

**Redacted Emails Sent In
on the Subject of the Workers' Compensation Forums
held in April, 2012**

**Prepared by the
Department of Industrial Relations**

Note: Emails were sometimes sent prior to a Forum date, following a Forum date, and regardless of a sender's appearance at any particular forum. Emails are organized in order of date received, and listed in the Table of Contents by email subject line; occasionally, emails are not redacted when submitted as a copy of oral public comment following a Forum appearance. Emails received as PDFs are published in a separate document, and redacted using a different method.

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Item 1: Improvements in Workers Compensation System; Reducing Liens

2/17/2012 email (redacted)

Good Morning,

I believe that the work comp system is not restrictive enough on recognizing LEGAL representation of lien claimants. Collection and Billing companies have little oversight in place to ensure that they are actually authorized to collect on behalf of certain lien claimants.

1. There is no policy on who the insurance companies should send payment too - i.e. the collection company or the doctor.
2. Although it is getting better in EAMS, there are still liens filed with the doctor's name and the collection companies address without the representative being listed separately. Lien claimant listings on liens should be restricted to ONLY the lien claimant's name, address (**both treating address and mailing address**), phone number and direct contact information. There should not be any collection company information allowed in these fields, not even phone number. If anyone besides the lien claimant is being contacted it has to be clearly defined in the "representative" section of the lien form.
3. As part of the itemized statement, a NOTARIZED (by lien claimant) agreement of representation should be included verifying that the representative is authorized to act on the lien claimant's behalf. The document should be an official document designed by the DWC indicating what the payment arrangement is between the collection company and the doctor, and who payment is supposed to go to - lien claimant or collection company. This document should only have a 12 month life-cycle requiring renewal every 12 months.
4. "Lien Claimants" need to be recognized by policy. For example, an AR purchaser of a provider's AR, is currently recognized as a lien claimant. However, they did not provide treatment. This difference should be clarified. A lien form could have multiple sections to clearly identify parties involved in the lien:

Section 1: Name, Address, Phone Number and Contact information for TREATMENT LOCATION if different than Section 2.

Section 2: Name, Address, Phone Number and Contact Information for Medical Professional Providing Treatment (Often a doctor contracting with the Treatment Location, but being paid by the Treatment Location. Not entitled to file a lien, but who should be included for informational and audit purposes). If the Treatment location and the Treatment Provider are one and the same, Section 1 would not be filled out.

Section 3: Name, Address, Phone Number and Contact Information for AR Purchaser or Billing Company (When applicable). A check box indicating if they are an AR Purchasing or Billing Company.

Section 4: Name, Address, Phone Number and Contact Information for Entity appearing at Hearing (Currently the Representative, but not always the same as the AR Purchaser, Lien Claimant, or Billing Company)

Each of the sections would have a check box indicating if that was the entity that payment was supposed to go to. This would be supported by the NOTARIZED representative letter.

I believe that a large portion of the excessive lien activity in the Work Comp system is due to multiple collection companies filing the same lien as relationships between doctors and collection companies change. Currently, when a lien claimant changes representatives, they are required to send in a "Change in Notice of Representation" for EVERY case affected. This is entirely too inefficient to be realistic. Each Lien Claimant's ERN (or Quasi UAN) should be allowed to be associated with at least one Representative UAN. When a relationship ends, the lien claimant should be able to simply indicate that the Representative UAN be changed or removed. Any cases associated with this combination of lien claimant ERN and Representative UAN would then programatically be updated.

Lastly, something must be done to more accurately recognize pharmacy compound providers on a lien form. The doctor that provided the original prescription should be recognized, the "Pharmacy" providing the prescription should be recognized, and the AR Purchaser (as there is almost always one) filing the lien should be recognized. Perhaps the "Pharmacy" listing should go under Section 1 in these instances.

##

Item 2: Concerning workmen's comp/April 10 forum

2/26/2012 email (redacted)

To Whom It May Concern:

From informatioin I received I heard about the April 10 Workmen's Comp Forum in West Sacramento and read that I can send an e-mail to address issues and that input from the public is taken into consideration.

I want to express concern for injured workers who are rated by the Workers comp system as **100% diabled being denied care due to the current system**. I have a close friend who has abided by the "rules" and spends so much time trying to get approvals for care. Sometimes nothing comes through, or maybe one of the orders, or an order okeyed one time is denied the next. There is no rhyme or reason to the okey or denial. There is no compassion for her condition whatsoever. This affects her health and leads to depression and anxiety at not knowing what is going to be okeyed or denied. I believe there should be a category established for those who have gone through all the requirements and have been declared 100% disabled. By then there is no doubt that they have permanent injuries and shouldn't be treated as though it is a problem that will go away with time, or that if they are ignored long enough that they will just "go away."

Thank you for your time listening to me, it is so hard to see my friend suffer as she does, and have added to that the troubles with getting proper care.

##

Item 3: Liens

2/29/2012 email (redacted)

Administrative Director Moran:

I am an attorney whose practice is located in Oxnard and which focuses on lien recovery in the workers' compensation system. I am corresponding with you out of concern over the tenor of the discussion regarding liens and because of the fact that I am unable to attend and participate in any of the upcoming forums.

For several years now I have heard many of the defendants' complaints about lien claimants, many of which are echoed by the Appeals Board. These include the statement that lien claimants are resurrecting old (sometimes ancient) claims for reimbursement, that lien claimants are clogging the system, that lien claimants are taking valuable court time away from injured workers, etc. In my opinion, this has translated into an open hostility on the part of many judges in the system toward lien claimants. The phrase "lien claimant failed to sustain its burden of proof" is routinely and perfunctorily included in many decisions, even where it is not the case. I recently appealed such a decision issued by an Oxnard judge, it resulted in him setting aside his decision and in him apologizing to me for his decision. His words to me when making the apology were that my argument regarding having sustained my burden of proof were completely correct, but that I had to understand that with the number of lien cases the judge had to address " . . . we just crank out any decision." I was told that a judge who sits at the Marina del Rey Appeals Board recently shouted at his courtroom full of lien claimants that judges did not go to law school to handle lien cases. As I said, the general antipathy toward lien claimants is translating into defective judicial review of those lien claims. However, the blame does not lie with lien claimants nor even with the Workers' Compensation Appeals Board and its judges. This current situation involving unpaid liens is almost entirely the responsibility of defendants and workers' compensation carriers in particular.

As you are probably aware, when a bill is received by a defendant and when liability for it is contested, it is a type of exposure termed Incurred but Not Paid (IBNP). Standard underwriting procedure requires that a reserve be established for that potential exposure. However, as I know from experience as a claims examiner and claims supervisor and in house counsel for a carrier, great pressure is put on the claims examiner to close the case and take down that reserve once the case in chief is resolved. This can be for internal actuarial reasons on the part of the carrier, because the insured wants to maintain a lower experience modification, or for premium calculations. Whatever the motive, the closure of a file and the elimination of the reserve with IBNP still unresolved is not proper procedure. This has gone on for years, and it is now coming back to haunt the carriers and self-insureds. Instead of accepting the blame for this situation, they have cast this as somehow being the fault of the lien claimants. Recently, in a case in which I represented a lien claimant, the defense attorney asked me accusatorily why my client had done nothing to recover his charges for the six years that followed the approval of the Compromise and Release. My response was to ask why the carrier had done nothing to resolve the lien

during that same period of time. I participated in the consolidation hearings regarding interpreters' liens convened by Judge Kahn at the Van Nuys Appeals Board on March 18, 2011, and in my opposition to the Petition for Consolidation filed on behalf of FirstComp of Omaha I pointed out that their claim that they had \$20,000,000.00 (yes, twenty million dollars) in unpaid interpreters' charges on their books was not a basis for reform or even consolidation, it was a clear example of the incompetence of this workers' compensation carrier.

I would also point out to you that the en banc Guitron decision that was filed on March 17, 2011 broke no new ground legally. It simply stated and applied existing law. The Appeals Board's approach in Guitron is what needs to be done regarding pending lien cases. Apply the law, not misinformed antagonism, to lien claims. From a procedural standpoint, the only reform that I feel is necessary is to end the constitutionally defective prohibition imposed on lien claimants (and their representatives) preventing them from requesting a mandatory settlement conference and limiting them to a lien conference. Time after time I appear at a lien conference and listen to the defendant's representative stating that the matter needs to be continued or taken off calendar as they have not had sufficient time to get their file, conduct a bill review, etc. With the exception of the State Compensation Insurance Fund, there is a general lack of preparation for these lien conferences for the simple reason that discovery cannot be closed as it can at a mandatory settlement conference pursuant to Labor Code Section 5502(e)(3). Keven Starr was kind enough to call me in response to an e-mail I sent to him some time ago, and he told me that he had to keep the system as it was with lien conferences set for lien issues because they needed to keep track of how many lien conferences there were. If your focus is also going to be on compiling statistics, then I am wasting your time. However, if true and equitable reform is your goal, establish lien mandatory settlement conferences subject to the same requirements as a mandatory settlement conference pursuant to Labor Code Section 5502(e)(3).

I recognize that you are a comparatively new appointee and that there are many issues with which you have to deal. As a consequence, you do not need to respond to this communication; I would only ask that you take my comments into consideration.

Thank you.

##

Item 4: Input on Work Comp System

3/1/2012 email (redacted)

I have worked as a physical therapy consultant for 13 years as a utilization reviewer, primarily for State Compensation Insurance Fund. My best recommendation regarding cost containment is to make sure that physical therapists are involved in the UR process on claims from the start of treatment (or shortly thereafter) The reduction in numbers of visits, number of procedures and modalities included in treatment, requests for DME, gym and aquatics programs were all greatly reduced by the inclusion of a knowledgeable PT overseeing treatment requests/authorizations.

Item 5: workers comp areas of improvement

3/4/2012 email (redacted)

Thank you for the opportunity to share my thoughts. I am an injured worker rated as 100% by the WCAB. Recently, I had to return to WCAB for another expedited hearing to obtain approval for treatments, radiological studies, reimbursements, PTD, and a benefit history printout. The court reminded me that this was my tenth (10th) time returning to gain approvals. (Some hearings were before the 100% rating.) I was told "That is a lot just to gain approvals". My concern is for injured workers who are rated as 100% disabled, do not have legal counsel, and have difficulty obtaining approvals for treatments, care, supplies, medications, and equipment. I have been told by DWC and by my claims adjuster that once rated as 100%, "it is a given that treatment and care will be needed for life". However, what I am told and my reality are not the same.

Once rated as 100% if legal counsel is dissolved (in my case, my lawyer closed her practice), the injured worker is expected to function as his/her own lawyer. I have tried on numerous occasions to retain a lawyer. Over the past six years repeatedly I was told "Because you are already rated as 100% you are no longer profitable to a practice". I am an injured worker not a workers comp. lawyer. I am not aware of all the legal regulations or ramifications which could arise during a hearing. Sometimes I don't even know what to ask WCAB help line because the situation does not arise until I am before the judge. By then it is too late. There have been some tense moments during hearings due to my not having a law degree.

According to the current workers compensation regulations, if one is rated as 1% or 100%, or any rating in between, the same process for obtaining and receiving care must occur. I believe it is not ethical or moral for those rated as 100% to be denied treatments by UR or the QME. It has already been established by the courts that once rated as 100% one truly does need the care. To delay, deny or restrict care (such as restricting PT to 26 sessions for life for someone who is 100% disabled) is not appropriate and is negligent medical care for a human being who genuinely needs the life time care as documented in the primary treating physician's progress reports. Although those rated as 100% will probably never be cured or relieved of their symptoms, (how do you cure one from a spinal cord injury or CRPS/RSD?) treatment and care are needed for life.

Please consider improving the workers comp system by including in the regulations:

Those injured workers **rated as 100% by the WCAB without legal representation regardless of the date of injury** shall by pass the UR/QME process for requests for care/treatments/equipment/etc. deemed medically necessary, as documented in the primary treating physician's progress reports, that is reasonably required to cure, relieve, or prevent further injury to the injured worker from the effects and complications of the industrial injury. Requests shall be made in accordance with CA regulations.

For the insurance companies, this could save money lost to UR, QME, and legal counsel. (Even though the injured worker does not have a lawyer, the insurance companies do.) WCAB would save in costs for preparation and repeated expedited hearings. The injured worker would save time, money, and energy related to dealing with the UR Department, and being assessed, again, by QMEs who have also already determined the worker has a life altering industrial injury. In addition the injured worker rated as 100% without legal counsel would save by not having to file the DOR (thus incurring related expenses, which by

law, are not reimbursable) and not having to pay out of pocket for care/treatments/equipment while waiting for approvals which could take a few months or years.

Thank you for your time.

##

Item 6: Department of Industrial Relations seeks input on the Workers' Compensation System

3/7/2012 email (redacted)

As a physician practicing Occupational Medicine in San Diego for over 25 years, I would like to comment upon a major deficiency in the workers' compensation system in California. Primary care physicians are paid too little for the work and hassles inherent in providing care for work related injuries. Since Gov. Schwarzenegger signed SB 899 in 2004, medical providers have been locked into a fee schedule that has only had one change in that time. As inflation continues, providers continue to be paid at a rate far too low to compensate for the time spent in caring for these patients with the added burden of dealing with the administrative aspects inherent in workers' compensation. The dysfunction in Sacramento has prevented any meaningful changes to the fee schedule and so providers in essence get paid less every year for providing care to workers' compensation patients due to the increase in overhead expenses relative to static compensation. Soon, it will become difficult to find providers willing to treat these patients. I implore the DWC to immediately increase reimbursement to primary care providers to keep the system fair and to ensure access of patients to adequate medical care.

##

Item 7: Submitted Comments for Public Forums on the Workers' Compensation System

3/14/2012 email (redacted)

To Whom It May Concern:

Thank you for granting us this opportunity to share our thoughts and ideas on how to improve the California Workers' Compensation System. We consider it a privilege to be involved in your open forum, an action that displays the desire to do the right thing for everyone involved. It is our hope that you not only gain a better understanding of our organization with this correspondence, but that you are provided ideas and areas of opportunities that will positively impact the system.

Our organization has been servicing various client groups (e.g. third party administrators, self-insured employers, insurers) in the workers' compensation industry for over 25 years. Core services offered by our company include pharmacy benefit management and durable medical equipment, but we also supply home health, transportation, translation, and other ancillary medical services. Since over 25% of our national business is conducted in California, we have a real vested interest and a commitment to our clients and injured workers in your state. Now, we will turn our attention to the main areas of concern: opioid drug utilization, overutilization of medication, lack of preferred drug selection (drug mix), and the pharmaceutical fee schedule.

Opioid Drug Utilization

The use of opioid medication is a topic that has gained critical mass over the past few years. The primary issues surrounding this drug class are chronic use leading to higher costs and prolonged disability; overutilization; unintentional harm; and prescription drug abuse. We must not forget the balance that must be obtained in order for those who are in need of pain relief, be able to be treated humanely and without prejudice.

Chronic Opioid Use Leading to Higher Costs and Prolonged Disability

Studies by *Franklin GM et al*, *Webster BS et al*, and *Kidner CL et al* reported extended disability and less successful outcomes related to chronic opioid use.^{1,2,3} Findings by *Volinn E et al* noted that the odds of chronic work loss were 11 to 14 times greater for claimants using opioids for at least 90 days compared

¹ Franklin GM, Stover BD, Turner JA, et al; Disability Risk Identification Study Cohort. Early opioid prescription and subsequent disability among workers with back injuries: the Disability Risk Identification Study Cohort. *Spine (Phila Pa 1976)* 2008;33(2):199-204.

² Webster BS, Verma SK, Gatchel RJ. Relationship between early opioid prescribing for acute occupational low back pain and disability duration, medical costs, subsequent surgery, and late opioid use. *Spine (Phila Pa 1976)* 2007; 32:2127-2132.

³ Kidner CL, Mayer TG, Gatchel RJ. Higher opioid doses predict poorer functional outcome in patients with chronic disabling occupational musculoskeletal disorders. *J Bone Joint Surg Am.* 2009;91(4):919-27.

to non-opioid users.⁴ This would suggest that chronic opioid use could be used as a possible indicator or flag for prolonged disability

Both higher medical and medication costs are associated with chronic opioid use. *Leider HL et al* discovered that chronic opioid users had significantly higher healthcare utilization leading to elevated medical costs when compared to non-opioid users (\$23,049 vs. \$4975; P <.001).⁵ In our national data set, we have observed a higher quantity of opioids prescribed; a shift from short-acting opioids to the more expensive long-acting formulations (\$427.08 and \$79.79, respectively); and a greater concentration of schedule II opioids as the injury duration climbs beyond the first year.⁶ All of these factors lead to increasing medication costs.

Overutilization

Opioid utilization has increased at an alarming rate. This is demonstrated by the average amount of opioid medication per person jumping from 74 milligrams to 369 milligrams over a 10-year period (402% increase). It also is astounding that Americans make up only 4.6% of the world's population but we consume 80% of the global opioid supply, 99% of the global hydrocodone supply, and two-thirds of the illegal drugs.⁷ These are sobering statistics.

Unintentional Patient Harm

Nausea, vomiting, and constipation are the most frequently reported adverse drug effects. Other common side effects of opioid medication include sedation, dizziness, physical dependence, tolerance, and respiratory depression. Delayed gastric emptying, hyperalgesia, immunologic and hormonal dysfunction, muscle rigidity, and myoclonus occur less frequently.⁸

Many of these adverse drug effects lead to additional medication management causing other adverse drug effects and drug interactions. Through our pharmacist provided medication review services, we have witnessed full reconstructive jaw surgery related to opioid use with multiple anticholinergic agents; dental caries and uncontrolled diabetes from the use of oral fentanyl lozenges; falls related to opioid use mixed with benzodiazepines; respiratory depression with hospitalization due to overdose; opioid dependence leading to misuse and abuse of these drugs; methadone and amitriptyline use with syncope and heart rhythm disturbance; and many other case studies that resulted in unintentional harm to the

⁴ Volinn E, Fargo JD, Fine PG. Opioid therapy for nonspecific low back pain and the outcome of chronic work loss. *Pain*. 2009;142(3):194-201.

⁵ Leider HL, Dhaliwal J, Davis EJ, et al. Healthcare costs and nonadherence among chronic opioid users. *Am J Manag Care*. 2011;17(1):32-40.

⁶ Data on file at Modern Medical, Inc, 2010.

⁷ Manchikanti L, Fellows B, Ailiani H, Pampati V. Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten-Year Perspective. *Pain Physician*. 2010;13:401-435.

⁸ Benyamin R, Trescot AM, Datta S, Buenaventura R, Adlaka R, Sehgal N, Glaser SE, Vallejo R. Opioid complications and side effects. *Pain Physician*. 2008;11(2 Suppl):S105-20.

patient.⁹ From our experience, these situations revolved around multiple medications being prescribed, many of which resulted in conflicting therapy, along multiple prescribers managing the patient.

The real danger with the opioid drugs is unintentional death. From 1999 to 2007, the death rate associated with unintentional opioid poisoning has almost tripled in the United States.¹⁰ This runs in parallel to the increase in drug availability as well as the number of persons seeking substance abuse treatment. More recent research also has identified that patients receiving the equivalent to 100mg of morphine or more per day have an 8.9-fold increase in the risk of overdose.¹¹

Prescription Drug Abuse

Last year, the Executive Office of the President of the United States stated that “Prescription drug abuse is the Nation’s fastest-growing drug problem.”¹² Opioid drugs are the most common prescription drug abused. As these drugs make-up over one-third of the prescriptions in our market space, we are feeling the impact of this epidemic.¹³

Healthcare utilization and medication costs are elevated in persons abusing opioid drugs. One study reviewed an administrative database with 2 million covered lives and reported that opioid abusers averaged 18.7 physician/outpatient visits compared with 7 for non-abusers. The patients abusing opioids had, on average, 41.6 prescription drugs compared with 13.8 for non-abusers. Average drug costs for opioid abusers were over 5 times higher compared to non-abusers (\$2,034 vs. \$386).¹⁴

Making an Impact

Historically, our approach to manage these claims has been a combination of services including real-time alerts on cases exceeding specific opioid duration and costs as well as medication reviews conducted by pharmacists. We also have an aggressive formulary management program which includes an ACUTE plan with only short-acting opioids limited to 60 days after which an authorization is required as well as a California MTUS formulary for chronic pain based upon the treatment guidelines. But that isn’t enough. This is what we suggest as opportunities to address the items discussed:

⁹ Data on file at Modern Medical, Inc, 2007-2012.

¹⁰ Dunn KM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010;152(2):85-92.

<http://www.cdc.gov/nchs/data/databriefs/db22.pdf>

¹¹ Ibid.

¹² Executive Office of the President of the United States. Epidemic: Responding to America’s Prescription Drug Abuse Crisis, 2011. Accessed at: http://www.whitehousedrugpolicy.gov/publications/pdf/rx_abuse_plan.pdf

¹³ Data on file Modern Medical, Inc, 2010.

¹⁴ White AG, Birnbaum HG, Mareva MN, Daher M, Vallow S, Schein J, Katz N. Direct costs of opioid abuse in an insured population in the United States. *J Manag Care Pharm.* 2005;11(6):469-79.

- It really starts at the beginning with the prescriber selecting the appropriate patients to receive opioid medication. Require pain management practitioners to use a risk stratification tool (e.g. ORT, DIRE, SOAPP) for chronic opioid therapy.
- Require pain practitioners to initiate pain agreements and keep ongoing documentation on the impact on pain and function for patients receiving chronic opioid therapy.
- Require random urine drug screens on patients receiving chronic opioid therapy for longer than 3 months and then every 3 to 6 months.¹⁵
- Institute the policy that patients using opioids in dosages that exceed 120mg per day of morphine equivalents be managed by a pain management physician.
- Allow organizations like ours that manage pharmacy benefits to obtain State Prescription Drug Monitoring Program (PDMP) reports on claimants identified from their claims database as being at risk for possible medication misuse.
- Accept the role that pharmacists play in managing the care of the injured worker by paying for Medication Therapy Management (MTM) services and supporting pharmacist-based medication reviews. Pharmacists are trained experts at identifying drug-related problems that lead to patient harm as well as inappropriate drug use.
- Like Colorado, reimburse physicians to conduct an in-depth review (e.g. urine drug screen, document trend in pain and function over time, state PDMP) on claimants using high dosages of opioids (> 120mg/day morphine equivalents).
- Update California MTUS guidelines.

Drug Mix- Lack of Preferred Drug Selection

The drug mix, or type of drugs covered, impacts medication costs. As you have discovered from the 2005 regulatory changes, only managing the price component (adopting the Medi-Cal rates) will not produce long-term savings. Both the drug mix and utilization must also be addressed.

The drug mix is impacted by the availability and use of generic drugs and prescribing of new, more expensive brand medication that either is add-on therapy or replacing existing, less expensive drugs.¹⁶ In the other healthcare sectors, preferred drug list (PDL) selection can drastically reduce medication costs and steer utilization towards generics and less costly brand medication. The majority of workers' compensation state systems do not provide guidance on this cost reduction tool. States that have put a

¹⁵ American Academy of Pain Medicine 28th Annual Meeting: Abstract #215. Presented February 24, 2012.

¹⁶ Kaiser Family Foundation. Prescription Drug Trends, May 2012. Accessed on March 13, 2012 at: <http://www.kff.org/rxdrugs/3057.cfm>

preferred drug list formulary in place have produced savings. Our clients in Washington consistently show very high generic utilization rates (80-87%) and lower average costs per prescription due to their PDL criteria.¹⁷

Making an Impact

While we employ an aggressive generic formulary program, we do not have the regulatory backing to direct drug product selection. Therefore, we recommend the following:

- State language that allows drug product selection with either a state constructed PDL or allowance for our clients to utilize a PDL managed by our organization.
- Consider forming a state pharmacy and therapeutics committee, if not currently in place.

Overutilization of Medication

Americans are consuming medications at a higher rate than 10 years ago. From 1999 to 2009, the number of prescriptions increased 39% even though the U.S. population growth was only 9%.¹⁸ Likewise, the percentage of persons taking three or more prescription drugs increased from 11% (1988-1994) to 21% (2005-2008).¹⁹ More prescriptions taken and prolonged utilization of these drugs will lead to higher medication costs.

Making an Impact

Utilization is controlled by ensuring that medication therapy is both appropriate and necessary. This is primarily achieved through proper formulary management and utilization review. Our medication review services also address this problem.

- Accept the role that pharmacists play in managing the care of the injured worker by paying for Medication Therapy Management (MTM) services and supporting pharmacist-based medication reviews. Pharmacists are trained experts at identifying drug-related problems that lead to patient harm as well as inappropriate drug use.

Fee Schedules

Even though the California DWC adopted Medi-Cal rates, the prescription drug costs per claim still rose by 71.7%.²⁰ Because of these low reimbursement rates, we have been picking up additional pharmacy

¹⁷ Data on file at Modern Medical, Inc, 2011.

¹⁸ Kaiser Family Foundation. Prescription Drug Trends, May 2012. Accessed on March 13, 2012 at: <http://www.kff.org/rxdrugs/3057.cfm>

¹⁹ NCHS. Health, United States, 2010: With chartbook on trends in the health of Americans. Hyattsville, MD; 2010. Available at: <http://www.cdc.gov/nchs/data/hus/hus10.pdf#listfigures>

²⁰ Swedlow A, Ireland J (CWCI). Analysis of post-reform outcomes: changes in pharmaceutical utilization and reimbursement in the California's workers' compensation system, September 2009. Available at: <http://www.cwci.org/research.html>

business due to our competition reducing their presence in California. Our organization has not yet come to the conclusion that pulling out of California is our only option. However, an additional 10% cut in reimbursement and the unknown impact of moving to actual acquisition cost, has resulted in future strategic planning to consider the possible detrimental outcome of these changes.

[Making an Impact](#)

Delink the workers' compensation fee schedules from Medi-Cal rates.

We thank you for your time in reviewing our submitted comments. If you should need any additional information or have any questions, please feel free to contact us.

##

Item 8: We need Mandatory Work Status Guidelines!!

3/16/2012 email (redacted)

Hello,

I believe the workers' compensation system is improved with the objective/evidence based approach exercised in UR for medical treatment and ACOEM for permanent impairment. However, the remaining benefit that has not been addressed objectively/standardized is lost time. There should be official standards regarding work status, ie. length of TTD versus TPD correlated to objective medical evidence. It is not uncommon for an injured worker to have subjective complaints that outweigh the medical findings but many doctors are too lenient with keeping these injured workers off work despite disability guidelines that have been exceeded and the lack of objective medical evidence for continued TTD status.

Modified duty should always be required to be addressed by treating physicians. Target dates for modified duty release, full duty release, and MMI should be required. Many employers are able to provide modified duty and need assistance from the State in getting doctors to objectively address work status and return injured workers back to work sooner when objectively and medically appropriate. Employers need their injured workers back to work contributing their knowledge/skills in other areas of the enterprise while they are recuperating. This is also beneficial for the injured worker.

Organizations are running very lean in today's economy and have financial constraints, such as Municipalities. This issue is now one of the most common complaints I see and hear and has a huge impact on the morale of all workers and costs municipalities heavily with claim costs and overtime to backfill spots.

I hope you make this a top priority because it deserves to be a top priority! Thank you for your time and consideration!

##

Item 9: DIR Workers' Compensation Forum Testimony Oakland

3/16/2012 email (redacted)

One of my most frustrating job tasks is to manage WC claims and to get payment for approved care from WC insurers. We healthcare providers often have to spend literally hours collecting what's owed from insurers. We hear untruths: "Never got the claim." "Wasn't approved" "Over the 24 limit." Claims are denied frequently and it takes months to get the claims reprocessed. We are almost never paid the interest and penalties the insurance companies owe, because we are just too busy to then take another hour out of our day to request a DIR audit. In addition, insurers arbitrarily down-code charges to a lesser-paying code. Upon appeal, they will not reverse the decision, but will offer a couple of dollars more.

I would also like to point out that because of the archaic coding and the deductions from an already out of date fee schedule, we get paid very little for what we do—less than for any other form of insurance except Medi-Cal. This only encourages poor quality care by under qualified personnel.

We providers need:

- To be able to bill worker comp claims electronically. (In the case of physical therapy, the billing codes are archaic and not used by other insurance, thus are bounced out of electronic billing clearing houses.) We can't prove to the insurer that we filed the claim in a timely manner without mailing claims registered, return receipt, which costs approximately \$7. You have given up approximately 12% of your expected payment for service just to prove the insurer received the claim!
- An easy, fast way to report an insurance company who unjustly denies claims or delays payments. We need these companies to be accountable for their delay tactics! The insurer's are getting away with murder.
- Revision of the payment schedule and WC codes. Billing codes should be the same codes used by every other insurer in the US, the CPT codes.

##

Item 10: Public Forum on the Workers' Compensation System

Would appreciate your opinion on why work comp carriers are able to own companies that create revenue streams i.e., transportation, DME, prescription and diagnostic. These to me are a stirring issue and please be able to tell why it does not fall under Stark Law. Are he these insurance companies exempt? Thank You

##

Item 11: Employers and Injured Workers Need a More Efficient, Effective Workers' Comp System

3/23/2012 email (redacted)

As a 70 year-old family owned manufacturer which employs over 250 people, workers comp weighs heavily on our company. Most of our customers are out-of-state. All of our competitors are located in low-cost worker comp states. Consequently improvements that you can make to the WC system will greatly improve our chances of growing our number of employees. The major areas in need of improvement:

. Post-termination claims. Every time, and I repeat, every time we must terminate an employee for cause, we receive a claim through a lawyer for multiple previously unknown workers comp issues and usually a wrongful termination claim.

. QME's seem meaningless. After a QME, judges ignore the findings and hold additional hearings based on an additional evaluations and rebuttals. This adds time and lawyer's fees.

. Statement of "if you file a fraud claim you will be fined \$50,000.00 and 5 years in jail. VERY UNTRUE, there is no such a thing in the state of California. I personally tried 3 times with the Congressperson, Assemblyman and a Fraud Investigator and there was nothing done about it, never got calls returned. Individuals are never held accountable for fraud - just employers.

. Is very easy to file claim (i.e. a worker is given an unsatisfactory performance review, all of a sudden has high blood pressure, heart, stress, etc., etc., and a workers' compensation is filed.

##

Item 12: Litigating Lien Claims in the Workers' Compensation System

3/26/2012 email (redacted)

Dear Administrative Dir. Moran,

I received a copy of an e-mail sent to you on February 28 by attorney XYZ who, like myself, represents lien claimants before the WCAB. His comments in part:

"As you are probably aware, when a bill is received by a defendant and when liability for it is contested, it is a type of exposure termed Incurred but Not Paid (IBNP). Standard underwriting procedure requires that a reserve be established for that potential exposure. However, as I know from experience as a claims examiner and claims supervisor and in house counsel for a carrier, great pressure is put on the claims examiner to close the case and take down that reserve once the case in chief is resolved. This can be for internal actuarial reasons on the part of the carrier, because the insured wants to maintain a lower experience modification, or for premium calculations. Whatever the motive, the closure of a file and the elimination of the reserve with IBNP still unresolved is not proper procedure. This has gone on for years, and it is now coming back to haunt the carriers and self-insureds. Instead of accepting the blame for this situation, they have cast this as somehow being the fault of the lien claimants. Recently, in a case in which I represented a lien claimant, the defense attorney asked me accusatorily why my client had done nothing to recover his charges for the six years that followed the approval of the Compromise and Release. My response was to ask why the carrier had done nothing to resolve the lien during that same period of time. I participated in the consolidation hearings regarding interpreters' liens convened by Judge Kahn at the Van Nuys Appeals Board on March 18, 2011, and in my opposition to the Petition for Consolidation filed on behalf of FirstComp of Omaha I pointed out that their claim that they had \$20,000,000.00 (yes, twenty million dollars) in unpaid interpreters' charges on their books was not a basis for reform or even consolidation, it was a clear example of the incompetence of this workers' compensation carrier."

I would add to this that once the insurer closes the claim and takes down the reserves, they ignore inquiries from IBNP providers, give providers the runaround by vaguely agreeing to look into the claim then failing to follow through, shift the claim around to other departments or claims adjustors, or direct the providers to defense counsel who, having been ordered by the insurer to close their file, ignore the IBNP provider's inquiries. I agree wholeheartedly with Mr. XYZ that the majority of fault for the liens currently choking the DWC district offices lies primarily with the insurance carriers, who are willing to spend countless dollars on litigation to defeat or drastically reduce the IBNP bills after the substantial delay, often years, that the insurers themselves caused. To allow insurers to spend so much money, unchecked in any way, to defeat providers' bills but conversely limit medical providers to only what the official medical fee schedule (OMFS) pays often results in a net loss to the provider. Medical

providers try for as long as possible to avoid litigating claims as the amounts owed rarely justify what the provider will have to spend in the protracted battle with a large and powerful insurance carrier committed to defeating the provider's claim even if it costs far more than the provider's fee. Many legitimate providers refuse to treat injured workers at the fees payable per the OMFS because there is no reliable and expeditious way to get paid while avoiding the significant fees and costs of collection and/or litigation before the WCAB.

I also agree that the bar lien claimants must get over to sustain their "burden of proof" is frequently set impossibly - and sometimes illegally - high by WCJs. And there is no uniformity about *what* is required by individual WCJs for lien claimants to sustain their burden of proof. The fact that WCJs try to force lien claimants to produce the applicant years after the case in chief has settled to testify where there is an alleged issue of injury AOE/COE is ludicrous and *unnecessary*; that there is case law on that very issue is a fact of which few WCJs seem to be aware. At a recent seminar given by WorkCompCentral, Presiding Judge Paige Levy (MDR), a knowledgeable jurist, stated that "lien claimants had better be prepared to produce the applicant where injury AOE/COE is at issue." Also, where there is a C & R for more than a nominal amount (over \$1,500 for example) with or without a *Thomas* finding, there's a presumption, albeit rebuttable, of injury AOE/COE. Although there is an appellate case that addressed that issue, few WCJs are aware of this presumption.

I represent a provider that works with physicians to manage the administrative aspects of the physician's in-office medication dispensing program, including billing, collecting and (where necessary) litigating for payment before the DWC. In cases involving prescription medication dispensed by a treating doctor, where there are medical reports showing that applicant had an injury and/or symptoms that the medication was appropriate to treat, there is a presumption that the medication was reasonable and necessary to cure or relieve that can only be rebutted by substantial medical evidence to the contrary. But individual WCJs frequently state that there needs to be a full and complete discussion of what the medication was for and why it was prescribed in the dispensing doctor's medical report in order for the provider of the medication to meet its burden of proof, even where defendant offers no medical evidence that contradicts the provider's provision of pharmaceuticals to the injured worker. In the absence of conflicting medical evidence (or UR in the case of an injury occurring on or after 01/01/2005), the treatment of a treating physician is presumed compensable and should be awarded. The WCJ should not second-guess a treating physician years after the provision of the treatment unless there is substantial medical evidence proffered by the insurer to the contrary.

The same goes for the problem of lien conferences and discovery supposedly remaining open (according to almost all WCJs) until the day of trial (which creates major due process problems; how can a lien claimant or *any* party adequately prepare for trial until all issues are *clearly* delineated and all evidence disclosed *and* provided at the time the case is set for trial? Defense attys should not be allowed to use the delaying tactics Mr. XYZ describes in his e-mail as it increases the number of appearances (which def attys generally don't mind as, unlike medical providers, they are paid by the hour by the insurance carrier), especially to obtain bill reviews so long after the disputed treatment. There should be a rule that where the insurance carrier didn't have a bill reviewed within a year of learning of the provider's

treatment, it isn't entitled to a review. However, the carrier often DID have the bill internally reviewed at or near the time received and the parties often have copies of those reviews. So why do WCJs routinely find defense counsel to be entitled to delay the proceedings further to obtain *another* bill review from someone like Griff Stelzner years after treatment was provided and the case resolved?? Yet the WCJs routinely authorize this "bill review shopping" without requiring any showing of due diligence by the insurer.

Also included within the scope of these important issues is defendant's and defense counsel's failure to serve *all* medical reports even after repeated demands by providers that often spans several *years* and even though the law requires it. I recently appeared at lien trial where the defense atty agreed at the lien conference 6 months earlier in response to my written, detailed demand to defendant (her client), to serve me with, inter alia, *all* medical reports in the case. Moreover, my client first demanded these medical reports back in 2007, five (5) years ago. The stipulation at October's lien conference was that these would be served *at least* 30 days prior to trial, along with all defense trial exhibits. The defense attorney failed to serve either, sending some (but nowhere near all) medicals addressed to me to the wrong address (an "understandable error" according to the WCJ) and finally sending some medicals and the trial exhibits on a CD to the right address approximately 2.5 weeks before trial. On the day of trial, I asked the WCJ to exclude the defense trial exhibits and the AME reports defendant offered as evidence for defendant's failure to timely or properly serve them. The defense attorney asserted that she had attempted to serve me all of the medical reports she had in her file, having admittedly made no effort to obtain medical reports from her insurance carrier client. A quick review of the AME reports revealed that there were many medical reports and records reviewed by the AME not included in what the defense attorney served. Nevertheless, the WCJ said "well, the def atty served you what she had in her file; that is all you are entitled to. Why didn't you make an effort to obtain medical reports directly from the doctors?" The *obvious* answer to this is that my client and/or I didn't make the demand for meds from the *def atty*; it was made to the defendant insurance carrier *through* its attorney and the defense attorney is obligated by law to obtain and provide *all* of the medical reports in her client's "possession and control." The additional answer is that the Regulations require the defendant to serve *all* medical reports in its possession six (6) days after either filing or receiving a DOR if they've previously been requested (see above). That should be common knowledge among WCJs and an adverse finding should be automatic where service of *all* medical reports isn't timely made per the applicable Regulations. *Particularly* where the case is on calendar for lien trial! However, the Regulations controlling service of meds are rarely, if ever, enforced by WCJs on behalf of lien claimants; where defendant fails to properly provide all medical reports, defense counsel is merely given more time to comply because (according to the WCJs) discovery never closes. In the case discussed here, the lien trial was continued to a lien *conference* to give the defendant ample additional time to procure and serve all medical reports and to properly serve trial exhibits in document form. The expense to my client of setting the matter for lien trial, serving all its trial exhibits and the fee for an attorney to appear and try the case on their behalf was completely wasted and to file a Petition for Removal would just be throwing good money after bad, especially since this happens on a regular basis at most DWC district offices. There is simply no way to justify the additional expense, and defendants

are not only aware of this, they count on it.

The BIGGEST problem by far with litigating liens is the lack of knowledge (in some cases extreme) of applicable law and procedure by the WCJs. The above illustrations are really part and parcel of the larger problem that WCJs either don't really know the law or for whatever reason refuse to enforce it. I and every lien representative I know have egregious multiple examples of this. The majority of WCJs appointed within the last 10 years don't understand the evidence code, proper procedure (both pretrial and procedure at trial), what "expert" testimony is and when it's appropriate, the applicable law (usually OMFS) and what is factually required for a lien claimant to meet its burden of proof. When I told a WCJ at a recent lien trial that proper application of the pharmaceutical OMFS is a matter of law and that where the correct version of the OMFS is applied, there will be no dispute over the amount, if any, owed by the insurance carrier, the WCJ informed me that he intended to determine *only* whether the medications dispensed were reasonable and necessary treatment. If he finds that it was, he stated he would order the insurance carrier to make payment "per the OMFS." When I informed the WCJ that there is a dispute as to which version of the OMFS applies to the dates of service at issue, he refused to consider making such determination as being outside the scope of what he was required to do. "If you can't agree on the amount, I will send the bill to an independent bill reviewer to make that determination." I expressed to the WCJ that determination as to whether and how the OMFS applies is a question of law for the trier of fact, not for a bill reviewer with little or no formal legal training. When I asked the WCJ if he intended to permit a bill reviewer, "independent" or otherwise, to determine a question of law, he said that is exactly what he intended to do and I could file my petition for removal or reconsideration if I disagreed. Such action, if taken as threatened, would be an improper delegation of judicial duty outside the scope of the WCJ's authority. It is particularly frustrating when the WCJs decision or ruling directly conflicts with express DWC policy.

Most lien trials I participate in consist of defense counsel and their "expert" bill reviewer attempting to obscure the issues with deliberate misrepresentations to the Board as to the actual issues in order to divert attention from the fact that their insurance carrier client should have paid the bill at issue *years* ago, or paid too little per the OMFS. In the case of the pharmaceutical OMFS, there is only one correct way to apply the law and calculate lien claimant's payment; barring affirmative defenses, that amount IS WHAT THE INSURANCE CARRIER OWES, together with penalties and interest on that amount which should be automatically imposed by the WCJ unless defense counsel affirmatively proves penalties and interest are not owed. However, P & I are rarely if ever awarded, even when expressly raised as an issue on the PTC Statement and at trial.

The net result of all of this is to substantially drive up the cost of providing medical treatment to an injured worker, far beyond what the OMFS allows as a fee. The OMFS is premised on the simple provision of treatment, without any consideration for waiting years to be paid, even when treatment is authorized, or litigating in a hostile environment where the adverse party outspends you \$10 for every \$1. The reasoning by insurance carriers is that these tactics will effectively dissuade lien claimants from enlisting the help of the WCAB to obtain proper payment, no matter that the provider should have

been paid per the OMFS long before. More often than not, the reasons cited by defense attorneys for why the provider has not been paid have *nothing to do* with the original reasons given by the claims adjustor's original EOR for reducing or denying payment. Why does the DWC and its' WCJs permit insurance carriers to cause this kind of disruption in the system just because they have the resources to do so?

The question is how best to address and resolve these problems in an expeditious and cost-effective way? It simply isn't practical for the average medical provider to deal with the same problems over and over in so many cases, particularly where the bill/lien is for less than \$2-3 thousand dollars. Moreover, doing so in individual cases only educates (maybe) a single WCJ at the LC client's significant expense; it does not result in *all* of the WCJs learning the law or following proper procedure. This is particularly true where the lien claimant's litigated cases are venued throughout all of the DWC district offices, as my client's are. Something needs to be done on a systemic basis to resolve these all-too-common problems with the WCJs (I have specific examples with actual case information that you really should hear). If the DWC is dealing with a bill that is over 2 years old *and* there is proof that the carrier knew about the bill before that time, (objection letter, UR, or a POS from LC), there should be a *presumption* that the lien is payable in full together with attorneys fees, costs, penalties and interest *unless and until* the defendant *timely* proves that it is not, particularly where the provider and/or lien claimant wasn't promptly (or ever) served with the settlement documents despite the carrier's full knowledge of the provider's outstanding bill.

The current system of litigating liens serves as an incentive to WC insurers to delay payment because **a)** the insurer retains the IBNP funds, often for years, and is permitted to take down its reserves; **b)** the provider is likely to simply give up and go away, or in desperation (see above) take less than is owed; **c)** the burden of proof rests with the LC so delay, also often for years, makes carrying that burden more difficult which also leads to the lien claimant agreeing to take substantially less than is owed per the OMFS, particularly where a lay representative (because most providers simply cannot afford to pay an attorney to collect the meager fees payable per the OMFS) is faced with the dual difficulty of litigating against a trained, skilled attorney and deliberately deceptive defense bill reviewers being paid by the hour to defeat the provider's claim AND the hostility of the WCJs (many of whom are former defense attorneys), who frequently treat lien claimants as though they are not entitled to litigate to collect fees for the services they provided. I can't tell you how many times I've had a judge angrily tell me that my client represents everything that is wrong with the WC system and is squandering finite WCAB resources, thereby depriving injured workers of the opportunity to litigate their far more important claims for benefits. Rarely is anything said to defense counsel about the fault of the insurers in refusing to timely and/or correctly pay for treatment provided. Unlike defense attorneys, Mr. Moloney and I spend most of our professional time litigating liens at the DWC district offices. With all due respect, we and others who represent medical providers of treatment to IWs are more knowledgeable about the real problems regarding the resolution/litigation of liens than those who rely mainly on the opinions of claims adjusters and others in the insurance industry or the lobbyists it supports without spending any actual time "in the trenches."

What we are looking for is some way to address the common problems stated (in cases too numerous to individually detail here) on a broader basis rather than doing so at far greater expense and investment of time in individual cases. In essence, to avoid re-inventing the wheel in each individual case since these problems arise so frequently and with distressing consistency.

Thank you for your time and for any assistance the DWC can provide to address these problems that are causing the untenable delays and driving up the costs of the litigation of liens for all involved.

Very truly yours,

##

Item 13: Workers' Compensation

3/28/2012 email (redacted)

I filed a claim. The worst experience of my life. What a joke. Throw out the entire system. It is corrupt, it stinks. A terrible waste of taxpayers money. You should all be fired.

##

Item 13: Public Forum testimony: request for data

3/29/2012 email (redacted)

RE: Carriers' non-payment and delayed payment of QME invoices

Dear Ms Baker,

This letter is a response to the DIR notice regarding the Workers' Compensation Forums scheduled in various California locations. I welcome the opportunity to provide feedback as requested in the notice. I am a QME in Psychology since 1995 and I have registered for the forum in La Mesa, CA in April (25th). My concern is delayed payments for the services of QME providers.

I could detail here many significant delays of payment and of non-payment that I have experienced myself. However my experience may or may not be typical. Rather than immerse this request in such detail I would prefer to learn from the DIR or your staff whether my negative experiences are part of some larger trends. If the WC Division or another component of the DIR has studied or reported on timely payment issues, I'd appreciate having that information, so as to be better informed about my own position.

Therefore I would be grateful for any expert staff assistance, suggestions, or data that the DIR has gathered on the following issues:

- 1. Timeliness of payments to QME evaluators.** If DIR data are not focused specifically on QME providers, perhaps data on timeliness of payments to all medical expert services, reports and treatment could be made available to me, in order to assess payment practices.

I assume that cases to be included would also include those that reached adjudication or settlement, so that one could separate unjustified payment delays from those cases where payment may be delayed for genuine medical, legal, or case-specific factors, e.g. ambiguities in QME reports, treatment issues, conflicts among experts, and so on. Presumably in the latter cases, an explanation for the payment delay would be in the file.

2. Possible patterns indicating selectivity in the delays or denials of payments to treatment providers and evaluators. For example, have insurance carriers been more tardy in paying some categories of experts than others? In my practice I have worked most often with chiropractors, neurologists, psychiatrists, and orthopedists. I wonder if the statistics would reveal whether some experts within each field are selectively subject to delays or denials, and whether specific fields are more subject to such.

