Copies of Email Attachments Sent In on the Subject of the Workers' Compensation Forums held in April, 2012

Part 3

Prepared by the Department of Industrial Relations

Note: Emails were sometimes sent prior to a Forum date, following a Forum date, and regardless of a sender's appearance at any particular Forum. What follows are attachments from emails received as PDFs, and are generally considered professional correspondence related to the public Forums; therefore, most of the attachments are not redacted.)

Stay-at-Work/Return to Work Considerations for the CA Department of Industrial Relations and CHSWC

The Commission on Health and Safety and Workers' Compensation (CHSWC) was established to evaluate the health, safety and workers' compensation systems and make recommendations for administrative or legislative modifications to improve the system.

Over the years, the California workers' compensation system has seen significant changes in statutory provisions pertaining to RTW practices for employees with work-related injuries/illnesses, causing functional disruption. As one example, see the Commission's recommendations pertaining to the application of Labor Code 139.48 (https://www.dir.ca.gov/chswc/Reports/2009/ReimbursementProgramRecommendations2009.pdf.) As another example, consider the ways in which the State of California has legislated RTW practices when an injured worker has been permanently precluded from returning to his/her usual work (e.g., the vocational rehabilitation system and the supplemental job displacement voucher) due to a work-related condition.

The Commission has authored various bulletins and other information to support more effective RTW practices. Examples of such publications include, "Helping Injured Employees Return to Work Handbook (2010)," and "Best Practices in Returning an Injured Employee to Work: Factsheet for Employers (2010)."

The California Consortium to Promote SAW/RTW (www.casawrtw.org established September 2007) requests that CHSWC consider conducting an evaluation of holistic SAW/RTW best practices in and beyond California.

- The CA Consortium (voluntary, comprised of professional, labor and business stakeholders) is an active and interested party in SAW/RTW practices, whether necessitated by functional impairments derived from work-related, or from personal (non-work-related) health conditions here in California
- Members of the Consortium believe that that such a study should at minimum examine what the State of California can do both legislatively and administratively to support Stay-at-Work options once an employee has sustained a functional impairment, irrespective of its origin or medically anticipated duration, as well as to minimize the extent of any temporary work disability should time entirely away from work be medically necessary.
- The California Consortium to Promote SAW-RTW presumes the practical equivalency of the value, to an employer, of the productive engagement of its workforce to the fullest extent of each worker's capability, within positions for which individuals were hired, irrespective of the circumstances of acquiring functional impairment.

This study should consider such factors as:

- Program models that are SAW-RTW outcome-oriented, e.g., are characterized by provisions that actively deliver the earliest interventions possible, designed to support transitional and/or reasonably accommodated work to employees affected by functional work disruption (physical and or mental, in accordance with CA's FEHA) due to new or emergent functional impairments
- Systems and standardized processes, including forms and communications for documentation of time away from work, transitional work assignments and the interactive process for reasonable accommodation (e.g., evaluate whether, and how these promote or discourage productive activity during healing)
- The active presence of reasonable options to assist injured employees in remaining in or returning to work when a return to their usual (pre-functional impairment) work activities has been medically precluded (e.g., evaluate whether and how the former VR and the current supplemental job displacement voucher processes provide such reasonable options; or, what reasonable alternatives might enhance or replace ineffective processes)

- To consider the State of Oregon's Employer-at-Injury Program or other similar programs around the country to determine if such approaches may be effectively adapted to benefit California employers and employees
- To consider the ways in which the Workers' Compensation Information System can be used to provide information on the financial impact of lost time, particularly in those cases where lost time is continuous and extensive (e.g., how do average claim costs escalate as days away from work mount from 7 to 30, 60, 90 days and beyond)
- To consider the extent to which the current 15% swing in permanent partial disability benefits (CA Labor Code) fundamentally influences, positively and/or negatively, SAW-RTW practices by employers
- To build an environment within the State of California through communications and policy execution that demonstrates to all stakeholders the State's strong and rationale support for SAW/RTW objectives, irrespective of the statutory framework (California Civil or Labor Codes) within which such responsibilities, financial and employment-related, are presently defined.

It is the view of Consortium members that the health and safety of employees is driven by a continuum of injury prevention and mitigation model that derives from six fundamental features. These features include:

1. A solid workplace injury and illness prevention program
2. Advocacy (e.g., State policy and program model) for individual and shared responsibilities for general health and well-being at work, in families and in communities, of working age Californians
3. An immediate and affirmative response by employers to employee complaints when they demonstrate symptoms reasonably attributable to work conditions or functions (e.g., ergonomic needs), minimizing the likelihood that a workers' compensation injury claim need be filed
4. An early intervention approach that supports keeping employees at work during healing from any disruptive functional impairment resulting from workplace injury, illness or a personal health condition (exclusions compliant with FEHA restrictions)
5. A Stay-at-Work/Return-to-Work program that meets the objectives of reducing medically unnecessary days away from work while appropriately using safe, productive engagement in the workplace to enhance healing
6. Other services that support SAW-RTW for employees, whose employers are compliant with FEHA and its rules and regulations, providing the interactive process for reasonable accommodation; and the full integration of this effort so as to meet existing opportunities and obligations under the Labor Code (accommodation as return to a permanent, modified position); as well as support for RTW through external, or out-placement when an employer is not able to accommodate an employee's compromised work abilities

Along this continuum of injury/illness prevention and mitigation, the audience for services declines. Most employees maintain safe work records but all benefit from injury/illness prevention programs. A lesser number of employees have workplace complaints (symptomatic of strains which could be mitigated before amounting to injuries.) Still fewer employees file workers' compensation claims, and so on through the continuum. We believe a serious study of effective policies and practices as suggested above could reinvigorate California's aspirations to become a "full productivity" state, and for developing a model for work disability prevention and mitigation.

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April 27, 2012

To: Christine Baker, Director
California Department of Industrial Relations

Rosa Moran, Administrative Director
Division of Workers' Compensation

Re: Comments Submitted to the Public Forum on Workers' Compensation

Dear Ms. Baker and Ms. Moran:

We represent PPG Aerospace Products, a global aerospace business headquartered in Sylmar in Los Angeles County. PPG Aerospace is a business unit of PPG Industries, a diverse manufacturer of coatings, chemicals, glass, fiber glass and specialty materials. PPG operates 16 manufacturing, research, distribution and retail facilities throughout the state of California with over 1000 employees.

We participated in the April 16 Public Forum on the California Workers Compensation system in Los Angeles and thank Governor Brown, the state legislature and both of you for that opportunity to present our perspective. The Los Angeles Forum was well-run, and it was clear that both of you were very interested in all the verbal comments offered.

PPG has been in business since 1883, and we know a great deal about operating modern, high tech and safe businesses. Employee health and safety is a top business priority, and we invest millions of dollars each year in training and safety improvement in our facilities in California, across the country and worldwide. Our high safety, health and environmental standards are applied consistently wherever we operate.

In the United States we have operations in 40 states. Accordingly, we have experience managing workers compensation over a wide spectrum of state programs. The California system is certainly one of the most costly for PPG. In 2011, our California operations represented more than 23% of our total company workers compensations costs even though less than 8% of our workforce in located in the state. PPG's California costs have risen more than 25% since 2009. Our Aerospace business operations located primarily in the Los Angeles area have seen their costs increase almost 70%. The costs have continued to rise during the first three months of this year.

These rising costs negatively affect our business in two very significant ways:

- First, by increasing our overall labor costs (over $1 for every labor hour), these workers' compensation cost limit our ability to offer the competitive salaries and benefits necessary to attract and retain a high tech workforce; and
- Second, they make our California operations less attractive for business investment.

As a global company, we have many options for investing in our businesses. If workers compensation costs continue to rise, we will not be able to make the kind of investments that help retain and grow jobs here in California.

So what are some of our ideas for addressing this major challenge? First of all, we do not believe that there is a need to completely overall the reforms enacted between 2002 and 2004. However, some stakeholders have learned new ways to exploit loopholes in the system. Those loopholes are driving up overall costs and those extra costs are not delivering benefits to injured workers. We recommend legislative action on the following four high priority areas:

- **Medical liens** – The new cottage industry of medical liens (particularly in Southern California) is forcing employers to address medical services costs that can be 5 to 10 years old and may be totally unrelated to the original occupational injury. Resolution of medical liens ties up the work of the Workers Compensation Appeals Board and drives up costs without providing any benefit to injured workers. To the best of our knowledge, no other state allows medical liens in their workers compensation systems. We support Senator Ted Lieu's bill SB 863 as a step in the right direction to limit this abuse.
- **Over prescription of Opioids and other Painkillers** – The excessive use of opioids is both a public health crisis and one of the leading causes of the rise in Workers Compensations costs. Employers pay many times for this problem; once for the drugs and again for the rehabilitation from addiction to these powerful drugs. Legislation is needed to ensure that the prescription of these drugs can be tracked and abuses prevented. In addition, regulations to revise the medical fee schedule could save an estimated $150 million. These types of cost savings could be used to increase the PD for injured workers.
- **Support reform of Permanent Disability (PD) rating schedules** – The new PD schedules were intended to reduce costs by $115 million per year but have instead increased costs by $240 million. We would like to see the PD 15% bump up/down eliminated from the system as it has created more expense for employers without delivering benefits to injured workers. We know that this will be a challenging issue to address and will take further evaluation and discussion to resolve. We hope that the Public Forums will generate some useful ideas for reform.
- **Review the Panel QME Process:** The current system takes too long to set up panels and encourages more litigation. Consideration should be given to the prior L.C 4060 defense/applicant consults for disputed cases rather than waiting for the state to issue a Panel QME.

These can be the first steps towards the meaningful reform needed to bring California Workers Compensation system costs under control and help ensure that the money spend goes primarily to legitimately injured workers. PPG will remain actively involved in this important reform process. Taking meaningful steps to reform the Workers Compensation system is a critical part of helping California be a competitive place to do business.

Thank you.

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EVIDENCE-BASED WORK CAPACITY EVALUATION ADVISORY COMMENTARY

PREPARED FOR THE

CHRISTINE BAKER / EXECUTIVE DIRECTOR / CA DWC

"The mark of a high society lies in its ability to provide meaningful compulsory employment for all able-bodied citizens. Today, the disability industry whose responsibility it is to define an "able" body stands at a perilous crossroad. One path of this road promotes the dignity of work as a therapeutic necessity essential to personal health and happiness, as well as, ensuring social and cultural stability; the other path – the current dominant discourse – is the "disease mongering of pain" – an escalation of unsubstantiated, pain-based (subjective) disability loss - that is fraught with rampant entitlement and discordant unfairness. This second path is also leading us to a precipice of unprecedented losses, that in the ensuing "death spiral", will threaten the very fabric of our economy if it remains unchallenged...FOR PAIN IS AN "UNSOLVABLE" PROBLEM. The pivotal challenge and victory that must be won, rests in our willingness and diligence as a society to promulgate equitable compensation (both monetary & treatment) based on true, objective, scientific, medical findings of "capability" (I CAN)...and to challenge, counter and curtail subjective, anecdotal and universally overstated guesstimates of "disability" (I CAN'T). The battle will be fierce, complex and difficult...true change always is...the lines of conflict are even now being drawn...nationally our overburdened disability system is stumbling under the weight of unsustainable enablement and is about to fail...it's time for the bar to be raised...the need for a paradigm shift is upon us...our call to participate has gone out...will we choose to lead or follow?" Bruno Kovacic / BioFunction®

Dear Ms. Baker,

Please accept the enclosed commentary as our suggestions for the development of regulatory reform leading to the creation of a more objective method for determining injured worker permanent impairment and work disability. In our opinions much of the "waste" of the system lies in the lack of an objective tool for measuring work capability; while the "disease mongering of pain" by others to exaggerate disability continues to erode our system.

Our outcomes (see enclosed outcome flier) show that by adopting a more objective system of work capability assessment that substantial cost savings and a greater fairness for all will be achieved. Stop to consider that Joyce Guzman, of the Almaraz-Guzman II ruling, was full duty capable even 5 years after her injury; yet this case formed the central arguments of a ruling on "work disability" that has placed further financial burden on employers by increasing settlement costs resulting from physicians who "analogized" [guesstimated] work disability.

The Members of our Advisory Panel are independent multi-disciplinary providers of evidence-based Work Capacity Evaluations. Our members are regular contributors to the advancements of physical performance systems in use today. Our Advisory Panel exists for the purpose of providing a formal expert group for use as a resource, to enhance the scientific credibility of physical performance testing, and to promote the learning and understanding of complex concepts that materially affect the disability industry today.

