



Research Update

Medical Review and Dispute Resolution in the California Workers' Compensation System

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EXECUTIVE SUMMARY

Following California workers' compensation reforms enacted in 2002-2004 and 2012, the process of approving payment for medical care for injured workers has undergone significant change, most notably through the adoption of an evidence-based medicine medical treatment utilization schedule and the addition of independent medical review (IMR) to resolve medical necessity disputes. The approval process includes a series of checks and balances to reconcile a request for authorization (RFA) from an injured worker's physician for a specific course of medical treatment with the Medical Treatment Utilization Schedule (MTUS) that defines the medical standard of care for workers' compensation in California. Components of medical review and dispute resolution may include review of medical reports and bills by claims adjusters, bill reviewers, nurses and utilization review (UR) physicians, and when requested, by independent medical review physicians. Recent studies have analyzed these various components, and this report updates and expands on those analyses using data from a sample of 5.6 million California workers' compensation medical services from 2014 and from the nearly 220,000 IMR decision letters issued in 2014 through June 2015, with a focus on the IMR letters from the first six months of 2015. Key findings include:

- 15.3 percent of the workers' compensation medical services in the study sample were requested in RFAs and underwent utilization review for medical necessity (this percentage varied significantly among claims administrators, ranging from about 9 percent to 19 percent). That means that almost 85 percent of medical services in the study were paid without being requested in RFAs and undergoing UR.
- Of the 15.3 percent of all medical services that were requested in RFAs and underwent UR, 59.8 percent were accepted after non-physician reviewers determined them to be medically necessary under the treatment guidelines, while 40.2 percent were forwarded to a UR physician for review and determination. That means out of the 5.6 million medical services in the study sample, 6.1 percent (15.3 percent x 40.2 percent) were reviewed by a UR physician. As with the percentage of medical services that were requested in RFAs and underwent UR, there was wide variation among claims administrators in the proportions forwarded to a UR physician, ranging from 1.5 percent to 76.2 percent of all medical services.

- The modification/denial rate for the 6.1 percent of all treatment services submitted for physician utilization review was 70 percent, which translates to 4.3 percent of the 5.6 million medical services in the study (1.1 percent were modified and 3.2 percent were denied). On the other hand, of the 6.1 percent of the treatment services that went to UR physician review, nearly 1 out of 3 (1.8 percent of all treatment services) were approved. Modification and denial rates as a percent of all treatment services also varied significantly among payors, ranging from a low of 0.2 percent to a high of 5.0 percent.
- In the first half of 2015, IMR physicians upheld 89.1 percent of the UR denials and modifications, while 10.9 percent were overturned. This result is consistent with the 91 percent uphold rate noted in CWCI's analysis of 2014 IMR outcomes and indicates that the vast majority of modifications or denials made by UR physicians are in-line with evidence-based medicine and in the best interest of the injured worker.
- Nearly a quarter of IMR decisions in the first half of 2015 involved claims with a date of injury from 2004 or earlier, but claim age had no effect on the IMR uphold rate.
- Almost half of the IMR decisions rendered between January and June of 2015 involved disputes over prescription drugs. One-third involved requests for opioids, while 11 percent involved compounded drug requests.
- The top 10 percent of all physicians (961 individual treaters) involved in IMR disputes were identified in more than 80 percent of all IMR letters; while the top 1 percent (97 individual physicians) were named in 40 percent of the IMR decision letters.
- IMR data from the first half of 2015 shows that 50,252 injured workers received at least one decision letter involving a 2015 determination, and that 5,225 (10.4 percent) of those workers received more than one letter relating to applications made on the same day. Consolidating applications from the same day and the same scope of service could lead to better informed decisions, greater efficiency, and lower costs (estimated savings of \$5.2 million per year in IMR vendor fees).
- Overall, 4.3 percent of the 5.6 million California workers' compensation medical services in the study sample were modified or denied through the UR process, making them eligible for IMR if the injured worker chose to dispute the UR decision. Of those denials and modifications that were appealed, 10.9 percent were overturned by the IMR physician. That, plus the medical services for which payment was authorized without going through IMR, translates to an estimated approval rate for all California workers' compensation medical services of between 95.7 percent and 96.1 percent.

Final IMR determinations that resulted in modified or denied treatment requests underwent multiple levels of review that often included review by claims adjusters and nurses in addition to the UR and IMR physicians. The end result is a consensus that the physician's treatment request did not align with the MTUS standard of care and consequently, the requested service could delay a worker's recovery or lead to further impairment or disability. The high level of system-wide agreement at these different stages of medical review realizes the legislative intent of reforms to provide the injured worker with the most effective medical care through a process that is more objective, transparent and consistent.

INTRODUCTION

California workers' compensation medical care delivery undergoes reform on a regular basis. Sometimes reforms are targeted in scope (for example, adjustments to the Official Medical Fee Schedule), while other times they lead to more significant, structural changes. Examples of the latter include 2002-2004 statutory changes that introduced evidence-based medicine as the new standard of care and changed the way in which quality of care is evaluated, and the 2012 reforms that included an expansion of clinical oversight to resolve medical necessity disputes between the injured worker's physician and the claims administrator.

From the moment the 2012 reforms were enacted, the debate over the scope, authority and reasonableness of the medical dispute resolution process intensified. A means of resolving medical necessity disputes is common to almost all other healthcare delivery systems including group health and federal programs such as Medicare, Medicaid and the Veterans Administration health system, yet it is important to restate the obvious: workers' compensation is not like other systems. Co-payments, deductibles and enrollee contractual language are common shared-risk strategies used by group health to manage utilization and cost. The use of these strategies in California workers' compensation is currently precluded by statute and antithetical to the original no-fault bargain between employers and employees. Without the use of such shared-risk controls, workers' compensation must rely on a more complicated process of establishing and enforcing a state-level, high-quality medical treatment standard through statute, regulation and legal decisions. Deciding the type, intensity and cost of medical care that is appropriate for injured workers is one of the most contentious, convoluted subjects in workers' compensation.

Historical Context

Crafting and implementing public policy and interpreting public policy research are often matters of historical context and current perspective. Since the early 1990s, the California workers' compensation system has been modifying its medical review and dispute resolution processes. Prior to 1993, the system operated under a "free choice" model in which injured workers selected physicians to treat their injuries, and disputes over medical care were determined based on a preponderance of the evidence. As in many healthcare systems, disputes over medical necessity were initially resolved through negotiation between the injured worker's physician and the payor, but unlike other systems, if no resolution could be found, the matter was adjudicated before a workers' compensation judge and ultimately decided by the Workers' Compensation Appeals Board (WCAB).

This dispute resolution process required expert medical evidence, so the injured worker and the payor would each hire forensic physicians to develop their rationale and compile supporting documentation, including medical treatment guidelines, community standards, and other conventions and hope to persuade the judge to rule in their favor. This process, commonly referred to as "dueling docs," was expensive, time consuming, and often led to arbitrary, inconsistent medical decisions.

In 1993, California lawmakers enacted major reforms that attached a rebuttable presumption of correctness to the primary treating physician's (PTP) opinion in regard to the calculation of permanent disability. Subsequent case law (Minniear) handed down by the WCAB in 1996¹, expanded the PTP presumption to give the injured worker's physician a presumption of correctness on all medical treatment issues including the appropriateness of any given medical service, severely limiting the payor's ability to

1. Minniear 1996 DCA 61 CCC 1055

question or object to medical utilization, even when it was clear that a given treatment would not cure or relieve the effects of the injury or could potentially cause harm.

The initial adoption of the PTP presumption and its subsequent expansion under the Minniear decision was associated with an unprecedented surge in medical benefit costs, with the average medical cost per claim more than tripling between accident years 1993 and 2003 – a period that also saw the financial insolvency of 28 insurance companies.²

Between 2002 and 2004, California lawmakers drafted a series of reforms that introduced elements of managed care into workers' compensation and dramatically altered the workers' compensation dispute resolution process. AB 749, enacted in 2002, partially repealed the treating physician's presumption of correctness. That legislation was followed in 2003 by SB 228, which mandated that the state adopt a workers' compensation medical treatment utilization schedule by December 2004 and specified that the new schedule incorporate evidence-based, peer-reviewed, nationally recognized medical treatment guidelines. SB 228 also called for 24-visit caps on physical medicine and chiropractic care – two service categories that had been associated with excess treatment and cost. The legislative intent of these measures was to ensure high-quality health care for injured workers by supporting the use of scientifically proven treatments in order to promote recovery and return to maximum functionality, and to decrease health care costs by reducing unproven, unnecessary and potentially deleterious medical care. In April 2004, state lawmakers took an additional step by passing SB 899, which among other things, allowed employers and insurers that establish or contract with workers' compensation Medical Provider Networks (MPNs) to control the provision of injured workers' medical care for the life of their claims.

In the years following the adoption of the MTUS and the introduction of MPNs, workers' compensation medical treatment disputes were adjudicated through the medical-legal process that involved qualified medical evaluator (QME) panels, med-legal exams, QME reports, additional discovery, and a trial before a workers' compensation judge. The final determination on appeal came from the WCAB and (rarely) the court of appeal or California Supreme Court. This again was considered a lengthy, expensive, and often unsatisfactory path for injured workers and claims administrators. Many felt that QME reports and the decisions of judges often failed to adequately consider and apply evidence-based guidelines and, consequently, failed to consistently enforce the statutory medical standard of care set by the MTUS. This, along with steady increases in medical treatment and medical dispute resolution costs, raised doubts about whether non-medical adjudicators were the optimal choice for medical necessity dispute resolution.

In late 2012, another round of reforms began to take shape in the form of SB 863, the stated purpose of which was “To reduce frictional costs [and] speed up medical care for injured workers.” In section 1 of SB 863, the Legislature expressly stated the rationale for creating IMR, declaring that:

- resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers injured in the course of employment.
- having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured

2. Gardner L, Swedlow A. The Effect of 1993 – 1996 Legislative Reform Activity on Medical Cost, Litigation and Claim Duration in the California Workers' Compensation System. Research Note. CWCI. May 2002.

workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy.

