Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING
September 27, 2018
Elihu M. Harris State Building
Oakland, California

In Attendance

2018 Chair, Angie Wei
Commissioners Daniel Bagan, Christy Bouma, Martin Brady, Mona Garfias, and Shelley Kessler.

Absent
Doug Bloch and Sean McNally

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

Approval of Minutes from June 7, 2018	**Approved**
No further action items for vote	**N/A**

Approval of Minutes from the June 7, 2018, CHSWC Meeting

Commissioner Wei noted that there were no action items at this meeting.

Commission Wei moved to approve the minutes from the June 7, 2018, meeting. Commissioner Mona Garfias raised the motion, which was then seconded by Commissioner Christy Bouma. The motion passed unanimously.

Commissioner Kessler asked the following questions about the June 7, 2018, minutes:

- On page 5, with reference to Mr. Parisotto saying: "If necessary, DWC will reach out to groups and specialty associations to tell them the direction DWC is going," she wanted to know what was meant by "if necessary."
- On page 6, Mr. Dworsky is quoted as saying: "There was no regular access to data reporting to DIR on employment outcomes; there is no mechanism for DIR to directly track what happens to an injured worker after a workers' compensation claim case is closed." She asked whether there is an effort to track that.

Chair Wei replied that she will ask George Parisotto, DWC Administrative Director, to respond to both questions in his report.

Update on DWC and WC Medical Unit

George Parisotto, Administrative Director, Division of Workers' Compensation

1. Pharmacy and Therapeutics (P&T) Committee met on September 25, 2018.
   - Role of the committee, use of drug identifiers in the DWC drug list, designation of drugs indicated as exempt, and the role of prospective utilization review in relation to medications indicated as exempt in the drug list. Goal is to make sure that the drug list is easy for prescribers and pharmacies to use.
   - Intended to meet quarterly, but may meet more frequently, based on the issues presented.
   - A revised Medical Treatment Utilization Schedule (MTUS) drug list was adopted and will take effect October 1.
     - The majority of changes are related to the Chronic Pain American College of Occupational and Environmental Medicine (ACOEM) Guideline update
     - 28 drugs were added to the MTUS Drug List

2. Qualified Medical Evaluators (QMEs)
   - Posted revisions to Medical/Legal Fee Schedule to DWC's website forum in May and received many comments.
   - Initiate stakeholder meetings—first will be held October 17—to establish a new fee schedule. Following that meeting, there will be smaller stakeholder groups. This meeting should resolve many issues.

3. Medical Treatment Utilization Schedule (MTUS)
   - The Division will soon be adopting the Traumatic Brain Injury Guideline to the MTUS in addition to three other foundational chapters.
     - Prevention, General Approach to Initial Assessment and Documentation and Cornerstones of Disability Prevention and Management
   - Working with the Reed Group to allow providers access to the ACOEM treatment guidelines without paying a licensing fee.
   - Ensuring that frontline physicians use the treatment guidelines and understand how the MTUS works is critical for our evidence-based medical treatment system to work.

4. Independent Medical Review (IMR)
   - 2017
     - The monthly average length of time to issue an IMR determination after receipt of all medical records ranged from 10 to 14 days.
     - An average of 14,350 IMR decisions were issued each month.
     - The number of eligible applications increased for the fifth year.
     - Case decisions continue to be similar when comparing demographic categories, including injured worker's dates of injury and geographic location.

- Requests for pharmaceuticals = 42.6%; 3 in 10 pharma requests for opioids.
- MTUS guidelines continue to be the primary resource for determining medical necessity.

- 2018
  - Application filings are steady throughout the calendar year.
  - Rate of overturned treatment request decisions increasing:
    - 8.8 percent in March
    - 9.9 in May
    - 10.9 in July
    - 12.2 in August

5. Independent Bill Review (IBR)
   - Applications have remained steady at around 2,000 per year. DWC thought the program was going to be robust, but it has not turned out that way.
   - Mandatory second bill review may have an effect on lower IBR volumes.
   - IBR case decisions must be issued within sixty (60) days of their assignment to an Independent Bill Review Organization (IBRO) reviewer. After initial volume issues were resolved, monthly averages range from 7 to 39 days. With few exceptions, all cases resolve within 60 days.
   - 70% of issued IBR decisions find that the provider is owed additional amounts. $12.3 million was reimbursed to providers for 2013-2017 services, including filing fees reimbursed to providers.
   - Billing for physician services is most often submitted for review, and most often overturned.
   - Billing practices under review by DWC, especially for electronic billing. DWC will be taking a closer look at that.

6. Fee Schedules
   - Will be adopting new geographic adjustment factors adopted by Medicare for our physician fee schedule. This is a change from the statewide factor used since the adoption of the RBRVS system used since SB 863 and will improve payment accuracy based on the region where the service was provided.
   - Will be posting on our online forum—probably today—proposed amendment to the pharmacy fee schedule, to conform to Medi-Cal changes. This will now include a two-tiered dispensing fee, which will raise the current fee from $7.25 to at least $10.05.

7. Fraud

   Lien Stay Activity

   - 153 criminally charged individuals (and their entities) currently have their liens stayed by operation of law under Labor Code 4615.
   - 567,464 liens are currently designated 4615 in EAMS.
   - Any individual or entity who believes the designation is inappropriate can bring the issue before a WC judge for a determination

   Suspension Activity

   - 324 physicians, practitioners, and providers have been suspended under Labor Code § 139.21(a).

   Lien Consolidations

   - There have been 14 lien consolidations ordered, of which 3 have been completed.

Comments by Commissioners

Commissioner Bouma commented that, according to the June 7, 2018, minutes, the average time from receipt of the medical records to IMR was 13 days. She asked how long it took from the application point until resolution. Mr. Parisotto replied that under the Labor Code, in the regulations, once the IMR application was received, DWC tried to determine the eligibility of the application using the following criteria: was the application signed, was the utilization review decision attached, and was it timely filed (in a day or two, at most). After formal assignment, the formal process begins. DWC sends a letter asking for that material, and parties have 15 days from the date of the letter to provide it. The Labor Code stated 10 days, so they have 15 days to provide that reference. It was initially a problem, but people have been doing much better in terms of submitting records. Now people were uploading the records to Maximus' online system. Once Maximus received those records, the clock started ticking, and they had 30 days from the receipt of the records to issue a decision. They have been doing that in about 10 to 14 days.

Commissioner Bouma asked about IMR statistics. After reviewing the July 7, 2018, minutes, and information about the categories of IMR denials, there was a clear statistic about how much is pharmaceuticals, and there was a chart about different types of services provided that were challenged in IMR, but it did not give uphold rates for those subcategories; she asked Mr. Parisotto if he had that data. Mr. Parisotto replied that he can provide that data.

