

**Commission on Health and Safety and Workers' Compensation**

**MINUTES OF MEETING**

**March 6, 2014**

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

In Attendance

2014 Chair, Angie Wei

Commissioners Doug Bloch, Christine Bouma, Martin Brady

Absent

Commissioners Faith Culbreath, Sean McNally, Kristen Schwenkmeyer and Robert Steinberg

Chair Wei announced that in the absence of a quorum, all decisions would be deferred to the next Commission meeting.

**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 thanked the Commissioners for the opportunity to provide an update on Department of Industrial Relations (DIR) activities. She stated that major efforts are being directed to putting together a budget which has integrity and under which hiring is done appropriately. She stated that the Division of Occupational Safety and Health (DOSH) had 30 positions that were unfunded. This year's budget includes full funding for DOSH, and this will allow DOSH to fill 30 positions, with another 15 positions in the refinery safety area. Previously unfunded positions in the Division of Labor Standards Enforcement (DLSE) will also be funded. A fee-based program will be developed to fund public works programs. DIR is implementing a special program on refinery safety that is in line with the Governor's Task Force. Refineries will be paying an extra fee. Emergency regulations are going through the final process to fund the Refinery Safety Management Program.

Ms. Baker stated that DIR is working to track data and information to ensure consistency, transparency and accountability for our staff and the public we regulate. A lot of efforts in DOSH and the Division of Workers' Compensation (DWC) have been to restructure. This includes the Qualified Medical Evaluation (QME) program. The goal is to have data come in electronically and be managed electronically to make it easier for the public and for staff.

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Ms. Baker stated DWC teams have been working to get all the regulations implemented in a timely way. The Return-to-Work Program is under design, and IT is working to build the portal for this program. Stakeholder meetings will be held this month and next month. The issues of distributing the monies fairly and expeditiously will be addressed. Ms. Baker stated that there is a trade-off between getting monies quickly to injured workers and targeting the right injured workers who has sustained the wage losses.

**Report on the Division of Workers' Compensation Regulations**

Destie Overpeck, Acting Administrative Director, stated that she would provide an update of Division of Workers' Compensation (DWC) regulations, including:

**Completed fee schedule regulations:**

- Ambulatory Surgery Center (ASC) regulations (80% of Medicare outpatient fee schedule) – effective 1/1/13.
- Inpatient Fee Schedule – spinal implant payment reduction – effective 1/1/13.
- Physician Fee Schedule – Resource-Based Relative Value Scale (RBRVS) – effective 1/1/14, public hearing 12/12/13 to eliminate the use of the Federal Office of Workers' Compensation Program's (OWCP) relative value units (because the structure of the OWCP data file results in erroneous fee calculations for certain procedures). These regulations instead state that those procedures will be billed "by report."

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

- Interpreter certification - certificate of compliance completed. Final regulations in effect 8/13/13 (extended to 3/1/14 per AB 1376).
- Qualified Medical Evaluation (QME) - certificate of compliance completed. Final regulations in effect 9/16/13.
- Supplemental Job Displacement Benefit (SJDB) – certificate of compliance completed. New forms effective 1/1/14.

**Finalized since the last Commission meeting in December 2013:**

- E-documents and lien filing fees – final in effect 1/1/14.
- Independent Bill Review (IBR) paper and electronic billing – final. Effective date 2/12/14.
- Independent Medical Review (IMR) and Utilization Review (UR) – final. Effective date 2/1/14, new forms must be used as of 3/1/14. Maximus is developing electronic application based on new form to steam line process.

**Regular rulemaking:**

- Predesignation/cap on chiropractic visits for primary treating physician (PTP) – Approved 2/12/14. Final regulations in effect 7/1/14.

**In Process:**

- Medical provider network (MPN) – First 15-day comment period ended 12/26. 2<sup>nd</sup> 15-day comment period. Final any day now.
- Outpatient Fee Schedule – public hearing 3/11/14 – to coordinate the outpatient fee schedule with the new RBRVS physician fee schedule (primarily the facility fees for diagnostic tests and clinical visits, which constitute 7% of the total outpatient services in workers' compensation).

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**Still to do:**

- Copy Services Fee Schedule – study presented 10/17/13, on DWC forum from 2/14/14 – 2/24/14. Expect to issue Notice of Rulemaking within a month.
- Interpreter Fee Schedule – conducting study.

Ms. Overpeck started that in addition, the final study for the Home Health Care Fee Schedule is close to completion and after that, the regulatory process will begin. Also, they are close to coming out with regulations on the Medical Treatment Utilization Schedule (MTUS).

Chair Wei asked about audit regulations, and Ms. Overpeck stated that they are on the to-do list. Chair Wei stated that the work by DWC on regulations has been impressive and each of the regulations has a very clear next step. She asked about the next step for the audit regulations, and Ms. Overpeck responded that the first step will be to put draft regulations up on the DWC forum.

**Update on DWC Medical Unit**

Dr. Rupali Das, Executive Medical Director stated that she would provide an update on the Independent Medical Review (IMR) and Independent Bill Review (IBR) programs. IMR is the process that utilizes medical expertise to resolve medical disputes about denied or delayed medical care. IMR is provided by a sole contractor, Maximus Federal Services (Maximus). DWC administers and provides oversight for the program. IBR is a process that resolves billing disputes between the provider and the payor; it is also provided by Maximus. With IMR, injured workers may request IMR if a request for treatment is denied or modified following utilization review (UR) and liability is not being contested. To request IMR, injured workers must sign the application form that has been completed by the claims administrator and submit it along with a copy of the UR denial to Maximus.

Dr. Das stated that there has been a dramatic rise in IMR applications from January 2013 when the program began with the peak for submissions in August 2013. The number of IMR applications has dropped somewhat since then, but continues to be high, representing four to five times the volume of applications anticipated prior to the initiation of the program. As of February 21, 2014, over 95,000 IMR applications had been submitted to Maximus, and over 12,000 final determination letters had been issued. Over 14,000 applications were closed because they were duplicates or ineligible or the requests were withdrawn because the treatment was given prior to IMR being instituted; this resulted in nearly 27,000 completed cases, or 28% of all applications submitted. Currently, additional information is needed to process almost 9,000 applications, and there are about 12,000 cases that are complete and awaiting final IMR determinations. Chair Wei asked at what point Maximum gets paid. Dr. Das replied that the fee is charged and paid after the final determination is completed. Chair Wei asked if Maximus gets paid if the case is closed, and Dr. Das stated that it depends on when the case is closed. If it is withdrawn prior to being assigned to a reviewer, there is no payment; if it has been assigned to a reviewer, there is partial payment. The payment is received at the end of the case. With IBR, the payment is required to be submitted when the application is submitted to Maximus.

