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California Workers' Compensation Aggregate Medical Payment Trends – 2016 Update

I. Executive Summary

This report summarizes the $2.3 billion in medical payments reported to the WCIRB on a transaction basis by the California workers' compensation insurance industry in Calendar Year (CY) 2016. This report compares 2016 results with the results issued by the WCIRB for CY2014[1] and CY2015.[2] This data is based on medical transactions collected from 50 WCIRB insurer groups and their vendors, representing 91% of the California insured market. This data does not include all medical costs incurred by insurers such as the provision for future medical costs associated with compromise and release claim settlements or the cost of Medicare set-asides.

The goal of this report is to identify overall medical costs and specific trends that continued or emerged in CY2016 and may persist in future years.

The overall data is summarized in Table 1. These findings show a cumulative 9% reduction in medical payments per claim from CY2014 through CY2016, which is comparable to the cumulative two-year reduction from CY2013 to CY2015 shown in last year's report. In part, this reflects a continuation of the savings generated by the medical reforms enacted by Senate Bill No. 863 (SB 863) in 2012 as documented in the most recent WCIRB comprehensive SB 863 Cost Monitoring Report[3] and the continued decline in pharmacy costs.

Table 1: Summary of Medical Data Call for CY2014 through CY2016[4]

	CY2014	CY2015	CY2016	Cumulative % Difference CY2014-CY2016	*Cumulative % Difference CY2013-CY2015*
Paid Transactions	19.1 million	18.0 million	17.1 million	-10%	*-11%*
Payments	2.5 billion	2.5 billion	2.3 billion	-7%	*-6%*
Unique Claims with Payments	647,305	664,327	660,792	+2%	*+4%*
Payments per Paid Transaction	$129	$132	$134	+4%	*+6%*
Payments per Paid Claim	$3,801	$3,576	$3,474	-9%	*-9%*

The drop in medical costs per claim was driven by a decline in the number of paid transaction per claim. The overall drop in medical transactions did not result in lower per unit payments to most providers. Overall, the average payment by transaction increased by 4% from CY2014 to CY2016. The physician general providers experienced a 12% rise in paid per transaction as expected with the adoption of Medicare's Resource-Based Relative Value Scale (RBRVS) in the California Official Medical Fee Schedule (OMFS).

The Medical Legal share of medical costs increased from 10% to 12% largely as a result from the number of medical legal reports per claim increasing 8% between CY2014 and CY2016. The Pharmacy total average paid per transaction dropped by 17% from CY2014 to CY2016 driven by decreases in all drug categories. The paid amounts and transaction volumes for the controlled substances categories dropped 57% and 52%, respectively. The decreases in pharmaceutical share and paid per transaction can be attributed to various factors including:

- Decreased opioid prescribing from greater awareness of the national opioid and prescription drug crisis
- Implementation of the Medi-Cal based Pharmacy Fee Schedule change as of April 2016, which included changes in Federal Government upper limits on pricing levels
- Use of Independent Medical Review
- Implementation of Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines and Opioid Treatment Guidelines effective July 2016
- Reductions in the level of physician dispensed and compound pharmaceuticals[5]

[1] WCIRB, *California Workers Compensation Aggregate Medical Payment Trends*, July 31, 2014.
[2] WCIRB, *California Workers Compensation Aggregate Medical Payment Trends – 2014 Update*, August 18, 2015.
[3] WCIRB, *Senate Bill No.863 WCIRB Cost Monitoring Report – 2016 Retrospective Evaluation*, November 17, 2016.
[4] The data in this report is as of April 7, 2017.
[5] WCIRB, *Patterns of Drug Dispensing in California Workers' Compensation,* September 2016.

