A REPORT TO THE INDUSTRY

Can Access to Medical Care in California Workers' Compensation Be Improved?

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MARCH 2022

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EXECUTIVE SUMMARY

Access to medical care remains a major concern for many California workers' compensation stakeholders, as well as those involved in group health and federal healthcare systems. Building on prior research and anticipating future legislative and regulatory interest in improving access to care, this report utilizes claims data and interviews with medical providers to examine key factors surrounding the debate over injured workers' access to care in California by quantifying the amount of time it takes injured workers to receive their initial treatment and the distance they need to travel to receive that care, and by assessing the administrative burden on treating physicians.

Using a database of more than 1.5 million work injury claims from accident year (AY) 2010 through AY 2020, the authors found little variation in the amount of time that elapsed between the employer's notification of injury and the initial Evaluation & Management (E&M) visit, with the median wait time indicating same day service across all 11 years and the average ranging between 4.1 and 5.2 days. The median wait time to the first Physical Medicine (PM) service varied over the study period, increasing from 15 days in AY 2010 to 20 days in AY 2015, then falling back to 15 days in AY 2020, with the average showing a similar pattern, climbing from 31.8 days in AY 2010 to 37.5 days in AY 2015, then decreasing to 31.2 days in AY 2020. The improvements in the time to initial PM treatment occurred after SB 863 (the 2012 reform bill) took effect, so the declines in both the average and median days to first PM treatment may reflect improved processes by payers and providers as they became more familiar with the new utilization review (UR) requirements that grew out of that reform.

In contrast to the E&M and PM services, access to care for the top 5 workers' compensation surgical procedures showed greater variation due to pre-surgery treatment conditions. For example, wound repairs and splinting are relatively simple surgical procedures that are often clear-cut treatment choices for injuries requiring immediate care, so both the average and median time elapsed between employer notification and the surgical visit indicated that across all 11 years, services were rendered on the same day that the employer became aware of the injury. On the other hand, aspiration of, or injection into, a major joint or bursa is a somewhat more complex surgical procedure that may be recommended by the treatment guidelines if a condition does not subside over time or with alternate treatment. In claims involving these types of surgery the data showed that between 2010 and 2020, the average and median number of days from the employer's notification of injury to the delivery of these procedures increased by 17 and 28 days respectively.

The authors also determined the injured workers' proximity to care by calculating the distance between each injured worker's residence and the location of the initial service. While rural residents needed to travel farther than urban and suburban residents to receive care, this analysis confirms that the distances that injured workers within each of the regional subcategories needed to travel showed little change over the 11-year span of the study.

Individual interviews with physicians (including solo and group practices with specialists in Orthopedic Surgery, Occupational Medicine, General Practice, Dentistry), and Clinic Administrators such as Medical Directors and Practice Administrators) revealed insights into the administrative burdens associated with rendering workers' compensation treatment. The interviews focused on administrative tasks relating to treatment (rather than med-legal issues) including continuity of care, reimbursement adequacy, dispute resolution, and administrative demands. Interview participants provided consistent responses in terms of the number of required treatment reports and delays in acquiring treatment approval, as well as suggestions for reducing the administrative burden.

The California workers' compensation system only represents about 2 percent of the state's healthcare economy, and many of the challenges to improving injured workers' access to care are the same ones faced by larger payer systems. To address these challenges within workers' compensation, public policymakers must look for realistic solutions. For example, it is clear that workers' compensation cannot unilaterally solve the national physician and nursing shortage. On the other hand, a focused effort to develop policies that would encourage more providers to participate in the workers' compensation system could go a long way toward improving access. Included in these potential policy areas are greater standardization and automation of forms, expanded claims adjuster latitude to approve care, modifications to the scope of practice allowed for nurse practitioners and physician assistants, and greater experimentation on alternatives to fee-for-service medical payments.

California Workers' Compensation Institute
March 2022

BACKGROUND

The National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine) define access to healthcare as the "timely use of personal health services to achieve the best possible health outcomes."[1]

Access to medical treatment, for all states as well as medical systems in the U.S., has been an ongoing public policy concern for decades.[2] In early 2021, California Assemblymembers Eloise Gómez Reyes and Lorena Gonzalez introduced legislation (AB 1465) which, as originally drafted, was intended to increase injured worker access to medical care by requiring that the state's Division of Workers' Compensation (DWC) create the California Medical Provider Network (CAMPN) as an alternative to the existing employer-sponsored MPNs that now render nearly 92 percent of all California workers' compensation treatment.[3]

Concerns over the CAMPN proposal arose immediately. For example, the bill allotted no funds for the development or maintenance of the massive new network, so the cost of developing the CAMPN was not addressed. AB 1465 also did not consider the logistical burdens that would be placed on the DWC, including the staff, expertise, and time that would be needed for contracting and credentialing of member physicians and the development of information and analytic systems. The proposal also did not account for the increased treatment costs that would arise from the likely elimination of contractual discounts currently available through existing employer-sponsored MPNs. CWCI concluded that, despite an estimated cost of $314 million per year, the CAMPN was unlikely to improve access to care.[4] AB 1465 subsequently failed to gain support among state lawmakers though it may resurface in the future.

Although AB 1465 did not pass in its original form, it is important to consider the assertions that prompted the legislation in the first place. Most pertinently, what is the state of access to care in the California workers' compensation system and how does it compare to access under other medical delivery systems?

When addressing access to medical care, the Agency for Healthcare Research and Quality (AHRQ), the lead Federal agency charged with improving the safety and quality of America's health care system, describes access to care as consisting of four components:

- coverage
- services
- timeliness
- an adequate workforce of experienced and competent providers[5]

[1] Milliman M, editor. *Access to Health Care in America*. Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care. Washington (DC): National Academies Press (US); 1993.

[2] National Research Council 1991. *Addressing the Physician Shortage in Occupational and Environmental Medicine: Report of a Study.* The National Academies Press. https://doi.org/10.17226/9494

[3] A review of AY 2021 treatment data in CWCI's Industry Research Information System (IRIS) database shows overall network penetration was 91.8 percent, with network utilization ranging from 85.8 percent for Surgery visits to 95.5 percent for E&M visits.

[4] *Assembly Bill 1465 and Medical Provider Networks in the California Workers' Compensation System.* CWCI Impact Analysis Report, April 2021.

[5] https://www.ahrq.gov/topics/access-care.html

Under the Knox-Keene Health Care Service Plan Act of 1975, timely access to care standards for managed care organizations licensed in California are defined by the Department of Managed Health Care (DMHC).[6] For urgent care, when prior authorization is not required by the health plan, care must be obtained within two days to be considered timely. When prior authorization is required, four days is the standard. For non-urgent care, the standard is 10 days for primary care physician (PCP) appointments and 15 days for appointments with specialty care physicians. The California Department of Managed Health Care monitors compliance with the timely access standards for non-urgent physician appointments among various types of health care plans, and the most recent results (reporting year 2019)[7] are presented in the table below.

