

HOW EMPLOYERS CAN CAPITALIZE ON KEY CHANGES IN CALIFORNIA WORKERS' COMPENSATION

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California employers, still weeding through the impact and clarification of major workers compensation reform streaming from AB 227 and SB 228 passed in September 2003, are now in the midst of sweeping workers compensation reform in the form of SB 899, a bill signed by Governor Arnold Schwarzenegger on April 19, 2004 and effective January 1, 2005.

The following is a summary of the key legislation changes and how they may impact companies in California,¹ along with suggestions on what employers may want to consider as they strive to balance quality, compliance, access, and employee choice with cost containment and claims management practices.

FINANCIAL IMPACT OF THE LEGISLATION

Gov. Schwarzenegger has estimated the new legislation will reduce workers compensation premiums by 25 to 30 percent. The overall savings forecast projected by the Governor is \$7 billion for state employers.²

MAJOR LEGISLATION CHANGES

This legislation is expected to impact services offered in the California market in these key categories:

- Medical Provider Networks
- Clinical Protocol
- Utilization Review
- Case Management /Return to Work
- Disability Determination

MEDICAL PROVIDER NETWORKS

Employer Medical Provider Network (LC 4616 Article 2.3)

Beginning Jan. 1, 2005, an insurer or self-insured employer may establish or modify a medical provider network to direct care. The network shall include physicians primarily engaged in the treatment of occupational injuries—with at least 25 percent of physicians in the network treating non-occupational

disability. The legislation directs the size of the network requirements in conjunction with employee base and ability to see providers quickly, and requires the employer or insurer to submit the plan for the medical provider network. The Administrative Director must approve the plan.

Suggestion: Employers should inquire as to whether their network providers have strong coverage in California and will be managing these networks to compliance. Investigate who has the best geographical and provider network coverage; also a requirement of the regulations. Selecting an MPN with the largest number of contracted providers will provide employers with a distinct advantage in ensuring that adequate numbers of providers and specialties are accessible in California and can be customized to provide flexibility while maintaining medical control and maximizing medical savings. (See economic profiling for additional comments.)

2nd and 3rd Opinion Process prior to Independent Medical Review (LC 4616.3)

When an employer has a medical provider network, the employer will select the treating provider for the first appointment from those providers in the network. If the employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may then choose another provider from the network. If a dispute remains, the employee may select a third provider from the network. If, after the third physician's opinion, the diagnosis or treatment remains in dispute, an application for independent medical review can be submitted.

¹ The material in this document was based on information posted on the California Division of Workers' Compensation Web site. For additional information, please refer to their site at: <http://www.dir.ca.gov/dwc/wcreformindex.html>

² Jim Christie, "California Lawmakers OK Workers' Comp Reform Bill," Reuters, April 16, 2004.

Impact: The employer (or employer claims payer) is in control of treatment for the first three opinions, as long as the employer has a medical provider network. The goal will be to keep treatment within the provider network. Medical case management, appropriately deployed, will be key to successfully managing this process. Utilizing clinical protocols, communication with the physician and understanding any unmet needs of the injured worker will assist in early medical recovery and resolution. If the injured worker progresses to an independent medical review, costs have escalated and pro-active management of medical diminished.

Transfer of Care (LC 4616)

If a covered injured worker is being treated for an occupational injury or illness by a provider prior to the MPN designation of an employer or insurer, one of two things occurs. If the treating provider is included in the MPN network, the employer or insurer will notify the injured worker that his/her treatment is being provided under the provisions of the MPN. If the provider is not in the MPN network, treatment will be continued with the provider outside of the MPN network under certain clinical conditions as outlined in the MPN Rule. Other conditions can be included in the Transfer of Care policy, filed as part of the MPN.

Impact: Evaluation of transfer of care is important in the MPN filing process. Ensuring that the policy is in place to choose to include those claims that initiated treatment prior to the MPN implementation, and who qualify clinically, is an option that may be beneficial to exercise to increase MPN participation.

Continuity of Care (LC 4616.2)

If an injured worker is receiving care from a network provider and the network contract with the provider expires or is terminated, the employer is under a duty to continue the care with that provider, if the provider is treating an acute condition with a limited duration, a serious chronic condition or a terminal illness. The physician is bound to the same contractual terms and conditions that were in effect under the network contract. Time limitations apply based on circumstances of condition.