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PHYSICAL PERFORMANCE TESTING

Physical performance testing (as per the California Medical Fee Schedule) can be separated into 2 categories:

- Function Capacity Evaluations (FCE) [CPT 97670] – Functional capacity measurement (e.g. combination of standardized tests of strength, flexibility, weight lifting, weight carrying, and pushing & pulling movements to determine functional ability.
- Work Capacity Evaluations (WCE) [CPT 97660] – Work tolerance testing (work simulated testing or testing related to the physical requirements of a specific work task or a field of work.

While all physical performance tests are not the same, each test can be weighted and separated into 3 primary and essential examination components:

- Data Collection Methods
- Analysis Methods, and
- Scientific Basis

A sound physical performance test must encompass robust methods for meeting each of these essential component areas in order to have the ability to objectively determine an injured individual's safe and sustainable work capabilities.

FUNCTIONAL CAPACITY EVALUATIONS (FCE)

FCEs are by far the most prevalent physical performance tests used in the disability industry today. It should be noted the use of the term "FCE" has generally been misapplied in the disability industry to include all types of disability assessments. This has caused great confusion when "real world" test choices are considered.

To a more discerning audience, the comparison of a FCE to a WCE would be like comparing an x-ray to a MRI. While both are physical performance tests, with respect to the specificity of the work capability image obtained, there are little comparisons between these two types of evaluations.

Data Collection

FCEs are essentially subjective manual observation tests that are limited by the test subject's pain reactions. FCE examinations will typically last 1-2 hours. During data collection FCEs use minimal test samplings of motion with little or no occupational or job correlation. Test termination (test end-points) occurs when the examinee reports either pain, or an increase to pre-existing pain levels.

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The minimal test sampling, with or without pain, conducted by most FCEs is frequently insufficient to meet the criteria for scientific validity, and the assumption that pain is a functional inhibitor is erroneous and not supported by medical & exercise physiology research.

Pain is a behavior (not pathology) that may influence an individual's desire to use their muscles, but it does not influence the strength and endurance capability (the ability to work) of those muscles. There are no physiological changes to the cellular, actin, myosin, and/or sarcomeric myofibril bundles that make up muscle tissue as a reaction to pain.

Notwithstanding, most FCE's end-results are frequently reported based on this early termination of test activities due to discomfort complaints and/or behavioral interferences being used by the examinee to obtain a lower test score [i.e. greater disability]. This is because FCEs cannot objectively separate "what an examinee actual can do" from "what they want, or feel, they can do."

In analyzing FCE data collection techniques there is great variation noted between competing methods, as well as, within the same FCE method itself. Because of the manual nature of FCE instructions there is also considerable variances in how they are administered leading to criticisms of favoritism & discrimination, and FCEs do not use definable objective test end-points making their exams "pain-focused" assessments.

FCEs also do not have the ability to objectively test for varied levels of work motion frequencies involving occasional, frequent or constant movement patterns. As a result, their conclusions are severely static in application to real world use where motions are dynamic and variable.

Analysis Methods

With respect to the contrasting of the FCE examinee's work performances, to a comparative analysis benchmark or standard, most FCE tests use "normative" or "norms" testing. This is a comparison of an injured individual's disability levels to the physical tolerances of a "healthy" non-injured worker population. The inherent error in this analysis approach is that the "healthy" control group is universally non-homogenous with the psychographic and disability characteristics of the individual being tested.

Correspondingly, FCEs are relatively easy to discredit in a med-legal setting. They also expose employers and insurance carriers to discrimination claims under The Americans with Disability Act (ADA), based on the ADA's inclusion and accountability standards for proper disability and employment testing. As a result, "norms" comparisons are suspect. This has lead to higher costs as opposing sides battle for acceptance of their opinion based on who as the biggest gun during legal and administrative hearings. This approach fosters an advocate for each side rather than a "finder of fact" approach using science and objective measurement of work performance.

FCEs also make no attempts to cross-validate an examinee's work performance to correct for "best effort" capability. Because of the short duration of testing the results are limited to those tolerances which the examinee feels or desires to do. FCEs do not require examinee's to confront pain-focused beliefs to discover their true work capability levels and instead limit such testing up to this pain response.

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Scientific Basis

As a general rule the scientific basis of FCE tests is minimal and vulnerable to much criticism. FCE tests use "face validity" (observation) science, which is the lowest form of scientific validity and reliability for determining conclusions. FCEs frequently do not have complete original peer-reviewed published science (validity, reliability, reproducibility, clinical, longitudinal and/or restoration studies) to support their methodologies or conclusions.

These examinations have poor test construct (design, test administration and control) and rely heavily upon an evaluator's anecdotal (best guesstimate) experiences to determine work capability. They are unable to determine 8-hr workday capacity (as defined by the US Department of Labor's Dictionary of Occupational Titles) which considers the effects of fatigue over a prolonged period of time, generally defined as an 8 – 12 hour workday in most occupational settings.

The American College of Occupational & Environmental Medicine (ACOEM[1]) & California Medical Treatment Utilization Schedule (CA MTUS) warns:

"Though functional capacity evaluations are widely used and promoted, it is important for physicians and other to understand the limitations and pitfalls of these evaluations. Functional capacity evaluations may establish physical abilities, and also facilitate the examinee/employer relationship for return to work. However, FCEs can be deliberately simplified evaluation based on multiple assumptions [evaluator bias] and subjective factors [pain-test] which are not always apparent to their requesting physician."

As a result, there is poor physician confidence in this form of testing as it universally overstates disability and frequently becomes nothing more than a "pain test", which offers the clinician no credible information of an injured individual's true work capabilities. In addition, some research shows that an experienced physician's anecdotal guesstimate of an injured individual's work capability is actually closer to the individual's true work levels than what an episodic FCE test can actually measure.

Typical FCE systems used today include:

- Matheson
- Blankenship
- Iserhagen
- KEY
- ErgoScience
- WorkAbility
- WorkSteps

[1] ACOEM Occupational Medicine Practice Guidelines; pp. 137-138

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TECHNOLOGY-BASED WORK CAPACITY EVALUATIONS (WCE)

Contrastively, the later appearing technology-based Work Capacity Evaluation was designed to replace many of the poor manual examinations practices of a FCE. There have been many who have resisted this premise, and have sought to persuade politicians that a "cold-reading" by a machine is not compassionate, in order to either preserve their control of the test outcomes or to perpetuate the status quo of "I feel pain, so give me money".

Most technology-based physical performance systems today can trace the scientific content of their methodologies back to the 1940's, where under the War Manpower Act the inclusion of time-motion studies (Methods-Time Measurements / MTM Association) became part of what is today a court-tested, international, industrial work standard for work speed and efficiency. Time-motion studies have also been the foundational instrument used in developing both the Scientific Management and Human Factors Engineering industries of today. MTM also accommodates the reality that persons with disability have the capacity to perform work.

Spinoscope

Spinoscope was an early technology version of what are known today as "work simulators". This technology attempted to "marry" a manual functional capacity evaluation with a surface EMG. It was a cross-over technology approach that attempted to base muscle strength on more objective grounds than manual observation.

Even so, it was later found, by the University of Vermont's Back Research Center [SPINE] to be non-scientific. The error of this technology was due to its use of surface EMG that could not account for the variability of fat layers under the skin. This created many false positives and negatives eventually leading to the loss of confidence in its conclusions. This technology has been antiquated for sometime; however, a few users are still known to remain who continue to promote its use, even in the courts.

ARCON / Hanoun (BTE)

Two other simulators that have come to market are the ARCON (VerNova) and Hanoun (BTE) systems. These devices use more robust redundant motion sampling tests to improve the validity of the examination. But, the biggest drawback of these devices is they persisted in the use of "normative" test result comparisons even to this day, and they did not allow for the left-right separation of motions, which are needed to properly assess many upper extremity injuries and real world work tasks.

Even so, of recent, these systems have begun using time-motion studies due to market demands forcing these deficient systems to contain more objective analysis methods. But, it is important to note that they still lack the essential scientific studies to prove validity, reliability, reproducibility, clinical, longitudinal and/or restoration outcomes for their specific methodology as these studies have not yet been completed by their manufacturers.

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ERGOS Work Simulator

The last of the simulators is the ERGOS Work Simulator (Work Recovery Systems). This is the only technology-based WCE that has relied exclusively on "criterion-based" performance testing since its original design. Criterion-based validity is the extent to which a test measure is able to demonstrate its relatedness to a specific concrete motion criteria found in the "real world" (i.e. true simulation). Criterion-based performance testing is free of all ethnic, gender, age, disability, and evaluator biases. Criterion-based testing simply asks "can they perform a particular motion, or not?"

Other advantages in the ERGOS system included the use of robust performance tracking capabilities through work speed & efficiency (MTM), and qualitative & quantitative work-effort (muscle-force contraction measurement) performance metrics. These metrics opened the door to the objective segregation of muscle strength & endurance from behavioral pain & psychosocial reactions to motion, albeit these reactions remained non-differentiated. In addition, the technology's use of cognitive distraction [blinded] testing capabilities provided further solidification of their results, and the left-right test performance separations were part of the technology's original manufacturing design.

To date, the ERGOS Work Simulator has published independent, peer-reviewed, method-specific concurrent validity, reliability, reproducibility and multiple clinical studies supporting its conclusions. At present, they are compiling the industry's first longitudinal [predictive] study, based on the work and research of the Work Evaluation Research Center (Cooke / WERC / Canada).

Due to the relative completeness of the ERGOS research studies, and its accompanying data collection, analysis methods and scientific basis, no other physical performance system has yet paralleled the objectivity of this work. As a result, the ERGOS system offers its users the preponderance of evidence in most jurisdictions both domestic and international, at least up to the level where pain behaviors become the dominant influence to alleged beliefs in functional inhibitions.

BioFunction

Of more recent events, the technology strengths of the ERGOS have been further supplemented by the innovations and research conducted by BioFunction [2008]. BioFunction's research was designed to address the need for further separating the non-differentiated behavioral reactions (e.g. physio-behavioral pain reactions, pain-related fears, psychosocial suffering reactions, and motivation interferences) encountered during the work capacity evaluation into causal conclusions so that remediation and/or mitigation could be achieved.

This level of specificity became critical to jurisdictions, such as California, where mandates for the proper assessment of the chronicity of pain and restoration (chronic pain guideline) considerations have become part of the disability equation.

To date, BioFunction's work has shown the ability to the objectively differentiate pain reactions via their discomfort and behavioral factorization methodologies. BioFunction has also pioneered the managing of the "uncertainty" variables of pain through an enhanced expert complexity-knowledge system that analyzes and quantifies behavior using a multi-method, test-retest, intra-data comparison algorithm, while safeguarding "best effort" quantifications using a crossover validation of the time-motion units

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(tmu) of the MTM score in conjunction with the laws of force, work and power (physics) as a decision reference point.

These advances allow BioFunction's work capacity evaluation methodology to further categorize and objectively identify the "remediable" patient from those who are considered "non-remediable" [an objective inclusion/exclusion examination] for restoration purposes. Peer-reviewed research supporting this premise was published by BioFunction in 2008.

THE FUTURE OF WORK & PAIN

It is important to note the emergence of "pain chronicity" is currently a problem exclusively germane to California's regulatory environment. It has not yet become prevalent in other State jurisdictions. Even so, it is likely to become an endemic phenomenon in the near future as "unresolved pain" is the single greatest factor reported by patients for their perceptions of "disability" and alleged inability to work. It is also the primary reason for their continued visits to their doctor that drives medical costs escalations. To confound the problem further some medical providers are also know to "disease monger" the pain reactions of their patients for financial gain by enabling and perpetuating their "I Can't" perspectives.

Occasionally, this pain perspective has been known to root itself in even the med-legal / regulatory environment in spite of all efforts to reach for an objective viewpoint on the matter. This was clearly demonstrated in California's most recent Almaraz-Guzman II ruling. This ruling correctly separated "impairment" from "work disability", as they are not the same, but the ruling failed to contain the subjectivity of allowing physicians to "analogize" work disability. This failure to contain subjectivity reintroduced the "guesstimate" and pain variables back into the work disability/capability equation. Insurance carriers have reported this has led to a recent onslaught of requests for FCEs by injured worker attorneys, as these "pain tests" universally show patient's to be "total disabled" for no other reason than pain, further escalating the settlement costs of a claim.

The good news is this subjectively can be corrected. But only by applying evidence-based work capacity evaluations where the separation of muscle strength & endurance, pain behaviors, work-related psychosocial overlays and motivational interferences can be objectively differentiated. By doing so, the "I Can't" [disability] belief can oftentimes be restored back into an "I Can" [capability] mentality. This will lead to the lessening of disability severity and its associated financial, economic and social impacts, with the majority of outcomes showing workers can actually be restored back to full work capability itself, even after "prolonged periods of disability".