Compliance with DMHC Timely Access Standards for Non-Urgent Appointments by Type of Health Plan

Health Plan Category	Compliance Range (%)	Average Compliance (%)
Individual/Family	60 - 91	79.9
Commercial	60 - 91	79.4
Medi-Cal	72 - 96	87.0
Combined	60 - 96	82.8

In 2017, Merritt Hawkins performed a simulated study[8] that surveyed access to care among primary care and specialty clinics across 30 regions in the U.S., including major metropolitan areas and mid-sized markets. Research associates from the firm called physician offices specializing in cardiology, dermatology, orthopedics, OB/GYN, and family medicine to request a new patient appointment. For each medical specialty, a specific concern defined in the study protocol was provided by the caller. For example, callers contacting orthopedic surgery clinics requested an appointment for knee injury or knee pain, whereas callers trying to obtain family medicine appointments requested to be seen for a routine examination. Results of the study varied widely across specialty areas and geographic regions. The average wait for a new patient appointment in a family medicine clinic in large metropolitan regions was 29 days, with a low of 8 days (Minneapolis, MN) and a high of 109 days (Boston, MA). The same metric within mid-sized metropolitan regions was 56.3 days, with a low of 7 days (Billings, MT) and a high of 122 days (Albany, NY). Within orthopedics, the average wait for large metropolitan regions was 11.4 days, with a low of 7 days (Seattle, WA and Atlanta, GA) and a high of 19 days (San Diego, CA and Detroit, MI). The same metric within mid-sized regions was 15 days, with a low of 8 days (Billings, MT) and a high of 34 days (Evansville, IN).

[6] DMHC. *Timely Access to Care.* www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/timelyaccesstocare.aspx
[7] DMHC. *Timely Access Report – Measurement Year 2019.* December 2020. www.dmhc.ca.gov/Portals/0/Docs/OPM/2019TAR.pdf
[8] Merritt Hawkins. *Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates.* Published online 2017. www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf

Data from the Merritt Hawkins' simulated study was compared to wait times within the Veterans Affairs (VA) Health System in a retrospective, repeated cross-sectional study.[9] The comparison revealed that average wait times for cardiology, primary care, and dermatology visits were shorter for patients in the VA system than for private sector patients, but the average wait times for orthopedic visits were longer for the VA patients. The study also demonstrated a substantial range of wait times across the 15 VA hospitals studied.

Aside from the differences in accessibility noted among the different medical delivery systems, geography also plays a key role in access to care. Studies have shown that individuals living in rural areas are likely to experience greater difficulty in accessing specialty care – both in terms of time and distance – than those living in urban areas. Although about two-thirds of practicing physicians in the United States offer specialty care services, specialists and subspecialists tend to provide those services in urban areas where demand is greater. Cyr et al. stated that the findings from their extensive literature review underscored the complexity of the healthcare access concept.[10] Among their conclusions was the finding that primary care clinicians servicing rural populations may also function as specialists out of necessity, but that they are already resource constrained, with long appointment wait times reported throughout the United States.

Access Within California Workers' Compensation

Labor Code §5307.2 requires that the DWC Administrative Director annually assess whether injured workers have adequate access to quality care. In recent years, the Department of Industrial Relations (DIR) has contracted with the RAND corporation to perform this work. The most up-to-date report was published in 2019 and uses data provided by the DWC its Workers' Compensation Information System (WCIS) for claims with 2016 injury dates.[11] Within that year, there were 371,964 injured workers who obtained an evaluation and management (E&M) visit. The mean wait time between the date of injury (DOI) and first E&M visit was 16.4 days, with a median of 2 days. When the subset of these visits which occurred outside the urgent care setting was reviewed, the mean was found to be 25.9 days, and the median 6 days.

In April 2021, researchers at CWCI analyzed time and proximity to initial treatment and found that claims managed by medical provider networks (MPNs) averaged 5.9 days from employer notice of injury[12] to the initial E&M visit compared to 5.6 days for non-MPN claims, and that 90.6 percent of the MPN claims vs. 92.9 percent of the non-MPN claims had an E&M visit within 14 days.[13] In addition, in 99 percent of the MPN claims and 98 percent of the non-MPN claims, the state's access standards were met. Injured workers had a choice of three workers' compensation primary care providers within 15 miles of their home, while a review of the injured

[9] Penn M, Bhatnagar S, Kuy S, et al. Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers.

[10] Cyr, M.E., Etchin, A.G., Guthrie, B.J, and Benneyan, J.C. *Access to Specialty Healthcare in Urban Versus Rural US Populations: A Systematic Literature Review.* BMC Health Services Research, 2019. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4815-5

[11] Kapinos, K.A. and Montemayor, C.K. *Access to Medical Treatment for Injured Workers in California – Year 3 Annual Report.* RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3058.html

[12] The authors used employer date of notice instead of date of injury due to the known distortion impact of cumulative trauma claims.

[13] *Assembly Bill 1465 and Medical Provider Networks in the California Workers' Compensation System.* CWCI Impact Analysis Report, April 2021.

workers' access to surgical specialists found that 96 percent of the MPN claimants and 95 percent of the non-MPN claimants had a choice of three workers' compensation surgeons within 30 miles of their home.

The CWCI analysis also confirmed that an injured worker's timely access to care is significantly influenced by whether the patient lives in an urban, suburban, or rural area of the state – an issue not only in workers' compensation, but in group health and government medical programs as well – but it found little difference in the average distance that MPN and non-MPN patients within each regional category needed to travel to obtain primary or specialty care.

STUDY GOAL AND OBJECTIVES

Anticipating future legislative and regulatory interest in improving access to care, for this analysis the authors utilized claims data and interviews with medical providers to examine the two key factors surrounding the debate over injured workers' access to care:

1. Days and distance to initial treatment
2. The physician's administrative burden

DATA AND METHODOLOGY

Access: Days and Distance to Initial Treatment

The authors expanded on a previous study[14] of time and proximity of treatment by compiling a large sample of treatment transactions on more than 1.5 million claims from the 11-year period spanning AY 2010 through AY 2020. The data used for this study includes medical billing and claim demographic data extracted from CWCI's Industry Research Information System (IRIS) database.[15] To account for the known distortion from an unspecific date of injury for cumulative trauma claims,[16] the authors calculated the days to first treatment using the date the employer was notified of the injury as the starting point for measuring access to care.

Days to first service were measured for three different types of primary care: Evaluation and Management (excluding emergency department and inpatient hospital services), Physical Medicine (including physical therapy, chiropractic, and acupuncture), and Surgery (defined as services listed in the Surgery section of the Official Medical Fee Schedule).[17] Service categories were identified using billing data that included Current Procedural Terminology (CPT) codes assigned by the service provider.

[14] *Ibid.*
[15] IRIS is CWCI's proprietary database containing data on employee and employer characteristics, medical service data, benefits, and administrative costs on approximately 7.5 million workers' compensation claims.
[16] Labor Code §5405 requires that a worker claiming a CT injury file a claim for benefits within one year from the date of knowledge, or the date that he or she should have known that the disability was caused by work activities.
[17] The Official Medical Fee Schedule generally follows the classification system of the American Medical Association's *Current Procedural Terminology Manual*. The authors excluded codes describing routine venipuncture.

In addition to the timing of the first medical service, the authors also measured proximity to care by calculating the distance between the injured worker's residence and the location of the initial service. The authors used the Quest Analytics[18] tool to calculate the mean and median distances for initial treatment and surgery. The software also adjusts for population density by employing U.S. Census data to each injured worker and medical provider's ZIP code as urban, suburban, or rural. An urban area is defined by a ZIP code population greater than 3,000 persons per square mile; a suburban area has between 1,000 and 3,000 persons per square mile; and a rural area has fewer than 1,000 persons per square mile.