Dr. Das stated that the contractor Maximus chooses reviewers who are specialty-matched to the medical issue being disputed. The names and identifying information of the reviewers are

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confidential outside the Independent Medical Review Organization (IMRO); the information is not available to DWC. The specialty and state of licensure are reported on the IMR determinations. Most reviews are performed by Physical Medicine and Rehabilitation specialists, followed by Occupational Medicine specialists. Surgeons are next, with the majority being orthopedic surgeons. On average, there continue to be two treatment decisions per IMR determination.

Dr. Das stated that the timeliness of IMR determinations is an important concern. DWC successfully implemented the IMR program within a very short time frame. As expected with the rapid implementation of such a large program, there have been some challenges, primarily related to timeliness of issuing decisions. The statute requires that standard decisions be issued within 30 days of the request and be assigned to an IMR reviewer (not from when the application is submitted); the time frame expands to 45 days when time is added for mailing and collection of records. Expedited IMR requests are required to be issued within 72 hours of assignment. Incomplete applications require additional follow-up and therefore take longer to move through the system.

Dr. Das stated that to date, DWC data show that it has taken 72.8 days on average for a standard determination and 11.7 days on average for an expedited determination, compared to 45 days for standard and 3 days for expedited. Since the previous report in December, the average number of days to issue and IMR determination has gone up, primarily because DWC has made a lot of efforts to clear up the backlog.

Dr. Das stated that there are three main reasons for the untimely decisions and the reason why more IMR decisions have not yet been issued. First, Maximus received four to five times the volume of applications anticipated prior to the initiation of the program. Second, 30% of IMR applications have been incomplete (typically missing the UR decision), requiring additional time and resources to obtain the missing information needed to determine eligibility. Finally, the paper submission process for IMR requires manual data entry and workload tracking. DWC has instituted several fixes to improve compliance with the required timeframes and to issue IMR decisions more quickly:

- Infused additional resources, including hiring additional staff.
- Increased frequency and clarity of communications with parties.
- Improved automation and technology, including an electronic IMR application process, which should be available soon.

As a result of these efforts, it is anticipated that by the next DWC report, IMR determinations will be issued in a timely manner.

Dr. Das stated that to date, IMR has upheld UR decisions in 82% of cases and has overturned UR decisions in 18% of cases. Pharmaceuticals continue to be most commonly requested, followed by durable medical equipment and occupational therapy. Denials are more common than approvals in all categories. Of the pharmaceuticals, steroid injections are most commonly requested, followed by narcotics. The category of injections consists mostly of steroid and other synthetic medications injected around the spine and peripheral joints, but also includes Botox for muscle spasm. If we look at surgical requests, spinal surgery is most commonly requested. Dr.

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Das stated that UR overturns IMR just as frequently with spinal as with non-spinal surgeries. Dr. Das stated that all the data presented to the Commission are being processed manually. The data discussed do not represent data up through February. Chair Wei asked when the electronic process will be in place, and Dr. Das responded that the electronic process for getting the data should start next week and it is expected that further catch-up on processing will be complete shortly.

Dr. Das stated that IBR details available are not as extensive because the focus has been on IMR, so the resources for IBR have been limited. IBR applications are a fraction of IMR applications, but they have also gone up. Slightly over 1,000 applications have been submitted, and 300 IBR determinations have been processed. Over 700 have been deemed to be ineligible. That means that 54% of applications submitted have been completed. Additional information is needed for 69 applications. At this time, determinations on about 300 applications are in process. 58% of the applications are decided in favor of the provider, meaning that the provider was underpaid. Dr. Das acknowledged the staff who helped put the report together: John Gordon, DIR Research Unit; Raymond Titano, DWC Medical Unit; DWC Medical Unit staff; and DWC Legal Unit staff. She stated that there will be additional data on IBR, as well as IMR, to present at the next Commission meeting.

*Questions and Comments from Commissioners*

Commissioner Bloch stated that they appreciate that the program is going through growing pains and he appreciates the work that has been done, and he stated that his questions are in line with improving the program. He also stated that he sees that 95,000 cases were submitted and only 75,000 were completed. He asked about the difference of about 20,000 other cases being somewhere in the system. Dr. Das responded that it has been challenging to identify precise numbers and she would check on that, but percentage-wise, the numbers represent the current status. Commissioner Bloch stated that he is concerned about the trend that the data indicate, as his union represents truck drivers, many of whom need physical rehabilitation, particularly for spinal issues. He asked whether it is accurate to assume that there are many workers coming into the system with chronic pain who are going through UR and IMR and being denied steroid injections, who have to wait for quite a while to have their claim processed. In the end, many of these workers are denied treatment. He stated that this seems to be the areas where most workers are being denied. Dr. Das responded that most of the IMR determinations do uphold the UR decision, regardless of which treatment category you look at. She stated that it is correct to point out that it has taken a long time to get to a decision. Many of the delays were from an earlier period, and DWC is currently making up for the delay. The data are not up-to-date and the catch up is not accurately represented as yet. Overall, the delay is going down. Commissioner Bloch stated that came to the Commission meeting with a lot of anecdotal comments from UPS drivers that there are a lot of delays in getting treatment. He stated that he was trying to see if there is a correlation between the data presented and the anecdotal comments. Commissioner Bloch stated that his final question is whether it is known why there are four or five times more applications coming in to the IMR system than anticipated, and Dr. Das stated that there was no centralized system to collect data in the past, and the estimates about the expected number of applications were therefore not based on complete data. Commissioner Bloch asked if there is any way to answer the question as the program moves forward. Dr. Das responded that DWC could

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collaborate with other researchers looking at other parts of the workers' compensation system to see what their data would reveal.

Commissioner Bouma asked whether they looked at other states that do IMR when they came up with the original estimates. Dr. Das stated that she was not part of that process. Department Director Baker stated that she believed the estimates came from a Qualified Medical Evaluator (QME) study done on treatment and the requests that were going through the QME process. Director Baker stated that they expected that the treatment QME, which used to take 18 months of litigation and costs, will start to speed up by going into an electronic system. She stated that these are different systems.

