Commission on Health and Safety and Workers' Compensation
MINUTES OF MEETING
October 19, 2017
Elihu M. Harris State Building
Oakland, California

In Attendance
2017 Chair, Daniel Bagan
Commissioners Doug Bloch, Christy Bouma, Martin Brady, Mona Garfias, Shelley Kessler, and Angie Wei

Absent
Sean McNally

At-a-Glance Summary of Voted Decisions from the CHSWC Meeting

Approval of Minutes from the last meeting (May 25, 2017)	**Approved**
Posting of the draft QME Report by Frank Neuhauser for feedback	**Approved**
Proposal for Center for Occupational and Environmental Health at UC Berkeley to develop a California Occupational Research Agenda	**Approved**
Finalize proposal to develop a model-training curriculum for occupational safety and health training for child-care workers and employers, requested by Assembly member Monique Limón.	**Approved**

Approval of Minutes from the May 25, 2017, CHSWC Meeting

CHSWC Vote
Commissioner Bouma moved to approve the minutes of the May 25, 2017, meeting, and Commissioner Brady seconded. The motion passed unanimously.

Update on Workers' Compensation Medical Issues/Formulary
Dr. Ray Meister, Executive Medical Director, DWC

Dr. Meister discussed updates on the treatment guidelines, MTUS (Medical Treatment Utilization Schedule), and the implementation of the formulary. A new and expedited process is in place for evidence-based updates of the guidelines.

- Proposed updates to all the treatment guidelines with the proposed incorporation with all the current ACOEM (American College of Occupational and Environmental Medicine) guidelines posted in early August on the website.

A 30-day comment period and a public hearing were held in early September. Responses to all the written and public comments received will be finished within a week. An order for the Administrative Director will be published to put the guidelines in place in the near future.

The formulary-making process started in mid-March 2017 with a 45-day public comment period. A public forum to collect more comments was hosted on May 1. The formulary consists of an MTUS Drug List.

The drugs are addressed in the ACOEM treatment guidelines and are part of the ACOEM formulary.

- The drugs on the list were given a status as preferred or non-preferred.
- The preferred medications are judged to be safe and effective treatment in acute cases.
- Some related rules cover how to access drugs not given the preferred status and how to access the many other FDA-approved drugs that they are calling "listed drugs."
- Some drugs are given a special fill status in the formulary in order to provide more "hazardous" medications that might be needed to treat an acutely injured worker when medication safety concerns are raised.
    - There is a similar category for drugs that might be used in a perioperative period.
        - The intent is to make it easier for doctors and injured workers to get the drugs needed in this perioperative period.
        - A generic drug preference will continue with additional rules in the formulary for compounded medications and physician dispensing of medications.
        - A 15-day comment period follows the initial 45-day comment period. The initial plan had the formulary in place July 1, 2017, but, based on the DWC timeline/comments, the implementation date is now January 1, 2018.
            - Because of this feedback, the terminology was changed from "preferred" and "non-preferred" to "exempt" and "non-exempt" because the drugs are exempt from the prospective utilization review (UR) process to facilitate the provision of those drugs to injured workers ("non-exempt" drugs may still be appropriate in some cases).
            - Additional specifications address injured workers with a date of injury date before January 1, 2018, and how their physicians can provide progress reports and RFAs (Request for Authorization) to address any needed change in medication.

Commissioner Wei: Has the DWC settled on the "exempt" and "non-exempt" labels?

Dr. Meister: The plan is to put the formulary in place with the "exempt" and "non-exempt" labels, as published in the first or second 15-day comment period.

An update from ACOEM was received with changes made to the formulary, so that the DWC formulary list is also kept current. Some drugs were changed from "non-exempt" to "exempt," and some special-fill medications were added.

Commissioner Wei: DWC changed the term from "preferred" to "exempt" and "not preferred" to "non-exempt." The term "non-exempt" sounds as if the medication has to be subject to utilization review [UR], and it is not exempt from UR, but it may not have to be "UR'd."

Dr. Meister: The formulary will be a living formulary. There will be, at a minimum, quarterly updates. There will be a Pharmacy and Therapeutics [P&T] Committee providing valuable advice on the formulary with respect to the new MPN [Medical Provider Network] regulation; there is no need to switch medication labels in order to get what is needed.

The other significant change in the comment period is that additional columns were added to the drug list, including "Dosage Form," "Strength," and "Unique Product Identifier(s)." This change allows further instructions and information for use after consultation with the P&T Committee—for example, perhaps utilizing a National Drug Code [NDC].

A compounded drug is subject to the compounded drug regulation even if it includes an active ingredient listed on the MTUS formulary drug list as "exempt." A provision related to repackaged drugs was removed because of the current structure of the MTUS Drug List, which does not require identification of a drug's status as repackaged.

- A completed rulemaking file will be submitted to the Office of Administrative Law [OAL] in the near future. OAL has 30 working days to approve the rulemaking action. The regulations are expected to be effective January 1, 2018. Applications for the potential P&T Committee members and preparations to convene the committee will be solicited.
- The division will continue current educational efforts and is actively preparing to hold webinars and issue informational bulletins to train medical providers, injured worker representatives, claims administrators, medical reviewers, and the public on the formulary and on the MTUS Guidelines.

In summary, they will have guidelines updates in place in the near future.

Comments by Commissioners

Commissioner Bouma: What about the interplay of SB 1160 and the MTUS and treatments subject to UR, as well as the accreditation of the UR companies with private insurers and the alternate accreditation for the public self-insured?

Dr. Meister: The first 30 days of care for injured workers should be facilitated, however, the accreditation process has not yet been updated.

Commissioner Brady: The efforts and sensitivity to the timeline for the formulary are appreciated; but even though the formulary goes into operation January 1, people still need to be trained and best practices observed, and they want to be consistent in how that is applied administratively.