By example, one such outcome came as a result of a pilot program conducted by BioFunction from 1999-2001 for the U.S. Postal Service's San Francisco District. In this pilot, 100% of 178 workers, who had been previously classified as being "totally" disabled (while receiving disability payments equating to their full salaries), were found to be "work capable" at some level of work activities (sedentary, light, medium, heavy and very heavy job categories) for which the US Postal Service is mandated by regulation to accommodate all levels of restrictions. More astonishing was the fact that 43% of these individuals also met their full duty job requirements. These work capabilities were discovered simply by using a technology-based work capacity evaluation to objectively quantify the worker's safe work tolerances. Yet, all of these workers remained on this Agency's disability rolls for years before this exam.

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A further review of this pilot showed that 63% of the examinations were considered "behavioral" based (the leveraging of pain to obtain a lower test result), with the remaining 37% having credible objective evidence indicating "pathology" was likely causing the degrading of biomechanical capabilities, but none to the extent that they were "totally disabled" as a result of this pathology. The cost savings potential for this pilot alone, by returning these individuals back to productive work assignments commensurate with their measured work tolerances, exceeded $65 million in avoidable lifetime disability payments.

Similar outcome studies in the private sector have also been done showing similar results. Through its history of all studies BioFunction's outcomes have shown that 100% of more than 700 cases were able to do some type of work activity. This offers hope to disabled workers that they can still achieve a productive lifestyle which includes work. It also demonstrates our disability system can be salvaged.

Based on BioFunction's latest study, of more than 300 examinations conducted from 2008 – 2011, it shows that full duty return to work capability rates are now exceeding 56% based on the examination metric alone; and when restoration is undertaken using criterion-based, work simulated, aggressive mobilization therapies to correct any deficiencies found these outcomes show that 100% of workers improve their work capability levels; with 75% of the workers recovering to their full duty work levels.

Developing "capable" individuals, either by proper examination or restoration, is the best and most cost-effective means for containing the unbridled disability costs that plague our disability system today. Left uncheck these escalating costs will threaten financial ruin taking form in the guise of:

- Bankrupt benefit plans & failed solvency of insurance carriers,
- Rampant employer insurance premium escalations,
- Faltering state-funded "last resort" risk pools,
- An eroding business tax base with increased stress & demand for further public assistance & entitlements programs,
- Failed disability program bailouts (such as is happening with the US Postal Service), and
- The escalating of hearing receipts requesting Social Security disability compensation that cost shifts the full disability burden onto an already overburdened Social Security system.

Pain, and its chronicity, is a very real disability problem that we cannot ignore! The best solution for salvaging our system is to empower capability, rather than continuing the enabling of disability.

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EVIDENCE-BASED WORK CAPACITY EVALUATION
ADVISORY COMMENTARY

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CHRISTINE BAKER / EXECUTIVE DIRECTOR / CA DWC

SUGGESTED GUIDELINES FOR EVIDENCE-BASED WORK CAPACITY TESTING

ESSENTIAL MOTIONS

Due to the large variance in the work environments, and the complexity of function which may encompass multiple biomechanical motions in sequence to complete a given task, whole body physical performance testing is ESSENTIAL in order to generate a safe and sustainable work capability.

Mandatory biomechanical tests should include:

Gross Motor Strength Tests

- Static Knuckle Lifting (With Left-Right Comparisons)
- Static Bench Lifting (With Left-Right Comparisons)
- Static Ankle Lifting (With Left-Right Comparisons)
- Static Shoulder Lifting (With Left-Right Comparisons)
- Pushing Cart Height (With Left-Right Comparisons)
- Pushing Shoulder Height (With Left-Right Comparisons)
- Pulling Cart Height (With Left-Right Comparisons)
- Pulling Shoulder Height (With Left-Right Comparisons)
- Dynamic Lifting Bench Height (Incremental & Progressive)
- Dynamic Lifting Shelf Height (Incremental & Progressive)
- Carrying (Incremental & Progressive)

* With the above constituting the minimal test requirements to meet the US Department of Labor's 8-hour workday strength capacity standard.

Body Dexterity / Posturing Tests

- Sitting
- Standing
- Walking

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- Stooping – Short Cycle
- Stooping – Sustained
- Kneeling
- Crouching
- Reaching Bended

Limb Coordination Tests

- Reaching Forward
- Reaching Overhead
- Handling / Grasping
- Fingering / Keyboarding / Finger Flexion & Extension
- Proprioception

Fine Motor / Upper Extremity Strength Tests

- Static Grip Strength (With Left-Right Comparisons)
- Static Key Pinch Strength (With Left-Right Comparisons)
- Static 3-Pt Pinch Strength (With Left-Right Comparisons)
- Static Wrist Flexion & Extension (With Left-Right Comparisons)
- Static Forearm Pronation Strength (With Left-Right Comparisons)
- Static Forearm Supination Strength (With Left-Right Comparisons)

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EVIDENCE-BASED WORK CAPACITY EVALUATION ADVISORY COMMENTARY

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TEST SAMPLINGS / ANALYSIS METHODS

Static Strength Test Sampling - Minimum Criteria

(Gross Motor Strength & Fine Motor Upper Extremity Strength)

- All static tests require a minimum of 3 test trials to achieve sufficient validity for assessing co-efficient of variations (CV).
- CV's are to be used as markers for measuring the consistency of performance only. CV's as a stand alone test cannot be used as a valid measure of effort.
- Static strength samplings are to include muscle-force contraction measurements (recorded at a minimum rate of 20 measurements per second) to demonstrate activity ramp-up behaviors; work motion fatigue and end-contraction deceleration in order to be used as markers for determining the presence, or lack, of maximum voluntary effort.

Dynamic Strength Test Sampling - Minimum Criteria

- All dynamic strength test samplings must include a minimum of 4 trials (preferably 6) for each incremental weight level.
- Progression of weight levels is to continue until test end-point targets of either full duty work capability (as per their job standard) has been reached, or objective evidence of biomechanical breakdown demonstrates compromised safety issues are prevalent.
- Progressive and incremental weights testing should commence based on a pre-designated safe motion level and be advanced in no greater than 10 lbs increments until either the targeted full duty job demand level is met or there is objective clear evidence of approaching biomechanical breakdown.
- Progressive and incremental weights testing should be applied to both bench and shelf height lifting; with the latter being at least ½ the former at end-point testing, unless alternate strength targets are required based on actual work environment physical demands.
- Progressive and incremental weights efforts must include the use of measured time velocities for both uplift motions, as well as, down lift motions to assess for ancillary muscle recruitment shifts, emerging biomechanical de-compensation and/or approaching breakdown of the biomechanic.
- Repeat progressive and incremental muscle fatigue lifting and carrying testing, using time-motion (MTM) analysis, must also be conducted at the end of the examination period to cross-validate for safe 8-hour lifting motion sustainability.
- Work performances where the examinee alleges severe pain reactions for their inability to fully complete a test protocol should document an explanation of whether or not there were

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observations of repeated objective signs of muscle guarding, biomechanical off-loading, ancillary muscle recruitment, physio-behavioral pain reactions, and/or transient disruptions in mobility while quantifying the severity of these events.

- In the absence of any clear accompanying objective physiological evidence of approaching biomechanical breakdown then such performances must be reported as being conditioned by self-limited, inordinately slow, uncooperative or refusal behaviors drawing particular attention to the non-organic (motivation) basis for this limitation.

- All dynamic strength performances are to be summarized as Gross Material Handling capabilities (cumulative loading amounts, distance, repetitions, the incremental weight ranges used to assess gross material handling & the lift activity time to complete the test protocol); with comparative full duty gross material handling requirements of the examinee's usual and customary work to be used for comparative purposes.

Body Dexterity Test Sampling - Minimum Criteria

- All body dexterity tests must include a minimum of 4 activity trials for each motion.

- Criteria for quantifying diminished test performances of physio-behavioral pain reactions and/or motivation as discussed above to apply as well.

Limb Coordination Test Sampling - Minimum Criteria

- All body dexterity tests must include a minimum of 4 activity trials for each motion.

- Criteria for quantifying diminished test performances of physio-behavioral pain reactions and/or motivation as discussed above to apply as well.

COGNITIVE DISTRACTION

- All examinees must be tested at least twice for the same motion. One test is to be administered where the test focus is readily discernable by the examinee. The second test must be administered using American Psychological Association compliant cognitive distraction tests where the test focus is not readily discernable [blinded] by the examinee.

- For motions where blinded test protocols are not available (kneeling & crouching) then repeat testing is required for these motions just prior to the conclusion of the examination period to allow for further evaluation of consistency and fatigue / endurance effects.

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EVIDENCE-BASED WORK CAPACITY EVALUATION ADVISORY COMMENTARY

PREPARED FOR THE

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TEST LENGTH, SEQUENCING & ADMINISTRATION

- Test lengths are to be commensurate with the examination time length used in the method's validity studies as published in a peer-reviewed medical or rehabilitation publication.
- All tests must provide for a procedure for establishing informed consent for the entire examination proceedings, as well as, individual test protocols so that allegations of being "forced" by the evaluator to do the test can be eliminated.
- All test administration and instructions must be scripted, standardized and administered in exactly the same way for every examinee.
- All test instructions shall comply with a Flesch-Kincaid readability of not more than a 9th grade comprehension level to avoid allegations of "misunderstanding" the test instructions.
- All individual test protocol administrations shall be in accordance with established peer-reviewed testing standards as determined by the manufacturer's specification and training.
- All evaluators must complete sufficient test administration training, so as to successfully meet and pass a peer-reviewed work capacity evaluation certification test, before being certified for independent test administration.

JOB STANDARDS

Comparative job standard benchmarks for all tests should encompass at least two of the following three sources to ensure as close a match, or greater, to the full duty physical demands of the examinee's usual and customary work assignment including:

- Employer – Specific Job Description / Analysis
- Examinee – Description of Job Duties (California Form: RU-91) or Equivalent
- US Department of Labor's Dictionary of Occupational Titles – for similar work activities

In the event Upper Extremity Strength testing is desired the following additional standard must be used to compare upper extremity fine motor performance results:

- University of Michigan & Staub [1982] - Anthropometric Study – Upper Extremity Physical Strength Analysis

All comparisons of work performances are to be commensurate with the physical demand categories as defined by the US Department of Labor's Dictionary of Occupational Titles (sedentary, light, medium, heavy & very heavy) that best correlate to the examinee's actual workplace demand levels.

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EVIDENCE-BASED WORK CAPACITY EVALUATION
ADVISORY COMMENTARY

PREPARED FOR THE

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The primary focus of job matching should be achieving a consensus between the examinee and employer as to what motions and physical demands are required to safely perform a particular job. Discrepancies and/or disagreements regarding any physical demand may be resolved either by:

- Obtaining an independent ergonomic assessment conducted in accordance with the definitions detailed in US Department of Labor's Revised Handbook For Analyzing Jobs, by a qualified ergonomist or properly trained safety professional, or

- Weighting the job standard preference to the most conservative description of the motion until clarifying information can be obtained, or

- Simply elucidating the discrepancies within the context of the report and identify the standard used (along with the rationale for choosing this standard) so the reader may understand what assumptions have been made with respect to the work environment, or

- In the absence of available job information, OR, should the physical demand perspectives by the examinee and employer both be found to be biomechanically unreliable, then the examination should default to the physical demand levels as defined by the US Department of Labor's Dictionary of Occupational Titles for similar work activities (or other established physical demand standards prevailing within the jurisdiction) as the comparative criterion.

    - In the event that this provision is exercised, written notice should also be given to employers explaining that "similar work activities", as generated by the US Department of Labor, represent "job clustering" which generally overestimates the physical demands of most work activities creating a very conservative [greater risk of work deficiency] standard of comparison. The employer should be strongly advised to obtain an employer-specific job analysis to achieve a more accurate work comparison.

    - It should be noted that this provision may be challenged by opposing parties. Since the Clinton administration the new Dictionary of Occupational Titles (now called O*Net) did away with the physical demand definitions for each job in the database at the behest of unions who did not wish to have strength criteria that could interfere with their control of hiring. This caused a problem for Social Security's Bureau of Hearings & Appeals because they no longer had an up to date measurable standard on which to make a ruling. It is our understanding that Social Security has funded an update of the original Dictionary of Occupational Titles so that they can continue making decisions based on measurable physical demand criteria, however, the results of this update are not yet available.

    - Even so, language might be added that until this update becomes available (in order to maintain the desired method of "criterion-validity" for work testing) that the prior physical demand definitions are to prevail as the current O*Net definitions only cite criteria (i.e. oral expression, concentration, inductive reasoning, gross body equilibrium, extent flexibility, and undefined measurable activity criteria) that are unrelated to the physics of motion and work. Consequently, without measurable physical demand criteria criterion-validity testing cannot occur.

