MORENO VALLEY UNIFIED SCHOOL DISTRICT

MINUTES OF THE STUDY SESSION OF THE BOARD OF EDUCATION OF NOVEMBER 2, 2009

The minutes of the Study Session of November 2, 2009, are being submitted to the Board of Education for approval at its Regular Board Meeting of November 17, 2009. The minutes are a complete and factual record of action taken by the Board of Education at its Study Session of November 2, 2009.

THESE PROCEEDINGS ARE BEING AUDIO TAPED PURSUANT TO GOV. CODE § 54953.5

CALL TO ORDER: The Board of Education opened the meeting at 5:31 p.m. to convene into a Study Session to discuss Workers' Compensation.

ROLL CALL: AYE – Ashe AYE – Baca AYE – Holguin AYE – Sayre AYE – Vackar

Administration Present
Rowena Lagrosa, Superintendent
Barbara Davis, Assistant Superintendent, Educational Services
Nancy Anderson, Director, Risk Management
Dolores Vasquez, Principal, Honey Hollow
Estuardo Santillan, Business Manager
Francine Story, Director, Budget and Finance
Sheryl Sanford, Administrative Assistant

Visitors

Lucy Williams	Debra Craig	Doris Howard
Terry Chapman	Janet MacMillan	

STUDY SESSION

- Workers' Compensation

Nancy Anderson, Director of Risk Management, introduced Lucy Williams, Deputy Director of Human Resources from Riverside County, who gave a presentation regarding managing the costs of workers' compensation.

Lucy Williams stated that the key to a successful claims operation is finding the balance between providing benefits and preventing fraud and abuse. The goal is to manage a claim for injury while keeping in mind the ultimate goal of providing quality medical care and ensuring a prompt and successful return to work. Labor Code 4600 reads, in part, "...provide medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his/her industrial injury shall be provided by the employer...". This may include medical/surgical, chiropractic, acupuncture, medical supplies such as nursing, crutches, etc., orthotics, and prosthetic devices/services.

Various reforms over the years have provided tools for keeping the cost of the medical benefit under control and providing safeguards to fraud, waste, and abuse.

The 1994 Reform states that the Official Medical Fee Schedule (OMFS) is presumed to be reasonable payment for services rendered. It also states that claims operations may use a bill review service to ensure the bills are in compliance with the OMFS.

The 2003 Reform calls for an expedited Second Opinion Process for Spinal Surgery. Whenever the employer objects to a request for spinal surgery, the Administrative Director assigns a Second Opinion Physician who renders an opinion on the need for the surgery within 45 days of the initial request for surgery.

The 2004 Reform has several key elements of legislative reform:

- A Medical Provider Network allows employers to direct their injured workers' medical care which directly impacts medical costs. The network ensures physicians who can identify the correct diagnosis and prescribe the proper treatment, which is the key to effective medical care. To make the network succeed, you must gain the support of your employees. If they have confidence in the physicians, it will enhance recovery.
- It added an internal appeals process for disputes concerning diagnosis or issues.
- The treating physician no longer has the presumption of correctness.
- Medical care for injured workers must follow the American College for Occupational and Environmental Medicine (ACOEM) practice guidelines which are presumed to be correct.
- The American Medical Association (AMA) Guides to the evaluation of Permanent Disability are used.
- No vocational rehabilitation benefits
- Apportionment to causation is a major change with the passage of SB899, effective April 19, 2004. The employer is only responsible for that "portion" of the permanent disability the employee has that was caused by the employment. The non-industrial portion of the disability is removed from the claim. Under the prior system, we could only apportion to a disability the evidence that the employee needed work restriction to function and the evidence the employee continued to treat for the injury. Another change under SB899 was that employees are required to disclose any prior disabilities, awards, or settlements. An employee cannot receive disability in excess of 100% for that body part for the employee's lifetime.

A worker may choose a Predesignated Personal Treating Physician; however, they must be a physician and a surgeon under the Business and Professions Code, be the employee's primary care physician' have treated the employee before, maintains the employee's medical records and medical history, and agree with the predesignation.

