



2010 BOARD OF DIRECTORS

ELECTED DIRECTORS

Bert Arnold
 Bernard Baltaxe
 Jamie Berenson
 Elliot Berkowitz
 Brett Borah
 Jim Butler
 Joe Capurro
 Charles Cleveland
 Bernardo de la Torre
 David Dugan
 Scott Ford
 Lester Friedman
 Barry Gorelick
 Robert Havens
 Arthur Johnson
 Tom Martin
 Charles Rondeau
 Christel Schoenfelder
 Robert Sherwin
 Lawrence T. Silver
 Dirk Stemerman
 Marguerite Sweeney
 Sam Swift
 Alan Wax
 Jim Yoro
 Robert Zeidner

CHAPTER PRESIDENTS

Heather L. Siles, Chico
 Maureen Burns, Sacramento Valley
 Don Cash, Greater Inland Empire
 Jack Don, San Diego
 Mark Gearheart, East Bay
 Benjamin Helfman, Shasta
 Brett Johnson, Santa Clara County
 Kim Kaufman, Coachella Valley
 Sharon Kelly, Stockton
 Michael Leyva, Los Angeles Metro
 Reuben Lucero, Central Valley
 Rick Meechan, Redwood Empire
 Jaela Nuovo, Monterey Bay
 Alan Riffel, Harbor Area
 George Roland, Southern California
 Julie Sherman, Los Angeles Valley
 Jill Singer, Central Coast
 Bryon Smith, San Francisco
 Dennis Thomas, Orange County

PAST PRESIDENTS

Lowell A. Airola (Deceased)*
 Linda F. Atcherley
 Arthur V. Azevedo
 Victor H. Beauzay*
 Susan Borg
 Melissa Brown
 Richard Cantrell (Deceased)*
 George DeRoy
 Mark Edelstein*
 G. Ronald Feenberg*
 John B. Frailing
 Michael G. Gerson
 Mervin N. Glow (Deceased)*
 Jerome H. Goldberg (Deceased)*
 William A. Herrerias
 Bernard Katzman*
 Laurence R. Lerner
 Eugene Leviton (Deceased)*
 Marc G. Marcus
 Eugene Marias (Deceased)
 Todd McFarren
 J. Andrew McKenna
 David R. Nelson
 Emmett O'Boyle*
 Michael Ozurovich
 Merle Rabine
 Kathryn E. Ringgold
 David N. Rockwell
 Steven Roseman (Deceased)
 Lloyd B. Rowe*
 N. Michael Rucka*
 Joel Rudof
 Frank Russo
 Barry Satzman (Deceased)*
 J. David Schwartz
 Jettie Pierce Selvig
 Marvin N. Shapiro*
 Gilbert Stein
 Eugene Treaster
 Robert I. Vines
 Harold Wax*
 Barry Williams (Deceased)
 Richard Wooley
 Donald Zellman

*Eugene Marias Lifetime Achievement Recipient

Adam Dombchik, President
Barry Hinden, President-Elect
S. Bradley Chalk, Treasurer
Lawrence I. Stern, Secretary
Todd McFarren, Legislative Chair

Karen L. Locke, Executive Director
CONSULTANTS

Donald C. Green, *Chief Legislative Advocate*
 Mark Gerlach, *Insurance Consultant*
 Stephen K. Hopcraft, *Communication Consultant*
 Richie Ross, *Legislative & Public Relations Consultant*

January 20, 2010

Angie Wei, Chairperson
 California Commission on Health and Safety
 and Workers' Compensation
 1515 Clay St., Room 901
 Oakland CA 94612

RE: Comments on "Preliminary Legislative Language for Discussion, November 2009"

Dear Ms. Wei,

The California Applicants' Attorneys Association appreciates the opportunity to provide comments on the package of draft legislative language posted on the Commission's website under the heading "Preliminary Legislative Language for Discussion." We believe the public interest is best served by an open and transparent discussion of this draft language.

Before we provide comments on the specific proposals in the draft language, we want to stress our deep concern over the tenor of these proposals. This statutory language is ostensibly presented as a trade-off under which a permanent disability benefit increase is balanced by cost saving "reforms." However, the reality is that injured workers are being asked to give up basic rights in exchange for an empty promise.

