

**Copies of Email Attachments Sent In
on the Subject of the Workers' Compensation Forums
held in April, 2012**

Part 2

**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. What follows are attachments from emails received as PDFs, and are generally considered professional correspondence related to the public Forums; therefore, most of the attachments are not redacted.)

LEGACY LA

April 25, 2012

Christine Baker, Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

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

Dear Ms. Baker:

I respectfully request you to immediately review and update your fee schedule for primary care services by supporting the passage of SB 923. As an advocate for injured workers and all workers, I continually fight for legislation that will improve the quality of life of workers. I believe SB 923 will increase access to quality health care to California's injured workers.

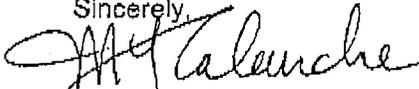
Updating your fee schedule for workers' compensation will help improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians. Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will control 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, the California economy, and the state budget!

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,



Maria Lou Calanche
Executive Director



Clínica Msr. Oscar A. Romero Community Health Centers

April 25, 2012

Christine Baker
Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

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

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 Primary Care 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,

Casey Rodriguez, MD, MsPH
Medical Director
Clínica Msr. Oscar A. Romero

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April 26, 2012
Christine Baker
Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

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

Dear Ms. Baker:

I respectfully request you to immediately review and update your fee schedule for primary care services by supporting the passage of SB 923. As an advocate for injured workers and all workers, I continually fight for legislation that will improve the quality of life of workers. I believe SB 923 will increase access to quality health care to California's injured workers.

Updating your fee schedule for workers' compensation will help improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians. Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, 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, the California economy, and the state budget!

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,

Sincerely,

Omar Corletto
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RECEIVED

MAY - 3 2012

**Department of Industrial Relations
Office of the Director (S.F.)**

Christine Baker
Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco CA 94102

Rosa Moran
Administrative Director
Division of Workers' Compensation
1515 Clay Street, 17th Floor
Oakland, CA 94612

Friday, April 27, 2012

VIA FIRST CLASS MAIL and e-mail

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On behalf of a very large and pro-active group from the private employment sector, and speaking on behalf of the businesses that support the California economy, we are obligated to comply and participate in your request to gather comments about workers' compensation issues from employers and other stakeholders. We applaud your efforts. You have indicated your interest in specifically addressing the following topics: (1) Providing appropriate medical treatment without unnecessary delay, the Medical Provider Network (MPN), Utilization Review (UR) or other issues. (2) Enabling injured workers to return to work as quickly as medically feasible. (3) Adequate compensation for permanent disabilities. (4) Reducing the burden of liens on the system. (5) Identifying appropriate fee schedules. (6) Reducing unnecessary litigation costs. (7) Assessing appropriate use of opiates and other care. (8) Any other improvements needed.

Ms. Baker, in your first keynote speech provided July 26, 2011, some of the salient points you raised were:

The DIR is looking to "consolidate" and "streamline"; with money being tight they will "have to do more with less"; Permanent disability benefits can be raised by reducing excessive costs elsewhere in the system; There should be focus on reducing unnecessary liens and the disputes that cause them; most of the liens involve medical issues; With the Electronic Adjudication and Management System (EAMS), although there is "more right than wrong", there are many problems and the plan is to implement conclusions of a recent EAMS study "where possible"; there's a need to streamline EAMS and the Workers Compensation Information system (WCIS); The administration is concerned that premium increases could damage the economy and therefore there is a need to reduce underlying cost drivers and "look for solid savings."; Medical benefits are the fastest growing component of California workers comp and closing some loopholes "could save tens of millions."; A goal should be to simplify the system where possible and the administration will weigh costs and benefits of changes. Overall, the administration seeks adequate benefits for workers and employer costs consistent with a recovering economy.; Fee schedules will be a focus.; The DIR's goal is to have the worker get appropriate treatment, to get the worker back to work where medically appropriate; the DIR seeks a balance, where there are adequate benefits for workers and where the costs to employers are fair. The goal is to restore the balance while restoring the California economy; you want to ensure that employers are included in this process.; In response to concerns that many feel the agreed medical evaluator/qualified medical evaluator process is broken, you noted that the DIR would take a look at the process and requested ideas on how to fix it.; In response to a question of whether medical dispute resolution could be taken out of the WCAB and resolved in some other way, you questioned whether savings could be achieved and whether labor would want to bargain with that.; you advised that the governor is concerned with increasing costs to employers in this economy.; Responding to a question on a revision of the 2005 Permanent Disability Rating Schedule that did not occur in 2010 as mandated by statute, you noted that if the DIR can't find things to offset increased costs, it might have to be done legislatively but that they don't want a "tidal wave of costs."

This letter is a coordinated and organized collaboration of effort from some of your hardest working and most efficient employer advocates. This letter is intended as a constructive opinion to assist in fixing what could otherwise become a broken system. This letter is intended to support and analyze the current state of the Workers' Compensation, and provide a consolidated analysis of opinion to help improve our Workers' Compensation community, from the perspective of the California private sector. We realize that you are partnered with the interests of both the judicial and legislative sectors. To that end, please allow us to address your query.

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I. WHO WE REPRESENT

Our clients are California Employers that include but are not limited to Temporary Staffing agencies, California Farms and Agricultural businesses, Construction and Healthcare Organizations. This current Workers' Compensation industry is jeopardizing jobs across many key employment sectors here in California.

II. OUR CLIENT'S CONTRIBUTION TO THE CALIFORNIA ECONOMY

Adding to the perception that California is antibusiness, and among the country's most toxic environments for entrepreneurial success, are costs generated by uncontrolled abusive practices within California's workers' compensation system. Those activities include the presence of medical mills, with attendant excessive liens and pharmaceutical expenses, copy service and interpreter overuse and multiple injury claim filings. Utilizing staffing firms operating in California as an example, more than 7.2 billion in annual payroll in was generated in 2010, with associated tax revenue directly benefitting the Golden State. Staffing agencies' collective total annual employment was almost 922,000 that year, employing an average of 244,456 temporary and contract employees per day. Nearly 316,000 employees bridged to permanent employment. Despite that level of contribution to California's growth, staffing companies are subjected to the highest level of workers' compensation insurance premiums, driven in part by largely ignored systematic abuses that create an increasing probability of collapse and certain failure.

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There is no question that causing California employers to pay 15-25% more per claim produces an adverse effect on their ability to survive, and generates an incentive to relocate business elsewhere, as businesses slowly climb out of the Great Recession that began in mid- 2009. While the workers' compensation system had as its initial objective of providing benefits to injured workers, that laudable goal has morphed into an unrecognizable sense of financial entitlement. Injured workers receive benefits as a last resort, all at the expense of California employers who face day after day claims that are expanded, embellished and exaggerated by an easily identifiable secondary cast of characters. As highly functional contributors and taxpaying citizens of this State, employers should not continue to be victimized by this unfair, abusive and despicable treatment. Instead this misconduct should be corralled, which will then permit those presently wasted resources to address California's actual need of reducing unemployment, and precipitate a return to the prosperity that once beckoned those with dreams and ambitions to this place of extraordinary promise.

III. COSTS OF WORKERS' COMPENSATION CREATED FOR CALIFORNIA EMPLOYERS

The California workers' compensation system, created in 1913, constitutionally guarantees every worker the right to compensation for workplace injuries and all medical treatment required in order to "cure and relieve" the worker. In the late 1990s, California's system of workers' compensation insurance began to experience massive cost increases. These increases were the result of overutilization of medical services, higher-than-normal indemnity benefit costs, and increased litigation. At the height of the workers' compensation crisis in 2003, employers in the state were facing double-digit insurance premium increases, causing California to have the most expensive workers' compensation premiums in the nation.

a. 2003 Commission on Health and Safety(CHSWC) Analysis of Medical Care Costs in California

In August 25, 2003, the CHSWC opined that the current system for workers' compensation medical care payments in California was unnecessarily complex, costly, difficult to administer, and, in some cases, outdated. They also pointed out that the lack of fee schedules regarding certain medical services and the delays in updating existing fee schedules create administrative inefficiencies and therefore higher costs. In addition, they found that medical costs in workers' compensation were increasing significantly. According to the Sacramento Bee's analysis of data provided by the California Workers' Compensation Institute, in 2003, coverage averaged \$6.29 per \$100 of payroll.

b. 2004 Legislation

In the 2002–2004 sessions, broad reforms were presented in the Legislature to reduce medical care costs in the California workers' compensation system. The reforms focused on delivery management and treatment cost containment while also ensuring appropriate delivery of quality care. As a study released by the California Workers' Compensation Institute pointed out, these reforms resulted in the creation of a Mandatory Medical Treatment Utilization schedule (MTUS), a 24-visit cap on specific care, and expansion of the Official Medical Fee Schedule. For the next few years, medical costs in the workers' compensation system sharply declined until 2008, when the trend started to creep up once again.

c. Assimilation of Economic Downturn and Drop in Insurance Premiums

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With factors including but not limited to a collapse in the housing market, the nation as a whole has suffered an economic downturn. Only 45.4% of Americans had jobs in 2010, the lowest rate since 1983 and down from a peak of 49.3% in 2000, according to the U.S. Census.

While jobs were suffering, new markets in the insurance industry were emerging, such as the growth in large deductible programs and captives. Workers' comp premiums fell 34% to \$32.2 billion from year-end 2005 to 2010, while the industry's loss and loss-adjustment expense ratios ticked up every year, rising from 74.5 in 2006 to 87.9 in 2010, according to BestLink.

The workers' comp industry's combined ratio for 2010 was 116.8, and A.M. Best Co. is estimating a combined ratio of 118.5 for 2011 and 120.5 in 2012, which would be the highest since the industry recorded a 120.9 in 2001. Harry Shuford, chief economist with NCCI Holdings Inc., said from 2007 to 2009, workers' comp premium fell 23%. Of that 23%, 7% was due to changes in bureau rates and loss costs, while four other factors were each responsible for a 4% drop: reducing in carrier pricing; decline in total payroll; the adverse impact on manufacturing and contractors; and that smaller companies were hit harder by the economy than larger companies.

d. 2005-2011 Rising Costs to Employers

Sources from the Los Angeles Times report that California has a current \$15- billion dollar Workers' Compensation system. Writers for the Sacramento Bee, in analyzing data provided by the CWCI, found that after the reforms, which tightened eligibility for benefits, payroll costs for Workers' Compensation per every \$100 in payroll dropped to as low as \$2.16 in 2008 before beginning a slow rise. Payouts also dropped from \$12.3 billion in 2002 to as low as \$6.7 billion in 2005 before also beginning a slow rise.