Commissioner Bouma asked about the fast-pass regulations: for the first 30 days of treatment, which categories allow UR review? She asked whether the accreditation requirement for Utilization Review Organizations (UROs) had gone into effect. She also asked whether there were rules developed for public agencies that had separate UROs. Mr. Parisotto replied that the draft rules had been completed; he will review those since the UROs will be applying the UR formulary, and there was confusion about exempt medication rules. A basic question about request for authorization of medication also came up during their P&T meeting on September 26, 2018. Since there was a lot of confusion, he will review the rules to see whether they are clear and simple. The last thing he wanted to do was add another 500 pages to the Labor Code and

confuse everyone as they were in the final stage; regulations should be finished by the end of the month. DWC had accreditation standards that required a form to be completed essentially applying for approval provided it was a public agency conducting UR. The public agency will be waived from the requirement as long as it can show that it meets other UR standards. Commissioner Bouma asked whether that was happening within 30 days and exactly when the rules will be applied for the mandate to accredit UROs and develop the rules for public agencies that have their UROs. The mandate for accreditation happened in July, and 41 of the 60 UROs already have the accreditation. It will have a rule to apply for approval with DWC. She asked when that rule will be in place. Mr. Parisotto replied: probably by the end of next week.

Commissioner Kessler asked what percentage of the 560,000 liens had been appealed and how many were overturned. Mr. Parisotto replied that people had challenged the Labor Code 4615 liens stay designation. He did not stay the liens, as the system only noted whether the lien was subject to a stay, so when they were finally adjudicated, a judge could determine whether it should be stayed. He knew that when the parties had the stay they had brought it to judges, and judges had overturned the stays after they looked at the evidence presented by the anti-fraud unit, and they could make that determination. This applied to various entities in some instances where an individual who believes he is an officer has been indicted on a criminal charge. A connection had to be made between the individual and the entity. Mr. Parisotto knew that there were various entities that have been at the Workers' Compensation Appeals Board (WCAB) and have gone before judges and have had that designation taken away. He knew that the anti-fraud unit is taking a hard look at the evidence presented to DWC that has allowed it to put a stay on, and he wanted to ensure that everybody had a chance to object to it. He knows that the process is in place and does not have the specific number but will see whether he can obtain that information.

Commissioner Brady thanked Mr. Parisotto for speaking at the California Joint Powers Authority (CAJAPA) conference and added that 90% of public agencies participate in this conference.

Commissioner Bagan thanked Mr. Parisotto for the update and congratulated him on his work. He stated that he agreed with Mr. Parisotto that the IBR process did not "take off" as they thought it would. He asked Mr. Parisotto for his theory on the reason. Mr. Parisotto replied that some physicians were deterred by the filing fee, but they are reimbursed for the filing fee if they prevail, and 70% do prevail. Also, there has been a second bill review process that has been successful.

Commissioner Bagan stated that IMR has been stable, in terms of the number that had been filed. However, he continued, a small number of providers had been driving a large number of IMRs, and he asked whether DWC had any plan to deal with those providers. Mr. Parisotto replied that he is continuing to monitor who is filing IMR, but it was tough because there was nothing inherently wrong with someone filing a large number of IMRs. He wanted to look at the decisions. However, first, he wanted to ensure treatment requests were made under the treatment guidelines, and although treatment may be appropriate for some IMR decisions, various dots were not connected. It was important to have treatment guidelines in place and get everyone on board. After the guidelines are in place, they will see how robust the requests are and how UR is affected. If the treatment is within the guidelines, there is no reason for it to be denied UR. Then they can take a really good look at IMR and determine who is driving the system.

Commissioner Wei commented that the original premise behind IMR was that the number of IMR cases would decline over time. They have not seen that in the five years of IMR, and she asked why. Commissioner Wei added that one possible pinch point was the number of doctors who continued to ask for treatment, and IMR was overturned by 90%. Another pinch point was why it was not taken care of in UR and just approved. Mr. Parisotto stated that in his opinion it may be too easy to apply. He received calls from injured workers, and they did not know that an application had been filed. Once again, he referred to the treatment guidelines. He was told by a P&T committee member that the doctors were not familiar with the treatment guidelines and do not use them. That is going to be a problem when they submit a request for authorization. Commissioner Wei added that, on some level, treatment had been under those treatment guidelines for 15 years. Mr. Parisotto replied that they had been under treatment guidelines for 15 years, and those guidelines had not been updated. He hopes that with the adoption of all the various AECOM guidelines, more people will get in line and use the most updated guidelines. DWC has been given the ability to update the guidelines more rapidly, and they are taking advantage of that. Commissioner Wei asked whether it could be another pinch point that the guidelines are not working. Mr. Parisotto replied that he does not have the ability to answer that. There has to be a study of a larger group. The doctors who have told him that they are using it state that the guidelines work well. Commissioner Wei stated that there was a layering approach based on a set of guidelines that they were supposed to use. They were supposed to go to evidence-based treatment, and that tells her that treatment should be factual and fair and aside from the edges it should be evidence based. And yet they still have this friction and conflict at IMR. Even with all these steps in between to mitigate this number, something was not working. It was bad for injured workers, and they were waiting until they got some other type of treatment. Mr. Parisotto stated that it was frustrating not to see the numbers decrease, and he hopes that it is a goal or vision for it to come down. His goal was that the numbers should decrease. The numbers were high, and there were a lot of problems. They need to look at why they were high; and if they get everything in place in terms of guidelines and access and those numbers still remain high, then they need to take a hard look.

Commissioner Wei asked about the price of an IMR review by Maximus. Mr. Parisotto replied that it was $350. Commissioner Wei stated there were 20,000 reviews a month at $350 per review, so the total cost was $7 million a month and $84 million a year; that money could be in the pockets of injured workers. Commissioner Brady asked if the IMR action was physician based or attorney based. He heard it was attorney based because there could be exposure for the attorneys in terms of legal liabilities. Mr. Parisotto stated that some attorneys felt that if they did not fill out an IMR application, it was malpractice. Commissioner Brady replied that if the attorneys do not have to pay, it was easier for them. Mr. Parisotto stated that 95% of all IMR applicants were represented; he does not know what conclusions to draw from that. Commissioner Brady commented that it seemed unfair to pour sand in the carburetor and then complain that the engine was running rough. Mr. Parisotto stated that they would have to look at the process. Commissioner Wei stated that the engine running rough cost everyone.

Commissioner Wei commented that there will be a new administration next year and asked about the goals and focus of the workers' compensation community since there will be new administration and to continue to improve the system for everybody. It would be helpful to determine a path for 2019 and beyond as part of the report for the next meeting. Commissioner

Kessler agreed, and she would like to know about the processes and how they would like to proceed. If they could send the report in advance, that would be helpful.

Commissioner Wei asked about feedback from stakeholders about the medical-legal fee schedule. Mr. Parisotto replied that it was positive from both payers and physician groups.

Overview of WC Medical Access Study

Kandice Kapinos, RAND

Kandice Kapinos presented the report on Access to Medical Treatment for Injured Workers in California (Year 2). This is a three-year study. The Year 1 report on Access to Medical Treatment for Injured Workers in California is on the RAND website.

The objective of this study was to assess access to medical care among injured workers in California using results from a workers' compensation (WC) physician survey conducted in spring 2017.