- the performance of IMR is a service of such a special and unique nature that it must be contracted pursuant to Government Code Section 19130 and that IMR is a new state function ... that will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations performed by qualified medical evaluators...The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of QMEs can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise of specialists that are not available through the civil service system.
- the establishment of IMR and provision for limited appeal of decisions resulting from IMR are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review of such decisions.

The inability of the adversarial and judicial systems in workers' compensation to effectively implement the standard of medical care intended by the 2002-2004 reforms through the adoption of the MTUS and UR led to the creation of IMR, as California lawmakers concluded that the final determination of medical necessity should rest with IMR physicians rather than judges.

Current Perspectives: Legal Challenges and Decisions and Media Attention

Workers' compensation medical necessity dispute resolution has become a hot topic in the courts. Among recent examples:

- In 2014, a WCAB panel decision held that a claims administrator is precluded from unilaterally ending approved nurse case manager services when there is no evidence of a change in the employee's condition.³
- The manufacturer of the H-Wave spinal stimulator filed a civil suit alleging that a claims administrator had established a "blanket policy" to deny all prescriptions for the device. At the Court of Appeal, the defendant argued that UR is a constitutionally protected activity, so it could not be sued civilly for performing statutory duties. The court rejected that defense and returned the case to the trial level, while the defendant has appealed to the Supreme Court.⁴
- Injured worker representatives challenged IMR as a denial of due process and as a violation of equal protection, separation of powers, and the right to a fair hearing. In October 2015, the California Court of Appeal ruled that there was no constitutional violation because the Legislature has plenary power over the workers' compensation system. The opinion was very detailed and could serve as a reference point for similar IMR challenges.⁵

3. Patterson v WCAB (2014) Significant Board Panel Decision 79 CCC 910.

4. Electronic Waveform Lab, Inc., v EK Health Services, Inc. (Unpublished decision of the Second District Court of Appeal February 2015)

5. Stevens v WCAB (Published opinion of the First District Court of Appeal October 28, 2015)
<http://www.courts.ca.gov/opinions/documents/A143043N.PDF>

While the legal issues surrounding UR and IMR play out in the courts, payors continue to be subject to tight timeframes and significant administrative requirements and associated expenses. A prior study noted that the reforms of 2002-2004 and 2012 contributed to an increase of 347 percent in medical cost containment expenses between 2002 and 2014, a conservative estimate that only in part reflects the costs associated with IMR. More recently, a series of media reports used selected examples of denial of care for injured workers to imply a system-wide failure to deliver appropriate medical care.⁶

BACKGROUND ON MEDICAL REVIEW AND DISPUTE RESOLUTION

It has now been more than a decade since California law required workers' compensation payors to establish utilization review programs that utilize an objective standard of care defined by evidence-based medicine guidelines and more than two years since lawmakers established Independent Medical Review as a corollary to UR. Under the current medical review and dispute resolution process, if a UR physician evaluates a medical service request for an injured worker against the MTUS or other applicable guidelines and determines it is not medically necessary, the injured worker may appeal the decision and obtain a final determination from an independent physician who has expertise in the treatment of that type of injury. The IMR physician reviews the medical records, the evidence on which the UR decision was based, and any subsequent information provided by or on behalf of the injured worker, then issues his or her decision.

The goal of medical necessity review and dispute resolution is to help ensure that injured workers' medical care is appropriate, while providing a check against prescription drugs, diagnostic tests, surgeries and other medical services that do not meet California's evidence-based medicine standards and that could delay a worker's recovery or lead to further impairment or disability.

Since IMR became effective for all claims in July 2013, there has been ongoing debate over how well the medical review and dispute resolution process meets those goals. During that time, the authors have conducted studies that measured outcomes of UR and IMR. The most recent of those analyses, published in April 2015, provided detailed results from the 137,781 IMR decision letters issued during 2014 in response to applications submitted after a UR physician modified or denied a requested medical service.

This study updates and builds on that analysis reviewing both UR and IMR. The UR analysis focuses on data from 2014 and the IMR analysis focuses on the decisions issued in the first half of 2015. The primary goal of the study is to advance the discussion on the current medical review and dispute resolution processes by using more detailed data to enable a finer level of analysis. The study also refines prior evaluations by focusing on each component of the medical review and dispute resolution process including:

- medical services that are paid without being requested in RFAs and without undergoing UR,
- non-physician utilization review of an RFA,
- physician utilization review of an RFA, and
- Independent Medical Review.

6. <http://www.propublica.org/article/the-demolition-of-workers-compensation>

THE MEDICAL REVIEW/IMR PROCESS

For most claims organizations, medical review is a multilevel process in which an injured worker's medical provider submits a Request for Authorization (RFA), which is initially reviewed by a claims adjuster or nurse who assesses whether the requested treatment is consistent with the Medical Treatment Utilization Schedule adopted by the DWC or other nationally recognized, evidence-based, peer-reviewed treatment guidelines for the injury and responds within tight timeframes.

A service for which an RFA is not received may be part of a prior authorization program. If a service is covered by prior authorization, the treating physician is not required to submit an RFA before, during or after the treatment, and the payor agrees to make the appropriate reimbursement for the specific treatment. Also, services can be deemed retrospectively approved by payment [per CCR 9792.9.1]. Other types of medical treatment services paid or approved without an RFA vary based on each claims administrator's parameters for approval. Examples include basic treatment services such as certain office visits, x-rays, or physical therapy under the 24-visit cap, emergency services as well as services associated with initial treatment of a specific injury type (such as fractures and wounds).

While claims adjusters, nurses, or other non-physicians who perform utilization review may approve treatment requested in an RFA, only physicians may deny or modify treatment requests, so if a non-physician is unable to determine a requested service is medically necessary, the RFA is sent to a UR physician for review. The UR physician then determines if the service is medically necessary in accordance with the MTUS regulations.

If the UR physician determines that the requested service is not medically necessary, the injured worker is notified that the request has either been modified or denied. After receiving the notice of the UR modification or denial, the injured worker or his or her agent (typically an attorney or doctor) has 30 days to submit an IMR application. If the injured worker disputes the UR decision and submits an IMR application, then the IMR process allows a final independent determination. The claims administrator must submit any supporting documentation to Maximus Federal Services, Inc., the independent medical review organization that is under contract with the state to manage the IMR process, within 10 days of the notice of assignment, or within 24 hours if there is an imminent threat to injured worker's health. An injured worker or his or her agent also may submit supporting documentation. The treating physician should already have provided any required reports and supporting documentation to the claims administrator. The cost of the IMR is set by regulation and is paid by the claims administrator.

After receiving an eligible IMR application, Maximus examines the application to determine the medical specialty or subspecialty required to perform the IMR and identifies an appropriate, board-certified physician to conduct the review. All IMR physician reviewers are independent contractors and according to Maximus, all spend at least 60 percent (24 hours) of their workweek in active practice. While preference is given to California licensed physicians, qualified physicians licensed in other states also may serve as independent medical reviewers. After verifying the physician's availability and knowledge regarding the injured worker's condition, the disputed service, and the treatment options for the condition, Maximus assigns the physician to the case. The role of the IMR physician is to review:

- the treating physician's reports and any other reports noted in the request for authorization or UR decision;
- the UR determination that the service was modified or denied;

- information given to the injured worker by the claims administrator regarding the UR decision;
- materials the employee or the physician provided to the claims administrator to support the treatment request; and
- any other relevant documents or information, including claims administrator statements explaining the decision to deny, modify or delay the requested treatment.

Within 30 days of Maximus receiving the IMR application and the supporting documentation and information, the independent medical reviewer must complete the review, determine whether the disputed service is medically necessary, and mail a final determination letter to the injured worker or his or her representative, with copies to the physician, claims administrator and the DWC.

DATA AND METHODS

Claims administrators track medical service authorization requests submitted in RFAs and processed through internal or external utilization review, and some also collect information on services approved outside the UR process. Given the variability in data tracking methods, for this study the authors compiled data on medical payments, RFA activity and UR and IMR decisions from multiple sources. The 2014 statistics on approval and payment processes were compiled from insurers representing 53 percent of statewide premium and a cross-section of public and private self-insured employers. The study population included payors that use in-house utilization review resources and those that contract with external utilization review organizations (UROs). In addition, some of the data contributors administer their own claims while others use third-party administrators.

The data compiled from study participants was used to identify the number of RFAs submitted and the count of services within each RFA; the number of approvals by non-physicians following an initial review; and the count of RFA services that were submitted for UR by a physician reviewer and the resulting approvals, modifications and denials. Withdrawals of requests, denials due to missing documentation or claim compensability issues, and denials due to treatment by a non-network provider were excluded. It is important not to mix determinations based on medical necessity with these other types of dispositions, so this study focuses on approvals, modifications or denials of requested services based on medical necessity.

Once the authors received data from each contributor, they interviewed several representatives within each company to understand their review process and data collection methods to ensure data comparability -- a process that confirmed the variability in the conduct of UR. During those interviews, the authors also asked participants what types of reviews were sent to DWC for their most recent UR audits.⁷

To understand the proportion of total care requested in RFAs that underwent UR, the authors calculated the count of 2014 paid services from CWCI's Industry Research Information System (IRIS) database⁸ for those submitting both UR data and medical bill review data to CWCI.⁹

To arrive at the total count of medical services, adjustments were made to make the services included in

7. The DWC conducts regular audits of UR programs to assure the timeliness, accuracy and completeness of responses to UR requests, and that the responses were delivered to the proper parties. Audits in which a sample of files that have RFAs are reviewed at a claims adjusting location in conjunction with the claims administrator's performance audit review (PAR) audit are known as URA audits. Audits in which a utilization review organization submits files to the DWC Medical Unit for review, and which also may include an on-site investigation, are known as URO audits.

8. The IRIS database is a proprietary database maintained by CWCI that contains detailed information, including employee and employer characteristics, medical service data, and benefit and other administrative cost detail on more than 4 million California workers' compensation claims.

9. The study estimated the number of medical services from transactional data as well as estimates for non-IRIS participants.

the study comparable to services eligible for the UR process. For example, physician reports were excluded, as were facility fees because there is typically a physician payment for that same facility service, and only one physical therapy procedure code was counted per service day. Exhibit 1 shows the distribution of services after those adjustments.

