Progress Report on Workers’ Compensation

California Orthopaedic Association
2014 Annual Meeting
Monterey

Rupali Das, MD, MPH
Executive Medical Director
California Division of Workers’ Compensation
Disclosures

Rupali Das

Has no relevant disclosures or conflicts of interests to report
Discussion Topics

- Overview
- Treatment
  - IMR
  - Evidence-based Medicine
- Reimbursement
  - IBR
  - Physician Fee Schedule
Workers’ Compensation System
Physician Roles in the Workers’ Compensation System

- **LEGAL**
  - Attorneys: applicant, defense; judges

- **MEDICAL**
  - Medical Dispute Resolution: QME, AME
  - Treating physicians

Employer
To Prevent Chronic Disability
Use Occupational Health Best Practices Early

Pre 2013 Workers’ Compensation: Complex Health Care System

Occupational illness/ injury

Treatment denied, delayed

Dispute resolution through QME Process

Court System

Delayed, inappropriate care

Disability

Appropriate care, return to work, healing
Intent of Independent Medical Review

- Timely, medically appropriate care for workers
- Medical expertise to resolve disagreements about medical treatments
- Reduce inappropriate Utilization Review denials; increase medically appropriate requests
- Enhance efficiency, reduce costs to system
Intent of IMR

Prevention

Occupational illness/ injury

Treatment denied, delayed

Medical Treatment dispute resolution via Independent Medical Review

Appropriate care, return to work, healing
Perception of IMR
IMR—Practical Aspects

• Determinations are binding
  • Limited grounds for appeal
• Provided by Maximus Federal Services until 12/31/14
• Reviewers specialty matched to request
  • Anonymous outside the IMRO
Utilization Review

Provider fills out RFA form

UR Denial, Delay, Modification

Liability dispute

UR denial letter to IW along with completed IMR form

Defer UR until resolved

Treatment Approved

Independent Medical Review
Independent Medical Review (IMR) decisions

The Independent Medical Review (IMR) program is part of an important essential overhaul of the California Workers’ Compensation System that was created pursuant to Senate Bill (SB) 863.

The IMR program provides an expeditious method to resolve medical necessity treatment disputes for work-related injuries occurring on or after Jan. 1, 2013. On July 1, 2013, IMR will be available to resolve medical necessity treatment disputes for all dates of work-related injury as long as the requested treatment was denied, delayed, or modified following utilization review after Jan. 1, 2013.

The DWC has contracted with an independent medical review organization (IMRO), to conduct IMR on its behalf. The list below shows all IMR decisions issued since the program began on Jan. 1, 2013.

All IMR decisions are posted on DWC’s website shortly after being issued. IMR decisions that are withdrawn or determined to be ineligible are not posted on the list below. Further, IMR decisions may not be issued according to numbering sequence. While each IMR request is assigned a number when it is received, gaps in numbering for posted decisions reflect withdrawn, ineligible, or pending requests.

- IMR Decisions 13-000001 thru 13-000099
- IMR Decisions 13-000100 thru 13-000999
- IMR Decisions 13-001000 thru 13-004999
- IMR Decisions 13-005000 thru 13-009999
- IMR Decisions 13-010000 thru 13-099999

https://www.dir.ca.gov/dwc/IMR/IMR_Decisions.asp
Independent Medical Review Final Determination Letter

Dated: 12/20/2013

IMR Case Number: CM13-0014800  Date of Injury: 08/17/2009
Claims Number:  UR Denial Date: 08/01/2013
Priority: STANDARD  Application Received: 08/22/2013
Employee Name: Provider Name:

Treatment(s) In Dispute Listed on IMR Application:
1. RIGHT SHOULDER ARTHROSCOPY WITH ROTATOR CUFF REPAIR AND SUBACROMIAL DECOMPRESSION 2. POST-OP PT 3X8 WEEKS

DEAR [Redacted].

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.
INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/19/2013 disputing the Utilization Review Denial dated 5/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. A decision has been made for each of the treatment and/or services that were in dispute:

1) MAXIMUS Federal Services, Inc. has determined the retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13 is not medically necessary and appropriate.

