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STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Thursday, January 17, 2008
Elihu Harris State Building
1515 Clay Street
Oakland, CA 94612

CHAIRPERSON

Destie Overpeck
Chief Counsel

PANEL

Suzanne Marria
Industrial Relations Counsel

Dr. Anne Searcy
Executive Medical Director

Reported by: Deborah E. Schneider
Karen Jordan

I N D E X

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4
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14
15
16
17
18
19
20
21
22
23
24
25

KRISTINE SHULTZ	4
California Chiropractic Association	
ED TROY	6
Orthopaedic Surgeon	
SUSAN BORG	7
California Applicants' Attorneys Association	
CARLYLE R. BRAKENSIEK	12
California Society of Industrial Medicine and Surgery	
STEVE CATTOLICA	17
AdvoCal	
DIANE M. PRZEPIORSKI	20
California Orthopaedic Association	
FRANK NAVARRO	23
DIANE M. PRZEPIORSKI	23
California Orthopaedic Association	
BARRY GORELICK	24

1 PUBLIC HEARING

2 OAKLAND, CALIFORNIA

3 THURSDAY, JANUARY 17, 2008, 10:00 A.M.

4 MS. OVERPECK: My name is Destie Overpeck. I am the
5 Chief Counsel for the Division of Workers' Compensation. With
6 me here is Anne Searcy, the Medical Director, and Suzanne
7 Marria, the attorney who has done most of the work on this set
8 of regulations. We will be here to discuss the proposed
9 revisions to the QME regulations. They are Title 8, Sections 1
10 through 159.

11 Today is the last day of the 45-day comment period.
12 In addition to any oral comments that you are making today, if
13 you have any written comments, please be sure and submit them
14 to us by 5:00 today. If you have them with you, Maureen Gray
15 is our Regulations Coordinator. She is here in the front row,
16 and you can turn them in to her. Otherwise, you can e-mail
17 them or fax them to us or just take them right upstairs and
18 turn them in.

19 The hearing today will continue as long as there are
20 people present who have comments to make. I don't anticipate
21 that this is going to go beyond lunchtime. If it does, we will
22 take a break and figure out what to do after that.

23 There are sign-in sheets at the front table. Please
24 be sure and sign in, and if you want to make a written oral
25 comment, please check the yes box. I am going to go through

1 the list and call the names in the order that they are signed
2 up. I will also make sure at the end that no one has changed
3 their mind and give a chance for anyone else who wants to speak
4 to speak.

5 The comments that you make will be reviewed by the
6 Division of Workers' Compensation. If we decide that revisions
7 need to be made to the regulations, we will send them out to
8 the public for another 15-day comment period. There won't be
9 an oral public hearing, but written comments will be allowed to
10 be made for that comment period.

11 All right. I think that is the general housekeeping.
12 So when you come up, please be sure and give a card if you have
13 one to the court reporters. Please state your name and spell
14 it and then proceed with your comment. And the first person I
15 have written down is Kristine Shultz.

16 **KRISTINE SHULTZ**

17 Good morning. Kristine Shultz representing California
18 Chiropractic Association. The California Chiropractic
19 Association believes that the DWC lacks the authority to adopt
20 a regulation where the DWC no longer recognizes physician
21 specialties that aren't recognized by the Physician Licensing
22 Board.

23 California Business and Profession Code, Section 651,
24 authorizes the advertisement of chiropractic specialties.
25 Neither the State Chiropractic Board, nor the DWC, limit the

1 use of specialties, unless the use of specialty is misleading
2 to the public. A doctor of chiropractic's right to advertise a
3 specialty designation is constitutionally protected commercial
4 speech. Only the Legislature can limit the use of specialty
5 designations, and even then, the Legislature can only restrict
6 the use of a specialty designation if it chooses substantial
7 State interest, or else it will be in violation of the U.S.
8 Constitution.

9 My organization also opposes this regulation on policy
10 grounds. If the regulation was enacted, it would have the
11 effect of preventing injured workers from selecting a
12 chiropractic neurologist, a chiropractic orthopaedist, or any
13 other chiropractic specialty as a QME. The injured worker
14 should be able to choose a QME with additional training because
15 that injured worker will get a QME report from a doctor who is
16 more informed on treatment protocol to that type of injury.