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EVIDENCE-BASED WORK CAPACITY EVALUATION ADVISORY COMMENTARY

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SCIENTIFIC BASIS

All Work Capacity Evaluation vendors wishing to perform examinations on behalf of the Social Security Administration or Federal Employee's Compensation Act / Office of Workers' Compensation Programs must submit complete, original, method-specific scientific studies including a:

- Concurrent Validity,
- Reliability,
- Reproducibility,
- Work-Related Clinical, and
- Restoration Studies

All studies must reference applicable resources, and/or a supplemental bibliography may to be provided, underlying the scientific tenets of their examination.

In addition, a bulleted list of features and benefits should be provided that shows the differences of their Work Capacity Evaluation (WCE) methods in comparison to a traditional Functional Capacity Evaluation (FCE).

Vendors should submit "real world" outcome studies showing the ability of their examinations to:

- Determine safe and sustainable objective work capability (return to work outcomes),
- Quantify "best effort" work tolerances via cognitive distraction cross-validation,
- Determine a baseline for use in a restoration program, and
- Demonstrating physician, employer and examinee usefulness / utility.

STANDARDIZED REPORTING CRITERIA

All WCE vendors should submit a sample of their Work Capacity Evaluation report. Suggestions for developing standardized reporting would include an Executive Summary highlighting an examinee's:

- Overall All Work Performance Levels
- Return-To-Work Considerations / Restrictions
- Muscle Strength & Endurance Capabilities / Deficiencies
- Pain & Psychosocial Coping Skills Levels

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- Motivation Concerns
- Treatment Recommendations

Detail sections of the report should include descriptions of:

- Analysis Methods Used
- Supporting Data, and
- Facts & Assumptions

Reports also need to cite relevant scientific references supporting their conclusions throughout the body of the report and discuss the scientific basis of the objective performance metrics used in their conclusions.

CONFLICTING SCIENCE ADJUDICATION

Suggestions for procedures to handle the adjudication of conflicting sciences and/or interpretation of results should include:

- Establishing a multi-disciplinary expert advisory panel which would include:
  - Various physician disciplines (occupational health, pain management, physiatrists, neurologists, orthopedic surgeons, etc),
  - Certified ergonomists,
  - Vocational rehabilitation specialists such as vocational evaluators,
  - Exercise kinesiologists,
  - Clinical exercise physiologists, and
  - Physical rehabilitation specialists (PT, OT, Rehab Nurses, etc.)
- The modification of the current "Strength of Evidence" rating system should be considered to provide for an improved "weighting" of scientific-based evidence studies published in peer-reviewed nationally recognized professional journals.
  - Suggested weighting of features would include using:
    - +2 For A Fully Met Criterion
    - +1 For A Partially Met Criterion

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- +0 For An Unmet Or Omitted Criterion
- -1 For An Undesirable Criterion

It is important to note that "original" and "method-specific" scientific studies must take precedence in an evidentiary hierarchy.

Care should be given to consider if a particular physical performance system's "validity" claim is based on actual METHOD-SPECIFIC research; or if the vendor is using theoretical scientific principles to infer "validity", without having to undergo the burden of proving their method actually meets this scientific principle.

Care should also be given to avoid weighting physical performance tests based on "literature-reviewed" studies, either to the credit or discredit of the methodology.

It is an unfortunate reality that much of the published physical performance studies allege "gold standard" compliance for which no such benchmark exists. In reality much of these "literature summaries" were generated by physical performance vendors hoping to cast a dim perspective on competing systems as a marketing ploy to up sell their wares, but in reality they have no first-hand knowledge of the actual mechanisms used in their competitor's testing methods.

More shocking is the rate at which these literature reviews proliferate throughout juried-journal publications and are touted as "definitive science". References of these "tainted" reviews are found in today's occupational medicine practice guideline certification criteria that determines the medical necessity of treatment, but with no regard being given to the lack of true scientific content in these articles.

Typical rating factors of DATA COLLECTION should include:

- Testing Construct (Criterion-based testing vs. face validity)
- Adequate Test Samplings
- Redundant Test Samplings
- Usual & Customary Job Comparisons
- The Use Of Computerized (Standardized) Test Instructions
- The Use Of Fatigue & Work Endurance Testing
- The Thoroughness Of Biomechanical Testing (whole body vs. partial body testing)
- The Use of Definable Objective Test End-Points

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- The Use of Both Linear and Non-Linear Examinee Discomfort Scales
- The Use of Functional Inhibition Perception Scales Correlating The Degree Of Body-Mind Motion Congruency
- The Use of Evaluator Concurrence Scales To Validate Examinee Functional Inhibition Perceptions For Congruency To Objective Third-Party Observations Of Motion Inhibition
- The Use of A Prime Factor Collection System To Segregate Biomechanical Integrity From Pain And Motivational Overlays

Typical rating factors of ANALYSIS METHODS should include:

- Ergonomic Equivalency Work Frequency Conversion Ratios
- Cross-Validation Capabilities of Performance Results
- Predictive 8-Hr Workday Capacity For All Work Frequency Levels
- The Use of a Valid Computational Algorithm For The Factorization Of Discomfort To Determine Normalization Of Pain Patterns During Motion
- The Use of a Valid Computational Algorithm For The Factorization Of Behavioral Reactions To Differentiate Work-Related Psychosocial Overlays Indicating Failures To Cope With Pain While In Motion
- The Use of a Valid Computational Algorithm For The Factorization Of Motivational Interferences To Delineate Individuals Who Have Disengaged From Active Recovery Efforts By Reasons Of Using Inordinately Slow, Secondary Gain, Uncooperative, Refusal and/or Malingering Interferences To Obtain A Lower Test Result.
- The Use of APA Compliant Cognitive Distraction Testing
- The Use of Time-Motion (MTM) Values To Measure Work Speed & Efficiency
- The Use of Co-Efficient of Variations (CV) Values To Measure Consistency
- The Use of Muscle-Force Contraction Measurements To Measure Maximum Voluntary Effort
- Weight-Bearing (Load) & Non-Weight Bearing (No-Load) Capability Segregations

Typical rating factors of SCIENTIFIC CONTENT should include:

- The Use of Original & Method-Specific Research

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- The Use of Independent Unpaid Researchers
- The Availability of a Juried Journal Published Concurrent Validity Study
- The Availability of a Juried Journal Published Reliability Study
- The Availability of a Juried Journal Published Reproducibility Study
- The Availability of a Juried Journal Published Varied Clinical Application Studies
- The Availability of a Juried Journal Published Longitudinal (Predictive Capability) Study
- The Availability of an Outcome Study Identifying Return-To-Work Rates
- The Availability of an Outcome Study Showing "Best Effort" Quantification Successes
- The Availability of an Outcome Study Showing The Methods Ability To Segregate Pain Reactions & Differentiate Work-Related Psychosocial Overlays From Muscle Strength & Endurance
- The Availability of an Outcome Study Identifying Physician, Employer & Examinee Utility and Usefulness Outcomes
- The Use of Randomization Within These Studies
- The Use of Evaluator Blinded Methods As To The Purpose Of The Study
- The Use of Examinee Blinded Methods As To The Purpose Of The Study
- The Use of Medical Provider Blinded Methods As To The Purpose Of The Study
- The Use of Compliance Metrics For Measuring Examinee Participation
- The Overall Degree To Which Bias Is Felt To Be Present In A Study

EXAMINER VENDOR QUALFICATION & SELECTION CRITERIA

A method of vendor selection and approval methodology should be developed to identify qualified examination providers. An application procedure should be developed to solicit vendor responses covering topics such as:

- Evaluator Qualifications
- Education & Physical Performance Test Training

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- Qualifications Required To Meet WCE Certification
- Clinical Background
- Credentials Held
- Types of Examinations & Restoration Services Offered
- A Copy of Their Curriculum Vitae or Resume
- A Description Of The Length Of Their Experience In Work Capacity Evaluations
- Estimated Annual Number Of WCEs Conducted During The Course Of Their Careers
- Estimated Number Of WCEs Conducted In The Last Year

In jurisdictions that require the differentiation of pain reactions additional explanations should be sought as to how the vendor will mitigate these influences to maintain an objective assessment of work capability.

Typically, it has been *assumed* that physical performance testing is the exclusive domain of physical therapists, but such is not the case. Contrastively, the American Physical Therapy Association has taken a position against technology-based Work Capacity Evaluations as it is felt the technology detracts from a therapists work. Correspondingly, they support only manual Functional Capacity Evaluations relying upon the observation skills (or lack thereof) and biases of the therapist's anecdotal experiences.

It is important to note that many healthcare disciplines are potentially qualified to perform Work Capacity Evaluations. In its original and most basic form biomechanical assessment (work factors assessment, human factor engineering, scientific management and ergonomics) is a matter of engineering and physics modeling.

Medical modeling is used to supplement the evaluation by offering insights into pathology, pain and behavioral overlays that may occur with motion activities. As a result, in addition to the physical therapist, successful and qualified evaluators may also be:

- Physician Assistants,
- Advanced Practice Nurses,
- Medical Case Managers,
- Registered Nurses,
- Chiropractors,
- Clinical Exercise Physiologists, and

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- Kinesiologists

who have been provided proper peer-reviewed training, and have successfully completed the course requirements for certification, as these healthcare professionals possess sufficient medical training in normal anatomy & physiology, and pathophysiology as well.

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Professional Association Management
Established 1983

April 30, 2012

Hon. Christine Baker, Director, Department of Industrial Relations
Hon. Rosa Moran, Administrative Director, Division of Workers' Compensation
1515 Clay Street, 17th Floor
Oakland, California 94106

RE: Town Hall Meetings on Workers' Compensation

Dear Christine and Rosa:

Thank you for holding your Public Forums on the Workers' Compensation System throughout California. We're confident that all stakeholders in the comp system appreciate these opportunities to express their concerns and share their ideas for improvements. We submit these comments on behalf of our clients, the California Society of Industrial Medicine and Surgery and the California Society of Physical Medicine and Rehabilitation.

Medical care for injured workers is the largest component of the workers' compensation system in California. With the mandate to use the AMA *Guides to the Evaluation of Permanent Impairment* beginning in 2005, the role of physicians in workers' compensation continued to grow. The future health of the workers' compensation system is dependent upon attracting and retaining the best medical providers. With this in mind, we have the following comments.

Medical Provider Networks. During your Public Forums, you heard numerous complaints about Medical Provider Networks (MPNs). The enabling legislation (SB 899) that authorized MPNs as a device for employers to retain control of treatment beyond 30 days was very anti-injured worker and anti-physician. As implemented, the MPN system is dysfunctional and burdensome with very few exceptions. Many MPNs require physicians to discount their services below the Official Medical Fee Schedule and at least one mandates that if a participating physician files a lien, he/she will be expelled from the network. These practices must be precluded.

MPNs have become ubiquitous but many, if not most, do not meet the statutory standards for providing adequate medical coverage. We urge your administration to sponsor or support legislation that mandates better transparency in MPN operations, better data integrity, prohibition of leased networks (phantom PPOs), a provider contract review similar to that for Health Care Organizations (WCHCO) and the establishment of a more effective "access to care" standard, all undergirded by periodic re-certification of every MPN.

The QME process. There is a dearth of QMEs and a back log of panel requests that despite the Division's best effort, remains permanently longer than the Labor Code requires and attendant scheduling delays with the few QMEs that are willing to participate.

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The panel request process bears only a semblance to the requisite "randomness" and certainly quality can suffer significantly as long as the list can be overwhelmed by the sheer number of a QME's listings. This is a controversial issue, but one that must be resolved. We suggest there is a way to manage this process in such that no QME can gain near the advantage as appears to be the case today. The solution is not complicated nor does it require legislation. The procedure of choosing QMEs would be changed to preclude any QME from being named more than once in a pool from which a panel of three is chosen. It would not help to have more than one address within a given search radius. There a number of ways to do this using the existing database.

The quality of continuing education providers is relatively good. However, new QMEs rarely, if ever, receive feed back about the quality of their reports except from the legal community when it is upset. Often this feed back is more negotiation tactic than meaningful critique. Thus, this type of feedback is rarely instructional. We suggest the Division commit to establishing a process by which periodic reviews and constructive, non-partisan, critiques of reports are provided by active, California AME quality physicians to those QMEs with less than five years experience.

Utilization Review. Senate Bill 228 in 2003 revised the law with regard to utilization review resulting in significant and unwarranted delays in the delivery of medical treatment to injured workers. Too many requests for authorization are unnecessarily sent to utilization review. Several studies have confirmed that, as implemented, UR costs more money than it saves. There is no reason, except in extraordinary cases such as requests for surgery or pain management programs, to send an MPN physician's request to UR. We support the California Labor Federation's recommendation to prohibit this practice.

