

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

**MINUTES OF MEETING**

**October 16, 2015**

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

In Attendance

2015 Chair, Sean McNally

Commissioners Martin Brady, Doug Bloch, Christy Bouma, Shelley Kessler, Angie Wei

Absent

Commissioners Kristen Schwenkmeyer, Daniel Bagan

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

Approval of Minutes from June 4, 2015, Meeting	Approved
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**Approval of Minutes from the June 4, 2015, CHSWC Meeting**

*CHSWC Vote*

Commissioner Kessler moved to approve the minutes of the June 4, 2015, meeting, and Commissioner Brady seconded the motion, which was then passed unanimously.

Referring to Dr. Das's portion of the minutes and the independent medical review (IMR) system, during the motion Commissioner Kessler asked how one knows whether the treating physician is following the guidelines. Director Baker explained that usually treatment decisions go through Utilization Review (UR) and then to IMR. IMR will determine whether the guidelines were followed, and this is documented in the decision.

**Electronic Medical Reporting Update, by Destie Overpeck, Administrative Director of the Division of Workers' Compensation (DWC)**

- September 4, 2015, Public Meeting on Electronic Transmission of Electronic Medical Reports
- Summary of comments posted on DWC forum: very positive meeting with excellent participation and comments and recommendations. The forum link is <http://www.dir.ca.gov/WcJudicial.htm>.
- Attendees included representatives from Kaiser (which currently uses electronic data transmission); provider groups, such as the California Orthopedic Association, and US HealthWorks; and representatives from a UR company, a copy company, Maximus, and Jopari Solutions, which is a clearinghouse. Sherry Wilson of Jopari Solutions gave a

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presentation about the current national standards for medical reporting, which she is involved in determining. This is important because, as California develops standards it wants to be as consistent as possible with nationwide practice.

***Issues Raised by Commenters at the Public Meeting***

- National standards for medical reporting (electronic data information [EDI], IAIABC, ASCX12);
- Different technology levels among providers;
- Transition to electronic reporting can be expensive for providers;
- The need to keep the process transparent for injured workers;
- The need for compatibility with different systems and for the security of data;
- Current silos between the billing world and the UR world.

They also discussed Maximus's progress on implementing the electronic IMR application pilot program and MOVE-it (electronic record submission).

***Recommendations from Participants***

- Start simple (e.g., the doctor's first report [DFR] of injury and electronic IMR application)
- Establish the framework and standards before taking the first step.

***DWC Plan***

- Draft regulations to mandate the use of electronic IMR application;
- Establish the framework and standards that DWC and by extension DIR want used;
- Begin with DFR because that is the first medical record in the system and is reported to DWC;
- Consider combining the Request for Authorization (RFA) and the Progress Report (PR-2) in a single electronic format;
- Initially not mandatory, but as people get comfortable with electronic reporting, make it a requirement.
- The plan is to make the reporting process faster and potentially more efficient and inexpensive for users.

***Comments by Commissioners***

Commissioner Bouma asked whether the public meeting included a discussion about group health and applicable electronic medical record-keeping requirements and the experience of medical providers including physicians, and insurers. Ms. Overpeck named some groups that create standards for EDI, such as the IAIABC, and various different formats, such as ASCX12. She said the standards apply to workers' compensation as well as to Medicare. She said she did not know whether private insurers use it, but there is interest in a common framework so that different systems can interact.

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Commissioner Bouma referred to the statement about silos and said doctors tend to work in silos, too, serving just Medi-Cal, Medicare, or only workers' compensation or group health; they support the ability of physicians to serve patients in all those programs. Ms. Overpeck said that Medicare has required electronic records from doctors for a few years now. She said it makes sense that doctors who are using that system have access to another system with a similar structure.

Commissioner Wei asked at whom the draft regulations mandating electronic medical records were directed. Ms. Overpeck said it would be for IMR applications, which would allow these records to create the application electronically by claims administrators and Maximus. IMR applications would then be sent to injured workers (who would have to decide whether to appeal the UR decision). The injured worker receives the application filled out and then signs it and sends it back to Maximus if they wish to appeal the UR denial. The creation of the application is important because Maximus is receiving incorrect data, mostly because people are filling in the form manually and sending it in, and because it comes from different sources. By mandating the creation of an electronic application, UR data could be sent directly to Maximus. Maximus could then fill in the data fields with accurate data, such as the claims administrator's address.

Commissioner Wei asked whether the IMR request form will have more fields pre-filled in. Ms. Overpeck said it could happen in two possible ways: either Maximus would take care of everything, or the claims administrator would have to go into the portal and fill in the information. The forms are already supposed to be filled in by the claims administrator, but that is not what happens in reality. Sometimes an applicant's attorney uses a form on the webpage, fills it out, and sends it in; sometimes a claims administrator has done that, so DWC ends up with two applications for the same claimant: this explains some of the duplicates, and why Maximus does not always have correct information when requests for records are sent out. Using electronic IMR applications would ensure that DWC gets only one application from the correct entity with the correct information.

Commissioner Wei asked whether using this process will still allow an injured worker or representative to download the form, fill it in, and submit it. Ms. Overpeck said that is not currently allowed. Under the statute, it is supposed to be filled out by claims administrators when they receive the UR decision and then send it to both injured workers and their attorneys.

Commissioner Wei asked whether the regulatory package is going to require that the actual medical records be sent electronically or whether this is going to be tied only to the initial request for IMR. Ms. Overpeck said that DWC had not decided that yet. The capability exists for Maximus to get all medical records electronically. Commissioner Wei said that she had raised the issue of electronic medical records not just to introduce efficiency to the system but to improve the ability of IMR to ensure the receipt of full medical records so that time is not wasted going back and forth over whether all the records are correct and complete. The point of moving to an electronic system is to get decisions faster for injured workers. She said she is not certain that what is planned for the regulatory package achieves that goal. Ms. Overpeck said that in at least one way it does: when DWC has the correct information, it can request the records from the correct party.

