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Features

ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH WORKERS' COMPENSATION CLAIMS

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ABSTRACT

Experience at a publically funded occupational health clinical center in New York State suggests that patients with work-related illnesses often have great difficulty accessing diagnostic and treatment services. A study was designed to more quantitatively investigate the extent and nature of barriers to medical services for patients with Workers' Compensation claims.

Medical practices from 13 selected medical specialties were identified from telephone directories. The directories covered six areas encompassing almost all of a 15-county region. All practices from each selected specialty were contacted by phone and asked a set of standardized questions regarding patient acceptance policies.

A number of barriers were identified by the survey including practices closed to new patients and practices closed specifically to patients with Workers' Compensation claims. Barriers also were found to be widespread among practices that did accept Workers' Compensation claims, primarily related to requiring a guarantee of payment prior to seeing the patient. The results were compared by medical specialty and geographic area.

While the study showed some of the difficulties patients with occupational illnesses face attempting to access medical services, it most likely underestimated the extent of the problem. Attitudes and practices that impede access, but were not measurable, create additional barriers.

Our study strongly suggests that policies that improve access to medical care for individuals with Workers' Compensation claims are necessary to better serve the needs of workers with occupational illnesses.

Between 1910 and 1930 Workers' Compensation systems were established in almost all states with a common rationale. Injured workers won a "promise" of streamlined access to medical and financial benefits while losing their rights to sue their employers for injuries and illnesses caused by work. Employers gained protection against the large awards sometimes won by injured workers' lawsuits, and could more accurately plan for the more limited costs of work-related injuries and illnesses under Workers' Compensation [1]. However, these systems' ability to effectively and fully fulfill their fundamental mandate has been persistently criticized for many years [2].

From the vantage point of an Occupational Medicine clinic in New York State specialized in the diagnosis of occupational disease, access to medical care for individuals with Workers' Compensation claims has seemed quite limited. The Central New York Occupational Health Clinical Center (CNYOHCC) is one of eight publically funded centers that comprise the New York State Occupational Health Clinic Network. Funding for the Network originates in a legislated surcharge on Workers Compensation insurance premiums paid by employers. The New York State Department of Health oversees the Network and determines the funding level for each center through a grant application process. Consequently, each of the Centers is housed in a unique institutional setting. The CNYOHCC was first funded in 1987 and is a part of the Department of Family Medicine at the State University of New York Upstate Medical University in Syracuse.

The Clinic Network was funded to address a documented need for qualified, multidisciplinary, independent, and universally accessible occupational health services focused on the diagnosis, treatment, and prevention of occupational disease. The definition of disease included musculoskeletal injuries from repeated trauma, but excluded acute traumatic injuries and most back injuries. The rationale for limiting the network clinics' role was to allow the application of the network's limited resources to functions not fulfilled by existing medical services. The treatment of acute injuries and back pain was presumably a role already played by the medical community [3].

The CNYOHCC employs a multidisciplinary staff, including an occupational medicine physician, a nurse practitioner/occupational health nurse, an industrial hygienist, a social worker, and nurse case managers. Services provided by this team include diagnosis and treatment, workplace recommendations and evaluations, facilitation of access to benefits, and psychosocial assessment and support. Individual patients are referred to the CNYOHCC from a variety of sources, including physicians (22 percent), unions (31 percent), attorneys (13 percent), and employers (7 percent).

Patients evaluated at the center suffer from an array of maladies. More than 40 percent are diagnosed with a respiratory disorder such as upper airway irritation, asthma, pneumoconiosis, and occasionally hypersensitivity pneumonitis. Approximately 15 percent are found to have work-related musculoskeletal

disorders (MSDs). Other relatively common diagnoses include noise-induced hearing loss, toxic encephalopathy, indoor air quality- related symptoms, contact dermatitis, overexposure to lead and occasionally other metals, occupational cancer, and stress-related syndromes [4, 5].

Patients frequently report to CNYOHCC clinicians that physicians they have sought treatment from before seeking evaluation at the occupational health center appear reluctant to consider the possibility that work has played a role in the patient's illness. At times, even when the treating physician has indicated s/he feels there is a good chance that work has played a role, s/he has declined to support a Workers' Compensation claim. Some patients describe efforts by their physicians to actively discourage them from pursuing the issue of work-relatedness, which at times escalate into angry outbursts by the physician and even dismissal of the patient from the physician's care.

Once the patient has been evaluated at the occupational health center, referral to other physicians is often deemed necessary by the CNYOHCC clinician. One reason for referral is to seek assistance in appropriately diagnosing a complicated or unusual medical condition. A second reason for referral is for treatment of the health condition. However, clinicians at the CNYOHCC have experienced great difficulty locating physicians willing to accept patients with Workers' Compensation claims.

Consequently, a study was designed to quantitatively assess the prevalence and nature of barriers to medical care for patients with work-related illnesses and Workers' Compensation claims. Barriers were assessed among physicians in selected specialties in the region served by the CNYOHCC.

Two sets of barriers were explored in the study. The first set included whether practices accept any new patients, since only those taking new patients would be accessible to patients with Workers' Compensation claims, and whether patients with Workers' Compensation claims are accepted. The second set included whether practices accepting patients with Workers' Compensation claims would do so without preauthorization by the Workers' Compensation insurance carrier, without referral from a primary care physician, and with a self-referral by the patient.

REGIONAL ECONOMY AND GEOGRAPHY

The clinic serves a region that includes 15 counties in Central New York. The region runs roughly 200 miles north/south, from the Canadian to the Pennsylvania borders, and 100 miles east/west. Syracuse is the major metropolitan area in the region and is situated in the region's center. Other significant population centers include Utica/Rome, about 55 miles to the east of Syracuse; Binghamton, about 70 miles to the south; and Watertown, about 70 miles to the north. These cities are all less than half the size of Syracuse. The "North Country" is the name given to three counties that make up the northern part of the region. As

the name implies, this area is large, encompassing approximately one-third of the clinic's region, sparsely populated, and relatively remote.

The population centers in the region are typical northeastern cities with a history of a strong industrial manufacturing base that has shrunk considerably over the last few decades. In its place, services, most prominently health care, education, and financial/insurance-related, have become much more important. Some re-industrialization has also occurred, with mostly non-union smaller plants replacing the bigger unionized facilities. In the rest of the region, industrial facilities remain scattered, with a concentration of traditional heavy industry and mining in the North Country. For many years, the region has been mired in a phase of no or slow economic growth [6].

