

Senate Bill No. 863
WCIRB Cost Monitoring Report — 2014 Retrospective
Evaluation

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I. Executive Summary

On September 18, 2012, the Governor signed Senate Bill No. 863 (SB 863) into law. SB 863 increased benefits effective January 1, 2013 and January 1, 2014 and provided for a number of structural changes to the California workers' compensation benefit delivery system. The WCIRB's prospective evaluation of the cost impact of SB 863 was published on October 12, 2012.

The WCIRB's plan to retrospectively monitor the cost impact of SB 863 based on emerging post-reform costs was published on March 27, 2013. The WCIRB's initial retrospective evaluation pursuant to this plan was released on October 28, 2013. This report includes an updated retrospective evaluation of the cost impact of a number of SB 863 provisions based on data emerging through the third quarter of 2014.

In total, based on the most current information available in the less than two years since the initial components of SB 863 became effective, the WCIRB estimates the impact of SB 863 is an annual net savings of \$0.2 billion, or 1.2%, of total system costs. However, there are several other components of SB 863 for which only very preliminary information suggests there may be a significant deviation from original WCIRB estimates or it is too early to make an initial assessment. As a result, it is possible that later SB 863 cost assessments may differ significantly from this estimate.

The WCIRB's principal findings based on emerging post-SB 863 costs are summarized below.

1. The impacts of increases to weekly permanent disability (PD) minimums and maximums for 2013 injuries are emerging consistent with initial projections. (The most significant increases to PD maximums did not become effective until 2014 and cannot be assessed based on post-SB 863 experience until next year.)
2. Changes to PD ratings for adjustments related to future earning capacity (FEC) and PD add-ons were projected to increase average PD ratings by approximately 6% (prior to any impact from the Ogilvie decision). This is generally comparable to data on early 2013 PD ratings from the Disability Evaluation Unit (DEU) which suggests an approximate 4% increase in average PD ratings.
3. The changes to PD related to FEC were estimated to eliminate any increases to PD for the Ogilvie decision. While specific information related to Ogilvie adjustments to permanent disability ratings is not available, average PD ratings from WCIRB unit statistical data, the estimated proportion of claims involving Almaraz/Guzman adjustments based on DEU information, and changes in total indemnity costs per claim do not suggest any significant post-SB 863 increases to average PD ratings.
4. Indemnity claim frequency was projected to increase by approximately 2% from 2012 to 2014, in part due to SB 863 changes to indemnity benefits, while emerging frequency through June 30, 2014 indicates a 6% increase.
5. The number of lien filings was projected to decrease by approximately 41% as a result of the SB 863 lien filing fee and statute of limitations, while filings in 2013 and 2014 have decreased by approximately 60% annually when compared to 2011 levels.
6. SB 863's elimination of the duplicate payment for spinal surgical implants was estimated to save approximately \$20,000 per procedure, which corresponds to approximately 1% of overall medical costs. WCIRB Medical Data Call (MDC) data shows an approximate \$10,000, or 17%, reduction in the average cost of these procedures in 2013 when compared to pre-SB 863 levels. However, WCIRB MDC data also shows an estimated 10% decrease in the utilization of these services for

the same period. As a result, the estimated 25% decrease in total paid amounts for these surgeries is generally consistent with the WCIRB's prospective estimates.

7. SB 863's reduction in maximum ambulatory surgical center facility fees was estimated to reduce those costs by 25%, which is consistent with the reductions observed based on WCIRB MDC data estimates comparing post-January 1, 2013 reimbursements to pre-SB 863 levels.
8. The frequency of independent medical review (IMR) requests through the third quarter of 2014, even after eliminating duplicate and ineligible requests, is far above the levels initially projected.
9. Medical-legal costs, utilization review costs, litigation costs, and average unallocated and allocated loss adjustment expense costs continue to increase through 2013, suggesting any savings to frictional costs from IMR or other SB 863 provisions are not materializing.
10. Temporary disability (TD) duration was projected to decrease by 5% as a result of SB 863 provisions related to IMR and medical provider networks (MPNs). CWCI information on average TD duration for accident year 2013 shows an increase of approximately 4% at 12 months and average TD duration for accident year 2012 also shows an increase. However, inasmuch as the issuance of IMR decisions has experienced significant delays during the initial transition period due to a far greater than anticipated volume of requests, the extent to which IMR may ultimately impact TD duration remains uncertain.
11. Although it is still too early to assess the impact of IMR on medical treatment levels, average medical paid per indemnity claim shows a modest decrease in 2013.
12. Preliminary estimates of medical provider network usage through 2014 show that network utilization in 2013 and 2014 is continuing to increase modestly and the impact of network utilization on cost levels is generally consistent with that for prior years.
13. The changes to convert the physician fee schedule to a Resource-Based Relative Value Scale (RBRVS) basis were estimated to increase physician costs by 2.4% for services provided in 2014. Conversely, preliminary estimates of medical payments through the first six months of 2014 suggest a modest decrease in physician payments per claim.
14. Relatively few independent bill review (IBR) requests have been filed when compared to IMR filings, with early information suggesting that the majority of decisions favor the provider and result in additional payments.

Table 1 presents a summary of the WCIRB's prospective cost estimates of SB 863's cost components along with the potential impact on savings estimates based on the most recent information and any updated cost estimates if applicable.

Table 1: November 2014 Evaluation of SB 863 Cost Impact				
	WCIRB Prospective Evaluation		November 2014 Retrospective Evaluation	
	Total Cost Impact (\$millions)	Total % Impact	Preliminary Impact on Cost Savings ¹	Adjusted Cost Impact (\$millions) ²
Indemnity Cost Components				
Changes to Weekly PD Min & Max	+\$650	+3.4%	=	—
SJDB Benefits	(\$10)	-0.1%	TBD	—
Replacement of FEC Factor	+\$550	+2.9%	=	—
Elimination of PD Add-ons	(\$170)	-0.9%	TBD	—
Three-Tiered Weekly PD Benefits	(\$100)	-0.5%	TBD	—
Ogilvie Decision	(\$210)	-1.1%	TBD	—
Medical & LAE Cost Components				
Liens	(\$480)	-2.5%	+	(\$690)
Surgical Implant Hardware	(\$110)	-0.6%	=	—
ASC Fees	(\$80)	-0.4%	=	—
IMR – Impact on Frictional Costs	(\$180)	-0.9%	-	\$0
IMR – Impact on TD Duration	(\$210)	-1.1%	-	—
IMR – Impact on Medical Treatment	N/A	N/A	TBD	—
MPN Strengthening	(\$190)	-1.0%	=	—
IBR	N/A	N/A	TBD	—
RBRVS Fee Schedule	+\$340	+1.8%	+	—
Indemnity Claim Frequency	Sm. Increase	—	-	—
Indemnity Severities	Sm. Increase	—	=	—
Medical Severities	Sm. Increase	—	+	—
ALAE & ULAE Severities	Signif. Declines	—	-	—
Total Estimate – All Items	(\$200)	-1.1%		(\$230)

¹ A "+" implies additional savings above those prospectively estimated by the WCIRB, a "-" implies less savings (or additional costs), and a "=" implies savings (or cost) estimates generally consistent with prospective estimates. "TBD" implies that it is too early to retrospectively evaluate the cost component at this time.

² Reflects the total impact on system costs for components for which the WCIRB has enough information to make a revised estimate. Amounts not shown imply total cost impacts equal to the prospective estimates.

II. Background

SB 863, which was enacted on September 18, 2012, increased benefits effective January 1, 2013 and January 1, 2014 and provided for a number of structural changes to the California workers' compensation benefit delivery system. Following the enactment of SB 863, the WCIRB reviewed the impact of SB 863 on the cost of losses and loss adjustment expenses (LAE) underlying 2013 advisory pure premium rates. On a prospective basis, the WCIRB estimated that the net impact of the provisions of SB 863 quantifiable at the time of its prospective evaluation, once fully implemented in 2014, was a 2.7% reduction in the total cost of losses and LAE.³ (SB 863 included a number of amendments which the WCIRB was not able to prospectively evaluate at the time.)

On October 2, 2013, the Division of Workers' Compensation (DWC) adopted a new fee schedule for physician services based on a Resource-Based Relative Value Scale (RBRVS). The WCIRB's prospective evaluation of the RBRVS changes was included in its Amended January 1, 2014 Pure Premium Rate Filing. In total, the WCIRB estimated the new fee schedule would increase policy year 2014 costs by 1.8%.

These estimates of the cost impact of SB 863 were in part based on judgmental assumptions that may or may not materialize. In addition, a number of SB 863 provisions that could not be evaluated at the time of the WCIRB's prospective evaluation may ultimately have a significant impact on costs. As a result, the WCIRB developed a plan to proactively monitor and quantify post-SB 863 costs as they emerge. The *Senate Bill No. 863 WCIRB Cost Monitoring Plan* was submitted to the California Department of Insurance (CDI) on March 27, 2013.

The monitoring plan involves a multi-year retrospective measurement of the cost impact of key provisions of SB 863 and identifies the cost components to be measured, the data elements needed to measure these cost components, the general methodology used to measure these cost components, and the scheduled timeframe by which each of the cost components will be measured. As noted in the monitoring plan, the ultimate cost impact of many provisions of SB 863 will not be known for many years. The WCIRB's initial report on the impact of SB 863 based on emerging post-SB 863 costs was published on October 28, 2013.

This report represents the WCIRB's evaluation of emerging post-SB 863 costs for the cost components identified in the monitoring plan which can be measured by the fourth quarter of 2014.

³ WCIRB Evaluation of the Cost Impact of Senate Bill No 863, WCIRB, updated October 12, 2012.

III. Cost Components Evaluated – Changes to Indemnity Benefits

A. Minimum and Maximum Permanent Disability Benefits

SB 863 provided for increases in the minimum and maximum weekly permanent disability (PD) benefits for workers with injuries occurring on or after January 1, 2013, with an additional increase to maximum weekly PD benefits for injuries occurring on or after January 1, 2014. In total, the WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would increase costs by 3.5%. These estimates were primarily based on the WCIRB's legislative evaluation model, which estimates changes in indemnity benefits using distributions of claim costs by claim type and PD rating.⁴

In 2013, the most significant of the changes were to weekly PD benefit minimums, which increased for all PD claims regardless of PD rating, with increases to weekly PD benefit maximums only for claims with very high ratings. In 2014, increases to weekly PD benefit maximums became effective for the majority of PD claims. Table 2 shows the changes to weekly PD benefit minimums and maximums by PD rating.

Table 2: SB 863 Changes to Weekly PD Benefits						
PD Rating Interval	Pre-SB 863		Effective 1/1/2013		Effective 1/1/2014	
	Min.	Max.	Min.	Max.	Min.	Max.
1 to 54.75	\$130	\$230	\$160	\$230	\$160	\$290
55 to 69.75	\$130	\$230	\$160	\$270	\$160	\$290
70 to 99.75	\$130	\$270	\$160	\$290	\$160	\$290

The WCIRB has compiled preliminary information on accident year 2013 PD claims based on unit statistical reports at first report level. Based on the reported weekly wage and PD rating for each claim, the estimated incurred PD benefits were computed under the 2013 level and pre-SB 863 (2012) statutory benefit level. The estimated change in average PD benefits using this approach is compared to the WCIRB's prospective estimates by PD rating interval in Table 3, with the results being generally comparable based on this sample of early identifiable PD claims.

Table 3: Changes in Average PD Benefits for AY 2013 Based on WCIRB Unit Statistical Data			
PD Rating Interval	Prospective Estimate ⁵	Retrospective Estimate ⁶	Percent of 1 st Report Claims
1 to 14.75	+1.2%	+1.1%	71.5%
15 to 24.75	+1.0%	+1.6%	21.4%
25 to 69.75	+2.7%	+3.4%	6.9%
70 to 99.75	+7.0%	+5.9%	0.2%

B. Supplemental Job Displacement Benefits

SB 863 provided that a supplemental job displacement benefit of up to \$6,000 shall be offered to an injured worker who has not received a qualified return-to-work-offer. SB 863 also modified the basis upon which the supplemental job displacement benefit is paid and the types of expenses that are reimbursed. These changes are effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes would reduce costs by 0.1%.

⁴ The model is based on WCIRB unit statistical data and other sources of claim characteristic information and the parameters underlying the model are periodically reviewed and updated by the WCIRB's Actuarial Committee.

⁵ Based on 200,000 indemnity claims that occurred on policies incepting in 2008 and 2009, restated to 2013 wage and benefit levels.

⁶ Based on 16,000 accident year 2013 PD claims from policies incepting in 2012.

Table 4 shows calendar year paid vocational rehabilitation-related benefits—which include supplemental job displacement benefits—that are reported on the WCIRB's annual Aggregate Indemnity and Medical Costs Call through 2013. Calendar year 2013 vocational rehabilitation-related benefits are consistent with that of the immediate prior years.

Table 4: Calendar Year Paid Vocational Rehabilitation Benefits		
Calendar Year	Voc. Rehab. Paid (\$millions)	% of Total Indemnity Paid
2010	\$32.0	1.1%
2011	\$32.3	1.1%
2012	\$36.2	1.1%
2013	\$37.2	1.1%

Since supplemental job displacement benefits are paid well into the life of a permanent disability claim, it is premature to assess the impact of the SB 863 changes related to the supplemental job displacement benefit at this time. As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the impact of these changes will be evaluated in subsequent years.

C. Changes in Permanent Disability Ratings

SB 863 provided that the PD impairment produced in accordance with the American Medical Association (AMA) Guides will not be modified for future earning capacity (FEC) as in the 2005 Permanent Disability Rating Schedule (PDRS). Instead, SB 863 provided that a uniform adjustment factor of 1.4 will be applied to the whole person impairment determined pursuant to the AMA Guides.⁷ Additionally, by eliminating the application of the FEC factor, SB 863 in effect eliminates the impact of PD adjustments made in accordance with the 2009 workers' compensation appeals board (WCAB) decision in Ogilvie v. City and County of San Francisco.⁸ These changes to PD ratings were effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would increase costs by 1.8%. These estimates were primarily based on analysis of PD ratings issued by the Disability Evaluation Unit (DEU) and judgmental assumptions.

The WCIRB has compiled the latest information on PD ratings based on claims available from the DEU. In total, approximately 2,400 ratings from 2013 and later injuries were available through mid-2014. Exhibit 1 shows average PD ratings by accident year and age of rating based on the DEU database. PD ratings issued within the first 15 months after the injury increased by approximately 4% in 2013, which is generally consistent with the WCIRB's prospective estimates.⁹

Using the information in the DEU database, the WCIRB is able to estimate the impact of the changes to the FEC factor directly by restating the ratings from 2013 and later injuries under the pre-SB 863 approach. For each claim, the PD rating was calculated based on the FEC factor implied by the 2005 PDRS and compared to the actual rating determined for the claim. Table 5 shows the average PD ratings based on this approach, which are generally comparable to the WCIRB's prospective estimates.

⁷ Prior to SB 863, the FEC factor ranged from 1.1 to 1.4 depending on the injury.

⁸ Ogilvie allowed for the PD rating on a claim to be adjusted based on a finding that the FEC component of the PD rating did not appropriately describe the loss of future earning capacity.

⁹ The WCIRB projected an approximate 6% increase in average PD ratings as a result of the SB 863 changes to the FEC factor in addition to the elimination of PD add-ons.

Table 5: Average DEU Ratings with Changes to FEC					
Estimate	Accident Years Used	Number of Ratings	Average Rating w/ FEC (Pre-SB 863)	Average Rating w/ 1.4 Factor (Post-SB 863)	Impact of FEC Change
Prospective	2005-2012	20,000	21.1	22.9	+8.5%
Retrospective	2013	1,800	11.9	13.2	+10.9%

Adjustments to PD for Ogilvie are typically not reflected in the DEU database. However, the WCIRB can review the DEU data and other PD data to assess whether the elimination of Ogilvie as well as other SB 863 provisions has an indirect impact on PD ratings, such as an increase in adjustments for the Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District (Almaraz/Guzman) WCAB decisions. Exhibit 2 shows the estimated prevalence of Almaraz/Guzman adjustments in the DEU database pre- and post-SB 863 based on information identified by the DEU rater. While the prevalence of ratings identified with an “Almaraz” or “potential Almaraz” adjustment had increased prior to the enactment of SB 863, these rates have been fairly consistent since the enactment of SB 863 in 2013.

Exhibit 3 shows average PD ratings based on WCIRB unit statistical data. Although unit statistical data include all PD claims including those not rated by the DEU, PD ratings reported at earlier report levels are typically claim adjuster estimates inasmuch as the majority of final PD ratings are not determined for several years. Nonetheless, preliminary information for accident year 2013 at first report level shows an overall decline in average PD rating.

D. PD Add-Ons

SB 863 eliminated increases in impairment ratings for psychiatric impairment, sleep disorder, and sexual dysfunction arising out of a compensable physical injury, with the exception of psychiatric add-ons for catastrophic injuries or injuries that resulted from a violent act. These changes became effective for injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would decrease costs by 0.9%. This provision included an estimated 10% offset to the estimated savings for psychiatric add-ons as a result of catastrophic injuries or injuries that resulted from a violent act.

PD ratings computed by the DEU include the impairment information to determine if the claim included a PD add-on. Exhibit 4 shows the proportion of claims in the DEU database that included an add-on for psychiatric impairment, sleep disorder, or sexual dysfunction by age of rating. Although the proportion of accident year 2013 claims with ratings issued within 15 months of the date of injury involving these add-ons is consistent with prior years, ratings involving add-ons typically do not appear until much later. At this time it is uncertain the extent to which the add-ons for accident year 2013 claims through 15 months identified in the DEU database are those intended to be eliminated by SB 863. As a result, the WCIRB will not be able to retrospectively assess the impact of the SB 863 provisions eliminating the PD add-ons until later monitoring reports.

