STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

TUESDAY, SEPTEMBER 24, 2019
Elihu Harris State Office Building
Room 7
1515 Clay Street
Oakland, California

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Chair

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DEIDRA LOWE, JD
JOSE RAZO, JD
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CRAIG SNELLINGS, JD
Commissioners

ANNE SCHMITZ, JD
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ANDREW WOOD, JD
Industrial Relations Counselors

DIR Official Reporter: Rex Holt

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(The hearing commenced at 9:19 AM.)

CHAIR KATHERINE ZALEWSKI: Are we all ready to begin?

Good morning. Welcome to the public hearing regarding the WCAB's proposed regulatory changes. This concerns the proposed rules that were posted on the WCAB web page on August 16.

I am Katherine Zalewski. I am Chair of the WCAB.

On the dais we have Commissioners Marguerite Sweeney, Deidra Lowe, Jose Razo, Katherine Dodd, and Craig Snellings.

At that table over there is Deputy Commissioner Anne Schmitz, and Patti Garcia is also our Acting Secretary; and to my far right are our staff attorneys, Rachel Brill and Andrew Wood.

So I believe most of you have been to public hearings before and kind of know the drill. One last call, if you plan to speak, please sign in over there. We'll take speakers one at a time. When you're speaking, please speak slowly and clearly so the court reporter can take down what you're saying. Each speaker will have ten minutes to speak, and Rachel will have a timer running that she promises will make an obnoxious sound so you know when your time is up.

As you also noticed, I posted that the written comments are also being accepted until 4 o'clock today. They must be actually received in the office by 4:00, either physically delivered or emailed, to be considered. Our schedule today is until 4 o'clock or until every speaker who wishes to speak has

spoken. We will take breaks. If we go into the noon hour, we'll take a break for lunch and come back in the afternoon.

All right. Just one more point for those of you who haven't been to public hearings before, we cannot respond to questions. So if you're planning to ask us why we did something, our stony-faced lack of response is not intended to be disrespectful. That is not the way the process is set up. This is your opportunity to give your comments on the proposals.

Without any further fanfare, come on up.

Can you tell us your name, and if you're representing an organization, what's your association.

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GREG WEBBER

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My name is Greg Webber. I'm a board member and responsible for Government Relations for Med-Legal, LLC.

Good morning, Chair and Commissioners. I thank you for the opportunity to present my statements regarding the proposed changes to the Rules of Practice and Procedure.

Allow me to introduce the company, Med-Legal. Med-Legal is a leading medical-legal provider that works broadly across the California Workers' Compensation ecosystem to provide the evidence that is so necessary to an evidence-based system.

I'm here today because we rely on the WCAB to adjudicate

claims for payments that are often unfairly denied or delayed for payment, and our concern is that some of the proposed changes may add confusion, potentially newly-increased denials, and, perhaps, trigger delay, which altogether will add friction, which, in the end, is costly for all of us.

Some context and background; Med-Legal deeply embraced a "grand bargain" of the 863 reforms and, in fact, worked closely with the administrators and a broad coalition of interests, some of which are here today, to frame the terms of agreement that would reduce costs for employers and payers, increase compliance, and ensure prompt payment, together resulting in less dispute and friction. Effectively, providers like Med-Legal agreed to substantial reduction in price, about 35 percent, on a promise of timely payment on claims and less dispute and friction overall.

While that reduction in price was immediate, the promise of timely payment was only slowly achieved. In fact, at the time of the 863 reforms, for providers like Med-Legal, less than 50 percent of our claims for payment were timely payments. However, given the "grand bargain" and some of the related/enabling rules in the Rules of Practice and Procedure, section 10451.1 in particular, providers like Med-Legal were newly able to effectively adjudicate claims, forcing areas of noncompliance into deeper, and continuing, compliance, which increased payment rates to 75 percent and more overall, cutting

costly friction in half, from more than 50 percent to less than 25 percent, which, by our estimate, saved the ecosystem almost $25 million in dispute costs, and that's on top of the savings of almost $40 million from the reductions in price.