3. Pattern of formal filing of objections to QME reports or treatments. I believe that the Defense has 30 days within which to file objections to a QME report. I wonder if there is any data collected by the DIR regarding these objections and their validity (i.e. filed within the statutory rules, and substantive). My experience with the few recorded objections is that they are motivated by harassment rather than substantive issues; especially when an objection of timeliness (and subsequent denial or withholding, of payment) comes from the Defense after my report is completed and submitted, rather than right after the 30 day statutory period for completion. My feeling is that the Defense has waited until I had spent extensive time completing the report before objecting on timeliness grounds only! I interpret this practice as a type of harassment, as these cases have involved prolonged litigation and treatment, along with depositions and multiple QME reports, etc., over many years since the date of injury; that is, the objection to **untimeliness** is not substantive but trivial and idiosyncratic. Many times the QME evaluations involve reviewing boxes of medical records, collecting applicant data, interpreting and reporting - all this within a 30-day period. This time constraint is unrealistic if a thorough evaluation is expected. In some instances the parties have been tolerant of the time constraint, knowing the complexities of the case. I have never had any formal or informal objections based on the **content** of my QME reports.

4. Are there any structural, procedural or legal remedies within the Workers Compensation system that allows redress of the delays and informal denials (simply withholding) of payment, by the carrier? The denials and withholding of payments are not justified by any explanation, formal or informal, rational or

irrational. In several instances I have had to deal with a payment service where the claims clerks had no idea what WC rules were, especially regarding QMEs.

In some instances, I have not been paid on cases several years old, with multiple hearing continuances, where my repeated QME report invoices have been ignored, even when liens were filed. In one case settled last year, no lien hearing was noticed, but my lien has still not been honored. I was advised to file a Declaration of Readiness to get paid (or not!). No formal (or informal) objection to my QME report was filed by anyone.

To sum up my concerns.

I know that my complaints are not unique but common to many Workers' Compensation providers; and I have heard about 'red-lining' practices whereby evaluators, seen as 'applicant biased', are given short shrift by the carrier. As my reports are always carefully based on the evidence I do not believe my reports are biased to one 'side' or the other. Indeed, if bias were complained of, I would expect a written statement of such concerns with supporting evidence. No such complaints have ever been made to me.

So the situation I have described suggests serious malfunctioning of the Workers' Compensation system in California. Applicants (presumably injured workers) cannot be treated effectively if carriers do not make prompt payments for doctor's services. I have heard of treating doctors who refuse to treat clients in the Workers' Compensation system because of payment delays, unpaid treatment, and ultimate denials. At the present time, I am able to sustain myself with income from private forensic referrals and my private psychotherapy clients. However the extensive time I spend on filing liens and re-filing invoices, over and over, subtracts from the time I could spend on patients and on improving my services, writing more thorough progress reports, etc. In short, the quality of my work can suffer because I have to deal with recalcitrant carriers who erect paperwork barriers to avoid or delay payment, in open violation of statutory rules – but which providers are then strictly held to. I have heard of similar complaints by experts that I meet, so I can assume that these problems are more pervasive

than only confined to a few providers. Hence my request for system-wide data would be a way to start defining the systemic dimensions of these distressing problems of experts' payment delays and withholding.

I have kept my files of the cases that have had problems of the nature described above and I can provide documentation to support my statements herein. I did not feel it worthwhile to burden you with more details than was needed to sketch out the issues that I have been facing for a number of years. I can make these documents available to you at the forum or anytime.

I would appreciate a timely response to this request for system-wide data, to help me present these pressing issues of invoice payment delays and related financial concerns, at the public forum on April 25, in La Mesa, in a manner that is objective and educational to those present.

Yours sincerely,

##

Item 13: Written Testimony for April 10th meeting

3/30/2012 email (redacted)

To Whom it May Concern,

Please accept this email as my written testimony as I am unable to attend the meeting on April 10 in West Sacramento.

I have had an open Workers Compensation claim since June of 2011. Though it has been less than a year I've had my share of insights into items that could be improved upon and that would benefit not only the injured worker but also the State and the Insurance Companies.

In your DWC Newsline #12-12 you had selected bullet points of items you are looking for information on. For ease of reading I will also use these bullet points and provide the information I can share.

- Provision of appropriate medical treatment without unnecessary delay, the medical provider network (MPN), utilization review (UR) or other issues

Since my claim has started every item requested by my Workers Comp appointed Doctor has been denied by the Insurance Company and sent to UR. Physical Therapy, Medication, Surgery Consultations, and Pain management requests, many of these items (stated by the Doctor) are items allowed per the Medical Guidelines that govern Workers Comp. As I understand it you are allowed medical treatment under a certain dollar amount until your Claim is accepted by the Insurance Company. If this is the case then there is no reason other than a time delay by the Insurance Company to deny every item requested. The denial by the Insurance Company can take anywhere from a few days to a couple weeks add to that time frame the time it takes for UR to review and judge you could be facing anywhere from a total of 4 to 6 weeks to get back to the Doctor and Injured Worker. 4 to 6 weeks is a long time for items that are under the Treatment Guidelines. Not only does this delay treatment for the Injured Worker this also takes time away from UR, who must be bogged down with a ton of requested items, who should be concentrating on items that truly need their judgement. If a Workers Compensation patient is allotted 24 physical therapy treatments there should not be a 4-6 week endeavor to get this approved. The only faction that gains from this current 'system' is the insurance company as it delays them having to pay for the treatment requested and in some cases saves them from paying for the treatment if the acting Doctor does not fight to get it approved or if the Injured Worker does not have an Attorney.

In regards to the MPN I feel it is important to allow the injured party time to choose their MPN from the list of providers the Insurance Company gives. Reason being to research the Doctor to make sure you are comfortable with whom you are choosing.

- Enabling injured workers to return to work as quickly as medically feasible

The goal of Workers Comp and the Injured Worker is to not only return to work but to return to normal. As an Injured Worker not only are you effected by your injury but also by the stress and depression that can be caused by the injury. It is very easy to fall into depression and it is even easier to be stressed out by the Insurance Company who is 'managing' your claim. It appears the Insurance Company is very interested in returning an Injured Worker back to work as soon as possible but is less interested in healing the Injured Worker. I hired an Attorney about a month into my claim so I do not have to deal with the Insurance Company any longer. I will say that my experience with the Insurance Companies Adjuster was not a good one. I was lied to by the adjuster and since I didn't know any better at the time I took him at his word. Had I not hired an attorney I am positive I would have endured many more lies and may have not received the benefits and treatment that are allotted to me.

To get injured workers back to work as quickly as possible you must allow them un delayed treatment and have a middleman to police the insurance company from taking advantage of the injured workers who are not versed in Workers Comp law.

- Adequate compensation for permanent disabilities

Compensation for permanent disabilities are currently based on a rating given by a Doctor. In my case it was determined by an AME doctor. My treating Doctor and the AME Doctor have very different opinions. My Doctor is challenging the report. For this to be a fair and adequate compensation I believe the treating Doctor should be the one to give a PD rating. After all who better to know just how much this disability is effecting the person and to give a fair rating.

- Reducing unnecessary litigation costs

If you'd like to reduce litigation costs you simply need to police the Insurance Companies to ensure they are abiding by the rules. Right now it seems as if instead of being proactive and checking to make sure the Insurance Companies are doing what they are supposed to it's reactive.

- Assessing appropriate use of opiates and other care

The current procedure for injuries that cause pain is to mask the pain with painkillers while awaiting approvals for tests to help correctly confirm diagnosis and/or treatment to fix the problem. The delay (in which I spoke about earlier) from onset of injury to treatment to fix either completely or to the best it can be is a very lengthy one. I have met people who are entering their 8th and 10th year in a claim. I am just shy of a year and have yet to have any real tests or treatment beyond physical therapy and medication, both of which were intended as a mask to the pain and problem and not the solution. As I'm sure you can tell this leads to numerous Injured Workers being placed on medications that turn into long term use and I'm sure in a lot of cases an addiction. If the system was like regular health care there would be less focus on medication and more on diagnosis and solutions. I know that it is not possible for the Workers

Compensation system to 'act' like healthcare, however, if the goal and mindset was the same you would see less delays, speedier recoveries and less medication dependency.

- Any other improvements needed

To close this I will end on an improvement that I feel is very important. Educating. Educating the workforce about Workers Compensation, what it is and what it covers. There is a poster in every workplace that no one reads, it is in fine print so even if you wanted to read it it is very difficult to do so. Management, at least in the companies I've worked for, are very uneducated on Workers Compensation and what it covers. In my case I had no idea that I was eligible for Workers Compensation benefits until almost a year after the onset of my problems and I was informed by a Doctor! My work knew I was in pain for several months. Never was I offered or told to file a Workers Comp claim. I believe this is due to not being educated. I did not know what a Cumulative injury was. I did not know that a Cumulative injury was covered by Workers Compensation. I also believe that if OSHA standards were adhered to there would be less injuries. OSHA standards is another in which education, in the general workforce, is very low.

I thank you for taking the time to read my written testimony. If you have any follow up questions you are welcome to return my email or call me at the number below.

Thank you,

##

Item 14: written comment for upcoming public forum

4/2/2012 email (redacted) – PDF deposition not included.

To Whom it May Concern;

I wanted to pass along some information to you and your office that you may helpful in your quest to receive feedback on the current state of California's Work Comp System.

To begin, I do not feel comfortable passing along this information in a public setting due to the risk of alienating the parties involved in this case. It is my theory that representatives from insurance carriers will be attending these seminars and anybody who speaks out against them and their illicit ways of conducting business runs the risk of being kicked off a MPN or worse becoming a target of their fraud unit; ultimately exposing ones business practice to bullying and intimidating tactics that the insurance companies have become known for. Of course these tactics are performed under the guise of "investigating" for fraud. The reality is that the insurance carriers would rather claim fraud now, expose one's business on the internet as potentially fraudulent, devalue the medical bills that they haven't paid for 2 years and finally settle for 10 cents to the dollar. Of course the fraud charges go away because nothing fraudulent ever took place, the carrier simply did not want to pay fee schedule for services provided.

I have attached one such example of an insurance carrier overstepping their boundaries. Attached is a deposition of a physician that dates back to 2010. This is the only piece of evidence that I have that proves and shows, under oath, the intimidation tactics used by the insurance carriers in our current system. As you read the deposition please pay attention to the bottom half of page 11 and read page 12 in its entirety. You will note that not only did the adjuster violate California's Labor Code by contacting the AME and commenting on the case to him, she also requested that he change his apportionment rating and commented that if he didn't she would have him removed from their MPN. The AME did not comply with her requests, as he gave a rating that he deemed appropriate and as she promised, within weeks, he was removed from the MPN. This behavior is unacceptable and unfortunately becoming the norm with various carriers.

Physicians have altered the way that they treat the patients at the risk of being removed from a MPN list. This is potentially harmful to an injured worker. Syptoms may not be properly treated because a physician is worried that one more diagnostic exam or referral to a specialist will place him or her in a category that economically profiles them as an expensive treater or surgeon. To prevent this unfair business practice from continuing, all MPN shall be removed and a patient shall have the right to seek medical attention from the physician of their choice.

Furthermore, Utilization Review should be addressed and changes need to happen. No longer shall UR doctors make a medical determination without evaluating the injured worker for at least one hour. UR doctors always make their determination only after reading through notes and flipping through medical records. UR doctors would benefit a lot from meeting with a patient in person and witnessing their

symptoms first hand. I have yet to meet a UR doctor that, upon denying medical treatment on a patient that they have never met or treated, is willing to put in writing that they can be held responsible for any adversary outcomes that may arise from their denying medical care that the patient's Treating Physician deemed medically necessary. This is a problem. No longer shall UR be able to make any medical decision without evaluating the patient themselves.

Therefore it is my opinion that California adopts and goes back to Presumption of Correctness. A physician should be in total control of their patient's care. The Doctor shall be able to make a request for any service that he or she knows is medically necessary and is supported by evidence, case studies or other research. Utilization Review can be made available on surgical cases, and they can make their determination only after evaluating the injured worker.

Regards,

##

Item 15: Worker's compensation, a PT perspective

4/4/2012 email (redacted)

Dear Directors:

Thank you for inviting public comment to improve worker's compensation. In general, I wish to point you to overwhelming evidence that supports early (as in, in the first week of injury) skilled physical therapy for musculoskeletal problems. It is out there: just contact the California Physical Therapy Association, which puts on a conference every year bringing research updates in every clinical aspect imaginable. They should be able to get you all those course materials with all those research references: the conference attendees download them before, during and after the conferences.

Here are examples of why, after 8 years of practice in California, I don't take worker's comp patients anymore:

A 19-yr-old delivery person has low back pain and is taken off work and sent home with meds x 30 days, THEN referred to physical therapy for 2 visits. Research would support two visits of physical therapy in the first week and this would certainly have gotten this kid back to work in about a week or two. Why the entire month off, and why so many meds for such a young person? Research supports a max of 3 days rest and then a "stay active" approach for low back pain.

As far as the "stay active" approach goes it is described in the research; furthermore, working people need to work because they go crazy being stuck at home. The work comp system needs to let people work as they can by letting them ease into their work schedule by doing part days or a couple days on with one day off, let them leave when needed or take longer breaks to do their home modalities and exercises. The people in my experience who have triumphed have done it by working as they can, listening closely to their bodies, being diligent with prescribed home programs, and staying on my caseload 1 to 4 x / month as they transition back to work.

Two visits of physical therapy arranged by a case manager whose entire life apparently revolves around a person who has been with her neck/head in pain for 2-3 years: surely work comp could afford a physical therapy visit or two sooner. Plus, after 2-3 years, it takes two visits just to document and measure all the pain complaints and movement impairments that arise when a person suffers for that long. Finding a treatment that works takes quite a bit longer in that kind of situation.

Pelvic floor physical therapy for a person who had a back injury and was given heavy pain meds, got constipated as a result of the pain meds, tried to pass a stool and had an anal fissure requiring surgical repair, plus had a back surgery to fix the back injury. During his care he was required to drive 3 hrs (really, after a back surgery?) one way for various appointments. He concurrently was sent to a "work hardening" program run at a health club, where he was challenged for several hours a day, 2 or 3 days a week, to lift in ways that would have increased his fecal incontinence had he not been under my care, and had I not grilled him on exactly what he was being asked to do.

A 22-yr-old office worker newly married has new onset of "carpal tunnel syndrome" of mild to moderate intensity, not disabling, but after 4 visits of physical therapy is sent to surgery. There was no mention of whether her oral contraceptive might be causing some hormonal problems / swelling / pain in the hands/wrists/forearms.

As you can see, it is several things that have continually frustrated my attempts to get people better: 1) the overuse of surgery, 2) the overuse of pain medications, 3) the "all-or-nothing" approach to returning to work, and 4) the lack of strategy in involving skilled physical therapy for problem-solving as the main conventional non-invasive intervention.

System / bureaucracy frustrations are 1) the numerous secretarial calls we used to get from the work comp payment contractors PER PERSON PER VISIT: is he scheduled, did he show up, did he reschedule, can you fax us a confirmation...seriously, I don't have that many secretaries helping me in my job...I'd be broke if I paid that many people to help me.

2) the length of time, usually 6 months, that it would take to get paid by work comp, during which we would have to re-submit all the same paperwork, sometimes 3 times...my secretary has been so much less backlogged since we stopped taking work comp.

3) the rate of pay for a work comp patient was extremely low, seeing as I do all the care myself. Because getting a person back to work is my primary goal, I don't farm it out to aides or assistants. By the time I get through paying my secretaries to collect for 6 months, I'm behind!

##

Item 15: Public Forum on the Workers' Compensation System

4/5/2012 email (redacted)

The goal of the County of Los Angeles self-insured workers' compensation program is to provide appropriate and expedient benefits when necessary for approximately 100,000 employees in a manner that promotes fiscal sustainability for County operations. The occupations covered range from physician to laborer, deputy sheriff to social worker, scuba diver to clerk, and many others. These County employees provide critical services to millions of residents, some of whom represent the poorest and neediest in California. Such services span the County's 4,000 square mile area.

Each dollar spent on the County workers' compensation program represents a scarce tax dollar that cannot be used to provide services. The workers' compensation reform of 2003-04 enabled the County to establish cost avoidance platforms and dampen the unprecedented expense escalation being experienced by California employers. This, in turn, freed up resources used to benefit the public. In recent years however, the County's workers' compensation expense experience has increased significantly. In all likelihood, the expense trend will require increases in the workers' compensation budget for FY 2012/13 and FY 2013/14.

Ultimately, the goal of any workers' compensation reform should be to provide adequate and unencumbered benefits to injured workers in an affordable and viable manner for payers.

Medical Treatment:

- Employee and claimant morbidity coupled with the fee-for-service structure of workers' compensation healthcare lead to intractable medical costs. These imbedded factors will require a sea change in the provision of medical care to remedy chronic medical cost pressures. Physician outreach programs, though useful, will not solve the problem. MPN statutes and regulations should be amended to promote ease of use and the ability to explore cost effective medical care including capitation, telemedicine, injured worker health empowerment programs, and reduce the failure of care delivery and coordination.
- Establish minimum treatment levels for the most frequently sustained work related injuries. These minimum treatment levels shall not be subject to utilization review. These minimum levels should be developed by medical doctors, based on the MTUS, and easily applied by claims administrators.
- For employers that significantly contribute to employee healthcare benefits, reduce the duplication of cost caused by the requirement to treat non-industrial disease processes under the workers' compensation program.

Liens:

- Support legislation and regulations that apply a reasonable statute of limitation, increase accountability on the part of lien claimants to specifically identify why additional payment is owed, require lien claimants to identify whom they represent, require payment to be

issued to the service provider, and allow workers' compensation judges to dismiss liens when the lien claimant fails to comply with established regulations.

Coordination of Indemnity Benefits (Public Sector):

- **Coordinate service-connected disability retirement and workers' compensation indemnity benefits to prevent overlapping benefits for the same disability.**

Labor Code Section 4658(d)(2)-(3)(B):

- **Promoting effective return to work programs, which focus on accommodating an individual's disability as soon as practical, is a sound policy decision. Such programs serve both employee and employer. Unfortunately, LC 4658(d)(2)-(3)(B) does not achieve this end. Rather it has created confusion and litigation and should therefore be amended or removed.**

##

Item 16: 100% disabled - workers comp

4/6/2012 email (redacted)

To Whom It May Concern:

I cannot attend the Workmen's Comp Forum in the Los Angeles area on April 16th, 2012. Thank you for making it possible for the public to express concerns via e-mail.

I know of injured workers who have a terrible time trying to get approvals for treatment, care, supplies, etc. due to the current workers comp system. I understand that cost containment is needed. The CA State Budget is a priority to me a tax payer.

I have concerns for those rated as 100% disabled, indicating **a life changing permanent injury**, yet having to continually be evaluated by the workers comp doctors to see if there is truly a need for care. If the injured worker's primary doctor documents the care is medically necessary then the injured workers rated as 100%, should not have to jump through hoops including going before a judge time and time again to get the delayed or denied care. To me, this is not good stewardship of tax payers money. It is hard enough being injured and having not only one's income but health robbed from them, let alone continually fighting for care, treatments, supplies, or equipment. I cannot conceive having a family member who is in a coma or whatever reason he/she is rated as 100% disabled having to go before a judge repeatedly in order to receive care. We, as a State, welcome and give care to undocumented workers through the current workers comp system. Why not improve the current system to help those rated as 100% disabled regardless of when they were injured by having a special division in the workers comp system to exempt them from delaying or being denied care, treatments, supplies, or equipment.

I do trust my tax dollars will be used in an appropriate manner so those needing care (i.e. rated as 100% disabled) can receive the care they need.

Thank you for your time listening to me.

Sincerely,

##

Item 16: Public Forum San Bernardino April 24, 2012

4/6/2012 email (redacted)

I have a seat reserved at the April 24, 2012 public forum in San Bernardino. I would like to speak for 3 minutes on encouraging the DWC to require EAMS 100% jet filing or e-filing by all DWC users. I believe that a 100% participation will save money at the DWC, individual legal offices, carriers and a domino effect where the California DWC and users can become 100% paperless. I have included a copy of this to the DIR email address and if you could help me get my request to the correct individual I would appreciate your help. I hope things are going well for you and we appreciate all that the EAMS team does for all of us. Thanks again.

##

Item 17: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/6/2012 email (redacted)- several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. feeschedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) systemwill improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers.Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer,and benefiting allof California's injured workers.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process - - where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 18: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/6/2012 email (redacted) - several emails with the same language were received from different parties.

Dear Ms. Baker:

As one of many practicing physicians, I urge you to update the fee schedule for primary care services within California's workers' compensation system -- which is still based on an outdated model from the 1970's. Updating the fee schedule will improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians.

As a workers' compensation Treating Physician, providing diagnosis, treatment, reporting, and case management services, I know that SB 923 will resolve both the availability and cost of care problems within the existing system.

Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will help retain quality primary care physicians in the California system; and will control increasing costs and unnecessary medical expenses incurred by some physicians.

By reducing medical costs and increasing delivery of quality medical services in the state's workers' compensation system, SB 923 will benefit all of California's injured workers. Reducing costs associated with the state's workers' compensation system also saves money for the State and taxpayer. SB 923 is a win/win for injured workers, treating physicians, and the State budget!

Importantly, SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 19: Support SB 923

4/6/2012 email (redacted) - several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

ADD YOUR EXPERIENCE WITH WC HERE

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process - where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

##

Item 20: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/6 /2012 email (redacted)

Dear Ms. Baker:

As a physical therapy business manager in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

The current WC fee schedule does not even cover our cost of providing care to patients. It is outrageous that we have a system that truly prevents injured workers from receiving beneficial care. Obviously, a business cannot keep its doors open, by providing services at or below cost. I've worked for the same small independently owned office for 21 years, and have yet to see an increase in the WC fee schedule. In fact, with all the additional PPO contracts, we've had to skim an additional 10-20% off of the already low CA WC fee schedule, just to be part of the PPO contract.

The system needs a serious overhaul. The current attitude toward workers comp. patients in the medical industry, seems to be, "Oh no, not another Worker's Comp. patient". That needs to be turned around. With proper reimbursement, the attitude could easily change to, "Wonderful, another Worker's Comp. patient!" The two sure ways to get that changed are to increase the fee schedule to an amount that will allow businesses to make money, and to streamline the authorization process so we can get injured workers scheduled quickly.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 21: Injured Worker

4/6/2012 email (only sender's name redacted)

My name is XYZ. I was injured 09-13-10. 4 months after my injury, Employers Insurance stopped paying me and said I owed them \$2000. They have not reimbursed me for anything since. My treating doctor had authorized temporary total disability payments until June, I just received the report from the QME who declared me NOT permanent and stationary and supports most of the opinions of my treating doctor, yet yesterday I received a notice from Disability that my claim had been exhausted. The only lawyer I've been able to retain (PBLSM - Long Beach, Ca) sent me to a Doctor (Dr Chan - Bakersfield, Ca) out in Bakersfield who's office looked more like an auto parts store, and he did nothing but prescribe me Vicodin for 5 months. Since I dismissed them, I can't get a lawyer to defend me. I don't know how I'm going to pay my rent this month much less make my next doctor's appointment. My job is waiting for me - I could have it back at any time - if I could only do it. My experience with Worker's Compensation has been indescribably frustrating. It has been a tooth and nail fight every step of the way. I feel that the emphasis of this whole program is to push drugs, not fix people. There is no one to help you through this. Disability does not return calls, the insurance company won't return calls, lawyers don't even return calls. Everyone seems to have something better to do and no one seems to care how much someone like me loses. The last person that this happened to where I work killed himself because no one would listen. They just kept giving him more painkillers. It appears that getting people strung out on painkillers rather than fixing the problem, then conveniently terminating the benefits of said people (if they haven't already killed themselves) on the basis of being drug abusers is much cheaper for the insurance companies and the state in the long run. Thanks for your time.

##

Item 22: Workers Comp within the University of California

4/6/2012 (only sender's name redacted)

The self insurance by the University of California is stated by UC to be less than the State of California's Workers' Comp plan. This results in a substandard coverage at UC.

Please fix this inequity.

##

Item 23: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/9/2012 email (redacted) – several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. feeschedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) systemwill improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers.Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer,and benefiting allof California's injured workers.

Having worked 4 years in a privately owned and operated physical therapy office, we have definitely have seen our fair share of workers comp patients. Every time we would see a new patient I have always been shocked and amazed of how many loops and obstacles one person has to go through to get quality care from the workers comp system. The bigger shock is when our office receives payment from the workers comp company. With reimbursement rates so low I don't know how many offices who see many workers comp patients stay in business. My experience is that they eventually stop accepting workers comp patients. As drastic as it sounds to deny workers comp patients treatment, when it means to either save a business or many people are employed or see a patient who insurance does not come close to reimbursing the providers time and specialty services they render. I Think modifying the workers comp system in the ways that SB 923 proposes will help Small Business providers as well as larger corporations put new faith in the Workers comp system which would also help the distribution among providers of Workers comp patients.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 24: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/9/2012 email (redacted) – several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers.

Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

The current fee schedule is so low that it is near impossible for quality providers to provide care above our cost.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 25: DWC Forum Testimony

3/28/2012 email (redacted)

My name is XYZ. I appear today on behalf of the State Bar Workers' Compensation Executive Committee. As you may know, this committee is comprised of judges, and applicants' and defense attorneys, so it represents a broad range of the major stakeholders in the system.

In 2009, our Legislative Sub-Committee undertook a project to identify non-controversial, obsolete or conflicting Labor Code provisions and to propose amendments or deletions that would resolve them. After completion of the project, the Executive Committee as a whole carefully reviewed all of the proposed changes. Some provisions deemed controversial were deleted. After final approval by our committee, the State Bar of California Legislative Committee also reviewed and approved the proposal.

Our "cleanup" proposal was introduced as AB 1564 and had several sponsors, including the chair of the Committee on Insurance. Despite broad bipartisan support, unfortunately the bill died due to lack of action before the legislature adjourned. It is our belief that the Schwarzenegger Administration had no objection to our proposed bill standing alone, but feared that it would be amended to include other substantive issues.

The Workers' Compensation Executive Committee again offers our cleanup proposal to improve and clarify the workers' compensation laws. Should the Administration wish, our committee will also review Labor Code and regulatory provisions enacted after 2009 to update our proposal.

You may wish to hear as examples a few of the provisions identified for amendment. We felt that it was no longer necessary to maintain the provisions in Labor Code section 5500.5(a) that reduce defendant liability for cumulative injury from five years to the final year of injurious exposure, commencing in 1979 and ending in 1981 and thereafter. We thought it wise to eliminate submission of the now obsolete Information Request form as a prerequisite to commencement of the period within which to object to venue based upon the location of the principal place of business of the applicant's attorney, currently set forth in labor Code section 5501.5(c). Some Labor Code sections continue to refer to Workers' Compensation Judges as Referees,

which we thought was no longer appropriate. As you can see, the sections identified are ones unlikely to arouse significant opposition.

As part of our goal to improve the workers' compensation system, the State Bar Workers' Compensation Executive Committee stands ready to assist the current Administration in any way possible, and would be pleased to undertake any further projects that you deem appropriate. Thank you for considering our proposal.

##

Item 26: SB 923

4/9/2012 email (redacted) – several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 27: SB 923

4/9/2012 email (redacted) – several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

Without legislative intervention, California Worker's Compensation may go by the way of Medi-Cal, forcing providers to stop accepting the insurance. This forces a massive shortage of providers leading to a delay or even denial to access health care services.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 28: Public Forum on Workers Comp

4/10/2012 email (redacted)

Unless we stop allowing doctors without California licenses to overrule, delay, and deny care that has been prescribed by doctors who are licensed in California, this exercise will be one largely of futility and cosmetics.

##

Item 29: Public Forum on the Workers' Compensation System

4/10/2012 email (redacted)

(Amended April 10, 2012)

The goal of the County of Los Angeles self-insured workers' compensation program is to provide appropriate and expedient benefits when necessary for approximately 100,000 employees in a manner that promotes fiscal sustainability for County operations. The occupations covered range from physician to laborer, deputy sheriff to social worker, scuba diver to clerk, and many others. These County employees provide critical services to millions of residents, some of whom represent the poorest and neediest in California. Such services span the County's 4,000 square mile area.

Each dollar spent on the County workers' compensation program represents a scarce tax dollar that cannot be used to provide services. The workers' compensation reform of 2003-04 enabled the County to establish cost avoidance platforms and dampen the unprecedented expense escalation being experienced by California employers. This, in turn, freed up resources used to benefit the public. In recent years however, the County's workers' compensation expense experience has increased significantly. In all likelihood, the expense trend will require increases in the workers' compensation budget for FY 2012/13 and FY 2013/14.

Ultimately, the goal of any workers' compensation reform should be to provide adequate and unencumbered benefits to injured workers in an affordable and viable manner for payers.

Medical Treatment:

- Employee and claimant morbidity coupled with the fee-for-service structure of workers' compensation healthcare lead to intractable medical costs. These imbedded factors will require a sea change in the provision of medical care to remedy chronic medical cost pressures. Physician outreach programs, though useful, will not solve the problem. MPN statutes and regulations should be amended to promote ease of use and the ability to explore cost effective medical care including capitation, telemedicine, injured worker health empowerment programs, and reduce the failure of care delivery and coordination.
- Establish minimum treatment levels for the most frequently sustained work related injuries. These minimum treatment levels shall not be subject to utilization review. These minimum levels should be developed by medical doctors, based on the MTUS, and easily applied by claims administrators.
- For employers that significantly contribute to employee healthcare benefits, reduce the duplication of cost caused by the requirement to treat non-industrial disease processes under the workers' compensation program.

Liens:

- Support legislation and regulations that apply a reasonable statute of limitation, increase accountability on the part of lien claimants to specifically identify why additional payment is owed, require lien claimants to identify whom they represent, require payment to be

issued to the service provider, and allow workers' compensation judges to dismiss liens when the lien claimant fails to comply with established regulations.

Coordination of Indemnity Benefits (Public Sector):

- **Coordinate service-connected disability retirement and workers' compensation indemnity benefits to prevent overlapping benefits for the same disability.**

Labor Code Section 4658(d)(2)-(3)(B):

- **Promoting effective return to work programs, which focus on accommodating an individual's disability as soon as practical, is a sound policy decision. Such programs serve both employee and employer. Unfortunately, LC 4658(d)(2)-(3)(B) does not achieve this end. Rather it has created confusion and litigation and should therefore be amended or removed.**

5710 Attorney Fees:

- **Labor Code section 5710 allows for a reasonable allowance for attorney fees for the deposition of an applicant. The County and other public entities such as the City of Los Angeles, Metropolitan Transportation Authority, and Los Angeles Unified School District, believe that hourly attorney fee rates currently allowed for applicant depositions are not reasonable. Based upon a survey of State Bar certified specialists in workers' compensation and criminal law, the hourly rate requested by and awarded for applicant depositions is often up to three (3) times more than the rate charged by State Bar certified specialists for significant legal work. Reasonable rates should be developed that will more accurately reflect rates actually charged by State Bar certified specialists, and reduce the frictional costs of discovery for employers.**

##

Item 30: SB 923

4/10/2012 email (redacted) – several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

ADD YOUR EXPERIENCE WITH WC HERE

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process - where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 31: DIR Public Forum Input

4/10/2012 email (redacted)

To: Christine Baker

Director, Department of Industrial Relations

Rosa Moran

Administrative Director, Division of Worker's Compensation

Re: DIR Public Forum Input

I contracted Lyme disease and babesiosis from a tick bite while employed as a Ranger-Naturalist at EBMUD. I was the third out of four on my crew to get Lyme disease. Two of us had to go through months of IV antibiotics to be cured after many months of failed attempts with oral antibiotics. We were the lucky employees, as we were actually able to get the treatment we needed. Others we worked with, who were also bitten by ticks, were denied coverage and have been forced to spend tens of thousands of dollars to treat their illness. This is due to some unfortunate interpretations of IDSA guidelines by our Workers' Comp administrators, QMEs, AMEs, and Kaiser Permanente.

Many doctors, who aren't Lyme-literate, rely on the outdated information in the *Physician's Desk Reference* and the scientifically unfounded IDSA guidelines. My own physician told me that there was no Lyme disease in California and would only give me a week of antibiotics when I begged him. This course of treatment wasn't nearly long enough to cure me, and I ended up with chronic Lyme disease for the following 8 years. I was almost completely mentally debilitated by the disease (my SPECT Scans at California Pacific looked almost identical to Alzheimer's Dementia), but managed to continue coming to work. It's just that I often couldn't remember what to do once I arrived.

Lyme disease is more epidemic than AIDS and tuberculosis combined. It has been found in every county in California. Education of physicians and workers is essential for effective treatment in the future. It would be great if WC could take a leading role in this effort.

The Workers' Compensation system can improve its service to those who have Lyme or other occupational diseases by expanding its focus to disease, not just to injuries. For example, the questionnaire sent before QME visits focuses almost entirely on physical disabilities, with questions like "how many stairs can you climb?" "how long can you sit?" "how far can you walk?" "how high can you reach" instead of "can you concentrate?" "can you remember anything?" "are you capable of performing daily tasks without frustration?" "are you sick to your stomach 24/7?" etc.

Another way WC can help outdoor workers is to assume, as you currently do with CCC crew members, that if we get Lyme disease, we got it at work. This way, insurance companies won't be able to deny coverage because the tick that bit us doesn't carry a passport stating its country (or county) of origin. At least one of my co-workers was denied coverage because of this. This change would be a significant improvement, and result in workers getting prompt treatment that could cure the disease before it gets chronic.

One-two months of inexpensive antibiotics within a month or so of the tick bite usually cures Lyme disease. But the average person sees 5 doctors over 2 years before even being accurately diagnosed. This results in years of treatment for chronic Lyme disease at a huge cost to the WC system. Why not be pro-active and treat workers asap instead? I know that if I ever get bit by a tick again, I will get a month of antibiotics quicker than white on rice. Why take chances when ticks are commonly transmitting three diseases in our area?

Lyme testing is so inaccurate at this point that treatment must be based on clinical presentation. This only works if doctors and workers receive training to recognize this disease in its many diverse manifestations. It also suggests that workers should receive pesticide-treated clothing, when working in tick country, as a prophylactic measure. WC could recommend this as a cost saving measure.

Anne Gershon, the president of IDSA, has pointed out that their guidelines are simply that—guidelines, not mandates. However, doctors (especially QMEs and AMEs) treat the guidelines as mandates. The IDSA itself has brought doctors in

front of medical boards for going beyond their “guidelines.” Insurance companies, more concerned with the bottom line than with the people who pay their premiums, have done likewise. Doctors treating Lyme patients are taking a large risk if they prescribe antibiotics for longer than 2-4 weeks, as a result of this attack on doctor’s judgment. This has led to lack of effective treatment for thousands with Lyme disease. It subverts all the training doctors receive and interferes with their oath to provide the best treatment possible.

At this point, prolonged antibiotic treatment is the only recourse for those with chronic Lyme disease. To deny patients this coverage is condemning them to a life of misery. WC needs to give doctors and patients a choice of guidelines to follow. Fortunately, two sets of guidelines already exist. One set are the IDSA guidelines, which only work for early intervention. The other set has been developed by ILADS, a medical organization of researchers and doctors who actually treat patients with tick-borne diseases. These guidelines allow the doctor to exercise his/her own disgression instead of treating him/her as a technician. Since IDSA guidelines are mainly based on expert opinion, not on peer-reviewed studies, this makes sense. Two studies of IDSA guidelines, one of which was done in Saudi Arabia (so there is obviously no conflict of interest involved), found that close to 70% of IDSA guidelines are based on third tier information, not medical research. But doctors are being forced to abide by them anyway. WC needs to put an end to this practice. In the case of Lyme disease, the ILADS guidelines make this immediately possible.

Another issue is that if workers file a claim based on tick-borne disease, and it is denied by WC, other physicians are not allowed to treat them, even at their own expense. So workers are now avoiding filing claims for tick bites, out of fear that they will be refused treatment by WC and their health plans. This goes directly against the original reason for creating the WC system. Workers need the option of seeking treatment from WC or their medical provider if denied by WC.

I hope this input will help you develop more helpful guidelines for treatment of Lyme and other work-related diseases. There are many other issues I could write

about, such as QMEs knowing which side their bread is buttered on, attorneys for our WC administrators preventing us from getting consistent treatment (mine sent me to the ER despite warnings I gave him about the dangers of arbitrarily discontinuing my antibiotic treatment), the WC requirement that doctors write updates every 45 days when we only see them and get lab testing once every 60-90 days, the inconsistent opinions from medical groups (like Corvel) that our WC administrators use for second opinions (that one month recommended that I stay on antibiotics due to Lyme encephalopathy, then the next month recommended that I should only be on Advil, then the third month that I be on antibiotics.)

Good luck coming up with changes that will improve how the system works. This is especially important for those with industrial diseases that are hard to diagnose and hard to treat.

Sincerely,

##

Item 32: Workers' comp System Reform

4/10/2012 email (redacted)

Good Afternoon,

Just receiving the email today regarding discussion on worker's comp improvement, I found myself unable to attend in person.

My injury occurred in 1993 requiring surgery at 32 years old for a low back injury resulting in permanent disability. It took years of light duty work and physical therapy to get my body mechanics to the point where I could have some form of life.

When Arnold Schwarzenegger changed the law to cover acute care only, it abruptly changed my life. I could no longer receive long term care of conservative manual therapy that is need for pain management and mobility. I was forced onto prescription pain killers to help dull the pain, but never enough to truly kill it. Dealing with a lifetime of pain has proven very difficult.

I have been given life time medical coverage in my worker comp settlement, but it requires months of fighting between my doctor and the utilization review board, which have never seen me. The attending physician knows what care I require, yet his hands are tied by this horribly biased law. I understand medical care costs are challenging, however turning disabled people into pill poppers does not create a healthy environment for anyone. It actually creates an endangered environment.

Please look into returning the previous law with providing long term care for people like me that are losing their life faster than most due to not receiving the actual care they truly need, rather than popping pills that destroy their body.

Best Regards,

P.S.

Dr. William Duffy, MD has been my attending doctor since the day my company sent me to him for evaluation, stating to him that they believed I was faking my injury. He is located on L Street in downtown Sacramento and is a prominent member of the community.

##

Item 33: 4 10 2012 forum

4/10/2012 email (redacted)

I attended and spoke at the forum, morning session, held in Sacramento today. I was a novelty and a minority, being as it appeared that I was the only injured worker there in attendance. Two minutes is not enough time to explain what information can be divulged from the NEW EYES of the injured worker, They experience first hand, what the issues are, and receive what the two sides deem appropriate.

I spoke on utilization review, where my claims adjuster refuses to use it, denys treatment and instructs my PTP, on what she can address. This causes time delays, and in most cases irreparable harm from not being treated, not to mention the repeated filing for hearings, this also runs the time clock.

The next Item, was on MPNs and QME's, I live north of Sacramento. The MPN physicians that I have seen, are at the mercy of the claims adjusters, and will do as asked by them, leaving the patient to come in last as far as treatment is concrned, not havind the proper medical record to take to Med-Legal review.

Except for a handfull, PQME's all belong to groups, of which there are three, Alluvial being the largest. when you treceive a pool of three, they for the most part have the same phone number, and many the same adresses and are all over the state of California. This information was taken from DWC;s web pages. Besides being Liking to carpet baggers, most of them belong to the insurance companies MPNs, and still work as per pre 2004 guides and rules, and confer with the claims adjusters.

##

Item 34: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/10/2012 email (redacted) – several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

Today California is the only state that still compensates workers' compensation doctors on a fee or service model from the 1970s. 33 other states have already adopted RBRVS for their workers' compensation systems, and none have gone back from that methodology. SB 923 will bring California into the 21st century by requiring the DWC to adopt a new fee schedule based on RBRVS for its workers' compensation system.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process - - where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 35: Workers' Compensation Forum comments

4/10/2012 – email (redacted)

Suggestion to help cut lien backlog: Add (1) Petition for Payment of Medical-Legal Fees and (2) Petition for Payment of Interpreter Fees at WCAB Hearing to the walk-through documents allowed by 8 CCR Section 10280(c).

Discussion: Case law is well established that medical-legal fees need not wait for the underlying case to be resolved before payment is to be made. However, medical-legal providers have no mechanism to compel payment if a defendant chooses to defer addressing the lien until the applicant's claim is resolved. Although a provider may file a petition for payment of medical-legal fees at any time after sixty days from the date of defendant's receipt of the itemized billing and any accompanying report, judges can simply defer action on the petition until the case resolves. Some medical-legal providers have many tens of thousands of dollars in unpaid fees with no certainty about when they will be paid, and an eventual possible entitlement to penalty and interest is small consolation.

Similarly, interpreters who provide services at a WCAB hearing are entitled to be paid without respect to the posture of the underlying claim. Defendants can and often do ignore these interpreter liens until case resolution without any consequence, since no statute or regulation attaches a penalty or interest to such deferral. Some interpreting agencies have six-digit accounts receivables solely related to services at WCAB hearings. Interpreters are forced to file liens and wait, sometimes for years, before being able to pursue recovery before the WCAB.

As lien claimants, neither a medical-legal provider or a WCAB-hearing interpreter may file a Declaration of Readiness to Proceed until the underlying claims has resolved or is abandoned and they become a party.

Currently, an attorney with a lien for a deposition appearance under L.C. Section 5710 may file and walk-through a petition for payment of attorney

fees. Legally and procedurally, no distinction is apparent between a walk-through for attorney fees and walk-throughs for medical-legal fees or WCAB-hearing fees for interpreters.

Adding the requested petitions to the list of approved walk-through documents will add little or no administration costs to the WCAB, will improve the financial health of important contributors to the workers' compensation system, and will reduce the number of liens filed.

Signed.

The writer is an attorney with twenty-plus years experience solely representing lien claimants.

##

Item 36: Sacramento Open Forum

4/11/2012 email (redacted)

Thank you for the Forum. I found it to be very enlightening. I have some observations I would like to share to share with you.

1. Employers will not let the patient file a claim. Employer wants to pay claim at the WC fee schedule and state they want to pay the claim as First Aide. There is no clear definition of what First Aide is. It would be nice to have more clarification.
2. Adjusters are unresponsive. Message and letters are not responded to. Denials from Adjusters are vague.
3. It takes multiple calls to find the correct Adjuster.
4. Providers of service do not have a clear understanding when a claim is denied, if and when, we can bill the patient.
5. Not allowed to do retro authorizations with UR Department, but must utilize the Adjuster who is the person who denied the claim in the first place.
6. Adjusters will pay some claims and deny others with the same treatment and diagnoses.
7. Liens - it's unclear when a lien should be filed.
8. I've never seen where an insurance pays up to the \$10,000.00 for a denied or disputed claim. These claims sit on our books for years.
9. It takes months for a claim to pay. Average time is approximately 60 days.
10. Department of Worker's Compensation website is a great tool, but it could be more user friendly when it comes to the fee schedule and would be nice if the site let providers know what to do when things don't go smoothly. If a claim is denied, not authorized, what if a patient goes to the hospital and not their MPN, etc. What are the "rules". We need layman information.

Thank you.##

Item 37: Comments re Public Forum 4/17

4/11/2012 email (redacted)

Dear DIR,

My company has been doing workers' compensation collections for 23 years for doctors, hospitals & surgery centers.

In respect to the problems with too many liens in the system & clogging up the WCAB calendar here is what we have noticed.

1) in the last couple of years adjusters do not take the time to adequately respond to lien claimants and force LC's to file DOR's. Adjusters tell you they can't talk to you on certain days and then when you try to get a hold of them on the days they will speak with LC's they do not answer and most of the time do not call you back. LC's do not want to go to court because this also takes up our free time in settling more cases at the office on the phone vs. handling just 1 or 2 cases at the WCAB.

2) defense attorneys unnecessarily delay cases because as there are fewer comp files being filed which leads to less billable hours. Defense attorney's needlessly string out cases for the billable hours.

3) Judges give all sorts of lee way to defense attorneys (continuances etc.) but rarely if ever to lien claimants

4) We know that there are "BAD" lien claimant's out there that make things tough on the system BUT there are plenty of good LC's out there as well.

SOLUTIONS -

1) I think that if the executive at the various insurance companies were willing to entertain more BULK settlements like our office has done with SCIF, then the system would be better for it because it reduces administrative issues, litigation costs and the WCAB's court calendar.

2) Setting up a system where liens are handled in a mediation type system (free of defense attorneys ??) where lien reps from both sides can freely negotiate.

I am always available to discuss further as **Director Rosa Moran** knows me **very** well from my many years in front of her at the OAK WCAB representing various surgery centers.

Thanks,

##

Item 38: WC Public Forum / Letter submitted

4/11/2012 email (redacted)

Dear Department of Workers' Compensation,

Unfortunately, I will be out of the country and will be unable to attend the WC forums. I am submitting comments via this email address. I thank you for taking the time to understand WC in California as I have submitted this letter for consideration.

We are an occupational clinic in Fresno and famously known for our lawsuit of **Palm Medical Group Inc. v State Compensation Insurance Fund** and the carriers PPN list of providers. That 1.13 Million Jury verdict and published decision has created great concern for many carriers and how they administrate their MPN list. On the flip side we have pre-existing relationships with hundreds of employers in Fresno and perform drug tests, physicals and WC injury care on their workers. We are in essence a first responder in the WC system and many times see an injured worker within hours of their injury. We are the Acute care facility that employers choose to use to resolve the injury quickly and timely. We have Medical, Chiropractic and Physical Therapy in one location and we are here to tell you the system currently doesn't work and SB899 did not fix the problems - they created a whole new set of them. It gave insurance companies tools to make the system better and they flatly failed to use those tools. Solutions can only come from a greater understanding of how the "system" works or doesn't work and I encourage you on your journey.

SB899 and MPNs: So MPNs were created and for what purpose? We as an occupational clinic already have/had relationships with numerous employers. They come to the clinic and we go to their work sites to better understand work conditions and injuries. We work with the employer and help resolve the work injury. For years 3rd party companies tried to get us to sign up to be on so called WC PPN lists and we declined as did many Occ Med Clinics. These companies wanted docs to take discounts in exchange for being on a "preferred" list that would be marketed to WC insurance companies, we marketed ourselves directly to the employers. We already had the clients, they already used us so we declined. Then came SB899...

