

## California's Workers' Compensation at a Crossroads

[THE FOLLOWING ARTICLE IS BASED ON A REPORT TO THE WOEMA BOARD  
PREPARED BY DON SCHINSKE OF THE ADVOCACY AND MANAGEMENT GROUP.]

**C**alifornia Workers' Compensation costs have grown from \$9 billion in 1995 to \$29 billion today. Currently, more than 6 cents of every payroll dollar in California gets fed into the system. The next most expensive program is in Florida, at just 4.5 cents per dollar. Everyone is clear that the system is broken and in need of overhaul. Efforts at reform have been hindered by bickering between various special interest groups: labor unions, attorneys, surgery centers, and insurance companies. The next year will be decisive in determining whether there will be real reform or whether special interests will continue to dominate the system at the expense of workers and employers.

### 2003 Reforms

Reform bills last year (AB 227 and 228) addressed primarily the medical portion of workers' compensation (see article on page 4). Of particular concern to physicians in occupational medicine, the reforms replaced the arcane Official Medical Fee Schedule (OMFS) with a schedule to be pegged at 120 percent of Medicare in 2006. This represents a major boost for the Evaluation and

Management codes, currently paid at an average of 70% of Medicare.

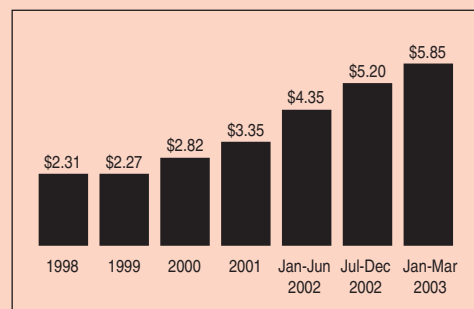
Another important part of the 2003 reforms, supported by WOEMA, adopts the evidence-based guidelines developed by the American College of Occupational and Environmental Medicine as the offi-

cial utilization and treatment schedule until December 2004. By December, California must adopt a medical treatment utilization schedule. The schedule must incorporate evidence-based, peer-reviewed, nationally recognized standards of care.

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## WOEMA Hires Lobbyist to Focus on Worker's Comp Reform

At its February 2004 meeting, the WOEMA Board of Directors hired a legislative advocate to focus on two urgent areas of concern: workers' comp reform and physician reimbursement. "What happens in California will resonate in other west-



Average California Workers' Compensation Premium Rate Per \$100 of Payroll

ern states, so we need to be an active voice on workers' comp reform and reimbursement, two hot issues in the California legislature." According to WOEMA President Constantine Gean, MD. "We see these as the most pressing issues for WOEMA members," said Gean. In addition, recent studies conducted by the Lewin Group have determined that occupational medicine as a specialty is reimbursed 30% below Medicare rates. "We are working to push this to 20% over Medicare reimbursement rates to put it where it should

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# President's Message

BY CONSTANTINE GEAN, MD



In January 2004, I became president of our professional organization, WOEMA, which exists solely for the benefit of its members. Many important changes are occurring in our field that are propelling Occupational and Environmental Medicine (OEM) into the

spotlight. In particular the adoption in California of the ACOEM Clinical Practice Guidelines by the state legislature gives WOEMA (the Western Component of ACOEM) a unique vantage point, and a singular opportunity, to influence worker injury care by supporting and promoting the guidelines and the evidence-based medicine principles on which they are based. Though occurring in California, these changes could easily have impact on Workers' Compensation practice in all of the states that comprise WOEMA.

Other issues currently on the front burner are the legislative changes in reimbursement that govern the apportionment of resources toward those that provide occupational medicine services to workers. As an example, there are currently 116 bills in front of the California legislature, some of which seek

to change the provisions of SB 228, which has some favorable treatment for primary care providers. This year and into the future the WOEMA board will seek to maintain appropriate reimbursements in all of its member states for good doctors who dispense good, evidence-based medicine such as that described in the ACOEM Clinical Practice Guidelines.

The 2003 WOHC held in Napa, California was a great success based on attendance, feedback and the quality of the program. This year's WOHC will be held in **Lake Las Vegas on September 16-18**, and will include up-to-date practical and cutting-edge OEM information, including sessions on the use and application of the ACOEM Clinical Practice Guidelines and will enable participants to obtain units toward their pain certification. To register, call **(415) 927-5736**.

If you would like to participate and assist, or to make suggestions, please call (415) 927-5736. I want to encourage you to get involved on a WOEMA committee and help bring positive change for all OEM professionals.

Looks like quite a year ahead! ■

## California's Worker's Compensation

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This reform replaces the current utilization review system where the treater is presumed correct. Physicians can still request treatment that goes beyond the ACOEM guidelines but they must document their request and state their reasons.

