



Workers' Comp Survey

Results and Summary (December 2014)

California's workers' compensation system is arguably undergoing its biggest period of transformation since its enactment in 1914. SB 863, signed into law on September 19, 2012, initiated fundamental changes in certain components of the workers' compensation system aimed at addressing areas deemed dysfunctional or deficient.

Significant changes to the utilization review process, implementation of an independent medical review and independent bill review process along with migration to a resource-based relative value scale payment system are some of the substantial changes to the California workers' compensation system since the passage of SB 863.

Feedback from California Medical Association (CMA) physician members thus far indicates significant challenges with the workers' compensation reforms implemented. In order to assess areas of reform that are working and those that need improvement, CMA conducted a survey to solicit physician feedback on their experiences with the SB 863 reforms.

Survey Summary

- * The survey gathered data from 231 practices representing physicians from over 35 different specialties within California over a period of 14 days.
- * Questions were divided into four topic categories: Utilization Review, Independent Medical Review, Independent Bill Review and RBRVS Fee Schedule.

Utilization Review (UR)

- * 67% of physicians report difficulties obtaining authorization for patient care through the workers' compensation UR process since the implementation of SB 863.
- * More than 50% of physicians reporting difficulties cite inappropriate denials of medically necessary tests, procedures or services as the greatest problem with the UR process.

Independent Medical Review (IMR)

- * Nearly half (49%) of the physician respondents report utilizing the IMR Process since its inception.
- * Two-thirds of physicians (67%) believe the IMR process has been unsuccessful in ensuring approval of medically necessary patient care.
- * Practices cite the slow response to IMR requests (34%) and the inappropriate denials of medically necessary tests, procedures or services (46%) as the greatest challenges of the IMR process.
- * One-third of respondents identified opioids/pain management as the type of service most frequently denied by workers' compensation payors.

Independent Bill Review (IBR)

- * Nearly 60% of respondents indicate that the IBR process has been unsuccessful in resolving billing disputes.
- * 40% of practices report the submission cost per issue to utilize IBR is cost prohibitive.
- * 30% state the response to IBR requests is slow and frequently beyond the required 60-day response timeframe.

RBRVS Fee Schedule

- * 90% of practices cite the downcoding of claims resulting in underpayment as the most significant problem with the new fee schedule and associated payment processing rules.
- * 16% of physicians indicate that they were unaware of a change to a new fee schedule, while 11% state they have experienced difficulties identifying rates as part of the new fee schedule.

CMA Survey – December 4, 2014, Results

Survey Results – 231 practices representing physicians in over 35 different specialties responded to the survey.

1. Since the implementation of SB 863, has your practice experienced difficulties obtaining authorization for patient care through the workers' compensation Utilization Review (UR) process?

Yes 67%
No 33%

2. What do you perceive to be the greatest challenge of the UR process?

Slow response to authorization requests (greater than 5 days for non-urgent requests or 72 hours for urgent requests)..... 23%
Inappropriate denials of medically necessary tests, procedures or services 54%
Lack of knowledgeable, qualified utilization review staff..... 7%
Frequent denials on first attempt, but upon appeal the request is approved though no changes were made to the information submitted with the initial request..... 13%
No problems with the UR process 3%

Comments (sample)

- The entire process has added layers of complexity that delay patient care.
- The process was always difficult but has become hideous in recent months.
- It has become a series of denials for even the most elementary medications or tests.

3. Since the implementation of SB 863, has your practice utilized the IMR Process set up by the Division of Workers' Compensation?

Yes 49%
No 26%
Had no idea it existed..... 25%

4. How successful do you believe the IMR process has been in ensuring medically necessary patient care is approved?

Very successful 7%
Somewhat successful 22%
Not very successful..... 21%
Not at all successful..... 47%
No opinion..... 3%

5. What do you perceive to be the greatest challenge of the IMR process?

Slow response to IMR requests (30 days for standard review, 3 days for expedited review [non-rendered] or 30 days for expedited review [rendered]) 34%
Inappropriate denials of medically necessary tests, procedures or services 46%
Lack of knowledgeable, qualified utilization review staff..... 9%
No problems with the IMR process 11%

Comments (sample)

- It is very, very slow. Seems closer to 6 months than 1 (month) in our experience.
- Almost 90% of the UR decisions that go to IMR are upheld in my practice.
- IMR review doctors do not get all medical records necessary to make a decision on patient care and they are making these decisions without having all the facts.

6. Of the services indicated below, which type of service is most frequently denied by workers' compensation payors in your practice?

Surgery 17%
Opioids/Pain Management 32%
Evaluation & Management services..... 11%
Radiology & Nuclear Medicine 16%
Other (please specify) 24%

Comments (sample)

- Prescription drugs of many kinds, not just opioids
- Non- opiate medications, epidural steroid injections, radio frequency rhizotomies, and standard pain management treatment
- Long established maintenance medications, not just opioids, but NSAIDS, muscle relaxants, tricyclics, etc.
- Pain medications as well as denials of PT, &/or acupuncture
- Physical therapy and medications

7. Since the implementation of SB 863, has your practice utilized the IBR process set up by the Division of Workers' Compensation?