II. Payments by Type of Provider

Table 2 shows the distribution of payments by types of provider for CY2014 through CY2016. This data shows a 0.8% increase per paid transaction for all provider types in the aggregate from CY2015 to CY2016, and a cumulative 4% increase since CY2014. This data shows increases of 12% for general providers and 13% for physician specialists consistent with the types of providers most likely to use Evaluation & Management (E&M) codes and which experienced significant upward revisions of the reimbursement values with the introduction of RBRVS physician fee schedule with the first year of a four year transition in January 2014. The downward revisions in reimbursement allowances for surgeons did not result in lower surgeons average paid per transaction costs. The average paid per procedure for hospital-based providers did, however, show an 8% decrease from 2014 to 2016.

Table 2: Payments by Type of Provider for CY2014 through CY 2016

	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
Provider Type	**% of Paid**	**Avg Paid per Trans.**	**% of Paid**	**Avg Paid per Trans.**	**% of Paid**	**Avg Paid per Trans.**	**Paid per Trans. Difference**
Hospital-Based Provider	19%	$260	21%	$247	22%	$240	-8%
MD General Provider	15%	$103	10%	$114	10%	$115	12%
Physician Specialist	11%	$118	12%	$128	12%	$134	13%
Pharmacist	10%	$140	8%	$139	6%	$114	-18%
Provider Not Otherwise Specified (Reported as 17440000X)	9%	$156	9%	$180	9%	$206	32%
Surgeon	8%	$154	9%	$152	10%	$167	8%
Physical Therapist	6%	$48	6%	$45	7%	$43	-11%
ASC Provider	4%	$952	4%	$1,226	5%	$1,292	36%
DME Supplier	3%	$228	3%	$231	3%	$233	2%
Occupational Health Provider	3%	$108	3%	$80	2%	$71	-35%
Psychology, Psychiatry & Neurology	2%	$290	2%	$301	3%	$312	7%
Lab Testing Provider	2%	$65	2%	$60	1%	$70	8%
Chiropractic	2%	$54	2%	$57	2%	$61	12%
Rehabilitation Provider	2%	$151	2%	$174	2%	$182	21%
Home Health Provider	1%	$331	1%	$359	1%	$355	7%
Acupuncturist	0%	$36	1%	$36	1%	$37	5%
Miscellaneous Provider	3%	$185	3%	$178	4%	$192	4%
Total	**100%**	**$128**	**100%**	**$132**	**100%**	**$133**	**4%**

III. Payments by Place of Service

Table 3 shows payments by Place of Service (PoS) for CY2014, CY2015 and CY2016. On an aggregate basis for all places of service, these results closely track the Provider Type findings in Table 2, reflecting a modest 3% rise in payments per transaction between CY2014 and CY2016. Nursing Facilities, newly segregated out in this table, show an increasing share for this PoS and may suggest a shift in service location to stepdown care in a non-hospital setting before the patient is transitioned to home. The significant reduced share and average paid per transaction for Pharmacy is due in part to reduced prescribing of controlled substances, reduced average paid per transaction for brand and generic drugs and an overall reduction in medication prescribing including reduced physician office dispensing. Although still a small component of total medical costs, emergency room costs increased 53% and transaction volumes increased 13.2% reflected in the average paid per transaction that shows the greatest increase from CY2014 to CY2016.

Table 3: Payments by Place of Service for CY2014, CY 2015 and CY 2016

Place of Service Type	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	% of Paid	Avg. Paid per Trans.	Paid per Trans. Difference
Office	52.5%	$90	52.6%	$92	54.3%	$92	3%
Inpatient Hospital	13.4%	$1,141	13.5%	$1,120	12.8%	$1,183	4%
Pharmacy	9.7%	$135	8.0%	$131	5.6%	$107	-21%
Ambulatory Surgery Center	6.1%	$597	6.1%	$658	6.6%	$691	16%
Outpatient Hospital	5.7%	$228	5.3%	$224	5.3%	$238	4%
Home	4.2%	$252	4.5%	$238	4.8%	$255	1%
Independent Laboratory	1.8%	$54	1.5%	$45	1.0%	$53	-1%
Emergency Room	0.9%	$104	1.0%	$110	1.5%	$142	36%
Nursing Facilities	1.3%	$960	1.3%	$1,031	1.6%	$1,050	9%
Urgent Care Center	0.5%	$59	0.6%	$61	0.8%	$64	10%
Others	3.8%	$455	5.6%	$500	5.7%	$375	-17%
Total	**100%**	**$128**	**100%**	**$131**	**100%**	**$131**	**3%**

