

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING

March 26, 2015

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

In Attendance

2015 Chair, Sean McNally

Commissioners Martin Brady, Daniel Bagan, Doug Bloch, Christy Bouma, Kristen Schwenkmeyer, Angie Wei

Absent

Commissioner Shelley Kessler

Approval of Minutes from the December 12, 2014 CHSWC Meeting

CHSWC Vote

Commissioner Bloch moved to approve the Minutes of the December 12, 2014 meeting, and Commissioner Wei seconded. The motion passed unanimously

Report on Department of Industrial Relations

Christine Baker, Director, Department of Industrial Relations

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

Dr. Rupali Das, Executive Medical Director, Division of Workers' Compensation

Comments by the Director

Ms. Baker stated that the Department of Industrial Relations (DIR) is committed to making government serve the people in a cost-efficient manner. A series of technology projects across the department is moving forward and rolling out. The registration process for farm labor contractors and public works organizations is now available on line. All the division chiefs are working on working on improving access to workers. They are also working on the Spanish-language website, and on translating materials across DIR into Spanish and other languages.

Ms. Baker stated that the workers' compensation offices are working to improve delivery of benefits more efficiently. Phone conferences should help do things more efficiently and at a reduced cost, and hopefully, cases will be able to move quickly.

Ms. Baker stated that DIR expects the online qualified medical evaluator (QME) panels to be up and running in July after user testing and other processes. Teams have been working around the clock to accomplish this.

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Ms. Baker stated that the return-to-work supplemental benefit regulations will be out for another 15-day comment period. There have been technical changes, and the remaining step is to address any new comments. Kiosks are available in District Offices, and all Information & Assistance (I&A) officers will be trained to communicate with injured workers to get through the application process for the return-to-work benefit. Work can now be done anywhere as long as there is a terminal. There is a simple process for filling out the application.

Ms. Baker stated that DIR continues to combat the underground economy; this is a huge effort that is ongoing. The Labor Enforcement Task Force (LETTF) continues to fine-tune data analysis, selection and targeting. The team deals with complaints from workers, with most complaints being about inappropriate payment of wages. DIR research shows that targeting is effective. The team finds that 80% of the targeted inspections result in penalties; when the targeted employers will have multiple penalties.

Ms. Baker stated that the goal of Chief Juliann Sum of the Division of Occupational Safety and Health (DOSH) is outreach and education, as well as fair enforcement. OSHA also inspects elevators and amusement rides. Increased resources are expected in the next budget, and the focus of the resources will be high-hazard workplaces. A number of regulations need updating and that is underway. Glenn Shor is working closely with the Cal/OSHA team to develop methodologies for fine-tuning the targeting for high hazard inspections.

Ms. Baker stated that the DIR team has strong leadership and has been doing great work with stakeholders. Destie Overpeck's leadership of DWC in implementing Senate Bill (SB) 863 has been tremendous. There are a number of legal challenges, but DWC is moving forward quickly with regulations. The IT team received an award for the lien system that was developed. A bill was passed, a feasibility study was done, and system implementation was finished within a few months. This is unheard of in state government. The IT team is very dedicated and worked overtime and did it for the people of California.

Ms. Baker stated that the team is amazing; leadership is strong, and the teams are doing great work with stakeholders. She stated that she wanted to commend the DIR teams for the work that they make things work for the people of California.

Update on DWC Medical Unit

Dr. Rupali Das stated that she would provide a brief update on Independent Medical Review (IMR) and Independent Bill Review (IBR) and mention progress on the Medical Treatment Utilization Schedule (MTUS). She stated that she would not review all the slides in the packet, but if there are any questions, she would answer them if there is time.

Dr. Das stated that in January, a new three-year contract was awarded to Maximus Federal Services, the organization currently conducting IMR. The Maximus contract is posted on the DIR website for the public to review. In addition, DWC continues daily to post individual IMR decisions redacted of personally identifiable information. Because of the effort and work required to ensure that the decisions are de-identified, DWC is currently posting decisions dated around the middle of last year. Those decisions do not have identifiers, but they do include the

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state of the licensure of the reviewing physician, the specialty of that physician, the rationale for making the decision, and other information that is important for the public to know in order to understand how a decision is made.

Dr. Das stated that DWC continues to identify where improvements can be made to make IMR more efficient and have the process flow more smoothly. One of the main issues slowing IMR down is the paper process, and DWC is moving more towards an electronic process. DWC is in the middle of conducting random reviews of decisions to make sure the process is working as it should and that the appropriate medical evidence is used and appropriate medical records are reviewed to make those decisions. A report was issued in 2014 on the first year of the project, and it is available on the website.

Dr. Das stated that based on review of the data available in DWC and DIR, DWC estimates that IMR applications are filed for between 1% and 5% of all medical treatment requests that come into the Workers' Compensation Information System (WCIS). She stated that the Commission had asked DWC to look into this. The Senate Bill (SB) 863 study being conducted by RAND is looking into this as well. IMR decisions are issued less than 30 days after receipt of complete medical records. The largest category of IMR requests and decisions – 42% of 2014 IMR decisions – are for pharmaceuticals. Of that 42%, 25% are for narcotic pain medications. Overturns of utilization review (UR) decisions are 12% of final determinations, and upholds are 88%, which means that 88% of IMR decisions agree with UR decisions. Regarding geographic representation, there are disproportionately more IMR applications coming from the Los Angeles region, compared to total treatments provided in the workers' compensation system.

Dr. Das stated that IMR becomes available to an injured worker if UR delays, denies or modifies treatment, and then the injured worker or representative must file an application within 30 days of a UR decision, by signing the IMR application which is filled out by a claims administrator and including the UR decision. Once the application is declared eligible, medical records are requested from the claims administrator who has 15 days to provide those medical records; once those medical records are received, they are assigned to a physician who is chosen on the basis of his/her specialty matching to the nature of the request or the medical treatment dispute. The complete process can take up to 80 days from the UR decision being issued -- 50 days in the diagram in the packet of slides is the sum of 15 days for the claims administrator to provide the records, 30 days for the time for the decision to be issued, and 5 days for mailing.

Dr. Das stated that DWC compared WCIS data, which is billing lines data for services provided in the workers' compensation system. All payers are required to report that data to WCIS. She put up a slide and stated that the bar on the right shows the total number of medical bill lines for services provided in 2013, and on the left is a high estimate of the total number of IMR applications submitted for treatment (26.2 million vs. 486,000). The latter is not actually a subset of the former, but this is the way DWC was able to use data it collects to compare the total number of treatment requests in the workers' compensation system with the number of disputed treatments that come into IMR. She stated that there was a big difference between the two numbers, and that raises more questions that need to be answered, but it gives an idea of the disproportionate number of treatments provided and disputes that come through IMR. Dr. Das

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stated that data from Alex Swedlow of the California Workers' Compensation Institute (CWCI) indicates a similar comparison.

Dr. Das stated that in terms of time lines, beginning with September 2014, a high number of decisions were issued at the end of last year because DWC was catching up from a previous backlog. The blue line shows the number of days it takes from a request for medical records going out to a claims administrator to the time a decision is issued is going up because DWC is not receiving records from claims administrators in a timely manner. When DWC gets medical records, the IMR final determination letter is issued within 30 days. The step that is holding up timeliness is the receipt of medical records.

Dr. Das stated that with the 2014 decisions, like the 2013 decisions, the largest category of treatment requests are for pharmaceuticals, while the next category, physical therapy, is much lower. DWC conducted a random sample of the pharmaceuticals. Of the 780 in the sample, slightly over 25% were for narcotic analgesics. The second highest category was for topical analgesics. As stated earlier, 88% of the IMR decisions uphold the UR decision, and of the remaining 12%, half completely overturn the UR decision and half partially overturn a decision, which means some of the medical requests are overturned and some upheld.

Dr. Das stated that DWC compared the total number of medical treatment request billing lines with IMR decisions as a % of closed IMR cases and % WCIS claims. IMR requests are disproportionately coming from the Los Angeles region – slightly more from the Inland Empire and Central Coast – but the significant difference is the L.A. region. Four sample cases, where the decision letter is available on the website, illustrate that IMR, whether an uphold or an overturn, does provide necessary medical care, and that that the rationale used is transparent. She stated that in the first sample case, a 51-year-old drug store clerk injured her back and has been in chronic pain and on multiple narcotics medications. The request was for an in-patient detox patient program that was denied by UR. IMR overturned the UR decision citing the chronic pain MTUS, stating that the worker met all the required criteria. Dr. Das stated that DWC believes that detoxification programs are good and medically necessary treatment that can help get workers off opioids and back to work.

Commissioner Bloch asked whether that would fall under Evaluation and Management or Psychology/Psychiatry. Dr. Das stated that the data show the top requests. DWC does not get many requests for detox, so she would have to look into that.