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Commissioner Wei said the decision over whether the regulations include the submission of electronic medical records is a big one. Ms. Overpeck said it is feasible. She said she is not focusing on it because the ability to electronically submit medical records already exists; Maximus has already been reaching out to encourage claims administrators to use this functionality that it currently possesses. She said that DWC could add its use to the list of requirements.

Chair McNally asked Commissioner Wei what she would like to be added to the regulatory package. Commissioner Wei said that if an all-electronic system is to be implemented, then all medical records should be submitted electronically. Chair McNally asked: “when possible?” or “or else?” She said that that is the question: is an electronic system to be put in place all at once or piecemeal? Will the regulation say “do it when you can,” which seems to be the current situation, or will it mandate full implementation or something short of that?

Ms. Overpeck said the goal is to go full bore, but DWC is in the process of rulemaking. During that process, DWC makes a proposal and then hears from the people affected to find out about any issues of which it is not aware. This seems to be the most practical way of dealing with medical records. She believes that those who have not previously used the electronic method find it to be quite simple and effective to use. She believes it is more a problem of process change: people are used to doing something one way and need to be encouraged to try it. Commissioner Wei said that if it was added to the regulation, then those people would come around. Chair McNally asked how much time should be given to allow people to get on board. Commissioner Wei said she did not know whether DWC is ready to go all-electronic; she asked whether there would be one separate regulatory package and whether it should be delayed until all the questions can be answered about the national standards and the framework that should be used. Ms. Overpeck said that the first regulatory package would involve the IMR application and the medical record Move-It with Maximus. They are connected, and the process already exists, as does a vendor that the firm uses. The other parts—the DFR and RFA—would be dealt with in separate regulatory processes. The platforms and the systems for those to work also need to be developed.

Commissioner Brady asked about the Maximus pilot program and how long that program would be in place. Ms. Overpeck said that Maximus started it and identified volunteers to participate in it. Some claims administrators are currently using this pilot program. DWC wanted to make sure that the system works before it is mandated. It is tricky to create regulations and say how it will work and set it up before telling people they have to use it. Commissioner Brady said he thinks the assumption is that the claims administrator actually has the records; a lot of times there is a lag time before the physician gets records to the claims administrator. Ms. Overpeck stated that that was not the case; they should have the records already because they needed them for the UR determination. Mr. Brady laughed, and said, “Hopefully.” He stated that he thinks California has so much geographic diversity that some people in very rural settings might struggle a little bit. He said he thinks there is still a lot to learn, so he looks forward to hearing a progress report about the “Move It” program. He said it sounds very good, and it’s great to have that pilot program because they can learn a lot from those initial activities.

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Commissioner Bloch stated that he is glad to hear about any sort of improvements that will make the system simpler and more efficient. He said that he guessed he was thinking about two things. The first is information that was shared in the past and the number of claims that were denied because of clerical and administrative errors. He said he always likes to put himself in the shoes of an unrepresented, nonnative English-speaking worker trying to navigate the workers' compensation system, which is something he would not wish upon anybody. He asked whether he understood correctly that this would require a worker to have a computer and be able to speak English to get access to their medical records. Ms. Overpeck replied, no. She said this would not change the process at all for the injured worker. The requirements fall on the claims administrator. Commissioner Bloch restated his understanding that the electronic requirements are all on the claims administrator, but the process has not changed for the worker, and Ms. Overpeck confirmed that. Commissioner Bloch stated that this gives him some comfort that he did not have a few minutes ago. Ms. Overpeck stated, "Excellent."

Commissioner Kessler stated that Ms. Overpeck said that this gets sent to the injured worker. Commissioner Kessler asked whether it is through the representative on the claims end. Ms. Overpeck said, yes, and that is how it currently works. She stated the filled-out application form and the UR denial are sent to either the injured worker or the injured worker's attorney, if that person has legal representation. Commissioner Kessler asked whether that would happen via snail mail or electronically. Ms. Overpeck said, it will still happen via snail mail. Commissioner Kessler stated that means the United States Postal Service. Ms. Overpeck confirmed by stating, "Exactly."

**Medical Care Provided to California's Injured Workers: Monitoring System Performance Using Administrative Data, by Barbara Wynn, RAND**  
[http://www.dir.ca.gov/chswc/Meetings/2015/RAND\\_10-16-15.pdf](http://www.dir.ca.gov/chswc/Meetings/2015/RAND_10-16-15.pdf)

Barbara Wynn from RAND presented highlights of the Workers Compensation Information System (WCIS) medical billing data and potential measures for monitoring system performance on an ongoing basis.

Presentation objectives:

- Decompose the cost drivers and account for changes in aggregate medical spending on an annual basis.
- Review changes in the utilization spending rates, return to work, access measures, and quality of care indicators.
- Review ad hoc studies for specific topics and present findings on medical legal billing patterns and how they have changed.
- Provide an update on the medical necessity dispute resolution process study.

Medical necessity dispute resolution process:

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- The preliminary findings were presented in the last Commission meeting and included both the qualitative and quantitative review of what is happening in the UR and IMR processes; she has received additional inputs from stakeholders since the last meeting.
- Reviewed Utilization Review Organizations (UROs) plans with a particular focus on preauthorized services: what the claims administrators are authorized to approve and when they do not need to go through the URO.
- Practices vary widely, in that either a lot can be preauthorized or nothing can be preauthorized.
- Investigated other State practices with respect to utilization treatment guidelines and UR to see whether policies are meshed as they are in California.
- The study is still compiling results and will present details and a final report at the Commission Meeting in December.