- The survey asked physicians about their practices and working with workers' compensation (WC) patients in the previous 12 months (no specific months noted).
- Analyzed data on Medical Provider Networks (MPNs) in California's WC system.
- Analyzed Workers' Compensation Insurance System (WCIS) claims data. This study was commissioned by the California Department of Industrial Relations (DIR) as mandated by California Labor Code Section 5307.2.
- The study was an interdisciplinary effort, and there were many people on her team.

Ms. Kapinos discussed the physician survey and its response rate:

- Response rate was low, so there are some caveats to the results of the survey and representativeness of the sample.
  - o Not surprising as physicians were very busy, and it was difficult for them to complete the survey.
  - o Literature documents low response rates from physician surveys versus other types of surveys.
- The sample size was 3,000. Of this number, 2,533 were eligible, and 2,308 did not respond. Approximately 247 completed the survey, and of those, 225 were eligible, yielding a response rate of 8-9%.

Highlights from the physician survey:

- Only 3% of physicians surveyed reported accepting no new WC patients, and some were not taking any new patients.
- Many physicians reported the following limitations on accepting new WC patients:
  - o They accepted new injured workers only if they were referred;
  - o Only if it was an established patient;
  - o Only if the patient was covered by an MPN/contract;
  - o Only certain cases/diagnoses;
  - o Other limits;
  - o Comparison to other states.

MPN highlights:

- 57% of physicians reported participating in MPNs: the majority (56%) reported advantages from participation, 15% reported no advantage, and some reported disadvantages.

Advantages/disadvantages to MPN participation:

- Retains WC patients (29%)
- Increases WC patient volume (36%)
- Improves access to care for your patients (23%)
- Rapid payment (8%)
- Better working relationship with claims adjusters (20%)
- Fewer delays or disagreements in obtaining authorizations for proposed care (20%)
- Fewer disagreements on payment issues 22 or 12% Easier patient referrals 36 or 20% Checked other and wrote response: 60 or 33% Listed other advantages 3 or 2%
- One disadvantage is problems with the system.
- No advantages (25%)

The majority of physicians report needing a referral/consult for at least one WC patient

- 17% reported that they did not need a referral for occupational therapy (OT) or a specialist
- 63% did not need a referral for acupuncturists
- 65% did not need a referral for chiropractors
- 33% did not need a referral to a specialist
    - Most of them needed a referral, particularly for OT, physical therapy (PT), or a specialist.

Among the 83% who reported at least one WC patient needing an OT/PT referral, 75% reported barriers or challenges, including:

- Utilization review (UR) denials, delays, speaking to a peer reviewer, IMR denials, administrative demands, and difficulties obtaining permission to exceed 24 visits.
- Among 66% with at least one WC patient needing a specialist referral, 28 reported barriers to referrals. There might be some differential issues or challenges depending on what type of referral the patient needs.

Most physicians (62%) usually request treatment authorization (RFA). They were asked about the barriers they faced in obtaining an RFA.

- The most frequently referred barriers were administrative demands of the WC system and speaking to a peer reviewer.

Quick Background on MPN data:

- Analyzed 146 unique MPNs (provided to us by DIR)
- As of June 2016-2017, there were 916 MPNs; the sample did not include MPNs that used health-care organizations/managed-care organizations
- 34,696 unique providers in the sample (compared to 70-75K providers in WCIS claims

data).

Background on MPN data:

- Analyzed 146 unique MPNs (provided to us by DIR)
    - As of June 2017, there were 916 MPNs
- Sample did not include MPNs that used health-care organizations/managed-care organizations

Most providers participate in multiple MPNs:

- 25% participate in five MPNs, but there is some overlap.

Average number of providers per MPN, by specialty:

- Family/general practice/internal medicine had the largest average number of doctors;
- Chiropractor/acupuncturists were after family/GP/internal medicine as providers for injured workers.
- Other MDs was the largest number of providers per MPN.

Claims data analysis from 2012-2015:

- In some cases, the study followed patients for 12 months after injury;
    - Excluded claims from injured workers with out-of-state zip codes.
    - Number of physicians has been relatively stable over the past four years;
    - Number of WC claims relatively stable around 834,000 in 2012 and decreased slightly in 2015;
    - Number of claims within first year of injury increased slightly from 2012 to 2015 but did not increase significantly.

WC physicians by specialty relatively stable:

- There are many internal medicine/family medicine and physical therapists.
- Change in the number of physicians from 2012 to 2015 shows WC physicians by specialty, in most cases they were relatively stable, with the exception of nurse practitioners, physician assistants, physical therapists and acupuncturists. Those groups saw the largest increase in the number of providers in the system.
- They also looked at changes in utilization and payments by service type payment across specialties.
    - No statistically significant increases from 2012-2015 for most providers.
        - Exception was acupuncturists, occupational MDs, and physical therapists all saw increases in the number of claims per provider, increases in the number of services per claim, and increases in the total annual payments to those providers.

They also looked at changes in utilization by service type:

- The biggest decline was in services related to drugs and medicine, 12% and 26%, respectively.
- Surgery and durable medical equipment (DME) also had a decline, and those were offset by other and unknown categories.

Time to first visit is relatively stable:

- Trying to assess access to see a provider.
- Focused on the median number of days to first visit in the dataset, which can have outliers that can skew the mean and are not meaningful to look at because it is stable. It was about two days to see a physician for an evaluation and management visit in 2012 and increased to over 3 days in 2015.
- First visit to primary-care physician was also stable between 2012 and 2015.

How many primary-care providers an injured workers sees (provider churn) because they were not getting the service they needed or they saw before needing a change in provider:

- Percentage of injured workers seeing more than one primary-care provider in the first year declined over time and is statistically significant: 20% in 2012 to 18% in 2015.

Summarize the findings:

- Physician survey—some areas of improvement identified, such as barriers to referrals.
- MPN analysis showed most MPNs have three or more providers, but there is significant overlap across MPNs; increasing the number of networks does not increase the number of providers for injured workers.
- Claims analysis revealed the number of providers, utilization, payments, wait times, and provider churn are relatively stable, except for specialties such as occupational medicine MDs, acupuncturists, and PT.

Comments by Commissioners

Commissioner Bouma stated that Ms. Kapinos had data on barriers to referrals, and she had data on time to first visit, but did she have data on the time it took to see the specialist from the referral? Ms. Kapinos stated that she could look at wait time to see a particular physician, but she did not think they could identify referrals in the claims data. The initial piece that she noted was gathered from the physician survey; but the wait times were calculated using the claims data. She did not think they could identify referrals, but they could look at people who go to primary care and follow up with a specialist, and that was what they did with the Year 1 report. Commissioner Bouma replied that this data would be helpful because for these complex injuries time to first visits might be meaningless as to the whole claim to how long it takes them for their injury to be addressed.

