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

PUBLIC HEARING

Wednesday, July 17, 2013
Elihu Harris State Office Building
1515 Clay Street
Oakland, California

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I N D E X

SPEAKERS

PUBLIC HEARING

OAKLAND, CALIFORNIA

Wednesday, July 17, 2013 - 10:08 a.m.

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MS. OVERPECK: Good morning. Thank you all for coming today. My name is Destie Overpeck. I'm the Acting Administrative Director for the Division of Workers' Compensation.

The public hearing is for the Physician Fee Schedule Regulations, and I have an announcement. Last night we received RAND's revised assessment of policy options for the California Workers' Compensation Program. We put reference copies up on the front desk, and we've made copies of their Appendix E, which is the explanation of the changes from the Initial Working Papers. It's all posted right now also on our Rule Making Page where the Fee Schedule Regulations are.

We've also received a detailed impact file for public use. The file is a comprehensive data file with a description of the data elements included in a separate document. This will allow you members of the public to focus on specific components of the proposed changes. So, the revised report and the detailed impact file for the public use have both been posted to our Rule Making Page. There are also copies of our proposed regulations at the front desk. I know most of you know this, but please be sure to sign in, so that we know that

you're here today and to check the box if you want to testify today.

Because of the revised analysis, the conversion factors that are stated in the proposed regulation will change. However, when Medicare announces the Medicare Economic Index, also known as the MEI, in the fall of 2013, we will be issuing an order that would be adopting the revised conversion factors that conform with the Medicare 2013 conversion factors.

Also, please know that we will have another 15 day comment period that will allow everybody time to actually digest the revisions to the RAND report, and you'll be able to submit more comments at that time.

So, let me introduce to you, we have here today our court reporters are Barbara Cleland and Kim Miller, and up here at the front we have Maureen Gray, our Regulations Coordinator, Dr. Rupali Das, Jarvia Shu, one of our attorneys who has done most of the work on these regulations, and George Parisotto, our Acting Chief Counsel.

When you come up to testify, please give your card to the court reporters and -- Oh, I'm sorry, to Maureen. All testimony will be taken down by the court reporters. If you have any written testimony, please also hand that into Maureen. I will call the names of people going through the list who have checked that they want to testify. I'll also make sure at the end that, if anyone changed their mind, if they didn't say they

do but now want to testify. Our hearing will go on as long as people are here and wanting to testify, but it will end by 5 o'clock tonight.

We'll figure out as we get closer to lunch time whether or not we need a lunch break.

Any written comments can be given to Maureen here or you can fax them or e-mail or deliver them to us by 5:00 p.m. at the 17th floor of our office.

So, the purpose of this hearing is to receive comments on the proposed amendments to the regulations, and we welcome any comments that you have. Both the comments we get orally today, as well as the written comments, will be considered in determining whether or not or which kind of revisions we will need to make to the Physician Fee Schedule.

Please restrict your comments to the regulations and any suggestions you may have to changing the proposed regulations. And please limit your comments to ten minutes in length. We won't be entering into discussion about the regulations, but we may ask you for clarification or to elaborate on points that you are mentioning.

Okay. Also when you come up, please be sure and state your name, spell your name and tell us who your testimony is on behalf of. So, let me start with Dr. Lesley Anderson.

LESLEY ANDERSON, M.D.

DR. ANDERSON: Good morning. I'm Lesley Anderson,

L-e-s-l-e-y. I'm an orthopedic surgeon in San Francisco. I'm in solo practice, and I represent the California Orthopedic Association. I'm the chairperson of their work comp committee.

I've been in practice for 30 years as a solo orthopedist this year. And as an orthopedic surgeon I've chosen to care for patients in the workers' comp system because historically these patients are some of the most vulnerable when they're injured due to the loss of livelihood. We fix things from a torn rotator cuff or meniscus to a fractured ankle sustained on the job. In most cases we're able to return patients back to work with no residual disability. While office visit reimbursements will increase by up to 30 percent during the transition of the fee schedule, an occupational medicine clinics will be rewarded for continued conservative care, we worry that many of these patients' referral to specialty care for torn or tendons or ligaments may be delayed increasing the disability time or off of work with increased cost to the employer. And once they are past that three month mark on disability, we all know that they're less likely to return to full duty.

