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COMMENTS  
OF THE 2012  
WORKERS' COMPENSATION  
FORUM**

**PART 3**

## Public Forum on Workers Comp

Wednesday, April 25, 2012  
La Mesa Community Center

Workers Compensation Insurance has been a great benefit for the hard working women and men in the State of California. However, and after living through some tough times with a work injury as well as listening to other workers talking about the horrors they have faced I will summarize the main topics of discussions:

- Workers Comp Doctors consistently make patients feel that regardless of any oath they have taken for the well being of the humane race, they still need to save their employer assets in order to be profitable when it comes to treating a work injured patient. I have seen it in person when after hearing a loud crack on my back and taken to see the Company's workers comp doctor, the Doctor assumes that there is no injury just by having me bend forward and touch my toes. No MRI, X Rays, etc. I had to wait more time to see the Doctor that the actual time the Doctor took to do a thorough inspection of my back.

I am a Union Representative and I hear from our members stories about how bad their experience was while going to the Workers Comp Doctor. Open wounds not being treated appropriately, lengthily recoveries and no accountability on part of the workers comp medical providers.

- Under the California Posting Requirements there are no notices informing workers when their workers comp benefits begin.
- Since a work injury may be covered under FMLA or CFRA and it may be considered as a "serious injury" Companies take advantage of the language and basically force employees to use their accumulated sick and vacation time during their work related injury leave. Employees cannot use their vacation time as it was intended in order to have time away from work to recuperate themselves both physically and mentally as well as enjoying time with loved ones. Now the time that should have been designated for rest and relaxation is used to recuperate to return to work, stress out during that time since the bills are getting bigger and bigger and the amount received from workers comp is not sufficient to cover their basic needs. We need to make sure that the injured employee, and the injured employee alone can make that decision and not the employer having to determine if the employee will have to utilize their well earned vacation time to receive payment while they are out injured.

- When a workers comp injury extends beyond a Company's allocated time to qualify for Medical Insurance Benefits the employee loses coverage and now becomes a burden on the State. Most employees are proud to work for an employer who does offer medical insurance. Employees with Health Insurance coverage are also aware that they are a contributing factor to the success of this Nation and when they start being part of the statistics on our State's budget, their moral declines and feel that they are now a burden especially when most of those employee's biggest fear is to get injured at work. Some employees have family coverage and some of them need to maintain their health insurance due to a family member having a serious health condition and an interruption to their medical treatments could have very serious implications. We need to make sure that employers continue providing the same Health and Welfare level of benefits that the employee had prior to being injured for the duration of the time that the employee is in recuperation.
- The law should be very clear when it comes for an employee to return to work after being released from the Doctor. I have seen cases where it almost takes a lawsuit against an employer to force them and bring the ready to work employee back to work without any harassment or intimidation. The law should be stricter on the amount of time needed to return an employee back to its work force and not allow them time to play around with the employee given them lame excuses on why its taken so long to schedule them back to work.

The bottom line is that most workers that I have had the privilege to talk with have the same argument: "I did not ask, wish, or desired to get injured but it seems that I am being punished for doing my job".

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LOCAL #12 IUOE  
April 25, 2012

Department of Industrial Relations Meeting  
April 25, 2012 questions and comments

1. Why is therapy limited to 12 sessions?  
Shouldn't the therapy sessions be geared to individual cases?
2. In Washington state employees are allowed to return to work and they pay up to \$10,000 a year claim. The program model tends to speed recoveries and reduce long term disability.
3. QME(qualified medical evaluators)should not only take in consideration bodily injury but the physical damages to family, etc.
4. MRI's should be used instead of x-rays in some circumstances for a better idea of treatment needed.
5. An injured employee should be contacted and instructed how to apply for Workers' Compensation?
6. Why must the employee request in writing for benefits, evaluation, or want a delay in 90 days. An individual should be evaluated by another person.

*(continued from page 9)*

a similar requirement (see *Washington Watch* on page 2).

A draft report by the California Commission for Health, Safety, and Workers' Compensation (CHSWC) found that companies that had I2P2s but violated other aspects of the requirement saw a drop of about 25 percent in worker injuries the year following their citation. That translated to an average annual decrease of only 0.29 injuries for smaller businesses and 0.96 injuries for larger companies.

The commission saw no improvement in job death rates in the state after the I2P2 rule was implemented. The report was conducted by the RAND Center for Health and Safety in the workplace. It determined that recently inspected facilities are no more likely to have written programs now than they were 20 years ago.

It also found that employers cited for not having a written injury and illness prevention plan had fewer injuries than sites with no I2P2 violations. That may point to the fact that small businesses underreport their injuries, according to CHSWC. California's I2P2 is the most frequently cited standard in the state, with violations in about 25 percent of inspections.

## WASHINGTON

### Program Rewards Employers For Keeping Workers on Job

Employers that provide light-duty jobs to injured workers may be entitled to a reimbursement from the state. *Stay at Work* is a new program designed to keep injured employees on the job and to help Washington employers make that happen.

The program is available to employers that pay premiums to the state Department of Labor & Industries (L&I). It partially reimburses them for the costs of bringing injured

workers back to safe, light-duty jobs before they are medically cleared to return to their former positions.

Although the program was launched January 10, the law creating it took effect last June. L&I expects several thousand reimbursement requests from employers that have been providing light-duty jobs since that time.

*Stay at Work* reimburses an employer for half of the qualifying worker's base wage plus some expenses up to \$10,000 per claim. The program model, which has proven successful in Oregon, tends to speed recoveries and reduce long-term disability, say state labor officials.

"This is a win-win for our employers," noted L&I Assistant Director Beth Dupre. "It's a strategy that will help their businesses and workers, and it won't negatively impact their premium costs." *Stay at Work* is part of a package of workers' comp reforms passed during the 2011 legislative session.

## OHIO

### OSHA Allies with Labor Over Equipment Operators

OSHA has established an alliance with the International Union of Operating Engineers Local 18 and its training program. The goal is to provide engineering workers with information, guidance, and access to training resources, particularly related to hazards associated with cranes and heavy equipment. The OSHA state-run consultation program will also participate.

As part of the agreement, OSHA representatives will make presentations at Local 18 apprenticeship training sessions. Participants will share information regarding on-site crane and heavy equipment management, case studies, and best practices related to noise, heat stress, and other hazards.

Victor H. Cooper

Added OSHA Columbus Area Director Deborah Zubaty, "We want to ensure that all workers understand the hazards involved in operating heavy equipment and how best to protect themselves. Alliances such as this one help develop effective safety and health programs, while also opening the lines of communication among OSHA, employers, and workers."

### Ohio Businesses Recognized With Healthy Worksite Awards

The eighth annual Healthy Ohio-Healthy Worksite Awards recently recognized 34 businesses in the state during a ceremony held January 31 during a state health conference. Presenters included *New York Times* best-selling author John J. Nance.

The recognition program is sponsored by the Ohio Department of Health, the Healthy Ohio Business Council (HOBC), and Medical Mutual of Ohio. A total of 97 businesses, cities, and townships applied for the 2011 awards. The program recognizes employers that demonstrate a commitment to employee health through comprehensive worksite health promotion and wellness programs.

The highest level (gold) award for large employers went to Mount Carmel Health System, Akron Children's Hospital, and Tri-Health. Winners of the small employer gold award were Technical Consumer Products, Inc., Main Street Gourmet, and Ericson Manufacturing.

According to HOBC Chair Laura Ritzler, health and wellness yield significant gains for employers and employees. "Positive returns on investment are realized in employees who improve their health resulting in decreased rates of absenteeism and increased productivity." She points to reductions in healthcare costs and improvements in productivity and job satisfaction.

*(continued on the next page)*

4/25/2012  
San Diego

Christine Baker/ Rosa Moran

Thank you for the opportunity to share some of my experiences.

I think we all need to remember that Insurance companies are not in business to get anyone better or get anyone back to work. They are in business to collect money from policy holders and turn it into huge profits. You pay them for protection only. Now we have let them be involved in, and have major influence over how exactly that protection is going to be provided and it is ever changing to their benefit. We are letting our system be turned into a carrier controlled HMO, and that does not effectively treat injured workers.

I want to just give some of my observations as a provider of services who is also very involved and compassionate when it comes to patient care.

MPN

The concept sounds great, unfortunately in reality it is a nightmare, and I do not think I need to re hash all of the specific problems patients and referring physicians have accessing other physicians via an MPN. I will say this though. To allow an employer the opportunity to hand pick each and every Dr that they want on their MPN and give them years to do it is fair. To then give those Dr's a treatment schedule that they **must** treat within is kind of fair. But to then allow them to hire an outside or carrier owned and controlled Utilization review company who can find ways to deny anything that is requested, depending on marching orders from the carrier is crazy and not really fair to anyone involved. What is the point of the MPN than?

And that brings us to the problems with Utilization Review itself.

Now I do believe there are a few companies that perform Utilization Review, just a few. Most companies out there that say they are performing utilization review are in fact just selling denials. There is a huge difference between doing UR and Selling denials, of course the profits and customer retention is huge when you sell denials, so unfortunately that is what most supposed UR companies are doing now to compete with one another.

I want to give you an interesting statistic. I have run reports in my own business that show this much of a disparity, I studied one specific request all submitted in pretty much the same format and all something that is included in the MTUS Chronic pain section. One UR Company over the course of a year or 2 denied 98% of all of the requests. On the opposite end of the spectrum I have a company who is very large and nationally recognized that denied 14% of the requests. Now these companies are using the same guidelines and this is happening. Letting companies sell denials does not work.

If you are going to continue with UR these Drs need to be certified somehow like an AME or a QME is. To just let anyone slap there name on a piece of paper and have this much power over treatment, and to then have the appeal process be such a burden to the injured worker while not letting the provider of goods or services have any right to object is crazy. And a burden on all parties involved. The system is pushing providers of services right out.

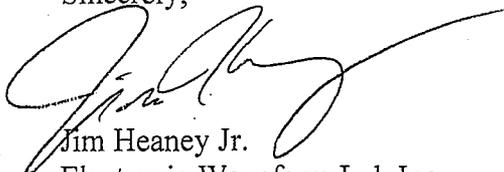
I was trying to think of something that could happen in my life that could maybe make me relate and the best I could come up with would be my Auto insurance implementing Utilization Review, so for example I need to put in a request to come to this hearing, I could see getting a denial like this " We are sorry we have reviewed your request and we do not believe it is socially or economically necessary for you to drive" If you wish to object you have 10 days to do so.

Imagine what a burden that would be, what if something came up and you needed to rush to help a friend or acquaintance in need, everything would be delayed. None of us would stand for this and we should not stand for it in Workers Compensation. We have already let it happen in General Health care, lets protect ourselves from this becoming an insurance carrier controlled HMO.

I do know that example was a little over broad but it does make sense. UR is like all of us needing to call our auto agent before we do anything. Don't we have a drivers license, don't we trust the Dr's we have put into our MPNs???

I would love to discuss this more in depth if you have any time.

Sincerely,



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*ELIMINATE PAIN. RESTORE FUNCTION.*

April 25, 2012

Dear Moderator, Div of Industrial Relations panel

Thank you for allowing me to address you today. My name is Jim Malone, I have been a consultant in workers' compensation for the past 14 ½ years. Prior to that I was the self-insured, self-administered work comp administrator for the San Diego Transit, prior to that a claims examiner with 3 different insurance companies, and prior to that, an injured worker, hired by an insurance company out of vocational rehabilitation.

