

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING

December 13, 2013

**Elihu M. Harris State Building
Oakland, California**

In Attendance

2013 Chair, Martin Brady

Commissioners Doug Bloch, Christine Bouma, Sean McNally, Kristen Schwenkmeyer and Angie Wei

Acting Executive Officer D. Lachlan Taylor

Absent

Commissioners Faith Culbreath and Robert Steinberg

Report on Department of Industrial Relations

Christine Baker, Director, Department of Industrial Relations

Destie Overpeck, Acting Administrative Director, Division of Workers' Compensation

Rupa Das, Executive Medical Director, Division of Workers' Compensation

Comments by the Director

Ms. Baker thanked the Commissioners for the opportunity to provide an update on Department of Industrial Relations (DIR) activities and stated that she and her dedicated team are busy implementing the reforms. They are finding some areas that may need review or tweaking, and they appreciate the research that the Commission does to help understand the impact. She stated that they are concerned that some of the savings may be in jeopardy as a result of legal challenges to the lien filling fees, and that she believes the Attorney General will be representing the DIR in these challenges. She also stated that they want to ensure that any change is based on empirical data and not anecdote, as the system is complex, and the empirical analyses that the Commission does is very value.

Ms. Baker stated that she expects that the regulations for the Return-to-Work (RTW) Fund should be ready at the early part of the year, and that she hopes to post them for comment. She stated that they are estimating that when fully operational, 120 million dollars per year will be available. She stated that of course, they are basing distribution on estimates of usage and that they may need to revisit this after the first year of implementation.

Ms. Baker stated that her focus this quarter has been on implementation of reforms, as well as a focus on Cal/OSHA modernization and accountability, and fixing structural and budget problems

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of the Division of Labor Standards Enforcement (DLSE) and the Division of Occupational Safety and Health (DOSH). She stated that these are long-time structural problems which they hope to fix this fiscal year.

Ms. Baker stated that she will defer to her team to discuss the status of various issues within the Division of Workers' Compensation (DWC). She stated that she hopes at the next meeting that Juliann Sum, Acting Chief Cal/OSHA, will provide a briefing on the status of DOSH and the need to update and implement approximately 40 regulations.

Ms. Baker stated that they are hiring staff throughout the agency. The baby boomers are moving through and retiring at a faster pace than ordinary, so a key focus is on recruiting, replacement and training.

Ms. Baker also stated that they have been asked by the Little Hoover Commission to speak on the underground economy. She stated that DIR has been taking a leadership role in combating the underground economy with a multi-agency collaboration by targeting employers that are not compliant with labor laws. She stated that practically all DIR efforts are focused on the underground economy, and that all the wage claims coming through are about low-wage workers with employers not compliant with wage laws.

Ms. Baker stated that the Governor also asked DIR to lead implementation of Assembly Bill (AB) 576 which is a multi-agency effort to lead the Revenue Recovery and Collaborative Enforcement Team Act pilot, which is going after criminal underground economy activity. One of the actions will be to create a central intake process and organizational structure to document, review, and evaluate data and complaints. The Governor felt that it was important to house this effort under one agency so that it is coordinated and effective. The effective work of the Labor Enforcement Task Force led to the Governor's action.

Ms. Baker also stated that DIR is working very closely on the Refinery Task Force and implementing new safety procedures for refineries. Another five million dollars will become available by assessing fees on refineries.

Ms. Baker stated that this has been an incredibly productive year and that she heartily wishes the audience and the workers' compensation community a Happy New Year.

Report on the Division of Workers' Compensation Regulations

Destie Overpeck provided an update of DWC regulations, including:

Completed fee schedule regulations:

- **Ambulatory Surgery Center (ASC)** (80% of Medicare outpatient fee schedule) – effective 1/1/13.
- **Inpatient Fee Schedule** – spinal implant payment reduction – effective 1/1/13.
- **Physician Fee Schedule** – Resource-Based Relative Value Scale (RBRVS) – effective 1/1/14, public hearing 12/12/13 to eliminate the use of the Federal Office of Workers'

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Comp Program's (OWCP) relative value units (because the structure of the OWCP data file results in erroneous fee calculations for certain procedures). These regulations instead state that those procedures will be billed "by report."

Emergency regulations – 6 sets in effect on 1/1/13:

- **Interpreter Certification** - certificate of compliance completed. Final regulations in effect 8/13/13 (extended to 3/1/14 per Assembly Bill (AB) 1376).
- **Qualified Medical Examiner (QME)** - certificate of compliance completed. Final regulations in effect 9/16/13.
- **Supplemental Job Displacement Benefit (SJDB)** – certificate of compliance completed. New forms effective 1/1/14.
- **E-documents and Lien Filing Fees** – certificate of compliance pending with Office of Administrative Law (OAL) – should be approved by next week.
- **Independent Bill Review (IBR), paper and electronic billing** – 2nd 15-day comment period ends 12/26.
- **Independent Medical Review (IMR), Utilization Review (UR)** – 3rd 15-day comment period ends 12/26.

Regular rulemaking:

- **Medical Provider Network (MPN)** – 15 day comment period ends 12/26.
- **Pre-designation/cap on chiropractic visits for Primary Treating Physician (PTP)** – hearing 10/17, preparing final regulations to submit to OAL.