The 2003 reforms were supposed to result in lower rates. However, most carriers have continued to announce increases in 2004.

### 2004: Round Two

As we go to press there are over 160 bills in front of the California legislature that address various aspects of the workers' compensation system. Many of the bills aim to roll back parts of the 2003 reforms.

Governor Schwarzenegger has made reform a key priority of his administration. His proposal aims to pare \$11 billion out from the program through a variety of reforms. These are being carried in Assembly Bill I X4 (Maldonado) and Senate Bill X4 II (Poochigian). The Governor has threatened to take his proposal to the voters through the initiative process if the Legislature does not pass a bill by March.

Key provisions of the Schwarzenegger plan include:

- Eliminating permanent disability payments for disabilities that cannot be objectively measured. Payments for permanent partial disabilities are now partly scaled to an employee's subjective self-assessment of their disability. (Not surprisingly, this feature of the current system often leads to litigation, which is one of the major cost-drivers of the program.) Evidence of injury must be established through "objective findings" that are reproducible, measurable, or observable.

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## California's Workers' Compensation

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- Requiring that for a "cumulative injury" to be compensable, an employee would have to demonstrate by a preponderance of medical evidence that the injury was substantially caused by actual employment activities.
- Prohibiting chiropractors from determining permanent disabilities.
- Establishing a system of Independent Medical Review to resolve disputes.
- Allowing any group of employers to create their own workers' comp system with a separate pool of funds and alternative dispute resolution. Current laws allows only unionized employers to carve out such a system.

Democratic counterproposals call for including some sort of cap on insurance rates, with any savings from the reforms to be returned to employers

For his part, Insurance Commissioner John Garamendi is pushing for a compromise, and is expressing concern that any changes made would not take effect until July 2005, by which time many more employers may move out of state. Some of the key elements of his proposal include:

- Allowing a second medical opinion to resolve disputes. Garamendi's proposal differs from the Governor's proposal, which makes the second opinion a decisive ruling.
- Imposing tougher penalties for fraud.
- Requiring the state's insurer of last resort, the quasi-public State Compensation Insurance Fund (SCIF), to shed any business that can be handled by other carriers. SCIF currently holds more than half the Worker's Comp market.
- Requiring use of objective standards to determine the degree of disability suffered (similar to Governors' plan).

### The Role of Occupational Medicine Physicians

*"The outrageous costs [of workers compensation] are often related to poor decision making, fraud, and inappropriate services. It's no wonder things are out of whack; we have a system where administrators not*

*doctors, are reviewing claims and making treatment decisions. Physicians trained in occupational medicine need to be making the decisions about treatment within the workers' comp program and identifying appropriate reimbursement levels – that will help us heal the system."*

-- WOEMA President Constantine Gean, MD

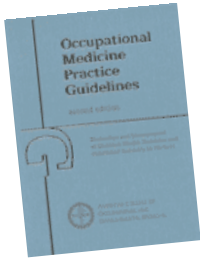
WOEMA aims to play a major role this year in the reform of workers' comp. WOEMA brings a scientific, evidence-based framework to the table that can cut through the maze of special interests that have been bleeding the system.

Key aspects of the WOEMA position are:

- Continued use of the ACOEM Guidelines for utilization review. The ACOEM Guidelines provide evidence-based, peer reviewed recommendations for care, written by physicians and reviewed by a wide-range of medical specialty organizations.
- Adoption of the AMA disability guidelines as a guide to disability management. It is the feeling of WOEMA that adoption of the AMA disability guidelines would further an evidence-based approach to disability management and put deciding medical issues in the hands of physicians rather than attorneys and administrators.
- Replace the current system of review by attorneys and administrators with a system of medical review by doctors trained in occupational medicine. Studies have shown that utilizing physicians trained in occupational medicine lowers costs and produces better treatment outcomes.
- Support for physician reimbursement that adequately compensates evaluation and management and does not reimburse surgery at a much higher rate, encouraging unnecessary surgeries.

"An occupational medicine physician's goal is to get the worker back to health and back into the workplace by following proscribed treatment protocols. We're working to get the specialists in the field into the position to make these important decisions so necessary for the success of the system," says Dr. Gean. "We believe that better treatment decisions and assessments will ultimately save the workers' comp system millions of dollars and improve patient care so we aim to make that happen." ■

## ACOEM Practice Guidelines Are Now “Law of the Land” in California



**N**ew California legislation (AB 227 and SB 228) stipulates that the ACOEM Practice Guidelines shall be “**presumptively correct**” on the issue of extent and scope of medical treatment.” The new law replaces regulations where the treating health professional is presumed correct. Under the new law, treating health professionals can recommend treatment outside the ACOEM Guidelines but must now document the reasons for any such treatment. This presumption went into effect in March 2004 -- 90 days after the December 22, 2003 publication of the ACOEM Guidelines, Second Edition.