Commissioner Bagan noted that, of the 225 physicians who answered the survey, did she have a breakdown of where they were located? Did she notice a difference between Southern and Northern California? Ms. Kapinos replied that the sample was designed to be somewhat geographically representative and took the WCIS data and used that as a sample from surveyed folks from different areas, and the response rate did occur across those geographic areas. Commissioner Bagan asked about the changes in utilization by service type and that medicine and drugs were down significantly, but he wanted to know what goes into the “other” unknown because it has increased by 43%. Ms. Kapinos replied that the “other” category includes unknowns, but it also includes the medical-legal, liens, and categories that do not fit into another category. It was discussed in the report, but Commissioner Bagan would like it broken down, and

if it is the medical-legal, that might be important to find out.

Commissioner Kessler noted that 2,300 people did not respond to the physician survey. She asked whether there was any follow up. Ms. Kapinos stated that they followed up at least three times, using three ways to get a response. Commissioner Wei asked about those three ways. Ms. Kapinos said that they mailed the paper survey and followed up by email two or three times. Commissioner Kessler said that her anecdotal experience is that personal contact or a phone call sometimes creates a better personal contact because a lot of folks don't read all their emails. She said that the lack of response may be indicative of something that is relevant to the whole process. She said that since the majority of people whom they contacted did not respond, there may be some underlying issues that should be identified in order to understand what those issues are and encourage a better response. Ms. Kapinos said it was a real challenge, and they had a limited budget to conduct the survey, but they did attempt to provide incentives. She said it was very hard to get physicians to take time out of their day. She said that there was also some follow up by DIR to reach out to physicians, and that did not go very well either. She said it was very common in the literature on surveying physicians that the response rate is very low. She said the response rate is usually closer to 20-30%, and this survey is still considerably lower than that.

Commissioner Kessler referred to the presentation stating the number of WC physicians was relatively stable (slide 17), which indicated that RAND did not pursue physicians with out-of-state zip codes. She said she was concerned about that because when workers are unemployed, they tend to be transient and travel to a location that they can afford. She asked whether RAND made any effort to include them. Ms. Kapinos said that they did include those types of workers in the Year 1 analysis, but they were asked to take them out because they are a different population. She said that the removal did not change the number of claims or providers very much; she recalls it was not significant, perhaps 3% of claims were from out of state. Commissioner Kessler asked who asked RAND to remove them, and Ms. Kapinos replied that it was DIR.

Commissioner Kessler referred to the presentation stating the percentage of injured workers seeing more than one primary-care physician (PCP) in the first year (slide 22) declined and asked whether RAND knew why there was a decline. Ms. Kapinos answered that they did not know why there was a decline. She continued that it is not exactly clear what it means, and that it is sometimes used as an access measure. Seeing multiple providers may mean there is something wrong with the provider, but that it could also mean that they simply did not like the person, or that they moved, etc., and that there are probably a lot of stories one could tell. She said that they cannot ascertain why from the claims data. Commissioner Kessler said that in the summary, Ms. Kapinos said that the physician survey identified some areas for improvement, such as barriers to referrals; Commissioner Kessler asked whether there was a list of particular barriers to be addressed. Ms. Kapinos said that it is in the report. Commissioner Kessler said that earlier in the presentation barriers were listed, but they were not prioritized in terms of which ones are the most problematic. Ms. Kapinos said that they could tabulate the most frequently noted barriers. She said earlier access studies looked at this question and noted similar barriers—for example, UR comes up every time. She said they could highlight and add that to the report.

Commissioner Garfias asked whether there was a way to look further into the barrier of delay of treatment on the RFAs. She said in a lot of their claims (in their janitor and facility services business), the clinic is not sending over RFAs, or the insurance carrier is not receiving them. She said that she has seen a lot of delay in treatment in that area. Ms. Kapinos said that she did not have access to the data that would allow her to look at that, but that she would ask staff at DIR whether they could look at that. Commissioner Garfias asked her to do that, as she believed that could be one of the barriers.

Commissioner Wei said that the law requires MPNs to meet certain standards to measure the robustness of the MPNs, such as whether enough doctors were available for the covered workers. She asked whether the study looked at the qualitative measures of MPNs. Ms. Kapinos said that they did not, other than asking physicians about any issues with the MPN in the survey. She said that the data they have allows them to see whether they meet the three-plus physician rule within a specialty, but it is not linked to injured workers. She said therefore they cannot determine whether there are three physicians within a radius of a certain worker, for example. She said there was little they could do, and did do, but beyond that, they are somewhat limited.

Commissioner Wei said that it seems that if they are going to do an analysis of the quality of the medical treatment that injured workers receive, the robustness and quality of the MPNs should be part of that analysis. She said she recalled that DWC was able to audit the MPNs, and DWC has the authority to review the quality of the MPNs, and maybe CHSWC could get some data on that, if such data exists. Ms. Kapinos said she could ask about that.

Commissioner Wei referred to the presentation (slide 6) and how the slides are tagged [i.e., titled]. She said it is tagged "Only 3% of Physicians Surveyed Reported Accepting No New WC Patients." She then referred to the pie chart in the slide and said only 27% "Accepts All." She said she did not know how that could be possible—to accept "All." She then said everyone else (in the pie chart) has limitations. She said that to say only 3% accept no new patients, when 73% have some or all limitations. Ms. Kapinos said only 73% have some or all limitations, but 70% of those 73% are (some) limitations [as opposed to all limitations, meaning no new WC patients, ed.]—or the patient has to be referred, or be covered by the MPN or be an established patient. Commissioner Wei said she understands the graph, but that the tag is not an accurate reflection of the experience of injured workers. [Perhaps simply adding, "Without Restrictions" in the tag line would clarify, ed.] She said to say only 3% are not seeing any new claims does not square with the experience, what they hear from injured workers, which is that they cannot find a doctor who will see them. Ms. Kapinos said she did not dispute that—it is just based on a survey of physicians. It is not necessarily what the injured workers experience. Commissioner Wei said she would regret to have the world, the public, and the Commissioners think that only 3% of physicians accept no new WC patients. Ms. Kapinos said this is common in other WC systems in other states. Most of the physicians report limitations on accepting; they do not accept all of them. She said she believes her findings are on par with … [other WC systems]. Commissioner Wei said she didn't question the findings, only the tag and what it indicates in terms of real-life experience. Commissioner Wei asked whether these types of limitations could be cross-walked to the quality of the MPNs themselves. She said, if there are statutory standards for what an MPN should reach, in terms of covered employees, the number of specialists, the geographic requirements, how does one measure the quality of those standards when only one-third take

referred patients? She asked whether that is reflected in the analysis of MPN quality; if only 15% take established patients, it limits the quality and the scope of how many workers an MPN covers. Ms. Kapinos said that they do not have the ability to link the survey response data to the claims data to observe the treatment provided by physicians who report that they are limiting acceptance of WC patients. Further, she said that they have not linked the claims to the MPN listing data—which she said could be an interesting exercise, allowing construction of various measures of the quality of the network, the breadth, and so on and look at the patients who are actually seeing physicians within the MPN. She said that they have not done that in the study, and those datasets have not been created.

