STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Tuesday, July 1, 2014
Elihu Harris State Office Building Auditorium
1515 Clay Street
Oakland, California

Destie Overpeck
Moderator
Acting Administrative Director

John Cortes
Industrial Relations Counsel

Rupali Das
Medical Director

Carol Finuliar
Industrial Relations Counsel

Maureen Gray
Regulations Coordinator

Reported by: Richard H. Parker
Julie A. Evans
INDEX

Medical Treatment Utilization Schedule

Ken Eichler 5
Steve Cattolica 9
Robert McLaughlin 10
Tim Madden 15
Bob Plank 16
Robert Kutzner 19
Patrick 25

Copy Service Fee Schedule

Greg Webber 27
Robert McLaughlin 33
Jim Butler 37
Dan Jakle 39
Carl Barkensiek 41
Diann Cohen 43
Patty Waldeck 46
Dan Mora 48
Robert Santoyo 52
Mark Sektnan 54
Richard Meecham 56

-000-
(Time Noted: 10:06 a.m.)

MS. OVERPECK: Good morning and thank you for coming today. My name's Destie Overpeck and I am the Acting Administrative Director for the Division of Workers' Compensation.

Today's public hearing is for two different regulatory packages that we have noticed. One is the Medical Treatment Utilization Schedule, specifically the strength of evidence, and the other is the Copy Service Fee Schedule.

What I'm going to do is first ask for commenters on the Medical Treatment Utilization Schedule. We will have everybody who is interested in testifying come up. We'll then switch over to the Copy Service Fee Schedule, get all those comments, and then we'll repeat until there's no one left who has any comments.

Please make sure that you sign in the sign-in sheet and indicate if you want to testify or not. If you change your mind today and you said no and you want to, that's no problem. You'll be able to come up and testify.

But by having your name, we will therefore be able to make sure that any additional revisions we make, we will e-mail those to you and you'll be kept in the loop on what's happening with the regulations.

I'd like to introduce who is here with me today. This is Maureen Gray who is our Regulations Coordinator. This is
John Cortes who is the attorney who has been working on the Medical Treatment Utilization Schedule. Next to him is Dr. Rupali Das who is, of course, also working on the Medical Treatment Utilization Schedule. And we have Carol Finuliar who has been working on the Copy Service Fee Schedule. Our court reporters are Richard Parker and Julie Evans.

When you come up to testify, please give your business card and who you're testifying on behalf of written on it and present it to the court reporters.

If you have written testimony that you also want to turn in this morning, please hand it to Maureen Gray.

Everything that you say will be taken down by the court reporters, so especially if you're reading off a speech, please speak slowly. We have a tendency to talk really fast and then it's hard for the court reporters to capture everything.

I will, as I said, be going through the sign-in list and reading off the names of the people that come up to testify.

If we start getting close to the lunch hour and it looks like we have a lot more testimony, we'll take a break. Otherwise, we'll see if we can just get it finished up before lunch, and we can all go back to the rest of the things you have to do today.

We will continue to accept written comments until 5:00
1 o'clock today. You can fax them in or e-mail them in or bring them in person up to the 18th floor.

   Everything that we get, both written and oral, is given the same weight, and we will very carefully listen and take a look at anything that you give us. We find your comments extremely helpful when we're trying to do rulemaking. So thank you for participating.

   We won't be entering into discussions. We're listening to what you have to say. We might ask a clarifying question if you're talking.

   And so with that, let's get started. So again, we're going to start with the Medical Treatment Utilization Schedule testimony. And so first I'd like Ken Eichler to come up.


KEN EICHLER

I'm Ken Eichler. I am the Director of Regulatory Affairs for Work Loss Data Institute who publishes the Official Disability Guidelines known as ODG.

   We'll be submitting full written comments on the proposed regulations, but we do want to go on record at this hearing as being in full support of the regulations.

   We believe California is taking a very forward, positive step, and we take that from a national overview perspective, see what other jurisdictions are doing. We believe that this gives an opportunity for the proper ranking
of evidence to be considered rather than locking in long term to any one set of specific recommendations.

The proposed regs also allow for updating and consideration of the dates of review which is very important.

One thing we would encourage the agency to -- the DWC to do is to more specifically clarify exactly who is responsible for ranking evidence and at what juncture in the claims process the evidence should be ranked.

For illustration purposes, for example, if a treating physician is submitting an RFA, a request for authorization, the question is, does the physician have to take the time to rank the evidence when they submit the RFA. We respectfully suggest that the treating physician should not have to rank the evidence on the first line. We think that will complicate matters with the treating physicians. There will be significant pushback from treating physicians and physicians may threaten to leave the system if they are on the front line required to rank the evidence when they submit it to the payors for approval.

It then raises to the next level which would be the next step in dispute resolution, utilization review process. Whether or not the UR doctor is required to rank the evidence of the treating physician and their own evidence and then contrast the two evidence to determine who meets the higher ranking of evidence.
If we then take it to the next level, which is the IMR process, we get back into who ranks and whose ranking trumps whose ranking. We get dueling rankings there. So the question then becomes is, does the IMR physician have the responsibility and is he or she mandated to rank the evidence from the treating physician, from the UR physician, and any new evidence that the IMR doc may put into play.

So we really think there's a need for clarity along the way to keep the process moving and so one knows how to go forward.

MS. OVERPECK: Thank you. Steve Cattolica.

STEVE CATTOLICA

Good morning. My name is Steve Cattolica. I represent the California Society of Industrial Medicine and Surgery, the California Society of Physical Medicine and Rehabilitation, and the California Neurology Society.

We too will be providing full, written comments later in the day, but I wanted to -- first I will amplify on Mr. Eichler's comments with respect to what we believe is an ambiguity in what's been written with respect to who's doing what, how often does it have to be done, and boiling it down to the concept of burden of proof.

It's pretty clear that the burden of proof is on the treating physician and always has been to make a case for what they want, what they believe is correct.
We believe that once the ball's been lobbed over the net however, that whether it's UR or IMR, that other side has an equal burden of proof to respond and respond in full. So that the record is clear, if anybody -- if the question needs to go upstream, let's say to IMR or to whomever. But we do want to compliment the Division and Dr. Das and the MEEAC for recognizing that consensus has always been a major part of the development of what evidence is.

We're going back now ten years to when ACOEM first became part of the nomenclature. We recognize and counted -- in fact, we provided testimony at the time -- that well over half the recommendations for or against a particular treatment were based on consensus for the, quote, lowest rank of evidence at the time. That hasn't changed. And so for the Division to recognize that is a big step forward and we applaud that.

However, we're also convinced that without a -- without a significant new set of incentives for the utilization review vendor and for the payors, a la what we were just speaking about with respect to, you know, the transparency that the Division mentions in its statement of reasons.

Without better incentives we're not sure that, despite what might now be required of the treating physician to go through the full scientific processes described in the regulations, that the UR response is not going to be just as cryptic as it seems to have been sometimes; check boxes,
references to diagnoses that don't apply and so on. So we're hoping that the Division takes a closer look at what has been proposed to be sure that the burden is -- of -- of full communication is held equally.

And I'll just close very quickly with a specific that has nothing to do with burden of proof or any of those things. In 9792.20, the definition of -- letter F, you have modified the definition for functional improvement and we -- we don't have -- we have no issue with how it's been modified, but we would like to, once again, as we have for a number of times going back to the implementation of the chronic pain guidelines some number of years ago, emphasize that there's a -- a huge need for the Division to accept and to define functional maintenance as a qualifying event for an injured worker with respect to getting treatment.