I'm addressing you in this forum today to share with you the incredible imbalance occurring in workers compensation countless times on a daily basis. This imbalance is related to the amount of power one party holds over the other in California workers compensation as it relates to the medical treatment aspect of these injury claims. This imbalance results in one party blatantly disregarding the statutes and times frames created by the most recent legislative changes, namely related to managing the Medical Provider Networks and the management of the processes related to evaluations, treatment, tests, and procedures.

I consider the Medical Provider Network concept a corrupt, inadequate and one-sided method of managing the medical provisions provided to injured workers. This management is, of course, at the hands of the claims administrators. I believe the legislative intent for use of MPN's was to provide a limited but qualified panel of medical providers, well-versed in workers compensation, sufficient enough to provide quality care to provide "relief or cure from the effects of industrial injuries."

I believe the MPN process appropriately served its main purpose; to eliminate evaluations and treatment provided by liberal medical providers and "mills". However, it has also served to limit and even eliminate evaluations and treatment from numerous, well-respected and very qualified medical providers. There is a subversive undertone to remaining on MPN for medical providers. The medical providers realize if they are "too liberal", or "too aggressive" in their diagnosis, treatment or final evaluations of patients, they may be immediately removed. Many qualified medical providers no longer take workers compensation cases because they cannot get on some MPN's or cannot remain on them.

Most MPN physicians are ultra conservative, providing the minimal amount of care while minimizing the bodily areas affected by work injuries. This usually leads to simple strain / sprain injuries becoming chronic, or simple strain / sprain injuries becoming degenerative and surgical, and usually results in litigation to fight for basic medical treatment that usually does not respond to delayed and minimized treatment. Many chronic ailments did not need to become chronic. Many "everyday" strains and sprains become pain syndromes that lead to increased time from work, increased need for various medical specialty evaluations, increased failed surgeries, additional bodily areas affected (psych, internal, overcompensation), litigation and permanent residuals that drive up the final settlement values of claims. One of my clients is a pain management specialist, and a majority of patient's we see provide this exact history.

Many of these patients did not wish to get injured and did not wish to be stuck in a work comp claim process that is measured in years, not months. Yet, they become so frustrated over the claims process, the "delay and denial" tactics, the loss of a job, the loss of a career, loss of accumulated vacation, sick and personal days, loss of savings accounts, loss of personal items, vehicles, homes, and even marriages from the downward spiral these work injury claims costs them. If / when they survive filing a work comp injury, many opt to simply get treatment for future work related injuries with their family doctors so as to avoid the work comp process. Even with they do retain legal counsel, most don't get their telephone calls returned and the majority do not even get an explanation of the work comp claim process or the litigation and / or settlement process and options. Many contemplate suicide, fewer actually attempt it, and a few even succeed. This should not be the cost of filing a work related injury claim.

I also consider the Utilization Review process as an over-utilized process that serves to interrupt, delay and outright avoid / prevent the provision of appropriate and timely medical treatment to injured workers. It also serves in creating issues that, in turn, results in increased litigation over medical treatment issues. I believe this issue is the number one reason injured workers consult and retain attorneys to help them with the workers compensation process.

Use of UR quickly turned into a revenue generating process for the entities administering claims and an added cost burden for California employers in an already financially difficult market. (This is eerily similar to the

legislative changes that led to bill review in the 1990's) The UR process costs California employers money immediately by the mere process and over time as the delay in providing medical treatment, the overall inadequate quality and quantity of care eventually provided, and the resulting residuals from the provision of delayed and inadequate medical treatment.

Many of the insurance companies own these UR companies (as they do with the bill review companies) and require that their adjuster send EVERYTHING through UR. When we have proposed treatment models or programs, and offered pricing at or below the medical fee schedule, some claims administrators refuse to consider because it would interfere, or decrease the revenue streams from the UR process. This is especially true with third party administrators whose main revenue source is the UR process.

Many of the UR reviews are provided by non-physicians, from out of state physicians, or from reviewers who are not educated or trained in the field the issue is related to. Many UR reviews are addressing issues they are not permitted to address, such as AOE / COE. Many peer-to-peer reviewers outright lie about attempts to contact the physician to discuss the issue at hand. After these so-called attempts, the reviewer denies the requested treatment based upon lack of response by the provider.

A large amount of the medical provider's time is spent on peer-to-peer discussions, addressing non-certifications and / or modified certifications, and / or appeals of decisions rendered. All these peripheral activities result in one constant, negative element for the injured worker...a delay and likely denial of basic, necessary and appropriate medical treatment.

Many of the time frames associated with UR reviews and adjuster authorizations are missed and even ignored by the claims administrators. Yes, the medical provider has steps he / she can take to remedy the situation, but with providing medical treatment after the time limitation has been exceeded, filing a lien for such services, pursuing penalties and interest for these situations leads to the medical provider being "black-balled" and ultimately removed from the MPN altogether. Many of these actions are routinely committed by certain claims administrators.

The MPN and the UR processes should be re-evaluated

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4/27/12

## California Public Forum on the Workers Compensation System

Kevin J. Fay, Global Director Environment, Health, Safety & Product Safety  
PPG Aerospace, Sylmar, California

Good afternoon. My name is Kevin Fay. I am the global director for the environmental, health and safety programs for PPG Aerospace. Our global headquarters are in Sylmar in the San Fernando Valley. 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, including 6 here in Los Angeles County.

PPG has operations in 40 states and the California Workers Compensation system is certainly one of the most costly for us. In 2011, our California operations represented more than 23% of our total company workers compensations costs even though less than 8% of our workforce is located in the state. Our California costs have risen more than 27% since 2009. Our Aerospace operations which are located primarily in Los Angeles County have risen 69% over the past 2 years. These rising costs adversely affect our overall labor costs, limiting our ability to offer the competitive salaries and benefits necessary to attract and retain a high tech workforce. In addition, they make our California operations less attractive for business investment.

We do not believe that there is a need to completely overhaul the reforms enacted between 2002 and 2004. However, some stakeholders have learned new ways to exploit loopholes in the system that add costs without delivering benefits to injured workers. We recommend legislative action on the following three high priority reform areas:

- **Medical liens** – The new cottage industry of medical liens (particularly here in Southern California) is forcing employers to address medical services costs that can be many years old and totally unrelated to the original occupational injury. 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. Legislation is needed to ensure that the prescribing of these drugs can be tracked and abuses prevented.
- **Reform of Permanent Disability (PD) rating schedules** – The new PD schedules were expected to reduce costs by \$115 million per year but have instead increased costs by \$240 million. The schedules have driven a high rate of litigation and associated costs. We know that this will be a challenging issue to address and will take further evaluation and discussion among all stakeholders to resolve.

In conclusion, if workers compensation costs continue to rise, PPG will not be able to make the investments that retain and grow jobs here in California. PPG intends to remain actively involved in this critical reform effort.

Thank you.

Kevin J. Fay, P.E.  
Global Director  
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April 30, 2012

Ms. Rosa Moran  
Administrative Director, Division of Workers' Compensation  
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**RE: PMSI Comments at CA Public Forum(s) Regarding Workers' Compensation**

Dear Ms. Moran:

First, I'd like to thank the California Department of Industrial Relations and Division of Workers' Compensation (DWC) for this opportunity to provide input and suggestions for improving the workers' compensation system. PMSI has always welcomed working with the Division and appreciates the constant openness and assistance in handling ongoing problems. Further, Division staff is always of great assistance in clarifying issues for providers such as PMSI. PMSI is a national provider of pharmacy services, including retail pharmacy services – through our PBM Tmesys – and mail-order pharmacy services solely for workers' compensation claimants. In California we provide pharmacy services for numerous large and small insurers and self-insured employers, chief among them are Chartis, Sedgwick, Zenith, SCIF and the Los Angeles Unified School District.

I will keep my comments brief and focus on a few specific areas we feel could be a platform for future legislative and/or regulatory improvement to the system.

#### Pharmacy Networks

California Labor Code 4600.2 allows medicines to be provided to injured employees through a contract. Payors contract with PBMs to perform a variety of functions, including providing a pharmacy network. Pharmacies agree to be part of the approved network and, in exchange, receive quick and consistent reimbursement at an agreed upon contracted rate between PBM and pharmacy. Currently contracts between payor, PBM and pharmacy providers can specify terms of service, pricing and reimbursements, as long as they are consistent with Labor Code and applicable Division regulations/guidelines. PMSI believes the Division has authority to promulgate regulations on Pharmacy Benefit Networks (PBNs), and attempted to do so in 2010. PMSI strongly encourages the Division to engage in stakeholder discussions and rule-making to establish guidelines on utilization of pharmacy benefit networks. This rule-making should include development of rules outlining notification requirements, ability to "direct" injured workers to utilize a specific network provider/pharmacy and payment for out-of-network claims.

### Opioid Usage and Abuse

Based upon discussions with our clients, it is abundantly clear that opioid usage in the workers' compensation marketplace is a growing cost driver and safety issue for injured workers. PBMs can be part of this solution by providing services to screen for overuse, multiple prescriptions for the same medication, multiple prescribers or "doctor shopping" and fraud, and then alert the dispensing pharmacy to pause dispensing of these non-medically necessary prescriptions. Targeted drug regimen management is a key component to controlling opioid usage, however, California must make these services a priority. PMSI strongly encourages the Division to study the extent of opioid usage by injured workers in California and, where necessary, utilize the assistance of stakeholders to address this safety issue with haste.

### Pharmacy Fee Schedule & Medi-Cal Linkage

Section 5307.1 of the Labor Code sets reimbursement for workers' compensation pharmacy services at "100 percent of fees prescribed in the relevant Medi-Cal payment system". Unfortunately the Labor Code does not consider distinctions between Medi-Cal and workers' compensation pharmacy services. Medi-Cal is the second largest General Fund program in the State and, in difficult fiscal times, is where the Legislature often looks for budget "savings". Additionally, it is also a "single-payor" operating model, while workers' compensation operates in an open, competitive multi-payor market. Thus, policy changes enacted through legislation that are targeted at reducing Medi-Cal budgetary costs but do not take into consideration the impact on the workers' compensation system are one-sided and dangerous. The current reimbursement link has created incredible instability for stakeholders involved in providing workers' compensation pharmacy services. It should be noted that when the two systems were linked pharmacy reimbursements were 7% higher than they are now – with the most recent cut being part of a "budget trailer bill" which had nothing to do with the real cost of providing workers' compensation pharmacy services.

PMSI believes the Division has the authority to alleviate this continuous burden and yearly panic over cuts to the workers' compensation pharmacy fee schedule in order to protect the frail access to pharmacy services in the marketplace. Thus, PMSI strongly urges the Division to make review of and engagement in policy making on the current WC pharmacy fee schedule and link to Medi-Cal a top priority in 2012 and beyond. The reduction in the number of pharmacies willing to provide pharmacy services for injured workers in California will be directly related to an increase or decrease in system pharmacy costs.

### AWP Unfreeze

The Department of Healthcare Services has indicated the AWP freeze is over and payment changes for Medi-Cal providers will be retrospective. This is a simple policy for Medi-Cal as a single payor model. This policy becomes much more complicated when you insert multiple payors, contracted rates and separate state reporting (EDI) requirements found in workers' compensation.

PMSI clearly understands the confusion which will ensue between providers, PBMs and payers – in a multi-payer marketplace such as workers' compensation – when the backdated AWP feeds are also

unfrozen. This confusion could easily lead to unnecessary work and stress on all system stakeholders as some entities may push for retroactive payment adjustments on even the tiniest price difference. Additionally, all of this activity will have a direct impact on EDI/State Reporting as changes in payment will necessitate a correction in payment reporting to the state. PMSI urges the Division to work with stakeholders to address and create a simple solution for these confusing issues and believes the Division has authority to waive mandated EDI corrections related to a payment discrepancy during the freeze period and only during the freeze period.