A potential indirect impact of SB 863 is the increased use of other types of PD add-ons in lieu of those eliminated by SB 863. Inasmuch as ratings involving add-ons typically do not appear until later in the life of a claim as discussed above, the extent to which additional add-ons have emerged in post-January 1, 2013 injuries is uncertain at this time.

E. Indemnity Claim Frequency

The WCIRB's prospective evaluation of SB 863 included provisions for changes in indemnity claim frequency (utilization) as a result of the changes to PD benefits and other types of indemnity benefits inasmuch as frequency changes have historically accompanied changes in indemnity benefit levels. These provisions were based on a WCIRB econometric analysis of the effect of a number of economic,

demographic, and claims-related variables on the frequency of indemnity claims.¹⁰ The study showed that changes in indemnity claim frequency are related, in part, to indemnity benefit changes. Specifically, the model shows that for every 1% change in average indemnity benefits, the frequency of indemnity claims changes by approximately 0.2%.¹¹ In total, the WCIRB's prospective evaluation estimated that the changes in frequency as a result of SB 863 changes to indemnity benefits would increase costs by 1.1%.

Exhibit 5 summarizes the WCIRB's latest estimates of accident year indemnity claim frequency changes through June 30, 2014. Current estimates for the 2012 through 2014 accident years indicate moderate to significant increases in indemnity claim frequency, particularly when compared to the typical long-term decline experienced in earlier years. Also, as shown in Table 6, the indicated indemnity claim frequency increases for those years are significantly greater than the changes projected based on the WCIRB's econometric claim frequency model.¹²

Table 6: Indemnity Claim Frequency Changes		
Accident Year	WCIRB Model Projected Indemnity Claim Frequency Change ¹³	Estimated Actual Indemnity Claim Frequency Change ¹⁴
2012	-1.3%	+3.2%
2013	+2.3%	+4.1%
2014	-0.1%	+1.9% (6 Months)

Claim frequency patterns can be influenced by many diverse factors including changes in benefit levels. Exhibit 6 shows the distribution of PD claims by the injured worker average weekly wage reported in WCIRB unit statistical data. Wages are adjusted to a common (accident year 2013) basis. In 2013 there does not appear to be a significant shift in the proportion of PD claims which would have received increases in minimum or maximum weekly PD benefits (see Table 2). As a result, it is unclear the extent to which the higher-than-projected indemnity claim frequency changes are due to the increased SB 863 benefits and the extent they are due to economic factors, other components of SB 863, or other claims-related factors. The WCIRB will continue to study recent changes in indemnity claim frequency and provide updated information and estimates as they become available.¹⁵

¹⁰ Brooks, Ward, *California Workers' Compensation Benefit Utilization – A Study of changes in Indemnity Frequency and Severity in Response to Changes in Statutory Workers' Compensation Benefit Levels*, Proceedings of the Casualty Actuarial Society, Volume LXXXVI, 1999, pp. 80-262.

¹¹ This utilization provision is assumed to apply to temporary disability and permanent partial disability claims but not to medical-only, permanent total disability, death, or vocational rehabilitation claims.

¹² The indemnity benefit level in the WCIRB's econometric frequency model is a leading variable. That is, a change in indemnity benefit levels for a year is assumed to also impact indemnity claim frequency for the prior year. In addition to changes in indemnity benefit levels, the WCIRB's frequency model also projects frequency changes based on a number of economic and other claims-related factors.

¹³ See Part A, Section B, Appendix B, Exhibit 2 of the WCIRB's January 1, 2015 Pure Premium Rate Filing submitted on August 19, 2014. Frequency changes include the projected impact of shifts in the classification mix. The estimated impacts of class mix shifts on indemnity claim frequency are -0.5% for 2012, +1.1% for 2013, and no change for 2014.

¹⁴ See Exhibit 5. The 2012 estimate is based on indemnity claim counts compared to payroll adjusted to a common wage level from WCIRB unit statistical data. The 2013 and 2014 estimates are based on a comparison of changes in reported aggregate indemnity claim counts on WCIRB data calls to changes in statewide employment.

¹⁵ For more information on recent changes in indemnity claim frequency, see *Analysis of Changes in Indemnity Claim Frequency* (WCIRB, August 2012) and *Analysis of Changes in Indemnity Claim Frequency – 2013* (WCIRB, December 2013).

IV. Cost Components Evaluated – Changes to Medical Benefit Delivery System

A. Liens

SB 863 included a number of provisions related to liens. Liens filed on or after January 1, 2013 are required to be filed with the Workers' Compensation Appeals Board (WCAB) using an approved form and be filed with a \$150 filing fee. In addition, no liens may be filed more than three years from the date of service for liens filed before July 1, 2013 or 18 months from the date of service for liens filed on or after July 1, 2013. The WCIRB's prospective evaluation of the impact of SB 863 on lien-related costs estimated a 1.8% reduction in medical costs and a 7.8% reduction in loss adjustment expenses (LAE), resulting in a 2.5% reduction in total costs.¹⁶

In the WCIRB's prospective evaluation, it was assumed that approximately 41% of liens would be eliminated by the SB 863 lien filing fee and statute of limitations. The Division of Workers' Compensation (DWC) maintains lien filing information in its Electronic Adjudication Management System (EAMS). Exhibit 7 shows the number of liens filed by region and type of lien through the third quarter of 2014 based on DWC EAMS data. As shown, following the passage of SB 863 in the third quarter of 2012, lien filings in the remainder of 2012 increased dramatically. However, since January 1, 2013 the number of liens filed has decreased significantly in all regions and for all types of lien. In fact, the number of liens filed in 2013 is approximately 60% less than the number of liens filed in 2011, and lien filing rates have remained stable through the third quarter of 2014.

The WCIRB's prospective estimate of lien demand, settlement, and administrative costs was based on its 2012 Lien Survey of a random sample of 1,000 PD claims. In 2013 and 2014, the WCIRB issued subsequent Lien Surveys on 1,000 additional PD claims for information on liens active in 2013 or 2014.¹⁷ The results of the WCIRB's Lien Surveys are shown in Exhibits 8 through 14 and summarized below:

1. Approximately 24% of claims surveyed from Southern California regions¹⁸ had lien activity during the first half of 2013 or 2014, compared to 38% of claims with lien activity during the first half of 2012. Similarly, claims from Northern California regions saw a reduction in the proportion of claims with lien activity during the first six months of the year from 16% in 2012 to 6% in 2013 or 2014 (Exhibit 8).
2. The average number of active liens per claim with an open lien was fairly consistent across the Surveys (Exhibit 9).
3. The average delay between the accident date and the lien filing date was 3.0 years for liens active during the first six months of 2013 or 2014 compared to 2.5 years for liens active during the first six months of 2012. The average delay between the lien filing and the lien resolution was 1.7 years for liens resolved during the first six months of 2013 or 2014 compared to 2.0 years for liens resolved during the first six months of 2012 (Exhibit 10).
4. The distribution of liens by lien claimant type was fairly consistent across Surveys (Exhibit 11).
5. The median settlement amount for liens resolved during the first half of 2013 or 2014 was \$900, compared to \$525 for the first half of 2012 (Exhibit 12). The increase in median settlement amounts were experienced for almost all types of lien claimant.

¹⁶ The WCIRB's prospective evaluation did not include any estimated impact of the lien activation fee inasmuch as the lien activation fee is only effective on outstanding liens and would not affect post-January 1, 2013 injuries.

¹⁷ The 2013 and 2014 Lien Surveys were conducted on accident year 2008 and 2009 claims, respectively. The 2012 Survey was conducted on accident year 2007 and prior claims.

¹⁸ Claims were mapped to Northern or Southern California based on the zip code reported on the workers' compensation policy.

6. The average lien defense cost per Southern California claim¹⁹ with a lien was fairly consistent across the Surveys, regardless of when the lien was active (Exhibit 13).
7. Exhibits 8 through 13 reflect liens active in the first six months of the survey year regardless of when the lien was filed. Although significantly fewer liens have been filed after January 1, 2013, the WCIRB has compiled preliminary information on the cost of liens filed after the effective date of SB 863. Exhibit 14 shows, for each survey year, the average demand and settlement amounts for liens based on the year the lien was filed. From this survey sample, liens filed after January 1, 2013 appear to be for amounts consistent with liens filed prior to the effective date of SB 863.

During the initial implementation of SB 863, there were concerns that some liens would be replaced by “petitions for costs” filings in an attempt to avoid payment of the lien filing or activation fees – particularly in areas such as interpreter and copy service fees. However, in mid-2013, the WCAB published an *en banc* decision clarifying that a claim for medical-legal expenses may not be filed as a petition for costs.²⁰

The WCIRB has updated its estimate of the impact of the SB 863 provisions related to liens based on the emerging information related to lien filing activity discussed above. A 60% reduction in the number of liens filed after SB 863 has been estimated in lieu of the 41% reflected in the WCIRB’s prospective estimate. This results in an additional impact of -1.2% for a total impact of -3.7% on total costs.

B. Surgical Implant Hardware

SB 863 eliminated the separate reimbursement for implantable medical devices, hardware, and instrumentation for spinal surgeries, beginning with services provided on or after January 1, 2013. Additionally, SB 863 required the Administrative Director to adopt a regulation specifying an additional reimbursement for certain diagnostic-related groups (DRGs) pertaining to spinal surgery to ensure that aggregate reimbursement is sufficient to cover costs, including implantable hardware.²¹ On a prospective basis, the WCIRB estimated that the elimination of the multiple reimbursements would reduce total medical costs by 1% for a 0.6% reduction in total costs. (The WCIRB’s prospective estimate did not include any potential change to the utilization of spinal implant procedures.)

The WCIRB’s prospective estimate was, in part, based on a California Workers’ Compensation Institute (CWCI) study estimating the savings from eliminating the multiple reimbursements on claims with spinal surgeries.²² The study found that the duplicate payment for spinal instrumentation on these claims added an estimated \$20,000 to each procedure.

The WCIRB has compiled information on spinal surgical implants performed through 2013 based on its Medical Data Call (MDC) data. Specifically, surgical implant services provided in the second half of 2013 were compared to the same services provided in the second half of 2012. The number and cost of surgical episodes involving these services²³ are shown on Table 7. The reduction in the average cost of these episodes was approximately \$10,000, which is less than the \$20,000 per procedure reduction projected in the WCIRB’s prospective estimate. However, the number of surgeries involving these implants in the second half of 2013 decreased significantly when compared to the second half of 2012 and total paid losses related to these surgeries decreased by 25%. As a result, the emerging data on

¹⁹ Due to the sparseness of the data, average defense costs for Northern California claims could not be credibly estimated. However, the defense cost on observed claims was small.

²⁰ *Martinez v. Terrazas* (2013) 78 Cal. Comp. Cases 444.

²¹ The regulation was repealed on January 1, 2014.

²² *Preliminary Estimate of California Workers’ Compensation System-Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries*, CWCI, June 2012.

²³ Includes payments for DRGs, the implant specific revenue code (0278), and other revenue codes on the same hospital bill (e.g., radiology, lab, pharmacy, supplies, and physical training).

spinal implant hardware procedures are, in total, generally consistent with the WCIRB's prospective estimates.

Table 7: Number and Cost of Surgical Episodes Involving Spinal Implants Based on WCIRB MDC Data				
Dates of Service	All Implant DRGs ²⁴			All DRGs – Total Paid (\$millions)
	Total Paid (\$millions)	Total Episodes ²⁵	Average Paid per Episode	
7/1/2012 to 12/31/2012	\$18.8	326	\$57,608	\$106.2
7/1/2013 to 12/31/2013	\$14.1	294	\$47,985	\$103.5
% Change	-25%	-10%	-17%	-3%

C. Ambulatory Surgical Center (ASC) Fees

SB 863 provides that the maximum facility fee for services performed in an ASC should not exceed 80% of the Medicare fee for the same service in a hospital outpatient department (the prior cap was set at 120% of the Medicare rate for hospitals). These amendments would have resulted in a one-third reduction in ASC facility fee payments if it was assumed that the change in the maximum fee schedule allowance would translate directly to ASC facility fee costs. However, many ASC fees are reimbursed under contract at levels different from those contemplated in the fee schedule. The WCIRB's prospective evaluation estimated the reduction in ASC facility fees would reduce total medical costs by 0.8% based on a judgmental reduction of 25% in ASC facility fees rather than the one-third indicated if the fee schedule reduction would be fully reflected in reduced costs, resulting in a 0.4% reduction in total costs. (The WCIRB's prospective estimate did not include any potential change to the utilization of ASCs or outpatient hospital services.)

Earlier this year, the WCIRB in conjunction with CWCI released a comprehensive report detailing post-SB 863 outcomes for ASCs.²⁶ The report, which is included as Attachment A, showed that ASC costs in 2013 are generally consistent with the WCIRB's prospective estimates

The WCIRB has compiled updated information on ASC facility fees paid on services provided through the first half of 2014 based on its MDC data. Table 8 shows the paid cost related to ASC facility fees on services provided after January 1, 2013 compared to the reimbursements on claims with pre-SB 863 dates of service. The average reimbursement to ASCs in 2013 is 26% lower than the average reimbursement on services provided prior to the implementation of SB 863, which is consistent with the WCIRB's prospective estimates.

Table 8: ASC Facility Fee Results Based on WCIRB MDC Data			
Date of Service	Number of Episodes	Total Paid (\$millions)	Average Paid per Episode
Pre-1/1/2013	20,640	\$41.3	\$1,999
Post-1/1/2013	37,110	\$54.8	\$1,476
Change			-26%

²⁴ Spinal implant DRGs include: 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473.

²⁵ Episode is defined as a unique surgical event with defined "from and through" days of service.

²⁶ *Ambulatory Surgical Center Cost Outcomes: The Impact of California SB 863 Workers' Compensation Reforms*, WCIRB and CWCI, February 26, 2014.

Table 9 shows ASC costs compared to costs on outpatient hospital services for the same procedures provided both before and after SB 863. The proportion of total episodes utilized by outpatient hospitals has remained generally consistent after the implementation of SB 863, suggesting that no significant shift from ASCs to outpatient hospital facilities has yet occurred. Table 9 also shows that the relative cost per outpatient episode compared to the average ASC cost has increased significantly after the Bill and, as a result, outpatient hospitals represent a larger share of the total paid amounts after January 1, 2013.

Table 9: ASC and Outpatient Hospital Episodes Based on WCIRB MDC Data		
	Pre-1/1/2013 Services ²⁷	Post-1/1/2013 Services
ASC Episodes	20,640	37,110
Outpatient Hospital Episodes (% of All Episodes)	5,550 (21%)	9,308 (20%)
ASC Paid (\$millions)	\$41.3	\$54.8
Outpatient Hospital Paid (\$millions) (% of All Paid)	\$13.5 (25%)	\$24.2 (31%)
ASC Avg. Paid/Episode	\$1,999	\$1,476
Outpatient Hospital Avg. Paid/Episode (Difference vs. ASC)	\$2,427 (+21%)	\$2,603 (+76%)

D. Independent Medical Review (IMR)

SB 863 created a new IMR process for handling medical treatment disputes. IMR became effective on January 1, 2013 for new injuries and on July 1, 2013 for all injuries regardless of accident date. The WCIRB's prospective evaluation of the cost impact of IMR was segregated into several components, including savings attributable to lien costs, medical-legal reports, expedited hearings, temporary disability duration, and litigation costs. In total, the WCIRB estimated these IMR components would result in a 2.1% reduction in system costs. IMR also has the potential to significantly affect medical treatment costs. However, given the uncertainty as to how IMR will impact medical treatment, the WCIRB did not prospectively estimate the impact of IMR on medical treatment costs.²⁸

Table 10 shows the number of IMRs requested through September 2014 based on information received from the DWC through the IMR vendor. Once IMR became effective for all injuries regardless of the accident date starting on July 1, 2013, the number of IMR requests increased significantly. This level of requests held steady through the first quarter of 2014 but increased further starting in the second quarter of 2014. Based on the IMR activity for the most recent four quarters, the annual number of IMR requests may be up to four times greater than initial WCIRB projections.²⁹ However, a number of requests are duplicate requests or requests ineligible for IMR. Exhibit 15 shows the number of IMRs requested to date and those identified to be duplicate or ineligible by the IMR vendor. Although eliminating up to 40% of IMRs due to duplicate or ineligible requests significantly reduces the estimated number of IMRs performed per year, it still remains over two times greater than that projected by the WCIRB in its initial assessment of SB 863 cost impacts.

²⁷ Reflects services in the third and fourth quarters of 2012.

²⁸ The CDI's decision on the January 1, 2013 and January 1, 2014 Pure Premium Rate Filings reflected a projected 2.5% reduction in medical costs coming from the impact of IMR on medical treatment.

²⁹ The WCIRB prospectively estimated approximately 51,000 IMR requests to be filed per year when the SB 863 IMR process is fully in effect.

Table 10: IMR Filings	
Year & Quarter	IMRs Filed
2013 1Q & 2Q	784
2013 3Q	35,131
2013 4Q	40,930
2014 1Q	37,083
2014 2Q	59,967
2014 3Q	61,793

The WCIRB's prospective evaluation of SB 863 assumed that liens related to utilization review disputes would be replaced by IMR reports. Although the number of liens filed decreased dramatically after the effective date of SB 863 (see Exhibit 7), it is uncertain as to what proportion of the eliminated liens were a result of IMR compared to other SB 863 provisions impacting liens. As shown on Exhibit 11 based on WCIRB Lien Survey data, a significant number of liens related to medical treatment disputes were still active in 2013 and 2014.

The WCIRB's prospective evaluation of SB 863 also assumed that Qualified Medical Evaluator (QME) reports related to medical treatment issues would be replaced by IMR reports. Table 11 shows the number and average cost of medical-legal reports based on WCIRB MDC data. Even after IMR became effective on all injuries starting in the second quarter of 2013, the number and cost of medical-legal reports has not shown a significant decline.