Dr. Das stated that the next sample case is a 30-year-old catering attendant who also injured his back and has also been on opioids but wants to get off them. The request was for a functional restoration program to assess function and improve it. UR denied that. The IMR decision overturned the UR decision, determining that evaluation for treatment in a multidisciplinary program was medically appropriate. Dr. Das stated that DWC encourages treatment in a multidisciplinary manner, so that was a good decision by IMR.

Dr. Das stated that the third sample case was a 35-year-old general industrial mechanic who also injured his back. He has been on multiple treatments, and the request was for multiple, different narcotic analgesics. IMR upheld some of the requests for narcotic analgesics because they were

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not shown to be effective at improving the pain, but overturned a decision on a new narcotic with the justification that perhaps a new medication might help the patient's pain. Dr. Das stated that this is an illustration that narcotics are not automatically upheld. Sometimes if the justification is there, UR decisions on narcotics can be overturned and the medications provided to the patient.

Dr. Das stated that the last case is a 25-year-old female teacher's aide who also injured her back and has been treated with physical therapy and medications. The request was for lumbar fusion. This was upheld. Lumbar fusion in a 25-year old is not necessarily a good thing. It often does not work and leads to complications. The IMR reviewer felt that not all of the possible treatments short of surgery had been tried. Dr. Das stated that these were just a few examples of how IMR decisions provide good care.

Dr. Das stated that the IBR system is working; people are submitting applications, many fewer applications than IMR. The majority of decisions, around 62%, are in favor of the provider.

Dr. Das stated that regarding the MTUS, DWC strength of evidence regulations are with the Office of Administrative Law. The MTUS lays the framework to review on how to evaluate the evidence and the hierarchy of medical evidence. The next two regulation guidelines on the use of opioids and the treatment of chronic pain will be coming out together; the goal is to have those two guidelines come out next month which will start the public comment process. That will be followed up with an update of the rest of the clinical topics in the MTUS.

Comments by Commissioners

Commissioner Bouma asked about a UR denial that was a modification. She asked about the case of an opioid with a request for 90 pills, and the UR modification was to wean with 30 or 60 pills. She asked whether that is appealed to IMR and it gets upheld, does that mean that the injured worker gets the 60-pill weaning regimen or nothing? Dr. Das responded that the IMR dispute is the difference between what the UR provides and what was originally requested. If UR provided 60 pills and the original request was for 90, it is the 30-pill difference which would be appealed to IMR. IMR is currently only able to uphold or overturn, not change the request. So if IMR upheld the UR decision, those 30 pills would be deemed not medically necessary, but the 60 pills that were provided by UR should be available.

Commissioner Wei asked what it would take to go to electronic medical records. Dr. Das responded that they are working with claims administrators to encourage electronic applications and submission of records. Some claims administrators actually do submit the medical records electronically to Maximus. The IMR application and the application materials are not electronic right now. She stated that DWC is working toward an electronic process for IMR, although the rest of the workers' compensation system is paper-based. Commissioner Wei stated that it seems like one of the significant issues that continues to come up with IMR is the timely receipt of medical records. She asked whether requiring electronic medical records would help and what it would take to require that carriers report electronically. She asked how far DWC is from that. Dr. Das responded that she will let Administrative Director Overpeck to speak to some of that in terms of what needs to be done. She stated that DWC's goal is to have electronic reporting this year. Ms. Overpeck stated that Maximus currently has a system called "Move It," in which any

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claims administrator can submit their records electronically. She stated she understands that those claims administrators who submit records electronically are very satisfied with the process and find it more convenient. She stated that DWC would have to do regulations that would require that medical records be submitted electronically.

Commissioner Bloch asked whether of the 486,000 treatments that were disputed through IMR in 2014 all the decisions are on the website. Dr. Das responded that 486,000 is a high estimate of the number of treatments, because some applications were deemed ineligible but were included in the high estimate. Also, each IMR application can have more than one treatment request. Dr. Das stated that DWC is in the process of posting those IMR decisions and are somewhere in the middle of 2014; the delay is due to making sure no personally identifiable information is included. Ms. Overpeck stated that there are 145,000 separate decisions.

Commissioner Bagan stated that there is either one of two issues: either medical treatment guidelines are difficult to follow, or they need to provide more training to medical providers. He asked if any work was being done to look at that issue in terms of updating the medical treatment guidelines or providing more training for medical providers in workers' compensation. Dr. Das responded that that was a very good question and that she suspects that it is a little of both. She stated that DWC is updating the medical guidelines and plans to do outreach to medical providers to educate them – first, that they have to use it, and second, what the content is as well as how to use the guidelines and how to obtain the best treatment for workers and patients. She stated that they are also working with professional societies to partner with them to do outreach to their member physicians to educate them that they have to use the guidelines and to show how to use the guidelines. She stated that she suspects that a lot of physicians do not know how to use the guidelines properly or do not know that the MTUS needs to be used in workers' compensation. She stated this is because many providers do not just treat workers' compensation patients, and these guidelines are just for workers' compensation.

Commissioner Brady stated that the Los Angeles area seems to be a unique ecosystem. He asked whether the training could be directed there just to find out a little bit more about why their numbers perpetually come out in an aberrant behavior relative to the rest of the state. Dr. Das responded that that was a good idea.

Commissioner Bouma stated that she had a follow-up question on the records issue, which she thinks was also written up in last meeting's minutes as well; the question is whether all of the records that the treating physician is using to make a determination about treatment and requesting authorization are the same records which move throughout the system from UR to IMR. She asked if there were any way to track more closely how many denials are because of an incomplete record. She stated that she understands that at each level, there is an opportunity to submit more, to collect those records, but that she also understands that they receive a UR denial for lack of medical records but the IMR application is in there, so she asked if the worker is getting the correct advice to pursue getting the correct medical records or they move to IMR and get the same answer because of the same lack of information. Dr. Das responded that there are several different issues. If the treatment is requested through UR and it is not certified because there were not enough records or the UR physician does not have enough information to make a decision, then the application is not eligible for IMR because the UR decision was not a medical

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determination; it was an administrative determination because there were not enough records. Those workers actually get an IMR application but are not eligible for IMR. Ms. Overpeck stated that the letter that is sent to them with the UR delay says that it is denied because they have not received all of the needed medical records, and when all the necessary medical records are received, IMR will then continue to consider what the treatment request was.

Commissioner Bouma asked if Dr. Das stated that they would still get an application for IMR. Dr. Das responded yes. Commissioner Bouma stated that that was confusing. Ms. Overpeck stated that they have a little problem with the statute because it says they had to send those out. Dr. Das stated that in those situations when the physician does provide records where determination is an issue, the records have to be submitted separately for UR and IMR. Dr. Das stated that in answer to the question of whether records were being reviewed, the publicly posted copies do not have the medical records listed because there are too many identifiers. Those will not be seen. She stated that when a worker or their representative gets the final determination, it does have a list of all the records that were reviewed. If someone notices that something is missing, there is the ability to request that that determination be reconsidered, if it is within the 30 days. Dr. Das stated that DWC is also doing a more detailed review of individual determinations and is looking at that question – did the reviewer look at the records and were the records the same as in UR – but that is very labor intensive, and DWC cannot do that on a global basis looking at each individual determination.

Commissioner Bloch stated that according to the slides presented, in 70% of the closed IMR cases in 2014, the injured workers had representation. He stated that he then looked at the most common reason that the IMR request was deemed ineligible was because they did not submit a UR decision. He asked if Dr. Das could speculate on the quality of the application for a worker who has representation versus one who does not, and if there is something that can be done to make the system easier for the unrepresented worker. Dr. Das responded that both represented and unrepresented workers have ineligible applications. The data also show that a represented worker is less likely to have an ineligible application. In terms of the process, yes, it could be clarified for unrepresented workers. DWC would have to think about suggestions for how to improve that process.

Commissioner Wei stated that she wanted to return to the electronic medical records issue. She asked if there were a way to push forward on this issue and whether Commission staff could study the issue and identify what is needed to get to a system that is based on electronic medical records. She stated that once they get that, injured workers on their own can track where their cases are; it would be nice to dream about a case management system where people can get on the system and track their cases, and potentially figure out on a computer screen where the records are and what is missing. She stated she did not want to lose the issue and that a member in the Senate Labor Committee had raised the issue. She stated that she thought there was an opening for an interest in it.

Director Baker stated that she thought this was extremely important and thanked Commissioner Wei for bringing it up. She stated that she thought it would take a multidisciplinary team across DIR, with IT and the Commission to work together on exploring the feasibility of this. She stated that they could turn that request around.