There's absolutely no -- well.... And we've elaborated a little bit more on that and I won't go into it here. But it's seems to make a lot of sense that if I happen to need something on an ongoing basis that doesn't necessarily improve my performance per se but allows me to function at work with limitations or accommodations, why shouldn't that continue; but yet if I don't, quote, improve, I stand a chance of having an ongoing treatment be denied. We don't think that's the way it ought to go.

So without some kind of a mention or a firm definition
or including that possibility in the regulations we believe that they're deficient.

So thank you for your time and we'll get those written comments to you. Thank you.

MS. OVERPECK: Thank you, Steve.

Robert McLaughlin.

ROBERT McLAUGHLIN

Good morning. My name is Robert McLaughlin. I'm from San Diego. I'm here representing myself. I am an Applicant's attorney. I represent injured workers. And I'm also a member of the California Applicants' Attorneys Association.

In preparing for my comments today, I remembered a story about when I was a young teenager. And I grew up back East. Huge New York Giants fan. Loved Lawrence Taylor. And I remember a particular game we were playing against the Dallas Cowboys, our hated enemy, and the running back was making a play and Lawrence Taylor just hit him so hard his feet went up in the air. He landed on his back and his helmet flew off.

And I remember stopping that morning and looking over at my dad who had been a good athlete, and I said, "Dad, did you ever think about playing football?" He stopped, looked up from his paper and said, "Yeah, but one play and then I'd be out for a month because I wouldn't be able to walk again."

The point of that story is how we treat one person has to be not necessarily how we treat everyone. My father was 50
years old at the time, not in the best physical condition and
had been previously a smoker. For him it would have taken a
lot of care to get him to recover from that hit.

This running back got up, put his helmet back on, got
in the huddle and played the next play. So not everybody can
be put into a nice, little box of treatment.

And what I do like about regulations is 9792.20(e) has
incorporated the need for clinical expertise in the definition
of evidence-based medicine. And this is very important because
that's what allows the doctor to decide what treatment is
necessary for the 50-year-old man versus the 23-year-old
running back.

And as the California Applicants' Attorneys
Association has noted in an article they submitted called
"Evidence-Based Medicine: What It Is And What It Isn't" on
page 72 I think they have a very good quote that we should
emphasize and that is, quote, "Evidence-based medicine is not
cookbook medicine. Because it requires a bottom-up approach
that integrates the best external evidence with individual
clinical expertise and patients' choice, it cannot result in
slavish, cookbook approaches to individual patient care."

Now the reason I'm emphasizing that is because
regulation 9792.21(k) appears to be inconsistent with the
definition of evidence-based medicine in the regs and as
provided for in that article as it appears to eliminate
individualized clinical expert approach that's mandated by the
evidence-based medicine.

Also in that same article is another quote and it says, quote, "Even excellent external evidence may be
inapplicable to or inappropriate for an individual patient."

My NFL example is a perfect example. I'm sure that running
back, he was probably hurting. He probably went after the
game, got ice, went to the whirlpool, got a few massages, and
he probably did that for a couple of days, and he was able to
go back to playing. Whereas, my 52-year-old dad would have
been, as he said, probably in the hospital for a month.

And this individualized approach is not just noted in
evidence-based medicine; it's also in other areas of workers'
compensation. Under the AMA Guides it states that the
physician should use his own clinical judgment, skill and
training with regards to that individual patient.

Also in permanent disability we note that we adjust
for age for the permanent disability. We give a higher
disability to those who are older because we do realize it is
not likely they are going to recover as quickly or as
efficiently from their injuries.

Another example where I see this come up a lot is with
my female clients in carpal tunnel syndrome. The federal
government's National Institute of Neurological Disorders and
Stroke has noted that women are three times more likely to
suffer from carpal tunnel syndrome than men.

Now the classic test for carpal tunnel is EMG and nerve conduction studies. However, statistics have shown that these studies are -- or produce false negatives at a rate of up to 20 percent. This means that despite a test result indicating no carpal tunnel syndrome, 20 percent of those results are wrong and in fact the woman does have carpal tunnel syndrome.

This high rate of inaccuracy is also noted in the ACOEM guidelines. They note that nerve conduction studies and EMG may be normal in -- and I quote -- "early or mild cases of carpal tunnel syndrome."

Therefore, in these cases the physician needs to base his treatment recommendations for the woman on his or her clinical expertise and not solely the negative EMG, nerve conduction studies or any other guidelines that tell them not to use his own judgment.

If the physician is not allowed to do so, then women will be disparately impacted with respect to men in the treatment of their carpal tunnel syndrome as women have a three times higher rate of carpal tunnel syndrome and hence would have a three times higher rate of having a false negative than men. For this reason 9792.21(k) should be deleted.

I would like to address 9792.21(i) at this time. This should be amended as there are not medical procedures for which
high-level medical evidence is available.

This fact is noted not only in many medical literature but also in the ACOEM guidelines through their alphabet system of a hierarchy. In many of those situations they indicate that the treatment recommendations are insufficient for irreconcilable evidence. This is also evidenced in my carpal tunnel syndrome example. Therefore, a medical literature search will not locate a higher level of medical evidence because there isn't any. This, in turn, will hamper the physician's ability to rebut the MTUS as authorized by Labor Code Section 4604.5(a).

Thus 9792.21 subsection E should be amended in accordance with the definition of evidence-based medicine in the labor code to allow the physician to rebut the MTUS with regard to specific medical treatment or testing. If the recommendation is the same level of medical evidence, you should support the MTUS recommendation. By doing this, it will provide that women with carpal tunnel syndrome and other injured workers will receive the care they need to get back to work as quickly as possible.

Finally, one further comment on 9792.21 subsection J. In order to avoid unnecessary requests of IMR, this should be amended to include that the level of evidence supporting the recommendation of UR be identified in the utilization review. What this will do is to allow all parties to easily determine
whether the highest level of evidence has been used and we must remember not everybody has counsel so therefore injured workers would be much easier if they could understand this.

So prior to deciding whether to file an application for IMR, it would be nice to know if we had the highest level of evidence or if there is a higher level of evidence because that will avoid many IMR requests.

Thank you.

MS. OVERPECK: Thank you.

Tim Madden.

TIM MADDEN

Good morning. Tim Madden representing the California Occupational Medicine Physicians. We're a group of 20-plus occupational clinics located here in California and our concerns are consistent with the first two speakers in relation to the confusion over the proposed regulations and there was a fair amount of debate amongst our members on what exactly is being required and why and, more importantly, when is the hierarchy of evidence required.

Some of our folks were reading the proposed regulations to say that even for an RFA, request for authorization, that they would need to go through this approach of doing a medical lit search and spending, in their view, upwards of an hour trying to justify what treatment they're trying to get for their patients.
And as it was also mentioned, our folks get really concerned when looking at that amount of time and taking it away from patients and the time they spend with them, and then they start raising up issues that we've talked about for years in terms of how much longer they want to stay in the system.

There was another part of our group that didn't necessarily read it the same way. So we would ask for a clarification as to when specifically it would be required to go down this pathway that you're establishing. I think there was agreement that the pathway you've established is better than what's in place today. So we like that. It's just a question of when it's invoked was the issue raised most frequently.