17 We thank you for the opportunity to provide comments
18 today. I also have submitted written comments, and it details
19 our legal concerns with the authority issue. Thank you so
20 much.

21 MS. OVERPECK: Thank you very much. Next is Ed Troy.

22 **ED TROY**

23 Hello, I'm Ed Troy. I have been described recently as
24 an itinerant orthopaedic surgeon, and I just wanted to come up
25 and comment philosophically about this 1.5 multiplier some of

1 my colleagues and I are concerned about. What it boils down to
2 as philosophically is just who these patients are and what the
3 function of the QME is. As I see it, they are patients that
4 need to have examinations to get their cases finalized, and
5 they are really State clients. They don't belong to a
6 municipality, a block, a neighborhood. They are patients that
7 happen to live somewhere if someone is willing to go to them to
8 see them.

9 I don't say that there should be this reverse
10 discrimination or affirmative action because somebody happens
11 to have an office within a mile. For the most part, it doesn't
12 really care to this type of patient anyway. Economically, it
13 is not feasible for a lot of guys in practice and have the
14 experience of having a lot of kickback QMEs where they are sent
15 to a treating physician. If this statement was true,
16 physicians opposed to people who do primarily this type of
17 work, and they say, "We don't want them." "It's too many
18 records." "Send them to somebody who does this stuff."

19 As I have said in an e-mail, there are, I think, the
20 (unintelligible) few who are trying to push this through. I
21 don't think it's necessary. I think the idea is to get the
22 patients seen and see them in a timely fashion. And the people
23 that do this work and travel around and go to these underserved
24 areas, and trust me, they are underserved because it wouldn't
25 be economically feasible for anybody to go there, and if

1 wanting to make the trip, stay in a hotel and see one patient.
2 It's because there is nobody seeing these people that creates
3 this opportunity. I'll save this for a time later. I have
4 some other comments that aren't really revisions that I
5 wouldn't mind making, but I'll let whoever wants to talk on
6 revisions can.

7 MS. OVERPECK: Thank you very much. Sue Borg.

8 SUSAN BORG

9 I am Sue Borg, and I am the President of the
10 California Applicant's Attorneys Association. Our detailed
11 comments -- excuse me -- have been submitted previously by
12 e-mail, but I wanted to take the opportunity today to highlight
13 just a few of the real-world examples of the impact of some of
14 these regulations -- these proposed regulations -- on the lives
15 of injured workers.

16 Oftentimes, the delays which are caused by confusing
17 or burdensome regulations are just enough to slide an injured
18 worker into bankruptcy or foreclosure or to cause them to use
19 up their medical leave time and lose their job and lose their
20 health insurance, sending them on a perilous course, so these
21 delays are very important to consider.

22 We had some serious concerns about the proposed
23 limitation of specialty of the panel QMEs to that of the
24 treating physician. I just spoke with a woman yesterday, for
25 example, who is telling me that after her injury, she was sent

1 to an occupational clinic where she had seen one doctor after
2 another for a couple of months, never the same one, may or may
3 not be the same specialty. They are probably mostly
4 occupational health doctors, but we really didn't even know.

5 Nobody really did anything for her in her mind, and
6 she spoke with her private doctor who suggested she see a
7 neurologist. She called the adjustor. She said, "I would like
8 to change doctors to a neurologist." "Can I see the list?"
9 And the adjustor said, "No, you have to go see a panel QME, and
10 that doctor will have the final say." She was frustrated,
11 obviously. She had done everything she was supposed to do, and
12 she wanted to make a change of doctor, which was her right, and
13 now she is channeled into the panel QME process, probably
14 prematurely and told she didn't have any choices.

15 So why should this woman be limited to the specialty
16 of the doctors that she had seen when these doctors weren't
17 really her choice in the first place. They may or may not have
18 had the same specialty. She had tried to change doctors and
19 was given the panel QME option instead of having the right to
20 change.