Now I have two points to make. The first is to let you know that we conducted an internal study of 25 orthopedic practices over a one-year period, which included the actual mix of CPT codes billed by each practice. We multiplied the frequency of the codes performed by the proposed conversion

factors and found a 30 to 40 percent reduction at the end of the transition for surgeons that predominantly perform arthroscopic knee and shoulder procedures, and a 20 to 30 percent reduction on a very time and risk intensive procedure such as total knee replacements. Surgical fees have not been increased in over 25 years, and with the new fee schedule an additional loss of revenue up to 30 to 40 percent will cause many capable and caring orthopedic surgeons to leave the workers' comp system.

Now my second point is that under the, and probably more important personally here, is that under the proposed regulations we will not be reimbursed for all of our post-op visits, which is a critical time in developing strong disability management plan for these patients to help them see a path to return to work. We have asserted for years that caring for the post-op patient under the workers' comp system takes substantially more time with no reimbursement in the first 90 days. With the fee cuts planned for surgical procedures, the Legislature intended that the visits in this global period should be reimbursed. To prove this hypothesis we just completed a study that compares the time it takes for injured workers versus Medicare or non-workers' comp patients during the post-op period, often 90 days for most surgical procedures. Two hundred and eleven patients were included in our study. We tracked post-operative patients that I saw in my

office over the past five months on a time spreadsheet that was filled in as the patient was seen for each portion of their visit. The study included medical assisting rooming time, M.D. face-to-face time, M.D. non face-to-face time after the visit, and medical assistant check-out time. This did not include M.A. time to obtain authorizations, mail the forms and process the paperwork.

In a Medicare population the visits are straightforward. We check on their rehab program, their wounds, their range of motion, strength, and there is rarely a discussion about work status as patients return to work quickly or are retired. There is little drama or tears, and there is rarely a language issue or translator needed. On the other hand, with the workers' comp patient we often spend a significant part of the visit on work issues, negotiating modified duty, listening to frustrations about lack of PT authorizations or delay in PT, papers they have received from their carrier, and many times managing pain with a patient in whom English is not their first language. In our study we found that the first post-op visit took a total of 20.9 minutes for a Medicare patient and compared to 29.9 minutes for a workers' comp patient. Of this time, total M.D. time was 12 minutes for Medicare patients and 18 minutes for work comp patients. This difference was statistically significant. After the first post-op visit, each work comp post-op visit

took over ten minutes longer in total M.D. time, which was statistically significant to P as .0001, as significant about as you can get. If the surgeon was billing a 99213, which is a middle level code for 15 minutes under the Medicare or the RBRVS system, an additional 10 minutes of that -- to that visit to make it longer for work-related issues nearly doubles the time that the surgeon spends with that work comp patient. This is additional time spent for an injured worker versus a Medicare patient or non-workers' comp patient.

We urge you to remember that our job in the post-op period is not just management of the orthopedic procedure. It also includes disability management which includes producing work slips and completing the PR-2 report, neither of which are ever, ever done on a Medicare patient. This additional ten minutes of time is not reimbursed. Over the course of a day this can add up to an hour or two of additional non-reimbursed time.

I must point out that this study probably under estimates this additional non face-to-face time required by orthopedists. As many of your nurse case managers will tell you I'm a very efficient office, and I use a scribe in my exam room with my patient, and she enters the objective data, the range of motion, the things that would take me time to stop and put in the record and then do later on my report. And then I complete the discussion on that which I do after my patient

hours are finished. Orthopedists that do this documentation in this sort of standard fashion are using the EMR, which we all know takes 15 percent longer to use an EMR than hand paper or manually undoubtedly takes longer. We believe this study provides hard data that additional M.D. face-to-face and non face-to-face time is required to treat injured workers versus non-work comp patients in the post-op period by over 50 percent on each visit. All of our data was statistically significant. Thus, COA is recommending that the post-op visits be reimbursed after the first post-op visit. We believe this will motivate surgeons to see patients more frequently in the first 90 days after surgery, which will have the effect of facilitating earlier return to work to modified duty which is what the employers are asking us to do. Otherwise, there is little incentive to see patients during the first 90 days over and above what is reasonably required to care for their surgical wounds and rehab. Disability management is not ever an issue or a need to be addressed in the Medicare non-workers' comp population.

Orthopedic surgeons will be hit by other reductions in the fee schedule in addition to the reductions in surgical fees. COA believes that access for orthopedic surgical services in care will be severely limited if surgeons are not reimbursed more fairly for the additional time and work involved in the post-op surgical period.

A draft of this data is going to be handed in at the end of the day. Hopefully that will be kept confidential since we hope to publish this in the next couple of months.