Thank you.

MS. OVERPECK: Thank you.

So is there anybody else who's here right now who wanted to testify regarding the MTUS regulations? Please come up.

BOB PLANK

Bob Plank, occupational medicine physician.

I'm working with a group of about a dozen occupational physicians and we've been discussing the same things that the representative from COMP just mentioned. And that is, number one, we're strongly in support of the revisions or clarifications of the hierarchy of evidence to be used. We
think that you got it right basically.

At the same time we're concerned that the -- there
appears to be an additional burden of documentation that's
been -- that's being loaded onto the system. And incrementally
the system is becoming increasingly difficult to work with and
the time commitments needed for compliance is really becoming
quite difficult.

So we'd like to urge -- besides the fact that we
support the hierarchy itself -- that the DWC look at the
concerns that we have about the complexity of the system and
how it relates to day-to-day practice, particularly for small
practices, but it affects large practices as well.

And for instance, there are many times, in fact, the
Cochrane people themselves have estimated someplace in the
neighborhood of perhaps 80 or 90 percent of the time when
evidence-based medicine is either not applicable or very
difficult to apply because of differences in patient age,
co-morbidities, genetic predispositions, past medical history,
et cetera and the art of medicine needs to be applied.

And so in those instances we rather encourage that
treating physicians justify their requests in a logical manner
referring to the facts of the situation and that any reply to
that, either in UR or in IMR, be required to address the logic
of the physician's request and not merely say that it doesn't
comply with some cold standard, I guess is the best way to put
So this is something that I think is -- it's very frequent. It happens all day long in an active practice and physicians are required to put their best foot forward. And I think we would ask that, number one, please address some effort at decreasing the complexity for day-to-day practice and, number two, recognize that the logical arguments used in justifying a request, if there's a denial from either IMR or UR, that the denying reviewing physician must address the logic of the situation and not merely refer to standards that perhaps do not list that particular event.

We know that there's a balance, and we are very appreciative of the balance between the need to control unnecessary and possibly harmful treatments that are not based in science versus the countervailing need to allow practice to proceed along high-quality lines.

One of the attempts that was made to encourage that was the MPN's and one of the things that we think would be useful would be to look at improving the safe harbors for MPN's -- excuse me -- for MPN's to police their own ranks and improve the quality within an MPN in order to justify a lower level of scrutiny of physicians who are practicing good medicine.

Thank you very much.

MS. OVERPECK: Thank you. Anybody else? Yes, please.
Hello, folks. My name is Bob Kutzner. I'm an anesthesia interventionist, a PMR and addiction medicine person. I had to come up here. I have a cold, feel terrible. So please excuse me.

I wanted to get before you and, first of all, encourage you that the MTUS is excellent. A lot of people have concerns about it, but in the -- any discipline that we have here, we practice evidence-based medicine. We run around. We get online. We get our journals. We go to conferences, and we're constantly trying to keep up with it.

I had a friend of mine years ago say, "Hey, have you seen the MTUS?" Now, keeping in mind I've practiced workman comp for many years. And no. But I go online, and I looked at the MTUS. And frankly, it was a little boring, but I thought it was very fascinating that you got together 20 or so professionals and they wrote it down. They were doing the work for me. They were doing all the evidence based -- let's go out and look all this stuff up. And it helped me immensely.

I know that we're doing this -- it was initially started for one very basic reason and that is to cut health care costs, improve functionality, you know, et cetera, all of the ramifications that come from that.

If we do properly implement the MTUS, if people do actually follow it, the majority of cases will be taken care of.
in a timely fashion. The problem that we have is that doesn't happen. And there are a few situations, like some of the people have mentioned, that, you know, they're complicated clinically, et cetera; you've got to try to figure it out. And it's not easy.

But we've got a real problem going on here I think in workman comp and the MTUS is an effort to correct that. The MTUS was put together and to be administered in a timely, integrated, multi-modal approach. The MTUS is intended to provide the most current and effective medical care for workman compensation patients.

And you have to keep in mind something. If I'm a pain specialist treating a pain patient, and I walk next door, and I take care of a patient -- a workman comp patient with a rotator cuff tear, then I walk right next door to the next room, and I see a regular pain patient that's not workman comp and he's got a rotator cuff tear, that MTUS information bleeds over into my practice.

So the standards that you create here have big, long-reaching fingers. They affect the care throughout California and I know personally many other states follow the MTUS.

The MTUS makes statements like the providers are required to follow it. It is the authority. And in fact, in general, I think it's very good. It's spot-on.
The problem that we have -- here's the problems, at least as far as I can see -- is insurance carriers are not required to know or implement the MTUS. This is what I run into every day. The State does not require insurance companies to even acknowledge the MTUS. If you want -- if you're an insurance company and you want to provide workman comp, then you apply to the State. You get your certificate. But there's nothing there saying that you at least even acknowledge or read the MTUS. Providers that get on the MPN list for the insurance companies, they are not required to read or even acknowledge the MTUS.

I'm not talking about running around and policing everybody, but last year the prescription overdose meeting that they had formed up here, I came up here, and I talked and there had to be four to 600 people there, including the board. And I asked them all, insurance companies, representatives, providers, et cetera, board members, leaders in the medical field here in the state of California, and one person raised his hand and said he knew about the MTUS. I run into this all the time. Okay?

Third-party payors, same thing. They're not required to even state that they've looked at or read or even know about or acknowledge the MTUS.

This MTUS is simply not implemented to establish the standard of care provided. It's not. But instead, it is used
to litigate care that's already been provided. It's a retrospective. It's not setting up what it intended to do.

Anyway, the consequences of that is the workman comp system has grown into a multi-billion dollar industry frequently abused and misused, often fraudulently. Excuse me.

Insurance companies regularly refuse or deny provider requests as a matter of course regardless if the request follows the MTUS. I'll cut and paste the MTUS and send it in as a request and they'll write back and say no. And instead of doing it in five days, it will take them ten days and then it will go to UR. And everything is fractionated. You can see that. It's exactly what happens.

Utilization review and independent medical reviews, they don't follow the MTUS. Seldom have I ever talked to -- I've talked to them and then they tell me straight up, "I don't follow the MTUS. I follow ACOEM." It's a law. Why don't they? Why don't they know? That's my question.

So what else happens because of that? Most providers don't even know what the MTUS is nor are they expected to by the insurance companies. In fact, it is financially probably more profitable for them not to know the MTUS.

The MTUS will quickly -- as quickly as possible bring a patient all the way to his P&S, most functional state. But if I keep the patient for years, you know.... What's the average time for a workman comp case in California? It's what,
one and a half years. The MTUS -- and just my simple logic, if I broke my legs and I was fed yogurt, Mother Nature would heal me in three months.

This is -- we've got a problem. And all these fine-tunings, they're good. Everything you're doing is good, but there's a bigger problem out there and that's that people are not aware of their need to follow or be aware of the MTUS. It's just that -- that simple.

Not requiring insurance companies and their providers to follow the MTUS has divided, in my mind, the workman comp industry, financially relegating each party to their formal adversarial position. Insurance companies fight with doctors. Doctors fight with insurance companies. There's UR. And everybody is back and forth. And who gets hurt in this; the state taxpayer and the patient.

Patients suffer more and longer. Disability claims soar. Loss of production and decreased functionality ensues. Costs rise, just from that simple fractionation.