There are two other options available to the employee if unhappy with the outcome or there is a dispute with the treatment. The employee has the option for a Qualified Medical Evaluator (QME) panel which provides the employee with a form to request the panel. The Administrative Director provides three medical evaluators selected at random. The employee selects the physician to perform the evaluation, and the employee makes the appointment with the physician. Another option is the Agreed Medical Evaluator (AME) option which is used if the employee is represented by an attorney who is allowed to select a physician that both the employer and employee agree to use, who becomes the AME. If the parties can not come to an agreement, then a panel of three physicians will be provided by the Administrative Director with each party striking one name.

Cost containment programs are key and can include Medical Provider Network (carve out), Modified Duty Programs, Prompt Interactive Process, and a Wellness Program. In the County of Riverside, the combined savings from the 2004 Reform and Cost Containment Programs is a reduction in premiums by 49%; the average cost per claim was reduced from $12,104 in 2004 to $8,448 in 2008; Temporary Disability reduced by 42%; and Permanent Disability reduced by 30%.

Authority limits that assist with oversight on high dollar exposures, which prevents fraud and protects all parties, have been established. A Board of Supervisors approval is required on all settlements of $50,000 or greater and establishes authority limits for adjusters to approve payments and set reserves.

It is important to recognize where vendors and services can be combined to provide greater benefits and streamline processes. Moreno Valley Unified School District has partnered with CorVel Services for bill review, Medical Provider Network Administrator, Utilization Review of medical treatment, claims management, and fraud detection. By blending together those services, it reduces the steps in each process and reduces costs overall.

The Insurance Code mandates that each insurer/claims operation maintain a Special Investigation Unit (SIU) to educate the staff regarding workers' compensation fraud and SIU procedures, identify and document suspected fraud, report suspected fraud to the Department of Insurance and the District Attorney, and assist in prosecution of suspected fraud.

To settle a claim, the adjuster prepares a settlement recommendation which is referred to the Supervisor for approval. In high dollar cases, the settlement recommendation is referred to a Claims Manager for approval. Settlements of $50,000 or more are referred to the Board of Supervisors for approval. When all issues of a claim have been resolved, settlement of the case needs to be finalized with a Stipulation With Request for Award (if still employed with employer), Compromise and Release Agreement (if no longer employed with employer), or litigation before the Workers' Compensation Appeals Board (WCAB) if issues cannot be resolved by parties.

A Stipulation with Request for Award is when the parties agree informally to the level of permanent disability, the length of temporary disability, and the need for further medical care. This agreement is formalized in a court document which is submitted to the WCAB for approval. The workers' compensation judge is there to protect the injured worker's interests.

The Compromise and Release Agreement is where the parties cannot resolve all the issues, they can agree to disagree. This agreement leaves the issues unresolved and the employer is released from the claim by paying a one time lump payment. The agreement is formalized in a court document and submitted to the WCAB. Again, the workers' compensation judge is there to protect the interest of the injured worker.

The Medicare Reporting Act requires the submission of any medical settlement if the injured worker is age 62 ½ or older, has applied for SSD or is eligible for Medicare within 24 months, any settlement over $250,000, or receipt of SSD/SSI. The 2003 MMIRR Amendment requires the same reporting for settlement of civil claims as well.

In 2004, there was the adoption of Whole Person Impairment (WPI) vs. Permanent Disability (PD). A PD was determined by a "objective/subjective index" which is the measure of physical or functional loss, the reduced ability to perform certain work (such as no heavy lifting). WPI is determined by AMA guides which is the reduced ability to perform certain activities (such as range of arm motion) and includes a diminished future earning capacity (FEC).

Costs are on the rise. Recent court cases held that AMA Guides could be superseded or rebutted if an impairment rating based on the Guides resulted in a PD award that was inequitable, disproportionate, and not a fair measure of the employee's PD. In another case, the court held the FEC may be rebutted if there is evidence that the employee's individual loss would differ from the average loss under the PD Rating Schedule for that particular injury. The WCAB revised decision include parties may not go outside the AMA Guides to rebut PD ratings (combining other impairments), but the worker could challenge a rating for any reason without the threshold of "unfairness".

There was Board discussion and clarification regarding the information presented.

ADJOURNMENT: There being no further business to come before the Board of Education, the Study Session was adjourned at 7:00 p.m.