Table 11: Number and Cost of Medical-Legal Reports			
Service Year & Quarter	% of Claims with Med-Legal Payments	Average Paid per Med-Legal Report	Total Med-Legal Paid (\$millions)
2012 3Q	9.4%	\$1,078	\$54.5
2012 4Q	9.2%	\$997	\$56.2
2013 1Q	8.8%	\$961	\$52.3
2013 2Q	8.3%	\$1,093	\$50.3
2013 3Q	9.2%	\$1,114	\$58.9
2013 4Q	8.4%	\$1,170	\$55.4
2014 1Q	9.0%	\$1,213	\$56.4
2014 2Q	9.4%	\$1,227	\$63.2

The WCIRB's prospective evaluation of SB 863 assumed that expedited hearings related to medical necessity would be eliminated by IMR. Preliminary information provided by the DWC suggests that the total number of expedited hearings has increased rather than decreased.

The performance of an IMR request is dependent on the execution of a valid utilization review (UR). Exhibit 16 shows preliminary estimates of the proportion of medical payments (including medical cost containment program (MCCP) costs) related to UR based on information from CWC1.

The WCIRB's prospective evaluation of SB 863 estimated significant savings to loss adjustment expenses (LAE) as a result of fewer frictional costs (as discussed above) in addition to reduced litigation related to medical treatment disputes. Table 12 shows estimated calendar year payments made by insurers to attorneys reported on WCIRB aggregate financial data calls. Payments to attorneys in 2013 have continued to increase compared to prior years.

Table 12: Payments Made to Attorneys Based on WCIRB Expense Calls				
Calendar Year	Payments to Applicant Attorneys (\$millions)	% Change	Payments to Defense Attorneys (\$millions)	% Change
2009	\$303	—	\$577	—
2010	\$349	+15.2%	\$608	+5.4%
2011	\$386	+10.6%	\$712	+17.1%
2012	\$450	+16.6%	\$774	+8.7%
2013	\$456	+1.3%	\$830	+7.2%

Table 13 compares 2013 projected changes in average unallocated loss adjustment expenses (ULAE), allocated loss adjustment expenses (ALAE), and MCCP costs per claim based on the WCIRB's prospective SB 863 estimates with what actually emerged. Average ALAE and ULAE costs per claim increased significantly in 2013, which is contrary to the significant declines initially projected.

Table 13: Change in Calendar/Accident Year 2013 LAE Costs Per Claim			
	ULAE	ALAE (Excl. MCCP)	MCCP
Prospective Estimate ³⁰	-12.3%	-7.8%	+2.1%
Actual Emergence	+3.8%	+6.2%	-0.5%

Based on the information discussed above, the WCIRB does not observe any savings to frictional or litigation costs from IMR emerging. As a result, the WCIRB has eliminated any savings related to these costs from its SB 863 cost estimates, which was prospectively estimated as a -0.9% impact on total costs.

The WCIRB's prospective evaluation of SB 863 assumed the new IMR process would reduce delays in medical treatment and as a result reduce the duration of temporary disability (TD) payments. Exhibit 17 shows the average number of paid days of TD based on CWCI data. The number of paid TD days for accident year 2013 at 12 months and accident year 2012 at 24 months continues to increase at approximately the pre-reform rate. However, inasmuch as the issuance of IMR decisions has experienced significant delays during the initial transition period due to far greater than anticipated volume of requests, the extent to which IMR may ultimately impact TD duration remains uncertain.

As discussed above, IMR has the potential to significantly affect medical treatment costs. At this time the extent to which IMR will impact medical treatment levels is still uncertain. As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB can retrospectively monitor changes in overall medical cost levels based on accident year paid medical severities from WCIRB quarterly aggregate financial data calls. Table 14 shows paid medical per indemnity claim severities for 2013 and 2014 compared to that for 2012. This preliminary estimate of post-SB 863 medical severities shows paid medical per indemnity claim emerging somewhat lower than the prior year.

³⁰ Includes the WCIRB's prospective estimates of the impact of SB 863 on calendar/accident year 2013 (MCCP was projected as a component of medical loss) in addition to the projected severity trends for 2013 reflected in the WCIRB's January 1, 2013 Pure Premium Rate Filing.

Table 14: Paid Medical per Indemnity Claim				
Accident Year	At 6 Months	% Change	At 18 Months	% Change
2012	\$2,102	—	\$7,029	—
2013	\$2,096	-0.3%	\$6,727	-4.3%
2014	\$2,038	-2.8%		

E. Medical Provider Networks (MPNs)

SB 863 made changes to MPNs to provide that reports prepared by a consulting or attending physician chosen by the injured worker and outside the MPN should not be the sole basis of compensation. In addition, SB 863 provided that the employer is not liable for treatment or the consequences of treatment obtained outside a valid MPN. The WCIRB's prospective evaluation estimated these changes to MPNs would reduce total costs by 1.0%, which included savings to PD costs, TD costs, and medical costs.

As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB will retrospectively monitor the utilization of MPNs before and after the SB 863 changes to assess whether any changes in the utilization of networks has occurred. Exhibit 18 shows the percentage of visits and medical payments made to MPNs through 2014 based on CWCI data compared to the proportion of visits and payments for prior years. Network penetration since 2013 has continued to increase at a rate consistent to that of prior years.

As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB will also monitor cost differentials related to MPNs to assess if any change in the cost of services provided within an MPN compared to out-of-network services has occurred. CWCI estimates the average medical cost per MPN managed claim is approximately \$500, or 4%, less than a non-network claim through 24 months based on services provided through 2013.³¹ This is generally consistent with estimates from prior years.

F. Independent Bill Review (IBR)

SB 863 created a new process of IBR to handle bill payment disputes effective on medical services provided on or after January 1, 2013. Specifically, for disputes not resolved after the employer's second review, the provider may request an IBR within 30 days of the second review or the bill will be deemed satisfied. The WCIRB did not include a prospective cost estimate for IBR in its SB 863 evaluation inasmuch as, at the time, there were a number of outstanding issues related to the IBR process that needed to be resolved through regulation.

Information on the number of IBRs requested through the third quarter of 2014 are available from the DWC through the IBR vendor and summarized on Table 15. The total volume of IBR applications is low and has been generally consistent in 2014. In addition, early information on IBR decisions suggests that the majority of the decisions favor the provider and result in additional payments.

Table 15: IBR Filings	
Year & Quarter	IBRs Filed
2013 1Q & 2Q	194
2013 3Q	352
2013 4Q	445
2014 1Q	489
2014 2Q	427
2014 3Q	522

³¹ *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System, CWCI, July 2014.*

G. Conversion of the OMFS to a RBRVS Basis

SB 863 provided that the DWC Administrative Director shall adopt a fee schedule based on a Resource-Based Relative Value Scale (RBRVS) basis for physician services, with the maximum reasonable fees paid set at a level not to exceed 120% of Medicare. The amendments adopted by the Administrative Director provide for a four-year transition period beginning in 2014. The WCIRB's prospective evaluation of the RBRVS changes were included in the WCIRB's Amended January 1, 2014 Pure Premium Rate Filing. Once fully implemented in 2017, the WCIRB estimated that the RBRVS changes would increase physician costs by 8.5% resulting in a 2.1% increase in total costs.

The WCIRB's initial retrospective evaluation of the RBRVS changes based on data through the first six months of 2014 is included as Attachment B. As discussed in Attachment B, the RBRVS changes were estimated to increase physician costs by 2.4% on 2014 services, while preliminary estimates of medical payments through the first six months of 2014 suggest a decrease in physician payments per claim of approximately 3.9%.

H. Other System Components

In addition to the areas discussed above, the WCIRB's SB 863 Cost Monitoring Plan includes a number of other system components that will likely be affected by SB 863 for which data is not yet available. The WCIRB will continue to monitor post-SB 863 costs and provide updates on the items identified as well as any other affected components as more information becomes available.

**Average Permanent Disability Ratings Based on DEU Data
Claims with Final Rating Before Mid-2014**

Average Final Rating

Age at Final Rating (Months)		Accident Year								
		2005	2006	2007	2008	2009	2010	2011	2012	2013
0	15	11.6	12.1	12.4	12.6	12.7	13.4	13.3	13.7	14.3
15	27	14.7	15.2	15.8	16.1	16.9	18.0	18.5	18.3	
27	39	18.8	19.8	20.6	22.1	22.4	23.8	23.5		
39	51	23.0	24.0	25.5	26.4	28.1	28.3			
51	63	26.8	28.5	30.2	31.5	31.9				
63	75	30.3	31.9	32.4	33.5					
75	& Over	35.1	35.5	36.4						

Change in Average Rating

Age at Final Rating (Months)		Accident Year								
		2005	2006	2007	2008	2009	2010	2011	2012	2013
0	15	---	3.7%	2.4%	2.0%	0.8%	5.2%	-0.4%	2.9%	4.0%
15	27	---	3.5%	3.9%	2.4%	4.8%	6.3%	2.8%	-0.8%	
27	39	---	5.1%	4.3%	7.2%	1.2%	6.2%	-1.2%		
39	51	---	4.3%	6.3%	3.6%	6.7%	0.6%			
51	63	---	6.4%	5.8%	4.2%	1.5%				
63	75	---	5.3%	1.8%	3.4%					
75	& Over	---	1.0%	2.7%						

Source: DEU database. 2013 data is preliminary.

**Prevalence of Almaraz/Guzman Adjustments to
Permanent Disability Ratings Identified by the DEU**

Final Rating in Year.Quarter	Percentage of Claims w/ Almaraz Tag		
	"Almaraz"	"Potential Almaraz"	All Almaraz
2009.2	0.4%	0.1%	0.5%
2009.3	3.1%	1.0%	4.1%
2009.4	6.5%	1.6%	8.0%
2010.1	6.9%	1.7%	8.7%
2010.2	5.7%	1.9%	7.6%
2010.3	7.7%	1.1%	8.9%
2010.4	7.7%	1.3%	9.0%
2011.1	7.8%	1.3%	9.1%
2011.2	7.8%	2.8%	10.5%
2011.3	8.2%	3.8%	12.0%
2011.4	10.8%	8.3%	19.1%
2012.1	10.2%	7.2%	17.3%
2012.2	10.6%	8.7%	19.3%
2012.3	10.9%	7.4%	18.3%
2012.4	10.4%	7.5%	17.8%
2013.1	10.3%	7.8%	18.1%
2013.2	10.0%	7.8%	17.9%
2013.3	10.3%	7.9%	18.2%
2013.4	10.5%	11.5%	22.1%
2014.1	11.1%	10.2%	21.3%
2014.2	11.1%	8.1%	19.2%

Note: "Almaraz Tag" refers to information identified by the DEU rater in the text of the rating. "Almaraz" refers to ratings citing Almaraz/Guzman directly. "Potential Almaraz" refers to ratings citing terms related to Almaraz/Guzman such as "per AMA Guides".

Source: DEU database.

Average Permanent Disability Rating Based on WCIRB Unit Statistical Data

Accident Year	Report Level						
	01	02	03	04	05	06	07
2007	11.9	14.5	16.2	17.3	17.8	18.1	<i>18.1</i>
2008	12.4	15.1	17.1	18.1	18.4	<i>18.4</i>	
2009	12.6	15.4	17.0	17.8	<i>17.7</i>		
2010	12.5	15.0	16.3	<i>16.6</i>			
2011	12.7	14.6	<i>15.4</i>				
2012	12.1	<i>13.8</i>					
2013	<i>11.1</i>						

Note: Latest diagonal (italics) is preliminary and is based on a partial accident year. For example, the average PD rating for accident year 2013 at 1st report level is based on policies incepting in 2012.

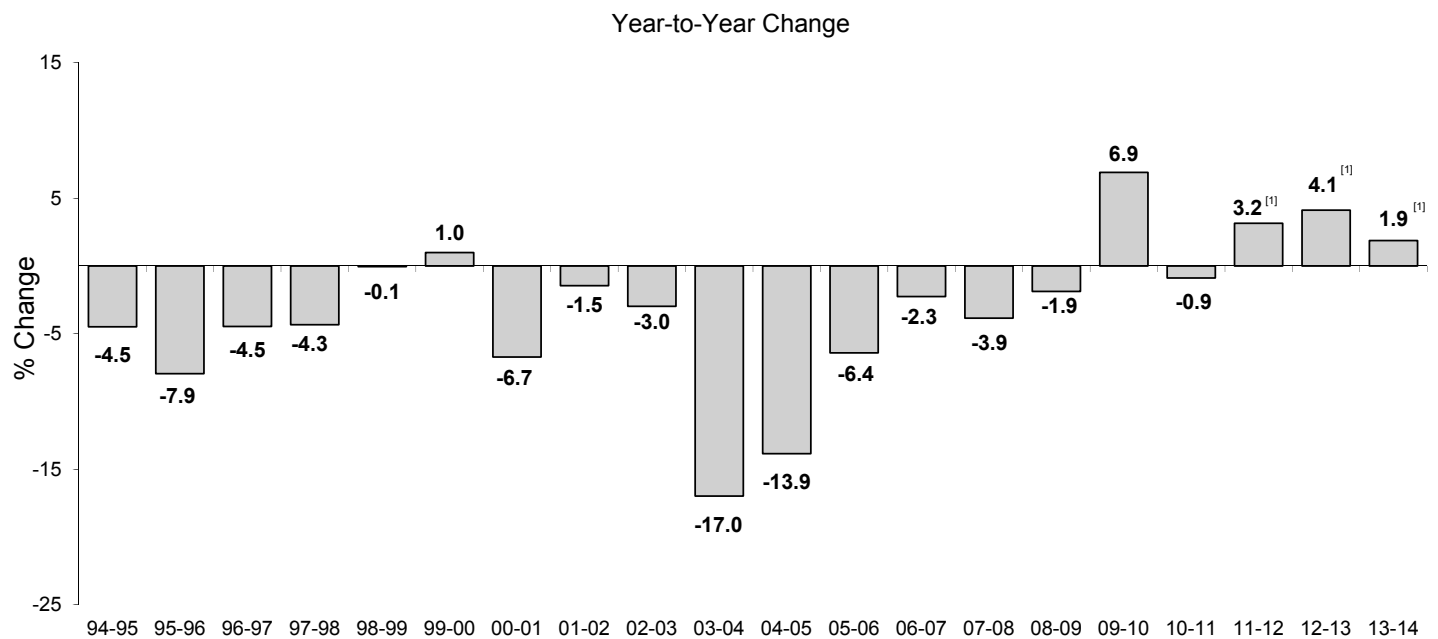
**Percentage of DEU Ratings Involving Add-ons
Claims with Final Rating Before Mid-2014**

Add-on for: Psychiatric Impairment, Sleep Disorder, or Sexual Dysfunction

Age at Final Rating (Months)		Accident Year								
		2005	2006	2007	2008	2009	2010	2011	2012	2013
0	15	0.2%	0.4%	0.6%	0.7%	0.6%	0.5%	0.7%	0.8%	0.8%
15	27	0.8%	1.3%	1.4%	1.2%	1.5%	1.5%	1.6%	1.4%	
27	39	3.0%	2.6%	3.1%	3.6%	3.2%	4.4%	2.8%		
39	51	4.3%	4.4%	5.3%	5.9%	6.6%	6.3%			
51	& Over	6.9%	9.3%	10.0%	9.5%	9.7%				

Source: DEU database. 2013 data is preliminary.

**California Workers' Compensation
Estimated Indemnity Claim Frequency by Accident Year**



^[1] The 2011-2012 estimate is based on partial year unit statistical data. The 2012-2013 and 2013-2014 estimates are based on comparison of claim counts based on WCIRB accident year experience as of June 30, 2014 relative to the estimated change in statewide employment.

**Distribution of Indemnity Claims by Average Weekly Wage
Based on WCIRB Unit Statistical Data at 1st Report Level**

Permanent Disability Claims

Average PD Wage* Interval		Accident Year					
Lower	Upper	2008	2009	2010	2011	2012	2013
[\$0	\$160]	7.8%	9.7%	10.3%	10.7%	11.2%	<i>11.2%</i>
(\$160	\$230)	12.1%	12.2%	13.0%	12.7%	12.6%	<i>13.8%</i>
[\$230	\$270)	10.1%	10.1%	10.3%	10.4%	10.6%	<i>11.5%</i>
[\$270	& Up	70.0%	68.0%	66.4%	66.2%	65.5%	<i>63.5%</i>

All Indemnity Claims

Average PD Wage* Interval		Accident Year					
Lower	Upper	2008	2009	2010	2011	2012	2013
[\$0	\$160]	22.5%	21.6%	21.7%	22.1%	21.7%	<i>19.5%</i>
(\$160	\$230)	11.0%	11.4%	12.0%	12.3%	12.1%	<i>12.3%</i>
[\$230	\$270)	8.5%	8.9%	9.3%	9.1%	9.0%	<i>10.1%</i>
[\$270	& Up	58.1%	58.2%	57.0%	56.5%	57.2%	<i>58.2%</i>

*PD wage is 2/3 the reported average weekly wage. Wages are adjusted to a 2013 wage level.

Note: 2013 (*italics*) is preliminary and is based on policies incepting in 2012.