#### Conclusion

Again, thank you for the opportunity to provide comments and suggestions to improve California's workers' compensation system. In summary, PMSI encourages the Division to take the following action:

- Engage in rule-making and establish guidelines or regulations on pharmacy networks.
- Examine and move to address the potential safety issue of opioid over-utilization in the workers' compensation marketplace
- Establish a pharmacy fee schedule which utilizes the existing Medi-Cal fee structure but is more properly tailored for the workers' compensation patient population
- Work with stakeholders such as PMSI to quickly address the AWP unfreeze and retrospective payment issue and state reporting requirement

As always, PMSI looks forward to working with the Division and Division staff to improve California's workers' compensation system. We hope to continue as a resource for you and your staff on these and any other workers' compensation pharmacy related issues.

Sincerely,

Kevin C. Tribout  
Executive Director of Government Affairs

April 30, 2012

Christine Baker, Director  
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Rosa Moran, Administrative Director  
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Oakland, CA 94612-1402

Dear Director Baker and Administrative Director Moran,

Over the past several weeks you conducted a series of public forums to gather input on current issues in California's workers' compensation system. In order to provide you a picture of the real-life experiences of employees in this system, members of the California Applicants' Attorneys Association (CAAA) asked some of their clients to participate in these forums. Although the details varied from case to case, each of these employees described a situation beset with repeated delays and plagued by inadequate benefits. The stories told by these individuals describe a system that has become unworkable for the very people it was designed to help – injured employees. Delay and denial have become standard operating procedure, leaving far too many employees without the medical treatment they need to recover and return to work and without adequate indemnity benefits they need to achieve at least a minimal financial security.

One of the purposes of these forums was to gather suggestions for improving the system. At a legislative hearing earlier this month, you told the committee that the Administration is seeking suggestions for reforms that will create savings to balance the cost of a much needed increase in benefit levels. As small businesspersons, CAAA members understand that controlling employers' workers' compensation costs is important. However, the focus of any changes should not be on simply cutting costs. Instead, the goal of any statutory or regulatory reforms must be on making the system work for injured employees. Adopting reforms that promote the prompt and efficient delivery of appropriate and necessary benefits, allowing cases to close and employees to return to work faster, is actually the most effective way to eliminate unnecessary expenses and generate needed savings.

The statutory changes adopted in 2003 - 2004 show how reforms that were designed solely to cut costs are more likely to have exactly the opposite effect. Consider, for example, the convoluted medical treatment authorization process created by overlapping "cost-cutting" reforms in SB 228 and SB 899. The employer selects the treating physician, treatment requests by this employer-selected physician are subject to statutory caps and mandatory treatment guidelines, those treatment requests are also subject to utilization review by a non-examining physician, and disputes go to a QME whose intended random selection turns out to be anything but random.

These overlapping provisions have created a quagmire that in far too many cases delays needed treatment for months or even years. Consider the case of Margaret Ramirez, a hospital technician who testified at the San Bernardino forum. Margaret has experienced month after month of delay. Treatment requests from her physician have been routinely ignored for months and then denied, Margaret told you. UR denials have spanned the range of requests and have included examinations, medication, surgery, even mileage.

Imelda de la Cruz, a testing technician who testified in Los Angeles, fell and tore her meniscus. Imelda told you how a recommended surgery was authorized only after multiple delays, and that her recovery took much longer than necessary because of repeated delays and denials of post-surgical treatment.

Any delay harms injured employees. For some, like Greg Candler, a driver who testified today in Oakland, a delay of more than four months in treating his rotator cuff tear could limit his ability to recover fully and may significantly increase his lifelong disability from this injury. For others, like Ralph Jones, a high school security employee who testified in West Sacramento, his surgery was delayed for more than two years, entirely using up his statutory 104 weeks of temporary disability benefits. Many others, like David Knapp, an airline employee who testified in West Sacramento, just want to get back to work. David injured his back, but despite objective medical evidence – two MRIs – his insurer took nine months to accept the claim and another seven months to authorize treatment. An AME projected a six month timeline to return to work, but his insurer simply ignored the recommendations of the AME and it was 23 months before David returned to work. Then following another injury David had back surgery but was denied therapy, again delaying his return to work.

As illustrated by these employees' stories, however, these delays don't just harm the employees, they also harm their employers by generating huge unnecessary costs. Attached to this letter is a copy of a report prepared by CAAA entitled "California Workers' Compensation 2012: The State of the System." That report highlights data from both the WCIRB and the CWCI showing that the fastest rising "medical" cost is actually the expense of medical cost containment – utilization review and bill review.

Rather than cutting costs, 2004 "reforms" like UR have now become the main cost drivers in the system. The convoluted process of providing medical treatment offers the opportunity to profit at each step of the way, with no disincentive to stop abuse and delay. Dan Maderios, a window installer who testified in West Sacramento, was billed by a clinic because the adjuster had denied payment for an evaluation, even though that evaluation had been ordered by the insurer. Dan had to get a judge to order payment by the insurer. Michael McClendon, who testified in Los Angeles, described to you how his medicines, therapy, and surgery are all denied despite his 100% disability rating. Kenneth Hoover, who was unable to attend the Los Angeles forum, described in an email to you how after two different physicians – both selected by his insurer – found his condition was work related, his adjuster went "doctor shopping" to get a report from a third physician, and that delayed acceptance of his claim for 18 months. Mary DeSoto, who testified in Fresno, told you how one recommended surgery was delayed for over a year

and was performed only after a judge ruled a UR report was defective, while a second surgery – *denied by UR despite the fact that it was recommended by an AME* – again was performed only after a judge's order. And Millie Mellun, a carpenter who testified here in Oakland, described how she was denied needed treatment despite an order by a workers' compensation judge.

As these cases illustrate, trying to get approval for most medical treatment has devolved into a morass of UR denials, QME/AME evaluations, physician depositions, and Board conferences and hearings. Each of these steps not only delays the provision of needed treatment, but exponentially increases both defense and adjuster costs. Delaying return to work also increases employers' expenses both by extending the period of temporary disability and by adding costs for hiring and training replacement employees.

In short, instead of providing the intended quick process for approving medical treatment requests, UR is far too often used simply to delay treatment, and has become a major cost driver in the system. The entire process needs to be re-examined to make certain that the provision of appropriate and necessary medical treatment is not delayed. Why, for example, should treatment requests from hand-picked physicians in a Medical Provider Network go through UR? Should there be rules regulating conflict of interest between UR entities and payers? Should there be some regulation of entities that conduct UR? Should UR entities be penalized or barred for a pattern of frivolous denials?

But UR is not the only stumbling block in this process. As illustrated by the unequal distribution of panel assignments documented by the CHSWC QME study of September, 2010, the current panel QME process creates perverse incentives for both the evaluators and the parties. Several employees told you how they waited for over a year to get an evaluation by a QME, and in many cases that delay is compounded by a further delay because one of the parties schedules a deposition. Then there are those cases in which the QME report is thrown out because it is untimely, or it doesn't constitute substantial medical evidence, and the lengthy process must start over, further delaying the provision of treatment.

As with the UR process, the entire panel QME process needs to be re-examined. Securing necessary evidence is a fundamental due process right of both parties, and procedures should be adopted that facilitate this process, rather than impede it. Steps can be taken to limit the ability of some QMEs to "game" the system, but ultimately the rights of the parties are best protected by creating a process that allows both parties to secure the necessary evidence as quickly and efficiently as possible.

The inefficient panel QME process is just one of the problems caused by the misguided incentives created by the 2004 "reforms." Major delays occur because there are no longer any effective deterrents in the system. The "reformed" §5814 penalties – even at the maximum 25% – are minuscule when applied to most medical treatment delays. It does not appear that audit penalties serve as an effective deterrent either. The entire penalty structure needs to be re-evaluated to provide an effective disincentive against unreasonable delay. An unjustified denial, or even a long delay, may cause the employee

to give up, or it may use up enough of the employee's statutory 104 weeks of temporary disability so that a needed surgery becomes impracticable.

The growing problem of liens has been similarly affected by the misaligned incentives created by the 2004 "reforms." Because virtually all liens are settled without a finding by a trier of fact, there is actually an incentive to ignore the rules. Payers can delay paying legitimate bills for years without fear of penalty, and are then further rewarded because most settlements are for less than the billed amount. Similarly some providers bill inappropriately, knowing that eventually they will be able to settle for at least a percentage of that inappropriate bill. Here again the system needs to reorder the incentives and disincentives to assure that reasonable bills are promptly paid and unreasonable bills are properly penalized.

In closing, CAAA stands ready to work with you, along with all other parties in the workers' compensation system, to address the very real problems facing injured employees. As illustrated by the testimony of employees at every one of your recent forums, in far too many cases the current system simply does not provide the prompt medical treatment and adequate indemnity compensation that is mandated by our state Constitution. Fixing these problems and getting injured employees the medical and indemnity benefits they need and deserve must be goal of any future changes.

This is not to ignore the need to control employers' costs. However, the best way to eliminate the unnecessary expenses in the system that have become major cost drivers is to adopt changes that promote the prompt delivery of appropriate benefits. Where overlapping requirements exist – UR and MPNs, for example – changes should be adopted to eliminate the delay and costs generated by this overlap. Where incentives are misaligned – the panel QME process, for example – the process should be redesigned to facilitate a prompt and efficient process to obtain necessary medical evidence. Payers should have the proper incentive to pay legitimate bills promptly, and providers should have a disincentive against submitting inappropriate bills.

Please feel free to contact me directly as efforts are begun to improve the system for injured employees.

Sincerely,

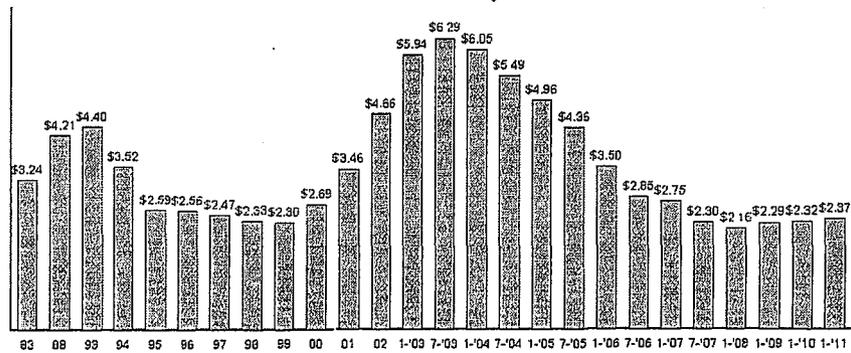


S. Bradley Chalk, President  
California Applicants' Attorneys Association

# California Workers' Compensation 2012

## The State of the System

Average Workers' Compensation Insurance Rate  
Per \$100 Payroll



Prepared by:  
Mark Gerlach

for the California Applicants' Attorneys Association  
January 2012

## Introduction

As the 2012 Legislative session opens there is widespread agreement by California's workers' compensation system stakeholders that permanent disability benefits should be increased. New data from the California Commission on Health and Safety and Workers' Compensation confirms that the adoption of the 2005 rating schedule reduced the average rating by 31.5%, and in any case the statutorily required amendment of the Permanent Disability Rating Schedule is now two years overdue.