The Guidelines, first published in 1997, provide evidence-based, peer-reviewed recommendations for care, written by physicians and reviewed by a wide-range of medical specialty organizations. Presenting consensus- and evidence-based information, the guidelines are intended for use by physicians, other health care professionals, insurers, employers, attorneys, and others with responsibility for/involvement in workers’ compensation.

ACOEM gave two one-day orientation sessions in January on the newly released second edition of the

“Occupational Medicine Practice Guidelines.” WOEMA President Constantine Gean represented WOEMA at the Los Angeles session and WOEMA Chairman of the Board Susan Tierman did the same in San Francisco. Other speakers included California Insurance Commissioner John Garamendi and Guideline creator and editor-in-chief Lee Glass, MD.

Drs Gean and Tierman’s presentations emphasized WOEMA’s support of the ACOEM Guidelines and the scientific evidence-based practice they circumscribe and how adherence to these guidelines should improve the overall quality of work-injury medical care, lead to more appropriate care, and allocate resources for the maximum benefit of injured workers. Also covered was the fact that WOEMA member physicians are particularly well-versed in the principles underlying the ACOEM Guideline’s approach and its application to practice situations. Also noted was that several WOEMA members have helped ACOEM create and revise these guidelines.

**WOEMA will be giving updated training sessions at the upcoming Western Occupational Health Conference (WOHC) in Lake Las Vegas on September 16-18, 2004, to register, call (415) 927-5736.**

### Workers’ Compensation Reforms

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be and we have a good chance of getting this through,” said Peter Swann, MD, Chair of WOEMA’s Legislative Affairs Committee. Swann, along with Steve Schumann, MD have been active participants on behalf of WOEMA in the working group to re-assess the RBRVS codes and have been vocal about occupational medicine codes being reimbursed well below what they should. According to Gean, “WOEMA is moving into the legislative arena with a passion and focusing on these two key issues in an effort to support our members’ interests.” ■



Governor Arnold Schwarzenegger and Insurance Commissioner John Garamendi meet to discuss workers’ compensation reform.

# News You Can Use from the Literature

BY CONSTANTINE GEAN, MD

**The available evidence suggests that if the current control measures are well enforced, then the CJD risk, if any, from U.S. cattle, is very low**— The big question being posed to officials and scientists — "Is U.S. beef safe?" — cannot be answered with 100% certainty. However, the diagnosis to date of roughly 150 cases of new-variant Creutzfeldt-Jakob disease worldwide — as compared with the roughly 200,000 cases of clinical livestock BSE that have been confirmed throughout Europe—indicates that cattle-to-human transmission has been rare even with exposure to relatively large epidemics of BSE. *N Engl J Med.* 2004 Feb 5;350(6):539-42 [also see MMWR 2004, Jan 9;52:1280-5]

**Graded activity was more effective than usual care in reducing the number of days of absence from work because of low back pain.** 134 airline workers who were absent because of low back pain were randomly assigned to either graded activity (n = 67 = a physical exercise program based on behavioral principles) or usual care (n = 67). The median number of days of absence from work over 6 months of follow-up was 58 days in the graded activity group and 87 days in the usual care group. From randomization onward, graded activity was effective after 50 days of absence from work (hazard ratio, 1.9). *Ann Intern Med.* 2004 Jan 20;140(2):77-84

**Daily intake of green-yellow vegetables was associated with a 26% reduction in the total risk of death from stroke in men and women** compared with an intake of once or less per week in the Hiroshima/Nagasaki Life Span Study. 1980-1981 prospective cohort study of 40,349 Japanese men and women followed until 1998. 1,926 stroke deaths were identified during follow-up. An increasing frequency of intake of green-yellow vegetables and fruit was associated with a 32% reduction in infarction in men and a 30% reduction in women. Daily fruit intake was associated with a 35% reduction in risk of total stroke in men and a 25% reduction in women. *Stroke.* 2003 Oct;34(10):2355-60.

**Of all the workplace interventions only exercise and the comprehensive multidisciplinary and treatment interventions have a documented effect on low back pain (LBP).** 31 publications from 28 intervention studies were found to comply with the inclusion criteria (controlled trial, work setting and assessment of at least one of 4 main outcome measures: sick leave; costs; new episodes of LBP; and pain). Exercise interventions to prevent LBP among employees and interventions to treat employees with LBP have documented an effect on sick leave, costs and new episodes of LBP.

