

**DEPARTMENT OF INDUSTRIAL RELATIONS  
COMMISSION ON HEALTH AND SAFETY AND  
WORKERS' COMPENSATION**

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DATE: January 5, 2011

TO: CHSWC Commissioners  
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FROM: Christine Baker  
Executive Officer

RE: System Monitoring

CHSWC is required by Labor Code Section 77 to issue an annual report on the state of the workers' compensation system, including recommendations for administrative or legislative modifications which would improve the operation of the system. Additional areas may be important to monitor on a regular basis. As indicated by a report entitled "Medical Care Provided California's Injured Workers: An Overview of the Issues" (RAND, June 2007), the State of California lacks a comprehensive performance monitoring system that supplies actionable information on a routine basis. At the August 19, 2010 meeting, CHSWC Commissioner McNally requested that CHSWC staff review what additional information could be included in the workers' compensation oversight monitoring.

CHSWC staff met with a number of employers and others to determine where additional information was needed to monitor the system (see attachment). The goal was to identify key indicators to evaluate how well the system is doing for injured workers and employers.

The focus of this effort is to improve the system for workers and employers and determine what additional measures need to be included to determine if the system is working well for workers and employers. The scope is currently somewhat narrow due to resource constraints. However, CHSWC staff is committed to tracking key indicators.

### Preliminary Findings

- The California Code of Regulations 9703 allows for the publication of a promptness of payment report by the Division of Workers' Compensation (DWC). DWC is working on publishing the data by claims administrators in a format similar to the Audit Unit data.
- DWC currently does not publish summary data on promptness of payment broken down by insured, private self-insured and public self-insured.
- Not all entities are reporting their data to the Workers' Compensation Information System (WCIS), the principal data base in which all claims are reported to the Division of Workers' Compensation. Approximately 25% of the claims are missing.
- Some WC evaluation studies should be done on a comprehensive basis; others could be done on a sample basis.
- Court delays and performance are a concern. A study of the number of appeals and reversals could provide insights into the areas that need refining.
- Backlogs of qualified medical evaluators (QMEs), liens, and Disability Evaluation Unit (DEU) ratings all have an impact on delays and increase costs and litigation.
- Lien filings are an indicator of a system in trouble.
- It is important to compare insured data, private self-insured data and public self-insured data separately.
- State of California data should also be examined and published.

### Preliminary Recommendations

- As soon as feasible (pending resources), create an ongoing report on promptness of first payment comparing insured, private self-insured and public self-insured, without identifying individual participants. Average and median information could be provided.
- Medical provider networks (MPNs) are currently not identified in the data base; develop a report that would indicate MPNs set up by an employer versus those set up by an insurer MPN and reveal the contrasts between the two entities to improve the results.

- Determine if a regular report on MPNs and outcomes of those who have an MPN versus those who do not have an MPN could be published.
  - Additional analyses and comparisons by sectors, if permitted, can be explored.
- Determine if a report on utilization review and the timeliness of decisions by insured, self-insured and public self-insured could be published.
- Determine the resources needed to add the additional analyses and request the information from DWC.

## **Attachment A**

### **System Indicators: Monitoring the Workers' Compensation System (Benchmarking)**

#### **SUMMARY NOTES**

**November 15, 2010**

#### *Background*

A key focus of the meeting was on improving the system for workers and employers and what additionally could be the best measures for workers and employers. During the discussion, it was noted that there are problems in data gathering to evaluate the overall system. CHSWC's annual report provides cost information of the workers' compensation system based on Workers Compensation Insurance Rating Bureau (WCIRB) data for the insurers which is extrapolated to the self-insurers and the public self-insurers because the data are not standardized nor reported in enough detail to Office of Self Insurance Plans (OSIP) for these groups. CHSWC also provides court hearing information in the annual report.

It was noted there are some data on losses that other data sources get but they are not broken down in the same manner. There are two sources of data such as California Workers' Compensation Institute (CWCI) ICIS and WCIS, but CHSWC does not access to ICIS and WCIS is accessible but there are resource issues to get data from WCIS. All losses are reported to DWC and could be extracted. CWCI's ICIS does not have public self-insured data nor comprehensive private self-insured.

It could be helpful to have self-insured data to compare to insured data. A concern was raised because WCIS does not receive all the data because some employers/insures fail to submit and there is a lack of enforcement. About 25% of the data may be missing. A suggestion was made to publish the names of those that do not report. Currently, there is no penalty for failure to report. Different types of penalties were mentioned, such as revoking licenses or publishing a list of those companies who are not complying.

There was a lot of interest in publishing the names of those who do not submit and or those who delay in the benefit payments. Note: The Division of Worker' Compensation has regulations that allows them to publish promptness of first payment information.

#### Discussion on Promptness of First Payment

The system has moved away from the focus on the promptness of payment on an individual insured or self-insured, towards auditing and fining those that do not comply. With scarce resources, there may be other more effective ways to bring stakeholders into compliance. If one could set up a system where employers and insurers are competing on the promptness of payment, this could serve both labor and management. The theory is that the faster the provision of benefits, the lower the rates of litigation. The employers felt that the ideal would be to have

two or three metrics that will drive good behaviors in terms of benefit provision. It is important to have a system where there are data and standards and that it be related to date of injury and date of accept/deny, and date of first payment. Promptness of payment is a good standard that drives good behavior.

Promptness of payment standards can be revived, provided the assignment of authority to do so. First, the key data indicators need to be decided upon, and then it will be possible to move forward. The key metrics that need to be reported publicly on the performance of payers and insurers need to be identified. Some of the metrics are somewhat of a moving target, since behaviors change, and new studies will have to be conducted to evaluate the system as it changes. For example, one year it may be outpatient surgery, another year compound drugs.