Then came MPNs and we were forced to join. Employers that purchase insurance have to use the Insurance MPN list. So Insurance Companies had leverage to force all docs to pay "discounts" to have access to employers and WC injuries that they already had as clients. The Insurance carriers did nothing to select the best providers as they were supposed to do, they simply wanted ANY provider for whom they had to pay a bill to be able to pay that bill at a "discount". They missed the whole point of SB899 and the incredible gift they were given. **The bill authors failed to state that the MPN docs would be paid at the WC fee Schedule and since now the Carriers controlled access to injured workers, the docs had to give a "discount" to have access.** Take this distraction away from them so they can concentrate of finding doctors that offer long term solutions and not short term discounts.

Why do you think there are 1800 certified MPNs with the DWC? Why do you think these MPN list docs that have no idea they are on the lists, don't take WC patients, might be retired or deceased? Because the insurance carrier's purchased lists from 3rd party vendors to have access to the discounts on any doctor bill. Their MPNs became a giant discount not a vehicle for change. Since the DWC never audited any of the MPN lists they became what they are - an effort to pay anyone they have to less. One simply needs to find any MPN list and start calling that office to see if they can make an appointment for a WC injury and then see what happens. Since employers initially thought that now only "good" doctors would be on these insurance lists, they also thought that their workers would get faster and better care and an overall improvement in the WC system. But the carriers erred on their MPN formations and an opportunity was missed.

Push Back: Employers start to complain, and having a "small" MPN becomes in vogue. Employers noticed the bad docs were still on the MPN list, those docs the SB899 was written to remove from the system. Those docs that are considered part of the problem. Also Injured workers noticed that docs they called or knew locally would not take them as patients because so many doctors avoid WC patients. And that is if the injured worker could actually get access to the MPN lists that were many times not publicly posted or required a password to access on some remote web site.

So what did the insurance carrier do next? They didn't want to lose discounts if they had to pay a doc, so they created another MPN list. Why change your list by 10% and have to have it re-certified when you can just start a new one. Hence the DWC has a ridiculous amount of MPNs. Many insurances have multiple MPNs and it's your guess which one is the "one" they use. We cannot figure it out, the employers cannot figure it out and the injured workers certainly cannot. **Legislative idea: require public access to the MPN list in whole, One MPN List per Carrier /Payor, audit the MPN lists and require public notice as to who administers it.** Put it in plain sight.

Now you have circles of MPN lists for any certain Insurance or self Insured Payor. There is the giant list of every doc alive or dead (make sure they pay bills at a discount), the smaller list of MPN docs as the MPN they "use" and the short list of providers they actually give to workers or employers to choose from since most employers or injured workers cannot find the MPN lists on their own.

Many employers change insurance from year to year: based on price or whatever carrier is writing coverage. Every year these employers have to figure out what insurance MPN list is currently in play. I cannot tell you how many times an employer has come to us to say we were great but they have a new insurance and PALM is not on the MPN list. Come to find out they were given only a partial list. Employers cannot maintain a constant relationship with providers as the 1800 MPN lists disrupt relationships as should be logical. Since they are not given complete lists, sometimes they leave and do not even know they didn't have to. So the MPN solution is not a solution but a disruptive obstacle full of inaccurate information. It has interfered with the exact process it was supposed to facilitate.

So what if the Employer wants a Doctor on the MPN? : In the PALM v State Fund lawsuit, PALM brought many employers to testify that they wanted to use PALM. State Fund did not have as part of their criteria that Employers wanting to use a clinic was reason enough to add a clinic to the provider list. Having lost the lawsuit State Fund closed their PPN list of providers and opened an MPN list as the new law offered them a new vehicle to chose doctors. Prior to the lawsuit I attended the CWCI conference on the new MPNs and the audience was told that if doctors didn't want to do what you say, take them off the list. It's your list and they need to be on it. So you have now legislatively created a process were doctors have to adjust behavior or they might find themselves no longer listed on the next generations of MPN. State Fund's new MPN requires doctors to not file Liens and not dispense meds. What else can you economically force a provider to do and should they have that power? This should be considered. Why does the MPN allow deviation for the Labor Code or the Rules and Regs that is otherwise already allowed?

As Carriers now develop these smaller MPN list (and Preach the epiphany of their idea) they don't always capture the best choices because they don't communicate with their customers, and employers asking to have a Doc added is not a reason to this day to have them on the MPN. Politics, preference and control are at the heart of the issue here, not objective rational decision making. Remember a doc can get a patient thru their own efforts or relationship with employers and then get paid a "discount" based on the giant list, but not get any patients sent to them as they are not on the short list or the small list. Inversely lose clients based on also not being represented on the Small MPN list as the employer/employee are told are currently being used.

Big Picture: Many employers that have recurrent injures are actively attempting to participate in the solution by interviewing and selecting a WC clinic that they will work with. That strangely is not a reason for an insurance company to want that clinic on the MPN list. To get on the list a Doc might have to track down and overcome multiple companies that are outsourced responsibility to manage a Carriers MPN list and now start to agree to a variety of random requirements beyond no liens or medication dispensing. Most providers cannot possibly overcome this process for the hundreds of MPNs listed that all have a unique process in play and thus many MPNs actually don't have proper representation of specialist on their panels. Other providers are just fed up with WC and more are not accepting WC patients. As the economy improves, this will become more prevalent.

Allow me the leave my frustration with MPN and touch quickly on the overall logistical burden that is WC for any physician with chooses to participate in this process.

Lets Quickly outline the complexity faced by a doctor participating in the WC process:

Doctor / Patient relationship = Doctor and the injured worker

Doctor / Employer relationship = Doctor takes time to understand employer work environment, communicated work status and alternative work environments, interacts with employer on helping resolve injuries and create a better work environment. Required doctor to give employers work status sheets filled out in various detail.

Doctor / MPN Relationship = Doctor needs to manage, track and Credential with 3rd party companies to be properly included in hundreds of MPNs

Doctor / Carrier Relationship = Doctor needs to send reports so the claims and benefits can be administrated for the worker based on LC 9785 and factors outline by the Physician.

Since many Carriers outsource bill processing function, bill review and Utilization UR etc, the provider also has to respond to and track documentation requirements to a number of 3rd party entities here now listed, failure to participate and perform risks MPN non participation.

Doctor / Billing Relationship = Doctor needs to figure out where the bills go, different than where the claim reports go otherwise he will not get paid. Many Carriers that write policies in California outsource to multiple entities these functions. Example Insurance A gets the claims but billing goes to B Administrative company. Like a general contractor that doesn't actually do the building but hire all sorts of subs.

Doctor / Bill Review Relationship = These are the 3rd party company that is hired to review the bills for "recommended" payment and administration of "discounts". They may also handle rebilling or reconsideration. In essence you haggle with this company so they recommend to the insurance company to pay all your bill.

Doctor / Utilization Review relationship = These are different for every different carrier and they can also change all the time. Doctors need to send reports to the carrier to admin the claim, the billing to the billing location and the requests for treatment authorization to this 3rd party entity.

Doctor / Peer to Peer Relationship = These are the 3rd party doctors hired by the utilization review to call the doctors in the middle of the patient day without an appointment to talk about the wc claim and talk about the request for some type of medical authorization. Peer to Peer docs get paid to do this but the Treating doc doesn't. We are told that utilization review is required to be in WC and part of the MPN, but cannot be paid for as its not covered under the Official Medical Fee Schedule for time taken to speak and respond to the UR requests.

Doctor / Nurse Case Manager relationship = These are the 3rd party company Nurses that come to patient visits as they are assigned to the claims, to facilitate the claim

Doctor / Attorney relationship = The worker and or the employer/carrier may have an attorney sending letters requesting information and or reports that the insurance will not pay for as they didn't request the report. Forces you to file a lien to get paid.

Multiple the number of Carriers, self Insured Payors, Third Party Administrators, MPNs, Bill review companies and Utilization Review companies and you have an unimaginable combination of entities you have to communicate with any one injured worker. **Legislative Idea:** The Carrier is the Claims administrator and the doctors should just send all the bills and reports to them. If they in turn want to farm out all their functions, then they should bear the burden to disseminate that information timely

and not the providers as another factor to be on their MPN. Doctors can reduce staffing which reduces overhead and makes WC more profitable without income increase.

Pay Doctors the WC fee schedule or whatever schedule is in legal force and remove discounts as nothing than having to pay to participate in the comp system. The legislature gave doctors a raise in lieu of the administrative difficulty of WC and the MPN then took that away with discounts. Then increase physician staffing as we have to provide the carriers secretarial function to all their sub contractors while we hear that they again needs a rate hike.

Why specialists are leaving the WC system: When you consider that normally going to the doctor is a simple matter. You and the doctor determine your clinic course of care, your insurance card is copied by the billing dept and it contains all the relevant and accurate information on where you claim is billed. Specialist (the good local ones) don't want to see WC patients due to the endless complicated processes here just briefly described. When the economy worsened they again started accepting WC claims but as the market improves, they are leaving WC for simpler patient management systems. WC complexity is pushing out good local docs and that void is being filled by providers that come to town one day a month to see WC patient or Providers that cannot make it in Healthcare and have thus become the WC doc that is often described and less than optimal by jaded employers. Fact simply stated is that the non clinical work in WC is a multitude greater than that in private health insurance and thus a headache to be avoided by many specialists. The difficulty is not clinical its logistical. Most good doctors given the option will avoid WC. Occupational clinics are having a harder time recruiting good providers and are suffering inflated staffing costs due to duplicity of work to get paid, get care authorized and stay in good graces to remain on the MPN while taking a "discount" .

This is of course a brief view and I would be happy to address questions or clarifications as required.

Sincerely,

##

Item 39: Speaking time and Imaging studies

4/11/2012 email (redacted)

After 7 spinal cord surgeries and the loss of 8.5 years of my life and that of my son's, My neck was broken 4 times, hardware from C3,C4, C5, C6, C7, And an artificial disc at C7-T1 and possibly facing another surgery for damage to my right vocal cord from four front entries and three back entries to my neck. I have been denied medical coverage so the state is having to pick up a big part of this. My work accident was avoidable, I was not allowed to fire a drunk employee who for 3 years showed up drunk, and was the cause of my industrial injury, yet I had to fire others for being 5 minutes late. I am fighting the biggest privately held OIL COMPANY in all of america. I am bring my CT Imaging studies.

Yes there is fraud out there, but for those ligitimaetly injured, it should be a given that care be rendered immediately and not take a year or three to get treatment.

The Insurance Companies are netting Billions of Dollars in profit while many thousands like me, cannot even afford rent, a car repair and barely food on the table. Not to mention how this has affected the children who cannot go off to college as they end up being the caregivers. Change is needed for the Workers. Be truthful and honest and nothing but good can come from it.

##

Item 40: Support passage of SB 923 and update Workers' Compensation Fee Schedule

4/11/2012 email (redacted) - several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

Worker's Compensation pays less than most other insurance providers. Additionally, it is very hard to collect payment for services rendered and preauthorized. It takes extra time and effort to get paid, and the payments received are at rates below PPO insurance plans and Medicare.

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process - where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 41: Support SB 923!

4/12/2012 email (redacted) - several emails with the same language were received from different parties.

To Ms. Christine Baker, Director of the Department of Industrial Relations:

I urge you to support SB 923 and update the workers' compensation fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers.

Thank you for your consideration.

##

Item 42: support of passage of SB 923

4/12/2012 email (redacted) - several emails with the same language were received from different parties.

Dear Ms. Baker:

As a physical therapist in independent practice, I urge you to update the workers' comp. fee schedule which is still based on an outdated model from the 1970's. Updating the fee schedule to a Resource Based Relative Value Scale (RBRVS) system will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. Higher quality providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

I have been treating patients under the workers' compensation system for over twenty years. There was a time when the payment for the physical therapy services was very fair and comparable to compensation from other types of insurance. Over time, more companies have becoming involved in administering and reviewing workers' compensation claims. These companies are paid by keeping a portion of the provider fee. This combined with no increase in payment has made it very difficult to afford to treat workers' compensation patients. Physical therapists salaries have increased slightly over the years to keep up with the cost of living and this combined declining workers' compensation reimbursement has made it necessary to drop many of my workers' compensation contacts. One company paid as little as \$45 for a visit. Our break even is about \$75 for a visit, and the average patient requires 8 to 11 visits to recover in our practice.

In addition to the out of date fee schedule, the way we must change for workers' compensation patients is different from the other carries. One procedure code is charged for up to 30 minutes. This makes it difficult to accurately depict the treatment rendered. Most patients receive multiple types of treatment within a 30 minute time period. The RBRVS system being proposed would take care of this problem.

SB 923 appropriately leaves details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

##

Item 43: Public Forum on the Workers' Compensation System

4/13/2012 emailed (only sender's name redacted)

My name is XYX

I'm unable to make to the speaking of experienced, Due that I have Dr. appt. I've been employed with city of pomona from April 1969 through Sept. 27 2004, Due to my injury to my skin, back, shoulder, knees, legs, cardiovascular system and psyche.

I've been treated from these injury, but number one I got the most painful is my back, The Health care resource group denied for my Facet Injection, I had these injection before it help me by 70% removing pain for about 6 to 8 month then due for another one, Not yet helping me as of today, My skin still growing large in rash on my lower body area as I have scleroderma which was exposures of solvents spray and parts cleaner, I got these as being heavy duty mechanic, Not yet to control it or stop the spreading, My knees gotten better after they did some surgery, My shoulder gotten better after controlling in lifting above shoulder height, My cardiovascular its come and goes not yet better, My Psyche is still presence, I cant understand why are Health care resource group is not back on track to help me, Denied, Denied, Denied, I'm tired of it, I want to thanks to my Attorneys Lawrence Stern and Jeffrey Stern for helping me to get Help!

##

Item 44: RBRVS for California

4/13/2012 emailed (redacted)- - several emails with the same language were received from different parties.

Dear PTPN Member:

This year we hope to get the legislature to mandate that the Division of Workers' Comp. (DWC) increase the workers' comp. fee schedule for PT by switching to the RBRVS system that was proposed by the DWC a few years ago. As proposed, this system should result in about a 10% increase for therapy services. (That previous effort at the DWC was stalled because of opposition from some provider groups who would not get an increase.) The stakeholders believe that the only way to get the DWC to move forward is to pass legislation, specifically SB 923.

This is the opening salvo in that campaign. Please email separately (or snail mail, but email is faster) the two letters below to their separate recipients – one to the DWC and one to State Senator De Leon who is sponsoring the bill. Senator De Leon needs to show support for the bill because the momentum at this point belongs to the opposition. The DWC also needs to see support for updating the fee schedule.

Please customize these letters to reflect your own experience with workers' comp.

Also, if you are planning on attending the DWC meetings around the state in the next two weeks, and you have the opportunity to speak, please mention your support for this bill and for updating the fee schedule.

This is the first step. There will be additional opportunities to influence the legislature, and we need to keep the pressure on all through the process.

Thank you!

PTPN

##

Item 45: Employers and Injured Workers Need a More Efficient, Effective Workers' Comp System

4/13/2012 email (redacted)

Dear Dep. Industrial Relations Dep. Industrial Rel.,

Thank you for convening community forums to discuss how California can improve its workers' compensation system. I am providing these written comments to help you achieve this goal.

As you know, California's workers' compensation system is too expensive, and costs are increasing. California has been ranked as the fifth most expensive state in the nation for workers' compensation, and workers' compensation costs increased by \$1.5 billion between 2009 and 2010. This hurts job creation and public services at a time when the state is struggling to emerge from a recession.

Inefficiencies in the state's workers' compensation system waste a huge amount of money. California spends more than \$5 billion to administer a \$15 billion system. These inefficiencies give special interests, such as attorneys and medical providers, incentives to litigate and game the system, which increases costs for employers and does not benefit injured workers.

Some problems in the workers' compensation system include abuse of the liens system, increased litigation due to the Almaraz-Guzman and Ogilvie decisions, increases in the amount and cost of medical treatment, and growing areas of abuse in prescription drugs and specialty services. These problems have increased the cost of the state's workers' compensation system by hundreds of millions of dollars.

We care about our workers. If they're injured, we want them to receive good treatment and adequate benefits and to return to work as soon as possible. We know the administration is interested in increasing benefits for permanent disability. We also know you are committed to offsetting increased costs with cost saving elsewhere. That's the right approach. Failing to do so would cost jobs, hurt public services, and delay California's economic recovery.

Sincerely,

##

Item 46: Public Forum

4/13/2012 email (redacted)

I just had to withdraw from appearing at the Public Forum in San Diego due to notice of a very complicated MSC scheduled that afternoon on one of my cases.

My comments regarding how to make the system run better would have been brief:

WCAB local office issues

- End judicial oversight of represented C&R's. There is no reason a WCJ should spend their time judging the "adequacy" of a negotiated settlement that considered multiple factual issues including questions of credibility, etc, that the applicant's attorney is in a much better situation to understand. The parties should simply execute the documents and file them with the local board with notice of whether a lien conference is required or not, which can be set automatically by the receiving clerk. I've noticed in the hours I have spent standing in line at the WCAB to walk through paperwork that ½ of the attention of the WCJ's are to represented C&R's. This is unnecessary.

Lien issues

- Mandate that all medical providers treating on an industrial basis serve defendants (not just file in EAMS) the medical reports and the supporting bills within 30 days of the provision of the services. Often the only way we know if there is a lien is to check EAMS just prior to filing a C&R because the provider never noticed us that they were involved in the case. This delay's resolving the claim because it's only after the C&R that we do our discovery regarding these providers.
- Put a time limit on the opportunity to file for hearing after filing a lien and close of the case in chief. For example, lien claimants should have 6 months or one year after the C&R to file for a lien conference. They shouldn't be able to hold us hostage.

UR

- Poor report writing is the #1 reason doctors requests for treatment are not approved by UR. I am litigating a request for "12 month's PT" that was denied by UR. How is that compliant with the Administrative Director's MTUS? What does that mean? 1 day a week? 7 days a week? What kind of PT? Yet Applicant's counsel has filed for hearing and we are going to trial.

WC docs were programmed to get their way for so long that the concept that their treatment requests must be shown to be efficacious is abhorrent to them.

PD

- I started in WC just before SB899, so I remember the bad old days of soft tissue back strains resulting in \$50K C&R's. It was embarrassing to be involved in a system where so much intellectual dishonesty prevailed. If you want to increase benefits to injured workers PLEASE just increase the monetary value of smaller PD awards. An ankle sprain does not warrant a 40% PD rating. Let's just make the 3% that it is worth more.

Thank you for listening.

Very truly yours,

##

Item 47: Comments on proposed change needed to WC system

4/13/2012 email (redacted)

I spoke at the conference in Sacramento and would like to follow up on my comments. I am willing to assist any way I can. The system is broken for injured workers.

1) It takes way too long for represented injured workers to get panel list. They shouldn't be discriminated against. Also why does the medical unit take 5 months to point out a problem when nobody is objecting or cares about the problem, like not waiting the 5 extra days for mailing to request a panel list. It is moot unless someone is objecting to it. Otherwise it is just make work that causes unnecessary delay.

2) Why not just have a web site that allows unrepresented workers to pick their qme based on availability and convenience and let represented parties choose their own.

3) Most of the qmes are not competent in comprehensively addressing permanent disability.

4) To avoid carriers from economically strong arming doctors into making opinions in their favor regulations are needed to provide objective criteria for including and removing doctors from medical provider networks.

5) The updating of the schedule with accurate data concerning the effects of loss of earnings capacity is long over due and can be done with actual earnings loss values. (see below)

6) If everyone is so concerned about increased premium to employers why don't we regulate the profit and exorbitant insurance costs charged too?

PROPOSED FIX FOR OGILVIE

To understand the remedy one must understand how was the CPDRS(2005) schedule was created. The Director of the DWC per the directive of Labor Code section 4660, created a schedule of permanent disability ratings.

As part of the formulation of the schedule she created a diminished future earnings adjustment factor. A permanent disability rating string starts with a body part, then a standard rating from the AMA Guidelines to Permanent Disability was placed next. This number is adjusted for (FEC) future earnings and capacity. Then the result is adjusted for age and occupation for a final adjusted rating. The Director in determining the FEC adjustment factor adopted the ratios of ratings over earnings losses as determined by the RAND for each body which divided the median standard rating for each body part and then divided that number by the three year proportional earning loss percentage resulting in a ratio of ratings over losses. This formula is complicated and explained in Exhibit 9.

The ratios ranged from a low proportional earnings loss of 1.81 for finger impairments to a high of .45 for psychiatric injuries.¹ (CPDRS 2005 schedule pages 1-6,1-7.) (Exhibit 9; Table 5 page 13) The lower the ratio the greater the proportional earnings loss compared to the percentage of disability. The schedule then broke the scheduled future earning adjustment factors into eight even ranges of ratios and correlated those to eight even adjustment factors that would increase a disability rating from 10% to 40%. (CPDRS 2005 schedule pages 1-6,1-7.)

I hereby advocate for the application of the same formula the RAND group and the Director of the DWC relied upon. That is, using proportional earnings lost once the schedule is rebutted. However, it should apply the ratio of Petitioner's actual loss of earning capacity divided by the control group, instead of the averaged proportional losses derived from uncomparable and stale data, then a more accurate result is obtainable. Although *Ogilvie vs. City and County of San Francisco*.(2011) 197 Cal.App.4th 1262;76 CCC 624, did not agree with the formula created by the WCAB Commissioners in *Ogilvie vs. WCAB* (2009) 74 CCC 248, this slightly different one is necessary to allow rebuttal of the schedule which is authorized per Labor Code 4660 ©). The practical problem with the formula applied in the reversed decision was it was based solely on post injury earnings, not necessarily earning capacity. Application of Petitioner's actual lost earning capacity to compare to the prima facie amounts contained in the schedule applies actual earning capacity.

The WCJ needs to make two essential factual findings to determine if the nature and severity of Petitioner's diminished future earning capacity was greater than what was contemplated in the CPDRS (2005) schedule.

Ogilvie vs. City and County of San Francisco.(2011) 197 Cal.App.4th 1262;76 CCC 624, reversed a WCAB en banc decision, *Ogilvie vs. WCAB* (2009) 74 CCC 248, The decision that was reversed had held that the 2005 California Permanent Disability Rating Schedule (hereinafter referred to as CPDRS (2005) schedule² could be rebutted using a mathematical formula based on the post injury earnings of the injured worker compared to similarly situated workers who were not injured and then comparing to the results of the studies as documented in the CPDRS (2005) schedule. The Court of Appeals in the First District determined the Workers Compensation Appeals Board Commissioners overstepped their authority in applying that formula and it reversed their decision. Which begs the question that if Labor Code section 4660 states that the schedule is only prima facie evidence how can it be rebutted? The practical problem with the solution contained in the reversed *Ogilvie* decision was it was based solely on post injury earnings which were not necessarily the injured worker's earning capacity. The reviewing Court however, did not instruct the Workers' Compensation Appeals Board and injured workers on an alternative method to rebut the permanent disability, and, specifically, the how to rebut the diminished future earnings factor contained in the schedule. This left the entire worker's compensation community scratching it's head in bewilderment. The incomplete opinion from the First District created a void in the law that significantly hurts every seriously injured worker in the state of California whose disability causes a significant loss in earning capacity or who has permanent disability from multiple body parts. It puts applicant attorneys in the difficult position of having to choose between waging expensive litigation on every case without a legislative or judicial rule, or just accepting a rating under the schedule they know is inadequate and inaccurate. The Division of Workers' Compensation has been under a legislative mandate to update the CPDRS (2005) schedule since 2010, ³ and it has failed to do so.

As it stands now the Division of Worker's Compensation still fails to act in response to the judicial mandate per *Ogilvie vs. City and County of San Francisco.*(2011) 197 Cal.App.4th 1262;76 CCC 624. The First District Court of Appeal clearly directed the WCAB to come up with an alternative method to deal with the issue presented here:

In certain rare cases, it appears the amalgamation of data used to arrive at a diminished future earning capacity adjustment may not capture the severity or all of the medical complications of an employee's work-related injury. After all, the adjustment is a calculation based upon a summary of data that projects earning losses based upon wage

information obtained from the California Employment Development Department for a finite period and comparing the earnings losses of certain disabled workers to the actual earnings of a control group of uninjured workers. (Working Paper at p. 3.) A scheduled rating may be rebutted when a claimant can demonstrate that the nature or severity of the claimant's injury is not captured within the sampling of disabled workers that was used to compute the adjustment factor. For example, a claimant who sustains a compensable foot fracture with complications resulting from nerve damage may have greater permanent effects of the injury and thereby disprove the scheduled rating if the sampling used to arrive at the rating did not include any workers with similar complications. In such cases, the scheduled rating should be recalculated taking into account the extent to which the claimant's disability has been aggravated by complications not considered within the sampling used to compute the adjustment factor. In this way, the employee's permanent disability rating gives "consideration" to an employee's diminished earning capacity that remains based upon "a numeric formula based upon empirical data and findings . . . prepared by the RAND Institute." (§ 4660, subs. (a) & (b)(2).) **We leave it to the WCAB in the first instance to prescribe the exact method for such a recalculation that factors the employee's anticipated diminished earning capacity into the data used by the RAND Institute** (*Ogilvie vs. City and County of San Francisco*.(2011) 197 Cal.App.4th 1262;76 CCC 624) (Emphasis added.)

##

Item 48: Work Comp. Coming Forum

4/13/2012 email (redacted)

My husband's case was never settled after 8 years in the work comp process... he then committed suicide. 12-29-2008

It took another year and a half and they tricked me into signing off on the case with no option to reopen.

Me and my Down Syndrome daughter got NO compensation in death benefits or anything else - because "they" drug out the case thus they quoted that the death occurred more than 240 weeks after date of injury and no new proceedings were allowed. The case was filed in 2001 and it certainly was NOT new in any way , shape for form or any sense of the word.

Employer (LA City) did not even quote the entire labor code properly. They also told me this in court but letter was dated and sent day before court. It took around 20 months to pay me the money they owed him at the time of his death.

I cannot drive down to Los Angeles for the forum.

Is there some way I can write my concerns and have submitted? My husband tried to hang in there knowing it would cost him his job and career, but he so wanted the truth be know to help others that would have similar circumstances in the future. Giving his life should not have been for nothing.

There is a lot of corruption in the "system" as well as corrupt persons who are supposed to be doing what is right. I want to go on record to honor what my compassionate husband stood for regarding safety not just on the job but in everything.

Ecclesiastes 7:1 A good name is better than precious ointment; and the day of death than the day of one's birth.

Pray for Blessings in Life and Love,

##

Item 49: My WC case

4/15/2012 email (only sender's name redacted)

My WC case is almost 17 years old. When I went out on medical leave, I thought I'd get better then go back to work. But my health deteriorated. My employer, Warner Bros., threw me to the wolves, even though I was one of their best employees for over 20 years.

In 1995, I talked by phone to a WC executive in the WC San Francisco office, who stated "The Workers Comp system is abusive." It took me 4 months to finally file a WC claim against Warner Bros." I had no other choice. That executive was right...not only is the WC system abusive, but so are the employers, the defense doctors and the Insurance adjusters.

##

Item 50: Pre- Filed Questions for DIR Work Comp Forum - Los Angeles 4/16/12

4/15/2012 email (redacted)

DIR/DWC,

On behalf of Coventry Workers' Compensation, and specifically Coventry's pharmacy benefits management division (First Script), I respectfully submit the following questions for your consideration either during or following the Work Comp Forum:

Compounded Medications:

Given the introduction of new billing and reimbursement rules required by 2011 AB 378/Labor Code 5307.1, is the DIR/DWC considering an update or changes to the existing OMFS section on pharmacy fees to address the following complexities created by the labor code amendments:

- "Documented paid cost" - how is this evidenced by a biller to a payer? What is the appropriate challenge for a payer who believes the documented paid cost is incorrect?
- Listing of individual ingredients - some compounding pharmacies have interpreted this new requirement to allow/encourage the billing of compounds by per/unit dispensed quantities, as opposed to actually billing the NDC of the bulk package size which a compounding pharmacy uses to create the compound. Is this appropriate?
- According to a recent clarification in DWC Newsline 17-12, the DWC approved format for the paper billing of pharmacy bills is the NCPDP form 1.1 (2009). If this is correct, how does the DWC intend to allow payers to manage paper bills on a format that is not optimized for compound billing and does not provide for an indication that a bill is for a compound, as opposed to a series of non-compounded NDCs?

Repackaged Medications:

The DWC has not revised the OMFS for pharmacy regarding repackaged medications since 2007. Since that time, no less than 8 jurisdictions have addresses and successfully adopted some form of meaningful reform efforts regarding the use of and payment for repackaged medications. Primarily dispensed by physicians, repackaged medications routinely carry an AWP markup of 200-800% over the same medications dispensed with an original manufacturer's NDC. Will the DIR/DWC consider an amendment to the OMFS closing the loophole in fee schedule that allows for the use of repackaged NDCs?

Pharmacy Benefits Networks:

Does the DIR/DWC intend to revisit the topic of pharmacy benefits networks by creating administrative guidelines as called for by Labor Code Section 4600.2?

Additionally, I noted you will be addressing the growing concern in California (and nationally) surrounding the prescription, use, abuse and diversion of opioid medications. Attached is a recently published article by Coventry's PBM Pharmacy Director, Brian Carpenter on the subject of opioid use in work comp. Additionally, I have personally just returned from the first ever nationally sponsored prescription drug abuse summit (<http://nationalrxdrugabusesummit.org/>), at which the topics of opioid prescribing, abuse and management were thoroughly debated by a number of work comp system participants.

Thank you for your time and your consideration, I look forward to attending the forum.

Sincerely,

##

Item 51: Standard UR Request for Authorization Form

4/16/2012 email (redacted)

As suggested in the previously promulgated UR regulations, (never went to public hearing) it is essential that a uniform "Request for Authorization" be adopted. With the upcoming electronic billing regulations and the increased number of TPAs and Carriers doing everything in a scanned and electronic environment it is essential that an RFA be easily identified.

##

Item 52: Comments on workers compensation issues

4/16/2012 email (redacted)

Hello. My name is XYZ. I was injured at work on a construction site on June 14, 2007. Shortly thereafter my claim was accepted. I have not worked a day since June 18, 2007. And my life has been a nightmare of pain and disappointment in a system that has all the tools available to get the injured worker prompt adequate care allowing them to return to productive work and maintain a level of respect without becoming addicted to mind altering and life changing pain medication.

The claims administrator and the employers attorneys delay, deny and modify without explanation and without judicial oversight. My MPN PTP does not request authorization for what I need only what she believes the claims administrator will approve and many times has stated that she should just "make me P&S" so at least I can get a little money since I can't get the medical care I need.

I have gone to court more times than I can count to have properly requested medical care ordered by the court when the Utilization review process has not been used and the requested treatment has been improperly denied. These efforts for the most part have resulted in the judge requiring numerous filings, hearings and trials and then taking the matter "off calendar" for one reason or another or acting as mediator to have the employer give some minor part of what is needed under a stipulation and agreement. This does not result in fines or penalties for the employers so there is no incentive to not continue in the stall tactics.

I have filed complaint after complaint with the Medical Unit about the lack of Utilization review when the employer is delaying, denying or modifying treatment requested by MPN doctors- all to no avail. I have had to resort to having medical care as a self pay patient without telling the providers that it is work related. And of course I can't get treatment from any doctors who ask that question because then they can not take payment from me and will not treat as it is not authorized by the employer or they don't take Workers compensation patients.

I have now spent many years in this system that sucks up resources needlessly and ineffectively. My time, money and efforts, the court's time and the State losing taxes on wages that I could have earned are all sacrificed so that the employer's legal representatives can line their pockets at everyone else's expense.

All is not lost however. There do not need to be new laws just enforcement of the laws, rules and imposition of penalties that already exist in the current system. Yes, there should be something done about permanent disability payments and about employer premiums. If injured workers were given prompt, reasonable and necessary treatment - and stiff penalties were actually enforced - for non-compliance, we would see savings all around and injured workers returning to productive lives. Of course defense attorneys would not be happy but the system is about employees and employers -not a full employment act for defense attorneys.

My injuries are now to the point that I have given up hope of ever returning to work and probably will never have a life without pain and agony again. My financial security has suffered. I can't get adequate treatment and can't afford to continue my own "self pay:" for treatment. But others could benefit if the laws were just made real and enforced as such. Thank you.

##

Item 53: DWC Forums Adjuster perspective

4/17/2012 email (redacted)

The process for the adjuster needs to be simplified, the adjusters are overworked and overwhelmed with the amount of regulations, benefits, notices, attorney's, employers, employee's and physicians they have to please.

If we do keep litigating why is it not more evidence based? Why does it take 3 months for a defense hearing and 1 month for an applicant hearing. Why when we are ready for trial does applicant get to push it off calendar but if defense attempts this it gets pushed to trial? The decisions should favor the injured worker as far as medical findings not for every aspect of processing the claim.

Here is an example of abuse in the system the i.w. skinned her thumb in a machine went to the doctor 3 times and then worked for 5 months, it was discovered she was here illegally and was terminated. She got represented and went for treatment at a non-mpn facility and we objected and went to a qme. She alleged right upper extremity, shoulders and neck and back, from the incident in which she skinned her thumb. The QME found for her right upper extremity and shoulder and found that she needed right shoulder surgery. She then got pregnant and the doctor has her on modified. She is going to school. She is on temporary disability because the er will not bring her back to work due to her work status. So she gets paid to go to school for and injury that is not caused by work and have a baby all on the employer's dime and she is not allowed to work for the employer. The issue is not her viability to work in this country but the fact that injured workers can add on endless body parts that were not caused at the time of the original injury and still get treatment and benefits.

The WCAB needs to be more consistent with the rules they follow in order to have a better level of fairness to all parties.

The injured worker's are getting denied treatment at the utilization review level because the treating physicians 9 times out of 10 are not including basic information in their reports and then refuse to get on the phone to discuss the case. This has turned the majority of the injured worker's into pharmaceutical addicts because that is the only thing that can get authorized.

The lien claimants have to stop being allowed to bill over fee schedule and must resolve their liens within 6 months from case resolution and not be allowed to come back 5, 10 years after the fact.

The applicant's attorney should pay for their own discovery costs.

The copy services should definitely have a fee schedule

Every provider must call to get authorization from the insurance company before providing services.

Thanks,

##

Item 54: Second DWC Public Forum

4/17/2012 email (redacted)

As a QME doctor that successfully pursued and was awarded Sanctions against a WC carrier, Jackson v. State Comp. Ins. Fund, SD 345671 (<http://smarterce.com/sanction/CWCR%20August%202007.pdf>) I am aware of how broken the system is.

The effort to enforce the ML regulations by the providers is not cost effective and it should not be their job. Less than half the time I am paid for QME services without repeatedly rebilling and calling the adjuster. I have filed hundreds of DEU audit referrals. I file WC liens on about one third of the QME/AME services I provide. (I wait at least one year to file a lien) The fines collected by the DEU should reflect that, but is easily seen by their annual budget that enforcement is lacking. As a QME instructor, I see a trend of QME doctors favoring the carriers in a desperate attempt to stay on a MPN and to be paid at all. The QME doctor can not pursue payment through the lien process until the case in chief is settled. This again is a counter incentive to report accurately if the patient is not found permanent and stationary. Many of my liens are several years old. The judges allow seemingly never ending continuances that make appearances at the WCAB uneconomical for a collection company to pursue a lien on a \$625 QME service.

This was in part one of the reasons that I learned to represent my self to collect my QME fees. I have had judges tell me to go away because most of my state mandated flat rate fee was paid. I have had a judge (now retired) write in his finding of judgment that I was not entitled to my trial fees as he heard I was retired. I have had judges tell me to accept no payment so the court could adjourn to watch a baseball game. I have had a judge tell me that I had no proof the defense ever received my report only to show him it was in the WCAB case file as the report that was used by the defense to settle the case. (He stormed out of the court room and rescheduled the trial) This also happened in a case where the judge was the one that pointed it out. (defense claimed they never got it but it was date stamped by them) I have had one trial case stopped to reschedule and reform the record three times as my petitions disappeared. Even the defense offered to waive the reformation as they showed their copy. Many times the defense has no argument claiming they have never seen the case in defiance of WCAB procedure policy. Keep in mind, these are all cases I have been asked by a judge or the DWC to review as an QME.

##

Item 55: Workers Comp Case

4/17/2012 email (redacted)

My name is XYZ, WCAB cases from Long Beach, CA. My case is about 7 years old now (June 2004), only because of the Attorney from the Insurance Company and my last 3 attorneys who would not do their job, meet and confer. So as a pro-se litigant against a Law Firm, I asked one simple question for their attorney,, please rate each covered injury accepted by your client. The attorney would not rate each injury but in fact bunched them all together to give a lower rating than the original rating for just one injury accepted by the Insurance carrier at 40% in 2005.

My problem, for my case only, is with the system there is no oversight, who is responsible for setting a meet and confer if the two sides can not come to an agreement as to settlement. My case could be another 5 years if their attorney does not respond to my inquires as to the issues with my case covered injuries. It is my opinion that the defense attorney through their client is intentionally delaying the progress of my case in the hope that I "die" before it is presented to the WCAB judge.

I did request the Evaluation Unit, for a preliminary rating of all accepted injuries from the information I supplied to them and to respond as to which way I need to proceed to get this case resolved. I have not heard or received a written response as of this email to your office.

##

Item 56: LAUSD Dumping Mentally and Physically Injured Teachers on Workers' Compensation

4/17/2012 email (redacted)

Workers' Compensation Forums

The following is an article I wrote for the www.perdaily.com blog about how LAUSD administrators, who are immune from liability for actions that are "malicious" and "without probable cause" under California Government Code Section 821.6, are targeting teachers for harassment and removal from teaching on trumped up charges. Since the Miramonte child molestation scandal, this practice has only gone into high gear.

By keeping these teachers in "rubber rooms" at local district offices or on unpaid administrative leave for years on end, it is no wonder that so many of these teachers have become mentally and/or physically impaired with afflictions that are completely avoidable, which subsequently has had a profound impact on the California State Workers' Compensation system.

You do not have to take my word for this allegation, since all you have to do is run the statistics on the number of claims to Workers' Comp coming from LAUSD and public school districts like it throughout the state and compare the claims filed for the last 10 years. What I think you will see is an explosion of claims by injured teachers, who continue to be brutalized by LAUSD with no intervention by their union UTLA, since alleging morals charges against teachers under California Education Code Section 44939 leapfrogs over any teachers' rights to grievance, arbitration, or any other legal remedy. These teachers are presumed guilty until proven innocent without the financial wear with all to do this- talk about a formula for human disease. .

In my own case, I will have been out of the classroom for 2 years and 8 months before I see the inside of the Office of Administrative Hearings on September 10, 2012, even though I was entitled to a hearing within 60 days under Education Code Section 44944- a statute which is never followed and, therefore, allows teachers to continue to be brutalized with the predictable result of further avoidable mental and physical injury. The fact that these charges against me only started after an immaculate 23 years teaching career, when I reported the graduation of students with low elementary school reading abilities, has never been examined by any legal entity.

Should you require more evidence of LAUSD's manipulation of the Workers' Comp system, I have a data base of teachers who have been subject to the various forms of the aforementioned unabated harassment by LAUSD and would be happy to share it with you or any other agency that realizes this kind of treatment of teachers will ultimately redound to all of our disadvantages.

<http://www.perdaily.com/2012/04/is-laUSD-helping-to-bankrupt-workers-compensation.html>

Sincerely,

##

Item 57: Employers and Injured Workers Need a More Efficient, Effective Workers' Comp System

4/17/2012 email (redacted)

Thank you in advance for considering our letter.

I was present yesterday (4/16/12) at the Los Angeles Forum. It was a GREAT FORUM to say the least. But I do have a comment, after hearing the awful injuries, denials, fraud, etc., etc., this is my concern:

WHY DO ILLEGAL WORKERS RECEIVE ALL BENEFITS UNDER WORKERS COMP SYSTEM. I AGREE THAT IF AN EMPLOYER (EITHER KNOWINGLY OR UNKNOWINGLY) HAS AN ILLEGAL WORKER AND THAT WORKER GETS HURT TO GIVE THE PROPER MEDICAL TREATMENT. BUT THAT 'S ALL!!! I KNOW FOR A FACT THAT ILLEGAL WORKERS EITHER WHEN THEY ARE TERMINATED OR THEY SENSE THEIR JOBS ARE IN JEOPARDY, THEY GO TO AN ATTORNEY AND 'INVENT' AN INJURY AND THOSE ATTORNEYS FILE CLAIMS AND THEY GET ALL BENEFITS.

I, IN FACT HAVE A CASE WHERE 'ICE' CAME IN AND DID AN AUDIT AND FOUND A PERSON THAT WAS 'NOT' LEGAL, I TERMINATED THAT PERSON, AND 3 MONTHS AFTER TERMINATION SHE OPENED A WORKERS COMP CLAIM, SHE IS GETTING PAY ALL BENEFITS. AS OF TODAY THAT CLAIM IS COSTING THE COMPANY OVER \$100,000.00. BECAUSE SHE HAS CLAIMED EVERYTHING IN THE MEDICAL DICTIONARY, WHICH OF COURSE THEY ARE FRAUDULENT.

AFTER HEARING YESTERDAY ALL OF THE 'LEGITIMATE' WORKERS COMP CASES, ETC., AND SEE THE HORRENDOUS ILLEGALS THAT ARE COLLECTING WORKERS; COMP BENEFITS, IS VERY UPSETTING.

THESE ILLEGAL WORKERS ARE COLLECTING BENEFITS UNDER A FRAUDULENT S.S. #, IDENTIFY THEFT ETC.,

I THINK THE SOLUTION IS IF AN ILLEGAL WORKER GETS HURT, YES, GIVE THAT PERSON THE APPROPRIATE MEDICAL ATTENTION, AND NOTHING ELSE. HAVE THE WORKERS COMP SYSTEM CHECK THEIR S.S. # AND LEGALITY OF THE WORK STATUS IN THE UNITED STATES. YOU BE SURPRISED THAT THE NUMBERS OF OPEN CLAIMS ARE OVER 70% OF ILLEGAL WORKERS COLLECTING BENEFITS (BECAUSE IS DIFFICULT FOR THEM TO FIND OTHER JOBS AND IS EASY MONEY) THAT SHOULD BE GIVEN TO LEGAL WORKERS WITH LEGITIMATE INJURIES.

I really hope you take this in consideration and I am pretty sure the system will definitely change. This is easy money for EVERYONE.

Thank you in advance for your kind consideration.

##

Item 58: Public Forum today in Garden Grove

4/18/2012 email (sender's name redacted only)

Dear People:

First and foremost, thank you for taking the time to travel up and down our State to listen to us.

As I mentioned in my 3-min. speech, we are having a huge problem managing the MPN participation in our medical group.

Here are the issues:

1. Increase overhead for the provider.

Insurance carriers remove or add providers at will without giving the providers any notice of their decision. Therefore, we don't know which MPNs we belong to from week to week. We have had to add staff to verify network participation and to credential and contract with the MPNs.

Due to the fact that MPN participation is unpredictable, we receive a lot of denials based on MPN. We then have to file a lien, research to find out if there is an MPN or if the employer properly notified the injured workers of the existence of the MPN. One of the biggest problems we are now facing is that when we first saw the patient, we were in the MPN but now that we are trying to get paid, we have been removed and we have no way of proving that we were in the MPN at the time the services were rendered. This is an issue with Travelers, Pacific Comp (Employers Comp Ins Fund) and AIG (now Chartis) to name a few.

2. Decrease revenue for the provider.

In order to participate in the MPN, providers are giving away 10 to 30% of their income to these networks. For the most part, doctors get 90% of the OMFS as payment while physical therapists and chiropractors get 85% to 70% of the OMFS.

I have attached a sample of the P.T. network based out of Florida. We received authorization from U.R. but the treatment needed to be done at HealthTech. Patient was to undergo post-op rehab and we called the 800 number to schedule. They did not have anything close to the patient so I left a message for them to call us once they found someone. HealthTech called our office and offered inclusion in their network so we could render the Physical therapy but they would only pay us 70% of the OMFS. We declined. See sample attached.

3. No uniformity.

Today, I spoke to an adjuster at Gallagher. We got a certification from Coventry for 12 PT visits on 4/05/12. We proceeded to schedule patient and began the care. The adjuster called today 4/17/12 and

said that the certification was not an authorization!!! She was sending us a letter stating that the physical therapy needed to be done through Med-Risk. I told the adjuster that nothing in the certification stated that we needed to get an authorization from her once we received Coventry's U.R. certification. Moreover, the adjuster was past the U.R. timeline to authorize, modify and/or deny care since our request was sent on 3/30/12.

This is a big challenge for the provider. Every MPN has their own guidelines and we just can't keep up!!!

4. Lack of Provider trust. Our providers are not able to refer patients to the therapist or orthotist or any ancillary service they trust because of the MPN issue. We look up providers in the directories and ask the doctors who do they want and sometimes, they don't know any of the ancillary service providers so we will choose the closest to the patient's residence. This is detrimental to the team-approach.

Another challenge we face is that the providers may be in the MPN but none of the hospitals or ASCs where he or she has privileges are in the MPN. We have to ask for Letter of Agreement (LOA) so we can give the hospital or ASC. I don't think the carriers pay attention to this when they are adding or removing providers or facilities in their MPN.

5. Increased Litigation.

As I stated at the Forum, the litigation costs have increased due to this "MPN Issue". This was proven in the CHSWC study which showed that treatment by out of network providers was the leading reason for lien disputes, as stated in page 27 of their Lien Report as noted in this Excerpt:

"Predictably, out-of-network providers account for the lion's share of disputes over provider authorization where the employer asserts MPN control. The data also show that out-of-network providers account for the largest share of liens in every category of authorization disputes."

We did not have this issue prior to the reform and we really don't have a need for MPNs because we have U.R. standards that should hold doctors and carriers accountable. Defense attorneys will raise MPN regardless of whether there is an MPN issue or not.

If we did away with these MPNs, the insurance carriers and the providers will save money, the injured worker will have easier and greater access to care and the WCAB judges will have less lien conferences over this issue.

I urge you to consider this solution as I am sure this will have a positive impact on our system.

Respectfully,

##

Item 59: Suggestions for Reforms.....Home Health Care

4/18/2012 email (redacted)

1.....Home Health Care....

