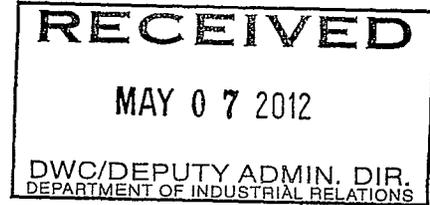


**COPIES OF MAILED
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COMMENTS
OF THE 2012
WORKERS' COMPENSATION
FORUM**

PART 4

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

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



Friday, April 27, 2012

VIA FIRST CLASS MAIL and e-mail

5354-2



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

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

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

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

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I. WHO WE REPRESENT

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

II. OUR CLIENT'S CONTRIBUTION TO THE CALIFORNIA ECONOMY

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

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

III. COSTS OF WORKERS' COMPENSATION CREATED FOR CALIFORNIA EMPLOYERS

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

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

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

b. 2004 Legislation

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

c. Assimilation of Economic Downturn and Drop in Insurance Premiums



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

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

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

d. 2005-2011 Rising Costs to Employers

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

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

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

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

e. Governor Browns' Administration attempts to bridge the gap

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

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

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

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

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

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

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

IV. FIXING THE SYSTEM

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

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

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

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

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

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

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

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

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



c. Adequate compensation for permanent disabilities.

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

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

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

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

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

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

d. Reducing the burden of liens on the system.

i. Consider expanded *Gregory* Formula Regulations

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

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

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

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

The report continues:

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

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Among the Commission's findings:

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

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

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

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

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

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

e. Any other improvements needed

i. Incongruous Judicial Opinions- EAMS Access expansion

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

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

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

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

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

We wish you the best in your endeavors.

Respectfully,

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5/2/12

Hello my name's _____

① I'm here before you to bring my on going 30 yrs work injury with PG+E. My medical care was just fine until Lying ARNOLD decided to flex his strength in politics and caused a disaster with my claim with prolong care between Rehab West. I ~~say~~ dismist this QUALIFIED, MEDICAL ELEVATION REGULATION the same way MARIA SHOWER HAVE ALLEVIATED his leadership.

② My W.C. case is unusual that need to be redress with ALL DONE RESPECT.

THE WHITE HOUSE

WASHINGTON

1994
August 16, 1994

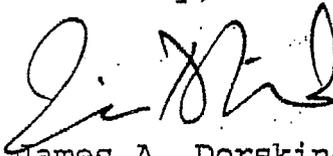
Dear Ms.

Thank you so much for your letter. President Clinton greatly appreciates the trust and confidence you have shown in him by writing.

To ensure that your concerns are addressed, I am forwarding your letter to the Department of Labor for review and any appropriate action. Please bear in mind that it may take some time to look thoroughly into the issues you have raised. Should you wish to contact the Department of Labor directly, you may write to: Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Many thanks for your patience.

Sincerely,



James A. Dorskind
Acting Director of Correspondence
and Presidential Messages

The logo for the State Fund, featuring the words "STATE" and "FUND" in a bold, sans-serif font, with "STATE" above "FUND". The text is white on a black rectangular background.

May 2, 2012

Christine Baker, Director
Department of Industrial Relations
Office of the Director
1515 Clay Street, 17th Floor
Oakland, CA 94612-1402

Sent via facsimile to: 510-622-3265

Re: **DWC Public Forum**
Written Statement of State Compensation Insurance Fund

Director Baker:

State Fund stands ready and eager to partner with employers and labor to make meaningful reforms. Three primary areas are in critical need of reform so that the WC system can support a fairly priced product for employers. Those areas are: Permanent Disability, Medical Management, and Liens. The outcome of any reform should re-direct the focus in our system to benefit injured workers and employers. All injured workers need a permanent disability rating schedule that provides reasonable compensation and ensures fairness, consistency, and predictability. Cost savings achieved by reducing/eliminating waste and inefficiency can be redirected to enhance disability benefits and focus more on high-quality medical care and functional recovery. Substantial savings can be achieved by reducing those system costs that add complexity but not value for the injured worker. The interests of injured workers, employers, and the economy are best served by making changes that place the primary emphasis on injured workers' functional recovery, speedy return to work, and return to independence.

A more effective workers' compensation system will be achieved by ending inflated medical billing practices, reigning in a lien system wildly out of control, eliminating the bloated costs of protracted litigation, and ending variable outcomes that create uncertainty in the system.

Reform Permanent Disability Rating System

The permanent disability rating system should be reformed to provide fair, consistent, and predictable results and reduce or eliminate runaway litigation costs. Permanent Disability results and litigation costs vary widely for the same or similar injuries. Many variable factors unrelated to the injured worker's condition and ability to return-to-work can influence disability ratings, such as the doctor's philosophy, the skill of a witness, whether or not the injured worker has an attorney, and the involved parties' willingness to engage in protracted discovery and litigation.

This situation exists because the *Almaraz/Guzman* and *Ogilvie* decisions made the burden of proof to rebut the PD Rating Schedule unclear. If the legislature unequivocally defined the burden of proof for determining PD and impairment, it would reduce or eliminate variable outcomes and reduce system costs associated with litigation and delays. By spending less

money on attorneys, medical evaluators, and vocational experts, those savings could be redirected to increase PD benefits. We estimate annual costs savings of \$684M if *Almaraz/Guzman* and *Ogilvie* were eliminated.

State Fund's data shows that litigation costs associated with *Ogilvie* resulted in a 64% increase in payments to vocational experts after the Appeals Board's *Ogilvie II* decision. This 64% increase is a conservative figure because it does not include vocational experts' charges in cases that are currently litigated. Moreover, there are the additional costs such as attorney fees incurred in connection with protracted litigation over rebuttal of the scheduled rating. In its white paper, the California Applicants' Attorneys Association (CAAA) cites a "50% jump in defense attorney fees paid by insurers after 2004." The most effective way to reduce litigation would be to eliminate *Almaraz/Guzman* and *Ogilvie*.

Some stakeholders believe that *Almaraz/Guzman* and *Ogilvie* provide needed flexibility in light of a permanent disability schedule that does not adequately compensate injured workers for their injuries. Many cite a recent study by Frank Neuhauser, Executive Director of the Center for the Study of Social Insurance at UC Berkeley. Neuhauser's study concluded that overall permanent impairment decreased by 58% due to the impact of the adoption of the AMA Guides to rate permanent disability, even when adding in factors under the *Almaraz/Guzman* and *Ogilvie* cases. However, Neuhauser's methodology did not capture the impact of *Ogilvie* on PD.¹

State Fund believes that revisions to the permanent disability rating schedule coupled with the elimination of *Almaraz/Guzman* and *Ogilvie* would benefit the key stakeholders—labor and employers. Significant savings could be realized by reigning in prolonged and costly litigation and redirecting the money to increase benefit rates. The elimination of *Almaraz/Guzman* and *Ogilvie* would also provide fairness, consistency, and predictability for all injured workers. This recommendation balances the needs of injured workers by increasing benefits without raising costs for employers operating in this fragile economy.