RESULTS

In workers' compensation, compliance with access to medical treatment standards depends on the availability of treating physicians within a reasonable distance from the injured worker's home or place of employment. For workers' compensation MPNs, which as noted earlier, now provide nearly 92 percent of all medical services to injured workers in California, the DWC has adopted regulations which set forth the access standards by which the networks are evaluated.[19] These regulations call for each MPN to offer:

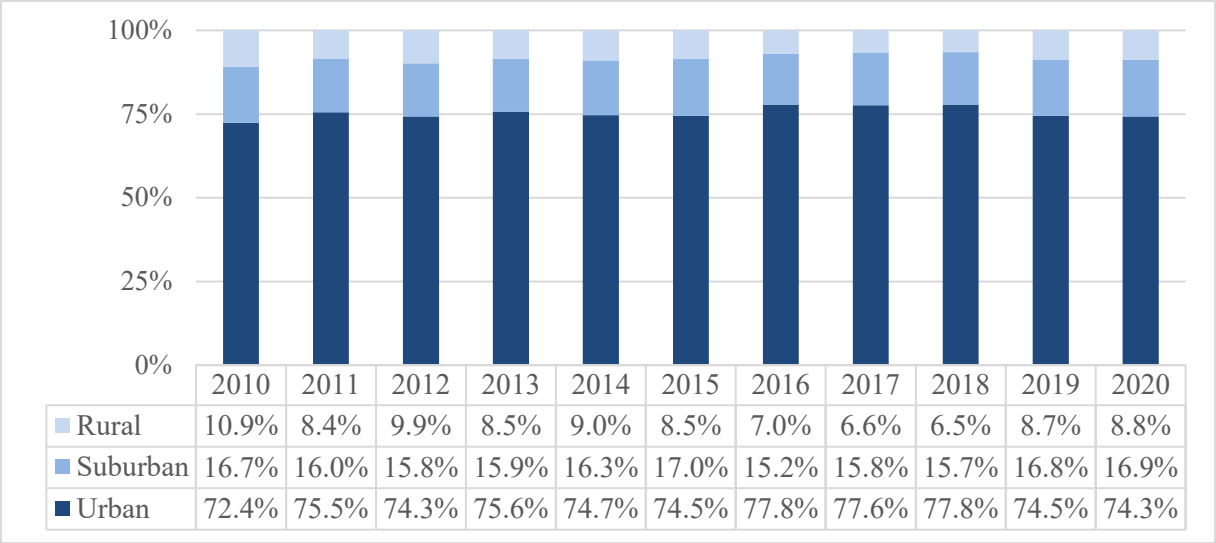
- A choice of three primary care physicians within 30 minutes or 15 miles of the injured worker's residence or workplace;
- A choice of three specialists within 60 minutes or 30 miles of the injured worker; and
- A hospital for emergency health care services, or if separate from such hospital, a provider of all emergency healthcare services, within 30 minutes or 15 miles of the injured worker.

Under the MPN access standards, primary treating physicians typically include General Practitioners, physicians who practice Family Medicine, physicians who practice Occupational Medicine, and Chiropractors.[20] Specialists treating injuries or diseases commonly found in workers' compensation include Orthopedic Surgeons, Internal Medicine, Neurologists, Neurosurgeons, and Psychologists.

Most California injured workers and providers are concentrated in and around major metropolitan regions. Exhibit 1 shows the proportions of injured workers who resided in urban, suburban, and rural areas during the 11-year study period. Between 2010 and 2020, the share of California's injured workforce residing in urban areas ranged between 72.4 percent and 77.8 percent. California's injured workforce located in more remote rural areas ranged between 6.5 percent and 10.9 percent of the sample.

[18] Quest Analytics is used by health plans and regulators, including the Center for Medicare and Medicaid Services (CMS), multiple state regulatory agencies, as well as both not-for-profit and for-profit health plans to facilitate, manage, and monitor health plan access and network utilization.
[19] 8 CCR §9767.5.
[20] SB 228 imposed a 24-visit limit on chiropractic treatment, and 8 CCR §9785(a)(1) subsequently stipulated that for injuries on or after January 1, 2004, a chiropractor shall not be the primary treating physician once the 24-visit cap has been reached.

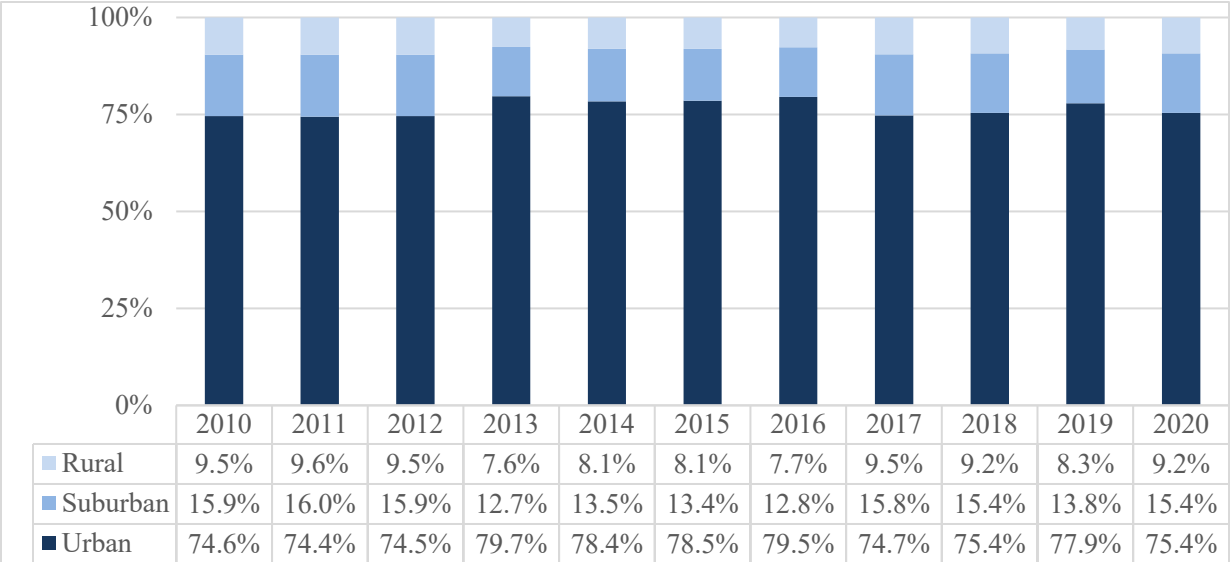
Exhibit 1: Location of California Injured Workers, 2010 - 2020



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Rural	10.9%	8.4%	9.9%	8.5%	9.0%	8.5%	7.0%	6.6%	6.5%	8.7%	8.8%
Suburban	16.7%	16.0%	15.8%	15.9%	16.3%	17.0%	15.2%	15.8%	15.7%	16.8%	16.9%
Urban	72.4%	75.5%	74.3%	75.6%	74.7%	74.5%	77.8%	77.6%	77.8%	74.5%	74.3%

Exhibit 2 shows the distribution of initial medical providers in rural, suburban, and urban regions of California for each of the 11 years studied. The regional distributions for injured workers and initial providers were similar over the 11-year study period as were the relatively minor shifts that occurred within those distributions over time. From 2010 through 2020, provider offices located in urban areas accounted for between 74.4 percent and 79.5 percent of the initial visits; suburban medical office settings ranged between 12.7 percent and 16.0 percent, and rural medical offices comprised between 7.6 percent and 9.6 percent.