Relative to the Copy Service Fee Schedule, well over $200 million in savings have been secured. However, with these proposed changes, we're concerned that some of these savings may be in jeopardy, and frankly I have to ask what are we doing here. While understanding the need for modernization, for simplification, and for update, the reality is that the currently-intended actions extend far beyond those simplistic administrative goals and instead also go to the depth, breadth, and likely unintended consequences associated with what is a sweeping rewrite of the rules and represent real risk, and it seems to me that risk is not even considered, let alone identified or quantified, anywhere in these proposed changes. From an ecosystem perspective, the real risk here is such a sweeping rewrite of the rules that results in unintended consequences of years and years of new litigation issues, perhaps resulting inasmuch as $100 million of additional costs across the ecosystem. I ask what are we doing here. In my view, the table stakes, $100 million, in increased costs of unintended consequences are just too large a risk to take.

A couple of specifics on section 10451.1, newly proposed as 10786, and I very deeply appreciate that the Commissioners

carefully consider the well-founded comments of the community. From my view, 10451.1 was a -- was intended to allow either a payer or provider, provided they have fully and faithfully executed their requirements, to request the WCAB expedite a conclusion on a medical-legal dispute. From my view, the key value in that section is to strongly motivate the full and, especially, timely compliance for all parties and, two, thereby allowing for a clear path to an early, complete, and simple resolution on disputes. Herein I worry, with these revisions, the changes provide more focus on pathways for dispute and friction versus driving toward resolution. I urge the Commissioners to take one more look at 10786 with the clear focus on tilting the language toward targeting resolution versus defining disputes.

Second, with the proposed repeal of section 10626, this section sets out the rights of the parties to have access to the evidence. Frankly, it's absolutely required for an evidence-based medical system. Further, it makes clear that it is a further subject of other privacy protection requirements set forth in law, regulation, or statute. While the Commissioners make a reasonable point that certain provisions of the Evidence Code address this requirement, those provisions speak more to the obligations of the custodians to provide this evidence versus the rights of parties to have access to such evidence. This is an important distinction, especially in an

evidence-based medical system, and I urge the Commissioners to maintain section 10626.

Relative to the proposed repeal of section 10888 because lien matters were bifurcated from the case-in-chief, importantly this section sets forth the responsibilities of the parties to not forget the important lien-related determinations may linger postclosing of the case-in-chief. Further, it encourages proactive settlements of such matters at the time the case-in-chief is resolved. While the Commissioners make the case that such "proactive encouragement" has been unsuccessful, stretching that position to "Let's just give up by repealing this section" will only further delay meaningful discussions and settlement. Rather than repeal section 10888, I urge the Commissioners to strengthen the provisions and encourage the boards to actually enforce them. Proactive enforcement is likely to enhance compliance, increase timeliness of settlement, and reduce the ongoing costs of dispute.

So in conclusion, I focused on three particular sections. I focused mostly on the potential unintended consequences and the costs, and I think these changes, while generally well intended, have great potential for substantial and costly unintended consequences. Since the implementation of the "grand bargain" of 863, the system has really managed to find and maintain a reasonable balance amongst all stakeholders and

these changes will newly challenge that status quo. I think the table stakes are just too high, and I encourage the WCAB and all of the Commissioners to consider a much more limited approach. The system may not be ready for this level of major reform.

Thank you.

CHAIR KATHERINE ZALEWSKI: Thank you.

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DEBRA RUSSELL

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Good morning, Commissioners. My name is Debra Russell, and I hold the position of Senior Director of Strategic Initiatives with Schools Insurance Authority. Schools Insurance Authority is a joint powers authority in Northern California, and we administer the workers' compensation programs of school districts with a combined payroll of over $1.9 billion and 33,000 employees.

My comments are in regards to section 10305(o), which pertains to the definition of parties. The current proposal is to make lien claimants a party to a case-in-chief. We do not understand what problem this change is attempting to fix.