¹ Neuhauser's study compared permanent disability (PD) claims evaluated by the DEU for the years 2003 and 2004 to claims during the period 1/1/2010 to 6/30/2011. Increases in PD due to *Ogilvie* are not captured by claims evaluated by the DEU because WCJs apply an increase under *Ogilvie* after the DEU has finalized the rating. The First District Court of Appeal in *Ogilvie* noted, "Permanent disability payments are calculated by first expressing the degree of permanent disability as a percentage and then converting that percentage into an award based on a table. Since 1937, permanent disability awards have been assessed using a schedule that was always expressly intended to manifest prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." The DEU calculates only the scheduled rating, not any increase under *Ogilvie*. Since *Ogilvie* allows the injured worker to rebut the scheduled PD rating, the WCJ increases the PD due to *Ogilvie* award over and above the DEU rating. As a result, the study's comparison of DEU ratings does not in any way capture the impact of the *Ogilvie* decision on permanent disability. The study's conclusion that, "the impact of the PDRS-05, the change in apportionment, and the case law involving *Almaraz, Guzman, and Ogilvie* was to reduce overall PD compensation by 58%" is not accurate. The reduction in PD is less than if *Ogilvie* had been taken into account in Neuhauser's study.

Simplify rules for Medical Provide Networks (MPN)

Enacting simpler rules for Medical Provider Networks (MPN) will increase their use and benefit both injured employees and employers in California. Injured employees receiving treatment through an MPN benefit from greater functional recovery and a quicker return to the workplace. For employers, providing treatment through a MPN reduces their medical costs and speeds valued employees' return to work.

State Fund promotes medical treatment that emphasizes functional recovery. By identifying risk factors early and providing appropriate care, injured employees can be quickly returned to functional recovery and independence. But there are obstacles that stand in our way that can be addressed to improve outcomes for injured employees.

A superior MPN that ensures timely, high-quality, and appropriate medical care is critical to producing superior outcomes for injured employees. CWCI studies have repeatedly shown that injured employees treated in an MPN return to work sooner, have less permanent disability, and require less litigation to resolve their claims.

MPN providers should provide medical treatment that is consistent with Medical Treatment Utilization Schedule (MTUS) guidelines. Additionally, when a physician provides treatment that is not addressed by MTUS, he/she must utilize nationally recognized peer-reviewed treatment guidelines or evidence-based medicine. By requiring MPN physicians to adhere to such rigorous standards, superior patient outcomes can be achieved.

Another important expectation is that MPN providers integrate disability management principles into the care of injured employees. Providers should not only be asked to address specific treatment modalities, but also to incorporate functional recovery goals as part of the treatment plan to achieve superior outcomes for injured workers. This includes knowledge and understanding of proactive return to work philosophies, including the use of the Official Disability Guidelines as a guide for return to work efforts.

The DIR and DWC can increase the number of injured workers treating within MPNs by simplifying the current MPN regulations. Despite the demonstrated success of the MPN in returning injured workers to independence, many still treat outside the MPN due to loopholes or procedural issues, like failure of an employer to post adequate notice. Currently the process to move an injured employee into the MPN after an employer notice violation is lengthy and cumbersome as referenced in CCR section 9767.9 (Transfer of On-going Care into the MPN). State Fund recommends that this process be streamlined to encourage expedited channeling into MPNs.

According to the California Workers' Compensation Institute (CWCI), medical care provided within MPNs costs 25% less than medical care provided outside MPNs. We estimate that simplified MPN regulations could save approximately \$8.7M for every 1% increase in MPN participation.

Support Streamlined Utilization Review Process to Ensure Appropriate Medical Care

The Utilization Review (UR) process is cumbersome for all parties involved and leads to delays in medical treatment. Implementing rules that streamline the UR process will speed the delivery of appropriate treatment, which will promote functional recovery and the return to

work. Additionally, through increased support for prior authorization programs within the UR process, commonly approved medical treatment can be provided without unnecessary delay.

Utilization Review was founded on the principle that appropriate medical care for a work-related injury or illness improves medical outcomes while containing costs. Quality medical care for injured employees is enhanced through education and timely communication between the payer and the medical provider. UR ensures that medical care is consistent with evidence-based practice and meets current peer-reviewed medical standards and guidelines. Additionally, it allows the payer and the medical provider to collaborate on the optimal treatment plan for an injured worker. Done right, UR achieves these goals and plays a critical role in ensuring proper medical care is provided as indicated.

By taking steps to streamline the UR process, the DIR and DWC can help to lower UR costs system-wide by encouraging greater efficiencies in the system.

Reduce Costs and Drug Dependency through Pharmacy Benefit Networks (PBN)

Most stakeholders in the WC system share concern about the alarming growth in the use of narcotics to treat industrial injuries. Promoting the use of Pharmacy Benefit Networks (PBN) will enhance claims administrators' ability to manage pharmaceutical utilization. A PBN can create a monthly report that identifies narcotics that are prescribed at high dosages and/or for prolonged periods. Rather than go through traditional UR, in a PBN model, a specialty-matched physician case manager reviews the case and sets an appointment to discuss options with the treating physician. The PBN manager may recommend other treatment modalities, including alternate medications and cognitive therapy. The outcomes of that mentoring session can then be tracked by the PBN and claims administrator.

Given the current issues surrounding the use of narcotics in the workers compensation industry, State Fund recommends that the DIR and DWC encourage appropriate pharmaceutical management by claims administrators, including the use of early identification processes and Urinary Drug Testing (UDT). By partnering with physicians, claims administrators can develop screening questionnaires to be given to patients before any narcotic medications are prescribed in order to identify potential problems. Implementing automatic triggers and specific parameters for UDT, such as narcotic treatment that extends for 90 days or more, can improve proactive treatment management. Under the ACOEM Guidelines, UDT should be started after 90 days of opioid utilization, with repeat screening up to 2-4 times per year and for cause. This testing needs to be performed in laboratories with specific certifications such as SAMHSA (Substance Abuse & Mental Health Services Administration) and DOT (Department of Transportation) with accreditation by the College of American Pathologists.

Emphasis must be placed on early intervention by sending physicians advice letters regarding the appropriate use of narcotics after the first fill of a long-acting opioid. Through proactive pharmaceutical management and a strong relationship with MPN physicians, claims administrators can help achieve superior outcomes for injured workers and policyholders.

State Fund also urges the DWC to enact reasonable Pharmacy Benefit Network regulations to aid insurers in establishing PBNs. A PBN saves on average 25% over non-PBN pharmacies. The drugs are the same but the prices vary widely. We estimate that widespread adoption of PBNs may save the workers' compensation industry \$167M annually.

Reduce the Burden of Liens on the System

Liens are over-burdening the workers' compensation system, placing great demands on resources and more importantly, increasing the costs for employers while often delivering no additional benefit to injured workers. Meaningful change is urgently needed to stop the waste and ensure the system continues to serve its key stakeholders – employers and their employees who are injured. The following measures would eliminate wasteful spending and streamline medical payment issues.

Statute of Limitations: The legislature should enact an effective Statute of Limitations to bar stale lien claims. We estimate that \$5.7M or more could be saved annually in Loss Adjustment Expenses alone resulting from a true Statute of Limitations.

Reinstate Lien Filing Fee: The DWC should reinstate the lien filing fee as recommended by California Health & Safety Welfare Commission (CHSWC). The last time a filing fee was in place the WCAB had no process to collect the money and no method of notifying the WCJ that the payment had been made according to CHSWC. A solution would be for the DWC to contract with a third party on-line payment service. Such a reform could result in savings by significantly reducing or eliminating frivolous liens. We estimate an annual savings of \$400M using the figures identified in the CHSWC report on liens. This could also create revenue of \$22.5 million which could be used to fund a Billing Dispute Resolution program.

DWC Billing Dispute Resolution Body: Establish a Billing Dispute Resolution Arm of the DWC for medical bills. This would allow arbitrators with medical billing expertise to evaluate the merits of the specific issues. Currently, judges frequently send issues to independent bill reviewers, which can drag the resolution out for months. Not only would this free up Workers' Comp judges to focus on issues involving injured workers, it would reduce the number of continuances currently clogging the court's calendar. We estimate that this could save the DWC \$7.2M. It would also provide some oversight over medical pricing issues and establish a framework for consistency statewide.