Commissioner Wei apologized before saying that she wondered whether the methodology of surveying physicians is an effective way to address these questions. She said it does not feel satisfying to see a [presentation] slide, admitting that she is not a researcher, with 75,000 doctors in the system and a response rate of 225. Mr. Kapinos said she agreed that it is disappointing; she said that they wrote in the report that one has to be very careful about drawing conclusions from these findings. She said they view the findings as contextual, adding context to what they found in the claims data; and even with that, they are not looking at the same measures. Commissioner Wei said that perhaps they should think about a different methodology or a couple of other things in parallel with the study in order to understand the experience of injured workers and access to medical treatment. She said that she worries that the results tell a very narrow and limited story.

Ms. Kapinos said that they have caveated the response as not representative, but that it was the best that they could do. Commissioner Wei said that the response rate from injured workers is probably also low, so how do they get at the issue? Ms. Kapinos said that one needs to take it together with the administrative data and quantitative analysis and do the best one can to try to relate those different sources. Commissioner Kessler said that it was a misleading title, stating that it is access to medical treatment for injured workers in California when it is only surveying physicians and the workers' voices about their ability to access is missing in the pie chart that Commissioner Wei is referring to. Ms. Kapinos said that they were only commissioned to do the physician survey. Commissioner Kessler said she just wanted to note that there was a contradiction. Ms. Kapinos said that one could argue that the physicians have to be willing to take WC patients as well, so they do need to learn something from the physicians. Commissioner Kessler agreed, but pointed out that there were two sides to the story that are important to reflect. She said if one talks about access for injured workers, it is both sides. She said they need to figure out if there is a way that can link both the injured worker and the physicians to develop a more accurate reflection of access and treatment.

Public Comments

Lisa Anne Bickford from Coventry asked to see a slide in the presentation that was not printed in the packet available at the meeting, a pie chart of MPNs. Ms. Kapinos apologized because it was an animation, so it did not print out. Ms. Bickford said she wanted to take a picture of it and did so.

Peggy Sugarman, Workers' Compensation Director for the City and County of San Francisco, said it runs and administers its own MPN. Ms. Sugarman said she had a comment about the

concern about the robustness of MPNs, the ability of injured workers to get to specialists, and whether there are enough specialists—she said this is a great concern of theirs as well, to make sure they have a robust MPN. She said she did not know anyone who could walk into a specialist's office, even in the non-occupational world, without a referral from the primary treating physician. She said accordingly, their specialists listed as "by referral only." She said that she believes that is a consistent practice across occupational and non-occupational specialists. She said that in the event that a worker is unable to get a doctor to treat them in the MPN—just as a reminder—that means that worker can access care outside the network, particularly workers who move out of state. They are not going to have MPN providers all over the country; it is just too much to administer. She said they will help that worker find a physician in their own area where they can access care. It is considered out-of-network treatment, and it [City and County of San Francisco] works that way—again, as a reminder to address some of the concerns mentioned.

Steve Cattolica, director of government relations for the California Workers' Compensation Services Association (CWCSA), asked about a slide in the presentation (slide 18) regarding changes in specialists. He said there was a specialty missing, psychologists. Ms. Kapinos said they should be there, and some of the labels on the bars dropped out—one is "occupational MD" and the other is "all else, occupational therapists." She said psychologists fall in "behavioral …" He said his question is about that category and psychiatrists, confirming that the number of the type of physician is to the left (y-axis) in thousands, and the change is the dot (with values listed on the right y-axis). Ms. Kapinos confirmed. He said looking at psychiatrists, there appears to be fewer than 1,000 psychiatrists—say 500—but over the three years from 2012 to 2015, the dot appears to show that the number has fallen by 200. Ms. Kapinos clarified that 500 was the 2015 number, so in 2012 it was 500 plus 200, equaling 700. Mr. Cattolica said that 700 is not a lot for the entire state of California, and to lose 200 out of 700 is huge. He said he did not want to take Ms. Kapinos to task about how she portrayed it, but she did not include psychiatrists and mental health providers in her description of those who have the greatest change. He said it is a huge change. He said that when Ms. Kapinos talks about overlap between one network and another, in other words, stating, "Dr. Cattolica is in 20 MPNs, and he shows up 20 times," he is still in only one office. He asked how many people is he supposed to be seeing in those 20 MPNs to meet the access standard? How could he possibly do that in a 24-hour day? Ms. Kapinos said that that is a big point that they made, when they have a physician in 20 MPNs it looks like there is greater access because they are in more MPNs or there are more MPNs, but it does not change the underlying supply of physicians to care for injured workers. It does not change the physician's number of hours per day. Ms. Kapinos agreed with Mr. Cattolica's point. He asked whether they could analyze the number of psychiatric or psychological diagnoses needed by the 500 people to see where those doctors are located and whether the access could possibly be matched to that demand. Ms. Kapinos restated his request as the number of claims with those types of services mapped by specialty and geography. Mr. Cattolica confirmed, and Ms. Kapinos said that she believed that they could do that. Mr. Cattolica said if they could do that with all the specialties, one would find the same problem—his example was only magnified.

Findings of Supplemental Job Displacement Benefits (SJDB) Voucher Program Assessment
Amy Coombe, DIR, Office of the Director Research and Policy

Ms. Coombe said the program assessment was requested by Senator Lara and acknowledged the efforts and significant contributions by DIR and CHSWC staff and colleagues. She recapped the efforts to date as, at the direction of the Commission, DIR engaged in a two-phase study of the program. In June 2018, DIR briefed on the beneficiary trends, demographics, and injuries based on WCIS claims data. For the September meeting, DIR is presenting the results of its review of the eligible training partners and counselors who provide SJDB services, the empirical evidence of effectiveness of vocational training, and findings on program efficacy based on responses to a survey of eligible injured workers.

- At the CHSWC meeting on June 5, 2018, DIR presented characteristics of beneficiaries based on WC claim data
    - Trends in the SJDB program
    - Sociodemographics of SJDB recipients
    - Injuries associated with SJDB recipients
- At this September meeting, DIR reports on:
    - Legitimacy and legal credentials of SJDB training partners
    - Vocational training process and benefit to workers
    - Program efficacy based on survey of eligible injured workers

SJDB training partners: eligibility determination
- SJDB program relies on California's Eligible Training Provider List (ETPL)
- Criteria for determining eligibility is established by the state Workforce Development Board and local boards
- CalJOBS hosts a searchable online list of approved SJDB training providers

Training and counseling qualifications
- Providers and programs may be but are not necessarily accredited by an accrediting agency such as the Western Association of Schools and Colleges
- Providers that are not accredited may instead qualify for the ETPL by securing the approval of the Bureau for Private Postsecondary Education, California Department of Education, or Chancellor's Office of the California Community Colleges
- DWC posts a list of Approved Vocational Return to Work Counselors (VRTWC) pursuant to section 10133.59 (b) of Title 8, California Code of Regulations, who meet the counseling qualifications

Vocational training process and benefit to workers: need for empirical support
- Literature focuses on apprenticeship and younger workers
- Such training benefits younger workers in developed countries
- Small but positive effects found for studies conducted in developing countries

More research in this area would be helpful to better understand the outcomes of workers who suffer occupational injury and receive vocational education training (VET).