IV. Payments by Procedure Code Type

Table 4 shows the distribution of payments across the three calendar years according to the various payment types, most of which are governed by fee schedules. The Physician Services and Medical Legal fee schedule sections, the service sections most likely to be rendered by a physician provider, accounted for 53% of payments in CY2016 and both sections experienced a modest increase in average paid per transaction. The Physician Services increase is consistent with the RBRVS-based reimbursement changes starting in 2014. The Pharmacy Fee Schedule section is the only schedule section to show a drop in both paid per transaction and percentage share.

Table 4: Paid Amounts Summary by Payment Type, CY2014 through CY2016

Payment Type	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid Per Trans.	% of Paid	Avg Paid per Trans.	Paid per Trans. Difference
Physician Services (RBRVS)	39%	$75	40%	$80	41%	$77	2%
Medical Legal Fee Schedule	10%	$1,639	11%	$1,650	12%	$1,672	2%
Pharmacy Fee Schedule	13%	$117	11%	$116	7%	$97	-17%
Inpatient	10%	$1,826	10%	$1,800	9%	$2,027	11%
Outpatient	9%	$506	10%	$572	11%	$584	15%
Medical Liens	9%	$862	9%	$915	9%	$1,078	25%
Other*	10%	$86	10%	$91	10%	$96	11%
Total: All Schedules/Payments	**100%**	**$127**	**100%**	**$136**	**100%**	**$133**	**5%**

* Details of Other are available in Table 4D.

V. Payments by Procedure Type – Physician Services (RBRVS)

Table 4A shows the distribution of payments and average paid per transaction for the nine categories in California's Physician Fee Schedule. The overall 2% rise in payments per transaction during this period was driven by increases in primary care (Medicine), including Evaluation and Management and Physical Medicine, which is consistent with expectations given the four-year phase-in of the RBRVS-based physician fee schedule.

Table 4A: Payments by Physician Fee Schedule, CY2014 through CY2016

Procedure Category	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
	% of Paid	Avg Paid Per Trans.	% of Paid	Avg Paid Per Trans.	% of Paid	Avg Paid Per Trans.	Paid per Trans. Difference
Evaluation and Management	12%	$107	14%	$114	15%	$120	12%
Physical Medicine	7%	$32	8%	$36	9%	$39	24%
Surgery	8%	$394	7%	$401	6%	$378	-4%
Radiology	4%	$121	4%	$108	4%	$103	-15%
Special Services & Reports	4%	$49	3%	$61	4%	$42	-14%
Medicine	2%	$109	2%	$113	2%	$120	11%
Anesthesia	1%	$342	1%	$326	1%	$305	-11%
Acupuncture	0.5%	$38	1%	$36	1%	$38	1%
Chiropractic	0.3%	$32	0.3%	$32	0%	$35	10%
Total: Physician Services	**39%**	**$75**	**40%**	**$80**	**41%**	**$77**	**2%**

VI. Payments by Procedure Type – Medical Legal Fee Schedule

Table 4B shows the distribution of payments and average paid per transaction under the Medical Legal Fee Schedule for CY2014, CY2015 and CY2016. Payments per transaction and the total share of medical payments generated by Medical Legal services have risen each calendar year. For CY2016, medical legal costs comprised 12% of total medical costs compared to 10% for CY2014. Despite no change in the fee schedule applicable to medical legal reports, the average paid per transaction increased 2% and the absolute transaction volume increased 8% from CY2014 to CY2016. The increase in costs is attributable, in part, to an increased use of ML 106, a supplemental medical-legal evaluation report and to a lesser degree by increased usage of the more complex code, ML 104.