DWC Medical Treatment Dispute Body: Establish a Medical Dispute Resolution Arm of the DWC for medical treatment disputes. Staffed with medical personnel, this process would enable those with medical expertise to make speedy decisions that foster optimal medical care and outcomes. We estimate cost savings in the range of \$300M or more. From this savings, one must net out the cost of establishing the new division within the DWC. CWCI has already argued for a variation of this approach.

Identification and Implementation of appropriate Fee Schedules

There is an urgent need for fee schedules in the following areas:

- o Attendant Care
- o Interpreters
- o Copy Service
- o Transportation

Attendant Care: Provision for attendant care (i.e. home health care, home infusion, etc.) has become more commonplace within the workers compensation system. As hospitals seek to control costs by discharging patients quickly from acute beds to step down care, we have

seen an increase in reimbursement issues surrounding attendant care. An added complication in this area has been the increase in injured employee family members seeking reimbursement for attendant care services. Establishing a reasonable reimbursement rate for these situations has been problematic in the absence of a fee schedule for these services.

In 2004 the Official Medical Fee Schedule was updated to include many services which were not previously covered. Included in this update was a placeholder for Home Health Services in CCR section 9789.90. To date, however, a fee schedule for these services has not yet been adopted. Without consistent billing rates, there has been an increase in the number of billing disputes and liens for home health services. Adoption of a reasonable fee schedule for attendant care, home health care, and home infusion services will benefit all parties through less litigation to obtain the services, consistent reimbursement, and the reduction or elimination of billing disputes and liens.

Interpreters: CCR 9795.3(b)(1) states in relevant part:

Interpreter fees shall be billed and paid at the greater of the following (i) at the rate for one-half day or one full day as set forth in the Superior Court fee schedule for interpreters in the county where the service was provided, or (ii) at the market rate. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.

This regulation does not provide any clear guidance as to what documentation is required to establish market rate. Due to the lack of clarity, the use of market rates has resulted in widely variable and sometimes exorbitant rates for the same or similar services. Providers who do not have an established a market rate are usually reimbursed at \$45 per hour for a 2 hour minimum (for Spanish interpreters). However, for interpreters who have an established market rate, the hourly rate can vary from just above \$45 per hour to well over \$100 per hour. Eliminating the market rate and establishing a reasonable fee schedule will produce significant savings, provide consistent reimbursement amounts, and eliminate the population of interpreter disputes resulting in liens.

The DIR and DWC can establish specific guidelines as to when the use of an interpreter is necessary during the course of medical treatment. Through this type of guidance, all stakeholders involved would have understanding of appropriate settings for interpreter use, resulting in fewer interpreter billing disputes.

Copy Services: There are no official fee schedule provisions governing reimbursement for subpoena and copy-service charges. State Fund often receives highly inflated billings from copy services, such as per-page charges that range to up to 65 cents per page for simple, black and white, 8 1/2 by 11-inch copies. The Evidence Code provides definitions of reasonable costs for custodians of medical records and business records. If the record custodian were to copy the records and deliver them to the plaintiff's attorney, he/she would be allowed to charge 10 cents per page for standard reproduction of documents that are 8 1/2 by 14 inches or less. In addition, the record custodian is allowed to charge for reasonable clerical costs incurred in locating and making the records available. The allowable clerical costs charge per person is \$16 per hour for medical records and \$24 per hour for business records.

Evidence Code § 1158 regarding medical records provides in relevant part:

"Reasonable cost," as used in this section, shall include, but not be limited to, the following specific costs: ten cents (\$0.10) per page for standard reproduction of documents of a size 8 1/2 by 14 inches or less; twenty cents (\$0.20) per page for copying of documents from microfilm; actual costs for the reproduction of oversize documents or the reproduction of documents requiring special processing which are made in response to an authorization; reasonable clerical costs incurred in locating and making the records available to be billed at the maximum rate of sixteen dollars (\$16) per hour per person, computed on the basis of four dollars (\$4) per quarter hour or fraction thereof; actual postage charges; and actual costs, if any, charged to the witness by a third person for the retrieval and return of records held by that third person.

Evidence Code § 1563, regarding business records, provides in relevant part:

"Reasonable cost," as used in this section, shall include, but not be limited to, the following specific costs: ten cents (\$0.10) per page for standard reproduction of documents of a size 8 1/2 by 14 inches or less; twenty cents (\$0.20) per page for copying of documents from microfilm; actual costs for the reproduction of oversize documents or the reproduction of documents requiring special processing which are made in response to a subpoena; reasonable clerical costs incurred in locating and making the records available to be billed at the maximum rate of twenty-four dollars (\$24) per hour per person, computed on the basis of six dollars (\$6) per quarter hour or fraction thereof; actual postage charges; and the actual cost, if any, charged to the witness by a third person for the retrieval and return of records held offsite by that third person."

While the above Evidence Code sections do not apply to copy services in workers' compensation cases, they provide some insight into what the legislature found to be reasonable reimbursement for copying and clerical costs. At the present time, billed charges for similar or the same services submitted by different copy service providers can vary greatly. For basic copy services, the rate can be as low as \$47 and as high as \$207. Additionally, the rate charged for copying each page can range from 10 to 65 cents. As a result of these widely varied rates and extra charges, there are a high number of billing disputes and liens from copy service providers. Copy service liens and reimbursement issues could be significantly reduced or eliminated by the establishment of a reasonable fee schedule, resulting in a significant reduction in costs and litigation.

Transportation: In the workers compensation system medical transportation reimbursement is covered under LC 4600 (e) 2. This section provides reimbursement at a per mile rate for the injured employee who uses their own transportation. However, when transportation is being provided by a non-emergency transportation service provider, there is no fee schedule. Therefore, there is no consistent rate in which these services are reimbursed or rules defining what sort of transportation is considered reasonable. This has resulted in an increase in the number of reimbursement disputes for transportation. Through the adoption of a reasonable fee schedule for these services, there will be more consistency in reimbursement rates and the elimination of billing disputes.

Yearly Revision of Fee Schedules

The DWC should revise medical fee schedules yearly to reduce costs caused by outdated rates and will result in more accurate billing and fewer adjustment factors. It has been four years since the main components of the OMFS have been updated. State Fund estimates that a savings of \$146M could result from up-to-date medical fee schedules.

Conclusion

The time has come for substantial and balanced reform. Over the core issues, we are all in agreement - benefits should increase for injured workers and rates should not increase as a result.

The yearly cost savings in these proposals are the estimates of State Fund's Chief Risk Officer and actuary. These changes could trim costs by almost \$1.5B. These significant savings could be used to benefit both injured workers and employers

As administrators, providers and insurers, we are bound to uphold the constitutional mandate: to accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character. Meaningful reforms will provide substantial justice to injured workers and employers—the two key stakeholders in the workers' compensation system.

Thank you for providing us with the opportunity to submit these comments. State Fund applauds the DWC and is grateful for the DWC's commitment to encourage participation by all interested individuals and stakeholders.

Sincerely yours,

Beatriz Sanchez

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Executive Vice President for Claims



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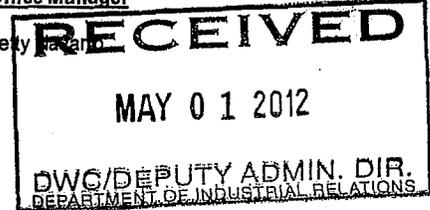
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April 20, 2012

Christine Baker, Director
Department of Industrial Relations

Rosa Moran, Administrative Director,
Division of Workers' Compensation

Dear Directors Baker and Moran:

On behalf of California injured and disabled workers, the California Applicant's Attorneys Association, and myself, would like to personally thank you and your staff for conducting the listening tour. Knowing how busy you both are, making such a time consuming commitment tells us a lot about your character and dedication to improve the workers' compensation system in California.

