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	Commenter has three points to make. The first in is regard to the potential confiscatory impact of the proposed regulation. Whether or not the regulations are confiscatory going forward with respect to purchases of drugs -- pharmaceuticals negotiated and made after the regulations effective date, they raise the very real possibility that they are confiscatory with respect to two types of drug purchases as to which physicians have already committed. The first relates to stock on hand. Many physicians have drugs on hand that they have already purchased, but they will be dispensed after the proposed effective date. These drugs were purchased at a price determined in the market where a physician has expected a certain level of reimbursement upon disbursement. The regulations will be changing this market in the middle of the game, and physicians stand to be reimbursed for these drugs at a substantially lower rate, potentially at a rate that is less than they paid for the drugs in the first place. As to these drugs, physicians may be able to mount a successful legal challenge under California legal authority related to confiscatory regulations. The second instance is how a confiscatory impact relates to long-term supply contracts. Many repackagers and physicians are in lengthy exclusive requirements contracts for periods even as long as five years; and during this time, a physician may be contractually	Peder J. Thoreen, Esq. Altshuler, Berzon, Nussbaum, Rubin & Demain October 31, 2006 Oral Comment	The Division concludes that, as these regulations were first proposed in January, 2006, and have been the subject of widely distributed commentary in the workers' compensation community, the physician community which dispenses drugs not in the Medi-Cal database has had adequate time to prepare for the changes in pricing. The Division disagrees with the contentions of the Commenter.	No action to be taken. No action to be taken.

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	required to purchase all pharmaceuticals from a certain repackager. Depending on the specific terms of a given contract, physicians may be left in long-term contracts in which he or she is making exceedingly little or nothing or may even be forced to operate at a loss. For these reasons, the potential confiscatory impact counts at least for a delayed implementation of the regulation for perhaps six months to a year, which would allow physicians to work through stock on hand and potentially renegotiate long-term supply contracts. Next commenter mentions there are three studies that are relied upon, and first he would raises the potential underlying bias with respect to two of those studies; one of which he has details about, another of which he will submit later in writing. One of the studies cited in the public statements is prepared by the Workers' Compensation Research Institute; and by all appearances, this is anything but a neutral institute. The Board of Directors includes representatives from twelve different insurance companies, including St. Paul's Travelers, Liberty Mutual, American International, Hartford, Zurich North America, and is also dominated by representatives of huge employers such as Marriott International, AT&T, UPS, and Nordstrom. Similar concerns have been raised with		The Division disagrees that a delayed implementation would be advisable, as that would continue exorbitant fees on some drugs for the period of time of the extension. Balancing the interests of the few physicians who may be bound by long term contracts against the interests of the entire workers' compensation industry in reducing unnecessary costs by as much as $300 million per year (as one study estimated) the Division finds that interests of the rest of the workers' compensation industry would prevail.	No action to be taken.

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	respect to another study that's relied upon which was prepared by the California Workers' Compensation Institute, and that is the group about which written comments will be provided later today. Second, with respect to the studies that have been cited relates to the Neuhauser study from 1992, The Study of the Cost of Pharmaceuticals in Workers' Compensation. It is apparently not located where the public statements designate, and this may be a violation of California Government Code section 11346.5, subsection A20, which requires that a proposed adoption -- a notice of proposed adoption of regulations state where on a document's web site a document relied upon can be found. The public may have effectively been deprived of the opportunity to meaningfully analyze the content of that report. There is a more recent study prepared by Mr. Neuhauser from July of this year, and we're providing written comments related to that report in the event that it's substantially similar to the 1992 report or if there is a typographical error and that was the report intended. Finally, commenter fears the very real possibility that after implementation of the regulation as written, physicians will stop dispensing drugs, which will result in the failure of the system to meet the statutory and constitutional requirements of ensuring a reasonable standard of services and care for injured employees. This possibility is hinted at in the recently accepted study of Matthew		The Division does not disagree that individual physicians will make individual decisions on whether physician dispensing will be sufficiently profitable for them, and that some will cease dispensing drugs. However, their patients will still be able to obtain pharmaceuticals from pharmacies,	No action to be taken.

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	Gitlin and Leslie Wilson, Repackaged Pharmaceuticals in the California Workers' Compensation System, at pages 17 and 18. There appears to have been an inadequate study of how these regulations will actually affect physicians' dispensing and how this will in turn affect health outcomes. Commenter encourages that, prior to implementation, this question specifically be the subject of further study, to ensure that the constitutional and statutory mandates underlying the workers' compensation system are met; and I'll point specifically to -- it's, I believe, Article 4, section 4, of the California Constitution and, in the very statute under which the regulation is promulgated, California Labor Code section 5307.1(f).		and their employers will still be obligated by law to provide medical treatment, including pharmaceuticals.	
	Commenter would like to point out the very real and difficult problems that patients face with medications under the current workers' compensation system and how the ability of physicians to distribute medicines helps them. Commenter notes that what has happened with medications recently is it has become harder and harder for patients to get medications through the traditional system. If you ask any physician who works in the workers' compensation system how it actually works on the ground, patients are denied authorization for medications on a regular basis, not because the adjustor necessarily decides that they shouldn't get the medicines but the system is so dramatically inefficient from the pharmacists to the pharmacy benefit managers to the adjustors, that patients, on a regular	James David Weiss, MD Psychiatry & Pain Medicine October 31, 2006 Oral Comment	Comment does not bear on subject matter of regulation. .	No action to be taken.

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	basis, are denied medications. Commenter states that physicians trying to treat patients with narcotic analgesics or antidepressants or anti-inflammatories will have these medicines suddenly cut off which would be devastating to their patients and medically dangerous because they suddenly will -- in the case of narcotic analgesics, which a lot of patients in chronic pain are on -- will go into sudden states of withdrawal if they are denied medications; and the patients are despondent about this. The patients that he sees are regularly despondent about the fact that their medications are cut off seemingly at will, and one of the things that the current system allows for when physicians are allowed to distribute medications is it prevents this kind of thing from occurring because then can . If he writes a script for a patient for medication, in his own experience it will be denied or delayed about half of the time. Commenter worries about what will happen if the system reverts solely to a system where the pharmacists, the pharmacy benefit managers, the adjustors -- and eventually the newer system where patients have to send away for their medications, it will become even harder for them to get the necessary medicines.		Comment does not bear on subject matter of regulation, which is the fees which can be charged. Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken. No action to be taken.
	Commenter feels that proposed regulatory action, in my opinion, is ill-advised as proposed, from three perspectives: The patient's, the physician's, and the workers' compensation system itself. Commenter believes the big winners will be the insurance	Daniel M. Silver, MD Diplomatic American Board of Orthopedic Surgery, Q.M.E. Silver Orthopedic Centers October 31, 2006		

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	companies, who will retain the savings as more windfall profits and not pass the savings on to the employers or the injured workers. The impact on patients -- the proposed changes will affect patients severely in a variety of manners. Under the old system where doctors did not dispense medicines directly to injured workers out of their private offices, patients would get a prescription and go to the pharmacy that would accept workers' compensation patients. While the pharmacy called the claims adjustor for authorization, there was a delay of hours to days before the response; and the approval would be given. Frequently the approval would not be given; and since there were very few pharmacies that would dispense drugs without approval, the patient would never get their medication. And this lack of obtaining medications to cure or relieve symptoms goes against the spirit of ACOEM and good medical treatment and ethics. If the new amendments to the section 9789.40 go into effect because of the lack of financial incentive to workers' compensation physicians to dispense medications directly to their injured workers without delay and hassle, commenter fears that the old system will reemerge. Patients will not receive the proper care to cure or relieve their pain, infection, spasm, depression in a timely manner. They will suffer unnecessarily for days and, in some cases, weeks. Acute injuries will drag out and become	Oral Testimony	The Division is not proposing that physician dispensing cease. The Division disagrees that the regulation will cause it to cease. The Commenter speculates on possible future events. The Division does not agree with the speculation.	No action to be taken. No action to be taken.