Commissioner Bouma asked about the data on IMR reviewer specialties. She asked what the Physical Medicine and Rehabilitation specialty was. Dr. Das responded that they are all physicians, specialized in the treatment of physical injuries; they also supervise the rehabilitation of people who are injured. They address musculoskeletal issues; they are not surgeons but they specialize in treating physical injuries. They are all MDs or DOs, except for the psychologists and chiropractors.

Commissioner Brady asked about the data on timeliness of IMR decisions and the fact that 30% of the applications are coming in incomplete. He asked if statistics were being kept on what makes them incomplete, whether they are not signed or not filled in properly. Dr. Das stated that primarily, they are not signed or they are not coming in with a UR determination. She stated that those two elements are required for an IMR application to be complete.

Chair Wei asked whether from a medical perspective, if DWC is pleased with the IMR determinations. She asked if the doctors doing reviews were thorough, robust and reflecting the treatment guidelines. Dr. Das responded that they are tracking to the extent possible how decisions are made, and they are tracking the use of the guidelines and the evidence used. They have looked at select cases in which some things could be improved. She stated that overall, she believes that the decisions are well-made because they do rely on guidelines and the guidelines are specified in the decisions themselves, so it is transparent. She stated that if there is a problem, people can actually look at the decision and bring up a reason why it is not in a decision. She also stated that the evidence that is used uses the hierarchy specified by statute starting with the Medical Treatment Utilization Schedule (MTUS) which is the guideline adopted by the DWC and then it goes to lower levels of evidence. She stated that that is part of the reason for the high UR uphold rate; when the guidelines used agree with the UR guidelines, it tends to uphold decisions. She then stated that for the most part, she believes that they are good decisions; there are some decisions that could be subjective, despite the use of guidelines. There are points where two physicians may disagree on an outcome, but for the most part, they are following guidelines and making good decisions.

Chair Wei stated that Administrative Director Overpeck mentioned new MTUS regulations coming out. She asked if there was a process to train those reviewing doctors about the changes to the treatment guidelines. Dr. Das stated that what DWC has asked for the contractor's training protocol and whatever process they use to train on the current use of evidence. When the new guidelines come out, and the first one is the strength of evidence, it will make it very clear what

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the hierarchy of evidence is and what to use when the MTUS is not applicable and what the next level is; in a way, that is much clearer than what is in the statute. She stated that DWC will make sure that the contractor uses appropriate training. The regulations themselves are so good that the training will be easy to provide; however, DWC will make sure that the contractor provides that training to the reviewers.

***Public Comment***

Jim Butler, President, California Applicant Attorney's Association, stated that the data on page four of the presentation reflect 4,319 treatment decisions. He stated that the data on page two reflect 12,321 determinations, and he asked for an explanation and how to reconcile the numbers. Dr. Das responded that the data reflect different dates; those now coming in electronically are more recent, whereas they are still catching up with those that will be going through the manual process.

Mr. Butler stated that anecdotally from their members, Maximus used to list the medical records that they reviewed; but they do not do that anymore. He asked if that would change in the future, because one cannot tell by looking at the IMR decision what the reviewer relied upon. Dr. Das responded that the determinations coming out now should reflect and will reflect detail on the medical records that were reviewed. She stated that that information will be redacted for public posting, but the parties should be able to see the medical records that were reviewed by the reviewer.

Mr. Butler stated that when he did the math on the current status of IMR, it looked like there were some 40,000 applications missing between the numbers submitted and the determinations listed. Dr. Das responded that as has been pointed out, there is a discrepancy on the table presented, and it has been a challenge; it has to do with the way the data are reported to DWC, and DWC will be sure to take a closer look at that. Mr. Butler stated that the difficult thing for him to reconcile is his experience with the length of time that it is taking to get IMR decisions back. He stated that he still has many applications pending from August and September, which do not seem to be within that guideline. He stated that his members are also reporting the same problem. Dr. Das responded that timeliness is a big concern for DWC and she understands Mr. Butler's concern. Other than following the statute, it is an issue for the worker who is waiting to hear about the treatment, so DWC is doing everything they can to figure out a determination and whether there is a reason for it. She stated that if there is a question about a determination that they feel is really untimely, they should contact Maximus; if they are not sure who to talk to there, DWC can put them in touch with the appropriate person to find out where it is in the pipeline. Mr. Butler thanked Dr. Das.

Kenneth Eichler, Government Affairs Specialist, Work Loss Data Institute, publishers of *ODG*, also Co-Chair of the International Association of Industrial Accident Boards and Commissions (IAIABC) Medical Issues Committee and the Return-to-Work Disability Management Committee, stated that he is able to offer a bit of a national perspective with what is happening with IMR and compare it to other states. He stated that it is like the old question, "How's Your Wife?" and the answer is, "Compared to Who?" He stated that they have to couch this with what is happening nationally. What is happening in California is very similar to what happened in

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New York about four years ago when New York adopted treatment guidelines and a process similar to the IMR process. In New York, the workers' compensation board anticipated 12,000-15,000 appeals, variance requests, which are similar to an IMR. He stated that in reality, what they experienced was 12,000 to 15,000 appeals per month. He stated that these were very similar numbers to that experienced in California. The 80% uphold of the IMRs is similar to the process that happened in New York as well as other states. They are seeing the same mirroring, the same percentages, roughly 76% to 82% depending on the states, of the actual findings being upheld. He stated that the results are not really that surprising when compared to other jurisdictions. He stated that he would encourage looking at physician behaviors and looking at payor behaviors in the data collection. He stated that they found in other jurisdictions that the large number of denials is coming to a very small percentage of physicians. He stated that it is similar to prescribing of narcotics; there are generally a very small percentage of physicians driving the majority of appeals, and those appeals are being upheld.

Bernardo Delatorre, California Applicant Attorneys' Association, asked if there was any information as to what percentage of unrepresented workers are filing appeals to IMR, and whether it corresponds to the represented workers. Dr. Das responded that that data are available; the application itself does not have a check box, but attorneys acting on behalf of their applicants; it is not something that DWC has specifically been tracking, but DWC could certainly try to see if they can get that information. Mr. Delatorre asked if there was a Spanish language appeal form. Dr. Das responded that there will be shortly; they were waiting for the regulations on the form to be finalized. It is currently being translated into Spanish and will be available soon. Mr. Delatorre asked whether that means that currently, a Spanish speaker is not filing IMR if he is not represented. Dr. Das stated that she could not comment on that as they do not track language. Mr. Delatorre commented that he also noted that there is a 55% increase in drugs, and that he did not know whether it was a good idea to move everyone to drugs instead of treatment.