On April 16, 2012, at the Los Angeles Forum, we heard from concerned Californians representing both sides of the pendulum. One employer insurer expressed concern that sexual dysfunction, sleep and psyche are on every claim. We know this is not the case, but must recognize the fact that the AMA Guides mandate the physicians to address the whole person. The Guides instruct the physicians to address functional loss and how the residual effects of the work injury impacts the activities of daily living.

As applicant attorneys, our first priority is to get the injured worker proper and expeditious medical care, then, to return the injured worker to this company as soon as possible. Unfortunately, the workers' compensation system does not allow us to accomplish this. Either the employer/insurer takes medical control through their MPN and provides inadequate medical care, or they instruct their doctors to address only those body parts accepted by the company, or they delay and ultimately deny the claim without providing any medical care at all. Before the establishment of MPNs, the injured worker could choose his/her treating physician 30 days after notice of injury (or before, if care was not provided). With MPN's, we potentially lose medical control from day one.

Our duties as applicant attorneys are to address every legitimate physical and/or psychological complaint our clients experience. We are lawyers, not physicians. It is the physician's duty and obligation to address the whole person per ACOEM, the MTUS and the AMA Guides, to determine if the complaints are legitimate, to address causation, to address impairment, and to address apportionment.

On April 16, 2012, I expressed my concern over the erosion of WC benefits to injured workers these past 10 years. We do not take this concern lightly, and have fought diligently in the courts to get some of these benefits restored. Unfortunately, many of these benefits were taken away by statute and cannot be restored by the courts.

We need the help of this administration to restore these benefits. To increase permanent disability to a level that enables an injured worker and their families to survive and have their dignity and self-esteem restored.

I remain at your service to help this administration and its directors accomplish their promise to increase permanent disability and insure that proper medical care and treatment is provided to all injured and disabled workers.

Thank you again for your time, commitment, and attention.

Respectfully submitted,

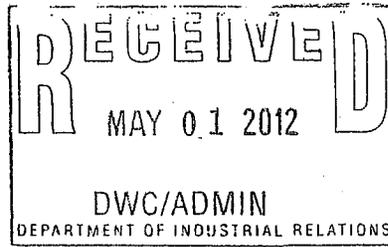


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Osteopathic Physicians & Surgeons of California
Comments on workers' compensation
April 2012

1. Official Medical Fee Schedule

- a. The current OMFS is not equitable. A more appropriate fee structure should be considered
- b. An RBRVS system better reflects the value of the treatment provided
- c. OPSC is not recommending any specific conversion factors but supporting the concept of transitioning to RBRVS as a replacement for current OMFS
- d. The basis of our support and recommendation is from the Lewin Study conducted in the mid 1990's which recommended use of an RBRVS system

2. Utilization Review

- a. Recommend that UR in general needs to be re-evaluated to determine its effectiveness in helping to deliver quality, efficient, and cost effective care for injured workers
- b. Measurable, achievable metrics should be developed and required of UR companies
- c. Differing guidelines cause confusion
- d. Guidelines were intended for clinician guidance, not UR especially when UR physician does not always have a full clinical picture
- e. Consider waiving use of UR when a physician or medical group has demonstrated positive outcomes as good or better than those seen under guidelines
- f. Treating physician must be allowed sufficient time to respond before UR deadline
- g. UR vendor to provide flexible/extended hours AND offer scheduled peer to peer calls at the treater's request

3. Opioids

- a. Opioid use is excessive
- b. Encourage alternative treatment options which are documented to reduce pain such as osteopathic manipulation
- c. Consider establishing benchmarks for patient function

4/30/12
Submitted

4/30/2012



CALIFORNIA CHIROPRACTIC ASSOCIATION

April 2, 2012

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

Dear Ms. Baker:

On behalf of the California Chiropractic Association (CCA), we would like to thank you for the opportunity to comment on the state of California's workers' compensation system. We are looking forward to working with the Department of Industrial Relations (DIR), the Division of Workers' Compensation (DWC) and other stakeholders to ensure patients will have timely access to high quality care while containing costs.

CCA respectfully offers the following comments:

Utilization Review:

CCA supports reducing utilization review (UR) and prior-authorization requirements. The UR process causes major delays in obtaining necessary care while UR is being conducted and initial determinations are reviewed. Insurance claims adjusters should be able to approve simple/minor cases.

- UR for treatment under the 24 visits is unnecessary. In most of these cases, after going through the entire UR process, judges approve the treatment. Thus, the UR process is burdensome and a waste of monies.
- Additionally, allowing out-of-state physicians to perform UR for the California workers' compensation system has proven to be problematic. One of the primary complaints CCA receives from doctors of chiropractic regarding UR is denial based on incorrect interpretation of California workers' compensation law. CCA recommends that all physicians performing workers' compensation utilization review possess a California license.
- UR physicians are not taking the time to invest the additional effort to make a fully informed and appropriate coverage decision for each patient. Instead, UR physicians

tend to make decisions based on a one size fits all approach of all services by strictly adhering to the MTUS guidelines.

- Many claims adjusters/carriers will only forward the PR-2 to the UR reviewer regardless of the complexity of the case or the existence of prior records that were mailed with the PR-2, which might include AME or QME recommendations for care. In those instances where the case has been sent to a UR physician, the relevant medical records are almost never sent.

The requesting physician is then expected to immediately forward all the medical records to the reviewer. This inefficient situation increases costs to everyone in the system and puts at risk the injured worker's eligibility for treatment.

Carriers should be required to forward the relevant medical records to UR within the specified time period. It is unfair to unilaterally burden the provider and potentially jeopardize the injured worker's care due to the expensive inefficiency of the carrier and UR.

Medical Provider Network:

More needs to be done to ensure that high-performing doctors have the opportunity to serve on panels. Existing law allows for employers to have total control over which providers can serve on MPNs. Many panels are closed to additional doctors of chiropractic, even if the doctors listed on the MPN do not accept workers' compensation patients.

- There must be a reasonable policy for adding members to MPNs. Certain panels are not accepting Qualified Medical Evaluators (QMEs) even when not full. All state qualified QMEs who elect to join any and all MPNs should be allowed to do so.
- Currently, carriers can unilaterally terminate providers from networks with no warning, explanation, recourse or due process. We believe that employers and insurers should not be relieved from the burden of proving due process was performed in the provider selection process to ensure physicians' rights are not violated.
- Networks are continuously being leased by different payers. As a result, if a doctor is not already in a network, it can be difficult if not impossible to be added to the panel. Further, multiple panels and sub-panels of various MPNs, create confusion among carriers and providers regarding which panel a provider is actually a member of. Without notification, physicians do not know which panels they are on, and in many cases, these physicians do not treat workers' compensation patients. This creates problems and delays care for patients. Physicians must have knowledge of the workers' compensation and accept workers' compensation patients in order to serve on panels.
- Plans deduct a certain percentage from treatment costs by claiming these funds support efforts to credential and recredential physicians. CCA recommends eliminating the PPO discounts from a physician's billing and instead charge a fee of no more than \$125.00 to credential and recredential every three years.
- Medical cost-containment expenses should be reported by category of cost. Currently, it is very difficult to determine the reasons for the increases in medical cost-containment expenses. We believe it is extremely important for carriers to disclose all costs. Those costs should also include monies deducted from providers as the "PPO" discount or MPN discount and the total of those dollars.