Table 4B: Payments by Procedure – Medical Legal Fee Schedule

Procedure Category	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	Paid per Trans. Difference
ML 104 exams w/ 4+ complexities	7%	$3,319	7%	$3,406	8%	$3,532	6%
ML 100-103 other ML exams	2%	$831	2%	$844	2%	$859	3%
ML 105, 106 testimony fees	1%	$711	2%	$744	2%	$789	11%
Medical Legal Total	**10%**	**$1,639**	**11%**	**$1,650**	**12%**	**$1,672**	**2%**

VII. Payments by Procedure Type – Pharmacy Fee Schedule

Table 4C shows the distribution of total pharmaceutical payments and the average paid per pharmaceutical transaction by calendar year. As shown, the share of medical costs represented by pharmaceuticals has declined dramatically from 13.2% in 2014 to 7.1% in 2016. Additionally, the total paid amounts and transactions for the two combined controlled substances categories dropped by 57% and 52% respectively from CY2014 to CY2016. The decreases in share and paid per transaction can be attributed to a number of factors including decreased opioid prescribing as well as implementing the April 2016 Medi-Cal based Pharmacy Fee Schedule that incorporated the Federal Upper Limits on pharmaceutical pricing.[6]

Independent Medical Review and Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines and Opioid Treatment Guidelines (effective July 2016) are also believed to be having an effect on prescribing patterns. Such changes in prescribing patterns are supported by non-narcotic medications used for pain control appearing in the top 20 fastest growing Pharmaceuticals list in Table 6.

The average paid per transaction for brand drugs did show an increase of 10% from Calendar Year 2014 to 2016. This increase may be the result of new formulas or strengths of brand name drug formulas that are being prescribed such as medications now formulated as Extended Release or drugs that cannot be crushed for illicit use.

Assembly Bill No. 1124, enacted in 2015, requires that a drug formulary be created and aligned with the MTUS, which contains specific guidelines for prescribing opioids. While the new drug formulary is currently expected to go into effect January 1, 2018, the downward trend of controlled substance prescribing suggests the workers' compensation system is already responding. The combined share paid for both controlled substances categories (opioids and other drugs with a Drug Enforcement Agency (DEA) Class Code assignment) halved from 4.3% in CY2014 to 2.0% in CY2016. Likewise, the paid per transaction cost decreased in this same period by nearly 22%.

Table 4C: Payments by Procedure – Pharmacy Fee Schedule, CY2014 through CY2016

Procedure Category	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	Paid per Trans. Difference
Controlled Substances (Schedule II)	2.4%	$117	1.7%	$122	1.0%	$95	-18.3%
Controlled Substances (Other)	1.9%	$114	1.4%	$112	1.0%	$110	-3.6%
Other Pharmaceuticals (Generics)	4.0%	$68	3.8%	$71	2.6%	$57	-15.8%
Other Pharmaceuticals (Brand)	4.9%	$296	3.8%	$312	2.5%	$325	9.8%
Pharmacy Total	**13.2%**	**$117**	**10.7%**	**$116**	**7.1%**	**$97**	**-17.0%**

[6] The Federal Upper Limit is defined as the lower of either the Estimated Acquisition Cost (EAC) plus professional fees or Maximum Allowable Ingredient Cost (MAIC) and the Average Wholesale Price (AWP) minus 17%.

VIII. Payments by Procedure Type – Other Fee Schedules

Table 4D shows the distribution of the 10% of total payments under the Health Care Procedure Coding System (HCPCS), Dental schedules and Copy Services (implemented in July 2015). The Other Fee schedule category (HCPCS) covers several categories including durable medical equipment (DME), prosthetics, orthotics and supplies as well as interpreters and home health services. The aggregate share of each fee schedule type changed little over the three calendar years from CY2014 to CY2016 except for Pathology and Laboratory that declined in both share and average paid per transaction due to multiple annual changes to Medicare's Clinical Diagnostic Laboratory Fee Schedule on which reimbursement is based. Previously, many providers were ordering multiple panels for tests in which the services were later bundled into a single test for billing purposes. Additionally, the decrease of opioid prescribing has also impacted the downward trend in Pathology and Laboratory share and average cost per transaction by reducing the need for urine drug screening.