Exhibit 1: Adjusted Medical Treatment Services by Service Category

Service Category	% of Paid Services (Adjusted Sample)
Pharmacy	25.4%
Evaluation and Management	24.2%
Physical Therapy	13.2%
Laboratory Services	8.6%
DME/POS	5.5%
Radiology (Excluding MRI/CT/PET)	5.0%
Surgery	4.0%
Psych Services	2.1%
Diagnostic Tests/Measurements	2.1%
Chiropractic Manipulation	1.6%
Acupuncture	1.4%
MRI/CT/PET	1.4%
Injections	0.7%
Other	4.8%
Grand Total	100%

The proportion of RFA services undergoing UR was then calculated by dividing the RFA service count by the eligible services (the adjusted count of paid services plus the count of denied services). The proportion of total care reviewed by a UR physician and modified or denied was calculated using similar methods.

The authors compiled the IMR data used in this study from all available IMR decision letters issued by Maximus from January 2014 through June 2015. There were 219,720 letters issued during the 18-month study period: 137,761 letters issued in 2014, plus 81,960 letters issued in the first six months of 2015. The authors obtained information on the submitted applications from the DWC.¹⁰ The Institute's April 2015 IMR study focused on IMR outcomes from 2014, so to gauge the latest IMR results, the authors reviewed the determination letters issued from January through the end of June 2015, and used the data to measure and analyze IMR experience for the first half of 2015.

While this study advances prior attempts to measure the outcomes of medical review and medical necessity dispute resolution, the authors were limited by available data and data sources. The final datasets used in the analysis were compiled from distinct information systems across each segment of medical review, RFAs and IMR. There was an abundant volume of data for each segment, but due to confidentiality requirements as well as different data capture standards across data sources (individual payors, independent UR vendors and IMR), it was not possible to link each medical service record across the

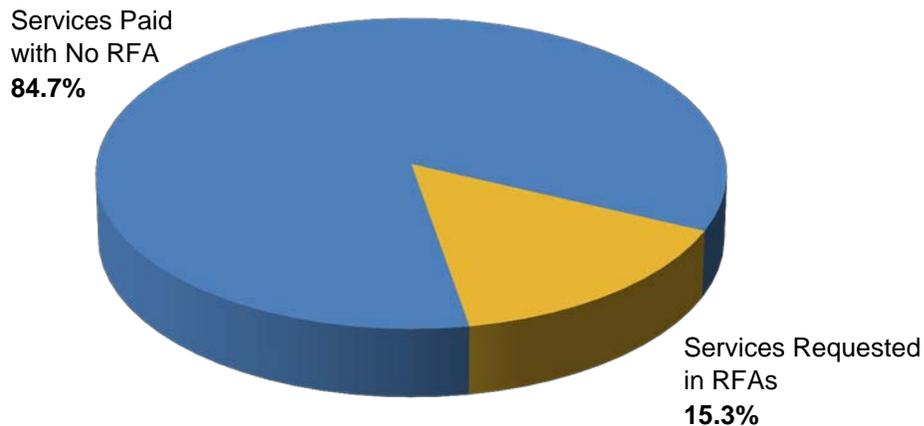
10. Memo from DWC, October, 2015.

continuum of medical bill review to utilization review to independent medical review. However, the volume of data for each data segment, outlined below, is sufficient to compensate for this limitation.

PART 1: 2014 UR OUTCOMES

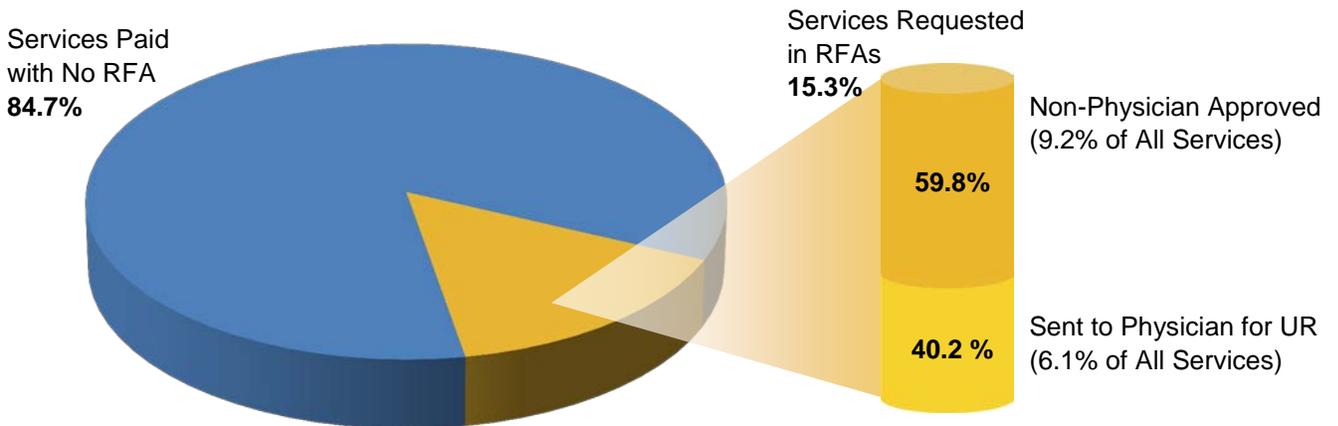
The first question addressed in the study is what proportion of workers' compensation treatment services were submitted through RFAs and underwent utilization review. As illustrated in Exhibit 2, of the 5.6 million medical services in the study sample, about 860,000 (or 15.3 percent) were requested in RFAs and underwent UR. That means that almost 85 percent of all 2014 medical services were paid without being requested in RFAs and without UR, either through prior authorization programs, retrospective authorization, or because no request for authorization was received and the service fell within the claims administrator's parameters for approval. Within the study sample the percentage of treatment services in which an RFA was submitted varied by claims administrator, ranging between about 9 percent and 19 percent of services.

Exhibit 2: 2014 Services Requested in RFAs vs Paid with No RFA



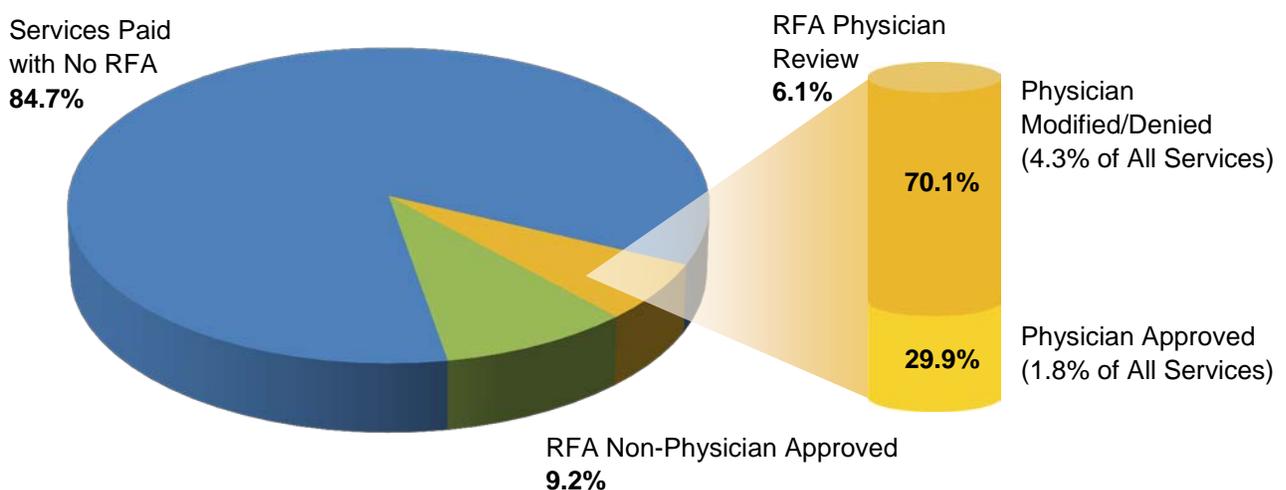
Of the 15.3 percent of all treatment service requests submitted in RFAs for UR, 514,212 (59.8 percent) were accepted after the claims adjuster or nurse determined them to be medically necessary under the treatment guidelines, leaving 345,771 (40.2 percent) that were forwarded to a UR physician for review and determination. As noted in Exhibit 3, the 345,771 service requests in which an RFA was submitted to physician UR equates to an estimated 6.1 percent (15.3% x 40.2%) of all 2014 treatment services.

Exhibit 3: UR Outcomes - 2014 Treatment Services



There was wide variation among claims administrators in the proportion of RFAs forwarded for physician UR review (ranging from 1.5 percent to 76.2 percent), which also affects the proportion of RFA services modified or denied by the physician. Exhibit 4 shows the proportion of care modified or denied by a UR physician. The modification/denial rate for the 6.1 percent of all treatment services submitted for physician utilization review was 70 percent, which means that 4.3 percent of the 5.6 million workers' compensation treatment services were modified or denied by a UR physician (1.1 percent were modified and 3.2 percent were denied). On the other hand, the approval rate for the 6.1 percent of the treatment services that went to review by a UR physician was 30 percent, which translates to 1.8 percent of all treatment services approved at the physician UR level.

Exhibit 4: 2014 Physician UR Outcomes



Although overall, 4.3 percent of all workers' compensation medical services were modified or denied in the UR process, as noted earlier, modification/denial rates as a percent of all treatment services showed significant variation among payors, ranging from a low of 0.2 percent to a high of 5.0 percent.¹¹ It is this 4.3 percent of the requested medical services that were modified or denied during UR that would have been eligible for IMR if the injured worker chose to dispute the UR physician's decision. Exhibit 5 traces medical services through the various stages of review.

Exhibit 5: 2014 Treatment Approval & Modification/Denial Rates

Process Summary	Percent
Paid without RFA	84.7%
RFA Services as Percent of All Medical Services (A)	15.3%
RFA Non-Physician Approvals (B)	59.8%
RFA Services Sent to Physician Review (C)	40.2%
Percent of Medical Services Reviewed by Physician (A*C)	6.1%
(Physician) UR Modifications/Denials (D)	70.1%
Percent of Medical Services Modified/Denied (A*C*D)	4.3%
Approved Care (Pre-IMR)	95.7%

As part of the interview process, study participants were asked about RFAs submitted to the Division of Workers' Compensation for URA audits. While some reported forwarding all RFAs, others reported submitting only those RFAs forwarded to physician utilization review. Without taking into account that 84.7 percent of medical treatment events were approved outside of the RFA UR process, relying on data from DWC's audits of UR programs would lead to the erroneous conclusion that as much as 70 percent of all medical services are modified or denied.