The goal for the cost driver analysis is to understand the drivers of annual worker's compensation medical spending:

- The study measured observable changes in potential cost drivers, holding all other factors constant:
  - Changes in employment, rate of claims filed by employees, changes in the nature of injury (including body part), and price inflation.
- After accounting for these factors, the residual (i.e., what the researchers could not account for) is attributable to changes in utilization, the intensity of services, and potentially unmeasured case mix changes.
- Looking at data from 2007 to 2012 that predates implementation of the SB 863 provisions, the study is trying to develop a baseline and methodology for post-SB 863 implementation.

System-wide spending rose much faster than predicted based on price inflation.

- The inflation factor is much lower than the medical consumer price index (CPI) (in 2012 the medical CPI increase of 18%). The lower WC inflation rate is due to the fact that most of the services under workers' compensation are subject to fee schedules; however, the inflation factor for physician services was negligible.
- The rise in spending is attributable to an increase in the volume of services.
- After fee schedules are taken into account, the gap between the actual spending and spending based on inflation (holding all other factors constant) in 2012 was \$1.1 billion.

Key findings from cost driver analyses:

- Predicted spending decreases for fewer worker compensation claims more than offset predicted increases for price inflation.
- Changes in the nature of injury and body part had a minor impact on changes in service year spending.
- The estimated residual spending of \$1.6 billion highlights the need for ongoing monitoring of system performance.
- Two-thirds of the \$1.6 billion is attributable to increases in payments to individuals.

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- Most of the increase is in settlement payments to individuals. This category of payment is not found in the medical data nor elsewhere in the system and is an actual breakdown of the payment to individuals category provided.
- The size of the residual highlights the need for an ongoing monitoring system to see what is happening on a per-claim basis in terms of utilization and spending and the intensity of services such as in-patient hospital stay and whether they are more resource intensive than they were previously.

Limitations of cost driver analyses are:

- They rely on available WCIS data, and they are representative but incomplete.
- The data begin in 2007, so the study can only account for changes in the claims mix from that point forward.
- They could not reliably examine the impact of changes in the type of claims (medical only) or occupational mix.
- The real impact of spending is that spending is switching from medical-only to indemnity claims.
- In the future the study needs to look at the occupational mix.
- The reasons for the large residual increases need to be reviewed.

The monitoring analyses used WCIS to investigate residual spending increases:

- Reviewed trends in medical care from 2007 to 2012:
  - Looked at per-claim utilization and spending within 12, 24, and 36 months of injury by service category.
  - Return to work for the first eight quarters following injury.
  - Reviewed the trends in quality and access to care indicators.
- Separate analyses by claims characteristics
  - Type of injury, payer status (insured or not), and selected conditions
  - Self-insured segregated into private and government employers
  - Geographic region
- Conducted the medical legal expense analysis

Utilization and spending per claim within the first 12 months of injury focused on the data from 2007 through 2012.

- Spending for drug testing increased fourteen-fold, and the increase in that period was particularly high for workers with private self-insured plans.
- A decline occurred in inpatient hospital and outpatient utilization, but there was a high increase in discharge per user, so the cost per stay is increasing while the number of stays is decreasing. It is not unexpected that if you see a shift of services from inpatient to outpatient settings and surgical services, the stays that remain in the hospital will require more resources.
- Drug utilization and spending increased through 2011. Utilization declined in 2012, but spending continued to increase.

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The average spending per user within 12 months of injury by service category shows that, compared to 2007:

- For all laboratory services, a fourfold increase occurred from 2007 to 2012.
- For inpatient hospital stays, the increase per user is almost 100% and not just because of case mix or price; this period included the pass-through for spinal hardware. The reasons for the increase are still being reviewed.

Prescription claim lines and payments per injured worker receiving drugs, comparing 2007 to 2012

- Opioid prescriptions increased from 1.19 per user to 2.1 in 2011 and declined 1.9 per user in 2012.

Spending increases do vary by type of payer

- Insured public employers do not necessarily have higher spending. If all the categories of services (drugs, evaluation and management, medicine, laboratory and pathology, radiology, surgery, outpatient facility services, inpatient hospital stays) are added, the public employers are low.
- The cost drivers are inpatient and outpatient hospital services and ambulatory services.
- The average increase for the State of California was 69% and for the self-insured it was 16%, for private 43%, and self-insureds 20%. So there is variation; the study did not adjust for case mix but did drill down into various categories by the type of employer.

Quality Indicators for Care

- Selected seven evidence-based measures for selected conditions applied using WCIS medical data.
- The number of indicators used is limited because they required WCIS medical records.
- Overall findings are:
  - Substantial room for improvement
    - Trends were in the wrong direction through 2011; some improvement in 2012.
    - Use of multidisciplinary teams for chronic pain management should be higher; it was less than 12% of injury claims in 2012.
- Variation across geographic regions and by payer status.

Mean rate of potential overuse of imaging studies, from 2007 and 2012 pooled data, lower back injuries by region (identified by patient ambulatory encounter for low back pain diagnosis with no prior encounter for the previous 180 days and patient had imaging within 28 days of that encounter and an ACOEM guideline):

- Southern California had higher rates of usage than Northern California.

Mean rate of potential overuse of imaging studies, from 2007 and 2012 pooled data, lower back injuries by type of payer:

- Higher incidence rate for the insured employers and the State of California does very well in this measure.

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Access Indicators track trends in care provided for the first 12 months post-injury.