Richard Meehan, Applicants' Attorney, stated that he represents injured workers, and that it seemed that the level of denial looks like part of the problem is with the primary treating physicians not knowing what to ask for or not getting what they want. He stated that he wondered whether DWC is looking at a program to train primary treating physicians to get the treatment that the injured worker actually needs and to get the paperwork right. He stated that this is a paper chase. If the paper is not right, the treatment does not happen. He stated that that does not necessarily mean that the treatment is inappropriate but that it was not correctly papered. Dr. Das responded that at the December Commission meeting, she addressed this issue and talked about other efforts in medicine, in general, to train medical students and physicians to make right decisions. She stated that she had made the comment then that the high denial or high UR uphold rate does not necessarily mean that people are getting the wrong treatment. She stated that as DWC comes up with the new MTUS guidelines, it would like to partner with other organizations to provide appropriate treatment to providers so that the right decisions can be made to start with and the appeal and IMR process could be avoided.

Dr. Ramon Terrazas of the San Francisco Fire Department stated that he wanted to address the issue of steroid injections. He stated that the MTUS is very specific about what criteria need to be fulfilled in order for the requested procedure, steroid injection, to be medically necessary. He

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stated that it is not verbose, it is not obscure, it is not vague; it is very clear. He stated that if the treating physician documents that the patient meets the criteria, by and large, you can expect that that request is going to be authorized. He stated that when the treating physician does not submit documentation that meets the criteria, then UR is going to get involved. UR will look at it and if the criteria does not meet the MTUS criteria, or, rather, if the documentation does not meet the criteria of the MTUS, the only obvious decision is to deny or not certify; unless, of course, the treating physician has gone through lengths to explain or detail why the particular patient should undergo the procedure, even though MTUS or evidence-based medicine does not apply. He stated that if that physician does not provide an explanation, the only determination that UR can provide is non-certification. He stated that one of the issues with steroid injection is that when the very first patient in the history of medicine received a steroid injection, it was for a very specific indication. As the procedure became well-known and as other physicians looked at other conditions, spinal conditions, to which a steroid injection might apply, by a natural extension the procedure was provided to patients who did not initially fit the criteria for that first patient. He stated that one of the things that MTUS is doing, one of the important drivers here, is altering physician behavior so that if that patient fits the criteria for MTUS, they should get the injection; if they do not fit the criteria, the injection will very likely not work, so why go through risk, why go through the effort to try to provide something that really is not going to work.

Dr. Das stated that she agrees with the last two commenters that the use of evidence-based medicine is important and if providers were more aware of the need to use evidence-based medicine, then there would be a different ratio of UR denials and IMR upholds of UR decisions as well.

Chair Wei stated that Dr. Das can probably tell that this is a very important topic for everyone present and that she appreciates the information presented, as the data are very helpful. She stated that it is probably clear that Dr. Das will be asked to return to future meetings to give additional updates, and that the information presented in the future would be very helpful to assessing the IMR system.

**Report on the Medical Access Study**  
**Henry Miller, Berkeley Research Group**

Mr. Miller stated that Berkeley Research Group (BRG) has contracted with DIR to study access to medical care for injured workers over a three-year period, producing annual reports. The year one report was issued in 2013; it was based on a survey of injured workers as well as an analysis of medical billing in the DWC Workers' Compensation Information System (WCIS). That study indicated that 85% of injured workers were satisfied with the medical care they received; these results were similar to studies previously done. The fact that the results were similar, led to a focus more specifically on medical billing that WCIS makes available.

Mr. Miller stated that in the second year, the WCIS data set used in the study consisted of approximately 50 million medical bills submitted to workers' compensation medical carriers for the years 2007 through 2012. Data were used to assess injured workers' access to medical care primarily by assessing changes in provider participation, the ways services were provided and

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the utilization of services, and types of services provided. Discussion in this presentation will focus on data analyzed for the State of California as a whole; the report identifies the same type of analysis for specific regions. The focus was on availability of professional services and particularly specialty services.

Mr. Miller stated that the number of injured workers who received medical care in the workers compensation system has decreased substantially by 28 percent from an estimated 696,700 in 2007 to 499,687 in 2012. Mr. Miller stated that the study could not analyze exactly why the change occurred. One factor for the decrease may be that 2007 was a pre-recession year and the rest of the years were during the recession with 2012 being post-recession. These years could reflect significant change in employment numbers. There also may have been improvements in health and safety technology which have affected the number of injured worker claims.

Mr. Miller stated that the number of providers treating injured workers decreased by 21 percent from 78,661 in 2007 to 62,390 in 2012 with some regional variation. The number of medical bills submitted declined from 10,679,807 in 2007 to 8,360,442 in 2012 (22 percent), with some regional variation. The most significant factor about this was that the number of services billed increased 11 percent from 2007 to 2012, with large increases in certain services such as lab tests. The number of drugs billed increased substantially by 55 percent from 2007 to 2012, including substantial increases in prescription of narcotic pain medications. Mr. Miller stated that the increase in pain medication instead of other treatments, such as physical therapy and related rehabilitation services, for injuries that result in pain are changing for all patients, not just workers' compensation patients.

Mr. Miller stated that back injury diagnoses increased; however, the number of back injuries diagnosed appearing on inpatient hospital bills decreased. More services were provided despite the decrease in number of injured workers; as a result, total billed charges were virtually unchanged (1 percent decrease) despite decreases in the number of injured workers, providers and medical bills submitted. The average charge per bill increased substantially by 26 percent. Total payments decreased 24 percent but due to decreases in the number of injured workers and the number of medical bills, the average payment per worker increased nearly 6 percent and the average payment per bill increased 5 percent.

Chair Wei asked if there is a baseline to draw the study conclusions. Mr. Miller responded that the baseline was 2007, the year in which the data set was most complete. Chair Wei asked if prior studies indicated that injured workers were satisfied with their medical care, and Mr. Miller responded that that was the conclusion of two prior studies in 2007 and 2010, but those results were based on surveys conducted, not on data. Chair Wei asked if the prior studies were done by BRG or by UCLA, and Mr. Miller responded that the first study was by UCLA and the second by University of Washington. BRG has done the third study and this presentation is based on the second year of the third study.