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Commissioner Bloch stated that he wished that this were their only agenda item for the day. He stated that the data were excellent and thanked Dr. Das. He stated that he was tempted to run down the rabbit hole of narcotics and what the data showed. He stated that on the one hand, they have deep concerns about workers getting injured at work and coming out of the injury addicted to narcotics. At the same time, people have legitimate pain issues for which narcotics are a legitimate treatment. He stated that he goes both ways on that. Clearly, pharmaceuticals dominate IMR. There are not many Evaluation and Management and Psychology and Psychiatry requests coming into the IMR system. The requests most likely to be overturned in IMR are Evaluation and Management and Psychology and Psychiatry. He stated that among the medical specialties of IMR physician reviewers, and psychologists are the lowest category. He stated that he was trying to see some trends in the system and what might speculation on this might be. He stated that he was also returning to an earlier question about detoxification, and whether detox falls into psychology or evaluation and management because he would like to think they were steering workers towards detoxification instead of ongoing narcotic prescriptions. Dr. Das responded that it was a very complex question. There are fewer psychology and psychiatry reviewers because there are fewer requests. If there were a clear request for a psychological or psychiatric issue, there would be a psychiatrist or psychologist to review that. Dr. Das stated that for something like a detox program, in the sample case, it was an occupational medicine specialist who reviewed that request because he/she was qualified to review that request.

Commissioner Bloch asked Dr. Das why she thinks they are seeing higher percentage of these psychologist requests being overturned despite a very low percentage of the overall requests coming in the system. Dr. Das responded that the percent of upheld or overturned will probably not reflect the proportion coming in; it will reflect the nature of the request and the justification and how well the record is documented and the guidelines. She stated that she would have to look more closely at those particular categories. Detailed reviews have been focusing on opioids, but DWC could certainly include Evaluation and Management and Psychology requests and try to identify why they are being overturned more frequently. Commissioner Bloch stated that he has already shared in this meeting that he has witnessed with his own eyes injured workers who were not able to return to work and who experienced the combination of chronic pain and financial pressures; he stated that he can only speculate, but he has watched those workers literally unravel before his eyes, and it is heartbreaking. He stated that psychology and psychological treatment is one of the options, and probably in his opinion, one of the harder injuries to classify is what happens to a person's psyche. He stated that he is curious about this and looks forward to more discussion about this in the future. Dr. Das responded that she appreciates the questions and that DWC encourages multidisciplinary treatment that includes psychiatry, cognitive behavioral therapy, and all the other non-medication alternatives that can help an injured worker not become dependent on opioids. She stated that DWC will look into this issue.

Report on the Division of Workers' Compensation Regulations

Destie Overpeck stated that she would provide an update on Senate Bill (SB) 863 Regulations that DIR is still working on.

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- *Copy Services Fee Schedule*
Status: pending with Office of Administrative Law (OAL) for review and approval. Next Steps: OAL's review ends April 30; expected July 1, 2015 effective date.
- *Benefit Notice Regulations*
Status: public hearing on September 3, 2014, and 1st 15-day comment period to begin the end of next week.
- *Home Health Care Fee Schedule*
Status: public meeting held March 3 with various sectors of home health care; drafting regulations. Next steps: draft regulations will be posted on the DWC forum for public comments within the month; then formal rule-making.
- *Interpreter Fee Schedule*
Status: draft regulations to be posted on the DWC forum within the next two weeks. Next steps: review comments, followed by formal rulemaking.
- *Medical Treatment Utilization Schedule (MTUS) Regulations – Strength of Evidence*
Status: pending with OAL for review and approval.
- *MTUS – Opioid and Chronic Pain*
Status: Opioid guideline posted on DWC forum on April 21, 2014; Chronic Pain guideline posted on DWC forum on December 18, 2014. Next steps: begin formal rulemaking next month
- *Workers' Compensation Information System (WCIS) Medical Bill Reporting*
Status: pending with OAL for review and approval; review time ends April 6. Next steps: formal rulemaking.
- *Qualified Medical Evaluator (QME) On-line Panel Request*
Status: notice will issue April 3, 2015; public hearing on May 22, 2015; DIR Information Technology (IT) is working on the system.
- *WCIS Penalties* (applies when claims administrators fail to report as required)
Posted on the DWC forum on April 16, 2013. Next steps: begin formal rulemaking in the next few months.

Process Safety Management Update

Clyde J. Trombettas, Statewide Manager and Policy Advisory, Department of Occupational Safety

Clyde Trombettas stated that he has been in the refinery field for 18 years and in the Division of Occupational Safety & Health (DOSH) for 14 years. August 6, 2012, was a pivotal time for process safety management. Prior to the Chevron refinery fire, Mr. Trombettas' stated that he managed a small unit and many people did not know about the unit or its function. He stated that some might say those were the "good old days." In 2012, he was the only district manager and the unit was staffed with two office technicians and seven compliance officers; his unit averaged about 22 refinery inspections and 50 non-refinery inspections a year. Both inspections took under 100 hours. The Process Safety Management (PSM) unit covered Title 8, 5189 of the Regulations and oversaw facilities with acutely hazardous materials, which included 15 refineries in the State

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of California and 1,617 facilities that included ammonia refrigeration facilities, waste water treatment plants, chemical facilities, and explosive manufacturers

Mr. Trombetta stated that on August 7, 2012, gas prices increased by one dollar right after the Chevron Richmond fire. The Governor developed a refinery task force, and its goal was to coordinate revisions of state safety regulations known as Process Safety Management (PSM) standards and Cal/ARP standards; a new fiscal assessment on the state petroleum refineries was implemented by the Department of Industrial Relations (DIR) in 2013 and gave the labor agency and DIR the authority to expand the PSM unit from 10 personnel to 25 today. The Unit expanded the quality of verification programs and expanded the training of the staff and interagency coordination with other agencies that have jurisdiction over petroleum refineries. In 2014, DIR convened and participated in 20 stakeholder meetings with the petroleum refining industry pertaining to changes in process safety management along with refinery workers, local unions and community-based groups. The goals at each of these meetings were to present the findings and recommendations, of the Governor's report provided the proposed revisions to the PSM standard. Three of these meetings consisted of DIR's PSM advisory committee which was established in 2013 and was comprised of representatives from labor and industry as well as the public. The refinery task force had seven recommendations, some new and some already in place, in February 2014, including: implement hierarchy or controls; conduct safety culture assessments; conduct damage mechanism hazard reviews and indicate how to treat the hazards; conduct a root cause analysis after significant accident releases; account explicitly for human factors, like number of consecutive days working; require structured methods to ensure effectiveness of safeguards, i.e., safeguard protection analysis; and ensure employee participation.

Mr. Trombetta stated that in 2013, an assessment of one and a half cent per barrel of crude oil in a refinery will go toward funding PSM. For 15 refineries, that would generate between 3 million and 5 million dollars per year. These funds are also supporting technical training for a new cohort of PSM compliance officers who have requirements of 200 hours of technical training and 400 hours of enforcement training. Prior to 2012, the PSM Unit conducted refinery inspections; each inspection was approximately 50 to 70 hours. In 2014, the PSM Unit had 5 compliance officers in the north and 5 compliance officers in the south each participating in two refinery inspections in 2014, with each inspection lasting over a 1,000 hours. This is a significant change in how enforcement is done.

Mr. Trombetta stated that the training the staff has changed. In April 1, 2014, his Unit hired eight compliance officers who could not conduct an inspection until after they completed all required courses totaling over 600 hours; the PSM Unit was conducting training from April 1st to November 1st and then these officers could participate in the inspections. Three to five compliance officers are leading joint inspections in the interagency task force, they are joined by compliance officers from each of the environmental protection agencies and federal Environmental Protection Agency (EPA) participates, air quality management district for a total of eight to nine compliance officers participating in a refinery inspection.

Mr. Trombetta stated that some other recommendations of the task force were to facilitate coordination of enforcement activities including cross referrals, cross training, and referrals and

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inspections and audits, with 20 personnel from different agencies participated in about 160 hours of refinery training that the Unit hosted. One of the other recommendations was to facilitate the development of an information and data-sharing system among state, local and federal agencies. Often, the Unit gets information about a particular facility that may not be doing something, and they receive this information after an accident. For instance, the local fire services may state that the organization was not inspecting its infrastructure properly after the accident which led to the accident; therefore, having a database to share information is vital.

Mr. Trombetta stated that in 2015, even more regulations were added for refineries. Senate Bill (SB) 1300, which Senator Hancock and Assemblyman Skinner had proposed, that changed Cal/OSHA enforcement to look at maintenance activities and what maintenance is being deferred; which is usually during the “turnaround.” California State legislators said that they wanted all 15 refineries to supply the agency with all the “turnaround” information, and the agency would review their deferred maintenance and determine whether it is appropriate or not, and if it is not appropriate, then the agency would open an inspection. The bill was passed, and in September 15, 2015, the PSM unit will gather all the “turnaround” information of all 15 refineries in the State of California and the Unit will review those reports and pick two refineries to inspect. At 60 days prior to turnaround for both those inspections, the Unit would request more documentation from each facility.