Collaterally, the Medical Treatment Utilization Schedule needs to be updated. The Medical Evidence Evaluation Advisory Committee (MEEAC) needs to resume its deliberations to update and expand the MTUS.

Finally, we urge your administration to support efforts to mandate the use of California-licensed physicians to perform utilization review. Unlicensed out-of-state physicians are accountable to no one and they are a major factor causing delays in needed treatment. UR is the practice of medicine and these physicians should be subject to the jurisdiction of the Medical Board of California.

Liens and Billing Disputes. There are two primary problems. Certainly the large lien backlog, particularly in southern California, is a formidable drain on resources and diverts the Appeals Board from its primary task of delivering benefits to injured workers. However, in the long run, perhaps more important is identifying and to the extent possible, elimination of the root causes of liens before they are filed.

While these problems share a degree of cause and affect, each demands a unique solution.

A significant percentage of the liens are for medical services. However, the vast majority of liens arise from either bona fide disputes or cases where the payor simply refuses to pay a legitimate bill, forcing the provider to file a lien to protect his/her interests. While we support your efforts to eliminate phantom liens, it should not be accomplished at the expense of honest providers who are

presented no alternatives but to file liens. Similarly, we oppose any efforts to reinstate the $100 lien filing fee. This will only encourage payors to short-pay providers'' invoices, further discouraging them from treating injured workers. In addition, a $100 lien filing fee would be contrary to Subdivision (d) of Section 3 of Article XIII A of the California Constitution.

Medical-legal reports are a significant proportion of the legitimate liens. Resolving the uncontested medical/legal liens could go a long way toward addressing the back log. Our members have hundreds of reports for which they have not been paid or been paid improperly. Many must subsequently provide additional AME and QME supplemental reports, re-evaluations and depositions, knowing their initial bill has yet to be paid. They cannot withhold these follow-up services even though they know that they are unlikely to be paid, except by filing a lien. Often, the QME or AME is a member of the payor's MPN making them reluctant to exercise their rights for fear of expulsion.

Even though medical/legal liens do not need to wait for the case in chief to be resolved before payment is made, medical/legal providers cannot force the defendant to pay the medical/legal lien if the payor simply chooses to not do so. Penalties are due and interest accrues, but ultimately neither is paid with any regularity and certainly not on a self-imposed basis as called for.

At the San Bernardino hearing, the Division received a suggestion that these uncontested medical/legal liens be handled with the same procedure as liens for attorney fees. We endorse the idea of adding these liens to the walkthrough calendar to expedite resolution.

Transition to RBRVS-based treatment fee schedule. Adopting the Medicare Fee Schedule in California will not save any money. In fact, it will cost the State of California, injured workers, employers, insurers and others millions of dollars a year. CSIMS and CSPMR continue to oppose any conversion of the Official Medical Fee Schedule to one based on Medicare RBRVS. Extensive research conducted by CSIMS and others amply demonstrates that a conversion to RBRVS on anything close to a "budget neutral" basis would create major problems such as:

- A conversion to the Medicare Fee Schedule will result in injured workers' loss of access to medical specialists for treatment of serious injuries and illnesses.

- A conversion to the Medicare Fee Schedule will hinder the ability of injured workers to prove their impairments, thereby offsetting any increase in the Permanent Disability Rating Schedule.

- Any transition to the Medicare Fee Schedule will increase costs to employers, insurers and the Division of Workers' Compensation even if the schedule change is budget neutral.

- A conversion to the Medicare Fee Schedule will disqualify many existing Medical Provider Networks.

- A conversion to the Medicare Fee Schedule will destabilize the workers' compensation

insurance market leading to higher premium costs for employers.

- The current fee schedule can be easily updated at substantially less cost to employers and without compromising injured workers' access to care.

- SB 923 -- the proposal to mandate the Medicare RBRVS Fee Schedule -- was overwhelming defeated by the State Assembly, indicating the legislature's opposition to that particular schedule.

Attached hereto, and incorporated herein by reference, is a more detailed analysis of the adverse consequences of adopting a low-multiple RBRVS Fee Schedule in California.

It is clear that time is the enemy of the workers' compensation system. Prompt and direct communication with the injured worker and his/her doctor always benefits the care delivered and the potential for return to work. Timely closure of files benefits the employer and timely adjudication of contested issues benefits closure of the file. The Division received ample testimony this month regarding the devastating effect that inappropriate and ultimately incorrect delays caused by the utilization review process have in the lives of injured workers. Billing and reimbursement issues create access issues that are exacerbated by delays and the lack of communication.

Therefore, we have two additional suggestions that strike at the heart of delays and thus a number of other issues.

The first addresses the unnecessary accumulation of liens waiting for the case-in-chief to resolve. We suggest that the parties and the court be compelled to adjudicate issues as soon as they arise rather than endlessly continued. Two disputes with far-reaching consequences that would benefit from an accelerated calendar would be AOE/COE issues, especially for a subsequent claim arising from an initial claim and MPN issues arising from improper notification, a lack of access to care and/or the AOE/COE issue itself.

The second is more fundamental. We observe that there is little or no incentive for claims administrators to follow existing benefit delivery or provider reimbursement rules. While the aggrieved public does have the means to request an audit, there is no direct feedback when such requests are submitted. The Division lacks the ability to audit with any meaningful speed or frequency and the penalties, except perhaps when a "business practice" can be proven, are so low as to be ineffective as deterrents. Imagine if the Division could prosecute improper claim handling complaints with the rapidity and thoroughness it investigates and prosecutes QME complaints. We therefore suggest at the very least, that the Division implement substantial increases in the penalties promulgated by CCR Title 8, Sections 10111, 10111.1 and 10111.2.

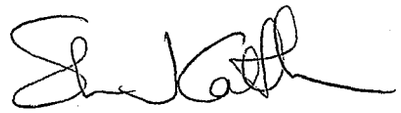
Thank you, again, for this opportunity to share our thoughts on improving the California workers' compensation system. Our two associations have been involved in the workers' compensation

process for more than 30 years. During that time, we have seen a decline in the willingness of good physicians to treat and evaluate injured workers. One-sided legislation and unenforced statutes create an atmosphere hostile to caring physicians. Too many physicians are retiring or reducing their occupational medical practices and too few younger physicians are filling the void. Injured workers have a constitutional right to quality medical care and the State of California should make every effort to create and maintain an environment that encourages the best physicians to offer their services.

The Division continually finds itself faced with a list of complicated and resource intensive tasks. As we have for nearly 30 years, we welcome the opportunity and stand ready to participate in any way possible to help with these endeavors.

Cordially,

Carlyle R. Brakensiek, MBA, JD
Chairman



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Director of Government Relations

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Workers Compensation Outlook

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Is the Sky Really Falling? — Getting to the Root of the Opioid Issue

An alarming increase in deaths from prescription drug overdoses, as well as driving costs, has made opioids the bane of the workers compensation industry. Employers, insurers, and government agencies are demanding solutions — and rightfully so. However, the best outcomes won't come from witch hunts and knee-jerk reactions, but from solid data analysis and well-thought-out holistic strategies. Preliminary research indicates that what looks like a black cloud has many shades of gray. This issue of Workers Compensation Outlook looks at the trends driving increased opioid use, with a special focus on pain management in workers compensation, suggesting areas that organizations should analyze before attempting to develop their own solution. It also examines the role of each stakeholder group — from the network to the adjudicator, the prescriber, the employer, the case manager, the worker — in addressing the issue of opioid use and abuse. Finally, it suggests approaches for each stakeholder group that could contribute to controlling costs, improving outcomes, and supporting greater patient safety.

Prescription pain medications in the news

Hardly a day goes by when prescription pain medications don't make the headlines — and the news is rarely good. The Lexington Herald-Leader reported, "nearly a third of Kentuckians report that a relative or friend has had problems as a result of abusing prescription pain drugs." The Lewiston Sun Journal covered the reprimand of a Maine doctor who prescribed methadone for a pregnant patient. Citing a new report from the Centers for Disease Control and Prevention (CDC), US News & World Report noted that "More Americans now die from drug overdoses than in car accidents," and a group of Tennessee legislators issued a press release on the passage of a new law designed to regulate pain clinics.

> All of those articles, and many more like them, were generated within a single 24-hour period in late December. Clearly, people are talking about prescription pain medications — and demanding solutions. Is the situation truly that bad, or is it hype? Is the media running around like a bunch of Chicken Littles? Finding an accurate answer to that question may not be as simple as it sounds, and organizations can't make good decisions based on headlines.

National statistics are sobering

The CDC is keeping a close eye on trends related to prescription

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pain medications – specifically opioid pain relievers (OPRs) such as Vicodin (hydrocodone), OxyContin (oxycodone), Opana (oxymorphone), and methadone. Sales of OPRs to pharmacies, hospitals, and doctors offices increased by 400 percent between 1999 and 2010. In that same time period, deaths from prescription painkillers have increased at nearly the same rate, resulting in what the CDC calls "a public health epidemic." Admission to substance abuse treatment programs has increased in parallel.

A November 2011 CDC Policy Impact brief on prescription painkiller overdoses points to a large and growing problem.

- Drug overdose death rates in the United States have more than tripled since 1990.
- In 2008, OPRs were involved in 14,800 overdose deaths – more than cocaine and heroin combined.
- OPRs were responsible for more than 475,000 emergency room visits in 2009 – more than twice as many as in 2004.
- U.S. physicians prescribed enough painkillers in 2010 to medicate every American adult around the clock for a month.

The CDC has called for workers compensation programs to monitor prescription claims information through prescription drug monitoring programs (PDMPs) for signs of inappropriate use. It also suggests regulatory action against providers who operate "outside the limits of accepted medical practice" and calls for states to enact and enforce new laws against doctor shopping and rogue pain clinics.

The American College of Occupational and Environmental Medicine (ACOEM) and the International Association of Industrial Accident Boards and Commissions (IAIABC) have expressed similar concerns. Last fall the two groups issued a joint comment about "the growing issue of prescription opioid abuse" and asked workers compensation jurisdictions to take steps to address the issue if they have not already done so.

Pendulum of pain management

Thinking about pain medication has evolved and continues to change. Years ago, physicians were reluctant to prescribe narcotics for all but the most intractable pain. That reluctance eroded as physicians were taught that narcotic pain relievers were not addictive. Now, the pendulum has swung back and physicians understand that addiction is always possible. However, at the same time, they stress the importance of pain management.

Pain that is not managed successfully can have several negative consequences. It can limit activity and therefore impede timely return to work. Patients may repeatedly switch providers, trying to find relief. If the pain continues, becoming chronic, it could lead to further complications such as depression, which may increase the patient's vulnerability to substance abuse issues.

Providers often prescribe OPRs because they are powerful and effec-

tive at relieving severe pain. Although nonopioid medications are available for pain management, there are also legitimate reasons to prescribe OPRs. For example, if a patient is at risk of heart disease, OPRs may be a preferable alternative to COX-2 inhibitors. Additionally, OPRs may be preferable to nonsteroidal anti-inflammatories (NSAIDs) in patients with ulcers or when the potential for bleeding is a concern. Despite the media headlines, it's important to remember that just because a pain reliever is an opioid doesn't automatically mean its use is inappropriate.

Increasing opioid use is part of an overall increase in prescription drug utilization in society. Experts point to direct-to-consumer marketing, pharmaceutical company profits, and the Internet as potential influencers. A July 2010 article in The Christian Science Monitor cites the instant gratification culture and Americans' unwillingness to bear even mild pain. Regardless, the issues are real, and clarity is needed.

Getting behind the headlines

It would be wonderful if the workers compensation industry could just say no to the use of opioids, but it's not that simple. To develop an appropriate strategy, an organization must get the real story – and that story is hidden deep in the data. Importantly, it's necessary to understand the drivers.

A national study of Schedule II opioid prescriptions, conducted by Coventry Workers Comp Services in August 2011, examined five years of prescription data, along with supporting bill review data, proprietary network provider data, and claims information from several large payor clients. The study design was similar to a March 2011 California Workers' Compensation Institute (CWCI) study and identified many of the same trends, with some notable differences.

Both studies found that a relatively small number of physicians were responsible for a large percentage of the Schedule II opioid prescriptions. The CWCI study found that the top percentile accounted for 33 percent of the prescriptions and 42 percent of the measured payments. The results of the Coventry study were less dramatic. The top percentile wrote only 31 percent of the OPR prescriptions for 28 percent of the measured dollars.

It is tempting to assume that this utilization equates to less-than-optimal outcomes, but it is important to dig deeper before jumping to conclusions. For example, Coventry's analysis of the data showed that half the providers in the top percentiles were pain specialists. Therefore, one would expect these providers to have more patients requiring pain medications, including OPRs.

To gain a better understanding, it's necessary to look at the kinds of injuries that the high-volume prescribers are treating with OPRs. An analysis of diagnosis codes is a start, but it may not provide enough detail.