The draft language would strip workers of their fundamental right to present evidence and prove the extent of their disabilities. Under this proposal the physical evidence of the worker's limitations would be disregarded, the opinion of the evaluating physician would be ignored, and the fact that a worker's injuries prevent a return to his or her job would have no relevance. Without the right to present evidence supporting an accurate rating, many workers would be shackled with arbitrary ratings that don't reflect their true level of impairment.

Although the draft language does not include a specific proposal with regard to the maximum weekly PPD benefit, the fact is that no increase would be a fair trade-off for giving up these fundamental rights. If workers have no right to prove their accurate level of impairment, it doesn't really matter how much the maximum weekly benefit is increased because workers will not receive those benefits anyway.

This draft language was developed following issuance of the *Ogilvie* and *Almaraz/Guzman* en banc decisions in February, 2009. Unfortunately, the reaction of the employer community to these decisions was based on a misunderstanding of the nature and effect of these decisions. These decisions did not establish a *new* right to rebut a permanent disability rating, that right had been available to both parties from the beginning of the workers' compensation system. This *fundamental* right is one that has served a vital role for many years allowing, in a limited number of cases, the parties to present additional evidence to insure an accurate disability rating for an injured worker. The real importance of these decisions is that they establish strict rules, in light of the statutory changes adopted in SB 899, that regulate how and when the parties may rebut a rating under the new 2005 PDRS.

Furthermore, after reconsideration the *Ogilvie II* and *Almaraz/Guzman II* decisions establish strict limits on rebuttals. For example, the *Ogilvie* decision allows only a very limited use of experts. In *Almaraz/Guzman II* the Board specifically required that in developing an impairment rating it is not permissible to use evidence other than the *AMA Guides*, and that any impairment assignment that is not based on the *AMA Guides* will be disregarded. After SB 899 and before these decisions, there were *no limits* on rebuttal evidence. These decisions maintain the important right to present rebuttal evidence within strict limits set forth in the decisions.

Ultimately, however, we are concerned not with only these two decisions. Presenting rebuttal evidence to prove a case is a fundamental due process right that is far from unique to workers' compensation. A conclusive rating schedule would not allow a trier of fact to provide the Constitutionally-required "substantial justice" because the judge and Board would be bound by the schedule regardless of the evidence presented by the worker. Requiring the judge and Board to disregard evidence also violates the substance of Labor Code §3202 which requires liberal construction of the law on behalf of injured workers.

Losing the right to present rebuttal evidence is the same as eliminating grievance and arbitration rights in a union contract. Workers would not trade away their grievance and arbitration rights for a wage hike; similarly workers should not be asked to trade away their rebuttal rights in workers' compensation for a chimerical benefit increase.

1. Permanent Disability Rating Schedule

The draft language proposes several amendments.

- §4660(e) is added, stating that it is the intent of the Legislature to abrogate the holdings in *Almaraz/Guzman* and *Ogilvie*.

We oppose this change. Eliminating the right to present rebuttal evidence would harm both workers and employers. As noted by the Board, in some cases rebuttal evidence may justify a higher rating, but in other cases such evidence will

justify a rating *lower* than the generic *AMA Guides* table rating. Furthermore, these decisions have limited applicability. They apply in a limited subset of cases. Many, many more cases will be rated using the generic *AMA Guides* table rating. These decisions and the strict limits they place on rebuttal evidence, including the requirement that rebuttal evidence is confined to the four corners of the *AMA Guides*, present a stable solution to the uncertainty and unpredictability that was previously feared to exist in the rating process.

As noted above, these decisions actually regulate and limit rebuttal in permanent disability rating. It took several years to establish these rules, and although there will be further refinement of these rules in the coming years they are now providing sufficient stability so that the parties can settle cases and resolve outstanding disputes. Statutorily overturning these cases would be a major step backward, re-introducing uncertainty and unpredictability to the rating process.

As noted in the recently released Commission report, “California’s Volatile Workers’ Compensation Insurance Market,” one of the major causes of the pricing problems experienced by workers’ compensation insurers in the recent past was “repeated legislative and judicial changes in the workers’ compensation benefit system.” These pricing problems contributed not only to the multiple insurer insolvencies of the early 2000s, but also to the extreme overpricing (insurance rates in 2005 were *100 percent too high*, according to this study) that plagued employers during that same period. Overturning these cases and introducing new undefined and vague provisions describing the rating schedule could lead to a repeat of those problems.

