

**COPIES OF MAILED
AND HANDED IN
COMMENTS
OF THE 2012
WORKERS' COMPENSATION
FORUM**

PART 2



William C. Velásquez Institute

April 16, 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 fees 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.

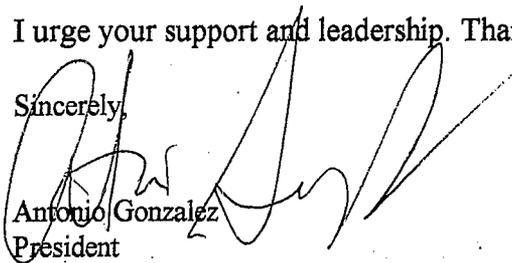
Updating your fee schedule for workers' compensation will help improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians. Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will control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


Antonio Gonzalez
President



William C. Velásquez

2914 N. Main St. 1st Floor, Los Angeles, CA 90031

LOS ANGELES CA 900

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APR 19 2012

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

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

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APR 20 2012

COMMISSION ON HEALTH
AND SAFETY AND
WORKERS COMPENSATION

94102356099





10401 LOS ALAMITOS BLVD.
LOS ALAMITOS, CA 90720-2107
562 - 596 - 1482
562 - 546 - 0038 FAX

www.sbalaw.net

STUART J. BARON
~~████████████████████~~

16 April 2012

Christine Baker, Director
California Department of Industrial Relations
455 Golden Gate Ave., 10th Floor
San Francisco, CA 94102

Re: CUMULATIVE TRAUMA (CT) – THE “WEARING OUT” DISEASE

Dear Christine:

It is time to revisit and re-evaluate the value of this statutory condition (L/C 3208.1), which is rapidly becoming yet another undue burden on both employers as well as the workers' compensation system. CT claims are currently being used, and in many instances abused by disgruntled employees who are no longer on the payroll. By filing Post Termination CT claims, employees are circumventing the legitimate needs of businesses to make personnel decisions based on the employer's current financial situation and needs.

One need only look at the increase in CT claims that are being filed after an employee has been laid off. While there has been no specific injury that they can point to, many are now claiming that “work” has worn them out and that they are therefore entitled to even more money than that which was bargained for as a part of their employment agreement.

I would not argue that there are real and viable events that can lead to a compensable situation. Asbestosis would be the best example of a condition that was unknown to either management or their employees for many years. Litigation over asbestosis has been ongoing since then and I believe that the compensation awarded to injured workers in such cases is justified.

However, when an employee, who is hired to do a job that produces no discernible injuries and who has been laid off for legitimate, non-discriminatory reasons is able to work around the system by claiming a cumulative injury, it is time to reassess the value of that part of the Labor Code. We must decide if both parties to this equation are being properly served. Or, is this an abuse of the system that has been allowed to fester too long?

As a starting point for this discussion, when someone is hired for a job whether it is for either brain or brawn, the employer is taking on the whole person as he/she finds them. When the employee arrives at the jobsite, he/she does not simply place their body in the corner to rest while they do their job. Employers hire the entire package as he/she finds them and is responsible for same.

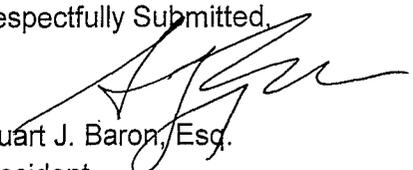
I would then point out that whether or not we like it, all of us are "wearing-out" as the years pass. The question then is, "Why should an employer be responsible for the normal aging process vs. being responsible for a specific injury?" I argue that they should not.

I therefore offer three possible options for consideration. Any or all of these will allow legitimate cumulative injuries to be raised as part of the work bargain while at the same time making employees responsible for their own "wearing out."

1. Take "cumulative" claims out of L/C [Section 3208.1(b)] so that it reads: "An injury may be either specific or cumulative occurring as the result of one or a series of incidents or exposure which causes disability or the need for medical treatment" and delete L/C 5412. This will allow employees to file a cumulative trauma claim as they would a specific injury. This would place the burden of proof on the employee to show, just as they do with a specific injury, how this "cumulative trauma" is more than just part of the "wearing out/aging" process.
2. Change the definition of a cumulative trauma injury to more closely mirror that of psych/stress claims (L/C 3208.3). In other words, let the employee show how the preponderance of actual work, absent the normal aging process, had caused a "disability" which should be covered.
3. Since the employer is hiring the entire package, we should set up a "depletion" allowance funded by the employee. There should be a percentage taken from each dollar earned which is placed in a fund similar to a 401K. It will belong to the employee and will be portable so that it follows him/her throughout their working career. At the time they become eligible for Social Security they would have access to this additional fund of dollars. This would result in taking the burden of the normal aging process off the backs of employers.

Regardless of which of these or any others you feel would be the best solution to this growing problem, the real point is that this is a further drain on employers, and therefore the California economy, and needs to be addressed.

Respectfully Submitted,


Stuart J. Baron, Esq.
President

Stuart Baron & Associates, Inc.

Stuart Baron & Associates Inc.
10401 Los Alamitos Blvd.
Los Alamitos, CA 90720

Christine Baker, Director
California Department of Industrial Relations
455 Golden Gate Ave., 10th Floor
San Francisco, CA 94102

Thomas Mendez

4666 Mission Gorge Place

San Diego CA 92120

I am a Business Agent representing workers in the retail and in the transportation Industries in San Diego, and I am in direct contact with injured worker on a daily basis.

Companies now are more numbers and goal oriented than ever ,that requires workers to do more with less ,this in consequence demands more effort and efficiency out of a worker, because of factors like the lack of realistic productivity standards or the lack of ergonomic studies or exercises in most Companies ,workers go into a more demanding job environment unprepared ,add to this mix the age factor ,repetitive nature of their field of work and you will find as time passes ,more workers see themselves in need of Workers Comp.

But then the delays take effect ,delays in Doctors to get approval for therapy ,MRI , Scans ,Cortisone and the tools the Doctors need to treat these patients ,some of these workers run out of Health insurance coverage on their Companies and their families are now at risk, their savings get depleted ,cannot claim Unemployment ,or Disability Insurance , so they turn to the Doctor to persuade them to either modify their work restrictions or even completely lift them in order for them to be more employable ,when in reality they are still hurt.

Pressure from employers and Insurance Companies to Doctors to release workers back to work do not help, in fact it interferes with their best judgment, not to mention their conscience and professionalism.

I have also notice that in some cases, the Doctors nationality plays a role probably due to a different perception of what level of injury constitutes an impediment for a worker to go back to work or be treated further ,again might be a cultural factor rather than a medical one.

So in essence it should be completely up to the Doctors to recommend and approve medical treatment and it should be completely up to the Doctor to release back to work, and delays will fall within reason as a consequence.

Thank you

 Thomas Mendez 3/25/2012

Thomas Mendez

619 582 0542

Statement by Fr. Richard Estrada
Forum on Workers Comp held in Los Angeles
April 16, 2012

My name is Father Richard Estrada, a Claretian priest at Nuestra Senora de Los Angeles, know as La Placita. Our church has a history of supporting workers rights, especially immigrant rights. We were instrumental in ~~the~~ organizing the immigrant march of over 1 million Angelinos who called for comprehensive immigration reform. La Placita was a refuge for the farm worker movement, for Cesar Chavez and Dolores Huerta, and continues to support the United Farm Workers. Fr. Luis Oliveras, a worker priest who was a close friend of Cesar and ^{we} remain strong supporters ^A the Dolores Huerta Foundation.

Last fall, La Placita hosted a day long Summit on Workers Compensation Sponsored by Voters Injured at Worker that was attended by Dolores Huerta and other key stakeholders who are calling for reforms in the worker compensation program in California.

La Placita is grateful for the opportunity to raise a prophetic voice in support of Voters Injured at Worker led by Jesse Cenicerros. We are present to urge the California State Department of Industrial Relations, And the Department of Workers Compensation to support the reforms delineated in the "White Paper" of Voters Injured at Work. We are mindful that last week the Los Angeles Times published an article entitled: "California Workers' Comp overhaul effort is stirring. The article quotes Jesse Cenicerros who calls for reforms: "Workers' Compensation is a \$14.8 billion system...The injured worker isn't benefiting from that." The article frames the struggle between labor and business as the major stakeholders.

However, just as in the case of the farm worker movement, the Interfaith community and public needed to support the farm workers, and in this case the Interfaith community and public joins in support of injured workers who have drastically lost benefits in California. As such, we are organizing support within the Interfaith community in Southern California for Voters Injured At Work.

La Placita is co-hosting this May, with CLUE, Clergy and Laity United for Economic Justice, a follow-up Summit on the Workers' Compensation Reform Movement being sponsored by Voters Injured At Work. CLUE is an organization of over 600 religious leaders from throughout Los Angeles County who come together to respond to the crisis of the working poor.

On April 6, 2012, Dolores Huerta, Rev. Deacon Sal Alvarez and I met with U.S. Secretary Hilda Solis in her office to indicate our strong support for Voters Injured at Work. Secretary Solis has assigned staff to attend the upcoming Summit at La Placita. We have hosted a number of sessions with Secretary Solis at La Placita. We would like to extend an invitation to the leadership of the California State Department of Industrial Relations to dialogue with Interfaith leaders at La Placita in this regard.

We have been involved in supporting the important work of Voters Injured at Worker, in as much as a number of our Latino parishioners have been injured on their jobs at sometimes during their lives. The lost of benefits is an injustice to them and their families is a grave injustice. As members of our church and of churches across California, we minister to injured workers and hear their cry for justice. More important, we support the reforms of a critical advocate of reforms, Voters Injured at Work. Again, thank you for holding these forums that give us an opportunity to inform the Brown Administration of our interest as important Interfaith stakeholders in this fight.

Fr. Richard Estrada

From the desk of John E. Riggs

April 16, 2012

TO: Christine Baker – Department of Industrial Relations

FROM: John E. Riggs

RE: California's Workers Compensation – Changes needed in the system

Thank you for the opportunity to participate in the Public Hearings on California's Workers' Compensation System in Los Angeles, California. Please note for the record these comments are my own personal viewpoints and not of my employer. I have devoted my entire career to the advocacy, administration and management of benefits paid to injured workers on behalf of employers here in California. The challenges of finding an acceptable and appropriate level of compensation are close to daunting.

In 2003 – 2005, California made great strides in reforming the existing benefit system with results that initially were quite promising. Employers found their premiums returning to manageable levels and true reform on certain aspects of the system was in place.