Dr. Meister: The formulary is expected to be out—even a little sooner than January 1; Jackie Schauer of the DWC is working diligently on having the formulary ready as soon as possible.

Commissioner Wei: Is there a review of the process of approval for the formulary? Perhaps they should start designing that study in order to capture the correct data?

Director Baker: A study is required in 2019, per legislation; RAND is looking at that to monitor the formulary going forward. This would be a stand-alone study and not part of the Medical Access study.

Commissioner Bagan: Regarding Dr. Meister's mention of injuries prior to January 1, 2018, especially if an injured worker is on a drug, say an opioid; what is the need to switch drugs based on the formulary?

Dr. Meister: By following the treatment guidelines or by following the medical evidence search sequence that is part of the MTUS, treating clinicians should have good guidance on what the best treatment is or be able to provide support for a better treatment that they decide is appropriate for their patient. Specifically, regarding opioids, the new opioid guidelines from ACOEM will be incorporated in the MTUS. For someone who has been on opioids for a longer period ("chronic phase"), there are recommendations on how to decrease the medication, to wean the person, optimally get them off the medication, or have the dosage decreased. A whole process exists that should be followed to wean, as needed; it can involve a specialist to assist in that process. It may be that the appropriate care is not to take the person off the medication; or not to decrease the dose. Following the guidelines and the other provisions of the MTUS will allow providers latitude to give appropriate care.

Commissioner Wei: Regarding the significant change to the system and [change] to injured workers that will happen after this formulary takes effect: the number of injured workers' prescriptions may change as a result; it might not be a cliff, but it will be a change. They are going to start hearing feedback from their members whose scrips change and whose care

changes. Would it be appropriate to provide a heads up or give some form of explanation for the changes? There will be a pretty big system shock and help will be needed to ameliorate or mitigate it so that it is introduced in a way that makes sense. The providers should look at the guidelines and the guidance there and discuss it with their patients. It is important to have those conversations and set expectations. The hope is that it is not going to cause problems.

Commissioner Bouma: They are operating with a worst-case scenario or that the doctor "should" and the insurance carrier "should."

Director Baker: Everything goes through UR—in theory. The formulary lifts UR from a large group of cases. In a way, that whole group going through UR should facilitate care. The change will be regarding what is appropriate care. Most doctors are providing appropriate care now; if they are not, this creates some issues. By identifying the fraudsters, good doctors who are in the system will be able to provide appropriate care to workers.

Commissioner Bouma: "Don't panic!" is the message I hear.

Commissioner Wei: The pinch point is going to be the pain medicines. That is one of the major issues here and people are going to feel it most acutely and it is where they will get the biggest reaction. For all the other prescriptions, it may be that the treatment guidelines are followed, that have been UR'd already, and will all stay the same. The issue is for new and ongoing claims and how the formulary deals with those. Employers and workers need to be ready for this: there are members who are in pain, and who think they still need their medicine, and they are going to have to be tapered off. That is going to cause a shock to the system.

Dr. Meister: The MTUS recognizes that opioids are not the only pain medications and does have an opioid guideline that has been in place for over a year. The new opioid guideline is an update and an evolution, but a lot of the recommendations are similar. At least theoretically, the guidelines in use now are not going to change a lot, at least as far as the opioids go. Hopefully, people are using the current guidelines, and, if they are, the new guidelines should not be problematic; rather, an evolution.

Commissioner Brady: Phone calls are coming now from claimants about opioid drugs. The issue is not necessarily about opioids being the solution but that it should be the last use, instead of the first use.

Dr. Meister: The "danger zone" exists in those first few days of treatment because the more days that people are on an opioid, the greater the chances are that they will still be on that medication one year later.

Commissioner Bloch: The interest is in the educational efforts and the fear is that the convenient excuse for the prescribing doctor is to just blame the workers' compensation system and the state for what is happening without any explanation. It is incumbent on them [labor representatives] to talk to their members to explain why these changes are happening. While there are good reasons for the changes, the first line of defense is the doctor who explains why a worker's prescription is being changed. A recurring theme in this Commission is the need to educate doctors in the workers' compensation system. Labor and management dealt with the fraudsters, and they made changes that make the system one in which doctors have some incentive to participate.

Public Comment

Steve Cattolica, California Society for Industrial Medicine and Surgery, noted that for all the issues that needed to be worked through before making the regulations effective, there has always been in the background an acknowledgment of a need for an "implementation period," a gap between when the rules are published and when everything actually starts. The time period that looked like it was six months has now shrunk to less than three.

In recent public comments, his organization emphasized the need for that time; it has spoken about education, issues about how it [education] will be related to the injured workers and physicians. Is there a mandatory reason that January 1, 2018, has to be the day? It would be better to move to March 1 or February 1 and give the time it took to get from July 1 to the present, and give some consideration on the other end.

QME Study Report

Frank Neuhauser, UC Berkeley

The Qualified Medical Evaluator (QME) study in 2010 for the Commission on Health and Safety and Workers' Compensation (CHSWC) reviewed the QME process. CHSWC and the legislature wanted an update to see whether the legislative and regulatory changes made since 2010 have been effective.

SB 863 in 2012 addressed the high-volume QME issue:

- SB 863 restriction to maximum 10 locations where they are doing evaluations.
- Eliminated very high volume QMEs (11-130 office locations).

- Limited QMEs to 10 locations at which they were doing evaluations so this would limit how often they were chosen.
- Increase the attractiveness of becoming a QME. However, if one wanted a wider number of panel QMEs, that goal was not being accomplished. SB 863 also adopted the IMR process, which eliminated the treatment issues that were among the reasons for the QME requests. IMR replaced the process and expects to see a decline in the number of QME requests given the same number of injuries because this issue does not have to be resolved by QMEs.