Still to do:

- **Copy Services Fee Schedule** – study presented 10/17/13.
- **Interpreter Fee Schedule** – conducting study.
- **Home Health Care Fee Schedule** – conducting study.
- **Vocational Expert Fee Schedule** – conducting study.
- **Benefit Notice Regulations** – preparing to notice public hearing.
- **Worker's Compensation Information System (WCIS) penalties** - on forum 4/16 – will begin formal rulemaking next.
- **Medical Treatment Utilization System (MTUS)** - hierarchy of evidence on DWC forum 8/21/13 – formal rulemaking by January; opioid guidelines on DWC forum in January.
- **Audit regulations**

Update on Medical Unit, Division of Workers' Compensation

Dr. Rupali Das thanked the Commission for the opportunity to provide the 2013 update on the functions of the Division of Workers' Compensation (DWC) Medical Unit and the progress that has been made this year. The five main functions of the Medical Unit are: Medical Provider Networks (MPNs); Utilization Review (UR); Independent Bill Review (IBR); Independent Medical Review (IMR); and the Qualified Medical Evaluator (QME), all of which were impacted by the legislative reforms of Senate Bill (SB) 863. Some changes were small and easy and others were large and more challenging. In addition, Dr. Das is responsible for a sixth area,

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the Medical Treatment Utilization Schedule (MTUS), which is conducted with the assistance of an outside expert committee.

Dr. Das touched briefly on the first three functions and then focused the bulk of her comments on IMR, the QME process, and the MTUS. Dr. Das stated that there were changes to the MPN regulations. MPNs offer workers access to care from an established network of providers while containing costs for the employer and insurer. Reportedly, 80% of injured workers in the California workers' compensation system are treated by providers who are in MPNs.

Dr. Das stated that the three most important Senate Bill (SB) 863-related MPN changes affecting injured worker access to care are:

- Medical Access Assistants, who are required to help injured workers find an available MPN physician.
- Physician acknowledgements, which require that providers affirmatively acknowledge that they are part of an MPN.
- New enforcement tools, which allow DWC a variety of sanctions to enforce compliance.
- In addition, DWC is working on an electronic application to streamline the application process.

Dr. Das stated that that the next major change that affected the Medical Unit was the changes to UR regulations streamlined treatment requests and removed redundancies. One of the main changes was IBR. As of January 1st of 2013, IBR is the process used to resolve disputes regarding the amount to be paid to doctors and other providers. Providers pay for IBR and they are reimbursed by the insurer if the decision is in their favor. DWC has contracted with Maximus Federal Services (Maximus), a private organization with national experience, to perform the reviews for IBR.

Dr. Das stated that of the IBR applications submitted from January to October 2013, the majority, or 62%, of IBR decisions are in favor of the provider. DWC is working on providing a more detailed breakdown of the IBR data indicating which ones are being denied and which ones are being approved. Much of the focus over the past year has been on the two issues: IMR and the QME program. IMR, as mandated by SB 863, is the process that utilizes medical expertise to resolve medical disputes about denied or delayed medical care; it takes the place of the system of Agreed Medical Evaluators (AME) or QME evaluations and decision-making by judges. Injured workers may request IMR if a request for treatment is denied or modified following UR and liability is not being contested. To request IMR, injured workers must sign the application form completed (except for the signature) by the claims administrator, and submit it along with a copy of the UR denial to the IMR organization Maximus. The contractor (Maximus) chooses the reviewers, who are specialty-matched to the medical issue being disputed; decisions are based on a review of the available records; no hands-on (physical) examination of the worker takes place.

Dr. Das stated that evidence-based medical determinations are made by these medical professionals who remain anonymous to everyone outside the IMR organization including DWC. The costs of the program are borne by claims administrators (or employers), who pay a set fee determined by the complexity and urgency of the request for each eligible IMR application.

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IMR decisions are considered to be decisions made by the Administrative Director (AD) of the DWC.

Dr. Das stated that there has been a dramatic rise in IMR applications since the program's inception. Between January 1 and the end of November 2013, Maximus received over 59,000 unique applications for IMR. The vast majority of these applications (nearly 8 out of 10 applications) were received between August 1 and November 29, 2013. This volume represents 4 to 5 times the volume of applications anticipated prior to the initiation of the program. During this same time period, Maximus issued 2,545 evidence-based medical decisions, and DWC declared 105 applications ineligible for IMR. There is obviously a big gap between the number of applications admitted and the number of decisions issued. The timeliness of IMR decisions is an important concern. DWC successfully implemented the IMR program within a very short timeframe. As expected with the rapid implementation of such a large program, there have been some challenges, primarily related to timeliness of issuing decisions.

Dr. Das stated that the SB 863 statute requires that standard decisions be issued within 30 days of the request being assigned to an IMR reviewer; the timeframe expands to 45 days when time is added for mailing and collection of records. Expedited IMR requests are required to be issued within 72 hours of assignment. In reality, the time taken from submission of a request to issuance of a decision is longer than 45 days. The statute's timeframe starts when the case is assigned to a reviewer, not when the application is submitted to the organization for IMR. Incomplete applications, which total about 30 percent of the applications received, require additional follow-up and take a lot longer to go through the system.