Mr. Trombetta stated that SB 54 focuses on contractors because there have been a number of concerns in the refining industry, among both contractors and workers, that many out-of-state contractors are coming to work in California, and these out-of-state contractors may not be qualified or as qualified as contractors who work in the refineries in the state. This perspective may be valid because California has different regulations and refinery regulations which are more stringent in California than in the state of Texas or Oklahoma. SB 54 was passed outlining this, and the chief of the Division of Apprenticeship Standards (DAS) would also review the safety training requirements for all the contractors prior to them working in a refinery. The refinery training must have at least 20 hours of training. Contractors have on-site training which includes: about six hours of training; eight hours of orientation in refining; and an additional 20 hours of refinery training which is craft-specific. Therefore, a pipe fitter would not get the same safety training as a welder or scaffolder. Mr. Trombetta stated that these regulations do not take full effect until 2016.

Comments by Commissioners

Commissioner Wei stated that the presentation was an impressive body of work and thanked Mr. Trombetta for doing this work.

Report on the Study on Utilization Review and Independent Medical Review (Under the Evaluation of SB 863 Medical Care Reform Study)

Barbara Wynn, RAND

Barbara Wynn stated that the medical necessity dispute resolution process has been a priority topic within the larger RAND study on the Evaluation of Senate Bill (SB) 863 Medical Care

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Reform. Senate Bill (SB) 863 streamlined the dispute resolution process which is a complex process that often took at least six months or longer to get an issue resolved and the decisions were not being made by medical experts. SB 863 shifted the resolution of medical necessity disputes from administrative law judges to medical experts. Dr. Das' slides showed that once the backlog has been eliminated, if documentation were submitted in a timely manner, Independent Medical Review (IMR) should take two to three months instead of a much longer period. DIR asked RAND to evaluate the IMR process with a particular focus on Utilization Review (UR) spillover effects. The presentation will share the common themes that have been raised with interviews conducted during the process. Ms. Wynn stated that she also will summarize some of the findings from the UR investigations and audits that occur about every five years for claims administrators or Utilization Review Organizations (UROs). The audits look at compliance with the regulations. She stated that she will provide some preliminary results from the review of UR decisions. RAND's assessment is intended to examine the processes and what is happening, rather than the quality of the medical necessity determinations. The RAND report on UR decisions will supplement DWC findings on the IMR process by linking the adverse UR decisions to the IMR process to get to the question of what percent of denials are actually been appealed to IMR.

Ms. Wynn stated that there are a couple of key points in the UR decision process. One is that the Request for Authorization (RFA) for treatment can be submitted to a claims administrator or directly to a URO that the claims administrator has contracted with. Many RFAs are submitted to the claims administrator, but due to the time frames for review, they are going directly from the claims reviewer to the URO and not going first to the claims adjuster for review. Within five days, action has to be taken on a request. The decisions are: whether treatment is compensable; whether the RFA is complete; and whether additional medical information is needed. An RFA for a compensable claim can be returned to the provider if it is not complete; if it does not need additional medical information, then the decision is to proceed. If an RFA needs additional medical information, that information needs to be requested within five days. If the provider submits the information, the UR decision has to be made within 72 hours, and if the provider does not submit the information, then a conditional denial has to be issued within 14 days. These conditional denials are not technically a UR decision yet the injured worker is getting the standard letter outlining the appeal process for an adverse UR decision. Including the IMR appeal rights in these conditional denials is raising issues and confusion.

Ms. Wynn stated that a consistent set of issues are being heard. The IMR process has increased reliance on medical treatment guidelines and evidence-based medicine. Many of the early implementation issues have been addressed. DWC has been working very closely with Maximus to improve the process and make the process transparent. That is something that is not done elsewhere. The main issue is the timely submission of supporting medical files by the claims administrators. The IMR clock does not start until those medical records are received. The physician who is requesting the denied treatment is not necessarily aware of the IMR request and does not know to add the additional documentation to that request. Ms. Wynn stated that that a key IMR issue is that the reviewer can either approve or reverse the UR decision but may not modify treatment. In the case of opioids, when there is a denial of the opioid treatment rather than a tapering off of the opioids, what is happening is not necessarily clear.

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There have been spillover effects on the UR regulations in implementing the IMR process. An RFA form has been developed and the regulations specify that the RFA has to be in writing. The form needs to be clearly marked that this is a treatment request so the clock starts to run. The RFA form seems to be popular both with providers and claims administrators. It has to be submitted with the doctors' first report (DFR) and the progress report. There is some confusion because the DFR and the progress report are submitted by the primary treating physician (PTP), and it is actually a secondary physician who is requesting the authorization and who needs to include documentation supporting medical necessity. Also, RAND is hearing from interviewees is that there seems to be more rigidity in the application of the Medical Treatment Utilization Schedule (MTUS) than before, so that treatments that might be necessary for reasons that are not covered by the MTUS are being denied more often than they used to be. The requirements for documentation have increased administrative burden on providers and have led to UR review of services that were routinely covered. The supporting documentation needs to be reviewed more closely. Long-standing treatments are being denied. The feedback loop on UR also has some defects in it. The requesting physician is told about the decision but the PTP and the secondary physician also need to know what happened.

Ms. Wynn stated the key questions emanating from the interviews are: what has been the frequency of the requests for additional documentation? how timely are the UR decisions and at what level are they being made? are the UR decisions being completed in-house by a claims adjuster or is there an internal in-house medical review or is there a referral to a URO? how often is there peer-to-peer review?; and how often are there withdrawals and re-submissions of the RFAs? Ms. Wynn stated that a claims adjuster can call the physician and talk about the treatment request and suggest the physician withdraw and resubmit the request. The disposition of the treatment request is important as well: whether it is to approve, to not approve, or to modify by type of treatment and what the percentage of denials and modifications are appealed to the IMR by type of treatment. RAND is trying to better understand these questions.

Ms. Wynn stated that data are not routinely available to answer the previous questions. RAND is using the UR audit investigation reports and files to explore and answer the questions. Every five years, DWC conducts an audit of each claims administrator and URO. The focus of those audits is on the timeliness of the decisions and compliance with the process requirements. The results from those investigations are posted on the DWC website so anyone can look up a claims administrator or an URO that was investigated and see how they score. Most importantly for this analysis, DWC requests a listing of every RFA that was submitted in the three full months preceding the investigation. DWC asks for the claimant, the date the RFA is received, and the type of review disposition. Some of those listings that DWC gets include other information such as the level at which the decision was made and the type of treatment that was requested. From the posted reports, RAND found that performance was weighted equally on three factors: timeliness; the content of the notice; and the distribution of the notice. Overall, performance ratings were high because performance on the notice content and the distribution (which means the right people were advised of the decision) are essentially 100 percent. For the 2013 audits, the range of overall performance was 89 to 100 percent; however, there was significant variation on the performance on the timeliness of the UR decisions. The range in the timeliness of UR decisions was from 68 to 100 percent of the decisions being issued timely; less than 85 percent of the decisions were timely for 9 out of 64 claims administrators. Ms. Wynn stated that there are

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definitely some interpretation problems because these are 2013 data and it was time of transitions. She stated that the hope is that once the 2014 data are posted, timeliness will have improved. However, the data do confirm that there were issues with some claims administrators in 2013. Data is also available on URO timeliness but is not presented today.

RAND's analysis of the UR investigation listings is still underway. RAND has UR listings for both 2013 and 2014. The initial focus has been on 2014 and the study probably will continue to focus on that year, because there was such an important transition in 2013. Ms. Wynn stated that what is most important is what is happening right now.

Ms. Wynn stated that UR audit listings for claims administrators are important because they give a full range of activity on a claim so that if it was referred out to a URO, it is incorporated into the claims administrator audits. RAND has 55,000 RFAs on those listings that represent 38 investigations. Each of those RFAs is being classified by type of treatment into categories that match those that the medical unit is using; therefore, they will be able to compare UR denial rates with IMR appeal rates by type of service. Both the RFA listings and the IMR listings have miscellaneous and unclassified categories that require further review. RAND needs to be able to match if an individual treatment request on a given day was appealed or not appealed because there are multiple treatment requests that are being filed on a single RFA. The report will include the percentage of decisions that are being approved or denied or modified, and will then link the denials or modifications to the IMR logs to determine the percentage of appeals.