The previous reforms brought a multitude of benefits to the California system including:

- Faster claims closure
- Improved return to work
- Increased in wage replacement
- Greater equity in how PD benefit dollars are distributed

However these improvements were short lived as the Applicant Bar representing injured workers was hard at work to find and force "alternatives" to the labor code. Decisions were forced down to every employer which drove the cost of managing both the medical and expense portions of the claim upward while driving the momentum of claim (settlement) to almost a standstill. The injured worker and the employer have both suffered at the hands some unscrupulous attorneys. With lower permanent disability percentage awards, the applicant bar drove new stakes into the system and sadly into the lives of their clients.

Applicant attorneys have managed through the use of add-on or "body creep" claims to not only drive the costs of managing liabilities; but also their fees to new heights. By adding body parts to existing claims, the injured worker is seemingly served and advocated by making them more disabled (via cumulative trauma, additional body parts, psyche, sleep and sex disorders). Many times the new restrictions put the injured worker at odds with their employer's ability to accommodate or modify work thereby plunging them in the depths of financial ruin.

Unfortunately, the legislature cannot predict all the ways in which special interests will adapt their behavior to changes in the law, or how regulators will implement and how the judiciary will interpret

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949-394-0948

From the desk of John E. Riggs

these changes. This is the history of reform in California and the fundamental challenge facing the system today.

Applicant Attorneys by bringing challenges and confusion into the system have done a great disservice to those they serve and the people of the State of California. The results are a more than 40% increase in cost per claim since 2005 due to greater costs for medical treatment, cash benefits and expenses. For injured workers, this process has increased confusion, slowed the provision of care and made the claims process more complicated and slower in momentum.

I know there is a great deal of change required in our system. The fact that the system has remained static and required adjustments in the Permanent Disability Guidelines were not implemented by the previous administration is clearly one of the main causes in struggle for a more appropriate compensation rate. I encourage you and your staff to continue working with the stakeholders (Labor and Management) on the revision needed to ensure a fair and smooth system of compensation.

My pain points at this time are few. I respectfully request the Department of Industrial Relations direct the Division of Workers' Compensation to call for changes in the following processes:

- **Medical Provider Networks** – the ability of an applicant attorney to pull their client from an approved network is fundamentally wrong. I understand the Chairman of the California Applicants Attorney Association takes great pride in challenging existing networks and encourages his associates to do the same. Ignoring the rules and referring to providers who will treat (at times in unscrupulous ways) on a lien basis. There is no due process in these actions and employers must fight this practice in every way. This drives the cost of claims higher, clogs the WCAB calendar and processing with unnecessary liens and slows the process of providing medical care to the injured worker. The Notification process is confusing and needs to be streamlined immediately. An approved network with one notification should suffice to allow the network to stand.
- **Division of Workers' Compensation Notices** – The current notice structure is outdated, confusing and a driver of litigation. The myriad of notices and their timing need dramatic overhaul. These notices are for the benefit of injured workers to understand the benefits being provided to them on behalf of their employer. Change / overhaul should not be at the direction of those providing the notices. In many conversations I have heard stakeholders say "why change them, they are working now and I don't want to have to re-program the system". That type of closed minded reasoning is unacceptable to me. I believe in transparency and the provision of information in a usable and understandable format. I recall a conversation with a noted Applicant's Attorney in of the meetings wherein she commented "these notices drive the injured worker to my door. There are even times when I cannot interpret the information.

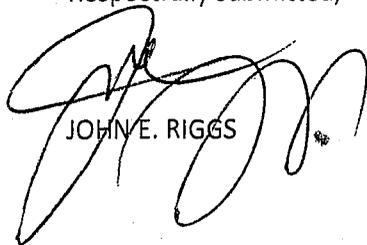
From the desk of John E. Riggs

- **Permanent Disability Benefits** – a thorough review of the Guidelines for Rating Impairment is needed along with the means for calculating an appropriate compensation rate.

Many of these and other changes can be implemented through the regulatory process and can be enacted quickly to bring the system forward and change the process for the future.

Thank you again for this opportunity to share my thoughts and feelings. I am truly an advocate for injured workers and their employers and offer my services where ever needed to help.

Respectfully submitted,



JOHN E. RIGGS

www.cwcia.com

4/17/12

One thing to stress from a lien claimants'/interpreters' perspective is that no changes/restrictions be made to LC 4903.5, and if anything, defendants must be held accountable for service of settlement documents, and medical records. We've heard that there is some movement afoot to limit the requirement of defendants to serve documentation and medical records on lien claimants, which would be a severe infringement on lien claimants' due process rights. I think they're looking at ways to cut costs in handling wc claims, so this may or may not come up, but if so, 4903.5 should be strengthened, not restricted.

4/18/12

My name is Linda Frappia. I have spent 40 years as a participant in the worker's compensation arena in different capacities from claims manager to medical practice administrator.

I would like to use this time to propose a solution to the lien problem. In my opinion, liens do not belong in the WCAB. The judges do not understand bill review. They have no idea what is proper coding or proper reimbursement. Hearing lien matters is a waste of their valuable time.

What I have proposed for many years is a separate tribunal for lien appeals staffed by experienced bill reviewers and bill payers. A place where, after appeal to the carrier due to an incorrect EOB has been fruitless, the matter can be submitted for a decision to an impartial third party. Perhaps binding arbitration with the arbiter paid by the losing party. A haven for both litigated and non-litigated cases. Arbitration that must be submitted to if one of the parties wishes to do so. In this way, doctors would have a chance of being paid in a timely manner rather than waiting for the case in chief to finalize before they can even try to get paid and then facing such exorbitant costs as to make the process prohibitive. The lien tribunal would have the parties put their money where their mouth is. If you

know you are correct in your evaluation of the bill, you would have no fear of proceeding to lien appeal. If these collection problems could be resolved quickly and easily without resorting to a lien, more doctors would be willing to treat (which is another serious problem facing the industry that needs to be addressed on a different day) and liens would become almost unnecessary.

I have here some samples of the kinds of problems we're facing. Thank you for your attention.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Handwritten notes: "11/10/11", "I will get u paid", "4/13/12", "Kevin McArthur 7/12/996-1976", "I define myself as a carrier"

Form sections 1-11: Insured's I.D. Number, Patient's Name, Birth Date, Relationship, Address, Status, Policy Group, etc.

Section 12: Patient's or Authorized Person's Signature. Signed: 09/29/2010.

Section 14-17: Date of Current Illness, Referring Provider, Hospitalization Dates, etc.

Section 19-23: Diagnosis, Medicaid Resubmission, Prior Authorization, etc.

Table with 6 rows and 10 columns: A. Date of Service, B. Place of Service, C. EMG, D. Procedures, E. Diagnosis, F. Charges, G. Days, H. EP01, I. ID, J. Rendering Provider.

Section 25-30: Federal Tax ID, Patient's Account No., Accept Assignment, Total Charge, Amount Paid, Balance Due.

Section 31-33: Signature of Physician, Service Facility Location, Billing Provider Info.

Handwritten notes at bottom: "1/2 year old", "ONE UNPAID!"

CARRIER (top), PATIENT AND INSURED INFORMATION (middle), PHYSICIAN OR SUPPLIER INFORMATION (bottom)

James Zelko
Claims Manager

Subj:
Date: 3/17/2012 9:37:23 A.M. Pacific Daylight Time
From: LFrappia@aol.com
To: james.zelko@kp.org

please pull this file and call me. this is a panel QME psych performed on 11/16/2010 and Jerry Hom will NOT pay me. the two times i have spoken to him, he has been INCREDIBLY rude. this is the first lien we've ever had to file in my 16 years with Dr Hall and it really hurts me to do it against Kaiser when I worked for Dr Benner for 10 years helping to set up the Kaiser On the Job program.

if I have to go to van nuys for this lien trial set for 7/3/2012, i will definitely be seeking lc5813 sanctions in the amount of \$2500. i have spent two years of my time trying to collect this. there is NO legal or evidentiary basis for non payment. the judges are cracking down on this type of behavior as they have 1 1/2 million liens clogging up the system, many of them for NO REASON such as this one.

the total is \$3076.93 and with 10% penalties \$307.69 and 10% for 1 1/2 years interest \$451.54

the total due is \$3836.16. i will accept \$3500 to end this matter right now. this offer is only good until 3/31/12.

attached is a copy of the bill in question.

HA (510) 625-3345

Bot 15 N OAKS 12927 PASADENA, CA 91105

1500

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

KAISER FOUNDATION

15 N OAKS 12927
 PASADENA, CA 91105

Old 24604

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
CITY					STATE					CITY					STATE				
ZIP CODE					TELEPHONE (Include Area Code)					ZIP CODE					TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED SIGNATURE ON FILE DATE 10/05/2010										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										b. EMPLOYER'S NAME OR SCHOOL NAME KAISER FOUNDATION									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										c. INSURANCE PLAN NAME OR PROGRAM NAME JERRY HOM									
19. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
1. 29622										SIGNED SIGNATURE ON FILE									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSPD Parity Plan I. ID. QUAL. J. RENDERING PROVIDER D.#										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
1. 11 16 2010 11 16 2010 11 ML104 94 1 2656 25 34 NPI PSY 12048										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
2. 11 16 2010 11 16 2010 11 96100 1 420 68 4 NPI PSY 12048										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES									
3. 10% per day 30) - NPI										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
4. 10% interest 30) - NPI										23. PRIOR AUTHORIZATION NUMBER									
5. 10% interest 30) - NPI										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
6.										28. TOTAL CHARGE \$ 3076.93 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 3076.93									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/>										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) HALL, PHD QME, DAVID SIGNED 12/16/2010 DATE									
26. PATIENT'S ACCOUNT NO.										32. SERVICE FACILITY LOCATION INFORMATION DAVID C. HALL, PHD 715 E GRAND BLVD CORONA, CA 92879									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										33. BILLING PROVIDER NFO & PH# (800) 660 7757 DAVID C. HALL, PHD 715 E GRAND BLVD CORONA CA 92630									

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

1 year old AmE!

From: Partida, Henry <Henry.Partida@yorkrsg.com>
To: LINDA FRAPPIA <lfrappia@aol.com>
Subject: RE: I
Date: Thu, Mar 8, 2012 12:24 pm

to pay penalty

I am sorry but I don't have authorization to do that. I don't want to have to go to a lien conference for this but if you insist on going to a Hearing on the matter I will have to cancel tomorrows payment. I can do one or the other but not both.