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	chronic, again violating the principles of ACOEM guidelines in Chapter 6. The cost savings on drugs will be offset, in my opinion, by the increased time of disability, more legal actions due to the anger and frustration of patients and more potential secondary psychiatric claims.			
	Currently under the present system that allows physicians treating injured workers to dispense medications at a fair and reasonable profit, there is incentive to give the patients what they need immediately at the end of the office visit, eliminating the involvement of a trip to the pharmacy and the usual hassles and delays. Physicians are willing to wait for authorized payments so that the patient is not inconvenienced. Occasionally no payment is received if the overall case is denied. In those cases we just write off as uncollectible the payments.		Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.
	Now the impact on physicians -- these proposed changes will affect physicians in specific ways that will ultimately cause most of us private, experienced, honest treating physicians to stop treating injured workers because financially it makes no sense.		The Division has proposed regulations which increase physician fees for evaluation and management.	No action to be taken.
	Over the past two years with passage of SB 899 and its implementation, there have been many changes. They include new rules and fee schedules for medical treatment and surgeries, prior authorization for everything, multiple denials and appeal letters that had to be written at my expense, utilization review		Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	companies that don't follow proper medical practices, and increased overhead in trying to get authorized payments in a timely fashion that are actually specified by the labor codes. Commenter has been in orthopedic practice for 30 years. Approximately 50 percent of his income came from orthopedic office visits, treatments such as injections, x-rays, and reports; and the other 50 percent came from surgery fees. Now, with the difficulty in getting prior authorizations for surgery, plus a very reduced fee schedule equal to 1974, only 20 percent of his income comes from surgical fees; and the dispensing of medication out of my offices makes up that 30 percent difference, which allows him to stay in practice. Now the impact on the workers' compensation system -- the proposed changes will affect the workers' comp system by having fewer physicians to treat injured workers. If these changes are implemented unmodified, there will be a disparity between the savings to the insurance companies and a reduction in the premiums to employers. Even after a large savings to insurance companies affected by SB 899, so far only a fraction of those savings have been passed on to the employers. Only the self-insureds have benefited directly from these savings of 899. In conclusion, commenter predicts that passage and implementation of these		Comment does not bear on subject matter of regulation, which is the fees which can be charged. Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken. No action to be taken.

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	amendments will actually harm injured workers, prolong their disability, increase potential litigation in psychiatric and secondary stress claims, in my opinion. The passage of the amendments will cause a significant drop in the number of available, experienced, competent treating physicians who currently are making a reasonable profit on medication dispensing to justify putting up with all the new hassles in dealing with the workers' compensation system. And the passage of the amendment will save money for the insurance companies and self-insureds but less than they think because disability will be prolonged from delays in pain relief, increased litigation, and stress claims. More will be paid out in disability dollars rather than in pharmacy dollars, I predict. Lastly, there must be, as part of any compromise in the regulations, a reduction in premiums to employers by insurance companies that equates to the pharmacy savings to the insurance company.		Comment does not bear on subject matter of regulation, which is the fees which can be charged. The Division has no authority to regulate premiums.	No action to be taken.
	Commenter believes that the insurance companies have gone whacko. They don't approve anything. It's almost like that movie where the guy was on the witness stand and he says, "Yeah, our company denies everything the first time around; and then when we're forced to the wall, we approve it." Everything is being denied. Even Utilization Review has become a joke in the State of California. Any physician who practices industrial medicine can tell you that, and it's being practiced by the adjustors who tell you no. So certainly	Marshall L. Lewis, MD Orthopedic Surgeon Pacific Orthopedic Medical Group October 31, 2006 Oral Comment	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	they are going to say no on meds. Commenter has had meds denied, durable medical equipment denied, surgeries denied, carpal tunnels denied, with positive electrical studies, with positive findings clinically. Commenter states that there are almost no M.D.s in the State of California to take Medi-Cal. So we're deciding all these rates based on Medi-Cal rates. Commenter does no understand it. You go to the average town and you ask how many people take Medi-Cal. Commenter has been Chief of Orthopedics at three different hospitals. Medi-Cal managed care -- I've written letter after letter after letter: "Who is covering your patients at night?" I can't get an answer. They have 60, 70, 80 million dollars in the bank that's given to them by the State of California, but no one knows who's taking calls for orthopedics. They don't have an orthopedist on call. They want the guy that's in the emergency room to take care of the patients. Refills and renewals on medication -- are you going to tell me that a physician can't make a living off dispensing medications. So he's going to have the pharmacy call him, someone making ten or $15 an hour. Then they're going to pull a chart. Then they are going to stop the doctor from what he's doing, seeing another patient. Then he's going to look through the chart and try to figure out what's going on with this patient: Have they had liver and kidney function, white count, platelet count, any of the other things that he has to check in relation to the medications they are		Comment does not bear on subject matter of regulation, which is the fees which can be charged. The Division disagrees that physicians in general will stop prescribing medication. Comment does not bear on subject matter of regulation, which is the fees which can be charged for physician dispensing (drugs not in the Medi-Cal database).	No action to be taken. No action to be taken.

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	on and then figure out what kind of case is it -- "Are they overusing? Under using?" And he's going to spend 25 minutes so that he can, for free, tell the pharmacist, "Yeah, give him the refill." Who's going to do it? No one. That's the answer. You're going to have no doctors prescribing meds that I know of that are specialists because they don't have the time. We're out of time. We get letters from the industrial carriers on all kinds of nonsense. Every 15 minutes it hits my desk, and it's stuff because they haven't read the reports to begin with. Now they want to cut out the medicine. You won't have doctors that are going to do it. They're just not going to do it. Now who's going to write the medicine. No one is going to be able to practice medicine the way it should be practiced in the State of California and the specialty area. Why don't we -- I think -- if you have a system -- these people get injured. As I say, I do defense work. I'm not an applicant's guy. If these people get injured, they are entitled to care. They are not entitled to a whole nonsense system where, on rare occasions, I've had to send them to an attorney that does applicant's work because I'm always on the other side. They're entitled -- if they get injured, these people -- they work hard. They know they have insurance. They're entitled to get care. I think what you're doing is creating a situation where the care is minimal to nothing. I mean it will work like the Medi-Cal managed care system in the State of California. It's worthless. We've got a Medi-Cal managed care system in Bakersfield		Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	where they just did an expose. They have $70 million in the bank. No doctor knows anyone that's ever gotten a decent check from them for any kind of treatment. I mean, what are we creating here? This is for workers. These people work hard. They are entitled to some type of care. I think medication -- you want to pay on Medi-Cal rates or you want the doctor to lose money on giving out meds, that's ridiculous. They won't do it.			
	Commenter has been involved in this issue through your initial informational hearing, through the regulatory process, and now today. As you've heard from some orthopedic surgeons who are members, they are very concerned about the changes. COA has always argued that there is value added when physicians dispense medications from their offices, and we appreciate the Division keeping that door open to allow the physicians to dispense the appropriate medications. You've heard from patients at the informational hearings that it may not be statewide, but there still are parts of the state, commenter believes, where there is a severe problem with injured workers actually getting pharmaceuticals from the pharmacist. So that door needs to stay open. Commenter believes that the testimony heard this morning is really at the fundamental problem with this issue, and that is that there is really no study that says that the Medi-Cal rates are appropriate for the pharmaceutical	Diane Przepiorski Executive Director California Orthopaedic Association October 31, 2006 Oral Testimony	Comment does not bear on subject matter of regulation, which is the fees which can be charged. Medi-Cal rates were prescribed by the Legislature.	No action to be taken. No action to be taken.