Exhibit 2: Location of Initial Medical Treatment, 2010 - 2020



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Rural	9.5%	9.6%	9.5%	7.6%	8.1%	8.1%	7.7%	9.5%	9.2%	8.3%	9.2%
Suburban	15.9%	16.0%	15.9%	12.7%	13.5%	13.4%	12.8%	15.8%	15.4%	13.8%	15.4%
Urban	74.6%	74.4%	74.5%	79.7%	78.4%	78.5%	79.5%	74.7%	75.4%	77.9%	75.4%

Time and Distance to First Treatment

Two other key metrics that can be used to measure workers' compensation access to care are:

1. the length of time it takes for the injured worker to receive treatment; and
2. the distance that the injured worker must travel to receive that care.

To assess how long it took injured workers in the study sample to receive care, the authors measured the average and median number of days that elapsed between the date of the employer's first notification of the injury or illness to the date of first medical service.[21] Exhibit 3 shows the average and median number of days between the date of employer notice and the date of the first medical service for each of the 11 accident years, as well as the average and median days between the employer's first notice and the first Evaluation and Management[22] (E&M) service and the first Physical Medicine[23] (PM) service.

Exhibit 3: Number of Days From Date of Employer Notice to First Medical Service

	First Medical		First E&M		First PM	
AY	Average	Median	Average	Median	Average	Median
2010	3.5	same day	4.4	same day	31.8	15
2011	3.3	same day	4.1	same day	32.3	15
2012	3.6	same day	4.4	same day	32.7	16
2013	3.8	same day	4.6	same day	35.0	18
2014	3.9	same day	4.6	same day	35.4	19
2015	3.9	same day	4.8	same day	37.5	20
2016	4.0	same day	4.9	same day	36.0	19
2017	3.8	same day	4.7	same day	35.3	19
2018	3.9	same day	4.8	same day	33.6	17
2019	4.2	same day	5.0	same day	33.8	17
2020	4.4	same day	5.2	same day	31.2	15

The average number of days from employer notice to the first recorded medical treatment fluctuated slightly over the 11-year study period, ranging from a low of 3.3 days for AY 2011 claims to a high of 4.4 days for AY 2020 claims. The average number of days until an E&M office or clinic visit followed the same pattern, with a low of 4.1 days in AY 2011 to a high of 5.2 days in AY 2020. While the amount of time that elapsed between the employer's first notice and the first medical service and between the employer's notice and the first E&M service varied by only 1.1 days, in both cases the median number of days showed no change, with median results across all 11 years showing the worker's first treatment and first E&M service on the same day as the employer's notice.

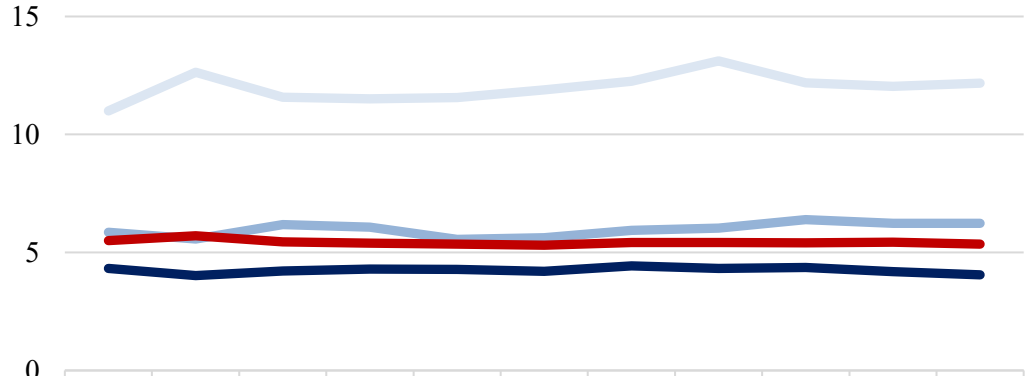
The average number of days to the first physical medicine service showed somewhat greater variation as it was highly dependent on injury type, patient condition, as well as provider availability. As noted in Exhibit 3, the average time to the initial physical medicine visit increased from 31.8 days in AY 2010 to a high of 37.5 days in AY 2015, before decreasing in subsequent years to a low of 31.2 days for AY 2020 claims. The median number

[21] The first medical service included emergency room, urgent care, inpatient hospitalization, and office/clinic visits.
[22] The Evaluation & Management codes used to determine the first E&M date exclude emergency department and inpatient hospital codes.
[23] Physical Medicine includes physical therapy, chiropractic manipulation, and acupuncture.

of days increased from 15 to 20 days in AY 2015, which was the highwater mark for the 11-year study period. The higher average and median values in 2015 were followed by decreases from 2016 through 2020, with the lowest average occurring in AY 2020, the same year that the median number of days fell back to 15 days, matching the low point recorded a decade earlier.

The increase in the number of days to first physical medicine service that began in 2013 coincided with significant legislative changes impacting MPNs and the UR process. SB 863 triggered emergency regulations mandating the use of a new Request for Authorization (RFA) form by the treating physician beginning January 1, 2013. The emergency regulations also implemented the statutory requirement for the Independent Medical Review (IMR) process to arbitrate treatment requests that were either denied or modified based on medical necessity. The subsequent declines in both the average and median number of days to first physical medicine treatment may have resulted from improved processes by payers and medical providers in working with the new utilization review requirements.

Exhibit 4: Average Distance to Initial Treatment, 2010 - 2020



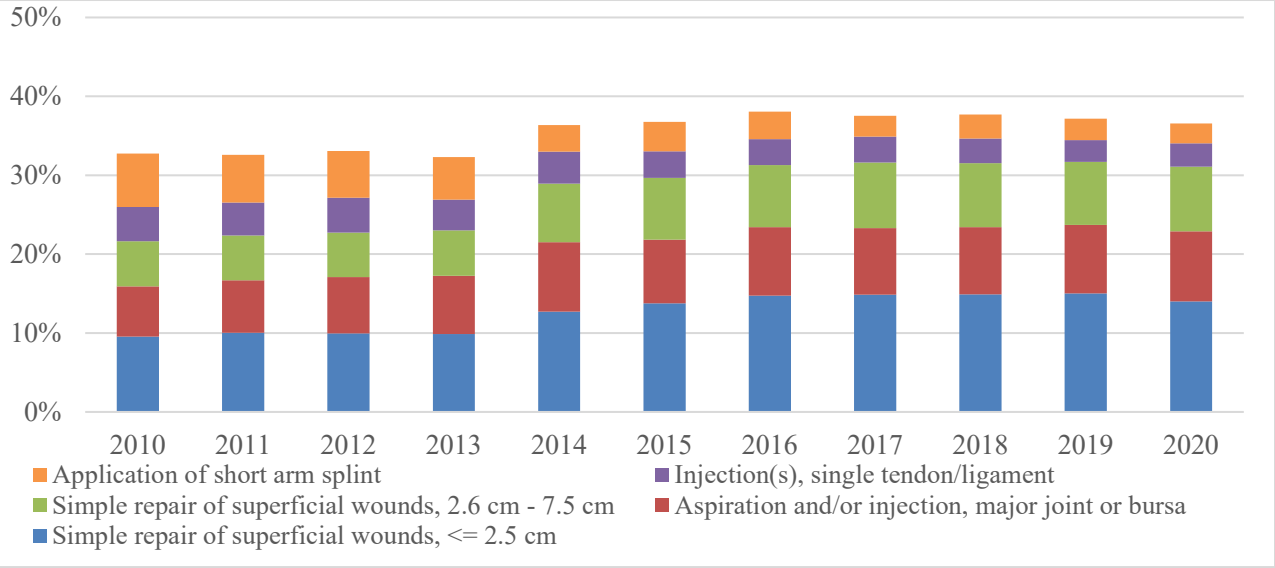
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Urban	4.3	4.0	4.2	4.3	4.3	4.2	4.4	4.3	4.4	4.2	4.0
Suburban	5.9	5.6	6.2	6.1	5.6	5.6	5.9	6.0	6.4	6.2	6.2
Rural	11.0	12.6	11.6	11.5	11.6	11.9	12.3	13.1	12.2	12.0	12.2
Grand Total	5.5	5.7	5.5	5.4	5.4	5.3	5.4	5.4	5.4	5.4	5.4