- Additionally, to be included in any MPN, providers should not be required to be part of any outside organization that will require a discount. For example, to be part of the State Fund MPN, doctors of chiropractic will have to be part of ASHP and a discounted rate structure is imposed. This requirement circumvents the fee schedule by requiring providers to take a discounted rate to be in the MPNs.

Liens:

CCA acknowledges the current lien system needs improvement to increase its efficiency in the processes and procedures to expedite claims. As we are discussing problems and solutions, we would like to highlight concerns that a number of our doctors has experienced with the system.

- Doctors are regularly told by adjusters and attorneys that any lien resolution issues will not be dealt with until the case-in-chief resolves. It is not uncommon for defendants to ignore medical bills for accepted injury claims and even authorized treatment bills for years until the case-in-chief finally resolves.
- Defendants commonly state at lien conferences that their clients require more time to review the bills and to request continuances, which are granted. If continuances are not granted, the case is again ordered off calendar for discovery. In most of these cases, the defendants have had the bills in their possession for years.
- The defense continuously fails to negotiate timely and settle the issues in good faith. If the defendant fails to pay uncontested amounts timely or object timely and appropriately, the Lien Answer filing should be rejected and the lien should be automatically ordered paid in full. Additionally, the defendant should be charged with penalties and interest plus the reimbursement of the lien filing fee to the lien claimant.
- Oftentimes a defendant may serve boilerplate objections timely and then later raise additional objections. This doesn't usually occur until after the case-in-chief is settled. This practice contributes to the lien problem as a whole by delaying any real effort to settle the lien until a lien hearing has been set.
- Additionally, very often lien claimants are not served with settlement documents and have no knowledge that the underlying case has been resolved.
- Current board Rule 10886 requires service of the compromise and release or stipulated award on the lien claimants of record. Yet, many defendants neglect this requirement. Defendants should face sanctions if they fail to comply with the service requirements.
- Too often, claim administrators are not forwarding to the bill review company relevant paper documentation to support the billing, resulting in a denial of billing for the provider. When providers protest, they are advised to resubmit the paper documentation to the bill review company, or file a lien. This process creates an unreasonable delay to all parties.
- Should a lien filing fee be considered, the regulation should allow the prevailing party to have their filing fees paid by the "loser." This makes both the lien claimant and defendant accountable.
- If a statute of limitations is imposed, it should be based on the date that a doctor

becomes aware that an injury is work-related, not the date of service. Doctors may not be aware on the date of service that an injury is work-related and in some cases it may take months before the doctor is made aware.

- Additionally, any statute of limitations that requires a lien claimant to activate a case within a specified period of time after the case-in-chief has settled should be invalid if the lien claimant is not served with settlement documents.

Fee Schedule:

CCA is concerned about timely access to needed care by injured workers. In that regard, while we agree that the California workers' compensation fee schedule is outdated, we strongly oppose resolving the issue through a piecemeal approach. We believe that when a new fee schedule is being considered, it is important that other critical factors such as the ground rules and conversion factors are evaluated as a whole as they all affect how healthcare providers will be reimbursed. Without doing so, it would be difficult to assess what the reimbursement rate would be.

- Under the current workers' compensation system, the reimbursement rate for healthcare providers - and especially for doctors of chiropractic - is already among the lowest in the nation, and any further reduction would almost certainly diminish access to care for injured workers. Additionally, since much of the medical care is reimbursed through MPNs which levy a fee on the provider as a "discount" any discussion of revisions to the fee schedule should include a discussion of these preferred provider discounts. Thus, any update to the OMFS must address reimbursement with rates that provide for no cuts to any fees.
- We would like to be included in any stakeholder consultation to discuss any proposed fee schedule and offer our service to assist efforts to improve this process.

Thank you in advance for your consideration of our comments. CCA looks forward to working with the DIR, DWC, and other stakeholders to discuss ways to improve the workers' compensation system to ensure patients will have timely access to quality care.

Sincerely,

Vernon Englund, DC
President

4/30/12

Oakland -

My name is

I was a Manager for [redacted] when I was injured in 2004.

Every month my co-workers and I had to unload pallets of ads.

Over time the pain in my back became overwhelming.

From the neck all the way down my spine, I felt extreme pain.

I was awarded all necessary treatment to relieve me from suffering from my work injury.

Ever since, I have had nothing but denials and delays of any requested medical care.

More recently, in December 2011, my doctor requested cortisone shot for my spine.

It was denied. We appealed it.

It has been four months and still no reply, and no injection.

A nerve study was requested for my neck

They approved a study on only 2 of the 16 nerves.

It is impossible the study must be done on all nerves.

I had to go to court to order approval for the full nerve study.

This delayed the process for a year.

Even with court approval, the insurer delays all requests by just not sending the approval letter to the doctor.

Physical therapy has been denied.

Cortisone shots have been denied.

Cortisone shots are the only relief I get for my back.

I have been to court to order the insurer to approve treatment four times just this year!

I have paid for treatment through my private insurance, because I cannot wait for the insurer to play their denial game.

I have a stack of bills that my insurance has paid.

Insurer delay and denial of their own doctors' recommended care is hurting me, and breaking the promise this state made to injured workers when we gave up our right to sue.

Stay-at-Work/Return to Work Considerations for the CA Department of Industrial Relations and CHSWC

4/30/12

The Commission on Health and Safety and Workers' Compensation (CHSWC) was established to evaluate the health, safety and workers' compensation systems and make recommendations for administrative or legislative modifications to improve the system.

Over the years, the California workers' compensation system has seen significant changes in statutory provisions pertaining to RTW practices for employees with work-related injuries/illnesses, causing functional disruption. As one example, see the Commission's recommendations pertaining to the application of Labor Code 139.48 (<https://www.dir.ca.gov/chswc/Reports/2009/ReimbursementProgramRecommendations2009.pdf>.) As another example, consider the ways in which the State of California has legislated RTW practices when an injured worker has been permanently precluded from returning to his/her usual work (e.g., the vocational rehabilitation system and the supplemental job displacement voucher) due to a work-related condition.

The Commission has authored various bulletins and other information to support more effective RTW practices. Examples of such publications include, "Helping Injured Employees Return to Work Handbook (2010)," and "Best Practices in Returning an Injured Employee to Work: Factsheet for Employers (2010)."

The California Consortium to Promote SAW/RTW (www.casawrtw.org established September 2007) requests that CHSWC consider conducting an evaluation of holistic SAW/RTW best practices in and beyond California.

- The CA Consortium (voluntary, comprised of professional, labor and business stakeholders) is an active and interested party in SAW/RTW practices, whether necessitated by functional impairments derived from work-related, or from personal (non-work-related) health conditions here in California
- Members of the Consortium believe that such a study should at minimum examine what the State of California can do both legislatively and administratively to support Stay-at-Work options once an employee has sustained a functional impairment, irrespective of its origin or medically anticipated duration, as well as to minimize the extent of any temporary work disability should time entirely away from work be medically necessary.
- The California Consortium to Promote SAW-RTW presumes the practical equivalency of the value, to an employer, of the productive engagement of its workforce to the fullest extent of each worker's capability, within positions for which individuals were hired, irrespective of the circumstances of acquiring functional impairment.