System currently allows injured workers to designate close family members as ONLY care taker when home health care services is prescribed for injured workers. The care givers are not required to have any skill training other than being a family member and no liability insurance required incase of any subsequent mishap to injured employee. We have some "family member care givers" earning over \$15,000.00/month, \$180,000.00 per year as Home Health Aide for injured workers with permanent disability award of less than 50%. Limit benefit to maximum of 4hours/day and limit service period. It should not be part of LIFE TIME AWARD for injuries with less than 100% disability.

2.....Foreign Country treatment requests.....

Injured employees that chose to live outside of the United States should be responsible for transportation back to US in order to receive Future Medical Award treatment. Employers should not be responsible for the transportation expense to fly injured workers back to the US to receive awarded treatment.

##

Item 60: Public Forum, Fresno, 4/18/12

4/18/2012 email (redacted)

I am sorry I was ill and unable to attend the meeting today. I had hoped to speak concerning MPNs.

A few years ago I recall a Fresno litigated claim where a treating psychiatrist was needed and an MPN was involved. There were 9 or 10 doctors on the list. I called ALL of them only to learn:

1 or 2 had moved, leaving no forwarding address and the phone number either was not working or had been assigned to someone else;

1 or 2 had retired from practice;

1 was dead and the facility's replacement psychiatrist was not on the MPN list;

5 or 6 had NEVER agreed to treat a workers' comp patient and said they doubted if they ever would . . . they were surprised and upset to even be on the MPN and wanted off the list!

Only 1 doctor was willing to treat, but there was a waiting list!

The calls above took a couple of hours and were very frustrating. I'm sorry to say virtually the same results were obtained a year or so later! I located my notes on the prior claim and found the list had not been updated even though the claims adjuster was notified of the deficiencies in their list.

Proposed solution: MPNs should be invalidated if they are not updated at least once a year to verify:

1. The doctors are still alive;
2. They are accepting new workers' comp patients;
3. Their phone number and address are current;
4. If they have a change in status they will contact the claims adjuster or employer.

One way to ensure compliance would be to allow an injured worker to treat for up to a year with a physician of choice if that same injured worker contactss 3 physicians on an MPN list for treatment only to learn they do not take any w/c patients and never have, they have moved, died, etc.

Employers and claims adjusters need incentives to keep their MPN lists up-to-date and accurate.
At present, there is no incentive.

##

Item 61: No subject line

4/18/2012 email (redacted)

It appears there is adequate money in the system to help the truly injured worker receive the appropriate care necessary to return them to work but the dollars spent are, unfortunately, not being allocated appropriately due to the waste, fraud and abuse which is crippling the system.

Our records reflect that our costs have nearly doubled since 2005. These are costs which do not directly benefit the injured worker in any fashion. These costs include applicant attorney copy service bills which are out of control, costs to defend add-on body parts to original claims (applicant attorney's now pretty much add-on psychiatric, sleep disorder and sexual dysfunction to most every claim), costs associated with the delay in obtaining timely and thorough PQME evaluations (in many cases parties to the case have to request multiple supplemental reports), the cost of the newest abuse in the system of rampant toxicology screening which can cost upwards of hundreds to thousands of dollars per bill, continual disputes regarding the cumbersome rules and regulations surrounding utilization review and, of course, the ongoing saga of liens.

These are just a few of the many barriers that result in a tremendous cost to all stakeholders without benefit to the most important stakeholder of all, the injured worker. We appreciate your time and effort in listening to everyone's concerns. If all parties would play by the rules this system could work but it will take a consistent bold effort to remedy the current state of workers compensation in California. We should not be so proud as to not look at solutions other states have implemented in an effort to put our house in order.

Some proposed solutions:

- Implement a copy service fee schedule and/or allow defendants to serve requested medical records to the opposing party within a specified time period
- Implement a mediation process whereby disputes can be resolved by a mediator in lieu of the WCAB
- Reinstate the \$100 lien filing fee and actually apply the statute of limitations in the labor code.
- Revise the cumbersome UR regulations
- Implement consistency among the boards, the judges, and the I&A Officers.

##

Item 62: Workers' Compensation Reforms; Liens

4/18/2012 email (redacted)

I wanted to share a few thoughts with regards to a possible reform that would make the system less litigious.

Liens for medical care are a big problem under the current system, especially in the southern part of the State. A good portion of the liens are attempts to collect on the unpaid balance after the claims administrator has reviewed the bill and paid the amount that they believe is due under the official medical fee schedule. The WCAB judges do not have the time and, quite frankly, the inclination to sort through the technical bill review to determine if the bill was paid correctly. This creates a backlog at the WCAB and leads to pressure on the employer to pay something to settle the lien in the interest of expediency.

The Division of Workers' Compensation should establish, as part of its Medical Unit, a subdivision dedicated to bill review. When a lien claimant is disputing the amount paid, the bill review subdivision would review the bills in question, adjust them according to the official medical fee schedule and issue its findings to the parties. If the bill review subdivision finds that the lien claimant was underpaid, the claims administrator would pay the difference. If the bill review subdivision finds that the lien claimant was overpaid, the lien claimant would refund the difference.

The new subdivision could be user funded. Charging the lien claimant for the review would both fund the bill review subdivision and discourage frivolous submissions.

It is a poor use of the WCAB's time to hold hearings and a possibly a trial to determine if the bill was paid correctly. It is also time consuming and expensive for the parties involved. It would be much more efficient to take these disputes out of the courtroom and substitute the opinion of a neutral arbitrator who would determine how much is due. Naturally, any issue of law or evidence would still go before the WCAB.

The current system encourages the medical providers to bill exorbitant amounts, knowing that they will be paid at least at the Official Medial Fee schedule. They can then pursue the balance at the WCAB, knowing that they are likely to receive at least a few cents on the dollar in settlement. They also have the option to bundle the outstanding liens for sale to a collection agency that will pursue them.

An independent arbitrator would simplify the system and reduce litigation costs while ensuring that medical providers are paid what they are due. That is a win for everyone, except those who are exploiting the current system.

Take care.

##

Item: 60: Public Forum on Workers' Compensation written comments

4/18/2012 email (redacted)

Dear DIR Director Christine Baker and DWC Administrative Director Rosa Moran;

I have been working in the Workers' Compensation, Risk Management and Safety field since 1990. I started my professional career with Crawford & Company as an "Inside Workers' Compensation Adjuster". I eventually became an "Outside Workers' Compensation Adjuster, then Supervisor of Adjusters with Crawford.

I continued my career, education and desire to help injured workers' and employers make the most of the California Workers' Compensation system. I turned to Risk Management, as I yearned to make a difference on both sides and do the right thing.

Today, I am the Director of Risk Management for StaffChex Management Group, Inc. and we employ approximately 4,000 temporary agency workers' amongst hundreds of clients here in California. Most of our temporary employees earn between \$8 to \$12 an hour, although some earn more depending on their skills and experience. Our labor force is basically unskilled and they do not have many employment options, if they are not performing manual labor.

Each year we have between 400 and 500 injuries. Most injuries are minor, including report only and first aid claims. Some injuries are more serious. My goal as Director is to keep all employees safe and injury free. When employees do get injured, I want them to receive the best possible medical care, so they can return safely back to work. This allows them to earn a living, so they may support themselves and their families.

If your forum can act on one idea to help injured workers and their families, I think it should be educating the injured employee about their injury and the process.

I am proposing that we provide the injured worker something they can read and understand (it should be in their own language too) what is taking place with them medically at every medical visit with their PTP and empower them to feel that it is their Workers' Compensation claim, their body and help them reach an outcome they can live with and accept. My proposed document would include the following and maybe several pages;

- ICD-9 code(s) – diagnosis. When multiple codes are used, I've seen some chiropractors use up to 10 or 11, this needs to be reviewed by someone to say...really, 11 codes for a non-complex injury.
- Explanation of the treatment protocols per ACOEM
- Prescribed treatment(s), including frequency and duration. This would even include medications.

- Inclusion of non-industrial factors, such as diabetes, obesity, alcohol and smoking and they impact the injury, diagnosis, treatment and recovery
- List both capabilities and restrictions, as this can help both injured worker and the employer determine if there is modified and/or alternate work available.
- Responsibilities of injured worker with medical treatment
- Expected outcome, including RTW and medical recovery prognosis
- List the number of days the injured employee has been off on both TTD and modified/alternate work.
- Indicate the dollar amount of the medical billing to date by the PTP. If medical care is transferred, then the new PTP must include the previous amount billed by the prior PTP in the total amount billed. Also, medical specialists referred by the PTP must be included in the total amount billed.

Most employees are lost and they don't understand the entire medical process, yet alone the Workers' Compensation process. They often resort to legal representation because no one is telling them things that they can understand. More often than not, it gets worse with legal representation. The injured employees are referred to physicians by their legal counsel who want make money and the outcome for the injured worker is ignored in my professional opinion.

I have often thought, if only the injured worker really knew how much money was being spent on their medical treatment and how much money is made within the system by everyone except them, including defense and applicant attorneys, AME's, QME's, photocopy service providers, private investigators, claim administrators they would be devastated and angry. Yet, these injured workers' are forced to return back to work somehow, or go onto General Relief or go homeless, yet those that were involved in the Workers' Compensation claim process are living comfortably, some even lavishly beyond their wildest dreams.

Thank you for the opportunity to share this e-mail with you and the other members of the forum.

I would be happy to provide more information concerning my proposal and be of any assistance to the forum committee.

Respectfully,

##

Item 63: Suggested Changes

4/19/2012 email (redacted)

Good morning,

After sitting through the forum yesterday, I started thing what I would want if injured. My first thought was the ability to pay my bills until I could get back to work. I thought why not pay the injured employee's full salary for 1 yr and the right to 2 yrs of TD following the one year of salary continuation. This is currently what Public Safety Officers receive. Then what could we give the employers in exchange for this, do away with PD up to a certain level of PD and/or PD for certain body parts/conditions. This would rid the system of secondary gain that is rampant is our system. Attorneys adding sexual dysfunction, psyche, and sleep disorders to embellish the level of PD in order to get larger attny fees. Making this type of adjustment, would also reduce litigation and the costs associated with litigated claims. If you recall in the beginning of reform, litigation went down. Quite a few attorneys stopped handling workers comp as it was not cost affective for them to handle. Then applicant's attorneys figured out new ways to get the cost of the claims increased by adding body parts, psyche, sexual dysfunction, sleep disorders etc. with the creation of medical mills to back/create these additional body parts. Then begins the Lien problem. Establish state mandated UR criteria. This would stop the abuse from Insurance companies/TPAs. Establish the IME process to resolve medical disputes and determine if the injury warrants PD under the new guidelines. Let's simplify the workers comp system and get it back to what it was intended to do which was to provided benefits to the injured worker and not strap the employer with all the add-ons that are now in the system from secondary gain.

I know my suggestions would not make apps/def attnys happy as it would do away with a lot of their jobs. It would not make the State happy as why would we need all the employees that are currently needed to run this monstrosity of a system.

##

Item 64: CA DIR to Hear from Full Houses During Public Forums that Start Today

4/19/2012 email (redacted)

To Whom it may concern from an Employer representative I would like to see:

1. New Limits on, and increased proof hurdles for, workers trying to establish permanent disability compensation.
2. Increased importance and legal support of employer selected authorized treating physician options over the workers IME expert opinions.
3. Multiple defenses for employers against TTD liability where the worker has voluntarily resigned, or has been terminated for cause unrelated to the injury.
4. New defenses related to preexisting conditions, impairments and prior work restrictions which allow employers more opportunity for compensation denials, subtractions and offsets for conditions unrelated to, and not caused by, the work accident
5. Tighter restrictions on the physician when adding and amending treating body parts that have no relation to the incident and are subjective in nature.
6. Clarified total claim denial defense if the employee fails to give timely notice of the work injury, or fails to give the particulars of the claimed work injury to the employer including time, date, place or if the employee fails to give proper notice to the designated person at the employer who is to receive all notices of work related injuries.
7. I would like to see new beefed up total claim denial defense for voluntary horseplay/fighting on the job.
8. Would like to see total claim denial for drug/alcohol impairment which contributes to accident work injury and could injure other employees.
9. Remove the rule that bars the Employer from being able to access the medical information such as the doctors notes that are digitally scanned into the system.

Thank You for your consideration

Respectfully,

##

Item 65: Public Comment regarding reforming the California Workers' Compensation System

4/19/2012 email (redacted)

Gentlepersons,

I have had the honor to work with injured workers and the physicians who care for them in California since 1990. Currently, I am the supervisor of the Scheduling Department and Manager of Insurance and Medical Provider Network Contracts for Allied Medical Group, a multi-specialty medical group serving injured workers in the South Bay and Long Beach areas.

I would like to voice my opposition to plans to grant insurance carriers additional control over injured workers' ability to select treating physicians to care for them after an injury. Further, I feel very strongly that all qualified physicians should be allowed to provide treatment to injured workers, regardless of employer or carrier designated Medical Provider Networks.

It has been my observation that the physicians in our medical group are being systematically removed or deselected from many Medical Provider Networks. These Board Certified orthopaedic surgeons are experienced and extremely well qualified. All are fellowship trained in their respective specialties. Most serve as Qualified Medical Examiners; some serve as Agreed Medical Examiners. But more importantly, they are compassionate physicians experienced in the treatment of injured workers. They fully understand the regulatory system governing their participation in the California workers' compensation system, including the utilization review procedure and proper application of the California MTUS and ACOEM treatment guidelines.

It is important to note that none of the physicians that I work with have been eliminated from Blue Cross, Aetna, CIGNA, Medicare or other private insurance provider networks. It is curious to me why employers and their carriers are allowed to exclude or deselect these well qualified physicians from workers' compensation Medical Provider Networks, when no such exclusion or deselection has occurred in non-employer based networks. Certainly there should not be a discrepancy in the variety of well-qualified physicians provided to any patient, regardless of whether they have been injured at work or are seeking care on a private basis. Unfortunately, with the employer controlled Medical Provider Networks, this seems to be exactly what is happening. And I fear that with the proposed plans to grant additional control to carriers, the inequality will only become greater.

The physicians with whom I work have been repeatedly turned down from joining existing Medical Provider Networks. Some of the reasons they have been given are that the MPN is full for the geographical area, or that providers are not accepted without a nomination from an employer, adjuster or defense attorney.

It seems counterintuitive to empower an employer or claims person to control the nominations of physicians to their networks when these same physicians have otherwise met all California standards for

licensure, have met all standards for inclusion in their respective specialty boards, and have continuously met the standards for care and treatment of injured workers within the California workers' compensation arena. In order to ensure that injured workers have a variety of physicians with a wide range of experience and points of view, it is essential that a physician's qualifications and actual record of care stand as the only fair criteria for nomination or acceptance to a Medical Provider Network. Allowing employees of insurance companies to act as non-biased judges of the quality and scope of a physician's capability has failed to provide injured workers with access to many well-qualified physicians who are kept out of networks based on rationale that has nothing to do with their ability to offer outstanding care to injured workers.

Again, I am voicing strong opposition to the proposed plan to grant insurance carriers additional control over injured workers' access to well-qualified, experienced, and caring treating physicians of their choice. I instead continue to ask for reform of the current Medical Provider Network rules, to stop unfair practices by insurance carriers and employers that limit the access of injured workers to qualified, non-biased and experienced physicians.

Respectfully,

##

Item 66: Reform is Desperately Needed

4/19/2012 email (senders name redacted only)

My name is XYZ and I am VP, Workers' Compensation Claims Management for Peter C. Foy & Associates. We are a Benefits and Property Causally Broker.

I am also a Certified Worksite Wellness Program Coordinator. I disseminates information on Healthy Lifestyle Management through, seminars, health tips and coordinating with Employers; Benefit Carriers; Workers' Compensation Carriers; Employee Assistance Programs; and Employees, to help maintain the health & viability of Employees... and Employers in all states across the US.

Education by Fire is the method California Employers are now coming to understand "*What doesn't come out of my Benefits pocket, WILL come out of my Workers' Compensation pocket!*....and more times than not, it comes out of both....and it is driving Employers out of the State of California and taking work out side of the US.

It is my job to be the voice for Health & Safety ACCOUNTABILITY of the Employer and the Employee.

I see the issues from all sides and angles.

- I have the perspective of an Employer, as I assist employers manage the health & safety of their employees
- I have the perspective of carriers, as I interact with them on a daily basis
- I have the perspective of lawyers (from both sides), as I deal with litigated claims daily
- I have the perspective of the employee, as I am married to a retired LAPD officer, who is dealing with his own chronic heart condition.

Most of the same issues that compound the workers' compensation system, also stress the US Health Care System. It is the lack education of the member/employee/citizen and the lack of responsible accountability to their own health, safety and moral standards. It is the fervent mentality that the member/employee/US citizen is owed something.....or, if something bad happens, it is someone else's fault. That ingrained attitude has to change, or the workers' compensation system, the health care system and ultimately the United States are destined to fail....and then everyone will lose.

From each of these perspectives I see:

A system that is wrought with fraud and abuse, from employers, employees, attorneys, physicians and the State of California. There are far too many "self-interest" groups who have their hand reaching into the deep-pockets of a well-meaning system - that was intended to compensate, through a no-fault system, truly injured employees

- From the employee who has little or no health insurance and looks to the workers' compensation system to fill the gap
- From the disgruntled employee who files a claim post-termination for skin and contents
- From the applicant attorneys who amend applications to pump-up PD and their % of compensation and refer claimants to ill-qualified medical providers and are illegally compensated under the table
- From the unscrupulous physicians and medical groups who prescribe medications, unnecessary procedures, unnecessary return visits and sometimes harmful surgeries, to increase their billing
- From the WCIRB who unjustly penalizes an employer with Ex-Mods from claims that are post-termination, or exacerbation of a non-industrial injury
- From Cal-Osha who penalizes an employer with their Targeting Inspection Consultative Fund assessments when a bad economy has forced lay-offs and those post termination and skin and contents claims follow.
- From SDI, who extends benefits without immediate investigation when a questionable WC claim is filed and denied.
- From the WCAB who does not deal firmly or swiftly with the intent of the law, as it relates to treatment and liens incurred outside a valid MPN
- From the Employer who under-reports, or fails to report, his payrolls or claims
- From our legislatures who ignore the sheer cost of defense - and do not curtails the abuse by means of legislating accountability for frivolous lawsuits.

What improvements could be made?

- ADR Alternative Dispute Resolution
 - Take the litigation (and the expense) out of the system by training Mediators (I believe you already have them and they are called I&A Officers) who deal with
 - AOE/COE from the Get-Go---don't let unscrupulous people control the system
 - Medical Treatment Approvals—a lot of unscrupulous doctors are bogging down the UR system with un-necessary and useless treatment requests.
 - Liens – Statue of Limitations and within MPN or UR approved guidelines
 - TTD – if it's due, it's due...but if modified is offered and refused, it not.
- Go back to what the allegation of “Stress” (psyche, Sleep Disorder, Sexual Dysfunctions, etc.) was intended
 - Life threatening and traumatic Injuries
 - LAPD/LAFD and Hospital Workers who deal with the mental and physical repercussions of the fight or flight responses on a daily basis

- NOT the disgruntled worker who had an injury, was treated and discharged as cured, the year before he was laid off
 - NOT to the Employee who chose to be laid off, instead of taking the alternate job offered, when his/her location was closed due to a bad economy
 - NOT to the factory worker who was terminated due to good faith personnel action
 - Not to the employee who was laid off when a new employer came in to take over a failing business and saw them as part of the problem
 - NOT to the employee who needs a deep-pocket because they didn't want to pay for their portion of the employer sponsored medical plan and now they have a life threatening non-industrial condition
- Apportion not only PD, but also the cost of medical treatment for injuries that involve aggravation to either a non-industrial, or pre-existing condition. If I have Parkinson's Disease, Diabetes and Rheumatoid Arthritis and no health care insurance, (yes...I have that claim on my desk), why is it my Employers responsibility to pay for 100% of all my medical care (with no co-pay, no out-of-pocket), because just showing up for work was difficult for me? Life is difficult. Stop blaming and turning to someone else to pay for your misfortune.
 - This is the newest windfall that medical mills and applicant's attorneys are turning to for their pot of gold. When you get an employee who reaches life pension status, due to pre-existing non-industrial complications
 - Coordinate with SDI before any benefits are blindly extended. If the carrier won't pay TTD....there must be a good reason. If there is a disagreement, go to ADR. Today's savvy employee knows, before anyone is wiser, the State will shell out the money, with no questions asked....all you need to do is go on-line and file. Don't even have to show-up. That is the State's biggest free-for-all giveaway there is!
 - Legislate that all invoicing for every aspect of a workers' compensation claim (i.e. treatment, prescriptions, PT, legal services, investigations, copying services, attorneys, etc.) be sent to the injured employee for review...**and incentivize** the claimant with a % of the recovery if they find errors, exacerbated, or fraudulent billing! Who needs a Fraud department if all eyes are on where the money is spent. Bring them into the loop on how much work comp actually costs everyone!

I could go on and on, but I am sure you are tired of reading....and hearing it again and again. Yet I do know, if I am not a part of the solution, I am a part of the problem. So if I may be of any further service, or the voice of change, please let me know

Yours truly,

##

Item 67: Employers and Injured Workers Need a More Efficient, Effective Workers' Comp System

4/19/2012 email (redacted)

Dear Dep. Industrial Relations Dep. Industrial Rel.,

Thank you for convening community forums to discuss how California can improve its workers' compensation system. I am providing these written comments to help you achieve this goal.

As you know, California's workers' compensation system is too expensive, and costs are increasing. California has been ranked as the fifth most expensive state in the nation for workers' compensation, and workers' compensation costs increased by \$1.5 billion between 2009 and 2010. This hurts job creation and public services at a time when the state is struggling to emerge from a recession.

Inefficiencies in the state's workers' compensation system waste a huge amount of money. California spends more than \$5 billion to administer a \$15 billion system. These inefficiencies give special interests, such as attorneys and medical providers, incentives to litigate and game the system, which increases costs for employers and does not benefit injured workers.

Some problems in the workers' compensation system include abuse of the liens system, increased litigation due to the Almaraz-Guzman and Ogilvie decisions, increases in the amount and cost of medical treatment, and growing areas of abuse in prescription drugs and specialty services. These problems have increased the cost of the state's workers' compensation system by hundreds of millions of dollars.

We care about our workers. If they're injured, we want them to receive good treatment and adequate benefits and to return to work as soon as possible. We know the administration is interested in increasing benefits for permanent disability. We also know you are committed to offsetting increased costs with cost saving elsewhere. That's the right approach. Failing to do so would cost jobs, hurt public services, and delay California's economic recovery.

Sincerely,

##

Item 68: Post-Forum Written Comment

4/20/2012 email (redacted)

Thank you for providing myself and others with the public forum opportunity to speak directly to Director Baker and Administrative Director Moran yesterday in Fresno. While the time for speaking was brief, it at least opened the door to a variety of insightful observations and suggestions that I hope will be pursued and expanded upon.

In my own role as a QME since 1991 and as an approved educational provider for the DWC-Medical Unit teaching both QME continuing education and Medical-Legal Report Writing for about 12 years, (as well as treating injured workers), I could relate many observations and suggestions regarding inequities and conflicts in the workers' compensation system. But I have limited myself below to a few significant areas that I believe deserve serious consideration and attention.

But I am also hopeful, and would strongly recommend, that the DIR attempt to form a variety of working committees made up of professionals who are working within the system on a daily basis. Such committees, I believe, would serve as a wealth of knowledge, practical and functional resource to highlight problem areas with regard to both treatment and dispute resolution through the medical-legal process. Personally, rather than leaving such matters exclusively up to State legislators who are often woefully inexperienced in such matters and often unduly influenced by various political factions, DIR administrators and staff would do well to seek the advice and counsel of professionals who must deal with the workers' compensation system on a daily basis. While such an approach would help to sort through and categorize a significant volume of system problems, as well as providing practical suggestions and models for refining, streamlining and making the workers' compensation system effective and equitable for all involved, I have (below) limited my observations and suggestions to just a few item that I believe should be addressed in the short term.

- 1. A significant problem with regard to QMEs that is occurring with significantly increasing frequency is both late payments and not**

infrequently complete failure to pay for their medical-legal reports. This situation typically occurs after the 60 day statute of limitation has run out under Labor Code 4622 and in most such instances the insurance carrier or its legal representative have often failed to write a formal letter of objection specifying what is being objected to, (i.e., the reason for non-payment). I am keenly aware of this problem as week in and week out QMEs that I have taught over the years contact me regarding such situations. While I try to help them compose letters to resolve this problem, many are compelled to file liens and to file DORs to pursue a lien hearing. Complicating the situation further is that most insurance carriers, and even staff at the WCAB and the Information & Assistance Officers, are unaware that liens for medical-legal expenses DO NOT have to wait for the case-in-chief to settle in order to be filed, which is a 1976 ruling by the Chairman of the Appeals Board and the Administrative Director under Policy & Procedure Manual Index No. 6.6.10. And, what makes this situation even more frustrating for the QME is that he/she cannot refuse to issue supplemental reports, do a re-evaluation or submit to a deposition in the face of unjustified non-payment at the risk of losing their QME status.

Significant in-house enforcement and oversight to protect QMEs from this not infrequent form of financial abuse needs to be implemented. Remember, QMEs and even injured workers and their treaters are held to the standard of criminal perjury and strict financial conflict of interest laws. However, until an insurance carrier is compelled to go to hearing, the insurance carrier has little if any motivation in terms of enforcement consequences to adhere to various statutes and regulations. At the very least, QMEs who have not been paid for their work and which have not received any timely written object per LC4622 should be allowed to refrain from any further requested input, (e.g., re-evaluations, supplemental reports, and depositions), without risking their status until they are paid. Please remember that QMEs have many statutory and regulatory obligations to adhere to under threat of significant penalty if not adhered to; yet QMEs have little ability or leverage to hold the parties to a case (especially insurance carriers) accountable short of pursuing formal complaint and hearing through the WCAB. And we are all keenly aware that such judicial involvement, (re: with re-

gard to liens), perpetually clogs up the court's calendar with items that should have otherwise been readily resolved without judicial intervention.

Frankly, unless unusual or extenuating circumstances can be formally and adequately documented, violation of LC4622 with regard to the payment of medical-legal expenses should result in the implementation of immediate sanctions against the carrier. And such sanctions should be of immediate consequence to the carrier in order to prevent the type of foot-dragging that now compels the initiation of the lien filing and hearing process.

If inadequate carrier staffing and excessive case-loads continues to be the excuse so often heard in response to such delays as payments for everything from medical-legal and treatment bills to the utilization review process, I would suggest that the carriers, (whose well known and substantial profit increases since the passage and implementation of SB899 have come about), invest back into their administrative systems with adequate staffing to diffuse this oft heard complaint.

- 2. Under the QME Regulations (revised 02/17/09), Section 32 obligates the QME to make medically necessary and reasonable referrals for consultations, diagnostic and other considerations in order to move a case along. Prior to Section 32, it was not uncommon for cases to drag out for many years because neither party to a case would timely or adequately follow the QMEs recommendations in order for the injured worker to achieve a permanent and stationary status. Section 32 now compels the QME to do so and to do so under very specific and stringent rules governing 'ex parte' interference from either party, time frames and other considerations. Unfortunately, many QMEs are not even aware of the existence of Section 32 let alone the stringent legal requirements set forth in this Section governing such referral situations. In my own classes for the last 2+ years, most QMEs attending are hearing about Section 32 for the first time. It would help immensely if QMEs were formally notified and informed by the Department regarding the existence and use of this Section and if insurance carriers were similarly notified regarding same.**

Furthermore, as many questions are beginning to arise as Section 32 becomes more utilized in the medical-legal process, the Department (in my opinion) would be wise to further clarify a variety of contingencies. For example, do such referrals include treatment, as opposed to just consultations and/or diagnostics? Must a QME make referrals under Sec. 32 only to MPN doctors if the carrier involved has an approved MPN? Inevitably these and other potential problems with Sec. 32 will no doubt make their way through the courts in the WCAB system to the *en banc* level and beyond to the District Courts of Appeal if further clarification is not made.

3. Another potential but very significant problem is also occurring under the radar in the medical-legal system. In my position I am exposed to many QMEs in all disciplines and specialties. Since the implementation of MPNs, I am hearing concerns and complaints regarding the very real potential conflict of QMEs who happen to also be members of a particular MPN in their treating practice evaluating cases where the PTP is a member of the same MPN. Some have even expressed to me that when this occurs they are consciously trying, to some extent, to temper and shape their opinions and conclusions in a way that they feel will not be a potential threat to the insurance carrier and, hence, to their own status within the MPN. While I am not an attorney, judge or legal scholar, it seems from a common sense point of view that a significant conflict of interest may well exist under such circumstances...a conflict that is not altogether different from the 139.3 statement that all QMEs and treaters must sign under penalty of perjury.
4. Given the cost differential between paying for an *agreed* panel QME versus a *default* panel QME, it is more often than not poorly if not at all communicated to a panel QME in a represented case whether or not the QME was 'the last man standing' after each attorney struck two names from a panel list or if the panel QME was *agreed* to by both parties. This frequently results in billing confusion on the part of the panel QME and not infrequently compels the panel QME to either bill incorrectly (resulting in delayed or non-payment) or to compel the panel QME to telephone the carrier or one of the

attorneys for clarification, thus resulting in *ex parte* communication.

Given this situation, it would help significantly if a rule or regulation were adopted that would require written notification to the panel QME selected clarifying the QME's status with regard to whether or not the panel QME has been agreed to or not.

5. I have been a QME in California since 1991 and I have been an approved educational provider for the DWC for about 12 years, teaching continuing education classes to both experienced QMEs and to doctor's who have just become or are about to become QMEs, which brings up the first topic.

The initial legislation that brought QMEs into existence to help resolve medical-legal disputes was done at a time when the former Industrial Medical Council (IMC) was dominated by the medical profession. As a result, while all other licensed health care providers had no requirements to sit for the State's QME examination, only doctors of chiropractic were singled-out and required to complete a 44 hour Industrial Disability Evaluator Certification Program just to become eligible to sit for the exam. As a result, irrespective of the additional financial burden to take this course, (which I taught), the DC typically had a much broader and more detailed understanding of how to write a medical-legal report that meets the standard of evidence. As attorneys soon found out, DCs in general wrote more credible and defensible QME evaluation reports than their medical counterparts. This became so obvious that by 2000 legislation was passed requiring all doctors to take a 12 hr. Medical-Legal Report Writing class (which I also teach) before being granted their QME status. The truth is that 12 hours is not sufficient to really teach the totality of the elements involved in writing a comprehensive medical-legal report that meets the standard of evidence.

Therefore, for sake of the Workers' Compensation system's credibility and effectiveness, it would be a significant step forward to eliminate the 44 hr. IDE Certification Program requirement for DCs and to level the playing field by requiring all doctors to complete a 16 hour/one weekend course of instruction on medical-legal

report writing. Currently, since the passage of SB899 on 4/19/04, the number of DCs willing to take the IDE Certification Program to simply qualify to take the State's QME examination has dropped to virtually zero. In effect, because of this antiquated and inequitable requirement, DCs who now serve as QMEs are slowly matriculating out of the system and in not too many years will all be all but eliminated from the panel QME system.

Please remember that DCs undergo a formal internship during their senior year of chiropractic college. I am not aware that licensed acupuncturists or psychologists have formal internship programs, let alone a residency, as part of their formal training, nor do DDS graduates. Yet such providers are not held to the same standard of QME training and requirement as are DCs. And while most medical physicians and osteopaths do undergo residency training, this provides virtually no preparation of any kind for conducting a comprehensive medical-legal evaluation. Such professionals, upon completion of such post-graduate training have little to no understanding regarding the issues of causation, apportionment, impairment, and the many other issues that must be addressed in order for a medical-legal report to meet the standard of evidence.

There are definitely many other considerations involving current and/or potential problems in the existing panel QME system in the California Workers' Compensation system. And, in my opinion, it would be of cost benefit for all concerned to study and rectify such problems before medical-legal evaluators become inexorably tangled in disputes that can easily jeopardize their status and possibly the status of a case. Waiting until such real and potential conflicts become fodder for judicial reconsideration, *en banc* decisions and possible District Court of Appeals consideration could in many cases be avoided if this were done.

For example, the lengthy, heated and expensive reaction to the Almaraz-Guzman 1 decision involving *impairment analogies*, (which resulted in an A-G 2 decision making process and ultimately a third case in the District Courts), could have likely been altogether avoided had due consideration been given to the simple directive on p.11 of

the AMA Guide (5th Edition), which basically (paraphrased) advises that if an evaluator can give adequate explanation and reasoning as to why the standard rating for a given condition does not adequately characterize the severity of the condition's impact upon the injured worker's *activities of daily living* (ADLs), then the evaluator should find another impairment in the book (i.e., *within the 4 corners of the Guide*) that more adequately characterizes the level of impairment. In other words, the original dispute that ultimately blossomed into three land-mark cases could likely have been resolved without such protracted judicial involvement had the initial ground rules and protocols already laid out in the first chapter of the AMA Guide (5th Ed.) been recognized and followed.

This is why I am advocating for consideration and resolution of potential conflicts and problems, (only a few of which I have delineated in my presentation), before further inevitable, unnecessary and irrevocable harm is done to the individual (whether QME or injured worker), not to mention considerations of cost to both individuals and to the system.

Thank you for allowing me this opportunity.

Respectfully submitted,

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Item 69: Work Comp Public Form submission

4/20/2012 email (redacted)

Dear Ms. Christine Baker and Ms. Rosa Moran:

I attended the Fresno Workers' Compensation Forum representing my employer which I found to be very good and a number of good ideas were brought up. At this time I do have a few concerns to bring up to your attention:

1. "Psyche" claims; our third party administrator warned us of these a couple of years ago as it is a growing trend in the LA area. As being something legitimate I do not have a problem with them being filed as serious injuries can bring issues to an injured worker. What is now happening is that we have applicant attorneys filing for "psyche" on a strain/sprain shoulder or ankle. I have one that he did not even know his attorney had filed it until I brought it to his attention as we had to modify his job duties since he drove a company vehicle and we did not want something to happen to him while he was driving. The employee ended up going back to his attorney with the letter we provided for him showing that his attorney did amend to add "psyche", it was later excluded and he returned to normal work. Filing "psyches" just because, is adding to litigation. To file a psyche it should at least come up in a doctor's report first. There should be limitations to filing a psyche and excluding normal type of injuries. Another way to put it would be if it happened at home would you have psyche issues?
2. In the Fresno area there are a few doctors as was mentioned in the forum that take up much of the time in litigation costs as they refer out to their "buddies" for additional treatment. This poses a problem when we want to bring people back to modified or alternate work. We are one of a few companies that has the availability that can take just about any modification or alternate work as we only need to know what the restrictions are. It may not be one single job they are performing as we have jobs that take a short amount of time so the injured worker would be performing multiple types of jobs depending upon the season or day. We have had to fight over not having specific job descriptions at times when someone does not fit into what we have written down, we just need to know what they can not do. More flexibility in providing the modified or alternate work would be beneficial for companies that can.
3. Adjuster work loads was brought up at the end of the forum; being self-insured with three of our companies I have the benefit of being able to talk to one person though knowing that the adjuster is working on claims for other companies as well. On the most part I can take care of claims via e-mail or a short phone conversation but there are times when a claim needs some serious handling which can take up my time as well as the adjuster's time. If I take up 30 – 60 minutes they are now falling way behind. What the state has set on an adjusters work load should be reviewed and even a reach out to adjusters to see what their work loads are. Not only do they need to talk with me but the claimant as well.
4. Lien claims are a big part of this but another aspect is that we have had an increase of employees coming to us with bills the doctor, hospital, etc sent them for payment after they have been paid from the fee schedule. There should be some type of recourse that we have with employees being billed or even ourselves which we have received billing to make up the difference of what they want versus what the fee schedule is.

Sincerely,

##

Item 70: No subject line

4/22/2012 email (redacted)

My biggest concern is, that when I do select a physician on the carriers approved mpn list, I cannot get an appointment until the adjuster sends written authorization. That may take several days if not longer for he adjuster to even return the call. If I chose a doctor on the mpn why can't I get an appointment quickly without having to go through the adjuster??

##

Item 71: DIR Public Forum Input

4/23/2012 email (redacted)

To: Christine Baker, Director, Department of Industrial Relations
Rosa Moran, Administrative Director, Division of Workers' Compensation

Re: DIR Public Forum Input

The "CDC Guide to Lyme Disease," published by their Division of Vector-Borne Infectious Diseases, says, "As the spirochete has a very long generation time and may have periods of dormancy, during which time antibiotics will not kill the organism, treatment has to be continued for a long period of time to eradicate all the active symptoms and prevent a relapse, especially in late infections. If treatment is discontinued before all symptoms of active infection have cleared, the patient will remain ill and possibly relapse further." Most QMEs and AMEs don't realize this.

"The Ticking Bomb Lurking in Your Yard," an article in the Wall Street Journal of 3/27/12, states: "About 75% of new diseases that have emerged globally in the last 30 years are spread from animals to people, many of them through ticks." This explains why Lyme disease is more epidemic than AIDS. Most QMEs and AMEs don't know this. The article continues: "Often hard to diagnose and tricky to treat, tick-borne diseases—led by Lyme disease—can cause symptoms ranging from headache and muscle aches, to serious and long-term complications that affect the brain, joints, heart, nerves and muscles." Most QMEs and AMEs don't know this and deny or misdiagnose claims based on a variety of these symptoms. I was sent to neurocognitive and psychological specialists by my QME, who wasn't convinced that Lyme disease was the cause of my symptoms. In fact, misinterpreting the IDSA guidelines in the common way, he believed that Lyme disease was easily curable with a couple weeks of antibiotics.

How does a reporter from the Wall Street Journal know more than an experienced QME or AME? Maybe one serious flaw in the Workers' Comp system could be resolved by sending patients who may have Lyme or other tick-borne diseases to a Wall Street Journal reporter instead of to a QME or AME. If this isn't practical, patients and doctors need a choice of which set of guidelines to follow—those of the IDSA or those of ILADS. The IDSA guidelines are usually effective for quickly diagnosed cases of Lyme disease, while the ILADS guidelines are the only ones effective for treatment of late-diagnosed, chronic Lyme disease.

However, doctors and QMEs are intimidated by the IDSA guidelines and are afraid to go beyond them—treating them like mandates, not like guidelines. Doctors also think that the IDSA guidelines are based on competent medical research, which they aren't. They are based on the opinions of whoever is sitting on the IDSA panel at the time, not on peer-reviewed, double-blind studies. The main reason any of the research by IDSA gets published is because members of IDSA own or are on the editorial boards of the journals that publish their articles. Two independent studies have found that close to 70% of all IDSA guidelines are based on third tier research—not on substantive, replicatable research. But as patients, we are at the mercy of QMEs and AMEs who know less about our disease than newspaper reporters.

Education of physicians would go a long ways to resolving this problem. And an important part of that education should be a) just how epidemic tick-borne disease is, b) how there are two standards of treatment to choose from, and that patients and treating physicians should be the ones to make this choice and c) how tick-borne diseases need to be treated based on symptoms, not on the unreliable lab testing.

Anything you can do to bring about these needed changes will substantially help thousands of suffers of tick-borne disease in California. Reassessing the QME/AME system in the evaluation of chronic disease might be in order as well. It seems, from my experience with various physical injuries in addition to Lyme disease, that Workers' Comp is set up to be much more effective evaluating physical injuries. It is weak on industrial disease. Maybe new guidelines need to be developed to ensure patients of fair and competent treatment for work-related diseases.

Thanks for holding the hearings and allowing public input. You will hopefully be able to bring about significant improvements in the system as a result. Good luck.

Sincerely,

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Item 72: Work Comp Problems

4/23/2012 email (redacted)

As a Certified Specialist Applicant Attorney I agree with the suggestion that we use only IMEs. It takes way too long to receive a panel QME report, many doctors on the lists are not available, incompetent and slow. Before a panel list is issued, the doctors should be confirmed as willing to make appointments in a timely manner and that they continue to be willing to perform their duties. The carriers should also at least be required to confirm that all MPN doctors are willing and able to treat applicants before they are listed in an MPN, as most are not.

##

Item 73: TESTIMONY RE: WORK COMP MEDICAL PAYMENTS

4/23/2012 email (redacted)

first let me state that we have never seen a patient who did not have a pre authorization signed by the insurance adjuster or defense attorney prior to the visit. WE DO NOT DO WORK ON A "LIEN BASIS" and we have \$140,000 outstanding over 1 year old for just one doctor. no wonder it is almost impossible to find a psych who will treat work comp patients. we are considering stopping ourselves. with the kinds of patients we see, i would not anticipate that we would have ANY collection problems. we bill right at fee schedule. we accept contract reductions we have AGREED to. the carriers will NOT pay us, they will NOT discuss the non payment. they just state "FILE A LIEN". most of our patients are not litigated. to file a lien is extremely tortuous and time consuming since an application must first be filed, then a lien, then a dor, then a trip to a wcab 100 miles away from the office, all to collect our \$600 for 6 visits which is already 1/2 of our usual and customary fee. it is soooo difficult that they get away without paying at all. who can afford to "file a lien" on every single bill they produce? 100% of our accounts require appeal as it is. and then they just stamp the appeal "duplicate" and send it back. they don't make any real effort at re analyzing the compensation due.

we have not had an increase in compensation since 1987 and in 2005 were forced to accept a 5% reduction in compensation. would you work at a job if you had not had a raise in 25 years??? and particularly if you can't even collect on this paltry sum?

there is a real conflict of interest in that some bill review companies take a cut of the "savings". therefore they just pay an arbitrary amount and tell us to "file a lien" for the balance. then they make more money. this practice should not be allowed in the system. bill review should be a truly objective non partisan process. and every bill submitted to any bill review company with the exact same codes should be paid the same amount. i have had, on many occasions, multiple eob's from one carrier on one day, all billed exactly the same codes and amounts and all paid a different amount in the check. how can this be? if there is a right and wrong amount that is paid, why wouldn't they always be the same? unless, you don't think, they cut bills arbitrarily? downcoding is still a problem even when the doctor swears under penalty of perjury that he spent two hours face to face, they knock the consult down to a 1/2 hour consult. their attitude when you call is, we paid you all you're going to get. if you don't like it FILE A LIEN.

we have never filed a lien in the 15 years i have been with doctor hall until this month. i have filed 51 so far and i have 104 to go. i wish i had done it much sooner. i just cannot believe that we are forced to do this to collect our money for pre authorized treating cases. and even AME's and panel QME's remain unpaid over 1 year. they tell me when i call, send it in again, send it in again. over and over. they want a new date stamp on the report in case the audit dept reviews that file. so it will look like they paid it timely. these are psych reports 30-50 pages long and i have had to re submit reports as many as 8 times on one case and still never got paid. and if you mention penalties and interest, "it is against our company policy to pay penalties and interest unless so ordered by the wcab" it's like a mantra.

now that we have filed liens, we are finding that reaching anyone to discuss this with is impossible just as it was when you were appealing the eob to bill review earlier. you get voice mail. no one calls back. a message on there says "we do not discuss liens until the case in chief settles". so the doctor just has to wait, as long as 3 years so far, before he can even start the process to get paid.. one of my favorite reasons for non payment is : " the case was denied". the case was denied based on dr hall's report that said it was not industrial!! and they won't pay us.

"we can only pay what bill review says" from adjusters when you seek their help. "you have to get the adjuster to pay this," from bill review. they pass you back and forth like a beach ball.

when i explain over and over again that i have a signed pre authorization and have provided enough copies of it to everyone in the system to wallpaper a large bathroom, they say "we don't care what the adjuster signed, we're NOT paying you. FILE A LIEN. I have names, dates and phone numbers on everything i am alleging here. Corvel is the worst, then comes Interplan and Wellcomp. State Fund is the best. they always add the self imposed penalty if they are wrong and actually APOLOGIZE for their error when you call to point it out to them. many carriers just take 15% off all of our bills even though we don't have any contract with them! and if you call, you guessed it, FILE A LIEN". what doctor would want to take work comp patients? i'm going to have to file a work comp claim for stress due to the stress of handling stress claims for workers' compensation insurance carriers!

The prevailing attitude of all bill reviewers is how little can we pay? rather than, what is the PROPER amount due? i have had bill review supervisors laugh at me when i point out that i stapled the pre authorization to the bill 6 times and stamped it in huge letters PREAUTHORIZED" in RED INK. they say "you don't think anyone actually looks at these do you? it would take too much time. and here we come to the biggest problem. scanners. they scan the bill in and the computer decides what to pay. no human being looks at the bill. so often the computer pays 1 unit of each line of the bill even if there were 10 or 4 or 7 units done. then when you call to point this out and collect the rest due? "FILE A LIEN"

I started working in an insurance company claims department right out of high school in 1964. i became a work comp claims adjuster in 1972. then claims supervisor, then claims manager. it is ASTONISHING to me the hostility shown me when i just try to collect the money we are owed.

##

Item 74: Comments for DIR DWC Public Forum on Workers' Comp

4/24/2012 email (redacted)

Dear Ms. Moran (via DWC Public Forum on Workers' Comp):

Thank you for the opportunity to provide comments regarding current issues in the California workers' comp system, specifically in suggesting improvements for the provision of appropriate medical treatment without unnecessary delay, utilization review (UR), and enabling injured workers to return to work as quickly as medically feasible.

The most glaring need right now is MTUS. California led the movement to evidence-based treatment guidelines in 2003, but since then much has been learned from the experience here and in other states. Most of MTUS (i.e. ACOEM 2nd edition) now stands at 10 years old. Improvements in workers' comp treatment guidelines over that time have been substantial. The market for these products, in its infancy in 2003, has matured. Lessons are as follows-

- Guidelines from the *American College of Occupational & Environmental Medicine* are seen by other providers as too narrow. Because they're written by occupational doctors for occupational doctors, they tend to promote occupational medicine over other specialties. There is just one of many specialties in workers' comp. To impose these guidelines on other specialties is like asking occupational doctors to follow guidelines by hand surgeons, chiropractors, or acupuncturists.
- DWC and MEAAC made moves to address this, replacing ACOEM with the ODG guidelines for Chronic Pain & Post-Surgical Rehab, recommending the same for Low Back, and this was met by resounding support from the medical community, exemplified in comments by Dr. Philip Lippe, Medical Director, American Academy of Pain Medicine, and the California Medical Association, thanking DWC for looking beyond ACOEM, "a source of immeasurable frustration to physicians and injured workers", and supporting ODG as fair and balanced, more comprehensive, and more consistent with the scientific literature.
- Guidelines adopted at the state level should have adequate tools for UR, where the rubber meets the road in medical necessity determinations and most users operate. The ACOEM Guidelines, however, were not developed for UR but instead for clinical practice decisions. As a result, while medical costs came down, UR costs skyrocketed, and the excess friction caused by confusion, disputes and denials has increased treatment delay to the detriment of injured workers, employers and providers. Payers and UROs stumble through lengthy narratives in the ACOEM Guidelines, unable to find UR guidance, before turning to ODG.
- Without regular action, the static nature of MTUS is self-limiting. DWC must be mindful of updates to guidelines, lest we be caught in a situation like today where much of MTUS becomes obsolete. A recurring annual review may be advisable.

