Workers' Compensation Medical Care in California: **System Overview** (2006 UPDATE)

FACT SHEET

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Workers' Compensation Insurance Coverage

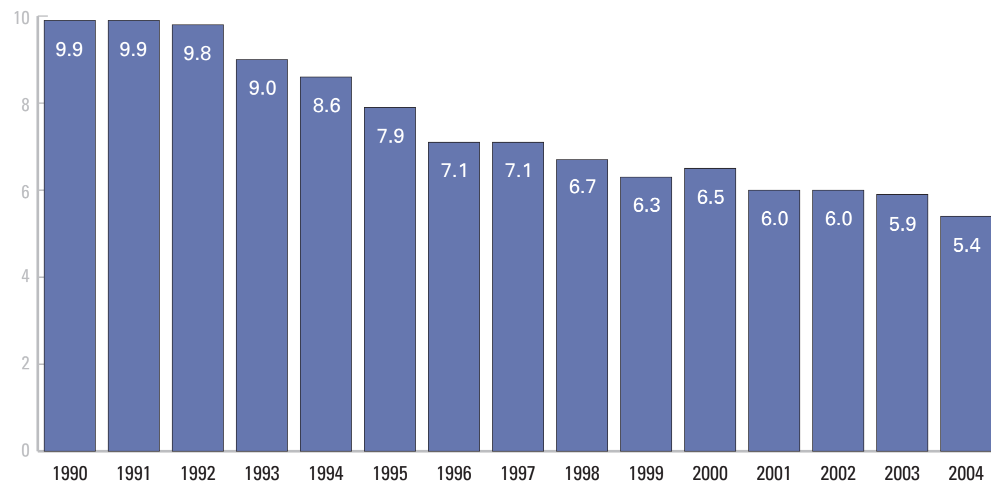
In California, workers' compensation (WC) insurance provides medical care, wage replacement ("indemnity"), and other benefits to workers who suffer job-related injuries and illnesses. Employers pay the entire cost of WC insurance, without deductibles, copayments, or premium contributions by employees. Workers' compensation medical care covers all diagnostic and therapeutic services reasonably required as a result of a work-related injury or illness, which can include specialist care, hospital services, surgery, physical therapy, laboratory tests, x-rays, and pharmaceuticals. WC insurance is intended to ensure that workers with job-related disorders can receive prompt and appropriate medical care without having to prove negligence on the part of the employer.

The delivery of WC medical care to injured workers is governed by the California Labor Code (Division 4) and by rules and regulations adopted by the Division of Workers' Compensation (DWC) of the California Department of Industrial Relations (DIR).

Recent System Trends

The California workers' compensation system is the largest of any state in the nation, covering approximately 14.7 million workers as of 2004, representing 11.7 percent of all covered American workers.[1] Employer WC premiums in California totaled $21 billion in

Figure 1. Incidence Rate of Reported Occupational Injuries and Illnesses in California, per 100 workers, 1990–2004



Source: California Division of Labor Statistics and Research.

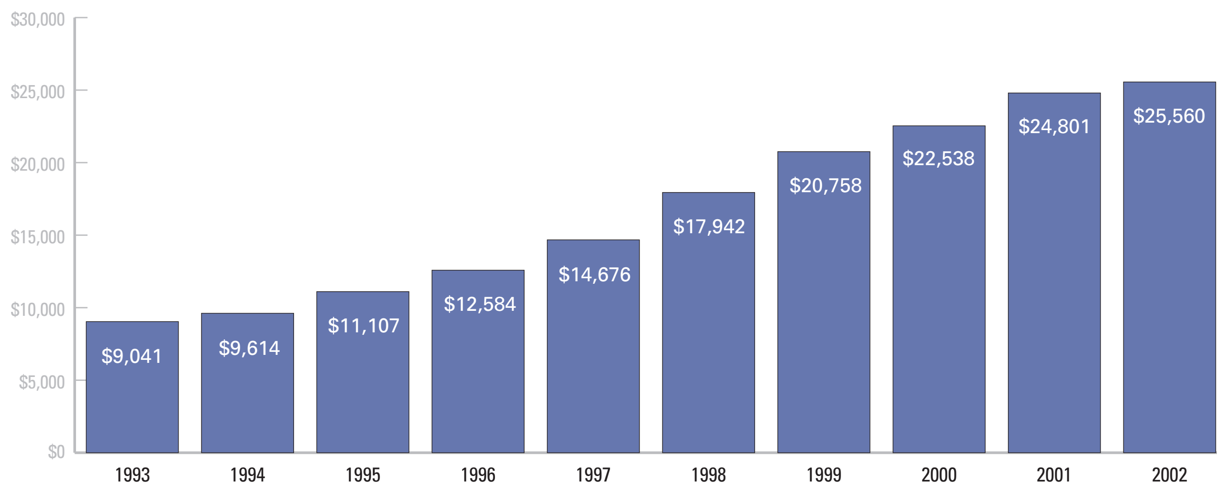
2005[2] and benefit payments made that year were estimated to be about $9.6 billion.[1] Over 600,000 injured workers file WC claims in California annually. The incidence rate of occupational injuries and illnesses in California has declined steadily since 1990 (Figure 1). Potential reasons for this decline include safer workplaces, shifts from high-risk (e.g., manufacturing) to lower-risk (service) industries, aging of the workforce (younger workers generally have higher injury rates), and other factors.