Exhibit 4 shows the average distance that injured workers living in urban, suburban, and rural areas of California traveled to obtain initial treatment for each of the 11 accident years in the study. The proximity analysis shows the average distances that injured workers traveled within each of the regional categories (urban, suburban, and rural) were very consistent across the 11-year timeline. The average distances that injured workers in urban and suburban areas traveled varied by only a fraction of a mile (0.4 and 0.8 respectively) across the 2010 through 2020 timeframe, while the average distance traveled by rural injured workers varied by 2.1 miles.

In addition to initial E&M and PM services, the authors analyzed services included in the Surgery section of the Official Medical Fee Schedule (OMFS). Surgery services are extremely varied in their complexity, patient readiness, and timing, ranging from simple wound repairs and injections to joint replacements and spinal fusions.

It was notable that the same services were in the top five rankings for each year going back to AY 2014, when the new Resource-Based Relative Value Scale Official Medical Fee Schedule took effect. [24]

Exhibit 5: Top 5 Surgery Services as a Percent of Total Surgery Services by Accident Year



For comparison purposes the top five surgical services from 2015 through 2020 were used to calculate the number of days to first surgery service. Exhibit 5 displays the share of total first surgery services for each accident year – the lowest combined share occurred prior to 2014, which coincided with the transition to the new OMFS, as well as new MPN and utilization review regulations. Exhibit 6 shows the average and median number of days from the date of employer notification to the date of the first surgery service for the top 5 surgery codes.

Exhibit 6: Average and Median Number of Days From Employer Notice to First Surgery Service Top 5 Surgery Services by Accident Year

AY	Simple Repair of Superficial Wounds, <= 2.5 cm		Aspiration and/or Injection, Major Joint or Bursa		Simple Repair of Superficial Wounds, 2.6 cm - 7.5 cm		Injection(s), Single Tendon/Ligament		Application of Short Arm Splint	
	Avg	Median	Avg	Median	Avg	Median	Avg	Median	Avg	Median
2010	0.1	same day	101.1	80	0.1	same day	92.2	70	6.0	same day
2011	0.4	same day	101.9	82	0.8	same day	95.7	75	5.3	same day
2012	0.7	same day	104.1	83	0.4	same day	97.2	71	6.8	same day
2013	0.7	same day	109.4	89	0.3	same day	100.8	80	5.6	same day
2014	0.3	same day	106.2	87	0.7	same day	94.0	71	6.1	same day
2015	0.4	same day	108.4	87	0.3	same day	96.3	76	5.5	same day
2016	0.3	same day	111.1	90	0.2	same day	102.8	82	3.6	same day
2017	0.2	same day	107.0	88	0.6	same day	98.0	77	4.5	same day
2018	0.2	same day	112.0	95	0.0	same day	102.7	84	5.3	same day
2019	0.1	same day	126.5	111	0.3	same day	113.8	94	7.4	same day
2020	0.1	same day	118.3	108	0.0	same day	104.7	91	10.7	same day

[24] Prior to 2014, the most common workers' compensation surgery service was low back strapping. The CPT code for this service was deleted by the AMA effective January 1, 2010, but remained in the OMFS until newer AMA codes took effect on January 1, 2014.

As noted in Exhibit 6, the top 5 types of surgery services are associated with significantly different timeframes for first service. The median values show that wound repairs and splinting were typically provided on the same date that the employer received notification of the injury, while injection services were provided approximately three months later. The average and median number of days before an aspiration of, or injection into, a major joint or bursa increased by 17 and 28 days respectively from 2010 to 2020. The average number of days to an injection of a therapeutic agent into a tendon or ligament increased from 92.2 days for AY 2010 claims to 104.7 days for AY 2020 claims, while the median days increased from 70 to 91.

The Physician's Administrative Burden

Administrative costs associated with the provision of healthcare in the United States are estimated to consume 15 to 30 percent of overall health care spending,[25, 26] and include the following:

- Scheduling patient appointments;
- Medical billing;
- Prior authorization;
- General business overhead (HR, legal);
- Credentialing costs;
- Customer service;
- Maintaining medical records; and
- Quality measurement and assessment.

Billing and insurance-related costs represent the largest component of healthcare spending, with estimates showing they may account for as much as 15 percent of total spending.[27]

In addition to the administrative tasks listed above, workers' compensation treating physicians have historically had unique administrative duties including preparation and submission of periodic reports and ongoing coordination with claims administrators, attorneys, nurse case managers, and/or return-to-work specialists. The degree and volume of administrative tasks have evolved over time. In 1993, California lawmakers enacted a reform package that enhanced the role of the primary treating physician (PTP) by attaching a rebuttable presumption of correctness to the PTP's opinion for the purpose of calculating permanent disability. The Workers' Compensation Appeals Board's 1996 en banc decision in *Minniear* expanded this presumption's application to all medical issues — including the appropriateness of any given medical treatment.[28] In so doing, the Appeals Board limited a payer's ability to question or object to medical utilization, applying the presumption

[25] Cutler, D.M. *Reducing Administrative Costs in U.S. Health Care.* The Hamilton Project. March 2020. https://www.hamiltonproject.org/papers/reducing_administrative_costs_in_u.s_health_care
[26] Gottlieb, J.D. and Shepard, M. *How Large a Burden are Administrative Costs in Health Care?* Econofact, September 6, 2018. https://econofact.org/how-large-a-burden-are-administrative-costs-in-health-care
[27] *Ibid*.
[28] *Minniear v. Mt. San Antonio Community College District* (1996) (en banc) [61 Cal.Comp.Cases 1055].

of correctness to the PTP's opinion on all issues unless rebutted by substantial medical evidence. This standard was rarely overcome in the appeals process, even when it was clear that a given treatment was not curative.