Since California's move in 2003, several states have adopted guidelines with mixed success. The approaches can be categorized as evidence-based (primarily ODG), and consensus-based (primarily using the Colorado Guidelines as a baseline, making changes based on the requests of medical panels assembled in each state). Not surprisingly, the results heavily favor the evidence-based approach, with ODG states showing the most overall system improvements, including medical cost savings of 64% in Ohio and 26% in Texas, premium rate reductions of 40% in North Dakota, 24% in Texas, and improved RTW rates and outcomes across the board in Texas, Kansas, Missouri and Ohio, to name a few. To the question "Did you feel ODG met the needs of your patients?" the average score by providers was 4.18 on a scale of five. The consensus approach, on the other hand, has been ineffective in NY, MT and LA, among others.

ODG is successful because it is comprehensive, covering 99% of workers' comp costs including a CPT-ICD9 UR Advisor tool and Drug Formulary, multidisciplinary, representing all medical specialties active in workers' comp, evidence-based, with links from each guideline to the supporting studies in abstract form that have been weighted according to a unique and transparent evidence-ranking process, updated on an ongoing basis, with annual publication of new editions, unambiguous, with guidance for both UR and clinical practice, easy to use, with Web-based, textbook, and mobile delivery platforms, and offers guidance on both treatment and return-to-work. The time-tested ODG philosophy is that the only way to achieve real and lasting cost-savings in workers' comp is through the delivery of quality and timely care.

On behalf Work Loss Data Institute, a California employer and publisher of Official Disability Guidelines (ODG), and thousands of customers throughout the State, I would like to suggest DWC replace the amalgamation in MTUS with the 2012 (or upcoming 2013) edition of *ODG Treatment in Workers' Comp*. We would be happy to maintain a separate California ODG site frozen in time, and give the MEEAC and DWC an opportunity to review new editions of ODG on an annual basis and make determinations on whether to replace the existing version in MTUS. As in other ODG states, we'll cut the subscription price by 50% to \$162.50 annually. ODG is already the most widely used treatment and UR guideline in California, but stakeholders first have to spend time and money searching and trying to apply a mix of antiquated guideline content, wasting resources and causing unnecessary delays, disputes and denials for injured workers and providers. The track record of ODG in other states is well-established and very successful at improving patient outcomes and reducing system friction using evidence-based medicine. Cost-savings are a major byproduct. Like the California Senate Committee on Labor and Industrial Relations in August 2008 comments to DWC, "we believe California's injured workers and the workers' comp healthcare system as a whole would be best served by adoption of the most current version of the published Official Disability Guidelines (ODG)".

Please contact me to set up a meeting to discuss. Thank you for your consideration, and your enduring efforts to improve the California workers' comp.

Sincerely,

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Item 75: Public Form regarding California's WC System

4/24/2012 email (redacted)

Thank you for this opportunity to speak on what I feel I am growing issues in the workers' compensation arena. I am a second generation Board Certified, Fellowship Trained Orthopedic Surgeon who has treated many injured workers'. I am a Fellow of the American Academy of Orthopaedic Surgeons and have served as Chairman of the Allied Health Committee for the last 4 years. I am also an Assistant Clinical Professor, of the Volunteer staff at LAC/ USC School of Medicine. I also serve as a Qualified Medical Examiner and as an Agreed Medical Examiner.

I am on many PPO insurance plans as well as a Medicare provider. I provide Emergency Room coverage at Providence Little Company of Mary Hospital and Torrance Memorial Medical Center. To my knowledge I have never been denied, excluded or deselected by any of the private insurance carriers. Yet since the passage of SB899 and the inception of the Medical Provider Networks, I have been denied enrollment in various MPNs, removed as a provider for certain MPNs and certainly threatened with removal by insurance adjusters and defense attorneys. It is unbelievable that the MPNs would limit the number of qualified Orthopedic Surgeons, who are willing to see the injured workers', to just a few in any one geographic area. I cannot understand why the carriers would not want to make available to the injured worker as many qualified physicians as they could. I believe that if a Physician is a Qualified Medical Evaluator, as approved by the State of California, Division of Workers' Compensation, then they should be an automatic and excellent candidate to be on any MPN. Sadly, this is not the case.

Some insurance carriers will not allow a Physician on the MPN without a nomination from an employer, adjuster or defense attorney. Does this make sense? Why can't a patient nominate a physician? Why can't an Applicant Attorney nominate a physician? Why can't I treat an injured worker as part of an MPN, yet I could be selected as the Agreed Medical Examiner, for the same patient? Currently the MPN system seems to be shrouded in secrecy. As it stands now, if a physician is "deselected" from the MPN, they are not informed. They usually find out when they are requesting treatment for a patient, and advised the treatment is denied because they are no longer on the MPN, or possibly the patient is notified that the physician is no longer on the MPN, but the physician was not notified. When questioned, the MPN gives no information on how to remedy the situation. For instance, if a Physician were to be deselected due to economic profiling, the reasoning should be shared with all concerned.

Even as well trained, Board Certified Physicians; we have to fight for quality treatment of our patients on a daily basis. In the private sector, we would be concerned about providing treatment that we know is appropriate for the patient. As Primary Treating Physicians in the Workers' Compensation arena, we are left to explain, clarify and justify our requests, waiting for a UR physician to determine the course of treatment. They are instructed to make these decisions based on various treatment "guidelines" but often times, they use the "guidelines" as absolutes. Although there are time limits in place for response from the UR Department, treatment requests are often delayed and ultimately denied as the carrier did not send all the appropriate records from which the UR doctor can make a decision. The UR

process slows down treatment, all in the name of saving the insurance companies money. One would wonder with an audit of any one patient's claim how much would be expended costs for administration type services (UR)?

Many times a treatment denial is made by a physician of a different specialty. An Internal Medicine physician could possibly deny surgery. How can a physician, who has never performed surgery, analyze and review only medical records, and make an informed decision? The UR process, as it stands now, creates too much interference, resulting in inferior patient care. The current UR process is cumbersome, time consuming, expensive and bad medicine. Basic treatment decisions need to be made by the treating physician, in accordance with their training and years of experience. The more complex issues can be submitted to the QME and AME physicians, who are truly peers. It certainly seems unnecessary to send a treatment request to UR when an AME has already recommended or approved the same treatment request.

I certainly believe there needs to be some type of modification regarding the Medical Provider Networks to create parity among all physicians as well as an overall reform of the Utilization Review process. The system as we have now is not working to the benefit of the injured worker, and requires attention immediately.

Thank you for your time.

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Item 76: Workers Compensation Forum

4/24/2012 email (redacted)

Hello Ms. Baker and Ms. Moran –

I respectfully would like to request that you address the following issues if its not that someone else has brought it up to your attention:

- Use of opioids for all injury types. You may have heard that more and more injured workers are becoming addicted to opioids. Medications such as Vicoding is prescribed for all injuries.
- Continuous Trauma cases: My company has had the need to restructure in great scale. As other employers have said, injured workers are now filing CT in addition to filing prior periods of disability under the State Development department alleging that such periods of EDD are work related. They opted for EDD because they wanted to avoid the WC process. When this occurs once, it might be credible but when the same person has declared to EDD under perjury the disability is a non-work related condition, it brings lost of doubt on the credibility of such individual.
- Applicant attorneys, such as subpoenaed employee records prior to notifying the employer of an employee injury.

We have cases in which

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Item 77: MPN's

4/25/2012 email (redacted)

Just a quick note ... I registered to show at the public forum but ended up with a conflict in calendar...

The issues I wanted to make known is:

1. There are several MPN's that only have Kaiser doctors or USHW doctors ... those doctors are instructed by adjusters to not serve the applicant with medical reports... I have to threaten subpoena before a judge to get reports.
2. Many of the MPN's doctors do not even take WC clients, or have the specialty required i.e.: Ophthalmology
3. While the DIR looks into the MPN system, maybe a look into the Fresno group who seem to be drawn the majority (maybe 80%) drawn when one files for a panel. What's up with that?
4. How does a doctor not in some other privity with any particular MPN get an application to join ... Is there a uniform system or is it by invitation only?

Thank you for looking at the system with clear glasses, maybe with the glitches removed we will see less injured workers losing their homes because of delays in payment of benefits due to having to see a non MPN doctor.

The system as it stands at least locally, has put a huge number of injured workers on the street with no income. One applicant called our office because she had an adjuster stop her TTD because the applicant insisted on a different doctor and demanded the internet address for the MPN. This applicant could not pay the electricity bill and it was turned off, the neighbor called social services and her kids were removed. She settled for \$1500 to hire an attorney to get her kids back. Once her children were returned she wanted to get treatment for the injury.

Unfortunately she called us after she settled by C&R for \$1500, we could not help her. The system has allowed the adjusters to be out of control, without penalty, using the MPN as their sword, to maim innocents, to protect the greedy, selfish insurance company.

Thank you for your efforts with these public forums to get the big picture.

##

Item 78: Injured Worker Comments

4/25/2012 email (redacted)

I am an injured worker - I never thought this would happen to me as I have been a nurse in workers compensation for many years.

I have come to know the employee side of workers compensation and it is not pretty.

I was injured in June of 2010 and due to MPN's, U/R, Insurance Companies and Physicians, I have still not received the treatment to cure or relieve my injury.

ACOEM Guidelines were followed when it was obvious that the treatment in the guideline was not working for me. I had to follow the guidelines before I could proceed to the next step in the guidelines when, as a nurse, I knew this treatment was not working.

I have continued to work the entire time - no time off, no temporary disability and have been getting worse and worse.

I have a documented back injury that is not soft tissue and yet I had to receive treatment as if the injury was soft tissue. This injury has caused weakness in both legs and I have fallen several times onto my left knee. The insurance company will not accept the left knee although I would not have fallen if I had not had this back injury. I have been forced to take care of the left knee under my private insurance in hopes that eventually the Work Comp Insurance Company will accept this.

I initially had the "recommended ACOEM" treatment and when this did not work for me, I was sent to a neurosurgeon who recommended a triple level fusion. I requested a second opinion and received one from an MPN physician who indicated that I needed only a one level fusion. The insurance company objected to the initial and second opinion physicians recommendations and sent me for a QME. I received a letter from the State indicating who the QME physician was and that this MD's office would be calling me. After waiting for 3 weeks, I finally called the physicians office and was given an appointment date and time at the physicians Bakersfield office. This is a 2.5 hour drive for me living in Fresno. I asked the Insurance adjuster if I could get a closer QME and was told I had to contact the State. I called the State WC number and was told that the QME could not be changed and I should keep the appt. I drove 2.5 hours for this appointment and after waiting 2 hours was told that the physician was not in the building and I would have to reschedule. I rescheduled another appointment and asked for the first appointment of the day - 8 am - I drove, again, for 2.5 hours to Bakersfield and waited for 3 hours to be seen. There were over 30 people in the waiting room and I kept asking the front desk why I was not seen at the appointment time of 8 am - I was told the "doctor is very busy". By this time I was in tears, there was no place to sit and I was in pain. I started to cry out of frustration and pain and was finally put into an exam

room. The physician came in, asked for my MRI and X-Rays. I only had the MRI as I had never had any X-Rays. The physician told me that first of all, he would not see me if I was crying and secondly because I had no X-Rays. After pleading with him, he finally did his exam that was minimal with mainly questions and reviewing the MRI and then went out of his office dictated his report and came back in, handed me a prescription that indicated I only needed a discectomy with a possible one level fusion. I followed up with the nurse case manager at the insurance company and was asked to yet, again, see another neurosurgeon. At this time, I decided that I needed an attorney. I can see why litigation occurs more often than not and it is sad that this is passed on to the employer as it is totally not needed if injured workers are treated appropriately .

I also cannot take narcotic medications. I am working and I have terrible side effects from medications. My primary treater had tried many different meds and each one has produced side effects that I cannot handle. My primary physician then recommended a Tens Unit for day use and an interferential unit for two 45 minute home session. These were denied because they "do not fit the guidelines". Although, I personally appealed this denial by reading the guidelines and seeing, in fact, I do fit the guidelines. Most injured workers would not know to do this. The TENS unit and Interferential units do help me take the edge off my pain and I will be proceeding with knee surgery on my private health insurance and then the spinal surgery. I am still waiting to see the original neurosurgeon who recommended the triple level fusion because he is the closest to me and on the MPN. Although, I would like to have the surgery with another physician, on the MPN but not in my area as I he seems to have better outcomes.

This has been an absolute nightmare for me. I have been told by an adjuster that since I am still working that there is little attention paid to my claim and I can see that this must be true.

I continue to wait for approval for the TENS and Interferential units that do help me and acceptance of the knee injury directly related to the back injury and once the knee is healed, I will eventually get the back surgery.

I am at the mercy of the insurance company and their UR physicians who have never seen me let alone examined me. My primary treating physician is trying to help me but his hands are tied as well.

This entire system needs to be changed so that all parties are winners.

My suggestions are:

1. Get rid of the MPN's - they are only money makers for the creator of the MPN, they are not monitored or revised when physicians are added or taken off. Many physicians do not even know how they got on some MPN's and even more of the physicians do not take workers comp patients.

2. Get rid of the discounts that the physicians have to take to even be on the MPN. This amounts to extortion
3. Pay the physicians fee schedule. I personally know many great physicians who get paid 40-60% of fee schedule even when authorized by UR and the Insurance company.
4. Get rid of UR except in cases that are going out of control by using specific protocol for cases that go beyond medical only or a specific period of time and have UR physicians who live and practice in the State.
5. Allow the patient to be treated as an individual rather than a person that fits so nicely into ACOEM, MTUS or ODG.
6. Allow physicians to practice what and how they know best.
7. Last but not least - do not allow adjusters to medically manage claims. They are not medically trained people and yet they seem to direct medical care quite often

Thank you for reading this and I look forward to changes within this system. This injury has allowed me to see the "other side" of the coin. If you would like any further information, please feel free to contact me.

##

Item 79: Injured worker's comments about MPNs

4/25/2012 email (redacted)

MPNs Are a Hinderance to Care Rather Than An Asset

A perspective from an injured worker in Southern California.

Thank you **very much** for this opportunity to provide input.

It is my understanding that one of the purported purposes of creating the MPNs was to expedite medical care for the injured worker by providing a list of pre-approved practitioners from which the injured worker could select. In theory this would remove the delay of treatment caused by the doctor's office having to wait for approval from the insurance adjuster. In addition, I presume that being a member of the MPN was supposed to assure the provider that they would be paid for seeing the patient without having to repeatedly phone, fax, or otherwise attempt to confirm with the adjuster that the provider was allowed to see the patient and prescribe reasonable treatment.

It is possible the MPNs started out accomplishing the above purposes, but my experience is that they have turned into an impediment to reasonable care of the injured worker because the MPN rules have been ignored, twisted, contorted, and/or taken to extremes by the insurance carriers. Most of the MPN doctors' offices that I have spoken to tell me that they require written approval from the insurance adjuster before they will even make an appointment to see a new patient because if they don't have written approval ahead of time they are risking whether or not they will be paid.

What I am repeatedly told by doctors' offices is that the insurance companies have used the MPNs as a way to limit and control what the doctors are allowed to diagnose or recommend if the doctor wants to be paid. If the doctor dares to write or diagnose something that the insurance company doesn't like, the doctor risks not being paid and/or being taken off of the MPN, generally with no warning whatsoever and often retroactively. Several doctors offices told me that it is not uncommon that they will be treating a patient and at some point when they are trying to collect their fees for past appointments, the insurance carrier will tell them that the doctor was removed from the MPN some months before (with no notice) and will not be paid for appointments that occurred after that time. This is incredibly inappropriate, unfair to the doctors, and in turn, negatively impacts the injured workers.

All of this results in:

- 1) Honest, caring doctors dropping out of MPNs and refusing to treat work comp patients at all because those doctors don't want to deal with such ridiculous games.
- 2) Injured worker still having to wait days, weeks or months before being seen, while doctor's office staff members waste valuable work hours in attempting to obtain approval from the insurance carrier.
- 3) MPN doctors who are beholden to exactly what the insurance company wants and who may make

decisions or recommendations regarding care of the injured worker based upon the doctor's desire to be paid rather than the true needs of the patient.

4) MPN doctors who refuse to accept an injured worker who has a disputed part of their claim because the doctor doesn't want to be in a position where he/she might have to make a controversial decision for fear of losing pay and/or being kicked off the MPN.

And, if the insurance carrier's financial grip on the doctor's throat isn't enough control, the insurance carrier may go so far as to remove a provider's name from their MPN website so that the provider can't be "found" by an injured worker. If necessary (meaning the injured worker complains and has documentation showing that the doctor was listed on the MPN website), the insurance company will then claim the doctor was no longer in the MPN as of some months prior, but for some unknown reason the doctor's name was not removed from the MPN website. And again, all of this will be claimed by the insurance carrier without there having been any communication to the doctor or other patients with the same carrier about the doctor's supposed earlier "removal" from the MPN.

Three times within a 6 month period, doctor's names have disappeared from the MPN website immediately upon my expressing interest in seeing those doctors. I find the timing to be more than coincidence. Since the MPN rules don't seem to prohibit this type of behavior by the insurance carrier and the carrier doesn't appear to have any commitment or obligation to the doctors in their MPN it seems that the insurance carrier can easily fabricate whatever arguments are convenient in order to prevent an injured worker from seeing a doctor the carrier doesn't want them to see. This is more than outrageous but appears to happen with considerable frequency per my personal experience and my discussions with medical providers' offices.

I have experienced all of the above examples in my attempts to receive appropriate care through the work comp MPN system. The MPNs are more than broken; they are an illusion to try to make it look like an injured worker has choices in the provider(s) they see. None of the above scenarios are beneficial to the injured worker and they defeat important purposes the MPNs were supposedly set up to provide, yet from what I can tell the above scenarios are not uncommon.

Rules allowing the insurance carriers to arbitrarily remove doctors from their MPNs must be changed. Rules allowing the insurance carriers to drop doctors with no notice and no pay for services already rendered must be changed. Doctors should not be forced to walk on eggshells in order to treat work comp patients or all of the honest doctors will disappear from the system. Many of the honest doctors have already left in disgust (although many of those names still appear on the MPN website to make it look as if there is a wide selection of doctors). If the MPN rules can't be fixed or the carriers' behavior behind the scenes more easily monitored, then MPNs should be done away with. MPNs are an abomination in their current state. As injured workers we are worse off with MPNs than we were before they existed.

Please feel free to contact me at: lotsagray@mindspring.com if you would like more information on my experiences. I would be happy to help as long as it does not jeopardize my own case or myself

personally. I live in enough constant fear from this system as it is. It has been a long nightmare; worse than I could have ever imagined.

Thank you again for this opportunity to provide input.

##

Item 80: non payment on Panel QME

4/25/2012 email (redacted)

Hello,

I attended your Garden Grove Location and also was a speaker. Regarding MPN Doctors not wanting to see Work comp patients but are on this list.

I also have a problems with Panel QME exams not getting paid.

Solution let us file DOR even if case has not settled. Let insurance company/adjuster be liable for non payment of the Panel Qme exam. Start Sanctions on adjuster.

Sincerely,

##

Item 81: Public Comments on Worker's Compensation Issues

4/25/2012 email (only sender's name redacted)

Dear Directors Baker and Moran,

My name is XYZ and I am the Administrative Division Chief for the San Miguel Fire Protection District in San Diego County California. We are a large Fire District with approximately 85 employees.

I have been in charge of oversight of our Worker's Compensation program for the last three years.

I would like to make the following comments and recommendations based on our experience with Worker's Compensation over the past few years:

1. We are experiencing a significant increase in the number of people, when close to retirement age, who have retained legal counsel to represent them in their claim. The applicant attorneys are adding multiple body parts and systems to the claims, including items such as sleep apnea, sexual dysfunction and Psyche (842). In our opinion, they are trying to come up with as many items as possible in order to increase the permanent disability payouts.
2. Another issue which is severely impacting our Worker's Compensation costs are the way some of the presumptions for firefighters are applied. We have one example of a worker who was diagnosed with a basal cell carcinoma on the inside of his forearm. He had surgery to remove the carcinoma, it was determined to be, at least in part, caused by his job as a firefighter. The permanent disability payout for this employee was over \$32,000 for an issue that required minor surgery and the employee is back to full duty with no restrictions. Since it is a presumptive injury, there was no ability to apportion the PD even though this person has a very active lifestyle which includes a lot of time out in the sun when he is not at work. With the proliferation of skin cancer in society as a whole, and the amount of sun exposure people get when they are not at work, this is a very unfair standard for the employer and is severely impacting our budget. We have several other pending skin cancer claims pending, and if this same type of PD is awarded, it could cost the District close to \$100,000 for the next three claims.
3. If things continue at this rate, as we are dealing with the economic impacts of the recession and collapse of our revenue due to the drop in housing values, it will severely hamper our ability to continue to provide the current level of service we give our constituents. As an employer, we recognize and accept our obligation to provide for medical care and other associated costs for employees who have work related injuries. However, the current system is resulting in unreasonable and un-sustainable costs to employers. We want to be fair to our employees, while still being able to afford the costs associated with Worker's Compensation in a way that is appropriately proportional to our number of employees and budget constraints.

Thank you for your consideration.

Sincerely,

##

Item 82: current workers comp system

4/25/2012 email (redacted)

my name is XYZ. I would like to address the issue of inadequate compensation for permanently disabled workers. this w/c system as it stands now is a disgrace. this is workers compensation, not insurance company comp. I worked for Kraft foods Nabisco from 3-97 to 1-2009. On 1-28-2009 while working with a forklift I struck a metal bar someone left on the floor, this bar flipped up and the result was the evisceration of my right eye. After three years of doctors and numerous evaluations I am now retired and receiving my pension. However this has been a three year ordeal of fighting a failed workers comp system. I have yet to receive a settlement from Kraft. I was 55 years old when injured, in financial terms this injury has cost me ten years pay, to say nothing of the emotional and life changing impact this injury has had. Yet Kraft using workers comp guidelines [set in stone] are refusing to pay even a years wages. This current compensation system should be thrown out. Judges should be reviewing each case on individual merit, not a chart designed by insurance companies. And finally the insurance companies with the support of the current w/c system have developed nothing less than a fascist attitude. their gleeful denial and delay tactics in paying medical providers has created a nightmare experience for doctors and patients alike. Is this workers comp policy? Was w/c created to cater to insurance companies? I think not. I thank you for your time. sincerely,

##

Item 83: Suggestion for liens

4/25/2012 email (redacted)

Hello, my name is XYZ and I have a suggestion for the lien problem:

- Eliminate the five year and one year statutes for liens and rely solely on the six month statute.
- Do not schedule any lien conferences for the first 180 days to allow lien negotiation.
- On day 181, automatically file a hearing and notice the lien claimants that preserved their liens under the six month statute.

This would eliminate lien claimants that watch hearings and trials come and go while they remain in the periphery, only to file their DOR after the trial ends. The board is forced to reset the lien process and start again from scratch. This can happen numerous times within five years. The goal is to have one lien conference, one pre-trial conference, one trial, one time for bill experts to appear, one time for lien reps, one time for defense attorneys to appear and one day of the judge's time.

All eligible liens are now in front of the judge for resolution.

The WCAB has electronic filing which makes it easier for lien claimants to file their liens; there is no extra burden or rush to file the lien as they can do it from their desks. No due process is taken away from lien claimants.

Two side thoughts:

- 180 days may seem like a long time to wait, but we are already taking that long for DORs at boards now.
- A five year statute for the lien claimants is even longer than the applicant has to file their claim. How can the lien claimant be in a better position when they do Workers Compensation for a living, can schedule care (you don't schedule injuries) and are multi-million dollar businesses? It doesn't seem right that a manual laborer with a weak grasp of the English language should get less time. If the manual laborer can file timely on his first claim, then lien claimants should be able to file in half the time on their 1000th claim.

In addition,

One of the reasons that we have lien claimants watching hearings and trials come and go is the structure medical collections.

The "inside reps", the ones that make phone calls and send faxes, only make money if they resolve the liens internally. If the lien goes to the board and a lien rep resolves it, the lien rep gets the fee.

This structure discourages timely filing of liens as the inside rep has less opportunity to resolve the lien and a shortened window upon notice of hearing; thus, less opportunity to negotiate and earn a collection fee. The vast number of inside reps will not going to take money out of their pockets to alleviate WCAB calendar congestion and file the lien when it adversely affects them.

If there is no WC AB lien filed, the inside rep has more opportunity and is only bound by the five year statute or the patience of the provider, which ever expires first. This is good for the inside rep, but wasteful for every other party involved.

Best wishes.

##

Item 84: No Subject Line

4/25/2012 email (redacted)

All of these hearings are about whose is getting paid and how slow they are getting paid. (lawyers, Doctors and administrators) And again I have read nothing about how the injured worker is waiting years to get medical treatment and a settlement on their case-- how can you speed that up and get the injured worker help. How about a Rehab program that really trains injured workers for other rewarding work....

I was injured in June of 2004 and have been jerked around by Better Business Systems (and their carrier Zurich) and the QME who is so old and taking directed from who is paying him it is ridicules. The examiner I got was a joke. He was asking me questions about things I did as a kid and the questions were all directed around trying to prove I had damaged my hearing as a kid and not the 54 yr old man I was at the time---with a severe case of hearing loss and tinnitus and also later, because of the damage the air bag did to my ears I began having vertigo. The **air bag blew the sunroof out** of my 2001 330i BMW--now that is force.

It is now almost May of 2012 and the case has gotten so diluted that they are claiming a 5% disability for Migraines.....They don't even talk about the hearing loss--which is severe---or the tinnitus which is outrageously loud and has pushed me to the

brink of saying fuck it. I also have hypercussis (sp?) severe sensitivity to noise..... and vertigo.....

Work/comp is there to take care of the worker not for the lawyers and clinics and whoever else is sticking their hands in the till to get their piece of the action.

##

Item 85: 2 quick solutions for workers' comp

4/25/2012 email (redacted)

1. Do not require the carriers/TPAs to issue the Notice of Potential Right to Supplemental Job Displacement Benefit **certified**. This notice is not very important and rarely does a claimant receive a SJDV. Simply require the defendants to issue the notice. If necessary, require the carriers to issue the notice Proof of Service. This simple change will save thousands of dollars in unnecessary certified mail charges.

2. Liens- Somehow, someday there has to be built in incentive for each side to handle the lien issues correctly. The most logical solution is loser pays the other parties costs. Treatment lines will need to continue to be handled based on the merits of the case. However, other items should be resolved under a "loser pays" theory. For instance, these types of liens should be resolved based on a loser pays rule:
 - medical providers that file liens for payment in excess of the fee schedule
 - medical providers who willingly provide treatment when the provider know he/she is not a physician within the MPN.
 - Medical providers who knowingly provide treatment beyond the caps listed in LC 4604.5.
 - Carriers who do not pay med/legal charges.

I understand that the LC allows for cost and sanctions, but the w/c system has to provide a mandatory deterrent to frivolous lien filings.

Thank you.

##

Item 86: Another suggestion to ease the lien backlog

4/25/2012 email (redacted)

Why should interpreters who provide services at a WCAB hearing have to file a lien at all?

Why not add a box to the Minutes of Hearing form so that a WCJ could check it and order defendant to pay the interpreter for services provided at that day's hearing? Defendant would, of course, be given an opportunity to articulate any objection thereto, and the WCJ would consider it in deciding whether to issue the order.

It seems like a simple, cost-free solution that would obviate many liens that otherwise will be filed.

##

Item 87: Public Forum on Workers' Compensation - Written Comments

4/26/2012 email (redacted)

We've heard allegations that injured workers aren't receiving timely treatment, they aren't get their cases heard in a timely manner, that cases are delayed because documents aren't served, and that it's the employers' or insurance carriers' fault. Allegations are one thing but what's actually happening in the workers' compensation system? More often than not, and by law, injured workers receive immediate treatment, up to \$10,000, upon reporting a work related injury, even if an investigation of the alleged injury is undertaken. Treating within the Medical Provider Network, the MPN, and implementing utilization review guidelines using evidence based standard assures appropriate care. The legislature has gone so far as to afford the injured worker the opportunity to doctor shop within the MPN. If the injured worker doesn't like the first physician, he or she can change treating doctors within the MPN again, and again, and again and if the injured worker still isn't satisfied, he or she can request an evaluation by a panel Qualified Medical Examiner. Pending that evaluation, treatment within the MPN continues. The injured worker then completes treatment, reaches maximum medical improvement, meets with an Information and Assistance Officer, and enters into Stipulations with Request for Award or a Compromise and Release that is walked through at the Board for approval. Case resolved.

What we're not hearing in these forums, and what is not being addressed, is the abuse of the system that is taking place every day. With alarming frequency, the Application for Adjudication of Claim is the defendant's first notice of claim. Along with the Application is notice of a medical appointment that already took place, preliminary reporting from the medical facility along with notice of referrals within that same facility for x-rays and MRIs, pain management, psychiatric care, orthopedic and neurological consultations as well as referrals to address the injured worker's alleged claim of sleep disturbance and sexual dysfunction. The next mailing received is a subpoena, with no Board number and therefore, without jurisdiction, calling for the claim records that don't yet exist. Next, the liens start rolling in. Any employer or insurance company would be remiss in their duties if such claims were not investigated.

Roadblocks to investigations are immediately encountered. A number of applicants' attorneys refuse to move their clients into the MPN and when it comes time to depose the Applicant, contract attorneys are sent who have no authority to discuss medical concerns or settlement. Hence, issues remain

unresolved, liens multiply, and the assistance of the DWC is needed. Requests for priority and expedited hearings are being set as Status Conferences and thereafter, trials. By the time the issues are heard, at least six months pass. The time in which to obtain medical evidence as part of the investigation of the claim has passed; but, the liens continue to mount.

While these very real scenarios clog the workers' compensation system, other realities include cases such as these:

A case was settled by Compromise and Release in March 2010. The only remaining issue entailed the liens. After 7 board settings, the lien trial took place in February 2012. The outcome of that trial was a take nothing of 9 lien claims. Regardless, the Board's calendar was overburdened and litigation costs were incurred.

In another case, the Applicant reached permanent and stationary status in 2005. A Declaration of Readiness to Proceed was filed on 12/06/05. Since then, this case has been set for hearing 20 times and there still is no resolution. Eighteen of those continuances were caused by the Applicant and/or his attorney, one was due to the judge's unavailability and one was due to defense counsel's unavailability.

The service of documents to lien claimants is also over burdensome. In one case, the copying and service of the documents resulted in billing to the defendant in the amount of \$17,270.28.

There are remedies to the problems facing our workers' compensation system. Those remedies could include holding attorneys, medical providers, and other lien claimants accountable at the onset of a case if found to have taken positions in direct violation of our laws. Protect our MPNs. In no other health care delivery systems, public or private, including Medicare, Group Health plans and HMO's are physicians allowed to treat patients without regard to medical guidelines and oversight. Why in work comp would we ever allow those same physicians to provide care to injured workers without any regard to evidence based medicine?

Whatever the remedy, please keep in mind that prior to the 2004 reforms, 300,000 jobs left California. Please also keep in mind that Los Angeles County was found to have the highest fraud rate in the United States. Our economy is frail and it's the struggling small business owner that keeps us afloat. Every dollar that is spent matters. Don't forget that when contemplating the remedies of our workers' compensation system.

##

Item 88: Add'l Comments

4/26/2012 email (redacted)

I thank you again for visiting our community and allowing our comments. As you heard, there are some serious issues.

There are a few points that I failed to mention and did not hear of lot of with the other speakers.

- insurance companies owning bill review and UR companies, forcing EVERYTHING to go thru the process even with a pre-negotiated fee agreement !
- the same criminal punishment for claims adjusters who grossly ignore the laws, mandates, WCJ's orders, etc as fraudulent injured workers and medical providers
- if a physician is qualified by the State of Calif to be a QME, they should be good enough for MPN's

thanks again

##

Item 89: SJDBA comments and MPN/UR idea

4/26/2012 email (redacted)

I spoke at the La Mesa forum yesterday regarding the supplemental job displacement voucher. I wanted to follow-up via email regarding the points I discussed:

1. The system of graduated voucher values based on permanent disability percentage is flawed. There is no way to determine that someone with only 10% permanent disability needs less vocational rehabilitation than someone with 40% permanent disability. I would suggest we return to a flat value for the voucher regardless of the permanent disability percentage. To illustrate this, I gave the example of a grocery store cashier who goes out of work with bilateral carpal tunnel disorder. If she has been working in this position for 20 years, she has very limited transferable skills. If she cannot return to her usual and customary duties she will have to be trained for a new career. Since the upper extremities do not rate very high under the AMA Guides, she is in all likelihood limited to a \$4,000.00 voucher she may need \$8,000.00 or more to be adequately reintegrated into the workforce. To base the voucher value on the PD percentage in this instance does not take into account all the other factors that affect her future employability. On the other side of the coin, someone with a higher PD percentage may not need a \$10,000.00 voucher. I think the voucher value should be a flat figure, much like it was with vocational rehabilitation under the old system, and a certified vocational counselor can determine how much is needed from the voucher to effectuate transition to a new career.
2. The voucher should be extended to injured worker at the first indication by a medical provider that the Applicant is a qualified injured worker. What I am seeing is that the voucher is not provided until we reach the end of the claim and settle via either stipulation with request for award or compromise and release. By that time, many years have gone by and the Applicant has been out of the workforce losing any transferable skills they may have left. By that time the fact is the injured worker is no longer employable no matter how much they are given to obtain more education or training for a new job. It only makes sense that the voucher be provided to the person at the time of first indication of QIW status so they can begin pursuing a future career with a vocational counselor or accredited institution for further education. Let's get people back to work.
3. There is currently no benefit for people who do pursue education or training through the voucher program. Since most injured workers have to tap into state disability because their TTD has run out due to the 104-week cap, these benefits are no longer available to them. I would suggest we return to some sort of maintenance program so there is some form of income coming into these people who are earnestly trying to get back into the labor market. Enough stress has been placed on them and their families, they should not have to go any further without any sort of income when they have been displaced by the job they were performing.

Finally, I would like to mention that after listening to a lot of comments regarding the MPN and UR programs and problems yesterday, I would like you to consider the following solution:

- If an employer has an MPN, they do not get to use UR. They have already hand selected these physicians and should not be able to hand pick what treatment recommendations do and do not get approved from their doctors. At the same time, if an employer elects not to have an MPN they should be able to use UR to reasonably monitor the physicians that have been selected by the Applicant or their counsel.

Thank you again for the opportunity to discuss these issues with you.

Sincerely,

##

Item 90: Comments for Workers' Comp Forum

4/26/2012 email (redacted)

Dear Christine Baker, Director:

I am an injured worker and attended the Workers' Compensation Forum in San Bernardino. I was really moved by the experiences shared and the real desire everyone expressed to improve the program in their area of concern. I have met others in your department locally and I think they really want to help the injured worker, yet the current rules and regulations prevent them from doing everything they can to help. Overall, I want to sincerely thank you for having the wisdom and concern to create the forums because it takes considerable dedication on your part to do this work.

I want to share some additional comments about my experience.

After my accident the doctor sent two requests for treatment to Utilization Review, but they did not include the information needed for approval and were denied. He wasn't sure how to respond to the first denial and expressed he was not going to write in the requested information and would request in another format. The second request was denied and the next month he declared me permanent and stable based on the denials which made it difficult to get further treatment. He told me to ask again later for more treatment and I did, but the WC adjustor argued against giving me a medical appointment to see the doctor. When she finally did give me an appointment the doctor seemed aloof and not concerned. He left the exam room to follow-up on getting me more medical assistance (so he said), but I heard him examining an older male patient for about 30 minutes in the room next to me. Then he came back into the room saying he could not help me. I began getting legal help and requested a QME appointment. When I saw his response to the QME evaluation, I secured an attorney. I worked with the WC system for about 1 1/2 years before getting an attorney, but my health was suffering and I saw no help coming my way. I didn't know the procedures or my rights. I was not aware that WC (as an organization) was there to help me since my job and the doctor represented WC to me. Later I learned there were others (injured) who did not like the medical care from my particular doctor.

I also learned that the orthopedic doctors who want to help patients are not able to order the tests or procedures they need to make medical diagnosis appropriate for their patients. So patients can be ill for years and not know the cause of their problem or if there is treatment available. I have to be prepared to get my own medical help. I have looked on the internet and found MRIs available for about \$300 as long as you have a prescription. The WC doctor will not give you the prescription since it becomes a legal issue so you have to find someone else. You can go to Mexico and get an MRI for \$400 and they have doctors to examine you. If cost is an issue, perhaps WC could use cheaper facilities like the ones above which are advertised by several companies.

I think the same medical standards should be practiced for everyone and WC should look for ways to minimize those costs. Medical care seems to be one of the main issues for injured workers. Failure to

provide this leads to increased time off work and more legal expenses which make the WC program more costly and leads to poor quality of life for injured workers.

Another area I would like to comment on is the way in which benefits are handled. I have been off work since November and I have never received money from WC for any of my time off. When they were aware that I got disability, they ended those payments. They have used all of my vacation, sick, and holiday time and now I will get no funds. I was trying to do my job, but because of work restrictions my job decided they would not keep me even after I received very good/excellent employee evaluations and I worked at the company for 18 years. When I left they told me I could not come back to that department at all, but then they learned I had not used FMLA time yet the thoughts were already expressed. I was told I apply for work at the hospital, but that requires much more walking on injured knees and charting with an injured right arm/hand so it's not a practical suggestion and there is an extremely high turnover rate in those positions. I am out on the Americans With Disability program which Human Resources administers, but they have not coordinated with WC and may not have influence. How can I get better and go to work when WC challenges my medical care at every opportunity and extends my time away from the job? I see no real effort for them being supportive.

How is it that I can be off work for about 6 months, yet get no income for two work-related injuries?

I think if quality assurance were used to evaluate some of these programs you might find pockets where the program is not being administered as it should. There should be a way for injured workers to easily make complaints about service - I submitted a complaint and it took a long time to get a response that it was received and then I never got more feedback on the problem. I thought it might be because I later got an attorney, yet I still want to know the response for my concern. Perhaps I would not use an attorney if I got the right answers for my questions and if I knew how helpful WC could be. (I got the brochure with the WC contact information, but I didn't know how much help they would be for me.)

I don't know what the compensation would be for my injuries, but I understand I will be very disappointed. Since I will be disappointed with it and it appears I will lose my job (and how can that happen?), I want to insure the best medical care for my injuries.

The employers are getting away with everything! To me that is evidenced by the very fact that most of the employers were not at the WC forum in my area. They are very satisfied that they can take advantage of the injured worker and be supported by the law. We need to be able to stop those employers from treating injured workers in ways that are not acceptable. Are the employers reprimanded or fined? Is there a routine survey completed by injured workers about their treatment and care? What happens to the doctors who don't evaluate the patient correctly? The attorneys know which doctors are not supportive since they get their cases?

My only hope is prayer and healing from God when it comes to most of my injuries because the WC system I have is limited. They appear to approve working with one injury at a time and not the whole person, but that's not conducive to getting back to work quickly. On the other hand when I go to the state WC offices, the staff is so supportive which makes me know the organization cares.

I thank you again for having the forum and for working out these issues.

##

Item 91: Suggestions for Solving the Lien Problem

4/26/2012 email (redacted)

Since comments were solicited at the San Bernardino DWC Forum to be sent to this email address here are mine.

I work with ARS Legal, a legal services company that does applicant copy service work among other things.

We don't just routinely file liens to get paid by the carrier. We first attempt to collect from the carrier usually over a period of several months or years. This is because we either get stonewalled on payment or faced with boilerplate objections already ruled in our favor previously but rehashed again and again as if never previously brought up.

The solution is to get the carrier to do what they are supposed to do – object timely if they are going to object at all, stop using the same objections that have been addressed and answered by the WCJ in our favor, negotiate with us in earnest, and pay the bill when required.

Here is how I would attempt to solve this situation:

According to the lien report from CHSWC dated January 5, 2011, two of the problems surfaced in this report are the inability of the WCAB to process the paper liens timely and another is the failure of one party to pay what it should.

(1) **PROCESSING PAPER LIENS** - I have surveyed all the copy services and more than 90% of them file electronically, so we are not part of the paper blizzard. There was also a recommendation for return of the dreaded filing fee. Since electronic filers do not bog down the system they should not be charged any filing fee. This would only discourage filers with small invoices to write off the invoice. This is what the carriers would like, but would be unfair to the vendors with small invoices.

(2) **FAILURE TO PAY WHAT'S OWED** - The carriers do not pay as they should and the courts are reluctant to penalize them. This only promotes their blatant disregard of the law. If the carrier does not object to the bill for copy services within 60 days, LC 4622.1 should be amended to require the carrier to pay the bill in full or suffer 100% penalty (or at least something significant that gets their attention) and 7% interest if not paid within 10 days.

- a. If the carrier does object to the copy service bill then only those objections raised within 60 days of invoice, should be responded to. Those objections must not be the boilerplate objections that have been ruled against

previously with the same parties. Then if the issue cannot be negotiated, the issue will go to arbitration. No other issues other than the objections first brought up can be brought up at this time.

- b. Workers Comp Judges must be consistent in their rulings, unlike today where you can never tell how a judge will rule on the same set of facts. Most judges are reluctant to set a lien trial. Normally the judge will suggest that we go out in the hall and reduce our bill to negotiate. We have tried that previously on the telephone with the carrier before we got to the lien conference. Now that we are expending more costs to defend our lien we should take less? The carriers think that they can wait us out and this is why they refuse to pay what is owed.
- c. If we return to dealing with the liens at the close of the case in chief, most copy service liens would never have to be filed – they would be dealt with at the settling of the case in chief.

Regards,

##

Item 92: SCIF Change of Location

4/26/2012 email (redacted)

Ms Moran,

Please see the response from SCIF below.

At the public forum recently held in San Bernardino, **SCIF leaders encouraged the audience to apply and work within the guidelines of their MPN.** Apparently what they practice is quite different than what they preach.

The fact is, SCIF hasn't accepted any new applicants in over a year, when they sent new contracts to their providers. This is the same contract that threatened to remove providers if they didn't abide by all of their rules. It is nice to know that physicians must now practice medicine according to contracts and not the health or well being of their patients.

The costs of workers compensation in California will continue to rise as long as adjusters, contracts and investigators are able to influence medical decisions. Doctors can not practice medicine while MPN are in place. There are thousands examples that prove this theory. Many times a physician has recommended surgery as has an AME as has a separate secondary orthopedic consultant. Despite 3 physicians agreeing that surgery is necessary, UR will deny surgery. Keep in mind that UR has never evaluated the patient, they only read chart notes. The 3 physicians spent time with the patient and concur that surgery is necessary. Going against the grain and pursuing surgery will get the physicians removed from the MPN. Several patients in this situation have ended up in the emergency room or, in one case I am aware of, used their private Kaiser insurance to have the surgery done.

More below.....

Good morning XYZ,

We thank you for your interest.

However, please be advised that State Compensation Insurance Fund has suspended admissions to its medical provider network (MPN) until further notice. The moratorium on admissions is in effect pending review and implementation of changes in the State Fund MPN.

Thank you.

Mani Karra for State Fund MPN

##

Item 93: MPN's

4/26/2012 email (redacted)

I recently spoke to you about MPN's at the San Diego Public Hearings about MPN issues. I am sure you have heard issues about accessing MPNs and physicians not be allowed into MPN's and being kicked off MPN's without being advised or having a chance to appeal. I wont reiterate my experiences regarding this. I did mention that some MPN's have certain clauses in the contracts which are cleverly worded, which allows any doctor on that MPN to not bill for more than 1 to 2 hours of record review even if there are extraordinary lengthy records to be reviewed. Non of my doctors were aware of this until their bills were downcoded. I reviewed the contracts and have been unable to find such language in the contract and I therefore have to lien those. As I mentioned in the meeting another does not allow psychologists to bill consultation E&M codes even if they are primary. The same one only allows psychologists to bill certain codes which do not list neuropsychological testing.

I went to court on a lien recently wherein my doctor received UR authorization from PTP and knew he was on the MPN for that carrier. During the course of treatment the carrier changed to a new carrier and eventually they wrote to the applicant saying the doctor was not on their MPN. My doctor was on 3 of the MPN's utilized by this carrier. Three letters to the AA indicated 3 different methods to get to the correct MPN. I now have a lien for \$8040.00 and the defense is adamant that my doctor was not on the MPN indicating that that particular employer has a carve out MPN with in the MPN which requires a password to access. Its a mess, because I have no way to access the MPN list from 2009 when the treatment began to prove that my doctor was on it when he started.

I truly love the idea of a state MPN list of providers. I am sure the providers would be willing to pay to be on it. They would pay for credits to learn MTUS, ACOEM or ODG. This would take control away from the carriers. With UR in place there is no need for MPN's.

Many of the MPN's in place have been taken from existing clinical PPO's and contain thousands of doctors who don't take workers' comp cases and if they did, would not know what to do and would not be able to provide substantial reporting. I once called 70 psychiatrists on the list to find that none took work comp.

##

Item 94: Liens

4/26/2012 email (redacted)

I do not support lien filing fees. I do support an alternative dispute resolution by an unbiased third party for strictly coding issues. Other issues such as AOE/COE and or unauthorized treatment I believe still needs to be handled with the case in chief.