Medical Qualifications of the Expert Reviewer:
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Case Summary:
Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 17, 2013.
Rationale for Decision

1) Regarding the request for 2nd set of epidural steroid injection Left L5-S1 lumbar transforaminal:

   Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:
   
   The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 300, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines used by the Claims Administrator were not appropriate for the issue at dispute. The Expert Reviewer used the Chronic Pain Medical Treatment Guidelines (May, 2009), Epidural Injection. Pg. 46, which is part of the (MTUS).

Rationale for the Decision:
The employee sustained a work-related injury on August 23, 2012 to the lower back. Medical records provided for review indicate treatments have included pain medication and epidural steroid injection. The request is for 2nd set of epidural steroid injection left L5-S1 lumbar transforaminal.

The MTUS Chronic Pain Medical Treatment guidelines indicates the criteria for repeat epidural steroid injections are documented pain and functional improvement, including at least 50% pain relief associated with a reduction of medication use for six to eight weeks. The medical records provided for review indicate some pain relief for 1-2 weeks with the use of less pain medications with symptoms increasing after six or eight week which would not meet guideline criteria for a repeat injection. The request for 2nd set of epidural steroid injection left L5-S1 lumbar transforaminal is not medically necessary and appropriate.
Average Days to Complete a Standard IMR

Determinations Thru April 2014
### Top Ten IMR Reviewer Specialties

<table>
<thead>
<tr>
<th>Reviewer Specialty</th>
<th>Percentage of Total Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Medicine &amp; Rehabilitation</td>
<td>34%</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>19%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>16%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>7%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>7%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>4%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>2%</td>
</tr>
<tr>
<td>Psychology</td>
<td>2%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2%</td>
</tr>
</tbody>
</table>

Data as of 12/26/13: 2,658 IMR Determinations
Most UR Treatment Decisions Upheld by IMR in 2013

5,619 Treatment Decisions (4,699 UR Upheld, 920 UR Overturned)

Data as of 12/26/13: 2,658 IMR Determinations
Pharmaceuticals Most Common Request

Data as of 12/26/13: 2,658 IMR Determinations
Most Common Non-Pharmaceutical IMR Treatment Decisions

![Bar chart showing the number of treatment decisions for different categories such as Equipment, Therapies (PT/OT), Surgery, Diagnostic Test, Radiology, Acupuncture/Chiropractic, Evaluation & Management. The chart compares the number of decisions overturned (UR Overturned) versus upheld (UR Upheld).]

Data as of 12/26/13: 2,658 IMR Determinations
Spine Surgery
Most Common Surgical Request

- Spine (All levels)
- Knee
- Shoulder
- Forearm, Wrist, and Hand

Number of Surgical Procedure Requests

UR Upheld
UR Overturned

26% of Knee Surgery Requests

Determinations Thru December 26, 2013
Arthroscopy Decisions

Data as of 12/26/13
Arthroscopic vs. Non-Arthroscopic Surgery

Determinations Thru December 26, 2013
IMR Case Discussions
IMR Decision Hierarchy

- Medical Treatment Utilization Schedule, LC § 5307.27
- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service
- Nationally recognized professional standards
- Expert opinion
- Generally accepted standards of medical practice
- Treatments likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious

LC § 4610.5(c)(2)
Medical Treatment Utilization Schedule

- Doctors in California's workers' comp system are required to provide evidence-based medical treatment
  - Guidelines are laid out in the MTUS
- Set in regulation based on recommendations from a committee of experts under the guidance of the DWC Executive Medical Director
  - “Rebuttable presumption of correctness”
Medical Evidence Evaluation Advisory Committee

- Lesley Anderson, M.D. – Orthopedic
- Melvin Belsky, M.D. – Physical Medicine and Rehabilitation
- Rajiv Das, M.D., M.P.H. – Occupational Medicine/Physical Medicine and Rehabilitation/Pain Medicine
- Mark Diaz, M.D. – Occupational Medicine (Subject Matter Expert)
- Mary Foto, O.T.R. – Occupational Therapy
- Gary Franklin, M.D., M.P.H. – Neurology
- Leslie Israel, D.O., M.P.H. – Occupational and Environmental Medicine
- Dong Ji, Ph.D., L.A.C. – Acupuncture
- Claire Johnson, D.C., M.S.Ed. – Chiropractic
- Frank Kase, D.P.M. – Podiatry
- Joshua Kirz, Ph.D. – Psychology
- Michel Kliot, M.D. – Neurosurgery
- Ronald Koretz, M.D. – Internal Medicine
- Robert Larsen, M.D., M.P.H. – Psychiatry
- Sean Mackey, M.D., Ph.D. – Pain Medicine
- Nancy Morioka-Douglas, M.D., M.P.H. – Family Medicine
- Lori Reisner, Pharm.D. – Pharmacology (Subject Matter Expert)
- Anne Searcy, M.D. – Family Medicine (Subject Matter Expert)
- Lee Snook, M.D., M.P.H. – Pain Medicine
- Leslie Torburn, D. P.T., M.S. – Physical Therapy
MTUS Regulations