Studies and reports showed that during the time that the PTP presumption was in effect, the workers' compensation system incurred dramatic increases in average medical treatment costs without a material change in the underlying mix of injuries.[29, 30]

In response to the rising cost of medical care that occurred following the *Minniear* decision, between 2002 and 2004 state lawmakers enacted additional reform legislation and policies that introduced fundamental changes to the workers' compensation medical benefit delivery system and added new administrative tasks. Assembly Bill 749 (2002), Senate Bill 228 (2003), and Senate Bill 899 (2004) eliminated the treating physician's rebuttable presumption of correctness, effectively striking down the *Minniear* decision. In an effort to control medical cost and utilization and improve patient care, in 2003 the Legislature passed SB 228, which required the use of medical treatment utilization standards that incorporate evidence-based, peer-reviewed, nationally recognized standards of medical care. Senate Bills 228 and 899 also sought to update and tighten fee schedule loopholes related to reimbursement for physician services, pharmacy costs, and outpatient surgery facility fees. In addition, legislators included provisions in SB 899 that sought to reinvigorate the use of medical networks as a tool to better manage medical treatment by expanding MPNs' control over medical care from the first 30 days post-injury to the life of the claim. Nearly a decade later, the state enacted another major overhaul of the workers' compensation system (SB 863) which introduced new requirements governing the type, frequency, and reasonableness of medical treatment rendered to injured workers, requiring that workers' compensation medical care be consistent with evidence-based treatment guidelines, with concomitant timeframes for filing of mandatory forms.

All of these changes led to new administrative processes that affected the delivery of workers' compensation medical care. Among the key changes that grew out of the reforms of the past 20 years:

- Mandatory Utilization Review governed by evidence-based medicine[31]
- Independent Medical Review to resolve disputes over medical necessity[32]
- Medical Provider Networks that require injured workers to be treated by in-network providers and extended employer medical control from 30 days to the life of the claim[33]
- Adoption of an evidence-based drug formulary as a component of the Medical Treatment Utilization Schedule[34]

[29] SB 899 added section 4616 to the Labor Code, effective April 19, 2004.
[29] AB 1124 – 2015 legislation mandating adoption of a drug formulary, effective January 1, 2018.
[30] Rudolph L, Linford-Steinfeld J, and Dervin, K. *Utilization Review in California's Workers' Compensation System: A Preliminary Assessment*. State of California Department of Industrial Relations, Division of Workers' Compensation, Public Health Institute Berkeley. July 2001. https://vdocuments.net/reader/full/utilization-review-in-californias-workers-compensation-utilization-review
[31] SB 228 mandated that every workers' compensation claims administrator adopt a UR process.
[32] SB 863 added section 139.5 to the Labor Code, effective January 1, 2013.
[33] SB 899 added section 4616 to the Labor Code, effective April 19, 2004.
[34] AB 1124 – 2015 legislation mandating adoption of a drug formulary, effective January 1, 2018.

Under the current system, medical providers also have recurring responsibilities that include providing, upon request, telephonic authorization of disability status every 14 days prior to disability indemnity checks being issued by the claims administrator, as well as mandated preparation of reports addressing medical treatment and disability status (PR-2, PR-3, and PR-4), as warranted by the medical status of the injured worker. In addition, physicians must submit a Request for Authorization (RFA)[35] when ordering additional physician specialty and ancillary services or certain prescriptions that may be subject to prospective UR.

Physician and Clinic Administrator Interviews

In addition to noting public comments submitted by medical providers during legislative and administrative stakeholder meetings, the authors conducted individual interviews with physicians and clinic administrators to gain insights into their thoughts on the administrative burdens associated with the provision of treatment to workers' compensation patients. The interviews focused on experience and administrative tasks relating to medical treatment rather than assessment of disability and medical-legal related issues.

Participants included physicians with solo and group practices, specialists in Orthopedic Surgery, Occupational Medicine, General Practice, Dentistry, and Clinic Administration such as Medical Directors and Practice Administrators. All the interviewees accepted workers' compensation patients and patients covered by group health and/or federal programs. All but one reported ongoing participation in one or more physician networks providing services to workers' compensation, group health, Medicare, and Medi-Cal patients. The interviewees' workers' compensation experience ranged from 3 years to 35 years. Results of the interviews focused on four issues: continuity of care, reimbursement adequacy, dispute resolution, and administrative demands.

A. Continuity of Care

There were comments on the difficulty of referring to specialists and physical therapists that are accepting new workers' compensation patients. Some providers pointed out the fluid nature of provider practices makes it difficult to know at any given time if a provider is either active within a network or is accepting referrals for new patients. Concern was also raised that some specialty physicians do not want to be responsible for generating any reports or involve themselves with any ongoing care.

B. Reimbursement Adequacy

There was a mixed response to the question of the adequacy of reimbursement to physicians for workers' compensation medical treatment.[36] Providers acknowledged that the OMFS reimburses at 120 percent of Medicare, the state's largest healthcare payer. The anecdotal comparisons to group health reimbursement reported both higher and lower levels of reimbursement depending on the service, plan, specialty, and network participation. As group health contractual rates are proprietary and closely guarded trade secrets, it

[35] See the Appendix for a listing of reports and forms associated with treatment of injured workers.
[36] Reimbursement here refers to the final direct payment to a provider for a given medical procedure or service.

was not possible to adequately reconcile and compare reimbursement levels for the most frequent workers' compensation medical procedure codes against the OMFS.

Prohibited from balance-billing the patient,[37] providers are limited to collecting payment from the insurance company or third-party claims administrators. Unless governed by a contract for services, payment rules and amounts are defined under the OMFS.[38] Rules governing the mechanism for bill submission, bill payment, and the appeals process are detailed by separate regulations and guides.[39] If the claims administrator reduces or denies all or portions of an invoice, the provider has 90 days from service of an Explanation of Review (EOR) to file an appeal. The second bill review process is mandatory prior to filing a formal Independent Bill Review (IBR) request if the dispute is limited to the dollar amount paid, or the provider may appeal to the WCAB in the event of total payment denial due to eligibility disputes.

C. Dispute Resolution

The adoption of mandatory UR, the evidence-based treatment schedule, and IMR for dispute resolution has created objective checks and balances in a system that, in the wake of the *Minniear* decision, suffered from overutilization, arbitrary treatment selection, and a 122 percent increase in average ultimate medical costs between 1996 and 2002, despite no corresponding change in the mix of injuries.[40] These administrative processes created a system in which treatment disputes are resolved by physicians rather than administrative judges, but they were the subject of complaints voiced by physicians and clinic administrators.

General comments for the UR/IMR process included inappropriate specialists used in peer review, uneven turnaround times for dispute decisions, and lack of complete documentation for denial reasons. However, CWCI research has found that despite a complex process of evaluating medical efficacy, approximately 94 percent of all requested treatment is ultimately approved following utilization review and independent medical review.[41,42] Suggested solutions for further improvements included claims administrators providing claim adjusters more latitude in approving treatment and allowing pre-approved referral to physical therapy (within MTUS guidelines).