Addiction, we all know about prescription overdoses; the big, you know, household term these days. Addiction and physical dependence is created in workman comp patients. Patients are required to comply with workman comp rules so they have to come see me once in while. And when I get delayed and denied, I'm sitting in front of the patient. Next month I can't do anything for them except give them narcotics, help him
with his pain. Either that -- because I'm a pretty cruel man. Now you're out on the case a year and a half later and you wonder why the person is addicted to narcotics. They're not following what you guys have written. Nobody's talking about it. We're not on the same page.

I believe the solution to this is not a gestapo approach, not the -- not the government stepping in and shoving medical care rules down our throats. That's not right. But the MTUS is written by our peers and if anybody knows anything about pain management, it's good. And this is not rocket science here.

So why don't we, please? That's why I drove all the way up here with a runny nose and cough, et cetera. Just to ask you my one opportunity; please, just put a sentence in the MTUS that says that doctors that want to be on a provider network should have to acknowledge that they will follow the MTUS. Simple.

Insurance carriers and TPA's that want to provide workman comp, they should have to acknowledge that they will follow the MTUS. Now you've taken that fractionation, and you've put it together. Now, we have changed our perspective and that we seek first to use the MTUS to establish the standard of care we provide. Then, when necessary, we use it as a measure of that care.

It's very simple. It's the law. You've written it.
And it works as intended if you get the providers and the
insurance companies to at least acknowledge that it exists.

Thank you.

MS. OVERPECK: Thank you. And I hope you feel better
soon.

Anybody else on the MTUS?

PATRICK

Hi, my name is Patrick and I'm -- I'm Joe Public. I'm
not a physician. I'm not in the insurance -- in the insurance
business. I'm just a good, old Californian that drove up here
to take advantage of the public forum to acknowledge the MTUS,
beautiful piece of -- piece of -- piece of work.

But I would like to plead to you and ask you to
implement some kind of process, some kind of check-the-box at
the end of this e-mail that will indicate that all insurance
providers and doctors in the workman comp program have
acknowledged the MTUS as a first step in its -- in its
regulation. Okay? So I wanted to get that statement out.

In regards to evidence based -- again, I'm no
physician, but, you know, sometimes, you know, good medicine
is -- is common sense. And I stumbled upon the MTUS as the
general public and it was a -- it was a good read. It -- it --
it made sense. I mean, multi-modality, multi-treatment, early
intervention, no narcotics, you know, if not necessary with
chronic pain kind of made sense.
And the gentleman that brought up the football injury, well, I was a receiver at Cal Berkeley back in '85. And I suffered a major shoulder injury. That's when they had that astroturf. Did they wait 40 days? Did they wait five weeks? No. They got me on to that cart, drove me in, took x-rays, automatically put ice on it, started the stim.

The next morning, as much as I wanted to, you know, sleep in, I had to get up in the morning, go to my physical therapy, do the ice, do the massage, do the heat, do the exercises, and the next thing you know, hey, ready to take some more punishment the next couple of days.

So in regards to evidence based, you know, if you get very complicated, but I think the essence of the MTUS makes sense and it's good medicine and I think it will put more workers back on the field, saving money, and increasing productivity, and doing a great job for the State of California.

MS. OVERPECK: Thank you. Anybody else on MTUS?
(Whereupon the following proceedings are reported
by Julie A. Evans - Time Noted: 10:48 a.m.)

MS. OVERPECK: Okay. So we're gonna switch over to
the Copy Service Fee Schedule. And as I said before, we'll
come back at the end to make sure we didn't miss someone who
came in late, but --

I'll take this from you.

(Whereupon Ms. Gray hands a document to Ms. Overpeck.)

MS. OVERPECK: So Greg Webber, please.

GREG WEBBER

Good morning. My name is Greg Webber, and I'm the
CEO of Med-Legal. We're one of the leading applicant copy
services in California. It's my pleasure to testify today and
add my comments to the many that I'm sure the Division will
receive on this matter. I've also previously submitted my
written comments to the Division.

I'm certain that you'll hear from a wide range of
interests on this matter, some speaking to complexity and
others speaking to simplicity. The fact of the matter is,
what copy services do is both complex and simple. Yet, even
that bifurcation is understandable. Sometimes what we do is
complex, but it's important to note that usually that
complexity results from exceptional circumstances. Most of
what we do is predictable and routine. At the same time, I
urge the Division not to confuse complexity or simplicity with
value. In either case, the value is the same. The value is
in the discovery, the evidence, the facts and the records we
produce, that together inform the case and the facts in
dispute, ultimately speeding the path to settlement and
reducing costs in the workers' compensation system.

Whether complex or simple, it's not easy, though.

Significant capability, effort, expense, knowledge and
investment is required to identify, retrieve, maintain and
produce accurate records and information. With that in mind,
I'll focus my comments in just three areas. First, I'll talk
to the very issue of value and the importance of not confusing
either complexity or simplicity with value; second, I'll talk
to the importance of reducing the potential for and costs of
dispute; and third, I'll close out with the importance of
providing a clear -- a clear path to complete discovery.

Starting first with value. I believe the Division
has found a reasonable balance for the values prescribed,
probably finding values above those communicated as reasonable
by the payers and values below those as reasonable -- as those
communicated as reasonable by the providers. Further -- and I
think importantly -- by bundling the majority of activities
therein, the sources of dispute are dis -- are minimized. But
it's clear one area of possible dispute therein remains, the
bundling of the so-called release of information fees, quite
clearly an area of exposure to the providers. I believe the
Division is wise in bundling such fees. With such fees bundled, the proraters will be economically motivated to best manage, limit and control such fees within the bounds of their statutory and regulatory control. Therefore, Med-Legal strongly supports the Division's determination of a single, mostly bundled, fixed-fee value.

That being said, the Division is reminded that in the case of Med-Legal, the overall average across every record retrievable -- such release of information fees average approximately $6, and it shouldn't. I'll also take note that any legislative regulatory or statutory movement impactful to the current limits, controls and provisions available to copy services -- to best control such fees should require the Division to revisit and appropriately adjust the bundled fixed-fee value. Any adjustments thereof, whether presently or in the future course of Division activity should be fully informed, market specific and appropriately -- and appropriately responsive to the overall averages.

Nonetheless, I'm sure you will hear many impassioned pleas regarding exceptional circumstances or select circumstances and the costs thereon, likely accompanied by suggestions that the only reasonable path is to unbundle the fee schedule value. I believe that is just the wrong course, rather the bundle is based on an overall view containing both the complex and the exceptional and the simple and the
routine. It is reasonable, it is fair, and it will reduce
dispute and costs. Over time, it even has the potential to
reduce the occurrence of exceptional circumstances and the
associated costs, as the providers will work to screen and
limit those occurrences. The Division should stay the course
on a bundled fee schedule value.

And I have a little analogy here. Can you imagine if
you pulled into a gas station for a gallon of gas, and as you
got the nozzle out to fill your car up a station attendant
rapidly approached and said, "Sir, today you're paying for the
oil that was retrieved from Saudi Arabia, brought here by
tanker with five miles under, went this far -- and by the way,
there was a storm so we had to take the long way around and it
had to go to another refinery" -- can you imagine if you had
to pay for that level of complexity when buying a gallon of
gas? The reality is, the company manages its business to
manage those overall costs. With the expense of oil, the cost
of retrieving it, returning it to the oil refinery, of
fracking those molecules, producing that gallon of gas, you're
paying a bundle value for that gallon. So I do urge that the
Division continue with the bundled approach.