Earlier draft regulations posted by the Division of Workers' Compensation (DWC) for informal comment for an interpreter fee schedule have allowed for improved reporting of this service type which may account for an increase in the paid per transaction. The decrease in all other HCPCS categories except DME, Orthotics, and Prosthetics may represent inconsistent reporting patterns since many services billed with HCPCS codes are not subject to any fee schedule such as home health services or air ambulance services.

Table 4D: Payments by Procedure – Other Fee Types, CY 2014, CY2015 and CY2016

Procedure Category	CY2014		CY2015		CY2016		Cumulative % Difference CY2014-CY2016
	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	% of Paid	Avg Paid per Trans.	Paid per Trans. Difference
DME, Orthotics, Prosthetics	2.5%	$221	2.9%	$230	2.9%	$230	4%
Home Health/Home Infusion	1.6%	$276	1.4%	$258	1.4%	$204	-26%
Supplies	0.8%	$74	0.6%	$72	0.5%	$67	-9%
Transportation – includes Emergency and Non-Emergency	0.9%	$219	1.0%	$205	1.0%	$189	-13%
Interpreters via Medicaid	0.5%	$101	0.7%	$114	0.8%	$113	12%
Pathology & Laboratory	2.2%	$47	1.0%	$36	0.6%	$34	-28%
Miscellaneous HCPCS	1.2%	$34	1.3%	$35	1.1%	$31	-10%
Copy Services			0.2%	$114	0.7%	$103	
Dental	0.6%	$551	0.6%	$556	0.6%	$556	1%
Total	10%		10%		10%		

IX. Fastest Growing Medical Procedures

Table 5 shows the twenty fastest growing fee schedule procedures in CY2016 compared to CY2015. There are approximately 4,900 codes receiving payments in Physician Services. The twenty fastest growing codes accounted for 55.6% of all Physician Services payments in 2015, and changes were modest. Copy service fees (WC020) topped this list in that it was a new code established by the DWC in July of 2015. The E&M and physical medicine codes are services for which values were increased by RBRVS. Office Visit E&M level 3 and 4 made up 26.8% of the Physician Services costs in 2016. Additionally, consistent with the continued decrease in opioid prescribing, the increased use of procedure code “Quantitative Assay Drug” used for drug testing, may suggest closer surveillance on the use of controlled substances.

Table 5: Fastest Growing Procedures, CY2016 vs. CY2015 (OMFS)

Growth Rank	Procedure Description	OMFS Code	Change	% Paid in OMFS CY2016
1	Copy Service Flat Fee (up to 500 pages)	WC020	1.1%	1.5%
2	Treating Physician’s Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14(b)(1))	WC002	0.8%	1.9%
3	Office Visit E&M Established Patient; Level 4 of 5	99214	0.8%	13.4%
4	Physical Medicine Treatment Initial 30 Minutes; Therapeutic Exercise	97110	0.7%	8.0%
5	Office Visit E&M New Patient; Level 4 of 5	99204	0.4%	4.0%
6	Office Visit E&M New Patient; Level 3 of 5	99203	0.3%	2.4%
7	Office Visit E&M Established Patient; Level 3 of 5	99213	0.3%	7.0%
8	Therapeutic Activity, Kinetic Activities; Initial 30 Minutes	97530	0.3%	2.6%
9	Primary Treating Physician’s Permanent and Stationary Report (Form PR-4) (Section 9789.14(b)(3))	WC004	0.3%	0.5%
10	Physical Medicine Treatment Initial 30 Minutes; Neuromuscular re-education of movement, balance, etc.	97112	0.2%	1.3%
11	Manual Therapy Techniques 1 or more Regions	97140	0.2%	3.4%
12	Psychotherapy, 60 minutes with patient and/or family member	90837	0.2%	0.5%
13	Patient Evaluation	97001	0.2%	1.2%
14	Quantitative Assay Drug testing	80299	0.1%	0.2%
15	Self-Care/ Home Management Training	97535	0.1%	0.6%
16	Copy Service Certificate of No Records	WC022	0.1%	0.1%
17	Consultation Reports Requested by the Workers’ Compensation Appeals Board or the Administrative Director (Use modifier -32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b)(5)). (Use modifier -30)	WC007	0.1%	0.2%
18	Unlisted Special Service, Procedure or Report	99199	0.1%	4.8%
19	Needle electromyography, each extremity, with related paraspinal areas, done with nerve conduction, amplitude and latency/velocity study	95886	0.1%	0.6%
20	Unlisted Physical Medicine/Rehabilitation Service or Procedure	97799	0.1%	1.5%