Multidisciplinary interventions have documented an effect on the level of pain. *Occupational Medicine* 2004; 54:3-13

**Long-term coffee consumption is associated with a statistically significantly lower risk for type 2 diabetes** Prospective cohort study. (Nurses' Health Study and Health Profs' Follow-up Study) of 41,934 men (1986-1998) and 84,276 women (1980-1998) measuring coffee use q 2 to 4 years via questionnaires. 1,333 new cases of type 2 diabetes in men and 4,085 in women occurred with relative risks for regular coffee consumption (0, <1, 1 to 3, 4 to 5, or > or =6 cups per day) in men were 1.00, 0.98, 0.93, 0.71, and 0.46, respectively; in women 1.00, 1.16, 0.99, 0.70, and 0.71, respectively. For decaffeinated coffee, 4 cups or more per day had relative risks = 0.74 vs nondrinkers (men) and 0.85 (women). *Ann Intern Med.* 2004 Jan 6;140(1):1-8

**Increasing cumulative days of antibiotic use were associated with increased risk of incident breast cancer,** adjusted for age and length of enrollment. For categories of increasing antibiotic use (0, 1-50, 51-100, 101-500, 501-1000, and > or =1001 days), odds ratios for breast cancer were 1.00 (reference), 1.45, 1.53, 1.68, 2.14, and 2.07. Case-control study among 2,266 women with primary, invasive breast cancer (cases) enrolled for at least 1 year between 1993, and 2001, and 7,953 randomly selected females (controls). The authors indicate these findings reinforce the need for prudent long-term use of antibiotics. *JAMA* 2004;291:827-835,880-881

**The annual number of spinal-fusion operations rose by 77 percent between 1996 and 2001** per AHRQ (<http://www.ahrq.gov/data/hcup/>). Hip replacement and knee arthroplasty increased by 13-14%. Average spinal-fusion hospital bill is more than \$34,000. Factors cited: population changes, technological advances, and uncertain indications (e.g., recently added indication of diskogenic pain, or low back pain without sciatica in patients with degenerative disks), and financial incentives. *N Engl J Med.* 2004 Feb 12;350(7):722-6

**The duration of the heart rate-corrected QT interval is directly related to the risk of coronary heart disease (CHD) and cardiovascular disease (CVD) mortality in healthy subjects.** From a study of 14,548 healthy middle-aged adults -- men and women, blacks and whites -- who underwent ECG testing. Compared with the other 90% of subjects, those with the longest intervals were 2.14-times more likely to being diagnosed with CHD and 5.13-times more like-

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## News You Can Use

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ly to die from CVD. *J Am Coll Cardiol* 2004;43:565-575

**Low doses of ionizing radiation to the brain in infancy influence cognitive abilities in adulthood** per a population based cohort study of 3,094 men who received radiation for cutaneous haemangioma before age 18 months during 1930-59. The proportion of boys who attended high school decreased with increasing doses of radiation from 32% among those not exposed to 17% in those who received > 250 mGy. Odds ratio was 0.47 (frontal dose) and 0.59 (posterior dose). A negative dose-response relation was seen for the three cognitive tests for learning ability and logical reasoning but not for the spatial recognition test. *BMJ*. 2004 Jan 3;328(7430):19

**Tumor necrosis factor (TNF)-beta polymorphisms appear to be associated with greater disease severity in patients infected with hepatitis C virus (HCV).** Researchers studied 52 patients with chronic HCV and healthy controls. The TNF-beta A/A allele was significantly more common in patients (28.8%) than in controls (12.8%); and patients with severe hepatic fibrosis were more frequently carriers of the TNF-beta A/A allele than were patients with milder disease. 14 of the 15 patients with the allele had severe liver disease and significant hepatic fibrosis. *J Med Virol* 2004;72:60-65

**New research suggests that the prevalence of aspirin-induced asthma among adult asthmatics is 21%, much higher than previously thought** based on an analysis of data from 21 studies that recorded the prevalence for aspirin-induced asthma (provocation testing). 21% of adults and 5% of children with asthma have a sensitivity to aspirin. Prevalence by verbal history alone indicated only 3% and 2%. Patients with aspirin-induced asthma were nearly always sensitive to other NSAIDS, such as naproxen, ibuprofen, and diclofenac. *BMJ* 2004;328:434-437

**Lost productive work time (LPT) costs from health conditions cost employers 225.8 billion US dollars/year** (\$1,685 /employee/yr); per a telephone survey of a random sample of 28,902 U.S. workers. 71% is explained by reduced performance at work. Personal health LPT was 30% higher in females and 2X higher in smokers (> or =1 pk/day) vs. non-smokers. Workers in high-demand, low-control jobs had the lowest average LPT/week vs. the highest LPT for those in low-demand, high-control jobs. Family health-related work absence accounted for 6% of all health-related LPT. Costs vary significantly by worker characteristics. *J Occup Environ Med*. 2003 Dec;45(12):1234-46