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	industry or for the physicians. And whenever you say Medi-Cal rates to orthopedic surgeons, or to any specialist in the state, as Dr. Lewis points out, it's just a hopeless system. Medi-Cal hasn't paid the costs of delivering their care in many years. So the fundamental premise that the Medi-Cal rates are the appropriate rates is flawed, and -- but at the same time, commenter understands the pressure that the Division is under to close this loophole. Commenter believes that we've all learned a lot about pharmaceutical dispensing since the informational hearing in the legislation, and have a better appreciation for the role of the repackagers and how fees are set. So that's all been enlightening to us. Fundamentally there probably is a very valid question about whether or not Medi-Cal levels are appropriate for any pharmaceutical dispensing, but commenter does understand the pressure of the Division to try to close this loophole. Commenter requests that whatever reductions that are implemented be phased in some form. Because as you can hear from the physicians, there will be a hardship on these practices, and we hope that they would continue to dispense medications, but it just can't happen overnight. The second issue then, you come to the dispensing fee, and physicians in the past haven't received any kind of a dispensing fee. So commenter understand that the Division is		Medi-Cal rates for treatment are not the subject of the regulation. See response to comments of Peder J. Thoreen. See response to comments of Joseph A. Zammuto in 45 day comment chart.	No action to be taken. No action to be taken. No action to be taken.

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	trying to help the physicians by allowing for a dispensing fee, and we have asked our members on many different occasions what it really costs them to dispense medications, and we found that to be a very elusive and a very hard figure to come up with because it varies significantly probably from office to office, and it's so intertwined with their other administrative costs that it's very hard for them to pull out just those costs. Commenter states that are a couple of things we do know. We do know that the cost that a physician would have to pay for purchasing the medications is higher than what it would cost a pharmacy because a pharmacy is just buying in larger volumes, so they have the benefit of getting lower costs from the pharmaceutical manufacturers or the wholesalers. We also know that, and has learned from her members, that about 20 percent of the time they don't get paid at all for these pharmaceuticals. "Well, why do you want to get in the middle of all this hassle if you're not even going to get paid for this?" And then I get the rationale from her members that it really is a patient service, and I think it would be bad to disrupt that relationship because I think there is, as I said earlier, some value added. The third thing we do know is that physicians don't get paid as timely as a pharmacy does.			

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	They have a more efficient way of submitting their bills for payment, and commenter has been told that they are paid in a much more timely manner. So those three things really do drive up the costs in a physician's office of dispensing medications. So back to what does it cost to dispense from your office. Commenter has heard that in an orthopedic practice that it costs them between ten to $15 to dispense a medication in their office. That's the best figures that they can come up with. Commenter is sensitive to some of the arguments heard in the legislative arena where medical offices were dispensing ten and 12 prescriptions in a single day. It's hard for commenter to envision a patient that would need that many different prescriptions on a single day; and if in fact there is such a patient, maybe that patient should go to the pharmacy so that the pharmacist can look at the drug interactions of that many medications. Commenter believes that if would be good for the Division to implement a tiered dispensing fee so that you would rein in potentially some of the abuses that might be out there in the multiple prescriptions in a single day. So commenter would like to propose kind of the middle ground, and that is that the dispensing fee be set at $12.50, the middle ground between the ten and $15 amount for the first three prescriptions dispensed on a single day; and that for prescriptions of four or more, that it would be at the $7.25 that the Division is proposing.		The Division has concluded that it would not be advisable to add the complication of a tiered dispensing fee at this time.	No action to be taken.

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	Commenter believes that that would help to reimburse the physicians more appropriately for their actual costs of dispensing these medications, and compensate them for the medications that they might not get paid for at all, and would still help rein in some of the abusive activity that she has seen reported.			
	Commenter submits a letter from the Honorable Wilma Chan, Assemblywoman, 16th District -- or the Chairperson of the Health Care Committee. Commenter quotes the text of the letter: "Dear Ms. Gray: This letter is written in strong opposition to the proposal to adopt the amendment of Article 5.3, Chapter 4.5, Subchapter 1 of Title 8 California Code of regulation, Section 9789.40. "Passage of this amendment will decrease health care access and especially hurt the ethnic minorities and lower-income injured worker. Many ethnic minority workers do not have private health insurance. Many pharmacies already deny some workers' compensation prescriptions. By decreasing reimbursement, it will be increasingly more difficult for the injured worker to obtain necessary medications. If the reimbursement of medications decreases to Medi-Cal rates, physicians will no longer be able to dispense from their offices, as the cost of medications far exceeds the Medi-Cal reimbursement. Passage of this bill will therefore limit the number of physicians who would treat the industrially injured worker, many of who are minorities or who a physician would no longer provide medication to the injured worker. "Moreover, the	Christopher Chen, MD. Also submitted letter from Assembly member Wilma Chan October 31, 2006 Oral Testimony	See response to comments of Wilma Chan in 45 day comment chart.	No action to be taken.

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	immediacy of obtaining medications from the physicians prevents delays to medical care due to lack of authorizations. Without adequate treatments and medication, the injured worker would be unable to return to work. I must stress that the workers are the ones who will suffer. Passage of this amendment will most certainly increase the health care disparity in California. "Sincerely, Will Wilma Chan, Assemblymember of the 16th District." Number two item, commenter submits a letter from Ethnic Medical Organization Society, also known as EMOS. It's an affiliation of the American Medical Association. It has signatures from many presidents of the medical societies. The presidents represent thousands of physicians in our state: Randall Fong, Chair of Ethnic Organization of the CMA; Arthur Flemming, Chair of Network of Ethnic Physicians of Network Organization, over 200 physician groups comprising thousands and thousands of physicians in our area; Margret Borres, President, California Medical Association; Ben Medina, Latino Medical Association of San Diego; and also Mark -- I'm sorry -- Lisa Benton, President of Miller Medical Association. This is an association of American physicians. Number three item, the CMA, California Medical Association, a 2005 performance study of almost 300 physicians: 63 percent of the physicians in this survey indicate that they		Comment does not bear on subject	No action to be taken.