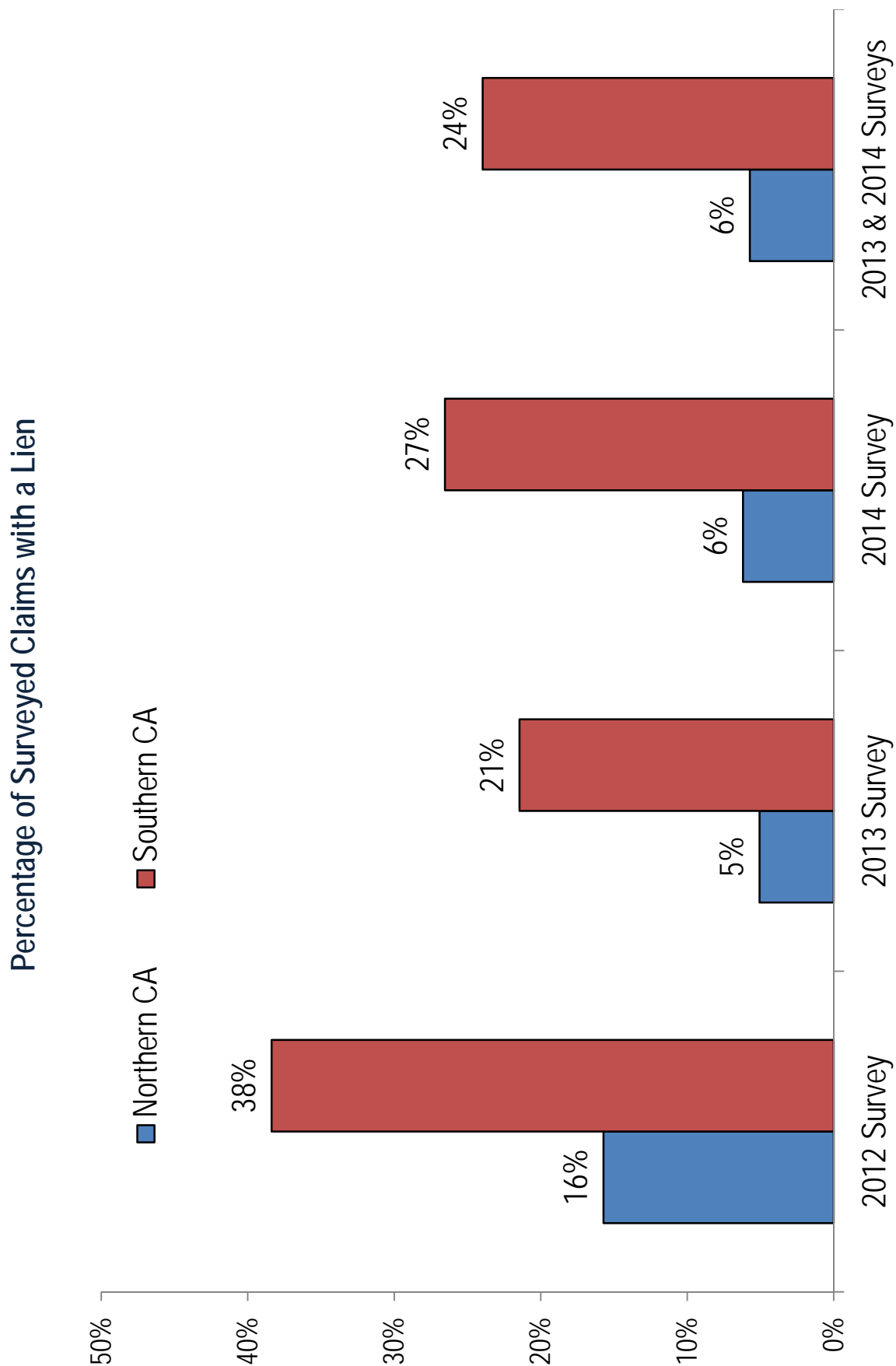
Liens Filed Counts*

Region**	Counts by Region											
	Calendar Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter
	2011	2012	2012	2012	2012	2013	2013	2013	2013	2014	2014	2014
Bay Area	18,723	5,490	5,467	6,434	10,397	1,232	1,450	1,607	1,928	1,841	1,697	1,941
Central Coast/Valley	24,414	7,245	8,970	15,289	25,730	2,193	1,562	1,795	2,025	2,029	2,306	1,996
Los Angeles County	283,774	97,245	122,040	207,639	342,549	46,830	18,947	25,999	29,537	25,668	29,417	29,665
Remainder of LA Basin	114,554	38,034	44,065	85,152	123,129	17,032	6,917	9,855	10,893	10,117	11,942	12,198
Remaining CA Zip Codes	2,535	895	1,102	698	1,119	230	211	247	276	239	265	239
Sacramento	3,934	1,248	1,322	1,407	1,557	268	339	410	358	384	354	424
San Diego County	15,922	4,936	4,991	6,611	8,523	1,312	684	991	1,136	1,165	1,263	1,378
Total	463,856	155,093	187,957	323,230	513,004	69,097	30,110	40,904	46,153	41,443	47,244	47,841
Region**	Region Percentage of Total											
	Calendar Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter
	2011	2012	2012	2012	2012	2013	2013	2013	2013	2014	2014	2014
Bay Area	4.0%	3.5%	2.9%	2.0%	2.0%	1.8%	4.8%	3.9%	4.2%	4.4%	3.6%	4.1%
Central Coast/Valley	5.3%	4.7%	4.8%	4.7%	5.0%	3.2%	5.2%	4.4%	4.4%	4.9%	4.9%	4.2%
Los Angeles County	61.2%	62.7%	64.9%	64.2%	66.8%	67.8%	62.9%	63.6%	64.0%	61.9%	62.3%	62.0%
Remainder of LA Basin	24.7%	24.5%	23.4%	26.3%	24.0%	24.6%	23.0%	24.1%	23.6%	24.4%	25.3%	25.5%
Remaining CA Zip Codes	0.5%	0.6%	0.6%	0.2%	0.3%	0.3%	0.7%	0.6%	0.6%	0.6%	0.6%	0.5%
Sacramento	0.8%	0.8%	0.7%	0.4%	0.3%	0.4%	1.1%	1.0%	0.8%	0.9%	0.7%	0.9%
San Diego County	3.4%	3.2%	2.7%	2.0%	1.7%	1.9%	2.3%	2.4%	2.5%	2.8%	2.7%	2.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Type	Counts by Type											
	Calendar Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter
	2011	2012	2012	2012	2012	2013	2013	2013	2013	2014	2014	2014
Interpreter	28,721	12,937	17,162	46,095	47,427	2,397	831	484	378	421	275	140
Medical	292,982	85,152	106,336	182,474	317,241	45,631	22,480	32,356	37,515	33,105	38,534	39,750
Medical-Legal	39,569	22,931	37,440	64,912	80,916	11,411	587	653	537	397	320	178
Other	102,584	34,073	27,019	29,749	67,420	9,658	6,212	7,411	7,723	7,520	8,115	7,773
Total	463,856	155,093	187,957	323,230	513,004	69,097	30,110	40,904	46,153	41,443	47,244	47,841
Type	Type Percentage of Total											
	Calendar Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter
	2011	2012	2012	2012	2012	2013	2013	2013	2013	2014	2014	2014
Interpreter	6.2%	8.3%	9.1%	14.3%	9.2%	3.5%	2.8%	1.2%	0.8%	1.0%	0.6%	0.3%
Medical	63.2%	54.9%	56.6%	56.5%	61.8%	66.0%	74.7%	79.1%	81.3%	79.9%	81.6%	83.1%
Medical-Legal	8.5%	14.8%	19.9%	20.1%	15.8%	16.5%	1.9%	1.6%	1.2%	1.0%	0.7%	0.4%
Other	22.1%	22.0%	14.4%	9.2%	13.1%	14.0%	20.6%	18.1%	16.7%	18.1%	17.2%	16.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

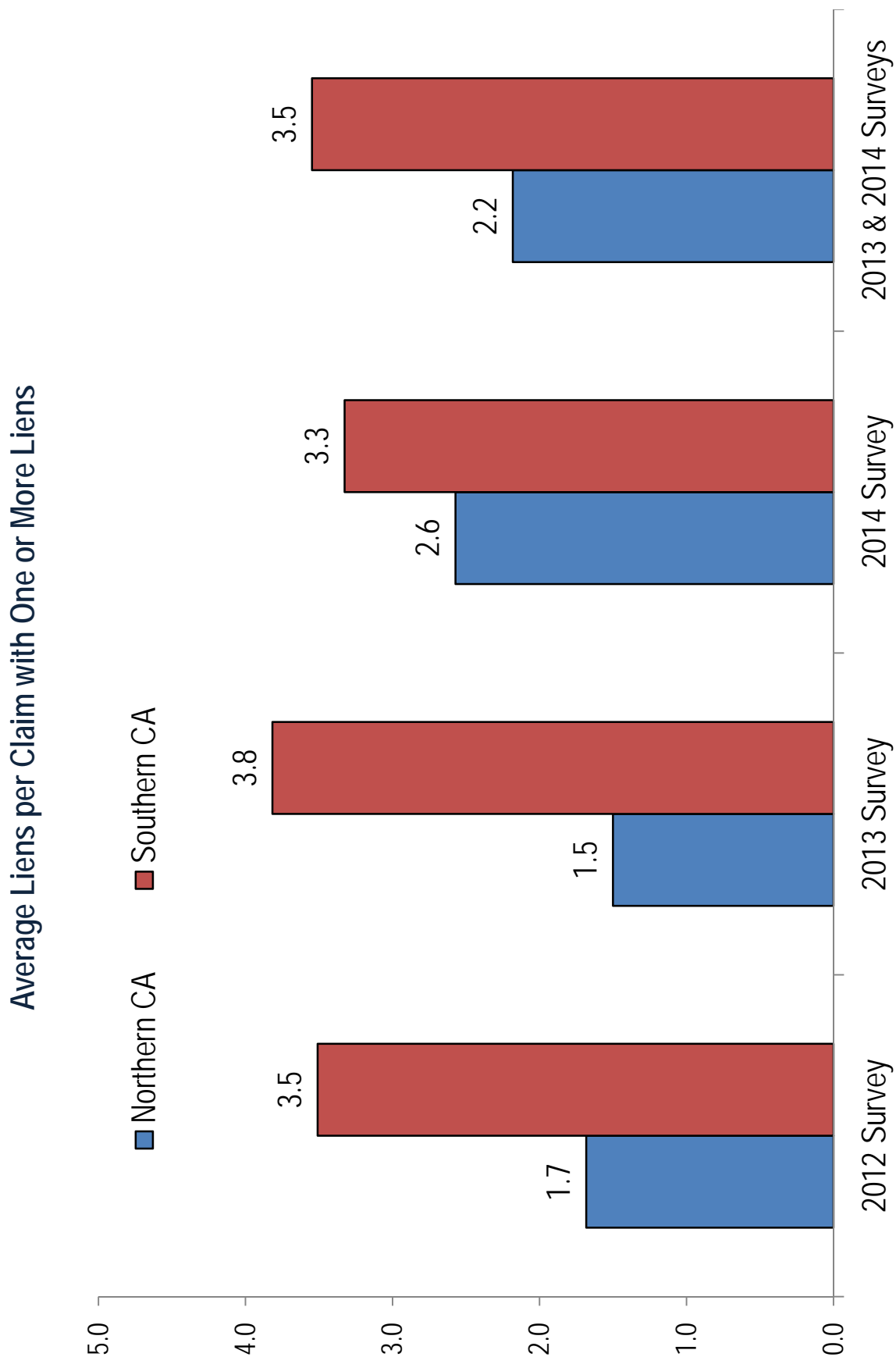
* Lien Counts exclude SDI/EDD Liens

** Regions reflect the following WCAB Office mapping: Bay Area - Oakland, San Jose, San Francisco;
 Central Coast/Valley - Bakersfield, Fresno, Goleta, Grover Beach, Salinas, Stockton; Los Angeles County
 - Long Beach, Los Angeles, Marina Del Rey, Pomona, Van Nuys; Remainder of LA Basin - Anaheim,
 Oxnard, Riverside, San Bernardino, Santa Ana; Remaining CA Zip Codes - Eureka, Redding, Santa
 Rosa, Sacramento - Sacramento; San Diego County - San Diego

Source: EAMS Liens Data

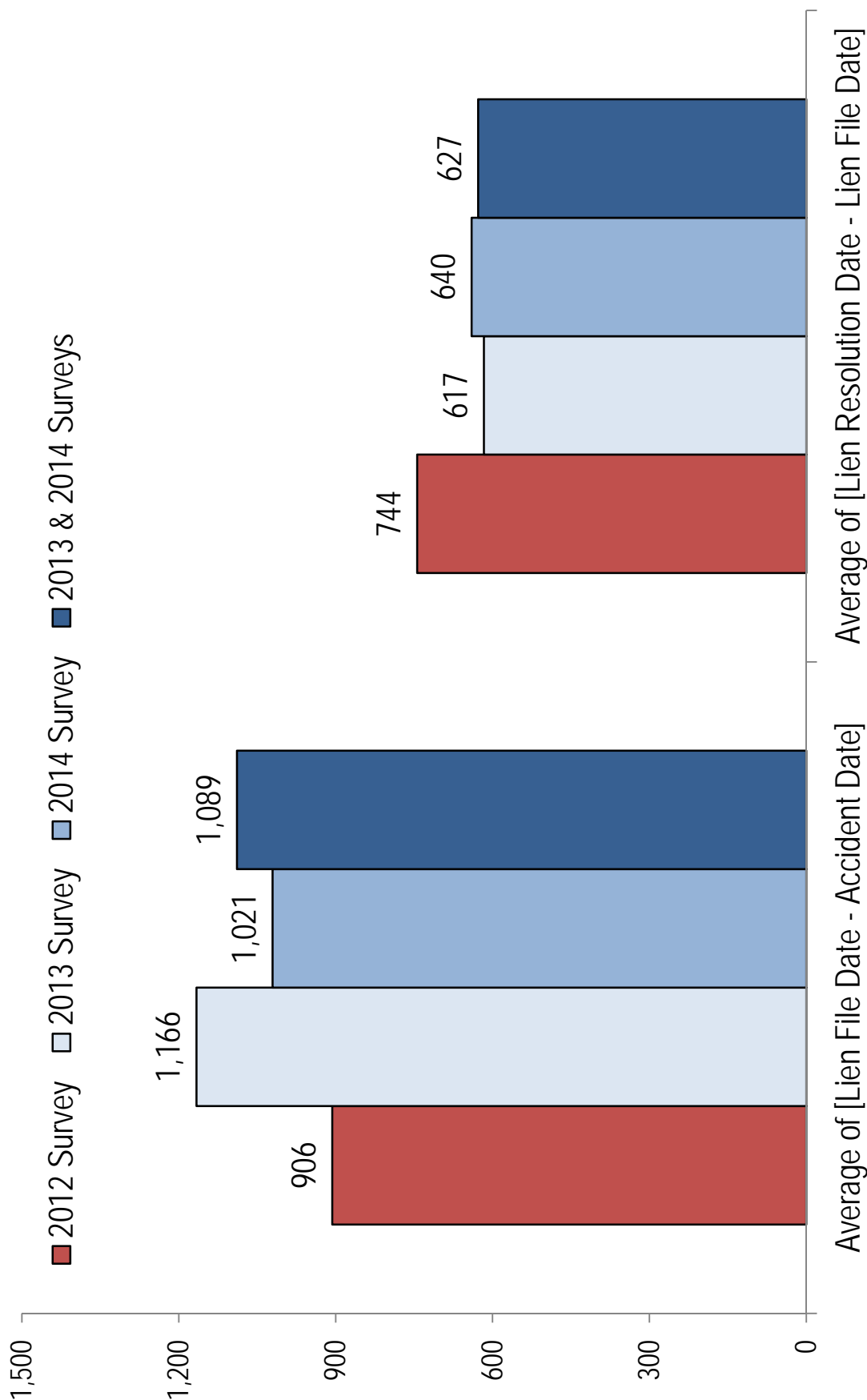


Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year.

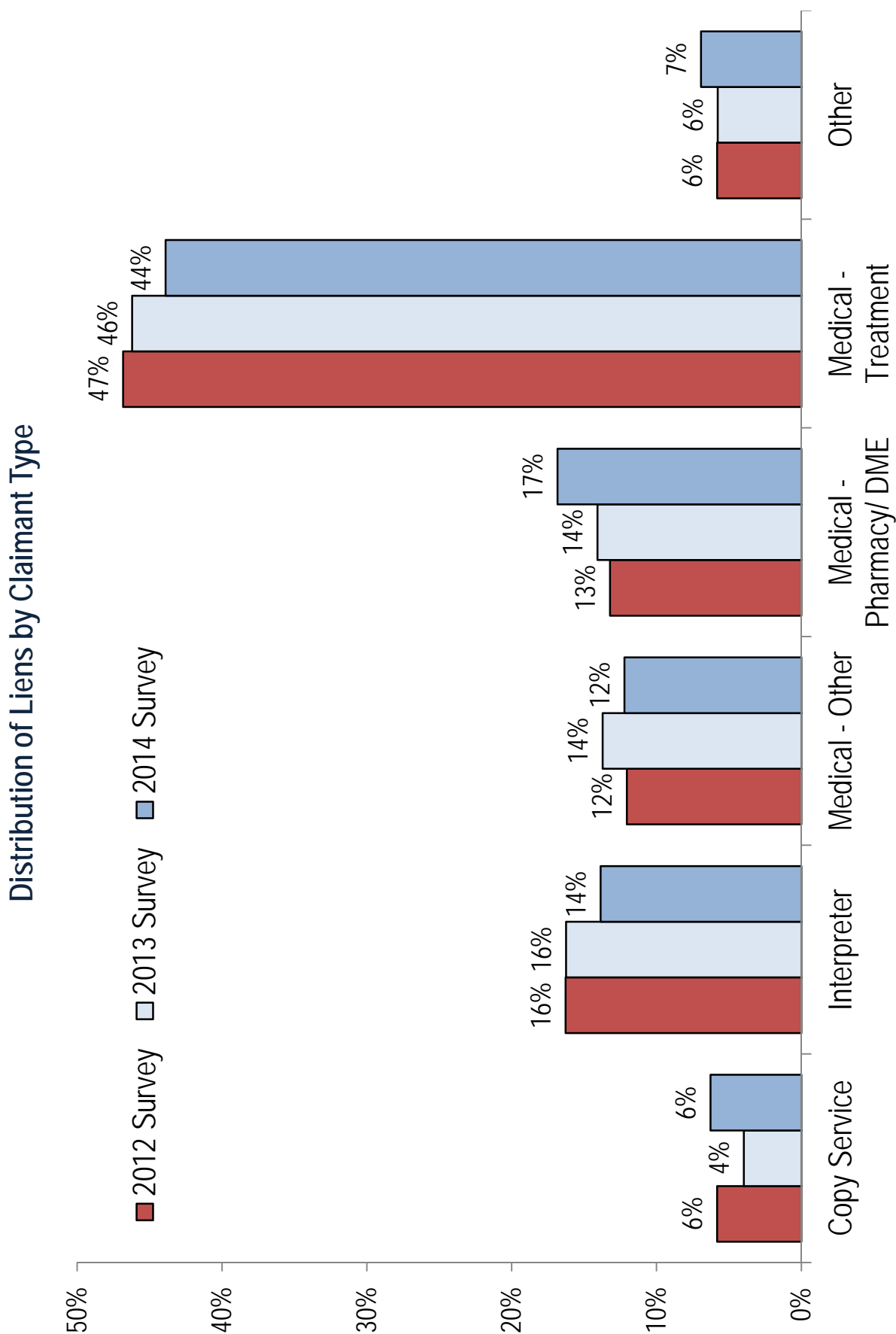


Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year.