Sources from the Sacramento Bee also found that California employers' costs of providing workers' compensation insurance rose slightly in 2011, but are scarcely half of what they were before then-Gov. Arnold Schwarzenegger and the Legislature enacted a major overhaul of the system in 2004. According to data released by the Workers' Compensation Insurance Rating Bureau, which was released Monday, March 12, 2012, the average cost of workers' comp insurance rose from \$2.32 per \$100 of payroll in 2010 to \$2.37 in 2011 as payouts to injured workers and their medical care providers also rose from \$7.8 billion to \$8.1 billion.

According to the California Chamber of Commerce, the average paid medical cost per claim is currently much higher than before the implementation of the 2003 reforms. According to the California Workers Compensation Institute (CWCI) Analysis of Medical Costs 2005-2009, individual medical costs per claim between 2005 and 2009 grew by the following amounts:

- 149 percent increase for physician medical-legal reports
- 68 percent increase for pharmaceuticals and medical equipment
- 29 percent increase for physician evaluation and management (driven by more office visits and treatment per visit)
- 23 percent increase for all outpatient services
- 15 percent increase for physical medicine
- 9 percent increase for surgery costs

e. Governor Browns' Administration attempts to bridge the gap

Sources at the Los Angeles Times indicated in April of this year that consensus may be forming that it's time for the workers' comp pendulum to swing back toward the victims that the system originally was set up to assist. The administration of Gov. Jerry Brown is hoping to broaden support for the changes by holding public forums up and down the state this month.

"It seems perfectly clear to the participants in this system that the permanently disabled worker is not being adequately compensated," said Martin Morgenstern, a top advisor to Brown and secretary of the California Labor and Workforce Development Agency. "We have a serious problem, and it needs to be fixed, and fixing it isn't going to be cheap."

But the Brown administration concedes that it could be counterproductive to raise the cost to employers at a time when California is battling double-digit unemployment.

"We cannot raise premium costs to employers at this time," Morgenstern testified at a recent legislative informational hearing. Money to boost disability benefits can be found within the workers' comp system, he said. Ms. Moran, in your first interview with the Hon. Kenneth B. Peterson after taking office, you stated:

This is not the economy we had previously. We have a very weak economy, and there will have to be some balancing

between the costs and the benefits. Injured workers deserve fair, reasonable, adequate and necessary benefits. But we also have an economy that is in its infancy of coming around. One of the things I plan to focus on is finding areas where there can be some streamlining and cost savings. I think I have some good people on it, and it is certainly a high priority and goal for me.

Based upon our analysis of the data presented, on behalf of the employment sector, we agree with the Brown Administration, Martin Morgensten, Ms. Christine Baker and Ms. Rosa Moran. Please consider this letter as an attempt to assist in your efforts of bridging the gap between your asserted goals of not raising premium costs to employers while adequately compensating the injured worker at a time when California is facing double-digit unemployment.

IV. FIXING THE SYSTEM

- a. Providing appropriate medical treatment without unnecessary delay: the Medical Provider Network (MPN), Utilization Review (UR) or other issues.

The MPN statutes (Lab. Code, §§ 4600, subd. (c), 4616-4616.7), enacted by Senate Bill 899 (Stats. 2004, ch. 34, §§ 23, 27), returned some limited control over injured employees' medical treatment to those employers who establish an MPN. (*Knight v. United Parcel Service* (2006) 71 Cal.Comp.Cases 1423, 1430-1432 (Appeals Board en banc) .)

Sections 4616.3 and 4616.4 establish how a validly established and properly noticed MPN ordinarily operates. The MPN statutory scheme establishes a multi-step process before an injured employee reaches the stage of an Independent Medical Review. (*Valdez I*, 76 Cal.Comp.Cases at p. 334 [sections 4616.3 and 4616.4 "allow an applicant to treat with any physician of his or her choice within the MPN, and also afford a multi-level appeal process where treatment and/or diagnosis are disputed."].)

The first step is that, when an injured employee notifies the employer of an injury, "the employer shall arrange an initial medical evaluation and begin treatment" (Lab. Code, § 4616.3, subd. (a).) The second step is that "the employee [has the] right to be treated by a physician of his or her choice after the first visit from the medical provider network" (Lab. Code, § 4616.3, subd. (b).) The third step is that, "[i]f an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician,[4] the employee may seek the opinion of another physician in the medical provider network." (Lab. Code, § 4616.3, subd. (c).) The fourth step is that, "[i]f the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician" (Lab. Code, § 4616.3, subd. (c).)

"If, after the third physician's opinion, the treatment or diagnostic service remains disputed, the injured employee may request independent medical review regarding the disputed treatment or diagnostic service still in dispute after the third physician's opinion in accordance with Section 4616.3." (Lab. Code, § 4616.4, subd. (b).)

We are not seeing adequate utilization of the Medical Provider Network and the multiple levels of appeals within the medical provider network when, not if, medical disputes arise. Like a zebra who can't change its stripes, Applicants are much more apt to treat outside of the network on a lien basis, await the expiration of state disability benefits, then pursue their remedies pursuant to Labor Codes §§ 4061 and 4062. This is preventing a potential delay of litigation, until the 104 week limitation on temporary disability benefits and the 52 week limit on state disability benefits have been exhausted. This is having the effect of delaying litigation well in excess of 3 years from the original date of injury. When military personnel and professional athletes are experiencing exponentially disproportionate recovery rates from that of the California injured worker, this discrepancy is not acceptable. We are seeing concerted efforts, at great length, to avoid the medical opinion of MMI status, by not just one physician in the MPN, but by 4 physicians in the MPN.

A more stringent regulation to utilize the multiple safeguards within the multi-level appeals process within the Medical Provider Network should be considered. Additionally, limiting regulations to make the receipt of any benefits (whether state disability benefits, temporary disability benefits, or Labor Code §4850 wage continuation benefits to peace officers) to run concurrent with any obligation for temporary partial or total disability, should be considered.

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

Despite previous legislative enactments to reform California worker's compensation system, California employers are not substantially incentivized to encourage injured workers to return to work. Thus, substantial incentives need to be instituted that provide substantial increased incentives to those employers that participate in returning the injured worker to work.

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c. Adequate compensation for permanent disabilities.

California employers strongly support fair and adequate compensation for permanent disability to injured workers. Due to the workers' compensation reform, Permanent disability calculations under the AMA guides proved to have a decrease in permanent disability awards.

As a result, legal counsel for the injured workers have found creative methods, "loop holes" in which to increase the value of permanent disability, by adding on phantom, claims of internal, psyche, or neurological complaints i.e. sleep deprivation, sexual dysfunction, etc. often times without medical substantiation or justification. Thus, employers are forced to defend against the phantom "add on" claims, incurring substantial medical evaluative costs in the fields of internal, psychiatric, and neurological medicine.

Prior to being represented, most injured workers had no reporting of symptomology or complaints to the newly alleged body parts. Judges need to be proactive in adjudication of these claims, and not turn a blind eye to the "multiple body" parts added when the facts support no reporting, merit or medical substantiation prior to the applicant becoming represented. Thus, the current environment encourages the continuance of these "add on" claims, which has resulted in substantial increased employer costs in defending them.

The case law decisions of *Alvarez/Guzman* and *Ogilvie*, additionally complicates and substantially increased the Permanent Disability awards, and allows for rebuttal of the permanent disability rating schedule, thus, causing delay in case resolution, and substantial increase in defense litigation costs on behalf of the employer.

Despite previous legislative enactments to reform California worker's compensation system, California employers are not substantially incentivized to encourage injured workers to return to work. Thus, substantial incentives need to be instituted that provide substantial increased incentives to those employers that participate in returning the injured worker to work.

In our effort to reform the current workers' compensation system, once the perpetuated waste and abuse is purged from the system it should be replaced with a fair, unencumbered system, one that provides adequate compensation for permanent disability fairly to ALL injured workers, represented or in pro per. This would promote the expediency of benefits to the injured workers, without increased and wasteful costs, which in turn would encourage the growth of jobs in new and existing companies throughout California.

d. Reducing the burden of liens on the system.

i. Consider expanded *Gregory* Formula Regulations

According to an article in the Insurance Journal written in 2011, they found that liens are "choking" California's workers' compensation system, with employers and insurers spending roughly \$200 million per year on loss adjustment expense to handle medical liens claims, according to a new liens report.

In the Golden State's workers' compensation system, a lien is a direct claim against the defendant for a benefit which is not otherwise payable to the injured worker. According to the California Commission on Health and Safety and Workers' Compensation:

The rationale is that the lien claimant has furnished medical treatment or other service that the employer was required to provide, so the lien claimant is entitled to payment from the employer. A medical provider must accept the payment allowed by workers' compensation and must not collect from the patient unless the claim turns out to be non-compensable. A lien is the medical provider's vehicle for contesting the employer's determination of the amount payable for medical goods or services. Unlike conventional liens, these are not obligations of the injured worker.

The Commission says the prevalence of liens is unique to California, and predicts approximately 350,000 liens were filed in 2010 in California, and more than 450,000 are expected in 2011. Workers' compensation experts say most liens occur in Southern California, rather than in Northern California.

The report continues:

[T]he volume of liens forces the courts to encourage settlement, almost to the point of coercion. The necessity of settlement rewards both unjustified claims and unjustified refusals... The volume of liens provides an environment where indefensible delays and denials by claims administrators and fraud and abuse by lien claimants can thrive, side by side.

Among the Commission's findings:

Medical treatment liens account for more than 60 percent of the liens filed, and 80 percent of the dollars in dispute; \$1.5 billion per year is claimed in medical lien disputes after adjusting for amended liens; One-third of medical liens involve disputes over the application of the Official Medical Leave schedule; Authorization for treatment was in dispute in seven out of 10 medical liens surveyed.

Reasons treatment was not authorized were: 37 percent provider not authorized to treat (mostly out-of-network); 7 percent denied claims; 6 percent medical necessity of treatment rejected by utilization review; 1 percent contested body parts; 20 percent authorization status unknown or not stated.

The volume of liens filings is sensitive to procedural changes, such as the adoption or repeal of a \$100 filing fee and the adoption of new filing procedures. Up to 30 percent of medical liens are prematurely submitted before the time has elapsed for the claims administrator to pay or object to the provider's bill. Ten percent of medical liens are submitted on the date the service is provided. Nearly one quarter of medical liens are filed more than two years after the last date of services for which payment is claimed, including 6 percent that are filed five or more years after the last date of services.