As noted earlier, the Board’s decisions after reconsideration significantly limited the scope of rebuttals. We recognize that both decisions have been challenged and are now awaiting action in appellate courts. It is to the advantage of both workers and employers to abide by the final disposition of these cases, rather than to plunge the system back into uncertainty where the only winner was the insurance industry.

- §4660(b)(1) is amended to require application of the “express methodology” of the *AMA Guides*.

Although the term “express methodology” is not defined, it is apparently intended to define a rating process under which the generic table rating from the *AMA Guides* must be “mechanically and uncritically” assigned. [See *Almaraz/Guzman II*, page 22.]

We oppose this change. Basing the impairment rating “on a rigid and standardized protocol that is devoid of any clinical judgment” [see *Almaraz/Guzman II*, page 22] is a clear *misapplication* of the *Guides*. The underlying philosophy of the

AMA Guides is that assigning a rating that most accurately reflects the injured worker's true impairment requires application of the evaluating physician's judgment, experience, training and skill. The Board cited numerous examples of specific directives in the *Guides* regarding how an impairment rating is to be assigned:

the physician is "to provide an independent, unbiased assessment" of the worker's medical condition;

"an impairment evaluation requires considerable medical expertise and judgment";

"the physician must use the entire range of clinical skill and judgment" and on that basis "the physician may modify the impairment rating;" and

"the *Guides* suggests that physicians use clinical judgment."

[See *Almaraz/Guzman II*, pages 22 - 23.]

The fact is that the *AMA Guides* are guidelines, not rigid standardized protocols that can be blindly applied without regard to the individual patient. The Board's holding in *Almaraz/Guzman* is nothing more than an affirmation of the *Guides*' own instructions.

Furthermore, an inflexible application of generic ratings in the *AMA Guides*' tables would produce inaccurate ratings because of internal deficiencies in the *Guides*. There have been strong criticisms of the *Guides* ratings, particularly criticizing the fact that the impairment percentages are not empirically based and often are inconsistent from chapter to chapter. [See, for example: Spieler, Emily A., JD, Peter S. Barth, PhD, John F. Burton, Jr., PhD, LLB, Jay Himmelstein, MD, and Linda Rudolph, MD, MPH, "Recommendations to Guide revision of the *Guides to the Evaluation of Permanent Impairment*," *JAMA*, January 26, 2000, Vol. 283, No. 4, p. 519.]

One of the most disturbing criticisms is that some ratings in the *Guides* are based on value judgments that are gender biased. [See Pryor, Ellen Smith, "Flawed Promises: A Critical Evaluation of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*," *The Harvard Law Review Association*, 1990.] Although this criticism was based on an earlier edition of the *Guides*, a review of the 5th Edition shows that many of the same problems persist. For example, descriptions of the activities of daily living of women include "shopping for groceries, cooking, cleaning, and helping her children with their homework" [see page 326], "light housework" [see pages 33 and 50], "mopping and cleaning" [see page 45], and "household activities and caring for her children" [see page 556]. For men, descriptions of activities of daily living often include the ability to engage in strenuous sports such as tennis, bowling, or golf. This stereotyping of women's activities of daily living can directly translate into lower ratings for a similar functional impairment.

A specific example of the gender bias in the *AMA Guides* is in the treatment of carpal tunnel syndrome. Unlike most other work injuries, carpal tunnel injuries most often affect women. Despite the fact that workers suffering carpal tunnel injuries have significantly more time off work than most other injuries, and thus wage loss is high for this type of injury, the *AMA Guides* assigns either a minimal or no impairment to this condition.

Case law holds that limitations in the rating schedule cannot be relied upon to assign an inaccurate rating. [See *Glass v. Workers' Comp. Appeals Bd.* (1980) 105 Cal.App.3d 297,307; 45 CCC 441, 449.] In order to assign an accurate rating the *AMA Guides* must be applied as directed by the *Guides* itself, allowing the evaluating physician, relying on his or her clinical judgment and experience, to develop an independent, unbiased assessment of the worker's medical condition and the functional limitations that arose from the work injury.

- §4660(b)(2) is amended to reduce statutory oversight on diminished future earning capacity, eliminating any reference to the RAND findings, and instead mandate that diminished future earning capacity will be a numeric formula determined by the Administrative Director.

We strongly oppose this proposal. This language would give the Administrative Director, a political appointee, virtually unlimited authority to manipulate the rating schedule. In 2005 the AD adopted a schedule based on her arbitrary "policy decision" and that schedule has been devastating for disabled workers who have seen their permanent disability benefits slashed by 60%.