This study should consider such factors as:

- Program models that are SAW-RTW outcome-oriented, e.g., are characterized by provisions that actively deliver the earliest interventions possible, designed to support transitional and/or reasonably accommodated work to employees affected by functional work disruption (physical and or mental, in accordance with CA's FEHA) due to new or emergent functional impairments
- Systems and standardized processes, including forms and communications for documentation of time away from work, transitional work assignments and the interactive process for reasonable accommodation (e.g., evaluate whether, and how these promote or discourage productive activity during healing)
- The active presence of reasonable options to assist injured employees in remaining in or returning to work when a return to their usual (pre-functional impairment) work activities has been medically precluded (e.g., evaluate whether and how the former VR and the current supplemental job displacement voucher processes provide such reasonable options; or, what reasonable alternatives might enhance or replace ineffective processes)

Stay-at-Work/Return to Work Considerations for the CA Department of Industrial Relations and CHSWC

- To consider the State of Oregon's Employer-at-Injury Program or other similar programs around the country to determine if such approaches may be effectively adapted to benefit California employers and employees
- To consider the ways in which the Workers' Compensation Information System can be used to provide information on the financial impact of lost time, particularly in those cases where lost time is continuous and extensive (e.g., how do average claim costs escalate as days away from work mount from 7 to 30, 60, 90 days and beyond)
- To consider the extent to which the current 15% swing in permanent partial disability benefits (CA Labor Code) fundamentally influences, positively and/or negatively, SAW-RTW practices by employers
- To build an environment within the State of California through communications and policy execution that demonstrates to all stakeholders the State's strong and rationale support for SAW/RTW objectives, irrespective of the statutory framework (California Civil or Labor Codes) within which such responsibilities, financial and employment-related, are presently defined.

It is the view of Consortium members that the health and safety of employees is driven by a continuum of injury prevention and mitigation model that derives from six fundamental features. These features include:

1. A solid workplace injury and illness prevention program
2. Advocacy (e.g., State policy and program model) for individual and shared responsibilities for general health and well-being at work, in families and in communities, of working age Californians
3. An immediate and affirmative response by employers to employee complaints when they demonstrate symptoms reasonably attributable to work conditions or functions (e.g., ergonomic needs), minimizing the likelihood that a workers' compensation injury claim need be filed
4. An early intervention approach that supports keeping employees at work during healing from any disruptive functional impairment resulting from workplace injury, illness or a personal health condition (exclusions compliant with FEHA restrictions)
5. A Stay-at-Work/Return-to-Work program that meets the objectives of reducing medically unnecessary days away from work while appropriately using safe, productive engagement in the workplace to enhance healing
6. Other services that support SAW-RTW for employees, whose employers are compliant with FEHA and its rules and regulations, providing the interactive process for reasonable accommodation; and the full integration of this effort so as to meet existing opportunities and obligations under the Labor Code (accommodation as return to a permanent, modified position); as well as support for RTW through external, or out-placement when an employer is not able to accommodate an employee's compromised work abilities

Along this continuum of injury/illness prevention and mitigation, the audience for services declines. Most employees maintain safe work records but all benefit from injury/illness prevention programs. A lesser number of employees have workplace complaints (symptomatic of strains which could be mitigated before amounting to injuries.) Still fewer employees file workers' compensation claims, and so on through the continuum. We believe a serious study of effective policies and practices as suggested above could reinvigorate California's aspirations to become a "full productivity" state, and for developing a model for work disability prevention and mitigation.

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Vocational Evaluations

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PGAP (Progressive Goal
Attainment Program)

Ergonomic Evaluations

Medical Management

ADA Consultation

Expert Testimony

April 30, 2012

PUBLIC FORUM ON WORKERS' COMPENSATION

OAKLAND, CALIFORNIA

I. Introduction

My name is Dr. Eugene Van de Bittner. I am a vocational rehabilitation counselor and consultant. I have a bachelor's degree in business administration, a master's degree in vocational rehabilitation, and a doctoral degree in rehabilitation. I have worked as a rehabilitation counselor and consultant since 1974. For 30 years, I provided on-going vocational rehabilitation counseling services to clients with a work injury to assist them through the vocational rehabilitation process and back to suitable employment.

Since 1978, I have also worked as a vocational expert on workers' compensation and civil cases. As a vocational expert, I evaluate the residual employability and earning capacity for individuals with a disability.

II. Supplemental Job Displacement Benefit – Training Voucher

Labor Code 4658.5 provides injured employees a supplemental job displacement benefit, or voucher of \$4,000.00 to \$10,000.00. Up to 10% of the voucher can be used for vocational counseling.

Currently, the training voucher is not available to an injured employee until there has been an award establishing the level of permanent disability. From my experience as a rehabilitation counselor, this is far to late in the process to wait for the injured employee to receive the training voucher. I would recommend that the regulations be revised to make the training voucher available to injured employees as soon as the primary treating physician concludes that the patient will not be able to return to his or her usual occupation.

III. Schedule for Rating Permanent Disabilities

Labor Code section 4660(c) states that the *Schedule* "shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." Based on my experience as a vocational expert and having evaluated hundreds of injured employees regarding the vocational implications of permanent disability, I recommend that this provision remain in effect in any future revision of Labor Code section 4660 or the *Schedule for Rating Permanent Disabilities*. The reason for this is that I often learn through a vocational evaluation that the adjustment factor for future earning capacity in the *Schedule* does not accurately reflect the employee's actual diminished earning capacity caused by the work injury.

Thank you.

VOTERS INJURED AT WORK

Voters Injured at Work is a non-profit political organization of injured workers and their families established in 2005 for the purpose of protecting and enforcing California's constitutional guarantee of a fair and adequate system of compensating workers and their dependents for injury or disability from a work injury.

Voters Injured at Work provides a strong voice in Sacramento to help enact legislation that will rebalance the California workers' compensation system that has been "fixed" at the expense of injured workers.

The Schwarzenegger era workers' compensation "reforms" of 2004, while seemingly well intentioned to improve the system, produced a number of unintended consequences that materially harmed injured workers and their families. In spite of well-documented examples of these devastating outcomes, the former Governor refused to consider any changes to address the inequities. The time has come to repair the damage and to restore justice and dignity to California's injured workers. The following subjects require the immediate attention of the Legislature and Governor Brown:

- Restore Permanent Disability Benefits: The statutory language of Senate Bill 899 in 2004, and the Schwarzenegger administration's interpretation of that language, slashed some permanent disability awards by as much as fifty percent (50%) or more. In spite of a clear legislative mandate, Governor Schwarzenegger failed to adjust benefits in 2009 and injured workers continue to suffer. Fair and equitable payments to injured workers for serious, permanent injuries must be restored immediately, without them being forced to accept "offsets" or "savings" that cause decreases in these and other benefits. The cases of Almaraz-Guzman and Ogilvie must not be overturned. *ADD WEEKS + DOLLARS. ADDRESS 0% RATINGS.*
- Prompt Access to Quality Medical Treatment: Injured workers need to be able to receive care from doctors of their own choosing and not forced into doc-in-the-box clinics controlled by insurance companies. Before the Schwarzenegger reforms, injured workers had free choice of physician 30 days after their injury. The basic right to choose your own doctor is good medicine and good policy. On balance, employers and insurance companies have abused the medical provider network (MPN) law and it should be repealed. In addition, payments to all doctors – both first injury treaters and specialists – should be fair and adequate to ensure that they will remain willing and able to treat injured workers and accept work injury cases.
- Eliminate Administrative Delays in Treatment: Urgently needed treatment for serious injuries is routinely delayed, modified or denied through the abuse of the utilization review (UR) process by employers and insurance companies. Recent studies have questioned the cost-effectiveness of UR. Some UR adds needless costs and impedes rapid recovery and return to work for workers needing treatment. Doctors' treatment recommendations that follow existing state-promulgated guidelines should be immediately approved and not subjected to administrative reviews and delays. In addition, VIAW supports the reintroduction of Assembly Bill 584 (Fong) that would provide that all physicians performing UR for insurance companies must be licensed to practice in California.