At the same time that workplace injury rates were declining in California, costs in the state's WC system rose dramatically. Employers' WC premiums in California skyrocketed from $5.8 million in 1995 to $20.2 billion in 2003 — a 348 percent rise.[2] Medical costs were responsible for much of this increase, with the ultimate medical cost per indemnity claim rising from $9,041 in 1993 to $25,560 in 2002 (Figure 2).[3] The medical cost increases were due to a variety of factors, including high utilization rates for some medical services, such as chiropractic and physical therapy, escalating costs for pharmaceuticals, and other factors.

Legislative Reforms

In response to the rapidly growing WC system costs during this period, the California legislature passed reforms between 2002 and 2004 that have significantly changed the way that WC medical care is provided in the state. Some major implications of these new laws for WC medical care are summarized in Table 1. California employers and their insurers have traditionally been allowed to determine which medical providers the injured worker must use during the first 30 days of care following a workplace injury. The new legislation expanded employer control by allowing employers to restrict care within designated Medical Provider Networks (MPNs) throughout the course of treatment. In addition, to be eligible for payment under WC, the treatment must be in accordance to a "medical utilization schedule" established by the state. At least initially, the state DWC adopted the American College of Occupational and Environmental Medicine's occupational practice guidelines (ACOEM Guidelines) as the basis for the utilization schedule. Treatments not addressed in the ACOEM Guidelines can also be paid

Figure 2. Average Ultimate Medical Payments per Indemnity Claim, 1993–2002



Source: Workers' Compensation Insurance Rating Bureau.

Table 1. Major Changes to WC Medical Care from Reform Legislation in California, 2002–2004

AB 749 and AB 486 signed into law 9/15/2002	AB 227 and SB 228 signed into law 9/30/2003	SB 899 signed into law 4/19/2004
• Eliminated the treating physician's presumption of correctness, except when an employee had predesignated a personal physician. • Streamlined requirements for employer use of certified health care organizations (HCOs). Expanded employer choice of physician within HCOs to 180 days. • Mandated adoption of pharmaceutical fee schedule and required pharmacies to offer generic drug equivalents when available. • Gave DWC authority to adopt an outpatient surgical fee schedule. • Limited disclosure of WC medical information to third parties. • Provided for electronic medical billing and a standardized billing form. • Required the DWC to develop educational materials for physicians.	• Limited chiropractic and physical therapy to no more than 24 visits. • Abolished the Industrial Medical Council (IMC). • Directed employers to develop a utilization review process and DWC to establish a medical treatment utilization schedule, which would be considered presumptively correct for legal purposes. Adopted the ACOEM Guidelines until the DWC development of the final utilization schedule. • Mandated establishment of a new official medical fee schedule (OMFS). Imposed an immediate reduction of 5 percent in fee rates for physician services. • Allowed employers to obtain second opinions for spinal surgery. • Prohibited self-referrals by physicians to outpatient surgical centers. • Expanded the requirement for generic drug alternatives for all dispensers . • Required payment of medical bills to be made within 45 working days.	• Authorized the formation and use of Medical Provider Networks (MPNs). • Allowed employees in MPNs to change physicians, obtain second and third medical opinions, and request an Independent Medical Review if there was still a disagreement after the third opinion. • Strengthened and clarified requirements for WC treatment to be evidence-based and to conform with the DWC's utilization schedule or (until the schedule is developed) the ACOEM Guidelines. • Required employers to authorize payment of up to $10,000 for initial care prior to formal claim acceptance. • Extended the 24 visit cap to visits for occupational therapy. • Clarified the medical-legal dispute resolution process involving examinations by AMEs and QMEs. • Specified that physicians determine the level of permanent disability based on AMA Guidelines. • Specified that indemnity awards will be based on a medical determination of the proportion of disability that is attributable to a specific work injury. • Allowed for the establishment of 24-hour care plans within unionized industries.

for under WC if they conform to other nationally recognized evidence-based practice guidelines.

