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SB 537: Access to Care for the Injured Worker

CPTA is seeking action in the following areas:

1. Physicians, injured workers, employers, and claim adjustors have little control in directing care to downstream providers. ***Medical Provider Networks must have transparent directories where referrals can be made directly to participating providers and not networks.***
2. Third Party Administrators interfere and change plans of care that have been established by the physician and provider in an arbitrary manner, thus limiting frequency and interventions. ***These entities should not be able to circumvent the adoption of American College of Occupational and Environmental Medicine guidelines adopted by the State.***
3. In addition to handling utilization, some Third-Party Administrators (TPAs) perform claims adjudication and have been found to "unbundle" claims in attempt to maximize charges passed on the carrier without the knowledge of the provider. This increases costs which can be passed down to the employer without their knowledge. ***The provider should be the only entity allowed to alter billing codes submitted to the carrier.***
4. TPAs have the ability to move a patient to a lower cost provider after care has been initiated. This is a blatant example in which the needs of the injured worker are placed secondary to costs. The actual carrier may not realize any benefit from the movement of an injured worker to a lower cost provider as it is the TPA that gains the upside financial benefits. ***Patients should not be relocated to alternate providers without their consent and the consent of the physician, case manager, and/or employer.***

History of the Issue

In the past 20 years, California has implemented legislative remedies to attempt to increase consumer access to care and allow for equitable payment for physical therapist services in order to stimulate provider participation in the workers' compensation system. In 2001, A.B. 1177 amended section 5301.11 of the California Labor Code to allow health care providers, licensed health facilities, contracting agents, employers and health plans carriers to contract for reimbursement rates different from the Official Medical Fee Schedule (OMFS). The original intent of this legislative change was to account for special circumstances in which the injured worker required services or equipment that exceeded the costs allowed for in the Official Medical Fee Schedule. However, the statute also allowed for discount medical provider networks to negotiate fees far below the OMFS. This shift created a market for care to be directed based on provider contract pricing with no regard for quality. With consumer access, quality, and reimbursement declining, providers chose to opt out of medical networks completely. Those accepting discounted provider rates could only due so if services were limited in exchange for high volume. In recent years, this has spawned schemes where networks have been playing one provider against the other to drive rates lower and lower without regard for quality

In 2014, SB 863, which redistributed provider payment to encourage providers of physical medicine services to re-enter the market, was passed into law. The Medicare Resource-Based Relative Value Scale (RBRVS) system was then adopted to better align provider payment with traditional methodologies. As stated during Assembly Health Committee hearings, "This legislation is needed to close loopholes that result in unnecessary employer costs to recipients other than the injured worker." However, SB 863 did not curtail the aggressive discounting by networks that has since proliferated. The rationale for the bill also goes on to say that "physicians have complained that they are leveraged to be in networks they do not want to be in." The Official Medical Fee Schedule presented a shifting of payment to primary care and physical medicine with annual adjustments to insure stability in the provider market and enhance access to care. This is where the effects of A.B. 1177 and S.B. 863 became intertwined. TPA utilization management organizations and middlemen saw the opportunity to enhance their profit by continuing to drive the payments down to providers while taking a larger margin often not disclosing their provider discount arrangements to the carriers. The recognition by the State that a fair system of payment was required to draw providers into participation was but subverted by discount networks that have driven provider payment back to 2004 levels while they realize the benefit without advantage to the injured worker. These organizations have come to control the Medical Provider Networks (MPNs) to such an extent that a physician who wishes to refer an injured worker to a specific provider (i.e., a physical therapist) cannot do so as only the discount network is listed in the MPN directory as the provider. It is the network that then directs care based on the pricing arrangement they created and not based on physician choice, quality or ability to return a worker to the job in a timely manner.

As also stated in Assembly Health Committee, "These reforms are designed to improve the quality of the MPNs and in that regard improve the quality of evidence-based medicine as *the basis of treating injured workers*." The activities of these TPAs do not include any requirement for outcome measures, patient satisfaction or tracking return to work statistics from the low-cost providers. A TPA is actually defined as an organization that processes health claims without assuming financial risk. The practices observed transfer the financial risk away from the payer and over to the provider in the form of heavily discounted care.

"Under state regulations, each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. MPNs are required to meet access to care standards for common occupational injuries and work-related illnesses. The regulations also require MPNs to follow all medical treatment guidelines established by the DWC and allow employees a choice of provider(s) in the network after their first visit. Additionally, MPNs must offer an opportunity for second and third opinions if the injured worker disagrees with the diagnosis or treatment offered by the treating physician." (http://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html)

Specifically, in Workers' Compensation the TPA will create a tiered network that discounts the OMFS as much as 50 percent in exchange for directed care. These aggressive TPA activities compel providers to either participate or lose volume. In the end providers stop accepting these patients or close their doors as they see this population of patients shift to other discount providers.

The ability for some of these entities to enter the state and operate as pseudo utilization management entities has spawned federal lawsuits by providers. The settlement that came out of a recent lawsuit clearly highlighted the loopholes in California statute and regulations. The settlement took a big step in curtailing the activities of a single company but has done little to change the practices of the industry. In addition, the enforcement of settlement violations occurs on a federal level and is due to expire in 2022. It is imperative that the state identify the shortcomings of current law and implement a permanent remedy. Specific action toward that remedy has been outlined at the top of this document. CPTA believes these actions will go a long way toward increasing injured workers' access to important quality care in order to get them back to work quickly and safely.