Because California's economy is still recovering from the recent recession, Governor Brown has signaled that any increase in permanent disability benefits should be balanced by changes that create savings. The purpose of this report is to review the state of California's workers' compensation system in order to identify areas where potential savings can be found. Highlights of the report include:

- California remains the largest state with the largest workforce.
- Workers' comp insurance rates dropped by two-thirds between 2003 and 2008.
- Paid indemnity benefits are down more than 40% from 2004.
- Paid medical benefits have increased since 2006 but are still down 13% from 2003.
- The main driver of medical costs is the expense of medical cost containment, including utilization and bill review expenses and medical network costs.
- On a per-claim basis medical-legal costs more than doubled post-reform.
- The expense of adjusting claims has significantly increased.

The following pages present these findings in more detail. These findings make evident that the usual solutions to achieving savings in workers' compensation costs – slashing indemnity benefits and/or reducing medical treatment fee schedules – are not the answer in 2012. Indemnity benefits need to be increased, not cut further, and there is no evidence that medical payments to providers are a problem.

Instead, efforts to find savings need to focus on the rapid growth in medical cost containment expenses like utilization review, on the sharp increase in average medical-legal costs, and on the doubling of claim adjustment costs. Given that medical cost containment expenses now total more than \$1.8 billion, while claim adjustment expenses exceed \$2.9 billion, it should be possible to achieve sufficient savings in these areas to balance the cost of amending the Permanent Disability Rating Schedule.

## I. The System

- Size of the Workforce

California is the largest state and has the largest workforce. The table below shows that the number of workers covered by workers' compensation insurance in California increased by more than 2.5 million between 1996 and 2007, but then decreased by more than one million in the recent recession.

1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
12.84	13.27	13.71	14.12	14.59	14.73	14.59	14.55	14.71	14.99	15.26	15.40	15.25	14.38
Millions of workers												Source: NASI	

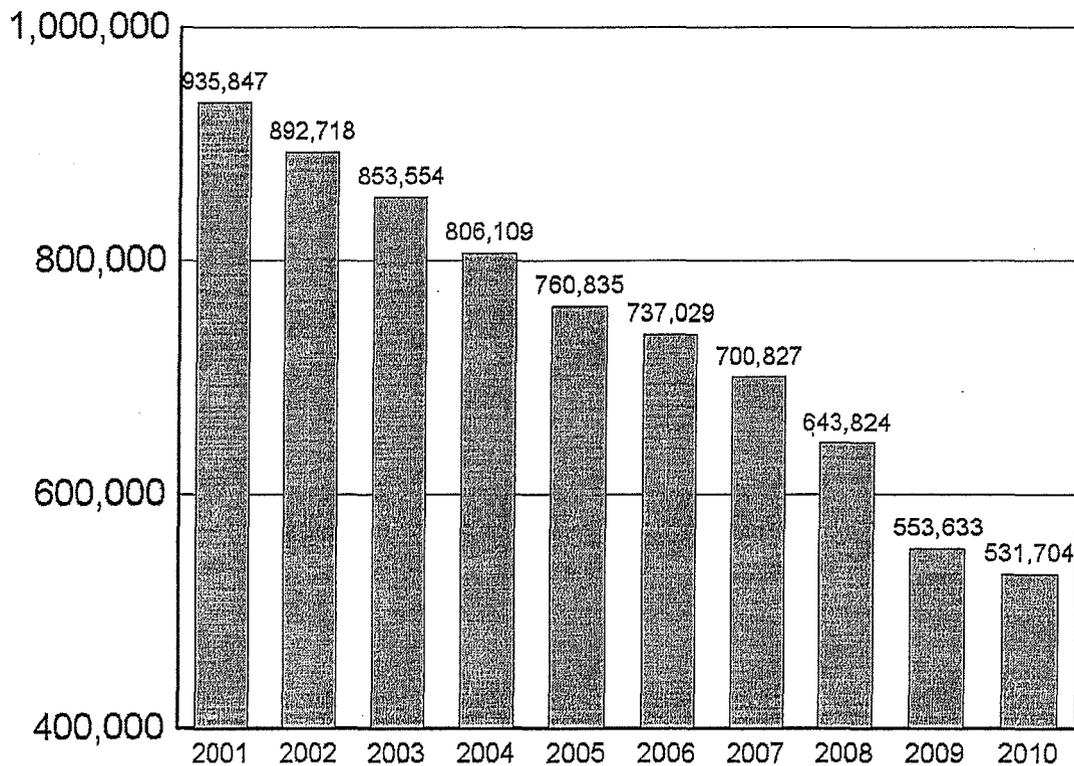
This data is from the National Academy of Social Insurance. NASI estimates that nationwide there were 122 million workers covered by workers' compensation in 2009, so California's workforce represented about 11.8% of the national total. Although the NASI data goes only through 2009, state EDD data show employment experienced a further decrease in 2010 but started to increase in 2011. Consequently the year-end 2011 workforce was about the same as the 2009 figure in the table above.

Looking at employment on a payroll basis, the total California payroll in 2009 was \$738 billion, which was 13.5% of the national payroll of \$5.48 trillion. The fact that California had 11.8% of the workforce but 13.5% of the payroll shows that average wages in California are higher than the average state. According to Bureau of Labor Statistics data, California's average weekly wage of \$1,003.55 for the first quarter of 2011 was the 6<sup>th</sup> highest in the nation.

- Number of Injuries

The number and frequency of work-related injuries has been decreasing for several decades. The graph below shows the number of workers' compensation claims reported under the Workers' Compensation Information System (WCIS) over the past decade. Over the 2001 - 2009 period, the number of reported workers' compensation injuries fell 43%.

## First Report of Injuries from WCIS



Source: Workers' Compensation Information System, DWC

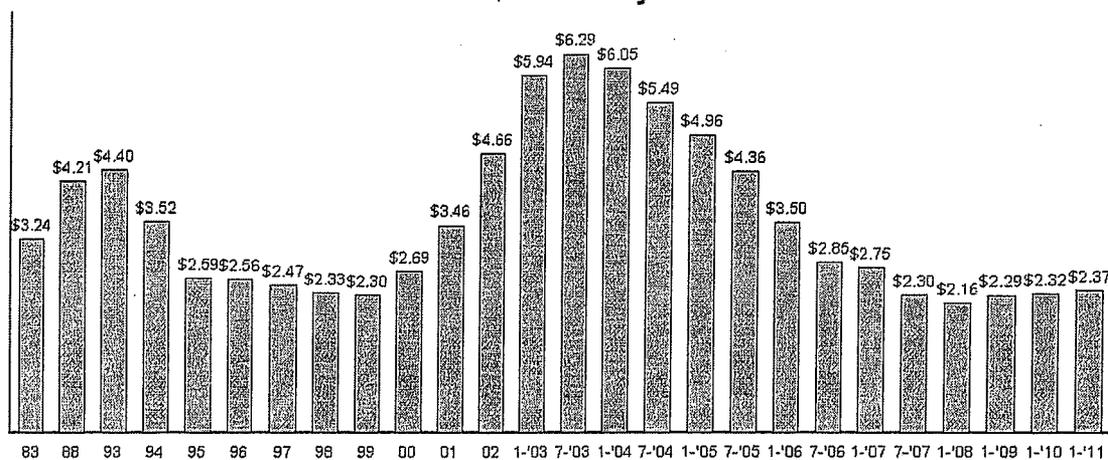
Data from the Workers' Compensation Insurance Rating Bureau (WCIRB) on the frequency of claims shows a similar downward trend, although the WCIRB data does show an increase in claim frequency in 2010. One reason for this difference is that the WCIS data include all claims while the insurance data measure the frequency of indemnity claims only. According to the WCIRB there was a growth in small indemnity claims in 2010, and the increase in the insurance claim frequency may simply be a shift of some minor claims from medical-only to indemnity, rather than an increase in claims.

## II. Insurance Data

- Workers' compensation insurance rates.

Workers' compensation insurance rates plunged between 2003 and 2008, dropping two-thirds. The average rate in 2008, \$2.16, was 66% lower than the peak rate of \$6.29 and was the lowest rate in more than 20 years. Since 2008 rates have begun to slowly increase, growing at about +3% annually, but the 2011 average rate of \$2.37 is still 62% lower than the 2003 rate. The graph below shows the rates actually charged to employers (as opposed to the "pure premium" rate or the "manual" rate).

### Average Workers' Compensation Insurance Rate Per \$100 Payroll



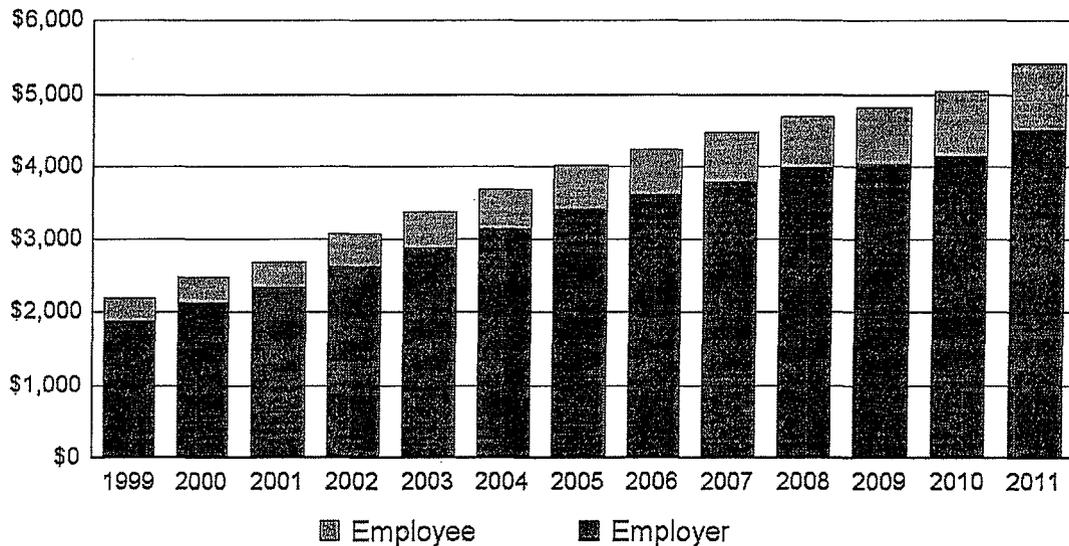
Source: WCIRB Summary of September 30, 2011 Insurer Experience

Primarily as a result of the huge decrease in rates after 2004, premium earned by insurers in California fell from \$23.5 billion in 2004 to \$8.9 billion in 2009. Earned premium in 2010 was \$9.8 billion, and 2011 earned premium will likely be around \$11 billion.

- Health insurance premiums.

As a point of reference for workers' compensation insurance costs, group health insurance premiums more than doubled over the past decade. The graph below shows the average group health insurance premium for a single worker, showing separately the employers' and employees' premium cost.