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	intend to leave or reduce participation in the workers' comp. Of this, one-third plan to quit entirely, mostly due to poor reimbursement, obsessive paperwork, and delays in authorization. Number four item, commenter is representing himself, the Chinese American Physicians' Association, CMA, and the ethnic medical organizations -- many pharmacies that you've heard already do not take workers' compensation due to poor reimbursement for medication. With the passage of this amendment, commenter states that sadly he will be among the 63 percent who will leave workers' compensation. 90 percent of his patients are latinos who do not speak any English. Many pharmacies such as Costco, Longs, do not have latino staff. Commenter's patients cannot get the medication authorized because they do not have the working knowledge of English to give the pharmacy the insurance information or whatever information that a pharmacy needs. And even if his patients can get the medication pre-authorized, his patients usually cannot take the medication. They do not take the medications because they do not understand what these medications are and how to take these medications. Commenter dispenses medication. His patients do not have to worry about getting medications authorized. They do not have to wait several months to get their medication authorized. Commenter and his staff explain in their language, the patient's language, how		matter of regulation, which is the fees which can be charged. Comment does not bear on subject matter of regulation, which is the fees which can be charged. The Division does not disagree that individual physicians will make individual decisions on whether physician dispensing will be sufficiently profitable for them. The Division disagrees with the contentions of the Commenter.	No action to be taken.

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	to take these medications. They get treated right away, thereby ensuring a speedy return to work. This amendment would decrease health care access by decreasing the number of physicians who take workers' compensation and by decreasing the accessibility of medications. This amendment will jeopardize patients' safety because of the language barrier. Stop this amendment so that the injured worker can go back to work sooner.		The Division disagrees with the contentions of the Commenter.	No action to be taken.
	Commenter is on his own, and is trying to represent three sections of society that they are not here today: First, the patient, since he has had three surgeries in his lower back; one laminectomy and two fusions -- second, as a minority group, since he's latino -- and third, as a middleman -- his business is interpreting, and he is a Spanish interpreter so he deals with minorities very often. And he doesn't see any of them here. First, as a patient, he doesn't know what he would be able to do after his first surgery. He wouldn't be here. He wouldn't be an interpreter if he didn't have the medications to help him out. He was going nuts. The pain was terrible. Commenter fell and broke his back, and it was hard for him to recover. Medications were the only thing that kept him sane. These three surgeries pass, and it happen in an average time of 15 or 20 years. But in his last surgery, which was in 2000, since he knew the time that I was going to spend out of the workforce,	Enrique A. Sigui October 31, 2006 Oral Testimony	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	he took the time to start again. He went to university. He went as an interpreter. And as a middleman now, he relates to patients because he's been there. He knows what this medication does, and can relate more to the patients, the minorities specifically, Spanish-speakers. He can relate more to them than the doctors because he talks to them. He knows what they're feeling. these regulations -- the only people that you're going to hurt if this regulation is passed is the mostly minorities even though it applies to everybody, even English-speakers. Everybody he sees as a patient -- they depend on this medication so much. And these doctors --he works with so many doctors. He can give you a list of 300, 400 doctors that he has worked with in the last five years that he has been business. And these wonderful doctors –He sees them after they pass the new laws in adult workers' comp. They lose their business, wonderful doctors that he knew. He can't believe it. They either quit or they left the business because there was no way for them to keep up with the cost of how much they have to pay for everything. Now the insurance companies – He doesn't know who came up with this beautiful idea, this regulation, on taking the only legal profit they can make from this medication to keep up. Commenter these doctors work in their offices, has seen them working with these minorities, and it's a shame. He feels very bad.			

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	If this regulation was to pass, a lot of these good doctors are going to close their office; or they dispense medications. Commenter does not know how these patients are going to be able to live with that pain when they can barely speak -- the minorities -- they can barely speak English. How are they going to get a prescription to -- from the -- they go to the pharmacy. They laugh at them. They can't speak English. Commenter requests that the Division not pass this regulation. He believes it is going to hurt a lot of the minorities and a lot of the people that are depending on that doctors to prescribe their medication.		The Division disagrees with the contentions of the Commenter.	No action to be taken.
	Commenter services almost exclusively lien-based claims. So those are the injured Californians that are falling through the cracks here that have been turned away by the pharmacy industry, and come to us because that is not their business model. Commenter also have other lines of business that he treats. The skilled nursing facilities, the assisted-living facilities; and he is intimately familiar with Medi-Cal and Medicare reimbursement. Medi-Cal and Medicare reimbursement works only when there is an electronic handshake between the provider and the payer, which is a real-time handshake and it acknowledges that the transaction is received and a payment is going to be made and that payment is going to be made within a reasonable time frame, about two weeks. And that business model is low-	Mark Russell Chief Financial Officer Express Pharmacy Modern Health October 31, 2006 Oral Comment	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	dollar, low-margin business, but it works because you do not have -- as you've heard a lot of good testimony this morning, you do not have the hassle of having objections and denials. You do not have the significant carrying costs of lien-based business as a lien claimant where you really have no control. You have to monitor the progression of the case in chief. You have to attend the hearings. You have real carrying costs in trying to provide service to a lot of these Californians who really have issues that are -- that need to be resolved over time, but as that time progresses, they also need their medication. The big chains are not going to do that for them. Commenter services approximately -- or has serviced and is servicing over 30,000 lien-based cases in California. And the official medical fee schedule changing to a Medi-Cal reimbursement or their equivalent rate, with the penalty and interest provisions on the OMFS, will be so woefully inadequate to cover the labor and the real carrying costs involved with managing these cases as a lien-based claimant under medical treatment. Rand Corporation -- what papers have been done in following some of this, but there is a flaw in the reform that you're working on here to do that, because you're going to have an access-to-care issue here. Commenter believes the doctor from Stanford mentioned it earlier. A lot of these people when their medications are cut off quickly and suddenly, there will be some significant clinical			

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	repercussions from that as well. So, again, as a pharmacy and unlike a lot of the medical clinics and doctors' offices here, Commenter does an exclusively lien-based business; and the official medical fee schedule -- really, my proposal should be that it would not be applicable to cases that are denied. If the insurance companies want to deny the case and push the case out for whatever reasons they have -- and they have a lot of them -- that really there should be -- a usual and customary charge should be predicated, and let the WCAB -- let the presiding judge of the case decide what is a fair reimbursement for the medications that are prescribed over time on these denied cases.		Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.
	The adoption of the proposed regulation -- after speaking with all the doctors, and hearing what they felt, and what this bill would do for them, and the most important thing was their patient care, and not being able to provide that kind of care that a patient needs, especially since most of these workers' comp. patients are low income. This last year in 2006 we as a company wrote off $424,000.00 of medications that we did not get money for. These are medications that the insurance companies denied and said these are not payable medications. A lot of them are psyche drugs. They still are not up-to-date that pain causes depression, and many of the adjusters continue to deny these medications. But our doctors want to see their patients get the kind of care that they need, and they continue to provide this medication.	Tamara Sanders Manager Pacific RX October 31, 2006 Oral Testimony	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	If this bill is passed, it's not going to allow them to perform the kind of care that they need to do for these patients. It is going to cause -- the overhead kind of makes up for what the patients that we can't get money for -- we charge a little bit more and it kind of evens out and they make money. But if this bill passes, and we start going to the Medi-Cal fee schedule, the psyche drugs aren't even on the scale. They are under costs, and I don't feel that this is fair at all. Commenter knows that the State Compensation of the State of California adopted their own program where rather than changing the entire program where you don't just Red Book, you don't use all the different fee schedules, you can keep your fee schedule and pay 93% of the AWP, the average wholesale price with the dispensing fee. Commenter feels like that's a fair amount of money. It's still -- it's a compromise to going Medi-Cal rates. It is a compromise rather than making these doctors go completely out of business, not being able to treat these workers' comp. patients. Like Dr. Weiss said, this is a personal thing. Commenter was very impressed with how he was talking about the care of his patients, and she feels the same way.		The Division disagrees with the contentions of the Commenter. Setting rates at 93% of AWP would not eliminate the exorbitant fees that such a rate creates for some drugs.	No action to be taken. No action to be taken.
	Commenter has submitted written testimony. Please refer to the written comment chart.	Steve Catollica US Health Works AdovoCal October 31, 2006 Oral Testimony	See response to comments of Stephen J. Cattolica in 45 day comment chart.	No action to be taken.
	Commenter is here today in his capacity as a	Mark E. Gearheart, Esq.	See response to comments of	No action to be taken.