Ms. Wynn stated that the claims administrators have varying practices about which RFAs are being listed. DWC asks for every RFA, but some of the administrators are including only those claims that are referred to the UROs or those that are elevated for review. They are not reviewing those RFAs that are approved by claims adjusters. The approval rates that RAND is calculating are straight off of those listings and are understated if the RFAs by the claims adjusters listing are not included, but they are also overstated if the RFA is withdrawn and resubmitted to meet the claims adjusters' criteria. Therefore, a lot of work is still needed to completely understand the process. In addition, the approval rates do not include treatments that have been prior-authorized because those do not require an RFA. Some claims administrators have no prior-authorization policies; some of the claims administrators do it for specific employers or for specific treatments or for specific clinics that are offering services, and some do it more across the board. The pre-authorization policies are in their UR plans, or are supposed to be in the UR plans but may not have been brought up-to-date. The UR plans are another area of review for RAND.

Ms. Wynn stated that the bottom line that there is a wide variation in the approval rates, and because of the variations in these practices between claims adjusters, it is difficult to interpret. An example is the DWC ratings that were posted on the website in 2013 where there is a frequency distribution of the percentage of UR decisions that were approved, and the range is large. Ms. Wynn stated that it is not known if the variation is attributable to different reporting practices to DWC for those audit investigations or whether there are differences in UR practices or pre-authorization practices. In terms of service categories, RAND has matched the decisions that have been denied or modified in those investigation listings, which basically identifies eligible cases that could be appealed to IMR. More work needs to be done in the miscellaneous category in terms of pharmacy lines where there is lower percentage going in IMR. It could be in

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part the result of how multiple drugs are requested on the same RFA. The study tries to break it out from the data when available, but if it is the same medication, this cannot be done. Therefore, the IMR log may actually be more discrete. Ms. Wynn stated that the next steps are to complete the analysis of the investigation and related information. RAND is not sure how far it will be able to answer the questions that were posed. Reporting inconsistencies affect the linkage of the adverse IMR decisions to the appeals logs and therefore RAND may not be able to answer what percentage of denials are being appealed.

Ms. Wynn stated that the Workers' Compensation Information System (WCIS) medical data are being used to get a better understanding of the implication of treatments that might be pre-authorized. The study will review what happened when care is disapproved through the UR IMR process, and what is seen in the claims data after that point with a particular emphasis here on the narcotic denials. The dispute resolution process could be improved to consider changes in the UR/IMR requirements, some of which are statutory and others regulatory, including:

- Information should be communicated both to the PTP and to other treating physicians that might be involved, both with respect to UR decisions, and the request for IMR appeals.
- The IMR appeal letter should not be sent on the conditional denials, and potentially, a follow-up mechanism for conditional denials is needed, such as one more attempt before they disappear and are lost.
- Mechanisms for electronic submission of documentation should be explored. Delays in getting documentation and concerns about submission of all pertinent documentation are also being raised in other work RAND is doing with medical-legal examinations. Ms. Wynn stated that RAND is finding in interviews that delays in getting the supporting documentation that the agreed medical evaluator (AME) or qualified medical evaluator (QME) needs to evaluate the patient is a major problem.
- Ways to reduce requests for high-volume services when the dispute has been requested or not should be considered.
- Also, revamping the UR audit program should be considered. Ms. Wynn stated that she is not sure if performance measures and scores are that meaningful when you are trying to understand the process. Texas and other states, such as Washington State, have implemented a drug formulary where the type of drugs that require an RFA is limited and the others are prior-authorization and do not require an explicit investigation. Also, there are some best practices like prior authorization for initial services that are requested on a doctor's first report of injury after the injury. That could be physical therapy or limited diagnostic testing and some medication to make sure the treatment gets started immediately and is not delayed for a week going through the UR process.
- There is a real need to standardize and clarify what is being recorded on the UR listings and to consider expanding those listings to get consistent information and knowledge about whether additional information has been requested and received. Ms. Wynn stated that RAND will recommend considering how the UR audit program can be revamped. She stated that performance scores are not that meaningful when trying to see what is going on within the process.

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Comments by Commissioners

Commissioner Bloch thanked RAND for the presentation and for raising the drug formulary. Ms. Wynn responded that DWC has an upcoming report which will also discuss drug formularies.

Commissioner Wei commented that she appreciates the study and needs to understand how to pursue the recommendations. She stated that she has wondered about the UR audit program for a long but has not done anything about it because of a lack of information. She stated that she heard in legislative committee yesterday that the carriers were stepping up and holding up their bargain under UR, and once the standards are reviewed for changes, there might be a different answer. She stated that therefore, this presentation is very timely and very helpful.

Commissioner Bagan asked about the different URO methods for approving RFAs; some methods are at the adjuster levels, some are at the nurse level, and some are peer-to-peer. He asked if there could be benchmarking to other states and other jurisdictions, because if the medical providers are having a difficult time following the treatment guidelines and they are getting a lot of material that is going to peer review, then that is expensive. In addition, it sets up expectations by the injured worker that they need treatment because their doctor recommended it. Then if the treatment does not get approved, there is some level of disappointment. Ms. Wynn responded that she will review what is underlying the benchmarking data and what is happening in California and she will review percentages because there is variation in the State. Ms. Wynn stated that they did not have the data on it, but there is a disconnect between when the reviewer tries to contact the physician and when the connection is actually made. Often, the connection does not happen. What one sees in the file is a repeated note that states “called and left message,” and then the request is denied. It is difficult to know the reason for this, for example, whether it is an orthopedic surgeon who is being called 8:00 a.m., when you are not going to find the surgeon. It is important to find ways to facilitate that connection; identifying who is doing a good job for peer-to-peer connections would be helpful too.

Commissioner McNally asked if there is confusion about what UR is. Ms. Wynn responded that there are underlying differences in the parts the claims administrators are submitting for the audit investigations. Her understanding is that UR starts when the request for authorization is submitted, and it ends with the final determination is made on the treatment of the case. When the RFA is submitted and the claims administrator approves it without elevating it to a medical review, it is still part of the UR process. Those RFAs are not being submitted on the UR listings, and that is troubling. In some of the interviews, the injured workers are still talking about the timeliness of the process, and differences in practices by claims administrators can be seen. If the claims adjusters are taking a while to respond or there is withdrawal and re-submission of the case, none of what is occurring with that procedure is being captured. Whether this type of process is timely they do not know. Commissioner McNally stated that it seems that what needs to be understood is what the process is and where it starts, because many of the procedures are left out. This constitutes a delay which is more informal and it is not being understood or recognized by the adjusters as being part of the process, then people will not understand the process.

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Commissioner Brady commented that it may be troubling that we do not know the details of this process but it is important to be patient and for the presenters to review the process in more depth, because coming up with an answer that is premature is probably an error.

Commissioner Bouma asked if the slides were available for circulation. Ms. Wynn responded that she has to get approval from RAND because there is a peer review process to go through before the report is widely circulated. Director Baker stated that the presentation slides could be labeled DRAFT and made available to the public by RAND, because if they are presented to the public in this meeting, then they become public.

Report on the Wage Loss Study
Michael Dworsky and Seth Seabury, RAND

Dr. Dworsky stated that the presentation will be a progress report on the Return to Work/Wage Loss Study today and is preliminary and subject to revision because it has not yet been through the formal RAND quality assurance process. The focus of the presentation would be the changes in the workers' compensation system that preceded Senate Bill (SB) 863, in particular, the wave of reforms in 2003 and 2004, namely SB 228 and SB 899, which were in response to a period of crisis in California's workers' compensation system. He stated that systemwide costs rose 270% over six years from 1997 to 2003. Far-reaching reforms in 2003-2004 introduced a wide range of changes to medical delivery and the disability rating system which were intended to reign in the costs. Most relevant for the wage loss and return to work study is that there were major changes to the disability rating system which had the effect of reducing permanent partial disability (PPD) benefits.

Dr. Dworsky stated that based on a chart from CHSWC's annual report from last year depicting costs in the system over time, in 2004 when those reforms entered implementation, there was a trend break and reversal in cost or growth in expenses, in both medical costs and in indemnity benefits. At least for some time, the 2003-2004 reforms were successful in limiting cost growth in the system, but beyond 2008 until more recent years, medical spending and expenses began to grow again. The focus of the wage loss study is wage losses and indemnity benefits. Because of changes to benefits in the 2003 and 2004 reforms, total spending on indemnity benefits was still below the level of 2001 all the way out to the present day, even though there was some increase over the past few years. Medical spending growth, in contrast, resumed more quickly and has continued. Those two divergent trends in medical costs and permanent disability benefits are thought of as the guiding principles in negotiations over SB 863. First, there was consensus that medical costs were growing too quickly and that led to changes that Barbara Wynn, Dr. Das and others have already discussed. There was also a sense that permanent disability benefits had fallen too low. The prior RAND wage loss study that came out in 2010 substantiates that to some extent. The wage replacement rate, which is identified as benefits as a fraction of losses, is the basic measure of benefit adequacy. The previous RAND wage loss study showed that the wage replacement rate fell by about 25% from 2004 to 2006 after implementation of SB 899. That study showed data through 2006. Information on benefit adequacy for the more recent period is not available yet.