- Tracked several types of access measures
  - Reviewed timeliness of non-emergency initial care from the time of injury.
  - Proportion of workers who change primary care providers during the first 12 months and trends.
  - Pathways that were taken by workers to both initial and follow-up care.
- Overall findings
  - Increase in average time from injury to initial evaluation and management visit; median number of days was stable for all injuries from 2007 to 2012 at two days.
  - Modest upward trend in the number of primary-care physicians seen in the first year.

Trends in the type of first encounter in WCIS following an injury:

- Trends in the type of encounter were slightly higher for emergency rooms and slightly lower for primary-care physicians.
- The number going to “Other Physicians”—specialties other than primary care—is increasing.
- The data did not originally have a category for physical medicine. This was added based on a finding that a notable proportion of first encounters were for physical therapy.

Pathway of care for referral to a specialist after a visit to a primary-care physician (PCP) visit: 2011 injuries:

- A demonstration of charting the pathway of three levels of encounters.
- A first encounter with a PCP had a median of 1 day and mean of 15.8 days.
- 64% of injured workers saw a PCP.
- Of those, one-third were then referred to a specialist. A median of 12 days elapsed before that encounter occurred, with a mean of 16 days—only a small difference.
- Of those with specialist encounters, 79% go back to a PCP.
- The question remains whether it is the same PCP or a different one. The median time to see that PCP is 6 days, and the mean is 9.8 days.
- 14% go on to other services, for example, therapy or radiology diagnostic imaging.
- 7% seek no additional service after the specialist encounter.

Ms. Wynn said that this is the type of mapping they have done. She believes it is a powerful tool to drill down into the categories and see what is happening.

Return to work outcomes:

- Used Employment Development Department (EDD) data to track the proportion of injured workers who were still employed after the first eight calendar quarters.
- Rates fall over time because the proportion of workers, injured or not, falls due to exits from the labor force.
- Patterns across injury years were similar.
  - The impact of the recession was small
  - Important differences emerged across nature of injury

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–Workers were more likely to be employed in Northern California than Southern California

Medical-Legal (ML) Evaluations:

The study focused on trends in the number and the type of ML evaluations:

- Could not look at the number of physicians doing med-legal services because one of the trends is increased billing by medical legal management organizations.
- Billing is under the group identification, rather than by the identification of the individual physician who furnished the service.
- Changes coming to the WCIS: each line item should have the name of the physician identified, so that issue will be addressed in the future.
- They did not look at fee schedule issues, which will be reviewed separately.

Overall findings on medical-legal evaluations:

- The number of evaluations per claim and average payment per claim have increased.
- Payment increases fueled by an increase in the number of units billed per evaluation. (Each unit is billed in 15- minute increments; for the most expensive units, the number of bills has increased to cover over 3-1/2 hours.)
- Substantially more evaluations in LA than elsewhere.

Number of ML evaluations at 12 and 24 months post injury by injury year:

- From 2007 to 2011, an upward trend is visible for initial as well as subsequent evaluations.
- When service by region is looked at, Los Angeles once again leads the state in the percentage of injured workers with ML services by service year (not injury year).
- For average paid amount per ML service by region, 2007 and 2012, Los Angeles again leads the state. Not only are they paying more, but the units paid are also higher.

Commissioner Bloch noted the low amount paid for the Central Valley and remarked that, the day before, 20 workers at a food-processing facility in Tracy were transported by ambulance after a chemical spill—for bleeding or fainting, including one pregnant woman. He said that care is a concern for him and that is the reason they are all active on the Commission.

Ms. Wynn said that these monitoring analyses can help inform policies to improve access and the quality of care, as well as spending issues and utilization.

Conclusions from monitoring analyses:

- WCIS contains a wealth of information that can be used to monitor trends in system performance.
  - Ability to “drill down” to investigate issues
  - Many quality indicators cannot be generated from billing data
- Trends provide a baseline for assessing SB 863 impact.
  - 2012 results need to be confirmed with more recent data

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- Value could be increased through benchmarking to group health medical data and analyses of factors influencing trends.

Policy Implications from Analyses:

- Incomplete WCIS reporting should be addressed through DWC enforcement mechanisms and penalties.
- Some potential issues may have been addressed but warrant close monitoring.
  - Drug testing fee schedule changes
  - Opioid treatment guidelines
- Some issues warrant policy review.
  - Medical-legal expenses
  - Growth in hospital inpatient payments
  - Chronic care management
  - Payments to individuals

***Comments by Commissioners***

*Opioids: Compliance and Other Drug Testing*

Commissioner Bouma asked if the reason for drug testing was to see whether the injured worker was taking the prescribed opioids. Ms. Wynn replied that there is significant compliance testing, but the codes include urinalysis and blood chemistry testing. Ms. Wynn believes blood chemistry and urinalysis testing are being addressed in the proposed medical treatment utilization guidelines.

Commissioner Bloch asked whether this testing after an accident is to determine whether the injured workers have drugs in their system. Ms. Wynn replied that she did not think so. Commissioner Wei asked if this testing was to determine whether the injured worker is taking the prescribed opioids rather than selling them. Ms. Wynn replied yes, but it could include some testing in the emergency room before medication is prescribed; but the bulk of it should be for compliance testing.

Commissioner Bloch asked whether employers pay for testing after an injury in an accident. Commissioner McNally stated that most drug testing of injured workers after an accident is paid for by the employer to determine whether the injured worker was under the influence of medication at the time of the accident. Commissioner Brady added that the school system is subject to the Omnibus Transportation Act, which is a federal standard. Therefore, bus drivers, mechanics, and others are given routine testing after most accidents, and testing also takes place on an ongoing random basis. Commissioner Bloch stated that his members are also subject to the same Department of Transportation regulations as Commissioner Brady's and asked whether workers' compensation covers the cost of testing after an accident when an employee is injured and the employer tests the employee to see whether the person was under the influence. Commissioner McNally stated that it was a first-aid cost or an incidental cost before a workers' compensation claims actually opens.