Dr. Das stated that between January 1 and October 31, 2013, 4 out of 10 standard decisions and over 7 out of 10 expedited decisions were issued within the required timeframe. The vast majority of the untimely decisions (94%) were issued in September and October 2013 when volume greatly increased and was much more than anticipated. The reasons for the untimely decisions and why more IMR decisions have not yet been issued were due to Maximus receiving 4 to 5 times the volume of applications anticipated prior to the initiation of the program and 30% of IMR applications being incomplete (typically missing the UR decision), therefore requiring additional resources to obtain the missing information needed to determine eligibility. An additional reason is that the paper submission process for IMR requires manual data entry and workload tracking

Dr. Das stated that she has implemented a number of fixes to the system to improve compliance with the required timeframes and to issue IMR decisions more quickly:

- Infused additional resources, including hiring additional staff both at Maximus and DWC, and doubled the number of fax lines used to receive documents.
- Increased frequency and clarity of communications with parties.
- Improved automation and technology, including a planned electronic IMR application that they hope to have in effect the first quarter of 2014.

These efforts will improve the timeliness of decisions. In fact, the backlog on initial data entry has been eliminated. At Maximus, initial data entry on applications received now occurs the day they are received.

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Dr. Das stated that IMR decisions were examined in greater detail. On average, each IMR decision contains two treatments decisions; some have one and others have four or five, but on average, there are two individual treatment decisions per IMR determination. Overall, DWC experience to date shows that only about one in five treatment requests are approved through IMR. Among the types of IMR requests, pharmaceuticals are most commonly requested type of treatment, followed by durable medical equipment, surgery, and physical therapy and occupational therapy. Denials are more common than approvals in all categories in the IMR data that the DWC Medial Unit has. There are some categories where the requests are approved more often than denied: E&M where there is a consult and physician visit request and diagnostic testing. Of the pharmaceuticals, injections are most commonly requested, followed by narcotic analgesics. The category of injections consists mostly of steroid and other synthetic medications injected around the spine and peripheral joints but also includes Botox for muscle spasm.

Dr. Das stated that the ratio of treatment approvals to denials deserves further comment. As mentioned previously, only one in five treatments is approved. What is a high rate of denials may, in fact, be appropriate medical care. According to an initiative of The American Board of Internal Medicine Foundation called “Choosing Wisely,” the current health care system (which includes all medical care) is based on overutilization. Medical students are taught to order tests and not to be selective about the tests that they order. Providers are not well trained on getting the right care, which includes making an informed decision to sometimes not recommend medical tests and procedures that may be unnecessary and in some instances may cause harm. More than 50 medical specialty societies have joined this “choosing wisely” campaign and have started to educate their membership about appropriate treatment. Just because treatment is denied does not mean that workers are not getting appropriate medical care. Dr. Das stated that DWC is looking more closely into factors that might account for the high proportion of denials, including providers requesting treatment that is not evidence-based.

Dr. Das stated that she would describe two brief examples of evidence-based medical decisions posted on the DWC website. IMR # 5407 describes a 58-year-old worker who strained his lumbar spine in 2007 and subsequently underwent a spinal fusion surgery in 2011. He complained of increased low back pain and discomfort radiating down his left leg despite physical therapy and medication. UR denied his request for a second lumbar fusion based on the appropriate MTUS chapter and other guidelines. IMR reviewer used similar guidelines and denied the repeat spinal surgery, stating that the MRI showed that the previous procedure was intact and there were no abnormalities in the spine that could be corrected with surgery.

Dr. Das stated IMR # 4346 describes a worker who presented with injuries to the neck, face and shoulder in 2011. UR denied the request for a trigger point injection but failed to cite any guidelines to back up the decision. The IMR reviewer stated that the requested treatment was medically necessary according to the MTUS Chronic Pain Medical Treatment Guidelines because the patient met the several criteria specified in the guidelines and the IMR document actually documented which criteria were met to justify the treatment. Dr. Das stated that posting the IMR decisions on the DWC website shows the transparency about why the decisions were made and shows the advantages and the short-comings of the IMR process.

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Dr. Das stated that in the QME process, DWC has made a number of improvements that will benefit workers, including: limiting the number of offices where a QME can be listed; requiring documentation of training to be listed as a QME specialist; and reducing the backlog in issuing the list of QME physicians, known as a panel, from which an injured worker chooses an evaluator. In September 2013, the Medical Unit had a backlog of QME panel requests that dated back to March 2013. Dr. Das stated that she was happy to report that within a six-week period, the Medical Unit, along with the help of other department staff, was able to bring the backlog of panel requests from both unrepresented and represented workers within regulatory compliance. DWC is currently processing unrepresented and represented QME panel requests submitted in the first week of December. DWC has eliminated QME panel backlog. In an effort to better communicate with the public, the Medical Unit has revised the language in the letters sent out to clearly identify any problems with the request for a QME panel (known as rejections). In addition, it has become a policy to give first priority to processing resubmissions of panels that were previously rejected. All of this helps get workers faster access to care.

Dr. Das stated that her final comments pertain to the evidence-based medical treatment guidelines, known as MTUS, which guide appropriate treatment for work-related illnesses and injuries in California. DWC is planning on updating a couple of regulatory updates as discussed by Destie Overpeck. The MTUS is being revised which includes the strength of evidence, chronic pain and other body parts, and is starting with strength of evidence because it forms the basis of the MTUS and also provides guidance on the proper method of disputing the MTUS which is presumed to be correct. If there is more recent evidence in the scientific literature that justifies why a worker should get treatment, the MTUS will show the strength of evidence that is needed for those treatments.