Yes 30%
No 38%
Had no idea it existed..... 32%

8. In your opinion, how successful do you believe the IBR process has been in addressing issues involving payment discrepancies?

Very successful 10%
Somewhat successful 21%
Not very successful..... 13%
Not at all successful..... 46%
No opinion..... 10%

9. What do you perceive to be the greatest challenge of the IBR process?

Slow response to IBR requests where determination is made greater than 60 days from the assignment of a dispute to an independent bill reviewer 33%
Submission cost per issue to utilize IBR is cost prohibitive (\$250 per case)..... 39%
Lack of knowledgeable, qualified bill review staff 16%
No problems with the IBR process..... 12%

Comments (sample)

- My IBR requests have taken 8-10 months for a decision and the \$250 fee is cost prohibitive.
- My office has submitted two IBR requests with full documentation and the required fee. Both have disappeared into oblivion with no replies whatsoever after several months and no return of fees.
- The IBR places an unnecessary burden on the treating physician. We know that there is wholesale downcoding for E/M procedures, that might amount to less than \$50, at most, in dispute. Why would you pay \$250 and carry the paper charges to dispute \$50. Disputed amounts are often less than the cost of IBR. Time value of money and pursuing payment erode the value of the receivable.

10. Since the implementation of SB 863, have you identified any payors who are not compliant with the new RBRVS fee schedule and payment rules?

Yes 33%
No 24%
Was unaware of the RBRVS and payment rules ... 16%
Not sure 27%

11. What types of problems have you experienced with the new fee schedule or payment rules?

Unclear on how to access fee schedule amounts..... 7%
Unclear on payment rules..... 12%
Downcoding of claims resulting in underpayment 55%
No problems – I am familiar with how to access the new fee schedule and payment rules..... 2%
Other (please specify) 24%

Comments (sample)

- Lack of payment for non face to face time, telephone calls, supplemental reports. It is a nightmare...

- 9 out of 10 claims for treatment submitted are downcoded as a matter of routine course. These are quite clearly intentional because the payors know that they can get away with it.
- Some carriers take a very long time to make payment on claims. Too often adjusters and bill review are very hard to get in contact with and very seldom do they make it easy for claims payment or status.
- It is too complicated to figure out what the fee schedule is and what should be paid. Also, the payers do not understand the new schedule as well.
- Some companies automatically downcode every code and hope you don't fight it.

Additional Comments (sample):

- The failure to pay for splints and crutches utilizing the MUE rule is crazy. I am supposed to send a fellow with a broken leg out of here with crutches, telling him to contact the company's DME provider to get the crutches?
- Many patients have been strained as a result of denials that clearly indicate that UR are not carefully reviewing the medical documentation supporting management/treatment
- I no longer take Workers Comp cases due to the impossibility of getting paid in a timely or appropriate manner without huge amounts of extra work.
- New requirements and penalties for noncompliance imposed on WC carriers do not result in more timely treatment approvals and payments for injured/disabled workers and their medical providers.
- Expenditures appear to have shifted from patient care to a cumbersome administrative system, involving 2-4 separate steps in different locations across state lines, for authorization.
- I have noted a tremendous increase in claims administrators denying my Agreed Medical Examination bills based on a dispute over injury. I would estimate 25% of my AME bills are denied based upon what WCAB 10451.1(g)(1)(C) defines as "bad faith actions or tactics."
- Most denials are not timely and make little to no sense. The reviewing physician either does not read the records or does not get them.
- The biggest impact to our practice has been the bundling of CPT code 99358 into the E&M service. Workers' Compensation is not like traditional medicine. You do not need to determine causation and apportionment issues nor rating impairments. We as physicians spend many hours reviewing medicals records and are not being compensated adequately for this time. In traditional medicine, if I have a patient presenting with low back pain with radiculopathy, I will treat the patient without having to determine causal relationship to the current employment or prior employment or dual employment. I don't have to address apportionment and I don't have to rate any permanent disability. I cannot bill the additional time required to address these issues because I do this as non face to face.
- We no longer take work comp, and only have a few long term patients we still assist. We stopped due to the inadequacies of the work comp system. We were downcoded, not paid, denied services, and wasted a lot of clinician time trying to assist with very little compensation

12. Size of practice(physicians in practice):

1-5.....	68%
6-10.....	15%
11-25	8%
26-50	3%
51-100	1%
101+.....	5%

Specialty	Count
Addiction Medicine	1
Allergy	1
Chiropractic	4
Dermatology	2
Emergency Medicine	2
Endocrinology	1
ENT	1
Family Medicine	5
Family Practice	8
Gastroenterology	1
General Practice	2
General Surgery	2
Hand Surgery/Plastic Surgery	1
Internal Medicine	7
Neurology	3
Neurosurgery	5
OB/GYN	3
Occupational Medicine	20
Oncology & Hematology	2
Ophthalmology	1
Orthopaedic Surgery	13
Orthopaedics	12
Pain Management	8
Pediatrics	3
Physical Medicine & Rehabilitation	15
Plastic Surgery	5
Podiatric Medicine and Surgery	1
Psychiatry	4
Psychology	1
Pulmonary Diseases	1
Radiology	2
Toxicology	1
Unidentified	91
Urgent care	1
Urology	1
Grand Total	231