The relevant parties in a workers' compensation case are the employee and the employer. All other appearances to the case, such as medical providers, copy services, and interpreters are vendors, not direct parties. Currently

subsections 3(a) and (b) limit the circumstances wherein a vendor can be a party in the case-in-chief. These two situations are when the case-in-chief is resolved or when the case is not being pursued. Vendors are not considered lien claimants until and unless there is an issue regarding payments for their services. In the proposed changes, subsections (a) and (b) are being deleted, which would mean lien claimants are now a party in the case-in-chief from the beginning of the adjudication process.

This change will result in severe unintended consequences. I'd like to highlight two of these. The first one is the confusion in the notice and service. The rules a practitioner now follows with regard to notice and service of medical reports to parties and lien claimants is different but clear. Redefining lien claimants now as parties would suggest that they have rights to service, as well as to appearances in discovery, depositions, pretrial proceedings, trial, and appeal. However, lien claimants are not required to participate in these.

What is the purpose of making lien claimants a party to a case only to withhold the legal rights and responsibilities that come with being a party. It is nonsensical to us to make lien claimants a party but not require them to be present at MSCs or hearings.

The second unintended consequence is a delay until the

injured worker is receiving their benefits. If a lien claimant is made a party to the case-in-chief, it would follow that all lien claims must be resolved prior to a settlement being finalized and approved by the WCAB. Depending on the number of lien claimants, this could very likely result in a delay in the injured workers' receiving their settlement funds. We don't believe this delay is warranted, or fair, to the injured worker.

And in closing, we truly do not understand the problem this change is attempting to fix. We see this proposed change as a solution in search of a problem. We respectfully request the WCAB abandon the change to 10305(o), which redefines lien claimants as parties to the workers' compensation case.

Thank you.

CHAIR KATHERINE ZALEWSKI: Thank you.

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SAUL ALLWEISS

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Good morning, Commissioners. My name is Saul Allweiss. I am an attorney and consultant. I'm speaking on behalf of CCWC today.

While we submitted written comments, I do want to highlight just a few areas that I'd like to emphasize in terms of this oral testimony. The first is in regard to significant panel decisions. We're referring to proposed regulation

10305(q) and 10325. We are recommending that these provisions be stricken in their entirety. These provisions are not authorized by statute. In fact, the origin of significant panel decisions actually date back to a press release that was put out by former Chairwoman Diane Marshall back in 1997. The Labor Code allows for the Appeals Board to, upon meeting and deciding that there is an important issue, to issue en banc decisions. The Labor Code provisions 133 do not allow -- I'm sorry -- 115 and 133 do not allow for significant panel decisions. Its creation -- and I can -- I don't how wide that occurred back in 1997, but that appears to be the only authority for what this regulation is now proposing to do.

We believe, by its own admission, significant panel decisions and regulation, at the same time they don't have binding authority, it's telling the community, "Oh, this is important. Please pay attention to this." We believe that if you -- if you believe that there is an important issue and that we should pay attention to those, we should be issuing en banc decisions, and notifying there is an en banc decision. And the best example I can give is the recent significant panel decision in *Puni Pa'u v. Department of Forestry*. That turned out to be an important issue the whole community was wrestling with, and we think that if the Appeals Board had gotten together, taking the time, "Oh, wow, this is a significant panel decision," why couldn't you have taken that same time to

have made the decision that this should have been an en banc decision. So, therefore, we believe that the creating, by regulation, of provisions for significant panel decisions doesn't serve any purpose. They are confused constantly with LexisNexis noteworthy panel decisions and arguably they have the same lack of authority in terms of binding authority that LexisNexis gives to its decisions. So if there is an important decision to be had, please issue en banc decisions.

The next area that I'd like to talk about is in regard to 10786, labor Code section 4622(c), to create a sea change in regard to non-IBR determination of disputes and requires admittedly the defendant has to file a Declaration of Readiness to Proceed along with a Petition for Non-IBR Determination. This unfortunately has created a problem for payers because they are reacting to what is being done by the medical-legal provider.