But I think it's also important that the Division
deeply focus on reducing the potential for costs of dispute by
providing a clear set of written provisions that are
knowledgeable, informed and consistent with the real world
activity around copy and related services. Most important
will be starting with the clear definition of "copy and
related services." A solid, clear foundation here will make
the scope a requirement in the deliverable clear, both for the
provider and the payer, with lesser opportunity for dispute.

In my written comments I've proposed an update to the
definition proposed by the Division. I
believe that definition is more deeply reflective of the real
world requirements we face. And also, while I believe that
specificity in billing is important, the Division should
provide more clarity relative to proposed billing codes.

Seemingly, two HCPHCS Level II codes are referenced but are
not specifically matched to the six allowable charges
specified in the fee schedule. At a minimum, if a specific
billing code is to be used, the Division must relay each of
the allowable categories and charges to a required and
specific billing code.

Finally, I noticed there was also some effort in the
proposed regulations to allow copy and related services to be
performed using authorization instead of subpoena. In the
case of the injured worker and their authorized
representative, it is inappropriate to request records under
authorization. Evidence Code 1158 is clear in its
prescription that such services can be done under
authorization only before the filing of any actions. These
provisions should be eliminated.

Taken together, I believe the Division should carefully focus on providing clear, complete, specific definitions, process and requirements, together finding the balance between real world conditions and the economic and functional limits necessary to provide the highest level of benefit for the injured worker. In speaking to that injured worker, I think it's important to protect that worker's right to discovery. My comments and suggestions here are important because some parties oftentimes seek to limit the discovery as a means to reduce overall costs. But it's important to note that such limits really have the potential to significantly increase friction and dispute and, therefore, costs, even if an unintended consequence.

Further, given the overall reduction in costs associated with the fee schedule values proposed, I believe such costs are specific, controllable and reasonable, even when broader discovery is specifically allowed for and provided hereunder. I strongly recommend that the Division carefully balance a clear right to discovery, the reduced costs thereon and the potential of increased costs, to the degree opportunities for dispute might be newly opened by steps, actions or provisions intending to set limits to independent discovery. In particular, I recommend that the Division craft a clear statement of allowable services perhaps
more simply than that currently represented in the proposed regulations. And where the Division seeks to limit services, especially around the 30-day rule, the Division should be more direct and prescriptive in its limits. I've offered suggestions for both in my comments.

To close, let me state clearly that I am supportive of the Division's efforts to formally define a Copy Service Fee Schedule and related regulations. I sincerely believe the proposal represents a step forward by defining a bundled fee schedule value. I support the bundle value. Second, I recommend steps to reduce the potential for dispute by further defining the regulations. And finally, with the costs of discovery reduced, I believe the Division can further reduce dispute by providing a clear path to discovery for all parties.

MS. OVERPECK: Thank you.

MR. WEBBER: Thank you.

MS. OVERPECK: Robert McLaughlin.

ROBERT MCLAUGHLIN

Good morning again. In looking at some of the copy service regulations, there's a few things that I have some issues with, one being 9982(c). I believe this needs to be amended, as it does not address situations in which partial or no records are produced but additional records are believed to exist. I would like to give you two examples in my own
practice that occurred within the last six months.

In one situation, I subpoenaed the records of a physician. I got back a certificate saying "No records." My client insisted he had been to this physician. I then sent out another subpoena, and I got one medical report. My client said, "There's a whole stack of medical records," so I set the doctor's deposition under a notice of subpoena and asked for a production of records. In response to that, we got a whole stack of records. Now, this was not only beneficial to the applicant but also to the defendant, who was trying to prove apportionment. We knew the records were there, we just didn't know why we weren't getting them.

When I took the doctor's deposition, his staff informed me that my client's name was Juan Jose Gonzales and they got confused with another Gonzales, and I didn't realize it until he kept insisting that there were records there and they realized that they had misfiled them. This is not an uncommon practice, unfortunately, in workers' compensation. And I don't mean that in a bad sense, but we are, for the most part, a volume-oriented practice, whether it be physicians or attorneys, and these are the kind of volume types of accidents that occur. But my client, not being able to get those records -- his due process rights and the defendant's due process rights probably would have been violated.

Let me give you another example. I subpoenaed a
personnel file on a case where the issue was good faith termination defense. When I subpoenaed records, I once again got back a certificate of no records. At the time of the hearing the defendant showed up with a personnel file that was about two inches thick. My initial reaction was "Where did that come from? There's no statement under penalty of perjury that these are all the records." So I asked for and got another subpoena of records and yet, this time, even more records showed up. So in each of those scenarios, especially with my first one where some records showed up the first time but then more the third time, and then what showed up the second time was also in the third group, the copy service may not be reimbursed and that may have impact on the due process rights of all the parties.

Now, I also would be remiss in not noting that I realize there's been some abuses by certain attorneys just sending out subpoenas every 45 days, whether they need it or not. What I think should be done is that it should be more like a Federal Rules of Civil Procedure or Federal Rules of Conduct, which is the attorneys should have to be enforced to sign something over and above what we sign for a subpoena, indicating they have a good faith belief that there are additional records. I don't feel the injured worker should be denied due process, but I do feel the attorneys should be responsible of their just willingly sending out documents
without a true good faith. I believe this would be a fair balance that handles both of those situations. Keep in mind also the attorney, if he were to constantly do this, would also be possibly opened up to a BAR review, so I think that might be a better compromise. It's for those same reasons that I think 9982(f)(1) needs to be amended.

One other section I would like to talk about is 9984(a) and (b). I believe this needs to be amended to include not just records produced by an authorization, but all records produced, whether under Section 10608 or by subpoena. This would require us to make sure that we have gotten all the records and it, again, provides us some protections.

I would like to give you two quick examples that have occurred both in the last week regarding Utilization Reviews. I'm getting Utilization Reviews that say, "Medical records and administrative records reviewed." Well, I can see the medical records, but what are the administrative records? So I make a request, and I didn't get them until the day of the actual trial. Now, they weren't noted as administrative records; they were noted as an intake form. I had no way of confirming that that was the same document that was reviewed by the Utilization Review. So, again, for my client's due process rights, these things need to be put on a declaration, under penalty of perjury, that we are getting the documents and the true and accurate documents.
Just one more notation regarding what Mr. Webber said about his example with the oil. I agree whole-heartedly with that, with just one exception. And that is, I am old enough to remember when oil was 55 cents a gallon. I'm now lucky if I can get $4 a gallon. It'd be nice to see if we can put some kind of a COLA increase into this so it automatically adjusts the $180, whether it be every two years or three years so we don't have to come back and revisit this again in five years or six years. Because if we don't do that, we will be here again having this same debate about what will be the proper pricing.

Thank you.

MS. OVERPECK: Thank you.

Rick Meecham?

MR. MEECHAM: I'll defer. Thank you.

MS. OVERPECK: Okay.

Jim Butler.

JIM BUTLER

Good morning. My name is Jim Butler, and I represent injured workers. I'm also President of the California Applicant's Attorney's Association.

There are really three regulations that we see as problematic. The first one is 9982(a). And our problem with it is that it creates an un -- an unequal playing field.