In the event the parties submit a Compromise and Release to the Board, the formula set forth hereafter may be used in determining the amount of recovery of a lien claimant under Labor Code §4903.1. The formula was established by the Court in *Gregory v. Foster Sand & Gravel* (1977) 42 Cal.Comp.Cases 1 (En Banc) see also *Kaiser Foundation Hospitals v. W.C.A.B. (Gregory)* (1978) 43 Cal.Comp.Cases 1300 (Published). However, a *Gregory* formula may not be applied where there is no dispute about industrial causation or the right to recover self-procured medical care.

We in the California employment sector are seeing a massive increase in liens, mostly as a result of dissatisfied out of network medical care providers, or their vast referral systems that are in place. We are seeing a culture of physician referrals and potential protection of this attorney physician relationship to the detriment of the injured worker. We would request that you assist us in regulating a more expansive *Gregory* Formula application. For example, at the time of any resolution, whether via Findings & Award, Stipulated Award or Compromise & Release, Labor Code Section 4903.1 be amended to allow for *Gregory* Formula application to any bills or liens. Should any of the billing providers subsequently perfect their lien with the WCAB, there will be certainty in the pre-determined ratio that will be awarded. Leaving matters open to the possibility of lien litigation more than five years from the date of injury also needs to be reconsidered. Please consider limiting the time limits to perfect a lien for services provided to within 6 months from the date services were provided.

Additionally, should you have access to research and analyze the ratio between the cost of medical benefits to the cost of indemnity benefits provided at the time our system was first instituted in 1913, and compare it with today's ratio, you will likely find that the ratio for today's injured worker in favor of medical care vs. indemnity benefits provided are disproportionately askew. Something should be done to bring this ratio closer to the ratio envisioned by those responsible for instituting our Workers' Compensation system in 1913. While we recognize substantial advances in medical technology, the ratio for medical treatment expenses today for the average injured worker is likely disproportionate to the very care being received through their own private medical care programs. At the same time that we are seeing advances in medical technology, we are also seeing advances in workplace accident prevention programs. We need assistance in closing this burgeoning gap.

e. Any other improvements needed

i. Incongruous Judicial Opinions- EAMS Access expansion

The State of California has made great strides in granting public access to records from the Workers Compensation Appeals Board. Ms. Moran, when you provided your first interview to the Hon. Kenneth Peterson, you discussed the topic of EAMS, stating:

"As a judge I know first hand the positive and negatives about EAMS due to daily use of the system. I'm now working with people more involved with the technical issues involving EAMS primarily in the reporting environment. EAMS has the capability to provide workload and work flow reports that are very useful for task assignments. This is an area that I am really looking at closely from a management perspective."

Ms. Moran, you have a very large sector of legal professionals that would like to see greater accessibility to the judicial opinions that circulate. The current system, as it stands, is very limited in depth, leading to the absence of uniformity of judicial opinions, or worse, judicial activism. The EAMS system has streamlined the ability to obtain identification of proper parties, case numbers, or procedural issues that need correcting. However, this type of access is artificial, not substantive. We would request

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that you force public access several levels deeper, like the movie Inception. We, the private employment sector, would request access to judicial findings and awards issued as far down as each and every district office from the Workers Compensation Appeals Board. If necessary, consider a partnership with Lexis-Nexis or Westlaw, and if necessary seek royalties for the publication of this information. Vendors for these publishers advise that other court systems may have similar negotiations in place.

To those points that we were not able to cover, we would request that you use the educated opinions of others to help us ensure the timely provision of care is provided to those that are truly injured as a result of occupational injuries, while at the same time, not doing so at the cost to the California employment sector, in this volatile economy.

We wish you the best in your endeavors.

Respectfully,

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April 30, 2012

Christine Baker, Director
Department of Industrial Relations
State of California
1515 Clay Street
Oakland, California 94612

RE: UTILIZATION MANAGEMENT : REVIEW AND RECOMMENDATIONS

Dear Director Baker,

Thank you for the opportunity to provide our perspective on the current utilization management (UM) process in California, recommendations for improvement and a national perspective that you may find helpful to further improve treatment outcomes for California's injured workers. As you well know, previous reforms designed to provide predictable and objective treatment protocols through the use of the ACOEM guidelines and (LC Sec 4604.5) and the adoption of the Medical Treatment Utilization Schedule (CCR Sec 9792.2) have helped to bring down skyrocketing average medical costs per claim (See Reference #3 CWCI March 2011).

We also note that the improvements in medical cost containment have, over time, begun to erode. For that reason, we wish to offer our thoughts and recommendations in several key areas where we believe the best chance for greater efficiency in the area of medical cost containment resides. Our focus here will be in the areas of: Request for Authorization (RFA), an improvement/clarification of the definition of 'authorization', a renewed process for third level appeals, recommendations for using the utilization management process to curb frivolous or unsubstantiated liens and improvements in the use of narcotics for pain management.

Request for Authorization (RFA) Form

Under CCR Section 9792.6(o) a provider is obligated to submit a completed RFA and has 3 methods for doing so. Our data show that approximately 49% of all RFAs received are incomplete and require follow up. And, unfortunately, these incomplete forms require up to 6 full time employees to secure the missing information. This, of course, further delays decision-making and treatment authorization. Currently our practice is to make two calls over 2 business days. Most missing information is critical and includes frequency/duration, diagnosis, procedure, address or physician's name. If we are unable to acquire the information, we hold the request for up to 14 days which is allowed under CCR 9792.9(b)(2) and 9792.9(l).

Recommendation: Timely and accurate information from the provider on an RFA (Form PR-2) is critical. Our suggestion would be to require a completed form from the provider before authorization could



proceed and that some level of obligation, including enforcement, be placed on providers. Attached in Appendix A are statutory and regulatory examples on this topic from Louisiana, Texas and Colorado.

Definition of Authorization

We understand that recent case law (*Sandhagen*) and the guidance under CCR 97926(b) attempts to establish clear standards for reimbursement and authorization for medical treatment. We also appreciate the guidance offered by the Division of Workers' Compensation following the *Simmons* decision to provide for a 'two-step' process for notification. Having said that, there still remains confusion as to what kind of authorization is implied by case law, statute and regulations. So, while *Sandhagen* requires UR for all medical treatment, LC 4610 indicates that utilization management is to be directed solely at determining medical necessity. California is unique among all states in that it focuses utilization management on payment. This definition usurps claims management decisions and essentially requires UM to verify all RFAs to assure compensability. This lack of clear practice and purpose, again, adds enormous delay to the process. Even the DWC's 'two step' approach can cause confusion. For example, while an RFA that is submitted for an ultrasound of a 12 week pregnancy may be medically necessary, utilization management would likely approve it and the employer would bear the burden of the cost. However, it is unlikely the pregnancy is the result of an industrial injury and, using the two step process, the treating provider would receive two letters—one from UM authorizing the treatment and another one denying the claim under LC 4062.

Recommendation: Timely and accurate information and notification will significantly help the process and we would support changes that would remove the current definition of 'authorization' and replace it with a notification process that allows compensability determinations to be made by employers and their representatives. For your information, the Appendix A includes regulatory language from Texas on this issue.

Third Level appeals (AME/PQME)

As you know, a cornerstone of the Workers' Compensation reforms was the adoption of treatment protocols that are generally recognized by the national medical community and scientifically based. CCR 9792.6(s) and 9792.8(a)(2) support this. However, we believe the AME/PQME process has, over time, been eroded based on not only the denial process included in CCR Section 9788.01 but also as a result of the *Cervantes* decision. Taken together, these changes have added further delay and a reversal of decisions based on evidence-based treatment guidelines. We have experienced a significant increase in the number of AMEs with opinions based more on personal judgment, experience and opinion—often far from evidence-based.

Recommendation: Given the often inconsistent and frequently inappropriate AME/PQME decisions, we would support a repeal of the current spinal second opinion and AME/PQME examination and replace it with a process allowing the appeal of a second level UM denial by an independent review organization (IRO). There are numerous benefits from such a process, which is currently widely utilized in group health. It is more timely in terms of securing a decision, is less costly, and the extent to which IRO



decisions follow accepted medical evidence and sound clinical reasoning can be independently audited to assure quality decision-making. An effective IRO could order a PQME if needed. The basis of the IRO would be based on a concordance of the documented findings and evidence-based treatment guidelines. The Division of Workers' Compensation may also establish an oversight and review process to assure impartial quality assessment of IRO determinations and to identify those peer reviewers that experience the highest number of overturned determinations, which could lead to an improvement in medical treatment of injured workers. Appendix A includes a reference to Texas regulations that outlines the IRO process.

Lien Process

We have previously provided comments on the overall medical lien process and provided detailed recommendations in a number of key areas. We continue our strong support for statutory and regulatory reform in this area, as we believe the costs incurred to have no direct or indirect benefit to injured workers.

In the context of Utilization Management's role in helping to curb the practices of invalid lien "claimants", we agree with the CHSWC Report where many liens are generated by treatment outside the MPN or UR statutory framework. Appendix A includes statutory language from Texas that provides for pre-authorization for medical costs.

Recommendation: Consideration should be given to revising the current Request for Authorization form to include a field where an RFA is required for all non-MPN and related liens where treatment has properly been denied—prior to the filing of a lien. This requirement would essentially remove a great deal of the administrative burden of these requests from the WCAB and the DWC.

Narcotic Utilization Management

We share the concerns of many that the overuse and abuse of schedule II opioids for pain management needs special consideration nationwide and are particularly interested in providing our views in this area in the context of reforming current UM practices. Appended below under References are several reports and studies that we feel offer support for improvement in this area.

Recommendation: We find that the State of Washington's holistic approach to opioid prescribing under the Agency Medical Director's Group (AMDG) has merit. The AMDG sets a daily threshold of 120mg MED/day. To exceed this threshold the patient needs to demonstrate "an improvement in function and pain or obtaining a consultation from a pain management expert" (AMDG, 2012, p.8) Washington's treatment guidelines require specific documentation and submission of a form of assessment of function at 2 weeks, 2 months and determination of effectiveness at 6 months (WA 2010). Basing the review criteria on MED allows treatment of pain and a stopgap measure to help prevent dependency and tolerance. A similar practice, including a requirement for pre-authorization when prescribing schedule II narcotics in excess of 120mg per day (MED), should be considered in California. But it should be noted that the Washington process does not prohibit prescribing above the suggested 120mg MED



limit, but does indicate to clinicians that above this dosage the morality from opioid prescribing begins to increase. In that sense, the 120mg limit could be considered a “yellow light” rather than a “stop sign”. Alternatives to pre-authorization also exist, and could include monitoring of frequent high-dose prescribers by the DWC.