21 Injured workers are entitled to choose their own
22 doctor and specialty within the NPN. That's their right by
23 statute. If that choice has been denied to them, a limitation
24 of the panel QME process only exacerbates that denial and
25 potentially for the duration of the case. And that brings me

1 to the difficulty in getting another evaluation in a different
2 specialty at a later time, which causes even further delays in
3 getting appropriate treatment and benefits for ramifications of
4 an injury that exceed the expertise of the original panel
5 doctor.

6 The proposed regulations require a showing of good
7 cause that does not recognize the far more prevalent need for
8 multiple evaluations in cases now involving the AMA guides.
9 The procedure for describing impairments relating to an injury
10 is far more complex and requires much more expertise on the
11 part of the evaluating physician. Hence, where in the past,
12 the evaluating physician, possibly an orthopaedist or physical
13 medicine doctor, may have been able to make some general
14 statements as to the impact of drug effects or some secondary
15 condition because that is all that was really required under
16 the old schedule.

17 Under the new schedule, descriptions of impairment are
18 largely beyond the expertise of non-specialists. So without
19 the additional panel in a new appropriate specialty, the
20 injured worker's whole person impairment cannot be deemed to be
21 accurate. There is no reason to add a delay -- an additional
22 delay in getting an additional panel where those needs are
23 readily apparent.

24 Along similar lines, we are quite concerned about the
25 proposed regulation, Section 31.1(c), where if the Medical

1 Director fails to issue a panel to a represented employee
2 within 30 days, either party may seek an order from a workers'
3 comp judge, so that a QME panel may be issued. Forcing the
4 parties to get an order from a judge will only add unnecessary
5 administrative delay and costs and still does not guarantee
6 that the injured worker will receive the evaluation that is
7 needed.

8 Furthermore, where an unrepresented worker shall have
9 the right to a QME of his or her choice if the panel was not
10 assigned within 15 days, the proposed language establishes a
11 lesser remedy with a longer timeline for represented workers.
12 Where is there any authority or justification for restricting
13 an injured workers' rights solely due to his having hired an
14 attorney?

15 We strongly urge you to amend this language to provide
16 the same remedy and time limits for represented employees as is
17 statutorily required for the unrepresented workers. Adoption
18 of any lesser remedy is unwarranted, unjustified, and without
19 authority.

20 Finally, we appreciate the effort that the Division
21 has made to make the QME selection process fair in light of the
22 number of QMEs who list multiple offices all over the State.
23 Unfortunately, we do not believe that the proposed language
24 corrects this problem.

25 For example, one of our members -- and we mention this

1 in our comments in San Jose -- examined the list of QMEs in a
2 particular specialty. There are 47 doctors on the list, but
3 more than half of them, 27, had their primary offices outside
4 of San Jose. Among those, the number of different offices
5 ranged from a low of 12 to an incredible 64. With a waiting of
6 1.5 through the primary practice locations, the truly local
7 doctors are almost irrelevant statistically, and the vast
8 majority of the panels will be out of area doctors to the
9 detriment of the local medical community. Given that the
10 definition of primary practice location requires at least five
11 hours a week of direct medical treatment and a doctor may list
12 up to four such locations, it's obvious that any other location
13 is really only a place for mail to come.

14 We, therefore, recommend that these regulations be
15 amended to provide that only those offices that qualify as
16 primary practice locations, be included in the QME lists.
17 Alternatively, if additional offices are included, we strongly
18 urge that the multiplier used in that subdivision be
19 substantially increased to somewhere between 5.0 and 10.0.
20 Otherwise, panel QME evaluators will be largely accomplished by
21 a band of traveling doctors who maintain numerous addresses
22 statewide, but are not really part of any local medical
23 community. It seems clear that this result will only further
24 discourage the local medical community from participating in
25 the evaluation and treatment of injured workers in their local

1 community, which is a goal, I think, we all want to see take
2 place.

3 So thank you for allowing our comments here today. We
4 appreciate the efforts being made. Thank you.

5 MS. OVERPECK: Thank you. Carlyle R. Brakensiek.

6 **CARLYLE R. BRAKENSIEK**

7 Good morning. Carlyle Brakensiek representing the
8 California Society of Industrial Medicine and Surgery. I would
9 also like to comment that this probably a first, at least in my
10 recollection, that I have joining me at the podium today
11 representatives of the California Medical Association,
12 California Orthopaedic Association, and California Society of
13 Physical Medicine & Rehabilitation. We have put together a
14 joint letter of comments on these regulations, and I at least
15 plan to be speaking on behalf of all our groups.