For example, an analysis by diagnosis code shows that 54 percent of the Schedule II opioid claims were for diseases of

the musculoskeletal system, accounting for 59 percent of the prescriptions and 63 percent of the costs. Matching that information with bill review data provides more useful information. Back/spine injuries account for 33.6 percent of claims, 46.4 percent of Schedule II opioid prescriptions, and 55.7 percent of dollars. However, this analysis does not differentiate between milder and more serious back injuries, which may require the use of OPRs.

Further analysis can help to validate the appropriateness of the medications for the injury. Using advanced techniques, it is possible to mine medical billing data to uncover the severity of the patient's injury or potential comorbid conditions such as smoking, diabetes, depression, and obesity – some of which might contraindicate opioids. In this study, 35.1 percent of claimants had at least one diagnosis code for smoking, diabetes, depression, obesity, or hypertension. These claims accounted for 53.7 percent of the Schedule II opioid prescriptions and 61.2 percent of the payments in the subsample.

It is also possible to use diagnosis-based data analysis techniques to measure the severity of injury. Using a simple index ranging from 1 representing the mildest acuity to 10 representing the most severe, analysis of the bill review and claim injury data shows 87.5 percent of the prescriptions for OPRs were written for claims grouped as moderate to severe (acuity 5 through 10).

The analysis performed also evaluated severity with and without comorbidity. It is interesting to note that the less severe claims with the presence of a comorbidity had an average of 13.5 OPR prescriptions versus those without comorbidities, which averaged 5.1.

Areas for further exploration

While not conclusive, the examination of diagnoses using bill review data and claim injury information does suggest that many of the claimants receiving Schedule II opioid drugs may be suffering from injuries that warrant at least some use of OPRs.

Additional analysis could be beneficial. It might be helpful to look at the quantities of drugs over time to evaluate dispensing patterns. It could be useful to measure medication per month and medication rates relative to the age of the claim. Reviewing other prescriptions, including nonopioid medications, within these claims, as well as reviewing other nonpharmacological treatment, might also provide additional context. For instance, opioids may be an adjunct therapy to increased physical medicine treatments.

Examining claimants' use of the health-care system, including the number of providers involved in their care, may provide insight into OPR utilization. Preliminary analysis shows that claimants in the top 10 percent of opioid prescription volume had approximately twice as many prescribers as the average claimant – 4.2 versus 2.0. Further analysis is necessary to uncover any patterns of drug-seeking behavior or to clarify other complicating health conditions. For example, the Coventry study drilled down on claimants receiving

Fentanyl, a powerful drug used for breakthrough cancer pain. Data mining showed that a measurable number of claimants did have cancer diagnoses; therefore, Fentanyl use was more likely to be appropriate (questions of compensability aside).

To achieve this kind of insight, it makes sense to partner with organizations that already have the data and the analytical skills to understand it, as well as the business acumen to apply the knowledge.

Strategies for all stakeholders

In their joint comment, ACOEM and IAIABC acknowledge that a solution isn't as simple as "passing a law against some easy target of abuse." Minimizing the potential for abuse or diversion while ensuring that injured workers get appropriate care – including appropriate pain medications – requires cooperation from multiple players. Working together, it is possible to achieve a positive outcome.

The CDC recommends monitoring prescribers for deviation from accepted medical practice in prescribing painkillers. Those using, or planning to use, an outcomes-based network should take this into account. A good outcomes-based network monitors its own providers to ensure that they are treating within accepted guidelines, including guidelines for OPRs. Even better, organizations should analyze prescribing patterns when selecting providers for outcomes-based network participation, given that pharmacy expenses continue to represent a substantial portion of the medical spend for indemnity claims.

Providers should follow evidence-based guidelines regarding pain management. The ACOEM and Official Disability Guidelines suggest limiting the use of opioids to cases of traumatic injury, fractures, severe pain, or post-operative pain. Based on national guidelines, prescription opioids are usually limited to two weeks from initial injury. Limiting the initial use of OPRs decreases the likelihood that use will become chronic and also limits the potential for diversion or theft of unused medication.

Providers also have a responsibility to educate the patient. A detailed consent form before initiating narcotic therapy provides an opportunity to do this. Providers should be aware of the connection between narcotic abuse and comorbid mental illness or other conditions when taking a patient's history. Monitoring or drug screening is a consideration for patients who use OPRs for an extended time.

Pharmacy benefit managers

Clearly, pharmacy benefit managers (PBMs) play a role. Currently 37 states have operational prescription drug monitoring programs (PDMPs) that can track prescribing and dispensing of OPRs. PDMPs are designed to help prescribers and pharmacists monitor for suspected abuse or diversion. Additionally, the pharmacist has a role in educating the patient about appropriate dosing and refill schedules to avoid potential abuse.

> It is interesting that jurisdictional law does not afford PBMs access to PDMPs. PBMs do, however, collect valuable utilization data that can identify patients whose medication regimen may need review. PBM access to the claimant's complete utilization history for the claim enhances this capability. The spectrum of utilization data makes it possible to identify inappropriate prescribing or utilization activities. PBMs also incorporate both nationally recognized clinical guidelines for point-of-sale edits as well as data analytic algorithms, and they are included in a variety of outreach programs. For example, the PBM pharmacist could alert the dispensing pharmacist to a potential drug interaction or could provide the prescriber with guidelines for the appropriate use of narcotics as they relate to workplace injuries.

At the adjuster level, there should be a positive complement between clinical decision support and claim adjudication. Here, PBM pharmacists can provide claims examiners with valuable information to help the examiners make complex decisions about OPRs. Support should include alerts to the adjuster regarding interventions, such as case management when necessary, to support improved patient safety and outcomes.

Nurse case managers

The nurse case manager plays a pivotal role in supporting positive outcomes when narcotics are involved. A nurse case manager should oversee and support appropriate management of narcotic medication use. The nurse case manager reinforces the education from the pharmacist to the patient about side effects and potential drug interactions. A trained field nurse case manager can holistically evaluate all treatment modalities, taking into account environmental and psychosocial factors that might put the patient at risk for narcotic overutilization.

> A properly trained nurse case manager acts as a coach, helping keep the patient motivated and moving toward the goal. This approach can break the cycle of pain-depression-inactivity that can impede progress and make the patient particularly vulnerable to the mood-altering properties of OPRs. The nurse case manager should also serve as a patient advocate, keeping the lines of communication open between the injured worker, the employer, and the health-care provider. If the treatment plan goals are not being met, the nurse case manager should provide patient education to enable the injured worker to make appropriate and informed decisions.

Ultimately, of course, the patient's actions determine the outcome. The patient will comply with the medication regimen and other modalities, such as physical therapy or a walking program. Or not. The provider, the pharmacist, and the nurse case manager can all provide critical information that can direct the patient to make decisions in his or her best interests.

High risk populations

Researchers are finding that certain populations are at higher risk of abusing OPRs. Several studies indicate that recreational drug use is higher among low-income Caucasian populations. Young adults

may also be more susceptible. A study by addiction researchers at the University of Pennsylvania reported that one in four 18- to 25-year-olds will abuse prescription painkillers in their lifetime. Teens and young adults with anxiety disorders, depression, or other mental illness are at higher risk, according to a University of Washington study presented at last year's annual meeting of the American Academy of Pain Medicine.

> These high-risk populations, as well as those patients with comorbid health conditions and those who are also taking sedatives, would benefit from early intervention. Employing best practices allows an organization to leverage the most appropriate clinical resource for the situation. With claimants who take sedatives or have comorbid conditions, the dispensing pharmacist is positioned to educate the patient and physician at the earliest opportunity. If such education does not result in reasonable outcomes, data analytics could identify claimant risk. The PBM or case manager could leverage such information to work with the prescriber to mitigate health and safety issues for the claimant.

Holding up the sky

Opioid pain relievers — and their potential for abuse — are a legitimate cause for concern. It's important to remember, however, that short-acting and long-acting narcotics, including opioids, are the two top therapeutic drug classes in workers compensation — so wishing won't make them go away. In fact, according to a Workers Compensation Research Institute (WCRI) study of some 75,000 nonsurgical workers compensation injuries, 55 percent to 85 percent of injured workers with more than seven days' lost time, and at least one workers compensation prescription paid, received narcotics.

> In a study on interstate variations on the use of narcotics, WCRI notes that "more frequent use of stronger, Schedule II narcotics does not necessarily lead to a problem if the regimen of Schedule II narcotics is used for relieving more severe pain to produce better outcomes. Without outcome data, we cannot tell if this is the case" in states where providers are more likely to prescribe the stronger medications.

While the industry works to develop a clearer picture of the drivers, stakeholders have many opportunities to make a positive impact and improve patient safety. Education is key to achieving this potential.

> It is critical for PBMs to stay up to date on recommended prescribing trends through continuing education and to participate in Risk Evaluation and Mitigation Strategies (REMS), such as the Food and Drug Administration's program for long-acting opioids. Similarly, it is important for adjusters and claims managers to review accepted conditions prior to medication overrides. Using established protocols for clinical intervention programs can also help ensure proper use and help reduce the potential for misuse, abuse, overdose, and diversion of OPRs.

As appropriate to their role, physicians, nurse case managers, pharmacists, and other clinical workers compensation providers

have a responsibility to stay up to date with current treatment guidelines and industry best practices for pain management and prescription pain medication. In turn, they serve the patient best by sharing their knowledge regarding the risks and benefits of opioid pain relievers, dosage regimens, weaning schedules, and other information that can help increase the patient's understanding and enhance patient safety.

> The sky may not be falling, but the clouds are threatening. The soundest approach seems to use common sense and work with a network whose members follow clinical guidelines, utilize leading edge pharmacy programs and technology, employ case management best practices, and base their strategy on insightful data analytics on an ongoing basis.

About the authors

Asha Gilson is a manager of decision support at Coventry Workers' Comp Services. An expert in the analysis of data originating in medical transaction systems, she is the lead statistical analyst for a number of initiatives, including Coventry's Outcomes Based Network. She holds a master's degree in statistics, and she has worked with medical data for more than 15 years as a SAS programmer/analyst and consultant.

Brian Carpenter is vice president of product development at Coventry Workers' Comp Services. He oversees product development and enhancements for both pharmacy benefit management and durable medical equipment. He has both workers compensation and group health expertise in PBM programs and managed both benefit implementation and plan design as well as formulary operations. He holds a bachelor's degree in pharmacy and has practiced in chain settings, a closed staff model pharmacy, and the group health pharmacy benefit management arena.

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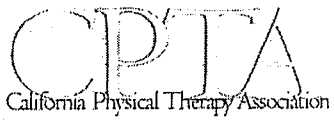

April 16, 2012

Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142
Attn: DWC Public Forums

Dear Division of Workers' Compensation,

On behalf of the California Physical Therapy Association (CPTA) and its 6,800 members, I would like to thank you for the opportunity to present our comments regarding current issues in Workers' Compensation. CPTA is the largest organization to represent licensed physical therapists and physical therapists assistants in California. Our participation in rulemaking for the State of California's injured workers is an integral piece in the advancement of rehabilitative services. I would like to offer comments regarding proposed Title 8 California Code of Regulations, Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services.

CPTA previously voiced its support for the Division's original plan to adopt a budget-neutral RBRVS schedule, eliminate the physical medicine cascade, and transition to a single conversion factor over a period of four years. In 2010, the Division of Workers' Compensation proposed to maintain the physical medicine cascade and adopt multiple conversion factors. Compared to the single conversion factor advocated in the previous proposal, the multiple conversion factors in this proposal set allowances that are an average of 24% higher for surgery services, 26% higher for radiology services, and 7% lower for all other services. Assuming no change in the mix of services, the conversion factors in this draft will result in estimated aggregate fees more than 3.3% higher than the previous budget neutral draft. This inequity in payment has created an environment in which physical therapists no longer desire to participate in providing care to the injured worker and have decreased access to care.

CPTA objects to separate conversion factors for surgery, radiology, and for all other services because assigning separate conversion factors corrupts the relative values and subverts the foundational RBRVS principles. Multiplying them by different conversion factors destroys their relativity and creates financial incentives for one type of service over another, which could work to the potential detriment of the injured worker producing significant costs for California employers.

Additionally, CPTA would ask that the Division consider the removal of the cascade payment methodology by evaluating provider payments per geographic practice expense indicators, professional liability expense and the value of the skilled service according to true resource-based relative value payment methodology.