Henry Partida

Henry Partida, W.C.C.P. | Senior Claims Examiner
York Risk Services Group, Inc.
P: (909) 942-4829 F: (866)548-2637
Henry.Partida@yorkrsg.com

From: LINDA FRAPPIA [<mailto:lfrappia@aol.com>]
Sent: Thursday, March 08, 2012 12:23 PM
To: Partida, Henry
Subject: Re:

penalty

no just issue another check for 10% interest and 20% interest as it's been TWO YEARS.
\$298.83

Linda

-----Original Message-----

From: Partida, Henry <Henry.Partida@yorkrsg.com>
To: LINDA FRAPPIA <lfrappia@aol.com>
Sent: Thu, Mar 8, 2012 11:57 am
Subject: RE:

So then should I stop the payment I set for tomorrow for the balance of \$996.10?

Henry Partida

Henry Partida, W.C.C.P. | Senior Claims Examiner
York Risk Services Group, Inc.
P: (909) 942-4829 F: (866)548-2637
Henry.Partida@yorkrsg.com

From: LINDA FRAPPIA [<mailto:lfrappia@aol.com>]
Sent: Thursday, March 08, 2012 11:43 AM
To: Partida, Henry
Subject:

did you include penalties and interest? there was a petition for penalties and interest attached to the lien and filed with the wcab . i cannot be spending all this time and money to collect on our bills and then just accept the balance due which should have been paid without all this work. you have NO idea how hard it is to get paid. and i only bill to fee schedule. my bills are correct. your bill review does not review the bills correctly. so i'm supposed to wait 2 years as i have on this one and then get no interest? i don't think so. i will go to trial.

and i'll never get paid for the report if you don't sign the pre authorization letter.

Linda

-----Original Message-----

From: lfrappia <lfrappia@aol.com>
To: Linda Frappia <lfrappia@aol.com>
Sent: Thu, Mar 8 2012 10:30 am
Subject: Fw:

Sent via BlackBerry from T-Mobile

From: "Partida, Henry" <Henry.Partida@yorkrsg.com>
Date: Thu, 8 Mar 2012 09:00:50 -0800
To: LINDA FRAPPIA <lfrappia@aol.com>
Subject: !

I received your lien for the above claimant I am having the balance issued out tomorrow. Please file a request for the lien to be removed.

Henry Partida

Henry Partida, W.C.C.P. | Senior Claims Examiner
York Risk Services Group, Inc.
P: (909) 942-4829 F: (866)548-2637
Henry.Partida@yorkrsg.com

Check# 0091257600

ICN#

Patient Name

FOR INQUIRES CALL: GALLAGHER BASSETT MANAGE CARE SERVICES AT 800-370-0594
P.O. BOX 23812, TUCSON, AZ 85734

BILLED PROCEDURE	MODIFIERS	REVIEWED PROCEDURE	MODIFIERS	UNITS	TOTAL CHARGES	REDUCTIONS	PPO REDUCTIONS	RECOMMENDED ALLOWANCES
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Date of Service: BLMSG
 PROCEDURE DESC: SEE MESSAGE BELOW.
 EXPLANATION CODE: *26400

Date of Service: BLMSG
 PROCEDURE DESC: SEE MESSAGE BELOW.
 EXPLANATION CODE: *26CA1

Date of Service: BLMSG
 PROCEDURE DESC: SEE MESSAGE BELOW.
 EXPLANATION CODE: *26106

Date of Service: 02-16-11
 ML104 94 ML104
 PROCEDURE DESC: MED LEGAL EVALUATION
 EXPLANATION CODE: *00820

Reconsider per report

spilloe All attached, 2nd TIME!

1250.00	1250.00	0.00
NPI: 0000000000		
TOTAL CHARGES:	1250.00	
BILL REVIEW REDUCTIONS:	1250.00	
RECOMMENDED ALLOWANCE:	0.00	

EXPLANATION CODES:

*00820 (BARC - G10) WE CANNOT REVIEW HIS SERVICE WITHOUT NECESSARY DOCUMENTATION. PLEASE RESUBMIT WITH INDICATED DOCUMENTATION AS SOON AS POSSIBLE
 *26106 TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOB OR CLEAR NOTATION THAT A REC
 *26400 AMOUNTS OVER THE RECOMMENDED ALLOWANCE OR FEE SCHEDULE AMOUNT ARE OBJECTED TO BY THIS PAYER. REQUESTS FOR RECONSIDERATION MAY BE DIRECTED.
 *26CA1 THE PAYMENT STATUS CODE REFLECTS THE RECOMMENDED ALLOWANCE AS A RESULT OF OUR BILL REVIEW ANALYSIS. THE ACTUAL PAYMENT WILL BE DETERMINED B

STATE SPECIFIC EOB MESSAGES:

AMOUNTS BILLED ABOVE THIS PAYMENT OR THE RECOMMENDED ALLOWANCES AS SHOWN ARE HEREBY OBJECTED TO AS BEING IN EXCESS OF AMOUNTS AUTHORIZED UNDER LABOR CODE 4620 THROUGH 4626 AND 5307.1 OR SECTIONS 9790 THROUGH 9795 OF TITLE 9, ARTICLE 5.5 OF THE DIRECTOR'S ADMINISTRATIVE RULES, REMEDIES AVAILABLE FOR CONTESTING THIS DETERMINATION INCLUDE FILING A LIEN AND/OR APPLICATION FOR ADJUDICATION WITH THE WORKERS' COMPENSATION APPEALS BOARD OR REQUESTING THAT THE DISPUTED ISSUE BE DETERMINED BY BINDING ARBITRATION. YOU MAY ALSO CONTACT AN ATTORNEY OR UTILIZE ANY OTHER REMEDY AVAILABLE UNDER THE LABOR CODE OR RULES OF PRACTICE AND PROCEDURE
 Unless otherwise noted, charges were reduced for exceeding the guidelines of the Official Medical Fee Schedule of the State of California.

12889584

*No hearing
 not PAID
 Report was
 STAPLED to
 ALL*

ENDORSE HERE
 X Warning: you are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty may be jail or prison, a fine, and loss of benefits.
 ADVERTENCIA: Es necesario que usted le avise a su patron o a su compania de seguro todo dinero que usted ha ganado por trabajo, durante el tiempo cubierto por este cheque, y antes de cambiar este cheque. Si usted no sigue estas reglas, usted puede estar en violacion de la ley y el castigo podria ser carcel o prision, una multa, y perdida de beneficios.
 DO NOT WRITE STAMP OR SIGN BELOW THIS LINE
 ENDORSEMENT DEPOSITORY BANK ENDORSEMENT

Welcome, dchall. You are logged in.
 Company: David C Hall PHD
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[Appointments](#) [Patient Visits](#) [Claims/Billing](#) [Accounting](#) [Manage Patients](#) [Patient Portal](#) [Manage Office](#)

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Edit Patient - [Patient]

Patient ID: Mid. Initial:	Last Name: DOB - Age:	First Name: Gender: M
Pat. Acc. No:	Account Type: Primary Insured/Guarantor	SSN:
Primary Provider:	Referring Provider:	Account Status: Active

[Patient Data](#) [Insurance](#) [Appointments](#) [Visit History](#) [Template](#) [Health Records](#) [Intake Documents](#)

Patient Visit History:

Visit ID	Date Visited	Reason For Visit	Provider	Total Charges	Balance	Status	Claim No	Create Claim
25810312	02/16/2011	PQME-AME TYPE	DAVID HALL	\$1250.00	\$1250.00	Claim Created	515143254	
22888987	09/21/2010	PQME-AME TYPE	DAVID HALL, PHD QME	\$5682.10	\$0.00	Claim Created	512429974	

Shortcut Keys: Alt F1-Help | F2-Add New Appointment | F7-Add New Visit | F8-Add New Payment | F9-Add New Patient | F10-Patient List

Patient/Provider Eligibility - Screening - EDI
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 86075-WEB05
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1500

York Claim Services
WX778

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA [] [] [] PICA [] [] []

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY STATE CA	8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 12/01/2011

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)	23. PRIOR AUTHORIZATION NUMBER
1. _____ 3. _____	07A1300-0186
2. _____ 4. _____	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPOSD Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER D.#
1 12 20 2011 12 20 2011	11		ML104 94	1	4843 75	62		NPI	PSY 12048 1730489139
2 12 20 2011 12 20 2011	11		96100	1	315 58	3		NPI	PSY 12048 1730489139
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$ 5159.33	29. AMOUNT PAID \$ 0.00	30. BALANCE DUE \$ 5159.33
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) HALL, PHD QME, DAVID SIGNED 2/26/2012 DATE		32. SERVICE FACILITY LOCATION INFORMATION QME/AME 715 E GRAND BLVD CORONA, CA 92879 a. 1730489139 b.		33. BILLING PROVIDER INFO & PH # (800) 660 7757 DAVID C. HALL, PHD 715 E GRAND BLVD CORONA CA 92630 a. 1730489139 b.	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

William S. Morris, ATTORNEY

Certified Workers' Compensation Specialist - State Bar of California

April 17, 2012

Please reply to:
P.O. Box 1640
Turlock, CA 95381-1640

Tel (209) 667-1948 - Fax (209) 667-8932
Service by Fax Not Accepted

STATEMENT OF WILLIAM S MORRIS

My name is William Morris. I represent injured workers. I am an Applicant's attorney.

My clients are from the central valley which is the agricultural bread basket of California. Most of my clients make less than \$50,000 per year, and many of them are undocumented. The agricultural field is unique in that there is a great demand for plentiful, but cheap labor. I am always surprised when I find that I am representing a man that is feeding and sheltering a family for less than \$10,000 per year, or I'm representing a woman that is holding down three or four full time seasonal jobs. Agricultural labor is strenuous, and the safety of the worker is not always a consideration.

I appreciate the opportunity to give my opinions with regard to the problems of the workers' compensation system with special attention to the debacle caused by SB 899. The concept of workers' compensation has been around for over 100 years in California, yet the system that had been initiated and tweaked for almost a century has now been delivered a sever blow by the concept of fixing what was not broken. SB 899 essentially threw the baby out with the bath wash. I do not consider it coincidental that the State of California is now having financial problems because I think much of the State's fiscal problems can find roots in SB 899. It is my intention to point out the financial effects of SB 899, the Court decisions interpreting SB 899, and the recent legislation immediately preceding SB 899.

THE REAL BASIS FOR WORKERS' COMPENSATION

I think it important to acquaint ourselves with the real reason the workers' compensation system was developed. It was not really a bargain to give the employee an expectation of certain benefits in exchange for the opportunity to get large sums from a lawsuit although that is the expected end result. It was to remove the burden of those employees being injured because of the industrial revolution from the backs of the taxpayer and place that burden upon the employer who could better control the workplace and determine his cost of goods and services to include the cost of the employer's injuring his own employees in producing those goods and services.

