Baker stated that the Commission has also been on the Insurance Commissioner's Task Force on experience rating. There are several issues that could be addressed either in the short-term or long-term. The Experience Rating Task Force has had several discussions on the safety incentives connected with experience rating. The consensus was that this was an important area but that research on the safety impact of Ex-Mods was nearly nonexistent. There seemed to be strong support for a research initiative in this area, including support from the Insurance Commissioner's representative. Also, participants felt that this work was probably better done through an organization other than the Workers' Compensation Insurance Rating Bureau (WCIRB). The Commission was suggested as a venue. Consequently, it seems appropriate for CHSWC to work on this.

*CHSWC Vote*

Commissioner Davenport made a motion to proceed with the study of how experience modifications reflect safety in the workplace, and Commissioner Aguilar seconded. The motion passed unanimously.

***Issue Paper on Reporting First Aid Claims***

Ms. Baker stated that reporting first aid claims and treating them as medical-only claims for Ex-Mod purposes was discussed as an issue. There are inconsistent reporting, inconsistent uses, and inconsistent requirements in the Labor Code, and the Commission would like to do an Issue Paper and identify the best uses and present some recommendations. This penalizes employers who correctly report their claims

*CHSWC Vote*

Commissioner Aguilar made a motion to proceed with an Issue Paper on the reporting of first aid claims, and Commissioners Davenport and Thacker seconded. The motion passed unanimously.

Chair Wei stated that this issue came up earlier from Commissioner Aguilar, and it is an important issue to consider. Commissioner Aguilar stated that there is confusion about how to utilize Ex-Mods even for self-insureds. It is supposed to be an indicator that a safety program is working, but it is not clear that it is working that way.

***Return-to-Work Advisory Group***

Ms. Baker stated that the Commission has been serving as technical support to the Administrative Director's (AD's) Return-to-Work Advisory Group.

**MINUTES OF CHSWC MEETING**  
**June 26, 2008    Oakland, California**

**Public Comments**

There were no comments from the public. Chair Wei stated that the Commission appreciates public comment and encourages it as an important aspect of the Commission's work.

**Adjournment**

*CHSWC Vote*

Commissioner McNally moved to adjourn the meeting, and Commissioner Aguilar seconded. The motion passed unanimously

The meeting was adjourned at 12:50 p.m. The next CHSWC meeting is scheduled for Thursday, August 21, 2008, in Oakland.

Approved:

\_\_\_\_\_  
Angie Wei, Chair

\_\_\_\_\_  
Date

Respectfully submitted:

\_\_\_\_\_  
Christine Baker, Executive Officer

\_\_\_\_\_  
Date