Giving the AD *carte blanche* authority over the schedule would inevitably leave the rating schedule as a pawn to be reconstructed whenever there is a change of administration. As noted above, constant system changes lead directly to higher costs for employers because of the uncertainty generated by these changes. The growth in insurer expenses since 2004 is a stark example of this problem. In 2004 insurers' expenses represented 24% of the collected premium, but by 2008 expenses represented nearly 40% of the premium.

In addition, the proposed remedy which allows the schedule to be rebutted only by empirical evidence showing that the "factual basis for calculating the numerical formula . . . is erroneous" is completely illusory. Because there is no statutory definition of this formula, whatever formula is created by the AD is, by definition, correct. In other words, the "factual basis for calculating the numeric formula" is whatever the AD says it is; consequently it can never be found to be "erroneous" and the schedule can, therefore, never be successfully rebutted.

Instead of adopting further vague and untested amendments, the most important change needed today is the adoption of a rating schedule that complies with both the letter and the spirit of §4660 as amended by SB 899. That section requires the adoption of an empirically based rating schedule that fulfills the goals set forth in the RAND Interim Study conducted under the auspices of the Commission. Importantly, that section does not require, or even suggest, that the overall benefit level was to be cut by more than half.

As noted by the Commission in its February 23, 2006 report, “Permanent Disability Rating Schedule Analysis,” empirical data needed to calculate adjustment factors as recommended by RAND were not available when the 2005 PDRS was adopted. However, the DWC now has data collected under the 2005 PDRS that can be used to formulate empirically based rating factors. In fact, a public hearing was held almost 18 months ago to consider possible changes to the FEC adjustment factors based on new empirical data, but to date no revisions have been made to the original non-empirical rating factors.

Labor Code §4660 requires the Permanent Disability Rating Schedule to be amended at least once every five years. The Commission should urge the DWC to comply with the law and adopt appropriate adjustments at this time through the regulatory process. The discussion should not be how to take away two decisions that add stability and certainty to the system. Instead, the DWC can ensure ongoing stability by complying with the law and immediately starting the regulatory process to consider appropriate revisions to the 2005 PDRS in light of the empirical data collected during the past five years.

Hundreds of thousands of disabled workers have received grossly inadequate benefits under the 2005 PDRS adopted by the Administrative Director. Expanding the authority of the AD to manipulate future revisions to the rating schedule is not a reasonable solution to this egregious problem.

2. Permanent Disability Benefits.

- The draft language proposes two amendments that affect PPD benefits:
- §4453 is amended to signal the intention to revise the weekly maximum PPD benefit; however no specific figure is provided.
 - §4658 is amended to eliminate the progressive schedule of weeks and assign instead a constant four weeks of benefits for every one percentage of a PPD rating.

CAAA believes that increasing the current inadequate level of permanent disability benefits is the most urgent change needed in California’s workers’ compensation system. As noted by the Supreme Court in *Benson v. Workers’ Comp.*

Appeals Bd. (2009) 170 Cal.App.4th 1535, 1557, “both workers and employers were to benefit from Senate Bill No. 899 as a whole.” Employers experienced a dramatic drop in their costs after 2004, with insurance rates falling by two-thirds – a much steeper drop than had been expected. Insurers also saw immediate gains, as profit levels skyrocketed in the years immediately following enactment of SB 899, again far exceeding expectations. But injured workers have experienced devastating and unintended cuts in their permanent disability benefits.

The proposed amendments in the draft language fail to correct this problem, and, in fact, impose further benefit cuts on many workers. Specifically, changing the number of weeks to a constant four weeks per 1% of the rating would significantly reduce the number of weeks awarded to the most severely disabled workers. As shown in the chart below, this reduction in weeks climbs as the rating increases:

Rating Percentage	Current # of Weeks	Proposed # of Weeks	Percent Change
50	286	200	-30%
60	366	240	-34%
70	446.25	280	-37%
80	536.25	320	-40%
90	626.25	360	-43%

For higher paid workers this reduction in the number of weeks would be at least partially counter-balanced if an increase in the maximum weekly benefit under §4453 is also adopted. However, lower paid workers will be unaffected by an increase in the *maximum* weekly benefit. Consequently, for these low paid workers the only change in their overall benefits will be the decrease in the number of weeks as shown in the table above. Thus, a lower paid worker with a 50% rating will experience a 30% drop in PPD benefits, a low paid worker with a 60% rating will experience a 34% drop in PPD benefits, *etc.*