Every time the legislature decides that the government can assume the burden of taking care of an injured worker, it removes the incentive for the employer to insist upon a safe work place. It harms the budget of the State by requiring the taxpayer to assume the cost that is the responsibility of the employer because of the employer's decision to produce those goods and services.

SAVINGS IN WORKERS' COMPENSATION IS NOT INTUITIVE

The saving of costs within the workers' compensation system is not intuitive. The concept of fairness should be abandoned because it focuses one's attention upon incorrect principles. It is not fair that a worker who has ruptured a disk in his back because of the demands of his employment should receive the paltry sum that is awarded in the workers' compensation system. At the same time, back injuries are common in the agricultural field where a person's reduced earning capacity because of a lack of education can be balanced against the earning capacity associated with a strong back. The economics of society just can not support awarding a fair sum to all of those workers whose earning capacity is destroyed when their back gives out. There is a balancing of what the employee needs to compensate him for his loss of earning capacity against what society can afford to pay in order to provide the employer with an incentive to produce necessary goods and services.

TEMPORARY DISABILITY SHOULD NOT BE FORESHORTENED

To demonstrate how the principle of saving money in the workers' compensation system does not follow intuitive principles, one should consider the reduction of temporary disability benefits. One would intuitively expect that reducing the period of time that temporary disability indemnity is paid would result in a savings by foreclosing the payment of temporary disability benefits beyond an established period of time. It doesn't happen that way. Establishing a fixed period of time for the payment of temporary disability benefits establishes a bottom line cost for the insurance companies. They now just presume that every injured worker will be paid 104 weeks of temporary disability, and they forget about trying to save costs with regard to this line item. Check the statistics on this, and I think you will find that very few industrial injuries are resolved within the 104 week period as opposed to prior to the establishment of a temporary disability benefit. The insurance company is no longer motivated to get the injured worker back to work in a timely manner. Instead, the insurance company can exert its efforts in delaying and denying the provision of medical care.

This is a cruel weapon because sometimes medical care that is delivered quickly will have a beneficial effect that is lost when it is delayed. The delay makes the treatment unnecessary. Further, there is the consideration of economic pressure upon the injured worker. As the injured worker remains unable to return to the world of work because of the delay of medical treatment, he finds himself unable to pay the simple costs of living because of the elimination of the temporary disability benefit. The economic pressure thus compels the worker to accept substantially less than his entitlement merely because of the delay and lack of benefits or resources. This egregious abuse of the injured worker is caused by the cessation of the temporary disability benefit.

I'm not through, however, because when the temporary disability benefit is foreshortened, the injured worker becomes eligible for public benefits such as State Disability benefits paid for as a tax

upon the injured worker's salary or if the employee is able to work at something, unemployment benefits which are a tax against the employer's profits. Since the insurance company no longer has to pay temporary disability benefits, The State coffers have to pick up the slack, and the State has no ability to control this expenditure because it is the insurance company that is driving the cost by failing to provide timely medical treatment. Lastly, the State is losing tax revenue because the injured worker is not being returned to the world of work. Thus my original comment that to me, it is small wonder that the State is having financial problems following the passage of SB 899 and the related legislation.

My solution is that the opposite should be done. Not only should there be no limit to how long an injured worker should receive temporary disability benefits, but there should be an automatic increase in temporary disability benefits after two years to account for loss of wage increases an employee would ordinarily expect to receive if working, and to motivate the insurance company to provide expeditious and timely medical treatment.

THE AMA GUIDES IS AN EXPENSIVE SOLUTION.

An obvious expense of SB 899 was the legislature's shirking of its responsibility under the constitution to do its own development of a system of benefits. It instead abdicated that responsibility in favor of the American Medical Association (AMA). The AMA has no responsibility to the government or the citizens of this State for what it does in producing its Guides, and there is already evidence that the part of the AMA responsible for producing the Guides has been invaded by insurance company skills. Further, the concept of impairment as defined by the AMA has no relationship to a person's ability to work, and the AMA Guides says so.

By the AMA definition, a person is not totally impaired until he is dead. A person's complete inability to work occurs far before that event, and an ability to work is not necessarily directly comparable to a person's impairment. Take for instance the fact that an AMA impairment related to a knee injury is determined by the amount of cartilage remaining without contemplation of a person's gait disturbance. The gait disturbance, however, is a much greater indicator of a person's ability to work. Luckily, doctors have realized this distinction, and have adapted by utilizing procedures that the Board has accepted as appropriate in the cases known as Almaraz/Guzman.

By deferring to the AMA, the legislature compelled every practitioner, judge, and participant in the workers' compensation system to buy a copy of the AMA Guides. Before SB 899 one could learn about workers' compensation disability by purchase a book from the State's printing office for \$15. At the time of SB 899's passage, the AMA Guides cost about \$370. By my calculation, that meant that the AMA received an influx of \$300,000 from the practicing Applicant's attorneys alone. I think that the teachers' union could have designated a better use for that \$300,000 than increasing the profits of the AMA. The AMA Guides is not an objective basis for determining

disability as represented by the insurance companies and other proponents of change. The descriptions of disabilities that had been established over almost 100 years of tweaking was well understood by the practitioners in the workers' compensation system, and they were no less objective than the AMA Guides have proven to be. A generous savings can still be had by eliminating utilization of the AMA Guides and returning to the descriptions of injuries that had served this state well for nearly 100 years.

THE DOCTORS CAN'T BE MADE TO COOPERATE WITH THE WORKERS' COMPENSATION SYSTEM

In determining how medical benefits should be delivered to the injured worker, the legislature failed to take into consideration the motivation and cooperativeness of the physicians. SB 899 fails to offer the physician a financial incentive to participate in the workers' compensation system. Instead, there are disincentives. The physician is required to accept less than he charges the open market, and the physician must cater to a complex system of permission and review that increases the physician's overhead and interferes with the proper delivery of medical treatment. I have had physicians decline to further treat my clients because their expertise in the delivery of medical treatment was delayed or declined by an adjuster. The explanation was that the physician could not adequately treat the patient's condition when his treatment decisions were being second guessed and not being timely followed. He therefore declined to treat at all. There are other physicians who simply decline to treat workers' compensation patients at all. As an aside, let me note that some of these physicians who decline to accept workers' compensation patients have been identified by workers' compensation insurance companies as members of the insurance companies' Medical Provider Network which really puts into question the credibility of the system as it now stands.

I remember having an informal discussion with a world renowned physician who was complaining to me and a defense attorney that the new system made it difficult for him to adequately treat workers' compensation patients, and that he was recently (at that time) approached by a physician who had graduated near the bottom of his medical school class to become a member of the other physician's new Utilization Review network. It seems that the other physician was making twice the income of this world renowned physician at this new enterprise. The utilization review process has set up a cottage industry in which the reviewing physicians are not accepted as the treating physician's peer, and with little wonder as I have had an anesthesiologist do a peer review of a request by an orthopedist for a dermatological consult. The reviewing physician is hired with the motivation to save the insurance company money by denying medical procedures. There is no motivation by the UR doctor to not deny a medical procedure other than his level of embarrassment. I have had denials of medical treatment that had already been approved by an Agreed Medical Evaluator; I have had denials of medical treatment for referral to a specialist to evaluate a condition because the condition had not yet been evaluated; I have had denials of post surgical leg braces because the type of brace had not been identified. The

reviewing physician creates an unacceptable interference by calling the treating physician at inappropriate times, and frequently. I recently conducted a deposition of a treating physician who alleged to me and the attending defense attorney that he received approximately five peer review calls a day as a regular circumstance.

SAVINGS IN UTILIZATION REVIEW IS A MYTH

I see no merit to Utilization Review. Any savings it allegedly incurs is a myth. Any allegation that proposes that Utilization Review saves money is either based upon the failure to provide adequate medical treatment thereby diverting the cost from medical treatment to the delivery of a disability benefit, or there has been an inadequate evaluation of all of the costs involved with the system. It should be eliminated in its entirety, especially the requirement for pre-authorization. At the most, I suggest that it could be utilized only as an excuse by the insurance company to justify its actions when called to account for failure to pay for a medical procedure. The success and relative expense of the medical procedure called into question should be considered significant factors in any litigation in order to reduce the "let's try it and see" scenario of medical treatment.

MEDICAL PROVIDER NETWORKS ARE FRAUDS

The Medical Provider Network is a fraud. Interpretation of the MPN statutes has resulted in the insurance company's entitlement to demand that a patient treat within the MPN network no matter the initial factors involved in the patient's medical treatment. Although the statutes require an insurance company to initially place a patient with a medical provider, it does not require the same initial placement when the insurance company merely demands a change of medical providers. I have a client that has been denied medical treatment for over two years because of this single issue. It has been litigated, and the Board has provided me with no satisfaction. I have attempted to prove that there are no physicians within the MPN that will accept my client as a patient, but the proving of a negative has been shown to be problematic. The insurance company provides me a list of physicians, and refuses to select one and schedule an appointment even when I have demanded that they do so. At trial, the insurance company presented a witness who had allegedly obtained the MPN contracts with the physician members of the MPN. When asked if it was a requirement of the MPN that the physicians agree to accept a referral, the witness snorted and said that no doctor would do that. In fact, few physicians accept referral from other physicians in the central valley.

I suggest that if the MPN does not require the physician to accept a referral, then it is a fake. In the central valley, most physicians will refuse to accept the problems established by a prior physician. In particular, an orthopedist will not accept a patient that has not completed treatment with a different orthopedist. There is small wonder that a physician will not accept the problems of a prior physician, and it is naive of the legislature to think one would do so.

To remain in good standing within an MPN, the physician is required to treat the dollar rather than treat the patient. I can not understand how the legislature could believe that treating the dollar is an adequate way to accomplish the Constitutional mandate of workers' compensation. One way to treat the dollar that I have observed is to have the MPN physician provide treatment according to a certain protocol. If the patient fails to recover according to the protocol, then he is dismissed as cured, and his complaints, which are unchanged, are asserted to be something different, but not the same as the industrial injury for which he came to the MPN physician in the first place. This is not a provision of medical treatment. It is a commission of a fraud upon the injured worker and the system.