At present, insurers and employers are submitting information but it appears that this information is incomplete. The question is whether the insurers and employers want to have their information come out, and whether they want to be individually identified. Stated otherwise, the question is whether someone in the State should publish a report by name of those who are in compliance vs. those that are not. The report would have a possible list of behavioral metrics that include promptness of payment, promptness of making a liability decision, and accuracy of Utilization Review (UR) function. It was pointed out that in addition to a report, there could be recommendations on how to improve the system both legislatively and through regulations. Making the entire system function better is as important as comparing companies' performance metrics. It was suggested that a number of studies could be done on a sampling basis.

#### Discussion on Lien filings

- Lien filings could be a measure of dysfunction in the system. They are resulting in higher costs and using resources that should go to delivery of benefits. There are estimates that the cost of medical liens (disputes) is equal to or higher than the total spent on medical payments. This suggests that there is significant uncertainty about the correct amount payable on each transaction. There are opportunities to underpay or seek overpayment compared to what is prescribed by fee schedules and statutes. Again, this is an example of the value of such "spot" studies.
- The lien study is an example of the need for an ongoing spot evaluation. Some of the problems related to liens are fraud; some are related to Labor Code language related to authorization of treatment and filing a lien when there has been no authorization. The Fraud Commission study was also mentioned, whereby \$1.1 billion was found in overpayment. The study was replicated by a self-insured employer (Safeway) that found about 25% of payments were for treatment that had not been requested nor appropriate using evidence-based medicine appropriate for return to work. Treatment may be within an MPN, but is not evidence-based medicine and is not appropriate. This same self-insured employer found that tying utilization review (UR) to bill review dramatically reduced medical costs.

Liens generated within and without MPNs were discussed. Recent analysis found that the single greatest reason for liens was denials for treatment outside of an MPN when an MPN was in place. Liens from non-MPN entities have not yet been investigated.

### Other Discussion Points

- Another metric might be comparison between stricter and more relaxed use of guidelines with evidence-based medicine and return-to-work outcomes.
- Comparing costs and outcomes of those who have an MPN versus those who do not was of interest.
- A compendium of elements that make up a good MPN would be useful, but outcomes such as return to work and costs are also important. This often involves different data sets and become much more complicated.
- There are also entities that overlay an MPN with an HCO, as well as those with neither, so a comparison of outcomes between the different arrangements would be helpful, especially across industry classes. Such a comparison is being done by CHSWC using WCIS, but it involves a lot of data analysis. Alternate dispute resolution (ADR) was mentioned as another arrangement, but it was pointed out that there were not enough data on ADR.
- Self-administered entities have different arrangements as well, but it was not clear whether the third-party administrator (TPA)/self-administered distinction would provide any best practice information.
- Promptness of the (UR) decision was identified as also important. One self-insured advised that it issues a UR decision in 8 hours or less, and that figure might set new metrics to encourage people to turn UR decisions around more quickly without necessarily having to change legislation. The date that a UR request is received vs. the date a UR decision is authorized is the ideal, as people can misreport the date sent. Another metric discussed was the percentage of UR that is automatically approved vs. the percent that goes to physician for denial or modification. Also, the number of denials based on lack of documentation is useful. One participant stated that up to 20% of UR requests for treatment are denied due to lack of sufficient information to make a determination. The average number of indemnity days paid is an important metric, despite the fact that different-sized firms are more or less able to offer temporary or modified work. Again, the point was made that the incentive should be to provide timely benefits rather than prevent penalties, in order to create a better system.
- Once such metrics are established and in place, unless the industry starts meeting the requirements, the Insurance Commissioner could decide to hold back on approving any premium increases; this was posited as a possible leverage point/outcome of such metrics.

- System monitoring and reasonable costs estimates would possibly benefit by comparison with neighboring states. Competitiveness of the insurance market with other states should be tracked. The Oregon ranking study was mentioned, but the industry mix that is developed by Oregon is not California industry mix. Likewise, the averages may be less relevant to individual industries that want information on their unique costs. Such a ranking study could be improved. The idea of reviewing rotating class codes each quarter was proposed. The results of revised rankings possibly being used against the California economy by competing states recruiting California employers were discussed. Despite that risk, the findings might also put pressure on California rates to come down.
- Performance of the court system is still a concern. Oregon does a good job of monitoring the efficiency of the judicial process. Suggested metrics: time frame from filing of application/to disposition by district office; number of hearings/proceedings prior to resolution, by district; number of approvals of stipulations (STIPs), findings and awards/compromise and releases (F&As/C&Rs) vs. number of hearings with F&A; number of trial settings for a claim to be heard by district office (and by judge?); number of decisions upheld at appeals board, i.e., number of reversals. It was noted that the Workers' Compensation Appeals Board (WCAB) should already be keeping track of this, but it is not known if that is being done.
- User studies/exit interviews are conducted in Oregon to record satisfaction levels. All judges are rated by claimants and employers.
- WCIRB reports on the cost driver of opiodes/heavy pain medications, and finds only 5% of the physicians are driving this cost. There might be an option to flag the "bad actors" systemwide.
- QME/AME and DEU backlogs might be tied into the promptness of payments issue. The DEU backlog is decreasing, but the backlog could be a continuing measure of how long it takes to get disability ratings. Walk-through ratings take up a disproportionate amount of DEU's time, compared to non-walk-through ratings which take an even a great amount of DEU's time.

### Project Participants

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