In closing, Senator Kevin De Leon (Los Angeles) introduced SB 923 to require the Division of Workers' Compensation administrative director, by January 1, 2013, to adopt an official medical fee schedule for physician services based on the resource-based relative value scale (similar to Medicare). As defined, this legislation would authorize the administrative director to revise the official medical fee schedule for physician services, and would delete obsolete provisions relating to the adoption of a medical fee schedule. This bill would require the initial resource-based relative value scale official medical fee schedule to use a conversion factor that is determined by the administrative director, as prescribed, to result in no overall increased costs to the Workers' Compensation system. CPTA supports SB 923 because the bill will guarantee a complete revision of the provider payment system utilizing

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Move CALIFORNIA
www.movecalifornia.org

current code sets that support improved treatment for injured workers. We would like to offer our assistance in establishing a streamlined Workers' Compensation provider payment and utilization review system. In addition, we request the opportunity to provide evidence-based literature as we continue to work toward improvements in the California Workers' Compensation System.

Please feel free to contact me should you have any questions regarding our comments. Thank you for your time and consideration.

Respectfully,

Richard Katz, PT, MA
Finance Officer
California Physical Therapy Association

White Memorial Medical Center

Adventist Health

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323-268-5000

April 12, 2012

Christine Baker, Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

RE: Support passage of SB 923 and update Workers' Compensation Fee Schedule

Dear Ms. Baker:

As a hospital executive, I urge you to update the fee schedule for primary care services within California's workers' compensation system -- which is still based on an outdated model from the 1970's. Updating the fee schedule will improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians.

Our workers' compensation treating physician, providing diagnosis, treatment, reporting, and case management services, I know that SB 923 will resolve both the availability and cost of care problems within the existing system.

Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will help retain quality primary care physicians in the California system; and will control increasing costs and unnecessary medical expenses incurred by some physicians.

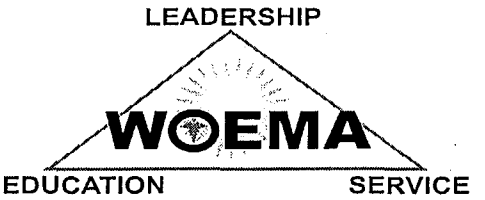
By reducing medical costs and increasing delivery of quality medical services in the state's workers' compensation system, SB 923 will benefit all of California's injured workers. Reducing costs associated with the state's workers' compensation system also saves money for the State and taxpayer. SB 923 is a win/win for injured workers, treating physicians, and the State budget!

Importantly, SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

Beth Dennis Zachary, FACHE
President and Chief Executive Officer



Western Occupational & Environmental Medical Association

A Component Society of the American College of Occupational and Environmental Medicine

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April 10, 2012

Recommendations for California's Workers' Compensation System

The Western Occupational and Environmental Medical Association (WOEMA) appreciates the opportunity to recommend improvements to California's Workers Compensation system. WOEMA is the regional component of the American College of Occupational and Environmental Medicine (ACOEM). Many of our member physicians provide the primary treatment to injured workers, while some serve as QMEs and IMRs or perform UR.

WOEMA believes the following changes will make the system more cost-effective, better align incentives to desired outcomes, and improve the quality of care delivered to our injured workers.

1) **Fee schedules: An update is urgently needed**

The current fee schedule for physician services was last updated in 2007, five years ago. Medical inflation is not stagnant for Occupational Medicine providers and the costs to maintain a practice have increased significantly. Despite being one of the most expensive states in which to live and practice medicine, physician reimbursement for office visits is amongst the lowest in the country. In particular, the E&M codes are markedly underpaid, and should be revised to take account of the extra work required for good disability evaluation and education about return to work and other gainful function.

2) **Align payment with quality metrics**

Although quality measures are well known, the system offers no incentives to score high on quality initiatives. WOEMA believes that compensation should be aligned with quality. A first step in this direction would be design and reimburse for quality systems within MPNs that provide timely feedback to providers about their performance on a number of quality metrics, including return-to-work, patient satisfaction, total claim cost, adherence to MTUS guidelines, and others.

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3) MPN membership: Streamline procedures for updating membership lists
WOEMA believes that the creation of the MPNs was a significant first step to improving the quality and efficiency of California's Workers Compensation system. Unfortunately, the potential benefits from MPNs have been undermined by the persistent debate over appropriate entry and exit criteria for participation inside an MPN. Physicians are routinely removed from MPNs without knowing why. They have issues when they attempt to join networks. Carriers, by contrast, report significant difficulty removing providers from an MPN due to a "restraint of trade" argument made by those providers. We recommend that MPNs use well-understood and established measures of quality and efficiency in determining entry and exit criteria.

4) Pharmacy carve-outs
The system should assure quality and ready access to prescriptions, and should foster the integration of health care services. Electronic prescribing capability should be retained where it exists.

5) Incentives for electronic health records
Practicing with electronic health records (EHRs) improves quality and decreases errors and wasteful duplicative care. However, implementation of an EHR is extremely expensive; Medicare providers, for example, are being given $40,000 as an incentive to implement and use EHRs. In the field of Occupational Medicine, EHRs are just as important, but currently there are no incentives to adopt and deploy them.

6) Utilization Review
The current UR system is cumbersome and costly, and in general has not been shown to improve value. Meaningful improvements are likely to flow from better integration of services, rather than maintenance of the current system with its multiple silos.

7) Liens
WOEMA endorses most of the reform proposals recommended in the CHSWC in its 2011 report.

8) Opioids
As use of prescription opioids has been shown to be associated with a dramatic spike in overdose deaths, as well as been a key contributor in the escalating costs of medical care in the Work Comp system, appropriate opioid prescribing is vital. Indeed, WOEMA has developed a guidance document for its members on proper prescribing. California should emulate the Colorado system, which codifies the need for additional clinical steps for patients who are on chronic stable opioid doses. These steps include administration of periodic questionnaires for red flags and periodic urine drug screens. Additionally, California must preserve and enhance the CURES system.

9) QMEs/ AMEs

Although there are some minimum criteria for licensure of QMEs, there is no real mechanism to assess their performance. We believe the significant power given to a QME in the California system should be balanced by a check on the quality of their evaluations.

10) Align legal incentives

A system of appropriate reimbursement for quality practice should be extended to the legal profession. At present, attorneys have incentives to keep patients off work, and to increase the utilization of expensive and potentially harmful treatment. The same sorts of quality incentives that ought to be built into MPN systems should be required for attorneys representing injured workers.

11) Expert panels

The DWC should establish a panel of medical experts to advise the Work Comp bench on disputed matters of medical fact, mirroring the processes that currently exist for Knox-Keene plans when disputes arise over coverage for certain requested medical services. Such experts would be called on to serve as a part of smaller sub-panels, to be convened on request of a member of the Work Comp bench. DWC should establish rules for the panels' deliberations and for the discoverability of their deliberations.

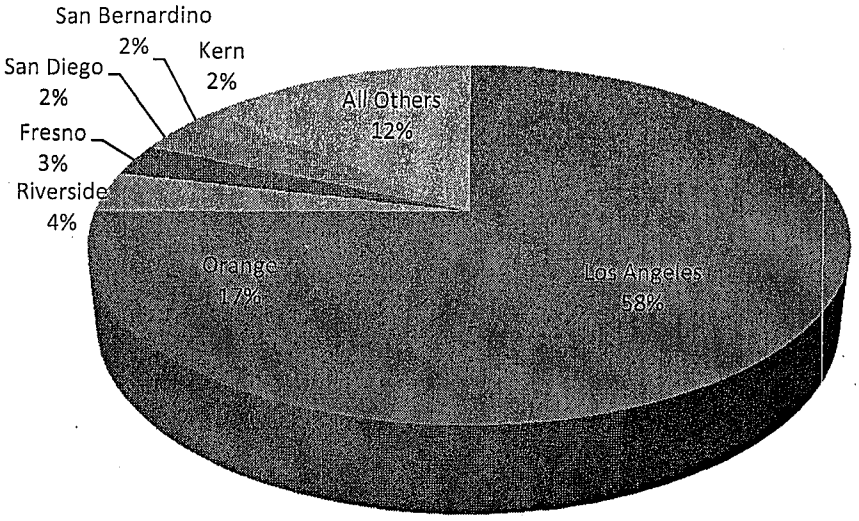
Liberty Mutual Lien Claims

California Workers Compensation

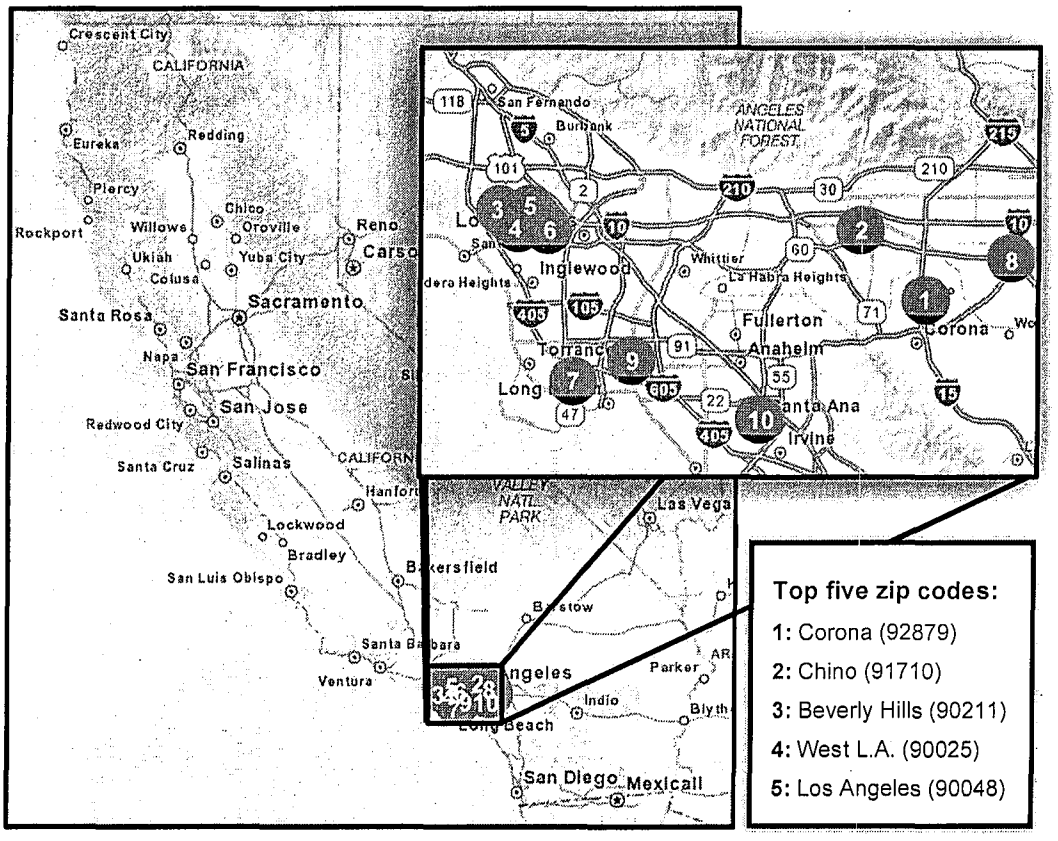
Issue: Lien litigation is placing costly and time-consuming burdens on the Workers Compensation system without providing benefits to California's injured workers. This litigation is largely unique to the area around Los Angeles, and is virtually unheard-of in the other 49 states. However, it has become so complex and expensive that it increases costs on all employers statewide. Proposed regulations will help in many areas, but the problem is so deep-seated that it requires comprehensive legislative reform.

- Only 20% of Liberty Mutual's WC business in California, yet the state accounts for 86% of our billing disputes nationwide.
- We receive an estimated 50,000 WC liens per year in California, demanding $200 million. However, our audits have found that most of these have little or no evidence to support them:
    - About 80% of liens are made up simply of a bill and a demand, which does not by itself constitute substantial evidence. This volume of litigation is costly for all involved, including the courts. However, the practice continues because there are no strong consequences to deter frivolous litigation.
    - About 15% of liens are genuinely in dispute. In other words, some evidence may have been presented, such as doctors' reports to support medical necessity, or fee schedule calculations to support the amount of the bill. However, the parties still disagree as to whether one side's position is stronger than the other's. These liens are usually settled eventually, but the process takes an average of 3 years. (This is largely because lien litigation has overburdened the courts. Lien cases get an average of 6 continuances before being resolved. Each continuance delays the case by 3 to 6 months.)
    - Only about 5% of liens are clearly payable. Most of these are either EDD liens or undisputed medical bills in which the provider filed its lien before sending us the bill. Liberty Mutual's position is that we will always pay what we legitimately owe, so we make every effort to resolve those liens without the need for litigation.
- This litigation is driven by two issues unique to California:
    - It has become common practice for some attorneys to refer applicants to providers who "treat on a lien." These providers are invariably outside of Liberty Mutual's MPN. Typically they make little or no attempt to request authorization, nor do they follow evidence-based treatment guidelines as required by Labor Code sections 4600-4610. Instead, they simply bill the file, then pursue litigation to collect on their billing.
    - Case law has made the Statute of Limitations nearly unenforceable in California, so collectors often pursue bills that are so old that the corresponding records no longer exist. Liberty Mutual keeps records longer than required by law, but we still encounter this issue regularly; for example, we receive liens from the 1990's on a daily basis, and from the 1980's on a weekly basis.