Dr. Das stated that the opioid guidelines are new, and DWC is pulling them out the chronic pain guidelines because of the importance of this category and because of the epidemic of opioid overuse and misuse. This is being done by a number of organizations as well, and DWC aims to follow with the rest of the MTUS and update the entire MTUS which is several years outdated.

Dr. Das stated that behind all the work that she has described is very dedicated staff and that she is grateful to work alongside the staff and managers of the Medical Unit, previously Kathy Patterson and now Melissa Hicks and Mary Jean Crisostomo, who have operationalized the new work processes and protocols; attorneys in the Legal unit as well as the entire Legal unit; and of course DWC and DIR leadership. Finally she wanted to acknowledge John Gordon of the research staff who tracks the IMR and IBR decisions and prepares the graphs and charts shown today.

Questions and Comments from Commissioners

Commissioner Bouma asked about IMR and stated that according to her recollection of SB 863, there were layers of criteria or measures that an IMR reviewing physician would use, starting with the MTUS and evidence-based and practice and outcome. Commissioner Bouma asked if Dr. Das is tracking where the decisions points exist, whether physicians use the MTUS as their sole criteria for the decision, and whether there is any tracking of documentation of the reasons for approval or denial of treatment. Dr. Das responded that the DWC Medical Unit is tracking

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the guidelines, or what is used to justify treatment, both by the claims administrators as well as the IMR reviewers, but the categories are not the same as the ones in SB 863. DWC is tracking what was used to make the decision: the MTUS, another guideline, or a paper. Dr. Das stated that the MTUS updates for the strength of evidence are strengthening the MTUS so that the hope is that the MTUS is so complete and conclusive so that one will not have to use lower criteria, or the MTUS will provide the direction about what to do if the MTUS is not specific about treatment. Dr. Das stated again that DWC is tracking and at some point Dr. Das hopes to present that data in the future.

Commissioner Bouma asked if there is an effort to track outcomes for these injured workers since she has an employees' perspective and there is an 80% denial rate for a requested IMR. Commissioner Bouma stated that she was sure that Dr. Das will uncover the reasons for that, but an important piece of data would be the outcome, return to work, and claims experience for a particular worker. Dr. Das agreed that it is very important to see how these treatment disputes are resolved; however, DWC is not currently tracking the outcomes. The researchers have expressed interest in tracking outcomes, and it would involve combining a couple of different databases. She stated that the Department and Division, as a whole, would like to do that in the future.

Commissioner Bloch thanked Dr. Das for giving examples of IMR cases that are on the DWC website. He stated that he appreciates the challenge around implementing these new regulations and that DWC is taking steps to address the timeliness of IMR decisions. Commissioner Bloch asked about the unanticipated high volume and the spike in the volume and what DWC's expectations in terms of volume were; he also asked what the reasons were for the high volume. Dr. Das responded that they were expecting a fourth or fifth of the number of applications, or about 4,000 or 5,000 maximum applications submitted per month, but they reached that point in July. After July, there was a spike in volume. Dr. Das stated she was operating with incomplete data and it is not certain about the reasons for the spike in applications. Ms. Baker stated that the law changed and treatment requests came to DWC which applied to all the treatments from the past. After July 1, when the volume spiked, it went to all injuries up to January 1 so that is what drove the spike. Ms. Baker stated that despite the spike, one has to look at the overall picture that shows that there are 20 million treatment requests coming throughout the year and this is a very small portion.

Commissioner Bloch asked about UR since there was little discussion about it; he asked if there was any correlation between IMR and what was happening in UR, whether there had been a spike in denials or there was something within the UR process that is contributing to the high volume of IMR requests. Dr. Das responded that in order to be eligible for IMR, UR has to deny the treatment. DWC does not have the ability to track the treatments that have been approved but, anecdotally, she has heard that 80% of the treatments have been approved. Theoretically, IMR reviews the 20% that have been denied, and probably most of the UR denials are coming through the IMR system. That is the reason for the high volume. DWC did not know the past volume of IMR requests because there is not a way to track the past UR denials. The Division was not getting the data; DWC is now getting the data but it is not complete, so they are not getting the universe of all treatment requests that are approved. Dr. Das stated that she cannot answer whether something has changed in the UR process since they were not tracking UR before and are not really able to tell if there were more approvals or denials now than in the past.

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Commissioner Wei thanked the Dr. Das and Ms. Overpeck for the hard work they have done throughout the year to get regulations approved and stated that moving regulations is the only way the system can stay on track. Commissioner Wei stated that DWC has made 2,500 or so decisions on IMR and she wanted to know about any qualitative sense of the quality about the decisions from Maximus, whether the decisions by Maximus looked legitimate, whether the doctors are spending enough time on making these decisions and whether they are being thorough. Commissioner Wei stated she does not have a good sense about who is making the decisions and how decisions are made. Dr. Das stated that when they looked at the quality of a decision, it was based on whether the rationale for the decision was documented and whether evidence-based guidelines were used. She stated that based on what she has seen, the length of the decision varies, which is often due to the medical records provided, and that some may be brief because they are recent injuries or there are not a lot of medical records. She stated that the quality has improved over the past year and the decisions are all evidence-based; there has been discussion in the past about what the evidence should be. She is confident that the evidence basis DWC would like to see being used is now being used. Dr. Das then stated that DWC relies on comments from the public about whether there should be more or less details in the decisions to assess the quality. She stated that the decisions are good-quality decisions, but there is always room for improvement, and she is consistently making suggestions to make sure that the reviewers are documenting what they should be, making the right decisions, and justifying those decisions.

