

CALIFORNIA



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DATE: May 17, 1999

TO: Lowry Jones, Jr., MD, Chair
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FROM: Diane Prezpiorski
Executive Director

SUBJECT: Workers' Compensation Reimbursement for
Evaluation and Management services

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As you know, California just completed substantial revisions to our Workers' Compensation Official Medical Fee Schedule (treatment) and the Medical Legal Fee Schedule. Many of the changes were to Ground Rules which clarify billing issues.

We were also successful in obtaining an 18.8% increase in reimbursement levels for all Evaluation and Management services. While many providers had input into this issue, we believe that one factor which was instrumental in obtaining this increase was a survey that COA sent to its members quantifying the additional time that is spent treating and reporting on Worker's Compensation patients versus their other patients.

You will see from the attached survey results, we found that on average, an orthopaedic surgeon is spending 4 hours and 42 minutes longer with an industrial patient over the course of their treatment than with their other patients. In addition, staff spent an additional 3 hours and 47 minutes.

The survey went on to validate some of the other fee schedule changes we were seeking.

We believe that this information may be helpful to other states as they attempt to increase their Workers' Compensation fee schedules.

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Preliminary Results of the Survey on the Costs of Treating Workers' Compensation Patients

An informal survey was conducted of COA members to determine the additional costs of treating Workers' Compensation patients versus those patients in other group health plans. The survey measured actual additional time spent by the physician and staff and also other areas unique to the Workers' Compensation system such as precertification and prior authorization, reporting requirements, billing and collection, and delays in payment. The preliminary results were compiled from information received from 93 orthopaedic surgeons and 2 primary care physicians. 83.2% of those responding participated as both treating physicians and QMEs in California's Workers' Compensation system.

Additional Time Involved in the Treatment of Workers' Compensation Patients

Those responding to the survey indicated that they spend additional time involved with treating Workers' Compensation patients versus patients in other group health plans in the following areas:

1. **Additional Physician Time (averaged time)**

Phone calls obtaining prior authorizations	11 minutes per patient
Developing treatment plan	16 minutes per patient
Completing required reports (progress reports, etc.)	29 minutes per patient
Completing forms required by carrier/UR companies	17 minutes per patient
Communicating with the employer about medical/work status	16 minutes per patient
Collection and billing disputes	18 minutes per patient
Determining work restrictions	18 minutes per patient
Reporting when a worker is permanent & stationary	36 minutes per patient
Determining future medical care	16 minutes per patient
Additional overall evaluation/treatment time for an average industrial patient	40 minutes per patient (2 responded - twice as much as a group health patient)
Write-in items to the survey under Other Factors:	
Case manager inquiries	29 minutes per patient
Talking with adjustors	36 minutes per patient
TOTAL ADDITIONAL PHYSICIAN TIME:	282 minutes - 4 hours and 42 minutes

Additional Staff Time (averaged time)

Phone calls obtaining prior authorizations	39 minutes per patient
Completing required reports (First report, progress reports)	25 minutes per patient
Completing forms required by carrier/UR companies	20 minutes per patient
Communicating with the employer about medical/work status	18 minutes per patient
Collection and billing disputes	46 minutes per patient
Reporting when a worker is permanent & stationary	14 minutes per patient

Write-in items to the survey under Other Factors:

Case manager inquiries	29 minutes per patient
Talking with adjustors	36 minutes per patient

TOTAL ADDITIONAL STAFF TIME: 227 minutes - 3 hours and 47 minutes

Other Cost Factor - Timeliness of Payment

Medicare, on average, pays within 45 days

Private carriers, PPOs, HMOs, etc. use the Medicare guidelines and also pay with 45 days.

In addition, providers do not have to deal with denials due to reports not being sent to bill review companies.