**Injury-attributable medical expenditures cost as much as 117 billion dollars in 2000, approximately 10% of total U.S. medical expenditures** according to CDC analyzed data on injury prevalence and costs from the 2000 Medical Expenditure Panel Survey (MEPS) and the National Health Accounts (NHA). *MMWR Morb Mortal Wkly Rep*. 2004 Jan 16;53(3):66

**Persons who wish to reduce their risk of death in a crash should wear their own restraint and should ask others in the same car to use their restraints.** Matched-pair cohort study of USA crashes in 1988-2000. Target same-car pairs, at least 1 of whom died were assessed: 61,834 front-seat pairs, 5278 rear-seat pairs, and 21,127 pairs on the left or right side. Risk ratio =1.20 for death within 30 days for a restrained front occupant in front of an unrestrained occupant vs. in front of a restrained occupant. RR was 1.22 for a restrained rear occupant behind an unrestrained front occupant compared with a restrained rear occupant behind a restrained front occupant. *JAMA*. 2004 Jan 21;291(3):343-9.

**High linoleic acid intake is possibility positively associated with cognitive impairment and high fish consumption inversely associated with cognitive impairment;** based on dietary history (1985 and 1990) and data (30-point Mini-Mental State Exam) from a cohort of 476 men (69-89y/o). High linoleic acid (a polyunsaturated fatty acid) intake was associated with cognitive impairment (odds ratio for highest vs. lowest tertile = 1.76). n-3 polyunsaturated fatty acids intake was not associated with cognitive impairment; high fish consumption was inversely associated with cognitive impairment (OR = 0.63) and cognitive decline (OR = 0.45). Beta-carotene, vitamins C and E, and flavonoids were not inversely associated with cognitive impairment or decline. *Am J Epidemiol*. 1997 Jan 1;145(1):33-41.

**Regular aspirin use may be an effective way to prevent Hodgkin's disease.** Data from 565 patients with Hodgkin's disease and 679 matched control subjects. Regular (2 tabs/wk for prior 5 years) aspirin users were 40% less likely to have Hodgkin's disease than non-regular users (regular use of other NSAIDS had no effect). *J Natl Cancer Inst* 2004;96:305-315,316-325

**Vitamin E bioavailability from fortified breakfast cereal was shown to be greater than that from Vitamin E pills** by three 4-day trials (2 wk apart). Five fasting subjects showed the mean vitamin E bioavailabilities of a 400-IU cereal was 26 X, the vitamin E bioavailability of a 400-IU capsule. *Am J Clin Nutr*. 2004 Jan; 79(1): 86-92

# Summary of 2003 California Workers' Compensation Legislative Changes

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**D**r. McKenzie has served on the Industrial Medical Council (IMC) staff since 1992 and has a historical perspective on the Council's activities. The 2003 legislative session was one of the busiest she can remember at the Division of Workers' Compensation (DWC). As in 1989 and 1993, workers' compensation is targeted for legislative reform. Reform is tied to reduction of the state's \$38 billion budget deficit and to shoring up a workers' compensation insurance industry that is suffering double-digit premium increases after deregulation. Employers, the Governor, and the legislature view reducing rising medical treatment costs in workers' compensation as one way to accomplish this task.

Over fifty bills on workers' compensation were introduced in the Senate and Assembly during the 2003 legislative session. Former Governor Davis and Insurance Commissioner Garamendi also offered proposals for reform. Medical fee schedules, utilization control, physician referrals, dispute resolution, fraud reporting and the IMC itself were but a few of the subjects dealt with by these varied proposals. After much discussion and committee work in both houses, the useful provisions of most of the proposals were wrapped into Senate Bill 228. The remainder of this article will be a bullet-point synopsis of the changes brought about by SB 228. Areas that the authors felt were of special interest to WOEMA members are in italics. The full text of SB 228, and its numerous precursors, can be accessed at <http://www.leginfo.ca.gov/bilinfo.html>.

## California Senate Bill 228

Senate Bill 228 was signed into law on September 30, 2003 and became effective on January 1, 2004. This bill makes numerous changes to California's workers' compensation program. This bill excludes group health and auto. This bill applies to workers' compensation only.