I can not see how an MPN can be made to work. I see much better that medical treatment should be handled on a case by case basis. There are those doctors, and we all know who they are, who over treat or who provide inadequate treatment. A proper method to avoid abuse of the system is to allow the parties to charge a physician with over treatment or inadequate treatment, and set up a system of holding a hearing to determine whether the charge has been properly brought. A record can be maintained of the number of valid and non-valid charges brought, and a system of adjustments to the physician's compensation based upon these charges can be derived. It is an abuse of the injured worker to allow those interested in the cost of medical treatment rather than the injured worker's welfare to be in control of the injured worker's medical treatment. The system should go back to allowing the injured worker the ability to select the physician with whom he gets the most benefit, and with whom the injured worker is most comfortable. I say that this is a procedure that would produce better results by fostering a rapport with the treating physician that would result in faster and more effective medical treatment thereby quickly returning the injured worker to work.

THE PANEL QME PROCESS IS BANKRUPT

The Panel QME process should also be abandoned as a wasteful delay of the delivery of benefits. I'm not certain of just how much the State of California is paying in salaries to have someone put together a piece of paper that contains a panel of three eligible QME doctors, but I fail to understand just why it takes six months to accomplish something that could be accomplished by playing a game of darts for half a minute. It could also be accomplished by putting together a roulette wheel for about \$100. Even if there is some sort of balancing technique being utilized that isn't patently obvious, it would take no more than \$5,000 to develop a sophisticated computer program that would accomplish all of the bells and whistles necessary to select three panel doctors in an instant. Besides the fact that it takes so long for a panel to be issued, there is the additional factor that whoever is selecting the panel doctors feels it is appropriate to substitute their own legal opinions in the place of that of a workers' compensation judge whose duty it is to determine whether a panel request was appropriately requested. This interference with due process causes great delay and necessitates the intervention of a

workers' compensation judge to order the issuance of a panel. No benefit is being provided by the panel QME system, and it is violating the Constitutional mandate that things be done expeditiously.

A further problem with the panel system is that the panels are structured into certain groups that are not always appropriate. For instance, a brain injury normally requires the expertise of a neuropsychologist, but I have experienced the problem that one can not get a neuropsychologist panel even when one is ordered by a workers' compensation judge. I have talked with evaluators who have advised that when they are evaluating pro-per injured workers they are restricted from doing what they feel is appropriate by the economic pressure of the insurance companies. For example, the principle known as Almaraz/Guzman is now a rule of law which should be contemplated by all evaluators without being asked. Otherwise, the pro-per injured worker is not getting the full due process rights an attorney would guarantee for a represented injured worker. Nevertheless, it has been reported to me that should an evaluator for a pro-per injured worker attempts to utilize the Almaraz/Guzman principle he can expect to receive telephone calls and have his fees threatened by representatives of the insurance company. If there is any more demanding evidence that injured workers should be represented by an attorney, I know of none.

There is no benefit being provided by the panel QME process. The detriment is that it facilitates the insurance companies' ability to violate injured workers' due process rights. It fails to provide adequate evaluators for all medical conditions that could occur, and it creates an excessive delay that can not justify the salaries being paid to support it. There is absolutely no reason why this procedure should not be abolished with a return to a procedure that allows the litigants to select their own experts.

THERE SHOULD BE A RE-EVALUATION OF THE QME PROCESS

I'm not finished with the QME process. I wonder if anyone has investigated whether money has been saved as a result of the institution of the QME process. When I first started in workers' comp, we had organizations like First Western Medical that trained their stable of doctors, and provided dictation services that resulted in a well prepared and justified medical report. The insurance companies took after these organizations with a vengeance and eventually got them eliminated. All that has occurred, however, is that the expense absorbed by First Western in the market economy has now been assumed by the State of California which provides training, supervision, and certification of QME's. I challenge that the system is better or that the money is well spent. In particular, I continue to get QME's who acknowledge that a person has sustained a cumulative trauma injury, but deny that it is an industrial injury because the exposure within the past year could not have been sufficient to cause the injury even though the actions being performed within the past year were deleterious. There are QME's who will refuse to provide an impairment rating simply because they have formed the legal opinion that an injury is not industrial. I have had a QME assert that a blister that admittedly formed as a result of repetitive use of a foot

pedal was a typical diabetic lesion so not industrial. Having to spend effort and time refuting these ignorant evaluators is not an expeditious delivery of benefits as mandated by the Constitution, and it is not due process for the poor pro-per injured worker who needs to have an attorney if he wants to obtain his true entitlements.

As an aside, I might point out at this point that Fresno is dominated by a group of orthopedists that travel to this location to perform evaluations, and who have the reputation in the Applicant's community to not perform adequate evaluations. These doctors claim to be independent evaluators, but none of them have registered with the City of Fresno for a business license as required by the Fresno laws. The QME process that was established to eliminate First Western is inadequate, and not worth the expense to the State of California that is required to keep it going. It results in a denial of due process. I believe an investigation of the expense to the State as opposed to the expense that was incurred in the market place will reveal that this procedure was a losing proposition. The QME process should be eliminated in its entirety, and injured workers should be allowed to obtain their own experts in the same way as litigants are able in a civil court of law.

Respectfully Submitted

William S. Morris

Presentation for Public Forum
Tuesday, April 24, 2012
San Bernardino, CA

Presented by Dennis Knotts, WCCP
Senior Workers' Compensation Claims Adjuster
Workers' Compensation Division
County of Riverside

MEDICAL EVALUATIONS:

1. Labor Code 4050:

Comment:

There is a need for Regulations to establish the procedure for obtaining a Labor Code 4050 evaluation.

Discussion:

Labor Code 4050 gives the employer the right to obtain a medical evaluation whenever compensation is found in favor of the employee. Labor Code 4053 enforces this right by finding that if the employee fails, refuses or in any way obstructs the employer's right to this evaluation, the employee's rights to begin or maintain any proceeding for the collection of compensation shall be suspended.

This is not the same things as Utilization Review. It is a physical evaluation of the employee by a physician provided and paid for by the employer. Previous Administrative Director, Casey Young, determined that the PQME process was the proper procedure for Labor Code 4050 with the passing of the Margolin Green Reform in 1989. This procedure remained in effect until the passing of SB 899 on April 19, 2004. It should be noted that Labor Code 4050 and 4053 were in effect, and the Legislature chose not to amend either Labor Code. This suggests that it was the intent of the Legislature to provide the employer a process whereby a medical evaluation could be obtained whenever compensation was found in favor of the employee.

It had been hoped that the Second and Third In-Network opinion would be used to give the employer this option, but Administrative Director Andrea Hoch and Carrier Nevans would not allow the employer any procedure for obtaining a Labor Code 4050 evaluation if the employer had a Medical Provider Network. There is nothing in the Labor Codes for the MPN that invalidates Labor Code 4050, and so a procedure is needed for an employer to obtain an evaluation under Labor Code 4050. Such an evaluation would have to be admissible before the WCAB as failure to cooperate with obtaining the evaluation would bar the employee from initiating or maintaining any proceeding [filing Application, Declaration of Readiness or obtaining medical evaluations] for the collection of benefits.

2. Labor Code 4062.1 Misinterpretation:

Comment:

Employers/Carriers are allowed by Labor Code to use the treating physician to obtain a medical report addressing causation on delayed claims. This point needs to be clarified for the industry.

Discussion:

Carrie Nevans misinterpreted Labor Code 4062.1 and created a position that PQMEs must be used to address causation on all delayed claims. This was further enforced by mandating that the AME/QME Fact Sheet be sent with all Delay Notices, and then in the sample Delay Notice, Carrier Nevans added the PQME Request form as an enclosure. There was never a Labor Code authorizing this requirement.

Labor Code 4062.1 (b) cites that if an evaluation is needed per Labor Code 4060, 4061 and 4062; then the PQME process is to be used. However, by citing these three Labor Codes, the Legislature allows us to go to these three Labor Codes, pull information from them and bring it back to Labor Code 4062.1 to better understand the application of this new Labor Code.

To hold that the PQME process is the first and only option in the resolution of medical issues contradicts all three of these Labor Codes. Labor Code 4060 (b) notes that neither the employer nor the employee shall be liable for any comprehensive medical legal evaluation performed by other than the treating physician. Labor Code 4060 also declares that the reports of the treating physician are admissible before the WCAB. Labor Code 4061 allows for the treating physician to provide the initial determination concerning permanent disability and future medical care. Labor Code 4062 notes that if either the employer or employee disputes any determination by the treating physician, then an appeal process is available.

The treating physician is the party identified by the Labor Codes as the physician to render the initial medical opinion on all medical issues. If there is a dispute; then the PQME process is the procedure for resolving that dispute.

Given the decision in the Valdez v Demo Warehouse case, where reports by unauthorized non-MPN physicians are not admissible as evidence; there is also a current need for the Administrative Director to resolve the conflict between Valdez v Demo Warehouse and Labor Code 4060. There are two possible solutions.

The first is that Labor Code 4060 only deals with comprehensive medical legal evaluations, i.e. issues of causation. As such the non-MPN treating physician reports would only be admissible for the sole issue of causation and not treatment.

The second is to provide a working definition that a treating physician must be legal to treat the employee before such reports are admissible. Thus an unauthorized non-MPN physician who is

treating does not obtain the status of treating physician until the dispute over the employer's medical control [i.e. MPN] is resolved in favor of the non-MPN physician.

Further, the treatment provided on delayed claims is mandated under Labor Code 5402. Labor Code 5402 does not reference treatment per Labor Code 4600. It references treatment per the Medical Treatment Utilization Schedule. As such, Administrative Rules are needed to stress the medical control of the employer during the delay period. Labor Codes 4620 through 4628 makes it clear that the employee is not entitled to obtaining a medical evaluation of his/her own choice until the decision-making process is complete, and the employer contests the claim. As such, Administrative Rules need to spell out that during the delay period of a claim, the employee is not free to change physician [that option was only under Labor Code 4600], treat with a pre-designated physician [that was only under Labor Code 4600], or seek other evaluations until the decision-making period on a delayed claim is complete. If the employer then accepts the claim, the employee shifts to treatment under Labor Code 4600 with those rights provided by Labor Code 4600, and this would also include 4616 – 4616.7 where the employer has a Medical Provider Network.

This way an employer is free to use his/her Medical Provider Network without fear of the employee changing physicians in the Network before the decision regarding compensability is resolved.

This also harmonizes the conflict between Labor Code 3602 (c) and Labor Code 5402 created by SB 899. Labor Code 3602 (c) holds that the employer has no liability under Division Four until the issue surrounding the condition of compensation are resolved in favor of the employee. It "is as if this Division had not been enacted." Labor Code 5402 creates a liability for the employer in contradiction of that Labor Code. This application of treatment only under Labor Code 5402 and not Labor Code 4600 would make it clear that Division Four still does not apply until the dispute concerning the condition of compensation has been resolved.