I am in court 3 to 4 days a week on liens. I stopped going to MSC's because defense attorneys refuse to deal with liens at MSC's even if the case in chief settles that day. For 99% of cases that get settled we get no phone call to try and resolve the lien and most do not even get set for lien conferences. We have to file the DOR after we happen to find out the case settled. We are getting copies of more C&R's since the lien statute of limitations have come out. Lien claimants actually love getting C&R's as it is a sign the we can start to try and collect. Legitimate lien claimants file liens timely. For us as soon as we receive objection unless we can appeal the objection by writing a letter, we file right away. But we do have to wait sometimes years before the case gets settled, even for QME liens that should be paid. We appeal and appeal to no avail and ultimately have to file liens. For QME's and AME's there should be higher rate of penalty for late payment per Lc4622. Penalties went up for late treatment per LC4603.2 but not for QME's. The judges should be reminded or it should be enforced that liens need to be attempted to be resolved at MSC's. It is my experience that when attorneys turn in a C&R, the judges don't even ask about liens at that time. State Comp in my experience wont even talk to lien claimants at MSC's when the case is settling. They just say you will have to wait for the lien conference. Why not settle when the case settles! I'm there, they are there, everyone is fresh with the issues of the case. I think it is the most expeditious time to settle everything at once rather that coming back again.

##

Item 95: Deputy Sheriff on duty traffic collision

4/28/2012 email (redacted)

My name is XYZ, I am a Deputy with the Los Angeles County Sheriff's Department. I have served with honor and pride and have been employed with the Department for the last 22 years.

On the night of November 26th 2009, Thanksgiving night, instead of being with my family and loved ones, I was doing something most people don't get to do, the job I love, patrolling the streets of Los Angeles County as a Deputy Sheriff.

I was assigned to a two deputy patrol vehicle, the standard black and white police car. I was in full uniform, protective vest, and duty belt; my partner was driving that evening. Well into our shift, we voluntarily responded to an emergent assistance request broadcast by one of your sister cars. Believing there was a need for us to respond as quickly as possible, we requested to respond Code-3, with lights and sirens. We proceeded to the emergency; little did we know this everyday action would be life altering.

While responding to the assistance request a drunk driver failed to stop at the opposing stop sign and collided with our patrol car. Our patrol car became a flying piece of black and white metal and we ended wrapped around a tree. My partner and I were both rendered unconscious. This incident changed my whole career, not for the positive.

I sustained numerous injuries that evening. The worst one, which has continued to this day, is to my lower spine area.

I wish I could say I was taken care of in a manner that would reflect the way I have served the citizens of L.A. County, with dedication, tenacity, and professionalism.

My experiences so far, for the last 2 ½ years, have been horrific. Aside from the popular, "This pill will solve all your problems" mentality, every treatment to solve or ease my continual and chronic pain has been denied, and has had to be appealed. Of course, after every appeal, there is a response, on average, 2 to 3 more months, while I wait and wonder when I can start to feel normal again, or at least as pain free as much as possible.

One year into this ordeal, my Dr. told me I needed spinal disk replacement surgery, I welcomed it if it could change things for me. Two and a half years later, I'm still waiting for someone who only spends a few minutes with me, who doesn't know me, to approve that surgery.

Seems the worker compensation process makes it very difficult to get any necessary treatment provided in a timely manner. I hate to be so blunt, but it seems to me, the agencies associated with workers compensation, such as Health Works, Tri-Star, Crovel, and the AME's that are contracted, do absolutely nothing to benefit the patient.

If my job performance as a Deputy Sheriff was similar to the agencies I've mentioned here, I

would be unemployed!

It is very common for me to wait 4 to 8 hours to see the AME assigned to me, Dr. Peter Newton, just to get 10-15 minutes out of him. At which point, he does not seem to listen to my concerns and has already prejudged my condition and treatment. I feel these days are spent wasted. One report he submitted mis-diagnosed me and a follow up report recommended denying my disk replacement surgery. He stated, "In my professional opinion the surgery will not help her and her back will just continue to degenerate." All I want to do is go back to work, if this surgery allows me to go back and do what I've been trained to do, what I feel like I've been called to do, why wouldn't you want me to try.

Two separate and independent doctors, including Cedars-Sinai Co-Chair medical director and world renown spine surgeon Dr. Rick Delamarter, said that this procedure would restore fairly normal range of motion for me and more than likely would require a quick recovery, allowing me to return to where I belong.

Two weeks ago, I was contacted by a division of my department that deals with injured employees. I was given the options that if I could not return to full duty, I would have to either retire or demote. This is unthinkable to me! After 22 years of dedicated service, my dreams and my career are in the hands of someone who doesn't know me, who doesn't seem to listen to me, and honestly doesn't seem to care about me, my AME, Dr. Peter Newton. It seems the fact of the matter is, he chooses to deny my surgery, deny my right to heal, and deny my wishes to move on and moved forward from this, because workers compensation does not want to pay for this surgery.

After the collision on November 26, 2009, I was off work as totally temporarily disabled for a few months. I did not like being at home, sitting around, doing nothing, feeling like a quitter. I obtained therapy for my injuries and returned to work at a "light duty" clerical assignment, I at least felt like I could help out my co-workers in one way or another.

On July 20th, 2011 I was told I had to attend a mandatory training session, even while working under my "light duty" status. I was told I had to wear my uniform and side arm. My fears came true that day and I injured my lower spine area again. I tried to do the right thing and be a good soldier, I worked for another 2 weeks after my second injury. My condition and the level of pain I felt was at an all time high, on 08-04-11 my doctor took me off work as temporarily totally disabled pending approval of further exams and approval of disk replacement surgery. Since then, I have been denied twice a diskogram exam, this exam is mandatory for disk replacement surgery. It was finally approved, after four long months.

To this day, workers compensation has not picked up my work time, I have used and exhausted all my save time, sick time, holiday time, and vacation time. My last paycheck was a whopping \$81.00, is there anyone in this room that can survive on \$81.00 every two weeks. I have exhausted my savings account and resorted to using my credit cards as a source of income, maxing them out of course.

Plainly, this is beyond unacceptable. No one should be subjected to this blatant form of disregard.

Do I need to mention the county jails and state prisons where inmates and convicts are treated better than this. I have always been well aware of the dangers and inconveniences that may come with my chosen career, I have always accepted them. What is unacceptable to me, is there is no reciprocation of commitment and service to those who are willing to sacrifice their time, their families, their bodies, and maybe even their life! No one should be forced to go through what I've gone through. What part of this story can anyone with a shred of intelligence not figure out that I was on duty working, performing my duties in uniform as I always had.

I was always told that public safety personnel had the best workers compensation systems in place, I never knew better, this was my first injury. Knowing what I know now, if for some reason other than a cruel joke, this belief is true. I genuinely fell sorry for and my heart goes out to anyone who suffers more than I have suffered.

I'm not a very political person, I simply believe in right and wrong, but this process has simply grown one true belief in me, this process is producing two things: someone is suffering and someone is making money!

Thank you!

##

Item 96: Workers' Compensation Forum Comments

4/28/2012 email (redacted)

To: DIR Director Christine Baker
DWC Administrative Director Rosa Moran

Dear Ms. Baker and Ms. Moran,

My name is XYZ and I am a law enforcement officer in California. Unfortunately, I was not able to attend a forum but am grateful for the opportunity to submit written comments regarding the Workers' Compensation System. I wanted to be a voice in the matter in the hopes of providing you with information so proper reform could be instituted, money not wasted and patients receive proper and efficient treatment.

I have had to use the Workers' Compensation (WC) System since 1989 for work-related injuries. I have been involved in both the old and current systems and it has always been a very frustrating system to use, especially the new system.

Under the current Workers' Compensation System the patient and physician are constantly placed in an adversarial position. Because of all the bureaucracy involved, the current system does not allow the doctor to treat their patient effectively and efficiently. The patient either does not get the care needed or does not get the needed care in a timely manner.

The patient is treated by the system and/or employer as if they are a malingerer or trying to defraud the system. Whereas I'm sure there are "patients" who do commit fraud, each patient should be treated as an individual case. There is much fraud and waste on the side of the system itself. The system involves numerous government entities, AME/QME systems, Utilization and Review systems, etc.

An example would be a patient who is legitimately injured on the job. They go to their employer's doctor or system, which is already by nature beholden to the employer. They are usually given minimal care by a general physician to "save money." Time after time, the patient returns to this same physician who will "band-aid" the situation with prescriptive medicines and claims that "rest will help" -- usually at the expense of the patient's condition worsening. Finally, the patient may be referred to a specialist who should have been seen long before. By this time, the patient usually has had to obtain legal counsel. The denials and appeals for pertinent and efficient care can go on for quite some time. For example, U&R processes - Genex and Intracorp - are quite the scams and are used at the employer's will based on how much the patient's treatment will cost. It is used to deflect costly treatments such as surgeries and post-surgical care. Every time a doctor has his suggested plan of treatment rejected by the U&R facilities - which have never seen or treated the patient - this costs the doctor his time and effort to see the patient again, write additional reports and appeal the U&R decision based on his prior

findings. This obviously increases costs; and all this time, the patient is suffering from his injuries and not receiving the care he needs. All of this costs money and time which, in the long run - could have been more efficiently spent treating the patient as their doctor saw fit to begin with, allowing the patient to heal and return to the workforce in a timely and less costly manner. I myself was diagnosed with a rotator cuff tear in May 2011. Because of the constant denials and bureaucratic red tape of the WC System, I only just received my needed surgery in April 2012. The surgery was more extensive because by April 2012, without receiving any care, my injury had worsened. If the doctor had been allowed to treat me as he had originally diagnosed, time and money could have been saved and probably less shoulder damage done.

The CA MTUS and/or ACOEM guidelines need to be addressed. These guidelines are so minimal that they prevent the patient from receiving the care diagnosed and requested by the patient's doctor, regardless of the patient's job description and/or severity of injury. These guidelines allow the employer to pick and choose who and what they want to approve or send to U&R, knowing that a denial will most certainly follow. This system, by default, allows discrimination of workers by employers based on their job class, job status, who you know, or the case adjustor's subjective opinion. To put it mildly, this system is very discriminatory. By these guidelines, the patient ends up being treated as minimally as possible, usually involving denials, appeals and unnecessary additional costs which ultimately come from the taxpayer/patient himself.

Doctors become frustrated because they can't treat their patient and are placed at odds with other doctors. MPN's are usually limited, with some doctors being good and patient-oriented but constrained by the system, and others merely controlled or beholden to the system/employer. I have seen many good doctors and /or medical groups -- out of frustration -- drop their patients and Worker's Comp because they can't treat their patients effectively and get underpaid or not paid at all. I have seen patients become so frustrated that they just give up and resign themselves to the fact that they will never get the treatment they need. They just say they feel better and return to their job with the injury not getting properly treated, which puts both them and the workforce at risk.

As a law enforcement officer I can understand how fraud abuse can occur from the WC systems and all its entities, from the employer, and from the patient -- and there *is* abuse. In my view and experience, it appears most abuse is at the top of the chain with the patient and taxpayer paying the costs both physically and financially in the end.

I could ramble on *ad nauseum* from my own and others' experiences, but hopefully I have made a point. The only suggestions I would offer would be to go back to the old system and streamline that to allow doctors to treat their patients efficiently and effectively and hold individuals or the entities accountable.

I would be more than willing to sit down and speak on this further with someone, so please feel free to contact me.

Thank you for your attention to this matter,

##

Item 97: Workers Compensation Forum comment

4/30/2012 email (redacted)

1. Shorten the length of time on the 10yr presumption for cancer in the case of safety employees (fire fighters) as this will prove to be fiscally unsustainable in the years to come.
2. Cancer and heart presumption should be further researched and determinations made regarding accessing a percentile for the employer and employee according to the employee's non work related activities, family history and US cancer/heart statistics. i.e. sun exposure outside of work time when looking at skin cancer; family history and statistics when looking at heart disease, prostate or breast cancer, etc.
3. Eliminate the ability to add on to claims.

##

Item 98: Input at La Mesa Forum Apr 25

4/26/2012 email (redacted)

Hello,

Here is the text of my speech at the public forum in La Mesa last Wednesday April 25, 2012:

Good afternoon. My name is David Ingrim. I am an occupational medicine physician and I am the medical director of RehabWest.

I am sorry to hear about all of the delays attributed to utilization review, however I am here to say that meeting the statutory timelines is possible, and that the vast majority of cases are actually processed timely.

Since 2007 the DWC has conducted investigation audits on all utilization review programs. A search of the DWC web site indicates that during this time there have been a total of 238 such audits. Only 18 – that is just over 7% – have received less than a passing score, with only 3 non passing scores since 2009. My organization and its customers have been involved in this audit process 11 times in the past 5 years, and have achieved 100% scores each time.

Additionally, I find that the employers and insurers that I work with commonly encourage me to deliver determinations **before** the statutory time line. I also have a default built into our system to process everything a day early whenever possible.

In my opinion, what are perceived as “Delays” are actually non-certifications of medical treatments that do not meet evidence based standards. This is what utilization review was intended to do.

I acknowledge that medical treatment is viewed by the system as a “benefit,” but we need to remember that any treatment entails risk to the patient. We see evidence of this all the time, particularly with complications and failures and other adverse outcomes of invasive treatment.

Any system needs checks and balances. The failure of the PTP presumption established this conclusively, and is one of the reasons the legislature implemented the standard of evidence based treatment.

I would like to close by encouraging communication, both documentation in medical reports, and the promulgation of a standardized treatment authorization form. I would also request that the DWC provide comprehensive and frequent updates to the medical treatment utilization schedule.

Thank you.

##

Item 99: Feedback re: Unsigned Stips

4/30/2102 email (redacted)

I applaud you for the forums you have held up and down the state. Taking the time to understand the scope and complexity of the problems in the Workers' Compensation system shows true leadership. I have not seen the issue of unsigned Stips mentioned in any of the news releases from the forums that were held and would like to bring it to your attention.

I am the workers' compensation program manager for the County of Orange. We are self-insured and use a TPA for claims administration. We have approximately 17,000 employees and 2,600 open claims; approximately two thirds of our claims involve claimants who are not represented by counsel.

Our problem is that these non-litigated claims are often impossible for us to resolve by Stipulations with Request for Award. Our TPA sends the stipulations to the injured worker numerous times. The claims examiners call the injured worker and offer to meet in person to explain the forms. The injured worker will sometimes indicate that they plan on signing the forms, but rarely follow through. The Santa Ana WCAB, where most of our claims are venued, does not have an I&A officer so that is not an option.

As you know, without signed and approved Stips, the statute of limitations for TTD, PD or new and further disability does not toll and the WCAB retains jurisdiction, basically forever. Since County employees tend to stay on the job for many years and frequently file more than one claim, the County also does not have the opportunity to obtain apportionment for prior claims, unless they were properly resolved by Stipulations.

Our only option is to file a DOR. However, we don't because if the injured worker then gets an attorney, the defendants (who in my case are the taxpayers in the County of Orange) become liable for any attorney's fees incurred by the employee in connection with the application for adjudication, per LC 4064(c). This situation unfairly prejudices the County of Orange, and probably many other defendants as well. We have asked Judges at both the local Boards (Santa Ana and Anaheim) for their suggestions on how to resolve this issue and received conflicting responses on how it should be handled, which is understandable.

I offer two solutions for your consideration:

Option 1: Establish consistent procedures to be followed by all WCAB offices including:

- A. A set number of attempts for claims administrator to make to resolve the claim by Stips (I would suggest 3 attempts by certified mail over a 90 day period which are clearly documented)
- B. Developing a notice with mandatory language that would be sent to the claimant after the set number of attempts has been made, advising him/her that the claim

will be closed and provide the injured worker with the effective date. (I would suggest 60 days out) The notice should also list the options available to the injured worker in case he or she has questions (call the claims examiner, the local I&A officer, the employer's claims representative, etc.)

- C. After the 60 days has elapsed with no response from the claimant, the claims examiner could then take the claim file, medical reports and the documentation of attempts which were made to communicate with the injured worker to the local WCAB office and walk the Stips through.

Option 2: Revise Labor Code section 4064(c) so that liability for attorney's fee is waived if the claims administrator files a DOR only for the purpose of having the WCAB judge approve unsigned Stips.

There is actually a lot more to this than meets the eye, for example, the actuarial liability that these claims represent to the employer. I thank you for considering the solutions I suggested and am sure you have some of your own to recommend as well. If you need additional information, please contact me at the address or telephone number below.

Thank you for allowing me the opportunity to communicate on this very important issue.

##

Item 100: Written Comments for the Workers' Compensation Forums - from XYZ (Injured Worker)

4/30/2102 email (redacted)

Re: Written Comments for the Workers' Compensation Forums

Thank you so much for sponsoring the recent series of public meetings on the Worker's Compensation System. I am grateful for an opportunity to hear more from those of you who manage the System as well as to offer my opinions on some of the topics which you are discussing at the public meetings.

I offer comments on the following scheduled topics of discussion:

- Provision of appropriate medical treatment without unnecessary delay, the Medical Provider Network (MPN), Utilization Review (UR) or other issues
- Reducing unnecessary litigation costs
- Adequate compensation for permanent disabilities
- Assessing appropriate use of opiates and other care
- Any other improvements needed

To begin, I would like to note that my career up to and including the injury-creating jobs that I held was in project management. I have an MBA, and a number of the responsibilities I had involved process improvement and business analysis. I believe this background qualifies me as a good observer of organizational dynamics, despite my obvious conflict of interest as a participant in the system.

Provision of appropriate medical treatment without unnecessary delay, the Medical Provider Network (MPN), Utilization Review (UR) or other issues

I imagine like many workers in the system, I have experienced significant delays in getting various medical treatments, tests, or appointments throughout the entire time I have been involved with the Worker's Compensation System. For example, it recently took over five months to schedule two specialist appointments recommended last October by the AME in my claim.

This particular issue came about at least in part from the insurer's insistence on applying Utilization Review. I was confused by the insurer's approach, as my doctor said that the direction of an AME should not be subject to UR; my attorney said that Utilization Review was "subject to discussion" in this situation.

Possible Solutions: 1- clarify and enforce situations where UR is not appropriate; when UR is required, establish standardized "Best Practice" timeframes for completion of UR or firm deadlines within which insurers must act, penalizing those who do not (new penalties gathered could create new revenues for new initiatives); 2- when AME/QME reports are issued, establish within the reports

standardized deadlines for follow-up action by any party who must take forward the AME/QME's report findings/recommendations (extending the deadline concept to all follow-up measures, not just UR); 3- assure adequate staffing for enforcement of existing policy and procedures and for back up of claimants and their doctors and lawyers (who are currently policing the actions of insurers who slow the system's delivery of medical services).

Note: When I, as Injured Worker, am in communication with an insurer or with the Administration of the Worker's Compensation System, there is usually a deadline imposed within which I must act. Similarly, there is usually a consequence if I do not appear at a meeting.

I have not noticed that similar guidelines, deadlines or constraints apply to insurers or their representatives. My personal experience has been that the actions of these parties are only moved forward by means of constant attention and follow-up on the part of the claimant and counsel. In my experience, when deadlines have been written into Status Hearing minutes, they are ignored unless the claimant is vigilant in follow-up.

I am aware that WCS already has extensive Policy and Procedures, so perhaps stricter enforcement of existing regulations will help tremendously. If added staffing to enable this enforcement is a challenge in these times of constricted budgets, perhaps public-private-NGO (non-government-organization) cooperation could help solve that problem. For example, the Federal Veteran's Administration works closely with the mostly-volunteer Disabled Veterans of America to deliver higher quality care to our injured veterans.

Perhaps there are union and other labor-friendly organizations that can spearhead the creation of volunteer help for our hard-working state administrators. Employers and insurers could be asked to solicit volunteers from their management and human resources areas. Closer association of managers with laborers, such as in the role of volunteer "health coaches," might help dispel some of the adversarial feelings that seem to have developed within the System.

Reducing Unnecessary Litigation Costs

My experience with the legal professionals within the Worker's Compensation System has not generally been happy. I get the impression that attorneys must represent a lot of claimants to make a decent living, so as a claimant, I end up feeling that my attorney does not really know me or my case very well. I can see that the insurer's representatives are also often ill-formed on my case, and create problems and time delays (and significant expense, I am sure).

The other issue with having so many cases adjudicated or at least settled between attorneys is that the insurers must, I think, fear creating precedent by granting services and agreeing to disability status, at least in certain cases. I believe that in my type of injury (repetitive strain), there is a lot of contradictory case law and medical opinion. So, despite seeing a clear rationale for my claim of work injury, my insurers are reluctant to admit it.

Possible Solutions: 1- if there were an alternative path for handling certain cases, such as standardized administrative approvals or special case handling guidelines for common industrial injuries, perhaps it would be cheaper, easier and healthier for everyone; 2- It might be time to consider having “patient advocates,” in lieu of attorneys or in addition to attorneys; 3- perhaps the WCS, participating employers and insurers could put together a set of experimental cases which test some new, non-litigated approaches to worker injury claims processing. Especially in light of the development of national health programs potentially covering all California workers (see comments below re this topic), this might make sense (Alameda County is currently experimenting with some new delivery models for Medicaid, in light of these potential changes and could be a good source of information on innovation techniques.).

Adequate compensation for permanent disabilities

My understanding is that a former Governor instituted changes to the compensation system for PD that related to body parts. This seems inappropriate as, for example, a hand injury constitutes a small percentage of one’s entire body but, of course little in human work endeavor can be achieved without the use of one’s hands, or at least some replacement or substitute for one’s hands.

In my case, the fact that multiple body parts were included in the original claim form seems to be complicating my insurers’ response to the case. Several attempts have been made to disallow or discredit particular body parts as industrial injuries, which is counterproductive to medical treatment and will certainly be a thorny issue when PD determination becomes a factor.

Possible Solutions: 1- an alternative system of compensation could be based on many factors considered universally fair, including income losses attributable to the injury, functional losses from the injury, etc.; 2- the algorithm used to calculate PD benefits could perhaps be enhanced to add factors such as future income lost due to the inability to work in the chosen profession.

Assessing Appropriate Use of Opiates and Other Care

I had a mediocre health result with my first treating physician in the Worker’s Compensation System. The man was very nice and we started out with a good relationship, but he seemed unknowledgeable about a wide variety of drugs and was unable to help control the pain that comes with my injuries.

Once I switched to a different treating physician, who was able to get my pain under control, I got much better results in physical therapy and home exercise. This doctor was willing and able to prescribe appropriate opiates and complementary drugs. For your information I am on a low dose of a very safe and low-risk opiate.

Possible Solutions: 1- doctors who are authorized to work with the Worker’s Compensation System should pass stringent tests to assure they are prepared to

deliver evidence-based medicine. They should be treated just as if they were being directly hired by the State of California, not just as contractors, and held to the same employment and qualification standards you require of yourselves and your staff members; 2- treating physicians should be held to the same standards of communication and claimant treatment as the AMEs/QMEs. Guidelines for how to provide “evidence-based medicine” could be provided and physicians could be tested as the QMEs are.

Not only the first treating physician I worked with, but two consulting physicians I was seen by during the course of treatment within the Worker’s Compensation System, did not, strictly speaking, practice evidence-based medicine. All three ventured opinions about my case before seeing records, and/or attributed my injuries to other factors, before they had seen or heard the case history.

Any Other Improvements Needed

- A. *COORDINATION OF CARE*: I’m sure you all have been thinking about how changes on the national health scene may affect Californians and specifically those in the Worker’s Compensation System.

For example, I am getting all my care for my repetitive strain injuries through worker’s comp, and these are the most expensive medical services I now receive. I am otherwise quite healthy, but must carry private health insurance in the event I have a flu, car accident or other more serious disease that requires medical care. This is a real strain on my finances and an inefficiency for our economy.

Possible Solutions: 1- how might there be coordination of care between the various health care systems? Especially if we end up with “national health care” that allows for everyone to be covered, it might make sense to perhaps combine premiums, grant vouchers or make allowances for services to be provided by the Worker’s Compensation System that would otherwise be covered in a standard private insurance program. This would help offset or reduce expensive health insurance premiums (paid for services that will likely go unused).

- B. *PUBLIC RELATIONS FOR INJURED WORKERS AND THE WORKER’S COMPENSATION SYSTEM*: I have wondered if there is a national professional organization for those of you in the worker’s compensation “business.”

If so, I think it would be great if all of you would get together and get yourselves and us workers some positive press. I don’t have to tell you the employers and insurers do a good job at highlighting the tiny 1% of fraudsters.

Possible Solutions: 1- There are so many good people working in government, to do good things for our citizens, and there are so many workers who are wrongly denied benefits or made to wait for services, that the other side of the story needs to be told. We injured workers are the perfect group to ignore or victimize, since our illnesses or health problems keep us from full productivity. If those things

don't trouble us enough, insurer paperwork, drug side effects and financial worries all contribute to our inability to be our own best advocates.

I hope you can find the resources to let people know we need more help from them in either getting back to work or better managing our health challenges. Note: I learned about the Alameda County program mentioned above through a public outreach program conducted at a local senior center by one of the county staffers. They did the "PR" about their program because they know that taxpayers would attend and that the programs they were working on are generally unpopular with many taxpayers (Medicaid and related programs).

WCS has a great story to tell taxpayers due to its 100% (I believe?) self-funding, so there is great reason to get out there and talk to California taxpayers about your good work!

With respect, I would appreciate these comments being forwarded to DIR Director Christine Baker and DWC Administrative Director Rosa Moran.

Thank you for your attention, and again, thank you for sponsoring the public meetings!

Respectfully,

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Item 101: The Over-utilization of utilization review by the County of San Bernardino (Self-insured Employer) on Injured Workers

4/28/2012 email (redacted)

Dear Ms. Baker,

Please first accept my congratulations on your assuming the task of fixing or improving SB899. I was to be one of the speakers this past Thursday in San Bernardino but unfortunately I developed an extremely bad case of laryngitis and still cannot speak above a whisper so I was not able to attend. I am sure my employer was overjoyed for once I was actually quiet and not at their direction.

So a little history if you wouldn't mind. My name is XYZ. I worked for the County of San Bernardino as a Social Services Practitioner which is a fancy title for a MSW level Social Worker beginning around the late 1980's. I have a BA in Sociology and a MS in Health Psychology as well. I was member of the initial MSW graduating program from California State University San Bernardino. I even did my first year Internship with the County of San Bernardino.

The County employs approximately 14,000 employees. The County is self-insured. At various times over the years the supervisors, managers, and employees, have attended different safety programs. Around 1998 Computers were introduced into the work environment.

Social Workers go out into the homes of families, go to schools, go to foster family homes ,hospitals, go to group homes and to institutions, jail and prisons to see the children and parents on their case loads *at least* once a month. The social worker is also required to see at least monthly parents and other relatives still involved in each case, foster parents, guardians, adoptive parents, service providers i.e., each child's service providers: speech therapists, occupational therapists, each child's teachers, counselors, each parent's service drug therapists, parenting class teachers, etc. Most Social Workers spend a lot of time driving, talking on the telephone, writing notes at interviews and meetings like IEPS, etc.

All these contacts now have to be entered into "contacts" and updated as to service providers, schools, phone numbers, addresses, etc. in the States' CMS computer system.

I haven't even mentioned the six month mandatory Court Reports or Case Plans and other various reports required by the Court.

And all the entries into CMS have time requirements as does the Court Reports, Case Plans, and the 100s of other reports required by the State. Picture all these Social Workers and Supervisors working at non-ergonomic workstations.

So now I've given you a little picture of my job. Any documents I refer to I will be happy to share with you but I do not want to paper you with at this time.

I received my first of many injuries working for SB County in 1998. You have my permission to pull my files and read and review them. I will point out that you need to know that I am 5'3" tall and weigh between 99-105#. Given all the pain medications that the County freely hands out I cannot tell you which of the many accidents I've had was the first or the most major. But I have had several to my lower back, mid-back, neck, shoulder areas, bi-lateral carpal tunnel, Right ulna nerve damage, migraine headaches.

The County paid for a Ergonomic specialist 3 times, after the one at the County finally wrote my superiors strongly written memos saying Cal-OSHA was going to be fining my department for their refusal to follow directions. The Ergonomic specialist recommended I be allowed to use the dictation program I used at home to dictate my contacts and court reports (they would have to move my work station from off the busiest aisle where they had put me as "punishment"), a different mouse, a specialized keyboard—since I had to take the \$20 replica of the one I used at home, back home; a phone with big buttons and a repeat button—I had one on my desk that I had bought and used for about 7 years but suddenly one day it no longer worked with the communications system at the county; the phones everyone had did not have a redial function.

Prior to Dr. Watkins there was another Ortho Doctor in Moreno Valley the County sent me to but he always had new meds for me to try--taken out of the bottom drawer of his desk and I was not comfortable with all the driving to his office—too far from home and my work appointments.

After five years of fighting with Claims—Risk Management over the carpal tunnel being work-related, I made an appointment with the Ortho Doctor I had been seeing (and we had done the meds, physical therapy, chiropractics, and braces on both hands)—I had gotten to chosen him, Dr. Barry Watkins at Loma Linda University we made an appointment for surgery. I gave the appointment paperwork for the time off to my supervisor, (I had lots of vacation time and sick time—I was an excellent employee—)and gave the Doctor my Blue Cross card and my attorney's name and phone number after he told me the morning of the surgery the County denied the Surgery and I proceeded to have the surgery and 6 weeks of physical therapy.

Funny thing happened while I was off from work. After I paid my deductible and used 6 weeks of my vacation time, my claims adjuster Allen Hunter (still is) decided it was Worker's comp and reduced my pay checks to reflect the change in pay. However it took over 6 months for me to be reimbursed the sick time hours and the \$\$\$\$ paid to Loma Linda for my deductible. That was ignored.

I think it was about 3 months after the Right hand carpal tunnel surgery, it was time to do the surgery on the left. This time things went the way it should have gone the first time around—except that I was still waiting for the deductible from the first surgery and the reinstatement of my sick hours.

When I was ready to return to moderate duty—no typing or repetitive work, Allen Hunter—the claims adjuster-- called a meeting to discuss what I should be doing on the job. My supervisor and I had worked out I would review court reports for him, assist new comers with ride-alongs and take it slow. As I am right handed, and this surgery was my left wrist, my supervisor, manager and I figured this would actually be a speedy recovery.

I was advised by Mr. Hunter the day following the meeting I was being transferred to another unit of Children's Services, where I would be reviewing computer spread sheets of payments to guardians, calling the guardians on the standard telephones to verify the children were still in the home, sending computerized reports to a department in accounting. When I stated to Mr. Hunter these were all repetitive motions and not what the doctor said to do, he said if I refused he would accept that as my termination.

I tried the job for two or three days. Then I went to see my union rep, called the doctor, and my attorney before being assigned the job my supervisor and I agreed I would be able to do.

On several occasions I was seen by Dr. Albert Simpkins as the AME.

In 2004 the pain in my right arm continued to interrupt my sleep and I refused to take anything other than a mild pain pill during the day. Dr. Watkins determined we needed to do surgery on the right ulna nerve. Surgery was scheduled for December 24, 2004. On the day before I turned in all the paperwork for being off work—still having plenty of sick time and vacation time if needed.

Two weeks later I received a paycheck electronically with \$00 on it. I called my supervisor Rick Kelly and asked him about it. He told me my Claims Adjuster denied my WC claim. I called payroll and asked to speak to the person who handled Disability Claims because I had that form from Dr. Watkins to turn in as well where they combine disability with sick pay for your check. (and the bill to Blue Cross with yet another deductible). The lady, name forgotten at the moment, advised me that she had an email from Allen Hunter that said that if I submitted a Disability Form to her, to ignore it as I would be getting WC. In other words, he lied to her.

It took an emergency court hearing six weeks later, for Allen Hunter's "mistake" to be cleared up.

When my doctor cleared me to return to work, I called and spoke to my supervisor, Rick Kelly who told me to make an appointment at the health center to be cleared and he would see me the following week. When I got to the health center I was advised Allen Hunter had cancelled my appointment and they told me he said I would not be cleared to return to work. When I tried to talk to him he refused and said to call my attorney. I did and my attorney told me Allen Hunter said I could not return to work.

If you are still with me time for a coffee break or lunch, cause it is now just getting interesting because now there is a new category: Injured Worker, unemployed, fired by the Claims Adjusted, not the Department or the medical doctor non-release back to work.

Eventually being suddenly unemployed meant I had to make some decisions. Dr. Barry Watkins, a very nice man as well as an excellent physician and surgeon, did not want to be my long term care physician for pain and sleep disorders. My attorney's office and Allen Hunter were notified of this decision and I was soon referred to a local physician on Hospitality Lane in San Bernardino. The reception area, the examination rooms, the staffs' uniforms including the physician's were so filthy I contacted my attorney and said I would NOT be using that Doctor for pain management.

Being unemployed gave me an opportunity to ask around and find an excellent pain specialist fairly close to home. I provided the information to my attorney who provided it to the County and Allen Hunter and the Inland Pain Management Center were approved just about the same time SB899 was approved and Utilization Review was now mandatory. I think Inland Pain Center became my treating physicians in 2005 or 2006.

Since beginning treatment with the Pain Center they have worked very hard to follow Dr. Albert Simpkins, AME's recommendations. They have worked hard with me to prescribe medications that I will not become addicted to. However, every month it seems Allen Hunter or one of his subordinates rejects medications that I have been taking for 5 or more years. I have been on Lidocaine patches on my upper, lower, mid-back as well as occasionally on my neck and shoulders. They denied them beginning a year ago. We recently went to court over the denial of medications. Both parties agreed on yet another (this is 5th or 6th written AME from Dr. Simpkins who said he agreed with his previous AME report and stop interrupting drug protocols if they are working for the patient.) This court hearing was 3 months ago. The County is still denying the Lidoderm patches. I was on Ambien for sleeping for 5 years. At the same time UR denied the patches, they denied the sleeping meds and all subsequent meds because they weren't pre-approved. When they were resubmitted and fought over, they continued to be denied 18 months later. Other medications were requested and repeatedly denied in the last 6 months by UR and Allen Hunter.

Dr. Simpkins in his latest AME report advised all participants that I will continue to need procedures like trigger point injections and neck ablations periodically in the future. The Pain Clinic following this last court hearing has attempted to get the pre-approval in place for when it will be needed. UR and Allen Hunter denied it, of course.

October 2011 to February 2012 I was in DESPERATE need of Trigger Point injections that I used to get with no arguments when Dr. Watkins was my primary. I begged, pleaded, and even offered the Inland Pain Center my Blue Cross Card—I would pay it myself—they said no they could not do anything for me because of UR and Allen Hunter. My friend Shelly Bodnar, who I understand you met, told me to go to the ER—I said who is going to pay for it, the County?? Long story short, I went to my 'real' doctor who took care of it in one afternoon and paid for it with my Blue Cross Card. I sent the bill to my attorney to send to Allen Hunter and UR. I seriously thought about taking more than a few pain pills to get rid of that pain in my back.

Which now brings me to the retirement story: Since I was out of work, I was told to go apply for retirement. I was told I was probably eligible for a category called Service-Connected Medical Retirement if not a Medical Disability Retirement. There are some legal differences in respect to taxes and a few other things. Similar to Worker's Comp where you have to see "their" Doctors, have records reviewed, etc., etc. Well Mr. Hunter went out of his way trying to have the Service-Connected Medical Retirement denied to me, saying my injuries and complications were not work related (not due to Worker's Compensation).

I apologize for my lengthy sharing of my tale but I am so happy to hear that someone wants to really hear from all the aggrieved parties. I wish you well in your position and understand you have many battles and arenas in front of you.

Feel free to contact me or review my records at the County of San Bernardino.

P.S. And with the passing of SB899 lawyers lost any desire to help injured workers whose cases have settled when the Injured workers need to return to Court. There are no penalties, financial or otherwise, for employers, insurers, claims adjusters, to follow the dictates of the Court or the Department of Worker's Compensation. But that would be another afternoon's worth of reading for you Ms. Baker.

##

Item 102: Chipotle - California Worker's Compensation

4/30/2012 email (redacted)

Hi –

I thought that I would share with you some data with regard to our experience with California's Worker's Compensation system. I'm in charge of worker's compensation and other risk management for all of Chipotle Mexican Grill's 1250 company owned and run restaurants, of which approximately 175 are in California.

We have found that California's worker's compensation system is by an order of magnitude the most employer unfriendly and difficult of all the 40+ states that we do business in. One perspective is our claims data – while California represents approximately 14% of our restaurants, it accounts for 47% of our worker's compensation costs.

The main issue that is problematic for us as an employer is that the system is rife with fraud. Specifically, subjective complaints for ill founded "psychological" injuries are wide open for fraud and are throw into most of the indemnity claims that we have. Very liberal evaluators will often find 20%, 30% and 40% psychological 'whole person' impairments related to also baseless claims of physical injuries, such as alleged continuous trauma claims that cover the whole body. These groundless claims which combine completely baseless physical injuries and completely baseless psychological injuries, often coming post termination and in groups of employees all filing their claims together with the same attorney can cost us \$20,000 to \$40,000 to defend. We have to invest huge amounts in attorney fees, investigators and IME exams just to have a *chance* to combat these ill founded claims that are linked to no specific injury.

Even when we spend tens of thousands of dollars investigating and defending these specious claims, the outcome is often uncertain and in our experience claimant oriented judges will at best 'split the difference' and award substantial permanency when we do take these cases to trial.

What it amounts to, basically, is there is a chain of fraud going from the claimant's attorney to claimant attorney referred doctors and then claimant attorney referred psychologists who come up with completely ridiculous assessments and we have then a Hobson's choice of fighting by spending \$20,000 to \$40,000 to defend the claim over a 3 year period or "settling" and paying \$10,000 to \$50,000 to get out – or go to trial and get what we get for a result. Nowhere else in the USA does anything else compare.

We've taken steps to survive in this hostile climate, namely implementing an MPN and adopting a policy where we simply spend the huge amounts involved in fighting putatively fraudulent claims and taking *all* of the claims we've marked down as fraudulent to trial. This has somewhat ameliorated the problem, but by no means entirely.

Going forward, California should rein in the psychological awards and reserve rewards for real, objectively verifiable injuries. Of course, since policy makers in California are *completely* beholden to the plaintiff attorney's bar, not to mention the medical / psychological fraud industry that is built up around this, you'll do nothing whatsoever to help employers out of this dilemma. It will just be yet one more (higher) cost of doing business in California.

California remains a vibrant place to do business and has a huge base of consumers, so we're still going to build many more restaurants in your fine State. You should recognize, however, that any employer who is free to base operations in California *or* somewhere else like Nevada, Arizona, Colorado or China would be absolutely nuts to build a manufacturing facility in California, due in no small part to the fraud ridden worker's compensation system.

Please feel free to contact me should you have any interest in discussing our not unique experience.

Cordially,

##

Item 103: MPN and QME concerns

4/30/2012 email (redacted)

To whom it may concern at the DIR,

I am a psychologist who treats Worker's Compensation claimants as well as other types of clients. I would like to share two concerns I am having.

First, I have been having trouble with SCIF's MPN nomination process. I contacted the MPN Representative for the Southern California Region. He asked me to send a letter of interest before he would send to me an initial application. I asked what were the requirements for the whole process so that if I could not meet them, I would not start the application. He said he could not tell me, and would inform me after I turned in the application. I sent in a letter of interest and received the application.

This initial application had documents that required notarization, which I paid to have done. I then sent in my package, but heard nothing for a few weeks. I called and left a message, which was not returned. The next time I called, the Representative answered. He looked up my file and informed me a few pages were missing. I promptly faxed them to him and my application was processed.

A few days later I receive a letter stating that I must send in four different types of standard WC reports from 6 different claimants, who must have been seen in the past 12 months. A deadline of 20 days was given from the date of the letter. I called within the 20 days to inform the Representative that since I worked part time, I did not have the required number of samples. He said he do some research and would call me back. At the end of the day, he called back to inform me that SCIF had temporarily closed their MPN, and that applied to applications in process as well. He stated that it was not specific to me, but to all applicants. He said no further details were known, but they had my application and I could check back to find out if the MPN was reopen.

I am frustrated because my time, effort, and money was wasted. The process seemed to be overly bureaucratic and random! I also feel that individuals who are new to treating WC, or returning from maternity leave, or work part time may be excluded from being on their network because they do not have multiple samples of reports from multiple claimants. I have heard that there are not enough psychologists on SCIF's MPN, so that whole chain of events really makes me wonder.

My second concern is one that many of my colleagues in Psychiatry and Psychology in San Diego have. I have already sent an email to Dr. Gratch, who has graciously responded. But I will just mention it again since I am writing. There are doctors from Los Angeles flooding the QME psychology and psychiatry panels. They and a few local doctors have listed as many as 30 offices in the region, thereby increasing their odds of turning up on a panel to almost every one. A few of these doctors do not go to the location listed and tell the claimant that they must schedule at the doctor's main office, as long as it is within 60 miles. Most claimants do not know they have the right to refuse to make such an appointment. Limiting the number of offices a QME can register to 5 and requiring that the evaluation take place at the location listed on the panel will greatly alleviate the current problems.

Thank you for your time.

##

Item 104: Improving the WC System - Board Rule 10888

4/30/2012 email (redacted)

AD Moran, et al,

PROBLEM: Lien Backlog & Streamlining the WCAB.

At the present time, many WCJs are ignoring the dictates of Board Rule 10888, which states:

After issuing an order approving compromise and release that resolves a case or an award that resolves a case based upon the stipulations of the parties, if there remain any liens that have not been resolved or withdrawn, the workers' compensation judge shall

- (1) set the case for a lien conference, or
- (2) issue a ten (10) day notice of intention to order payment of any such lien in full or in part, or
- (3) issue a ten (10) day notice of intention to disallow any such lien. Upon a showing of good cause, the workers' compensation judge may once continue a lien conference to another lien conference. If a lien cannot be resolved at a lien conference, the workers' compensation judge shall set the case for trial.

An agreement to "pay, adjust or litigate" a lien, or its equivalent, or an award leaving a lien to be adjusted, is not a resolution of the lien.

SOLUTION: By insisting all WCJs comply with Board Rule 10888, and setting a lien conference after the case in chief resolves, this will result in fewer lien claimants having to file a DOR to have a lien conference set. This will also reduce the paper DOR backlog at many offices of the WCAB.

##

Item 105: Improving the WC System - Board Rule 10608

AD Moran, et al,

PROBLEM: Lien backlog and streamlining the WCAB.

At the present time, few parties (defendants, applicants, and lien claimants) comply with the dictates of Board Rule 10608, which states:

(a) All medical reports and medical-legal reports filed with the Workers' Compensation Appeals Board shall be filed in accordance with the regulations of the Court Administrator, or as otherwise provided by these rules. Service of all medical reports and medical-legal reports on other parties and lien claimants shall be made in accordance with the provisions of this section.

(b) After the filing of an Application for Adjudication, if a party or lien claimant is requested by another party or lien claimant to serve copies of medical reports and medical-legal reports relating to the claim, the party or lien claimant receiving the request shall serve copies of the reports that are in its possession or under its control on the requesting party or lien claimant within six (6) days of the request, if the reports have not been previously served. The party or lien claimant receiving the request shall serve a copy of any subsequently-received medical report or medical-legal report within six (6) days of receipt of the report.

(c) At the time of the filing of any Declaration of Readiness to Proceed or Declaration of Readiness to Proceed to Expedited Hearing, the filing declarant shall concurrently serve copies of all medical reports and medical-legal reports relating to the claim that have not been previously served and that are in the possession or under the control of the filing declarant on: (1) all other parties, whether or not they have previously requested service; and (2) all lien claimants that have previously requested service. The filing declarant also shall serve a copy of any subsequently-received medical report or medical-legal report relating to the claim within six (6) days of receipt of the report.

(d) Within six (6) days after service of any Declaration of Readiness to Proceed or Declaration of Readiness to Proceed to Expedited Hearing, all other parties and lien claimants shall serve copies of all medical reports and medical-legal reports relating to the claim that are in their possession or under their control, and that have not been previously served, on: (1) all other parties, whether or not they have previously requested service; and (2) all lien claimants that have previously requested service. The other parties and lien claimants also shall serve a copy of any subsequently-received medical report or medical-legal report relating to the claim within six (6) days of receipt of the report, consistent with subsections (d)(1) and (d)(2).

(e) If, at any time after the periods specified in subsections (b), (c) and (d), a lien claimant initiates a request for service of medical reports and medical-legal reports, all parties and other lien claimants shall serve the requesting lien claimant with copies of all medical reports and medical-legal reports relating to the claim that are in their possession or under their control, and that have not been previously served, within six (6) days of receipt of the request. The parties and other lien claimants also shall serve a copy of any subsequently-received medical report or medical-legal report relating to the claim within six (6) days of receipt of the report.

(f) All medical reports or medical-legal reports relating to the claim that have not been previously served shall be served on all other parties and lien claimants upon the filing of a compromise and release or stipulations with request for award, unless the rights and/or liabilities of those parties or lien claimants were previously fully resolved.

As a lien claimant, my company has made numerous demands upon the defendant to be served with the medical reports relating to the claim since 1/1/2003. Between 1/1/2003 through 11/16/2008, I made these demands per Board Rule 10608(a), and from 11/17/2008 through the present day, I made these demands per Board Rule 10608(b). Simply put, I don't get served with any medical reports from the defendant until after a WCJ orders the defendant to serve me.

When a DOR has been filed by either Applicant or Defendant, and my company has made prior demands to be served with the medical reports, Board Rule 10608(c) requires service of the medical reports upon my company, as we have made prior demands. Again, my company does not get served with any medical reports until after a WCJ orders the defendant to serve my company.

After my company has filed a lien with the itemization and supporting medical documentation upon all parties as is required by Board Rule 10770, and the case in chief resolves, my company usually receives a copy of the Compromise and Release, or Stipulations with Request for Award, but never once has my company also been served with all medical reports relating to the claim as is required by Board Rule 10608(f). When my company appears at a lien conference, my company does not get served with any medical reports until after a WCJ orders the defendant to serve my company.

Each lien conference continuance is, in essence, a CT injury upon the WCAB - resulting in numerous repeat lien conferences, simply due to the failure to serve medical reports relating to the claim upon the lien claimant as is required by Board Rule 10608(b), (c), and (f).

The WCAB, on its own motion, should sanction non-compliant parties and lien claimants as allowed by Board Rule 10561(b)(3). This will result in fewer continuances of lien conferences, and reduce the lien backlog as well as streamline the WCAB.

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Item 106: Workers Compensation- Public Forum Comments.

5/1/2012 email (redacted)

To the Administrative Director, or concerned parties.

My name is XYZ, I am with the Law Offices of XYZ and have represented injured workers for 10 years.