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Ms. Wynn added that the database is robust enough that the incidence of drug testing on the day of injury can be determined. The database would not track the emergency room testing, but most of the testing is ongoing compliance, so the increases track the increase in prescription medication. The structure of the fee schedule was problematic. Every test and every type of drug was counted separately and paid for separately and that was addressed when the Resource-Based Relative Value Scale (RBRVS) was implemented to improve bundling the fee schedule payment. Even if the incidence of testing remains the same, we should be seeing drops in payment after 2014.

Commissioner Wei asked whether SB 863 addressed compliance testing and was told it did not. Commissioner Wei would like the compliance testing issue to be raised in the formulary discussions that are coming up. Director Baker stated that it is part of those guidelines. Director Baker asked Ms. Wynn whether workers' compensation has excessive testing when compared to group health for the same kind of injuries or issues. Ms. Wynn replied that this study did not have access to group health data, but there may be other data sources. Ms. Wynn suggested waiting until 2014 data are available to do that comparison. The SB 863 study will look at group health trends relative to workers' compensation trends.

*Access to Physicians by Injured Workers*

Commissioner Kessler asked Ms. Wynn whether she could determine why timeliness had changed, that is, why it took longer for some injured workers to access physicians. Ms. Wynn was trying to understand that. Commissioner Kessler also asked whether injured workers went to their primary-care physicians because they determined that they would go to them as a result of workplace injury or whether they had been sent there by their employer. Ms. Wynn replied that they are not able to track pre-designation and have not been able to find any data for that because employers keep that information in an individual's personnel file, rather than any kind of administrative record. Commissioner Kessler commented that Ms. Wynn could determine whether the employer had a pre-designated physician for injury or not, which would necessitate that the workers see their primary-care physician to claim workers' compensation.

Commissioner Kessler commented that Ms. Wynn's report shows an upward trend in the number of primary-care physicians seen in 2015. Ms. Wynn replied that an injured worker's first visit has to be to an employer-designated physician or the MPN. What the study does not include is a first aid visit. Some of the initial medical visits might be underreported. In addition, WCIRB has been wrestling with the problem of inexpensive claims, which may not be reported because the claims could affect the experience ratings. It may be easier to pay "under the table," so this study does not have information in the medical data.

*Sufficiency of Primary Care Physicians; Return to Work Outcomes*

Commissioner Wei said that she was stuck and asked to go back two slides in the presentation. Ms. Wynn said that they found 64% have a primary-care evaluation and management visit as the first encounter that they find in WCIS data. Commissioner Wei stated that the rest went somewhere else. Ms. Wynn stated that they mapped each of these destinations as to what happens. She stated that she is selecting one. Chair McNally stated that they only mapped the

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64%, and they have not mapped the others. Ms. Wynn stated that that is not what she is presenting, but that the report maps them. Commissioner Wei asked about the median of one day and mean of 15.8 days; she said she needed to talk to her math teacher here. She asked what this means. Ms. Wynn stated that it means you have a long tail. Commissioner Wei stated that you mean you have a lot of workers who are waiting much longer than 16 days to have that first visit. Ms. Wynn said yes, and that they may well be missing something. Commissioner Bouma stated, so everybody above the half, the midway point, must be really big numbers to bring that down. Ms. Wynn stated that they are trying to dig into that because that is also the trend line that she showed them. Ms. Wynn stated that they really need to understand this, and it may be more of a data issue in terms of what is getting reported to the WCIS. Commissioner Wei asked whether changing to RBRVS will have any effect on this. She said what she thinks happened there was to get more doctors to be primary care and even out the specialists; she asked whether that is going to change in 2015. She asked whether part of the problem is that they don't have enough primary-care doctors.

Director Baker pointed out that this data was pre-reform, when part of the problem was with the MPNs; a lot of work was done to ensure that there was a nurse or an assistant to help workers find care immediately. She stated that the data for 2014 will give a better idea. Commissioner Wei stated that this is a big flag for her, and she asks why workers are waiting so long to get that first appointment. Chair McNally said that the data could be misleading because injuries are not always reported on the first day of injury. Injured workers may not immediately realize they have an injury until they notice a condition that is not going away. They see their doctor, and he asks when the condition first started and find out it started a week or two or a month before. He said it may not be an access issue, but that they need to know more. Ms. Wynn stated that they were focused on the bottom line—when does the worker encounter occur?—but they definitely heard that knowing the date the employer was notified of the injury was an important date that they also somehow needed to filter in. She said that they will be taking that upper group to see what is happening. It may well be better to just move to the 98th percentile.

Chair McNally said that it might be more illustrative if they could see when the employer had knowledge of the injury or when it was reported, instead of the date of injury. The date of the injury is often retrospective. In the case of cumulative trauma or something else, it might turn out that the injury actually occurred before the injured worker realized it. The worker may have just had symptoms without knowing where they came from. He stated that you would have a better sense if you chart it to the date it was reported to the employer than from the reported date of the injury. Ms. Wynn said they could look at that. Chair McNally said it was misleading to have it as the date of injury.

Commissioner Bloch asked whether PCP and primary treating physician (PTP) refer to the same terms. Ms. Wynn explained that a PTP can be more than a physician, such as an acupuncturist. She said that the data do not readily identify the PTP but can attribute who is providing the most care at any given point, and where does that change, and that is why they looked at some of the change in the number of physicians. They cannot really identify the primary treating physician, but they can identify the type of physician treating the patient. She stated that she suspects that in

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the “other physician” box, whose entries grew, when they are able to drill down more, they may well have had an encounter in which this occurred before it can be seen in the medical data.