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	member of the Board of Governors of the California Applicant's Attorneys Association. He submitted a written comment, but appreciates the opportunity to add to that with a few points orally this morning. The cost supports the concept of a fee schedule for repackaged pharmaceuticals to address some of the billing abuses that may have occurred in the past. At the same time commenter is very concerned about preserving and protecting access to care for injured workers, and believes that the current regulation would not do that. Adopting a schedule which applies Medi-Cal payment rates to repackaged pharmaceuticals is likely to undermine access to timely care, and for that reason we're opposed to it. Commenter urges adoption of a fee schedule for repackaged medications that sets a reasonable rate of compensation for the physician, and fully supports and endorses the proposal put forward by the California Society of Industrial Medicine and Surgery. Commenter would like share something that I think was alluded to today, but is not sure that it's been made entirely clear. Commenter represent hundreds of people. Over the years he's represented thousands of people in the compensation system, injured workers. It's very, very, common for his office to get phone calls from injured workers who are unable to get their medication. It's an accepted claim, their physician, who's authorized to treat, has prescribed various medications, they've gone to their neighborhood pharmacy or whatever	October 31, 2006 Written Comment	Stephen J. Cattolica in 45 day comment chart. Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	pharmacy they go to, and the pharmacy won't fill the prescription because they can't get an authorization from the carrier. They are waiting for a call back. They need to fax another copy of the prescription. The adjuster isn't in today. The person who handles medical billing is going to call them back and doesn't. So they go home, and they go there the next day, and there's still a problem. We can't get a call back. We can't get it authorized, so they go home, then they go back the next day. Well, one of your medications is authorized but they've got a question about the other one, and the adjuster has called the doctor's office. At a certain point they get fed up and call our office, and we intervene, and eventually they usually get their medications, but by the time they get them, days or weeks have gone by. The therapeutic affect has obviously been lessened by the delay. These folks are frustrated understandably. The carrier is now going to have to pay for mileage for them to go to the pharmacy 3, 4, 5 times. The carrier was exposed to risk because when they're driving to the pharmacy to pick up the prescription, if they get in a car accident that's covered by the Workers' Compensation Act, and we're going to claim that as part of the claim. He has had to, and he will, and it's extremely inefficient. And what he contrasts that with is his clients who are treating with a physician's office -- and not all physician's offices do this -- but a physician's office that will dispense the pharmaceuticals at the doctor's office -- he never get calls from those clients saying they			

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	couldn't get their medication. Never. The reason he doesn't is those physicians dispense the medications during the office visit, and they'll wait to get paid. They'll bill it along with their regular services, and they'll wait to get paid. Unfortunately they're used to that. They in the larger medical practices often have a staff employee who's trained in dealing with insurance companies, getting authorizations, getting bills paid. They often have someone on their payroll whose whole job is to get these bills paid, and they take care of it in-house. That's expensive. Pharmacies don't do that. But it's better care for the patient, but it's not free. It costs them something. He believes that if the fee is set too low on these packaged/repackaged drugs what's going to happen is the doctor, understandably, is going to say, well, this is below my costs, I can't do this; and so these folks are all going to be thrown out to deal with the pharmacies. Some of them will fair well, many of them won't. You're going to have increased temporary disability because if somebody is waiting a week, or 2 weeks, or 3 weeks to get their medication, and they're off work, that's just extending the temporary disability. You're going to get sub optimal medication treatment out of this because a lot of these medications -- the point is that they provide them promptly and on a time schedule. You provide them			

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	with the delay and they're interrupted and then started again, you don't get the same therapeutic effect, so you're going to have a less than optimal medical outcome. You're going to have increased mileage costs, and increased exposure by the carrier to the risks of car accidents on the way to the pharmacy. And it just doesn't make any sense. Commenter believe that it undermines the purpose of the system to provide prompt quality care to injured workers. It also increases friction costs, because these folks, understandably, become frustrated and angry, and he thinks that what all sides prefer to see is negotiated compromised settlement of cases rather than increased litigation, and he can tell you, having practiced workers' comp. law for 26 years, it's a lot easier for him to settle a case if his client feels like they have been treated fairly than if his client feels like they've been abused, their treatment's been delayed, the carrier has done nothing but throw up road blocks, and you know that client's going to be angry. They don't want to compromise. So there's friction costs here that you can't quantify with an MBA approach, but you're going to increase those if do you this. So, in conclusion, he states that the purpose of the comp. system is to provide prompt quality care to speed people's recovery and return to work, and he believes the proposal, while well intentioned, will undermine that very important purpose. He urges the Division to seriously consider the CSIM proposal, which			

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	he thinks, and which the California Applicants' Attorneys Association thinks, is a reasonable approach.			
	The dispensing of medications from the physician's office does greatly expedite care to these patients. Currently, 10 to 20% of these work comp. patients cannot have their prescriptions filled by their doctor's office because their insurance carrier will not allow them to do so. Those patients frequently encounter delays in getting prescriptions filled in pharmacies due to administrative problems, additional paper work, phone calls, and pre authorizations. This not only inconveniences the patient and delays care, it also adds more chaos in the doctor's office due to the fact that the doctor now has to check if that patient's insurance carrier is one of the insurance companies on the list that requires the patient have their prescriptions filled only by a pharmacy. Since the proposed regulation decreases the cost to the insurance company for providing this prescription service, and it will now cost the insurance company the same as if the prescription is filled by a pharmacy, Commenter is proposing that this new regulation adds language to allow the physician who is already authorized to treat the patient, be allowed to provide this prescription service regardless of the insurance contract.	Irene Georgiou Licensed Pharmacist October 31, 2006 Oral Testimony	Comment does not bear on subject matter of regulation, which is the fees which can be charged. Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken. No action to be taken.
	Commenter notes that he has yet to hear any testimony in favor of this proposed rule, and he is going to limit his comments to 3 points that he'd like to address from the perspective	Robert Goodrich Director of Operations & Regulator Affairs Southwood		