I'll give you an example of what occurs. I'm going to be focusing on copy services. So within days of the filing of an application, sometimes on the day that the application is filed, the copy service issues subpoenas for the file of the employer, for the file of the insurance company, for all the medical records, for all the medical reports, sources of medical records that might have existed to date, but again this occurs within days. The claims administrator will, many times, promptly respond to say the copy service regs do clearly state

that there is a specified period of time that you have to wait to be served with the documents. The copy service hopefully, in many instances, will abandon their efforts to subpoena the records, but then they go and they submit a $75 cancellation fee. The claims administrator objects to this cancellation fee, and then the copy service sends their request for second review. The claims administrator says in your second review, "The $75 wasn't an allowable charge. You shouldn't have subpoenaed any of this in the first place."

And then the copy service then announces their intent to file a non-IBR determination, and at that point -- I'm sorry. The copy service files an objection, claiming that there is a non-IBR dispute. Now, admittedly defendants, the payers, they actually dropped the ball in this instance because, in their mind, they've done everything right, and then, as a result, what's in the existing regulations and continues to be adopted in 10786 is a clear path to costs and sanctions, and we think that's where the problem lies because once -- right now what we're seeing is that this Petition for Costs and Sanctions automatically comes in over a $75 dispute; but now, because costs might be alleged 3- or $400 an hour, now we're looking at maybe a $2,000 cost claim and the $75 claim that was initially being offered initially as part of the dispute, which we believe, you know, was properly raised from the get-go, that the copy services now are negotiating about their $2,000 claim

for costs and attorney fees. And as a result, the -- this $75 issue is no longer the issue; it's the $2,000 assessment for fees.

If there is truly egregious conduct by either party in regard to what happens in regard to any dispute -- in this case, non-IBR determinations -- a judge has the ability to raise issues of sanctions under 5813. By putting -- by this being placed in the regulation and as this clear path to sanctions, it then actually encourages the copy services, or the other medical-legal providers, to go down this path so that they can raise a $2,000 claim for costs and let's not forget about the $75 claim for the $75 that really is the dispute. We think that, as far as the regulation is concerned, that everything should be taken out in regard to costs and sanctions. Judges have the ability to take under consideration a claim for costs and sanctions if it's ever raised by the parties and if the conduct is ever egregious, but let's just take out the specific reference in the regulation to allow this direct path to go to costs and sanctions.

Thank you.

CHAIR KATHERINE ZALEWSKI: We will take a ten-minute break. So by my watch, it's 9:45. We'll reconvene at 9:55.

(Pause in proceedings from 9:46 AM to 9:57 AM.)

CHAIR KATHERINE ZALEWSKI: All right. We will go back on the record now and continue with our next speaker.

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MATTHEW O'SHEA

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Commissioners, my name is Matthew O'Shea. I'm with Albertsons/Safeway. We are the second largest private employer in the State of California, and thank you for the opportunity to speak on the proposed regulations.

I'd first like to point out that the WCIRB in the 2019 State of the System report noted the total loss adjustment expenses increased by $600 million since 2013. These are one quarter of the total costs in the workers' compensation system and more than twice the median of the entire country -- of the national median. It's with these costs in mind that I'd like to talk about some of your proposed regulations.

The first one being 10555, the Petition for Credit. We had a lot of discussion about this, trying to determine when it applied, and when I read your statement of reasons, it appears that it applies to third-party credit situations, but as we were reading it, we were concerned that it may also apply to more TD overpayments and whether litigated or unlitigated, and we weren't really clear if it applied. We weren't clear if it only included litigated cases. We weren't clear if the WCAB considered the existing case and statute case law and statutes in drafting the regulation, and it doesn't appear that the regulation allows the party to resolve the dispute by

agreement. There is no option for a resolution by agreement.