Conclusion

We appreciate the opportunity to provide our thoughts and recommendations on this important topic and we hope you find this information helpful. If you wish to discuss this information in more detail, please let us know. We look forward to working with you and your team in the future.

David Dietz, MD, PhD
National Medical Director

Kathleen G. Bissell, CPCU
AVP, Sr. Regional Director, Public Affairs



REFERENCES

- AMDG (2010). Interagency Guideline on Opioid Dosing for Chronic Non-cancer pain: an educational aid to improve care and safety with opioid therapy. *Agency Medical Directors Group*. Available online at: <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>
- Ireland, J. & Swedlow, A. (March 2011). Medical Development Trends in California Workers' Compensation Accident Years 2002-2010. *California Workers Compensation Institute*, Oakland, CA. p 1-8
- MMWR (2012). CDC Grand Rounds: Prescription Drug Overdoses-a US Epidemic. *Morbidity and Mortality Weekly Report (MMWR)*, 61(10); 10-13.
- Okie, S (2010). A flood of opioids, a Rising Tide of Deaths. *New England Journal of Medicine*, 363(21). P. 1981-1984
- Swedlow, A, Ireland, J, & Johnson, G. (March 2011). Prescribing patterns of Schedule II opioids in California Workers' Compensation. *California Workers Compensation Institute*, Oakland CA. p. 1-12
- WA (2010). Guidelines for outpatient prescription of oral opioids for injured workers with chronic, non-cancer pain. *Medical Treatment Guidelines, Washington State Department of Labor and Industries*. Available at: <http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/Opioids.pdf>



APPENDIX A

RFA Form Examples:

Louisiana Title 40 §2715(1)(a)

<http://www.doa.louisiana.gov/osr/lac/books.htm>

- a. Recognizing the importance of establishing a process for the making of such treatment decisions, the Officer of Workers' Compensation Administration hereby promulgates the following criteria as the minimum submission by a provider or practitioner seeking to provide care beyond the statutory non-emergency medical care monetary limit:
- i. history and physical to include clinical summary;
 - ii. diagnosis with ICD-9 codes;*
 - iii. type of service;
 - iv. plan of care to include expected length and frequency of treatment;
 - v. prognosis to include expected outcome of treatment; and
 - vi. any diagnostic test results and interpretations.

*The provider will provide the narrative/description and the carrier/self-insured employer will provide the ICD-9 code.

Colorado Rule 16

<http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDLE-WorkComp%2FCDLELayout&cid=1248095316073&pagenam=CDLEWrapper>

(9)(E) To complete a prior authorization request, the provider shall concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure and include:

- An accurate definition or description of the procedure
- Documentation of the relevant diagnostic or surgical indications as listed in the Medical Treatment Guidelines
- Justification for any variance in an established procedure, when appropriate
- A listing of any similar procedure and value, and
- The justification for the difference in the value.

Texas *Proposed* URA rule §19.2007

(b) When conducting utilization review, a URA must request all relevant and updated medical records in order to complete the review. This information may include identifying information about the injured employee; the claim; the treating physician, doctor, or other health care provider; and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the injured employee and the medical history of the injured employee relevant to the diagnoses and the compensable injury, the injured employee's prognosis, and the plan of treatment prescribed by the



provider of record, along with the provider of record's justification for the plan of treatment. The required information should be requested from the appropriate sources.

134.600(f)

(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

- (1) name of the injured employee;
- (2) specific health care listed in subsection (p) or (q) of this section;
- (3) number of specific health care treatments and the specific period of time requested to complete the treatments;
- (4) information to substantiate the medical necessity of the health care requested;
- (5) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the insurance carrier;
- (6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;
- (7) name, professional license number or national provider identifier of the health care provider who will render the health care if different than paragraph (6) of this subsection and if known;
- (8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and
- (9) estimated date of proposed health care.

Definition of approval

Texas 134.600

(h) Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury, regardless of:

- (1) unresolved issues of compensability, extent of or relatedness to the compensable injury;
- (2) the insurance carrier's liability for the injury; or
- (3) the fact that the injured employee has reached maximum medical improvement.

(l) The insurance carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

- (1) the specific health care;
- (2) the approved number of health care treatments and specific period of time to complete the treatments; and
- (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury.



Third level appeal decisions

Texas 133.308

<http://www.tdi.texas.gov/wc/rules/documents/133.pdf>

(k) IRO Assignment and Notification. The Department shall review the request for IRO review, assign an IRO, and notify the parties about the IRO assignment consistent with the provisions of Insurance Code §4202.002(a)(1), §1305.355(a), Chapter 12, Subchapter F of this title (related to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

(l) Carrier Document Submission. The carrier or the carrier's URA shall submit the documentation required in paragraphs (1) - (6) of this subsection to the IRO not later than the third working day after the date the carrier receives the notice of IRO assignment.

(n) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the Division require an examination by a designated doctor and direct the employee to attend the examination pursuant to Labor Code §413.031(g) and §408.0041. The IRO request to the Division must be made no later than 10 days after the IRO receives notification of assignment of the IRO. The treating doctor and carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical documents to the designated doctor appointed by the Division, to arrive no later than three working days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical necessity dispute. The designated doctor shall complete a report and file it with the IRO, on the form and in the manner prescribed by the Division no later than seven working days after completing the examination. The designated doctor report shall address all issues as directed by the Division.

Lien

Texas 134.600

(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or



(D) when ordered by the commissioner;

(2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

April 30, 2012

California Division of Workers' Compensation
Administrative Director Rosa Moran
1515 Clay Street
Oakland, CA 94612

Delivered via Email: DIR@DIR.CA.GOV

Re: Workers' Compensation Forum – Comments on Pharmacy Care for Injured Workers

Dear Director Moran:

StoneRiver Pharmacy Solutions is the nation's leading provider of third party claims and billing support for pharmacies dispensing workers' compensation related prescriptions. StoneRiver serves small, community pharmacies and large national chain pharmacies. Our services help ensure access to pharmacy care for injured workers by handling the billing and claims processing for pharmacies and guaranteeing payment to the pharmacy for the workers' compensation prescriptions that they dispense.

We appreciate the opportunity to participate in the Workers' Compensation Forums and to provide our suggested changes in writing to the Division. Our comments are based on years of experience managing pharmacy care for injured workers across the country. Our goal is to maximize access to quality care, minimize administrative friction in the system and to employ pharmacy care strategies that are cost-effective, and have a higher probability in hastening the return-to-work of the injured worker. Our recommendations will focus on the pharmacy fee schedule adequacy and the challenges associated with its link to the Medi-Cal system, eliminating the ambiguity surrounding payment for out-of-network care and supporting higher use of network providers, promoting clinical strategies for reducing the use of opioids in the system and transitioning injured workers currently using opioids to other, less addictive and more effective therapies where possible, and suggesting a simplified payment dispute process in cases where compensability has been established. We believe, based on our experience, that our suggested changes will ultimately reduce costs in the system by providing appropriate and efficacious care, helping the injured worker better understand how to use their medications safely, and reducing administrative costs by clarifying the rules of pharmacy care delivery and payment.

Pharmacy Benefit Networks

Pharmacy Benefit Networks have proven to be an effective tool for controlling costs, managing pharmacy care and streamlining administrative processes. Providing and requiring pharmacy care in a network presents some unique challenges that should be addressed in any reform legislation. While we strongly support the use of pharmacy benefit networks, we also recognize

specific issues that arise in the delivery of pharmacy care that do not manifest in other areas of medical networks.

Injured employees often do not view pharmacy care as a "medical service" and may not understand that there is a specific network they should access for care and therefore will default to the pharmacy they typically use for their other prescription needs. Frequently, prescriptions may also be requested from a pharmacy by a spouse, parent, sibling, or friend who will have no idea that a pharmacy network requirement exists. It is also fairly common that prescriptions are not identified to a specific network at the time of fill by an in-network pharmacy and those bills are processed at the fee schedule rate by a third party billing entity. Any reforms should anticipate these realities in the pharmacy arena and provide for notice provisions to be given to pharmacy providers and their billing agents who may unwittingly provide out-of-network care and risk not being paid for their services. StoneRiver Pharmacy Solutions recommends that any reforms include a specific notice section for pharmacy care that would provide for payment of "out-of-network" or otherwise unidentified network prescriptions at the fee schedule amount until such time that the pharmacy and their third party billing entity have been given notice that the specific claim is subject to a pharmacy network and that out-of-network prescriptions filled for that claim following the date the notice was delivered would not be reimbursed by the workers' compensation payor and any in-network care would be reimbursed according to the network contract. This approach provides fair warning to the pharmacy provider and their billing agent and will not unnecessarily delay care, or burden the injured employee with the expense of pharmacy care for their workplace accident. This approach will also likely reduce administrative costs by providing clear rules of payment expectations and eliminate some of the back-and-forth correspondence that often occurs between payors and out-of-network providers or billing agents.

Recognition of Third Party Billers

It should be noted that most pharmacies use the services of a third party billing agent to process workers' compensation bills that are not identified to a specific pharmacy network. The third party billers typically guarantee payment to the pharmacy and the pharmacy assigns their right to the claim to the third party biller. Third party billing agents help provide access to care for injured workers by providing a solution for pharmacies to send unidentified claims and removing the financial risk to the pharmacy for their workers' compensation claims. Any reform measures should specifically recognize the role of third party billers in the system and should recognize their right to payment for the services they provide. When a bill is submitted by a third party billing agent, payors should be required to pay the billing agent at the fee schedule rate and not circumvent that process by sending payment directly to the pharmacy. Such a practice creates unnecessary accounting expenses for the pharmacy, their billing agent and the payor, and does not ultimately save the system any money. Nothing in the reform measures should prohibit a payor and a third party billing agent from contracting for reimbursement rates that are different from the fee schedule.