Throughout the region, including Syracuse, the relatively small population centers and large rural areas allow one or a few employers to play a large role in the local economy. Changes in the fortunes of these firms can ripple through the community, significantly impacting employment levels, taxes, consumer buying, and government services.

METHODS

All medical practices were identified using the yellow pages of 1999 telephone directories for seven areas within the region: Auburn, Binghamton, Cortland, Gouverneur, Ithaca, Syracuse, and Utica. These directories covered the vast majority of the region with the exception of the Oswego and Cooperstown areas. The Cortland and Ithaca areas were combined into one area as the directory listings were found to be virtually identical.

Specialties were selected using two criteria: relatively frequent referral to that specialty by the occupational medicine clinic; and the clinic's experience suggesting difficulty making referrals to a specific specialty. Specialties chosen were: Allergy; Dermatology; Ear, Nose and Throat (ENT); ENT/Allergy; Family Practice; Internal Medicine; Neurology; Pain Management; Physical Medicine; Psychiatry; Psychology; Pulmonary; and Rheumatology. Orthopedics was excluded because the occupational medicine clinic has not experienced great difficulty referring patients to physicians in this specialty. Other specialties were excluded because referrals are rarely, if ever, made by the clinic to them.

Specialists were identified by listings in the directories that separated practices and individual physicians by specialty. In two directories, Gouverneur and Ithaca/Cortland, practices and individual physicians were not listed by specialty. In these areas, specialists were identified by their specialty being listed along with, or as a part of, their name. Physicians or practices listed by name only in these directories were not included in the study. They were excluded because neither the occupational health clinic nor the injured worker would be likely to seek referral to a physician whose specialty was unknown.

Each identified practice was called and a scripted set of standardized questions was asked. Calls were made by occupational medicine clinic staff, a student intern, and a work/study student. No specific person, (i.e., an administrator, a clinician, a billing clerk) was requested, and it was left to the person answering the phone to decide if, and to whom, the call should be transferred. This protocol was felt to be consistent with the experience of the clinic or a patient attempting to access medical services of the practice.

If no one was available to respond at the time of the call, or an answering machine responded to the call, the practice was asked to call the occupational medicine clinic. Those practices not calling back were re-contacted twice to attempt to elicit a response.

The questions asked of all practices included:

1. Is the practice accepting new patients? If not, the interview ended at this point.
2. Does the practice accept patients with Workers' Compensation claims? If not, the respondent was asked the reason(s) why Workers' Compensation insurance is not accepted and the interview ended at this point.
3. Does the practice require pre-authorization by the Workers' Compensation insurance carrier prior to accepting the patient?
4. Does the practice accept self-referrals of patients with Workers' Compensation claims?
5. Does the practice require referral from a primary care physician prior to accepting a patient with a Workers' Compensation claim?

Responses from each practice were coded, entered into a computerized database and analyzed. Microsoft Access was the database used.

RESULTS

Number and Location of Specialty Practices

A total of 469 practices were identified and called. The distribution of the practices by specialty is shown in Table One. As might be expected, the primary care specialties of Family Practice and Internal Medicine were the most numerous, making up 45 percent of the total. Mental health specialty practices, Psychiatry and Psychology, were the next largest group, making up 26 percent of the total. The remaining nine specialties accounted for 29 percent of the total. Allergy, Dermatology, ENT, Neurology, and Pulmonary were all clustered at approximately 4 percent each. Physical Medicine, Pain Management, and ENT/Allergy practices were the fewest in number, each contributing 1–2 percent of the total.

Except for Psychiatry and Psychology practices, the response rate was nearly universal as documented in Table 1. Responses were obtained from all of

Table 1. Specialties Called and Responses Obtained
(Total Called = 469)

	Practices called	Practices responding	
Medical practice type	Number	Number	Percent
Allergy	18	18	100
Dermatology	20	20	100
ENT	22	22	100
ENT-Allergy	5	5	100
Family Medicine	119	117	98
Internal Medicine	92	90	98
Neurology	23	23	100
Pain Management	12	12	100
Physical Medicine and Rehabilitation	8	8	100
Psychiatry	67	48	72
Psychology	54	37	69
Pulmonary	19	18	95
Rheumatology	10	10	100

the Allergy, Dermatology, ENT, ENT-Allergy, Neurology, Pain Management, Physical Medicine and Rehabilitation, and Rheumatology practices. One of the Pulmonary and two of the Family Practices and Internal Medicine practices did not respond. In contrast, 19 of 67 (28 percent) Psychiatry practices, and 17 of 54 (31 percent) Psychology practices did not respond.

The geographic distribution of the practices is illustrated in Table 2. Practices located in the Syracuse area accounted for more than a third of the total, while the Auburn area contributed the smallest proportion, 2 percent. Three of the remaining areas, Gouverneur, Ithaca/Cortland, and Utica had roughly equal proportions of 13–14 percent, while Binghamton practices were more numerous, contributing just over 20 percent to the total.

Table 2. Medical Practices Called in Each Geographic Area
(Total = 469)

• Auburn	11
• Binghamton	99
• Gouverneur	59
• Ithaca/Cortland	66
• Syracuse	167
• Utica	67

THE FIRST TWO HURDLES: MEDICAL PRACTICES ACCEPTING NEW PATIENTS AND WORKERS' COMPENSATION

The distribution of practices accepting new patients by specialty is shown in Table 3. Psychiatry and Psychology stood out among the specialties due to the high proportion of practices, 49 and 46 percent respectively, not taking new patients. It should be noted, however, that 58 percent of the Psychiatry practices and 68 percent of the Psychology practices counted as not taking new patients were counted as such because they failed to respond to the survey.

Approximately 20 percent of both Family Practice and Internal Medicine practices reported being closed to new patients. Neurology, Pulmonary, and Dermatology had similar proportions of practices closed to new patients: 10–15 percent. A quarter of Physical Medicine Practices were not taking new patients, a total of two out of eight. All practices in the 6 other specialties reported accepting new patients.