- The litigation is driven by a small subset of providers:
  - Los Angeles and Orange Counties make up only a third of the state's population, yet these two counties account for the overwhelming majority of our lien cases:



  - When lien claimants' filings are tracked by zip code, most are located in the same area. 97 of the top 100 zip codes (including all of the top 10) are in the inset below:



- When liens are broken down by the type of treatment, a similar pattern emerges, in which a small fraction of providers account for the vast majority of liens. For example:
  - Of all the pharmacies who bill us under California WC:
    - 2.3% of providers account for the majority of liens filed.
    - 18.0% of providers account for ninety percent of liens filed.
  - Of all the Durable Medical Equipment vendors who bill us under California WC:
    - 0.7% of providers account for the majority of liens filed.
    - 11.5% of providers account for ninety percent of liens filed.
  - Of all the interpreters who bill us under California WC:
    - 0.8% of providers account for the majority of liens filed.
    - 10.5% of providers account for ninety percent of liens filed.
  - This pattern repeats itself across virtually all categories of medical billing, including chiropractors, acupuncturists, hospitals, and surgery centers.

- The litigation is complicated by the fact that certain WCAB venues are reputed to have varying approaches to liens. These reputations may or may not be warranted, but lien claimants routinely try to litigate their liens in the venues that they feel are most favorable. For example:
  - MPN disputes are most commonly litigated in Marina del Rey.
    - Virtually all lien claimants are outside the MPN, so they argue that the MPN is unenforceable. In most cases, they do this by alleging that the applicant was not properly notified of the employer's network. Even if the employer is able to show that the applicant was indeed notified, lien claimants typically demand copies of all MPN notices, including notices that are irrelevant to the case. Lien claimants also demand witnesses who can testify as to whether the notices are authentic, or whether the applicant remembers getting them. The WCAB recently ruled in the Clifton panel decision that this burden of proof is unreasonable; however, Clifton is not binding case law as it was not an en banc ruling. Consequently, this issue is still being litigated on thousands of cases.
    - Several Marina judges have publicly stated that they are reluctant to rule on MPN disputes before the case-in-chief settles, because they feel it could constitute "declaratory relief." Lien claimants have interpreted that as license to keep billing the file until the time of settlement. This results in a large volume of liens, often exceeding tens of thousands of dollars apiece.
  - Interpreting bill disputes are most commonly litigated in Long Beach.
    - Several lien claimants acknowledge that they perceive Long Beach judges to be more sympathetic to their position than judges elsewhere. As a result, they are filing hundreds more petitions and Declarations of Readiness in Long Beach.

        - These interpreting liens now take up so much time on Long Beach's calendar that these hearings are routinely being set 9 months out.

- These disputes divert a great deal of money and resources away from assisting injured workers while increasing costs on employers.
    - Frivolous or unnecessary liens do nothing to cure or relieve from the effects of an injury.
        - Many liens violate the medical treatment guidelines in Labor Code section 4604.5. Those peer-reviewed guidelines are designed to protect injured workers by ensuring a standard quality of care. When lien claimants ignore those laws, the result is usually inappropriate treatment.
        - Many lien claimants' medical reports simply deem the injured workers to be disabled, with no discussion as to when or how they may return to their jobs. These providers also make little or no effort to cooperate with the employer to help get the employee back to work. This results in poor outcomes.
        - The large volume of questionable liens has also created a "crying wolf" effect by crowding out legitimate disputes.
    - CHSWC's 2011 lien report estimated that the average defense cost is $1,000 per lien, which is consistent with our own estimates. Those costs are virtually unavoidable because they are still lower than the costs of simply paying the liens. (On our liens, the average demand is $4,000.) These costs are ultimately borne by California employers.
        - Liberty Mutual has added staffing in California so that WC adjusters' average caseloads are lower than in any other state. However, these adjusters must still devote a substantial percentage of their time to liens, which takes time away from assisting injured workers or policyholders.
            - Internal studies have found that adjusters receive an average of 7 calls from lien claimants per day. This adds up to an average of 45 minutes per day on the phone with lien claimants. This constitutes 10% of a typical 7.5-hour workday.
            - Adjusters must also spend valuable time on unavoidable lien-related tasks such as reviewing and pricing liens, and preparing for hearings.
            - In all, we estimate that at least 25-30% of adjusters' time is spent on liens. (This is roughly in line with the WCAB's own statistics, which have shown that about a third of judges' time is spent on lien disputes.)
        - Liberty Mutual has also dedicated a team to managing and resolving these liens. The team includes 4 lien specialists, 3 support staff, and one manager, all of which are full-time positions.
        - With so many cases in litigation, legal fees are also unavoidable. For example, attorneys and hearing representatives must make an average of 5 to 7 appearances at the WCAB on each case. Billing experts and other witnesses must also be available to testify at trial.

- Billing disputes do arise in other states, but most are resolved quickly with little need for litigation. That is because other states' procedures include three elements that are lacking in California:
    - Many states have consistent billing forms for all providers. (California did adopt standardized billing for most providers in 2011; however, many lien claimants still litigate their bills using non-standard forms. The 2011 changes also excluded certain providers, including interpreting and transportation services, which file a large volume of liens.)
        - New York has a specific form, called the HP-1, which must be used to resolve billing disputes. That form is much more effective than California's equivalent "Notice of Request for Allowance of Lien," because the HP-1 requires the parties to first try to resolve these issues informally, and if that is not possible, to outline the specific items in dispute. (California's form only asks for basic information. In practice, most lien claimants simply write in boilerplate language that includes little or no usable information.)
        - Florida has specific protocols on how to apply HICFA's and other standardized billing forms to various types of providers, including ambulatory surgery centers, drugs and medical supplies, and home health agencies.
    - Many states have specific timeframes in which to raise a dispute.
        - Some states such as Oregon, Mississippi, and Pennsylvania require disputes to be noticed within 30 to 90 days.
        - Others such as Georgia, Louisiana, New York, and Texas allow for a few months to a year.
    - Many states have a consistent process to resolve disputes.
        - Oregon and New York handle disputes through administrative processes set forth by law.
        - Utah and Pennsylvania refer disputes to state bill-review agencies.

Recommendations:

- The 2011 proposed WCAB regulations should be adopted, which would amend CCR sections 10582.5, 10770, and 10770.1. Those regulations are designed to reduce delays and more easily sort out the merits of given liens. However, the lien problem is so complex that these regulations are only the first step to a solution.
- The following additional changes should be made. All of these were recommended by CHSWC in its 2011 lien report:
    - The lien filing fee should be reinstated. It should be set at a minimum of $100 to cover at least a portion of the court's costs, and should be collected at the time of filing.

- To be fair, if the lien ends up being payable, then the claims administrator may be ordered to reimburse the fee. However, if the lien is not found to be payable, then the lien claimant should shoulder the cost. That way, both parties have an incentive to avoid unnecessary litigation.
- Other states have similar fees. For example, New York charges an "arbitration fee" which varies depending on the amount in dispute, up to $350.

- Fee schedules should be revised to cover areas that are often disputed. They should apply to all outstanding billing disputes, regardless of the date of service.
  - Copy service fees should be subject to a fee schedule. To be fair, independent copy services may charge more than contract vendors because they receive fewer referrals; however, the fees must still be reasonable.
    - Claims administrators should be required to pay for a single set of records: either electronic or hard copy, but not both. Duplicative services or charges should be prohibited.
    - The fee schedule should establish consistent basic charges such as file setup and clerical work, as well as field charges such as parking and mileage, and scanning or copying charges. The fee schedule should also make clear when ancillary services are reasonably necessary.
  - Interpreting fees are governed by CCR 9795.3, but the current regulations lack clarity and consistency. That section should be revised as follows:
    - Rates should be consistent. The current regulations set forth one set of rates for legal appearances, another for medical-legal exams, and no set rates at all for medical treatment exams. There is no compelling reason to differentiate between these three, because they all cover the same basic services. A consistent rate would make interpreting bills easier to adjust, and would limit disputes.
    - If interpreters provide services on multiple cases in quick succession, then the fees should be applied pro rata. For example, many interpreters are located at doctors' offices or WCAB venues. This allows them to provide services on multiple cases in quick succession, often spending a few minutes on each one. They should be paid according to the actual time spent on each case.
    - The Guitron case law established 4 criteria for evaluating interpreter bills at medical exams. These criteria should be applied to all interpreting bills, including services performed at hearings and other events in the course of the claim. In other words, in the event of a dispute, interpreters should be required to prove all of the following elements:
      - The services were reasonably required.
      - The services were actually provided as billed.

        - The interpreter was qualified.
        - The fees charged were reasonable.
    - Similar fee schedules should be adopted in other areas that commonly result in disputes. These include fees for surgery centers, Durable Medical Equipment, and compound medications.
- Authorization protocols in Labor Code sections 4610 and 4616 should clearly outline how to resolve disputes involving unauthorized medical treatment.
    - If the parties disagree on whether or not treatment should be authorized, including whether the applicant is subject to an MPN, then those disputes must be adjudicated within a reasonable amount of time. The parties should be required to file for an expedited hearing (which is already designed as the proper venue for treatment disputes). If the parties are unable to reach an agreement at the hearing, then the judge should issue a ruling. This procedure is routinely used in Northern California to keep the amount of disputed treatment to a minimum, and it should be enforced statewide.
    - Self-procured treatment should only be allowed in cases where the employer showed "a neglect or refusal to provide reasonable medical treatment" under Labor Code 4600(a). This would prevent attorneys from referring applicants to self-procured treatment as a matter of course.
    - Employers and claims administrators should have a reasonable burden of proof in order to enforce the MPN. In other words, in the event of a dispute, the employer should be able to satisfy its burden by proving 2 elements (which are outlined in detail in the WCAB's panel decision in Clifton):
        - The claims administrator must prove that its MPN was approved by the DWC. This should be a clear-cut issue because the list of approved MPN's is publicly available on the DWC website.
        - The claims administrator must provide evidence that it provided the required notices to the applicant. The burden would then be on the applicant or lien claimant to rebut that evidence; if no rebuttal is made, then the evidence should be allowed on its face.
- Labor Code sections 4903-4906 should be rewritten to bring California's lien protocols in line with other states. Specifically, they should include the following three elements:
    - Consistent billing forms.
        - The 2011 changes were a step in the right direction, but California should apply standardized forms to all providers.
        - There should also be a consistent form for billing disputes, which cannot simply be filled out using boilerplate language. New York's HP-1 may serve as a model in this regard.

- Consistent timeframes. The Statute of Limitations must be enforceable, and must explicitly apply to all outstanding billing disputes.
    - Labor Code 4904 needs to be revised to make clear that all liens must be formally filed with the WCAB. The existing language states that simply giving written "notice" constitutes a lien, yet it does not clearly define what constitutes "notice." This is the loophole that has rendered the current statute unenforceable, because case law has found that any written correspondence is enough to toll these timeframes. (The proposed WCAB regulations already address this issue. However, since this language remains in the statute, it leaves the regulations vulnerable to court challenges.)
    - Labor Code 4903.5 should be revised so that the Statute of Limitations is based on the provider's date of service. Currently the statute is based on either 6 months after the resolution of the case-in-chief, 5 years after the date of injury, or 1 year after the date of service, whichever is latest. In practice, however, those timeframes create a loophole that often put claims administrators in a Catch-22. To enforce the current statute, claims administrators must first notify lien claimants that the case-in-chief is resolved; but if no lien has been filed, then we have no way of knowing that anyone needs to be notified. This allows lien claimants to effectively keep tolling the statute.
- Consistent adjudication process. We recommend that the WCAB set up a dedicated unit to resolve lien disputes, which can be done at minimal cost.
    - For example, many lien cases are already being referred to Oxnard to reduce the burden on other venues. The WCAB could designate Oxnard—or any other district offices—to be the designated venues for lien issues.
    - This would create numerous benefits for the WC system as a whole:
        - By centralizing the process, the WCAB can ensure consistency statewide and avoid the variations (or perceived variations) that currently exist between venues.
        - The WCAB can also concentrate its expertise in the areas where it is most needed. By bringing disputes before a limited number of judges—who have expertise in fee schedules and other highly technical areas pertinent to liens—the WCAB can minimize the need for expert testimony and generally speed up the litigation process.
        - Most importantly, a centralized process would free up resources in other venues, allowing judges to focus more attention on injured workers' claims.