Workers' compensation claims represent roughly 2% of a pharmacy's volume and do not produce enough revenue to justify the creation of a separate claims handling department to

deal with the unique and labor intensive process of submitting workers' compensation claims. Third party billers and pharmacy benefit networks help make the workflow at the pharmacy feel the same for workers' compensation claims as it does for group health and government sponsored pharmacy programs. Both entities are able to scale the cost of processing claims across a broad section of the marketplace making their services more affordable to the individual pharmacy than self-providing claims processing services. Though, some pharmacies still do process their own workers' compensation claims.

Some employers may opt not to use a medical services or pharmacy benefit network. Because of that fact, unless a card or some other notice is presented at the time the prescription is filled, it would be impossible for a pharmacy, or a third party billing entity, to determine at that time that the particular claim is subject to a network since the claim processing work occurs hours, if not days, after the dispensing of the medication.

Pharmacy Fee Schedule

The linking of the pharmacy fee schedule to the Medi-Cal system pharmacy fee schedule has created some unique challenges for the workers' compensation system. The Medi-Cal fee schedule does not contemplate the additional costs associated with processing a workers' compensation claim nor does it adequately address the patient set and hoped-for outcomes in the workers' compensation system. Since the last reform effort in 2003, the Medi-Cal pharmacy fee schedule has seen several reductions. The workers' compensation system was subject to the earlier cuts reducing the fee schedule from AWP - 10% to AWP - 17%, but language has been added to the budget bill in the last several years that exempted workers' compensation from the proposed cuts. All other medical providers have seen incremental increases in their fees. Pharmacy is the only segment that has suffered a reduction since the last reform efforts.

StoneRiver Pharmacy Solutions recommends that any reform legislation clearly require and empower the Workers' Compensation Division to establish a pharmacy fee schedule that is specific to the workers' compensation system and not tied to other, unrelated government programs. The fee schedule should be developed with input from workers' compensation stakeholders, should consider the additional costs associated with processing a workers' compensation claim, and should also consider access to care and the appropriate care management and outcomes required to provide more significant, long-term pharmacy cost savings in the system.

Opioids and Pharmacy Care Management

The use, overuse and abuse of opioids in the workers' compensation system has been a concern for quite some time but has reached epidemic proportions in the last few years. Reducing opioid dependency and addiction requires consistent monitoring of medication usage and frequent communication with prescribing physicians regarding alternative drug therapies. Prevention efforts require the targeted education of prescribing physicians and early intervention in the treatment and prescribing process. Education efforts should also be directed at injured workers, helping them understand the risks associated with opioid use and

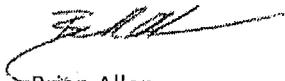
the availability and benefits of alternative pain management therapies. Such clinical programs require technological and human resources that are targeted to specific claims and injury characteristics. There is not currently a financial mechanism in place in California to cover the costs of these critical clinical services. The Medi-Cal fee schedule amount is not adequate to cover the additional clinical costs. As reform efforts move forward, consideration should be given to how best to provide and pay for the aggressive clinical intervention that needs to occur if significant inroads are to be made in preventing and curbing dependency and addiction to opioids in the workers' compensation system. By providing greater clarity on the payment of pharmacy claims, those administrative savings could be directed toward providing more effective clinical services which ultimately will help reduce pharmacy costs which will also free up existing dollars to pay for these services.

Simplified Payment Dispute Process

The current lien process for settling payment disputes is cumbersome, expensive and overwhelmed. StoneRiver Pharmacy Solutions believes that in situations where a claim has been deemed to be work-related and compensable, a simplified dispute process could be used to settle short-payments or non-payments of medical bills. The process would require a small filing fee and would initially be handled at an administrative level based on a written complaint from the filing party and a written response from the responding party. If either side was unhappy with the decision they could request an informal hearing in front of an administrative panel. Either side could "appeal" that decision by entering into the more formal lien process.

Thank you again for the opportunity to express our thoughts on reforms for the California workers' compensation system. We look forward to working with you and offer our expertise to assist you as you begin developing legislation or regulations related to pharmacy care and pharmacy billing services. Please feel free to contact Brian Allen at 801-230-8379 or at Brian.Allen@stoneriverrx.com if you have any questions or require any additional information.

Sincerely,



Brian Allen

Vice President of Government Affairs



California Medical Association

Physicians dedicated to the health of Californians

April 30, 2012

The Honorable Rosa Moran
Administrative Director, Division of Workers' Compensation
1515 Clay Street
Oakland, CA 94612

RE: Comments of the California Medical Association (CMA) on the current status of the California Workers' Compensation System, presented in response to the DWC "Listening Sessions."

Judge Moran:

On behalf of the California Medical Association (CMA), thank you for the opportunity to comment on the current status of California's workers' compensation system. CMA member physicians and staff were pleased to participate in several of the recent listening sessions organized by the Division of Workers' Compensation (DWC), and we are now presenting more comprehensive written comments.

We have broken out our comments by topic area, based on topics DWC published prior to the listening sessions.

- **Provision of appropriate medical treatment without unnecessary delay, the medical provider network (MPN), utilization review (UR) or other issues**
- **Enabling injured workers to return to work as quickly as medically feasible**

CMA is combining our comments on the first two bullet points, as we believe they address the same issue. In fact, we believe that the most effective way to get injured workers healed and back to work faster is to eliminate the waste and delays caused by excessive utilization review.

When SB 899 was first proposed, medical provider networks were supposed to lessen the need for insurance carriers to perform UR. In theory, employers and insurers would have the ability to select physicians, and work collaboratively to handle injured workers.

In truth, the opposite has occurred. According to research published by the California Applicant's Attorneys Association (CAAA), from 2005 to 2010 payments to physicians actually declined 12%, while cost containment activities skyrocketed by almost 400%¹. This dramatic increase represents myriad impediments being put in the way of physicians who are trying to provide needed care to their workers.

¹ "California Workers Compensation 2012: The State of the System." California Applicants' Attorneys Association, January 2012.

Part of the problem appears to be the MPNs themselves. MPNs were originally conceived as small, tight-knit groups of doctors that would coordinate all needed care for injured workers from a particular employer. Instead, many employers and insurers have turned to commercial "off the shelf" networks put together by consultants and health plans². In some cases, physicians do not even know they are being put into these networks. MPNs, if they are going to exist, need to return to being small networks of willing providers.

In addition, CMA strongly supports changing the law to require utilization review physicians to be licensed in the State of California³. In the opinion of the Medical Board of California, utilization review is the practice of medicine. However, the Board is often powerless to act against physicians who abuse their positions, as they are not licensed in this state.

CMA looks forward with interest to the coming CHSWC study regarding utilization review. If we can provide any perspectives or input to that study, we would be happy to do so.

- **Adequate compensation for permanent disabilities**

CMA agrees with the proponents of increasing awards to permanently disabled workers. Some published estimates are that there would need to be between \$400 and \$500 million in savings in order to fund a "PD fix."

With our above comments in mind, CMA believes that this fix could be funded by squeezing costs out of excessive UR. The paper published by CAAA⁴ states that insurance cost containment efforts now exceed \$4 billion per year in California. The state would only need to reduce that by a small percentage to find money to assist injured workers.

- **Reducing the burden of liens on the system**

CMA is very concerned about the explosion in the filing of medical liens. In truth, most physicians hate resorting to liens, as they are a slow and inefficient means of receiving fair payment. Unfortunately, however, physicians increasingly find that resorting to the legal system is the only way to resolve payment disputes.

In order to reduce the need for liens, CMA has consistently supported policies similar to a recommendation made in the CHSWC Lien Study⁵, which would create an objective administrative process for resolving minor fee disputes without having to resort to the use of a lien.

Many fee disputes could be resolved by simply comparing the treatment provided to the Official Medical Fee Schedule (OMFS) or to a contracted rate. CMA believes that DWC, if given proper staffing, could

² "Investigatory Hearing Report on Workers' Compensation Cost Drivers." California Department of Insurance, July 7, 2009.

³ See, for example, AB 584 (Fong, 2011).

⁴ "Workers' Compensation 2012," *ibid.*

⁵ "Liens Report." Commission on Health, Safety, and Workers' Compensation, January 2011.

handle many of these disputes and move them out of the court system. This would be a more efficient process for everyone involved.

- **Identification of appropriate fee schedules**

CMA acknowledges that the current Official Medical Fee Schedule (OMFS) is outdated and needs serious revision. At the same time, we must express concern with the concept of moving to the resource-based relative value system (RBRVS) model.

RBRVS was developed for the Medicare program. Elderly patients and injured workers have very different treatment needs. CMA believes that, if the RBRVS system is to be adopted, it must be carefully constructed as to not compromise access to care for injured workers.

With that general concern in mind, CMA respectfully offers the following comments on RBRVS:

1. **Conversion factors need to be set to at least hold all physicians harmless.**

CMA agrees that it is important to increase reimbursement for primary care physicians. However, we continue to believe that, at a minimum, all physicians should be held harmless in the transition to RBRVS. Cutting reimbursement for one group of physicians to increase payments for another group does not solve an access problem; it only moves it around.

2. **RVUs should not be subject to the volatility of the Medicare program.**

The relative value units (RVUs) used for the Medicare program are likely to be increasingly volatile due to pressure on the federal budget. If the RVUs adopted for workers' compensation moved with them, it would make the system similarly volatile. CMA believes that the RVUs for workers' compensation should be set based on the fee schedule in effect as of the adoption of the regulation, and adjusted as described below.

3. **Any RBRVS proposal should provide for automatic annual updates based on medical inflation.**

In order to maintain access over time, the physician fee schedule should be updated annually based on medical inflation. For example, the increase could be tied to the Medicare Economic Index (MEI).

4. **Physicians need to have active input on the development of billing rules for workers' compensation.**

CMA renews our call for DWC to convene a stakeholder panel of treating physicians to develop appropriate billing rules (sometimes known as "ground rules") for workers' compensation. Incorporating the ground rules from the Medicare program is inappropriate, as they were based on treating elderly patients, not injured workers. Only treating physicians fully understand the complexities involved in treating injured workers. DWC should consider their input.

- **Assessing appropriate use of opiates and other care**

CMA agrees that it is important for DWC to ensure that opiates are being prescribed and used appropriately, to avoid the problems associated with addiction and diversion for sale.

However, CMA will oppose arbitrary limits being placed on the practice of medicine as was done by State Fund in their 2011 contract amendments. These limits invade on the patient-physician relationship, and may be illegal under the Intractable Pain and Treatment Act⁶.