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	of the supplier. The first is mechanical. The proposed regulation asks that we are reimbursing under a Medi-Cal fee schedule. These supplies are going to be reimbursed under an NDC number that is not contained on the package label. There is no cross reference that allows the NDC number that we as a repackager are required to put on the label that exists in the Medi-Cal data base. This was the source of the confusion of implementing this back in 2004. So, when a physician is trying to get reimbursed for one of our products, they would have to find an NDC or methodology which doesn't exist now to be able to cross reference that item with the Medi-Cal data base; and then if it's not in the Medi-Cal data base the requirement is to use the NDC of the drug that we obtain the product and before we repackaged it. Now, as a repackager he procures a product based on availability, therapeutic equivalent, preference of our prescribers, and the discretion of his pharmaceutical staff, and he will put the same product from different sources under the same NDC, the same label, and so by following this path of Medi-Cal language and Medi-Cal data base, it is possible that the same item for practical purposes would be reimbursed at different rates, and there's no way to augment it, and so he's been asked how to do this, and how to facilitate the reimbursement from our customers. This is very difficult, and he asks that the department consider the practical	Pharmaceuticals, Inc. October 31, 2006 Oral Testimony	See response to comments of Robert H. Goodrich in 45 day comment chart.	No action to be taken.

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	aspects of that. The second point concerns the language of the proposed rule. Well, actually the language of the existing law going back to SB 228, that the maximum reasonable fee for pharmacy services rendered after January 1st, 2004 is 100% of the fee prescribed in the relevant Medi-Cal payment system. The key word is relevant. Medi-Cal has 4 methods of establishing payment: The MAIC, the FUL, the EAC, and the usual and customary practice. Commenter purposes that the relevant Medi-Cal payment system for repackaged drugs whose NDCs are not part of the Medi-Cal data base is either BAC practices, which is currently AWP minus 17%, or usual and customary costs to the general public, which ever is less. The third point concerns implementation. The notice of this hearing with the rule indicated that any changes would occur on December 1st of this year, which is 30 days away. Commenter is sure that the department will absorb the comments here, the written comments, and from the proposed rule I would expect a final rule, and at that point he would also ask for a reasonable implementation period in order to make any changes.			
	In his practice, Commenter sees the worst injured workers, including city workers, state workers, police officers, sheriffs, cooks, firemen, nurses, just all. Among them a group of patients to him is very special. Those	Edward Lin, MD October 31, 2006 Oral Testimony	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	patients essentially do not know how to speak well English. They really have a hard time and to name a few those are the patients who work in the construction work, those are patients work in restaurants, some of the patients that work in the service providing to all of us. Commenter enjoys going to all the nice restaurants in Bay Area. He hopes that everyone does, but behind those nice restaurants somebody is working. Somebody is doing the job to keep this place stay running, so he really hopes that whatever proposal comes along will compromise so he will be able to continue to provide service to those injured workers, because a lot of them really have a hard time. They don't speak English. Even if he tries to tell them specifically what to do they really require a lot of explanation, and many time with interpreters, all of them require interpreter. Sometime it's speaking his own language. He speaks to them in Chinese, or Portuguese, he speaks Portuguese as well. But again, his daily patients require that they do not speak English, they require interpreter, so they require, you know, those services that would provide by giving them medication. Commenter explains to them, tells them about what possible risks, what complication, how to use it, and so I think it is this service that he can provide to the injured worker, so he just hopes that whatever regulation the Division sets it will preserve those assets.			
	Commenter's group consists of 6 board certified pain management specialists, 2 psychologists, a marriage and family therapist, 3 physical therapists, and 20 support staff.	Paul A. Estes Administrator Bay Area Pain & Wellness Center	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	Commenter owns a primarily a community based practice, but by nature of his specialty he see patients referred to him from centers all over northern and central California. They serve approximately 7,000 active patients at the moment, about 65% of whom are injured workers. Their specific role is to accept referrals of the worst cases of chronic pain that have been through really every other type of care available and ultimately end up at our door step referred by other physicians, nurse case managers, insurance companies and attorneys. They see the worst of the worst. His physicians are used as consultants, QMEs, as well as they serve as primary treaters, and all are on the faculty at Stanford actively teaching at the pain program there. His practice is unique in that their model is based on an interdisciplinary approach which seeks to get patients ultimately off the medications, back to work, and certainly back to life. These patients generally come to them completely wrecked, and their mission is to put them back together. His practice involves shifting responsibility from the providers back to the patient to take responsibility for their care, to take control of their pain management. This includes conservative intervention, use of interventional procedures, conservative use of medication. With that said, the nature of his practice is that he dispenses a very large volume of medications. He sees this as both a service to the patient, particularly those in the workers' compensation system, and it's an important	October 31, 2006 Oral Testimony		

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	source of revenue to his practice. He believes the speakers today are being too polite, because this really is about money. Commenter makes a good margin on selling medications. In fact, it's just the right amount of margin to offset the losses that he incurs in serving workers' compensation patients such that he's able to break even in his clinic. It's difficult to know what was in the mind of the person or persons who created this initial regulation and the formula that exists now, but his best guess is it was somebody who understood the concept of cost shifting. That is you're going to make us hold over here to offset the losses that we incur in another part of serving this patient population. In his practice the ability to make a sizeable margin is what offsets the equally sizeable loss. Even though we're here to discuss a regulation regarding reimbursement for medication, commenter would ask that you recognize that if you change this part of the system in isolation, and fail to create an offsetting source of revenue somewhere else in the workers' compensation system, what do you imagine is going to be the response of a practice like his, or any other, that has to some how find a way to keep itself whole? Do you imagine that he could really absorb $100,000 a month decrease in his revenues without some how dramatically altering his practice model? The answer is no. It appears that the proposed regulations really are equal to crapping in a vacuum, and really		The Division does not disagree that individual physicians will make individual decisions on whether physician dispensing will be sufficiently profitable for them. The Division has proposed regulations which increase physician fees for evaluation and management.	No action to be taken. No action to be taken.

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	disassociated from the economics of a typical medical practice that's still willing to serve workers' compensation clients. Physician offices dispense to workers' compensation is foremost a service to patients who really have difficulty accessing the service elsewhere, and that's been addressed here. They really can't obtain pharmacy access in their locale, or they can't receive a timely access from the pharmacies in the big box. It's also good care. In his practice medications are prescribed and refilled only after a dialogue with the patient. We assess the patient's understanding of the medicines they are taking, their compliance with the medication regimen, their tolerance to the medication. These are all assessed, and ultimately the medication is placed in the patient's hand by a prescriber, a physician or nurse practitioner. It is simply notwithstanding a dynamic of putting a piece of paper in a patient's hand and sending them over to the pharmacy where we have no control over what that conversation is going to contain. In-office dispensing also makes it financially feasible for him to sustain a large percentage of workers' compensation patients in his practice. His practice is paid less for seeing a patient in a clinic from the workers' compensation system than it is for just about every other payer with the exception of Medi-Cal. So in a practice like his, it's easy for them to adapt, and perhaps easier than other			

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	practices to adapt to this change in regulation. He just simply changes his base of business. But he doesn't know where those patients are going to go because you can't imagine that physicians are going to assume and absorb a huge reduction in their compensation. They'll just find another way. In his case he can find a way by changing his mix. Commenter's greatest concern is that in the dark under belly of the workers' compensation system there's a group of players who don't control their mix as the quality providers can. His concern is that they're going to find some other way to exploit injured workers to keep themselves whole. Commenter currently collaborates with a local pharmacy, as was mentioned here, to fill prescription medications and to compound a specific drug called Buprenorphine that is used to weed patients off medications. The pharmacy has put us on notice that they can't afford to take our referrals any more, and they've asked us to either buy the medication from them directly so we sell them to the patients, or simply dispense the medication ourselves. So, it's an irony that the proposal here is to shift all this business to pharmacies when it really only appears that it's going to be the large pharmacy chains that are going to be able to absorb this business, and we know from experience that they're not going to be able to provide the service that's needed, nor are they going to be able to provide it in a timely way.			