## Fee Schedule

- The Administrative Director, after public hearings, shall adopt and revise periodically an Official Medical Fee Schedule (OFMS). Reasonable maximum fees shall be established for medical services other than:
  - Physician services
  - Drugs and pharmacy services
  - Health care facility fees
  - Home health care
  - All other treatment, care, services, and goods in Labor Code §4600.
- The Administrative Director must contract with an independent consulting firm to perform an annual study of access to medical care. If, based on this study, there is insufficient access to quality care for injured workers, the Administrative Director may make adjustments to the medical and facilities' fees (including fees higher than 120% of Medicare).
- Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems.
- *Physician services – Maximum fees for physician services, for the calendar years 2004 and 2005, shall use the existing OMFS, but these rates must be reduced by 5%.*
- *The administrative director may reduce fees of individual procedures by different amounts, **except for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.***
- Outpatient surgery centers – Maximum facility fees for services performed in an ambulatory surgical center or hospital outpatient department may not exceed 120% of Medicare.
- Pharmacy – Pharmacy services and drugs not covered by Medicare may not exceed 100% of fees prescribed in the relevant Medi-Cal payment system. The bill also clarifies that all dispensers for workers' compensation prescription drugs must dispense generic, unless a brand name has been

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## Workers' Comp. Legislative Changes

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- specifically prescribed.
- Medical services other than physician services – Maximum fees for medical services other than physician services may not exceed 120% of Medicare.
- Medical-legal expenses – the OMFS does not apply to medical-legal expenses.
- Prior to the adoption of an OMFS, any treatment, facility use, product or service not covered by a Medicare payment system, including acupuncture services, or with regard to pharmacy services and drugs not covered by a Medi-Cal payment system, the maximum reasonable fee shall not exceed the OMFS fee as of 12/31/03.
- The following Medicare payment system components may not become part of the OMFS until 1/1/05:
  - In-patient skilled nursing facility care;
  - Home Health Agency services;
  - In-patient services from exempted general acute care hospitals; and
  - Out-patient renal dialysis services.
- Employers or insurers may continue to enter into contracts paying rates other than those in the OMFS.
- As of 1/1/06, the Administrative Director shall have the authority, after public hearings, to adopt and periodically revise an OMFS for physician services.
- Implantable medical devices, hardware, and instrumentation for Diagnostic Related Groups (DRGs) 004, 496, 497, 498, 519 and 520 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10 percent of the provider's documented paid cost, not to exceed a maximum of \$250, plus any sales tax and shipping and handling charges actually paid.
  - This section is operative only until the Administrative Director adopts a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries.

### Medical Treatment Utilization Schedule

- *The Administrative Director must adopt, after public hearings, a medical treatment utilization schedule by 12/1/04.*
- The schedule must incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the Commission on Health and Safety and Workers' Compensation.
- The schedule must address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.
- *Until the Administrative Director develops the medical treatment utilization schedule, the medical care guidelines established by the American College of Occupational and Environmental Medicine (ACOEM) will be "presumptively correct."*
- The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guideline is reasonably required to cure and relieve the employee from the effects of his or her injury.
- Presumption afforded to the treating physician is not applicable where these medical treatment utilization schedules exist.
- Temporary disability cannot be terminated unless the primary treating physician with a presumption finds the condition permanent and stationary.
- Relevant portions of medical treatment protocols published by medical specialty societies are admissible at, or subsequent to, a hearing before the Appeals board as proof of any disputed fact.
- *For injuries after 1/1/04, an employee would be entitled to no more than 24 chiropractic and 24 physical therapy visits per industrial injury.*
- An insurance carrier may authorize, in writing, additional visits to a health care practitioner for physical medicine services.

### Prompt Payment

- *Requires an employer to provide payment to a physician for a workers' compensation claim within 45 working days after receipt of each separate, itemized billing which must include required documentation. Previous law requires payment within 60 days.*
- *Claims not paid within 45 working days shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill. Currently the interest rate is at 10 percent.*
- If the employer is a governmental entity, the prompt payment timeframe is 60 working days.
- Bills submitted by a physician or provider that are reduced to the amount specified in the OMFS, preferred provider contract, or negotiated rate for the procedure codes billed are no longer exempt from the prompt payment requirements.

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## Workers' Comp. Legislative Changes

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- Rules and regulations requiring employers to accept electronic claims must be adopted by 1/1/05 and must require all employers to accept electronic claims for payment of medical services by 7/1/06.
- *Electronic billing must be paid within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the OMFS. If the billing is contested, denied or incomplete, the timetable for payment will revert to the 45 working days as described above.*