MS. OVERPECK: Oh, I'm sorry. If you give us something for the rule making file, it will be public.

DR. ANDERSON: Oh, it will be.

MS. OVERPECK: Yes.

DR. ANDERSON: Okay. All right. Thank you.

MS. OVERPECK: Thank you. Dr. Basil Besh.

BASIL BESH, M.D.

DR. BESH: Good morning, and thank you for allowing me to speak. I'm Basil Besh. I'm an orthopedic surgeon practicing in Fremont. I'm here on behalf on the California Orthopedic Association. Pretty difficult to follow Dr. Anderson. That was very thorough and made some strong points. I was hoping to kind of take a step back and just put into perspective some of the differences we experience as physicians in our office between treating Medicare patients and work comp patients. Dr. Anderson highlighted the differences are more than just clinical. And when RBRVS was envisioned back in the '70s and '80s, the RVU or the relative value unit took into account the risk and training of the physician, and the work that went into the clinical management only. Nowhere in that RVU or that RBRVS was the disability management. The daily negotiations trying to get patients back to work, the stopping what you're

doing and getting on the phone with the peer-to-peer doctor to review authorization. In fact there's no authorization at all in Medicare. Medicare publishes that their overhead, administrative overhead, is three percent, three percent. That means you almost never talk to anybody administratively in Medicare, ever. In work comp for every dollar spent on medical care in California $7 are spent in indirect costs, and I would propose to the audience here that, if we efficiently spend money on medical care, we dramatically reduce that indirect cost. Dr. Anderson gave an example where we get asked by employers and by adjusters to see the patients more frequently. Doctor, we have opportunities for modified work. Can't you see this patient sooner, and see if there's any way to reduce their restrictions? We are constantly negotiating and even refereeing between adjusters, employers, work comp carriers, and the patients in this inherently adversarial system, trying to make the best of getting them as productive as possible, limiting the deconditioning.

What's being proposed in its totality, and obviously Dr. Anderson spoke to the specifics, is, hey, Medicare has said this is what that treatment value is worth clinically. But nowhere in Medicare does it take into account all these additional things that are done. Nowhere in the concept of RVU or RBRVS is there a stopping your practice. We have -- Diane will be submitting some samples and we'll be collecting more,

where adjusters will send us a letter along with the patient visit. Please address these eight different issues during your visit. If that's in the post-op, that's basically, if we're contemplating eliminating the medical reporting reimbursement, the post-op visit reimbursement, all these things, where does this additional time and energy come from? Where is it compensated? A typical trigger finger treated in my office. I operate on them. I see them in two weeks. I take out their stitches. This is Medicare. I don't seem them back for three months. That's it. One post-op visit. A typical work comp patient, I'm going to see them pre-operatively to start the negotiation process for how long they're going to be off of work, when we're going to get them back to work, what work modifications we're going to have. You see them the first visit for a bandage change. Again, hey, you only have one more week that we can keep you off. Then we're going to get you back to modified work, and I anticipate full duty by six weeks. Second week take out stitches. Dr. Besh, I'm really in pain. Please just one more week off. Okay, but listen, the most I can give you is one hand work only. That's the only part that is part of the claim. Then I get a call two weeks later. The patient wants to come back and be seen again, on their request, not mine. I don't need to see them clinically. Dr. Besh, I'm in too much pain. I can't go back to work. Okay, listen. We can treat your pain medication, but we've got to get you back

to work. The longer you're off of work, the harder it is to get back to work. None of this happens in Medicare, ever.

The totality of these contemplated changes where we don't want to reimburse for these things and we're not here asking for handouts. We do this work. We really do. Any doctor in here, any clinic manager in here, will tell you that's what work comp is. To do, and the harder -- the better you want to do work comp, the harder it is to do. Imagine a scenario where doctors just stop getting on the phone with peer-to-peer doctors. Oh, I mean, why would we, right. We don't get reimbursed for it. I have to stop what I'm doing, excuse myself from seeing a patient to go and take a phone call from a peer-to-peer reviewer for some authorization for an additional three sessions of therapy that I'm doing on behalf of the patient and clinically it's required. How do we reimburse for that? So, I think that, if any point that I can drive home, one last point was the consultation codes. Medicare approximately 7 years ago eliminated or 5 years ago eliminated consultation codes, saying that there was no difference in the reporting requirement between a new patient visit versus a consultation. In work comp that's completely different. There's a primary treating physician who refers to a specialist for a consultation for a red flag, and that specialist has to produce a report addressing a myriad of issues that are not relevant in Medicare addressing causation,

and actually producing a report that goes back to that treating physician. In Medicare, when a patient comes to see me, the only thing I do is chart in my chart. That's it. Just normal documentation that any physician would do. There's no actual transcribing a two-page report, transcription fees, corresponding with that treating physician who remains the treating physician, even though I should remain the consultant. And this is yet another example of the fundamental difference between treating a Medicare patient and a work comp patient.