Table 3 also illustrates the proportion of practices accepting patients with Workers' Compensation claims. Proportions ranged from a low of 21 percent among Psychiatry practices to a high of 92 percent among Pain Management practices. Allergists (22 percent) and psychologists (39 percent) joined Psychiatry at the lowest end of the range. ENT (55 percent), Pulmonary (58 percent), Internal Medicine (54 percent), Rheumatology (60 percent), and Dermatology (50 percent) were clustered in the middle of the range. Family Practice (69 percent), Neurology (72 percent), Physical Medicine (75 percent), ENT/Allergy (80 percent), and Pain Management (92 percent) practices made up the higher end of the spectrum.

GEOGRAPHIC DISTRIBUTION OF PRACTICES ACCEPTING PATIENTS WITH WORKERS' COMPENSATION CLAIMS

The geographic distribution of practices accepting patients with Workers' Compensation claims was roughly similar to the overall distribution of practices

Table 3. Barriers to Medical Care for Individuals with Workers' Compensation Claims by Specialty

	Practices called		Practices taking new patients		Practices accepting Workers' Comp		Practices not requiring authorization		Practices not requiring PC referral		Practices accepting patient self-referral	
Medical practice type	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Allergy	18	100	18	100	4	22	3	17	3	17	4	22
Dermatology	20	100	17	85	10	50	6	30	4	20	9	45
ENT	22	100	22	100	12	55	8	36	4	18	6	27
ENT-Allergy	5	100	5	100	4	80	1	20	2	40	2	40
Family Medicine	119	100	102	86	82	69	65	55	NA	NA	70	59
Internal Medicine	92	100	74	80	50	54	32	35	NA	NA	42	46
Neurology	23	100	21	91	18	78	6	26	3	13	1	4
Pain Management	12	100	12	100	11	92	2	17	3	25	6	50
Physical Medicine and Rehabilitation	8	100	6	75	6	75	3	38	2	25	4	50
Psychiatry	67	100	34	51	14	21	3	4	5	7	12	18
Psychology	54	100	29	54	21	39	8	15	10	19	16	30
Pulmonary	19	100	17	89	11	58	4	21	2	11	4	21
Rheumatology	10	100	10	100	6	60	3	30	0	0	1	10

shown in Table 2, with more practices in the larger population centers. However, Binghamton and Gouverneur were somewhat exceptional in that Binghamton had more and Gouverneur fewer practices that accepted Workers' Compensation than what might have been expected based on the total number of practices surveyed.

Binghamton was the only area surveyed in which there was at least one practice in every non-primary care specialty that accepted Workers' Compensation. In Syracuse there was one specialty in which no practice accepted Workers' Compensation, in both Ithaca/Cortland and Utica there were four, in Gouverneur there were eight and in Auburn there were nine. In both Gouverneur and Auburn there was no non-primary care specialty in which more than one practice accepted Workers' Compensation.

The geographic distribution of Allergy, Dermatology, ENT, and Pulmonary practices is illustrated in the Figures 1–4. These specialties were selected because referrals to them are more frequent relative to other specialties.

Approximately half the ENT, Pulmonary, and Dermatology practices reported accepting Workers' Compensation. The Dermatology practices accepting Workers' Compensation were distributed roughly proportionally to the total number of Dermatology practices. In contrast, there were no ENT and Pulmonary practices accepting Workers' Compensation in the Utica area. Specialists accepting Workers' Compensation were concentrated in the Syracuse and Binghamton areas.

Only approximately a fifth of the Allergy practices accepted Workers' Compensation. Strikingly, only one Allergy practice in the Syracuse area accepted Workers' Compensation.

ADDITIONAL HURDLES: BARRIERS TO CARE AMONG MEDICAL PRACTICES ACCEPTING WORKERS' COMPENSATION

Practices accepting patients with Workers' Compensation claims without requiring pre-authorization from the Workers' Compensation insurance carrier ranged from a low of 4 percent among Psychiatry practices to a high of 55 percent among Family Practitioners, as illustrated in Table 3. Fifteen to 25 percent of practices in five of the remaining specialties (Allergy, ENT/Allergy, Pulmonary, Psychology, and Pain Management) reported accepting patients without pre-authorization. Twenty-six to 38 percent of Dermatology, ENT, Neurology, Physical Medicine, Internal Medicine, and Rheumatology reported accepting patients without pre-authorization.

The proportion of practices in each specialty accepting patients with Workers' Compensation claims without requiring referral from a primary care practitioner ranged from a low of 0 percent among rheumatologists to a high of 40 percent among ENT/allergists. Twenty percent or less of Allergy, Dermatology, ENT,