The results of SB 863:

- A continuing decline in the number of QMEs in the system. A 17% decline between 2007 and 2016, even though becoming a QME is more profitable. Decline in QMEs not matched by decline in the number of injuries since 2007; the number of injuries in the workers' compensation system has been flat. Result is more panels per QME.
- QME panels increased dramatically by 101% since 2007; underlying driver unknown. Number was expected to decline, especially after the 2012 introduction of IMR. There are fewer QMEs, many more panel assignments, more panel assignments per QME, and income of average QME is substantially higher.

There is a 17% decline in Agreed Medical Evaluators (AME) and an increase in the average dollar per report by about 69% since 2006, despite a lack of increase in the medical-legal fee schedule. Average QME income is up about 240% since 2007. Total cost of QME reports is up about 180%. This result is not entirely consistent with what would have been expected with the flat injury rates, the impact of SB 863 and a fee schedule that has remained constant.

Commissioner Wei: Asked about calculations in footnotes of this report.

Mr. Neuhauser: The average cost of a QME panel and the cost of an average QME report was based on all medical-legal reports in the system, and there is not yet a way to track the cost of a panel QME report separately from the medical-legal reports, as the data are not published. He assumes that the cost of a QME report is similar, tracking with the costs of all medical-legal reports. The cost of an AME Primary Treating Physician [PTP] outside the QME process compared to the QME process is unknown; the division could develop an answer because it has the data.

Commissioner Brady: About the decline in the number of QMEs: there is also a migration of physicians moving to a more "system" type of work, leaving private practice and moving into larger systems, due to economies of scale and the complexity of medicine these days. Perhaps there is a correlation between that migration and the decline in the number of QMEs?

Mr. Neuhauser: The consolidation of private practice among a small number of major medical providers in the Bay Area has changed the nature of private practice but he does not know if that affects their willingness to participate as QMEs. The penetration of the MPNs in the workers' compensation system has a lot of employers and insurers taking advantage of the MPNs, and primary treating physicians are expected to be much more skilled in report writing. There are more reasons we do not understand and there could be many reasons for the decline in the number of QMEs. Also, large medical consolidation like Standard Health and Catholic Health Care and these kinds of groups may not be interested in this particular process.

- The number of QME reports is going up but not in all areas. The DWC defines two different tracks of QME reports with slightly different regulatory and statutory regulations. They have an unrepresented track, where the worker chooses the QME and the defense attorney chooses the third QME on the panel. All the QME panel requests' increase come from represented cases.
- All increase in panel requests is from represented claims (+400%) since 2006 and 2007.
- There is a substantial increase in the QME requests and the panel QMEs. The Workers' Compensation Insurance Rating Bureau (WCIRB) does not show an increase in medical-legal costs. The medical-legal costs increased substantially. Something else is happening to increase the medical-legal costs of the QME process. The higher number of panel assignments and higher reimbursement rates and the impact of this is much higher for providers who are using or participating in the QME process. All the increase is coming from represented claims. A substantial decrease is coming from unrepresented workers and an increase of about 400% from represented workers.
- Decrease in unrepresented track panels entirely driven by decrease in requests by injured workers (-55%) since 2007.
- Two parties that can request a panel are the claims administrators or the injured workers. The claims administrators' request for panel QMEs has not changed but the injured workers request for panel has declined dramatically. All of this change is the result of a decline in the injured worker request for panels.

Since SB 863, the change for represented and unrepresented workers is new requirements for injured workers. If a claim is determined non-compensable, which is the most common reason for requesting a panel, then:

- The injured worker has to include the objection letter from the claims administrator regarding the compensability (they did not have to do that before). The injured worker has to "serve" that request to the claims administrator. "Serving the request" is not very demanding, the worker simply has to mail a copy to the claims administrator. However, if an injured worker is not very sophisticated about the legal system then having to serve the claims administrator with a panel request sounds technical, and likely discourages some workers from moving forward with this process. Finally, injured workers are required to sign, under penalty of perjury, that they served the claims administrator and have done all the other things required for submitting a request. And, they have to do this "Under

penalty of perjury." This sounds very intimidating. However the risk of the penalty of perjury means virtually nothing in this situation. Workers will never be charged with perjury on the basis of filing a QME request. The penalty of perjury is included in many workers' compensation documents because it allows legal action when people are committing fraud or other criminal activities. This is important in certain situations, but in this situation there is no need for this perjury certification attached to a worker's request for a panel. It merely discourages workers from filing or drives them to representation.

- The represented track has increased dramatically, and that increase is evenly distributed between the claims administrators and applicant attorneys. We do not see the parties acting differently, as they do in the unrepresented track. This again suggests that something specific is happening to the workers in the unrepresented track that discourages workers' applications for the panel QME.

Before and After SB 863:
Comparing 2001 to 2017, the number of panels assigned with just one office location declined from 20% to less than 10% even though panels were spread more widely and extremely high-volume were eliminated. The majority of panel assignments went to doctors with 11 or more offices but typically had 25, 50, or 130 offices. Prior to SB 863, 30 doctors dominated the panel assignments.

In 2017, many QME doctors have exactly 10 offices; a small number of doctors have 11 or 12 offices because they work with underserved populations. Virtually all the high volume doctors have 10 offices. They have seen a decline in the number of panel assignments to doctors with only one, two, or three offices. Efforts to encourage providers or QMEs to enter the system, or for a few QMEs with a small number of offices to stay, have not worked.

They are seeing a consolidation in the system in which QMEs are operating for aggregators. It is not individual providers operating a couple of offices; it is providers who are working with aggregators. The aggregators handle the billing and identify office locations. The aggregators are dominating the market.

- Positive role could be possible improvements in efficiency of the system.
- Negative trends (without any underlying obvious driver) such as: unit price increases in medical-legal reports and increased panel requests.
- A large number of panel requests need to participate with an aggregator.
- Might be barrier to entry for new QMEs with just one or two offices.