With respect to utilization review, PTPs have commented on the repetitive nature of preparing RFA forms and supporting documentation for submission. Beginning in January 2013, PTPs were offered a dispute resolution remedy requiring strict adherence to IMR filing timeframes. CWCI reported that 95 percent of IMRs are filed by attorneys who act as the employees' agent for filing the IMR form and required

[37] Labor Code §3751(b) prohibits a physician from billing the injured worker for medical treatment unless first notified in writing that liability for the claim has been rejected.
[38] https://www.dir.ca.gov/dwc/omfs9904.htm
[39] 8 CCR §9792.5.1(a)
[40] WCIRB 2021 State of the System, Chart 31. https://www.wcirb.com/sites/default/files/documents/wcirb-report-2021_state_of_the_system-ho.pdf
[41] David, R., Bullis, R., Jones, S., and Young, B. Post-Reform Medical Service Approval Rates in California Workers' Compensation. *CWCI Research Update*. October 2019.
[42] David, R., Jones, S., Ramirez, B., and Swedlow, A. Medical Review and Dispute Resolution in the California Workers' Compensation System. *CWCI Research Update*. December 2015.

documentation.[43] If the claim is litigated, the process involves an increased demand on the physician's time due to coordination with the employee's attorney. In the event of a treatment request denial, the PTP may appeal to the WCAB, on limited grounds, within 20 days of service of an adverse IMR decision by filing a "Petition Appealing Administrative Director's Independent Medical Review Determination."

D. Administrative Demands

Interview participants provided comments and suggestions on the array of required forms.[44] Estimates of the amount of time spent on workers' compensation administrative tasks ranged from less than 20 percent for common medical treatment to more than 50 percent for more complicated surgical procedures. These estimates were materially higher than the interview participants' estimates of 10 percent for Medicare and up to 20 percent for their commercial health plans. Physicians also commented on the difficulty of determining the claim number and claims adjusters' contact information needed for the submission of reports and billing.

In addition to the required forms, physicians note that it is the process involved in UR, dispute resolution (IMR), and the repetitive nature of document submissions for each claim that have caused frustration, leading some treating physicians to question continuation of their workers' compensation practices.

Suggestions to lessen the administrative burden included the reduction in the volume of required forms and automation of standard forms and reports for both the provider and payer.[45]

DISCUSSION: HOW CAN ACCESS BE IMPROVED

The California workers' compensation system, which accounts for approximately 2 percent of the California healthcare economy, is one of the smallest medical payment systems in the state. Attempts to improve access to care face the same challenges and hurdles as the largest payer systems and must approach the problem by targeting solutions within a realistic sphere of influence.

Setting reasonable expectations on how to improve access to care depends on several factors, beginning with physician supply. Even before the COVID-19 pandemic placed an unprecedented level of demand and associated stress on the nation's healthcare delivery system, there were concerns about significant shortages of physicians, nurses, and ancillary providers. The COVID-19 pandemic has only further aggravated those shortages.[46]

Physicians interviewed for this report shared comments on the difficulty of making referrals to specialists and physical therapists that accept new patients. Zhang et al.[47] found the number of states receiving a grade of "D" or "F" for their physician shortage ratio will increase from 4 in 2017 to 23 by 2030, with a national shortfall of

[43] David, R., Bullis, R., Jones, S., and Young, B. Post-Reform Medical Service Approval Rates in California Workers' Compensation. *CWCI Research Update*. October 2019.
[44] See the Appendix for the inventory of forms and documents.
[45] The DWC has engaged stakeholders and solicited participants for a pilot program for the electronic submission of Doctor's First Report of Injury in February 2020. DWC also announced plans to revise the PR-2 form and RFA during last year's DWC Educational Conference.
[46] https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment/
[47] Zhang, X, Lin,D., Pforsich, H. and Lin, V.W. Physician workforce in the United States of America: forecasting nationwide shortages. Human Resources for Health; 18: 8. February 2020

72,472 physicians in 2025 and 139,160 physicians by 2030. California is projected to have the largest physician shortfall, 32,669 by the year 2030. As a result, California will fall to 39th of 50 states in the ratio of physicians to population, moving its overall grade from a C- to a D. The authors reported that 33 percent of all active physicians in California are over 60 years old and within 5 years of retirement. California is also projected to incur the highest nursing shortage, with a projected shortfall of 44,500 RNs by 2030.[48]

To offset the lack of available physicians, some states grant a provisional license to supervised medical school graduates working in medically underserved areas who have not yet been placed in a residency.[49] In addition, at approximately 25 percent of the total physician inventory, the U.S. has by far the highest number of foreign-trained doctors of any country.[50] Some healthcare systems rely to a greater extent on nurse practitioners and physician assistants. Kerns and Willis suggest that it is the lack of flexibility in the approach to healthcare delivery that has created the perception of a provider shortage.[51] Solving the uneven distribution of physicians, nurses, and physician assistants across regions, the inefficient use of physician labor, and inflexible care models could increase access to care to more than cover current and future demand for primary care services. California workers' compensation statutes and regulations, the current fee-for-service reimbursement model, the high levels of attorney involvement, as well as the absence of shared risk between payer, provider, and injured worker, impede innovation for payers to develop and implement alternative care models, such as capitation, case rate, and pay-for performance .

Technology and Administrative Offsets

Artificial intelligence is being adopted in medical service delivery, showing some promise in recommending treatments and surgery, forecasting patient progress, monitoring patients, as well as other tasks.[52] Electronic health records have been associated with increased physician productivity, to a point. Downing, et al found that U.S. clinicians spent substantially more time using electronic health records than non-U.S. health providers, suggesting that U.S. clinicians have a greater administrative burden that may be associated with nontechnical factors.[53] Scheinker, et al found that standardizing processes such as physician billing and insurance-related reporting could yield potential savings, ranging from 27 percent to 63 percent of total administrative expense in various multi-payer models.[54]

[48] National Center for Health Workforce Analysis (https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf)

[49] Dayaratna K, O'Shea J. Addressing the physician shortage by taking advantage of an untapped medical resource. Washington, DC: The Heritage Foundation; 2017

[50] 2016 OECD Stat (the most current data available): https://stats.oecd.org/Index.aspx?QueryId=68336#

[51] Kerns, C., Willis, D. The Problem with U.S. Health Care Isn't a Shortage of Doctors. Harvard Business Review. March 16, 2020

[52] Artificial Intelligence in Health Care:Benefits and Challenges of Technologies to Augment Patient Care. GAO-21-7SP. Nov 2020 https://www.gao.gov/products/gao-21-7sp

[53] Downing, N. L., Bates, D. W., Shanafelt, T. D., Milstein, A., Sharp, C. D., Cutler, D. M., Huckman, R. S., Schulman, K. An Assessment of Electronic Health Record Use Between US and Non-US Health Systems. JAMA internal medicine.

[54] Scheinker, D., Richman, B. D., Milstein, A., Schulman, K. A. Reducing Administrative Costs in US Health Care: Assessing Single Payer and Its Alternatives. Health Services Research. March 31, 2021.

Reducing the Administrative Burden

The interviews conducted for this analysis highlighted significant levels of dissatisfaction with the administrative burden carried by physicians treating California injured workers. Medical dispute resolution, specifically UR and IMR, was a source of complaints with explicit criticisms focused on uneven peer review and protracted turnaround times for dispute resolution decisions.[55] Interview participants also provided comments and suggestions on the array of required forms.[56] Estimates of the time spent on administrative tasks for workers' compensation patients ranged from less than 20 percent for common medical treatment to more than 50 percent for more complicated surgical procedures. Suggestions to lessen the burden included removing barriers for referrals, providing insurance claims adjusters with more discretion in approving treatment requests, allowing pre-approved referral to physical therapy (within MTUS guidelines), and further automation of required forms and reports for both the provider and payer. In fact, beginning in February 2020, the DWC has engaged stakeholders and solicited participants for a pilot program for the electronic submission of the Doctor's First Report of Injury (Form 5021). The DWC also announced plans to revise and automate additional required forms such as the PR-2 form and the Request for Authorization.