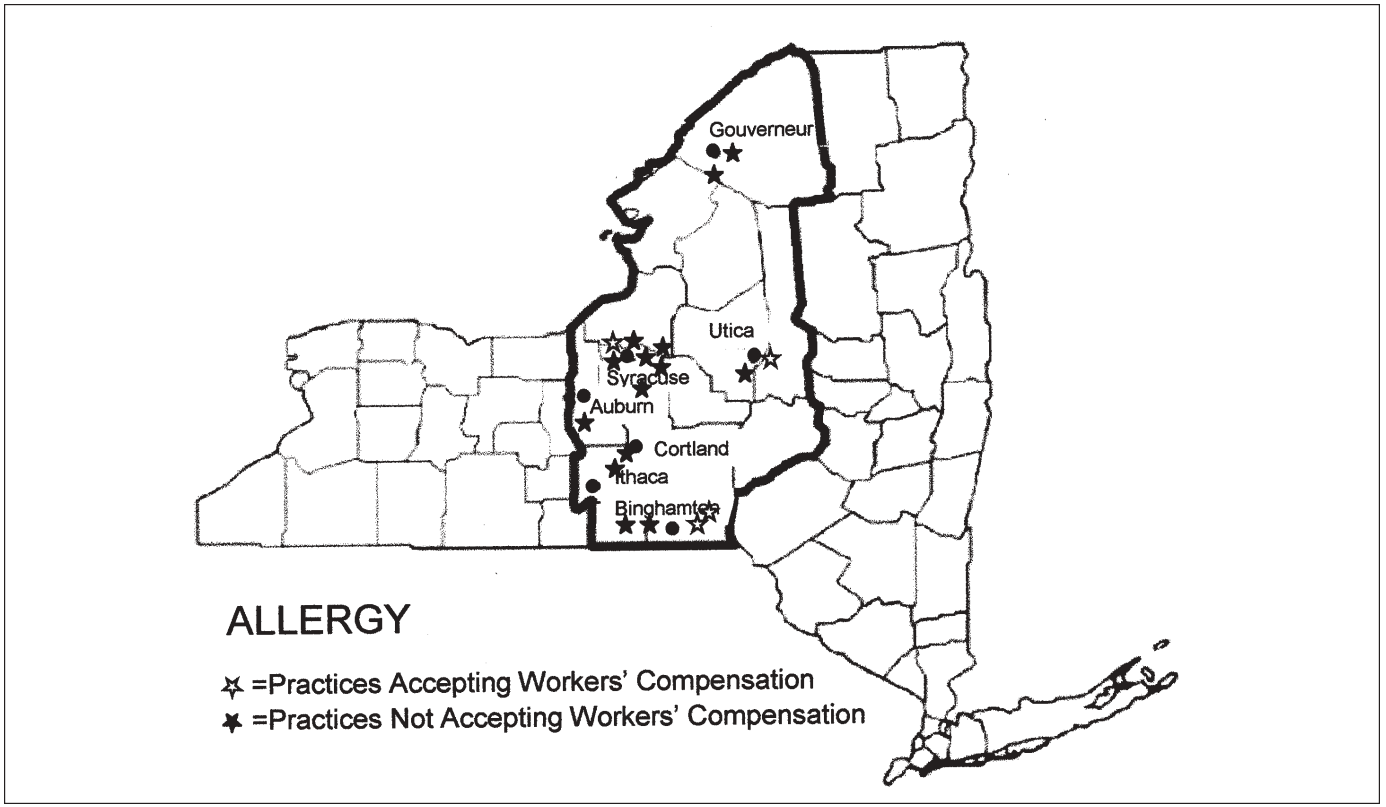

Figure 1. Where are they?: Locations of medical practices taking Workers' Compensation by specialty.

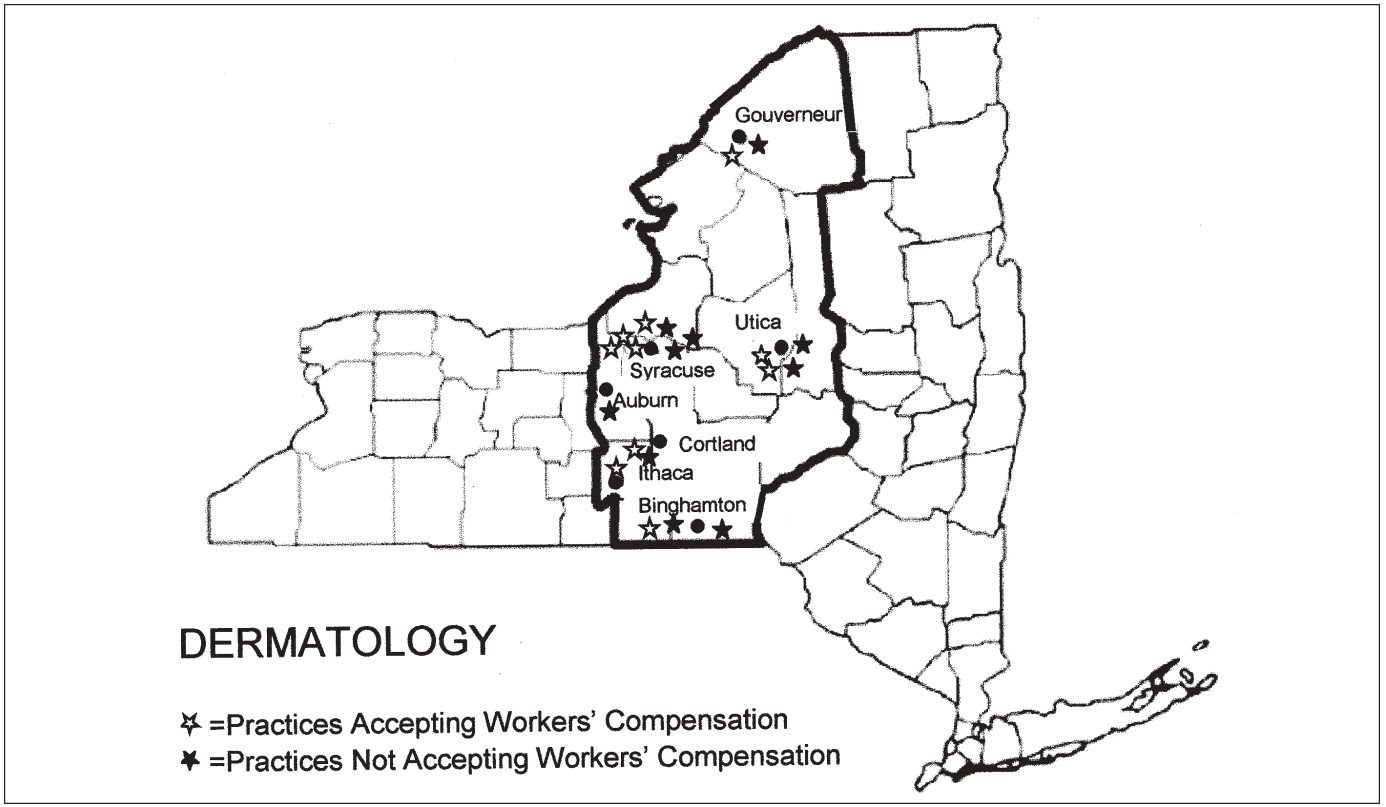

Figure 2. Where are they?: Locations of medical practices taking Workers' Compensation by specialty.