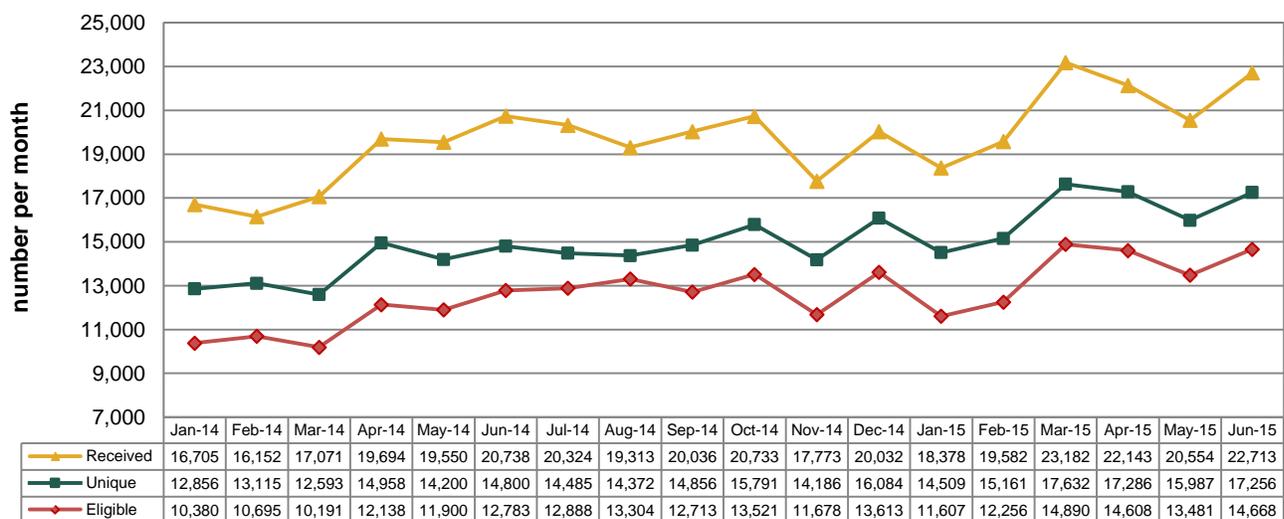
11. Similar variation among payors was noted for the 15.3 percent of all treatment services for which an RFA was submitted. The overall modification/denial rate for these RFA services was 28.2 percent, but that rate varied by payor, ranging from a low of 1.3 percent to a high of 55.9 percent.

PART 2: IMR OUTCOMES: JANUARY 2014 THROUGH JUNE 2015

DWC reported that 228,121 IMR applications were submitted in 2014 and 126,552 were submitted in the first six months of 2015, for a total of 354,673 applications received during the 18-month study period. Of these, 23.8 percent, or 84,546, were duplicates, leaving 270,127 for evaluation.¹² After receiving an IMR request, Maximus reviews each application to determine that it meets the eligibility requirements set by the regulations.¹³ Those applications it cannot verify as eligible, Maximus forwards to the DWC for eligibility determination. For example, the DWC deems an application ineligible if it is untimely or incomplete, an application for the service was already filed, or an outstanding legal issue must be resolved before the request can go to IMR.

The top line on Exhibit 6 shows the number of applications received with and without duplicates from January 2014 to June 2015, while the middle line shows the count of unique (non-duplicate) applications that were reported by the DWC. The bottom line on the graph shows that of the 270,127 unique IMR applications filed between January 2014 and mid-2015, 227,314 were determined eligible. The volume of received, unique and eligible IMR applications remained at or near record levels from March through June of 2015.

Exhibit 6: Received, Unique & Eligible IMR Applications, January 2014 - June 2015



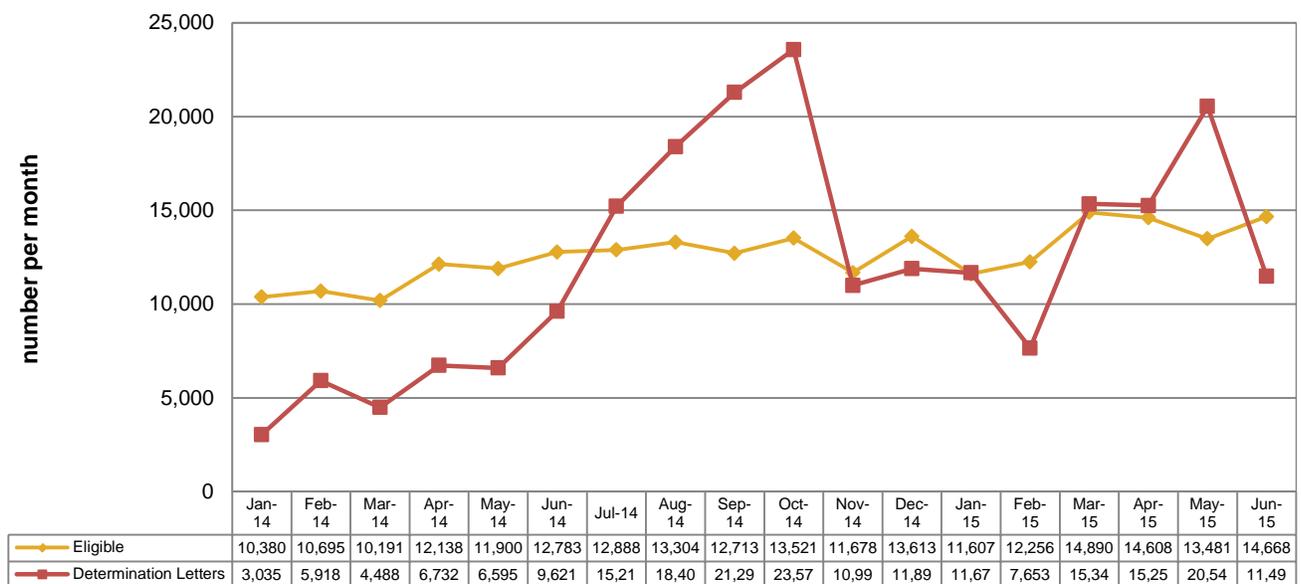
12. Memo from DWC, October 2015.

13. CCR §9792.10.3(a)

After Maximus receives an eligible IMR application, it must request, receive and process the medical records and assign the case to a reviewing physician to complete the review. Within 30 days of receiving the application and all necessary records, Maximus is statutorily required to issue an IMR determination letter to the injured worker or his or her representative – typically an attorney or the requesting doctor – explaining that decision and the rationale behind it and send a copy to the claims administrator, the requesting physician, and the DWC. Soon after the introduction of IMR in 2014, the DWC was inundated with IMR applications, with volume far exceeding initial projections.¹⁴ For several months this created a backlog of applications, as illustrated in Exhibit 7. By the end of 2014, however, Maximus reported that it had put the personnel and processes in place to handle the huge volume of applications and work through the backlog that had clogged the system.

The unexpected high volume of IMR letters and their associated costs in 2014 and 2015 have been noted as a contributing factor in increasing claim-adjusting expense while at the same time dampening the overall medical utilization trend.¹⁵

Exhibit 7: Eligible IMR Applications & Determinations, January 2014 - June 2015



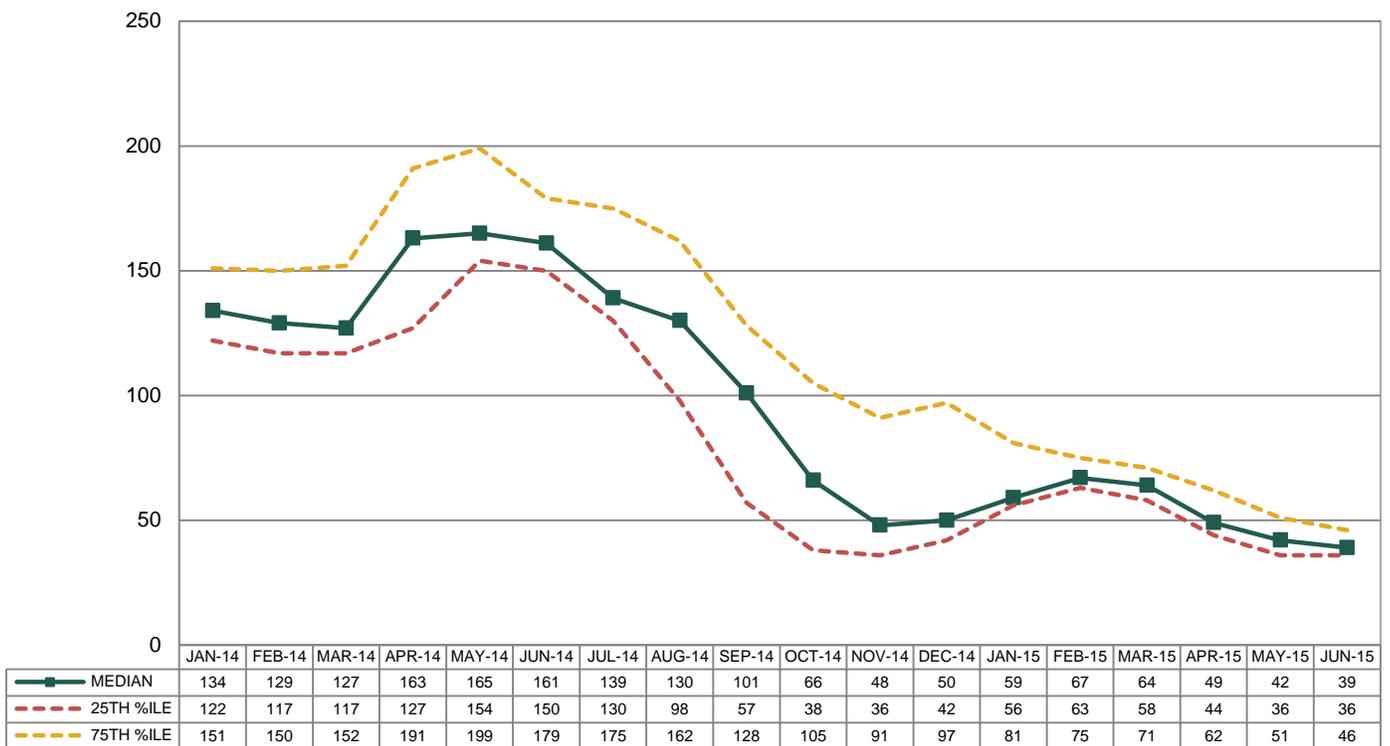
Altogether, 227,314 eligible IMR applications were submitted from January 2014 through June 2015, while the total number of IMR determination letters issued by Maximus during that period was 219,720. Even though the number of eligible IMR applications in the first 6 months of 2015 remained relatively high (81,510 through June – with monthly totals ranging between 11,607 and 14,890), Maximus appears to have kept up with the volume, as it issued 81,960 IMR determination letters during that period, with monthly totals ranging from a low of 7,653 in February to a high of 20,542 in May.

