



Western Occupational & Environmental Medical Association

Quality Assurance and Quality Improvement in the California Workers' Compensation System: A Focus on Utilization Review and Beyond

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■ I. PURPOSE AND INTENDED AUDIENCE

This paper is intended for legislators and other policy makers who might be interested in improving California's Workers' Compensation System through legislative or regulatory change.

■ II. INTRODUCTION

In complex health care systems, excellence in medical care depends on assuring "quality" throughout the system's components. California's Workers' Compensation System has multiple components that affect the delivery of care, which are potentially susceptible to the application of quality assurance (QA) and quality improvement (QI) principles. The goal of QA and QI would be to improve clinical outcomes, reduce needless work disability, control costs, streamline administrative friction, and assure fairness and appropriate compensation to injured workers. In this instance, QA would apply to systematic review of actions by various entities, while QI would include data analysis, feedback to the entities and adjustments to the system in response to data collected.

Particular value may be expected from strengthening QA of various "components" or stakeholders within California's Workers' Compensation System, as detailed below.

■ III. THE WORKERS' COMPENSATION SYSTEM IS COMPLEX

There are four principal stakeholders within California's Workers' Compensation System, with a partial breakdown of related subsets within each:

- A. Patients (workers claiming work-related injury or illness)**
 - 1. Applicant attorneys
 - 2. Union representatives

B. Providers of care

1. Primary treating physicians and medical consultants
 - a. Individual practitioners and medical groups
 - b. MPNs (Medical Provider Networks; regulated amalgamations of providers that contract with a specific employer to provide medical services for their injured workers)
2. Other treaters such as physical therapists
3. Medical testing entities such as imaging and laboratory, and networks of these
4. Pharmacies and medical equipment suppliers
5. Other: translators, transportation, etc.

C. Payors (employers and their insurers)

1. Self-insured employers
2. Workers' compensation insurers (contracted by an employer)
3. Third-party administrators (contracted by an employer to actually perform the day-to-day duties of the insurer while the insurer is ultimately responsible for the financial aspects)
4. Utilization review (UR; contracted by the insurer to allow control by authorizing or denying treatment requests by the providers)
 - a. Administrative personnel with no required medical training, who may approve requests or refer to a contracted physician for further review
 - b. UR reviewing physicians who may approve, deny or modify the treatment request
 - c. Pharmacy Benefit Managers (PBMs; contract to insurers to oversee medications used)
5. Case management
 - a. Administrative review
 - b. Nurse case managers

D. Regulatory apparatus

1. WCAB (Workers' Compensation Appeals Board)
2. Administrative law judges may hear individual case disputes
3. Independent Medical Review (IMR): independent mechanism to review disputes over treatment
4. Independent Bill Review (IBR): independent mechanism to review disputes over payment

This is only a partial list of the complex ecosystem of California Workers' Compensation. Many of the parties listed may have multiple subsets of agents and subcontractors, or may be part of larger groupings that may have their own protocols.

■ IV. OPPORTUNITIES FOR IMPROVEMENT VIA QUALITY ASSURANCE / QUALITY IMPROVEMENT

A. In our view, the following entities appear to show the most promise for system improvement through Quality Assurance / Quality Improvement implementation:

1. Individual medical providers
2. MPNs
3. Workers' Compensation insurers and TPAs
4. UR agents, including PBMs
6. Agents for payment of medical bills and worker benefits
7. Attorneys, both for the applicant and defense;
8. Workers' Compensation Administrative Law Judges

B. Furthermore, because of the complexity of the clinical processes involved in caring for injured workers, multiple steps in health care delivery might be subjected to QA scrutiny, including:

1. Initial communication with workers by employers or carriers about the Workers' Compensation System
2. Medical visits and treatments, and ancillary treatments (e.g. by physical therapists, including documentation)
3. Accuracy of billing and coding of medical services
4. Authorization for certain elements of care, performed under UR
5. Resolution of conflicts at various stages of clinical care (claim acceptance, authorization, and others)
6. Resolution of conflicts surrounding billing