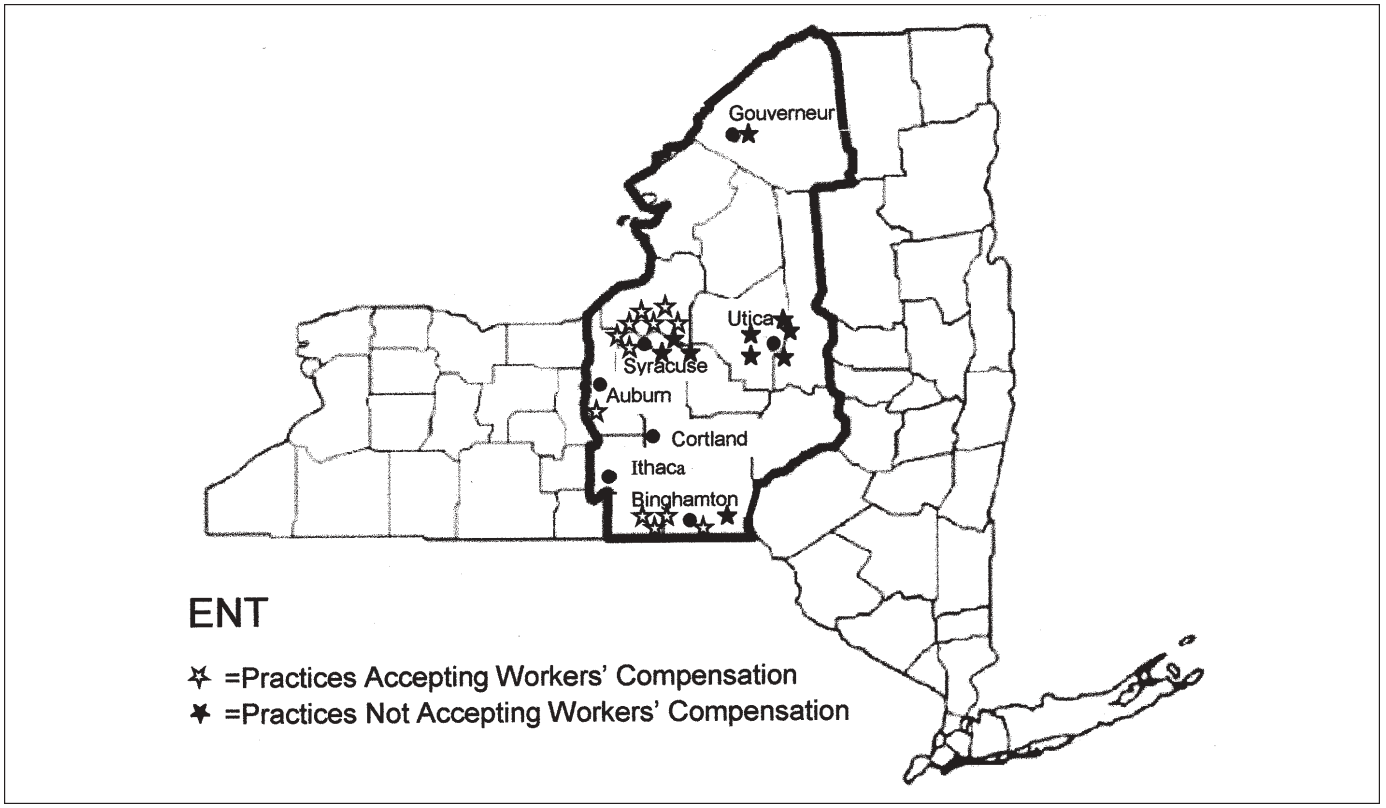

Figure 3. Where are they?: Locations of medical practices taking Workers' Compensation by specialty.

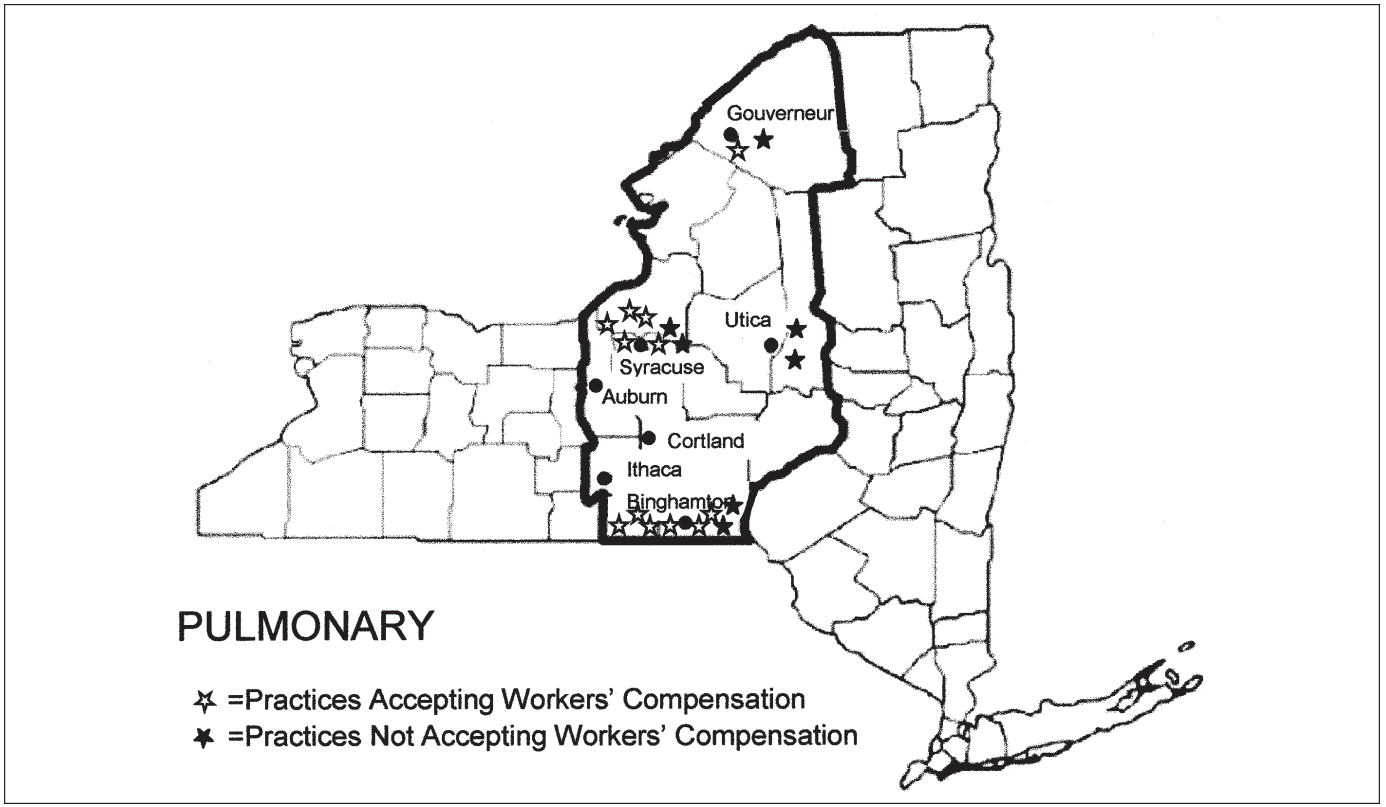

Figure 4. Where are they?: Locations of medical practices taking Workers' Compensation by specialty.