Under the proposed fee schedule, the injured worker's rights
to pursue discovery are severely limited by what will get paid for under the fee schedule. By contrast, the defendant can enter into contract -- contracts whereby they can obtain services outside of the regulations at a lower cost. The injured worker cannot do this. Therefore, a different fee schedule is being applied to defendants by these regulations. The second regulation is 9982(c). This section will work only in cases where the defendant claims the Administration or workers' compensation insurer failed to provide any records within 30 days from the employee's request. But what happens if only partial records are produced? The injured worker or their attorney will believe that there are additional records but be unable to prove who is in possession of the missing records. If a subpoena issues for the additional records and duplicative records are sent, then the injured worker and their attorney must pay for the cost of the records.

We understand that Labor Code Section 53 -- 5307.9 provides that the Copy Service Fee Schedule will not allow for payment for records that are produced within 30 days from an employee's request through an employer, but the regulations must address the situation where partial records are produced. Therefore, we recommend that the following language be added to subdivision (c): "If only partial records are provided within 30 days, this fee schedule applies to obtaining the
additional records in the employer's or insurer's possession which were requested by the injured worker. If duplicative records are included in the records requested after 30 days, this fee schedule shall also apply to those records as the employer claims administrator or workers' compensation insurer should bear the burden of identifying what was previously produced within 30 days of the initial request."

Thirdly, and perhaps most importantly, we see a problem with 9982(f)(1). This section should be amended to read: "... duplicative records are previously obtained" -- excuse me -- "... duplicative records previously obtained and timely served on the opposing party from the same source."

It's too often records are not served, and the injured worker or their attorney should not be charged with having to complete a declaration to accompany the subpoena when they have no knowledge that there are any records in the possession of defendant.

Thank you.

MS. OVERPECK: Thank you.

Dan Jakle?

DAN JAKLE

Hi, my name is Dan Jakle. I represent ARS. We are a major copy service in California, and there was a couple of specific items in the regulations I wanted to address.

The first one has been addressed, I think, by Jim
Butler regarding 9982(f)(1) on duplicative records. We feel that the -- that this particular regulation, the way it's written, severely impacts the applicant attorney's right to discovery, and -- and that just should not be. We're limited here to the fact that the -- the records provided would likely be edited by the defense, and they'd be the only records available.

The second one is 9981, which is the bills for copy services, and I think that Greg Webber identified this. The HIPAA codes that are currently in place -- there's only two of them, and there's not sufficient codes to allow for all six of the charges that the copy services can make.

The third item is Regulation 9982(e)(1). And, basically, the item -- what I wanted to say about that one is that it needs to be more specific. If an applicant copy service allows the 30 days, plus five for mailing, for the defense to provide records, then on the 36th day the applicant copy service should be able to subpoena those records and go out and get them, irrespective of the fact that the defense might provide them on the 38th or the 40th day after their time limit has expired.

Those are my comments. I've also submitted my comments electronically.

MS. OVERPECK: Thank you.

Carl Brakensiek.
CARL BRAKENSIEK

Good morning. Carl Brakensiek on behalf of the California Workers' Compensation Services Association.

First of all, I'd like to congratulate you and your staff for your efforts on this fee schedule. It's been a long process and you've put a lot of time and effort into this, but I think it's not quite ready for prime time. It needs more work. We have heard a lot of testimony already this morning, we have provided our written comments that go into great detail, so I'd like to give just a couple of general comments on the fee schedule.

For those of us who have worked in and were involved with SB863, we know a strong message that that legislation conveyed was that the legislature wants to make workers' compensation more efficient and reduce frictional costs. Secondly, we have laws that we must live with. Both the California Constitution and the Federal Constitution mandate due process of law for all parties.

In this case, the applicant copy services work for the injured worker, and their job is to participate in process, to make sure that injured workers receive due process of law. They have the burden of proof. If they are not entitled to get all the evidence they need to prove their case, they lose. And so when we put together a fee schedule for copy services, we must keep that in mind, that our overall
objective is to ensure due process of law for injured workers.

In the case of copy service fees, there is presently a very high incidence of disputes regarding the bills. Most of the bills the copy services submit for reimbursement are objected to, and so there's a big incidence of friction that exists, and we see very little in these regs that will reduce that amount of friction. We still think that there are going to be disputes, which with more detailed regulations could help them reduce.

Secondly, we're concerned that the proposed fee schedule ought to be revisited and considered in light of the comments that have been made by the various parties to promote independent discovery. Again, the burden is on the injured worker, and we should not be imposing any restraints on their ability to prove their case.

One particular area that I want to touch on is the ROI fees that are mentioned in the regulation. But in your Regulation 9983(a)(3), you basically say that ROI fees are subject to Evidence Code Section 1563. In my opinion, that mere statement is not adequate. Those fees are often out of hand. And even though the Evidence Code attempts to put a cap on them, that limit in the Evidence Code is widely ignored, and you have regulations that do not appear to have any mechanism for addressing that issue, and
that's a common issue.

ROI fees impact employers, they impact injured workers, they impact their attorneys, they impact the copy services. And I think that we need to consider that if there is a situation where the custodian is attempting to extort more than the statutory fees permitted by the Evidence Code, I think there ought to be a mechanism to address that. We believe that you have the power to -- to regulate those fees. And at a minimum, there may be additional costs imposed on the WCAB, perhaps in handling expedited hearings, requests for orders to compel production, et cetera. And so we would urge that you consider those if you're going to revise these regulations.

I guess I just want to conclude by saying there are -- we've made a good start with these regulations, but there are more fine-tuning that needs to be done. And we certainly look forward to continuing to work with you to -- to improve these regulations.

Thank you.

MS. OVERPECK: Thank you.

Diann Cohen.

DIANN COHEN

Good afternoon, everyone. MacroPro and myself have been proponents of the reform. And we really believe that employers should pay what's fair and what's reasonable, and
that's what we have been thumping along for the last three years. And we do appreciate the predictability, simplicity in reducing the issues that cause liens in the reforms. However, we believe that the pendulum has swung a little too far.

First -- our first concern is that when developing this new fee schedule, there was no data based on the type of business we provide or the services we provide that was considered. Data from other states and the federal government was used for medical, for interpreting and court reporters, for their reforms, but none for the document retrieval services that we provide. Obtaining x-rays or films from the custodian -- we're allowed now $5.26. That's just unrealistic. The industry standard is $15. If we say to them, "But we're going to pay you $5.20," they're going to say, "Then you're not gonna get records." And that's just the way it is, so it's unrealistic. So the copy service would then have to lose $9.74 for every x-ray that they produce on behalf of the injured worker, and that's -- that doesn't make sense, that you would legislate a loss automatically.

These regulations also cause concern because there is a lack of the cost of living increases. And notably, the doctors and -- and the California Workers' Compensation has been -- insurance has been -- just been granted an increase of more than what COLA would have provided, and yet there's nothing built in for our industry.
It is important to note that when this process originally occurred, it had nothing -- it had nothing to do with passing on the fees of the custodians. It had to do with billing practices. These regulations do address the billing practices. However, the State only provided a Band-aid on the regulations when it comes to the huge issue that is plaguing the workers' comp system, which is unregulated custodians. Sadly, the State is unwilling or refuses to figure out how to control the costs from these custodians and to regulate them. What they did was they transferred -- they simply transferred the responsibility of who was going to pay for these fees.