3. Administrative Rules 1 – 159:

Comment:

The revision of Administrative Rules 1 – 159 dealing with the QME/AME process exceeded its legal authority by usurping the right to make legal decision concerning the PQME/AME process from the WCAB and the WCJ, and transferring it to a department [the Medical Unit] which is not empowered with the authority to make legal decisions. The proper domain of the Medical Unit is to deal with medical issues; not legal ones.

Discussion:

The revision of Administrative Rules 1 – 159 re-designed the PQME forms and added language asking under which Labor Code the request for the panel was being made. This took the legal decision concerning a party's right to a PQME from the WCAB, and transferred it to the Medical

Unit. This Unit is not a legal unit. It is not trained in case law and legal decisions, and it places a task upon this Unit that is properly the domain of the WCAB.

Although Rule 30 was declared a contradiction of Labor Codes, it had continued to remain in the listing of Administrative Rules on the PQME/AME process. It needs to be removed.

Rule 35(f) gives the parties the right to conduct discovery to determine the accuracy and authenticity of a non-medical document prior to the AME/QME evaluation. This Rule needs some clarification because the case law of *Yee Sanchez v Permanente Medical* forbids a party from invoking the authority of the WCAB [i.e. depositions, subpoenas, etc] prior to the filing of an Application. This point is not clear in this Rule and may misguide parties to violate this case law.

Rule 35 (d) forbids the employer from submitting any objected non-medical information/documentation to the PQME unless otherwise order to do so by the WCAB. This forbids the employer from conducting the deposition of the PQME and introducing it to the PQME as part of the deposition. Barring this option literally forces the PQME physician's medical opinion to become invalid and inadmissible as it cannot meet the substantial medical opinion threshold which forbids medical opinions based upon incomplete or incorrect information. Denying the employer the option of correcting this lack of substantial medical opinion forced the parties to bar the PQME opinion rather than correcting it. This would force the parties back to second or third PQME. Each one would have the same results as the employee would continue to bar the non-medical documents/information.

Rule 36 (a) list three parties that the PQME must be served on. It does not list the defense attorney. This violates the panel decision of *Cormier v Safeway* (31 CWCR 182) which holds that a report is not properly filed until it is served on all parties, including the defense attorney.

4. Medical Legal Fee Schedule – ML 104:

Comment: The ML 104 fee has become an area of abuse for physicians to charge per ¼ hour.

Discussion:

Labor Code 4663 mandates that the physician conducting an evaluation must address causation. It also notes that the report is not considered complete until the physician also addresses apportionment. These are two medical issues that are mandatory per Labor Code, yet they are listed as issues which raise the complexity of the report and by asking the physician to address issues mandated by Labor Code, the physician is able to move to the level of ML 104.

The Administrative Rules dealing with the Medical Legal Fee Schedule and the ML 104 level need to be clarified to make it clear that this is an exception to the evaluation process, not the norm. The employer can remind the PQME/AME that these issues need to be addressed and it does not create additional issues to raise the complexity of the report to the ML 104 level.

There also needs to be amendments to the Administrative Rules on the PQME and the AME process that forbid the physician from holding the claim hostage by either seeking prior agreement to the ML 104 level or a level higher than is reasonable for the evaluation, or holding the medical report until the physician gets paid in full.

5. Conflict of Interest Referrals:

Comment:

The Medical Unit is sending PQME lists that have physicians who have a conflict of interest with the treating physician. The same is happening with the Expedited Second Opinion Spinal Surgery physician.

Discussion:

There have been situations over and over again where the PQME, and in some case the AME, are affiliated with the treating physician, i.e. in the same medical clinic or who are business associates. There are also cases where the Physician assigned as the Expedited Spinal Surgery Second Opinion Physician has business affiliations with either the treating physician or the employer/carrier. There have had several times where the physician assigned is a member of the employer's Medical Provider Network, and is also a physician in the medical group where the treating physician is located. In all these cases the physician does not disclose the affiliation.

The Regulations need to be amended to forbid this practice and either hold that failure to do so makes the report inadmissible, the fee is forfeit and the physician can be suspended or removed from the referral list.

MEDICAL PROVIDER NETWORKS:

6. Poorly Managed MPNs:

Comment:

Some Medical Provider Networks are so large that there is not adequate staff to properly manage the network. This results in poor medical service to employees.

Discussion:

Applicant Attorneys are constantly claiming that they are unable to find physicians in an MPN who will take new patients, or who are even available to treat. It is obvious that these Super MPNs are so large no one knows what is going on in them. They cover the entire state; there are thousands of physician, clinics, etc. The Administrator is just running credentials and that's as far as they can go when it comes to monitoring compliance. The super MPN use complaints

systems as the trigger to realize there is a problem. Thus many non-compliant physicians go unnoticed for years. This is unacceptable.

The Administrative Director needs to establish a maximum size and ratio of physicians, clinic, administrators, employers and employees for any given MPN. If the network cannot service the employees who are enrolled in it, then the Network needs to be reconsidered and audited to bring it into compliance.

7. Vendors Forcing Their Way Onto MPNs:

Comment:

Many MPN have added physicians who created the problems that led to the concept of an MPN to keep them out. Employers need protection from such vendors forcing their way into MPNs.

Discussion:

There was a lot of damage done when the Palm Medical sued SCIF for not letting them into the Network. There needs to be a process whereby an employer can create smaller MPNs to just meet their immediate needs. There needs to be Administrative Rules that protect the employer from law suits for selecting some physicians and rejecting others. An employer should be free to select those physicians that they believe will best service their needs and the needs of their employees without fear of civil litigation over the decision.

8. Simplify The MPN Process:

Comment:

Most employers are not expert in work comp laws and regulations. They just want to run their company, protect themselves and their profits from fraud and abuse. However, the system has become too complex and detail-driven that it is too easy to miss something and open the employer back up to the fraud and abuse he/she was trying to avoid.

Discussion:

The focus really needs to move from the quantity of the network to the quality of the network. Unfortunately, the litigation process has created a monster for employers trying to use an MPN, and an employer can do everything just right, miss one detail and the WCJ and A/A cry foul; and invalidate all the efforts of the employer.

There also needs to be some revised Administrative Rules that simplify the process rather making the MPN so detail-driven. There are four points where the notice must be made. There is at the time of hire. There is at the time they are put into the MPN. There is the NOPE Notice with the DWC-1 and the MPN Poster at the place of employment. It would seem that rather than having to prove all four of these, proving one should be adequate that the employee had notice of the MPN. If the employer advised the employee of the right to pre-designate a personal treating

physician at any point before the injury, and the employer notifies the employee of the MPN when setting up the initial evaluation, that – along with the NOPE revised 6/2010 – should be adequate notice and protect the use of the MPN.

ELECTRONIC BILLING REGULATIONS:

9. Electronic Billing Regulations Did Not Address All The Issues:

Comment:

The Electronic Billing Regulations are adding to the difficulty the Department of Insurance Fraud Division and the District Attorneys have in prosecuting vendor fraud.

Discussion:

In the rush to simplify electronic billing process, the focus was on the needs of the physicians and sometimes the process sacrificed protection for the employer. One of the key problems the District Attorney runs into is the failure of the industry to hold vendors to making their billing statements and reports to the “penalty of perjury” level. By allowing electronic signatures, name stamps, no signatures and not holding the vendors to the requirement to submit their bills and reports under penalty of perjury signatures [pen to paper by the physician], then the vendors can avoid arrest and prosecution by claiming someone else sent the bills, did the billing, typed the report, etc.

There is a need to pull back the electronic billing regulations and sit down with the Law Enforcement members who investigate and prosecute workers’ compensation fraud and bring the vendors back to an accountability as required by Labor Code 4628 and Administrative Rule 10606 which requires signatures under penalty of perjury by physicians submitting bills and reports to support their charges. Without this, there is no way that Law Enforcement can hold a physician accountable and prosecute these kinds of abuses.

UTILIZATION REVIEW:

10. There Must Be A Way To Hold Reviewing Physicians Accountable:

Comment:

Some Utilization Review services use physicians outside of California to conduct reviews. There is no way to hold these physicians accountable to the standards developed by the California Legislature or the Administrative Director. The industry needs a way to remove physicians from these services where the physician is non-compliant.

Discussion:

There have been three attempts in the Legislature to change the Labor Code and mandate that physicians conducting Utilization Review must be licensed in California. All three times these bills have been vetoed. The feeling is that it creates a double standard since Group Health does not have this requirement.

However, Group Health does not have the issues that are developing in workers' compensation. Utilization Review services are putting profit above quality. They outsource to other states. When the physician does not comply with our Administrative Rules or Labor Codes, or ignores the Medical Treatment Utilization Schedule; there is no way to file a complaint and force compliance or disciplinary action. If there physicians were licensed in California, parties would file complaints with their licensing boards to force compliance or removal. If a party files complaints in other states, they are ignored.

There needs to be an oversight committee that has the power to discipline Utilization Review services operating here in California for using physicians who are non-compliant. This oversight committee should be empowered to remove physicians from practicing in California Utilization Review if they are non-compliant and refuse to correct their practices.

11. The Panel PQME/AME Process Is Part Of The Problem:

Comment:

Forcing an employee to suffer while treatment decisions are being delayed is unreasonable and unprofessional. The process of sending a dispute either through the PQME/AME process adds further delays to the process. A more streamlined method is needed.

Discussion:

When the Utilization Review physician non-certifies a request for treatment, the employee is not provided treatment until the dispute is resolved. This starts with twenty days to issue a written objection. Next comes ten days, plus five days for mailing to request the PQME on litigated cases. It means another delay in receiving the PQME list. For a litigated case we add, the ten days to select a PAME from the list or another three days to strike one name each. Then there is the process in setting the appointment, sending the medical records, the evaluation taking place and thirty days for the decision – if the AME or PQME is compliant [which many are not]. All this time the employee is waiting for treatment. To be honest, this is unacceptable.

There are other options that the Administrative Director could create through Administrative Rules. The first would be to create a mandatory resolution process before the PQME/AME route. This would involve a physician to physician discussion. Force the treating physician and the reviewing physician to contact each other within 48 hours of the non-certification and discussion treatment options, what was missing from the request that was needed for approval, etc. This could take place while the twenty days to file a written objection is running so it does not extend the current time frames for appeal.

Another option is to create a position of an Employee Advocate who would act much like the Information and Assistant Officer, but have medical background and be able to discuss options with both treating physician and reviewing physician; and bring about a timely solution.