The consequence of that is we have a small number of providers or QMEs doing the majority of QME evaluations. The top 10% of QMEs are doing 55% to 60% of the QME evaluations. The bottom 29% are doing about 1% of QME evaluations, and the bottom 50% of QMEs are doing about 8% of the QME evaluations. One reason is that the QMEs who work for aggregators have 10 offices. Some QMEs are also in specialties that are rarely requested, such as internal medicine

and would expect them to have few referrals. However, the system is still dominated by a small number of QMEs but that number is much larger than the QMEs that dominated prior to SB 863. The top 10% comprise the 250 QMEs that dominate the system.

Prior to SB 863, the high-volume QMEs gave very conservative ratings; and substantially more conservative ratings, they gave lower QME ratings than the average QME. That has changed. After SB 863, conservative ratings continued among high-volume QMEs, but the difference between that and the average QME is small. The difference is significant but not substantial. Workers with a panel QME are not taking the same chances as they were before SB 863 in 2010. The impact of this is much more balance among high-volume QMEs.

Mr. Neuhauser was asked to review the impact of providers who were restricted or suspended under Labor Code (LC) sections 129.21 and 4615.

- The doctors who were suspended or indicted criminally and on the DWC list were reviewed.
- 41 suspended providers active as QMEs between 2007 and 2017 compared to 2,700 QMEs (as of September 2017) or 1.6% of assignments
- 4.6% of all panels with at least one restricted or suspended QME for criminal activity.
- Within specialties, there is reason for concern. When a panel is requested, so is a specialty. The top four requests are for pain specialists. In the top three requests, 40% to 50% of the panels with these specialties had one doctor who has been indicted or suspended. Within certain specialties, real reasons exist for concern about the quality of the doctors that workers are getting based on the concentration of suspended and restricted doctors in these specialties.

Summary

- Number of QMEs continues to decline, but more slowly than prior to 2007 and slower even with rising assignments and steady injury rates. It is surprising that the decline is continuing.
- Rapid increase in number of QME requests is perplexing given that IMR was implemented.
- Substantial increase in QME requests and substantial increase in panel QMEs. Workers' Compensation Insurance Rating Bureau (WCIRB) has not seen an increase in medical-legal costs. Something is happening that is moving other reports to the panel process.
- Higher number of panel assignments, higher reimbursement rates, and impact is much higher for providers participating in the QME process.
- More assignments, higher reimbursements per report—240% increase in average QME income. All increase in panel requests is from represented claims (+400%).
- Decrease in unrepresented track panels driven entirely by decrease in requests by injured workers (-55%).
- SB 863 restricted the QMEs to a maximum of 10 locations. This successfully eliminated the very-high-volume QMEs.
- QME panel assignments now dominated by providers with exactly 10 offices.

- Steep decline in number of providers with just 1-4 offices.
- If we want a wider pool of QMEs, we are not accomplishing that and have concerns.
- QMEs suspended under LC sections 129.21 and 4615 represent a small proportion of QMEs; However, for specific specialties, there is a very high concentration of suspended providers and should be the focus of CHSWC and the legislature.

What can DWC do?

It is appropriate to evaluate the role of QME "aggregators" in the system.

- Positive role could be improvements in efficiency of the system.
- Reduce problems for doctors and improve the quality of reports and oversight.
- Negative trends due to aggregators (without any underlying obvious driver) such as:
  - Unit price increase in medical-legal reports.
  - Rapid increase in panel requests.
  - Large number of panel requests need to participate with an aggregator, and it might be a barrier to entry for new QMEs or QMEs with just one or two offices who do not have sufficient requests.

It is important to review the issue of QME pain specialists; real issues exist with the doctors who are signing up with the specialty. DWC is addressing this issue aggressively. There are some issues with this particular specialty, and with the oversight by the specialty boards and pain specialists as a separate specialty in workers' compensation for QME evaluation. This specialty needs to be eliminated or have better oversight; this is an issue for CHSWC and the legislature and future research.

- Review requests from injured workers who are filing for panel QMEs, and dramatic decrease in the requests by unrepresented workers, and this deserves review by CHSWC.
- Review requirements for unrepresented workers filing QME requests.
- Elimination of "penalty of perjury" statement, which does not serve any purpose except to discourage an injured worker from filing for QME.
- Elimination of the need to serve claims administrator; replace with automatic notification by the Division.

Reasons for panel requests:

- DWC has been doing a good job since 2015 about why a represented worker requested a panel, but data not collected on unrepresented workers.
- Capture, electronically, the reason for unrepresented worker QME requests; this is easy to do because unrepresented workers file this information with the request.
- Link WCIS unit cost data for medical-legal reports and QME panel data and answer the question. DWC can link unit cost reports with panel QME medical-legal reports with its costs and answer that question. DWC can also answer what is driving the overall

increase in price: is it panel QMEs or others. If it is panel QMEs, is it represented panels or small number of doctors who are high-volume operators under aggregators?

- To answer questions, link the WCIS on First Report of Injury (FROI) with Subsequent Report of Injury (SROI) with Electronic Adjudication Management System (EAMS) data, QME panel data and Disability Evaluation Unit (DEU) data on permanent disability evaluations and ratings. Some of this analysis was done in this study but it will be easier for DWC to have these systems set up to analyze these questions on a regular basis. Questions such as, what is the driving force in the increase in unit price - is it panel QMEs or medical-legal costs.

Comments by Commissioners

Commissioner Bouma: Regarding the represented cases and the increase in panel QME requests, for both the applicant and defense sides, why do they not know the reasons for the increase in QME panel requests? The reason could be that they are timing out and they cannot get the panel in 60 days, and they have to ask again, and that is what is driving it up.