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	Like others that have spoken, he has the same problem with medications for depression, for example, and what's not been said is this is a dangerous phenomenon. These patients -- you can't simply stop taking your depression medication for 4 days while you wait for an authorization, and that's exactly what happens to these patients. The nurse case manager is out of town, the adjuster is not available, and they're left for days having summarily stopped the medication. That can cause seizures, that can cause all kinds of problems. But that's what happens at the retail chains. It seems that the situation he described is the potent of things to come; that only the large chains will be able to absorb this book of business, and there's no possibility that they will be able to provide service in the way that the patients are going to require. In conclusion, it would be more appropriate for the Division of Workers' Compensation to consider its payment policy in a broader context. It would be less disruptive and far more responsible to address the issues that are essential to proceeding currently, that is adopting regulations that simultaneously seek a pharmacy and physician appropriately, and enable each to stick to their divisional roles in a coherent system. That is adjust the Official Medical Fee Schedule at the same time you adjust the pharmacy reimbursement formula, and I think you'll avoid the problems			

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	discussed.			
	This particular regulation, as you heard from many providers, will drive, especially the specialists, out of business. Commenter expects that particularly those that seek say 20 to 25% of their business is workers' comp., will not absorb this. They are just going to leave. It's gotten so complex over the years with pre-authorizations, utilization review, and all the other bureaucratic stuff -- they're having to hire 2, 3, 4 people to manage those issues -- and we're talking providers on a daily basis. They're saying we're done. They say if this does through -- yes, it has been cost shifted so the PR2s, for example -- the $12.30 -- nobody can handle paperwork for $12.30. The $7.25 on dispensing fee to manage the payment is -- there's just not enough money there, so they'll just stop, and when they stop those patients have to go somewhere or they will -- their care will drag out, and out, and out. Some you'll have an increase -- increases in those patients' costs, and many of them -- at some point people are just going to say just send them to the ER and be done with it. Expect that to happen. That payment process in the pharmacy is real and it's 90 days at a physician's office for the pharmacy. That electronic handshake definitely helps out. At this point he doesn't know if there's an easy way to manage an electronic handshake, in a physician's office, but that's something he recommends the	Charles Smith Pharma Pac October 31, 2006 Oral Testimony	The times by which payers must pay medical treatment bills is set by statute.	No action to be taken.

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	Division should look at. Lastly, he believes the Division does need to take into account – this change occurred when pharmacy and pharmacies said oh, we're not going to continue to do this business, and in fact the pharmacy is, in fact, providing work comp. patients their scrips. Physicians are in a far different game. They -- first of all they are not a large chain, so they can make very quick decisions and with this significant hit on their margin many of them will bail. Many of them are baby boomers, and they are close to retirement already, and they're just going to say we're done. So, the impact is going to be far greater than what all of the regulations, CHSWC, and research reports have stated.			
	Commenter is one member of 4 members of this alliance that contracts with pharmacies to process workers' compensation prescriptions. Commenter's alliance basically takes the arduous process for pharmacies that do not submit workers' comp. prescriptions on their own, and guarantee payment. Commenter represents companies such as Longs, Safeway, Walgreens -- all the major chains and many of the independents. Today the Division heard a lot of people talking about the issues at the pharmacy counter. Many pharmacists are not -- are still in the payment process of dispensing prescriptions and that is true. A lot of the independents have not decided to participate in the workers' comp. system since it is so arduous, and the process is still not working	Perry Lewis Workers' Compensation Pharmacy Alliance October 31, 2006 Oral Comment	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	very efficiently. However, part of the problem is that there's quite a vast difference between the Medi-Cal program and the workers' compensation program. In the Medi-Cal program when a prescription is dispensed at the pharmacy level, the pharmacist knows immediately that the prescription is going to get paid. It's online, real time, adjudicated. In the workers' comp. environment, that is not the case. So, they either contract with companies such as one of the 4 member companies that he has, or they try to process it on their own. And a huge -- this online eligibility process when tied to Medi-Cal -- it's tied the system down quite a bit where pharmacies are going to have to make a decision are we going to continue to fill workers' comp. prescriptions or not. Commenter is hearing also from the physicians that they're going to have to make these decisions on their own. Commenter reiterated some comments that were submitted in writing.			
	Commenter is an orthopedic surgeon who runs industrial medical clinics. He has 7 industrial medical clinics. He used to be the past owner of a small community hospital in Paris which he closed. He was the owner of that hospital for about 10 years and saw happening at that time what's happening now to the system that forced him to close that hospital, and that's the decreased reimbursement rates. Commenter left a community totally uncared for. He had mayors and councilmen calling	Dr. I. Silva Jr., M.D. Southern California Orthopedic/Sports Medicine Center October 31, 2006 Oral Testimony	Comment does not bear on subject matter of regulation, which is the fees which can be charged.	No action to be taken.

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	him Dr. Silva why are you closing the hospital? Why are you doing this? And the reason is decreased reimbursements working in the Medicare and Medi-Cal system, and under Medi-Cal, and it didn't work. What's happening with the independent hospitals, and a lot of hospitals leaving the State of California, selling out their hospitals 5 or 6 at a time, because they can't make it on the Medi-Cal system, and they can't take the burden of caring for these patients on an emergency basis uncared for. Commenter has over 200 employees, and runs a very clean organization. Commenter has never been on the plaintiff side, but always been sort of caring for the patients, the employers from American Express to American Airlines, to Pepsi Cola, etc. Commenter has an interest in both the employer, the patient, and the insurance company in play. He's never gone and done anything that we charged for -- Xanax -- $300 for Soma. He's always taken a fair profit. Right now our system has gone to the point where we're looking at our whole organization and saying if this system gets in there I'm going to close offices and we're going to leave care undone. Commenter's patients, 75 to 80% are Hispanic. He has offices in Ontario, Anaheim, Lakewood, Temecula, Paris -- 80% of the prescriptions that he prescribes are rejected by the pharmacies.			