Because of this adverse impact, we oppose the proposed changes. Instead, a fair benefit adjustment should increase both the maximum weekly benefit and the number of weeks awarded for each percentage of disability. California’s maximum weekly PPD benefit – just \$230 per week for most workers – is nearly the lowest benefit in the nation and is less than half of the median state. This deplorably low benefit must be significantly increased to make certain that disabled workers are able to meet their financial burdens and are not forced to rely on other taxpayer supported programs (food stamps, Medi-Cal, welfare, State Disability Insurance, Unemployment Insurance, Social Security Disability, *etc.*) to survive.

However, as noted an increase in the maximum weekly benefit would not affect many lower paid workers. These workers are being rated under the 2005 PDRS, and as a result experienced the same steep decrease in benefits as all other workers. Consequently, any changes designed to correct the unintended decrease in permanent disability benefits must also include an increase in the number of weeks.

3. Medical-legal Evaluations – AMEs/QMEs.

The draft language proposes several changes in this area.

- Amend §4062.1. Current law gives an unrepresented worker 10 days to request a QME panel before the employer can make such a request; this proposal eliminates that right.

We oppose this change as it would effectively stack the deck against the injured worker. The current provision recognizes the fact that an unrepresented worker has much less knowledge of the system than a professional claim adjuster. In order to prevent the much more experienced adjuster from steering the worker to a particular evaluator or specialty, the law gives the unrepresented worker 10 days to exercise the right to select the specialty of the evaluating physician.

Since the employer can now file a request for a QME panel if the unrepresented worker does not make the request within 10 days, this change would not actually speed up the process. Instead, the sole intent of this change is to eliminate the unrepresented worker's right to select the specialty of the QME panel physicians. If the proposed change were adopted, adjusters would automatically file a request for a panel because that action would cancel the worker's right to designate the evaluator's specialty. In fact, this change would allow the adjuster to file a request for a QME panel before the worker even knows that there is a dispute over a treatment request or that an evaluation is otherwise required.

If unrepresented workers are failing to send in timely requests for a QME panel, the solution is not to take away important rights but to improve benefit notices and other communications with these workers to make certain they understand and exercise this right.

- Amend §4062.2 to eliminate the requirement for represented parties to seek agreement on an Agreed Medical Evaluator (AME) before requesting assignment of a QME.

We oppose this proposal because it would have the effect of reducing the use of Agreed Medical Evaluators. Although the proposal also includes language allowing

the parties to select an AME at any time, it would be inefficient and add unnecessary costs if the QME selection process is started and the parties then select an AME.

We also have concerns about the extra cost and burden this will put on the State and the DWC. Since 2005 the panel QME process has been anything but efficient. Many panel QME requests are not issued on a timely basis, resulting in unnecessary delays in resolving claims. Because it would flood the DWC with added requests for QME panels, this proposal would only exacerbate the administrative delays. Furthermore, due to a steady decline in the number of QMEs in recent years, it is likely there would not be a sufficient number of QMEs to handle the added volume of requests, even if the DWC could turn around the panel QME requests in a timely manner.

The use of a physician who has been agreed upon by both parties minimizes further disputes over his or her findings, reducing delays and costs. Consequently, we strongly believe that the use of AMEs should be expanded, not curtailed. We recognize there is a problem in that some AMEs have such a large caseload that there is a delay in receiving an appointment with these physicians. However, the solution to this problem is not to discourage the use of AMEs, but to make necessary changes in the system to encourage more physicians to act as AMEs. In this regard, please also see our comments regarding lien changes below regarding the imposition of added bureaucratic burdens on both treating and evaluating physicians.

- Amend §4064 to eliminate the employer's liability for attorney fees where the worker is unrepresented and an employer files an Application, instead providing that such fees are payable only when the employer files a Declaration of Readiness.

We oppose this proposal because it places the unrepresented worker at a severe legal disadvantage. The fact is that the litigation process starts when the employer files an Application for Adjudication. Thus, the employer's liability for attorney fees should commence at that point, when the employer initiates the formal dispute resolution process.