Mr. Neuhauser: The number of panels here can be counted in two ways. The first is to count the number of panel requests. This was substantially higher than was discussed in the report because sometimes people can request a second panel because the doctor is not available within 60 days, or the specialty has changed, or there was a dispute about the panel. Those requests were taken out of this report; only the final unique set of panels were used, and the number is increasing and is independent of churning that is going on with specialty. This is for specific claims for individual plan requests that are un-replaced. Subsequent panels replace some panel requests, but he has counted just the final un-replaced set of panels in this report. They are still seeing a 400% increase for represented cases.

Commissioner Bouma: What was the reason for this increase?

Mr. Neuhauser: One reason for the increase is a substantial shift from unrepresented workers to represented workers. So in the indemnity claims, WCIRB does track this, and the number of indemnity claims represented by an attorney has increased from 71% to about 79% or 80%. In addition, the number of unrepresented cases has significantly declined. That only explains a small portion of the increase in panel requests. One of the things they see is that panel requests are replacing primary treating physicians (PTP), certainly in evaluating permanent disability. Some of this moves away from PTPs and use of panel QMEs—they are up about 30%. What is driving workers to represented status and keeping people away from resolving their case by PTP report?

Commissioner Bloch: Mr. Neuhauser's information is appreciated in view of how difficult it is for unrepresented workers in this system, whether it is the proof of service requirement or the

QME requirement about signing a Form 105 declaration. He supports the recommendations that Mr. Neuhauser made on these issues. It is important to note that for the injured worker, who is unrepresented, it is up to the employer to choose the doctor. He was looking at a DWC form for a worker who is on the fourth request for a panel; it concerns him about the 60 days and the timeliness of the treatment if the worker has to make multiple requests for panels. The concern is that injured workers cannot find a doctor, or they are represented workers, or the two doctors get struck out of a panel, and the other doctor is not available or because they have multiple specialties within these requests. He believes these issues need to be investigated.

Mr. Neuhauser: There can be multiple panel requests without any processing problems; and there can be a panel request on the issue of compensability, which is about 40% of panel requests for represented cases; and subsequently there can be another panel request for permanent disability. Those would be two unique panel requests for the same claim because they are two different issues. It is unusual for them to be replaced because the doctor is not available in 60 days and panels are not replaced. It may be an emerging problem but not a major one. Multiple panel requests is a sign of a problem.

Commissioner Bloch: There was a 240% increase in QME compensation, so the provider is getting better pay, and there was higher demand due to the number of requests: why did the number of doctors decline? It is a basic supply and demand question; there was more demand and more money in the system, so why is the number of doctors going down? How does this affect other issues when somebody has to request four or five different panels?

Mr. Neuhauser: They are probably intertwined; on average QMEs should be making about 240% more than they made 10 years ago; instead they are doing more work [for the same rate of pay] because being on a panel requires it. The QMEs have had higher income, so one would expect more doctors to come into the system, but it is possible that the system has changed because of the role of aggregators. Aggregators could be a barrier to entry for new doctors, and doctors who have only a small slice of the market, or only one location, and participate in a limited specialty such as dentistry or podiatry or any specialty that was rarely requested. These doctors are not seeing that huge increase in income; and the doctors who are new to the system, unless they participate in the system wholeheartedly, dedicate a substantial amount of time and do a substantial amount of business. Aggregators can act as a source of efficiency or a barrier to entry.

Commissioner Brady: He would not associate efficiency with the QME system. He has heard that the system is "broken." If there is a delay in treatment for injured workers, it is in the QME system. If there is an expense pocket, it is here, and if one looks at the pharmaceutical contribution and the cumulative trauma contribution, they will see the biggest spikes. It is a complicated system and it is not serving the injured worker or anyone else very well. Therefore, he would encourage to look at what the alternatives are and would not cobble together "old

cloth" and put together a more streamlined, more efficient system.

Commissioner Bagan: Is there any geographic difference in the data, for example, between Los Angeles (LA) and the Bay Area?

Mr. Neuhauser did not analyze the data according to geographic regions. However, the changes are statewide, and surprisingly the issue is not concentrated in LA. Data can be analyzed for that issue.

Commissioner Garfias: Does this study include carve-outs?

Mr. Neuhauser: This study included anyone who requested a panel QME. In a carve-out, if an independent request was made for a QME that happened to be a panel QME to do an evaluation then he is not looking at that issue. One can pick an AME or QME, and it does not enter the panel data.

Commissioner Garfias: QME injuries are being addressed for compensability carve-outs and cases are being settled, so it helps her carve-out program. There are many cases that are litigated and her carve-out program had unrepresented cases.

Director Baker: Are QMEs selected outside the panel process [as chiropractors do?].

Commissioner Garfias: Originally, they had had a panel QME, but it is not selected from a state panel.

Director Baker: They went to an automated QME process, so the QME panels were faster. Previously, it took nine months to get a report and nine months to get a panel and hearing, so it has been streamlined. They do need to look at QME issues. They have to go deeper into the issues and find out the quality of the QME reports, and there is inconsistency.

Chair Bagan: They have this problem with supplemental reports. They need to look at how often the claims administrator has to request a supplemental report because of the poor quality of the original.

Director Baker: They need to have standardization about what is needed in the QME reports.

Mr. Neuhauser: The 106, which is the supplemental report— shows the greatest growth in the number of requests and the second-highest increase in the cost of the reports. They do not know whether the supplemental reports are being requested by QME panels or other medical-legal reports. They do know that the DWC could know this. Sometimes a supplemental report is legitimate, but it is also a marker of quality if it is requested too many times.

Commissioner Bouma: About the AME, that change was driving more people to request a panel

QME.

Mr. Neuhauser: Prior to SB 863, the parties had 10 days to agree on an AME, and if they could not agree on an AME, then they went to a panel QME process. SB 863 changed that, so they did not have to agree on an AME. The number of AME reports has not changed. What has changed is the substantial number of DEU ratings done by the PTP reports. SB 863 would have been expected to reduce the number of AME evaluations, and that is not seen in the PD issues, and compensability issues are not known.