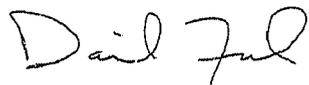
In order to provide constructive input to DWC on this issue, CMA has convened a working group of physicians to review published guidelines on the prescribing of opiates. This working group is under the auspices of the CMA Council on Scientific Affairs. When the white paper is completed, CMA will be happy to share it with DWC.

CMA would also ask DWC to encourage the Brown Administration to fully fund the CURES database. This database aids physicians in assessing whether their patients may be involved in drug-seeking behavior.

Conclusion

Thank you again for the opportunity to present our comments. CMA looks forward to continuing to work with DWC in the weeks and months to come.

Sincerely,



David Ford
Associate Director, CMA Center for Medical and Regulatory Policy

⁶ Business and Professions Code Section 2241.5.



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April 30, 2012

Rosa Moran, Administrative Director
Division of Workers' Compensation
P. O. Box 71010
Oakland, CA 94612

Dear Director Moran:

We appreciate the Division's effort to reach out to the Workers' Compensation community for their input through the Public Forums. We submit the following comments for your consideration:

1. Official Medical Fee Schedule – Physician Services - Conversion to RBRVS

COA has concerns with converting the **Official Medical Fee Schedule – Physician Services to an RBRVS system** since the Medicare RBRVS system and its annual updates focus on an entirely different patient population. Should the Division decide to move forward with this transition, the following issues must be addressed:

Maintain injured workers' access to medical treatment

A key factor to maintaining injured workers' access and helping to ensure the continued participation of physicians within the Workers' Compensation system is the adoption of multiple conversion factors. Labor Code 5307.1(b) already allows the Division to implement multiple conversion factors for the OMFS – physician services fee schedule.

One way to transition the OMFS without negatively impacting reimbursement for providers is to include a hold harmless clause that would keep reimbursement at existing levels. Reimbursement for surgical procedures has not increased in over 25 years and surgical procedures above Medicare reimbursement levels in 2004, were reduced by 5%. We are adamantly opposed to any further reductions in surgical reimbursement rates.

Cost-of-living increases alone in the last 25 years alone would warrant an 81.1% increase in surgical reimbursement rates just to maintain the reimbursement levels of 25 years ago.

WCRI published a study entitled, Medical Price Index for Workers' Compensation, Fourth Edition in March, 2012 which compares fee schedules for 25 states. The report shows that California's reimbursement rates are the lowest of the states included in the report. Major surgical reimbursement is 25% lower than the median reimbursement and 161% lower than the highest reimbursement levels. Evaluation & Management services are 29% lower than the median rate and 89% lower. The report represents nearly 80% of all Workers' Compensation claims in the United States and covers data from 2002-2011.

We understand that the Division may be considering increasing reimbursement for Evaluation and Management (E&M) services. E&M codes were last increased in 2007. We support an increase in E&M reimbursement rates, but not at the expense of other codes. It is critical to at least maintain the current reimbursement rates for surgical codes if we have any hope of maintaining access to these services for injured workers.

For the new CPT codes that are added during the transition, we believe they should be valued at comparable rates to other codes within the family of codes – e.g., shoulder codes valued similar to other shoulder codes. We would be happy to help the Division come up with a process for valuing these codes. Many of the new codes may not be commonly utilized in a Worker's Compensation system, so they could remain as "By Report" codes with no value assigned in the fee schedule.

Once transitioned, the Division could review specific areas that may be of concern and take appropriate action. By having multiple conversion factors, changes could be made to only the affected codes, not the entire fee schedule which would be less disruptive to the overall system.

Annual Cost-of-Living Update

So that the fee schedule does not immediately become outdated, we would urge the Division to include an annual inflation update based on the Medicare Economic Index (MEI).

Ground Rules

The Ground Rules included in the fee schedule are also key to an efficient system and can serve to clarify many billing issues and reduce the number of disputes and medical treatment liens. There are Ground Rules that are integral to how a procedure has been valued and should be adopted (e.g., multiple surgical rule). Other Ground Rules are inappropriate in California's Workers' Compensation system (e.g., copayments, the elimination of consultation codes, no payment for reports, non coverage for acupuncture services or work hardening/conditioning programs, etc.). There are also California-specific Ground Rules that need to be retained (e.g., reimbursement for reports, interpreters, and other rules that clarified billing rules that the Division previously identified as problem areas, etc.).

Panel QMEs

The panel QME selection is intended to be a random selection of a QME in a particular medical specialty. The current system of allowing QMEs to have multiple addresses in the system – sometimes hundreds of practice locations -- is collapsing the current system. The current practice of allowing multiple addresses is driving away the physicians who only have one address in the system, and; thus, are seldom, if ever, selected for a panel. This narrow selection of panel QMEs has become so dominant that it is even skewing the disability ratings for unrepresented injured workers as reported by the Commission on Health and Safety in Workers' Compensation (CHSWC).

This must be stopped to preserve any credibility for the panel QME system. We urge the Division to impose a limit on the number of practice locations that a QME may have in your system. The ultimate fair system would only allow each QME to list one address.

Labor Code Section 4050

Workers' Compensation carriers are uncertain whether they can require an injured worker to be examined by a physician of their choosing. In discussing this issue with claims administrators, it seems this examination would be needed when treatment is not progressing as expected and the employer/claims administrator wants to obtain a second opinion. It is our understanding that Labor Code 4050 currently allows for this examination as long as the request is made at reasonable

intervals and the employer pays for the examination. We would envision that the physician chosen by the employer/carrier would not necessarily take over the care of the injured worker, but examine the worker and provide a consultation report.

We urge the Division to issue a *Newsline* which clarifies the employer/carrier's ability to arrange this second opinion examination and would appreciate the Division's comments on whether the consultation report would be admissible.

This one clarification would significantly help claims administrators obtain additional clinical information they need to manage the care of the injured worker.

Utilization Review

COA is working with Workers' Compensation payors to:

1. Identify red flags that would warrant a formal utilization review of the requested medical treatment.
2. Develop protocols for when the claims administrator could typically make the treatment decisions without sending the request to utilization review.
3. Help payors understand what is "quality" orthopaedic care.

These efforts help to establish a more coordinated and team approach to care and takes advantage of the specialty knowledge that a specialist brings to the discussion. We know that the Division has received many complaints regarding the existing Utilization Review system. The current system might do a good job on the process of administering a utilization review system, but comes up short on making timely and good medical treatment decisions. Many times the utilization reviewer does not even have the complete medical record to review before making a decision which, in our opinion, greatly hinders their ability to make good medical decisions.

We have long argued that the utilization review system must be streamlined. Reviewers cannot call surgeons in the middle of their surgical day and expect to reach them. They must be peers so they can understand what treatment is being requested. Surgeons requesting authorization for a service cannot be expected to submit medical records for care that they did not even render. Reviewers should not be paid based on the number of times they review a request. This system incentivizes reviewers to deny the request and let it come through a second time when the treating physician appeals the denial, only to be paid each time they review the claim. Reviewers must be physicians and surgeons licensed in California, so there is recourse through the Medical Board of California to file a complaint should they make inappropriate treatment decisions.

We strongly urge the Division to revamp the Utilization Review system to make it more outcome rather than process-oriented.

Medical Treatment Utilization Schedule (MTUS)

COA was instrumental in the establishment of the MTUS. We strongly believe that the Division needs to have a team of experts that will help evaluate treatment guidelines and make refinements to published guidelines that may be appropriate. We support the work that the MTUS has done in the past, and would urge the Division to reconvene this team of experts.

Thank you for this opportunity to submit these comments to you for your consideration.
We look forward to working with the Division on these issues.

Sincerely,

Lesley Anderson, M.D., Chair
COA's Workers' Compensation Committee

City and County of San Francisco

Edwin M. Lee
Mayor



Department of Human Resources

Micki Callahan
Human Resources Director

April 30, 2012

Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 17th floor
Oakland CA 94612

Dear Director Baker and AD Moran,

I respectfully submit the following comments, which I hope you will consider during your discussion of changes to the workers' compensation system:

- ❖ City and County of San Francisco is self-insured, self-administered
- ❖ Our injured workers are our colleagues, and what we pay out for workers' compensation benefits has direct impact on our citizens, so we see every aspect of the system on a personal level
- ❖ Thank you for holding the forums. I know it's exhausting and there are not a lot of easy answers in a system this complex, so I'll start by talking about some of the positives:

1. Reform benefits

- Because of reforms, city has saved \$53 million cumulatively, or \$7.6 million annually, since FY 04/05
- Lean budget times, like most local agencies we watch every dime
- These annual savings add up to 56 firefighters available to save lives in emergencies
- Administratively it means we have the bandwidth to be thoughtful about who we include in our MPN and to keep our listing current
- We can use UR appropriately by empowering our staff to approve treatments at the adjuster level.

2. EAMS efficiencies

- Another area where we've gained major efficiencies is using EAMS e-form filing
- Our turnaround on Stips went from two months to two days
- DEU rating requests from up to six months to five days
- We just changed our method of service to email so we are now saving even more staff time opening, copying, scanning those documents
- When we need a document we don't have from a case file, we just log on and pull it from FileNet.

❖ **Our biggest problem areas similar to others you've heard about:**

A) Over prescribing of narcotics

- We have to look at how the intractable pain law intersects with workers' compensation
- Some IWs do have long term intractable pain and we want them to get the help they need, but that help should have an emphasis on improving quality of life and functional abilities

- Still see conflicts of interests like:
 - Treaters dispensing in and charging from their offices
 - Compounding medications without pharmacists or health standards
 - Having financial interest in pharmacies or functional restoration programs
 - In-house “drug tests” that have to be sent out to an accredited lab for confirmation
- One very important tool we want our treaters to use is the Controlled Substance Utilization Review and Evaluation System--CURES
- In case anyone may be unaware of CURES, it’s part of the California Department of Justice’s Prescription Drug Monitoring Program (PDMP), which allows licensed healthcare practitioners to access patient controlled substance history, identify potential substance abuse or multiple prescribers, and to assess the clinical appropriateness of opioid therapy for the patient at the initial evaluation and on an on-going basis
- The problem is the funding for CURES was cut in the last budget and there is basically one man at DOJ trying to keep the system going, make it easier to use, and market the benefits of CURES to providers, many of whom do not know about the system or the value of utilizing CURES for improved medical management and patient safety
- We’ve been talking with Kaiser, one of our biggest medical providers, DAs and others and there is a “coalition of the willing” very interested in ensuring this valuable database is funded
- We want to **strongly advocate** for funding the CURES system.