C. Measurement of “quality” in health care has been well studied¹, and falls under the following framework:

1. Structural quality: Are the component stakeholders well prepared to play their roles skillfully and professionally?
2. Process quality: Are the individual steps which these stakeholders execute done well, as measured against a set of process standards (such as the ACOEM guidelines or URAC standards)?
3. Outcome quality: At the end of a case, has the system delivered good outcomes? In the case of the Workers’ Compensation System, such good outcomes would include the worker’s recovery from the illness or injury, a high level of functional capacity on the part of the recovered worker, the promptness of recovery and case resolution, satisfaction on the part of the worker and other stakeholders, and the cost to deliver these outcomes, among other measures.

Some forms of QA are in place in the system already, including UR on provider requests for authorization (RFAs), the existence of IMR and IBR, and URAC (an independent UR accreditation entity) certification of UR entities. However, IMR itself has no QA mechanism that transparently evaluates how well it evaluates clinical quality or affects outcomes; and URAC certification of UR entities is primarily focused on mechanistic and technical adherence to program structure and protocols without significant attention to the clinical aspects listed above. Thus, while there are some QA mechanisms in place, there is a major lack of QA and QI required by the system. Some individual providers and payors do have self-imposed QA built into their systems voluntarily, efforts which are to be lauded.

■ V. CURRENT PROBLEMS

California’s Workers’ Compensation System continues to be costly, compared with systems in other states; furthermore, the current system all too often delivers care that is of poor quality as measured against well established process guidelines, and is the source of friction and dissatisfaction among many stakeholders including health care providers, employers, and injured workers themselves. Furthermore, many of these problems have proved difficult to solve over recent decades, partly because of the often-adversarial nature of the system and its complexity.

Furthermore, there is evidence that many of the system’s problems follow a “Pareto” distribution. That is, a small percentage of stakeholders appear to account for a disproportional share of the problems in such key areas as surgery and other medical procedures done without appropriate clinical indication, wasteful and useless drug prescribing patterns, potentially dangerous opioid utilization, irrational denials and delays of reasonably necessary care by UR agents, needless work disability, and frivolous initiation of medical-legal and billing appeals which consume administrative resources within the system.

■ VI. DIRECTIONS FOR FUTURE IMPROVEMENTS

The California Workers’ Compensation System has been subjected to policy experimentation and huge policy shifts in the last 20 years [e.g. SB 899, SB 212, SB 863 and others], and currently may be on the verge of additional legislative change. To that end we suggest a suite of possible improvements in the current California Workers’ Compensation System, categorized according to the QA framework mentioned above.

A. QA Measures related to “Structural Quality”

The system “components,” that is, structures (as opposed to actions) that might be measured to assure that they are prepared and fit for successful performance include the following:

1. Medical providers

Providers might be “credentialed” in order to demonstrate that they are familiar with the system’s details and willing to adhere to key clinical concepts such as disability management and appropriate communication with stakeholders. Implementation of such credentialing might be done through regulation (incentivizing training or certification on adhering to the system) or through incentives such as “gold card” programs (automatic UR authorization for certain medical services) or modest payments for such adherence.

¹ Ayanian JZ, Markel H (2016). Donabedian’s Lasting Framework for Health Care Quality. *N Engl J Med* 2016; 375:205-207.

2. Medical provider networks

Networks are potentially a key locus of QA activities. Networks might be required to demonstrate that they have QA/QI procedures for all providers in their network, with procedures to track compliance with treatment guidelines or formulary adherence with feedback to providers on these measures, and procedures to track and report certain outcome measures for network performance generally. Additionally, alternate models for health care delivery under workers' compensation might be considered, such as capitation or modification of the structural arrangement for "carve-outs."

3. Insurers and UR agents (including PBMs)

In addition to such well-established measures as those used by URAC, insurers might be required to demonstrate that they meet minimum requirements for periodic training of key staff including UR peer reviewers, and that ancillary agents do not have conflicts of interest that might vitiate high quality decision making.