Suggestion: Employers should find out whether the process to continue a physician under these special requirements will be included in the network part-

nership arrangement beginning Jan. 1, 2005.

Employers should also inquire as to the process for transfer of care to ensure the least amount of disruption to the injured worker. Generally, larger networks offer more continuity and transfer of care options, decrease the patient's potential to opt out of network, and increase the probability for more medical control over the life of the claim.

Pre-designation of Treating Physician (LC 4600)

If the employee has notified the employer in writing prior to the date of injury that he or she has a personal physician, the employee has the right to be treated by that physician for the work injury as long as the employer provides non-occupational group health coverage in a health care service plan or a group health insurance policy that meets the LC requirements (LC 4616). There is an extended list of specific criteria for when pre-designation is in effect that can be found in LC 4616. Note: The maximum percentage of all employees who can be pre-designated at any time in the state is 7 percent. This sub-division is in effect only until April 30, 2007.

Impact: The extent to which predesignation will have impact is not determined at this time. Expressed concern related to the manageability of these cases should be dealt with pro-actively. Assignment to case management may be an elected trigger whenever a pre-designated employee receives a work injury. Utilization review of any proposed diagnostic or treatment that would be outside specific occupational case management guidelines would also be indicated and is specifically allowable in this regulation.

Economic Profiling (LC 4616.1)

Economic profiling as defined by this Article "shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group or individual practice association" (4616.1(c)). The Article states that if an insurer or employer that offers a medical provider network under this division and that uses economic profiling shall file with the administrative director a description of any policies and procedures related to economic profiling utilized.

Suggestion: Economic profiling can be beneficial if the profiling and selection of providers is aimed at better outcomes, in terms of cost of care, duration of care, frequency of visit and an overall faster return to work. Employers should inquire if their MPN uses economic profiling and whether the criteria for profiling is outcomes based.

CLINICAL PROTOCOL

Independent Medical Review (LC 4616.4)

If, after the third physician's opinion, the treatment or diagnostic service remains in dispute, the injured employee may request an independent medical review. The employee must apply to the Administrative Director and the AD then assigns an independent medical reviewer.

Impact: Case management may be critical to a file at this time, depending on what services have previously been offered. Coordination of all of the medical records, with directed questions to the IMR physician, may yield a clearer history and assessment of medical and return to work considerations. If vocational services have not been previously engaged, a job analysis with specific functional assessment of regular duty and opportunity for modified duty may assist with the IMR evaluation of return to work status.

Definition of Treatment (LC 4600)

The new legislation has redefined medical treatment to mean treatment that is based on the medical treatment utilization schedule. The American College of Occupational and Environmental Medicine (ACOEM) guidelines are those designated for use in California. **Suggestion:** Employers should ensure that ACOEM guidelines are used for case management, utilization management, physician review and any other medical treatment assessment services.

UTILIZATION MANAGEMENT AND GUIDELINES

Repeal of the Primary Treating Physician Presumption (LC 4062.9)

Section 4062.9 of the LC has been repealed. Sec 46 has been added to the Labor Code. The repeal of the treating physician presumption of correctness will now apply to all cases, regardless of date of injury.

Impact: In the prior SB 228, the pre-designation of a personal physician or chiropractor set forth presumption of correctness. The repeal of 4062.9 and the addition of Sec 46 indicate the repeal of the personal physician's or chiropractor's presumption of correctness. In accordance with 4604.5 of SB 899, the ACOEM Guidelines will be presumptively correct until the Medical Treatment Utilization Schedule adopted by the Administrative Director is in place. Employers should find out whether their case management provider has leased the ACOEM Occupational Medicine Practice Guidelines and can operate under the regulation of presumption as outlined in LC 4604.5.

Limits Added to Occupational Therapy (LC 4604.5)

Existing law limits an employee to no more than 24 chiropractic or physical therapy visits per industrial injury. The new regulation expands the limit to occupational therapy visits at no more than 24 visits.

Suggestion: Employers who use connected bill review and case management/utilization services should expect triggers from bill review to manage these ancillary services within these compliance requirements.