So in terms of TD overpayments, many times TD overpayments are caused by the late receipt of an MMI report, the late notice to the third-party administrator, or sometimes even a late notice to the employer of return to work. If you return to work at a specific location, the claims department -- we're self-insured, self-administered -- may not know right away that the person is actually back at work. There is a slight overpayment. In most cases in these non-litigated situations and in litigated situations, the employees either immediately repay us the overpayment, call us up with the check and say, "Hey, look. You guys overpaid me. How do you want to handle this?" or we can either waive the overpayment or assert a credit against any PD they may be owed, knowing that there is probably going to be PD in the case. There is no option for any of that in these regulations.

I think clarifying when it applies is going to enable us all to better understand when the regulation applies. Labor Code section 3858 this is in terms of third-party Petition for Credit says, after payment of litigation expenses, attorney's fees fixed by the Court pursuant to 3856, and payment of liens, the employer shall be relieved of obligation to pay further compensation on behalf of the employee under this subdivision up to the entire balance of the judgment without any deduction. Labor Code section 3861 empowers the

Appeals Board to finalize the credit. Interestingly, this section comments the Appeals Board is empowered and shall allow a credit to the employer to be applied against liability for compensation. The proposed regulation seems to be contrary to case law already addressing the statute in *SCIF v. Brown (1982)* -- do you want the full cite? It's in our comments.

CHAIR KATHERINE ZALEWSKI: If it's in your written comments --

MATTHEW O'SHEA: *130 Cal.App.3d 933*. The Court allowed automatic credit involving third-party cases specifically to avoid unjust enrichment and duplicate recovery. The regulation, as drafted, is not consistent with this case. Instead it should reflect the right of the employer to assert the credit to avoid the unjust enrichment. The regulation should permit resolution by stipulation or third-party C&R and, failing an agreement, by a Petition for Credit. If the parties are unable to reach an agreement, the Petition for Credit is the proper tool.

There is nothing in the case law or statutes that permits the WCAB to delay assertion of a credit pending resolution of the workers' compensation claim or determination of credit rights pending the approval of a petition. In terms of the resolution of a claim at the district offices, quite often that's what we find as well, "Come back when the case is resolved." By the time the case is resolved, we paid out all

these benefits that we may not assert a credit to. That's a problem.

Proposed 10555(b)(1) requires the party asserting the credit shall include the settlement or judgment from the civil case. Well, a judgment is a public record so certainly we can get the judgment, but settlement agreement between parties in civil cases are often considered confidential, even though case law says they are not. I'll get to that in a second.

So they are note available to the employer even by subpoena. They are considered confidential and not provided. So employers are really stuck in a hard place by this regulation requiring that we provide an agreement that we can't get. You essentially nullify any chances of us getting a credit in these situations, and that applies both to the litigated and non-litigated civil cases, many of which resolve without any litigation and without any notice to the employer or the third-party administrators.

In *Swanson v. WCAB S.Ct.(1994) 59 CCC 806*, they held that third-party settlement agreements are not confidential as they pertain to credit before the WCAB, and consistent with existing case law, a regulation to that effect would go a long way in ensuring those are followed.

We further think that a regulation requiring disclosure by the injured employee and requiring production to the employer will aid in filing complete and timely petitions where an

agreement can't be reached. In the absence of regulations enforcing these, you're basically putting us in a situation that we can't secure a timely credit. The only way for us to secure a timely credit would be to require us to be an intervenor in every single civil case. That's a substantial increase in costs versus as a lien claimant.

ATTORNEY RACHEL BRILL: Sorry. Your time is up.

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BRETT FREEBURG

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I want to thank you for the opportunity to speak to you. My name is Brett Freeburg. I have a company called Med-Legal Xchange. I work with a number of QMEs -- I'll slow down -- in providing back-office administrative services: Billing and clerical and scheduling. I'm not here to belabor the points made at this public forum, some of the opinions regarding 10451.1 overwhelming responses from the -- from the QME med-legal provider community about how they feel about the proposed changes.