Commissioner Wei asked if Dr. Das is satisfied that she has a good feedback loop with Maximus and if there is a productive discussion about the improvement process. Dr. Das responded that she feels that there is a good working relationship with Maximus and that the decision-making is independent and DWC does not influence the decision-making on an individual case; when DWC does make suggestions, the suggestions are to be used for future cases. If DWC noticed an egregious problem or felt there was a real mistake in an individual decision, then it would make that comment and have a discussion on what needs to be done. She stated that the decision-making needs to be independent and DWC does not ask Maximus to change the decision. Overall, the communication is very satisfactory and as soon as there is an issue, Maximus is receptive. DWC has either weekly or more-often-than weekly meetings of several hours with Maximus and they are receptive to DWC's comments

Commissioner Wei stated that the real problem in her opinion is that it is employer-and insurer-controlled MPNs and employer-chosen doctors who are making medical treatment decisions that the carrier challenges, and then the challenges are not getting upheld through IMR. Commissioner Wei stated that if the system was perfect and everyone was being treated fairly and treatment guidelines were being upheld, then they would not be having the challenges to this process. She stated that she would like to know what can be done about the problems given the MPN changes that were included in SB 863. She stated again that these are employer-side doctors who are making treatment decisions that the carrier is then challenging, and then the system pays more to go to IMR and then the applications are getting denied. She asked why if the decisions are medically sound decisions, this is happening. Dr. Das responded that doctors and providers need to be better educated about MTUS guidelines. There would be fewer disputes if all providers used the appropriate guidelines. When DWC revises the MTUS, it intends to have an educational campaign, as there are many areas of improvement in terms of educating the

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providers in the guidelines. Dr. Das stated that has spoken to the providers and they sometimes do not know about the MTUS, so clearly, more needs to be done to educate them. If all providers used those guidelines, then there would be less inappropriate requests, less requests for IMR, and more appropriate treatment. Commissioner Wei stated that she would like Dr. Das to come to every Commission meeting during the next calendar year and provide an update on IMR, as the presentation of data is very helpful. Dr. Das responded that she would be happy to do so.

Commissioner Bouma stated that Ms. Baker noted that the spike in the volume was tied to new claims after January 1 and then older claims flooded the system; she asked whether there is a split in the analysis of the behavior between the January to July rates versus the August to October time period and whether the denial rate was much higher in the latter period. Dr. Das stated that they did look at the data but have not shown it to the Commission because they have to refine the analysis. However, the data show that the data in June had a slightly high rate of treatment being given. Looking at the current data, there is not a significant difference in the injuries this year versus older injuries in terms of denials. The portion of denials has gone up but they cannot pinpoint why the rate of the denial has changed. Commissioner Bouma stated that that the denial rate has hovered around 80%. In the discussion around SB 863, there might be some behavior modification in the outcomes that either UR will deny less frequently once they see the outcomes of the IMR or maybe requests to go to IMR will be greater. Commissioner Bouma asked if Dr. Das anticipates that the denial rate will be larger and approach 85 to 90 percent because the cases that are going to IMR are not the cases based on the body of work of the system. Dr. Das responded that she could not speculate about the pattern of IMR denials but the pattern could change. Maximus has stated the same thing because they have done IMR and other programs in the Department of Managed Healthcare and they did see variation in the rate of denial and approvals. Maximus has seen the difference between the rate of denial and approvals and has stated that at some point it will even out. Dr. Das stated that if there is learning that will occur in UR, it will be evident over time. What needs to be seen is the treatment overall and not just the IMR request to see if the learning process had occurred. Dr. Das stated that even though she will be happy to provide the data, it could change; drawing a conclusion on less than a year's worth of data does not predict what will happen in the future. Commissioner Bouma thanked Dr. Das and added her accolades for her and the staff for the huge amount of work they have done.

Commissioner Bloch stated that the comparison to the Department of Managed Health Care is like comparing apples and oranges because of the volume of IMR cases. He is particularly concerned about the volume of IMR requests and any correlation with UR and he echoes the comments of fellow commissioners and he would like to be updated as the implementation moves forward. He stated that there may be a good reason for a high denial rate, but being an advocate for workers, it immediately draws concern. Commissioner Bloch stated that he has been dealing with large group of workers in the Central Valley who get injured on the job and get sent to the employers' doctor and get sent back to work immediately, and if these workers file for workers' compensation claims, they get fired. These are unrepresented workers and they do not have the luxury of an attorney or a union representing them. He stated that obviously, this is one snapshot of a group of about 900 workers, but when Commissioner Bloch hears stories like that and then he sees what workers who are represented have to go through in the workers' compensation system, he wants to make sure that the workers who need treatment are getting it.

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Commissioner Bloch stated that he would appreciate getting the reports as Dr. Das comes back to the Commission and thanked her for putting the program together. Dr. Das stated that she agrees that comparing DWC and the Department of Managed Health Care is comparing apples and oranges.