Average Annual Premiums - Single Coverage  
Employer Sponsored Health Insurance



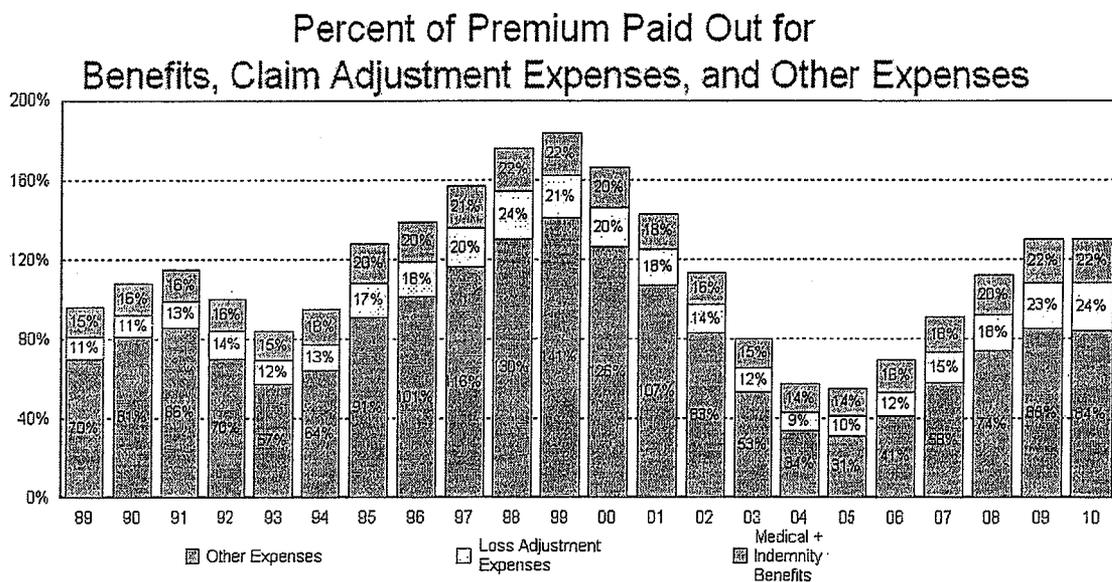
Source: Kaiser Family Foundation Employer Health Benefits 2011 Annual Survey

Between 1999 and 2011 the average employee premium cost nearly tripled from \$318 to \$921, while the 2011 employer premium cost of \$4,508 was almost two and a half times the 1999 figure of \$1,878. Over this 12 year period the combined employer plus employee premium grew from \$2,196 to \$5,429, an increase of 147% or almost 8% annually.

Of course the increase in health insurance premiums should not be directly compared to the increase in workers' compensation insurance rates shown on the previous page. Nevertheless, when the majority of benefits provided under workers' compensation are medical benefits, it is instructive to review the steep upward trend of health insurance premiums.

- Insurers' profitability.

Insurers had grossly excessive profits for several years following enactment of SB 899, but are now at about a "break-even" position. The graph below shows the "combined" ratio – the percentage of the premium paid out for benefits plus insurer expenses – for California workers' compensation insurers over the last two decades.



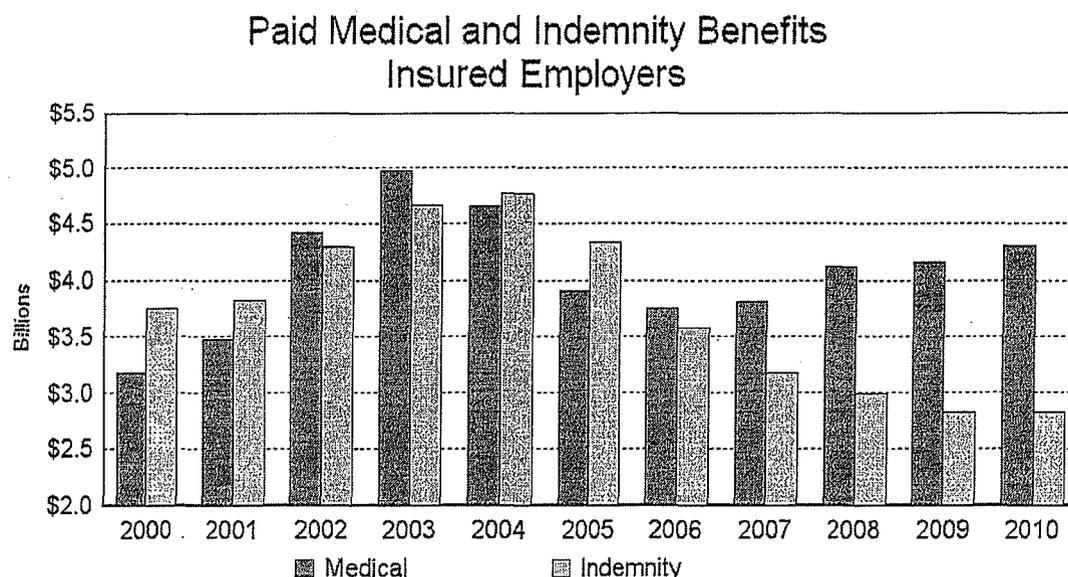
Source: WCIRB Summary of September 30, 2008 Insurer Experience

Keep in mind that because it ignores investment income, the "combined ratio" does not measure profitability. Nevertheless it is apparent that industrywide results swung from huge losses in the late 1990s to grossly excessive profits by 2004 / 05. More recently the loss ratio – the percentage of premium paid out in medical and indemnity benefits – has significantly increased, largely as a result of the huge drop in rates and collected premium, and is now at about a "break-even" level for insurance companies.

However, over the past five years there has also been a significant increase in the percentage of the premium needed to cover the cost of insurers' expenses. The cost of insurer expenses under the old "Minimum Rate Law" averaged less than 30% of the premium; in 2009 and 2010 insurers' expenses consumed nearly half of the premium. Consequently, where in 1991 insurers had a loss ratio of 86% and a combined ratio of 115% that was still profitable (after considering investment income earnings), the same 86% loss ratio in 2009 resulted in a much higher combined ratio of 131%. Although 2009 may still have been profitable because insurers are experiencing unusually high levels of investment income from the excessive premiums collected during the 2003 - 2008 period, a combined ratio at this level is likely not sustainable for the long run.

- Medical and Indemnity Benefits

Paid medical and indemnity benefits in 2010 were both lower than the peak years of 2003 - 2004. The graph below shows medical and indemnity benefit payments by insurers over the last decade:



Source: WCIRB 2010 California Workers' Compensation Losses and Expenses

Paid indemnity benefits increased significantly after adoption of AB 749 in 2003, but sharply declined beginning in 2005 due to the adoption of the 2005 rating schedule, application of the 104 week cap for temporary total disability benefits, and elimination of vocational rehabilitation benefits. Between 2006 and 2010 paid temporary disability benefits dropped more than 10% and paid permanent disability benefits fell 28%. Permanent disability payout for claims with ratings below 70% declined by 22%, and permanent disability payout for claims with ratings of 70% and higher dropped by 72%.

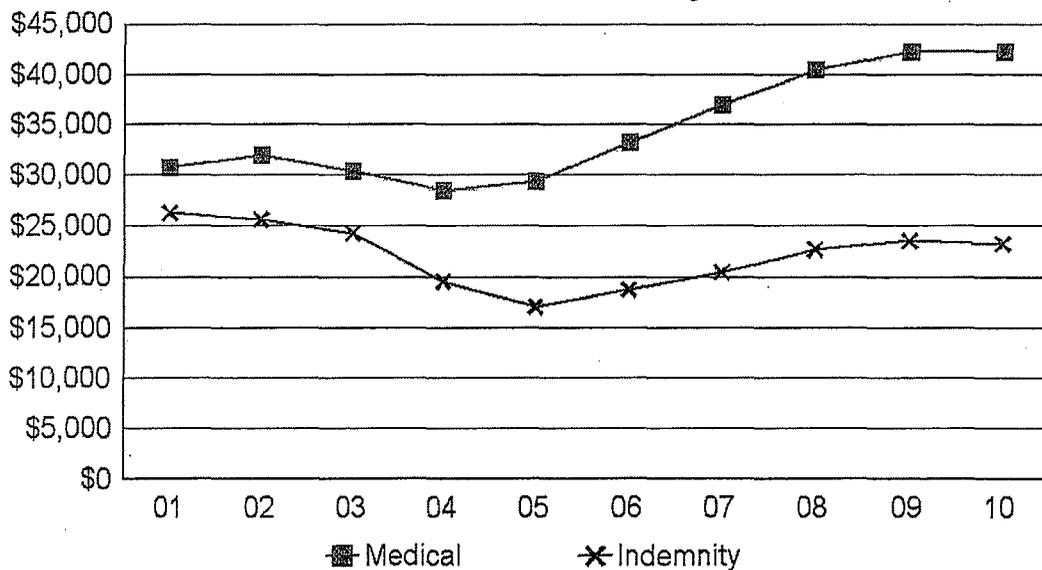
Paid medical benefits were also increasing prior to adoption of the 2003 - 2004 statutory changes and experienced a similar decline immediately thereafter. This decline, however, lasted only three years; beginning in 2007 paid medical benefit started to increase. The 2010 medical payout is almost 15% higher than 2006, but is still more than 13% lower than the peak year of 2003.

- Average Benefits per Claim.

On a per-claim basis, medical benefits have increased over the past decade but indemnity benefits are down. Between 2001 and 2010 average medical benefits per indemnity claim grew by 37.5%, but there were significant fluctuations in the rate of change. Average medical benefits per indemnity claim dropped slightly after enactment of the 2003 - 2004 statutory changes and then increased for several years. However, growth slowed in recent years and between 2009 and 2010 there was no change in average medical benefits.

Average indemnity benefits per claim followed a somewhat similar pattern, but average indemnity benefits per claim in 2010 are still 11% lower than average indemnity benefits in 2001. The fact that average indemnity benefits in 2010 were lower than in 2001, despite the adoption of significant statutory benefit increases in AB 749 that took effect between 2003 and 2006, starkly illustrates the magnitude of the indemnity benefit reductions in SB 899.

Average Benefit per Indemnity Claim  
Medical and Indemnity

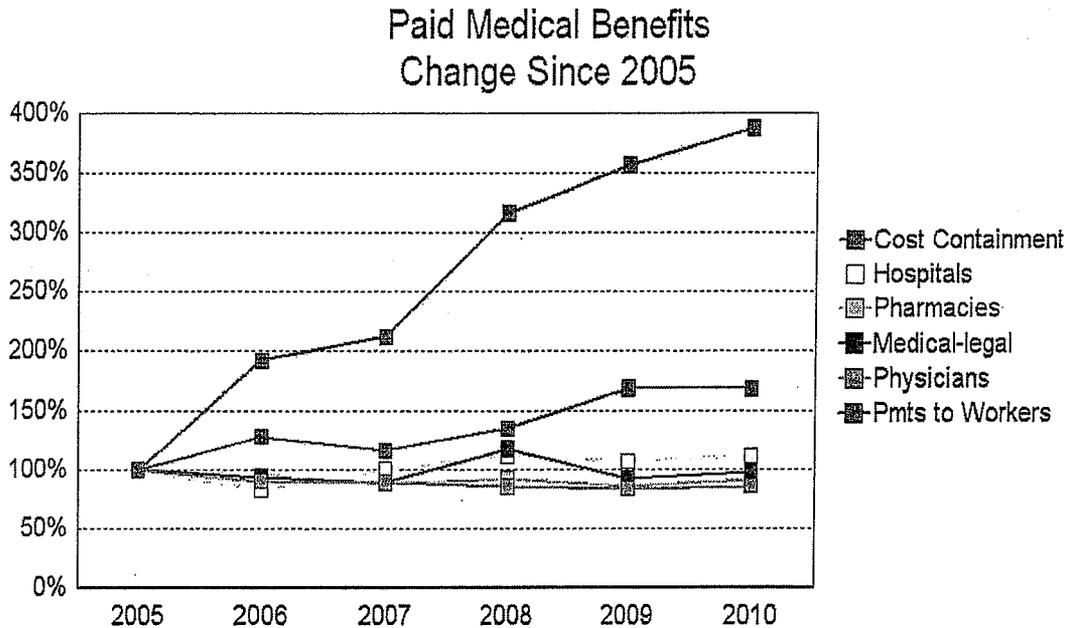


Source: WCIRB Summary of September 30, 2011 Insurer Experience

### III. Cost Drivers

#### A. Medical Cost Drivers

As illustrated in earlier graphs, after declining in the two years after adoption of the 2003 - 2004 statutory changes, both average and overall medical benefits have been increasing. However, a closer look at medical cost data shows that the principle medical cost drivers are not the usual suspects:



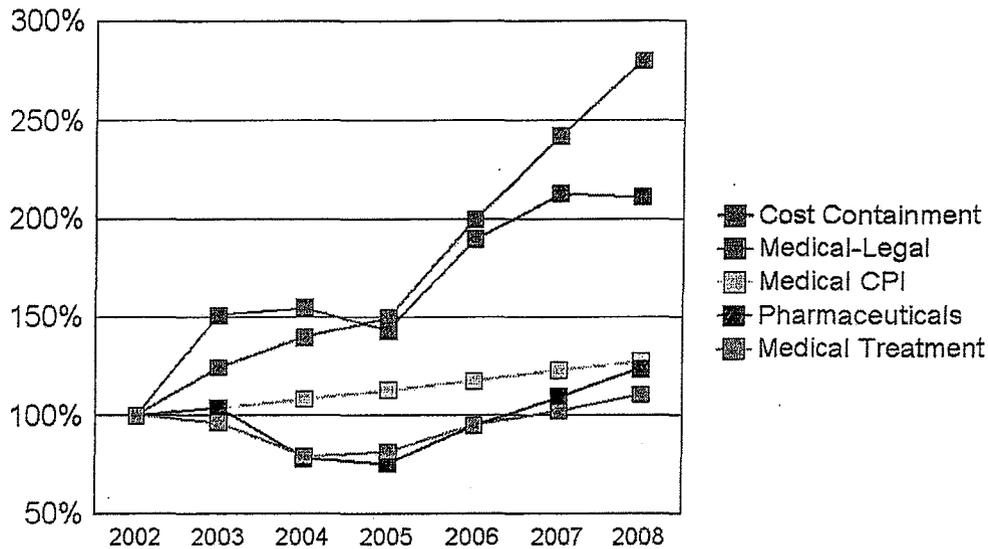
Source: WCIRB 2010 California Workers' Compensation Losses and Expenses

This graph is based on the same insurance company data as the earlier graph showing paid medical and indemnity benefits. This graph sets 2005 as the base year and shows the changes in the individual components of medical costs over the next five years. Between 2005 and 2010 payments to physicians *declined* 12%, payments for pharmaceuticals *fell* by 9%, and medical-legal payments were *down* 2%.

The overall growth in paid medical benefits was due to three factors. One was a small growth in the total payout to hospitals, up 12%. Another was an increase in medical payments made directly to injured workers; these grew by 68% between 2005 and 2010. Medical payments made directly to injured workers primarily involve the settlement of future medical benefits, and the increase in this category reflects the increasing impact of Medicare Set-Aside arrangements on the cost of workers' compensation claims. But the fastest growing medical cost driver was the expense of medical cost containment, primarily expenses for utilization and bill review and medical network expenses, which nearly tripled.

The role of medical cost containment expenses as the primary cost driver of medical costs is confirmed in data on the average medical benefit per claim from the California Workers' Compensation Institute. The graph below shows the change in the average payout of medical benefits per claim by individual cost component, using 2002 as the base year:

### Average Medical Per Indemnity Claim Increase / Decrease Since 2002



Source: CWCI Analysis of Post-Reform Outcomes: Medical Benefit Payments and Medical Treatment in California Workers' Compensation System; data at 24 months post injury

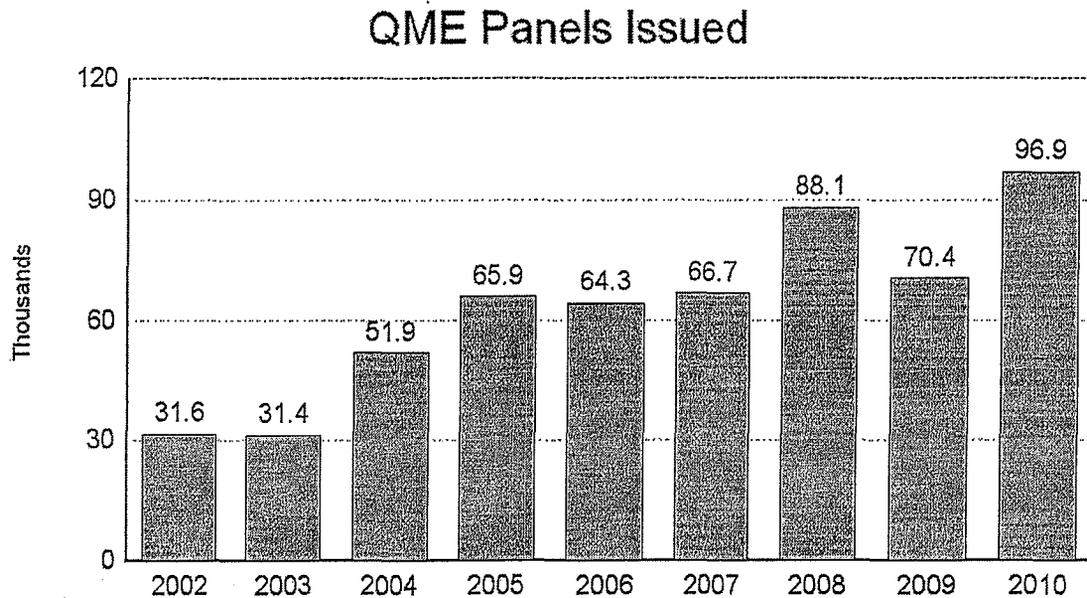
Between 2002 and 2008 the average payout per claim for medical treatment and pharmaceuticals increased less than 20%, which was less than the rate of medical inflation (the medical Consumer Price Index).

Average medical-legal payout per claim more than doubled over the same period. There was a significant jump in the average cost of a medical-legal evaluation between 2004 and 2006, probably caused by introduction of the Medical Treatment Utilization Schedule, adoption of the 2005 rating schedule, and mandatory consideration of apportionment. By 2008, however, the growth in average medical-legal cost per claim leveled off, and it is possible that the post-reform growth represents a one-time bump in costs rather than long-term cost inflation.

However, the same is not true of the fastest growing component, medical cost containment expenses. The average payout per claim for cost containment expenses nearly tripled between 2002 and 2008 and this rapid growth shows no sign of slowing.

- Medical-legal Expenses.

There was a sharp increase in the number of QME panels issued by the DWC following the statutory change making the panel QME process mandatory for represented workers, as shown in the graph below:



Source: CHSWC 2011 Annual Report (Based on DWC data)

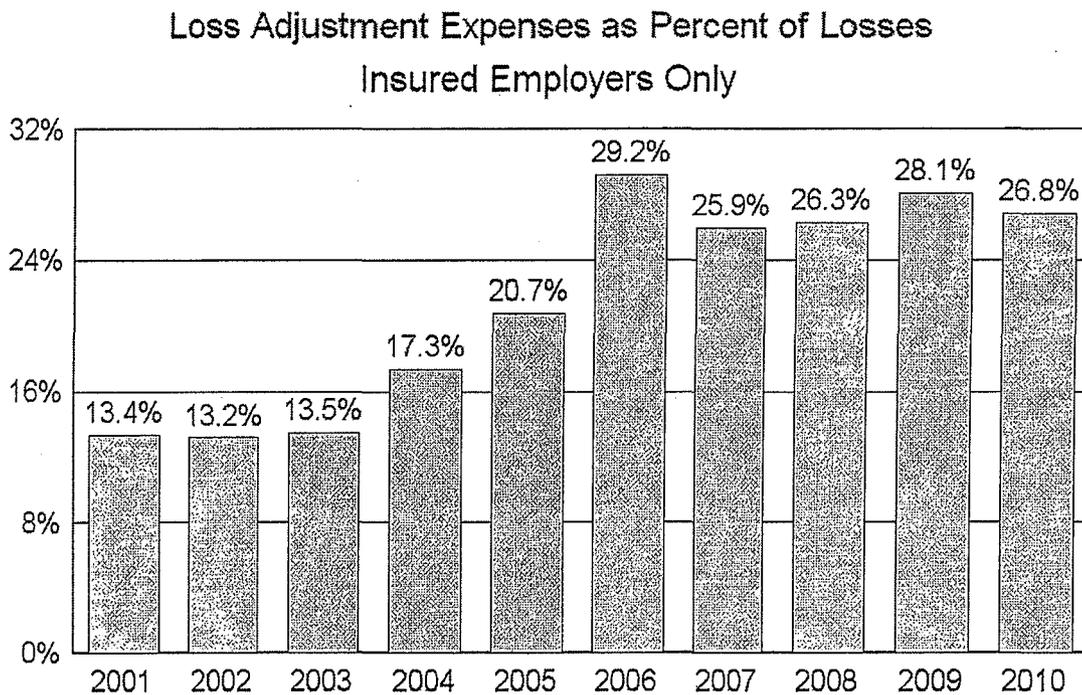
Although the number of QME panels issued more than tripled between 2003 and 2010, the average number of evaluations per claim has stayed relatively constant at around one evaluation per claim for more than a decade (0.85 evaluations per claim in 1997 and 0.91 in 2008).

A 2010 CHSWC report found significant problems in the QME assignment process. Specifically it found that 3.9% of QMEs are registered at 11 or more locations, and this small number of QMEs conducts nearly 40% of all medical-legal evaluations. In addition, the CHSWC report found that permanent disability ratings assigned by the "high-volume" QMEs were substantially and significantly lower than ratings assigned by all other QMEs.

B. Expense Cost Drivers

- Insurer Expenses.

In its initial evaluation of the 2003 - 2004 statutory changes the WCIRB projected that both benefit costs and expense costs would be reduced. However, although benefit costs plummeted, expense costs remained relatively unchanged. Consequently, as a percentage of losses (which is "insurance-speak" for benefit payouts), claim adjustment expenses doubled after the 2003 - 2004 statutory changes. The graph below shows claim adjustment expenses as a percentage of total losses (benefits).



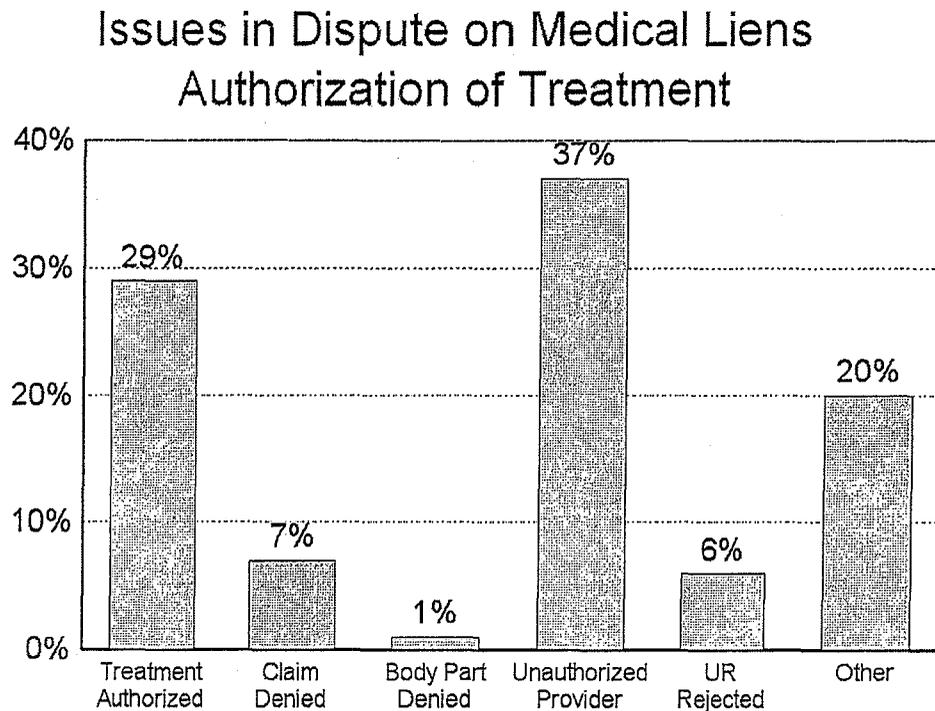
Source: WCIRB January 2012 Pure Premium Rate Filing

● Liens

One factor contributing to the increase in claim adjustment costs is the cost of resolving liens. In its 2011 Report on Liens CHSWC estimated that \$117 million of litigation costs could be saved by reducing the number of liens by one-third. CHSWC estimated that over 350,000 liens were filed in 2010, and that over 470,000 would be filed in 2011. In a survey conducted by CHSWC, 62% of liens were for medical treatment bills, and those liens represented 80% of the dollars in dispute. Copy services liens were 17% of surveyed liens but only 2% of dollars in dispute, while interpreter liens accounted for 7% of liens and 1% of dollars in dispute.