16 We appreciate the AD going forward with these
17 regulations to comply with the statute and to make some changes
18 to make the system more efficient. We have reviewed these
19 regulations, and we do have some comments that we have made in
20 our written comments, and I will try to summarize in part my
21 comments. As the applicants' attorneys have just commented,
22 they have some concerns with the primary practice location
23 definition. We also have problems with it.

24 We certainly understand the problem that you are
25 attempting to address. The multiplicity of, I guess you would

1 call it, phantom offices of Qualified Medical Evaluators, and
2 that is certainly something that needs to be addressed. We are
3 concerned, however, that the solution that is offered in the
4 regulations is contrary to law. The law requires that panel
5 assignments be made at random, and we are of the opinion that
6 by giving a primary practice location 150 percent weighting,
7 that makes your selections inherently non-random. We think it
8 is defective.

9 We, in our letters, suggest a resolution to that
10 problem and that would be to require that any location that the
11 doctor registers with the Medical Director as a practice
12 location, that doctor spend at least five hours a month at that
13 location. We think that limitation would enable you to address
14 the problem of the phantom offices at least to a significant
15 degree, and it would still comply with the statute.

16 Next, section 10 of your regulations would propose to
17 deny QME status to a physician who happens to be on probation
18 by his or her licensing authority. The purpose of probation by
19 a licensing authority is to permit the physician to continue to
20 practice with certain restrictions. And we are of the opinion
21 that as long as the doctor is practicing within those
22 restrictions, then he or she should not be entirely precluded
23 from being a QME. This regulation basically exceeds and
24 interferes with the authority of the licensing authority to
25 discipline physicians.

1 Section 30 of the proposed regulations would
2 disqualify a physician who is assigned to a QME panel if that
3 particular physician has a financial relationship with another
4 one of the physicians on that same panel. First of all, we are
5 concerned how that works. If you had, let's say, three doctors
6 selected and two of them have a financial relationship with one
7 another, you can't tell which one you are going to kick off the
8 panel. That's conceptually one problem.

9 Secondly, we don't understand or don't perceive what
10 that evil would be even if there was a financial relationship
11 between two physicians and how that would necessarily affect
12 the outcome of the medical-legal report. And just for example,
13 if you consider a large medical group, for example, Kaiser
14 Permanente, which has hundreds of doctors, who because they are
15 all in the same medical group, have a financial relationship,
16 would that have the effect of precluding almost any Kaiser
17 physician from ever being on a panel. I think it's a problem
18 that needs to be addressed.

19 Section 31.5, which deals with medical-legal
20 consultations, we would recommend that since these are clearly
21 medical-legal matters, that the medical-legal fee schedule be
22 amended to create a payment category for these consultations.
23 Right now, that does not exist. We are calling these clearly
24 medical-legal. It would make the definition under 4620 as
25 being a medical-legal report. That there is no mechanism in

1 the current medical-legal fee schedule to reimburse the
2 facility. We would suggest an amendment to the Medical-Legal
3 Fee Schedule.

4 Secondly, we are concerned with the regulation that
5 establishes the procedure for basically if a consult is
6 necessary, that the Medical Director be required to put
7 together a -- basically a panel three consultants to do this
8 consultation. We are strongly of the opinion that the
9 physician -- the evaluator who is requesting a consult, ought
10 to be permitted to select the physician who does the
11 consultation.

12 It is extremely important for the evaluator to have
13 the consultation done by a physician that he or she knows their
14 reputation, knows their skills, their competency, and they have
15 confidence in the consultation that they are going to do. If
16 basically an evaluator is required to have a pig-in-a-poke
17 consultant that they don't know, that would reduce the
18 confidence they have in the report of the consulting physician.
19 So we would request that part be stricken from the regulations,
20 and that the doctor, as is the current law, be continued to
21 select the person who does the medical-legal consultation.