The new legislation also provided for reductions in reimbursement rates for particular services, allowed employees to obtain a second medical opinion before authorization of spinal surgery, and adopted new fee schedules for outpatient surgery and pharmaceuticals. In addition, to control excessive utilization of physical medicine services, the number of allowable physical therapy, occupational therapy, and chiropractic visits was capped at a maximum of 24 visits each over the life of a particular WC claim. The reforms also imposed new requirements for resolution of medical disputes and specified that the medical determination of permanent disability must be based on guidelines for impairment rating established by the American Medical Association. The rise in WC medical has slowed significantly, and in many cases begun to decline, since the enactment of the new legislation.

Current Issues in WC Medical Care in California

The ability of California's WC system to move ahead successfully depends on several key issues that are now facing decision-makers in the state:

Medical Treatment Guidelines. An analysis of California's approach to medical practice guidelines in WC was conducted by the RAND Corporation in 2005.[4] The study concluded that although the ACOEM Guidelines seemed to be the best available, they are not completely comprehensive nor valid as a basis for the state's utilization schedule. RAND recommended that additional efforts are necessary to supplement or amend the existing guidelines and that a process should be undertaken in the state towards that end. That recommendation is currently under consideration.

System for Monitoring the Quality of WC Care. Concerns have been expressed that recent efforts to constrain costs in the California WC system and limit employee choice of provider could potentially jeopardize access, quality, and effectiveness of care received by injured workers. Although recent legislation and regulatory actions have established requirements for Medical Provider Networks and Certified Health Care Organizations, there is, at present, no comprehensive data collection or reporting system in place by which the state can monitor the quality of care and thereby assure that cost containment measures do not have a detrimental effect. RAND and other organizations have recommended that a quality-of-care monitoring system be developed.[5] A new statewide WC database (the WC Information System) that is now beginning to collect information on WC claims and medical bills may be useful in this regard.

Medical Fee Schedules. Evidence suggests that the existing Official Medical Fee Schedule (OMFS) used in California's WC system is not entirely adequate insofar as it does not adequately reflect true costs of delivery care, does not reflect geographical differences within the state, and may be outdated. Proposals are now being considered to revise the OMFS to be based on a resource-based relative value fee schedule basis, as is done in Medicare and other state WC systems.[5]

Additional information about California's WC system can be obtained through the sources indicated in Table 2.

Table 2. Resources on Workers' Compensation Medical Care

California Commission on Health and Safety and Workers' Compensation	www.dir.ca.gov/chswc
California Department of Health Services, Occupational Health Branch	www.dhs.ca.gov/ohb
California Department of Industrial Relations	www.dir.ca.gov/
California Division of Labor Statistics and Research	www.dir.ca.gov/dlsr
California Division of Workers' Compensation	www.dir.ca.gov/dwc
California Workers' Compensation Institute	www.cwci.org
Labor Occupational Health Program	www.lohp.org
National Academy of Social Insurance	www.nasi.org
Workers' Compensation Health Initiative	www.umassmed.edu/workerscomp
Workers' Compensation Insurance Rating Bureau of California	www.wcirbonline.org
Workers' Compensation Research Institute	www.wcrinet.org

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ENDNOTES

1. Reno, V.P., and I. Sengupta. *California Workers' Compensation Benefits and Coverage, 2004.* Workers' Compensation Brief No. 3. National Academy of Social Insurance, July 2006.
2. California Commission on Health and Safety and Workers' Compensation (CHSWC). *2006 Annual Report.* San Francisco: CHSWC, Draft, September, 2006.
3. Workers' Compensation Insurance Rating Bureau (WCIRB). *Summary of March 31, 2006 Insurer Experience.* July 5, 2006.
4. Nuckols, T K.; Wynn, B O.; Lim, Y-W; Shaw, R.N.; et al. *Evaluating Medical Treatment Guideline Sets for Injured Workers in California.* Santa Monica, CA: RAND Corporation, 2005.
5. California Commission on Health and Safety and Workers' Compensation (CHSWC). *2005 Annual Report.* San Francisco: CHSWC, December 2005.

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Additional fact sheets on workers' compensation medical care in California are available at either of the above two Web sites.