### Utilization Review

**Definition:** Utilization review (UR) – functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services.

- *Every employer must establish a utilization review process, either directly or through its insurer or an entity with which an employer or insurer contracts for these services. Previous law was permissive not mandated.*
- *Each UR process must be governed by written policies and procedures. The policies and procedures must ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization (as described above).*
- *The policies and procedures, and a description of the utilization process, must be filed with the Administrative Director and must be disclosed by the employer to employees, physicians, and the public upon request.*
- *The employer, insurer, or other entity must employ or designate a medical director who is a California licensed medical doctor or osteopathy physician.*
- *The medical director must ensure that the process by which the employer or other entity reviews and approves, modifies, delays or denies requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services, complies with the UR requirements.*
- *The criteria or guidelines used in the UR process must be:*
  1. *Developed with the involvement from actively practicing physicians;*
  2. *Consistent with the medical treatment utilization schedule adopted by the administrative director (or ACOEM treatment guidelines prior to adoption);*
  3. *Evaluated at least annually and updated if necessary;*
  4. *Disclosed to the treater and the injured worker the basis of the decision; and*
  5. *Made available to the public upon request. (An employer may charge members of the public reasonable copying and postage expenses related to disclosing the guidelines.)*
- *Only a licensed physician competent to evaluate the specific clinical issues, which are within the scope of the physician's practice, may modify, delay, or deny treatment plans.*
- *Prospective or concurrent decisions must be made in a timely fashion that is appropriate for the nature of the employee's condition, within five working days from receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.*
- *For retrospective reviews the decision must be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.*
- *In cases of serious threat to the employee's health, a decision must be made within 72 hours from the receipt of all necessary information.*
- *All UR prospective and concurrent determinations must be communicated to the requesting physician within 24 hours of the decision. If the decision is to modify, delay or deny, then the following communication process and timeframes are required:*
  - *Concurrent reviews – initially by phone or fax to physician and in writing to physician and employee within 24 hours.*
  - *Concurrent review – medical care shall not be discontinued until physician has been advised of decision and a care plan agreed upon.*
  - *Prospective reviews – initially by phone or fax to physician and within two business days.*
- *If the request is not approved in full, disputes must be resolved in accordance with the dispute resolution process.*
- *Communications regarding the UR determination must specify:*
  - *The specific medical treatment services being approved; or*

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## Workers' Comp. Legislative Changes

*Continued from page nine*

- for modification, delay or denials of services, a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.
- If the employer, insurer or other entity cannot make a decision within the required timeframe because it has insufficient information or requires further testing, they must immediately notify the employee and the treating physician in writing and provide specific reasons for the delay and provide the anticipated date on which a decision will be made.
- Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary must be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments. No fees will be levied upon insurer or self-insured employer making these required reports.
- Every employer, insurer, or other entity must maintain telephone access for physicians to request authorization for health care services.
- The administrative director may impose administrative penalties, which will not be the exclusive remedy, for anyone failing to meet the UR procedures and timeframes.

### Presumption of Correctness

- For dates of injury before 1/1/03 and cases where the employee has "pre-designated" his or her personal physician or chiropractor, the treaters' presumption of correctness is retained. *In all other cases, the treaters' presumption of correctness is repealed.*

### Referrals

- Current law prohibits a physician from referring a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy or diagnostic imaging goods or services if the physician (or immediate family) has a financial interest with the person or in the entity that receives the referral. This bill adds outpatient surgery to the list of prohibited services.
- Outpatient surgery includes both of the following:
  - a. Any procedure performed on an outpatient basis in the operating rooms, ambulatory surgery rooms, endoscopy units, cardiac catheterization laboratories,

or other sections of a freestanding ambulatory surgery clinic, whether or not licensed as a clinic under the Health and Safety Code.

- b. The ambulatory surgery itself.
- *This section shall not apply where the referring physician obtains a service preauthorization from the insurer or self-insured employer after disclosure of the financial relationship.*

### Industrial Medical Council

- *Eliminates the Industrial Medical Council and transfers many of its functions and duties to the Administrative Director.* ■

Synopsis of the legislation for the following topics can be found in the full article on WOEMA's web site [www.woema.org](http://www.woema.org)

**Alternative Dispute Resolution (ADR)**

**Fraud Reporting**

**Injury and Illness Prevention Plan**

**Medical Lien Filing Fee**

**Second Opinion for Spinal Surgeries**

### INTERESTING AND USEFUL WEB SITES

## Evidence-based Medicine Demystified in a Quick Duke Tutorial.

BY CONSTANTINE GEAN, MD, MA, MBA, FACOEM

Have you ever felt secret guilt because everyone except you seems to know what Evidence Based Medicine (EBM) really is—perhaps occasionally reducing you to offering wise nods to convey mastery while secretly hoping not to be asked your opinion? You can now transform this burden into legerdemain with the help of the Duke University Medical Center Library that offers an easily-accessed and concise tutorial on EBM at: <http://www.mclibrary.duke.edu/respub/guides/ebm/overview.html>. Tutorial units include: (1) What is Evidence Based Medicine? (defines and explains EBM steps) (2) The Well-Built Clinical Question (describes a patient and types of clinical questions) (3) Literature Search (reviews literature search techniques) (4) Evaluating the Evidence (goes over criteria for study validity), and (5) Testing your Knowledge (gives practice cases).