I had meetings with the State, and I sat in the meeting and I asked "How is it reasonable that you're transferring the responsibilities of the custodial fees from the benefiting party to a company that is merely making the records available to be used in their research and their discovery?" And Lach Taylor looked me straight in the face and said, "Diann, if you can figure out how to control their cost, we would reverse our decision."

All we're doing is transferring it. It's not fair to those companies, and a lot of small companies will go out of business because of it. The custodian fees are the elephant in the room. And unless they are rela -- unless they are regulated, the State is merely transferring who is writing that check.
And lastly, the DIR increase their own fees for copying records. Is it reasonable that they would regulate and object to a company charging $1 per page, but then allow themselves the same $1 per page? Theirs is a one-step process. They go, they copy the records, and it's done, $1 per page. Copy services have a 19-step process, and they are being asked to do it for ten times less than what the DIR is now allowing themselves. I don't know if that's quite that reasonable, but in the same bill I think it is something that we should ponder.

Thank you.

MS. OVERPECK: Thank you.

Patty Walpeck (sic)?

PATTY WALDECK

Good morning. My name is Patty Waldeck. I'm the founder and president of MacroPro, a defense-only copy service. I think I need my glasses.

I don't want to go over what Diann already talked about, but I would like to talk about the fact that I do also feel that the new regs prevent the injured worker from getting the evidence they need to prove their case. I think where you're talking about the films and the ROI's and the fact that those charges are not the responsibility of the copy service, because we are not a party to the case, we have no claim, we're just a pipeline, if you will, to pre -- to get the
records and give them to whoever should have them, that they
-- the injured worker is not going to be able to get their
records because it won't be paid for if there's an ROI.

Now, the ROI's we haven't talked about, out of state,
have no regulations that prevent them from charging us $1 a
page, plus other charges. So how would the injured worker,
who -- who's -- who needs to get those records, but the copy
service can only charge $180 -- how is that gonna happen? I
don't think that will happen. The same goes for x-rays. When
it's $5.26 a page, we were told that we should tell the
doctors that we won't pay them any more than that and they'll
have to give us the x-rays. Unfortunately, they don't have
to. They'll just tell us to take a walk. I sent Lach Taylor
and also Destie, and others, the note we got from a doctor's
office up here in San Jose where he -- we had objected to a
50-dollar ROI. And he said, "Take it or leave it. The longer
you say 'no,' the longer it will take you to get the records."

So it really isn't up to us to enforce this. It's
really up to the DIR, the WCAB, whoever wants to fight the
fight. And if you think that they will pay attention to the
-- the Code of Civil Procedure where it says that they can
only charge 10 cents a page and $24 an hour, sorry. There's
nobody watching those people at all. And we can't do anything
because we're not a party, and we're not an injured party
because we're a neutral party.
I thank you for listening. I hope that you guys will really look over this again. And I agree with Diann about giving us some way to increase pricing, not us. We do defense, and I'm not terribly as concerned about us as I am about the injured worker. WCIRB approved amended filing for the insurance industry of 9.6 percent this year, and the physicians' costs were approved for an increase of 7.3 a year. What we're asking for is a way to let the businesses who have been started by entrepreneurs, who are in the public sector, to have a way to be able to increase their fees as the State increases workers' hourly pay and other in -- increases go up.

Thank you so much.

MS. OVERPECK: Thank you.

Dan Mori. Mora. Sorry.

DAN MORA

Good morning. My name is Dan Mora. I represent -- I'm the CEO and founder of Gemini Duplication. I also am a member of CWCSA and the former immediate past president. Thank you for the opportunity. I think that it's -- I think it's great that we can have this opportunity, so I appreciate that. I hope that we -- we all listen in the room.

I have done a diagram here, and you guys should all have -- or you will eventually have -- a copy of it. It is the -- it's a simple flow chart of the effected portion of the copy service process, and I would like to walk you through
that, starting with the first block. It's an injured -- the interview of the injured worker, followed by the letter of representation. And those two light -- lighter highlighted boxes are the new process that we're looking at. I'm gonna kind of skip that, but I do want to point out that the current state in this process includes the letter. At least most applicant attorneys send a demand letter via the authority of Regulation 10608 with their letter of representation, so those are usually in one box. But I want to point out also that that 10608 is optional, if you read it. There's a big "if" in there.

Let's see. The next block is the request for records via copy service and subpoena duces tecum, a.k.a. copy-related services. And then this second -- or the next box is the -- the -- what we are all here for really, is to set the ground rules to accomplish the administrative -- Administration's goals to decrease the amount of dispute. That block says, "Respond to Objections and/or Motion to Quash." I put a nice little burst next to that that says if this process doesn't receive -- receive attention via these regulations, unintended consequences are imminent. To the degree we fail to be specific enough in the regulations, that would correspond to the degree of dispute.

I put a nice red line to the likely consequence, and that points to an alternate process in discovery. You have --
you can obtain records through subpoena duces tecum, but you also have the option to depose. Instead of the standard form of discovery, likely copy serve -- through copy services, the applicants and applicants' attorneys must achieve medical evidence reimbursable under law through deposition. I should additionally point out that discovery can be conducted, again, in many ways in a deposition. For example, parties may request the services of a deposition officer to perform copy-related services at the deposition, a service that copy services are uniquely and specifically qualified for.

The next piece I'd like to draw your attention to, again, is those -- those lighter highlighted boxes surrounding the Regulation 10608 demand letter and Labor Code 5307.9, the 30-day waiting period. And I need to point this out. This was in our last meeting with the Chief Counsel -- the former Chief Counsel to the DIR, Kathy Zalewski, validated this for me, which I was glad. This 30-day waiting period, unfortunately, the way it's worded, can be bypassed. The 10608, or at least the 30-day waiting period, starting on -- is triggered by Regulation -- or the invocation of Regulation 10608, which is specifically optional. Without clarification, again, dispute is likely.

I want to speak quickly on price and where we are there. The Labor Code 5307.9 prescribes that it shall require specif -- specificity in billing for these services. I just
want to point out that in CWCSA regulations that were
submitted to the Administration, it separates out into blocks,
or bundles, the actual work that's being accomplished. I
think that's really important to understand because the work
that's actually being accomplished can be verified, and it
should be ver -- or it can be verified, should be verified, by
the judges if there's a question about the discovery process,
et cetera.

I'd like to also speak -- you know, the funda --
fundamental origination of dispute -- these regulations cannot
-- cannot -- cannot fix that. To bridge this gap, trust needs
to be reestablished, specific policy needs to be deliberate,
and enforcement must be held accountable. I will also submit
and I will be e-mailing later on today a white paper on the
understanding of discovery. As you look over that, please --
I want to echo my -- everyone else discussing the right for
the injured worker under the constitution for independent
discovery and right to -- to that.

Finally, please seriously consider subject matter
expert input. Our motives are -- are pure in that we want to
reduce dispute, period. It's a cost to the system, it's a
cost to us that just has to be eliminated. We only desire
stability and fairness. All are available through these
regulations if you choose.

Thank you for your attention.
MS. OVERPECK: Thank you, Dan.

Robert Santoyo?

ROBERT SANTOYO

Hello, my name is Robert Santoyo. I'm the owner of United Document Imaging. First, I'd like to thank the Administration and the staff here for the countless hours you put into, of course, the regulations.