Since the implementation of 10451.1, I feel like we actually begun to -- finally begun to see the trickle-down effect where the claims adjusters, attorneys, even WCAB clerks have stopped -- WCAB clerks have been told just reject every petition that they see. Workers' compensation judges have an understanding of the petition, of what it means and involves,

and has finally begun through the payer behavior. It's gotten to the point where, now, even a well-written letter to the defense counsel prior to filing a petition often can resolve a non-IBR dispute. So I would urge you to consider any changes you make to that pathway to resolve these disputes that may derail the progress that has been made in the past year since the implementation of 10451.1. I would urge you to -- sorry -- stay the course with 10451.1 as it forces the payers to be held accountable to timely pay, timely object, and follow the rules that are fairly straightforwardly written on how you object to a med-legal bill or issuing an EOR or whatever that process entails.

QMEs, as you know, have very strick rules and timelines that they must comply with and I think it's only fair that the payers be held accountable and these appear to me to be fair rules regarding payments for the services provided by the QMEs who, in many cases, are the crux of the evidence that's going to resolve a dispute. I have numerous occasions where it has taken over a year to get paid, even with this system, and that's just a burden to QMEs, to their offices, to their overhead. It's just not necessarily fair when we have this method right now to resolve these disputes, and I feel it actually started to really work.

Some of my other comments may, or may not, be something that you guys have authority to deal with based just solely on

the rules. My first point is that I noted, in the forum, someone from Zenith complained about the use of kind of a dual non-IBR and IBR track wherein the petitioner gets an objection or they get a partial payment and they file for a second bill review and they file a petition and they feel like you should not be able to object on a non-IBR basis in a second bill review.

I would urge you to reconsider that notion because, going back to the Zenith's point, even in the situation where a dispute is obviously non-IBR and they issued a ridiculous objection -- I'm sure any one -- whether it be a medical-legal objection, we get an EOR that is sometimes absurd that can be resolved by objecting to the SBR paperwork itself. Other than that, your course of action would be to object, wait 60 days. I have not once seen a party respond to a non-IBR objection by filing a petition and a DOR, not once in four years of dealing with these. So it never happens.

So now you wait 60 days and now you have to file a petition. Well, oftentimes that same, even though it's a non-IBR, dispute gets resolved if you simply lay it out in the 205 characters, or whatever you get on the IBR form, and it's resolved in 14 days.

If you go the route of requiring a non-IBR dispute to be handled in that other pathway, you're just adding frictional costs, because now even a non-IBR dispute for an absurd

objection, like the provider is not in the MPN -- not in the MPN or the service was not authorized. Even those things that often are in a lien, 90 percent of the time when I file an SBR on that -- something like that, it gets resolved. We don't have to file a petition. I would urge you guys to allow providers to object and have that kind of dual path, if that's what you want to call it, because I think that will help to continue to reduce the frictional costs. That, I think, is what's driving all these proposed changes.

My second point is that EORs should be required to contain valid objections. We can't respond appropriately if there is a nonsensical objection. The most common objection that I see on EORs is, quote, "This charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance," and that's it. They've just arbitrarily cut it in half. That's the objection. It's a med-legal bill. "On what basis are you saying that it doesn't exceed the medical-legal fee schedule?" So how do you respond to that. Even when it's paid in full, most EORs actually have that objection on it. It's paid in full, and they are still objecting. And some of the other nonsensical objections, which I think people talk about a lot on the forum, were the provider is not on the MPN or the service was not authorized, something along those lines.

I would also request that EORs should be required to

contain the name of the bill reviewer. As it is, there is no way to know if that person was certified, if it was just rubber-stamped, and there is no way to fight back against that nonsensical review of your bill.