Workers' Compensation carriers, on average, pay within 90-120 days on a defense claim. **The wait for payment is at least twice what it is for other group health plans for applicant claims.**

2. What is the average hourly salary for your staff: \$ 14.60 to \$ 21.81 per hr.
3. Have you had to increase your staffing in the last four years in order to comply with the requirements of workers' compensation? Yes 77% No 18% Did not answer this question 5%

On average 1.5 full-time staff were added
1.2 part-time staff were added
6% responded that there was additional overtime in lieu of hiring additional staff

Monthly increased overhead and overtime costs ranged from: \$1,500 per month to \$12,575 per month.

4. Has the time necessary for a workers' compensation patient visit increased because of insurers using case managers/rehab nurses who accompany the patient on visits? Yes 84%, No 12%, Not responding 4%

Increased time due to case managers/rehab nurses:	5 minutes: 2.6%
	10 minutes: 23%
	15 minutes: 35%
	20 minutes: 1 %
	30 minutes: 18%
	40 minutes: 1%
	60 minutes: 15%

5. Have you experienced a decrease in the number of patients you see in a day due to increased carrier requirements? Yes 67% No 28% Not responding to this question 5%

Of those responding yes, they are seeing the following fewer patients each day:

1 patient	3.8%
2 patients	19.2%
3 patients	48.1
4 patients	21.2%
5 patients	5.8%
7 patients	1.9%

6. How often do insurers/bill review companies/employers ask you for reports or other information that you have already provided to them?

Almost always – 52.6% Sometimes 41.9%, Rarely 3.2% Not Responding 2.2%

The following companies were cited as requesting duplicate information most often:

State Fund	27%
Liberty Mutual	19%
City of LA	17%
Firm Solutions	17%
Helmsman	17%
Kemper	17%
All companies	16%
Beech Street	12%
Reviewco	11%

7. How often are you denied reimbursement for services that were authorized in advance?

Almost always 1% Sometimes 80% Rarely 11.8% Not Responding 7.5%

The following carriers/bill review companies/employers were cited as routinely denying reimbursement for services that had been previously authorized.

Helmsman Management	St. Paul Fire
Liberty Mutual	CCN
Dept. of Labor	State Fund
All carriers	Accumed
CNA	Reviewco
Hertz	Travelers
Cigna	

8. Are there certain insurers/bill review companies with whom you experience a significant amount of "hassle" routinely? Yes 78.5% No 4% Not Responding 17%

The following companies were listed as routinely "hassling" providers.

Liberty Mutual
State Fund
Helmsman
Kemper
Dept. of Labor
Almost all carriers
Beech Street
Applied Risk Management
Reviewco
Applied Risk Management
Golden Eagle
Hertz

9. Do you routinely obtain prior authorization from the insurer/employer before providing treatment?

Yes 96% N 4% For all services: Yes 84% No 10%

Only certain services: Yes _____ 14% No 0%

Services for which physicians are routinely obtaining prior authorization:

- All surgeries
- Referral to another physician/Second opinions
- Diagnostic testing
- MRIs
- Cat Scans
- Bone Scans
- EMG/NCV
- Physical Therapy
- Injections
- Prosthetics/Orthotics
- Pain Management

10. What percentage of the time do you request verbal authorizations versus written authorizations?

Request verbal authorizations:	<u>100% of the time</u>	<u>47%</u>
	<u>99% of the time</u>	<u>2%</u>
	<u>95% of the time</u>	<u>3%</u>
	<u>90% of the time</u>	<u>7%</u>
	<u>80% of the time</u>	<u>6%</u>
	<u>50% of the time</u>	<u>21%</u>
	<u>40% of the time</u>	<u>13%</u>
	<u>10% of the time</u>	<u>1%</u>

How long does it usually take to get the verbal request approved?

<u>1-5 days</u>	<u>51%</u>
<u>6-10 days</u>	<u>22%</u>
<u>11-15 days</u>	<u>9%</u>
<u>16 or more days</u>	<u>17%</u>

Do carriers send verbal requests through their formal UR system?