22 Finally, I would just like to comment on Regulation
23 32.7 regarding the requirement that physicians establish a
24 mandatory panel QME time slots. This section is extremely
25 controversial. We have a number of conceptual problems with

1 the proposed requirement in the bill.

2 First of all, for virtually all AMEs and most QMEs,
3 they would be required under your regulations, as we understand
4 them, to reserve at least three slots per month for panel QME
5 examinations. And there is a chance and even a likelihood that
6 these slots would go unfilled. And so you are requesting to
7 block out certain time that may go unused. The regulations are
8 silent as to whether or when a physician can fill that slot
9 assuming they haven't received a request for a panel QME during
10 that time.

11 So you have the likelihood that you are going to have
12 a physician sitting around -- a very busy physician sitting
13 around with an open time slot and no one to fill it. Assuming
14 they do get a request, and if you take let's say a busy AME,
15 and that we have AME's who are booked up a year in advance, a
16 year and a half in advance -- I talked with an AME earlier this
17 week who is booking in May of 2009 for appointments.

18 If this regulation goes through requiring the creation
19 of these time slots, they are going to have to bump some
20 injured workers who have been previously scheduled for a number
21 of months in order to create these slots, which again may go
22 unfilled once they have been bumped. The amount of time
23 involved here could be great.

24 If you took, for example, a psychiatric evaluation,
25 some complicated psychiatric evaluations take up to ten hours

1 to interview the patient, review the records, and compose the
2 report and then edit it. And if a very busy psychiatrist is
3 required to create these three time slots, that's 30 hours a
4 month that would have to be blocked out, could not be filled at
5 least in the long-run and may not go filled in the short-term.

6 Another problem we have with the proposed regulation
7 is that it gives the Medical Director the right to examine the
8 appointment books of the QMEs. We believe that since the
9 appointment logs contain the names of private patients, as well
10 as injured workers, that you have got some serious privacy
11 issues which have not been considered.

12 And perhaps the biggest concern that we had is that if
13 this regulation goes forward in its present form, a number of
14 AMEs have told us that they will simply decline the QME
15 process. No law requires them to be QMEs to do AMEs, and if
16 you have a physician who does virtually exclusively AMEs, and
17 they put through this regulation, we are concerned that they
18 will simply resign their QME status, and the system will be
19 worse off than it is now.

20 With this having been said, I would like to turn the
21 microphone over first to Steve Cattolica who has a couple of
22 comments, also.

23 **STEVE CATTOLICA**

24 Good morning, my name is Steve Cattolica. I am glad
25 to be part of the group that has brought forward these comments

1 in behalf of the California Society of Physical Medicine and
2 Rehabilitation.

3 We mentioned in our comment letter to you, Section
4 33(c), the unavailability of the QME. And (unintelligible)
5 same concern that Carlyle just spoke about with respect to the
6 availability issue, we believe that the inability for AMEs to
7 perform evaluations simply because they may not be available
8 for QMEs will have the net effect of AMEs dropping their QME
9 status. And with the initialed statement of reasons, the
10 Division says that the proposed changes are intended to allow
11 the QME process to better meet the needs of -- and I'll skip
12 the physician's part -- injured employees, employers and claims
13 administrators are shrinking (unintelligible) will not
14 accomplish that.

15 Next, Section 34(b), the location of the QME exam.
16 The current regulations, of course, contemplate that the QME
17 exam be accomplished only at the address that's listed on the
18 panel. The Division has seen that it's more appropriate to
19 expand that if it's necessary, but has limited the extension to
20 only those addresses that are actually on the QME list, another
21 alternate address of that particular QME. We believe that if
22 that's appropriate, and if it's mutually agreeable to the
23 parties, there is no reason why the exam cannot be carried out
24 at any appropriate location, for instance, the injured worker's
25 home if they are not ambulatory.

1 on the number of hours that a QME spends at the practice
2 location. You know, we started with five hours, at least five
3 hours per month, as a way of reigning in a lot of the abuses
4 that I think the Division has seen in the forty or sixty or
5 hundreds of offices that may be in their system.