- Clinical Topics
  - Neck and upper back
  - Shoulder
  - Elbow disorders
  - Forearm, wribs, hand
  - Low back
  - Knee
  - Ankle and foot
  - Stress-related
  - Eye
- Special topics
  - Acupuncture
  - Chronic Pain
  - Post-surgical treatment

*In Progress*
- Strength of Evidence
- Opioid Treatment
- Updates of all sections
- *To be combined with provider education*
Evidence-Based Medicine

http://www.cochrane.org/about-us/evidence-based-health-care
Proposed Strength of Evidence Regs
Clarifies process for ranking medical evidence

MTUS

(MTUS silent or not applicable)

Best available medical evidence in evidenced-based medical treatment guidelines or peer-reviewed published studies that are nationally recognized by the medical community
Evidence Search Sequence

ACOEM/ODG (five years old or less)
↓
Most current version of other evidence-based medical treatment guidelines
↓
Current studies, five years old or less that are scientifically based, peer-reviewed, and published in journals nationally recognized by the medical community
Levels of Medical Evidence

- **1a** Systematic review of randomized controlled trials with low risk of bias
- **1b** Randomized controlled trials, low risk of bias
- **1c** Randomized controlled trials, identified risks of bias
- **2** Non-randomized cohort studies that include controls
- **3** Case-control studies or historically controlled studies
- **4** Uncontrolled studies (case studies or case reports)
- **5** Published expert opinion
Who Must Use EBM?

- Medical providers in the workers’ comp system are required to use the MTUS/EBM
- Patients benefit when clinicians use evidence-based practices in clinical settings
- UR and IMR must use the evidence search sequence and cite the level of evidence in their decisions
Independent Bill Review (IBR)

- Process to resolve disputes regarding the amounts paid for medical services in workers’ comp system

- Will not apply to cases:
  - Where the injury itself is in dispute
  - Where there is a dispute about whether or not the provider is authorized to treat the worker

- Provided by an independent organization
  - Maximus Federal Services under contract until 12/31/14
IBR: Who and What?

- Providers File for IBR
  - Must use the AD form (DWC Form IBR-1)
    - Can be completed online or mailed
  - Provider must pay a fee ($335)
    - Reimbursed by claims administrator if provider prevails
  - May request consolidation of separate requests
- There must be a fee schedule for service billed
What’s Needed to Request IBR

- **Initial bill review** by the Claims Administrator [Explanation of Review (EOR)]
  - Reasons for rejection or reduction of bill

- **Mandatory second review** requested by the provider with additional information
  - DWC Form SBR-1 or standard modified bill
  - Second Explanation of Review
  - Request within 90 days of first EOR
Data to Feb 2014: 1,265 Determinations
Most IBR Determinations Provide Payment to Provider

42% Payment Denied
58% Payment Approved

266 IBR Decisions (109 Upheld and 157 Reversed)

Data to Feb. 2014
Medical Practitioner Fee Schedule

http://www.dir.ca.gov/dwc/OMFS9904.htm
Background to New Fee Schedule

- RBRVS under consideration since 1999
- SB 863 required adoption of RBRVS-based physician fee schedule
  - Annual updates
  - Four-year transition
  - Inclusion of ground rules that differ from Medicare as appropriate for WC
Major Differences Pre-2014 OMFS vs. New RBRVS-Based Fee Schedule