Commissioner Bloch stated that he had two more comments. First, it would be helpful to add to the pathway the return to work outcomes. It would be helpful to see the mean and median for return to work and that it would probably have to be broken down by the nature of injury. He said that this would be a request for the future. Slide 14 in the presentation says a request for an imaging study took 28 days, and Commissioner Bloch asked whether this was a specialist encounter; Ms. Wynn said it was not; rather, it was “other ambulatory.” Commissioner Bloch then asked why Slide 14 indicated an assumption of potential overuse of imaging studies. She said this is based on ACOEM Guidelines about when the imaging should occur. Basically, with a low back injury there should be more conservative treatment first, unless there are certain red flags. Therefore, one would not expect to see this within the first 28 days if the guidelines are being followed (except in a small percentage of cases).

Ms. Wynn said that the pathway itself is dependent on the timeframes being examined. They looked at a 60-day time frame. A 30-day or 90-day timeframe would change the percentages and days involved.

Ms. Wynn stated that in this chart, basically, what you have for each line is a different year of injury. It indicates how many were employed in EDD data within the time frame of each quarter. The shaded blue period is during the recession. She stated that you did see a slight drop during that period and then you see it rise. Injury year 2011 is the most recent one available for EDD data that shows eight quarters of return. That is post-recession, when the outcomes are better, and when you compare them to injury year 2007, a slightly higher percentage were actually employed after the eighth quarter. This has not been risk adjusted; this is the overall group. She said this is actually charting the same thing, but if the two different types of injury, chronic pain and lower back injuries, are compared you can see a very different pattern.

Commissioner Kessler asked, with reference to Slide 20, whether the return to work outcomes track that people don’t return to work because of inability or because they are disabled from returning to work in a specific craft, trade, or job. Regardless of whether it is due to exits from the workforce, did you track the relation between injury and retirement? Ms. Wynn said that, unlike previous studies, this one did not use control groups to compare outcomes for injured workers and their trajectory relative to the rest of the labor force; rather, they compared one year to the next within the injured worker population. There could be some differences in injury mix during that time. They also looked at some specific types of injuries.

Commissioner Kessler asked why Southern California had worse return to work results. Ms. Wynn said that on all measures Southern California performs worse, including return to work.

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Commissioner Bloch asked Ms. Wynn to elaborate on the outcomes based on the differences in the nature of injury. Ms. Wynn said she could but would prefer to send him something rather than try to do it from memory. Commissioner Kessler asked that it be sent to all of them, and Ms. Wynn said she would. Commissioner Bloch referred to the slide with return to work outcomes for lower back pain. He said that, because he represents Teamsters, he is very sensitive to the issue, given the fact that lower back pain is probably the top issue for their truck drivers. They would like to reduce those numbers, and obviously imaging is an important part of the treatment for diagnosing lower back pain and getting people back to work.

**Report on Medical Access Study, by Henry Miller, Ph.D., Berkeley Research Group**  
[http://www.dir.ca.gov/chswc/Meetings/2015/ACCESS\\_INJURED\\_WORKERS\\_Study.pdf](http://www.dir.ca.gov/chswc/Meetings/2015/ACCESS_INJURED_WORKERS_Study.pdf)

Henry Miller stated that the Medical Access Study used the 2013 Workers Compensation Information System (WCIS) data to measure access.

**Study Background**

- Third in an annual series of access studies.
- In the first year of the study a survey of injured workers was conducted to determine their perceptions of access. Like earlier studies, this study found that approximately 85% of workers were satisfied or very satisfied with their access to care. No additional surveys were performed in the second and third years of this study.

**Activities in the Third Year of the Study:**

- This study included data through 2013, and therefore, does not reflect impacts after the implementation of SB 863.
- Study is based on a large database with a focus on medical bills; data is from 2007 through 2013 and comprises 70 million medical bills.

**Findings:**

- The number of medical bills submitted and the number of injured workers decline from 2008 through 2012, but increase in 2013.
- Specific reasons for the increase in injured workers were not known. The recession may not have had the same impact in California; the size of the California workforce grew.
- The number of providers treating injured workers followed the same pattern as the number of injured workers. Just as the number of injured workers declined, so did the number of providers but at a lower rate.
- In 2013, the trend started to reverse and the number of injured workers increased slightly, but at a higher rate in California than nationally. There was a corresponding increase in the number of providers, although at a lower rate; thus, overall the number of providers remained relatively more stable than the number of injured workers.
- Declines in the number of providers were the most significant in the Bay Area and Sacramento Valley and less so in the Inland Empire and San Diego.
- The number of out-of-state providers substantially increased

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- Possible reasons include an increase in the use of mail-order pharmacies and purchase of durable medical equipment outside California. These two reasons do not account for the significant increase.
- Some medical bills have data identifying addresses of billing and management companies, rather than the actual location of the provider. Mr. Miller is continuing to investigate this possibility and has not been able to document reasons for the increase in out-of-state providers.
- The number of medical bills per injured worker has been steadily increasing.
- California Workers' Compensation payment rates are better than those of Medicare and Medi-Cal and may not be reflected in the physician's perception.
- Drug testing has increased substantially.
- The number of office visits classified as simple (lower billing rates) declined and the number of office visits that were more complex (higher billing rated) increased, as is the case nationally.
  - This may be due to coding, which is reflected in increased cost.
- The average charge per medical bill increased consistently. The average amount paid is constant. There has been a consistent increase in the complexity of the visits, which is not necessarily a reflection of an increased complexity of the patient's problems but, rather, a result of coding. The average amount paid per injured worker, however, was higher in 2013 than in all but two other years (2008 and 2010) because of an increase in the number of medical bills submitted per injured worker.
- When payment rates for specific services are compared, in 2013 the California Workers' Compensation program paid 176% of Medi-Cal and 104% of Medicare, although comparisons to Medicare are difficult because of differences in payment methods.