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Dr. Dworsky stated that SB 863 implemented several changes to permanent disability benefits. There were a number of provisions intended to increase the generosity of benefits. SB 8673 also created the Return to Work Fund which is still in progress. He stated that somewhat mechanically, increases in benefits have to increase benefit adequacy if there is no change to earnings loss. One of the questions addressed in the study report is what happened to benefit adequacy and earnings losses prior to SB 863's enactment. Outside the worker's compensation system, there were dramatic changes in the labor market and the broader economy involving the financial crisis, the housing market bust, and the great recession of 2008-2009. Unemployment rates in the rest of the US and the state of California show that California was differentially hard hit by unemployment during the great recession. Seasonally adjusted unemployment rates (in California) were about 5% in 2007 and up to a high of 12% at the start of 2010. Even though the recession officially ended in the fourth quarter of 2009, the labor market recovery has been extremely slow in the U.S. broadly but especially in California. After five years of recovery in 2014, seasonally adjusted unemployment in California is still 7%, so it is higher than it was in 2007. This presentation explores the extent to which this sustained unemployment is differentially affecting outcomes for permanently disabled workers.

Dr. Dworsky stated that he is presenting an overview of where the wage loss study is going, and there will be more results to present before the final report comes out in the fall. The guiding question is how SB 863 will affect benefit adequacy and return to work, taking in to account those changes in the labor market. The 2010 RAND study examined labor market outcomes for permanently disabled workers in California and found an improvement in return to work during that period of 2000-2006. That improvement buffered some benefit reductions in benefit generosity that followed SB 899. However, that study ended with workers injured in 2006, so it is necessary to extend that period of earnings loss going forward through the end of 2012. The full wage loss study will look at how adequately permanent partial disability benefits compensated disabled workers over this time period, as well as analyze the implications of the changes in disability benefit increases from SB 863 for benefit adequacy, fairness and other metrics.

Dr. Dworsky stated that when focusing on how labor market outcomes for permanently disabled workers evolved between SB 899 in 2004 and SB 863 in 2012, three main outcomes are identified: earnings losses; employment following the injury at the at-injury employer; and return to work. Analysis of benefit adequacy and the impact of SB 863 changes is not available yet. The study built on methods used in previous RAND studies for CHSWC. Administrative data on workers' compensation recipients will be linked to quarterly data on earnings from unemployment insurance (UI) records maintained by the Employment Development Department (EDD). In addition to identifying wage history for the injured workers, the study will match injured workers to control workers who are observably similar workers who are at the at-injury employer at the time the injury took place and who have very similar earnings prior to the time of injury.

Dr. Dworsky stated that if the focus is on earnings losses, then reduction in earnings capacity caused by a worker's injury needs to be identified. This can be defined as the difference between the worker's actual earnings following an injury and what the worker would have earned had the injury had not occurred. The problem is that what the injured worker would have earned in the

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absence of the injury is not seen. Therefore, it is impossible to distinguish the effect of the injury from all the other things that happen to workers in the labor market. There are other sources of earnings dynamics that cause people to change jobs or cause wages to change, i.e., retirement, promotion, job changes, and layoffs. One can never conclusively separate the effect of the injury unless there is some other way to measure what the injured worker would have earned if he/she remained healthy.

Dr. Dworsky stated that matched controls make it possible to estimate the true impact of injury on earnings capacity. He described an example: suppose a worker is earning \$6,000 prior to the permanent disabling injury and after the injury is earning \$3,000. The natural estimate of earnings losses is \$6,000-\$3,000 or \$3,000. He stated that that is only valid if it is assumed that the worker would continue to earn \$6,000 indefinitely in the absence of the injury. Because there are so many factors that can alter the earnings, that is not a very convincing assumption. He stated that the analysis selects a worker at the same employer who is earning the same amount prior to the injury and then does not get injured. They can follow that worker over time and have some idea of how wages may have changed if the worker had remained healthy. For example, if this worker moves to another job and earns \$7,000 at the time the injured worker is earning \$3,000, then the earnings loss would be \$4,000. Data from the Workers' Compensation Information System (WCIS) was used to identify permanently disabled workers injured between 2007 and 2012, drawing first and second reports of injury for 3.1 million injured workers. According to the data, 8.8% are permanently disabled, as indicated by received benefits or a compromise and release settlement. Of the 268,000 permanently disabled workers that were identified, 77% or 205,329 were matched to control workers, both to their earning history in EDD data and to earnings history with comparable control workers at the same employer. There is one caveat: wage data shown here end in 2013Q4, so the follow-up period for 2012 injuries is short, and the long-term earnings losses may not be fully apparent yet with only one year of follow-up data. Therefore, the results interpreted after 2011 should be interpreted with additional caution.

Dr. Dworsky stated that the study took all of the injured workers from 2007 to 2012 and pooled them together and looked at the time profiles for earnings for injured control workers. Looking back in time to the year preceding the date of injury, there is a very close match in earnings between the injured workers and the control workers. That close match is by construction and is based on data used to select the control workers. The assumption is going to be that the earnings for the injured and control workers would have continued to evolve together if it were not for the injury. If that assumption is made, then the sharp drop in earnings after the injury is in fact a causal effect of the injury on earnings. It is possible to test this assumption indirectly by looking further back in time before the period used to select control workers. The match in these earlier periods is also very close, lending credibility to the RAND method. Earnings drop sharply after the first quarter post-injury, then stabilize a year post-injury. The second year post-injury is used as the time to measure earnings losses. The average distance between the control worker earnings and the injured worker earnings is used to determine that that is the estimate of earnings losses. That will be scaled by the control worker's earnings because the control worker provides an estimate of how much the injured worker would have earned. Dr. Dworsky stated that for everyone on average between 2007-2012 who was injured and became permanently disabled, earnings losses in the second year post-injury were 31% of what earnings would have been had

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these workers remained healthy. A similar approach can be taken to measure the impact of injury on employment. With the fraction of the control workers who are employed anywhere in the California economy, there is a very close match before the injury and then divergence. At a fixed a point in time following the injury, either one year or two years post-injury, employment is measured relative to the control workers as the fraction of injured workers who are employed divided by the fraction of control workers who were employed. At both one year and two years post-injury, employment is about 28% lower for the permanently disabled workers than for the control workers.

Dr. Dworsky stated that employment at the firm where the injury took place can also be distinguished from overall employment. Relative employment at the at-injury firm actually continues to decline between one and two years post-injury. The control workers are also less likely to be employed at the at-injury firm. This underscores the importance of having control workers because there are normal things such as job turnover that might cause a worker to leave a firm where he/she is injured over a two-year period. Even taking the control workers' mobility into account, return to work is substantially lower for the permanently disabled workers. Those decreases in return to work are 30% after one year and about 37% after two years. Those are the findings on average for all workers injured between 2007 and 2012 who went on to become permanently disabled. Dr. Dworsky stated that these measures can be plotted out over time to observe trends. With proportional earning losses over the past six years of injuries up to SB 863, proportional earnings losses increased dramatically during the great recession. The preferred measure with two years of follow-up data increases by 10 percentage points from the start of 2007 to the depths of the recession in 2009. This number recedes slightly by 2011, but overall earnings losses were 8% higher in 2011 than they were for permanently injured workers in 2007. He stated that for one year of earnings losses, as earlier stated, needs to be interpreted with a bit of caution because earnings losses may not have fully stabilized. However, this at least indicates looking forward to injured workers injured in 2012. In this case, there is not as much of a peak during the great recession, but there is not really much of a sign of recovery in 2012. Earning losses may be stabilizing or increasing more slowly, but they do not seem to be declining yet.

Dr. Dworsky stated that when looking at trends in employment relative to control workers for injured workers, it is essentially a very close mirror image to what was seen with earnings losses. That was not so surprising because non-employment seems to be the driving force behind earnings losses in general, rather than changes in wages. There is a sharp drop from 2007 to 2009, with relative employment falling 8%, measured either at one year or two years post-injury. He stated that there might be some stabilization in employment from 2009 to 2012. Overall, employment relative to controls remains much lower, 9% lower at the one-year time horizon than it was in 2007.