6 The one point, though, that I wanted to expand on is
7 that there are some of our members who are semi-retired who may
8 be gone for extended periods of time, and we would like to see
9 it be on a 12-month average that they have to spend x-number of
10 hours in practice at the primary practice location to meet your
11 definition. I think that would be important for those
12 semi-retired doctors, who many of which are very well known
13 QMEs and AMEs that participate in the system. So that's one
14 change that I would like to expand upon.

15 My second comments would be on Section 11.5, the
16 Disability Evaluation report writing course. In the past, the
17 regulations had said that, if feasible, the physician should be
18 required to write a report as part of that course. We think
19 that's really just kind of fundamental to taking a report
20 writing course, and they actually be required to write a report
21 that would be reviewed by the entity that's putting on the
22 course, and that the entity be required to give some feedback
23 to the prospective QMEs to make sure that they really have
24 learned how to write a ratable report. So we recommend taking
25 out the "if feasible" section and make it mandatory that a

1 report be written.

2 And then, finally, Section 35, exchange with
3 information. We continue to have problems not receiving either
4 the joint letter or the medical records prior to the scheduled
5 QME evaluation. It's maybe true that some QMEs do not want to
6 review the medical records prior to the evaluation, but I have
7 a fair number of members who would like to review the records
8 ahead of time. Particularly, AMEs that have the more complex
9 cases. You know, if some cases that don't even receive the
10 joint letter ahead of time, it's hard for me to understand how
11 the QME or the AME could do a good job in addressing all of the
12 issues if they are really not clear on the issues that they
13 receive. So we would urge the Division to put a -- I
14 understand that currently they are supposed to get the medical
15 records and the joint letter ahead of time, but it just doesn't
16 seem to always be happening, so we would like to see the
17 Division build a time frame into the rates that would require
18 that the medical records and joint letter be received, and we
19 are initially proposing at least ten days prior to the
20 evaluation.

21 We think that would give those evaluators that do want
22 to review the records ahead of time, time to do it before the
23 evaluation, and we don't believe that it's so onerous that the
24 time frame couldn't be built into the process for delivering
25 the medical records. We think it's critical for not only doing

1 a good job at the evaluation, but limiting and reducing the
2 number of supplemental reports that you are probably currently
3 getting to deal with medical records that would arrive after
4 the evaluation.

5 Thank you very much. I might just add, CMA and COA
6 have some additional separate comments, and I don't know if
7 it's appropriate to go into those at this time, or if you want
8 us to wait.

9 MS. OVERPECK: Go ahead.

10 MS. PRZEPIORSKI: It's just really two additional
11 points -- Oh, I'm sorry. I apologize. Frank Navarro would
12 like to make one comment on our joint --

13 FRANK NAVARRO

14 Good morning. Frank Navarro. I'll bring my card up
15 in a moment. N-A-V-A-R-R-O. I just want to make clear that
16 you have put up the weighing system, and we have come back with
17 a different view on this.

18 We would not be opposed to upholding this particular
19 section and having a (unintelligible) holder meeting to discuss
20 it better with you to deal with the problem of the shelf
21 offices. We know this is a significant problem. I've
22 certainly heard this complaint from solo physicians for a long
23 time now. I just want you to understand if you can't go with
24 our recommendation of the five hours on average per month for a
25 year, we certainly would like to have more discussion on it, if

1 possible.

2 Thank you.

3 **DIANE M. PRZEPIORSKI**

4 Thank you, again. For the record, Diane Przepiorski
5 with the California Orthopaedic Association and commenting on
6 the joint comments from the California Medical Association and
7 from the California Orthopaedic Association. Really, just two
8 additional points.

9 One on Section 11.5, again back to the Disability
10 Evaluation report writing course. Really just to support the
11 Division's change to allow the entire 12 hours to be the
12 distance learning, we think that it would make these courses
13 more available, perhaps encouraging more entities to offer
14 these courses and really make them more available throughout
15 the year. Because recently we started offering these courses
16 and we do periodically get calls from people, not around the
17 time -- the specific time that we were doing the QME test, that
18 they would like to take the report writing course. So I think
19 this would be a good change, and we would support that.

