Dynamic Chiropractic

NEWS / PROFESSION

Gauging the Impact of Workers' Compensation Reform in California

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On Sept. 30, 2003, then-Governor Gray Davis signed into law a parcel of bills designed to reform California's workers' compensation system. Among the bills Gov. Davis signed was Senate Bill 228, which significantly altered the delivery of chiropractic services for injuries incurred while at work. Prior to SB 228's passage, California had no limit on the number or frequency of visits a person could make to a DC for a work-related injury; chiropractors also were allowed to be an injured worker's primary treating physician, if the worker so desired.[1]

Senate Bill 228, which took effect in January 2004, created a mandatory utilization review program that limited chiropractic visits in two ways. First, it called for the adoption of guidelines promulgated by the American College of Occupational and Environmental Medicine (ACOEM), which suggested that the use of any chiropractic services had to be supported by nationally recognized, peer-reviewed guidelines based on high-quality medical evidence. Second, the bill imposed a cap of 24 visits on chiropractic services for industrial injuries suffered on or after Jan. 1, 2004, except for instances in which additional visits were authorized by an insurance carrier.

Three recent reports[2-4] published by the California Workers' Compensation Institute (CWCI) examined the impact Senate Bill 228 has had on the utilization and cost of chiropractic services among injured workers. Combined, the reports' results paint a devastating picture for the typical doctor of chiropractic in California, with the use of chiropractic care and reimbursement of chiropractic manipulation for work-related injuries declining significantly since SB 228 went into effect.

Changes in Visits and Claims Payments

In one of its analyses, the CWCI evaluated data from more than 610,000 workers' compensation claims filed between January 2002 and September 2004 that involved chiropractic manipulation or physical therapy. Claims were then grouped according to the month and year of injury, with the average number of visits and treatment costs tabulated at three, six and nine months from the date of injury.

Change in Average Chiropractic Manipulation Visits and Payments Per Claim, Accident Years 2002-2004

Average Visits	2002	2004	Net Change
3 months	14.9	8.1	- 45.6%
6 months	22.8	10.8	- 52.6%
9 months	28.5	12.6	- 55.8%
Average Payments	2002	2004	Net Change
3 months	$612	$275	- 55.1%
6 months	$915	$376	- 58.9%
9 months	$1,139	$445	- 60.9%

Analysis revealed significant reductions in the average number of chiropractic manipulation visits and payments, coinciding almost precisely with the implementation date of the utilization review guidelines and the cap on the number of visits. For example, the average number of chiropractic manipulations recorded nine months post-injury declined from 28.5 visits in 2002 to 12.6 visits in 2004, a reduction of 55.8 percent. The average amount paid per claim for chiropractic manipulation at nine months also declined significantly, from $1,139 in 2002 to just $445 in 2004 - a net reduction of 60.9 percent.

"This analysis shows a clear association between the January 2004 implementation of the utilization schedule (ACOEM guidelines and the 24-visit caps) and significant decreases in the number of visits and average amounts paid for chiropractic manipulation during the earliest stages of workers' compensation medical treatment," the report concluded.

Changes in Reimbursement

In its second analysis, the CWCI examined changes in reimbursement patterns for physician services following the implementation of SB 228. California's workers' compensation system relies on an official medical fee schedule (OFMS) to determine fair and reasonable market rates for medical fees. Prior to 2004, the OMFS included formulas for determining reimbursements for professional services, supplies, pharmaceuticals and other materials. SB 228 revised the fee schedule by reducing the maximum reimbursement allowances for services under OMFS by 5 percent (but not below the Medicare rate), and requiring the administrative director of the Division of Workers' Compensation to monitor future Medicare adjustments to assure that the 5 percent reductions would not reduce maximum OMFS allowances below the Medicare levels.

To measure the average amounts paid and the changes in average payment for common physician services before and after the revisions to the fee schedule, CWCI developed a database of more than 49 million paid physician-based procedures with pre-SB 228 dates of service (January 2002 through December 2003) and post-SB 228 dates of service (January 2004 through December 2004). Each procedure was grouped by the year of service, with the 2002 and 2003 levels adjusted for medical inflation.