Commissioner Kessler: There are many questions, so instead of an action item about this issue at this meeting, a public comment session is suggested so that they can discuss these issues. She would also like a study session to allow an in-depth discussion about this issue, given the current time constraints.

Mr. Neuhauser agreed to find ways to go forward.

Commissioner Bloch would like this item to come back at a CHSWC meeting so that more questions could be answered. He would be willing to submit his questions in writing in advance. The QME process is where determinations are made whether an injured worker has a valid claim. If this is done incorrectly, then someone does not get treatment, so this is worthy of further investigation.

Chair Bagan said he would take that under advisement.

Commissioner Wei: The report was posted online for public comment, and they will take comments there to maximize public comments and include it in the agenda for the next commission meeting. Further discussion is needed before it comes to a final vote before the commission. Public comments need to be heard, with responses from Mr. Neuhauser, and the CHSWC Executive Officer. This is just research; it is up to the rest of us to do something about this research.

Mr. Neuhauser will talk to all the commissioners about additional details on this report.

Public Comment

Steve Cattolica, California Society of Industrial Medicine and Surgery, is heartened by the suggestion to have a study group between now and the next CHSWC meeting. There was imprecise language and conjecture when it came to an injured worker and his claim. There was a comment about the delay due to the QME process, but he thought it was the opposite because QMEs cannot refer in their reports to their current treatments. The inference that supplemental QME reports were a reflection of poor quality was not true. If the records do not arrive in time, a

supplemental report is automatically created. There was a statement about why we are using PTP reports. RAND has stated that the PTP reports were not very good. There is a statement about the increased number of hands. The rule of 35 was rapidly changed over the period of the study and eliminating consults. Where consults were necessary to complete the report, now they may need a separate panel. There was also an inference that suspended physicians are poor physicians, that the quality of their medicine is not very good, and injured workers are being treated to an inferior set of skills. One does not know why the doctor was suspended, and many doctors have been cornered into giving up their QME. He looks forward to participating in this study group.

Commissioner Wei's recommendation is that the study group was only for the Commissioners. There was an opportunity for public comment today, and public comments could be submitted in writing.

Mr. Cattolica hopes the study group could be a public meeting.

Commissioner Wei: Mr. Cattolica had ample opportunity to defend suspended doctors in public comments.

Mr. Cattolica is not defending suspended doctors but stating that there is no correlation between suspended doctors and quality.

Jim Butler, represents Applicant Attorneys, said the reason workers seek attorneys is that they cannot get medical treatment and have no idea "which way to turn." That might bear more scrutiny. The way that this system was intended to function, an attorney should be rarely used. However, looking at the data, the number of attorneys is going up on both sides. He answered the question as to why PTPs are not being used more often, and the answer was that because things had become so complicated that the average PTP does not know how to write a permanent and stationary report, and it is frequently deficient. Additionally, pain management physicians predominate. If there is a deficit, it goes across the board.

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Director Baker acknowledges the first responders and firefighters for their incredible work the past few weeks in Northern California and acknowledges the efforts and all the people who are in the fire district. The following study was done with retrospective data and does not really speak to the issue of post-traumatic stress disorder (PTSD). Many people will experience PTSD from these fires. Director Baker lost her home to the Oakland fire, and that fire pales in comparison. Teams have pivoted over the past several weeks to get information to workers and to get help to people, such as masks. There has been a collaborative effort between agencies to help the fire victims.

First-Responder Behavioral Health Issue Brief
Amy Coombe, DIR Research Unit

Assembly member Tim Grayson (District 14, author of AB 1116) requested information regarding occupational behavioral health for emergency response personnel in California.

Her presentation is a cursory overview to define the scope and refine the perspective if further study is interesting to the Commission.

DIR examined the following questions to help outline potential areas for additional study:

- What guidance does the MTUS offer for WC doctors to ensure streamlined delivery of medical treatment for behavioral health disorders such as PTSD and other behavioral health disorders?
- What information is available from workers' compensation claims data on first-responder claimants with PTSD diagnoses?
- What specific treatments are requested, and what are the outcomes of the requests? (not specifically the health outcomes)

MTUS Guidance on Behavioral Health Disorders

Offers appropriate guidance to address any condition

- MTUS treatment guidelines include "stress-related conditions."
- MTUS Medical Evidence Search Sequence is very broad and comprehensive and gives treating doctors the ability to provide information from a variety of sources to support their treatment requests.

Data Source Used for Assessing PTSD in Workers' Compensation

California's workers' compensation information system (WCIS) uses electronic data interchange (EDI) to collect comprehensive information from claims administrators to help the Department of Industrial Relations oversee the state's workers' compensation system. Electronic transmission of first reports of injury was required beginning March 1, 2000, and electronic versions of benefit notices were mandated as of July 1, 2000. Electronic reporting of medical billing data is required for any medical service that has occurred on or after September 22, 2006.

Because of small sample size ($N = 133$), results reported for first-responder PTSD WC claims should be interpreted with caution.

Commissioner Bouma is compelled to put on the record that this is the second time since she was on the Commission that a first-responder-related study has been put forth, and both of them have similar cautionary language about having a small sample size and a lack of confidence in the data. Her concern about the lack of public agency data is not foreign to the administration or to the Director. There are stakeholder groups trying to capture that data better, but it continues to be a concern.

Claim information (from WCIS) and variables:

Age
Gender
Nature of injury
Cause of injury
Claim duration
Tenure on job
Service request outcomes
Provider specialty
Instances of multiple claims
Geographical distribution of claims
Services paid amount
Services/treatment types billed

Commissioner Kessler did not see the job classifications spelled out. An emergency responder could be a firefighter, a dispatcher, or a nurse. The type of job could affect PTSD, for example.