20 And then the second comment is on Section 12 and
21 Section 13, the recognition of specialty boards and/or the
22 physician's specialty. We certainly understand the previous
23 comments made by the Chiropractic Association this morning that
24 this really has been a long standing area of disagreement that
25 we would very much support the Division clarifying that they

1 would only be recognizing the boards that are recognized by the
2 licensing boards of the prospective physicians.

3 We do think it is misleading to injured workers to
4 just have a list of subspecialty areas for which the licensing
5 board does not recognize, and we have long objected to that,
6 and in orthopaedics, we have a long line of specialty interests
7 that we could potentially list as well. We have never gone
8 down that road because we always felt that it would be hard for
9 the Division to implement, and we believe that your proposed
10 changes to Sections 12 and 13 will be more transparent, will be
11 easier for the Division to enforce, and would be less
12 misleading to the injured worker.

13 So we very much support the changes that may lead to
14 Section 12 and 13. Thank you.

15 MS. OVERPECK: The next name I have listed is Barry
16 Gorelick.

17 Frank, were you done?

18 MR. NAVARRO: Oh, yes, I was done.

19 MS. OVERPECK: Thank you.

20 MR. NAVARRO: Thank you. Unless you want to hear some
21 more from me. I'd be happy to talk.

22 **BARRY GORELICK**

23 MR. GORELICK: My name is Barry Gorelick. I'm an
24 attorney practicing here in Oakland. I represent applicants
25 who regularly appear at the Oakland Workers' Compensation

1 Appeals Board.

2 And first of all, I would like to say that I -- I'm
3 here personally and also as a member of the California
4 Applicant Attorneys Association. I'm in full agreement with
5 the written comments submitted by our president, Sue Borg, and
6 her testimony here today.

7 I had one particular thing that I wanted to discuss,
8 which was in Section 32(c), that's the current existing
9 regulation. The plan was to eliminate a Panel QME's ability to
10 obtain a consultation either from a treating doctor or another
11 reasonable doctor. And I'm in agreement with Carl Brackensack
12 and CSIMS, that you ought to -- you ought to allow a Panel QME
13 to do that. Let me give you an example.

14 In one of my cases, we had a Panel QME assigned in the
15 case, and an issue came up which was far beyond the specialty
16 of a Panel QME. It was a woman who had had a neck injury,
17 which was -- which seemed like a fairly routine strain, but it
18 turned out that she had a thoracic outlet syndrome and may --
19 may have needed surgery. And if you looked at the -- with your
20 current regs, as you propose them, she'd be required to go try
21 and find a specialty, get another QME. Number one, you
22 wouldn't find -- you'd have trouble finding somebody who could
23 do thoracic outlet syndrome. You'd be -- you'd have a serious
24 medical condition where we really need some immediate answers,
25 so there would be delays in a system that should be expedient

1 and simple. And I think that it would be appropriate in a case
2 like that to allow -- in all cases, to allow the Panel QME to
3 consult with the treating doctor or to, in their opinion,
4 obtain a reasonable consultation. And I think that that's a
5 right that exists in the system and should be -- should remain
6 in the system.

7 Thank you.

8 MS. OVERPECK: Thank you.

9 I don't have anyone else listed who wanted to speak,
10 but is there anyone else who is here who would like to make any
11 additional comment?

12 (No response.)

13 All right. Seeing no movement out there, we will now
14 close our hearing, and thank you all very much for coming.

15 (Proceedings adjourned at 10:50 a.m.)

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R E P O R T E R S ' C E R T I F I C A T E

I, Gay L. Castellano, Chief Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that the foregoing matter was reported by Deborah E. Schneider and Karen Jordan, Hearing Reporters for the Workers' Compensation Appeals Board;

The preceding transcription of the proceedings was accomplished by the aforementioned Hearing Reporters via computer-aided transcription, with the aid of audiotape backup, to the best of their ability.

Kimberlee Miller thereafter merged the respective sections of the electronic file portions of transcript to produce this transcript of one volume, being a complete transcription of the proceedings.

Gay L. Castellano
Chief Hearing Reporter
Division of Workers' Compensation

Dated: February 20, 2008
Sacramento, California

/s/