Program efficacy: survey of eligible injured workers

- Over 12K workers meeting eligibility requirements invited to survey
    - Receipt of $5,000 Return to Work Supplemental Program (RTWSP) benefit or
    - Report of SJDB payment to WCIS

Total number of eligible sampled workers cannot be determined due to unknown number of invalid phone numbers and email addresses

- 90 completed surveys
    - Phone survey: 32% (English/Spanish options)
    - Online survey via email invitation: 32%
    - Online survey via text invitation: 36%
    - Online survey available in English, Spanish, Chinese, Korean, Tagalog, and Vietnamese
- NOTE: due to small sample size must interpret findings with caution

Findings from survey

- Employment at time of survey:
    - 24% full time, 20% part time, 2% were retired
    - 26% still looking for a job, 28% indicated they are not able to work
- 70% reported they received the SJDB voucher (63 workers)
    - 8% reported taking a test to determine the best training for their needs
    - 43% received training in their preferred language
    - Types of services:
        - 33% received vocational counseling
        - 56% received a computer
        - 48% received training
        - 19% received payment for licensing or certification fees
        - 32% received payment for something else

Among survey respondents, 24% found it easy to find the best training for their needs.

In response [to the survey], DWC streamlined access and posted instructions on its website. The SJDB voucher was also translated into Spanish and posted online. The RTWSP application instructions are now available in five other languages and posted on the web.

Was the training helpful?

- 33% reported they were currently taking the training so it was too soon to tell
- 25% indicated they thought the training was helpful because they are applying the skills they learned; however, they do not currently have a job
- 25% did not complete the training
- 10% completed the training but reported it was not helpful
- 6% registered but did not begin the training
- 6% reported they got a new job using the skills they gained.

- Over 50% indicated that a $4.000 cash benefit would be more helpful than training to learn new skills or help in finding a job.

How workers learned about SJDB: Most replied that their attorney informed them.

Reported educational attainment: Nearly 25% went to college or had a two-year degree, but few completed higher education. Over 25% had a high school diploma or GED. Just under 25% went to high school but did not graduate. Around 20% completed high school or less.

RTWSP $5,000 benefit participation:

- 47% participated in the RTWSP $5,000 benefit
    - 7% paid someone to help them apply
- Reasons that workers did not apply despite being eligible for RTWSP:
    - 81% did not know about the benefit
    - 4% could not provide all the required information (however none indicated they had a problem providing a copy of their SJDB voucher)
    - 4% workers found the application too confusing
    - 2% could not access a computer (the RWTSP application is online only and available to workers at kiosks in every DWC office in the state)

Discussion: characteristics of beneficiaries

- SJDB eligibility and payments are increasing
- Most (58%) beneficiaries are male, and the average worker is 43.5 years old and earns around $635 in weekly wages
- 50% live in southern California (mostly Los Angeles)
- Manufacturing, retail, and administrative support industries have the greatest share of SJDB recipients
- 1 in 3 beneficiaries work in labor and maintenance occupations
- Claims data revealed that strains and lifting injuries, followed by cumulative trauma, were the leading causes of injury and accounted for a greater share of SJDB claimant injuries than WC claims in general

Discussion: program effectiveness

- Because these workers were not offered a job with their at-injury employer, securing a new job is critical
- Less than 50% of respondents were employed at the time of the survey
- Of those eligible for the SJDB who participated in the injured worker survey, only 6% indicated they got a new job using the skills they gained
- In its current form, the benefit may not be producing intended results for permanently disabled workers, namely, workforce re-entry

Discussion: alternatives to consider

- A majority indicated that a $4,000 cash benefit would be more helpful than training to learn new skills or help finding a job

  - This type of benefit aligns closely with the $5,000 one-time cash benefit these same workers are eligible to receive through the RTWSP, although only a portion apply
- While a body of evidence supports conditional and unconditional cash transfer as an efficient and effective means of benefit delivery, an examination of the literature produced little evidence regarding the effectiveness of VET for helping permanently disabled workers re-enter the workforce
  - Additional research in this area is merited

Discussion: matching intent with need

- Although SJDB payments for VET services are issued, anecdotal evidence and survey responses suggest that workers are not receiving education or training that leads to employment
- Given the low unemployment rates, these workers are among a few not succeeding when searching for a job
- For workers who are no longer actively seeking employment, perhaps because they are not able to work, as reported by 28% of survey respondents, VET delivered through the SJDB may be ineffective
- It may be time to consider alternative benefit options that may better serve these workers

Comments by Commissioners

Commissioner Kessler said that employers don't always seek to hire injured workers if there are young, uninjured workers available to take the jobs, even if they are unskilled and untrained, because they do not want the liability. She wondered whether there was an option, like the Return to Work (benefit), to give an automatic payment to those who qualify. She commented on reducing the friction in the system and asked whether there was a way to reduce it, maybe reduce delay and improve access for workers who are having a hard time getting through the system. She further asked which stakeholders should or could be involved going forward to help formulate potential solutions to some of the problems identified in the report. The issue of whether injured workers can get through the process, whether it is too difficult or confusing, and, considering that 81% did not know about the benefit, are some opportunities being missed to help people in the community who qualify gain access to the benefit?

Ms. Coombe said many of the issues are related. She said the automatic payment idea was a recommendation that came out of the RAND study of the RTWSP, which was recently presented to the Commission and is also posted online. It detailed some of the advantages of seeking ways to reduce friction in the system, and increase the rapidity and equity of people in gaining access to the benefit. She said that Commissioner Kessler's comment aligns with the (RAND) suggestion. She said that there is an opportunity for discussion with key stakeholders to figure out what that looks like. One of the key aspects necessary is a reporting mechanism so that DIR knows who should be getting the benefit. She said currently that link is missing. She said if automatic payment is the desired goal, they would need to find a way to get that information passed to DIR through some mechanism. She said they would need to find the best way to do that and also ensure the contact information is current and accurate—with permanent disability

that is more than two years down the road. She said having good contact information is a challenge when one is trying to automate something. She said there had to be a way to ensure the correct person receives the benefit. Stakeholders would want to have employers involved, workers' voices heard, as well as the claims administrators or others who are in the middle of the pipeline of reporting to DIR, whether it is the WCIS or another mechanism. The claims administrators would be able to help identify the path of least resistance to getting data in the least burdensome way. Commissioner Kessler said that it seemed the Employment Development Department (EDD) should also be involved because it deals with these people in the field. She said she wondered whether there is a role for the EDD staff who do job development or referrals to be part of the discussion as well because they deal with issues of placement. Ms. Coombe said that EDD is a great sister agency and that DIR partners with it a lot, and the two agencies share data. She agreed that EDD would be a great partner to have in the room to address some of these issues, particularly since it is in charge of the ETPL.