Of the medical liens in the CHSWC survey, one out of three involved a dispute over a bill received by the adjuster after a payment had been made. Although CHSWC could not identify the exact reason for these disputes, the report termed these "fee schedule disputes." In the CHSWC survey a fee schedule dispute was the only issue in 17% of medical liens. CHSWC recommended adoption of an administrative bill determination system to resolve these disputes.

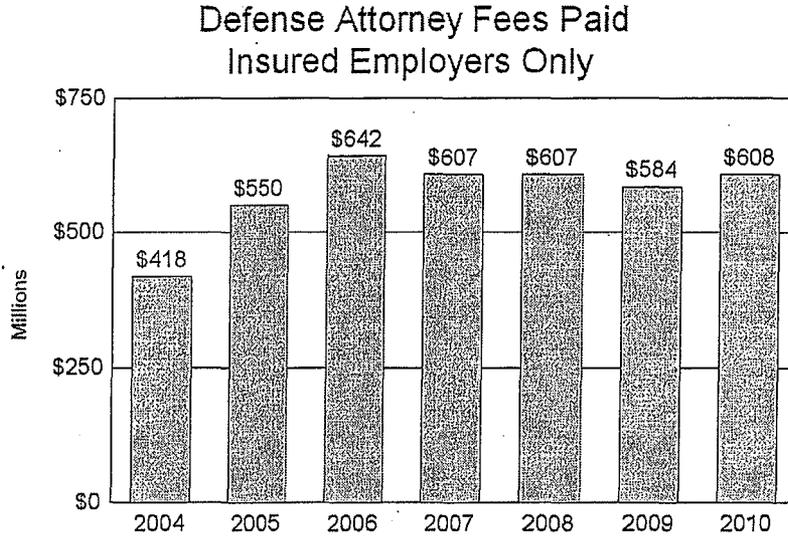
Based on the CHSWC survey, the following graph shows how claim adjusters categorized the issues in dispute on medical liens by authorization of treatment:



Source: CHSWC Liens Report, January 5, 2011, Figure 8

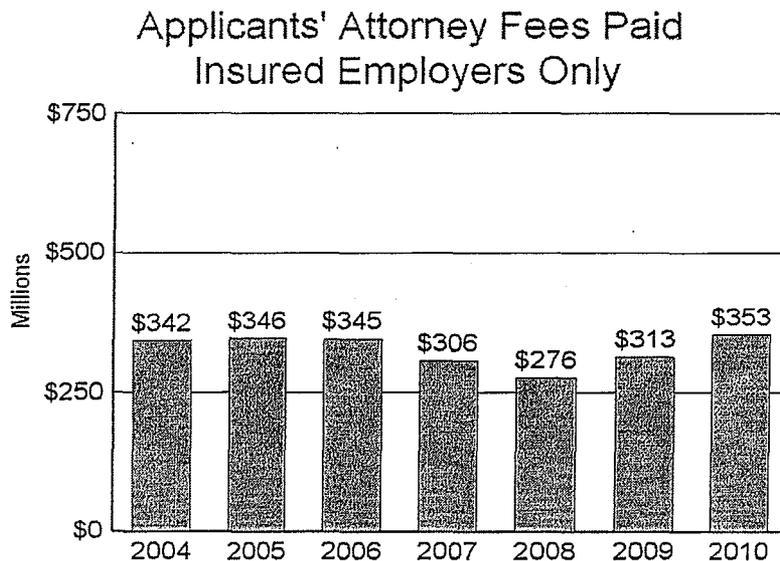
- Defense Attorney Fees.

Another cost contributing to the growth in loss adjustment expenses is defense attorney fees. The graph below shows almost a 50% jump in defense attorney fees paid by insurers after 2004.



Source: WCIRB Report on Workers' Compensation Losses and Expenses, 2007 - 2010

Fees paid to applicants' attorneys fluctuated slightly but were essentially unchanged over the past seven years. Since applicants' attorneys' fees are paid by the applicant, these fees are not included in the loss adjustment expenses in the previous graph.



Source: WCIRB Report on Workers' Compensation Losses and Expenses, 2007 - 2010

4/30/12

Hi, my name

I had worked for 34 years as a photo equipment repair technician when I injured my spine in July 2008.

Our company had outgrown the size of our building, and we were in the process of moving the company to a newer building.

I was driving the moving truck when the pneumatic driver's seat blew out and I was slammed down on my spine.

The x-ray showed a spine injury: my spine was barely sitting on my sacrum.

The first delay with the insurer was with the so-called "approved doctor" list that I was sent.

**It contained names of doctors who do not take workers' comp patients, doctors who were deceased and retired doctors.**

It took 3 requests to the insurer's adjuster for me to finally receive a list that included a doctor that would see me.

There were no doctors in Santa Cruz County.

The closest doctor was in Santa Clara County, 46 miles round trip.

My back injury caused urological problems and the surgeon referred me to a urologist, but the closest one who would see me was in Hanford, CA, over three hours away from where I lived.

That required staying overnight in a motel to be at an early morning appointment.

**It took a year to finally receive my first appointment with a Spine Specialist.**

While in surgery for my spine, the insurer's doctor damaged an artery to my left leg almost killing me.

I almost had to have that leg amputated.

I now have permanent nerve damage, partial and full paralysis.

Every request from the company's own chosen doctor is denied.

The tests are denied.

Surgery is denied.

Medication is denied.

Acupuncture is denied.

Physical therapy is denied.

Each denial is completely unnecessary and unwarranted.

Each denial is then appealed.

Once we finally have an approval it can be months before the test, exam, surgery or treatment actually happens.

One of the original surgeons dropped me like a hot rock without explaining as to why a Pain Management Doctor was needed.

The work comp insurer has denied approving a new doctor.

My Temporary Disability payments have now run out due to the long delays in getting treatment and I still had 2 more surgical procedures scheduled.

I have had 15 surgical procedures, so far.

I am still not healed and am unable to return to work.

I have had to pull money out of savings to live on that I had spent years putting into my savings.

I have taken a huge loss financially.

I will never be able to work again.

I have lost my job, my ability to contribute to my 401k plan, my family's health benefits and my future.

My wife and I are facing homelessness in about four months.

My life has been turned upside down since this nightmare started.

AVP.  
JHRS.  
6288P

*I WORRY ABOUT MY FUTURE.*

Why is it that denial is the standard procedure with the insurer?

Is there no penalty, no remedy, no oversights of the abuses of "Utilization Review", and the unwarranted denials of medical treatment recommended by the insurer's own chosen doctor?

The behavior of the insurer in my case is outrageous and should be illegal.

Thank you for listening.

Monday, April 30 at 1:30pm Elihu Harris State Building Auditorium, 1515 Clay St.,  
Oakland, CA, 94612

April 30, 2012

Hon. Christine Baker, Director, Department of Industrial Relations  
Hon. Rosa Moran, Administrative Director, Division of Workers' Compensation  
1515 Clay Street, 17<sup>th</sup> 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.

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.

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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



Stephen J. Cattolica  
Director of Government Relations

Sjc/moi

Enclosure

# California Society of Industrial Medicine & Surgery



## Position Paper on the Possible Transition from the Official Medical Fee Schedule to the Medicare Fee Schedule for Workers' Compensation in California

### Background – The Current Official Medical Fee Schedule:

With the challenge to find savings to support an increase in permanent disability benefits, it will be counterproductive to adopt a Medicare Fee Schedule for workers' compensation cases. Except for some office visit billing codes, all medical treatment billing codes presently pay 5% less than the 1986 fee schedule. Reimbursement for the vast majority of medical procedures has not been increased in 26 years! No one is talking about adopting the Medicare Fee Schedule at less than a revenue-neutral basis, and many recognize that it cannot be done properly without adding several hundred million dollars a year in new money. As such, there can be no "savings" from adopting a Medicare Fee Schedule and California should not waste its time pursuing that course. Nevertheless, we need to elaborate further on the likely damaging outcome of that effort should it proceed.

By way of background, the current Official Medical Fee Schedule (OMFS) was first created in 1975 and was market-based. That is, as the result of data sampling of actual physician fees being charged, the original fee schedule reflected the relative value of medical services in the community at the time. It was supposed to be updated every two years based on market data but, because of the failure of previous Administrative Directors to perform the biennial updates, it is sorely out-of-date. This is particularly true for procedures provided by medical specialists. As mentioned above, the current OMFS pays for specialty procedures at the same amount, minus 5%, that was paid in 1986. Since 1986, however, the Evaluation and Management (E&M) Code reimbursements for office visits have been increased three times (1994, 1999, and 2007).

The Medicare RBRVS schedule, in contrast, is not market-based. It is a politically-driven fee schedule that provides extra compensation for office-based E&M services. Its principal objective is to provide maintenance care to senior citizens; not aggressive care to promote prompt healing, minimize residual disability and encourage swift return-to-work. In other words, Medicare's objective is not the aggressive and expert care that is required for the relatively younger population with the target of returning to work and helping the economy grow.

The reality California must face is that injured workers need both primary care physicians (who primarily bill E&M codes) and specialists (who bill more procedures and fewer E&M codes). Given the Administration's pronouncement that it wants close to a revenue neutral transition to the Medicare Fee Schedule, it is mathematically impossible to increase the E&M codes, as the RBRVS does, without cutting other procedure codes. Low income and high risk occupations such as farm workers, construction workers, restaurant workers, freight handlers, teachers, and

maintenance workers typically sustain more serious injuries that require medical care from specialists, not general practitioners.

California's current market-based OMFS is extremely efficient in allocating scarce medical resources at the lowest cost to employers. California is so efficient, it has the third lowest fee schedule in the nation, yet we do not have any serious "access to care" problems.

A Medicare RBRVS Conversion Would Result in Workers' Loss of Access to Medical Specialists:

The California Society of Industrial Medicine and Surgery (CSIMS), over the past decade, spent in excess of \$100,000 in research to study, in other states, the effect of moving to a Medicare RBRVS Fee Schedule at a budget neutral low multiple (e.g., less than 125% of Medicare). Without exception, every state that moved to the Medicare Fee Schedule at less than 125% of Medicare, as would be expected in California, suffered severe "access to care" problems. California would be no exception. We would need close to 150% of Medicare to avoid access problems, and that's not likely to happen unless the Administration is prepared to add hundreds of millions of dollars to the equation. If that doesn't happen, most medical specialists will be unable to continue to treat injured workers. This has happened time and time again in other states. Collaterally, research also documents that once physicians stop seeing injured workers, many do not return, even after the state reverses course and significantly increases reimbursements.