4. Administrative law judges and attorneys

Officers of the court might be required to demonstrate that they have a reasonable familiarity with key concepts in occupational health and safety, including principles of clinical care related to prevention of delayed recovery and needless work disability, and appropriate use or avoidance of certain medical services such as invasive procedures and chronic opioids.

5. System-wide communication:

Given the complex ecosystem of parties involved in the Workers' Compensation System in California, stakeholders often are poorly informed as to what role is filled by whom. It is very important that all parties identify themselves and their role in all communications, and that all essential roles be filled at all times by identifiable responsible parties. For instance, there should be a way for all parties to identify the names and accurate contact information as to:

- Current designated Primary Treating Physician,
- Responsible insurance claims representative or designee,
- Any nurse case managers with authorization to obtain information, etc.

B. QA Measures related to "Process Quality"

Various processes in the delivery of care to ill or injured workers, or in the administrative management of these cases, might be measured and improved to assure that they are consistent with established guidelines or other quality measures, including the following:

1. Behavior of employers and carriers when first notified of a possible work-related illness or injury

The processes that an employer and/or carrier might use to assure that ill or injured workers access needed medical care promptly might be tracked. Recognizing that multiple incentives already exist within the California system for good compliance (e.g., financial sanctions for failure to comply, and systematic enforcement activities by LETF and others), it may be reasonable to measure how often workers in certain higher risk groups (low wage and contingent workers) remain disadvantaged.

2. Clinical decision making, including requests for authorization

The Medical Treatment Utilization Schedule (MTUS) now guides process quality in a general way, but further improvements may be possible, particularly in persistent problem areas such as needless surgery and inappropriate opioid prescribing. In particular, carriers, MPNs, and regulators should adopt the general goal that marginal providers should be offered incentives and tools to improve their practice. However, providers whose level of quality consistently falls below established standards and who do not improve could be excluded from the system of care.

3. CPT coding of medical visits

The current coding rubrics for medical care, particularly for the E&M (evaluation and management) codes, are badly flawed in that they do not "incentivize" those medical services known to correlate with functional recovery; nor have they been validated against evidence-based practice guidelines. Accordingly, the State of California may wish to consider alternate CPT coding rules for use within the Workers' Compensation System (such as those already

adopted in Washington, Colorado, and other states, and as recently recommended by ACOEM), in order to align billing and coding rules with other proven measures of medical quality.

4. Utilization review (UR)

We regard UR as being an important element in improving clinical quality, yet the process is problematic. Many real-life medical decisions do not lend themselves to even the best cookbook recipes but deserve thoughtful consideration by knowledgeable physicians in the appropriate specialty.

Patients can be harmed by errors of both commission and omission, as well as by unnecessary delays. Measures to promote prompt, scientific and appropriate care decisions are needed for best outcomes for the patient, employer, and costs to the system.

For this, UR decisions should be subjected to systematic quality review, to assure that an acceptably high percentage of UR decisions comport with the community standards of care for medical practice. Such quality reviews might take the form of randomized audits of a certain percentage of decisions (including those certified, non-certified, and modified), with appropriate safeguards to assure the independence and reliability of such reviews.

Furthermore, some of the frictional costs of UR should be tracked and improved where possible, including attention to the ease of communication between UR agents and providers.

WOEMA has observed that many UR disagreements about authorization arise because of either inadequate documentation by the requesting provider, incomplete records availability as supplied by the insurer or UR entity, or technically adherent but clinically overly stringent application of MTUS provisions in cases where documentation is incomplete or where medical decision-making falls within a gray zone requiring clinical judgment.

Many of such clinically erroneous decisions result in needless delay of care, needless work disability, or outright harm to the patient. In the best of circumstances, many such unfortunate results can be prevented by a peer-to-peer (PTP) conversation, the opportunity for which is required by the present system. However, in practice such conversations are often not accomplished for the simple reason of the difficulty of scheduling with the busy provider.