Commissioner Bagan commented on the slide in the presentation that said more than half the respondents indicated that a $4,000 cash benefit would be more helpful than training to learn new skills or help finding a job. He said it reminded him of the adage, "Do you want to give someone a fish or do you want to teach them to fish?" and which is more beneficial. He said maybe in the short run giving someone a fish is easier, but in the long run teaching them to fish is more beneficial. He asked whether the 28% who were not able to work matched up with those who said that the $4,000 would be more beneficial because they cannot work or are unable to work? Ms. Coombe said that they did not do any cross-matching for this briefing but they could look at it in a cross-tab fashion, if that were interesting to the Commissioners. He said that it would be, because the answer is problematic—the whole goal of the system is to retrain people so that they can get a new job. He said part of the benefit is obtaining a computer—over half received a computer—$500 cash for anything, and the rest for training. He said it seemed to him an odd answer to prefer the cash, but if you cannot work or you feel that you cannot work, then he said that makes sense, and he would probably say the same thing.

Commissioner Brady commented that, whatever they come up with, they should try to simplify what they can; he said it seemed that an easier pathway that already has a distribution is a more equitable path through the PD system. He asked: if there are X dollars for PD, can that be an alternative? Commissioner Wei asked for clarification on that thought and whether he meant getting rid of this whole piece of the system and putting it into PD benefits? He said yes, as it does not seem to be working. He said if the injured workers are saying repeatedly that they would like cash instead … Commissioner Wei asked if he was ready to abandon the hopes of returning to work? Commissioner Bagan said he did not think that the people who are looking to get back to work are taking advantage [of the SJDB]. He said that it seemed to him, for whatever reason, that people who cannot return to work are going to say that they want the cash, of course. He asked: why would they [injured workers] train for something if they don't feel like they can work anyway? Commissioner Kessler said that the other situation is that cash is immediate, and they can use it immediately. Not everyone knows what the result of their training is going to be in the immediate way to get re-employed. She said it is an ethereal idea while they are trying to deal with whatever challenges they have because they do not have any income. She said it seemed to her that both issues are at play—that they need both the money to survive and the training to find a new job in a capacity other than what they no longer do or used to do. She said

it is both, not one or the other. Commissioner Brady said his comment was to look at how they avoid creating more friction/unintended consequences. How can they simplify things? He said those have been the touchpoints for a few years, now that they have tried to usher in the system, and he wants to be consistent with that, whatever they do. He said [that he supports] looking at new ideas and fresh approaches. He said it is helpful to review the information, and it is difficult as well, because they want this to be more effective and get people back on their feet and retrained. He said it seemed that that was not what was happening most of the time.

Commissioner Wei asked about who was on the eligible training provider list, how big it is, and what types of programs are on it. Ms. Coombe said it is a very large list on CalJobs. It is a universe of providers; a subset of that are eligible providers that are available for SJDB. The composition and selection are all done by EDD. She said that she did not have any insight into the process, other than what is posted on its website. She said that they could look at that, if it is interesting to the Commissioners. Commissioner Wei said that it was her limited experience that the CalJobs website is a little bulky and overwhelming; whether training resources can be presented in a clearer way on the DWC website is a question that has existed for decades. She said that she is thinking of recommendations, which takes them back full circle, to vocational rehabilitation (voc rehab) counselors. She said she is also not ready to throw out all hope that the best outcome for an injured worker is to get back to work. She said that that is what people want. She said she believes people would be interested in training opportunities if they knew what they were and that they were relevant and they guaranteed—or somewhat guaranteed—a job in the end. She said the issue is training for what purpose. She said she is not convinced that linking to the ETPL system is the best way to do it.

Commissioner Wei asked Mr. Parisotto, regarding a roadmap for 2019, to put a little thought into this piece. Mr. Parisotto replied in the affirmative. She said it was the state's shared goal to get injured workers back to work—that is the best outcome for the workers, the economy, and for employers—and they are still failing to meet that objective. She asked what could be done to keep trying.

Public Comments

Brett Graham of Latino Comp said his practice represents applicants. He said the number one goal is to get people the treatment they need, time off from work, and return to the at-injury job. He said to make that process faster, they could get physicians to fill out Form 10133.36, the RTW voucher form. Physicians still do not understand what they are supposed to do with it; they do not understand that they are required to do it. He said he believes the form should say, "When you find the injured worker to be permanent and stationary, fill out the form." He said every QME and AME to whom he has talked is concerned that there may be other conditions that they are not treating or do not know about. Mr. Graham said they should let the parties deal with it later on. They should let the physician fill out the form when they release the worker to go back to work. He said that would shorten the time for employers to determine whether they have a job for the person. He said currently it is 60 days—30 days for a QME report, 60 days for the voucher report from the doctor, totaling 90 days that the injured worker is in limbo. He said that he tells workers to go back to work the day they are released and to tell employers that they are ready to go back to work. He said if they shorten the time, people will go back to the at-injury

job, or they will get the voucher in their hands sooner. He said he also thinks the language barrier has been an issue for non-English-speaking injured workers. He said Labor Code section 124 requires all notices and forms to be in Spanish—it's been the law forever. He said he is pleased that it is finally getting implemented. He said there is also the issue of pushback from the White House on immigrants. Immigrants do not understand that when they access the RTWSP, they are giving their personal information directly to the government. He said he believes there is a way to make them feel more secure that that information is not going to be shared with other government agencies, and that will increase the amount of access. He said that he was very disappointed that to date they have $690 million that was supposed to go to injured workers—$120 million per year for 5¾ years—and only $210 million has been distributed, assessed, and paid. He said he believes part of that is due to the voucher form; he said what is needed, in boldface text is: "You may also be eligible for $5,000 from the Return to Work Supplemental Fund program." He said if that were done, virtually every injured worker who wants it would fill out the form and either submit it through their vocational counselor or the school or their attorney, and some intrepid people themselves—which is unlikely. He said if they did that, they should get up to the projected number, which is 2,000 per month; over the past five years, there has not been a single month in which 2,000 applications were received. He said that was disappointing.

Commissioner Wei announced that Mr. Graham's time had run out, and he ended his comments.

Commissioner Wei said that Mr. Graham raised a good point. There is a new public charge rule from the federal government that talks about immigrants who may be barred from receiving permanent status or citizenship status if they rely on public assistance and defines public assistance. She said they will have to carefully look at this [definition] to ensure that it does not pick up things like the RTW fund and other benefits for injured workers.

CHSWC Report

Eduardo Enz, Executive Officer, CHSWC

Mr. Enz thanked the commissioners for the opportunity to brief them on commission staff activities. Since they last met on June 7, staff implemented Commission decisions, fulfilled requests, and monitored and worked on a variety of projects and studies.

The RAND report on Medical Care Provided to California's Injured Workers was posted for 30 days for feedback and comment and received no public comments. The report was posted as final on the CHSWC website in early July.

CHSWC Studies Update

The RAND update on the Frequency, Severity and Economic Consequences of Musculoskeletal Injuries to Firefighters study is in process, and a draft report will be completed early next year. Based on the two briefings on the SJDB program assessment presented at last two Commission meetings, a final issue brief on the SJDB program will be submitted in response to Senator Lara's February 5 request to the Commission.