Psychiatry, and Neurology practices did not require a primary care referral. Twenty-one to 40 percent of ENT/Allergy, Pulmonary, Psychiatry, Pain Management, and Physical Medicine practices accepted patients with a primary care referral.

The third additional barrier assessed was the proportion of practices accepting self-referral of patients with Workers' Compensation claims. Neurologists ranked lowest in this category, with 4 percent of practices accepting self-referrals, while 59 percent of Family Practitioners accepted Workers' Compensation self-referrals, making them the highest ranked specialty. In between the extremes, fewer than 30 percent of practices among allergists, ENTs, pulmonologists, psychiatrists, psychologists, and rheumatologists accepted self-referrals. Twenty-one to 40 percent of Dermatology, ENT/Allergy, Pain Management, Physical Medicine, and Internal Medicine practices reported accepting self-referrals.

REASONS GIVEN FOR NOT ACCEPTING WORKERS' COMPENSATION

Many respondents stated they did not know why their practice would not accept Workers' Compensation insurance. All of the responses of those stating a reason or reasons were recorded. Several major themes were revealed by the responses.

Delays in payment and non-payment for services provided was commonly cited as a reason for not accepting Workers' Compensation insurance. The time-consuming nature of the Workers' Compensation process was another frequent reason for non-participation. Respondents noted that the process is generally fraught with problems, and more specifically that there is excessive paperwork. Some respondents' comments pointed to a distrust and/or fear of the legal system as an important reason for not participating. A suspicion that patients seeking Workers' Compensation are using the physician to pursue financial rather than health-related goals was also given as a reason for practices' avoidance of Workers' Compensation.

Examples of specific comments given are shown in Table 4.

DISCUSSION

A fundamental premise of Workers' Compensation legislation in New York, as in other states, was that workers with occupational injuries and diseases would have rapid access to medical care. However, the data collected in this study documents major barriers to care for workers in Central New York with Workers' Compensation claims. These barriers are widespread among 13 medical specialties and around a large geographic region. Clinical experience suggests that

Table 4. Common Reasons Stated for Not Taking Workers' Compensation

"It's the only thing we don't accept."
"Too many problems in past; too many reasons to list."
"Don't want to get involved; don't want to deal with it."
"Doctors don't want Workers' Compensation patients."
"Just had to stop; too much back-dated paperwork."
"Always a hassle getting paid."
"Do not have to."
"Never got into Workers' Compensation; don't know what it is."
"Too involved; just don't want to do them."
"Problems in court in past."
"Payment issue plus mixed motives of some patients."
"Prefer health insurance."
"Don't get paid if lose case."
"Don't want to; too busy."

unnecessary prolongation and progression of illness, suffering, and disability are major likely consequences of these barriers.

The lack of access to medical care documented in this study has relevance primarily to workers with occupational illnesses, including those with arm, neck, and upper back disorders associated with poor ergonomics. The specialties chosen for study were those utilized most commonly for referral by a specialized occupational health center with an occupational disease focus. Consequently, access to care for those with acute injuries and low back disorders was not assessed in this study.

BARRIERS

Lack of response to the survey was considered a barrier to accessibility. Each practice was called three times on different days. An explicit message regarding the purpose of the call was left each time. Consequently, it seems reasonable to assume that a lack of response indicates lack of interest in accepting patients with Workers' Compensation claims. Only among Psychiatry and Psychology practices was lack of responsiveness a significant issue.

A practice closed to new patients was also considered a barrier to access for patients with Workers' Compensation claims, as the total number of practices

was defined by telephone directory listings. Consequently, all practices listed were considered potentially available for referral and closed practices reduce the availability of medical care for patients with work-related illnesses.

Under New York State law, Compensation Insurance carriers must pre-authorize medical evaluation and treatment modalities that cost more than $500 for any claims that have been recognized as work-related [7]. Pre-authorization must be sought for any medical evaluation and treatment if the claim has been challenged or controverted by the insurance carrier. Controversion of occupational disease claims is routine and resolution is often quite prolonged [8, 9]. When a claim is controverted, insurance carriers routinely resist paying for medical testing or treatment. In the CNYOHCC's experience, it routinely takes up to a year to resolve a pre-authorization request that has been denied by the insurance carrier. It is not uncommon, however, for disputes to delay authorization well beyond a year. While the claim is disputed, workers may attempt to use their health insurance to pay for medical care while the case is moving through the Workers' Compensation system. However, the health insurance companies are not obligated to cover medical expenses related to care for a work-related malady. Even if the health insurer will pay, injured workers who are often financially strapped as a result of their illness and consequent loss of work income have difficulty affording the required deductibles or co-payments their policies mandate. In addition, many injured workers have no health insurance, having lost it when they left work because of their illness, or having never being covered to begin with. Consequently, when a medical practice requires pre-authorization by the Workers' Compensation carrier prior to the provision of care, this constitutes a significant barrier to care for the affected worker/patient.

Many practices also require referral by a primary care physician and/or will not accept a patient on the basis of a self-referral. Some practices choose this requirement to guarantee payment for the care provided. Some specialists base this requirement on their perception that referrals from another physician are more likely to be "serious," that is, of significant severity and within the specialist's realm of expertise. Many health insurance plans require referral by the primary care physician to the specialist in order for the services to be covered by the plan. Consequently, many worker/patients desiring access to a specialist must first obtain approval by their primary care provider and their health care plan. Primary care providers and health care plans vary in their willingness to refer. There is often pressure on the primary care provider to refer sparingly, and to refer only to other providers within the plan. The burden for injured workers without a primary care provider is even greater as they must first establish a relationship with a primary care provider, and then hope that referral to the specialist can be effected.

It would seem that the questions regarding primary care referrals and self-referrals are two ways of asking the same question. Logically, practices requiring

primary care referrals would not take self-referrals, while practices not requiring primary care referrals would accept self-referrals. However, in eight of the eleven specialties responding to both of these questions, a higher proportion of practices reported accepting self-referrals than those requiring primary care referrals. It is possible that some practices responded that a primary care referral was necessary when in actuality referral was preferred rather than unconditionally required. Another possibility is that the requirement varies, depending on the type of health insurance the patient has. Most practices participate in a variety of health plans, which may make it difficult to give one answer to these questions that covers all patients.