The proportion of service dollars paid for chiropractic manipulation "declined sharply in 2004," coinciding with SB 228's introduction of the ACOEM guidelines and the 24-visit cap on chiropractic services. In contrast, reimbursements for evaluation and management services (i.e., office visits) increased 2.4 percent between 2003 and 2004, and reimbursements for surgical procedures increased 4.8 percent.

Significant changes also were seen in the average amounts allowed for chiropractic manipulation following the fee schedule revisions. In 2002, the average allowed fee for chiropractic manipulation for treatment of an injured worker was $37.48. By 2004, the average amount had been reduced 11.4 percent to $33.19.

In addition, there were "significant and varied changes" in the average amounts paid across all fee schedule sections. Payments for chiropractic manipulation codes fell by an average of 10.4 percent between 2002 and 2004, from an average of $34.83 to $31.22. On the other hand, average payments for surgery codes increased 28.2 percent during the same time.

Changes in Utilization and Average Cost by Service Type

In the third analysis, the CWCI examined changes in medical utilization and reimbursement based on the type of medical services provided at the early stages of claim development. The analysis looked at over 303,000 open and closed

indemnity claims of workers who had been injured between January 2001 and December 2004, with utilization rates and payments measured at three months, six months and nine months post-injury. All claims were grouped by year and then sorted into ACOEM injury categories, with details provided on seven service categories:

- evaluation & management
- physical therapy
- surgery (excluding injections)
- chiropractic manipulation
- medicine section services
- radiology
- injections (including steroid injections and other therapeutic injections)

Four of the seven treatment categories showed decreases in the proportion of indemnity claims that received a particular service. Of those four, however, the most significant decrease was seen in chiropractic: 13.9 percent of the 2004 injury claims received chiropractic manipulation services, compared to 21.4 percent of the 2003 injury claims - a relative reduction of 35 percent.

Utilization of Chiropractic Manipulation, 2001-2004 Indemnity Claims				
Chiropractic Manipulation Utilization	2001	2002	2003	2004
% of all indemnity claims	17.7%	19.7%	21.4%	13.9%

Average # of visits at 3 months	11.3	11.3	10.7	8.0
Average # of visits at 6 months	24.0	24.8	22.3	13.1
Average # of visits at 9 months	35.9	37.0	32.6	17.4
Average total paid for services at 3 months	$530	$540	$499	$348
Average total paid for services at 6 months	$1,116	$1,154	$1,028	$569
Average total paid for services at 9 months	$1,675	$1,721	$1,488	$748

Utilization of Surgery, 2001-2004 Indemnity Claims				
Surgery Utilization (Excluding Injections)	2001	2002	2003	2004
% of all indemnity claims	45.5%	48.1%	49.0%	49.7%
Average # of visits at 3 months	1.6	1.6	1.6	1.5
Average # of visits at 6 months	3.1	3.2	3.2	2.8
Average # of visits at 9 months	4.7	4.9	4.8	4.1
Average total paid for services at 3 months	$783	$755	$793	$988
Average total paid for services at 6 months	$1,910	$1,871	$2,031	$2,509
Average total paid for services at 9 months	$3,110	$3,009	$3,447	$4,086

In six out of the seven treatment categories, the average number of visits post-injury declined in 2004, with chiropractic again experiencing the effects of SB 228 more than other services. According to the analysis, "the largest percentage drop in average visits was in chiropractic manipulation services, where at 9 months of development there was a 46.6 percent reduction in visits in 2004 (17.4 visits) relative to 2003 (32.6 visits)."

Just as the average number of chiropractic visits for indemnity claims was associated with the implementation of utilization controls, so did the average total payments for chiropractic services. Average total amounts paid for chiropractic services at nine months were reduced 49.7 percent between 2003 and 2004, the largest reduction among any treatment category. In contrast, the average total amount paid for surgical procedures increased 18.5 percent over the same duration, even though the average number of surgical visits decreased 17.1 percent.

"It is important to note again that the utilization and cost trends presented here represent data compiled at very early stages of claim development," the report's authors stated. "[We] caution not to extrapolate these results to potential future savings on fully developed claims, as several external issues may have contributed to these results."

References

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