Yes 69% No 11% Did not know 20%

All carriers: 9% Some carriers: 60%

Request written authorizations:	<u>50% of the time</u>	<u>19%</u>
	<u>40% of the time</u>	<u>1%</u>
	<u>25% of the time</u>	<u>3%</u>
	<u>10% of the time</u>	<u>3%</u>
	<u>5% of the time</u>	<u>11%</u>
	<u>1 % of the time</u>	<u>1%</u>
	<u>Takes too long</u>	<u>23%</u>
<u>Carriers Rarely Respond to Written Requests</u>		<u>14%</u>

How long does it usually take to get the written authorization approved?

<u>1-5 days</u>	<u>6%</u>
<u>6-10 days</u>	<u>15%</u>
<u>11-20 days</u>	<u>32%</u>
<u>21 or more days</u>	<u>11%</u>

11. Are there services which are routinely disallowed that you believe should be paid? Yes

81% No 10% No Response 9%

Services listed and carriers which usually denies the service

Service	Carriers Which Usually Deny Service
Generally routinely reduce treatment code billed	State Fund Fremont Golden Eagle All carriers - certain procedures
-26 - Professional component of reading x-rays	Beech Street City of LA
X-rays - additional views	All carriers
Injections and E/M service on the same day	State Fund City of LA Beech Street All carriers
Supplies	All carriers
Reports - even when requested	All carriers CNA Colen & Lee SCRMA Travelers Aetna
Consultant reports	All carriers Zenith
Physical therapy	Cigna
E/M services	All carriers Zenith Calcomp Chubb Applied Risk Management
Permanent & Stationary reports	All carriers

12. What percentage of your patients end up having litigated claims?

<u>5% - 10% of claims</u>	<u>12%</u>
<u>11 %-20% of claims</u>	<u>30%</u>
<u>21% -30% of claims</u>	<u>11%</u>
<u>31%-50% of claims</u>	<u>11%</u>
<u>51%-70% of claims</u>	<u>22%</u>
<u>more than 71%</u>	<u>12%</u>
<u>did not know</u>	<u>6%</u>

13. How often do you need an interpreter in order to communicate with an injured worker?

<u>0% - bilingual staff/physician</u>	<u>9%</u>
<u>1%- 9% of claims</u>	<u>21%</u>
<u>10% of claims</u>	<u>27%</u>
<u>11 %-20% of claims</u>	<u>13%</u>
<u>21%-30% of claims</u>	<u>8%</u>
<u>31%-50% of claims</u>	<u>16%</u>
<u>more than 51 %</u>	<u>5%</u>

14. Are you using a Physician Assistant or Nurse Practitioner to perform a portion of the evaluation/management service?
Yes 6% No 94%

Those reporting that they utilize a PA or NP indicated that their reimbursement is not reduced when they report that the PA or NP participated in the E/M service.

15. Do you experience a routine downcoding of evaluation/management services billed?

Yes 85% No 15%

All carriers were listed, however, the following were listed most often:

- Beech Street
- Reviewco
- State Fund
- Comp Review
- Zenith
- City of Anaheim
- Risk Administrator
- Keenan

16. When you are billing a permanent & stationary report with issues of disability, does the carrier pay you for the appropriate evaluation/management or consultation code, the report (99080) and if appropriate, a prolonged service code? Yes 17% No 80% Did not respond 3%

If no, which code do they disallow? E/M 44% Report 58% Prolonged Service 47%

17. Do you file liens in order to obtain payment for services that were disallowed or downcoded by carriers?

Yes 26% No 74%

If they answered yes, the average number of liens filed in a year ranged from 3-4 to 1000.

18. Would you prefer that the current treatment fee schedule be abandoned and that instead reimbursement levels would negotiated with the carriers? Yes 13% No 87%

The primary reason listed for those that did want a negotiated system was that the providers would have little negotiating power with the carriers.

19. Are you considering leaving the workers' compensation treatment arena? Yes 36% No 64%

The primary two reasons listed were: due to hassles and paperwork
more overhead/costs than reimbursement levels