Dr. Dworsky stated that finally, looking at return to work at the at-injury employer, there is perhaps a less encouraging picture than what was seen for earnings losses or employment anywhere in the California economy. The same sharp drop at beginning of the great recession between 2007 and 2009 is seen. Again, relative return to work declines by 9% or 7% points. However, the same signs of stabilization or recovery are not seen. Return to work continues to decline all the way out to the most recent cohorts of injured workers, even though there has been essentially five years of labor market recovery. Measured at the one-year time horizon, relative

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return to work was 12% lower in 2012 than it was in 2007 before the recession. Other data in WCIS can be used to try to better understand what might be driving these overall trends. WCIS reports industry data and RAND will also be adding industry data later on from EDD records. Dr. Dworsky stated that when the data are broken out by industry, there are very different levels of return to work at the at-injury firm prior to the recession across different industries. In 2007, 70% of manufacturing workers returned to the at-injury firm, 55% for construction and above 90% for public administration. There is also a decline from 2007 to 2012 across all industries regardless of what the original level of return to work was. There is also a similar picture for an additional four industries – transportation and warehousing, administrative support services (including PEOs and temporary agencies), accommodation and food services, and agriculture. There are declines in return to work between 2007 and 2012 across every sector of the economy the study looked at; therefore, it is not the case that this is entirely driven by a couple of industries that were differentially hit by the recession.

Dr. Dworsky stated that disability ratings data in WCIS are then used to classify the severity of the disabling industry. He said that they take a very coarse approach to classification, where workers are defined as low-severity (permanent disability rating below 5%), medium-severity (5%-14% permanent disability), and high-severity (>14% permanent disability). Overall, earnings losses are increasing with severity, which is what one would expect in a disability rating system that is doing what it is supposed to do. Looking at the trends from 2007 to 2011, there are actually increases in earnings losses at each severity level. Those increases are about 3% for the high-severity and medium-severity, and 4% for the low-severity. It is not just the case that the most severely disabled workers are responsible for increases in earnings losses; that pattern is being seen across the board. Looking at the same classifications for return to work over the period, widespread deteriorating return to work can be seen across all severity levels. The most severe decline in return to work is apparent in the high-severity group. For the most severely disabled workers, return to work fell by approximately 10% in 2007 through 2012 on average. It is worth noting that the high-severity workers were the ones who experienced the most rapid improvement in return to work in the prior wage loss study that followed workers in 2006. Some of those improvements that buffered the effects of changes in benefits may have been reversed in recent periods, but benefits have not been looked at yet, so it is difficult to say what the net impact on adequacy is going to be.

Dr. Dworsky stated that to summarize the findings of the study, the great recession led to worse economic outcomes in terms of earnings, employment and return to work for permanently disabled workers in California. Recovery to 2007 levels shows earnings losses has been slow and incomplete. There are perhaps more signs of recovery in terms of earnings losses than there are in terms of employment or return to work. This deterioration of economic outcomes was felt broadly across all economic sector industries and across all injuries at all severity levels.

Dr. Dworsky stated that the full return-to-work/wage loss study that will be available in the fall will incorporate more detailed information on disability ratings using data from the Disability Evaluation Unit (DEU), and will then to extend this analysis to benefit adequacy and simulate the impact of the benefit changes in SB 863. That will provide answers to questions such as how SB 863 affects the generosity of the system for these workers who were injured prior to SB 863. Early findings of the first cohorts of injured workers injured after SB 863 was in place may be

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possible, but that will depend on data availability. Finally, the study will try to understand whether there were other economic factors outside of the workers' compensation system that might have contributed to a very broad and sustained decline seen in return to work. Return to work is a very important objective for the workers' compensation system, and if it can actually be understood what causes those trends, it might be possible to develop a policy to mitigate those losses in the future.

Comments by Commissioners

Commissioner Brady stated that he believes everyone agrees on the importance of return to work – it involves not just physical but also psychological and emotional benefits. Workers get a lot of support and satisfaction when they can be productive in their efforts. He stated that he appreciates the detail and looks forward to the full report.

Commissioner Bloch stated that he was getting a little history lesson from Commissioner Wei, and he stated that he read a report by Mr. Seabury and Mr. Neuhauser that they did 2013 looking at impairment vs. disability ratings, and he was trying to figure how they got from there to here. He stated that he thanked Dr. Dworsky for the research.

Report on Infection Risk from “Sharps” Injuries for Non-healthcare Workers
Frank Neuhauser, University of California, Berkeley

Mr. Neuhauser stated that “Sharps” injuries in medical settings involve any sharp object capable of piercing the skin and which may be contaminated by an infectious agent. California was a leader in legislation about blood borne infections, and such injuries are covered by both federal and state regulations. The Commission received a request from the Legislature to look at non-healthcare settings which are not specifically covered by the current federal and state regulations. Some industries have an elevated risk for coming into contact with sharps. Assembly members Mark Stone and Susan Eggman held a hearing and then requested that the Commission assemble data and assess the occupational risk of sharps injuries to non-healthcare workers not covered by the current regulations, as well as the cost to employers. The study concludes that occupational injury risk for work-related infection from sharps injuries in non-healthcare settings is very small, and additional regulation would not be cost-effective or appropriate if the concern is occupational risk or cost to employers. Mr. Neuhauser acknowledged that Glenn Shor and Rebecca Jackson of the Department of Industrial Relations (DIR) did a lot of the research and data analysis for the report.

Mr. Neuhauser stated that sharps in non-healthcare settings are almost exclusively needles, with two sources being legal home use of injectable drugs, such as insulin, and illegal IV drug use. There are three diseases of concern with sharps injuries. Human Immunodeficiency Virus (HIV) has been the disease most studied and documented; it differs from the other two diseases because it is difficult to contract; in addition, there is no vaccine and no cure, and prophylactic measures are of unknown effectiveness. The second disease is Hepatitis B (HBV), and there is an effective vaccine, which may also be effective as a post-incident prophylactic measure if you have not had

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the vaccine and you get exposed/infected; and the third disease is Hepatitis C (HCV), there is an effective cure, not a vaccine but drug therapy. HIV infection has the greater risk of the three.

Mr. Neuhauser stated that when determining the risk of infection from a needle stick, the key elements are: whether or not the original needle user is infected; there is a significant viral load in the blood of the original user; an amount of blood is remaining in the needle; and the time between original user of the needle and subsequent needle stick is sufficient for infection. The viruses are not robust and do not survive outside the human body beyond a very limited time. If the needle has not been used for a period of time, the risk of infection goes down. The key factors for known risk in a needle stick in a health care setting have been well documented. Under ideal conditions the risk for contracting HIV infection from needle stick is 1/3,000. Very few needle sticks, even under ideal conditions, result in infection. In the ideal setting, 100% of patients were known to be infected with HIV; there is a high viral load; there is a large-gauge needle, which is typical of hospital needles (for example, a home needle size is 1/100th or 1/200th of hospital needle size); and the needle stick is nearly coincidental with patient blood draw. For home use, there will be a low viral load and a much smaller-gauge needle, and the blood in the needle will have degraded significantly due to exposure to the elements. A very conservative estimate for the risk for home use is 1 in 100 million.

Mr. Neuhauser stated that in a search of research literature from 1990 to the present covering Europe, North America, Australia and New Zealand, there were no non-healthcare, occupational-related infections; for HCV, there were three possible non-healthcare, occupation-related infections, although one of the two people had a high-risk life-style, and in one case, a police officer was purposely attacked with an infected needle.

Mr. Neuhauser stated that the Division of Workers' Compensation Workers' Compensation Information System (WCIS) and paper First Reports of Injury identified all reported needle stick claims and segregated healthcare and non-healthcare occupations. Some of the needle sticks included other injury factors. Also identified were medical cost, including treatment, prophylactic measures and psychiatric counseling, as well as indemnity cost. Looking at 2010 to 2012, the analysis confirmed that for needle stick claims: there is very low medical treatment cost (\$750/claim); very few indemnity claims (2%); very low indemnity cost per indemnity claim (\$2,200); and almost all claims were small, medical-only claims.

Mr. Neuhauser restated the conclusions of the study, that needle stick injuries in non-health care settings are very low-risk situations and they do not warrant more regulations. The Division of Workers' Compensation could play a useful role in disseminating that information.

Comments by Commissioners

Commissioner Bloch stated that he is proud to be a member of the Commission and proud of the work that it does. He stated that his union represents solid waste workers throughout California, and it is continually hearing concerns about needle sticks from members. That is why they brought the concern to the Legislature. He is very pleased to learn from the study that the low risk from these types of needle stick injuries does not require legislation. The question for members and leadership will now be what else should be done to address the concerns about

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needle stick injuries. He stated that he is open to suggestions from Commissioners and the public. He then stated that the Commission funds excellent health and safety programs through the UC Berkeley Labor Occupational Health Program (LOHP), and he would be talking with LOHP about training and information to address this issue.