Average Number of Days until Lien Filed or Resolved

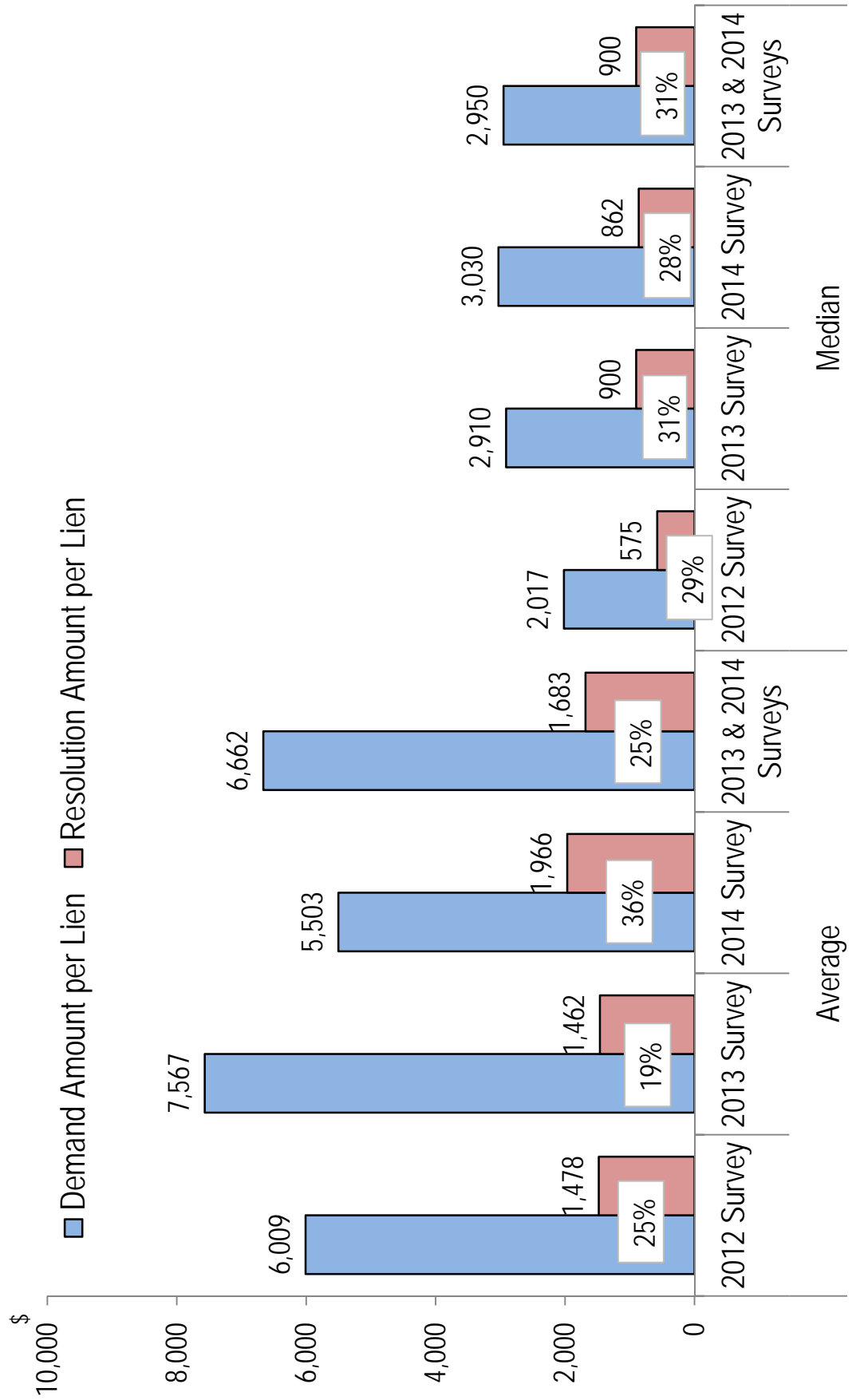


Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year.



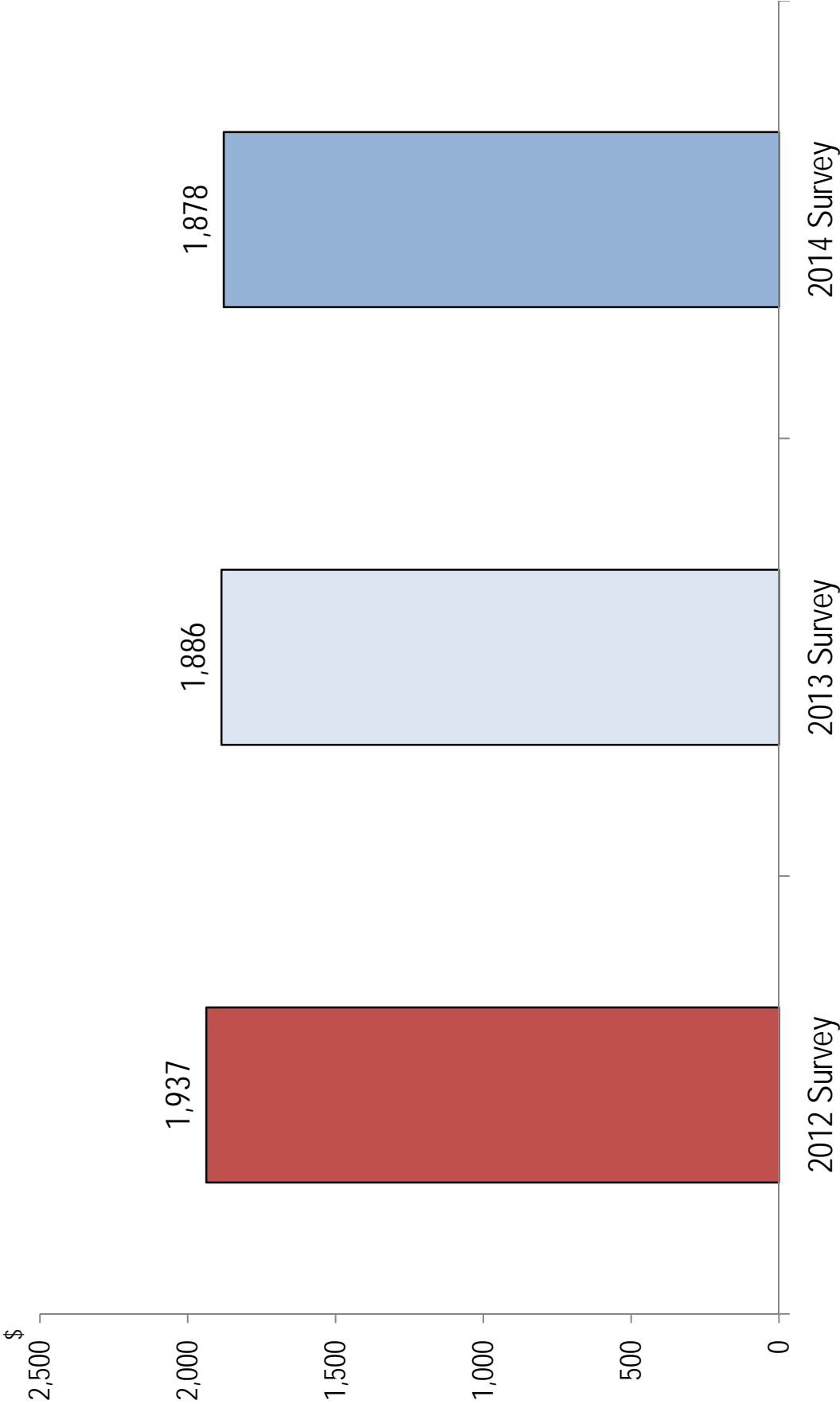
Source: WCIRB Liens Survey. Figures represent liens active during the first six months of the survey year. Excludes SDI/EDD liens.

Resolution and Demand Amounts on Resolved Liens



Source: WCIRB Liens Survey. Figures represent liens resolved during the first six months of the survey year.

Average Lien Defense Cost per Claim with Lien – Southern CA



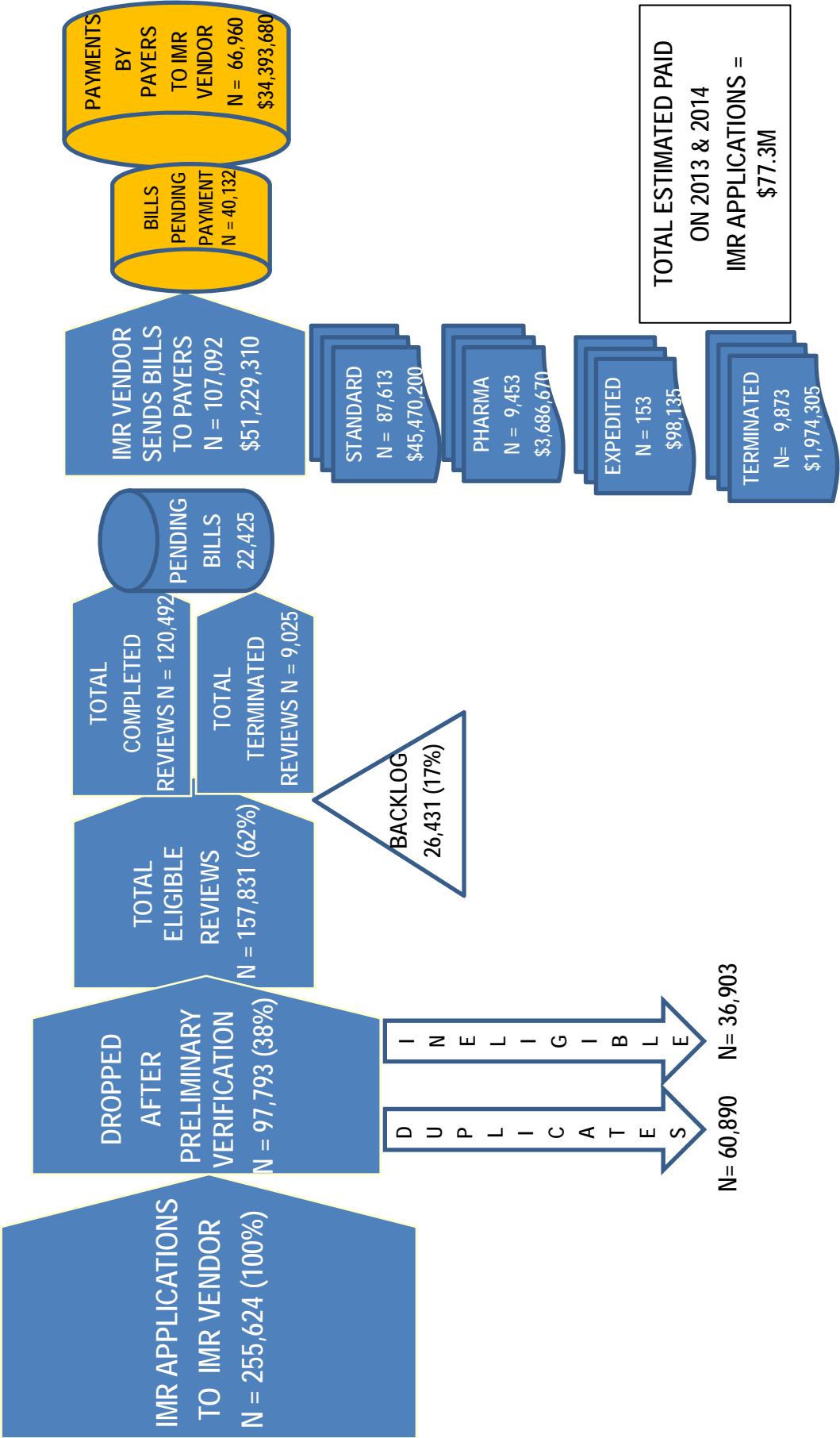
Source: WCIRB Liens Survey. Figures represent total lien defense costs on claims with at least one lien active during the survey year.

WCIRB Lien Survey Results by Survey Year & Year Lien was Filed

Number of Surveyed Liens with a Lien Demand Amount									
Survey Year	Lien Filing Year								
	2007	2008	2009	2010	2011	2012	2013	2014	
2012	43	118	120	142	118	58			
2013		6	19	45	64	102	12		
2014			10	34	59	105	36	34	
Median Lien Demand Amount									
Survey Year	Lien Filing Year								
	2007	2008	2009	2010	2011	2012	2013	2014	
2012	1,590	2,449	1,812	2,273	1,538	3,118			
2013		4,402	1,885	2,764	2,901	2,872	2,432		
2014			3,400	2,244	1,831	2,250	4,508	2,226	
Number of Surveyed Liens with a Lien Resolution Amount									
Survey Year	Lien Filing Year								
	2007	2008	2009	2010	2011	2012	2013	2014	
2012	6	16	26	16	27	21			
2013		4	7	15	32	35	5		
2014			0	8	14	30	21	11	
Median Lien Resolution Amount									
Survey Year	Lien Filing Year								
	2007	2008	2009	2010	2011	2012	2013	2014	
2012	225	855	550	1,191	400	500			
2013		1,773	800	800	1,200	1,000	450		
2014				525	750	500	1,159	400	
Percentage of Liens Resolved									
Survey Year	Lien Filing Year								
	2007	2008	2009	2010	2011	2012	2013	2014	
2012	14%	14%	22%	11%	23%	36%			
2013		67%	37%	33%	50%	34%	42%		
2014			0%	24%	24%	29%	58%	32%	
Median Lien Resolution Amount as a Percentage of Median Lien Demand									
Survey Year	Lien Filing Year								
	2007	2008	2009	2010	2011	2012	2013	2014	
2012	14%	35%	30%	52%	26%	16%			
2013		40%	42%	29%	41%	35%	19%		
2014				23%	41%	22%	26%	18%	

Source: WCIRB Liens Survey.

IMR Process Flow – 2013 and 2014 Applications As of 10/1/2014



Utilization Review Costs as a percentage of Medical Payments

Percent of Medical Cost Containment			Medical Cost Containment as a			UR/IMR/IBR* as a Percentage of			
Payments by MCC Type			Percentage of Medical Payments			Medical Payments			
Transaction	(1)	(2)	Accident	(3)	(4)	(5)	= (3) X (1)	= (4) X (1)	= (5) X (1)
	UR/IMR/IBR*	Medical Bill Review/PPO/MPN		9 Months	12 Months	24 Months	9 Months	12 Months	24 Months
Year	Year		Year						
2005	39.8%	60.2%	2005	11.7%	11.9%	11.2%	4.7%	4.7%	4.5%
2006	45.0%	55.0%	2006	14.4%	14.2%	12.5%	6.5%	6.4%	5.6%
2007	48.8%	51.2%	2007	15.2%	15.0%	13.6%	7.4%	7.3%	6.6%
2008	48.2%	51.8%	2008	16.4%	16.4%	14.6%	7.9%	7.9%	7.0%
2009	49.2%	50.8%	2009	16.8%	16.6%	14.8%	8.3%	8.2%	7.3%
2010	51.5%	48.5%	2010	16.6%	16.7%	14.7%	8.5%	8.6%	7.6%
2011	50.3%	49.7%	2011	17.4%	16.7%	14.2%	8.8%	8.4%	7.1%
2012	49.5%	50.5%	2012	16.9%	16.7%		8.4%	8.3%	
2013	51.0%	49.0%	2013	20.6%			10.5%		

*IMR and IBR did not become effective until 2013 and few payments for IMR or IBR were made in 2013.

Source: CWCi 2014 Claims Monitoring Report

Temporary Disability Outcomes

Accident Year	Average Duration of TD Payments in Days		Average TD Paid Per Claim	
	<u>12 Months</u>	<u>24 Months</u>	<u>12 Months</u>	<u>24 Months</u>
2005	75.8	108.4	\$5,602	\$8,134
2006	79.6	112.6	\$6,226	\$8,748
2007	78.8	112.2	\$6,247	\$8,923
2008	80.7	117.9	\$6,517	\$9,637
2009	83.3	129.8	\$6,776	\$10,552
2010	91.8	133.4	\$7,130	\$10,609
2011	85.0	129.1	\$6,766	\$10,435
2012	88.6	132.8	\$6,889	\$11,009
2013	92.5		\$7,141	

Annual Change

Accident Year	Average Duration of TD Payments in Days		Average TD Paid Per Claim	
	<u>12 Months</u>	<u>24 Months</u>	<u>12 Months</u>	<u>24 Months</u>
2005	---	---	---	---
2006	5.0%	3.9%	11.1%	7.6%
2007	-0.9%	-0.3%	0.3%	2.0%
2008	2.4%	5.1%	4.3%	8.0%
2009	3.2%	10.1%	4.0%	9.5%
2010	10.2%	2.7%	5.2%	0.5%
2011	-7.4%	-3.2%	-5.1%	-1.6%
2012	4.3%	2.9%	1.8%	5.5%
2013	4.3%		3.7%	

Source: CWCI ICIS data.