CSIMS has steadfastly supported and petitioned for further increases in the E&M portions of the OMFS. New money needs to be placed in the OMFS to provide a needed increase to primary care physicians. At the same time, however, it is inappropriate and inequitable to take the money from specialists because they will decline to treat injured workers. Furthermore, by their very nature, most specialists' services cannot be performed by primary care physicians.

In addition to the impact a revenue-neutral move to the Medicare Fee Schedule would have on injured workers' access to medical care, it would also affect their permanent disability benefits. Since California now uses the *AMA Guides to the Evaluation of Permanent Impairment*, heavy reliance in determining disability is placed on certain diagnostic services performed by specialists that are compensated under the OMFS. Many of these services would not be performed if their reimbursement was slashed as the result of conversion to RBRVS. Even employers would be harmed because of their inability to obtain diagnostic tests to prove apportionment.

Adoption of the Medicare Fee Schedule will be Costly to the DWC.

Adopting the RBRVS-based fee schedule doesn't involve simply copying some pages from a book or anything that easy. CSIMS has been involved in every revision of the fee schedule since 1982. The last modest change enacted in 1999 was a three-year effort, and it involved hundreds of hours of meetings between DWC staff and stakeholders. A change from the current OMFS market-based fee schedule to Medicare's geriatric maintenance fee schedule will take considerably more time and effort, particularly for DWC's staff.

For example, DWC will need to conduct extensive research to determine whether to adopt single or multiple conversion factors, including an assessment of how many conversion factors will be optimal for maintaining access to care as required by Labor Code Section 5307.1(f). Thereafter, the AD will have to decide upon the dollar figure(s) for the conversion factor(s).

Previous DWC proposals have suggested multiple conversion factors, recognizing the need for higher conversion factors for surgeons and radiologists, but neglecting other medical specialists, such as internists and neurologists. That was a major weakness of these earlier proposals and must be revisited.

The DWC will also have to study and evaluate whether or not to adopt a uniform statewide fee schedule as at present or Medicare's Geographic Price Cost Indices (GPCIs) for California. So far, none of this research has been undertaken and previous studies by the Industrial Medical Council and the DWC are now out-of-date and will need to be repeated and updated.

Some states' administrators have supported the adoption of the federal Medicare Fee Schedule believing that it will reduce their duties and overhead. This would clearly not be the case in California. Adoption of the Medicare Fee Schedule in California will actually involve more work for the staff of the Division of Workers' Compensation than if they merely maintained the current OMFS. Since Medicare does not recognize Consultation or Report codes, California would still have to create, price and maintain a set of California-unique codes for these procedures.

All fee schedules must have companion "ground rules" to clarify and specify how the schedules are used. In California, the OMFS ground rules are ten pages long. In contrast, the Medicare ground rules are 50,000 pages long. How many of those 50,000 pages will apply to workers' comp? We don't know. Some will and some won't; but every page – and every amendment to every ground rule – will have to be evaluated by the Division of Workers' Compensation to determine if it applies to workers' comp. Adopting a Medicare-based schedule with new ground rules will involve significant state resources without benefit to injured workers or their employers.

California hasn't changed its ground rules since 1999. Medicare changes its ground rules at least semi-annually, sometimes even more frequently. Every time Medicare changes a ground rule, the DWC will have to decide whether or not to follow suit and it will have to conduct public hearings before adopting anything. Think about how these frequent changes will affect how doctors bill? Consider the numerous billing disputes, increased lien filings and new litigation that will arise from dealing with up to 50,000 pages of Medicare ground rule minutia.

#### Adoption of the Medicare Fee Schedule will be Costly for Employers and Insurers:

Historically, fee schedules have been used to promote predictability of costs so insurers can accurately set their premiums and self-insured employers can budget their expenses. Experience from the other states that have adopted the Medicare Fee Schedule at rates similar to what we would expect California to establish convincingly documents that the vast majority of medical specialists will decline to treat injured workers and the health care delivery system will become

destabilized, making it very difficult for insurers to set reserves and establish insurance premiums. To hedge against the uncertainty, insurers will have to increase premiums. Delayed treatment, the inability to diagnose injuries quickly and accurately, and the inability to secure necessary pre-operative medical clearances will prolong temporary disability, increase residual permanent disability, and delay return-to-work that will translate into higher premiums and other costs for employers. Furthermore, with constantly changing ground rules, the number of billing disputes, liens and litigation is bound to skyrocket.

California could soon experience what has happened in Massachusetts. The Massachusetts Medicare Fee Schedule is very similar to what we would expect California to adopt. In the Bay State, many medical specialists refuse to treat injured workers under the fee schedule. Insurers are forced to negotiate on a case-by-case basis to obtain needed services from medical specialists, and they often end up paying more than 200% of Medicare.

Bear in mind that all of the new DWC costs associated with the adoption and constant maintenance of the Medicare Fee Schedule will be paid for through new employer assessments.

#### Adoption of the Medicare Fee Schedule will disqualify many MPNs:

One of the hallmarks of the 2004 workers' compensation reform legislation was a new law permitting employers and insurers to maintain control of medical treatment through the creation of medical provider networks (MPNs). MPNs have become very popular with employers and insurers and they're now used extensively in California. The Labor Code, however, requires MPNs to maintain an adequate number of primary care physicians and medical specialists in every network. If the Medicare Fee Schedule leads many specialists to decline to treat injured workers, the MPNs will become noncompliant with the law and employers will lose their ability to manage treatment costs.

#### Loss of Access to Care Due to Medicare RBRVS Implementation is Well Established:

Current state law – Labor Code Section 5307.1(f) – requires the DWC Administrative Director to conduct an “access to care” study before revising the fee schedule. To date, this has not been done; but based on the previous research mentioned above, it is clear that anything near a revenue-neutral transition to the Medicare Fee Schedule will lead to a severe access to care crisis. This eventuality was duly noted last year when the state Assembly overwhelmingly defeated Senate Bill 923 (de Leon). That bill would have forced the AD to adopt the Medicare Fee Schedule. Injured worker groups, several labor unions, applicants' attorneys and all medical specialist societies (including the California Medical Association) opposed SB 923.

During the debate last year on SB 923, the proponents of the measure claimed, “no [Medicare] RBRVS state has ever returned to their prior payment system.” In fact, last year, South Carolina considered repealing its Medicare schedule for workers' comp and several states (including Hawaii, Texas, West Virginia and Maryland) had to revise their Medicare-based schedules upward by millions of dollars a year in an attempt to keep medical specialists in the system.

The proponents of the Medicare Fee Schedule also cite the success of Utah's move to the Medicare Fee Schedule. Utah's schedule, however, pays 143% of its state's Medicare. If the California

Administrative Director was to adopt a revenue-neutral fee schedule, it would be at between 112% and 115% of California's Medicare rate. The national average workers' compensation conversion factor is 173% of Medicare. Other states that have successfully transitioned to the Medicare Fee Schedule all have conversion factors substantially higher than what we could expect in California. For example: Pennsylvania (145%), Oregon (201%), Michigan (145%), Minnesota (171%) and Mississippi (179%), and Tennessee (160%).

#### Preserving Medical Access at Low Cost:

What are the alternatives to the Medicare Fee Schedule? As noted above, the current California OMFS is extremely cost-effective in delivering medical benefits to injured workers despite being the third lowest fee schedule in the nation. Unfortunately, the OMFS is somewhat out-of-date because prior administrations failed to perform the necessary maintenance required by the Labor Code. This can change, however. Historically, stakeholders and the state worked together to maintain and update the fee schedule and they can do it again. They could update the current schedule quicker and at much less cost than by moving to the Medicare Fee Schedule. Physicians stand ready to do their part. We are committed to continuing to deliver quality medical care and evaluation to California's injured workers. California should not destabilize the health care delivery system by moving forward with an ill-conceived Medicare Fee Schedule. Injured workers are constitutionally entitled to all medical care necessary to cure or relieve their occupational injuries. Cutting payments to medical specialists from 20% to 48% by a move to the Medicare RBRVS fee schedule at inadequate reimbursement levels would create a constitutional crisis.

With a relatively low-cost and efficient fee schedule presently in place that can be inexpensively updated to repair its shortcomings, should California really risk destabilizing the delivery of care to injured workers by moving to a Medicare-based fee schedule?

April 2012

## Workers' Compensation Forum (2 Minutes)

4/20/12

I worked an active position in the community for 18 years. Prior accidents were treated successfully with great medical care and without legal representation. However, I had a WC accident January 2010, but received poor medical care and poor customer service. My problems started with poor medical care by a doctor who was either unwilling or not capable of providing the medical care I needed and who was also known to favor WC employers.

The poor service I got from my Workers' Compensation adjustor allowed for no second opinion or change in doctors. My injury occurred when a van hit the vehicle and I was a passenger. I continued to work with a fractured knee, torn shoulder muscle, and a hip/thigh injury. None of these diagnoses were made by the WC doctor. This doctor argued against treating me despite a ~~CME~~<sup>QME</sup> evaluation.

I was still suffering after 1 ½ years. One day I fell and sustained more injuries including a concussion to my head, hearing loss, ringing in the ear, carpal tunnel, eye injury, shoulder and elbow injuries. I was evaluated by the same doctor as required by my employer, yet none of these injuries were diagnosed. He said I had no problems. I found another doctor and continued to work until my company said my restrictions were too much and I could not work in their department.

At one point, I finally got an attorney so that I could get medical care. I never wanted to go that route, but felt it was needed to receive any medical treatment for my injuries.

The improvements I would like to see for WC:

- Requirements for physicians to address medical problems according to Standard Medical practices. There should not be a treatment for WC patients and another treatment for private patients. The injuries are all the same so why the difference in standards? In addition, all injuries should be approved for treatment at the same time – there is an inherent delay in the system. This really does not help control costs.
  - For example, WC did not do an MRI for my knee until required by the CME over 1 year later. I had a knee fracture which they did not treat.
  - Another example, I now have additional bone growth where it should not be due to nerve damage because of delays in treatment. As a result, I have difficulty in my walking, sitting, and standing.

- **Delay in medical care is equal to denial of medical care.** The care I got under WC was equivalent to negligence in medical practice. It is only allowable because the WC system receives protection under the laws.
  - WC adjustors are able to deny medical care without having a medical degree. They are the first line for treatment and their determination can be equivalent to practicing medicine over the telephone.
  - Poor customer service produces more injuries and more litigation. There needs to be more accountability at the point of service. (Who is watching the hen house?)
  - Doctors who side with WC are not providing a beneficial service to WC. Their service delays and denies needed medical care to the patient which can affect their quality of life for an entire lifetime. It is contradictory to their medical oath of, "Doing No Harm."
  - Doctors who provide good medical care in spite of WC are doing a great service for their patients and these doctors should be commended for doing their work in spite of difficult odds. (A stitch in time saves nine.)
    - These doctors should be given the tools necessary to perform their work. They don't need another **Standard of Care for WC patients**. All injuries should be treated equally;

In summary:

WC patients are intelligent patients who know when substandard care is provided.

Many doctors want to do the right things for the patient, but are discouraged and prevented by the system. The patients suffer the results which are distributed throughout the healthcare system.

Patients will always have problems and seek legal representation when unequal treatment is standard and poor customer service goes unchecked in the WC system.