Waiting until the employer files a Declaration of Readiness (DOR) is too late. By statute a Mandatory Settlement Conference (MSC) must be held not less than ten or more than 30 days after the filing of a DOR. The WCJ has full authority to resolve the dispute at the MSC, and if the dispute is not resolved, discovery is closed and the matter is set for trial. [See Labor Code §5502(e).] This means that the employer may have had months or years to develop its case and produce necessary evidence, while the worker and the newly hired attorney may have less than 10 days.

Thus, this change would effectively eliminate the employer's liability for attorney fees where the employer initiates litigation. The consequence would be that there would be no disincentive for employers to file Applications for Adjudication and delay settlement on unrepresented workers' claims. In fact, after an employer files an Application, this change would actually create a *disincentive* to file the DOR as that action would trigger the employer's liability. Instead the employer would have an added financial incentive to delay the case. The result would be that unrepresented workers would face more delays and would be under more pressure to accept inadequate compensation.

- Amend §4062.5 to make AMEs subject to regulatory time frames.

This change is unnecessary because recent amendments to QME regulations already make regulatory time frames applicable to AMEs. [See California Administrative Code, Title 8, §38, Medical Evaluation Time Frames; Extensions for QMEs and AMEs.]

4. Liens.

The draft language proposes several changes in this area.

- Amend §5304 to establish an administrative bill dispute resolution process.
- Amend §123 to allow the Administrative Director to hire medical billing specialists.

We support the concept of an administrative bill dispute resolution process. The resolution of purely medical billing disputes through the Appeals Board has caused problems at some Board offices, and adoption of an administrative process that fairly adjudicates billing disputes could reduce this unnecessary workload.

However, we caution that such an administrative process cannot and must not restrict or delay the provision of prompt and appropriate medical treatment to injured workers. In many cases what is portrayed as a "billing dispute" involves issues of AOE/COE, determination of the appropriateness of a medical treatment, or some other similar issue that affect the fundamental rights of injured workers to receive full medical treatment for their work injuries. Any disputes involving the worker's right to full medical treatment must continue to be resolved through the appropriate forum, the Workers' Compensation Appeals Board.

Furthermore, this is not an appropriate time to adopt changes that would require setting up an entirely new unit and hiring new personnel. Despite the fact that the DWC is 100% user-funded, in 2009 it was still forced to participate in the mandatory furloughs. In addition, the adoption of the Electronic Adjudication

Management System (EAMS) has caused a tremendous increase in workload for the Board offices.

Unfortunately, it has been the injured worker who has paid the price for these problems. Paperwork has not been processed and hearings and trials have been delayed, leaving many workers in limbo while their two-year limit on temporary disability benefits runs out. Attempting to set up an entirely new unit at this time would only increase the problems experienced by the DWC, which would inevitably lead to more delay and more harm to injured workers.

- Adopt § 4903.05 to re-establish a \$100 lien filing fee.

We oppose this proposal which would re-adopt a provision that was originally adopted as part of SB 228. A \$100 lien filing fee was introduced in 2004 and immediately caused problems for the DWC. According to the Administration, the lien filing fee requirement “created a workload that does not positively impact the settling of claims and instead has created a process that is inefficient for the division and the district offices.” It was also determined that the lien filing fee may have been a barrier for legitimate claims by small businesses such as interpreters, document copy services and transportation services. [See Senate Budget Subcommittee No. 3, Agenda, May 18, 2006, at: http://www.senate.ca.gov/ftp/SEN/COMMITTEE/STANDING/BFR/_home/out/051806LABOROUTBRIAN.PDF]

The re-adoption of this fee would generate the same problems, creating unneeded additional work for the DWC and removing any incentive for insurers and employers to pay minor billings. Service providers should not be forced to pay a \$100 filing fee to collect a \$75 billing for minor services such as a prescription, an X-ray, interpreter’s services, or a medical transportation fee. Such a fee would have the consequence of driving providers out of the workers’ compensation system and possibly out of California, and this extra “tax” on providers would not help California’s ailing economy.

- Amend §4903.1 to mandate that treatment must be pre-authorized and physician must be an authorized provider.
- Amend §4903.7 to require physician to include extensive new documentation and declarations under penalty of perjury in any lien filing.