14. Original estimates of IMR referrals were thought to approximate the estimated annual number of 20,000 to 50,000 Qualified Medical Examiner reports prior to the 2012 reforms.

15. "Senate Bill No. 863 WCIRB Cost Monitoring Report — 2015 Retrospective Evaluation," WCIRB, November 2015.

Exhibit 8 shows the median time that elapsed between the IMR application date and the date of the decision letter, with results broken out by the month of the decision letter. In addition to showing the median time elapsed, the exhibit notes the 25th and 75th percentiles. After an application is received and deemed eligible, Maximus must request, compile and process the medical records and assign the case to an appropriate physician reviewer. The 30-day timeline for issuing the determination letter does not begin on the application date, but on the date that Maximus receives all of the requested records. The median IMR response time peaked in May 2014 – coinciding with the huge backlog of IMR applications – but since then the median response time between the IMR application and the determination has fallen by more than 3 months, declining to 39 days for decision letters issued in June 2015.

Exhibit 8: Days from IMR Application Date to Date of Decision Letter

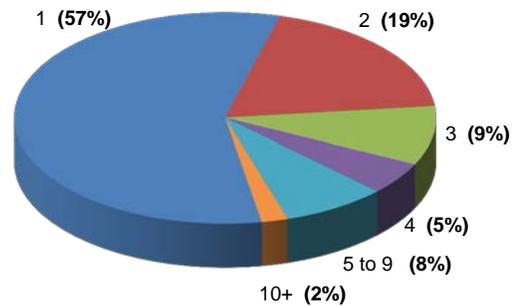


As Exhibits 9 and 10 show, it is not uncommon for an injured worker to have had multiple IMR reviews in the study time period. The 219,720 decision letters issued from January 2014 through June 2015 involved 103,964 injured workers,¹⁶ and on average, those workers received 2.1 letters during that 18-month timespan. Ten percent of those workers received five or more letters.

Exhibit 9: Number of IMR Letters to Injured Workers by Decision Year, 2014 – June 2015

Year of Decision	Number of Injured Workers
2014 Only	53,712
Both 2014 & 2015	21,600
2015 Only	28,652
Total	103,964

Exhibit 10: Number of IMR Letters per Injured Worker, 2014 – June 2015 IMR Decisions



Isolating the data from the first half of 2015 shows that 50,252 injured workers received at least one decision letter involving a 2015 determination, and that 5,225 (10.4 percent) of those workers received more than one letter relating to applications made on the same day. Applications from these employees resulted in 12,568 letters regarding IMR determinations performed by different reviewers, and often for the same type of service and/or condition. There could be multiple causes for such a separation of duplicates:

- Physicians could be submitting separate RFAs for each service;
- UR reviewers could be splitting out individual requests; or
- Injured workers or their representatives could be separating the requests.

Whatever the cause, there would be better informed decisions, greater efficiency and lower costs if such applications were consolidated. For example if two different opioids were requested separately, they might each have been approved, whereas if the morphine equivalent dose (MED) of the two together exceeded a safe level, only one might have been authorized if they were reviewed together. If consolidated there would also be great efficiency and administrative cost reductions, as that would have resulted in 7,343 fewer letters in the first of 2015 (9 percent of the total volume), which would translate to an estimated savings of \$5.2 million per year in IMR vendor fees.

16. This is measured by unique combinations of Employee Name, Claim Number and Claims Administrator.

IMR Results: January 2015 through June 2015

As mentioned previously, 50,252 employees received 81,960 determination letters from January through June 2015. As shown in Exhibit 11, each determination letter can contain decisions on multiple services. There were 142,280 service decisions¹⁷ in the first 6 months of 2015, compared to 260,899 decisions made in all of 2014.

Exhibit 11: Number of IMR Letters per Injured Worker, January – June 2015

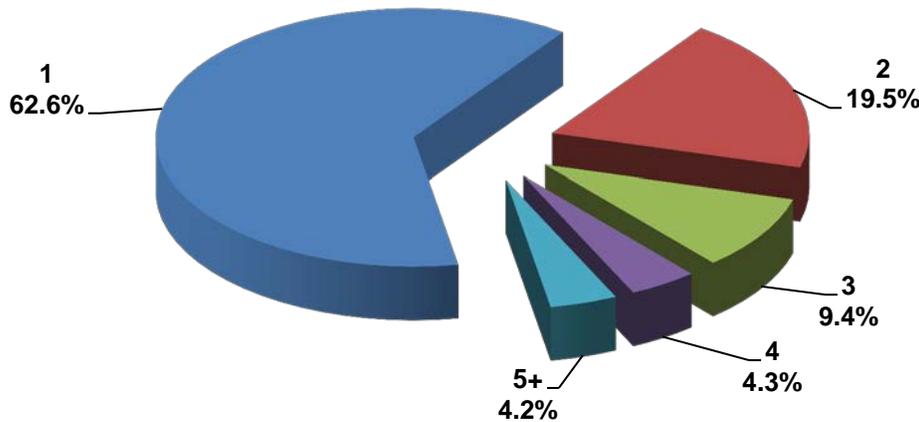


Exhibit 12 shows that 89.1 percent of physician UR decisions that were reviewed by an IMR physician in the first half of 2015 upheld the physician UR decision while 10.9 percent were overturned.¹⁸

Exhibit 12: IMR Decision Results January – June 2015

Result	Services	Percentage
Upheld UR	126,712	89.1%
Overturned UR	15,568	10.9%
Total	142,280	100.0%

17. The total services submitted for decision was 146,119 however 3,839 were identified as being associated with a primary service and the medical necessity determination was not separately determined.

18. Each letter contains a summary statement of results on the cover page. The proportions for January-June 2015 were 8.5% Overturn, 85% Uphold and 6.4% Partial Overturn (mix of Upheld and Overturned).

Exhibit 13 shows the distribution of IMR decisions from January through June of 2015 by treatment category. Pharmacy-related decisions were by far the most prevalent, accounting for 49.3 percent of all IMR determinations issued in the first half of 2015, up from 44.7 percent in 2014.¹⁹ More than 90 percent of the pharmacy-related IMRs upheld the UR decision.

IMR uphold rates were highest for requests involving physical therapy (92.7 percent); acupuncture (92.4 percent); chiropractic manipulation (91.9 percent); and durable medical equipment, prosthetics, orthotics and supplies (91.0 percent). Electric stimulation devices were the most frequently disputed type of durable medical equipment (DME), as disputes not only arose over the medical necessity of the devices themselves, but in many cases, over the necessity and reasonableness of renting versus purchasing, and over the duration of rentals. IMR most often overturned UR modifications/denials for evaluation and management, which are typically consultations (30.1 percent); psychology/psychiatry services (18.2 percent); diagnostic tests and measurements (14.9 percent); laboratory services (14.4 percent) and surgery (13.1 percent).

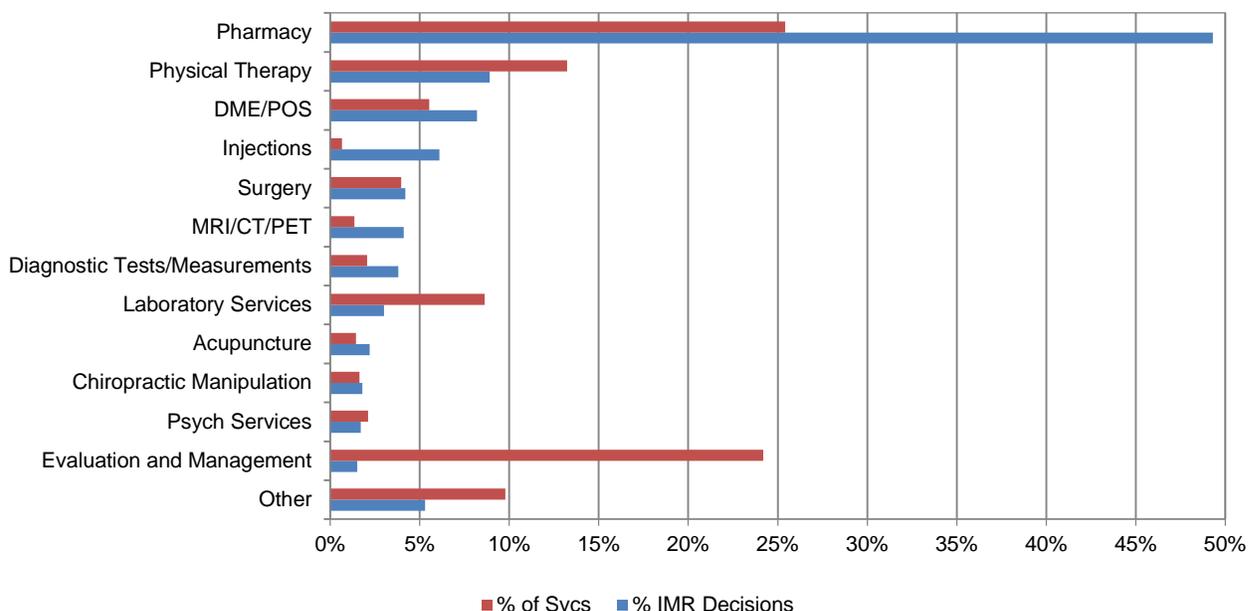
Exhibit 13: Distribution & Uphold Rates: January – June 2015 IMR Decisions by Type of Service

Type of Service Requested	% of Service Requests	% Upheld
Pharmacy	49.3%	90.2%
Physical Therapy	8.9%	92.7%
DME, Prosthetics, Orthotics and Supplies	8.2%	91.0%
Injections	6.1%	87.3%
Surgery	4.2%	86.9%
MRI/CT/PET	4.1%	87.0%
Diagnostic Tests/Measurements	3.8%	85.1%
Laboratory Services	3.0%	85.6%
Acupuncture	2.2%	92.4%
Chiropractic Manipulation	1.8%	91.9%
Psych Services	1.7%	81.8%
Evaluation and Management	1.5%	69.9%
Other	5.3%	86.0%
Grand Total	100.0%	89.1%

19. "Independent Medical Review Outcomes in California Workers' Compensation," CWCI Research Update, April 2015.