- Disability Payments and Other Benefits Should Not Be Reduced or Denied Based on Discrimination: Age, gender, race, national origin and immigration status are all currently being used to reduce or deny permanent disability and other benefits to injured workers. This is morally wrong and cannot continue. Under existing law, this impermissible discrimination is called "apportionment," and is used to reduce benefits that should otherwise lawfully be paid to injured workers. Discrimination, whatever its form or fancy name, must be eliminated in workers' compensation. For this reason, VIAW supports the reintroduction and swift enactment of Assembly Bill 1155 (Alejo).
- The 2004 Reforms Should Not Change the Rules for Cases Settled Previously: Injured workers who settled their cases before the reforms of 2004 that included awards for future medical care should not be subject to UR or forced to obtain treatment from subsequently-created medical provider networks. If they have established a rapport with a treating physician, it should continue. Injured workers with old settled awards should not have to change physicians solely because their current treating physician is not a member of their employer's MPN.
- Physically Able Permanently Injured Workers Need to be Retrained As Soon As Possible: Employees, employers and the State of California all benefit when someone who is seriously injured at work is able to return to a meaningful, productive job in the workforce. Currently, there is no effective training program for workers who cannot return to their pre-injury jobs. This leads to many injured workers being unable to work even though they want to work. Current law must be reformed to provide that once injured workers have been medically cleared to return to work, their employers must bring them back to their jobs, accommodate them, or provide appropriate retraining funding. Experience demonstrates that the sooner retraining starts, the more likely the injured worker will return to the workforce as opposed to becoming needlessly unemployed and eventually dropping out of the workforce.
- Workers' Privacy Must be Protected: In response to the filing of a workers' compensation claim, some insurance carriers and third party administrators use private investigators to provide surveillance of injured workers. These investigators conduct *sub rosa* recordings and use other investigative tools that would not be available to government entities. As private companies, they are not required to obtain prior court approval for any part of this surveillance. Current law provides little oversight of this cost driver to the workers' compensation system. Carriers and TPAs should be limited in their ability to use material collected during these investigations and the workers should have access to materials even if no fraud is ever alleged. It also may be necessary to require prior approval to use certain investigative tools.

- 0 -

For further information, contact:

Jesse Cenicerros, President
 Voters Injured At Work
 P.O. Box 7307
 Burbank, CA 91510
 (909) 855-2509

4/30/2012

INA CLAUSEN

inaclausen@earthlink.net

Voters Injured at Work Policy Position

Posted on 22 March 2012 by admin

Voters Injured at Work is a non-profit political organization of injured workers and their families established in 2005 for the purpose of protecting and enforcing California's constitutional guarantee of a fair and adequate system of compensating workers and their dependents for injury or disability from a work injury.

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President

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California Society of Industrial Medicine & Surgery



Position Paper on the Possible Transition from the Official Medical Fee Schedule to the Medicare Fee Schedule for Workers' Compensation in California

Background – The Current Official Medical Fee Schedule:

With the challenge to find savings to support an increase in permanent disability benefits, it will be counterproductive to adopt a Medicare Fee Schedule for workers' compensation cases. Except for some office visit billing codes, all medical treatment billing codes presently pay 5% less than the 1986 fee schedule. Reimbursement for the vast majority of medical procedures has not been increased in 26 years! No one is talking about adopting the Medicare Fee Schedule at less than a revenue-neutral basis, and many recognize that it cannot be done properly without adding several hundred million dollars a year in new money. As such, there can be no "savings" from adopting a Medicare Fee Schedule and California should not waste its time pursuing that course. Nevertheless, we need to elaborate further on the likely damaging outcome of that effort should it proceed.

By way of background, the current Official Medical Fee Schedule (OMFS) was first created in 1975 and was market-based. That is, as the result of data sampling of actual physician fees being charged, the original fee schedule reflected the relative value of medical services in the community at the time. It was supposed to be updated every two years based on market data but, because of the failure of previous Administrative Directors to perform the biennial updates, it is sorely out-of-date. This is particularly true for procedures provided by medical specialists. As mentioned above, the current OMFS pays for specialty procedures at the same amount, minus 5%, that was paid in 1986. Since 1986, however, the Evaluation and Management (E&M) Code reimbursements for office visits have been increased three times (1994, 1999, and 2007).

The Medicare RBRVS schedule, in contrast, is not market-based. It is a politically-driven fee schedule that provides extra compensation for office-based E&M services. Its principal objective is to provide maintenance care to senior citizens; not aggressive care to promote prompt healing, minimize residual disability and encourage swift return-to-work. In other words, Medicare's objective is not the aggressive and expert care that is required for the relatively younger population with the target of returning to work and helping the economy grow.

The reality California must face is that injured workers need both primary care physicians (who primarily bill E&M codes) and specialists (who bill more procedures and fewer E&M codes). Given the Administration's pronouncement that it wants close to a revenue neutral transition to the Medicare Fee Schedule, it is mathematically impossible to increase the E&M codes, as the RBRVS does, without cutting other procedure codes. Low income and high risk occupations such as farm workers, construction workers, restaurant workers, freight handlers, teachers, and

maintenance workers typically sustain more serious injuries that require medical care from specialists, not general practitioners.

California's current market-based OMFS is extremely efficient in allocating scarce medical resources at the lowest cost to employers. California is so efficient, it has the third lowest fee schedule in the nation, yet we do not have any serious "access to care" problems.

A Medicare RBRVS Conversion Would Result in Workers' Loss of Access to Medical Specialists:

The California Society of Industrial Medicine and Surgery (CSIMS), over the past decade, spent in excess of \$100,000 in research to study, in other states, the effect of moving to a Medicare RBRVS Fee Schedule at a budget neutral low multiple (e.g., less than 125% of Medicare). Without exception, every state that moved to the Medicare Fee Schedule at less than 125% of Medicare, as would be expected in California, suffered severe "access to care" problems. California would be no exception. We would need close to 150% of Medicare to avoid access problems, and that's not likely to happen unless the Administration is prepared to add hundreds of millions of dollars to the equation. If that doesn't happen, most medical specialists will be unable to continue to treat injured workers. This has happened time and time again in other states. Collaterally, research also documents that once physicians stop seeing injured workers, many do not return, even after the state reverses course and significantly increases reimbursements.

CSIMS has steadfastly supported and petitioned for further increases in the E&M portions of the OMFS. New money needs to be placed in the OMFS to provide a needed increase to primary care physicians. At the same time, however, it is inappropriate and inequitable to take the money from specialists because they will decline to treat injured workers. Furthermore, by their very nature, most specialists' services cannot be performed by primary care physicians.

In addition to the impact a revenue-neutral move to the Medicare Fee Schedule would have on injured workers' access to medical care, it would also affect their permanent disability benefits. Since California now uses the *AMA Guides to the Evaluation of Permanent Impairment*, heavy reliance in determining disability is placed on certain diagnostic services performed by specialists that are compensated under the OMFS. Many of these services would not be performed if their reimbursement was slashed as the result of conversion to RBRVS. Even employers would be harmed because of their inability to obtain diagnostic tests to prove apportionment.

Adoption of the Medicare Fee Schedule will be Costly to the DWC.