5. We believe that measures to increase the rate of successful PTP calls will have a strongly positive return on investment. Such measures could include:

- a. An option on the RFA form for the requesting provider to designate times he/ she will be available, which the reviewing provider must honor;
- b. The option to communicate by alternate methods such as secure fax, voicemail, or digital means to accomplish the transmittal of needed data;
- c. Availability of the reviewing physician during extended hours.

6. Quality and timing of ancillary services, including prescription fills and physical therapy

In order to assure that delivery of ancillary services remains “patient-centric,” the timing and convenience of such services might be measured by tracking potential delays or by using well established “customer satisfaction” methods.

7. Quality and timing of procedural and legal services

With the recent implementation of IMRs and IBRs, it would be reasonable for the state to track how promptly and efficiently these appeals are being resolved.

C. QA Measures related to “Outcome Quality”

1. Key case-closure metrics

Although carriers typically compile detailed data about time-to-case-closure and claim costs, including total claim cost, medical costs, indemnity costs, and frictional costs, such data is not currently “benchmarked” across carriers in the state; nor is such data typically shared with medical providers and other stakeholders to allow them to modify their practices in response to QA/QI opportunities, or with employers to allow informed decisions on choice of insurers, providers, MPNs, etc. Accordingly, carriers might be either required or incentivized to report on their claim

cost data, stratified by various predictor variables, in order to allow cross-state benchmarking comparisons and to allow feedback to other stakeholders.

2. Patient satisfaction

The satisfaction of the ill or injured worker with the care and the administrative processes, while perhaps a problematic outcome metric due to inherent conflict of interest when secondary gain such as financial impact is an issue, should nonetheless be a concern to all system stakeholders. (Compassionate and competent care is certainly what all of us would want for ourselves, our families, and our friends if any of us should suffer a work injury.) Accordingly, patient satisfaction measures, using well-established survey instruments, might be tracked and rewarded.

3. QA measures related to “functional outcomes”

Just as data on claim costs and case duration might be tracked and benchmarked among carriers, so also patient outcome data might be tracked and benchmarked. In the world of Occupational Medicine, it is critically important to know whether injured workers return to a high level of functioning at the time of case closure, and what future anticipated medical costs or risks are present.

D. Quality and Feedback Loops

Among the cardinal principles of QA and QI practice are the following:

- One cannot improve what one does not measure;
- Timely feedback to stakeholders about their own performance is critical;
- Continuous quality improvement depends on continuous engagement of the stakeholders.

Accordingly, mere measurement of the above quality metrics is not enough. WOEMA recognizes that the disparate parts of the Workers’ Compensation System must be brought together collaboratively, so that quality measures can be shared and acted upon. In general, it is best to locate QA/QI activities as organizationally close as possible to the stakeholder. That is, QA feedback delivered from outside is typically less beneficial than QA feedback delivered from within one’s own organization. As an example, feedback delivered to a medical provider by an outside UR agent will be less effective than QA feedback delivered from the provider’s own medical group or medical network. Such an internal QA/ QI system would then be an appropriate target for DWC oversight.

Therefore, it will be of critical importance to design systematic incentives, including financial incentives for disparate stakeholders to work together to improve the California Workers’ Compensation System for the benefit of California workers, employers, and other participants.



Western Occupational & Environmental Medical Association (WOEMA)
575 Market Street, Suite 2125, San Francisco, CA 94105
415-764-4918 | woema@woema.org
www.woema.org

ABOUT WOEMA:

The Western Occupational and Environmental Medical Association (WOEMA) is a regional component of the American College of Occupational and Environmental Medicine (ACOEM), and is dedicated to high quality medical care and ethical principles governing the practice of occupational medicine. WOEMA represents over 500 physicians and healthcare professionals in five western states (AZ, CA, HI, NV, UT). It is the mission of WOEMA to promote and protect the health of people at work and in their environment through preventive service, clinical care, research, and evaluation. WOEMA is committed to assuring a safe work place, minimizing worker injury and illness, and serving as leaders, educators, collaborators and facilitators in preventing and resolving marketplace health problems. We value and focus on preventive medicine as well as the expeditious and effective management of illness and injury.