And last -- not last. So I can't tell you how often we get a response, maybe one in 15 times, from bill review that says, "The review cannot be completed without the report." We send the report, the bill, PHI form if it's in the proof of service, and actually send a separate legal proof of service documenting every document that was in the envelope, because one in 15 times we get that objection that "We can't review this without the report." So the claims adjuster, or whoever is handling these claims, should be held accountable in some way so that we're not dealing with these frictional costs. I've had these go to petition because they just won't pay. We'll send them another copy of the report. They don't pay. 60 days goes by, we don't get an EOR, nothing happens with it. They've sent their objection and they are happy with it.

We actually track every report that we send out via USPS so we can document when it was received. I can't tell you how many times that has become an issue. So the EORs should be required to both have a received date and a proof of service. Many times the EOR will have a date -- or field called the business received date and it will say business received X and say printed date and printed date X. It will be like four

weeks apart, but we've tracked the report. We know they've received it.

ATTORNEY RACHEL BRILL: I'm sorry, sir. Your comment time is up.

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LORI KAMMERER

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Good morning, Madam Chair. Lori Kammerer, K-a-m-m-e-r-e-r. I am here on behalf of the Coalition of Professional Photocopiers, who represent both the applicant and defense service providers for legal discovery services.

We are basically respectfully requesting that you keep the section 10451.1. This section is used by medical-legal providers to hold payers accountable for promised payment for non-monetary disputes, like systematic neglect of timely payments. The only path to the court is this section and the lien process.

We also respectfully request that you keep section 10626. Currently this section gives explicit rights for all parties to examine and make copies of the documents -- document evidence. The WCAB is governed by the Rules of Practice and Procedure but Labor Code section 57085 gave WCAB discretion to ignore statutory Rules of Practice and Procedure. We therefore respectfully request that both the sections, 10451.1 and section 10626, remain in the regulations.

Thank you.

CHAIR KATHERINE ZALEWSKI: Thank you.

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GABRIELA RUIZ

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Good morning, Commissioners and Chair. My name is Gabriela Ruiz, R-u-i-z, and I am the collections and litigation manager for Med-Legal, LLC. My primary function for the organization includes managing the day-to-day operations related to the investigations, including overseeing the objections and non-IBR process. Med-Legal is a med-legal provider delivering discovery and evidence services to various parties in the workers' compensation system. Our primary objective is to ensure that parties independently maintain their equal and unencumbered discovery rights. My objective here today is to convey the viewpoint of the stakeholders that execute the day-to-day operational processes to ensure compliance and adherence to the regulations set forth by the WCAB.

It should be recognized that the WCAB made significant revisions to the first proposed amendments and repeals. However, through its intent to simplify the existing language of the rules for clarity and break up the complexity of other rules, the WCAB is inviting ambiguity and misinterpretation, which will result in further litigation. According to the DIR

statistical table, the number of Petitions for Reconsideration filed has continuously decreased in the last ten years despite the steady increase of case filings. One must agree that the comprehensive and in-depth rules as they exist today have been a critical component in obtaining such a decrease. The current rules have provided guidance and a mechanism for the providers to incorporate to exercise due diligence and due process.

This morning, in the interest of brevity, I'll be limiting my comments on three specific amendments. The first comment is on proposed amendment 10872. It is a current industry practice of providers and defendants to resolve matters after a hearing date is set but before going to a hearing itself. This is due, in large part at least, to delay carriers' assignments and/or authority to the defense and the practicality of defense attorneys having the ability to assess their files far in advance.

The amendment would greatly reduce the resolutions and clog up the courts of time with unnecessary appearances. A large driver to reaching early resolution is the avoidance of costs associated with an appearance. This amendment takes away that strong incentive.

In addition, it is a practicing term that payment is due and payable within 30 days after an agreement is reached. A stringent time frame will only be counterproductive since no provider will withdraw absent confirmation of payment and

excusal from the WCAB to appear.

My next comment is related to the proposed amendment 10862. This rule does not clarify, nor define, the parameters of filing an amended lien. I can't imagine the intent of this either. Is it to obligate the provider to incur the costs of filing and serving constant allegations at any and all times in value changes from the original lien filing amounts. This was a catalyst of the elimination of lien amendments from Senate Bill 899. A consideration of this impact should also be placed on the amount of amended liens and supporting documents that would be filed in FileNet.