Adopting the RBRVS-based fee schedule doesn't involve simply copying some pages from a book or anything that easy. CSIMS has been involved in every revision of the fee schedule since 1982. The last modest change enacted in 1999 was a three-year effort, and it involved hundreds of hours of meetings between DWC staff and stakeholders. A change from the current OMFS market-based fee schedule to Medicare's geriatric maintenance fee schedule will take considerably more time and effort, particularly for DWC's staff.

For example, DWC will need to conduct extensive research to determine whether to adopt single or multiple conversion factors, including an assessment of how many conversion factors will be optimal for maintaining access to care as required by Labor Code Section 5307.1(f). Thereafter, the AD will have to decide upon the dollar figure(s) for the conversion factor(s).

Previous DWC proposals have suggested multiple conversion factors, recognizing the need for higher conversion factors for surgeons and radiologists, but neglecting other medical specialists, such as internists and neurologists. That was a major weakness of these earlier proposals and must be revisited.

The DWC will also have to study and evaluate whether or not to adopt a uniform statewide fee schedule as at present or Medicare's Geographic Price Cost Indices (GPCIs) for California. So far, none of this research has been undertaken and previous studies by the Industrial Medical Council and the DWC are now out-of-date and will need to be repeated and updated.

Some states' administrators have supported the adoption of the federal Medicare Fee Schedule believing that it will reduce their duties and overhead. This would clearly not be the case in California. Adoption of the Medicare Fee Schedule in California will actually involve more work for the staff of the Division of Workers' Compensation than if they merely maintained the current OMFS. Since Medicare does not recognize Consultation or Report codes, California would still have to create, price and maintain a set of California-unique codes for these procedures.

All fee schedules must have companion "ground rules" to clarify and specify how the schedules are used. In California, the OMFS ground rules are ten pages long. In contrast, the Medicare ground rules are 50,000 pages long. How many of those 50,000 pages will apply to workers' comp? We don't know. Some will and some won't; but every page – and every amendment to every ground rule – will have to be evaluated by the Division of Workers' Compensation to determine if it applies to workers' comp. Adopting a Medicare-based schedule with new ground rules will involve significant state resources without benefit to injured workers or their employers.

California hasn't changed its ground rules since 1999. Medicare changes its ground rules at least semi-annually, sometimes even more frequently. Every time Medicare changes a ground rule, the DWC will have to decide whether or not to follow suit and it will have to conduct public hearings before adopting anything. Think about how these frequent changes will affect how doctors bill? Consider the numerous billing disputes, increased lien filings and new litigation that will arise from dealing with up to 50,000 pages of Medicare ground rule minutia.

Adoption of the Medicare Fee Schedule will be Costly for Employers and Insurers:

Historically, fee schedules have been used to promote predictability of costs so insurers can accurately set their premiums and self-insured employers can budget their expenses. Experience from the other states that have adopted the Medicare Fee Schedule at rates similar to what we would expect California to establish convincingly documents that the vast majority of medical specialists will decline to treat injured workers and the health care delivery system will become

destabilized, making it very difficult for insurers to set reserves and establish insurance premiums. To hedge against the uncertainty, insurers will have to increase premiums. Delayed treatment, the inability to diagnose injuries quickly and accurately, and the inability to secure necessary pre-operative medical clearances will prolong temporary disability, increase residual permanent disability, and delay return-to-work that will translate into higher premiums and other costs for employers. Furthermore, with constantly changing ground rules, the number of billing disputes, liens and litigation is bound to skyrocket.

California could soon experience what has happened in Massachusetts. The Massachusetts Medicare Fee Schedule is very similar to what we would expect California to adopt. In the Bay State, many medical specialists refuse to treat injured workers under the fee schedule. Insurers are forced to negotiate on a case-by-case basis to obtain needed services from medical specialists, and they often end up paying more than 200% of Medicare.

Bear in mind that all of the new DWC costs associated with the adoption and constant maintenance of the Medicare Fee Schedule will be paid for through new employer assessments.

Adoption of the Medicare Fee Schedule will disqualify many MPNs:

One of the hallmarks of the 2004 workers' compensation reform legislation was a new law permitting employers and insurers to maintain control of medical treatment through the creation of medical provider networks (MPNs). MPNs have become very popular with employers and insurers and they're now used extensively in California. The Labor Code, however, requires MPNs to maintain an adequate number of primary care physicians and medical specialists in every network. If the Medicare Fee Schedule leads many specialists to decline to treat injured workers, the MPNs will become noncompliant with the law and employers will lose their ability to manage treatment costs.

Loss of Access to Care Due to Medicare RBRVS Implementation is Well Established:

Current state law – Labor Code Section 5307.1(f) – requires the DWC Administrative Director to conduct an “access to care” study before revising the fee schedule. To date, this has not been done; but based on the previous research mentioned above, it is clear that anything near a revenue-neutral transition to the Medicare Fee Schedule will lead to a severe access to care crisis. This eventuality was duly noted last year when the state Assembly overwhelmingly defeated Senate Bill 923 (de Leon). That bill would have forced the AD to adopt the Medicare Fee Schedule. Injured worker groups, several labor unions, applicants' attorneys and all medical specialist societies (including the California Medical Association) opposed SB 923.

During the debate last year on SB 923, the proponents of the measure claimed, “no [Medicare] RBRVS state has ever returned to their prior payment system.” In fact, last year, South Carolina considered repealing its Medicare schedule for workers' comp and several states (including Hawaii, Texas, West Virginia and Maryland) had to revise their Medicare-based schedules upward by millions of dollars a year in an attempt to keep medical specialists in the system.

The proponents of the Medicare Fee Schedule also cite the success of Utah's move to the Medicare Fee Schedule. Utah's schedule, however, pays 143% of its state's Medicare. If the California

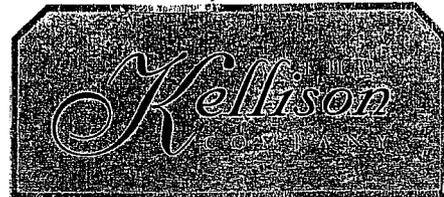
Administrative Director was to adopt a revenue-neutral fee schedule, it would be at between 112% and 115% of California's Medicare rate. The national average workers' compensation conversion factor is 173% of Medicare. Other states that have successfully transitioned to the Medicare Fee Schedule all have conversion factors substantially higher than what we could expect in California. For example: Pennsylvania (145%), Oregon (201%), Michigan (145%), Minnesota (171%) and Mississippi (179%), and Tennessee (160%).

Preserving Medical Access at Low Cost:

What are the alternatives to the Medicare Fee Schedule? As noted above, the current California OMFS is extremely cost-effective in delivering medical benefits to injured workers despite being the third lowest fee schedule in the nation. Unfortunately, the OMFS is somewhat out-of-date because prior administrations failed to perform the necessary maintenance required by the Labor Code. This can change, however. Historically, stakeholders and the state worked together to maintain and update the fee schedule and they can do it again. They could update the current schedule quicker and at much less cost than by moving to the Medicare Fee Schedule. Physicians stand ready to do their part. We are committed to continuing to deliver quality medical care and evaluation to California's injured workers. California should not destabilize the health care delivery system by moving forward with an ill-conceived Medicare Fee Schedule. Injured workers are constitutionally entitled to all medical care necessary to cure or relieve their occupational injuries. Cutting payments to medical specialists from 20% to 48% by a move to the Medicare RBRVS fee schedule at inadequate reimbursement levels would create a constitutional crisis.

With a relatively low-cost and efficient fee schedule presently in place that can be inexpensively updated to repair its shortcomings, should California really risk destabilizing the delivery of care to injured workers by moving to a Medicare-based fee schedule?

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