**Bonus Site:** Updated SARS Clinical Guidelines

The CDC released updated SARS Clinical Guidelines and Healthcare Facilities Checklists. These are available at <http://www.cdc.gov/ncdod/sars/clinicians.htm>.

## WOEMA's Future Initiatives Updated as Board Reviews the 'Five Bold Steps'

BY CONSTANTINE GEAN, MD

**T**he WOEMA Board held its annual strategic planning meeting in El Segundo at the end of February and discussed and updated the '5 Bold Steps', which is the name for the key initiatives the Board originally created in 2001. Each step was assessed for its current status, its compatibility with WOEMA's strategic direction and what should be done next to achieve the desired results.

**Bold Step #1** "Make the WOHC annual conference more innovative & interesting" was assessed as a success to date.

**Bold Step #3**, "Pursue Corporate Memberships" has had only modest progress and this remains an area of emphasis.

**Bold Step #4** "Develop Relationship With ACOEM" is beginning to move forward with co-presentations, joint

course offerings and activities involving the ACOEM guidelines anticipated.

**Bold Step #5**, "Develop Legislative Plan" has made considerable progress with the broadening of the legislative committee and the Board's agreement to engage in active lobbying activities for workers' compensation legislation.

**Bold Step #2** "Develop Phase 1 Knowledge Network" has been accomplished and is now being transferred from 'Bold Step' status to committee for ongoing servicing. Replacing it is the new Bold Step, "Secure WOEMA's financial future" and is anticipated to involve promoting the awareness and the ability of outside groups and individuals to make financial contributions to WOHC and WOEMA. ■

### Welcome New WOEMA Members

Maria Aceves, PA-C, *Palm Springs*  
 Rey T. Aquino, *Brea*  
 Bret M. Bellard, MD, *Carson City, NV*  
 R. Timothy Butler, DC, *Fresno*  
 Kenichi Carrigan, MD, *San Francisco*  
 Robert S. Charlap, MD, *Anaheim*  
 Philip L. Denniston, Jr., MBA, *Encinitas*  
 David S. Emery, PA-C, *LaQuinta*  
 Tony C. Fernandez, MD, MPH, *Fresno*  
 Robert A. Fried, MD, *Petaluma*  
 Jeff Gao, MD, MPH, *Fremont*  
 Otashe N. Golden, MD, *Elk Grove*  
 David Z. Hall, MD, MPH, *San Bernardino*  
 Thomas W. Henn, MD, MPH, *Sun City West, AZ*  
 David E. Hjerpe, MD, *Santa Rosa*  
 Edward B. Holmes, *Sandy, UT*  
 Alan Hsu, MD, *Los Angeles*  
 Tony S. Hunt, MD, *Huntington Beach*  
 Mark H. Hyman, MD, *Los Angeles*  
 Gary A. Jacob, DC, LAc, MPH, *Los Angeles*  
 Michael A. Kelsh, PhD, *Menlo Park*  
 Brenda M. Klass, PhD, MFCC, *Encino*  
 Scott Kramer, MBA, *Rancho Cordova*  
 Alexander Latteri, MD, *Long Beach*

Alan H. Le, MD, *San Francisco*  
 Brenda W. Lee, MSN, *Seattle, WA*  
 Frank H. Leone, MBA, MPH, *Santa Barbara*  
 Ghan Shyam Lohiya, MD, MS, FACOEM, *Santa Ana*  
 Peter A. Lucero, MD, *Los Angeles*  
 Keegan M. Lyons, MD, MPH, *Edwards AFB*  
 Charles J. Martell, MD, *Los Altos*  
 Susan R. McKenzie, MD, MA, *South San Francisco*  
 Jeff C. Moon, DO, *Mercury, NV*  
 Geri J. Plotzke, RN, MBA, *Long Beach*  
 Baer Rambach, MD, *Santa Rosa*  
 Alfred N. Roven, MD, *Santa Monica*  
 Brian Schnare, MD, *Simi Valley*  
 Suzanne L. Sergile, MD, *Los Angeles*  
 Alastair K.A. Smith, MBBS *San Francisco*  
 William Spaller, MS, CPDM, CDMS, *Carmichael*  
 Anthony D. Streutker, MD, *Cathedral City*  
 David Suchard, MD, MPH, *Santa Rosa*  
 Stephen J. Svastits, DC, *Baldwin Park*  
 Christine Y. Wang, MD, *San Francisco*  
 David A. Wender, DO, MPH, *Oakland*  
 Leigh R. Wilson, MPH, *Westlake Village*  
 Eric M. Wood, MD, MPH, *Salt Lake City, UT*  
 James N. Yarusso, MD, *Tucson, AZ*

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Register online at [woema.org](http://woema.org)

# SEPTEMBER 16-18, 2004

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