*Recommendations*

- There is a need to determine whether the increase in injured workers and medical bills that occurred in 2013 is the beginning of a trend.
- There is a need to determine whether the changes in payment methods that were instituted at the beginning of 2014 have affected access to care.
- WCIS data has steadily improved. There is a need to ensure a continuing improvement in WCIS data. Data were considerably more complete in 2013 than in 2007: far fewer medical bills now lack procedure and diagnosis codes.

*Comments by Commissioners*

Commissioner Bouma asked about the mix in the type of providers. Mr. Miller responded there has been a decline in some of the more traditional providers, such as orthopedic specialists and chiropractors. The number of PCPs has also declined but not as significantly, and other physician specialists have increased. The decline from 2007 to 2012 was across the board, but so is the increase; thus the net effect is that the number of orthopedic specialists, physical medicine specialists, and chiropractors has not recovered as quickly as that of other specialists.

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Commissioner Bloch asked why the number of providers is not increasing. Mr. Miller replied that he can only speculate because nothing in the data provides the reasons for the decline. Commissioner Bloch commented that he has heard anecdotally from physicians that they are frustrated by the denials, the requirements, and the reimbursement rates of workers' comp. Commissioner Bloch asked whether the Commission has researched doctors' reasons for participating or not participating in the workers' compensation system. Mr. Miller replied that he did not explore the reasons in the current study but previous studies indicate a great deal of consistency: physicians said they were frustrated over paperwork or denials. However, other studies, rather than the current data, find that the number of providers relates closely to the number of patients. So when the number of injured workers declines, so does the number of providers, and when the number of injured workers increases, so does the number of providers. Therefore, it is hard to determine whether the doctors' frustration has any impact.

Commissioner Bloch stated that the decline in the number of providers was the greatest in the Bay Area and Sacramento Valley, and there was a regional variation and change in the number of medical bills submitted, with a substantial decrease in the Sacramento Valley and the Bay Area seems to reinforce the correlation: fewer doctors are treating fewer injured workers, and thus fewer bills were submitted. He asked whether there has been a correlating decrease in the number of injured workers in the Bay Area and the Sacramento Valley and a correlating decrease in the number of injuries. Mr. Miller replied that the number of injured workers has been much more consistent across geographic areas. Commissioner Bloch commented that it is interesting that the number of injuries is the same but fewer doctors and consequently less billing. Mr. Miller replied that he agreed with Commissioner Bloch that there are fewer doctors, but several factors affect billing, particularly in the way bills were measured in this study,—each bill was counted—but this is unrelated to current issues. Physicians are providing services to injured workers, and more bills are being generated; it may or may not relate to the current injured worker's condition. This pattern is not unique to workers' compensation. Part of the reason is economic: the rates of payment provided have increased slowly, and more services are being provided. This reason is hard to find in this data, but it is found in the general literature.

Commissioner Kessler asked, notwithstanding the increase in the workforce, which types of jobs have increased? Mr. Miller responded that the types of jobs that have increased have not been determined and it is the types of injuries that have occurred that should be examined. Whether the types of industries that have come back more slowly after the recession had an impact and higher-risk industries took longer to come back might be reflected in the data.

Commissioner Kessler stated that the industries that have come back significantly are the low-wage service-sector industries, and those have less oversight of health and safety issues. These industries have typical and common injuries, such as back injuries and carpal tunnel syndrome. For example, the San Francisco International Airport has been cited for 21 health and safety violations such as having empty first-aid kits with nothing in them or kits with cockroaches or needle sticks. The labor force is an immigrant workforce and is the most exposed to injuries, so she suggests that the classifications of some service sector industries that have come back be studied. While the industrial and construction-based sectors are coming back more slowly than service-sector industries, the latter offer less protected environments and thus may be significant for this study.

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Commissioner Kessler inquired whether doctors are being compensated fairly for the work that they are providing. She also asked whether the study investigated whether the doctors are getting the kinds of pay or even not getting the kinds of pay for the services they are providing to the injured workers. Mr. Miller replied that there is no evidence that this was the case. There is a change in the payment method that took place immediately upon the conclusion of the data collection and could have the answers, and 2014 data will likely give the answers.

Commissioner Bloch was skeptical that 85% of the workers are satisfied with their access to care as found by this study. He wanted to know how the workers were selected, how this was done, and what questions were asked to allow that conclusion. Mr. Miller replied that what was being reported in the first study and the survey was a random survey of workers. The important point is that there were two previous studies by different entities and those studies had the exact same results. The questions were worded slightly differently, but asked respondents their level of satisfaction with the care received and the range of answers was similar; when they say 85%, that means that 85% of the respondents are satisfied or very satisfied with the care they received. Although the responses consistently indicate that the respondents were satisfied, there are individual issues included in this survey if patients are denied care or had to wait an excessive period of time; these are all based on patient perception. All the data is in the report. If 85% were satisfied then the other 15% reported that they were dissatisfied or very dissatisfied. The study does have a breakdown of the type of workers who were surveyed.