CHSWC Report

Eduardo Enz, Acting Executive Officer, CHSWC

Mr. Enz stated that on behalf of Commission staff, he wanted to first acknowledge and congratulate both Christy Bouma and Sean McNally on being reappointed just yesterday by Governor Brown to continue to serve as commissioners. The Commission is fortunate to have them continue serving this Commission and the people of this great state.

Mr. Enz stated that since the last Commission meeting, staff has finalized, posted and published the 2014 CHSWC Annual Report and continues monitoring and tracking projects supporting and consolidating the implementation of Senate Bill (SB) 863 reforms and evaluating its effects.

Current Studies

Mr. Enz stated that Commission staff is continuing to monitor the progress of several ongoing studies that are critical to help better understand the effects of SB 863. RAND's Evaluation of the SB 863 Medical Care Reforms study is progressing well and will help reveal critical insights into how medical delivery, dispute resolution and payments introduced by SB 863 are affecting workers and employers. Commission staff is also closely tracking another crucial RAND study, the Wage Loss study, which will help highlight recent trends in workers' compensation claims, costs and earnings losses and help evaluate the impact of SB 863 reforms on workers' compensation adequacy and equity.

Final Draft Reports

Mr. Enz stated that the final draft report on the infection risk from "sharps" injuries for non-healthcare workers by Frank Neuhauser of UC Berkeley has been received. This study collected data on the frequency and severity of "sharps" injuries (essentially needle sticks) among non-health care workers to help identify appropriate prevention activities needed for non-health care work settings and the actual impact of "sharps" injuries on employer insurance costs. The report is ready for approval for feedback and comment and for final posting in 30 days, as well as submission to Assembly members Mark Stone and Susan Eggman who were the original proponents of this study in the Assembly.

Mr. Enz also stated that a final draft of the UCLA-Labor Occupational Safety and Health Program (LOSH) study "Patterns of Work-Related Injury and Common Injury Experiences of Workers in the Low-Wage Labor Market" has been received and is ready for approval for final release and posting pending final edits and updates.

New Proposals and Commissioner Requests

Mr. Enz stated that in an effort to follow up on recent Commissioner requests to focus more attention on health and safety, Commission staff has asked UC Berkeley's Labor Occupational

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Health Program (LOHP) to put together a proposal to determine whether to resource training for older workers who are more injury-prone. Building on a 2011 UC Berkeley study titled “Working Safer or Just Working Longer? The Impact of an Aging Workforce on Occupational Injury and Illness Costs” by Frank Neuhauser, LOHP proposes to conduct a project addressing the occupational and health needs of the aging workforce. More specifically, LOHP would first conduct a needs assessment by collecting information on employment rates, injury rates, occupational safety and health issues and needs, and other issues related to the employment-related rights of older workers and the responsibilities of their employers. This proposal is ready for approval.

Mr. Enz stated that staff will also continue to work to address Commissioner requests for a study on medical cost shifts from workers’ compensation to group health insurance. Staff is researching this important issue and honing in on the best options to develop a project/study that will result in useful recommendations on how to address medical cost shifts to group health.

Finalized and Posted Reports

Mr. Enz stated that the 2014 CHSWC Annual Report has been posted on the Commission’s website and was released in early February 2015. This was the 20th edition of the CHSWC Annual Report in which information about the health and safety and workers’ compensation systems in California and recommendations to improve their operations are presented. In addition, the 2014 WOSHTEP Annual Report has been posted on the Commission’s website and was released in late January 2015. This was the 11th edition of the WOSHTEP Annual Report which evaluates the use and impact of the programs developed for WOSHTEP.

CHSWC Vote

Commissioner Brady moved to post for feedback and comment and for final posting in 30 days the DRAFT “Infection Risk from “Sharps” Injuries for Non-healthcare Workers” report by Frank Neuhauser of UC Berkeley, and Commissioner Bagan seconded. The motion passed unanimously.

CHSWC Vote

Commissioner Bloch moved to submit the draft of the study to Assembly members Mark Stone and Susan Eggman, and Commissioner Bagan seconded it. The motion passed unanimously.

CHSWC Vote

Commissioner Brady moved to approve for final release and posting, pending final edits and updates, the DRAFT “Patterns of Work-Related Injury and Common Injury Experiences of Workers in the Low Wage Labor Market” report by Kevin Rile and Doug Morier of UCLA, and Commissioner Bagan seconded it. The motion passed unanimously.

CHSWC Vote

Commissioner Brady moved to approve for final release and posting, pending final edits and updates, the DRAFT “Patterns of Work-Related Injury and Common Injury Experiences of Workers in the Low Wage Labor Market” report by Kevin Rile and Doug Morier of UCLA, and Commissioner Bagan seconded it. The motion passed unanimously.

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CHSWC Vote

Commissioner Bloch moved to approve the Aging Workforce Proposal by the UC Berkeley Labor Occupational Health Program for between \$32,650 and \$38,000, and Commissioner Brady seconded it. The motion passed unanimously.

CHSWC Vote

Commissioner Wei moved to approve that the Department of Industrial Relations dedicate staff time to a study of the feasibility of all electronic medical records, and Commissioner Schwenkmeyer seconded it. The motion passed unanimously.

Comments by Commissioners

Commissioner Brady stated that there could be cost-shifting from general health to workers' compensation, as he was asked in a recent annual physical if the visit was work-related.

CHSWC Vote

Commissioner Wei suggested that the Commission put staff time into determining the feasibility of moving to an all-electronic medical record system for the purposes of medical treatment, and Commissioner Bouma second. The motion passed unanimously.

Public Comment

Karl Brakensiek, from the California Society of Industrial Medicine and Surgery (CSIMS), stated that a lot was presented on the UR/IMR issues. He stated that the major problem is the delay in delivery or the inadequate delivery of medical records to the IMR reviewer. He stated that he had spoken to one of the members who is an IMR reviewer who stated that there is a major problem with not receiving all relevant medical records. In the current law, the claims administrator is only required to transmit relevant medical records, and therefore the claims administrator is in a position to decide which medical records are to be transmitted. He stated that CSIMS would support Commissioner Wei's recommendation to move to an all-electronic transfer of medical records for UR or IMR purposes, so that all medical records in possession by the claims administrator will be submitted.

Rick Meechan, a workers' compensation attorney in Santa Rosa and a member of the California Applicants' Attorneys Association (CAAA), stated that all the documents for presentation at Commission meetings should be available for all interested parties to review a week in advance. He also stated that moving public comment to the end of Commission meetings means that some questions for speakers cannot be answered as the speakers have already left. This means that the Commissioners cannot hear other points of view other than that of the State. He also stated that the voting on proposals on the day they are received does not give adequate time for considerations. This may fall under the Brown Act, an important California law, which should be followed. He stated that in terms of Dr. Das's report, older injuries involving continuing medical care are where there are the most difficulties in getting adequate medical care. He also stated that he believes that there is cost-shifting from workers' compensation to Medicare and Medical. He

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also stated that there has been a consolidation of PTPs, and this is affecting the availability of medical care by workers' compensation specialists, particularly in rural areas, for example, Sonoma County. He stated that he would like the Commission to look into whether doctors are actually making decisions, or whether doctors are just approving decisions made by others, such as nurses. This would be important to evaluate in terms of UR and IMR.

Mark Telles, an employee of Medtronic in Southern California, stated that Dr. Das discussed the work on the Medical Treatment Utilization Schedule (MTUS) which will be coming out next month. There is a lot of concern about the processes involved. Dr. Das cited the use of evidence, but the proposed MTUS guidelines in December 2014, did not provide for key medical devices to treat chronic pain because key pieces of evidence and medical indicators have not been included in the MTUS. He also stated that the Medical Evaluation Advisory Committee (MEAC) has not been consulted about these changes. He stated that he would like the Division to shed some light on this and provide for more insight and discussion before the guidelines come out.

Chair McNally asked CHSWC Acting Executive Office Eduardo Enz to follow-up on this.

Another member of the public stated that it was important not to gloss over the seriously injured workers. He stated that he wants to eliminate work-related injuries. He stated that he is a health and safety expert and would like to present to the Commission his health and safety protocols based on evidence-based medicine. He stated that over 150 people are dying per day. He stated that he works with those people. He stated that it is necessary to learn to manage the hierarchies of safety controls to prevent injuries and illnesses. Many employees are going broke and are dealing with pain. Chair McNally stated that if he would like to provide information, he should speak with Mr. Enz.

Other Business

None.

Adjournment

The meeting was adjourned at 11:15 a.m.

Approved:

Sean McNally, 2015 Chair

Date

Respectfully submitted:

Eduardo Enz, Acting Executive Officer, CHSWC

Date