Exhibit 14 shows the mix of services in IMR compared to the distribution of the 5.6 million treatment services evaluated in the UR study. Although prescription drugs account for 25 percent of the adjusted treatment counts, disputes over pharmaceuticals represent almost half of the RFAs that undergo IMR. At the other end of the spectrum, evaluation and management services comprise a quarter of all treatment services, but account for a disproportionately low share of the IMR disputes – just 1.5 percent of the IMR decisions in the first half of 2015.

Exhibit 14: Proportions of IMR vs Overall Medical Treatment by Service Category



Pharmaceutical Detail and Uphold Rates

As noted above, pharmaceutical requests represent a disproportionate share of disputed medical services in workers' compensation. In 2014, 43 percent of physician UR involved prescription drug disputes,²⁰ and the data from the first half of 2015 show that 49 percent of IMRs involved prescription drugs. One reason the number of IMR determinations involving prescription drugs is so high is that in addition to determinations on the medical necessity of the class of medicine requested, independent medical reviewers may need to address disputes over drug strength, quantity, frequency, duration of prescription, or necessity for compounding. To identify the types of drugs that go through IMR, the authors examined the 84,828 prescription drug IMR decisions rendered in the first six months of 2015, and classified them into three categories: compounds, injectables,²¹ and traditional prescriptions.

20. Ibid.

21. A drug listed in the service description for an injectable was classified as a traditional Rx. If the request was for an injectable compound it was classified as a compound. All other injections were listed under "Injections," and they represented an additional 6.1 percent of IMR services.

Exhibit 15 shows the number and distribution of IMR applications in these three categories, and the percentage of UR denials or modifications in each category that were upheld following IMR.

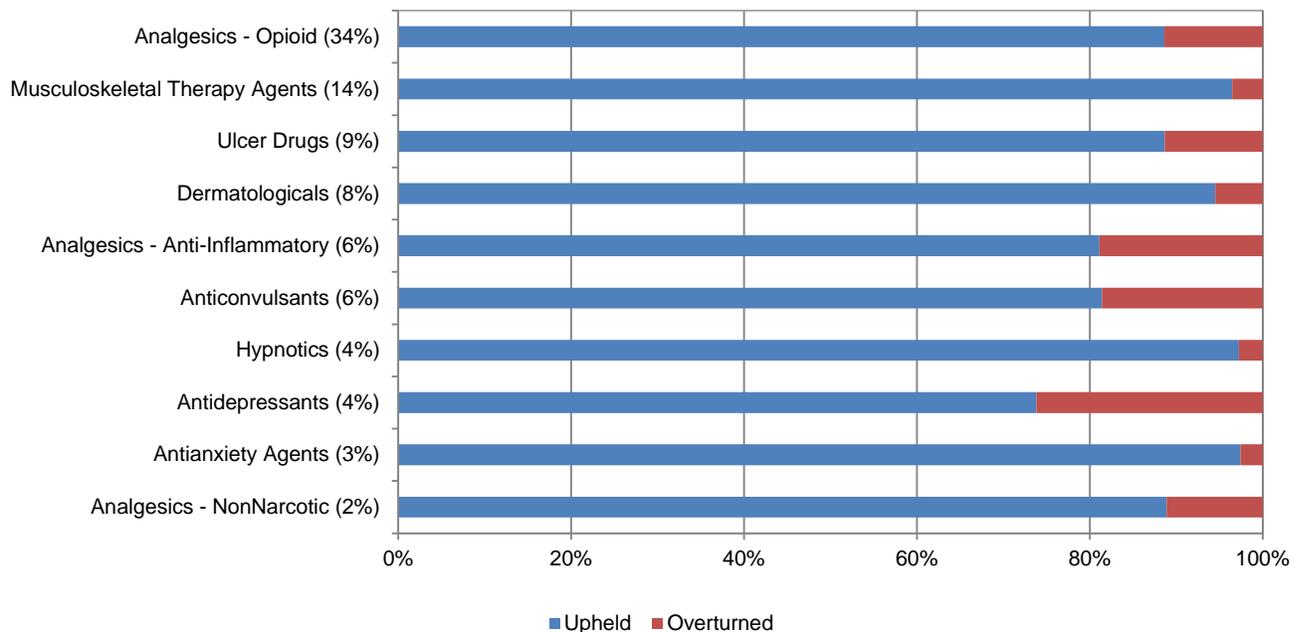
Exhibit 15: Rx Drug IMR Apps by Drug Category & Uphold Rates (January – June 2015)

Drug Category	# of IMR Applications	% Rx	% Upheld
Compounded	7,426	10.8%	97.5%
Injection	8,587	1.7%	88.9%
Traditional Rx	68,815	87.5%	89.3%
Total Rx	84,828	100%	90.2%

Compounded drugs accounted for 10.8 percent of prescription drug requests submitted for IMR in the first half of 2015, and the UR modifications or denials of these requests were upheld 97.5 percent of the time. Less than 2 percent of the pharmaceutical IMRs involved requests for injectable drugs, and in nearly 9 out of 10 cases (89 percent), the IMR physician upheld the UR modification or denial. More than 7 out of 8 disputed pharmaceutical requests submitted for IMR involved traditional prescriptions, though again in nearly 90 percent of the cases, after conducting an independent medical review, the IMR physician confirmed that the requested medication was not medically necessary and upheld the UR decision.

Exhibit 16 shows that in the first half of 2015, one third of IMR disputes involving traditional (non-compound) drugs were for opioids. After reviewing the medical records, clinical evidence and the treatment guidelines, in nearly 90 percent of the cases the IMR physician upheld the UR physician's determination that the use, strength or quantity of the opioid was not medically necessary. Requests for anti-anxiety agents and hypnotics had the highest uphold rates, with IMR physicians agreeing with the UR modification or denial of these drugs in all but 2 to 3 percent of those cases, while requests for anti-depressants, anti-inflammatory drugs and anticonvulsants (sometimes prescribed for off-label use for neuropathic pain) had the highest overturn rates, with the IMR physician finding them medically necessary between 19 percent and 26 percent of the time.

Exhibit 16: Distribution & Outcomes of Non-Compound Drug IMRs by Drug Type



CASE LEVEL ATTRIBUTES

IMR determination letters include the injury date, which the authors used to develop a distribution of the 2015 IMR decisions by injury year and to assess whether there was significant variation in the uphold rates for injuries that occurred in different years. Exhibit 17 shows the mix of RFAs by year of injury, using four periods: pre-2004 accident years, accident years 2004–2009, accident years 2010–2012, and accident years 2013–2014. The IMR decisions rendered in the first half of 2015 were fairly evenly split across these four accident year groupings, with each accounting for between 20.7 percent to 28.8 percent of letters and a similar distribution for the requested services that were reviewed. There was little variation in uphold rates across the four periods, with UR decisions upheld between 88.8 percent and 89.2 percent of the time for an overall uphold rate of 89 percent for RFAs from all injury years. This confirms the finding from the prior study that the age of the injury has no impact on the outcome of the IMR decision.

Exhibit 17: IMR Letters, Services and Outcomes by Injury Year Category

Injury Year Category	% Letters	% of Services	% Services Upheld
< 2004	20.7%	22.0%	88.8%
2004 – 2009	22.2%	22.6%	88.9%
2010 – 2012	28.3%	27.7%	89.2%
2013 – 2014	28.8%	27.7%	89.2%
Grand Total	100%	100%	89.0%

Geographic Distribution

To measure the prevalence of IMR in different parts of California, the authors examined regional data from the 81,960 IMR letters issued in the first half of 2015. Many contained multiple medical service decisions, so altogether there were decisions on 142,280 services in these letters. The geographic distribution used the ZIP code from the address of the injured worker or representative listed on the letter. Exhibit 18 shows the regional mix of the IMR decisions and the percentage of claims from each region as identified by the IRIS database. The regional breakdown shows slight variations among different areas of California with uphold rates ranging from a low of 86.0 percent in San Diego to a high of 91.0 percent in Los Angeles.