Mr. Miller stated that the number of injured workers declined more quickly in recent years than the number of providers treating them, which implies that workers have adequate access to providers on an aggregate level. While the number of bills submitted is decreasing, the number of services billed is increasing which means that providers are billing for more services.

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Mr. Miller stated that physical therapy services have held steady and chiropractic services have declined from 2007 through 2012, while bills for drugs, especially narcotic pain medications, have increased over the years studied. Providers are seeing fewer injured workers but are providing more services per injured worker.

Mr. Miller stated that the study would focus in greater depth on the changes in the types of providers treating injured workers, including the decline in chiropractic care and primary care, and an increase in specialty services. Additional investigation of inpatient services and costs will require improvements in data. The study will include investigation of changes in services being billed and by which specialties, including lab tests and drugs.

*Questions from Commissioners*

Commissioner Brady stated that the 55 percent increase in the use of drugs definitely commands attention and indicates that there is a need to analyze this further. The federal government has been using words like “epidemic” across the country. Commissioner Brady asked if BRG is aware of other states reporting a similar pattern of drug use. Mr. Miller stated that this issue is not limited to California but is definitely a national issue in terms of the quantity of drug use, though there is not enough information to determine the effectiveness of drug use.

Commissioner Bouma stated that there have been substantial changes through Senate Bill (SB) 863 which may impact satisfaction with access to medical care and provider participation. She stated that she gets anecdotal calls from firefighters stating that providers are notifying them that they will no longer provide treatment. Mr. Miller responded that they could not identify changes in the data, because the changes were too recent, but they would do their best to include that analysis.

Commissioner Bloch stated that he shares Commissioner Brady’s concern about the spike in narcotic prescriptions. He stated that he appreciates the presentation of the data in this presentation, as well as in the presentation on IMR. He asked about the 85% satisfaction rate by injured workers receiving treatment through the workers’ compensation system. He asked if the study looked at the numbers of injured workers who came into the system but did not receive treatment. Mr. Miller responded that that was discussed but that there was no means to analyze that area. Commissioner Bloch stated that this issue relates to the previous presentation on IMR, and that he hopes that through the IMR process, sound medical decisions are being made based on sound medical evidence, as well as that workers are receiving the medical care they deserve and are being denied medical treatment they do not need. He would like to be sure that injured workers are not “slipping through the cracks.”

Chair Wei asked whether workers responded to a question about the medical care that was provided, or also a question about the process of getting medical care. She stated that there have been many comments about the difficulty of getting to a provider to get medical care. Mr. Miller responded that both questions were asked and that the level of satisfaction with both the overall process and the medical care provided was the same.

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**Firefighter and Peace Officer Study: Evaluation of the NIOSH Report**

Mark Priven, Bickmore

Mark Priven stated that this is a follow-up presentation to a preliminary presentation discussed in an earlier Commission meeting. The major issue with the earlier study was that it could not incorporate information from a particularly important NIOSH study that had not yet been released, which was going to focus on the differences in cancer incidence and mortality among the firefighters versus the general population. The NIOSH study has since been released, and Mr. Priven stated that he has amended his report to incorporate the NIOSH study.

Mr. Priven stated that the current death benefit process provides death benefits for public safety officers who have cancer and who are active at the time they are diagnosed with cancer or they are diagnosed up to 10 years of becoming inactive, depending on the type of safety officer and number of years of service. One is only eligible if the date of death is within 240 weeks of diagnosis. The death benefit is up to \$250,000, but it can be a little higher based on whether or not there are dependents. The proposal the study looked at is based on the most recent version of Assembly Bill (AB) 1373 from the past year, which would increase the death benefit, so it applies to people who die within 480 weeks of the date of diagnosis but only applies to active personnel. Based on this study, a rough estimate is that the change in the death benefit from 240 to 480 weeks would increase annual costs by about \$4.75 million dollars. The study's conclusion is based on the recently published NIOSH study in the journal of *Occupational Environmental Medicine* in October 2013.

Mr. Priven stated that the NIOSH study followed three specific fire departments in San Francisco, Chicago and Philadelphia. These were very large fire departments and included 29,993 firefighters, and it compared the incidence of cancer and mortality of cancer versus the general United States (U.S.) population between 1950 and 2009. The results of the NIOSH study were that the ratio of overall firefighter mortality was 0.99 compared to the U.S. population. The ratio of 0.99 means that firefighters' mortality is 1% lower than the general U.S. population. However, if one looks at the cancer mortality for firefighters, there was an elevated experience of mortality of 14% above what would have been expected from the general U.S. population. For firefighters, the cancer incidence was about 9% higher than what would have been expected of the general U.S. population. It is possible that the reason firefighters died from cancer at a higher rate than the general U.S. population but their overall mortality is lower is because firefighters are healthier in general and therefore had fewer deaths from other causes than cancer. Mr. Priven stated that while cancer mortality on average is 14% higher on average than expected, the NIOSH study results indicate 95% confidence that the incidence of cancer mortality is between 10% and 18% above what is to be expected based on the general U.S. population.

Mr. Priven stated that the first step of the study was to get information on how many active safety personnel there are. The study looked at the number of fire and safety officers separately. The other variables were age, since cancer incidence is very different by age. Next, the study examined cancer frequency by age and by type of cancer. Once age and type of cancer are given, then one can calculate the cancer incidence by age and type of cancer. For cancer frequency, the study adjusted for the NIOSH study which noted that there was a 9% elevated risk of cancer incidence risk for firefighters. Once cancer incidence for firefighters is identified, then the

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question is what the mortality rate is for that cancer. The study looked at cancer incidence by age, by type of cancer, and by survival period between diagnosis and mortality, because the key piece in this legislation is the survival time. The survival period is very important, and the study looked at the survival period between 240 and 480 weeks of diagnosis. Mr. Priven stated that the study did adjust for the NIOSH study which showed a 14 percent elevated risk of mortality for firefighters. Then the study multiplied the number of cancer deaths by the death benefit to get the annual cost of the study.

