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April 14, 2017

The Honorable Tom Daly
Chair, Assembly Insurance Committee
California State Assembly
State Capitol, Room 3120
Sacramento, CA 95814

Subject: **AB 1295 (Chu) Workers' Compensation: aggregate disability payments - OPPOSE**

Dear Assemblymember Daly,

The organizations listed above must respectfully oppose AB 1295, which would complicate the claims-handling process and create a disincentive to apply medical standards prescribed by the State of California. Additionally, we believe that the entire premise of this bill is based in the sponsor's erroneous assertion that the Utilization Review (UR) and Independent Medical Review (IMR) processes are purely expensive mechanisms designed to delay and deny medical care. An assertion that just isn't supported by the data.

HOW MEDICAL TREATMENT DISPUTES GET RESOLVED

Current California law puts disputed medical treatment decisions in the hands of physicians that apply nationally-based, peer-reviewed, and evidence-based treatment guidelines to make determinations about what will help the injured worker heal most effectively. There are two main decision-making processes that are separate and distinct from one-another, even though they perform roughly the same function:

1. *Utilization Review*

When a claims administrator receives a medical treatment request (known as a Request for Authorization, or RFA) from a physician, they can either approve the treatment or refer it to

UR for review. UR has five days to approve, deny, or modify (meaning to change in some way; e.g. approve 6 weeks of physical therapy instead of 10) the RFA. That can be extended to 14 days if the treatment request wasn't supported by medical records and some additional information is needed from the requesting physician.

If the RFA is approved, then the process stops here. A claims administrator can NOT challenge a UR approval. If the RFA is modified or denied, then the IMR process can be triggered by the injured worker.

If IMR is not requested, then the decision stands as final. The UR process is controlled entirely by the claims administrator, or a contractor. However, it is tightly regulated and every claims administrator and UR provider are audited frequently to review their performance. Audit scores are public and compliance errors are met with steep financial penalties.

2. *Independent Medical Review*

If UR modifies or denies an RFA, then an injured worker has 30 days to request IMR. The IMR provider applies the exact same medical standards that were used by the UR provider in the decision to modify or deny medical treatment. IMR serves as a sort of "check and balance" on the decision that was made by the UR provider. Once IMR is triggered by a request, a claims administrator has 14 days to deliver records to the IMR provider. Once the IMR provider gets the records they have 30 days to deliver a decision. The decision is final.

The UR portion of this process is quite fast – 5-14 days. The IMR portion, with the 30 days to request and 30 days to reach a decision, extends the process considerably. However, this is a vast improvement over the prior dispute resolution mechanisms and the final decision on disputed medical treatment is reached within 90 days, and most frequently much earlier.

Prior to the UR / IMR processes we had situations where medical treatment disputes were settled by a medical evaluation that often took months to schedule, and then litigated in a hearing that also took months to schedule. In many cases to took 6-12 months to resolve disputes of medical treatment. The legislative history on this issue is clear. It is indisputable that the UR and IMR processes have streamlined the decision-making process and delivered treatment more quickly to injured workers.

DATA SHOWS UR DECISIONS UPHELD AT A RATE EXCEEDING 90%

Not only are the combined UR and IMR processes faster at delivering decisions to physicians and care to injured workers, but the UR process itself is impressively accurate in its decisions. The California Workers' Compensation Institute (CWCI) recently released a report entitled, "*Independent Medical Review Decisions January 2014 through December 2016*". The report contains some key findings:

- IMR physicians upheld UR modifications and denials at a rate of 91.2% in 2016.
- The number of IMR determinations issued in 2016 was 176,002, up from 142,983 in 2014.
- A small number of physicians drive a high volume of IMR requests. In fact, 1% of physicians account for 44% of disputed treatment requests. Just ten providers account for 11% of the disputed treatment requests. The report also notes that the same providers continue to be a problem year over year.

The data, we believe, shows that UR is extremely effective at quickly and accurately applying medical guidelines to treatment requests from physicians. We also believe that the data demonstrates the nature of the real problem – that a very small number of physicians submit a high volume of medical

treatment requests that are contrary to the medical standards set by the State of California, and that more and more injured workers, or their attorneys, are choosing to pursue IMR despite the nearly 90% probability that the UR decision was correct.

We would respectfully submit that the source of the delay is neither the UR process, or claims administrators. Claims administrators and UR providers, as is clearly outlined above, control only a portion of the process by which medical disputes are resolved. And, per the data, the decisions made in that portion of the process are upheld over 90% of the time.

If the sponsor of this bill were truly concerned with delay they would simply refer fewer treatment modifications and denials to IMR and encourage physicians to make more suitable treatment recommendations. However, we would submit that their clear record is sponsoring legislation that infuses friction, conflict, and delay into the system. The result is a more complex system that forces injured workers to hire an attorney, and pay that attorney out of their permanent disability benefits, just so they can navigate their claim.

ADDITIONAL CONSIDERATIONS

In addition to our general premise that the bill is based on the sponsor's erroneous conclusions that aren't supported by data, we'd offer the following observations:

- Roughly 50% of the IMR requests from 2014-2016 were to resolve disputes over pharmaceuticals. These requests will no longer be subject to UR or IMR as of 1/1/2018 because a drug formulary will have been implemented.
- This bill necessitates a complicated record-keeping process that the claims administrators must follow to demonstrate compliance when audited. Processes like this make claims administration more cumbersome and expensive, and takes attention away from the primary function of providing benefits to injured workers.

CONCLUSION

We are strongly opposed to AB 1295 because it is based in misunderstanding of the claims administration process, and it creates additional unnecessary bureaucratic barriers to the effective administration of claims. The data and legislative history on this subject don't lie – UR and IMR result in faster and more effective dispute resolution, and the delay that the sponsor is purportedly concerned with could easily be remedied if they were to simply apply a bit of discretion when requesting IMR.

Sincerely,

California Coalition on Workers' Compensation
California Manufacturers & Technology Association
California State Association of Counties
National Federation of Independent Business
California Association of Joint Powers Authorities
California Association for Health Services at Home

California Chamber of Commerce
Association of California Insurance Companies
CSAC Excess Insurance Authority
Association of California Healthcare Districts
League of California Cities
American Insurance Association