Dr. Das stated that they will be taking comments in January 2014 for IMR and UR and are inviting stakeholders to provide feedback for what they think the issues are with UR and IMR. She stated that there will be a meeting in Northern California and Southern California.

Chair Brady asked whether for the number of IMR applications filed there is data on who is filling the applications and how many are coming from injured workers versus attorneys. Dr. Das responded that they are starting to track that, but the data are not at a point where she feels confident in presenting it. Chair Brady thanked Dr. Das for the hard work she and her staff are doing throughout the many months it took to assemble the data.

Approval of Minutes from the October 17, 2013 CHSWC Meeting

CHSWC Vote

Commissioner Wei moved to approve the Minutes of the October 17, 2013 Commission Meeting, and Commissioner Bouma seconded. The motion passed unanimously.

Election of the 2014 Commission Chair

Commissioner Bouma nominated Angie Wei for the position of 2014 Commission Chair, and Commissioner McNally seconded. The motion passed unanimously.

Update on the Worker Occupational Safety and Health Training and Education Program
Laura Stock, Labor Occupational Health Program, University of California,
Berkeley

Ms. Stock commented that an overview description of the Worker Occupational Safety and Health Training and Education Program (WOSHTEP) was presented previously this year. There is a new WOSHTEP project focusing on materials and training for small businesses on how to create and implement an effective Injury and Illness Prevention Program (IIPP). This project, called Taking Action for Safety and Health (TASH), targets owners, managers and lead workers in small businesses which have been defined as having 50 or fewer employees. The project is being planned and implemented by a committed group of partners that meet regularly – the Department of Industrial Relations (DIR), CHSWC, Cal/OSHA Consultation Service, State Compensation Insurance Fund, California Department of Public Health Occupational Health Branch, two small business associations, Small Business California and California Small Business Association, and the Labor Occupational Health Program (LOHP).

Ms. Stock stated that the project is funded and administered by DIR and CHSWC as part of

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WOSHTEP. The project includes materials, such as a Guide for how to write an IIPP, an IIPP template, factsheets, tools like checklists, forms, and a resource list. The training program for this project is a half-day, participatory class where participants learn how to develop and implement an effective IIPP. The main message is that an IIPP needs to be a living document specific to the workplace which needs to be updated and implemented. During the class, the participants write down on a worksheet how they will implement the IIPP elements they have just learned about back in their workplace. The idea is that they leave the class with a pretty good idea of what their IIPP will look like. The class is taught by trainers from LOHP and a Consultant from Cal/OSHA Consultation Service.

Ms. Stock stated that as a reminder, as part of WOSHTEP, a day-long training for larger businesses on how to develop and implement an effective IIPP is also offered. In addition, a WOSHTEP partner, the University of California Davis Western Center for Agricultural Health and Safety (WCAHS), has just adapted the materials for the agricultural industry, and they are posted on the Commission's website. The training program is being developed and will soon be pilot-tested.

Ms. Stock stated that during 2013, 6 Small Business IIPP trainings were conducted in Oakland, Vacaville, Pleasanton, Stockton, Salinas and Sacramento. Currently, a 7th training is scheduled for January 22 in Oakland in the State Building and an 8th one is scheduled for February 19 in Santa Ana. In the WOSHTEP proposal for this project, the commitment was to provide 4-6 trainings in this fiscal year. A total of 113 small business owners, managers and supervisors have attended the 6 classes held to date, representing 84 small businesses from such industries as manufacturing, construction, building maintenance, restaurants, warehousing, landscaping, auto body and agriculture. A few insurance brokers have also attended with the idea of learning more so they can better advise their clients. Ms. Stock stated that the evaluations from these classes have been extremely favorable. Trainees have commented that: "the class was extremely helpful"; they are "way more confident than before"; and "creating notes during the class for what they will do afterwards is helpful."

Ms. Stock stated that several exciting new ideas have emerged from advisory group discussions about how to support small business owners and managers after the training as they go back and work to create safe workplaces, as well as how to fund the ideas. Ideas include:

- Developing an online discussion forum that can provide ongoing support and facilitate communication between trainees, LOHP staff and Cal/OSHA Consultation staff. A listserv has already been created and additional resources are being sent after the training, as well as reminders to contact LOHP with questions, and people are responding.
- Developing refresher trainings that can be done online as webinars.
- Linking local Industrial Hygiene/Safety specialists with small business owners who attend our classes to provide small businesses with free mentoring on issues that come up after the class. These specialists could offer their industry-specific real world experience that is beyond the scope of the class. The California Industrial Hygiene Council president is exploring whether her members are interested in doing this on a *pro bono* basis.

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- Offering a premium reduction from State Fund but possibly other carriers as well for attending the class and then demonstrating that they have developed and are implementing an effective IIPP. Metrics would be developed for implementation efforts.
- Creating a class for insurance safety specialists who can provide training and support for their clients, thereby extending the reach of the project.

Ms. Stock stated that the overall goal is to find a way to make TASH a truly comprehensive and model project that incorporates not only the easy-to-use materials and a participatory training method, but also provides ongoing support so that small businesses can create and implement effective health and safety programs that help reduce injuries and illnesses on the job. She stated that California's Small Business IIPP project can potentially serve as a model for other states as federal OSHA works to put into place a federal IIPP standard. Representatives from the National Institute for Occupational Safety and Health (NIOSH) have been extremely interested in this program and discussions have taken place about providing support for evaluating the impact of the program.