My suggestions are some mostly simple common sense fixes:

1. Eliminate the PQME process for represented injured workers. This leads to more litigation, not less. Go back to dueling QME's- pre SB899 law on QME process. If we must have the PQME process the way it is, I think QMEs should be limited in the number of offices that they can have evaluations out of to no more than 3 offices. I find it to be fundamentally unfair to constantly have the same QME's appear on all panels, regardless of location. Also, I think we need to eliminate most if not all the sub specialties. Pain management/ Orthopedic/ Orthopedic Surgeon for example can be combined. Psychiatrist/ Psychologist can be combined. This will eliminate some litigation. I also believe that if a PQME is used, and the defendants request a deposition of the QME, I believe that the attorney for the applicant should be afforded an 5710 like fee for attending the deposition, if it was requested by the defendants. Defense attorneys are paid for this service, why not applicant attorneys.
2. Eliminate Utilization Review for De-minimis medical treatment issues. There is really no reason to have UR review of post surgery Physical therapy sessions as requested by the surgeon. There needs to be a common sense approach to UR. I don't disagree with UR in general, just how it has been applied to every single medical treatment request no matter how small the request is. There needs to be more flexibility for adjusters to simply authorize some treatments. Maybe UR should be reserved for treatments that cost over \$250.00?
3. Eliminate the 15% bump up/ down for all cases where the employer is not self insured. This is completely useless, and just creates another issue to litigate over. It does not create any employer incentive as far as I can tell (unless the employer is self insured).
4. Eliminate the 2 year cap on TTD for those cases that involve failed surgeries, or where revision surgery is necessary, and other special circumstances where additional TTD is clearly warranted. It is simply cruel to tell an injured worker suffering from failed back surgery that he/she has "capped out" on TTD.
5. There has to be some adjustments to the AMA guides rating system. The reason we have Almaraz-Guzman is precisely because the AMA guides are deficient in so many ways. For example, someone with a herniated disc at L3-4, but has not elected surgery, and who rates out under a category 3 DRE under the AMA guides, gets 13% maximum. This is just ridiculous. That injured worker is usually limping with excruciating pain caused by a nerve impingement. He/she is not going to be able to work. In many cases, such as the one I just mentioned, there is no connectivity between the rating, the corresponding monetary value, and the loss of function caused by the injury that will probably keep the IW from returning to work. An alternative rating criteria/ guideline, that perhaps incorporates some aspect of the Old PDRS with the AMA guides, but eliminating subjective complaints, could be incorporated. I believe that a panel of doctors who regularly perform AME/QME evaluations, should be provide some input on the rating criteria, and perhaps a commission of evaluating doctors and stakeholders can be created to work on this.

##

Item 107: Workers' Compensation Forum Comment

5/1/2012 email (redacted)

Ms. Baker and Ms Moran:

I attended the Oakland Forum yesterday and did not sign up as a speaker, assuming that there would be many in the audience that would address the issues I face everyday. I was wrong and I regret not speaking.

I suspect people like me were not aware of the forum or could not take the time off work to attend the meeting. We are in the trenches of actually dealing with payment for services to injured workers. It's time-consuming and frustrating trying to get authorization to treat a patient, and then to get payment for approved treatment. Many quality physical therapy practices refuse to treat workers' comp patients because of the complexities of management of cases.

Because of the extremely low fee schedules, a quality physical therapy clinic loses money on each patient. Practices that gladly accept workers' comp patients use under-qualified or non-qualified personnel to treat patients (athletic trainers, aids, volunteers), a practice that does not promote speedy recovery to injured workers. Payment for a physical therapy treatment is lower than any PPO and the management of those claims requires much greater effort.

These are some suggestions that would help us people in the trenches:

- Reform the fee schedule and do away with the cascaded payments. Each service provided a injured worker has the same importance and requires the same one-on-one effort. Cascading, combined with the PPO discounts, substantially reduces payment. In short, direct WC insurers to pay us more.
- Allow the use of the current CPT codes. Using the old code set prevents physical therapists (and I suspect other medical professionals) from billing electronically. When you cannot bill electronically, you can't prove that you billed in a timely manner.
- Improve the Division of Workers' Compensation website. I have searched and searched for answers, contact numbers, and resources on how to get my claims paid, but can find nothing. Create a page for medical providers who are having trouble getting paid for their services. Describe the audit request system and the green lien. Create an on-line complaint form that can be automatically submitted. This would create a database of insurance companies who have complaints lodged against them and will pinpoint those insurance companies that should be investigated and audited.
- If it is determined that a workers' comp patient needs physical therapy, eight visits should be approved, automatically, with some exceptions. Some patients need only one to four visits to be instructed in a home exercise program. (I strongly disagree with the chiropractor who suggested that if a patient is allowed 24 visits, all 24 should be approved without question. We have rarely needed to treat a patient 24 times.)

Please allow me to to describe just one interaction with one insurance company: Keenan & Associates.

A workers' comp patient was treated in early January of 2012. We send clean claims and always attach copious chart notes to justify each claim to avoid denials. Keenan & Associates paid for the first visit. But they denied the second visit and all other visits, saying our clinic was not in network.

I called and was told that the therapist that treated the patient was not in network and that the owner of the practice was the only one in network. I argued that I'd been billing Keenan & Associates for many years and had never had this problem. None-the-less, I re-billed the denied dates of service, so that the claim would point to the practice name and tax ID, rather than the treating therapist. The claims were denied again. I telephoned again, arguing that we were in network. I finally was told by a Keenan & Associates rep that the claims were denied due to their error. Their database listed only the owner of our clinic and not the business name. I asked why the first claim had been paid and that all other patients' claims had been paid in the past. The rep mumbled something about recent changes to their database.

These telephone calls and re-billing cycles took me at least two hours. On April 29, I received payment for dates of service in January that had been denied. Even though Keenan & Associates had admitted that the denial had been their error and I verbally told the rep that I expected penalties and interest on the claims, I received no extra payment on those payments.

This experience is not unique. We medical providers should be paid and be paid promptly for services rendered without delays and repeated billing. If these denials are not intentional, then the insurer's need to reform their payment process. Such denials are too common, though, and we billers believe the denials ARE intentional.

In my experience, Keenan & Associates and Gallagher Bassett are two insurance companies who need investigation. All too often we do not receive payment from these companies and when we telephone, we are told that they have no record of the claim and that it needs to be re-billed. I have asked the DWC to audit Keenan & Associates on two different occasions, and I would be extremely happy if someone would intercede on my behalf to make them pay the penalties and interest that are owed.

Thank you for the Forum and for taking the time to read this long email. If I'm taking the time to write, there are many, many others who are having the same problems that don't even know where to write.

##

Item 108: Forum

5/1/2012 email (redacted)

The system is obviously broken. Though SB899 created more cumbersome system and thus created more cost in some parts, while trying to save money in others.

How do we "control" liens:

1. Create a system, which makes liens unnecessary. Specifically, encourage insurance to pay for necessary treatment.

In my personal practice, most of the cases I see are admitted. Less than 10% get reviewed by UR. Nevertheless, I still have significant number of cases going for collections. The reason why, is because most of the charges go unpaid without any explanation. A lot of requests for treatment go unchallenged, yet, when it comes to pay, the reason stated is "no prior authorization obtained" even though I have produced multiple reports where I ask for authorization.

Sandhagen made it clear that the carrier has to follow 4610 if the treatment is to be denied. However, it left a loophole: treatment has to be medically necessary. Thus, most carriers feel, they can argue medical necessity retroactively. As a result, the case goes to court and process becomes a drag. Both parties end up going to court multiple times, case gets referred back to AME for an opinion on Medical Necessity. My suggestion to limit the number of these cases by not allowing retroactive debate on Medical Necessity. If the carrier wants to argue this issue, it has to do it within the frame of 4610 proactively, unless treatment was performed without request for authorization. Penalties beyond today's 15% if denial is frivolous.

2. The other reason for lien litigation is disagreement on how much should be paid. Most of my practice is PTP. 99% of my services are within the frames of OMFS. Still significant number of them are underpaid. I suggest to have DIR develop a system where OMFS value is attached to a statement. It may involve billing professionals employed by DWC or even a simple software, where CPT codes get entered and the value is produced, representing OMFS value of the balance. There is no high quality training involved. A clerk with billing education may do it.

The other issue I see is disorganization of MPN's:

I am on most MPN's, but I never know, which MPN I am still on. It's like musical chairs. One day I get a note from some MPN saying I can not treat a specific patient since I am not longer on one. For instance, ever since 2005 I was on Liberty MPN. Suddenly, at the end of 2007, I was removed. Apparently, they switched from First Health to Blue Cross. Even though I was also on Blue Cross, I was no longer a part of Liberty. There was no grievance process, no evaluation, no specific reason for removal. The decision was completely random. Many times I tried to talk to Liberty officials, I would get the same answer: we have enough doctors in your area. When I looked on their listing, I saw many doctors listed who used to belong to a specific medical clinic and not employed by them anymore, and others who have nothing to do with WC, such as pediatricians. In the mean time, the patients who have been with me for a long time because of the complexity of their treatment, had to chose a new PTP.

The process of enrollment in MPN and dismissal from it has to be based on specific doctor's professional performance, such as standing with Medical Board. Just as any PPO, all the doctors have to be allowed

to apply. There must be a grievance process, where the doctor has a chance to challenge the decision. Again, the decision to remove must be based on the doctor's professional reasons.

##

Item 109: ACOEM DWC Public Forum 4 30 2012 v2.doc

5/1/2012 email (NOT redacted, submitted as a copy of public oral comments)

Good Morning, My Name is Chris Wolfkiel, and I am the Director of ACOEM's Practice Guidelines. Thank you for giving me the opportunity to speak this morning.

I'd like to comment briefly on the status of the ACOEM Practice Guidelines with respect to the Medical Treatment Utilization Schedule – and bring to your attention to options that we feel would be very beneficial to workers in California who are injured.

As we know in 2004, California adopted ACOEM's second edition of the Guidelines as the basis for MTUS, as well as ACOEM's evidence definitions, as part of its workers' compensation reform efforts. As part of ACOEM's updating commitment, we completed the Third Edition of the Guidelines in 2010 as well as a transition to a new electronic platform which allows state level customization. It should be noted that while the Second Edition is out of print, ACOEM is committed to making it electronically available for California stakeholders.

There are significant advantages in the Third Edition that would benefit California workers who are injured.

One of the most important is that the Third Edition represents a complete systematic evidence review performed by the Rocky Mountain Center of Occupational and Environmental Health. This includes more than 2000 evidence table entries and 14,000 literature citations. The result is greater depth and breadth of content: There are 2500 evidence-weighted recommendations in the Third Edition compared to 500 in the original MTUS guidelines adopted almost 8 years ago.

While the current implementation of utilization review in California allows for use of additional evidence where MTUS is silent, this situation results in an overly complex and costly system that is based on out of date evidence and results in poor delivery of care to California workers who are injured.

Our new edition and technology platform offers a solution. I urge the Division to make MTUS compliant with the evidence standards legislated 2004 with the most up-to-date evidence-based recommendations from ACOEM's Third Edition.

Thank you for your time this morning.

##

Item 110: Workers Compensation Mess

5/1/2012 email (redacted)

We have slipped back into the era before the reforms of 2004. The system is not going to function efficiently until we reduce the incredible involvement of attorneys. The workers compensation system was designed as a no fault system to care for injured workers and help to put them back into the workplace. Attorneys and physicians are treating the system as a lottery system for themselves. It is easy to find an injured worker to complain about how he or she was not treated fairly. But in reality, the very vast majority of injured workers are taken care of properly and many injured workers are “used” by attorneys to further their gain. Alamar/Guzman doesn’t even make sense. It is a decision that is convoluted and only benefits the attorneys in extorting money from insurance companies. The reforms as implemented by Governor Schwarzenegger were terrific and gave everyone a fair deal. The attorneys found a way to undermine the system. There is no fixing this. Companies will be vacating the state next year as quickly as they can pull up their pants and get out.

##

Item 111: Considerations for Work Comp Reform

5/1/2012 email (redacted)

Hello,

Here are suggestions I have for consideration for work comp reform:

- 1) Implementation of an RBRVS fee schedule. Bundling of medical treatment services based on diagnosis. With the current fee schedule, Evaluation and Management codes are compensated at barely 100% of Medicare, while surgeries and other procedural codes are compensated at 150% - 180% of Medicare and more, with additional reimbursement possible for unbundling the requested services. This provides too strong an economic incentive for surgical and other invasive treatment, while undervaluing evaluation and management services to the extent that primary care doctors are incentivized to transfer patients to surgeons and pain doctors after as little as 30 days of conservative treatment. Medicare and private health care are facing significant reimbursement cuts, so it is unlikely that specialists will flee the work comp system if an equitable reimbursement structure is implemented.
- 2) Implementation of a flat fee compensation for applicant attorneys. The current commission-based reimbursement structure provides a perverse incentive for the applicant attorney to drive up disability. This reinforces the injured worker's conviction of injury, thwarts recovery, and is at cross purposes with the efforts of the treating doctors. Commission-based reimbursement structures drive up costs in every system that they are in place (even real estate), and are contrary to any efforts to bring about work comp cost containment and reform. A flat fee structure should be implemented.
- 3) Implementation of patient co-payment for medical treatment. As it stands, the injured worker has no investment in their own treatment. Private health care has convincingly demonstrated that co-payments for treatment make the patient a more intelligent consumer, provide the patient with incentive to recover, and contain costs. The work comp system should implement a modest co-payment, at least for office visits.
- 4) Implementation of a default Official Medical Fee Schedule (OMFS) based on Medicare. For many years we have seen providers exploit "loopholes" of treatments not covered by the OMFS to charge outrageous fees for services and products with no evidence based support. This leads to "whack-a-mole" treatment fads, with a new loophole popping up each time one is closed. Earlier there were surgicenter charges, most recently there have been compounded medications, and now urine drug tests. The OMFS should be set up so that it defaults to Medicare for any service or product not specifically covered.
- 5) Implementation of a standardized medical treatment request for authorization form ("RFA"). Use of DFRs, PR-2s and narratives is well meaning, but unfortunately the language in them is

typically very vague. Telephone calls to clarify requests are often necessary, causing delay or noncertification. Here are suggestions for a standardized RFA that will streamline the treatment review and approval process.

1. The RFA form should be a list. "Here are the requests: 1)...2)...3)...etc."
 2. The RFA form should specify that the treatment request should be in the form of a **request**, not an observation, a consideration, a possibility, a potential future plan, etc.
 3. The RFA form should specify whether the request is an **appeal** of previously reviewed treatment.
 4. The RFA form should specify that it must be authored and signed by **a physician** per LC 3209.3.
 5. The RFA form should specify that it must be authored and signed by the physician **who is actually going to do the treatment**. It should not be from a proxy physician (even the PTP) who is simply weighing in on what the actual treater is requesting to do.
-
- 6) Updates of the Medical Treatment Utilization Schedule. This is a very valuable schedule, and is very effective in providing an evidence-based framework for medical treatment, and it should be preserved. However, medical treatment is becoming broader in scope with each passing day, and the MTUS needs to be updated frequently, I would suggest approximately every six months.
 - 7) Checks and balances on accountability of insurers to return savings to employers. As it stands, cost savings realized by work comp reforms are simply retained by insurance companies. There should be a systematic pass-through of a substantial proportion of these savings to the employers.
 - 8) Medical Legal Evaluators per LC 4062(a) and 4062(b) need to be accountable to Evidence Based Medical Standards per MTUS. AMEs and QMEs are currently not held to any standard for treatment recommendations. There needs to be a statute that specifically holds AMEs and QMEs accountable to the MTUS, with DWC review of QME certification for those evaluators who demonstrate a pattern of disregard for the MTUS.

##

Item 112: public forums on workers' compensation

5/1/2012 email (redacted)

Gentlepersons:

As a veteran workers' compensation attorney (now completing my 38th year of practice), I believe that I have a unique perspective on the system and how it functions. During my career I have been both an applicant's and defense attorney, thus clearly understand the differing views on what is "wrong/broken" in the system.

Recently there has been much dialog regarding SB899 and its impact on the system and the delivery of benefits. It is hard to disagree with the applicant's viewpoint that permanent disability benefits were drastically reduced as a result of SB899, as we see the differences daily as we resolve cases. This in turn has forced some applicant's attorneys to add on body parts such as: psych, internal, sleep disorder and sexual dysfunction to even the most basic of cases. This in turn has aggravated the defendants because of the seemingly frivolous nature of these added on claims.

Applicant's attorneys have also been quite creative with going outside the AMA guidelines with case law interpretation such as the Ogilvie and Alarez/Guzman decisions.

However what all of this has done, is to increase litigation and slow down the normal progress of cases.

On the medical cost side of the equation, multiple referrals to secondary treating physicians, compounding drugs, more frequently proscribed opiates and other alternative treatments has gradually increased the cost load to a level where the gains achieved by SB899 have been greatly eroded.

In response the defendant's now send everything through the Utilization Review process and seem to have abandoned any independent discretion in approving what would otherwise be logical approval of treatment recommendations.

With all of this as a backdrop I would like to propose some suggestions for your consideration.

1. Do something to deal with the tremendous backlog of liens in Southern California and to prevent the continuing problem from growing even larger. You have better minds and input than mine that have spoken extensively on this subject. Listen to them and adopt some of their ideas.
2. Utilizing the AMA guides and the PDRS, increase permanent disability levels to a more realistic level.
3. Eliminate tough legislation Ogilvie and Alarez/Guzman. This will drastically reduce litigation at the WCAB and cross-examination of AME's and PQME's.
4. In some way limit the added on body parts, perhaps by requiring some medical necessity for a referral to a doctor in an additional specialty.

5. Create a fee schedule for collateral vendors such as interpreters, copy companies, process servers, etc.

Thank you for taking the time to consider the above thoughts. I would be happy to discuss these ideas at your convenience.

Very truly yours,

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Item 113: Attn., following CA DWC Public Forums: written comments/recommendations for improving our WC process

5/1/2012 email (NOT redacted, submitted as a copy of public oral comments)

To our esteemed leaders, CA DIR Director Christine Baker and DWC AD Rosa Moran,

In behalf of the members of the California Consortium to Promote SAW-RTW and myself, thank you for your vision, and for the extraordinary, graceful patience you each have shown in hosting these DWC Public Forums, statewide. The tone that you have set together of civility, respectful interest and commitment to envisioning constructive change is heartening. We clearly share a love of our state, for its people and its great productive capacities.

Several of our members have attended these Public Forums throughout the state to speak up as concerned Californians. We all are stakeholders in basic worker health, function and workplace productivity matters: “Stay-at-Work and Return-to-Work,” who deeply and urgently wish to contribute to our State’s resurgence of worker health and workplace productivity.

We would like you to know: We are certain of California’s potential to more effectively meet pressing medical and economic needs of working Californians who have acquired medical and/or functional impairments, during their working lives. We believe that serious examination of reforms, and transferable program models we’ve suggested will also help meet the closely associated needs of their employers, and the broader health and productivity needs of California workforces, families and communities.

I would like to share scripted comments our group prepared as “talking points” for reference in our participation, if desired, in these Forums. Please see these, as follows:

I am speaking today as a concerned California Stakeholder in work disability prevention and absence management, and as an independent consultant in work disability and absence management. I am a volunteer member of the California Consortium to Promote Stay-at-Work and Return-to-Work.

The California Consortium is an independent, voluntary group of California-based stakeholders and professionals (employers, labor partners, physicians, insurers, government and private sector representatives) engaged with stay-at-work and return-to-work policies, and practices. The original group was formed in, and has met continuously since 2007. **The CA Consortium's purpose** has been to share ideas, innovations; develop specific projects to illuminate solutions; and build support for those which will best keep Californians working safely and productively while healing from and/or coping with medical or functional impairments.

Over the past 10 months, our group has developed a series of suggestions in the form of opportunities we wish to offer to the CA Department of Industrial Relations. These are posed for the sake of improving early workplace intervention whenever an employee experiences functional impairment due to injury or illness. These suggestions encourage safer, faster and more beneficial return-to-work outcomes for all California workers and their employers, alike. The CA Consortium believes that functional impairments due to an employee’s injury, illness or from side

effects of medical treatment, may emerge in the course of anyone’s normal work life. These events need not directly cause the serious personal, organizational, fiscal and social harms that all stakeholders presently experience in California under workers compensation, short-term and long term disability subsystems governed by laws with overlapping but non-integrated RTW requirements and obligations. Our suggestions call out the critical importance of engaging California Healthcare Providers in the unfortunate custom of presumptively advising work absence, rather than explicit activity restrictions based on **authentic medical necessity**.

Our group advocates for thoughtful medical guidance that advises patients to engage in safe activity, however restricted, as a healthy component of treatment regimens Intended to achieve optimal medical and functional recovery. We believe that, in most instances, this activity guidance would support employer-provided early return to work, and in many instances, would indicate to all stakeholders a medical “green light” to safely remain at work, while healing from myriad functional impairments.

We believe that California employers would quickly recognize the fiscal and productivity value inherent in this quality of guidance. We think fiscally smart California employers would meet these opportunities by removing existing workplace barriers to productive, temporary transitional work. In other circumstances, the provision of the interactive process for reasonable accommodation under the FEHA would proceed more easily from proactive, plain-spoken medical guidance for safe, restricted activity. **These collaborative interactions are understood as “work disability prevention.”**

We believe that encouragement in these matters by the CA Department of Industrial Relations will help move all California Stakeholders toward policies and practices more congenial with preventing medically needless, and often harmful work disability – whether it results from work-related circumstances, or not.

The CA Consortium to Promote SAW-RTW is now recommending a serious study, possibly under the leadership of the Commissions on Health and Safety and Workers Compensation, of effective policies and practices as in our proposal document. We believe the effects of such conducting such a study, and its anticipated findings could reinvigorate California’s aspirations to become a “full productivity” state, and could lead to developing a model for work disability prevention and mitigation.

It is the view of CA Consortium members that the health and safety of employees is driven by a continuum of injury prevention and mitigation model that derives from six fundamental features. These features include:

1. **A solid workplace injury and illness prevention program**
2. **Advocacy** (e.g., State policy and program model) **for individual and shared responsibilities for general health and well-being at work**, in families and in communities, of working age Californians
3. **An immediate and affirmative response by employers to employee complaints when they demonstrate symptoms reasonably attributable to work conditions** or functions minimizing the likelihood that a workers’ compensation injury claim need be filed
4. **An early intervention approach that supports keeping employees at work during healing** from any disruptive functional impairment resulting from workplace injury, illness or a personal health condition (exclusions compliant with FEHA restrictions)
5. **A Stay-at-Work/Return-to-Work program expectation of employers**, that meets the objectives of reducing medically unnecessary days away from work while appropriately using safe, productive engagement in the workplace to enhance healing
6. **Other services that support SAW-RTW for employees, whose employers are compliant with FEHA and its rules and regulations, providing the interactive process for reasonable accommodation; and the full integration of this effort** so as to meet existing opportunities and obligations under the Labor Code (accommodation as return to a permanent, modified position); as well as support for RTW through external, or out-placement when an employer is not able to accommodate an employee’s compromised work abilities.

I have attached the summary of policy suggestions you have been personally given, by myself and other members of the CA Consortium, throughout these April Forums.

Thank you again for your generous attention to voices of your fellow Californians for stronger, healthier and more productive industrial relations, in our state.

Sincerely,

Robin M. Nagel, MS, CDMS, HEM

##

Item 114: Opinion

5/1/2012 email (redacted)

I work for a small medical laboratory. In the last 5 years, we have had 1 actual on the job injury and 7 claims listed below. Our Workers Comp rate went from .91 or 2.35. Over the past 5 years we have had claims by employees who have gone to an attorney. Examples of our Workers Comp claims:

- 1) An ultrasound technologist claimed injury to his right shoulder, torn rotator cuff. No witnesses or injury report filed. We provided videos of him working in his yard and lifting heavy planters. The insurance company would not accept them. Included in the information we gave the insurance company was proof that the tech was working part time doing the same job in the evening for another company while claiming to not be able to work because of the injury. Total cost of the claim = \$94,500.97
- 2) A Billing Manager who was terminated for theft of company documents. She received a \$25,000.00 settlement. We have and gave the insurance company a video of her giving the documents to a salesman who was going to work for the competitor. She even solicited the salesman to get her a job with the competitor. The insurance company would not even listen to our explanation. She filed her claim 6 days after being terminated and claimed that she reported the claim before she was fired. She did not and I have witnesses. Her witness that she did was her sister who had worked in the same department. She even tried to falsify the DWC form. Total cost of the claim \$53,541.04
- 3) An employee who resigned her position filed for Workers Comp 19 months later claiming cumulative trauma, back and should injuries. She went to an attorney. She never told anyone about an injury even though she visited our office and talked with the CEO of the company numerous times for over a year after she resigned. She claimed that a box of x-ray film fell on her head and gave a specific date for the injury. (Mind you, a box of x-ray film weights 60 pounds. If she had been hit, there would have been a definite injury.) We provided proof that she was not at work due to medical reasons on the date she claimed it happened. She then changed the date to another date which was also not possible because she did not go to the site where she claimed the injury happened. She then changed the location of the injury, twice. She now claims that the box fell on her while she was driving on the freeway, another change. That is not possible because all of our vans have a protective shield behind the driver so there is no possible way for anything to fall on the driver. There is no possible way for anything to even be above the driver. The insurance company provided her with a secret deposition because she stated she would be intimidated and could not tell the truth if a company representative was there. At one point, the insurance company told us that it was none of our business anymore. The case is still open. Now the insurance company wants our help because of the amount of money she is demanding. Total cost of the claim to date = \$255,523.43
- 4) A courier was involved in a car accident. He was hit in the rear end, not his fault. He claimed no injury but went to an attorney. He got a \$25,000.00 settlement. Unfortunately, he was involved I another accident, again hit in the rear end, again not his fault. Again he claimed no injury. He got another \$25,000.00 settlement before we even knew he had filed a claim. In both cases, the employee did not miss any work time nor did he claim any injury or ask for any treatment. We later caught him passing out his attorney's

business cards while telling his fellow employees that this attorney would get them a huge settlement, all they had to do is make up an injury. We have that on video also. Total cost of the claims = \$109,234.57

- 5) An employee claimed to have tripped over a plastic insulated carrying bag, claimed a shoulder injury. She had claimed the same injury in a previous Workers Comp claim. The previous doctor stated that there was a benign growth in the shoulder but it was not due to any injury. The insurance company would not accept the medical opinion of their own physician. She received a \$7,000.00 settlement for the second claim. Total cost of claim = unknown because the insurance company claims it is confidential information.
- 6) An employee claimed to have smashed her thumb and claimed Workers Comp. She was off work 6 months. I offered to take the insurance company agent to the Chino bowling alley so they could watch her bowl every Saturday night. The insurance company declined. Total cost of the claim = \$18,252.90
- 7) A current employee is off work on Workers Comp due to an auto accident. He is claiming shoulder and lower back injuries. The insurance company is treating him for his diabetes, palsy, high blood pressure and obesity because they have to treat those in order to treat his injury. All conditions existed before his accident. He has been off work now for over 8 months. Total cost to date = \$53, 252.90

Do I believe that the above claims are fraudulent, of course I do.

What we have learned is that if an employee goes to an attorney, there is only 2 possible outcomes. A settlement or a bigger settlement. The cost of taking a claim to trial is in excess of \$150,000.00, not including expenses already paid. The insurance company will settle the claim whether the insured agrees or not because it is financially advantageous to them. The insurance company then increases the Worker Comp mod which increases the companies premium. The insurance company has no incentive to investigate the claim nor do they have any interest in anything the insured has to say or can offer in the claim. They are financially better off to settle the claim and adjust the mod of the employer because it increases their revenue. There is one claim that is not listed here. It was a valid claim, the only valid injury in 5 years. The employee did not go to an attorney but was off work for over a year. She received full treatment for that period of time. She ultimately moved out of state so she did not return to work for us.

California has a Workers Comp system that entitles settlements for questionable or fraudulent claims by employees. All they need do is go to an attorney and they will get a settlement. The attorney has no incentive to validate the claim because he/she knows the only outcome is a settlement and he/she gets paid. I have filed false claims complaints with the State of California and have never received even an acknowledgement that the filings were received, much less looked at. In the State of California, the employee does not have to prove that they were injured. The company and insurance company has to prove that they were not. That is virtually impossible because Attorneys are very good at including a list of injuries that cannot be disproved such as psych, soft tissue back and shoulder pain, emotional trauma, etc. There are a legion of doctors that will validate any injury for a fee with no possible

repercussions from anyone. The system is designed so that the company/insurance company automatically loses. It guarantees workers comp fraud.

Where is there a mechanism in the Workers Comp system to identify false claims? Where is there a mechanism to protect the employer against false claims? Where is there a mechanism designed to protect employers against opportune insurance companies. Where is there any mechanism that protects employers in any way? I do not argue that an injured employee is not entitled to treatment and I do not argue that all claims are false. If an employee is injured and the employer does not provide treatment, there should be severe penalties including getting an attorney. I do argue that if an employee's goes to an attorney, there should be some mechanism to protect the employer from the biased system now in place. As it is now, there is no other outcome other than a settlement and penalty to the company, even for false claims. There is little or negligible chance of a false claim being investigated. Oh yes, I have seen the list of false claims investigated by the State and found to be fraudulent. Most are claims that were so blatant that they should have never been accepted in the first place. What is the percentage of these "investigated claims" against the number of claims filed? Miniscule! By California law, the company has no rights to protect themselves from false claims or from attorneys whose only motive is to get the settlement they are entitled to receive because of California's worker comp entitlement program.

What is the impact on our company you might wonder for all of these claims? My company now pays over \$422,000.00 per year in Workers Comp premiums because of the above listed claims. No one in the company has had a raise for over 4 years because the company cannot afford them. The owners of the company are now considering closing the company because of the excessive premiums. One hundred and fourteen people may lose their jobs because of 7 workers comp claims that are questionable at best and fraudulent at worst, in my opinion.

##

Item 115: work comp: need changes.

5/2/2012 email (redacted)

The worse part of my overall bad experience with work comp, is the denial of treatment for my RSI injuries. If work comp would have authorized timely treatment and time off work in the first 6 months of my injury, I likely would not have been off work for the last 5 years, barely able to use my hands or lift 2 pounds. Now, I am permanently disabled. Work comp must do a better job of authorizing treatment and encouraging time off work for RSI injuries. Utilization review should be eliminated for doctors working within the medical provider networks; perhaps utilization review could be used for doctors outside of the network. Also the medical provider networks should be expanded with greater choice of doctors. There should be a variety of doctors to choose from in a close distance to patient's homes. When you can't use your hands, transportation is very difficult.

Currently, it is almost impossible to get authorization from a doctor outside the medical provider network (like SCIF). Please change this so that work comp must accept doctors outside the medical provider networks.

##

Item 116: Comments...on Issues Plaguing the W/C System

5/2/2012 email (redacted)

There is a concern that possibly there should be standard payments to Applicant Attorney's for their fees. I find it interesting that most attorneys in the open market of legal issues get paid \$290 an hour...but under Work Comp for depositions – costs can range between \$350-400 per hour. What is more interesting is that Defense Attorney's range between - \$130-\$175 hour. Not only that add into the cost of the 15% that They receive as the percentage of the PD payable to the employee...otherwise, look at capping the percentage That Applicant Attorney's receive on the Employees Award.

##

Item 117: UR and MPN issues

5/2/2012 email (redacted)

Department of Industrial Relations director Christine Baker and Division of Workers' Compensation administrative director Rosa Moran

Dear Director Moran and Director Baker,

I spoke at the Fresno meeting a few weeks ago. I have been a UR physician with SCIF for over 15 years working part time out of the Fresno office. I am also a QME and treat injured workers. I am concerned with two issues:

Utilization review and MPNs.

1. UR- The UR system is not a good one. I am seeing delays in treatment due to a slow system. I know that the response to a PR-2 should take 5 working days and with some of the companies it happens in a timely manner. I **usually** never hear from the insurance company or I get a call from the UR doc from out of state that doesn't want to hear my reasons for treatment but is going to deny. I appeal and always get approved. If I am always getting approval then that tells me that I was asking for care within the guidelines. By the time the process is over it takes months.

Solution:

No out of state UR

Have some type of expedited way to get care either with the information and assistance officers, judges or arbitrators to get things moving.

Eliminate UR all together. It is costly and most of the care is allowed anyway.

2. MPNs- MPNs are set up to keep Injured workers from seeking the best providers. They are given the choice of a Workers Compensation PTP like Concentra and they never get out. Most of my patients that I get from the system are at least 6 months to a year out from the Date of injury because the PTP wants to hold on to them for as long as possible. There are too many MPNs to figure out if we are in them or not. Some insurance companies have MPNs that we are a part of and with different employer groups we are not. We are also charged to be in a number of MPNs by the companies skimming a percentage off of our reimbursement for treatment. The OMFS is already reduced.

Solution:

Set up a state wide MPN. Charge all of us a fee to join and require CE to keep all of the PTPs up to speed. The PTPs don't need more than a couple of hours a year. Have a review board who can get rid of the bad guys. Have them sign a binding contract that specifies termination etc.

Eliminate the MPN altogether. Manage with UR.

Don't allow the insurance companies to pay for their MPN on the backs of the PTP.

Thank you for your time.

##

Item 117: Re: Worker Compensation Reform

5/2/2012 email (redacted)

My suggestion is to allow an examiner to authorize the treatment however if the examiner disputes or questions the treatment (include surgeries as mandatory) then it should be sent to Utilization Review. This would increase the speed of treatment and the ability for workers to be returned to work sooner rather than later while they are waiting for authorization or for conservative care to run out till they get the necessary care.

It would also cost less on the medical side of the claim due to the Utilization Review charges which can cost up to \$250.00 - \$300.00 each when the item is only worth \$500.00 so after UR approves the care then the item now costs \$800.00 then you need to add on the examiner's time, faxes, emails, postage, and the doctor's charges his fee for a Peer to Peer conversation which can add another \$300.00. Now you have more than doubled the cost of the original item.

The only group it would hurt would be Utilization Review. Utilization Review has become a bureaucracy added to delay and deny treatment. I can't believe some of the non-certification decisions that have been produced that never should have been denied.

I think we should use the expertise of UR when you dispute the treatment or make it mandatory for surgeries. I believe WC claims would resolve faster and there would be less costs and less disgruntled injured workers if we utilized UR to dispute treatment and not to review all treatment requests.

I also think you should get rid of Permanent Disability – It is just a carrot for an employee to get money for not having a good recovery. TD and Medical treatment only. Plus it would get rid of a lot of litigation.

The Voucher is a joke and a big waste of money, time and paperwork – I have only issued one or two since it has started. Nobody wants it. There is no time limit to end the exposure.

If you reserve \$8000.00 on all of my claims for the Voucher x 168 claims = \$1,344,00.00 of unused money. Nobody can afford that now.

The training for claims examiners is also a joke – 85% of the time it is just an infomercial for an investigator, Medicare vendors, Structure Settlement Brokers, copy work service providers, and an Attorney trying to get business.

Thank You for taking the time for my suggestions.

##

Item 118: More information for Christine Baker

5/2/2012 email (redacted)

Dear Ms. Baker;

After hearing the people speak at the last forum in the Elijah Harris Bldg. The majority felt that QME and AME is distracting worker injuries for adequate care. I couldn't say all of what I wanted to bring because, it would have taken more than the time allows to speak publicly, so I typed by e-mail for Ms. Christine Baker to understand my 30 yrs. injury with Pacific Gas & Electric (PG&E) and why my case needs to be redress especially from the outcome of wrongful termination due to an *ergonomics* issue. Here goes respect.

The year was 1982 when America was introduced to the first computer chip to speed productivity with less paperwork surrounding our workstations. The 'Documate' billing machine where manufacture by National Cash Register (NCR) that isn't design effectively for repetitive body movement and the 70's secretarial chairs didn't help the situation any better.

I was the first to complain however; lower management felt that I was a troublemaker after I return back to work after a month ago auto accident with a mail carrier in the city after my shift from work. In San Francisco, for a police report to be documented you needed to go to emergency room and that what I did and stated neck and lower back with a weeks of rest and second week of lite duty.

Return back to the job I was hired and work good with the 'Readoc' billing machine until they were replace with 'Documate.' I complain for two months without any medical treatment or time off that caused severe injuries to the body like for example; constant bending, twisting and reaching caused my L4 or L5 bone to chip on my sciatica nerve. OUCH!

Finally, six other workers started to complain with the same pain and we seek a Worker Compensation lawyer that made PG&E look into the situation with this machine plus my recommendation to replace the chairs that caused lower back pain.

I received medical for life with a low rating and Vocational Rehabilitation (V.R.) as a mainframe computer operator believing that a 500+ major corporations (injury wasn't under ADA) would fine work within another department instead, I was told that since I went through V.R. that I had to seek work outside the company.

Starting in the year of 1986, I lost my job, career, home and family with all my accomplishment from by previous employers that left me homeless and working temporary just to avoid any company to take the blame of PG&E wrongful termination, just to avoid permanent disability. From 1987 to 2004 Social Security award me disability after 1.5 million or more have RSI due to *ergonomic* an issue that's still an ongoing problem globally. We need care with chiropractors, acupuncture and Herman Miller chairs.

Listening to the people at the forum all I could say is that I been through those cycles of HELL with a rule and regulation that shouldn't been touch IN THE FIRST PLACE. It's in your hand now to balance the rules and regulation for all not just the 'special interest' groups whom snatch our income right under our feet's.

My case needs to be redress because our economy falls under energy, computers and a frail Social Security and housing. Make them paid not only in public safety for San Bruno but, in back pay in worker safety. JUSTICE and RESPECT bring equality.

##

Item 119: Listening Tour Feedback

5/3/2012 email (redacted)

Christine,

Although I was unable to participate in the meetings, I wanted to add my voice to two areas of concern which I feel can be addressed forthwith.

1. Improve Productivity of Appeals Board judges.

As the Commission on Health and Safety and Workers' Compensation (CHSWC) reported on January 19, 2012 in their annual report, productivity at the local Appeals Board offices continues to fall below established standards. It now takes nearly six months to get a Hearing for Trial, and as much as 40 days for an expedited Hearing.

The primary reason for this dismal performance is the requirement that judges approve Stipulations and C&R's. Less than 5% of the DWC's Case-Closing Decisions arise from "case-closing decisions evolved from an Finding & Award (F&A) or Finding & Order (F&O) issued by a WCAB judge after a hearing" according to the Commission report. As a consequence, most of the judge's time is being spent approving resolutions already agreed to by the parties, and not conducting trials in disputed matters; an activity one would think is an important function of this administrative body.

If injured workers and employers could take their disputes to the Appeals Board and count on a quick determination, the effectiveness of the Workers' Compensation system would be improved immediately and immeasurably. If relieving judges of their responsibility to approve Stipulations and C&R's cannot be accomplished by regulatory means, the DIR should sponsor and support legislation to accomplish this important, and desperately needed change.

2. Improve the QME process.

Again, referencing the Commission report, issuing faulty panels over 20% of the time is only one part of the problem.

Requesting a panel, getting an appointment date, and receiving the actual report often takes months. And, the reports often fail the "substantial evidence" test and require the parties to litigate the matter further. All the while, the injured worker waits for the resolution of his/her claim.

The solution requires prompt issuance of panels, implementation of quality control efforts by the DWC, and ongoing monitoring of individual panel physicians to satisfy the requirements that the panel reports be both timely issued and prepared in accordance with current treatment guidelines and the AMA Guides.

If taken, these steps would serve to improve a process the Legislature created to avoid the sins of the past and facilitate the resolution of disputes.

Regardless of other changes you may be considering, implementation of these two changes, would go a long way toward improving the system for injured workers who benefit from the system and the employers who pay for it.

I would be happy to discuss this further if need be.

Thanks,

##

Item 120: PMSI Public Comments - Workers' Compensation Forums

5/3/2012 (NOT redacted, submitted as a copy of public oral comments)

Dear Ms. Moran:

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

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

Pharmacy Networks

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

Opioid Usage and Abuse

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

workers in California and, where necessary, utilize the assistance of stakeholders to address this safety issue with haste.

Pharmacy Fee Schedule & Medi-Cal Linkage

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

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

AWP Unfreeze

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

PMSI clearly understands the confusion which **will** ensue between providers, PBMs and payers – in a multi-payer marketplace such as workers' compensation – when the backdated AWP feeds are also unfrozen. This confusion could easily lead to unnecessary work and stress on all system stakeholders as some entities may push for retroactive payment adjustments on even the tiniest price difference. Additionally, all of this activity will have a direct impact on EDI/State Reporting as changes in payment will necessitate a correction in payment reporting to the state. PMSI urges the Division to work with stakeholders to address and create a simple solution for these confusing issues and believes the Division has authority to waive mandated EDI corrections related to a payment discrepancy during the freeze period and only during the freeze period.

Conclusion

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

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

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

Sincerely,

Kevin C. Tribout
Executive Director of Government Affairs

##

Item 121: Comment on EAMS walk-through procedure

5/3/2012 email (redacted)

Although there are many aspects of the system on which I could comment, most of those have already been discussed. I have a small issue I've not heard mentioned: walk-through settlement procedures. Although I realize that the WCAB expects that in the future all documents will be e-filed, at this time, many are not. Until the day when everything is submitted electronically, I think there should be some consideration to reducing the time and waste in the present procedure.

It isn't clear as to why the WCAB in San Francisco can manage a same-day walk through but the other Boards where I appear can not (I don't know about Southern California). As I understand it, the documents must be at the WCAB to allow them to be scanned in and sent to a judge. The party then collects the actual document the following day and appears before that judge for an order approving. The order is signed, then that is scanned into the file.

Why need it be done this way? Isn't it possible for a party to appear for a walk-through, be assigned a judge, take that judge the settlement documents and all other relevant evidence, have the judge sign it, and *then* the entire document can be scanned into EAMS?

This would not only ease frustration, it would reduce time and litigation expense. The present procedure wastes paper. It wastes time, as a party is required to physically bring the documents to the WCAB one day and return another day to complete the process. It costs employers, carriers and TPAs more in legal fees and causes an unnecessary delay.

That is my one small suggestion to speed up one small part of the process. A small thing, yes. But any little step that eases the journey is worth taking.

Thank you,

##

Item 121: WC System Suggestion

5/3/2012 email (redacted)

Ladies/Gentlemen.

It is obvious there are many areas for improvement in the system, with a lot of common themes coming out at the public forums. There is an area that seems worth it to take a look at, along the lines of the disparity of what copy services charge, that could potentially save employers a lot of money. It is what certain carriers charge for bill review. Since they are now required to put bill review charges in the expense bucket and not the medical bucket, some pretty large numbers were starting to pop out on non-complex cases, for instance, someone who may have had a knee surgery, no complications, returned to work, etc. I have seen total paid on the expense line exceed what was actually paid for in medical treatment. There is a huge disparity of what carriers charge, which can be extremely detrimental to an employer, as those charges go on their x-mod. For example, construction companies are asked a lot of information before they can bid a large job, and one item is the x-mod. If my carrier charges unreasonable amounts for bill review, it could have affected my x-mod to the point that it put me over the threshold of what that particular construction job allows, and I couldn't even bid the job. (I have projected x-mods using the expense and not using the expense, and usually see a 5-10 point swing).

It seems completely unfair to an employer that certain carriers are making huge amounts of money from bill review, and the spectrum of what is charged is so great. I have seen flat fees ranging from \$8.50-\$10 to adjust a bill down to fee schedule from what the medical facility charges (I have only seen a small number of facilities actually bill at fee schedule), all the way to 28% of those "savings." I'm not even sure how adjusting a bill from what the medical provider charges, bringing it down to fee schedule can be considered savings, as it's mandated what is supposed to be paid. The carriers that charge a percentage of savings, there is usually a cap on what they can charge a file for a particular bill, ranging from \$10,000-\$25,000, but I did come across a carrier that had no cap. I also came across a couple of carriers that charge differently, depending on whether someone is fully-insured (so they're basically charging themselves), and if they were in a loss-sensitive program (the employer is footing the bill). In both of those instances, it was a small charge (like \$10) to review a bill for a fully-insured, but 27-28% charged to the claim if the employer had a stake in the game.

A rough example:

Surgery bill - \$112,964.38, adjusted down to \$31,050 = savings of \$81,914.38.

The carrier that actually adjusted the bill charged the file \$10.18. If you use the same scenario for a carrier that charges 25% of savings, they would have charged the file \$20,478.60 to review the same bill.

Surgery bill – 99,038.53, adjusted down to \$48,184.65 = savings of \$50,853.88

The carrier that actually adjusted the bill charged the file \$10.18. If the bill was adjusted the exact same why by a carrier that charges 25% of savings, the file would have been charged \$12,713.47.

Surgery bill - \$103,229.80 – nothing paid on the bill, so the “savings” were \$103,229.80. This particular claim was charged the \$25,000 cap for the bill review.

Those charges go on the insured’s x-mod, so if I’m with the 25% carrier, my competitor is with the \$10 carrier and we have exact same payrolls and claims history, my x-mod is going to be higher, merely because I’m being charged a whole lot more for bill review.

I’m not sure how carriers can perform the same function and be at total opposite ends of the spectrum with what they’re charging. I have a large client who paid \$198,000 in bill review fees last year, for all medical services performed during that year (not just dates of injury last year). That is a lot of money spent to reduce bills down to what the OMFS already tells us is to be paid.

Thank you for your time.

##

Item 122: Workers compensation benefits for injured workers

5/3/2012 email (redacted)

Injured workers are to receive medical care free of charge, but is it required that they go to their appointments on company time?

##

Item 123: My W/C Situation

5/3/2012 email (redacted)

I was injured on December 20, 2011 and my claim was "conditionally denied" 90 days later. The condition was that the claims adjuster wanted a report from a QME to determine whether the injury could have occurred at work. Not once did he contact my co-workers or human resources manager to whom I informed of the accident within minutes of occurring.

To add insult to injury, the majority of the discussions I had with the adjuster were very upsetting due to his attitude and rudeness. An injured employee should not be treated like a criminal. When I brought this up to him, his excuse was that he is abrupt and I misunderstood (I don't think so).

So, in summary, I fell at work over 4 months ago, and have yet to receive a dime of compensation. When I asked what the deadline is for him to make a decision after receiving the QME report, he told me there is none. I find that hard to believe.

Thank you for taking the time to look into this broken system.

##

Item 124: Input: workers' compensation / stay-at-work and return-to-work

5/4/2012 email (redacted)

Hi Christine and Rosa,

Thank you very much for all the work you have put into creating opportunities for the public to provide input on the current and possible future regulations for workers' compensation.

I have been working in the return-to-work field for over 20 years, and have worked with a large number of employers who have sought assistance in both meeting their obligations under workers' compensation as well as finding ways to keep employees working productively and/or returning them to the workplace.