Finally, there should be an Expedited PQME process when dealing with Utilization Review issues. This would be a short, five-day process at a maximum. The only issue the PQME should address is the need for treatment. All other medical issues should be referred to the normal PQME/AME process. This may involve a phone conference with the employee and treating physician and review of the medical records. If needed and if the employee waives the five-day decision process, a medical exam could be obtain on an expedited basis which would extend the decision by five additional days – to a total of ten days from start to finish. This Expedited PQME would have two working days to issue his/he decision after the phone conferences or the evaluation.

WORKERS' COMPENSATION APPEALS BOARD:

12. Parties Practicing Before the WCAB Need To Be Held Accountable For Their Actions:

Comment:

Various parties appear before the WCAB in conferences and trials presenting evidence, arguments and statement that may be questionable or even false in order to obtain or deny payment. Those who do this must be held accountable by the industry.

Discussion:

Parties come down to the WCAB and submit questionable bills with little documentation. Other parties make all kinds of claims and arguments to obtain or deny payment on a workers' compensation claim. Where these parties misrepresent the facts or alter documents, there needs to be a procedure in place to hold these parties accountable and to make it clear that the WCAB is not a place where fraud and abuse will be tolerated.

When a WCJ hears a case and makes the determination that a party is not entitled to benefits, or that a party is obligated to pay a benefit; where that party misrepresented the facts to the point of making a knowingly false or fraudulent material statement for the purpose of obtain or denying workers' compensation benefits, the WCAB needs a procedure in place to require that WCJ to report this potential fraud to the Department of Insurance Fraud Division to investigate the action to see if it should be prosecuted a workers' compensation fraud.

PERMANENT DISABILITY BENEFITS:

13. The Need For A Current PD Schedule:

Comment:

There is a need to bring the DWC into compliance with the Labor Code and have a revised PD Rating Schedule.

Discussion:

Labor Code 4660 (c) mandates that the Permanent Disability Schedule be amended no less frequently than every five years. A schedule was proposed in 2009, but it was never approved. It was reviewed by the public and so technically it could be used to amend the current schedule. Rather than delaying changes which were needed back in 2009, the Administrative Director should adopt the proposed 2009 Schedule to bring the DWC into compliance with the Labor Code. Those proposed changes were needed then, and will fix some of the problems now. Obviously it is not the perfect fix.

Per Labor Code 4660 (c) the wording is that the Schedule is amended "at least once every five years." There is nothing to prevent the adopting of the 2009 Schedule and then begin work on a more comprehensive solution which can be issued in less than five years.

14. Bring The Permanent Disability Rate Up To A Reasonable Level:

Comment:

Reduction in impairment due to the use of the AME Guides 5th Edition reduced awards, and there has not been any increase in the rate. There is a need to provide for injured employees.

Discussion:

Although it would take a Legislative change to increase the PD rate, the adoption of the proposed 2009 Schedule would increase the PD by about 16% for the injured worker. This would be a start until a more comprehensive increase can be negotiated.

Further, Labor Code 4650 (b) notes that Permanent Disability Advances are to begin within 14 days of ending Temporary Disability Benefits. This Labor Code was amended as part of SB 899 which created caps on Temporary Disability Benefits. The wording of Labor Code 4650 (b) states that “regardless” of whether or not the amount of PD is known, the employer shall “nevertheless” begin advancing the PD based upon either an estimate or a rating and shall continue advancing PD until the estimate or the rating is paid out. The wording of this amended Labor Code seems to bar the option of delaying PD Benefits. The employer shall either make an estimate and advance the estimate, or deny the benefit. However, when Carrier Nevans amended the Benefit Notices in 2008, she included the option of continuing to use a Delay Notice with regards to Permanent Disability Benefits. Based upon Labor Code 4050 (b) there is no legal authority to do this.

It seems the removal of the delay option for Permanent Disability Benefits was intended by the Legislature as an off-set to placing caps on Temporary Disability benefits. This way is an employee is still temporarily disabled when the caps run out; there will be Permanent Disability Benefits advances to replace the Temporary Disability Benefits that have ended.

Implementing both of these changes will provide at least some small relief to the injured employee with permanent disability.

15. Change The Impairment Evaluation Process For Psyche:

Comment:

The use of the GAF as a single declaration without objective evidence has opened the door for increased abuse of the psychiatric injury claim. There is a need for a method that is evidence-based and objective as attempted by the AMA Guides 5th Edition.

Discussion:

The current method of assigning impairment using the PD Rating Schedule and a single declaration of the GAF [Global Assessment of Functioning] turned the entire evaluation into a subjective-only process. A simple unsupported statement by an employee can create and increase disability to an unrealistic level.

One of the problems in the 1985 – 1992 Fraud Crisis era was that various diagnostic testing was used to establish the level of disability for the employee with a stress claim. These tests were basically self-administered, subjective and perfect for abuse. The Beck’s Depression Inventory simply asked the employee to describe how depressed he/she was. The fill-in-the-blank and complete-the-sentence tests all were open to abuse. The Mental Health Field defended these tests by saying that a person would not intentionally make himself/herself worse that they were. This assumption was made based upon the belief that the person did have a mental disorder, and would not want to appear worse than he/she was. These tests were not designed for a worker who knew the more disabled he/she was, the more money they got.

The same is true with the single GAF declaration. Labor Code 3208.3 notes that the employee must have a mental disorder that is diagnosed using the DSM III or current edition. This involves a five-part diagnosis. Axis I identifies the mental disorder. Axis II identifies development problems as the employee was growing up. This would show pre-existing, non-industrial emotional/mental problems. Axis III is the physical over-lay or the industrial injury aggravating the mental disorder. Axis IV is the severity of stressors. This puts the employee's reaction to the stress they are dealing with into perspective of how others would react to this same stress. Finally, Axis V is the Global Assessment of Functioning [GAF]. However, unlike the single declaration of the employee's current GAF; it required two readings. The first was the current GAF, and the second was the employee's GAF a year ago. This puts the employee into perspective with himself/herself. If the current GAF is 62, and the GAF a year ago was 65, this level of GAF is not abnormal for this employee.

There is a need for a similar, objective, evidence-based method to measure the impairment of the employee other than comments he/she makes during the evaluation; especially if the employee knows or is told that making such statements increased their settlement.

16. Hold The Increase For Pain To Three Percent Per AME Guide 5th Edition:

Comment:

The cases of Almaraz, Guzman and Ogilvie along with other case law have created a smoke screen for the industry. A physician is now allowed to use pain as the basis to increase the level of impairment more than 3%.

Discussion:

SB 899 amended Labor Code 4660 (a). It struck and deleted the standard of "inability to compete in the open labor market" and replace it with a "diminished future earning capacity."

Labor Code 4660 (b) was amended to mandate the use of the AMA Guide 5th Edition as the proper method of evaluating impairment.

The Schedule was to promote consistency, uniformity and objectivity. However, it seems the uniformity that is being created recently is to make the 2005 PD Rating system uniform in the level of awards provided by the pre-2005 PD Rating Schedule. In Brodie/Welch the Supreme Court ruled that there were two Legislative Intents created by SB 899. The first was to reduce the cost of workers' compensation premiums to employers, and the second was to include as many employees under the SB 899 system as possible. Any interpretation of a Labor Code contrary to these two intents is the incorrect one.

However, the industry seems to have forgotten this.

Almaraz and Guzman allow a physician to ignore the procedures of the AMA Guide and to create work restrictions – which was never part of the SB 899 method of impairment evaluation, and to use pain as a basis to add on to the impairment far beyond the 3% limit.

Ogilvie has allowed A/A to use the inability to compete in the open labor market as the new standard to adjust impairment rather than the diminished future earning capacity.

By renaming these terms and dressing them up so they look and sound like something different, the A/A have pulled the entire industry into the pre-2005 PD Rating Schedule with subjective complaints outweighing objective finding. Where speculation, conjecture and surmise outweighing evidence-based medicine.

Either a Legislative change or Administrative Rules need to be created to bar a physician from using subjective complaints or work restriction based upon subjective complaints or prophylactic work restriction to be re-introduced into a system that voted them off the island eight years ago.

BILL REVIEW:

17. Bill Review Services Should Be Mandated To Report What They Know:

Comment:

Bill Review services claim to know the vendors and players who are committing the fraud and abuse, and how they are doing it. They need to be mandated to report the fraud and abuse.

Discussion:

When a case is taken to trial, Bill Review Experts testify to levels of fraud and abuse by various vendors. However, the industry rarely sees this kind of information being disclosed to the customer short of litigation.

Bill Reviewers have to be certified by the Dept of Insurance as Experienced Bill Reviewers. This is the same Dept of Insurance that mandated Special Investigation Units in each insurer's claim operation to identify, document and report the fraud.

The industry needs an Administrative Rule or a new Insurance Code that places this same burden to identify, document and report fraud to the Department of Insurance and/or the carrier being defrauded as mandated by the SIU operations in claim operations. They have the information. They have the documentation. They should be mandated to report it in order to clean up the industry.

18. Bills Reduced Per Contract:

Comment:

Bills that are reduced per contract should not tie up the resources of the WCAB.

Discussion:

Explanations of Review are mandated to list the reason for reduction of a submitted medical bill. Many times the reason listed is that the reduction was per a contract.

The problem comes about that the employer/carrier is not a party to that contract. The carrier does not have a copy of the contract, and those who hold the contract will not release it without a subpoena and an appearance before the WCAB. This wastes the time and resource of the WCAB. A contract dispute does not fall under the jurisdiction of the WCAB. The issue being raised is not an issue the WCAB can address.

There should be Administrative Rules that note that where an EOB/EOR lists the reduction is due to a contract agreement, the lien claimant cannot file with the WCAB until this contract dispute is resolved in civil court.

19. The Need For A Bill Review Dispute Resolution Process Separate From The WCAB:

Comment:

The Resources of the WCAB are being wasted dealing with frivolous claims that bills were not reduced correctly. The parties involved are not bill review experts. Some are self-trained, but are not certified before the Dept of Insurance as Experienced Bill Review experts. WCJ are not trained to be experts in Bill Review.

Lien claimants rely upon the ignorance of the other party to make allegations that are unsupported and inapplicable to force settlement of more money on a bill that was paid either per fee schedule or contract.

Any dispute over the bill review process should be pulled from the WCAB and sent to a Bill Review Expert recognized and appointed by the DWC to deal with these issues and free up the WCAB. It would also insure that false claims and frivolous accusation and litigation would not be involved.

PHOTOCOPY SERVICES/BILLS:

20. There is a need for a Fee Schedule controlling Photocopy Services:

Comment:

It has become increasingly difficult to compare one photocopy service to another as each service bills one way, charges for some items, does not charge for other, and creates a billing system that is difficult to analyze due to the description and varied charges. This makes the industry ripe for abuse and fraud.