Medical Provider Network Utilization

Accident Year	Percentage of First Year Visits to Network Providers		Percentage of First Year Payments to Network Providers	
	<u>Total</u>	<u>% Growth</u>	<u>Total</u>	<u>% Growth</u>
2005	68.7%	---	57.1%	---
2006	70.9%	2.2%	59.4%	2.4%
2007	72.2%	1.3%	60.3%	0.9%
2008	74.8%	2.6%	62.7%	2.4%
2009	76.2%	1.4%	65.3%	2.5%
2010	78.4%	2.3%	67.5%	2.2%
2011	80.1%	1.6%	70.0%	2.5%
2012	82.6%	2.6%	73.5%	3.5%
2013	85.7%	3.1%	77.9%	4.4%
2014*	87.3%	1.6%	76.7%	-1.2%

*2014 figure based on visits within the first 30 days.

Source: CWCI ICIS data.

Ambulatory Surgical Center Cost Outcomes: The Impact of California SB 863 Workers' Compensation Reforms

February 26, 2014

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California Workers' Compensation Institute

Gregory Johnson, Ph.D.
Workers' Compensation Insurance Rating Bureau

A joint study prepared by:



Workers' Compensation Insurance
Rating Bureau of California



California Workers' Compensation
Institute

SB 863 and the ASC Fee Schedule
February 26, 2014

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SB 863 and the ASC Fee Schedule
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Executive Summary

The costs of treatment at ambulatory surgery centers (ASCs) have been one factor in the escalation of California workers' compensation medical costs. In 2012, however, state lawmakers, seeking to reduce workers' compensation treatment costs made several changes, including reducing the maximum facility fees for services performed in ASCs to 80 percent of the fee paid by Medicare for the use of hospital outpatient surgery departments. The Workers' Compensation Insurance Rating Bureau, initially projected that this change in the fee schedule would reduce ASC payments by 25 percent.¹

The authors undertook this study to measure the extent to which the change in ASC reimbursements achieved its intended goal of reducing these costs. The authors examined several factors before and after the implementation of the new ASC Fee Schedule in January 2013, including:

- Fees billed;
- Fee schedule adjustments;
- Network discounts;
- Payment per episode;
- Mix of services;
- Service intensity; and
- Sites of service

The results indicate a 26 to 28 percent decline in average ASC reimbursements following the adoption of the ASC fee schedule. This decline occurred despite increases in ASC billed amounts, reduced contract savings, and an increase in the percentage of episodes with billings for services unaffected by the fee schedule change. The study also found no material change in the mix of services or the location of services from 2012 to 2013.

¹ Workers' Compensation Insurance Rating Bureau, Amended January 1, 2013 Pure Premium Rate Filing – Additional Information Related to WCIRB Evaluation of Senate Bill No. 863, Oct. 12, 2012.

Background

Prior to 2004, California workers' compensation outpatient surgery facility fees were not subject to a fee schedule and payments varied widely as payers negotiated or paid usual and customary (U&C) fees. In the absence of a fee schedule, California workers' compensation paid significantly more than federal health care programs such as Medicare for comparable services, as was noted in a 2002 study by Kominsky and Gardner.²

In 2003, California lawmakers amended Labor Code §5307.1(c)(1) in SB 228 to require the Division of Workers' Compensation (DWC) to promulgate a fee schedule that utilizes the Medicare payment rules for the use of outpatient surgery rooms and emergency rooms. Under Medicare, each Current Procedural Terminology (CPT) code for a specific outpatient surgical procedure is classified into an Ambulatory Procedure Classification (APC). The final fee is calculated using a formula rather than a prescribed dollar amount.³ Under the fee schedule which took effect for services on or after June 15, 2004, maximum facility fees could not exceed 120 percent of the Medicare fee.

The adoption of the outpatient facility fee schedule had an immediate effect on costs. CWCI research from 2005 compared pre- and post-SB 228 payments for 239 distinct outpatient procedures performed in ASCs and found that after adjusting for medical inflation and changes in the mix of medical procedures, average outpatient surgery facility fee payments fell 38.9 percent following the adoption of the Outpatient Surgery Facility Fee Schedule in 2004.⁴

By 2012, however, several years of escalating workers' compensation medical costs and a growing desire to increase injured workers' permanent disability benefits led state lawmakers to revisit the issue of ASC fees as one cost-saving component of a legislative reform deal (SB 863) hammered out by representatives of labor, employers and the Brown Administration. The final version of that bill called for the DWC to modify the Outpatient Facility Fee Schedule so that maximum facility fees for services performed in ASCs were reduced from 120 percent to 80 percent of the Medicare fee for those services, though hospital-based outpatient facility maximum fees were kept at 120 percent of the Medicare rate.⁵

² Kominsky and Gardner, Inpatient Hospital Fee Schedule and Outpatient Surgery Study, California Commission on Health and Safety and Workers' Compensation, February 2002.

³ The Centers for Medicare and Medicaid Services (CMS) maintains APC relative weights (APC Wt), Status Codes for each APC, and conversion factors. The DWC also used Medicare conversion and geographic wage index factors to produce adjusted conversion factors by county. The APC weights and conversion factor are revised periodically, sometimes several times per year. There are also some allowances for outliers and other adjustments. If more than one procedure is performed during the same event, fees for most secondary procedures are reduced by 50 percent. The maximum fee for any given procedure is: APC relative wt x Adjusted Conversion Factor x Multiplier to Medicare Rate x Secondary procedure adjustment (where applicable).

⁴ Swedlow, A. Early Returns on Workers' Comp Medical Reforms: Part 1. Changes in Outpatient Surgery Payments Following Adoption of the Outpatient Surgery Facility Fee Schedule. CWCI ICIS Says Report, September 2005.

⁵ On February 7, 2014, the California Division of Workers' Compensation announced public hearings on a proposed revision to the regulations governing non-facility fees rendered in a hospital which, if approved, may have an indirect impact on hospital outpatient reimbursements.

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Research Goals

In evaluating the potential savings of the SB 863 reforms in 2012 as part of its January 1, 2013 pure premium rate proposal, the WCIRB used data from the Commission on Health and Safety and Workers' Compensation and estimated that the change in the ASC fee schedule could reduce medical costs by 25 percent. This study was undertaken to provide a preliminary assessment of the changes that have occurred in California workers' compensation outpatient care and reimbursement following the January 1, 2013 implementation of the revised fee schedule based on actual payments made to ASCs. Specifically, the authors' goal was to generate and analyze data in seven key areas that may impact ASC payments:

1. **Per Procedure Billed Amounts.** How much did the average amount billed per ASC procedure change in 2013?
2. **Per Procedure Paid Amounts.** How much did the average payment per ASC procedure reimbursed under the fee schedule change in 2013?
3. **Negotiated Discounts.** Did networks adjust their discount rates for ASC services after the fee schedule revisions took effect?
4. **Average Payment per Episode.** What was the combined effect of the changes in the fee schedule and network discounts on the average amount paid per episode?
5. **Types of Services Delivered.** Did the mix of services change between 2012 and 2013?
6. **Service Intensity.** Did providers increase the number of non-primary procedures within the specific episode (e.g., more injections on the date of service)? Was there an increase in billings for services not subject to the ASC fee reductions (e.g. office visit charges)?
7. **Place of Service.** Did the reduction in ASC fee allowances result in a shift of services to outpatient hospital settings which were not affected by the change in reimbursements? If so, what was the financial impact?

Data and Methods

For this study, the authors used WCIRB's Medical Data Call (MDC) database⁶ and CWCI's Industry Claims Information System (ICIS) database⁷ to compile separate data sets on California workers' compensation insured claims experience. These data sets included billing and payment information on outpatient surgical facility services rendered at hospitals and ambulatory surgical facilities from January 2012 through June 2013. The data detail included:

- Injured worker information;
- Provider and ambulatory surgery facility site of service identifiers;
- Official Medical Fee Schedule (OMFS) CPT procedure codes;
- Billed amounts;
- Taxonomy (provider type);
- OMFS maximum allowable amounts; and
- Network discounts

The authors compiled separate data sets from the MDC and ICIS databases to address both ASC and hospital settings, with the goal of producing the most robust possible methods to answer the research questions.

In conducting the analyses, the authors used taxonomy/provider type, place of service and location of service to tag and isolate facility settings, while ambulatory surgery services were analyzed using several grouping systems:

- Unique CPT procedure;
- Medicare's Ambulatory Payment Classification (APC); and
- Major service types (surgeries, injections and spinal stimulators)

ICIS data was used to analyze services by specific unique procedure, while the MDC data was used to examine "episodes" of care in which the primary OMFS/CPT codes were grouped with any additional paid procedure codes on the same date of service. In addition, the authors collected data on any other services provided on the same date of service, and adjusted the data to control for changes in the mix of procedures and locations of service after the revised schedule took effect.

⁶ The MDC database contains data on California workers' compensation medical transactions, compiled from 90% of the California insurance market starting with third quarter 2012 transactions. This database includes medical payment data on 875,000 unique claims generating \$3.3 billion in payments.

⁷ ICIS is a proprietary database maintained by the CWCI that contains detailed information, including employer and employee characteristics, medical service information, and benefit and other administrative cost information on more than 4 million California workers' compensation claims.

Results

Changes in Average Billed and Paid Amounts Per ASC Procedure

The ICIS data on ASC billings and payments reflect ASC procedures with January 2012 through June 2013 service dates for which reimbursements were made prior to July 1, 2013. Using the data on the 2012 ASC procedures, the authors calculated the average amounts billed and paid per ASC procedure prior to the adoption of the ASC fee schedule changes, then after adjusting the 2013 figures to account for the year-to-year shift in the mix of services, ran the same calculations using the 2013 data to determine how much the average billed and paid amounts changed after the fee schedule took effect.

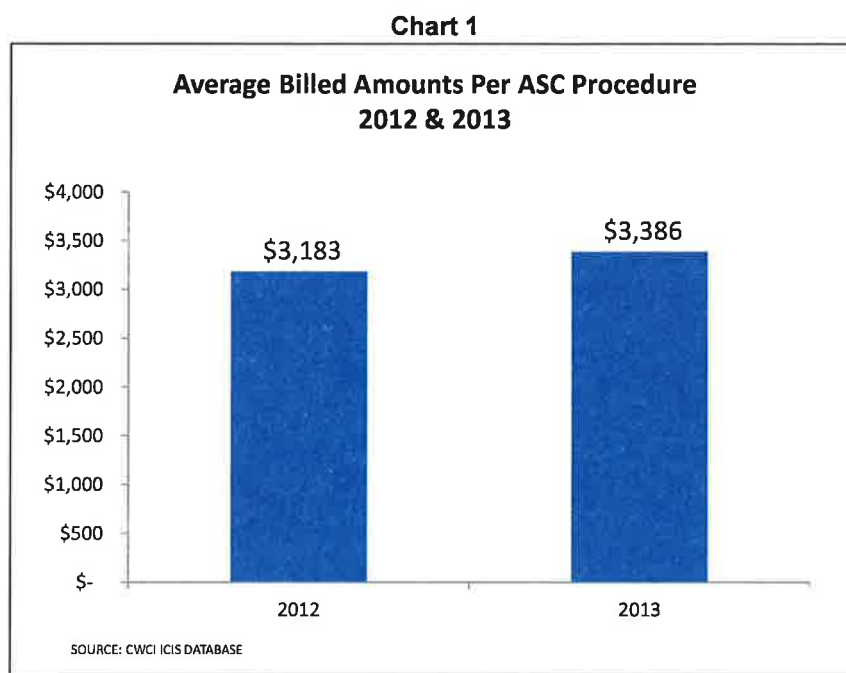
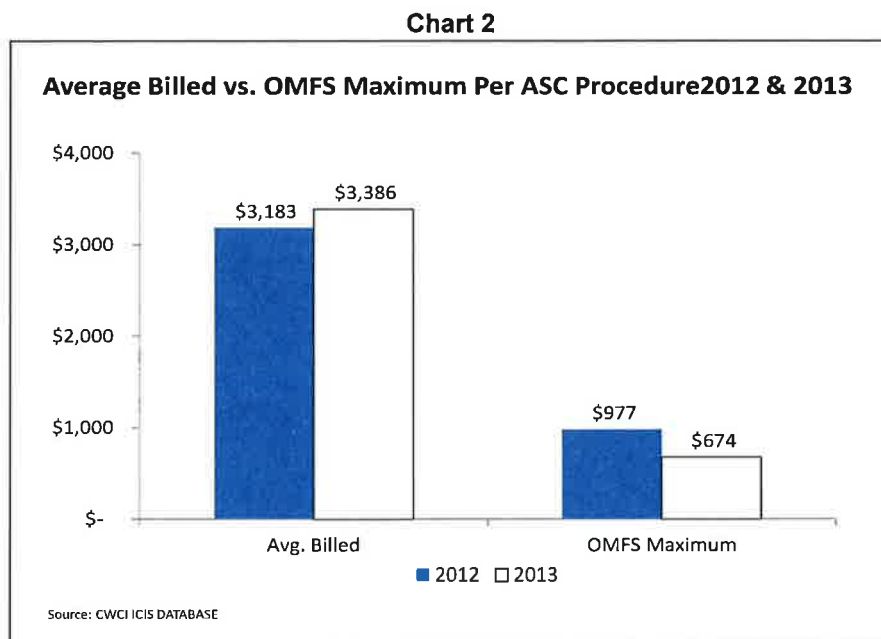


Chart 1 compares average amounts billed for 2012 and 2013, and shows that following the implementation of the fee schedule changes in January 2013, the average amount billed per ASC procedure increased 6.4 percent from \$3,183 to \$3,386.

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Chart 2 shows that while the average amounts billed for ASC procedures increased 6.4 percent between 2012 and 2013, the reduction in the conversion factor multiplier from 1.20 to 0.80⁸ caused the average ASC fee schedule allowance to decline by nearly 31 percent, from \$977 to \$674. With the increase in the average billed amount and the reduction in the fee schedule allowances, the spread between the billed and scheduled amounts for ASC services widened from \$2,206 in 2012 to \$2,711 in 2013.

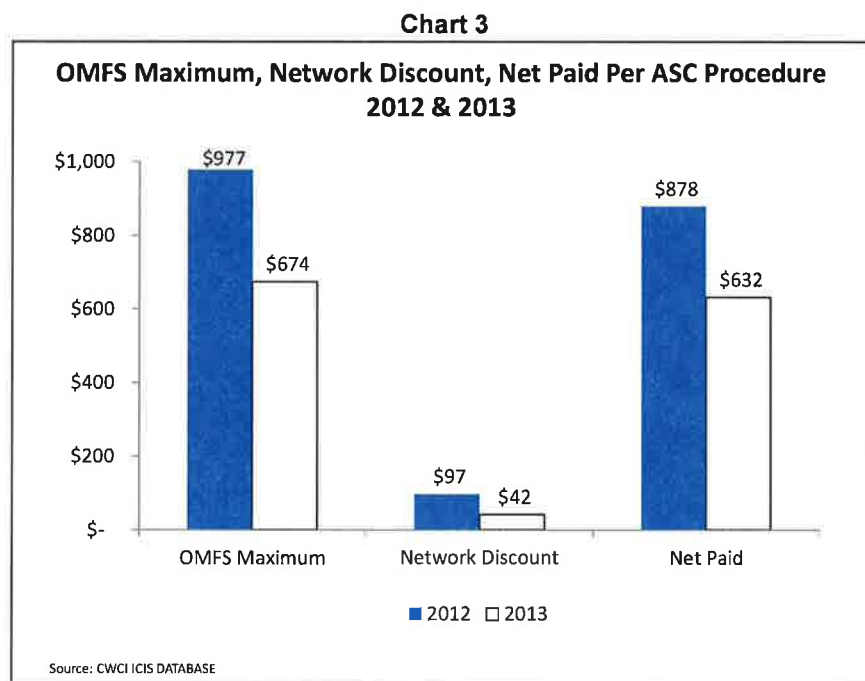


⁸ The multiplier for most facilities also includes an adjustment of +0.02 for outliers.

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As the SB 863 revisions to the fee schedule reduced the maximum facility fee allowances for ASC services, the discounts for ASC services negotiated between networks and workers' compensation payers also declined.

Chart 3 shows that discounts for ASC services, which averaged \$97 per procedure (or 10 percent of the fee schedule allowance) in 2012, declined by 56 percent to \$42 (or 6 percent of the fee schedule amount) in 2013. Despite this decrease in the negotiated discounts, the net reduction in average payments for ASC services following the implementation of the ASC fee schedule was 28 percent.



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Changes in Paid Amounts Per ASC Episode

In addition to using the ICIS data to assess the changes in the average ASC billed and paid amounts per procedure, the authors used the MDC data to measure the combined effect of the fee schedule changes and network discounts on a per episode basis.

For this portion of the analysis, the authors identified the top 30 ASC procedures used in California workers' compensation (based on volume of services in the 2012-2013 claim sample), then grouped the data into "episodes" of care, which included all procedures and ancillary services delivered by an ASC or hospital outpatient department on a specific claim, a specific bill and a specific date of service.