Far too often the first call I get from an employer goes something along the lines of "We need your help in trying to bring someone back to work (or "we need you to help facilitate the permanent modified/alternative work meeting"). The employee has been off for about a year (...sometimes longer) and we now have permanent restrictions..." I then have the job of explaining to them how challenging our task is at that point, with the employee having been away from the workplace for so long. I also see far too many slips from doctors that when asked for return-to-work status they simply note "off work" with no explanation and no specific limitations.

I have worked with employers to try and get them to consider and incorporate efforts to bring employees back to work as soon as possible, identifying what the employee's current temporary limitations are, and finding transitional (temporary "light duty") productive work the employee can do as they recover. I think this is a hugely missed opportunity that has such positive and clear benefits for both the employer and employee.

My suggestion would be to incorporate incentives / requirements related to employers considering temporary "transitional" work and providing tools to the employers that can help facilitate this. When equipped with the tools and know-how to get the information they need from the doctors right away, and with knowledge of how to identify, facilitate and document temporary task assignments as employees recover, I have seen employers do a great job of minimizing unnecessary time away from work for employees, and as already stated, this is a win-win for the many benefits that early return to work has for both the employer and employee.

Thank you again for the opportunities you have provided, and if you have any questions or if you need any assistance with developing tools and structures for employers to facilitate transitional task assignments, I would be happy to assist however I can.

Thanks again,

##

Item 125: Input on the WC system and needed changes

5/4/2012 email (redacted)

Hello,

Here is some input from a broker perspective. I deal with frustrated employers every single day of my job.

Fraud is rampant and employers are frustrated! I see disgruntled employees filing fraudulent claims all the time and employers are frustrated that there is very little that can be done. These employees sit on TTD for two years and treat excessively and everyone is afraid to go to trial because the WC Judge's are so liberally swayed to the injured worker. This happens often when employees retire. They see a WC claim as a "nest egg". It is very difficult to defend these claims, even though they are often filed post-termination. Common sense needs to be utilized and WC Judges need to take a stand and send a message that these types of fraudulent claims will not be tolerated. The Employer shouldn't have to pay for everything that is wrong with a person when they are retirement age!

Almaraz Guzman is being overly utilized and it is not properly supported. WC Judges need to throw them out unless there is substantial evidence shown that it should be applied, and only in unusual cases, not every case! Same goes for Ogilvie.

Liens are a huge issue and the negotiation/litigation of same prevents claim closures, sometimes up to years. I think it would be a good idea to reinstate the filing fee to reduce or eliminate frivolous liens. Also, if lien claimants do not prove their case as to why they are owed additional monies beyond the fee schedule, the liens need to be thrown out and sanctions ordered to send a message and change the whole process. Lien claimants know that all they have to do is file a lien and they will get more money (often when they are not legitimately owed more) because carriers don't want to litigate them and drag out the case. Liens keep claims open far longer, sometimes for years! We just had two claims settle for the same employee, which were denied. Each claim settled for \$2,500 nuisance-value. Outstanding liens are \$100K+.

MPNs need to be enforced and WC Judge's need to force employees to stay in unless it was truly a case of improper notices.

Thank you for listening.

Sincerely,

##

Item 126: Interpreting Issues

5/4/2012 email (redacted)

Dear Miss Baker and Miss Moran:

Unfortunately I did not have the opportunity to attend the public Forum held in San Diego.

We are a family owned business which has been working diligently since 2001, providing Interpretation Services and nos Transportation. We have been struggling since the work comp changes in 2005 for one reason or another. Insurance companies did no want to pay interpreters on medical treatment because it was not included on the California Labor Code. On March 2011 there was an En Banc Decision which supports interpreters in medical treatment.

Now Insurance Companies are contracting with big Care Management Companies Nationwide and are lowering down fee schedule. Since 1987 fee schedule for interpretation has been \$11.25 per quarter hour for a minimum of 2 hours \$90.00, or Market Rate, whichever is Greater. At this point this big Companies are charging \$88.00 or less, distroying small businesses which have been providing services in the community for years. There is nowhere in the California Labor Code which comtemplates a Service Provider Network.

Since 2005 I have seen very good interpreters changing carreers, due to the fact that the profession is not paying what it should with skyrocketing gas prices etc. There are few good interpreters in San Diego Area and I am really concern about the fututre of Interpretation if this big companies keep on pulling down prices.

I have also heard that the WCAB is trying to implement a charge of a \$100.00 to file a Lien again, due to the fact that Lien Claimants are clogging the system. We have to constantly file liens on the amount of \$90.00, \$100.00 or \$110.00 for one time consult, no shows etc.We would be really affected if this would be implemented again.

I believe that if Insurance Companies would pay on timely manner instead of hiring such an expensive Law Firms which are benefiting from this delays and making our life miserable, we would not be clogging the system. There should be stronger sanctions for adjusters not paying on timely mannner and basically they are the ones to blame for clogging the system, I would say that WCAB should only be used for big and difficult cases not on daily basis for objections that adjusters should be paying anyways.The burden should be on Carriers not on Lien Claimants seeking payment.

Thank you very much in advance for trying to turn California Workers Compensation System in a more useful and productive environment for the benefit of all, not some which generally are the BIG ONES.

Yours Sincerely##

Item 127: Recommendations from a Wholefoods Risk Manager to save at least 1/2 Billion Dollars (estimate)

5/4/2012 email (only sender redacted)

Dear Ms. Baker,

1. Jurisdictionally, in Southern California, we are getting a disproportional amount of Post Termination notice Cumulative Trauma claims. Given the lack of medical evidence, these claims are generally denied. The Ex-Worker is sent by an Attorney to a Dr. who gives them the disability slip and EDD pays for up to 1 year; for just getting massages by a Chiropractor. After development, these claims are hitting us at around a \$100K clip; sometimes more if there is true pathology.

A) Is this trend in Southern California common knowledge? If so, what is being done about the Claims Environment?

B) Wholefoods feels that there is plenty of money to carve out of the WC System by creating a Labor Code to prohibit Post Termination Notice Cumulative Trauma Claims. We need to give the benefits to Truly Injured Workers, not those that are filing claims because they are displaced from their jobs. You should do a Rand Study to see how much you can carve out of the Work Comp System by the avoidance of unjust payments to Post Termination Notice Claimants and instead earmark this money for the truly injured Workers In California. In addition, you will stop the Bottom Feeding Attorneys who take Post Termination Notice claims and the Doctors who are knowingly enriching themselves on the "Uninjured Workers". I bet the banning of Post Termination Notice Cumulative Trauma claims will save the California Workers' Compensation system between 1/2 Billion and 1 Billion dollars.

C) We do not see the type of WC abuse that goes on in Southern California in States that do not have a State Disability Program. It is too easy to get EDD/State Disability payments (as evidenced by number 1 above). I have been told that EDD does not have enough resources to pay for more IME exams. Without an IME indicating there is no disability, EDD will pay for up to one year as long as they receive disability slips. To stop the abuse in the California Workers' Compensation system, EDD needs more money to pay for more frequent IME exams, especially for those claims where there is a concurrent denied Workers' Compensation case. If Sacramento can't get enough money to EDD, The California Workers' Compensation system should as this would help stop the abuse. I would also suggest that EDD IME's be impartial and banned from doing Workers Compensation AME/QME work, and if possible any Workers' Compensation work. This way, they would truly make impartial decisions.

Thanks,

##

Item 128: EXAMPLE of QME PAYMENT PROBLEMS

5/4/2012 email (redacted) and attached billing statement NOT included

Dear Ms Baker:

Attached is an annotated billing of a QME Billed in April 2010. The annotations document the numerous attempts to determine why it has not been paid.

The numerous calls to the bill review department are not noted as they simply referred back to the adjuster. Most of the annotations note leaving a message and faxing. In two years I have yet to receive a return call.

This is the cancer that eats in the QME system.

Sincerely,

##

Item 129: Workers Compensation System is broken

5/7/2012 email (redacted)

The current Workers Compensation system invites many workers to see it as a way to get “free” health care, “free” compensation and paid time off. We have seen this in several of our own employees, one blatantly stated to a claims person that he didn’t want to pay the co-pay on the health insurance we provide so he wanted to have some hand surgery done under workers compensation and he did. We had another employee who claimed she twisted her knee on some stairs at a jobsite and even though she apparently had several previous knee injuries from sports, the “system” ruled that our insurance had to pay for her knee surgery and 6+ months of disability to heal. We feel we were set up to get the surgery done as she only worked here for a month.

It is also an easy way for many medical providers to abuse the system as well by writing prescriptions for things such as Tylenol and making return visits mandatory for trivial first aid type injuries. We just changed Urgent Care providers because of this blatant abuse. This not only drives up costs in the system it also forces an employer to file these trivial first aid type injuries as a “recordable” injury to OSHA due to a) a prescription being written and b) forcing a return visit that is unnecessary in many, many cases. Recordable injuries do not affect Workers Compensation rates but they very much affect our ability to work for other businesses and government agencies who are looking at our overall injury rates as a deciding factor in choosing someone to do business with.

In a very hazardous occupation and in 25 years in business we have had only 1 minor electrical injury. This is due to a safety culture at our company that promotes good safety habits. However mostly due to a minority of employees who have found out that the Workers Compensation System is easily abused, our Experience Modification (X-mod or EMR) which was below 1.0 for many, many years is now consistently above 1.0 and is at 1.5 this year. To put this into perspective, for our size company this is costing us a \$50,000 premium penalty as our “normal” 1.0 rate premium is approximately \$100,000.

Combine the 2 issues of employee abuse and medical provider abuse with lawyers and you have a system open to widespread abuse and very costly to employers. In the bigger picture these costs are passed on to consumers and taxpayers as well as cause employers to leave the state to find a less costly system. If we had the choice we would not continue to be employers in California as this is just one more glaring example of the unfriendly business climate in this state.

thank you,

##

Item 130: Workers Compensation needs to be fixed!!!!

5/7/2012 email (redacted)

I was just notified by an email from Workers Comp Executive News Desk that you are still accepting written comments about “what is ailing the system as well as recommendations for improving the process”. As a “victim” of the Workers Compensation program here in California (I have an ongoing Workers Compensation case for the injuries from toxic fume exposure at work) I have a lot of experience in dealing with the system and the doctors and lawyers that work it. When I say “work it” I refer to the difficulty in finding an honest and competent lawyer and doctor to help you.

Lawyers won't represent you if you don't have an easy case. I have heard and read terrible stories about the rip offs and poor jobs many lawyers do for their Workers Compensation clients once they do accept them. After talking to close to a dozen lawyers who refused my case I finally got lucky and found a good one. I am one of the few lucky ones. Unfortunately, the reason why good legal representation is so hard to find is that there really isn't enough money to compensate the lawyers fairly for any case that is very complex under the present system.

Doctors are even worse than the lawyers in a lot of the same ways. First try to find one to treat you. There are no doctors locally that would see me as a Workers Comp patient. I have had to travel hundreds of miles to see a doctor for my Workers Comp injuries. My personal doctor has told me that he doesn't work with Workers Comp patients because of all the paper work involved, low allowable charges, and slow payment for his services. The few doctors that do take Workers Comp patients seem to have figured out how they can make easy money from the system by doing basic examinations and then charging a lot of money for their report.

The present system is not only rigged to the advantage of employers and the insurance companies, it illegally takes away the fundamental legal right of an injured person to bring a lawsuit for damages against the person or persons legally responsible for those injuries. This is not just unconstitutional, it is absurd, and it leads to the dysfunctional system we now have.

The whole system does not work because the focus of Workers Compensation needs to be on safety and injury prevention and not treatment of injuries after they have occurred. OSHA, or some similar government agency that has the power to enforce safety in the work place, and not just a Workers Compensation “after the injury” type program needs to take the lead.

There needs to be at least an annual safety inspection of all businesses and if that inspection is not passed Workers Compensation insurance companies can suspend their coverage on that business. More importantly, any business that does not pass their annual safety inspection can then be sued by ANY employee injured on the job because the company is now considered to be legally negligent in its safety practices. The only way that businesses will take safety seriously is if they can no longer hide behind the Workers Compensation law that prevents them from being sued by an employee injured on the job.

The lack of liability for business owners for an employee injured on the job beyond their Workers Compensation insurance premiums is absolutely at the center of the problems with Workers Compensation. Business owners have no reason to invest in a safer working environment (especially in manufacturing from my experience) because the expense of this premium is the limit of their liability if an employee is injured and they have already had to pay it!! They have no risk of further loss, so except for

the employers that actually care about the safety of their employees they all too often just don't give it much attention.

Thank you.

##

Item 131: written comments

5/7/2012 email (redacted)

I've listened to all those who came with complaints.

I believe every attorney who wants to handle work comp claims should first be required to handle claims as a claims examiner. Then they would have a better understanding of how a claim is actually control to provide benefits as required by Labor Code and case law, yet try to maintain costs.

After 25 yrs as a claims examiner, I find it would be best to just let the applicant attorneys control the claims they file Applications on and then justify the costs and PD level at the WCAB.

##

Item 132: THANK YOU

5/11/2012 email (ONLY sender's email and telephone redacted, submitted as copy of oral public comment)

Dear Christine Baker and Rosa Moran,

I want to thank you both for coming to Los Angeles. And holding the April 16, 2012 LA Workers' Comp Forum. I really appreciate the fact that you both want to change the Workers' Comp system and save the lives of the Injured Workers.

Thank you again. It was much appreciated by so many.

We are all praying and believing for a change.

This is what I said on Monday, April 16, 2012 at Gov. Brown's Worker's Comp Forum in Los Angeles.

My WC TALK

My name is Rozy Press.(Rosalind Press ADJ2750886)

Thank you for coming and wanting to change the Workers' Comp System. And Save Lives.

I have a LAUSD 12 year old WC case, It has been an Admitted case since 2002. LAUSD in 2002 awarded me a very hard to get "Act of Violence" meaning I have physical injuries from being attacked. I was sprayed in my face with the toxic chemicals from a fire extinguisher. My students were too.

No paramedics were called. My classroom was never properly cleaned up from the Toxic chemicals. 180 students were exposed to the toxic chemicals for months. I now have Documented Lung damage, Fibromyalgia, pain, extreme exhaustion and etc.

My case is not what Article 14 Sec 8 of the Ca. Constitution intended my Workers Comp case to be.

I do not get the proper medical treatment or even paid!

My Rating of 100% was lowered by Judge Jerold Cohn and Dr. John Stalberg.

Why is my Trial Judge, VNW CAB Judge Jerold Cohn able to make a medical diagnosis, an "Unsubstantiated" Axis II Psychiatric Diagnosis, use Inadmissible Evidence, change all the facts, add his own facts, changed mine and my witness' testimony, delay my case over and over again, lose records and reports, libel me, malign my character, lower my Rating and deny my benefits.

I Won an Appeal on April 1, 2011. The Appeals Board sent my case back to Judge Cohn for a new Decision. I won because Judge Cohn's Decision was Not based on substantiated evidence. He based his Decision on Dr. Stalberg's 2008 Report.

Judge Cohn decided to try again and he sent the WCAB file and all the Trial proceedings which is highly unusual to Dr. John Stalberg. Dr. Stalberg again backed him up even though there wasn't any substantiated evidence to do so.

Dr. Stalberg followed Judge Cohn's "Unsubstantiated" medical diagnosis in his 11/15/2011 Report for \$16,770. That's \$700+ a page.

Dr. Stalberg hadn't seen me, talked to me or examined me for 4 years. But he wrote a \$16,770 Report

I have all the Documented evidence that refutes what Dr. Stalberg reported.

In Dr. Stalberg's Deposition of Jan. 2012 he admits he didn't even have all the reports/records. His computer was stolen. He followed Judge Cohn's medical diagnosis and all of Judge Cohn's "facts". The facts that Judge Cohn made up. But, still he wrote a \$16.770 Report. \$700+ a page.

I was a military wife for 21 years, A Hostage, Target and Evacuee out of Iran in 1978 NOT 1979. I'm an American War Hero.

Workers' Comp is the most Corrupt system I have ever been associated with.

And unless you get rid of all the unethical doctors, lawyers and judges you will never have a fair, honest and just system.

I even called Judge Cohn, Dr Cohn there by mistake. I told them I call Judge Cohn a doctor sometimes because he made a medical diagnosis in my case. And he's not even a doctor.

I called up to Oakland to the office of Industrial Relations to ask if Judge Cohn could make a medical diagnosis, use Inadmissible Evidence, change all the facts, add his own facts, changed mine and my witness testimony, delay my case over and over again, lose records and reports, libel me, malign my character, lower my Rating and deny my benefits.

But, no one could tell me.

Law 1871.4 says that I can't lie and neither can the judges, doctors and lawyers to take away my benefits.

I wanted to know why they aren't going to jail.

I complained to the Ethics Advisory Committee. Why didn't they think what Judge Cohn did was unethical? 2010 Complaint #38? And do something when Judge Cohn was changing the facts and making a medical diagnosis?

Thank you,

Rozy Press

Wish I would had more time to mention that the Ca. Workers' Comp system is a Billion dollar business for Insurance Companies, unethical doctors, lawyers and judges. It just draws them in like a magnet. The Injured Worker is just the victim they use so they can make all their money.

The Injured Worker usually dies from the lack of proper medical care, not being paid properly or at all. They never follow the Workers' Comp Laws. News of an Injured Worker dying, is reason enough for the Insurance Co. personnel to party. They celebrate the fact that the Injured Worker has died. And they don't have to spend anymore money on them.

Dr. Markovitz examined me with a stethoscope for Fibromyalgia. No Professional, Board Certified Doctor uses a stethoscope to exam for Fibromyalgia. They use their fingers. Judge Cohn and Dr. Stalberg used Dr. Markovitz' Report as the final authority on Fibromyalgia.

##

Item 133: Written Comments

5/11/2012 email (redacted)

Thank you for taking the time to address the workers compensation issues we're facing. I attended the workers' compensation forum on April 30 in Oakland, I also attended in Sacramento but my late arrival kept me from speaking. Although I was able to say what was most important on April 30th, there was much that was not said, not only because of the minimum of two minutes to speak, but the level of distress over what happened altogether has made this extremely hard to deal with, including talking about it, and more so, having to talk about it in public.

On May 21, 2008 I had a surgical procedure known as decompression/descectomy of the lumbar region for back pain, Fred F. Naraghi who is located at One Daniel Burnham Court in San Francisco was the surgeon, the name of the clinic was San Francisco Multi-Specialty Medical Group.

According to workers compensation: Fred Naraghi reported to them that I was experiencing leg pain. This was not right, I never told Fred Naraghi or anyone else prior to May 21st that I was experiencing leg pain. Naraghi asked me several times if I had any leg pain during my visits prior to surgery and the answer was repeatedly no. I had no idea what was about to happen. My medical records were falsified when Fred Naraghi reported to workers' compensation that I was experiencing leg pain, but here are the facts surrounding this surgery, The doctors that treated me just weeks prior to my visit to Naraghi did not report any leg pain. There were five to ten doctors prior to Naraghi, none reported any leg pain. Joel Renbaum, the knee specialist who partners with Naraghi at the clinic and examined both my knees did not report leg pain. Rena Dioxin, the pain management doctor at the San Francisco Multi-Specialty Medical Group who works with Naraghi and did an epidural just prior to surgery did not report any leg pain. He did however report pain in the left thigh, which was not right either, just an attempt to help Naraghi by trying to show there was pain on the left extremity when there wasn't. The surgical procedure was presented and compared to an epidural, so it took away my reason think twice about it. This is a very disturbing to me.

Also disturbing are doctors who write and use "notes" prior to, during and after surgeries or other medical procedures instead of writing a true full report for everyone to see including the patient. These "notes" are a manner and an excuse for doctors to hide mistakes and malpractice. Notes are a tool for doctors hiding the facts and the truth, and a manner of swaying situations to suit their needs or hide their fraud by omitting or submitting notes at their convenience. What Fred Naraghi did was not a mistake, he took advantage of a vulnerable disabled patient, he took away my chance to return to any gainful employment at all, unless it's inside my own home. My social life is almost non-existent. It was planned and executed (surgery for profit) assault and battery, illegal. I will suffer for the rest of my life because of this. Doctors reports need to be written and presented within a couple of days, not weeks not months and not a compilation of a bunch of notes. And they also need to be presented to the patient as well as the claims adjusters. The idea that doctors can use notes as reports for visits is ludicrous, and even worse using notes to create your own surgical outcome that stemmed from a false

medical report, and then sweep it under the rug when it fails and take credit when it doesn't. I wonder how many victims there were before me and how many after me. Or was I the lone victim at a time when the economy tanked (May 21, 2008). It's not difficult to examine this doctor and this clinic's financial records at a time they destroyed a young man's life.

Immediately after surgery when the medication wore down I was experiencing pain in my lower left leg, both of my feet, numbness in the left thigh, my back was also in additional pain due to the procedure, right side and left side now, before it was just the left side.

When Naraghi reported leg pain to workers compensation just before the surgery, he did not say left leg or right leg, he did not say upper or lower, he did not say what type of pain, ie, sharp, dull, ache, throbbing ect ect, he just wrote "Leg". he didn't mention the pains in my feet, which vigorously took center stage along with the pain in the left lower leg after surgery. He mentioned none of this in his first report, why? Because it wasn't there prior to surgery.

So Naraghi lied to cover the procedure and then continued to lie to cover the first lie. Everything that was done by this doctor after surgery was to protect himself and his clinic. Any non-medical individual can look over the medical records and see what he did. It was not until January of this year 2012, almost four years later, that I find what may be the true diagnosis and explanation for the pain in the left leg and both feet. Myelopathy as I understand from my primary care physician, is irritation of a nerve and may have developed after surgery due to the invasive use of a surgical needle. As opposed to a pinched nerve which usually develops after many years of work and or a mechanism of impact. So now it starts to make sense why I was never told of this myelopathy by Naraghi and the doctors at the San Francisco Multi Specialty Medical Group, because it would point the finger at the procedure done by Naraghi, which of course I already knew.

It took awhile for me to gather everything that happened, I didn't know until months later that Naraghi had falsified my medical report, I was communicating with the claims adjusters directly. Which leads to the next problem. Why didn't workers compensation pick up the phone and call me to say that Naraghi's reports were different than mine? The medical board is made up of doctors that are only there to protect other doctors, (There is no cure for Myelopathy).

Losing a home, or losing a job is a terrible thing to happen to anyone, but it is nothing in comparison to losing your ability to function in life.

(Signed)

Claims Adjuster: Alice Low, City and County San Francisco, Workers' Compensation Division.
Fred F. Naraghi MD, QME, (Orthopaedic surgeon) One Daniel Burnham Court, San Francisco: falsifying medical records, workers compensation fraud, medical malpractice, surgery for profit, assault and battery, impeding recovery, abandonment, deliberate misdiagnoses.

Rena Dioxin MD, QME, (pain managment) One Daniel Burnham Court, San Francisco: falsifying medical records, deliberate misdiagnoses.

Bruce McCormic, MD, (Neurosurgeon) spoke with me for a few minutes (less than 5) billed workers compensation for multiple hours. Never examined me. Never looked at the mri until I told him to, wasted consultation.

Clement Jones, MD, (Orthopaedic surgeon) 1700 California, San Francisco, wasted consultation.

##

Item 134: Comments regarding the workers' compensation forum, my experiences with my husband as an injured worker and as a workers' compensation biller

5/15/2012 email (redacted)

Comments on the worker's compensation system from the attendance of the conference, my experience with my husband's two trips through the w/c system and my experience as a biller:

1) 1. MPN - the employer is handpicking the doctors and then dismissing them from the MPN without due process if the doctor does not follow the rules of the MPN. I wholeheartedly believe that a doctor has a degree for a reason and an MPN should not be limiting treatment to the cheapest possible options.

a. A single statewide MPN with required credentials would be best - with definitions as to what would get the doctor kicked off the list. As well as due process for the doctor to fight against an unfair removal seeing as currently it is completely arbitrary as indicated by a lawyer in the conference.

2. 2. UR - if the MPN is in place, why is this needed? The doctors used for UR, for the most part, are in another state - they are not required to meet California requirements for licensure and they definitely do not actually interact with the patient so how could they really know what is in the best interest of the patient? They don't - they go with the best interests of the insurance carrier.

Accountability is necessary for these URs!

a. Statistics given by one conference participant indicated that one UR denied a service 98% of the time vs. another national UR who denied that exact same service only 14% of the time. Obviously there is a discrepancy here.

b. So not only are the employers being very selective in the MPN - they are also hand selecting the UR to get the maximum amount of denials and thereby eliminating treatment for the worker.

c. Case in point: one provider (who once was an injured worker) indicated it took 19 months to get an EMG approved and 27 months for surgery on the affected body part.

3) 3. SCIF - non-existent care for the injured worker, non-existent customer service for the payments to providers - all they do is create a mountain of paperwork - which then costs more money for everyone. We receive a ridiculous amount of denials from SCIF. And the worst part is that half of the ones sent are wrong - i.e.: third party billing for a doctor for prescriptions is to be billed on a HCFA and yet we get form letters telling us it's on the wrong form. A few were billed on the incorrect form (NCPDP 1.0) and we even get letters telling us that it's on the wrong form and needs to be billed on the NCPDP - well that was wrong but it happens to be what was sent - they can't have it all ways.

4) 4. Multiple injured workers presented their cases in front of us and repeatedly told the conference they wished they had not submitted a worker's compensation claim but rather had gone to their private health insurance so that they would have been taken care of in an expedient, reasonable fashion where they were treated like human beings and were healed so they could get back to work and their lives instead of continued suffering due to pain, stress and financial pressure crushing them from the worker's compensation claim. Many people do this already. I am certain that shifting the cost of doing business from the worker's compensation system to the private health care system is not acceptable or appropriate.

5) 5. Chronic underpayment (and the above mentioned MPN / UR issues) is causing providers to

leave the state at an alarming rate. As one provider asked, (a gray haired doctor,) "What will happen when there is no one left to treat the injured worker as none of the young doctors have any incentive to treat worker's compensation?" In the case of my husband, he went in under his private health insurance and they determined it was a worker's compensation case. He was already being treated at CORE Orthopaedics so that's where he was treated. The doctor that did his elbow surgery was great - he recognized my husband's pain and issues in his elbow and then referred him to a doctor for his shoulder. The shoulder doc doesn't do worker's compensation - he sent my husband for an MRI. After the MRI did not show anything, he sent my husband to physical therapy after giving him a steroid shot. Three shots and a lot of physical therapy later, we finally got the doctor to apply for exploratory surgery. When my husband was in surgery, it was discovered that while the doctor said there was nothing wrong - my husband needed 6 clips to reattach the labia to the shoulder, he had three tears and a bone spur that needed to be removed. Yet this doctor insisted there was "nothing wrong" with my husband.

a. If the OMFS is set, then the carriers should not be able to discount. The carriers complain about "billing over OMFS" but if the biller doesn't, they are guaranteed to get a discount taken on the bill anyway which will pay less than OMFS. What good is OMFS if the carrier does what it feels like?

b. MPNs have small written clauses indicating payment at 1 of 3 fees schedules - whichever is lowest... clauses also list the only CPT codes that can be billed & no additional evaluation.

6) 6. Vocational training - what a joke! My husband was given a voucher for \$4000 to "retrain." First let's start with the fact that he was off for almost two years trying to get his elbow and shoulder fixed from a work injury. He was a Union Heavy Duty

Repairman and I was working part-time when it happened. We went from his full pay (around \$6600 before taxes a month) to w/c pay which was about \$3200 a month which was a very large cut that required me to go and get a full-time job to go with my part-time job so we could survive. Then we have the \$4000 tuition voucher which is only able to be used at certain schools which are not necessarily geographically reasonable. Also, the trades that are available to retrain are not even reasonably comparable to what he was doing. So even if there was a reasonable available trade, how were we going to make ends meet while he went to school??? Even with the full-time and part-time positions, I could not possibly have made up another \$3200 per month. The only option we had was to throw out the voucher and he put his resume out there everywhere as he could no longer be a heavy duty repairman in the Union.

a. The voucher is too limited and based on the percentage of the injury which is fairly arbitrary also. There is no concern in this process for loss of future income by having to change employment when you are completely unable to return to your line of work.

b. Why not start re-training earlier in the process so the worker and family can survive while learning something new? Or offer a maintenance allowance during training.

7) 7. Liens - billers wouldn't lien if there was any other way to get a carrier to respond to billings. You can call 9-10 times and only get an answer once and even then the person that answers you may not have any experience or desire to help you. The only time someone wants to talk to you and settle is once the first lien has been sent.

8) 8. Make the case workers / adjustors accountable - there are way too many out there that just deny / ignore the workers' (let alone billers / providers etc) because that's what they have been told to do. The carriers absolutely do not care

about returning workers to work - only about saving money. The case workers need more training not just to be told send x, y or z denial letters. Teaching them to do their jobs better and understand what's necessary would save both the carriers and the providers money.

The focus needs to be on better care for the injured worker and returning him/her to work in the best possible fashion and not at the expense of their health. The carriers need to start taking care of the patients more and worrying about their bottom line less as the whole point to paying them is to get the workers healthy and back to work. And if that is not the purpose of these carriers, why the heck do we allow them to sell worker's compensation insurance in our state?!?!

In conclusion, the 2004 changes have all been manipulated in favor of insurance companies not injured workers. The savings that have been achieved are primarily from the insurance companies squeezing the workers' into giving up their cases. Overhauling the entire system is mandatory or there will be no doctors for the programs and no businesses with workers to need them.

Thank you for your time in reviewing my comments in regards to the workers' compensation situation.

##

Item 135: QME Phantom Office Issue

5/1/2012 email (redacted)

Dear Ms. Patterson,

I serve as a QME in San Diego County. I have been informed that you are aware of an issue that has become increasingly problematic for those QMEs who wish to serve in the Workers Comp system but are not part of what have customarily been referred to as "Doctor's Mills". A cursory examination of the QME database across all of California reveals that each zip code is flooded with out-of-town doctors. Some of those individuals have more than 30 offices, thus increasing their statistical odds of getting randomly selected for the QME panels.

It is not uncommon that all three doctors on a given panel do not even primarily practice in the county where the panel had been requested. What is equally disturbing is the fact that on the website of at least one of the doctors, he went so far as to state that his office location for the QME may change (so that he would not have to actually drive that far, but once selected, reschedule the appointment to a closer office, thus having many offices simply to increase the statistical odds of getting selected onto the panels). This seems to me to be a patent corruption of the intent of the QME selection process. Further, out of town phone numbers are commonly attached to San Diego County office addresses of most of these individuals.

I have discussed this matter with many of my San Diego colleagues and there is a high level of agreement about the unfairness of these practices. Surely there is a more equitable and fair way to regulate this practice. When the QME system was adopted in the early 90s, it seemed to embody the principle that the medical legal evaluation process benefitted by impartiality and distribution of labor to a broad range of physician providers of services.

In 2008, a DWC Educational Conference was entitled, "A QME Regulations Update". It was presented by Suzanne Honor, Workers' Compensation Manager, DWC Medical Unit; and Suzanne Marria, Industrial Relations Counsel III, DWC Legal Unit. Significant attention was given at this meeting to the issue of placing a limitation on QME office locations listed with DWC. The Proposed regulation was: §§1(x),17(c),30(f). This regulation stated, among other things, that QMEs could designate only up to 4 locations

as primary practice locations. Primary practice locations were to be given 1.5 weight in assigning physicians to a panel.

The stated goal of this regulation was “to even the playing field”. The Primary practice location was defined as location where QME spends 5 or more hours/week in direct medical treatment, or for retired status QMEs or for AMEs where spend 5 or more hours/week doing AME or QME evaluations

In the past 4 years since that 2008 conference the situation has devolved substantially in terms of the numbers of QMEs who list large numbers of office locations, or phantom offices to be more accurate. It is my hope that you will address this matter with appropriate regulations so that injured workers, employers, and the professionals who serve the system will benefit. I am sure the DIR and DWC strive for fairness in all aspects of its operations. Thank you for your consideration and time in this very important matter.

Sincerely,

##

Item 136: RECOMMENDATIONS FOR WORKERS' COMPENSATION REFORM

5/25/2012 email (redacted)

(Top 10 highlighted in bold)

Medical-Legal/AME/QME

1. Rather than allowing individual party cover letters, develop a form similar to the Application that contains a list of admissions and disputed issues agreed to by all parties. This form would be provided to the QME/AME/IMR so that the doctor knows what issues are in dispute and can respond accordingly. Only disputed issues are to be addressed.

This would avoid confusion by the doctor based on conflicting content in cover letters; limit medical-legal evaluation to only issues in dispute; and prevent evaluating physicians from creating new issues in their reports such as added body parts or conditions.

STATUTORY – New mandate, no current statutory authority.

2. Require that AME/QME physicians use the PR4 or similar form for all evaluations, to reduce paperwork and create consistency by all evaluators.

This may encourage new doctors to become panel QMEs and AMEs. Simplification should result in timely reports and a level playing field for billing.

REGULATORY – I think the A.D. has authority over the format of reports, but not content. As long as the form has all the required information, this is a regulatory change.

3. Reimbursement for medical-legal reports should be based on the number of issues in dispute and on the time spent evaluating the patient and reviewing records.

This addresses QME and AME physicians who add and duplicate information in reports to increase the size of the report for billing purposes. Tactics include longer than necessary record reviews and duplication of information within the report.

Standardized reports (see number 2) will help to establish a level of consistency for reporting and billing.

REGULATORY – the medical-legal fee schedule is in the regulations.

- 4. Disallow additional fees for supplemental medical-legal reports if the AME or pQME fails to address the appropriate issues in the initial report. Allow fees only if additional information is submitted or received after the initial report.**
If all information has not been received or reviewed, the evaluator should hold on issuing the initial report until he/she has received and reviewed all available information.
This eliminates situations where the evaluating physician issues the initial report to comply with statutory or regulatory timelines or perhaps to enable billing for both initial and supplemental reports, but the findings are incomplete because all information was not received or reviewed. Incomplete and multiple reports should be avoided to the extent possible.
STATUTORY – LC 139.2 mandates timing of initial reports. This would have to change.
- 5. Replace the current medical-legal process with new Independent Medical Review and Independent Medical Evaluation processes under the direction of the DIR. These would be used to resolve all disputes – IMR for disputes over reasonable and necessary treatment and IME for AOE/COE, PD, TD and any other issues. The current process of panel OME is long and subject to gamesmanship in terms of specialty and choice (it would be interesting to see what % of panels issued are pain management). Moreover, it is becoming difficult to find an acceptable pool of AME physicians. There are not many new physicians coming in. Many of the existing AME physicians have developed a bias over the years. An independent process would resolve disputes with a timely and neutral procedure involving physicians outside the “usual” medical-legal process, rather than judges or partisan evaluators.**
STATUTORY – Current process for treatment disputes is in LC 4062.
- 6. Allow each party to obtain their own QME evaluation if no agreement to an AME. The current process of requesting a panel, agreeing or striking, is time-consuming and subject to disputes over choice of specialty. With the above suggestions to streamline reports and issues, and considering the Legislative intent to encourage consistent rating, disparity between reports should be less than pre-SB 899.**
STATUTORY – Current process is in LC 4062.2.

7. Reduce the number of specialties in the current panel QME process. It is unnecessary to have so many and the process is rife with gamesmanship over the choice of specialty. Have the choice of specialty assigned by a neutral third party at the Medical Unit based on medical criteria.

REGULATORY – the A.D. is required to assign panels in the specialty requested and of a type “appropriate for the employee’s injury”, but statute does not list specialties required.

8. **Repeal Rule 36(e) and allow supplemental reports from the pQME prior to issuance of a DEU rating. There is no statutory authority for this rule, and it delays issuance of supplemental reports. Sometimes, supplemental reports are needed in order to clarify rating or apportionment issues. It is unnecessary and costly to have the DEU rater do a rating based on an incomplete report, request a supplemental and then do another rating.**

REGULATORY – Repeal of existing regulation, for which we argue statutory authority does not exist.

MPN

1. Impose sanctions on applicant attorneys who knowingly ignore MPN statute and rules, and self procure treatment on a lien basis.

STATUTORY – New penalty.

2. Incorporate information on the MPN notice into the initial benefit notice. Streamline notice requirements, allowing initial notice at the time of injury and notice of new MPN by posting.

REGULATORY – We do not see mandates on notices prior to implementation in the statute, just the regulations.

3. **Codify that all referrals made by the predesignated PCP must be made to providers within the MPN. There is case law on inadmissibility of reports (Valdez).**

STATUTORY – New law.

UR/Treatment

1. Create an independent medical review (IMR) process for medical treatment disputes related to reasonableness and necessity (see 5 under Medical-Legal/AME/QME above).

Pharmaceutical/Narcotics

1. **Urgent and meaningful reform is necessary to curtail the growing pharmacy problem in this State. Look at what reform has been done in other states such as Florida and Washington – ask Alex Swedlow if there are any Rand or other studies. Such reform should include:**
 - a. **A formulary, to exclude drugs that are not medically appropriate per guidelines, ensure patient safety and control costs through use of generics.**
 - b. **An expedited independent medical review process that can be engaged when doctors are prescribing Schedule II or other narcotics that place the health and safety of an injured worker at risk. Examples would be when UR advises that there is a medical question over the medication type or dosage, or when urine drug testing has inconsistent results and the physician does not address.**

STATUTORY- New law.

2. Establish fee schedule for urine drug testing, to control costs and reduce overuse or overbilling by physicians using this as a revenue generator. OR Allow employers to control selection of provider so that they can contract for rates and services.

REGULATORY – Medical fee schedule is regulatory.

3. As part of the above-mentioned IMR process, establish an expedited review that can be engaged when doctors are prescribing Schedule II or other narcotics that place the health and safety of an injured worker at risk. Examples would be when UR advises that there is a medical question over the medication type or dosage, or when urine drug testing has inconsistent results and the physician does not address.

STATUTORY – Current process for treatment disputes is under LC 4062.

4. Require that physicians comment on all inconsistent urine drug test results within 10 days. Allow IMR if the response is questionable or the physician does not respond OR add this as a basis for requesting a change of treating physician.

REGULATORY – Content of reports and reasons for change of physician requests are in the regulations.

Permanent Disability:

1. **Eliminate the current 15% bump up/bump down process set forth in LC 4658; not working as intended. Consider other ways to incorporate return to work into the determination of PD.**
STATUTORY – Current process is under LC 4658.
2. Reform LC 4660 to remove the FEC, increase the weekly rate to \$250 which is split of the two rates, and eliminates two rates. Flatten the PD schedule to 4 weeks for each percentage of disability.
REGULATORY - The contents of the rating schedule do not appear to be elaborated on in the Statute.
3. Eliminate the SJDB system as onerous. Repeal 4658.5 and 4658.6. There are already a protections, time frames and processes under ADA and FEHA which have consequences built in to those regulations. Instead, establish an Unemployment voucher payable for \$5,000 to anyone who doesn't obtain gainful employment within 1 year of the date of MMI. This would be payable so long as the employee was not terminated for cause, voluntarily resigns or retires with SS or retirement Pension. A query system would allow employers to verify whether or not someone obtained employment. *Alan Leno, a VR expert will prepare a time line history of FEHA, ADA, VR and WC to demonstrate why it is no longer necessary. This should be available in one week*
STATUTORY - repeal of §4658.5 and 4658.6.
4. Applicant attorney fees will be payable at 20% if all claims resolved within 3 months of MMI, and will be limited to 15% if resolved w/in 1 year. Cases taking longer than 1 year will be payable at 12% except cases involving Medicare which will be payable at 15%.
REGULATORY - revision could be done in §10775, §10776 and §10778
5. **Make AMA guides conclusively presumptive and preclude chapter hopping within the guides for diagnostic conditions covered in established chapters. STATUTORY – revision of section §4660 (b) (1).**
6. **Repeal subdivision (e) in Labor Codes Section 4663, which is the exemption of the application of apportionment for injuries or illnesses, covered under specific safety member presumptions.**
STATUTORY- repeal.

7. Amend Labor Code section 4650(b) to say that if an injury causes permanent disability, the first payment shall be made within 14 days after *receipt of the first admissible medical report that is ratable under the AMA Guides*. Currently, PD is required when TD stops, but we often have no idea what the PD will be at that point. Delaying PD puts us at risk of penalties and including Audit Unit violations. Moreover, it is almost impossible to recover overpaid PD and issues like apportionment and legal representation are unknown and may impact final PD due. PD should not be required until there is medical evidence sufficient to rate the PD with all factors included.

STATUTORY – revision.

Temporary Disability

1. Amend 4853 to include all retirement systems, not just CalPERS with regard to discontinuation of TD at retirement.

STATUTORY – revision.

2. Expand LC 4656 to include all salary continuation programs including but not limited to LC 4800, 4850 and education and government codes within the 104 week limitation.

STATUTORY - revision.

WCAB Procedures

1. Allow for telephonic hearings to facilitate prompt resolution and unclog the court calendars.

REGULATORY- revision.

2. Establish uniform interpretations of case law and procedures for all judges and disallow independent deviations from the rules of practice and procedure.

REGULATORY- revision.

3. Eliminate Information and Assistance Officers and establish an Ombudsman program of retired (non-practicing) judges, applicant and defense attorneys in good standing who will randomly assist injured workers for a monthly stipend to be established by the DWC.

REGULATORY – revision.

4. Evaluate and implement retroactive applicability of each area of the reform package to create uniform consistency of application of these benefits. The goal is to establish one track of benefits and rules regardless of date of injury to eliminate risk of error and future litigation.

REGULATORY- revision.

5. **Repeal Labor Code section 4064(c), which states that if a defendant files an Application on a case where the employee is unrepresented, the employer SHALL BE liable for attorney fees. Such fees are not taken out of the EE's award. We are currently seeing all kinds of legal tactics where attorneys are controlling cases behind the scenes, without disclosure of representation or the filing of an App. They are controlling QME panels, doctor choices and even telling employees not to sign releases or provide statements. It is complicating claim discovery and increasing our time and costs. Filing an Application does not put the case on calendar at the WCAB, but it enables the employer to perform reasonable discovery.**
STATUTORY – repeal. (ADDED 5/17/12)

SROI

1. Exempt public agencies from SROI reporting for a period of 5 years to develop another data tracking system which will gather better data. Exempt public agencies from SROI reporting if they report to the other data tracking system. STATUTORY revision of 138.7 and REGULATORY revision of §9702.

Cumulative Trauma (added 5/7/12)

1. **Create a threshold for coverage of CT injuries, such that work factors must be the predominant of all factors (51%), and a substantial cause of the injury (35-40%) in order for the claim to be compensable. Require the determination to be made based on evidence-based medicine, if any is available for that type of injury (example of carpal tunnel, where EBM supports non-industrial causation).**

Item 137: Worker's Comp - Plea for Certified Interpreters

5/6/2012 email (redacted)

CERTIFIED INTERPRETERS will not survived working for a fee schedule.

If Insurance Companies are allowed to have interpreter's networks, CERTIFIED INTERPRETERS will lose their right to work as independent contractors and will be forced out of Worker's Compensation system.

CERTIFIED INTERPRETERS must be differentiated and considered separately from the bulk of interpreting services in Worker's Comp done by non-certified interpreters at medical treatments.

Only interpreters certified by the State of California or the Federal Government are proficient to interpret at Trials, Depositions, appearances at the WCAB and at Med-Legal Evaluations.

To pass the State Certification Test interpreters must be born with a natural talent to interpret simultaneously, be fully bilingual, have an extensive life experience in both cultures and must invest time and resources to learn the legal and medical vocabulary.

Certified interpreters are few, and our cost to Insurance companies is insignificant within their total budget.

Certified Interpreters will not be able to survive under a fee schedule and so must continue having the right to charge their market rates. Unlike interpreters employed by the counties on a fee schedule, we do not work everyday, we have no benefits, we pay higher tax rates, pay the full 15% in social security and we must also make ourselves available to drive all over the place.

Even though our hourly rate is much higher, **we provide greater savings as we are paid only when needed.** To make ourselves available, we must take great risks and must compensate for huge gaps when our work is not needed. Under a fee schedule we will be forced out of worker's comp and the low pay will fail to attract new interpreters.

Insurance Companies should not use only Interpreters in their own approved networks, which will pay the least and blacklist everyone else.

It will kill our right to be independent contractors and to charge more for a better service. The experienced and the beginners will be forced to work for the same agency, earning all the same. Under their power, interpreters will not be able to remain neutral.

These proposed changes by the Insurance Co. Are against free enterprise and against free market. ##

Item 138: still having problems getting dental treatment

4/16/2012 email (redacted)

On or about 1990 I suffered a severe injury to my back. Since that time I struggled with obtaining the proper and necessary medical care that has been recommended by my treating physicians. The Insurance company has constantly blocked my ability to get the medical care to which I am entitled.

OBTAINING THE NECESSARY SURGERY RECOMMENDED

1. My treating physician recommended back surgery. He had examined by a surgeon who agreed I needed back surgery.

2. Surgery was scheduled at St. John's Hospital. It was cancelled at last minute because the Hospital had difficulty with the Insurance company Broadspire not paying and

3. The surgery required an implant but Broadspire would not authorize the implant. So surgery was not approved.

4. So surgery was changed to Cedars because Cedars would provide the implant without getting authorization from Broadspire

5. The primary treating physician, after the surgery, prescribed home health care. Authorization request was submitted to Broadspire for the home care. Broadspire requested the prescription and said they would authorize home care to the person indicated but they never provided it. Wife and mother provided the home care for a little over 4 months.

6. A special bed was prescribed by the primary physician. The prescription was never honored by Broadspire.

7. On at least six different occasions Broadspire has refused to authorize, or has refused to completely fill my medications or refused to pay the pharmacy for the medication prescribed to me by my primary treating physician. This has caused tremendous amount of distress and discomfort.

DENTAL ATTENTION

1. Dr. Alban, Agreed Medical Examiner, concluded that the Applicant should be referred to a dentist or a TMJ specialist because the stress was causing me to clench my teeth and causing dental injuries.

2. Broadspire would not authorize any treatment unless a physician was selected under their MPN. None of the physicians listed on the established MPN were able to treat the condition.

3. Broadspire continued to object to the treatment recommended by Dr. Shames as indicated by the AME.

4. Finally a dentist was found that could perform the work that was required for my teeth. However Broadspire would not authorize the visit. My attorney had to go to court twice to obtain the authorization for one visit with that dentist.