We oppose these changes as they would create unnecessary burdens on service providers. The workers’ compensation system is already the most highly regulated medical delivery system in California, consisting of an extensive and sometime bewildering array of statutory and regulatory controls. Medical treatment is subject to a treatment utilization schedule adopted by the AD. All treatment requests are subject to mandatory utilization review. If an employer has contracted with a Medical

Provider Network (MPN), all treatment must be provided through that network, and MPN statutory provisions include a second and third opinion procedure along with a separate Independent Medical Review process to handle disputes regarding treatment. We would welcome a recommendation to require that employers and insurers authorize medical treatment recommendations made by MPN physicians. This would significantly reduce unnecessary medical utilization review costs, speed the delivery of appropriate medical treatment, and improve return to work.

Most of these controls were adopted as part of the 2004 statutory changes, and the unfortunate impact was the inappropriate denial of many medical treatment requests. These improper denials obviously harmed injured workers, who were forced to either wait or to attempt to secure the necessary treatment through another (possibly taxpayer supported) system. But these problems also affected providers, who were faced with a huge increase in workload in order to deal with these new rules, while also receiving lower fees (which were reduced as part of the 2004 statutory changes).

This situation has caused a number of physicians to drop workers' compensation claims from their practice. Creating additional burdens for providers to receive payment for their services will only increase this trend. Furthermore, the proposed language includes many new but vague provisions that will create new disputes. For example, proposed language in §4903.1 includes the following condition: "if at the time the expense was incurred the provider either knew or in the exercise of reasonable diligence should have known that the condition being treated was caused by the employee's present or prior employment." Determining whether the provider "knew or should have known" a specific fact will in most situations be a subjective determination, not subject to a cut-and-dry answer. In addition, adding such vague language would also lead to increased litigation, the increased use of experts, and significant unnecessary costs.

The current statutory and regulatory controls are more than adequate to assure that only necessary and appropriate medical treatment is provided to injured workers. Adding these new provisions would only lead to a further exodus of providers from the workers' compensation system. The decline in the number of physicians who act as QMEs is already creating unnecessary delays in the system; any further decline in this group will have a major detrimental impact on both workers and employers.

- Amend §4903.7 to restrict the time limit for filing a lien.
- Amend §4904 to extinguish the provider's right to reimbursement if a lien is improperly filed.

We oppose these proposals because these changes are also unnecessary. Rather than creating added burdens on providers who file liens, we strongly recommend that statutory or regulatory changes be developed to reduce the need for

providers to file liens. If the provided treatment is consistent with the adopted medical treatment guidelines, if a treatment is approved through a utilization review procedure, if a treatment is provided by a physician in an approved MPN; in each of these cases, why is it necessary for the provider to file a lien in order to receive payment?

It is important to assure that disputes are not caused by preventable problems. For example, some bills may be disputed because the CPT codes used in our system are woefully out of date. Bringing these codes up to date could eliminate a significant number of disputes, and thereby eliminate the need for the provider to file a lien. The DWC should also be urged to expedite implementation of the proposed electronic billing system in order to improve the timeliness of payments and obviate the need for many providers to pursue payment via the lien process. Instead of proposing improper restrictions on the right of providers to file a lien, potential changes to lien rules should focus on reducing the number of liens filed by assuring that providers' billings are paid promptly.

5. Permanent Disability Benefit Advances.

The draft language proposes to amend various Labor Code sections to eliminate the requirement that an employer pay permanent disability benefits prior to issuance of the final award if the employee has returned to work or has failed to provide documentation of his or her employment status.

We oppose this proposal because it would slow down the settlement of cases. If PPD advances are not required, the employer and/or insurer has no incentive to promptly resolve the case. Delaying the settlement of PPD benefits will have no cost – in fact, withholding PPD advances would represent a windfall for insurers and employers who would profit from continued investment earnings during this period of delay. Delaying settlement could also lower PPD benefits if workers are forced by the delay to eventually agree to a lower settlement.

Many workers experience major financial hardship during their period of temporary disability. Although maximum TTD rates have been significantly increased in recent years, it must be recognized that many workers still experience problems following a work injury. Even if these workers return to work, they depend upon the PPD advances to dig themselves out of the financial hole caused by their injury.

Furthermore, implementing this proposal would entail establishment of a multi-track system to pay PPD. The insurer/employer would be required to constantly update the worker's earning status, creating additional new expense costs. This proposal would also create a number of new issues that will inevitably lead to more disputes, which will add costs and slow down settlements.

Finally, we urge that one change that should be considered is to add a provision to statute that whenever there is a delay in PPD advances for any reason, interest should be paid on the delayed benefits during the period of delay.

6. Supplemental Job Displacement Benefits and Return-To-Work Incentives.

The draft language proposes two changes in these areas.