COMPARING SPECIALTIES SERVING SIMILAR FUNCTIONS

As noted earlier, almost half of the patients with work-related illnesses evaluated at the occupational health center are diagnosed with a respiratory disorder. These patients often require referral for diagnosis, testing, and treatment. Specialties referred to include Pulmonary, Allergy, ENT, and ENT/Allergy. Among pulmonologists and ENT specialists, options for referral are reduced almost in half by practices refusing to accept Workers' Compensation. Among allergists, the picture is even more dismal, with only four of 18 practices accepting Workers' Compensation. Particularly underserved by the lack of respiratory-related specialists are the Utica and North Country areas. In Utica, there are no pulmonologists, no ENT specialists, and only one allergist accepting Workers' Compensation. In the North Country, there are no allergists, no ENT specialists, and one pulmonologist accepting Workers' Compensation. In contrast, 80 percent of the pulmonologists and ENT specialists and half of the allergists in the Binghamton area accept Workers' Compensation. Requiring pre-authorization and/or primary care referrals, and not accepting self-referrals, reduce the patient's options further. For ENT and Pulmonary, these reductions are substantial, as two-thirds of the ENTs and four-fifths of the pulmonologists require pre-authorization. Approximately four-fifths of the allergists, ENTs, and pulmonologists require primary care referral and reject self-referrals. As a result of these combined barriers, patients with work-related respiratory disease face formidable barriers to medical care. In the eastern and northern parts of the region, patients typically travel at least 50, and sometimes almost 200, miles to obtain medical care.

Referrals to Physical Medicine and Rehabilitation (PMR), Pain Management, Rheumatology, and Neurology specialists are frequently necessary for patients with work-related musculoskeletal disorders (MSDs). Referrals for these conditions are also commonly made to Orthopedic surgeons. Individuals with MSDs evaluated at the occupational health center typically have chronic and complicated problems. Referral to an Orthopedic surgeon is usually made when

surgery and/or joint injection are deemed potential treatments. The occupational health center has not experienced difficulties making referrals for these purposes. However, the role of the orthopedist for most patients with MSDs seen at the center is limited as they do not require surgery or injection or they experience ongoing problems even after treatment by the orthopedist.

In comparison to the specialties treating respiratory conditions, specialties involved in treating MSDs reported higher rates of acceptance of patients with Workers' Compensation claims. Approximately 10 percent of the pain management groups, 25 percent of the neurologists and PMRs, and 40 percent of the rheumatologists said they would not accept Workers' Compensation insurance. Compared to the respiratory-related practices, except for neurologists, overall there were fewer MSD-related specialty practices, and none was located in the North Country. Among this group, the rheumatologists were unique in that a higher proportion did not accept Workers' Compensation claims, significantly reducing or eliminating options in the population centers of Utica and Syracuse.

For those of the MSD-treating specialties accepting Workers' Compensation insurance, the existence of additional barriers greatly reduced their accessibility. Fewer than a fifth of pain management practices, a third of rheumatologists, a fourth of neurologists, and 40 percent of PMRs would accept a patient without pre-authorization. None of the rheumatologists, 13 percent of the neurologists, and 25 percent of the PMRs and pain management practices accept patients without a primary care referral. The frequency of these barriers among the MSD-treating specialties was comparable to those encountered by patients seeking referral to respiratory-related practices.

Patients seen at the occupational health center may require referral to a mental health professional for three major reasons. Individuals with chronic work-related illnesses often experience serious psychological sequelae, including depression, anxiety, and anger, and would benefit from psychotherapeutic intervention, including medication. Some individuals experience cognitive and emotional symptoms that may be a result of neurotoxic workplace exposures. Referral to a psychologist or psychiatrist may be necessary to further evaluate this possibility. Other patients experience significant stress on the job resulting in somatic and psychological symptoms. In these situations, referral to a mental health specialist is often made for treatment of this condition.

Access to mental health professionals for patients with Workers' Compensation claims is very restricted. In contrast to other specialties, almost half of the psychologists and psychiatrists did not respond or would not take new patients. Almost four-fifths of psychiatrists and just over three-fifths of psychologists would not accept Workers' Compensation insurance. Access was reduced even further by required pre-authorization, and primary care referral. The proportion of psychiatrists accepting patients without pre-authorization or primary care referral ranked just above the rheumatologists as the lowest of any specialty.

Psychologists also ranked toward the lower end of these categories. The Ithaca/Cortland area stood out geographically as 11 of 14 psychologists reported accepting Workers' Compensation, giving this relatively lower population area more than half of the region's total of psychologists accepting Workers' Compensation.

Patients evaluated at the occupational health center frequently require referral to a primary care physician. Usually these patients are diagnosed with a chronic condition such as asthma and require ongoing care. Often they also suffer from some untreated non-work-related health condition such as hypertension, which requires treatment. Some of these patients have no previous relationship with a primary care provider. Others have lost their relationship due to loss of health insurance. Some patients report feeling their primary care provider has become less supportive or even antagonistic after the patient has begun pursuing a Workers' Compensation claim. In those situations, patients often seek another provider or at times the provider encourages the patient to seek care elsewhere.

Around the region, patients with work-related illnesses would have greater access to a family practitioner who accepts Workers' Compensation than a specialist in Internal Medicine. More than two-thirds of the Family Practices surveyed reported accepting Workers' Compensation compared to just over half of the Internists. Family Practitioners ranked the highest of any specialty with regard to not requiring pre-authorizations and acceptance of Workers' Compensation-related self-referrals, whereas Internists were in the middle of the range compared to other specialties on these measures. While Family Practitioners did well relative to the other specialties surveyed, it should be recognized that a substantial proportion of practices do not accept Workers' Compensation, and many that do accept it reported additional barriers to access.

Occupational skin disorders are relatively commonly diagnosed at the CNYOHCC and sometimes require referral to a Dermatologist. In a pattern similar to many of the other specialties surveyed, only half the Dermatology practices around the region reported accepting Workers' Compensation, fewer than a third accepted patients without pre-authorization, and only a fifth accepted patients without primary care referral. In contrast to most other specialties, Dermatology practices accepting Workers' Compensation were located in every area of the region, including two in Utica and one in Gouverneur. In the Binghamton area, only one out of three Dermatology practices accepted Workers' Compensation insurance.