My final statement relates to the now-proposed amended regulation 10862. There is an essential need for specificity, detailed rules, and clear definition specifically to this regulation. The genesis of dispute between a payer and provider is nonpayment. The former 10451.1 had finally provided clarity that either drove prompter payments or a detailed process to reach dispute resolution in a timely manner. Removing some of this clarity will result in a reversal of the progress made and increased litigation.

Accordingly, the former definition should be brought back into this new amendment regulation. They are fundamental to the implementation of the lien process. Anything less will create a potential for misapplication of definitions from other regulations or statutes that are neither appropriate nor

applicable. In conclusion, while simplicity is usually best, oversimplifying can often lead to unintended consequences, considering the unintended consequences as simplifying a complex process in a highly litigious industry.

Thank you for your time and consideration.

CHAIR KATHERINE ZALEWSKI: Thank you.

Is there anyone else who signed in to speak who has not yet spoken?

Okay. Let's take -- yes?

LINH LE: I haven't signed it, but I'd like to briefly talk.

CHAIR KATHERINE ZALEWSKI: Sure.

LINH LE: Would it be okay if I signed in now?

CHAIR KATHERINE ZALEWSKI: That would be fine.

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LINH LE

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Good morning. My name is Linh Le, L-i-n-h, last L-e. I'm an attorney with Boehm & Associates, who represent lien claimants, including healthcare plans, self-insured employee panel plans, public and local and federal health care providers.

Just two points I want to make for section 10305, classifying lien claimants as parties. I am in agreement. I think the statement of reasons suggested that it pulls

conceptual and practical issues by not listing the lien claimants as parties. I agree. If a party in a given work comp case wants to put the lien at issue, lien claimants will typically show up. Lien claimants also file recons and answers in the cases-in-chief.

In terms of discovery, I think it was raised as to whether medical reports should be issued to lien claimants. Under the current regulations, physician lien claimants are, with whom we represent, are entitled to med reports -- med-legal reports within ten days' request. Non-physician lien claimants are entitled to same with an order from the judge. Lien claimants have due process rights in the cases-in-chief. It does not trigger due process rights once a case-in-chief resolves. That's supported by case law. So I'm in agreement with that.

Second point is 10752, that is, the appearances for lien claimants. I'm also in agreement with that. I believe the statement of reasons indicated that the value of the lien should not dictate whether or not a lien claimant is required to appear at an MSC and/or trial. You could imagine the practical issues if you have a lien that's, current regulations, higher than 25,000 accepted and excused by the judge or show up for settlement authority even though oftentimes -- most times the work comp carrier doesn't have authority in the case-in-chief to resolve the lien. So I'm in agreement with that. I think it really just expedites the

process, less requests to be excused from the judge; and back to the statement of reasons, it really shouldn't matter about the value of the lien.

Thank you for your time. Thanks.

CHAIR KATHERINE ZALEWSKI: Thank you. Is there anyone else?

All right. We're going to take a break just to be sure that no one else comes to speak. So we'll call this a ten-minute break and then see if any more commenters arrive or if anyone who's here who hasn't spoken already wants to.

(Pause in proceedings from 10:31 AM to 10:55 AM.)

CHAIR KATHERINE ZALEWSKI: All right. We will go back on the record. Last call. Essentially, if there is anyone who has not spoken who wishes to comment on our proposed rules, please step forward now. If not, we will adjourn the hearing.

Thank you all for coming today. Class dismissed.

(The hearing adjourned at 11:06 AM.)

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REPORTER'S CERTIFICATE

I, the undersigned DIR Official Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, hereby certify that the foregoing matter is a full, true, and correct transcript of the proceedings taken by me in shorthand, and without the aid of audio backup recording, on the date and in the matter described on the first page thereof.

Dated: October 8, 2019
Oakland, California

/s/ Rex Holt
Rex Holt
DIR Official Reporter