CHSWC Projects Update

CHSWC staff is working diligently to prepare the draft 2018 CHSWC and the WOSHTEP Annual Reports in time for the December meeting. The Janitorial Training Curriculum for workers and supervisors to comply with AB 1978 is in progress. LOHP is finalizing the lesson plan for workers and a short video for janitors on sexual harassment and assault has been completed. The model training curriculum for occupational safety and health training for child-care workers and employers is also in process. LOHP is finalizing a needs assessment for the child-care project with recommendations for adjustments to the workplace health and safety curriculum for center-based child-care workers as well as next steps. Finally, this week CHSWC staff along with partner organizations attended the biannual California Partnership for Young Worker Health and Safety meeting in Oakland. The meeting covered Young Worker project updates, outreach and legislative efforts, understanding apprenticeship, strengthening health and safety training, resource sharing, and plans for future initiatives.

Action Items

There were no action items for consideration at today's meeting.

Comments by Commissioners

Commissioner Kessler stated that the June 7, 2018, meeting minutes (p. 6), in discussing tracking injured workers, reads: "to sum up, the labor markets are not reported to DIR, impeding monetary and research and evaluation. RAND is working with DIR and EDD to build the structure for wage loss monitoring as a remedy for this gap." She asked about the status of any work that had been done and whether any proposals were forthcoming. Mr. Enz replied that he would ask Misha Dworsky and then answer Commissioner Kessler's question.

Commissioner Kessler stated that in reviewing the Wage Loss Monitoring for Injured Workers in California's Workers' Compensation System report published by RAND, she found herself rereading paragraphs to understand the report. She noted that as someone who is not a researcher, she had concerns about how the information was presented in the report. For example, on page 25 of the report there is a post injury change in earnings, and she is not clear how to interpret it. In the creation of these types of reports, it would be helpful for them to be clearer for those who do not come from a similar research environment. She also stated that the charts do not include clear legends to identify the lines and dots as well as definitions, because the report refers to measurements that are not defined. If the reports are easier to understand, it will help an advisory body to offer input. Mr. Enz replied that he will discuss her concerns with Misha Dworsky.

Commissioner Bouma asked about the update to the Wage Loss Monitoring for Injured Workers in California's Workers' Compensation System study that has the 2014-2015 injury data and when it was expected to be released. Mr. Enz replied that the update to the report should be available in December 2018. Commissioner Bouma added that not only did the RAND report presented today identify a reduction in access to mental-health providers, which was articulated by a witness in the last meeting with more anecdotal evidence, but now it has been substantiated

by this study that access to mental-health providers in WC is abysmal; it is critical for her members. They need to stay on top of that data point and offer solutions.

Public Comments

Steve Cattolica, director of government relations for the California Workers' Compensation Services Association (CWCSA), commented on Mr. Parisotto's IBR report: the low IBR use, which may be due in part to the fee, not because of its dollar amount but because, regardless of the findings, the payors do not return the fee to the provider. So the provider submits an IBR, and the provider wins and does get reimbursement of the fee. The provider has to file a $150 lien and does not get that back. So there is something wrong with the process. If they are recalcitrant with respect to the explanations of reviews (EORs) to physicians for the first time, on an initial submission on a treatment case, the only way that the doctor can recover that money is by filing a lien. They cannot get a second bill review, and they cannot file a petition. The incentives lead them not to participate in the process. Even when they win, the results are not complete because there are no teeth behind paying back the fee. Mr. Cattolica added that the Commission could improve the second bill review and IBR process quite a bit if it took a look at this process, how well it is working, and where the incentives and disincentives are.

Gabor Vari, chief executive officer (CEO) of California Medical Evaluators, a medical management company, stated that his firm is active in the QME process. He shared his experience about QMEs with the commissioners. Earlier this month, he had the opportunity to speak at the Dana Point conference on the current QME crisis in California, and he wanted to share feedback from many of the employers who attended the conference. The two main issues in the QME system as it exists today are: (1) access to QMEs and (2) report quality from QMEs. He stated that DWC has been very active in the QME space over the past couple of years by throwing hundreds of doctors out of the system, and disciplinary measures, subpoenas, and derogatory lawsuits cause a tremendous amount of friction. For all the attention DWC has paid to QME issues, unfortunately neither of these two issues has been adequately addressed. The unintended consequence of DWC's actions had made them worse. He stated that access to QMEs faces an all-time low of doctors in the system: 2,450 doctors, compared to 4,000 ten years ago. The California Workers' Compensation Institute (CWCI) study that came out earlier this year showed a 20% reduction in QME headcount over the past several years. This was an opportunity to identify the root causes of issues. The question is why QMEs are being thrown out. In July, several QMEs were thrown out because they allegedly issued late reports, and this resulted in more litigation and more expense, and many of the doctors were ultimately reappointed. The fundamental question should be why so many QME doctors issue late reports. The system is getting progressively more strained. The fewer QMEs there are, the more QME reports need to be done per physician. What is being done to ensure that the number of doctors is adequate, so that the existing pool does not become more strained and a vicious cycle is created in which no doctors may be left to do any of this important work? Interest among doctors in becoming QMEs is at an all-time low. One data point they look at is the number of doctors registered to take the QME exam. The exam is offered twice a year, and only 85 doctors signed up to take the exam. Historically, 50% will pass, of which only a small percentage go on to become QMEs. QME headcount is a major issue. Report quality: QMEs' efforts to throw doctors out focus on doctors' billing at the Aggregate ML-104 rate. This has led more doctors to bill at the fixed fee ML-102

rate, which means more doctors aren't being compensated adequately for doing the comprehensive report and looking at all the medical records and important issues. As the report quality declines, frictional costs rise, with more supplementals, more depositions, and fewer questions answered. So the solutions to these issues are that: (1) doctors need to be treated more fairly and interactively; (2) the rates paid to doctors need to increase as they have not changed in the past 12 years. He welcomed the opportunity to participate in the stakeholder process. He thinks it will be great to have everyone at the table, including payors, employers, attorneys, doctors, and management companies, to engage in a meaningful process to come up with a workable and permanent solution to this problem.

Scott Thompson, CEO Arrowhead Evaluation Services, a medical management company in business for 30 years, thanked the AD for announcing a meeting on October 17, 2018, with a roundtable on the issue. In the early 1990s, they discussed the issue and came up with a fee schedule, but, he said, it is not working. He stated that his son had graduated from college and worked on ML-104 authorizations, which are the most complex cases. The doctors' nightmare was receiving a box of medical records and being paid a QME fee of $625. His son played an important part in the system, and he called the insurance carriers about ML-104 and requested pre-authorizations. He would like to simplify the system and make the doctors happy about doing this work. The doctor had to spend approximately 10 hours reviewing many records, and this drives doctors out of the system.

Commissioner Wei stated that the December meeting date has not been set yet.

Adjournment

The meeting was adjourned at 12:10 p.m.

Approved:

12-14-18

Angie Wei, 2018 Chair — Date

Respectfully submitted:

12.14.18

Eduardo Enz, Executive Officer, CHSWC — Date