GEOGRAPHIC MALDISTRIBUTION

Medical care is not distributed evenly throughout the region studied. Non-primary care specialists tend to cluster in the population centers. Consequently,

many individuals in large areas of the region, particularly the North Country, must travel significant distances for medical care. The issue of Workers' Compensation exacerbates these disparities as choices for medical care are restricted significantly further by the high proportion of practices in every specialty not accepting Workers' Compensation or maintaining other barriers to access.

Among many specialties, the proportion of practices not accepting Workers' Compensation did not reflect their overall geographic distribution. For example, of eighteen Allergy practices, six are located in the Syracuse area. Only one of the six accepts Workers' Compensation. Since the survey was completed, the one allergist accepting Workers' Compensation has left the area. Among other specialties, the North Country and the Utica areas were particularly underserved, leaving patients with a drive of one-and-a-half to as much as three hours to receive medical care.

UNDERESTIMATION OF THE PROBLEM

The barriers to medical care for patients with Workers' Compensation claims identified and measured in this study most likely underestimate the barriers patients with work-related illnesses face. Respondents refusing Workers' Compensation gave a number of reasons for their refusal, including payment delays, paperwork demands, and a desire to avoid legal entanglements. Physicians participating in the Workers' Compensation system experience these same problems and a number of those who do accept Workers' Compensation may harbor attitudes toward the system similar to those of their non-participating colleagues. Consequently, despite nominally accepting Workers' Compensation, some may seek to avoid participation through informal mechanisms [10-12].

Avoidance may be achieved in a number of ways, all of which have been reported by patients evaluated at the occupational health center. Physicians may tell patients they lack expertise to make a decision regarding work- relatedness or to assess impairment and/or disability. Some patients report their physicians have agreed the patient's problem is work-related, but have discouraged the patient from pursuing a Workers' Compensation claim because they are unlikely to win or face a long fight. Other patients perceive changes in their physician's attitude ranging from a subtle coolness to outright hostility and anger when the patient has expressed a desire to pursue Workers' Compensation.

Other informal barriers may be created by the physician's general attitude about workers, as well as his or her relationship to local employers. In many areas of the region, the local economy is dominated by one or a few large employers. On a number of occasions, patients evaluated at the occupational health center have reported their physician has explicitly expressed reluctance to offend an employer by recognizing a work-related illness. Other patients have suspected

similar reluctance without explicit "proof" [13]. Patients have also reported that their physicians seem suspicious of them for wanting to pursue a Workers' Compensation claim. Some have had the experience of their doctor asking them directly what they hope to gain by filing a claim and if there is some agenda other than health that the patient is pursuing. These patient observations are corroborated by direct interaction between the occupational health center and other physicians, which has revealed prominent suspicions of malingering, secondary gain, and patient character weakness.

Physicians may not have an understanding of the benefits Workers' Compensation provides, and the impact benefits might have in relieving the financial burden for an injured worker. Without such understanding, many physicians do not see the need to expend time and energy pursuing Workers' Compensation when reimbursement through health insurance is so much easier.

These patient reports and physician interactions strongly suggest that a practice's stated policy of acceptance of Workers' Compensation insurance claims is not a guarantee that acceptance is easy or enthusiastic. The existence of informal barriers greatly compounds the problems patients face accessing medical care for their work-related illnesses.

VALIDITY, GENERALIZABILITY, AND OTHER ISSUES TO CONSIDER

This study was designed to assess barriers to medical care for individuals with Workers' Compensation claims from the perspective of a community-based occupational health center attempting to make a referral or a patient attempting to make an appointment. Because of the large geographic area the clinic serves and the opening of new medical practices over time, the clinic often calls practices to make referrals without knowing whether the practice accepts Workers' Compensation insurance. When these calls are made, the clinic relies on the person answering the phone for the practice to determine if s/he can respond to the questions regarding acceptance of Workers' Compensation and other details of referral or to say if another individual would be more appropriate. It is possible that respondents may have given information that would be judged incorrect by the practice's owner or manager. However, this is irrelevant to this study, which replicated the clinic's real-life practice and would likely simulate the experience of a patient.

Telephone directories were used to identify and define the number of practices. It is unlikely that this method missed any practices except those that might have moved into the area since the directory was printed or those choosing not to be listed. Since the time since printing was less than a year, the number of practices missed for this reason likely was very small, if any. It can reasonably be assumed that all medical practices seek to be listed in the directory. Consequently, the

method used to identify practices should be considered a valid way to identify all medical practices in a given area.

Other issues that may have affected the results and conclusions are discussed below. The study surveyed medical practices instead of individual physicians. If large practices were more likely to accept Workers' Compensation than smaller ones, then the study would overestimate the problem of access. Conversely, if larger practices were more likely to not accept Workers' Compensation claims, the study would underestimate the access problem. Information on practice size was not consistently available. Clinical experience and available information on practice size provide evidence that, except for the primary care specialties, the vast majority of specialty practices are relatively small, and that "large" practices are neither numerous nor large enough to significantly impact the results and conclusions, even if a pattern of acceptance of Workers' Compensation insurance by size of practice could be discerned.

It was assumed both that the responses elicited from a practice regarding the acceptance of Workers' Compensation insurance applied to all physicians in the practice, and that the responses elicited were valid and uniform for patients with any type of health insurance. Most medical practices are likely to strive for administrative simplicity. Toward this end, physicians and/or administrators charged with running a practice would develop standardized billing policies for the practice. In fact, the collected data supports the validity of these assumptions. When asked whether their practice accepted Workers' Compensation, no respondent indicated the answer varied depending on each individual physician. Only a handful of practices indicated their policies varied depending on whether a patient belonged to a Health Maintenance Organization (HMO) or not.

CONCLUSION

This study documents and quantifies a number of significant barriers patients with work-related illnesses face when attempting to obtain medical care for their condition. While this study focused on Central New York, the Workers' Compensation system is a statewide system, and the conditions impacting medical practices in central New York are likely to be similar across the state. The problem of restricted access to medical care is potentially an extremely serious one for patients with occupational illnesses. As appropriate treatment is denied or delayed, patients' suffering and disability are unnecessarily prolonged and severe, and livelihoods and long-term health are threatened. While Workers' Compensation reform has been on the political agenda for a number of years in New York, these efforts have not effectively addressed the fundamental issue of access to medical care [14, 15]. Attention to this issue is critical if the Workers'

Compensation system is to serve the needs of injured workers in the way it was originally intended.

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