<table>
<thead>
<tr>
<th>Pre-2014 Fee Schedule</th>
<th>RBRVS Fee Schedule - 1/1/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge-based relative values</td>
<td>Resource-based relative values</td>
</tr>
<tr>
<td>Single relative value for each procedure</td>
<td>Work, Practice Expense, Malpractice relative values for each procedure</td>
</tr>
<tr>
<td>Same relative value/fee regardless of site of service</td>
<td>Practice Expense relative value usually different in “facility” vs. “non-facility”</td>
</tr>
<tr>
<td>Multiple Conversion Factors</td>
<td>Multiple Conversion Factors, transitioning to single CF in 2017</td>
</tr>
<tr>
<td>No geographic adjustments</td>
<td>Apply average statewide geographic adjustments to Work, PE, MP</td>
</tr>
<tr>
<td>Non-physician practitioners and physicians paid same rate</td>
<td>Nurse Practitioners and Physician Assistants paid at 85% unless “incident to” physician service (then paid at 100%)</td>
</tr>
<tr>
<td>CPT Consultation Codes for consultations</td>
<td>Use CPT visit codes for consultations</td>
</tr>
</tbody>
</table>
### Major Differences contd.

<table>
<thead>
<tr>
<th>Pre-2014 Fee Schedule</th>
<th>RBRVS Fee Schedule - 1/1/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate payment for consultation service and consultation report</td>
<td>Consultation report bundled, not separately payable unless requested by an AME/QME or by the WCAB or Administrative Director</td>
</tr>
<tr>
<td>Prolonged E&amp;M Service without direct patient contact CPT 99358/99359 payable</td>
<td>Prolonged E&amp;M Service without direct patient contact CPT 99358/99359 NOT payable; Status Code B (bundled)</td>
</tr>
<tr>
<td>Interpreter used by patient – 110% of usual value of service</td>
<td>No extra payment for use of interpreter by patient</td>
</tr>
<tr>
<td>Anesthesia time units – 1 unit per 15 minutes for first 4 hours and 1 unit for each 10 minutes thereafter; 5 minutes or more is a unit</td>
<td>Actual anesthesia minutes reported divided by 15, then round the time unit to one decimal place</td>
</tr>
<tr>
<td>Anesthesia units increased for qualifying circumstances and specified patient status codes</td>
<td>No additional units</td>
</tr>
<tr>
<td>Pre-2014 Fee Schedule</td>
<td>RBRVS Fee Schedule - 1/1/2014</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Physical Therapy Cascade Formula reduces 2&lt;sup&gt;nd&lt;/sup&gt; – 4&lt;sup&gt;th&lt;/sup&gt; procedures</td>
<td>Multiple Procedure Payment Reduction Formula is different and applies only to Practice Expense RVUs (not to Work RVUs, MP RVUs)</td>
</tr>
<tr>
<td>Radiology multiple procedures paid at full value</td>
<td>Radiology MPPR applies to specified major radiology codes (CT, MRI, Ultrasound)</td>
</tr>
<tr>
<td>Supplies and materials “beyond those usually included with the service” may be separately billed</td>
<td>Supplies and materials generally bundled into the payment for the procedure; not separately payable</td>
</tr>
<tr>
<td>No coding edits specifically included</td>
<td>National Correct Coding Initiative Edits</td>
</tr>
<tr>
<td>No E&amp;M documentation guidelines specifically included</td>
<td>E&amp;M Documentation Guidelines – 1995 and 1997 adopted</td>
</tr>
</tbody>
</table>
Procedure Coding – Mostly CPT

- **AMA CPT® 2014**
  
  [https://commerce.ama-assn.org/store/](https://commerce.ama-assn.org/store/)

  It is incorporated by reference into fee schedule regulation. Purchase from AMA

- **Other Codes Used**
  - WC-specific codes (§9789.12.14)
    - WC001 – WC012
  - Physician-administered drugs use HCPCS J codes and NDC codes
  - Radiopharmaceuticals use HCPCS Q codes and A codes

- **Specified Exceptions to CPT Code usage**
  - Codes listed in §9789.19

- **National Correct Coding Initiative (NCCI) applied**
Changes of Particular Interest

- Consultations use CPT, E&M codes
  - Separately payable under specific circumstances

- Multiple PT/acupuncture/ chiropractic
  - Multiple Procedure Payment Reduction (MPPR)

- Global surgery period
  - Surgical procedure, immediate pre- and postsurgical services, follow-up E&M services