Each episode may include more than one procedure, so the per-episode analysis provides an event-based view into these services. For example, an arthroscopy episode may include billing and payment data for both the arthroscopic procedure as well as a "debridement" procedure (removal of tissue from the surgical area) that was performed on the same date and included on the same bill.

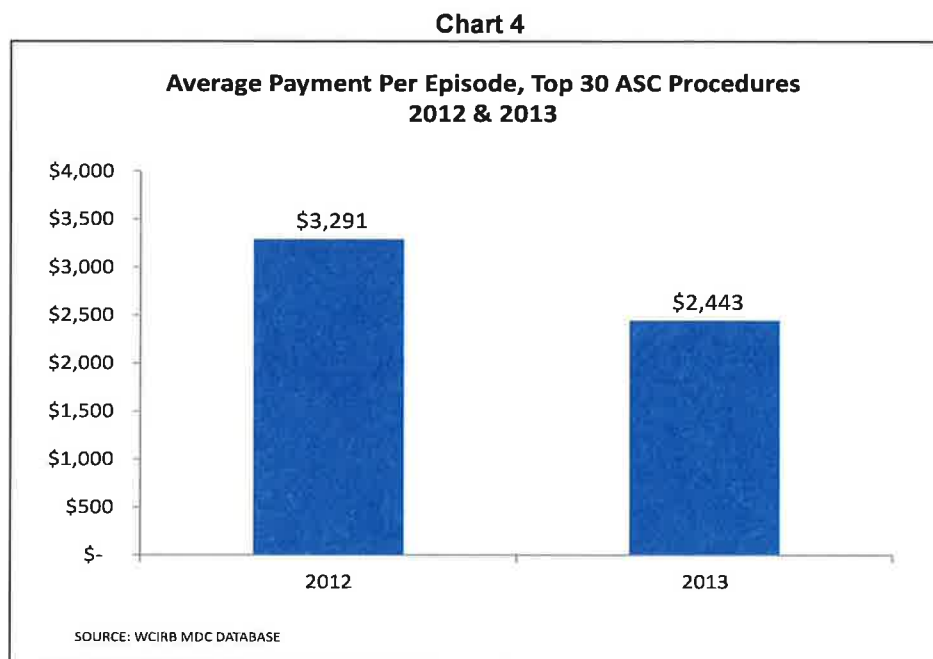


Chart 4 shows the average amount paid for ASC services per episode declined 26 percent from \$3,291 to \$2,443 following the adoption of the fee schedule changes in January 2013 – which tracks closely with the 28 percent reduction in per procedure payments noted earlier in Chart 3.

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Mix of Services

The most frequently used outpatient surgical procedures in California workers' compensation, comprising 85 percent of all ASC services in the system, fall into three groupings: surgeries, nerve impingement procedures and spinal cord stimulation procedures. Surgeries include knee and shoulder arthroscopies, as well as hand and hernia procedures; nerve impingement procedures are primarily injections in the back; and spinal cord stimulation procedures are primarily neurostimulator implants. To determine if there was a shift in the mix of these procedures under the revised fee schedule, or in the setting in which they were delivered, the authors reviewed the MDC data and identified the top 30 ASC procedures by service type, then compared the 2012 and 2013 distributions for procedures rendered at ASCs (Chart 5A) and on an outpatient basis at hospitals (Chart 5B).

Chart 5A

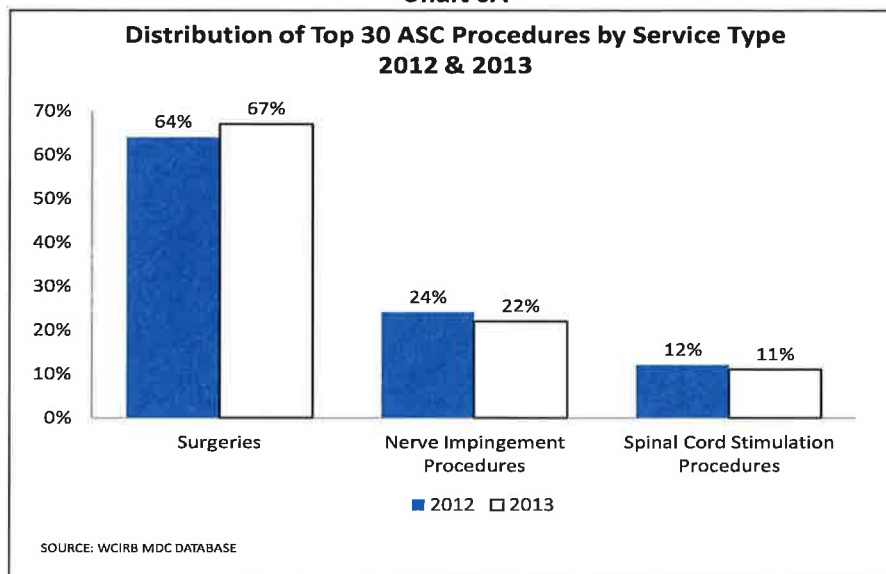
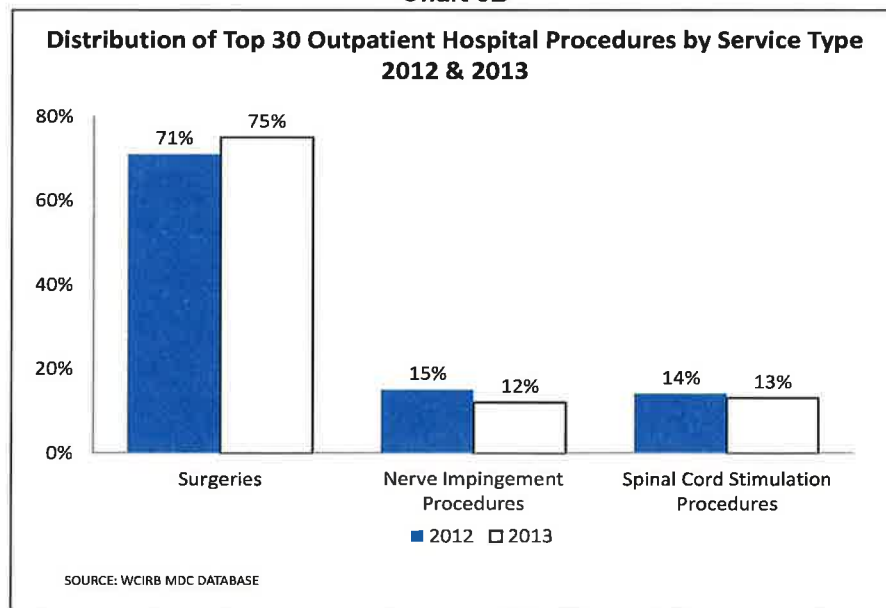


Chart 5B



SB 863 and the ASC Fee Schedule
February 26, 2014

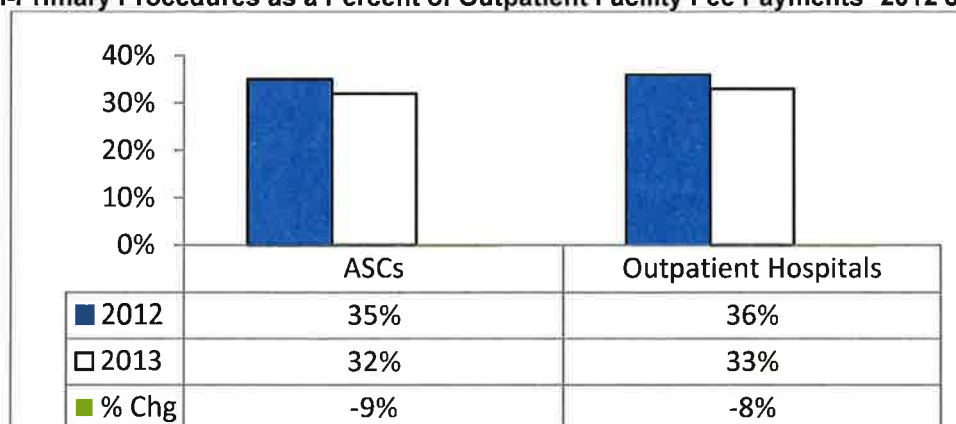
The results show that between 2012 and 2013 there were only minor shifts in the distributions of outpatient procedures rendered at ASCs or on an outpatient basis at hospitals. These relatively stable distributions indicate that at least thus far, the fee schedule changes had little effect on the types of ASC procedures performed in these settings. Furthermore, on a per-episode basis, reimbursements for each of the three major service types changed at similar rates for both settings after the changes to the fee schedule took effect.

Service Intensity

The revised fee schedule reduced facility fees for procedures performed at ASCs, creating a potential incentive for ASCs to deliver more services to compensate for the lost revenue. For example, an ASC that was treating an injured worker with epidural injections might provide additional non-primary procedures during the same surgical event, generating additional fees.

To determine if the provision of services outside the primary procedure code changed after the revised schedule took effect, the authors used the MDC database episode data to calculate the proportion of total outpatient facility fees that paid for such services in 2012 and in 2013, and then compared the results from each year for ASC and outpatient hospital settings.

Chart 6A
Non-Primary Procedures as a Percent of Outpatient Facility Fee Payments⁹ 2012 & 2013



SOURCE: WCIRB MDC DATABASE

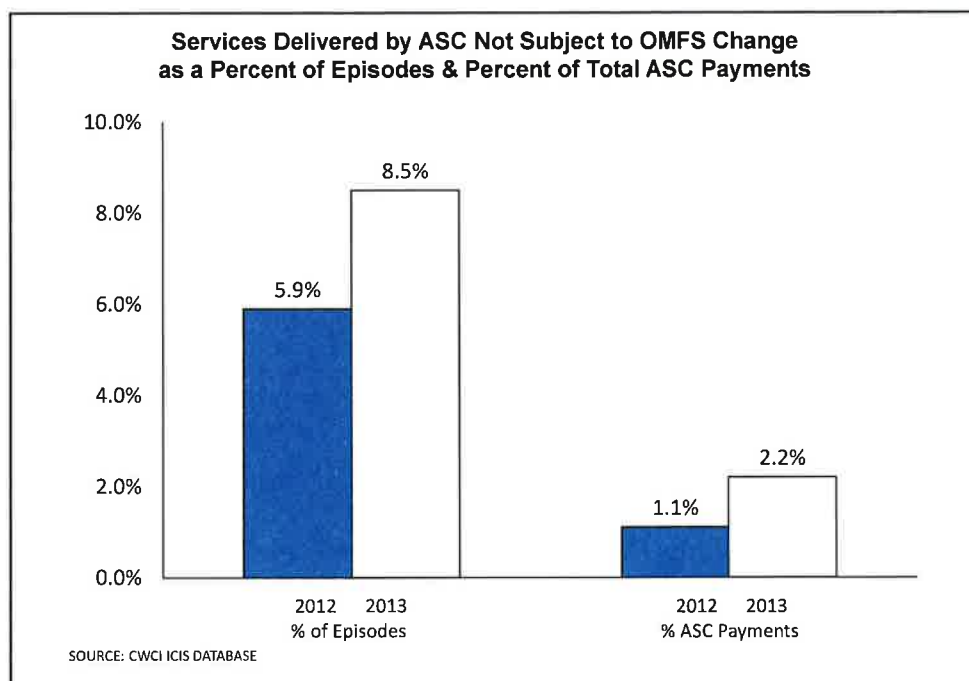
The results, noted in Table 6A, indicate that rather than an increase in non-primary procedures following the implementation of the new schedule, both ASCs and outpatient hospitals experienced a slight (3 percentage point) reduction of the proportion of outpatient facility fees that went toward additional services associated with the primary paid procedure. These reductions translate to a relative decline of 9 percent in the use of these procedures by ASCs and a relative decline of 8 percent in the use of these services by outpatient hospitals. In both settings, these types of services accounted for about one third of all 2013 outpatient facility fee payments.

⁹ Defined as paid procedures on the same claim, the same bill and for the same date of service as the primary medical procedure. For example: Additional spinal injections beyond the primary injection procedure.

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The authors further refined the analysis by isolating any additional paid services that were not subject to the new ASC fee schedule reductions¹⁰ (such as x-rays and lab tests) to determine if the financial incentive would drive a differential increase. For this part of the study, the authors reviewed the ICIS data from ASCs to identify episodes where these other services were performed, then calculated the percentage of episodes from 2012 and 2013 that included payments for these types of services, as well as the percentage of all ASC payments represented by these services (Chart 6B).

Chart 6B



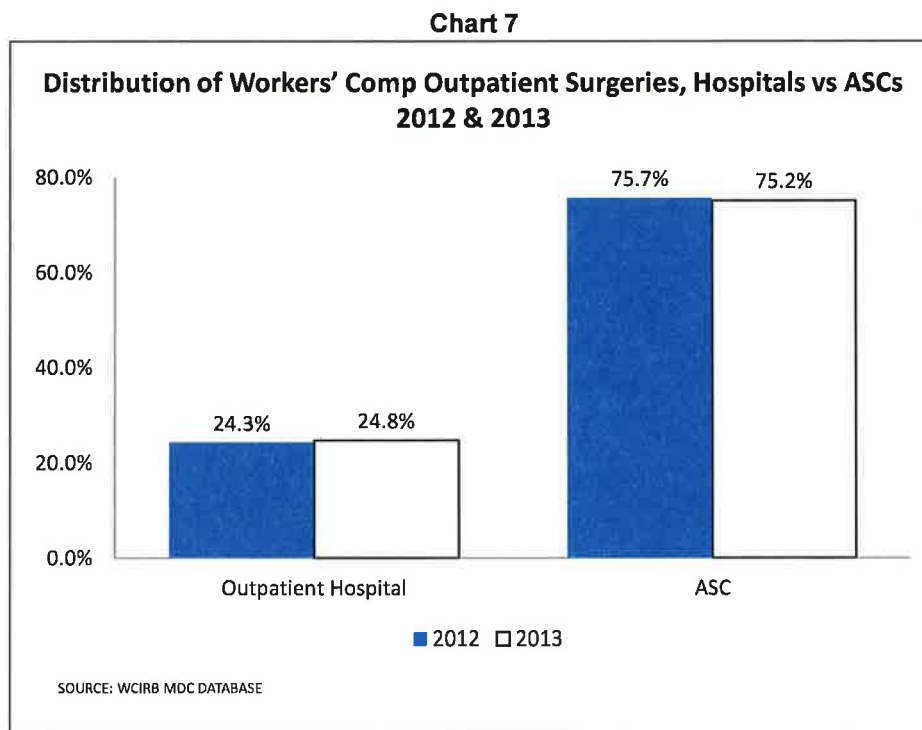
In 2012, 5.9 percent of the ASC episodes included payments for services not subject to the fee schedule reductions, but after the revised schedule took effect in January 2013, that percentage increased to 8.5 percent of the episodes. Over the same period, payments for these services increased from 1.1 percent to 2.2 percent of the total amount paid for ASC services, but continued to account for only a small fraction of the total ASC reimbursements.

¹⁰ Paid services not subject to the new ASC fee schedule included only those rendered on the same claim, at the same facility and on the same date of service as the procedures that were impacted by the fee schedule reduction.

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Sites of Service

The revised outpatient fee schedule reduced the facility fee allowances for ASCs, but not for outpatient hospitals, so the authors assessed whether this change caused a shift in the setting for outpatient surgeries. Using the MDC data, they calculated and compared the proportion of workers' compensation outpatient surgical episodes that occurred in each of these settings in 2012 and in 2013 (Chart 7).



The resulting distributions show that the proportion of workers' compensation surgical episodes conducted at outpatient hospitals and at ASCs were nearly identical in 2012 and 2013, with outpatient hospitals accounting for just under a quarter of all surgical episodes and ASCs accounting for the balance in both years. Thus, the study found no evidence of a shift of services from ASCs to outpatient hospital settings following the implementation of the revised fee schedule.

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Summary

The changes to the California workers' compensation outpatient physician fee schedule mandated by state lawmakers in SB 863 and in subsequent regulations were intended to reduce ambulatory surgery center facility fees. In projecting the financial impact of this change, the WCIRB estimated this reform would reduce ASC fees by 25 percent.

This study offers an initial look at the outcomes of that reform by using two independent sets of data to measure and compare the average amounts billed and paid for outpatient surgical facility fees. The findings indicate that by reducing the conversion factor used in the ASC reimbursement calculation, the revised schedule produced a net reduction of 28 percent on a per-procedure basis, and 26 percent on a per-episode basis. Such results suggest that thus far, the change in the ASC fee schedule has achieved its intended objective of reducing one aspect of workers' compensation medical costs.

Moreover, the study found no evidence of changes which would potentially undermine the fee schedule savings. Although billings increased and negotiated discounts eroded, the net paid amounts were not materially affected. On the question of service intensity, both ASCs and hospital outpatient departments registered declines in the proportion of outpatient facility fees paying for additional services associated with the primary paid procedure. The proportion of ASC payments attributable to services not subject to the fee schedule change increased, but remained relatively small. Likewise, the data indicate no change in the mix of services or the percentage of episodes occurring in outpatient hospital settings and ASCs.

Finally, it should be noted that all of the data used in the study reflect transactions that took place either in the year immediately preceding the effective date of the revised fee schedule (2012) or in the first six months following its implementation (January through June 2013). Thus, the findings from this analysis should be considered preliminary. They do, however, provide important benchmarks for measuring future experience, and the authors will continue to monitor California workers' compensation ASC and outpatient surgical fees, and will update this report later in 2014 to include all 2013 transaction data.

Workers' Compensation Insurance Rating Bureau of California®

Preliminary Analysis of the Impact of RBRVS on Medical Payments

Released: November 14, 2014

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Executive Summary

The new RBRVS-based physician fee schedule effective January 1, 2014 encompasses approximately 50% of all workers' compensation medical payments. The WCIRB studied comparable periods in 2013 and 2014 to determine the impact of this new schedule. This preliminary study indicates that the financial impact of the new schedule may be less than originally forecast. Additionally, the legislative intent to shift a greater share of total workers' compensation medical payments to primary care providers may have been achieved.