CASE MANAGEMENT/RETURN TO WORK

Vocational Case Management (LC 139.5 and LC 4658.5)

The changes made by SB 228 effective Jan. 1, 2004 have been repealed. The repeal of this section is misleading, though, because the Supplemental Job Displacement Benefit (SJDB) has been retained. LC 4658.5, not amended in SB 899, still extends the SJDB to workers with injuries after Jan. 1, 2004.

The language regarding vocational rehabilitation that was in the workers compensation regulations prior to AB 227 and SB 228 is reinstated for injuries occurring prior to Jan. 1, 2004. This language would include vocational benefits such as retraining, written rehabilitation plans, and vocational rehabilitation maintenance allowance of \$246 per week.

Impact: Whether these services are legislated or not, there is still much value in vocational rehabilitation services, such as those that incorporate evaluation of transferable skills or return-to-work services.

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Return to Work Disability Payment Incentives (LC 4658)

This regulation is amended to require a disability payment adjustment based on whether or not employment is offered by an employer when a disability becomes permanent. The regulation states that if the employer does not offer an injured employee regular work, modified work or alternative work within 60 days of a disability becoming permanent and stationary, each disability payment remaining owed to the employee must be increased by 15 percent. Likewise, if an employer does offer regular work, modified work or alternative work within 60 days of permanent disability, each disability payment remaining can be reduced by 15 percent, whether or not the employee accepts the employment. The employment must last for 12 months. If the regular, modified or alternate work is terminated by the employer before the end of the period for which disability payments are due the injured worker, the amount of each of the remaining disability payments will be paid at 15 percent above target entitlement.

Impact: The intent of this regulation is clear—return to work is the focus. The variable disability pay-out does not come into play until permanent disability is established. The timeframe that occurs between injury and permanency may be significant and can drive up costs and reduce the likelihood of return to work. Managing the return to regular, modified or alternate duty as soon as possible following the injury will be key. LC 4658 spells out dollars specific to disability pay-out variability based on return-to-work status once permanency is reached, but many other dollars are at risk. Establishing return-to-work as quickly as possible will reduce disability ratings by improving the evaluation of future earning capacity (see next section), as well as reduce the indemnity pay-out between injury and the determination of permanency. Employers should ask their case management providers if they offer day-one return-to-work program and will continue to offer, as well, case-by-case return-to-work services.

Definition of Diminished Future Earning Capacity (LC 4660)

The regulation now changes a factor in the determination of disability rating. The requirement previously to consider the ability of the injured employee to compete in the open labor market has been replaced

with the evaluation of an employee's diminished future earning capacity. The Administrative Director formulated an adjusted rating schedule based on empirical data and findings. The permanent disability rating schedule released on Dec 31, 2004 provides a calculation to assess the impact of the injury on an employee's ability to perform work within the functional requirements of an employee's prior job.

Impact: The changes in this rule diminish the opportunity to provide a complete assessment of an employee's ability to compete in the open market. Instead, this rule now includes a calculation for assessing capabilities that does not necessarily take into account variances in job requirements and/or functionality that could impact an employee's ability to perform their job.

DISABILITY DETERMINATION

Medical Evaluation of Permanent Disability (LC 4061)

Together with the last payment of temporary disability indemnity, the employer shall provide the employee with either a notice that no permanent impairment or limitations result from the injury or notice of the amount of permanent disability indemnity payable. The employer must also include information concerning how the employee can obtain a formal medical evaluation if he or she disagrees with the position taken by the employer. The notice must also include a form prescribed by the Administrative Director for requesting assignment of a panel of qualified medical evaluators. Stipulations regarding employee legal representation are noted.

Impact: Employers should be knowledgeable about these requirements and be prepared to operate accordingly when an employee is going through the permanent impairment decision.

EDITOR'S NOTE: DATE OF ENACTMENT

The amendment, addition or repeal of any provision of law made by this act shall apply prospectively from the date of enactment of this act, regardless of the date of injury, unless otherwise specified, but shall not constitute good cause to reopen or rescind, alter or amend any existing order, decision or award of the WC Appeals Board. Basically—if not otherwise indicated, the regulation of SB 899 is in effect as of 4/19/04.