- Amend §§4658.5 and 4658.6 to repeal the Supplemental Job Displacement Benefit.

We oppose this change. Because the vocational rehabilitation program has been repealed, the most severely disabled workers now have only this limited program to acquire the retraining they need to return to work. **The importance of job retraining assistance and its positive impact on California's economy cannot be underestimated in this time of record unemployment.** Eliminating this program will force workers to either self-fund retraining costs or look to public programs to acquire necessary job skills, which would shift costs from employers to taxpayers and/or the disabled workers themselves.

- Amend §4658 to eliminate the benefit adjustment (+/- 15%) which was originally intended to increase incentives to return-to-work.

We also oppose this change because it directly contradicts repeated recommendations from RAND and other researchers that a major goal of our system should be to *increase* return-to-work. Eliminating incentives to improve return-to-work can only lead to increased wage loss for disabled workers who cannot return to work.

We understand that employers and insurers assert that these two programs have been poorly administered and have not provided the level of assistance needed by some workers. However the solution is not to toss out the entire programs. Statutory changes that would have corrected some of the problems were agreed upon by all parties but the legislation was inexplicably vetoed by the Governor. Rather than eliminate these programs, further efforts should be made, either through regulatory or statutory changes, to resolve any administrative problems in these programs.

7. Second Opinion for Spinal Surgery Process.

The draft language proposes to amend §4062 to eliminate the Second Opinion for Spinal Surgery process.

We oppose this change. The original intent behind adoption of this separate process is still valid. The Legislature created a faster dispute resolution process for spinal surgery disputes because the timely resolution of these disputes assures that appropriate treatment is expedited. Prompt treatment is important not only because it reduces costs, but also because unnecessary delay in these cases can aggravate the worker's condition.

According to the most recent data from the Workers' Compensation Insurance Rating Bureau, back injuries remain the single most common body part injured, and the medical costs of back injuries are among the highest of all injuries. Consequently, maintaining this expedited dispute resolution process for spinal surgery disputes remains important to minimize delay, speed recovery and reduce costs.

Furthermore, an *en banc* decision (See *Cervantes v. El Aguila Food Products, Inc.*) recently issued by the WCAB clarified this second opinion process. A previous Board decision required an unnecessarily cumbersome process and permitted unreasonable delay in resolution of spinal surgery disputes. However, with issuance of this new decision all parties are aware of their rights and responsibilities and the process can now work as intended, providing the intended expedited resolution for spinal surgery disputes.

8. Official Medical Fee Schedule.

The draft language proposes two changes.

- Amend §5307.1 to revise the fee schedule for Ambulatory Surgery Centers.
- Amend §5318 to eliminate the "pass through" fee for hardware in spinal surgeries.

We believe that further information must be collected and analyzed before the advantages and disadvantages of these proposals can be determined, and therefore we have no position on these changes at this time.

We support the adoption of reasonable medical fee schedules. However, adopting fees that are too low is as harmful as adopting fees that are too high. We recommend that both of these proposals be studied further to determine whether adjustments need to be made in the current fee schedules. Adopting inappropriate changes could create incentives not to provide necessary treatment, or to exit the workers' compensation practice altogether.

For example, one of the assertions regarding the "pass through" fee for hardware in spinal surgery is that the cost of these devices is already included in the baseline fee for the surgery. Consequently, it is asserted that providing the "pass

through” fee is a double payment for the same item. While this may be correct (see below for comments on the data), the proposed solution – eliminating the “pass through” fee – would simply create another major problem. If it is true that the cost of the hardware is included in the baseline fee, then the facility gets this fee whether or not it uses the hardware. Consequently the facility will be reimbursed for hardware whether or not it the hardware is actually used in the surgery. Although we are not in any manner suggesting that facilities are governed solely by such financial considerations, it is nevertheless inadvisable to establish a fee structure that has a built-in incentive *not to use* hardware in spinal surgery.

With regard to the data, it is our understanding that the current cost information is based solely on Medicare patients and procedures. There are major differences between Medicare and workers’ compensation patients, and Medicare costs may or may not be representative of workers’ compensation patients. Efforts should be made to acquire appropriate workers’ compensation cost data to determine whether changes are needed in the fee schedules in these areas.

Conclusion

Again we appreciate the opportunity to comment on these proposed changes.

Sincerely,



Adam Dombchik, President
California Applicants’ Attorneys Association