Mr. Priven stated that for the demographics of active safety officers, the breakdown is by age, which is a very important assumption for cancer incidence. The frequency of cancer incidence increases by age; the older one is, the higher the chance of getting cancer. This study has two levels of detail; one result is adjusted for the NIOSH study and reflects the 9% elevated risk for cancer, and the second is not adjusted. Next, the study reviews the type of cancer. The NIOSH study of firefighters shows that by far the highest number of cancer deaths were from lung cancer, followed by intestinal cancer and then prostate cancer. The NIOSH study showed that lung and digestive cancers were among the most elevated cancer risks for firefighters. Mr. Priven stated that key information from Surveillance Epidemiology and End Results (SEER) data is the survival rate once the person is diagnosed with cancer. For lung cancer, the percentage of people who pass away between one to five years after being diagnosed with cancer is very high, and the survival period is only slightly influenced by age. The risk of contracting cancer is dependent on age, at least for lung cancer. However, once one gets cancer, specifically lung cancer, the survival period, at least for lung cancer, is not that dependent on age. The most interesting time period for the current Commission study is what occurs five to ten years after contracting cancer. Only about 5% of the cancers that are diagnosed fall into the mortality period of 240 to 480 weeks, and those are the cases which are affected by the proposed legislation.

Mr. Priven stated that the survival period changes quite a bit by the type of cancer. While the mortality or survival period of one to five years and beyond 10 years varies by type of cancer, the percentage of people who died between the six to ten-year-period after diagnosis is consistently about 5%. Overall, weighted for all types of cancer, the percentage of people who die within the five to ten-year period is about 5%, and the number that is impacted by this legislation is about 5%. Based on all these projections of the number of people who are diagnosed with cancer, the mortality rate, and those who die within the 240 and 480 weeks, the study calculated the projected number of annual deaths for active safety officers. The data are broken down by age. The number of deaths was 19, and that is where the annual cost of \$4.75 million dollars is derived from. Mr. Priven stated that the 19 deaths calculated by his study times the \$250,000 dollars that are given as the current death benefit gives an increase in the cost of \$4.75 million dollars. Therefore, in summary, the study estimates the cost to be \$4.75 million dollars to increase the death benefits for firefighters, and it incorporates the key element of the NIOSH study which did show the increase incidence of cancer by 9 percent and mortality of 14 percent specifically for firefighters. The NIOSH study did look at whether the mortality was different for San Francisco versus Philadelphia versus Chicago, and the results were robust based on region. Based on the NIOSH study, the results are applicable to California, and the results do vary by the type of cancer.

Mr. Priven stated that there are several limitations in this Commission study. The first is that the

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study had to apply the results of the NIOSH study to the California safety officers. However, the study only applied that to firefighters, and there was no evidence in the NIOSH study for police. In addition, the study did not assume that there is an elevated risk of cancer for police officers. The issue of survival time is very important, because they are looking specifically at a 240 to 480-week period, and the study used nationwide statistics on that, so there is nothing specific to California or California peace officers, and it would be a great improvement if they had that data. The study was looking at a benefit of \$250,000, but that would be different if the safety officers have dependents, and statistics on the number of dependents were not available. Mr. Priven stated that over time, the exposure to asbestos and other types of carcinogens has changed between 1950 and 2009, and that would affect cancer incidence and mortality. Therefore, he stated that this is not a static number but a number that is changing over time.

*Questions from Commissioners*

Commissioner Bloch stated that the study is very sobering. This study only prescribed a modest increase in cost given the number of deaths that occur in a relatively short time frame after a firefighter is diagnosed with cancer, regardless of what kind. Commissioner Bloch asked the following questions: what impact will an increase of about \$4,750,000 dollars have on current statewide benefits? what are the current annual statewide benefits? and what percent of the proposed increase in benefits would be from the current benefits? Mr. Priven stated that he does not have an answer, but he will have to get that information. To find an answer to Commissioner Bloch's question, Mr. Priven would need to know if Commissioner Bloch is asking about benefits provided by municipalities, counties or by the workers' compensation system as a whole. Commissioner Bloch stated that he wanted to know about the current benefits for cancer treatment and his guess was that \$4,750,000 was a modest increase in the annual cost in treating cancer for firefighters. Commissioner Bloch stated that based on this study, it is clear to him what the impact would be.

Commissioner Brady stated that on page 15 of the Commission study, there is an entire page of limitations; he stated that he is concerned about the length and significance of the layers of assumptions and asked Mr. Priven for additional comments about that. Mr. Priven replied that there were many assumptions that were extrapolated from the general cancer statistics, even nationwide statistics, to safety officers, particularly regarding the survival period, and that this was a big weakness of this study. He stated that if he could get more relevant data on California workers' compensation about the survival time, that that would be helpful. The data on changing incidence of cancer over time for firefighters would be helpful because data about the survival period are weak. In addition, for the changing incidence of cancer over time, it will be helpful to track the safety methods and exposures because they will change over time. Therefore, better data specific to California firefighters and police and safety officers would be very helpful. Commissioner Brady stated that some of the limitations in the NIOSH study were due to the historical data going back to the 1950s, and that time period was both normatively and socially different from today. For example, Commissioner Brady stated that he served on the American Cancer Society board, and it was clear then that smoking was promoted as a health benefit years ago versus how smoking is regarded today.

Commissioner Bouma thanked Mr. Priven for his report. She stated that the study had limitations

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and Mr. Priven had to make broader assumptions than what the actual experience is and work as best possible with the data available. However, she stated that believes that Mr. Priven has an accurate analysis. Commissioner Bouma stated that California firefighters maintain a memorial wall, and that memorial wall has the names of all California firefighters who have given their lives in the line of duty since the State's inception. Unlike the peace officers memorial, the firefighters also memorialize those who have succumbed to cancer. Commissioner Bouma stated that she and the firefighters' families know, although the data may not indicate how many firefighters in California have died due to cancer-related deaths. She stated that this study and the data presented today are much closer than the outlandish estimates that have been seen in previous attempts to look at this issue. She also stated that culturally, the environment in which firefighters operate has changed. Firefighters used to perform their entire mop-up duties until the flames were gone without breathing apparatus, and that does not happen now. In addition, firefighters have their own cancer support network that advises them how to protect themselves and their families. For example, they are advised not to throw their dirty clothes in the back of the cars or trucks because they will continue to inhale the toxic chemicals that are on the clothing, and they are warned that appropriate cleaning and disposal on-site before they go home to their families are important. Commissioner Bouma stated that even though the culture has changed, society creates substances which create unknown toxic chemicals when they burn, so that problem keeps growing. She stated that the behavior of the firefighters is also changing because they realize that they did not think they would be susceptible to pre-mature death due to cancer and that their past practices could be a part of that reality.