Ms. Stock stated that as part of the Small Business IIPP class, trainees are provided with WOSHTEP materials that were developed in previous years which can help owners and managers train their employees and involve them in illness and injury prevention efforts. WOSHTEP has safety training materials for general industry, as well as industry-specific materials and training for restaurants, dairies and janitorial companies, all in Spanish and English. The restaurant materials have also been translated into Chinese. A couple of years ago, a national version of the general industry training guide was created, and there are national versions of many of the TASH IIPP materials as well.

Ms. Stock stated that LOHP is pleased to announce that we just learned that State Fund is providing additional training money that will supplement existing DIR/CHSWC funding so that additional classes after our February class can be offered. With this funding, at least one class per month will be offered through the summer in collaboration with our partners at UCLA LOSH. State Fund is also funding the development and delivery of a two-day Training-of-Trainers class for safety specialists from State Fund. These State Fund specialists will be prepared to teach the half-day class to State Fund policy holders. LOHP will continue to track these classes and include participants in the TASH database so that they can be included in future follow-up efforts.

Ms. Stock stated that LOHP would like to hear about people who would benefit from one of our classes.

Questions from Commissioners

Commissioner Bloch stated that he is enjoying working with LOHP on WOSHTEP trainings in the Central Valley. Chair Brady asked about the amount of the funding from State Fund, and Ms. Stock responded that it was in the range of \$29,000. She stated that the advisory group collaboration has been very strong and is greatly appreciated. Chair Brady stated that the collaboration is important, as well as that this is a prevention program. He also stated that the

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emphasis on implementing the IIPP and keeping it applied is critical. Commissioner Wei stated that the support from State Fund is terrific, and the next step would be to create incentives to take the training, including premium discounts, so that people who go through the training will actually practice the injury and illness prevention actions. Ms. Stock stated that NIOSH talked about models in other states for State Fund equivalents that provide incentives and premium reductions.

Acting Executive Officer Report

D. Lachlan Taylor, CHSWC

Pending Reports

Inspection Targeting Issues for the California Department of Industrial Relations Division of Occupational Safety and Health Study

Mr. Taylor stated that the RAND report for CHSWC by John Mendeloff and Seth Seabury, “Inspection Targeting Issues for the California Department of Industrial Relations Division of Occupational Safety and Health,” was posted to the Commission’s website for public comment. The public comment received warrants further examination, so a vote on the report will be deferred until the next Commission meeting.

Potential Impact of Assembly Bill 1373, Study on the Impact of the Changes to the Statute of Limitations for Cancer for Public Safety Officers

Mr. Taylor stated that there was a report by Bickmore Risk Services for CHSWC on the Assembly Bill (AB) 1373 proposal to increase the statute of limitations for public safety officer workers’ compensation death benefits for public safety officers for specific causes of death, especially cancer. The goal of the study is to investigate the financial impact of extending the statute of limitations. Mr. Taylor stated that rather than ask for final action, the Commission is embarking on second phase per the Commission’s request. Mark Priven of Bickmore Services will be evaluating the impact of a proposed change in the statute of limitations for firefighters and police officers in light of the data from NIOSH. The NIOSH study of firefighter cancer includes more information on the age at onset and the mortality from cancer, so it should enable Mr. Priven to estimate the impact of the proposal with more confidence. This study includes the San Francisco Fire Department, representing data from California. A report on this second phase of the study will be presented at a later time.

Formulating a Copy Service Fee Schedule Study

Mr. Taylor stated that at the previous Commission meeting, Commission staff was requested to be involved in the process of rulemaking on the Copy Service Fee Schedule. Commission staff invited stakeholders, both payers and providers and applicants’ and defense attorneys, to a stakeholder meeting on November 19, 2013. Mr. Taylor stated that that meeting has apparently stimulated ongoing conversations among the stakeholders, and it seems that the range of dispute is narrowing; it seems that this would pave the way for the rulemaking process and adoption of a fee schedule. Should the offline conversations come to an impasse, it is hoped that CHSWC would step in to stimulate further discussion.

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Public Sector Self Insured Program Study

Mr. Taylor stated that the Public Sector Self Insured Program Study is underway. It will rely largely on publicly available data and will use information survey questions to public sector employers. There will also be access to data from the Division of Workers' Compensation (DWC) Workers' Compensation Information System (WCIS).

Two New Proposed Studies

Proposal to Study the Independent Medical Review Process

Mr. Taylor stated that Frank Neuhauser of the University of California (UC), Berkeley, has proposed a study on the volume of Independent Medical Review (IMR) requests based on drawing a sample 100 to 200 IMR cases for in-depth analysis of where the requests are coming from. This study will include linking the cases to the WCIS and EAMS databases to learn more about the environment of the IMR cases than can be learned from the summaries on the DWC website alone. Commission staff would work with Mr. Neuhauser to refine the questions for the study. The proposal request is for up to \$45,000 to do some preliminary investigation of causes for the increase in IMR requests.