I'm gonna keep it short and sweet. I'm gonna agree with my colleagues here but also disagree with one, and that would be with Med-Legal compared -- concerning the ROI fees. The ROI fees are running ramped. They're not regulated, and I'm gonna give you two examples right off the bat, last week. Since they're brazen in doing it, I'm just gonna go say this. An imaging center for MRI's -- we subpoenaed the records, followed all the rules, waited 30 days, and they send me an invoice for -- let's just jump to the future. Let's say this is all in place -- $150. So $150 for what? No explanation, no invoice, just an invoice that says "$150." I don't know if it's records, I don't know -- I don't know what it is. When I called them and asked, they said, well, my cost is my cost: "If you want 'em, get 'em. Go ahead and file a motion if you want." I just ask to be reimbursed at that time.

This is the kind of reaction we're getting from many of these doctors now. There's even entities which are not entitled to ROI fees which are actually asking for them. I
had a copy service send me a bill from a carrier, a carrier
file. Carriers are party to the case. It's clear -- it's
clear in 1158 that they're not entitled to these fees.
They're charging me $80 to turn around and pay me back with my
own money. It makes no sense.

I think we just -- I'm not gonna sit here and beat up
the whole thing. I think it does have holes in it. I think
it's a work in progress. It's great. I do feel that the ROI
fees are what we should concentrate on. We should regulate
the ROI companies. We do make exception with the WCAB, where
they charge certain fees, but -- unless it is the injured
worker and they're charged a different fee, 10 cents a page,
other things like this.

Compared to Med-Legal, I'm a mom-and-pop shop. This
great nation is made on entrepreneurs. It's gonna put -- this
is a job killer. The ROI fees being implemented are a job
killer. I don't want to have to close down. I'm sure there's
a lot of other small businesses that don't want to close down.
I don't want to put single mothers, fathers or college
students out of work. I'm not gonna do that. I'm sure we'll
all be fine. We'll find a way to build our business model and
survive. But let's put the cost where it belongs, not on the
provider. We have no recourse. We have to wait 'til the end
of the case before we become a party, to turn around and file
a 150-dollar lien to try to get a 180-dollar bill, and it
makes no sense.

We need to take that out. We need to be sensitive to the needs of the injured worker because they're not going to get their records. They're just not going to. It's gonna inundate the courts with motions to compel and produce records. It's going to. It's already happened. I have many of my clients that are saying, "It's okay, Robert. Don't worry about it. We're gonna go ahead and file a motion to compel and produce, we're gonna take up a judge's time in a courtroom to do what we could have easily done."

I do want to say, please be sensitive and understand that the ROI fees do not belong bundled up. Do I support the bundle? I think it's a great way to go, it's -- it's transparency, it's just -- it's -- it's simple. But the ROI fees need to be removed and made a -- a reimbursable by a proof of an invoice and a cancelled check from the bank, as a -- as a reimbursable commodity, something of that nature. It can be fixed if we work together.

Thank you for your time.

MS. OVERPECK: Thank you.

Mark Sektnan.

MARK SEKTNAN

Good morning. I'm Mark Sektnan on behalf of the Association of California Insurance Companies. I'm also here on behalf of a large employer insurer coalition, including the
California Chamber of Commerce and the California Coalition of
Workers' Comp.

I just want to highlight a couple of things. And we
will, of course, have a more detailed letter in later. First
of all, I want to thank the Division for the work they've done
on this. You know, the problem with SB863 is in the
implementation and in the fee schedules and development and
predictabilities that we all need that makes the system work,
and we think this goes a long way. Even though we have some
concerns about the 180, it's higher than the study done by the
Commission on Health and Safety and Workers' Comp, we
appreciate the Division's effort to try and hit that sweet
spot between a reasonable return for the payment for the
services and reasonable and predictable costs for payers. We
appreciate that.

There are a couple things that I do want to highlight
in -- in here. We have two things that I want to bring up.
One is, a lot -- there's been a lot of talk about the subpoena
issue. We all have some language in our letter that deals
with trying to -- we feel that subpoenas are often just thrown
out there just for the sake of throwing them out, even though
there's no intent that the records actually be produced. And
the cancellation fee -- we feel that should also be shared
with the people introducing the -- the subpoena.

Also, the definition has come up -- in 9983(1), we
think you should add the term "but not limited to." One of
the concerns we have and have alway seen in workers' comp --
and we know this comes up -- is that if you're not specific in
the statute, there are those out there in the system who will
find a way around it and try and find a way outside of the fee
schedule. That's why we keep coming back here. You know,
we've done it with drugs, and we did -- we started with
repackaging and then compound, and now we see it with -- we
want to make sure it doesn't happen with -- it's happening
with -- happens with copy fee services. So we'll provide more
detailed comments later.

Thanks.

MS. OVERPECK: Thank you.

Patrick Godinas?

Bob Link?

We're losing our audience. So that's everybody I
have checked. Are there any other people in the audience who
would like to come up and testify regarding the Copy Service
Fee Schedule?

RICHARD MEECHAM

Hi, I'm Rick Meecham. I'm an applicant's attorney.

Your study identified the problem with the cost of
copy services as being billed without getting paid and the
copy services having to wait. I don't see that being
identified or addressed or providing the copy services with a
way to get paid. Instead, what I'm seeing is more regulations. And when we have regulations, regulations become a reason to say no.

After these regulations go out, you will see letters from insurance companies that list all these reasons to say no in their denials for paying these bills, and the copy services will continue to wait to get paid. The regulations need to provide a way for the insurance companies to say yes. If -- if the copy services follow procedure, then they need to get paid. The burden needs to shift to the insurance carriers to pay, and I don't think the Regs have done that and I think they need to.

Thank you.

MS. OVERPECK: Okay. Thank you.

Anybody else who'd like to testify on the Copy Service Fee Schedule?

Okay. I see no one raising their hand, so we will close the testimony for the copy service fee schedule. Please remember that if you have any written comments that you would like to send in, to do it before 5:00 o'clock today. And make sure we get it either upstairs on the 18th floor or e-mail or fax it in.

So now I'm gonna turn back over to the MTUS regulations. Is there anyone in the audience who wanted any more testimony on those regulations?
Okay. No one's raised their hand on that either. So like the Copy Service Fee Regulations, you have until 5:00 o'clock p.m. today to send in any written comments that you would like us to take a look at and address.

Thank you all very much for your participation. We will go back to the office, we'll get the written transcripts which, by the way, we will post on the DWC web page. We will look at every comment and read every comment and make a determination whether or not we want to make revisions for another 15-day comment period. That comment period would be only written comments. And as I said, as long as you've signed up today, you will get notification for the next step that we'll be doing with the regulations.

And thank you, everyone.

(Time End: 11:44 a.m.)

--o0o--
REPORTER'S CERTIFICATE

I, Julie A. Evans, Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that the foregoing matter is a full, true and correct transcript of the proceedings taken by me (pages 27 through 58) in shorthand on the date and in the matter described on the first page hereof.

Julie A. Evans
Official Hearing Reporter
Workers' Compensation Appeals Board

Dated: July 8, 2014
San Francisco, California
I, Richard H. Parker, Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that the foregoing matter is a full, true and correct transcript of the proceedings taken by me (pages 1 through 26) in shorthand, and with the aid of audio backup recording, on the date and in the matter described on the first page hereof.

Dated: July 8, 2014
Fresno, California
/s/

RICHARD H. PARKER,
Official Hearing Reporter
of the State of California,
Workers' Compensation Appeals Board