Discussion:

A Fee Schedule that applies to all photocopy services that would standardize what terms are, what charges are allowed, when these charges are allowed and what is reasonable for the various services would remove the obligation to answer these questions via litigation before the WCAB.

21. There Is A Need For Administrative Rules That Clearly Define The Scenarios Where An Applicant Attorney Or Other Party Can Obtain Records And Bill The Employer/Carrier For The Services:

Comment:

Currently there is only Labor Code 4620 that authorizes an employee to obtain medical records at the employer's expense. Discovery is too vague a concept and needs clarification to limit and identify the fraud and abuse in the system.

Discussion:

As noted above, Labor Code 4620 is the only Labor Code that specifically authorizes the employee or Applicant Attorney to obtain medical records at the employer's expense. However, the criteria for Medical Legal Expense must be met. This means the employer knows of the injury. The DWC-1 form has been returned to the employer, the claim has been contested, and it has been contested based upon a medical issue.

Per case laws, where an Applicant Attorney desires records, the request is made to the employer or carrier. If the employer/carrier does not provide the requested records, a Petition to Compel is filed with the WCAB. The matter is now adjudicated to see if the attorney is entitled to these records. If so, an Order to Compel is issued. If the employer/carrier does not comply, then a motion is made to bar these records from being submitted as evidence. There does not appear to be any legal authority that permits the Applicant Attorney to obtain the records and send the bill to the employer/carrier; but this seems to be a practice that has grown up and permitted in the industry. It is also a source of abuse, liens, possible fraud and frivolous litigation.

Leaving the process whereby records are obtained as a vague process without clear guidelines encourages this continued practice. Administrative Rules could create a process that outlines the proper procedures, obligations and time frames which would expose and shut down the areas of abuse in the industry.

DURABLE MEDICAL EQUIPMENT AND PRESCRIPTIONS:

22. There is A Need For A Clear Procedure In Requesting Authorization And Dispensing DME and Prescriptions:

Comment:

We are seeing a lot of abuse and fraud centering on dispensing of durable medical supplies and prescriptions. There is a need to establish a clearly defined procedure for the entire industry.

Discussion:

The proposed procedure would be that the request for authorization for DME and prescription should come through the treating physician to the employer/carrier. Those providing the DME and medication should never be the one seeking the authorization as this creates the potential of a conflict of interest. These requests should be made in the same manner and format as a utilization request: 1) Doctor's First Report, 2) PR-2 or; 3) a narrative report which clearly state it is a request for treatment authorization written across the top of the first page.

These requests should be processed through utilization review and if authorized should be provided by the employer/carriers-selected vendors. Physicians should bear the same burden of proof regarding the medical necessity. Per Administrative Rule 9785 the physician must specify the kind of prescription/DME rather than making a vague suggestion. The physician bears the obligation to monitor the effectiveness of the prescription/DME with each office visit and to make the determination what results are expected and when they have been achieved.

The Razor/Razor Blade scam where just because a DME has been issued there is a need to send supplies every month needs to be shut down. If there is a need for supplies for the DME, the employee should make the request to the employer/carrier who will contact the authorized provider and have the needed supplies issued.

Prescriptions should not be issued from the physician's office as this removes the necessary third party, i.e. the pharmacist, who can verify that the generic or name-brand drug was issued, the strength, the quantity and that the packaging and instructions comply with the Pharmacy Law of California. If there is an emergency need because the pharmacy is unable to fill the prescription, then the physician should be required to contact the employer/carrier for permission to dispense directly, but these should be rare exceptions.

When filling prescriptions – where medicines, DME or other – there needs to be a clearly established procedure with instructions as to what documentation and authorization is needed before the prescription is filled.

Those vendors who chose to ignore these procedures should be barred from seeking to collect from the employer or employee for the costs of the prescriptions filled without following proper procedures. These should be viewed by the court in the same light as free samples given to the patients.

When dealing with DME, the rental or bills can never exceed the cost of the unit. The employer/carrier should be allowed to present documentation as to what the DME would have cost through it vendor to establish the presumption of the actual cost of the DME. Barring an approved vendor, copies of web site selling comparable DME should be accepted.

LIEN REPS:

23. There Is A Need To Certify Or License A Lien Rep Who Works In The Workers' Compensation System:

Comment:

There is a need to raise the quality of those litigating before the WCAB to ensure the resources of the WCAB are not wasted on frivolous litigation.

Discussion:

Attorneys must be licensed and pass the bar. Claims Adjusters must pass the State's Self-Insurance Test and be certified by the Department of Insurance. Those who are working in the Work Comp Industry must demonstrate some level of competency to be allowed to work in the industry. The exception to this is the lien rep. There is not certification. There is no established education or training requirement. There is no state test to prove competency. As such, there is no established method of addressing fraud and abuse of the system short of litigating to bar the person from practicing before the WCAB. By establishing some form of licensing or certification through some agency; the WCAB could address those abusing the system to the agency for disciplinary action rather than tying up the resources of the WCAB.

LIENS:

A separate paper was submitted to the Administrative Director during the open comment period for revision of the Lien Regulations. We ask the Administrative Director to take note of those comments rather than repeating them all here. Two additional comments do need to be made.

24. The Administrative Director Needs To Establish The Value Of Liens That Have Been Sold

Comment:

There are scenarios where a vendor sells its outstanding liens to a third party. Those who purchase the liens misrepresent the value of the liens before the WCAB.

Discussion:

The true value of the lien is what the vendor who performed the services is willing to take for resolution of the lien. When a third party vendor purchases an accounts receivable, the cost the third party paid for the accounts is the true value of the lien.

Administrative Rules need to be created that govern this practice in the industry. The third party that purchased the accounts must disclose the purchase and be barred from representing that they were hired or that they are the original vendor.

Those who are being asked to pay for these bills should have the right to see the actual amounts paid and the agreements between those who have purchased the account or who are collecting for the account.

25. The Needs To Be A Procedure Where An Employer Can File On Behalf Of A Vendor

Comment:

An area of abuse is that many vendors and/or collector intentionally refuse to file their lien and thereby avoid the jurisdiction of the WCAB. A procedure is needed to protect employers from this practice.

Discussion:

Certain vendors/collectors seek to "fly below the radar" and not be drawn into lien conference or lien trials. This way the WCAB has no jurisdiction over their bills. These vendors/collectors keep calling for years seeking to collect. Because they were not a lien claimant of record, no notice of settlement was ever provided. Many employers do not know who these vendors are until years after the case was settled and closed this vendor comes back and seeks to file long after the Statute of Limitation should have run. However, because the vendor was unidentified, no notice of settlement [or in many cases there was not settlement] was sent to the vendor and so the six month Statute of Limitation does not run.

There is precedent with one party filing an Application on behalf of another before the WCAB. Family members can file for a relative. An Attorney can file for a client. Lien claimants can file for employees. Therefore, it just seems reasonable that an employer should be allowed to file a lien on behalf of vendors who refuse to do so. These need to be brought before the WCAB for resolution. Labor Code 4905 gives the WCAB the authority to file a lien for a vendor if the WCJ feels the party should have filed a lien but did not. Why can't this option be created by Administrative Rules for the employer/carrier?

There should also be a presumption that an EOB/EOR that reduces the amount requested by the physician is the same as an objection, and the vendor is on notice there is a dispute. If the vendor does not file his/her within six months of the EOB/EOR, then it should be presumed the vendor is accepting the proposed amount and waiving its right to litigate the issue.

LITIGATION OF NON-MEDICAL ISSUES:

26. The Administrative Director Needs To Clarify The Right/Need For Medical Evaluations On Legal Issues:

Comment:

In Southern California there is the practice that if a case is denied based upon a medical issue, the parties are pressured to obtain medical evaluations prior to trial. This practice contradicts

Labor Code 4620 (c) which mandates that before an employee is entitled to a medical legal expense, the case must be contested based upon a medical issue which the evaluation can prove or disprove. Legal issues cannot be proven or disprove by medical evaluation. It clouds the issues and creates unnecessary expense for the parties.

Discussion:

There needs to create a separate hearing process similar to an expedited hearing at the WCAB where the only issue to be resolved is a legal issue barring benefits. As such no medical evaluation is needed to litigate this single issue. Such a hearing classification would prevent a WCJ from pressuring parties to obtain unnecessary medical evaluation on a claim.

If the WCAB finds the legal issue bars the claim, then the parties have been spared the costs of medical evaluations, and the WCAB has been spared the tedious litigation process of litigating liens for treatment and inadmissible medical evaluations. It also protects physicians from providing evaluations and treatment; and then not get paid.

There should be an Administrative Rule noting that once such a hearing is held and the employee is found to be entitled to benefits, the employer has fourteen days to provide the treatment or the employee is then free to self-procure treatment until such time as the employer fulfills its obligation to provide treatment.

THE AUDIT APPEAL PROCESS:

27. The Audit Appeal Process Needs To Be Made Fair For All Parties:

Comment:

The current Appeal Process places a disproportionate burden on the party being audited. In some cases this burden results in the party being audited being denied their due process to appeal.

Discussion:

The DWC employs full-time, trained auditors. Their only job is to audit files and prepare documents. They are familiar with all the fine point of the audit, the fines and the penalties. They are also trained in the appeal process. In short, the DWC employs full-time trained professionals to conduct the audit and bring the results against the party being audited.

The Audit Unit comes into an operation with multiple professional auditors and spends two or three months reviewing files and documents. They leave, and spend another two or three months preparing their case against the audited party.

The audit results are served on the party and the audited party has seven days to decide if they are going to appeal or not. If the document which is not clearly identified in the audit package is not sent in that time, the party loses their right to appeal the audit.

Should the party find the required form and send it in within the required time, the audited party then has only a few weeks to review the audit, research the Regulations and Labor Code involved, educate themselves on the audit process and appeal system, go through the same files and document the audit unit spent two or three months going through and then prepare copy and serve the appeal.

The time frames and procedure for the audit are designed to deny the audited party their due process and to place an unrealistic burden on that party if they wish to appeal. The party audited is not working full time to audit files. It not trained in the fine points of the audits, the regulations and Labor Codes being raised. The party seeking to appeal must still handle the claim files and legal obligation of the claims operation and then pull staff from their regular duties, train them and prepare a response. Where the auditors had several months to prepare the case against the audited party; the audited party is limited to only a few weeks to review the allegation, research the issues, go through files and document their appeal; while still maintaining a claim operation.

The procedures and Regulations need to be revised to make the burden of the audit party fair and workable for all involved.

Respectfully submitted;

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