Exhibit 18: Distribution of 2015 IMR Decisions and Uphold Rates by Region

Region	% of Decisions	% of Claims	% Upheld
Los Angeles	34%	23%	91.0%
Bay Area	19%	17%	87.4%
Valleys	15%	19%	88.1%
Inland Empire/Orange	15%	17%	89.2%
Central Coast	6%	6%	88.2%
San Diego	5%	8%	86.0%
North Counties	1%	3%	88.7%
Sierras	1%	2%	86.4%
Other/Unknown	4%	5%	89.0%
Grand Total²²	100%	100%	89.1%

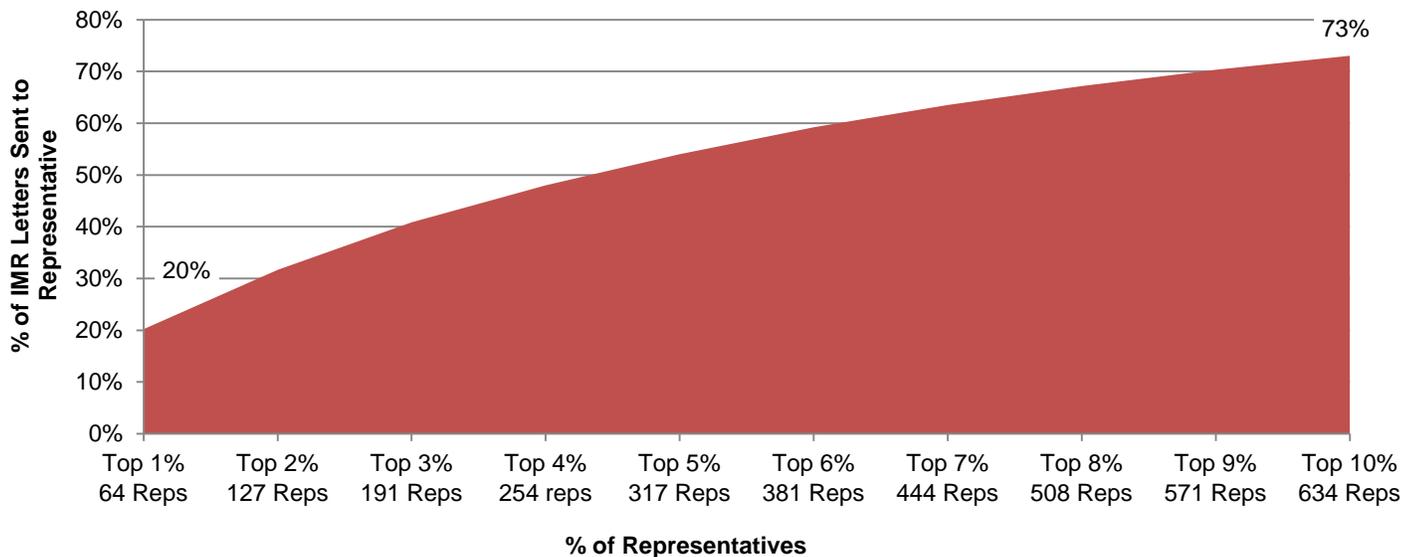
22. The regional analysis omitted 4,531 IMR determination letters that had formatting issues or that were addressed to out-of-state recipients.

Representatives

Most injured workers who chose to dispute a UR physician's determination regarding the necessity of a requested medical service were represented by counsel. The Institute's analysis of 2014 IMR outcomes published in April 2015 found that nearly two-thirds of all IMR decision letters were addressed to the injured workers' attorneys. Furthermore, that analysis found that a relatively small number of employee representatives – either the injured worker's attorney or physician – were named on a majority of the IMR decision letters, with the top 10 percent of the representatives named on 65 percent of the 2014 IMR determination letters.

Exhibit 19 shows that once again, most of the January through June 2015 determination letters that were addressed to someone other than the injured worker were concentrated among a small number of representatives. The top 1 percent of representatives (64 individuals) were named in 20 percent of the determination letters issued in the first half of 2015, and the top 10 percent of the representatives (634 individuals) were named in 73 percent of the letters. These results are consistent with the results from 2014.

Exhibit 19: Percent of IMR Letters Addressed to High-Volume Representatives
(January – June 2015 IMR Letters Addressed to Someone Other Than the Injured Worker)



Treating Providers

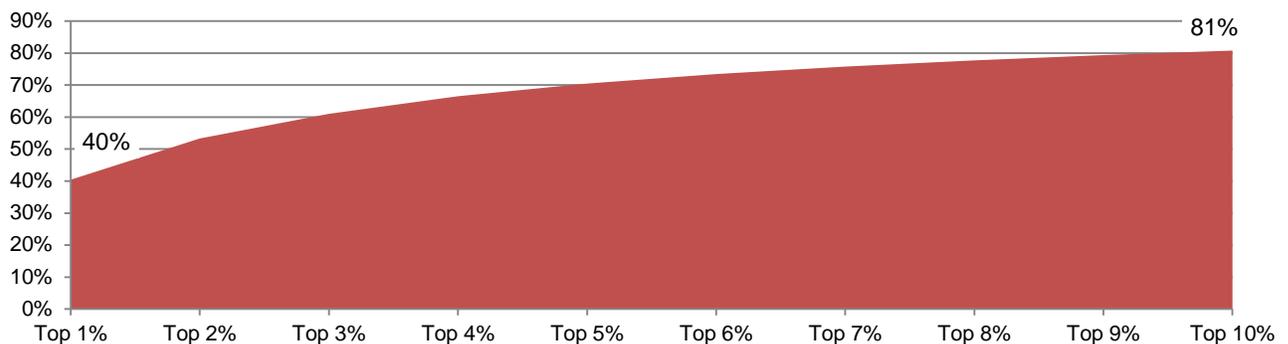
To identify the specialties of the physicians who requested the disputed medical services submitted for IMR in the first half of 2015 the authors grouped the physicians based on their National Provider Identifier (NPI). The NPI is a 10-digit number issued to each physician by the federal government for use in their billings and transactions with health plans. Although identifying and linking an NPI with a physician's name is imperfect, the results in Exhibit 20 indicate that orthopedic surgery is the top specialty.

Exhibit 20: Top 10 Provider Classes of Requesting Physicians, January – June 2015 IMRs

Provider Classification Based on NPI	% of Providers	% of Decisions
Orthopedic Surgery	20.7%	28.1%
Other Specialist	6.8%	13.9%
Family Medicine	6.6%	3.6%
Internal Medicine	6.6%	2.5%
Physical Medicine & Rehabilitation	6.4%	11.9%
Anesthesiology	6.2%	11.7%
Chiropractor	5.3%	1.6%
Psychiatry & Neurology	4.1%	3.2%
Psychologist	2.8%	1.0%
Counselor	2.3%	1.6%

High-Volume Providers: The authors identified 9,610 unique provider names in the IMR determination letters issued in the first half of 2015. As with the employer representatives identified in the decision letters, a small number of medical providers accounted for a disproportionate share of the medical service requests that went through IMR. Exhibit 21 shows that the 97 physicians who comprised the top 1 percent of medical providers named in the January through June 2015 IMR decision letters were linked to 40 percent of the letters responding to disputed medical service requests, while the 961 physicians who comprised the top 10 percent were named in 81 percent of the IMR determination letters.

Exhibit 21: Percent of 2014 IMR Decisions Associated with High-Volume Providers



% of Providers	1%	2%	3%	4%	5%	6%	7%	8%	9%	10%
% of Letters	40%	53%	61%	67%	71%	74%	76%	78%	79%	81%
# of Providers	97	193	289	385	481	577	673	769	865	961

The disproportionate share of disputed treatment requests coming from a subset of medical providers is more evident in Exhibit 22, which shows the number of IMR decisions and requested services linked to the 10 physicians who were named in the most IMR determination letters in the first half of 2015.

Altogether, these 10 providers were identified as having requested authorization for the disputed service in 8,515 IMR decision letters that included determinations on 16,668 medical service requests that went through IMR between January and June of 2015 – 11.7 percent of the statewide total. In 89.7 percent of the decisions, the UR physician’s finding that the requested service was not medically necessary was upheld by the IMR physician.

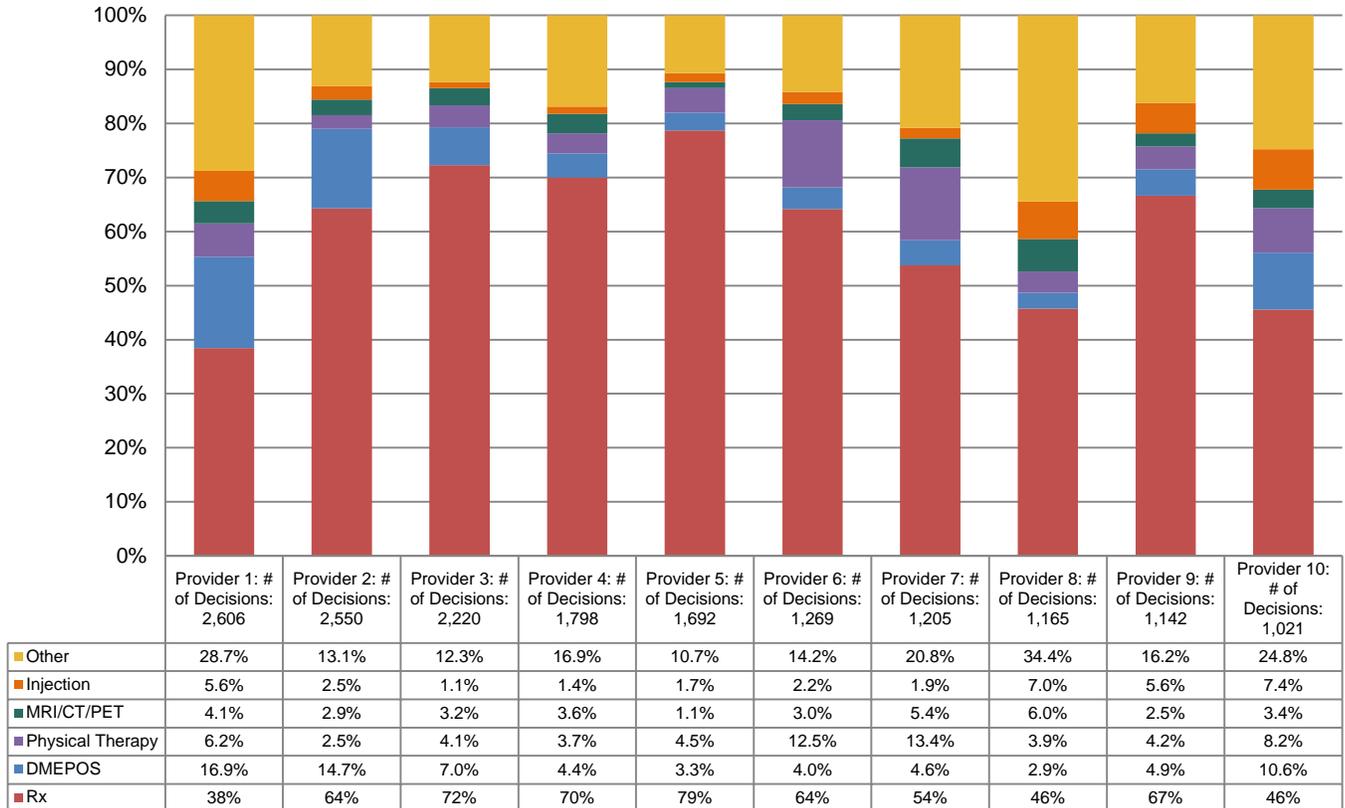
Exhibit 22: IMR Letters, Requested Services, Claims - Top 10 Providers