Ms. Coombe: They did provide an issue brief that details the methodology a little further and look at specific groups of injured workers, and it included emergency response personnel, EMTs, firefighters, and police officers.

Commissioner Kessler: Did they provide the job titles by name? In the recent massacre in Las Vegas, it was the nurses and the security guards. These people are not always going to be first responders in the exact situation, but they are in fact first responders because they are dealing with the situation, which she believes would have an impact on them.

Ms. Coombe: They could provide that and, depending on what the Commission prefers, they could expand that delineation of job classifications.

Initial findings from WCIS data:

- Nearly half (47%) of first-responder PTSD claimants were 40-49 years old
- Females represented a larger share of PTSD claims (30%), considering the lower female first responder labor force participation rate
- Mental stress reported as 'nature of injury' for 40% of first responder PTSD workers' compensation claims
- Cumulative injury reported as the cause of 28% of first responder PTSD workers' compensation claims

- Although 25% of all industry PTSD claims were filed in the first year on the job, tenure with job at injury varied for first responders with PTSD claims
- 92% of first responders who filed PTSD workers' compensation claims filed additional injury claims; 34% were for strain, sprain, or tear injuries.
- $2 million was paid for medical services for first responder PTSD workers' compensation claims (as of date of data extracted).

Requested Treatments and Outcomes of the Requests

- Physical therapy and psychology lead in physician specialties for first responder PTSD workers' compensation claims.
- Physical and other therapies comprise the most frequently billed PTSD related treatments.
- To complement WCIS data, the IMR database provides insight into treatment requests and outcomes.
- California's workers' compensation system uses IMR to resolve disputes about the medical treatment of injured employees. As of July 1, 2013, medical treatment disputes for all dates of injury are resolved by physicians through IMR. (One limitation is that the specialty or occupation cannot be examined, so IMR data covers PTSD cases, as opposed to cases specific to first responders.)

IMR of PTSD claims

- Data available for filings submitted January 2013 to May 2017.
- 694 unique IMR claimants with a listed PTSD-related diagnosis.
- 1,138 IMRs were reviewed and decided.

Although IMR generally upheld UR decision for filings related to PTSD, the overturn rate was higher for several PTSD-related filings compared to general overturn rates for the same treatments. The treatment categories of pharmacy, psychological services, and diagnostic testing were by far the most common requests.

Potential Next Steps

- Determine whether there are model programs to prevent and/or treat PTSD
  - Conduct a literature review of programs designed to help with mental health issues and/or serve as a resource for first responders
- Assess the effectiveness of existing programs
  - Review any evaluations that empirically support practices or programs, especially those in California, such as the California Peer Support Association
- Examine other states/countries for lessons learned and experiences
  - Massachusetts (existing programs since 9/11)
  - Canada
  - States with pending/recent legislation: Colorado, Florida, New York, Vermont

Comments by Commissioners

Commissioner Bouma appreciated the comment about taking a closer look. Some of the questions in Mr. Grayson's letter regarding the reasons were not addressed, particularly what is in place with different employers that prevent or manage PTSD-related effects prior to having to file a workers' compensation claim. There was no information about what happened after filing a claim and on denials and compensability if it is work-related. The 92% statistic on PTSD claims that occur with other claims, such as strains or shoulder injuries, are notable. Members (firefighters) don't want to just file a claim for doing what they do every day and say that it is affecting them emotionally—because it is a tough thing for a first responder to admit. So while they (an injured first responder) file a claim for a bad back or shoulder, they might also talk about the stress they face on the job every day. It is important to figure out how to dissect that and figure out what kind of access there is, both in the system but also in encouraging firefighters and other first responders to admit and address these needs early on, before it becomes a claim in the system.

Commissioner Bloch would like to forward Commissioner Bouma's recommendations and express his condolences to the families of firefighters who lost their lives fighting these horrific fires. The Teamsters, also represent first responders, although a small number of them. They represent the police in San Bruno, who were there with the fire right on the line at the PG&E explosions. They represent Riverside County employees who were there when that shooting happened. There are questions, especially in the public sector, about what city or municipal and local government is doing in advance to prepare for these events. These fires don't seem to be going away and seem to be an ongoing issue. Although he is not on the Commission about gun control laws, that is not what they do, but that is also an issue that does not seem to be going away either.

Public Comment

Ramón Terrazas, medical director of the San Francisco Fire Department, noted that in any study that looks at anything in the area of workers' compensation, one must keep in the background two distinct elements. The first is that in terms of filing a workers' compensation claim for a mental behavioral medical problem, the threshold for getting the claim accepted is much higher than the threshold for the compensability for a low back injury. The second element is that the state legislature a long time ago legislated pieces of the law with the intent to decrease the number of workers' compensation claims filed for mental or behavioral issues.

There is another element—when any injured worker files a workers' compensation claim for mental or behavioral issues, they literally have to open the book on their life; every single aspect of their past mental history and past problems becomes an open book, and many injured workers are reluctant to have their life opened up to a claims administrator in that fashion. That alone serves as a barrier to pursuing a workers' compensation claim. First, we see underreporting of the problem. A lot of care is taking place outside the workers' compensation system, and it is occurring in that manner because they do not want to report it. Second, getting treatment is technically difficult, and it is a lot easier to pursue treatment they need outside the workers' compensation system.

Proposal to Develop California Occupational Research Agenda

Julia Buss, Deputy Director, Center for Occupational and Environmental Health (COEH) at UC-Berkeley

Ms. Buss presented a proposal to bring together key stakeholders to identify occupational research priorities to help have a positive impact on the injury- and illness-related work in the State of California.

The key stakeholders include employers, worker representatives, academics, health and safety professionals, and community-based organizations to bring together to identify where they need to focus efforts for the greatest positive impact.