Commissioner Wei asked if the Workers' Compensation Information System (WCIS) database showed only 174 cancer-related death claims between 2000 and 2012, and if this data were accurate. Mr. Priven answered that those 174 deaths were the only ones he could identify in the WCIS database. It is possible that there were more than 174 deaths, but only the 174 deaths were reported as cancer in the database. There is also a possibility that the number of deaths could be much smaller. Commissioner Wei stated that the universe of cancer deaths was small. She stated that as the sample size gets smaller, there is a question about the confidence levels and the robustness of the data; however, the data does get more granular and possibly more precise because one can get details about specific cases. Commissioner Wei stated 174 claims over 12 years is not a high incidence, but for the families, the deaths are extremely important. Commissioner Wei asked rhetorically how one weighs the public policy cost given the data, and she stated that she knows her position on this subject.

Commissioner Brady asked if there were going to be further studies by NIOSH. Mr. Priven replied that NIOSH will look at the results of the exposures and the safety methods. NIOSH has completed the statistics on the elevated risks, and now the unanswered question is why there is an elevated incidence of lung cancer for firefighters, specifically a question about what toxins firefighters are exposed to over time and how the firefighters can deal with the exposure to carcinogens.

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**Acting Executive Officer Report**

Irina Nemirovsky, CHSWC  
Eduardo Enz, CHSWC

Irina Nemirovsky stated that CHSWC Acting Executive Director Lachlan Taylor is out of town on a family matter and she and Eduardo Enz have been asked to provide a briefing on staff work.

*Copy Service Fee Schedule*

Ms. Nemirovsky stated that the following narrative is Mr. Taylor's summary of the status of the copy service fee schedule project. Per Judge Taylor, at the October 2014 meeting, the Berkeley Research Group (BRG) presented its recommendation for a flat-fee schedule in two tiers: \$103 for prompt and undisputed payments; and \$251 if payment is not made within 60 days. There were numerous objections to that recommendation. The Commissioners instructed staff to continue working with the stakeholders on developing an acceptable fee schedule.

According to Mr. Taylor, Commission staff convened a stakeholder roundtable in November 2013. The two-tiered fee structure that BRG recommended has been widely opposed. Some stakeholders, including Macro-Pro and a recently formed association of service providers, proposed an alternative structure with certain basic rates and a limited number of itemized add-ons or pass-through costs. That roundtable led to private negotiations between payor representatives and one of the major applicants' copy services. Commission staff did not participate in those negotiations, but the participants told staff that they are making progress. Payors were represented by Jeremy Merz for the Chamber of Commerce and Jason Schmelzer for the California Coalition on Workers' Compensation. Safeway's attorney, Saul Allweiss, also was involved. The applicants' copy services were represented by Greg Webber, CEO of Med-Legal. Mr. Webber advised us that he had other applicants' copy services ready to agree to his final proposal, as well.

According to Mr. Taylor, participants in the negotiations explained that they were working on an all-inclusive flat fee for records productions of up to 500 pages, and an additional per-page allowance for more than 500 pages, subject to an upper cap. Their last big hurdle was whether to include any release of information (ROI) providers' charges within the flat fee or whether to allow a pass through of ROI charges. ROI providers are companies that contract with medical providers to manage the release of information from medical records and assure compliance with HIPAA and state law. The companies often provide records management services for the medical records, as well. These services may charge fees to the person requesting the record. Mr. Webber advised that the majority of medical records production jobs did not incur ROI fees, and a percentage was given. The average of ROI fees when they were incurred was also reported. Mr. Taylor did not keep notes of any of those numbers. From memory, he thinks he heard that the average ROI fee was around \$30 when fees were incurred, and significantly less when averaged across all copy service jobs.

According to Mr. Taylor, when those negotiators reached an impasse, each side told Mr. Taylor what their final positions had been. Mr. Merz and Mr. Schmelzer reported that they had proposed an all-inclusive flat fee of \$175, but they could go no higher. Greg Webber reported that he could agree to an all-inclusive flat fee at \$200, but he would not agree to absorb the ROI fees if the

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basic flat fee is any less than \$200. In all other respects, the two sides seemed to be in close agreement. However, the negotiators for the payors have subsequently informed Mr. Taylor that he misunderstood the cap on additional per-page charges for jobs in excess of 500 pages, and the cap was supposed to be a global cap that included the basic flat fee, not a cap on the amount that could be added onto the basic fee. Canceled jobs and no-records declarations were discussed in general terms without specific agreements.

According to Mr. Taylor, at that point, he suggested to DWC that the regulations should follow the structure that the negotiators were trying to reach, and that the DWC should assign a dollar value since the negotiators had not agreed on one. Mr. Taylor suggested \$180. This is substantially less than the \$251 upper-tier fee in the BRG report because first, that figure was all-inclusive, second, the BRG recommendation was for jobs of up to 1,000 pages, while the proposed flat fee that only goes up to 500 pages, and thirdly applicants' copy services had told us early in 2013 that collections cost were around \$100. On the other hand, Mr. Taylor suggested that the value would be substantially more than BRG recommended for prompt payments because it was not clear that the lower tier included all pass-through costs, and because a fee schedule will not eliminate all collections costs.

According to Mr. Taylor, DWC posted draft regulations on its forum for public comment in mid-February. After reviewing those comments, DWC may proceed along the same lines as that draft, or DWC may consider an alternative approach.

Per Mr. Taylor, Commissioners should be aware that the copy service industry was not united in those private negotiations. The California Workers' Compensation Services Association, formed in 2013 and represented by Carl Brakensiek, attempted to convene a stakeholder meeting, but payor representatives declined to attend. Diann Cohen of Macro-Pro says that nobody would return her calls. Both of them have told Mr. Taylor that including the ROI fees in flat fee is unacceptable. Ms. Cohen suggested that \$150 plus a pass-through of the ROI fees would be more appropriate. All of those who were not invited into the private negotiations are getting a chance to respond directly to the DWC now.

According to Mr. Taylor, while it would have been nice to have a community consensus on the outline of a fee schedule, or at least an agreement between some of the major players from both sides, the remaining gaps between their positions will apparently require the DWC to make the decision. At this point, Commission staff has worked with stakeholders to facilitate their communication and to identify the critical issues that DWC needs to resolve, with or without a community consensus. While Commission staff would not rule out the possibility that DWC will proceed along the same lines as the draft that was on the forum, Mr. Taylor has suggested that DWC further explore the possibility of a \$150 fee with pass-through of the ROI costs.