B) Reforming the PDRS

- A majority of city employees have very different working situations than non-represented workers in low-wage industries
- Big difference includes 4850 pay, presumptions
- Sheriff gets a knee sprain is off work on 4850 pay for a year, goes back to the same job, has some permanent disability, but really hasn’t lost anything in terms of her earnings or earning capacity
- Farmworker or laborer in same situation very different
- Individual workers vary in work circumstances and personal resilience, yet disability rating schedule is based on aggregate data
- Reforming the PDRS is a difficult and delicate balance between ensuring injured workers have wage replacement they need and employers, including government agencies, can continue to be solvent and provide necessary public services.

C) Liens

- Support lien reform that includes fee schedules for copy services and interpreters
- Strongly support advisory group setting in which lien claimants and payers work together with state to develop consensus solutions.

Sincerely,



Susan Gard
 Process Improvement and Automation Manager
 City and County of San Francisco
 Workers’ Compensation Division

HAIM BELZER, Ph.D.
CLINICAL AND CONSULTING PSYCHOLOGY
LICENSE # PSY8146

May 1, 2012

Kathy Patterson
Division of Workers' Compensation
Medical Unit

Dear Ms. Patterson:

I have served on the QME panel since 1998. In recent years, I have noticed the number of unrepresented QMEs disappear and the caseload of panel QME's become sporadic. I know it has been brought to your attention as a serious matter affecting us in San Diego, as well as the rest of California, including the Bay area. As you may already know, the panels are flooded with out-of-town doctors, or doctors who have more than 30-40 offices, thus increasing their statistical odds of getting randomly selected for the panels.

I have seen panels where all three doctors were not local. What was even more disturbing was the fact that on the website of at least one of the doctors, he even went so far as to state that his office location for the QME may change (so that he would not have to actually drive out 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 is a "loophole" that may be feasible for these doctors who join physician mill companies, or spend almost all their efforts and time on doing solely QMEs (perhaps not meeting the requirement for QMEs to still do 1/3 clinical work), but for most of us individual practitioners, it is an onerous burden to try to keep up with the statistical game, so that we can stay competitive in being selected in the panels.

This has disgruntled and affected the practices of many of our local doctors, who do not work with these "unfair loopholes." We are aware that the physician mill companies, such as the one based out of Fresno, have quite a few offices and send out physicians all across the state. The local San Diego doctors request that this unfair competitive advantage be investigated and appropriate measures placed to close such "loopholes."

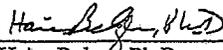
Suggestions that I have to reduce these issues are to limit the number of locations that are listed. Four offices has been a number considered in the past, and I believe that that is a fair number. Others ask that there be no more than three offices per QME doctor. However, I realize the large practice mill corporations and those doctors vested in 10 plus offices will put up a huge fight at that number. I would rather have a reduction to even 5 than none at all. In addition, there should also be a restriction of having two offices listed within 10 miles of one another. In addition, the rule should be changed that neither the doctor nor the claimant cannot change the appointment location from the one chosen on the panel (as this is what is already written into the California Labor codes), and if the claimant does not want to go to any from that panel, they will have to present a valid

4550 KEARNY VILLA ROAD, SUITE 109, SAN DIEGO, CA 92123 858-278-0203 FAX 858/278-4972

reason why and request a new panel.

I enjoy serving as a QME for the legal-justice aspects of the job. 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,



Haim Belzer, Ph.D.
Licensed Clinical Psychologist
Qualified Medical Evaluator
QME #108382



May 2, 2012

Via email submission: DIR@DIR.ca.gov

Ms. Christine Baker
Director, Department of Industrial Relations
State of California

Ms. Rosa Moran
Administrative Director
Division of Workers' Compensation

RE: Proposed Reforms to California's Workers' Compensation System

We are providing this letter in response to an invitation for comment on proposed reforms to California's workers' compensation system. We appreciate this opportunity to provide our views and look forward to working with the Department and the Division as you move forward in this process. We are the "front-line" primary care providers in workers' compensation and believe our size and position offers a perhaps unique viewpoint.

U.S. Health Works Medical Group is headquartered in Valencia, California and has over 170 medical centers and worksite locations in 15 states, including 65 in California. These centers make California's workforce more competitive and productive by providing the highest quality medical care and helping to control work-related injury costs through effective management of workers' compensation claims. U.S. HealthWorks is the largest occupational medicine physician group practice in California, with 430 physicians and clinicians and more than 1.5 million patient visits per year in California alone.

The U.S. HealthWorks motto is, "The right care, right away." Recently, a leading California workers' compensation insurance carrier reviewed five years of injury cases handled by U.S. HealthWorks and its principal competitors. The review determined that cases handled by U.S. HealthWorks received more medical care and cost many thousands of dollars less overall due to effective management and fewer legal conflicts.

1. The Official Medical Fee Schedule

As you are no doubt aware, the most serious issue facing occupational medicine providers in California is the outdated and inadequate official medical fee schedule for physician services ("OMFS"), particularly with respect to our state's dedicated primary care physicians. Numerous studies have focused on this issue and have recommended that the Division move to a Resource

Based Relative Value Scale ("RBRVS") system, which tends to more fairly allocate reimbursement among providers. The Division proposed a new OMFS schedule based on RBRVS in 2010, and related legislation is being considered. We continue to support the Division's efforts in revising the OMFS, whether with RBRVS or otherwise, to increase reimbursement for primary care occupational medicine physicians.

The role of primary care occupational medicine doctors in workers' compensation cannot be overstated. These are the front-line doctors, providing not only rapid and high-quality medical care but also managing the cases with a focus on returning patients to productive work. Recent independent studies in California have shown *savings of 20-40% in total case costs* where dedicated U.S. HealthWorks occupational medicine doctors are managing the process.

Despite these terrific results we are finding it increasingly difficult to recruit and retain these valuable doctors in the face of reimbursement codes for primary care doctors that are often lower than Medicare, while some specialist codes are 200% of equivalent Medicare rates. Studies have shown that California's occupational medicine doctors have the second-lowest reimbursement rate in the nation, this despite having one of the highest costs of doing business. The lion's share of this low-reimbursement burden falls on the primary care physicians, who have not had a rate increase in almost 13 years, resulting in real wage decreases in light of the always-increasing cost of living.

Those physicians who might otherwise want to practice occupational medicine in California can practice in nearby Oregon or Washington where reimbursement rates are close to double what they are in California. Or they can do something other than occupational medicine. In either case, California's workers' compensation system is losing its doctors, forcing injured workers into expensive and inefficient emergency rooms or to doctors who do not practice occupational medicine. This results in inefficient care for California's injured workers and markedly increased costs for employers and their insurers.

During the recent series of public forums we were struck by the many stories of injured workers who are unable to get the treatment and resources they need due to administrative and legal snafus. We find that treatment by qualified occupational medicine providers tends to dramatically reduce these horror stories. Because U.S. HealthWorks primary care doctors are also experts in how the workers' compensation system works, we not only provide high quality medical care, but also help injured workers and their employers navigate the system.

Further, the inadequate fee schedule makes it unattractive for a company like U.S. HealthWorks to invest its limited resources in occupational medicine in California. We are forced to look elsewhere to expand our occupational medicine business.

We strongly recommend that the Division, acting pursuant to emergency rulemaking authority, immediately undertake to revise the OMFS to adequately compensate California's primary care doctors. In the alternative, we will continue to support efforts to fix the OMFS through APA rulemaking, legislation or a combination of same.

2. Indemnity Benefits

We understand that there is significant pressure to revise indemnity benefits to address inequities that have arisen since the adoption of SB 899 in 2004 and its implementation in subsequent years. We would note that in considering changes to disability benefits, the Division should keep in mind the significant cost savings that can be obtained by adequately compensating primary care physicians. Not only are documented case costs significantly lower when using dedicated occupational medicine providers, but quality medical care and effective case management that gets injured workers back to work will reduce the number of injured workers who need indemnity benefits in the first place, saving further money for the workers who truly need this assistance.

3. Utilization Review and Liens

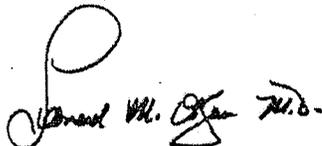
We recognize the challenges to the system occasioned by abuses to the utilization review and the medical treatment lien processes. We also recognize the legitimate need of insurers to act as a check on unscrupulous providers and the need for providers to have a remedy when they are not being fairly paid. In general, we agree with the recommendations of the California Labor Federation in this area with respect to MPN review, augmentation of ACOEM treatment guidelines, limitations on utilization review for MPN-approved providers and addressing the proliferation of medical liens.

4. Return to Work

We agree that the best outcome for California's injured workers is for them to return to work when ready and able. It is a core principle of our California-based company. We believe that the very best way to ensure prompt and effective return to work is to maintain a stable force of highly-trained occupational medicine primary care physicians. These physicians, who are "specialists" in their own right, work with the injured worker and his or her employer to ensure the very best outcome for both parties – the highest quality medical treatment for the injured worker and return to productive duty, even if temporarily modified, as quickly as possible. This specialized occupational medicine approach to care and case management will be lost if doctors in California are not adequately compensated for their efforts.

We appreciate the efforts of the Department and the Division over the past months to hear from the stakeholders and seriously address the much needed reforms to California's workers' compensation system. Thank you for the opportunity to add our perspective to the mix and we look forward to working with you as you move forward with your agenda.

Sincerely,



Leonard Okun, M.D.

President – U.S. HealthWorks Medical Group, Prof. Corp.



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Christine Baker
Director
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455 Golden Gate Avenue
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April 17, 2012

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Executive Director and Founder

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

Dear Ms. Baker:

I respectfully request you to immediately review and update your fee schedule for primary care services by supporting the passage of SB 923. As an advocate for injured workers and all workers, I continually fight for legislation that will improve the quality of life of workers. I believe SB 923 will increase access to quality health care to California's injured workers.

Updating your fee schedule for workers' compensation will help improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians. Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, 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, the California economy, and the state budget!

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.

SALEF's mission is to advocate for the educational advancement, civic participation, leadership and economic prosperity of Salvadoran and other Latino communities in the U.S.; and to advance democracy and social justice in the U.S. and El Salvador.

I urge your support and leadership. Thank you for your consideration, should you have any questions please call me at (213) 480-1052.

Sincerely,

Carlos Antonio H. Vaquerano
Executive Director



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May 3, 2012

Ms. Christine Baker, Director
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 455 Golden Gate Avenue
 San Francisco, CA 94102

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* deceased

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Updating your fee schedule for workers' compensation will help improve access to high quality medical care for California workers injured on the job, by retaining high quality primary care physicians. Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, 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, the California economy, and the state budget!