Background

Senate Bill No. 863 (SB 863), directed the Administrative Director of the Division of Workers' Compensation (DWC) to adopt a fee schedule for physicians based on a resource-based relative value scale (RBRVS) with the maximum reasonable fees not to exceed 120% of Medicare fees, adjusted for inflation. In late 2013, the Director adopted a physician fee schedule based on RBRVS effective January 1, 2014, which is the start of a four-year transition period to continue through 2017.

The RBRVS schedule is maintained and updated by the Centers for Medicare & Medicaid Services (CMS). The Schedule includes relative value units for each medical service associated with the physician's work and conversion factors that convert the relative value units into a maximum amount to be paid for the service. Physician services covered under this schedule encompass approximately 50% of all California workers' compensation medical costs.

Estimated RBRVS Cost Impacts

The 2014 physician fee schedule change has long term financial implications for the California workers' compensation system. As part of the amended January 1, 2014 Pure Premium Rate Filing, the WCIRB evaluated the potential cost impact of the transition to RBRVS.¹ In the amended filing the WCIRB estimated that the impact of the new fee schedule on policy year 2014 physician payments was 7.3%, which had an estimated impact on overall policy year 2014 medical costs of 3.6%.

As part of its monitoring of the cost impact of SB 863, the WCIRB will evaluate its prospective assessment of SB 863 components against the data actually emerging. Currently, the WCIRB has six months of post-RBRVS experience available from its Medical Data Call (MDC) medical transaction database. The WCIRB used these data to address eight questions in its evaluation of RBRVS based on this very early post-RBRVS information:

1. What is the overall financial impact of RBRVS?
2. What were the differential impacts by fee schedule section?
3. How did these changes compare to WCIRB estimates?
4. Did RBRVS shift the share of total payments from specialists to primary care?
5. Was there evidence of a change in coding patterns?
6. Which procedures and services increased in frequency and cost?
7. Which procedures and services decreased in frequency and cost?
8. Was there evidence of delays in payments due to the new schedule?

¹ Section B of the WCIRB's amended January 1, 2014 Pure Premium Rate Filing submitted on October 23, 2013.

1. What is the overall financial impact of RBRVS?

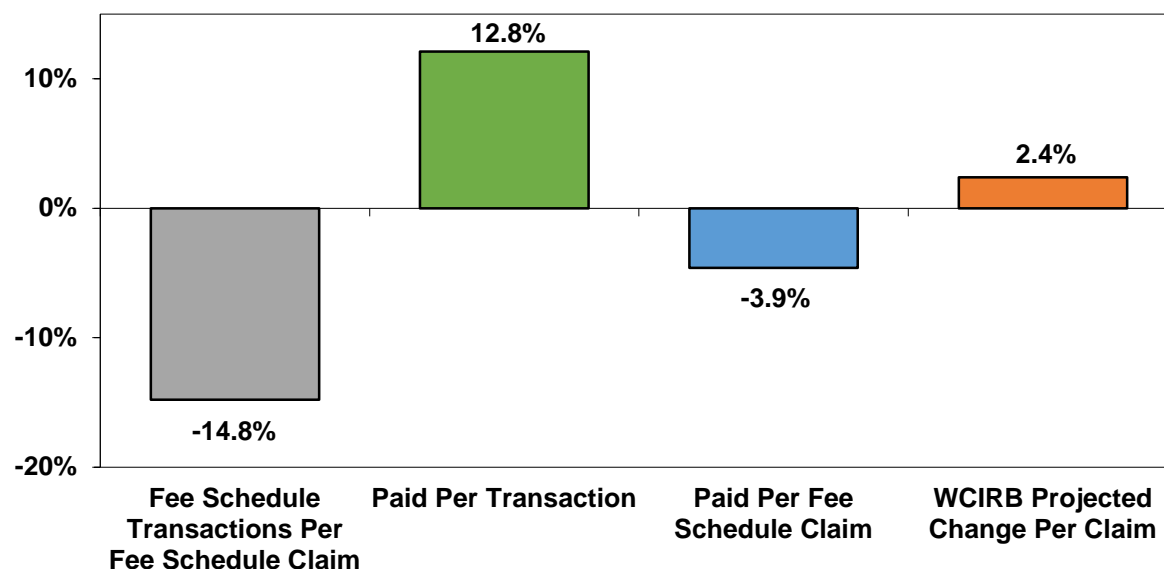
To determine the overall impact of RBRVS based on the preliminary emerging information through June 30, 2014, the WCIRB compared medical services and payments from the first half of 2014 to those from the first half of 2013. Table 1 compares paid medical transaction data from the first and second quarters of 2013 (1H2013) to the first and second quarters of 2014 (1H2014). Both sets of data consisted of provider services delivered and paid in the first half of each year, allowing comparability in payment development over these periods. The data show a slight 0.3% decline in overall paid amounts in 1H2014. This result, although preliminary, indicates that RBRVS may not generate the \$300 million increase WCIRB forecast for 2014.

Table 1: Fee Schedule Payments by Service and Payment Quarter (in Millions)

Service Quarter	Paid within 1Q2013 OMFS	Paid within 2Q2013 OMFS	Paid within 3Q2013 OMFS	Paid within 4Q2013 OMFS	Paid within 1Q2014 RBRVS	Paid within 2Q2014 RBRVS
1Q2013	\$100.6	\$103.5	\$22.9	\$8.0	\$4.3	\$2.9
2Q2013		\$100.1	\$112.7	\$18.8	\$7.8	\$4.3
3Q2013			\$107.6	\$102.7	\$18.9	\$6.8
4Q2013				\$106.0	\$99.3	\$16.4
1Q2014					\$95.6	\$103.4
2Q2014						\$103.7
Combination 6 Service/Payment Quarters		\$304.3				\$303.3

Table 2 shows these preliminary results on a per claim basis. This information indicates a 14.8% decrease in transactions per claim which offset a 12.8% growth in paid per transaction. The 3.9% overall decrease in paid physician cost per claim is lower than the WCIRB's forecasted 2.4% increase in paid per claim for services in 2014, which was reflected in the amended January 1, 2014 Pure Premium Rate Filing.

Table 2: Percent Change in Fee Schedule Cost 2013- 2014



2. What were the differential impacts by fee schedule section?

Table 3 examines each section of the fee schedule. While the total paid transactions decreased by 12%, the average paid per transaction under RBRVS increased by 12%, resulting in total payments being flat between the first six months of 2013 and the first six months of 2014. Note there were considerable changes for several fee sections.

- (A) Evaluation and Management (E&M) payments increased by 16%. This increase was driven by a 25% upward adjustment to the RBRVS payment formula, which offset a 7% decline in E&M transactions.
- (B) Medicine (including physical medicine, psychiatry, acupuncture, chiropractic and office-based procedures) decreased by 6% in overall payments, reflecting a drop in both transactions and RBRVS unit charges.
- (C) Surgery total reimbursement remained flat in the first six months of 2014, reflecting a 12% drop in transactions and a 12% increase in cost per transaction. This finding differs from original prospective estimates of the impact of RBRVS which projected a reduction in surgical costs.
- (D) Pathology services were captured by only a handful of RBRVS codes. The vast majority of pathology services are reimbursed by Medicare's Clinical Laboratory Fee Schedule (CLFS). For this reason, WCIRB combined the RBRVS Pathology and Medicare CLFS codes. This calculation revealed that Pathology and Laboratory reimbursement was essentially flat in 2014 compared to 2013.
- (E) Special Services and Reports showed the greatest payment decline at 28% down for the first six months of 2013 compared to the first six months of 2014. RBRVS did not contain codes for

these services, and contemplated that they would be bundled into E&M codes. The introduction of new WC reporting codes enabled some of these services to be separately reimbursed in 2014.

3. How did these changes compare to WCIRB forecasts?

The WCIRB forecast the impact of the service year 2014 RBRVS changes by section in its amended January 1, 2014 Pure Premium Rate Filing.

As shown in Table 3, WCIRB forecast the increase in E&M payments to be 15.8% in 2014, very close to the actual increase of 16.1%. The WCIRB somewhat underestimated the declines in Medicine and Radiology, but overestimated the declines in Anesthesia and Surgery. The projected payment decline in surgery costs has not yet materialized; these cost levels were sustained in 2014 by an unexpected increase in per transaction payments for surgical procedures.

The greatest divergence from the forecast was for items not accounted for in RBRVS (such as Clinical Laboratory and Special Services and Reports). Driven by a 28% decline in payments for Special Services and Reports, overall paid for non-RBRVS services declined 13.3% compared to a WCIRB estimate of a 3.1% increase.

Table 3: Comparison by Fee Schedule Section

Type Of Service	1H2013 Paid Medical	1H2013 Paid/ Transaction	1H2014 Paid Medical (Change from 1H2013)	1H2014 Paid/ Transaction (Change from 1H2013)	% Change in Paid From 2013 to 2014	WCIRB Projected % Change for 2014
Anesthesia	\$6,504,886	\$346	\$6,314,319 (-3%)	\$340 (-2%)	-2.9%	-4.7%
Evaluation & Management	\$84,981,786	\$87	\$98,596,239 (+16%)	\$109 (+25%)	+16.1%	+15.8%
Medicine	\$74,152,230	\$34	\$69,750,293 (-6%)	\$37 (-9%)	-5.9%	-1.3%
Path & Lab Subject to RBRVS	\$476,005	\$68	\$234,544 (-51%)	\$36 (-28%)	-50.8%	-41.0%
Radiology	\$31,674,916	\$129	\$29,029,421 (-8%)	\$116 (-10%)	-8.3%	-3.4%
Surgery	\$57,965,031	\$412	\$57,359,744 (-1%)	\$461 (+12%)	-1.0%	-4.8%
Subtotal – Subject To RBRVS	\$255,754,854	\$72	\$261,284,561 (+2%)	\$82 (+11%)	-2.1%	+2.0%
Not Subject to RBRVS	\$48,525,154	\$45	\$42,053,110 (-13%)	\$46 (+1%)	-13.3%	+3.1%
GRAND TOTAL	\$304,280,008	\$66	\$303,337,679 (-0.3%)	\$74 (+12%)	---	---
# of Claims With Payments	300,571		311,810			

4. Did RBRVS shift the share of total paid from specialists to primary care?

The RBRVS scheme involves major changes in the way specific services are reimbursed. The adjustments in conversion factors were expected to shift more of the total payments to primary care and less to physician specialists. Initial WCIRB results based on the initial six months of post-RBRVS experience suggest that this was achieved. As shown in Table 4, the share of paid services defined as Primary Care (E&M and Medicine) increased by 2.2% from 2013 to 2014. Specialty Care (Anesthesia, Pathology, Radiology and Surgery) declined by a corresponding 2.2% of total paid services. E&M was the only RBRVS category with an overall share increase, showing a 4.6% rise from 2013 to 2014.

Table 4: Shares of Fee Schedule Payments- OMFS VS. RBRVS (\$ in Millions)


Fee Schedule Section	1H2013 Paid OMFS	Share of OMFS Total	1H2014 Paid RBRVS	Share of RBRVS Total	Share Change 2013-2014
Primary Care					
E&M	\$84.9	33.2%	\$ 98.6	37.8%	+4.6%
Medicine	\$74.2	29.0%	\$ 68.8	26.3%	-2.7%
Total Primary Care	\$159.1	62.2%	\$168.4	64.4%	+2.2%
Specialty					
Anesthesia	\$6.5	2.5%	\$6.3	2.4%	-0.1%
Pathology	\$0.5	0.2%	\$0.2	0.1%	-0.1%
Radiology	\$31.7	12.4%	\$29.1	11.1%	-1.3%
Surgery	\$57.9	22.7%	\$57.4	22.0%	-0.7%
Total Specialty	\$96.6	37.8%	\$92.9	35.6%	-2.2%
GRAND TOTAL	\$255.8		\$261.3		

5. Was there evidence of a change in coding patterns?

The RBRVS increase in Evaluation and Management (E&M) conversion factors led some analysts to predict that provider coding practices may be altered to bill less aggressively bill for more medically intensive codes (Level 4 or Level 5 services).

As shown in Table 5, evidence of less aggressive coding was minimal: Level 4 codes in 2014 were billed at the same frequency as 2013, despite a 25% unit price increase. There was, however, some evidence of a drop in the most complex codes (Level 5) and a corresponding increase in the more routine Level 3 codes. In total, the average E&M coding level did not change significantly in the first six months of 2014.

Table 5: RBRVS Impact on E&M Coding Patterns

	E&M CODING LEVEL	% of 2013 E&M Transactions	% of 2013 E&M Paid	% of 2014 E&M Transactions	% of 2014 E&M Paid
	Level 1	0.7%	0.3%	0.7%	0.3%
	Level 2	3.6%	2.3%	3.8%	2.2%
	Level 3	36.2%	26.7%	37.8%	29.5%
	Level 4	47.3%	52.3%	47.6%	53.7%
	Level 5	12.1%	18.4%	10.1%	14.3%
	All Levels 1 Through 5	100%	100%	100%	100%

6. Which procedures and services increased in payments?

Several specific procedures and services increased in frequency and payment under RBRVS. The fastest growing procedures are displayed in Table 6. A total of 15 codes accounted for 45% of 2014 payments, compared to 15% for these same codes in 2013. This analysis suggests that increases were largely driven by a combination of fee schedule upward adjustments and the selective use of codes with higher reimbursements.

Table 6: Fastest Growing Procedures and Services Under RBRVS

Fee Schedule Section	Fastest Growing Code	2nd Fastest Growing Code	3rd Fastest Growing Code
Evaluation & Management	Office Visit: Level 4 - Established Patient	Office Visit: Level 4 - New Patient	Office Visit: Level 3 - Established Patient
Medicine (including PT, Psych., Chiro., Acupuncture)	PT- Initial 30 Minutes	PT- Additional 15 Minutes	Psychological Testing
Pathology & Lab (including Medicare CLFS)	Chromotography- Urine Testing Column	Chromotography- Urine Testing Mobile	Assay of Opiates
Radiology	MRI with dye- Upper Extremity	MRI with dye-Upper Extremity (non joint)	MRI with dye- Lower Extremity
Surgery	Shoulder Arthroscopy- Rotator Cuff Repair	Athrocentesis- Draw Fluid from Major Joint	Shoulder Arthroscopy- Mumford Procedure
Special Service & Reports	Progress Reports - WC002	P & S Reports - WC 004	WCAB Reports - WC 007

7. Which procedures and services decreased in payments?

While some procedures increased, others dramatically declined. The fastest declining codes are shown in Table 7. Decreases appeared to be driven by the expiration of some codes and the abandonment of others for similar codes with higher reimbursements. The 15 most significant declining codes accounted for 40% of 2013 payments. These codes decreased to account for 10% of 2014 payments.

Table 7: Fastest Declining Procedures and Services Under RBRVS

Fee Schedule Section	Fastest Declining Code	2nd Fastest Declining Code	3rd Fastest Declining Code
Evaluation & Management	Prolonged E&M	Office Consult - Level 5	Office Consult - Level 4
Medicine (including PT, Psych., Chiro. , Acupuncture)	Myofascial Release	Nerve Conduction Studies	Electrical Stimulation-Unattended
Pathology & Lab (including Medicare CLFS)	Chromotography - Urine Testing Gas/Liquid	TRH Stimulation Panel	Clinical Chemistry Test
Radiology	MRI- Any joint Upper Extremity	MRI Spinal Canal	MRI- Any joint Lower Extremity
Surgery	Shoulder Arthroscopy	Knee Meniscectomy Medial/Lateral	Shoulder Arthroscopy With debridement
Special Service & Reports	Special Reports	Required Reports	Unlisted Special Services

8. Was there evidence of delays in payments due to the new fee schedule?

Given that the new RBRVS-based schedule is a major change in bill processing, the WCIRB examined whether average service-to-payment intervals changed in 2014. Table 8 indicates that the interval between service and payment increased by 3.4 days (8%) for RBRVS payments in 2014. The interval for non-RBRVS bills (such as those from hospitals and pharmacies not affected by RBRVS) increased in 2014 by 4%.

It appears that the ramp-up to the new RBRVS reimbursement system may have contributed to slight delays in processing bills and payments. The WCIRB will monitor these data in the future to assess whether payment intervals stabilize.

Table 8: Timing of Payments Before and After the Introduction of RBRVS

	1st Half 2013 OMFS	1st Half 2014 RBRVS	Days Difference %	1st Half 2013 Other Schedules*	1st Half 2014 Other Schedules*	Days Difference %
Average Days/ Service to Payment	43.5	46.9	3.4 (+8%)	37.7	39.1	1.4 (+4%)

*Not covered by OMFS/RBRVS: Pharmacy, ASC, Supplies, Inpatient and Outpatient Hospital

Summary of WCIRB Preliminary Findings

WCIRB's preliminary assessment based on the medical transactions from the first six months of 2014 of the impact of RBRVS indicates:

1. Early indications of the impact on physician costs suggest a 3.9% per claim savings, rather than the 2.4% per claim increase originally projected.
2. The primary savings were generated by a 28% decrease in payments for Special Services and Reports in the first six months of 2014.
3. Primary care (especially Evaluation and Management) showed a 2.2% increase in share of payments, while specialty services showed a corresponding share decline.
4. The new schedule generated significant increases and decreases in paid services, while the total payments remained flat from 2013 to 2014.
5. There was a 3.4 day average increase in the interval between services and payments in 2014, which may be attributed to, in part, the ramp-up to the new schedule.

This preliminary assessment is based on six months of medical services and payment data. As such, WCIRB will regularly update these findings to determine if these initial trends persist.



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