Ms. Nemirovsky stated that this is an update on the results of the Commission's request that staff remain involved in the development of a copy service fee schedule. The focus of activity has now shifted to the Administrative Director's rulemaking process.

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*Implementation of Senate Bill 863*

Eduardo Enz stated that in addition to the staff involvement in the copy service fee schedule implementation, Commission staff has been working on projects to support implementation of Senate Bill (SB) 863 and evaluate its effects as well as other projects.

*Evaluation of SB 863 Medical Care Reforms*

There is a successful bidder on the study of Evaluation of SB 863 Medical Care Reforms contract, and Commission staff is waiting for the Department of General Services (DGS) to approve the contract. This will be a multi-year study to examine how the changes to medical delivery, dispute resolution and payment are affecting workers and employers.

*Public Sector Self Insured Program Study*

The Public Sector Self Insured Program study is underway. A key study objective is to identify objective measures and to identify improvements. The Memorandum of Understanding for access to data from the DWC's Workers' Compensation Information System (WCIS) for this study has been finalized and the report is expected in June 2014.

*Health and Safety*

The Worker Occupational Safety and Health Training and Education Program (WOSHTEP) has continued to present training programs and resources through: 3-day Specialist courses; Awareness Sessions; Small Business trainings; and a Young Worker Leadership Academy. New materials have been developed including a Model Injury and Illness Prevention (IIPP) Training Program for Small Businesses and General Industry. IIPP training activities and materials were developed in partnership with the California Department of Industrial Relations, Cal/OSHA Consultation, State Compensation Insurance Fund, Small Business California, California Small Business Association, and the California Department of Public Health Occupational Health Branch. In addition, a model IIPP Program for Agriculture has been developed. All of the materials are posted on the CHSWC website.

*Comments from Commissioners*

Commissioner Brady stated that he appreciated the report and that it was very comprehensive. Chair Wei stated that the copy service information was fascinating. Commissioner Bloch stated that he appreciated the way Commission staff persisted with participation in the Copy Service Fee Schedule private negotiations. He is pleased to hear that there are negotiations, but he is disappointed to hear that there are many factions. He stated that he understands the difficulties in that type of negotiations. He also stated that he wanted to express his gratitude for the health and safety training done by UC Berkeley Labor Occupational Health Program (LOHP) under WOSHTEP with agricultural workers in the food processing industry, an industry with a high amount of occupational hazards.

**Other Business**

None.

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**Public Comment**

Bryce Docherty, representing the California Ambulatory Surgery Association, asked if the BRG study is complete and when it will be published. Ms. Baker responded that this is a DWC study that is ongoing and published every year and that the current study is complete and will be published soon. Mr. Docherty stated that the key issue for this study is the implementation of SB 863 from an access standpoint. He stated that they would like to see the study look at 2012 as the baseline. He stated that they would like to have analysis done about how cases are migrating from the outpatient into inpatient medical care or vice versa. He then stated that as early as last week, the Workers' Compensation Rating Bureau (WCIRB) and the California Workers' Compensation Institute (CWCI) published impact data from SB 863 regarding Ambulatory Surgery Center (ASC) cost outcomes and that this is a six-month look at access issues. He stated that they have found anecdotally, that it takes providers at least six months for providers to move through the workers' compensation system. He stated that BRG should look at the whole body of billing data for 2013. The data that is available now is not particularly robust.

Mr. Docherty then stated that they are looking forward to the pending RAND study being done on the possibility of migration of cases from the outpatient setting to inpatient workers' compensation setting. He stated that the study was pending publication and was due July 1, 2013, and Ms. Baker stated that the study was under peer review.

Carl Brakensiek, California Society of Industrial Medicine and Surgery (CSIMS) and California Workers' Compensation Services Association (CWCSA), stated that he was sorry that Dr. Miller of BRG was not present. Mr. Miller stated that the study represented the full spectrum of cases. He stated that a lot of the satisfaction may be coming from workers with minor injuries. He stated that he hoped that study final report will take into account access issues based on the severity of the conditions. He stated that the greatest concern regards those injured workers with the most serious injuries.

Mr. Brakensiek stated as one of the representatives of the copy services groups in the industry, that the burden of proof is on the injured worker, and copy services is charged with producing information that is used as evidence for the injured worker to prove his or her case. If the fee schedule is inadequate, it will affect the ability of injured workers to prove their cases. They are looking for a fee schedule that minimizes frictional costs so that injured workers can obtain full documentation to which they are entitle and with which need to prove their case. He stated that he thanks the Commission for its continued interest in this issue.

Greg Weber, CEO of Med-Legal, stated that he has worked across interests in the discussion on the Copy Services Fee Schedule. He stated that he wants to compliment the Division and its approach to this issue, as well as all participants. There have been differences of opinion but the parties came close to a deal. He stated that it was clear that the Division used sources of the information and guidance from all sides of the negotiation to come up with recommendations. He also stated that he felt strongly that the Division and staff had reached a reasonable balance of all interests across all interests in the industry. He stated that release of information (ROI) fees are driving the dialogue, and he hopes that the Division and staff will look at the averages because the averages matter; while a certain percentage, 15-20%, do have ROI fees in the range

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of \$30, but in making the final recommendation, it would be important to look at the overall average which is actually closer to \$6.00. He stated that he looks forward to the continuing work.

Richard Meehan, California Applicants' Attorney Association, stated that he wanted to discuss the Return-to-Work Fund. It is a \$120 million annual fund that is supposed to go to injured workers to help them return to work. According to the RAND study, injured workers who do not return to work due to any type of injury lose 75-95% of earnings for the rest of their life. He stated that currently, there have been recommendations that money not be paid until after the fourth year or paid in the fifth year an injured worker has been out of work. He stated that this would do nothing or almost nothing to help any injured worker; after five years, it would be highly likely that an injured worker would be able to return to work. He stated that injured workers not returning to work in the first year after injury can be identified; those would be the workers who would need funds. He wanted to urge the Commission to push the Administration in that direction.

**Adjournment**

The meeting was adjourned at 12:08 p.m.

**Approved:**

\_\_\_\_\_  
Christy Bouma, Acting Chair

\_\_\_\_\_  
Date

Respectfully submitted:

\_\_\_\_\_  
Eduardo Enz, CHSWC Staff

\_\_\_\_\_  
Date