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,

Fr. Gregory J. Boyle, S.J.
 Executive Director

NEWTON MEDICAL GROUP

A Professional Corporation

180 Grand Avenue, #100
Oakland, CA 94612

Voice: (510) 208-4700; Fax: (510) 208-4710

a multi-disciplinary medical practice specializing in occupational illness and injury, disability evaluation and forensic medicine

May 4, 2012

**CARDIOLOGY/
INTERNAL MEDICINE**
Norman Panting, M.D.

Christine Baker, Director
Department of Industrial Relations

CHIROPRACTIC
Moses Jacob, D.C.

**MENTAL HEALTH/
PSYCHIATRY**

James R. Cole, Ph.D.
Sandra H. Klein, Ph.D.
* Albert J. Kastl, Ph.D.
* Robert W. Lauridsen, Ph.D.
* Marc Lehrer, Ph.D.
John Parke, Psy.D.
James S. Robbins, M.D.
Glenhall E. Taylor, M.D.
Miles L. Weber, M.D.
Larry J. Wornian, Ph.D.

Rosa Moran, Administrative Director
Division of Workers' Compensation

Dear Director Baker and Director Moran,

I am writing to you as a representative of a practice of physicians that are designated QMEs and AMEs in the industry. I have been with Newton Medical Group for 20 years in a variety of roles but currently oversee the daily functions of our Front Office, Scheduling, Medical Records, Billings & Collections and Transcription Departments.

NEUROLOGY

Robert R. Herrick, M.D.
Fredric H. Newton, M.D.
Thomas W. Wallace, M.D.
Jacquelyn A. Weiss, M.D.

I appreciated the opportunity to listen to the public forum that was most recently held in Oakland. I am taking this opportunity to provide to you in writing some of the points that I think are important from our perspective.

NEUROPSYCHOLOGY

James R. Cole, Ph.D.
* Albert J. Kastl, Ph.D.
Sandra H. Klein, Ph.D.
Claude S. Munday, Ph.D.
Larry J. Wornian, Ph.D.

Antiquated Regulations

Labor Code Section 9795 was enacted in 2005. Unfortunately as costs to our practice and doctors have grown, our fees have remained stagnant. Under these circumstances, unnecessary and wasted staff time chasing down bill payment is particularly onerous.

NEUROSURGERY

Jim D. Anderson, M.D.

OPHTHALMOLOGY

Paul D. Anders, M.D.
A. Alan Weber, M.D.

ORTHOPAEDICS

Richard G. Baker, M.D.
Michael F. Charles, M.D.
Robert M. Murphy, M.D.
* Marjorie Oda, M.D.
William H. Ramsey, M.D.

Inherent Flaw in billing regulations

There is an inherent flaw in the codes for cases where there is a single significant issue to address such as future medical care. Even if the doctor spends 30 minutes with the patient, 3 hours on the records and 2 hours preparing the report (for a total of 5.5 hours) we can only bill an ML102.

PODIATRY

Barry E. Weincr, D.P.M.

* Recently Added

CLINICAL OFFICES:

OAKLAND
180 Grand Avenue, #100
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Fax: (510) 208-4710

SACRAMENTO
1851 Heritage Lane, #101
Sacramento, CA 95815
Voice: (916) 736-9716
Fax: (916) 736-9724

SANTA ROSA
2200 County Center Drive, #E
Santa Rosa, CA 95403
Voice: (707) 527-4172
Fax: (707) 527-4174

SAN JOSE
For Additional Information
Contact:
(510) 208-4700

Late Cancellation/Reschedule - No Show Fees

Some of our clinicians are booked up for the remainder of 2012 and beyond. Obviously their appointment slots are in high demand. There should be actual fees attached to a no show or late-cx/late-r/s. It is unfair to other injured workers if slots are taken but there is no penalty for "forgetting" to cancel appointments.

Lack of Payment

Although NMG is at the forefront of accurate and consistent billing, we are still have difficulty getting paid EVEN ON OUR AMEs.

There are currently no penalties for guarantors that string you along for payment. It is not blatant but rather "we didn't get the fax" or the adjusters simply will not call back in order to try to get some assistance in working with a bill review company.

HCFA Forms

Bills are still being rejected because the HCFA is "not filled out correctly". Bill review companies in particular have not been fully trained on the handling of medical-legal bills using LC Section 9795.

Inappropriate PPO Discounts

Testing that was done in connection with a QME/AME should fall in the same billing rules as the medical-legal report itself and not be looked at as a separate entity. PPO discounts are being taken even though our practice has NEVER had PPO contracts with anyone and we do not treat so we obviously wouldn't have any. This is VERY DIFFICULT and time consuming to work through with the different groups and in the meantime, our bills do not get paid.

Liens

We have filed liens on several cases only to have the carrier, the day or week before the lien conference date, agree to settle the case, usually for the full amount minus penalties and interest.

Administrative Tasks

In addition to some of the billing issues, there are administrative tasks that are time consuming and appear unnecessary or are simply unclear to the parties.

The idea of "ex parte communication" needs to be more clearly defined in the Labor Code. Some attorneys will not speak with staff even if it is to schedule an appointment or attempt to obtain a

cover letter or records for the physician. I understand the general thinking behind the LC sections but unfortunately the interpretation of case law by individuals has made many situations very muddled.

On Panel QMEs where permanent disability is found, we do not always have DEU 100s or 101s. When attempting to obtain them, adjusters are not always clear that they are to complete the "Request for Summary Rating" form. In addition, if we do not have the forms, we send the reports to the DEU anyway but they simply return it to us. Why can these not be forwarded onto the carriers for handling just like we do?

Service of Medical-Legal Reports

Can reports be served to the parties via fax or email? There is currently no conclusion on this in the Labor Codes and I cannot obtain an answer.

Electronic Signatures

Has thought been given to electronic signature? I know there can also be some legal issues with this but we are seeing electronic signatures accepted more and more in a variety of legal settings.

These are just a few items that I am bringing to your attention. I would be happy to discuss these or provide specific examples if you would like. Again, thank you for your time.

Respectfully,

Corrinne Goldberg
Senior Director, Department Functions & Logistics
Newton Medical Group
www.newtonmedicalgroup.com
phone: (510) 208-4700, ext. 222
fax: (510) 208-7771


**HOLLYWOOD
PRESBYTERIAN
MEDICAL CENTER**

May 22, 2012

Christine Baker
Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

RE: Support Passage of SB 923 And Update Workers' Compensation Fee Schedule

Dear Ms. Baker:

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.

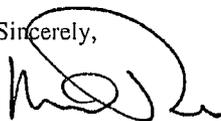
Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will help retain quality primary care physicians in the California system; and will control increasing costs and unnecessary medical expenses incurred by some physicians and hospitals.

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,



Michael A. Rembis
President & CEO

1300 North Vermont Ave.
Los Angeles, CA 90027
www.hollywoodpresbyterian.com
213.413.3000

Post Termination CT Claims

Employees sign forms when they enter into employment so add a form that has to be given to employees when they leave that has to be signed by the employee and kept in their employee file.

It can simply ask the employee to state the reason or reasons they are leaving.

Add a section that asks if there are any discrimination issues associated with their departure. If so, give details.

Another section could ask if the employee has or suspects he/she might have a work comp injury? If so, state nature of injury and details.

If the employee answers yes to either of the questions, the employer would be required to take appropriate actions immediately. For work comp matters, a claim report would have to be submitted to the work comp carrier for investigation.

If the employee leaves without signing the form, the employer would be required to show proof of sending the form in a certified letter to the employee requesting the information along with a stamped return addressed envelope.

Inform employees that it is their responsibility to return this form to their employer immediately or they will lose their rights to any future recovery of any type. Form to be kept in employees personnel file.

Employee Advocate or Ombudsman

A majority of legitimate litigated claims come out of some form of miscommunication between the injured employee and the insurance carrier. The purpose of the Advocate would be to assist injured workers, who feel they are being ignored or not being treated fairly by insurance carriers handling their claims.

In 2002, a Senate Bill, SB 800 was established in an effort to reduce legal claims arising out of construction defects. It provided a provision that required homeowners to try to work out disputes directly with the builder before being allowed to seek a remedy through the legal process. A time frame of 60 days was adopted to get matters resolved.

Establishing a similar vehicle for workers comp claims would greatly reduce litigation. Make it mandatory for injured employees to utilize the services of an Employee Advocacy Firm before they can contact an attorney. Make the services free for employees, but set standards for what would be considered frivolous or unreasonable requests from claimants so the firm does not get bogged down in unwarranted claims.

Employees of Advocacy Firms should have backgrounds in work comp claims or other special skills that would be required for such work. Require licensing and continued education to assure they remain familiar with claims laws. They could contract with the DWC. They could not be associated with any insurance carrier or TPA firm nor could they have any affiliation with any law firms. Establish minimal acceptable standards for the firms and a way to monitor the effectiveness of their activities.

Make work comp insurance carriers contribute a minimum, proportionate share to the fund based on the number of policies or amount of premium they write. The cost would be a fraction of what they are currently spending for litigation.

In addition, establish a minimum fine for every time there is a complaint against the carrier with additional fines and penalties for those carriers incurring more than usual complaints. Establish a means of measuring and tracking the number of complaints and comparing carriers claims services. Carriers would be responsible for TPA firms they contract with too if they don't handle claims direct. The cost could not be passed onto Employers unless it is integrated as part of the rates charged by the individual carriers.

Allow the Advocate a reasonable amount of time, 30 to 60 days, to resolve depending on the issue between the employee and the carrier. Make it illegal for Advocates to provide names of law firms or advise injured workers to accept settlement offers from a carrier.

Make the injured worker sign a statement stating they have not been in contact with an attorney regarding the matter and subject to laws of perjury if they lie. If they did speak with an attorney before going to the Advocate, they must disclose the name and dates of such meetings and agree not to contact an attorney while working with the Advocate. It

would also be illegal for an attorney to give advice to a claimant, who is working with an Advocate to resolve problems.

If the matter can not be resolved within the time frame allowed or to the employee's satisfaction, then the employee can hire an attorney for help. Reports from the Advocate could be used as evidence for both applicant and defense attorneys.

This would not end all litigation, but at least it would give the employer and/or the insurance carrier a chance to resolve the issues before they become litigated.