Commissioner Kessler asked whether any follow-up had been done with the initial respondents to the survey to see whether their perception of their treatment had changed. Commissioner Kessler stated that it is worthwhile to follow up with these survey respondents over time, especially workers who think they are getting lifetime treatment for an injury that created a disability or temporary disability, to find out the patient's current status. She said that would give us an idea over time of how the injured worker feels about the system and believes that is worth considering. Commissioner Kessler asked how much time had passed between when the injury occurred and when the survey for this study was completed. Mr. Miller stated that the injury time varied, but the respondent had to be injured in the previous year. Commissioner Kessler asked about the percentage of workers who knew they would get lifetime medical treatment and whether they obtained it for permanent disability. Mr. Miller stated that he did not know.

**CHSWC Report**

Eduardo Enz, Executive Officer, CHSWC

Mr. Enz briefed the Commission on staff activities:

- Since the June 4 meeting, CHSWC staff has worked with the Division of Workers' Compensation to implement the CHSWC-approved action item on electronic reporting: to convene an Advisory Group on Electronic Reporting.
- Staff continues to manage and monitor ongoing projects and studies.

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Mr. Enz reminded the Commission that the Medical Access Study by Berkeley Research Group is a DWC study, not a CHSWC study.

*Advisory Group on Electronic Reporting*

- DIR, DWC, and CHSWC staff held a meeting to discuss electronic transmission of medical records and reports in Oakland on September 4.
- A wide range of stakeholders participated in this meeting and helped narrow the focus and objectives.
- The use of electronic medical records in the workers' compensation system will accomplish the following goals:
  - Improve processing time in providing medical care
  - Improve oversight, accuracy, and accountability
  - Expedite payments to providers
  - Reduce administrative costs

*RAND Studies Update*

In addition to the overview of the RAND study for the commission presented by Barbara Wynn today, *Medical Care Provided to California's Injured Workers: Monitoring System Performance Using Administrative Data*, two other ongoing RAND studies will help the Commission better understand the effects of SB 863.

- *Evaluation of the SB 863 Medical Care Reforms* study by RAND focuses on how the SB 863 reforms have affected both workers and employers especially in the areas of medical delivery, dispute resolution, and payments in California's workers' compensation system.
- The *Wage Loss* study by RAND evaluates both earnings losses and disability ratings in the post-SB 863 era and will determine whether benefits compare more favorably with losses under the current system than before the implementation of SB 863.

*Aging Workforce Project Update*

- Interagency agreement with UC Berkeley's Labor Occupational Health Program to develop a needs assessment with stakeholders.
- CHSWC staff is researching the injury trends.
- Aging Workforce project Roundtable to be held in Oakland on November 13, focusing on eliciting promising strategies, best practices, and potential interventions.
- LOHP will prepare a summary report of the roundtable discussion and present it at a Commission meeting in the near future.

Additional CHSWC Activities:

*California Partnership for Young Worker Health and Safety taskforce meeting*

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- On October 22, WOSHTEP partners (LOHP, LOSH, and WCAHS), CHSWC personnel, and other agencies and organizations dealing with youth employment and education issues will participate in a California Partnership for Young Worker Health and Safety meeting in Sacramento.
- The California Partnership for Young Worker Health and Safety is a statewide task force partially funded by the Commission that brings together government agencies and statewide organizations representing educators, employers, parents, job trainers, and others.
- The partnership develops and promotes strategies to protect youth at work and serves as an advisory group.

*SASH*

- On October 27, CHSWC staff will host a SASH Advisory committee meeting in Oakland.
- The SASH Advisory committee meets yearly to review and make improvements to the School Action for Safety and Health program that CHSWC established as a Schools Injury and Illness Prevention Program (IIPP) model program, to help schools statewide improve their injury and illness prevention practices.
- The program includes training and resources to enable schools or school districts to develop or improve IIPPs and to make other health and safety improvements to help protect school or school-district employees from injuries and illnesses on the job.
- The target audience focuses on K-12 schools and school districts at high risk of occupational injury and illness to school employees.

*SEIU-United Service Workers West (USWW) Janitorial union study proposal*

- The Executive Officer involved in joint meetings between the DIR and the SEIU-United Service Workers West (USWW) Janitorial union to identify a possible study due to the increasing injury rates in this area due to excess workload.
- Hope to have a proposal ready for the next meeting in December.

*Action Items*

There were no action items aside from the approval of the June minutes.

*Closing*

- CHSWC is proud of and excited about all the important work it is doing to benefit California's workers and employers.

*Comments by Commissioners*

Commission Bloch reminded Mr. Enz that he had requested a report on the formulary. Commissioner Bloch said he did not know whether the AB 1124 (Perea) bill had been signed.

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Mr. Enz stated that it had been signed. Mr. Enz said that CHSWC is in the process of compiling a study and will provide an update at the next Commission meeting. Ms. Overpeck stated that a public meeting on the formulary had been held since the June meeting that is a first step toward working on the regulations. She stated that it would go forward, regardless of whether AB 1124 was signed.

Commissioner Kessler asked Mr. Enz also to ask about the airport issues when he meets with SEIU-United Service Workers West. She said 21 complaints had been filed with the union, which is part of the same union although from a different sector. She also asked to be informed if there is another public meeting about electronic reporting; she does not know if she missed the last one by accident.

Commissioner Bouma asked about the public self-insured report that was supposed to be done in cooperation with CHSWC as part of the SB 863 reform, "to examine and publish a preliminary report." She asked about its status.

**Public Comment**

There were no requests for public comment.

**Other Business**

None.

**Adjournment**

Commissioner Bouma moved to adjourn the meeting, and Commissioner Brady seconded the motion, which was passed unanimously.

The meeting was adjourned at 12:10 p.m.

**Approved:**

\_\_\_\_\_  
Sean McNally, 2015 Chair

\_\_\_\_\_  
Date

Respectfully submitted:

\_\_\_\_\_  
Eduardo Enz, Executive Officer, CHSWC

\_\_\_\_\_  
Date