Commissioner Bloch stated that this study is very timely. He stated that when looking over the proposed methodology, it is clear that there is a need to investigate what is happening in the utilization review (UR) process as well to see if there is a correlation between UR denials and increased IMR requests. Mr. Taylor responded that going into the UR process would require additional data which would be difficult to access. It is on a wish list to look into these issues. Commissioner Bloch stated that the study could be looking at the symptoms and not getting to the cause. Mr. Taylor responded that this would not be a comprehensive study of the issues. Commissioner Wei stated that the study should at least look at UR outcomes and how they influence QME requests for the set number of cases. That would be the only way to understand the increase in IMR requests. She stated that the sample size of 100 to 200 seems small, especially because this is such a big question. She stated that pharmaceutical claims are important but that that data might not be the most important and that there might not be enough data about other claims in the sample. Mr. Taylor responded that the sampling of pharmaceutical claims could be reduced and other claims could be looked at. Commissioner Wei stated that she believes this would be the first of a number of studies and therefore it should set a wide enough look so that it would lead the way appropriately to other studies. Mr. Taylor responded that a small sample limits the precision of the data, but if something happens frequently, it can be seen even in a small sample.

Mr. Neuhauser stated that one part of the study is an in-depth look at the sample, which could be larger than 100, but 100-200 is where the analysis would start, but another part is to look at the entire set of IMR requests and to link back to underlying claims and see where the requests come from to see what the reasons are for the concentration of reasons for the request.

Chair Brady stated that he wanted to be clear about the cost, and Mr. Taylor responded that the details of the amount needed to be worked out but it would be up to \$45,000.

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CHSWC Vote

Commissioner Bloch made a motion to approve the proposal by UC Berkeley as may be modified in discussion with Commission staff to conduct the study of the IMR process, including possible reasons for the large number of requests, for up to \$45,000, and Commissioner McNally seconded. The motion passed unanimously.

Proposal to Study the Prevalence and Causes of Work-Related Injury and Underreporting Among Workers in the Low-Wage Labor Market

Mr. Taylor stated that the UCLA Labor Occupational Safety and Health (LOSH) Program has proposed to do a study of the Prevalence and Causes of Work-Related Injury and Underreporting Among Workers in the Low-Wage Labor Market. The prior work analyzed the wage and hour violations that were committed against low-wage workers, but it barely used the injury-related information that it collected. This analysis will help to identify the prevalence of on-the-job injuries in relation to worker characteristics and job characteristics and the reasons for non-reporting of the injuries that do occur on the job. This study would consist of further analysis of data already collected, so the high-cost field work of data collection is already done. There would also be stakeholder meetings. Understanding the causes for non-reporting will help ensure that each employer pays its fair share instead of shifting the costs of its business onto taxpayer-supported safety nets.

Chair Brady stated that the costs seemed high as the study is further analysis of work done previously, and he asked whether the focus groups could be limited. Mr. Taylor stated that conducting focus groups could be separated from analyzing the data. Chair Brady stated that he would suggest that modification as it is re-treading work that had been done earlier and that would curtail costs. Mr. Taylor stated that analysis of the data would be a good return on investment in the study. Commissioner Bloch stated that focus groups are not needed to tell why most of the injuries in the Central Valley go unreported; if workers file a workers' compensation claim, they do not go back to work. In addition, the workers can be undocumented and do not want to make waves. Commissioner McNally stated that that might not be the reality in the food processing industry, but that he would attest that it is dangerous work. Commissioner Bloch stated that there are employers with excellent health and safety practices. He stated that he appreciates the study as it is a very important area to better understand. Chair Brady stated that it would be more appropriate to analyze the available data first and then to see if more analysis or focus groups are needed. Mr. Taylor stated that the costs will be worked out with UCLA-LOSH to mine the data.

CHSWC Vote

Commissioner Wei moved to approve the proposal by UCLA-LOSH to conduct the project, "Prevalence and Causes of Work-Related Injury and Underreporting Among Workers in the Low-Wage Labor Market," as modified by the Acting Executive Officer with an eye to bring down the costs by evaluating the existing data but eliminating the focus groups, for up to \$45,000, and Commissioner McNally seconded. The motion passed unanimously.

2013 CHSWC Annual Report and 2013 WOSHTEP Advisory Board Annual Report

Mr. Taylor stated that the CHSWC Annual Report and the 2013 WOSHTEP Advisory Board Annual Report are ready for posting, pending final data and edits.

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CHSWC Vote

Commissioner Wei moved to approve for final release and posting, pending final edits and updates, the DRAFT 2013 CHSWC Annual Report and the DRAFT 2013 WOSHTEP Advisory Board Annual Report?, and Commissioner McNally seconded. The motion passed unanimously.

Comments from Secretary of Labor David Lanier

Mr. Lanier stated that he wanted to thank the Commission for all its hard work, which he is familiar with from his previous position. He stated his congratulations to the Commission for a very productive year.

Other Business

None.

Public Comment

Steve Cattolica, California Society of Industrial Medicine and Surgery and other organizations that provide occupational medicine, stated that he was concerned about the relationship between the Department and Maximus. He stated that there is a huge effort to make communication work; he stated that there are electronic interfaces being built between the payer community and Maximum. He asked whether the interfaces would be scalable for other IMR organizations that might contract with the Department in the future, and he suggested that the Department not rely only on a relationship with Maximus. He stated that the interfaces being build should allow for being duplicated, and this question should be explored in depth.

Adjournment

The meeting was adjourned at 10:45 a.m.

Approved:

Christy Bouma, Acting Chair

Date

Respectfully submitted:

Eduardo Enz, CHSWC Staff

Date