The proposal is a collaborative effort and involves three state entities: the Department of Industrial Relations, the Occupational Health Branch of the California Department of Public Health, and the Center for Occupational and Environmental Health (COEH) at UC Berkeley.

The proposal is an update to a report by the Commission over a decade ago that summarized research priorities. The need is still great because of the burden of illness and injury on employers and workers in the state to resummarize and reprioritize the research agenda. The proposal would involve a couple of phases over a six-month period. The research priorities that have been identified at a national level by the National Institute of Occupational Safety Health need to be scrutinized in order to see which of them are relevant to California. They would also look at data on illness and injury rates in California and send out a survey to a wide group of stakeholders—employers, insurers, worker representatives, and health and safety professionals. The stakeholders can respond to the survey anonymously and voice their concerns about what they see are the key issues.

The second phase of the proposal generates a report from that information that can be presented at a meeting of key stakeholders that could be convened, say about 20-25 people identified by the state entities involved in this project. The areas of priority that they should focus on to have the greatest positive impact will be found. The proposal was over a six-month period with an estimated cost of $40,000.

There were no questions or public comments.

CHSWC Report
Eduardo Enz, Executive Officer, CHSWC

Since the last meeting in May, the staff has taken steps to implement Commission decisions. The evaluation of the Return to Work Fund approved in May is underway, and the staff expects findings and recommendations to be compiled by the spring of 2018. The evaluation of SB 863 Medical Care Reforms report is also in process, with completion pending final edits; the staff anticipates its release by the end of this year. The Labor Occupational Health Program (LOHP) at UC Berkeley has begun to develop a training module to comply with AB 1978 that includes development of a training program for janitorial workers and supervisors in English and Spanish. This training program, a short video for janitors on sexual harassment and assault and provision of four "Training of Trainer" sessions, among other things, will take place over a two-year period culminating in the summer of 2019.

Commissioner Kessler: In the hope that part of the video is being made for the workers, will there also be a video for management? Management is responsible for ensuring there is no sexual harassment and abuse on the job (though some managers are themselves the perpetrators of such bad activities). Perhaps they should augment or include the video for the management team as well.

Mr. Enz: The training also has a supervisory component.

There are three action items for consideration:

1. Does the Commission wish to post for feedback and comment for 30 days the DRAFT report titled "Qualified Medical Evaluators: Updating Trends in Evaluations, Availability and Equity," by Frank Neuhauser at UC Berkeley?

Chair Bagan called for a vote, and the motion passed with no opposition.

2. Does the Commission wish to approve a proposal to have the Center for Occupational and Environmental Health at UC Berkeley develop a California Occupational Research Agenda?

Commissioner Kessler approved the motion, and Commissioner Brady seconded it. The motion passed unanimously.

On September 12, a letter was received from Assembly member Monique Limón requesting that CHSWC solicit a proposal to develop a model training curriculum for occupational safety and health training for child-care workers and employers. The goal of this program is to prevent occupational health and safety risks for child-care professionals and reduce the costs of injuries for employers and employees.

> 3. Does the Commission wish to approve directing CHSWC staff to finalize a proposal to develop a model-training curriculum for occupational safety and health training for child-care workers and employers requested by Assembly member Monique Limón?

Commissioner Kessler approved the motion, and Commissioner Brady seconded it. The motion passed unanimously.

Public Comment

Jim Libien, workers' compensation defense attorney, is with the law firm Renne Sloan Holtzman Sakai, which assists clients in developing carve-out programs under Labor Code section 3201.7. He has set up four programs that are currently running, and everybody is happy with them. He is working on a fifth program at this time. The Commission was established to conduct continuing examination of the workers' compensation system and is charged with recommending administrative or legislative modifications to improve its operation. In that regard, LC section 3201.7(c)(4) authorizes the State of California to enter into a carve-out; no state (agency) department has done so yet. The only in-depth report that the Commission has ordered concerning carve-outs was in 1999, and that involved construction carve-outs, referring to LC section 3201.5. The programs under LC section 3201.7 are a different animal and deserve a closer look by the Commission. These programs are run by a joint committee in which labor and management jointly seek solutions to workers' compensation issues and utilize a joint savings program, which in effect makes labor and management partners—something that the Commission should look into. He suggests the Commission order a study of these programs and requests that it inquire why no progress has been made in the State of California to develop a carve-out. The correctional officers have been interested. Corrections is the most expensive portion of the state budget. California spends more on corrections than it does on education. A lot of money could be saved by implementing a carve-out. He offered his services to work with Commission staff to make some progress in this area.

Commissioner Wei appreciates the gentleman for raising the issues; she did not know that there were four carve-outs with local city government employees. Mr. Enz could connect with Mr. Libien so that the Commission can learn more about those carve-outs, and the employees of those carve-outs could also be contacted so that they could have a mini-report to bring some information and some narrative to the Commission so that they could determine whether appropriate studies were needed.

Ramón Terrazas, medical director of the San Francisco Fire Department, noted that on the issue of the formulary, whenever there is a change in the workers' compensation system that directs how an individual physician delivers care to an injured worker, it happens in two ways: either the physician accepts the change and provides an explanation to the injured worker as to why the treatment needs to be changed, or the physician decides that this is the state's problem and not theirs, and they are not going to follow the changed approach to care for the injured worker, so they are not going to take the time to educate the patient on why they are doing this change and just refer them back to their carrier. The Commission should be aware of that.

Other Business

Prior to the motion to adjourn, Commissioner Kessler invited the public to make contributions, if they can, to the victims of the Santa Rosa fire via any charitable organization; she asked the public to be considerate and charitable to those who are suffering.

Adjournment

The meeting was adjourned at 12:17 p.m.

Approved:

David C Bagan 12/15/17

Daniel Bagan, 2017 Chair Date

Respectfully submitted:

Edward C 12/15/17

Eduardo Enz, Executive Officer, CHSWC Date