Despite the challenges and hurdles, it is noteworthy how well the California workers' compensation system has fared in delivering timely medical treatment to injured workers. RAND reports that injured worker access to care in California is comparable to other payer settings, while prior CWCI research has shown that despite a complex process of evaluating medical efficacy and resolving medical disputes between provider and payer, approximately 94 percent of all requested treatment is ultimately approved following utilization review and independent medical review,[57,58] objectively challenging anecdotal assertions of wholesale denial of care.[59] The results of this study's 11-year trend analysis, which included the first year of the COVID-19 pandemic, showed relatively consistent values in both the number of days to initial treatment as well as the distance to care.

The analysis was limited by data availability. Among the data limitations:

- The need to trend accurate counts of individual active physicians accepting injured workers was compromised by the lack of consistent physician identification (NPI) data.
- The authors used the employer's notification date in its measurement of time to treatment because there was little to no data available to measure the day between a request for primary or specialty service and the treatment date.
- Assessing access to care for injured workers with cumulative injuries was often hindered because the date of onset was unclear.

[55] According to the DWC's "2021 Independent Medical Review (IMR) Report: Analysis of 2020 Data," only 500 of 136,698 IMR decisions (0.37 percent) were made outside of statutory limits.
[56] See Appendix A.
[57] David, R., Bullis, R., Jones, S., and Young, B. Post-Reform Medical Service Approval Rates in California Workers' Compensation. CWCI Research Update. October 2019.
[58] David, R., Jones, S., Ramirez, B., and Swedlow, A. Medical Review and Dispute Resolution in the California Workers' Compensation System. CWCI Research Update. December 2015.
[59] Grabell,M., Berkes, H. The Demolition of Workers' Comp. ProPublica, March 4, 2015 (https://www.propublica.org/article/the-demolition-of-workers-compensation)

- Days to treatment and proximity measures for chronic conditions lacked physician scheduling details, physician referral dates, and the injured worker's date of request for treatment.

In 2021, concern regarding access to care for injured workers prompted legislative action in the form of AB 1465 (discussed above). Anecdotal evidence aside, it is unclear to what extent these concerns were founded upon an evidence basis, as the legislation did not cite any relevant scientific publications, and our literature review did not reach the conclusion that access to care for injured workers in California is poor relative to other payer systems. CWCI's analysis did find that access to care varies by region and medical specialty. The DWC Administrative Director has stated that the Division intends to hold new stakeholder meetings on access to care and medical provider networks to determine if there are structural or operational issues that can be addressed through regulations in order to make the process more efficient and to increase access to care.

There will be continuing access to care issues in the California workers' compensation system as well as group health and federal programs throughout the country. The debate over solutions should objectively consider options that are within the capacity of the system to promote better injured worker outcomes and reduce the cost of benefit delivery.

APPENDIX

Mandatory Treating Physician Forms and Reports

[unless otherwise stated, all references are to Title 8, California Code of Regulations]

1. **Form 5021** [§14003 and §9785(e)(1)] - Doctor's First Report of Occupational Injury or Illness
   - Physicians shall file, within **5 days** of the initial examination, a complete report of every occupational injury and/or illness
   - Applies to each new treating physician for the injured worker

2. **DWC Form PR-2** [§9785(f)] – Primary Treating Physician's Progress Report
   - Submission of a progress report to the claims administrator is required no less than **every 45 days** when continuing treatment is provided. Submission of a progress report to the claims administrator is required within 20 days if any of the following events occur [§9785(f)(1-8)]:
     - There is a sudden or material change in the employee's condition;
     - There is a significant change in the treatment plan (such as frequency or duration of care);
     - Employee's condition permits a return to regular or modified work;
     - Employee's condition requires placement on temporary disability (unable to continue working) or requires changes in work restrictions;
     - Employee is released or discharged from care;
     - The PTP determines that the employee is permanently precluded from returning to the employee's usual occupation or job performed at time of injury;
     - The claims administrator reasonably requests additional written information necessary for the administration of the employee's claim.
   - Timeframes for submission of reports are outside limits not to be exceeded (i.e., 20 or 45 days). However, in practice, many PTPs submit PR-2 forms (accompanied by invoices) concurrent with each employee's office visit such that the frequency of these submissions can be more often than every 45 days.

3. **DWC Form PR-3** [§9785(h)] – Primary Treating Physician's Permanent and Stationary Report (PR-3):
   - Submit report within **20 days** of the employee's condition becoming permanent and stationary, with findings of permanent disability and need for further medical care
   - This form to be used for P&S reports when the former (1997) Schedule for Rating Permanent Disabilities (PDRS) is applicable

4. **DWC Form PR-4** [§9785(h)] – Primary Treating Physician's Permanent and Stationary Report (PR-4):
   - Submit report within **20 days** of the employee's condition becoming permanent and stationary, with findings of permanent disability and need for further medical care
   - This form to be used for P&S/MMI reports when the 2005 Schedule for Rating Permanent Disabilities (PDRS) is applicable

5. **DWC AD Form 10133.36 (SJDB)** [§§10133.31, .36] – Physician's Return-to-Work & Voucher Report (SJDB):
   - Attached to a PR-3, PR-4 or any narrative report finding the employee's condition permanent and stationary (P&S) or Maximal Medical Improvement (MMI) with evidence of permanent partial disability (PPD)

6. **DWC Form RFA** [§9785(g), §9785.5, and §9792.9.1, and Lab. C. §§4610(g)(2) (A-B), (j)(2)] – Request for Authorization/DWC Form RFA:
   - PTP must attach to a report with other substantiating documentation each time there is a request for authorization for a specific course of treatment. If there is oral confirmation of the request for treatment, it must be stated at the top of the submitted document

7. **DWC Form IMR** [§9792.10.1, .2 and §§4610.5(h)(1)(A-B)] - Independent Medical Review/DWC Form IMR:
   - Physician may dispute UR determination [§9792.10.1(b)(2)(A)(ii)] by filing form (copy to parties):
     - Formulary disputes – submit form **10 days** after service of the UR decision
     - All other medical disputes – submit form within **30 days** after service of UR decision

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Acknowledgments

The authors would like to thank Dr. James McNicholas for his invaluable contribution to background research on access to care. Dr. McNicholas' work on this study was made possible by the University of California, San Francisco, where he is a resident in the Occupational and Environmental Medicine training program. We also are grateful to the Physicians, Medical Directors, and Office Administrators of medical practices for participating in the focus group interviews. We are grateful to CWCI staff members Rena David, Rob Bullis, Ellen Sims Langille, Sara Widener-Brightwell, and Bob Young for their peer review suggestions and draft reviews. Any errors found in the report however are the exclusive fault of the authors.

California Workers' Compensation Institute

The California Workers' Compensation Institute (CWCI), incorporated in 1964, is a private, nonprofit membership organization of insurers and self-insured employers. CWCI conducts and communicates research and analyses to improve California's workers' compensation system. CWCI members include insurers that collectively write about 79 percent of California's workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's website, www.cwci.org.