* Relative contribution of a specific procedure to overall increases in all procedures.

X. Fastest Growing Pharmaceuticals

Table 6 shows the twenty fastest growing pharmaceuticals in CY2016 compared to CY2015. Approximately 450 pharmacy Therapeutic Classes received payments in 2016. The twenty fastest growing codes represented nearly 31.4% of all pharmacy payments in CY2016 compared to 44% in CY2015 reflecting a lesser concentration of payments in more Therapeutic Class types. In CY2016 this data reflects very small increases overall for the top 20 drug codes. The most common non-opiate analgesics and topicals such as NSAIDs (Non-Steroidal Anti-inflammatory Agents), Corticosteroids (Steroidal Anti-inflammatory Agents) and other medications sometimes used to treat pain, namely anticonvulsants and central muscle relaxants, collectively, saw greater increases (4%) than Opioid Agonists and Opioid Partial Agonists (0.4%).

Table 5: Fastest Growing Pharmaceuticals, CY2016 vs. CY2015

Growth Rank	Class Description[7]	Therapeutic Class	Change from 2015 to 2016	% Paid in NDC CY2016
1	Corticosteroids – Topical	9055	2.2%	2.3%
2	Anticonvulsants – Misc.	7260	1.1%	7.4%
3	Anti-inflammatory Agents – Topical	9021	0.6%	2.5%
4	Antidepressants – Misc.	5830	0.4%	1.0%
5	H-2 Antagonists	4920	0.4%	0.5%
6	Impotence Agents	4030	0.4%	1.0%
7	Bradykinin B2 Receptor Antagonists	8582	0.3%	0.3%
8	Opioid Partial Agonists	6520	0.2%	1.4%
9	Peripheral Opioid Receptor Antagonists	5258	0.2%	0.3%
10	Antiretrovirals	1210	0.2%	0.5%
11	Direct Factor Xa Inhibitors	8337	0.2%	0.3%
12	Opioid Antagonists	9340	0.2%	0.2%
13	Local Anesthetics – Topical	9085	0.2%	6.2%
14	Restless Leg Syndrome (RLS) Agents	6256	0.1%	0.2%
15	Insulin	2710	0.1%	0.5%
16	Central Muscle Relaxants	7510	0.1%	5.3%
17	Postherpetic Neuralgia (PHN) Agents	6254	0.1%	0.4%
18	Sympathomimetics	4420	0.1%	0.5%
19	Cephalosporins – 2nd Generation	220	0.1%	0.2%
20	Modified Cyclics	5812	0.1%	0.4%
	Total % Paid – Top 20			31.4%

[7] Pharmaceuticals are grouped at the Therapeutic Code level.

Appendix

Changes to 2017 Aggregate Report Layout
In 2016, the underlying assignments of provider taxonomy codes for each provider type in Table 2 were updated from last year's report. The data in this aggregate report for calendar years 2014 and 2015 were recast using these new provider assignments to provide consistency for annual comparisons. Additionally, the Provider Not Otherwise Specified (Reported as 17440000X) field was added in 2016. This code is generally assigned by claims adjusters when there is uncertainty as to which provider code to assign.

Pathology and Laboratory were taken out of the Physician Services (RBRVS) and combined with other categories, such as Dental and Copy Services, under Table 4D, Other Fee Schedules.

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