January through June 2015

Requesting Provider	# of IMR Decision Letters	# of Medical Service Decisions	% of Medical Service Decisions	% of UR Decisions Upheld by IMR	Requesting Physician Specialty	Requesting Provider Region
Provider 1	1,423	2,606	1.8%	88.7%	Orthopedist	So Calif
Provider 2	1,021	2,550	1.8%	92.1%	Orthopedist	No Calif
Provider 3	892	2,220	1.6%	93.5%	Orthopedist	So Calif
Provider 4	581	1,798	1.3%	98.7%	Orthopedist	So Calif
Provider 5	1,037	1,692	1.2%	83.2%	Phys Med & Rehab	No Calif
Provider 6	862	1,269	0.9%	87.2%	Orthopedist	So Calif
Provider 7	808	1,205	0.8%	87.3%	Orthopedist	So Calif
Provider 8	636	1,165	0.8%	88.5%	Orthopedist	So Calif
Provider 9	692	1,142	0.8%	82.5%	Phys Med & Rehab	No Calif
Provider 10	563	1,021	0.7%	88.1%	Spinal Surgeon	So Calif
TOP 10	8,515	16,668	11.7%	89.7%		

Exhibit 23 shows the mix of treatment requests for the top 10 providers associated with the January through June 2015 IMR determinations. Most of the disputed requests were related to pharmaceuticals and durable medical equipment (DME). Among the 10 providers who were identified in the greatest number of IMR determination letters, prescription drug requests accounted for between 38 percent and 79 percent of their IMR disputes; requests for durable medical equipment/prosthetics, orthotics and supplies accounted for between 2.9 percent and 16.9 percent; and requests for physical therapy accounted for between 2.5 percent and 13.4 percent of their IMR disputes.

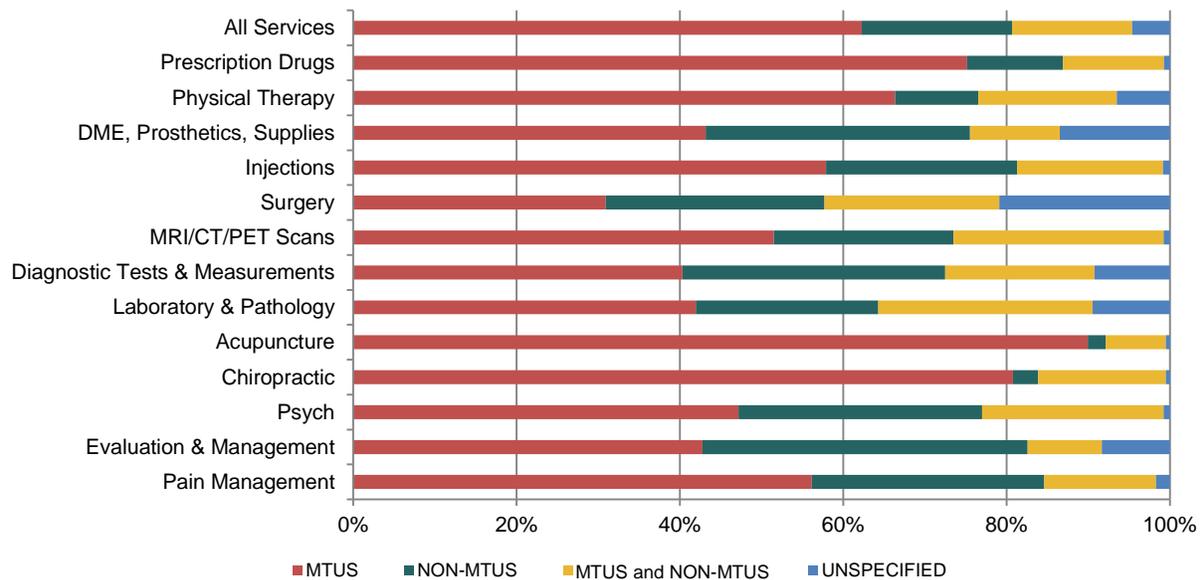
Exhibit 23: Number and Service Mix of IMR Decisions for Top 10 Providers



Guidelines Used in Decisions

Each decision on the IMR determination letter contains a section where the independent medical reviewer identifies the guidelines used to make the decision and labels them as “MTUS” or “non-MTUS.” Among those that specified the guideline used, 81 percent listed the MTUS guidelines or both the MTUS and non-MTUS guidelines (e.g., Washington State Guidelines, Blue Cross / Blue Shield Guidelines). The rest reported exclusive use of non-MTUS guidelines. Exhibit 24 shows the distribution of guidelines listed by the reviewer as the basis of their decisions, broken out by the medical service category of the requested service.

Exhibit 24: Guidelines Listed as Basis of Jan-June 2015 IMR Decisions



DISCUSSION

The changes to the California workers' compensation medical necessity dispute resolution process mandated by the 2012 legislative reforms significantly altered the way in which the system regulates and evaluates quality-of-care decisions for injured workers. This study concludes that ultimately, about 96 percent of all California workers' compensation medical services that meet claim compensability and in-network requirements are authorized. In addition, when medical services are submitted for independent medical review, the UR physician's modification or denial of the request is found to be in-line with evidence-based medicine in nearly nine out of ten cases.

Public debate over approved and denied care often centers on anecdotes, which focus a disproportionate level of attention on a few, isolated events. By piecing together all the links in the dispute resolution chain and measuring how much each component of the process contributes to the system-wide outcomes, this study presents a broad context, offering public policymakers and stakeholders a comprehensive view of medical review and medical dispute resolution in California workers' compensation.

From a system-wide outcomes standpoint, the medical review/IMR process should be evaluated as a multi-step process. To review, the study found:

- 84.7 percent of medical services were paid by or on behalf of claims administrators without being requested in RFAs and undergoing UR. These included services approved through prior authorization.
- Of the 15.3 percent of the medical services that were requested in RFAs and underwent UR, nearly 6 out of 10 were approved by the claims adjuster, nurse or other non-physician reviewer, leaving just 6.1 percent that were forwarded to a UR physician.
- Of the 6.1 percent of all medical services that went through physician UR, one-third were approved, leaving 4.3 percent eligible for IMR if the injured worker chose to appeal the modification or denial of the service.
- Of those denials and modifications that were appealed in 2015, 10.9 percent were overturned by the IMR physician. That translates to an estimated approval rate for all California workers' compensation medical services of between 95.7 percent and 96.1 percent.

From a process standpoint, there is significant variability in how payors conduct UR. The California workers' compensation market is competitive, and each insurer operates under its own, unique set of business practices and rules. Among the study's data contributors, the proportion of medical services requested in RFAs and undergoing UR ranged from 9 percent to 19 percent, while the proportion of RFA services forwarded for physician utilization review ranged from 1.5 percent to 76.2 percent. These ranges reflect the varied mixes of policies, employee injuries, and levels of network provider use among other things. In terms of the volume of IMR requests, it is clear that a small number of high-volume providers generate the majority of disputed treatment requests that undergo IMR. The top 10 percent of all physicians who were involved in the most IMR disputes (961 physicians) were named in 81 percent of all IMR letters; while the top 1 percent (97 physicians) were named in 40 percent of the IMR decision letters.

An analysis of the underlying IMR requests also reveals areas for potential administrative improvement. For example, in many cases IMR applications on behalf of the same injured worker for the same date of service were submitted in piecemeal fashion, with individual medical services and pharmaceutical requests submitted separately rather than as a whole. These types of multiple reviews for the same proposed set of treatments may create delays and excessive UR and IMR related fees.

In addition, the data suggest that the state could optimize select treatment areas within the current MTUS to resolve high-volume areas of dispute. The authors found that 49 percent of all IMR involves disputes over pharmaceutical requests – with nearly half of those being requests for opioids and compounded drugs (another national controversy). Recent legislation²³ requires the DWC to create a drug formulary, which holds the potential for significant improvements in the system. Institute research published in 2014 estimated that the creation of a formulary could not only restrict unproven therapies and lower system-wide cost, but also reduce the administrative burden of UR and IMR in the review of pharmaceutical requests.²⁴

23. AB 1124 (Perea) enacted in 2015, requires the DWC to adopt a workers' compensation prescription drug formulary by July 1, 2017.

24. Swedlow, A. Hayes, S., David, R. "Are Formularies a Viable Solution for Controlling Prescription Drug Utilization and Cost in California Workers' Compensation?" CWCI Report to the Industry, October 2014.

This study's core finding that 96 percent of all workers' compensation medical services are approved and delivered to injured workers also means that only 4 percent of treatment is modified or denied. The impact of that 4 percent on injured workers is certainly worthy of additional discussion. After all, injured workers and their physicians care more about their medical treatment request than the public policy finding of 96 percent approval outcomes.

Modified or denied treatment requests underwent multiple levels of review that often included review by a claims adjuster or nurse in addition to UR and IMR physicians. All the reviewers supported the same judgment that the physician's request did not align with the Medical Treatment Utilization Schedule's standard of care, and if provided, could have delayed those workers' recovery or led to further impairment or disability.

The high level of system-wide agreement at different stages of medical review realizes the legislative intent of reforms to protect the injured worker from harmful or unnecessary treatment and to provide the injured worker with the most effective medical care through a process that is more objective, transparent and consistent. Updating guidelines with new medical evidence and adopting prescription drug formularies are examples of how the standard of care can be further refined and modified to avert or resolve disputes over what is, and what is not appropriate medical care.

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Acknowledgments

The authors would like to express their thanks to members of the CWCI Claims and Medical Care Committees for their thoughtful suggestions in shaping data collection and research methods. Additional thanks to CWCI Communications Director Bob Young for his substantial contribution in the drafting and production of this report.

California Workers' Compensation Institute

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CWCI Research Updates are published by the California Workers' Compensation Institute.

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