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	Commenter provides examples how he saves money to insurers. A full transcript is available in the Hearing Testimony of October 31, 2006.			
	Commenter represents hundreds of physicians in the workers' comp industry, some of which dispense medications from point of service. These groups include Kerlan Jobe Orthopedics out of Los Angeles; Southern California Orthopedic Institute, which has seven offices and over 50 treaters, as well as individual single practices in Bakersfield and Fresno and Salinas areas that provide almost 100 percent of the workers' compensation industry in that area. Commenter has presented his discussion topics to the Board. Commenter has been presenting this to the legislature for a couple of years, and would like to point out a couple issues. The first that you've heard several presenters mention the lack of access that will happen if this fee schedule is reduced to a Medi-Cal rate, and he wants to emphasize that this is not conjecture. This is not hearsay. The leaving of work comp for a physician or going to another state is real. This has happened in several states, for example, in Florida where the state government recreated a fee schedule that was so low, comparable to Medi-Cal, that physicians in the work comp industry, up to 40 percent, left the state, left the industry in turmoil and has changed that fee schedule some three times since the late '90s to get it back to an AWP-based system that works.	Michael R. Drobot President Industrial Pharmacy Management, Inc. October 31, 2006 Written Comment		

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	Commenter notes that several people here mentioned that 83 percent of AWP seems reasonable and fair. Commenter has presented this to both the legislature and the administration who have told us in the past that they do not like an AWP-based system for two reasons, one because there are some physicians that have gamed the system by over-utilization. Since 2004, the ACOEM guidelines and AOE/COE reviews have curtailed this greatly, if not completely. Also, there are repackagers in the state and other states that dispense -- that distribute their medications in California that also game the system with their excessively high AWPs, some of which that are above that of the brand. Commenter proposed to take care of that, to tie the AWP back to the levels in 2004 where this was deemed reasonable. The largest insurance company for workers' compensation in the State of California is State Comp Insurance Fund. They currently have adopted this level of 83 percent of AWP across the board. They're paying at this level. They have deemed it reasonable, and commenter believes that this will keep not only access to injured workers, it will keep physicians back in the system, but it will also accomplish the intent of SB 228 and 899 which was to reduce the fee schedule by 35 to 45 percent, thus saving a minimum of $500 million out of the system. Commenter believes this is a win-win-win		See response to comments of Nileen Verbeten 45 day comment chart.	No action to be taken.

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	system. Commenter requests that the Division consider this and, if there are further reasons why they think that this system doesn't work, doesn't accomplish the goals or still allows people to game the system, commenter requests the opportunity to try to address a system that will be failsafe and accomplish your intent.			
	Rural health care clinics are usually set up in areas where no other people want to practice. The Central Valley has, from information taken from AMA journal, about one doctor for every three doctors, compared to LA and San Francisco, because it is an undesirable area. Commenter advertises sometimes up to six months to get one provider to come, and offer to pay them sometimes 40 to 50 percent more to come to his area than what they can get in LA and San Francisco. Inherently, when they come to his town and they see where he's located, they usually just say, "No thanks. You know it sounds like a lot of money, but I There are only a few rural clinics left after the new laws that will actually even see a work comp patient. A friend of his has eleven clinics in small towns such as Exeter. Sometimes he's the only provider in the town. About two months after the new laws came and he got the negative letters on how he wasn't treating the patients properly, he stopped seeing in all 14 clinics. By him doing that, in some of the towns, those patients had absolutely no place to go because he does not see them. They come in, and they can be a patient there for 20 years, but if they are a work comp patient, he won't see them. There	Dolphus P. Pierce	Comment does not bear on subject matter of regulation, which is the fees which can be charged. This comment does not suggest a change.	No action to be taken.

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	are a few of us left that have rural clinics. Even though his clinics get a high reimbursement from Medi-Cal, he is the only one left that takes these patients. He states that he won't take them anymore. His clinics are the only ones left and he gets a huge number of denials. One of his patients fell off a cotton -- 14-foot cotton -- where they throw the cotton in when the cotton bale doesn't get all the cotton. He fell off. The farmer sent him to his clinic. He got denied. That patient got denied even though their person drove him to our office. So if that person is denied, he has nowhere else to go. Commenter treated him, and his office does dispense medications. That's a patient that will never get authorized in a pharmacy. In Commenter's area, two of his three clinics -- there is no pharmacy in the town. They don't have a place to go to the pharmacy. In order for them to get to the pharmacy, they have to pay what's called a ride-a-dero. That's what the English people call it. That's the best translation. What that is, is people who don't have jobs, but they have a car, and they will give this person a ride to the nearest town for future help. Since his office is in a rural setting -- that's why he got this federal rural status. All of our patients fall into that.			

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	One of the towns, I think, 97% are below the poverty level. So they are very poor people. For them to save up this money to get to go to the orthopedic or the neurologist, it's a lot of money for them to pay the $50 or $60 to go to Fresno, which is 75 miles away, to get this done. Now they are going to have to go to another town and pay these guys $50 to get the medications. They are not going to get to go. They can't afford it. They've lost their jobs. They have three or four kids. Their wife doesn't work. They are living in small apartments, usually Medi-Cal. These people are going to have a great difficulty getting into a pharmacy that doesn't exist. One of the towns his clinic is located in does have a pharmacy, but they just laugh. They said, "We would never take workers' comp. Why would we want to do that?" So even though there is one small pharmacy -- it's a local pharmacy that's been there for many years. That person won't take workers' compensation. He's let us know that. It doesn't matter if you can go to a Long's or not. There is not one within 45 miles of this area. So that's just nonexistent. There are lists of doctors that don't see workers' comp in these clinics, and he states his clinics will be the next ones that will stop because he's not going to do all this paperwork and have the patients complaining to him how come they are not getting better,		The Division is not proposing that physician dispensing cease. The Division disagrees that the regulation will cause it to cease	No action to be taken.

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	how come he can't get referrals for them, how come their case is taking three to five years to make it through the court system. He has to monitor these people for years, not days, sometimes, like this person who fell off this cotton thing. So it isn't going to be worth his time to continue to deal with that if he doesn't get some sort of reimbursement. He can't afford to sit there and buy these medications and give them to them and maybe wait months or years or until who knows when, to get paid for them.			
	Commenter has studied the submissions of the various people who have presented material, and he believes that all of his points have been and he not reiterate. He heard of an interesting occurrence. One of his doctors working in a correctional setting got decked by a client who was doing one to 20, probably for attempted murder, and sustained significant injuries. These injuries were able to be repaired, and when the surgical procedure was done, it was past 5 o'clock. It was determined that he could be treated on an outpatient basis and could go home and could take the prescription that the doctor had and just have it filled. But it also turned out that he lived in an out-of-the-way place where there were no pharmacies. The doctor pointed out that it was not a smart thing even for him as a physician to wait. This prescription should be filled. Fortunately the doctor he was seeing was able to prescribe and dispense from his office in the workers' comp system, so he did so. It was an interesting example	Robert Weinmann		

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	that brought home very significantly how important physician dispensing is. With regard to this -- with regard to physician dispensing, Commenter feels that the best testimony the Division has hear so far, because it's so well balanced, so scholarly, and so well worked out, was by Steven Cattolica, who presented you to a proposal dated 27 September 2006. Commenter stands by that document and says that is the document that he supports most. He believes the figures in it are reasonable. Commenter recognizes that they have used restraint when they urge a minimum of $15 because he believes that there are other costs that should make it higher.		While the Division agrees that it is possible that physician expenses may differ from pharmacy expenses in dispensing a drug, no scientific economic study undertaken by impartial economists has been encountered which adequately determines what expenses are incurred by California physician in various areas of the state, or how they differ from those of pharmacies.	No action to be taken.