So, the specifics will be handed in, in paper format. I just wanted to give kind of a frame of reference about what we've all experienced day to day. I invite any of you to spend time with me in my office. I would love to have you. You don't even have to wear a white coat. To see what happens day to day in treating a work comp patient. And you know, even Medicare as a base line, I thinks it's probably important to remind everybody that, if you survey the 50 states who all have work comp, California is the second from the lowest physician reimbursement. For all the greatness of this golden state we are the second from the lowest. For all the promises that we've made to our injured workers about the quality of care that we ought to be providing we are the -- only North Carolina is lower that we are. I think that's something to keep in mind.

Any questions?

MS. OVERPECK: Thank you.

DR. BESH: Thank you.

MS. OVERPECK: Andy Parker.

ANDY PARKER

MR. PARKER: I've also taken the liberty to invite Maureen Marston to speak.

Good morning. I am Andy Parker, A-n-d-y, P-a-r-k-e-r. I'm vice president of US HealthWorks, and I want to thank you for giving me the opportunity to speak today.

I actually had a prepared statement, one-page, double spaced, but I think I'll probably ad lib this, especially in conjunction with the wise comments by the California Orthopedic Association.

But I think it's probably best that we step back maybe 20 years and look at why RBRVS was developed in the first place. It was to take scarce health care resources and allocate them effectively across a broad spectrum of specialties so that those health care dollars would be spent wisely. So the work was done at Harvard. It was adopted by CMS. Scientifically it's valid. I've looked at it myself. It makes a lot of sense.

What Medicare did is and what Harvard did is they said one conversion factor, you can use one conversion factor to sort of equivilate across all specialties what the resources that went into that service would be. So it is essentially a

one-to-one comparison, and I understand the comparison between Medicare and workers' compensation.

Other states, 33 other states have already adopted RBRVS. Of these states, none have ever gone back to the original fee schedule. And what they do, and what I think that the Division eventually will want to do, is they take a look at the conversion factor that they use to make sure that the physicians are paid reasonably and fairly.

So, for example, at 120 percent of Medicare, theoretically the premium is going to be 20 percent of Medicare -- above Medicare for those services that a primary care occupational medicine physician might do or an orthopedic physician might do.

In Washington State, for example, the conversion factor there is 1.58, certainly better than California, but I believe that California is taking a step in the right direction in going over to RBRVS.

US HealthWorks Medical Group, we fully support the Division and the conversion to RBRVS. We have 66 medical clinics in this state. We have 300 medical providers, some of those providers are specialists, some are primary care occupational medicine physicians.

I was thinking the other day, you know, I feel like I've been in this discussion for years and years and years; and, you know what, I added it up, and, you know what, I have

been in this discussion for years and years and years, and we all have. We all have. I think it's time to move on.

I think it's a fair system. It's a well-researched system. I think it actually, if it can be done to appropriately, reimburses the physician, including the orthopedics -- but I think importantly the ones right now that really need to be reimbursed are the primary care physicians. They truly are the gatekeepers of the system. They truly understand the indemnity issues. They truly understand the return-to-work issues, and I think workers and the environment in our state is better for having them there.

We do absolutely support the regulations. We understand a lot of work went into them with RAND. We thank you for the work that you've done on that.

We have some minor technical comments, and I would like to ask Maureen Marston, who is actually our head of our RBO, to comment on these.

Thank you.

MAUREEN MARSTON

MS. MARSTON: Hi, Maureen Marston, it's M-a-u-r-e-e-n, M-a-r-s-t-o-n.

Some of the differences that we noted in reviewing the conversion to RBRVS, again, are Medicare versus workers' compensation. And getting paid for reports for specialty services, we feel, is a very important piece in communicating

what the specialist physician has found for claim adjudication. They are looking at AOE-COE. They're looking at what they feel as a specialist the remainder of the claim for the portion that's accepted and their treating will involve. So it may be lost time. They may be able to help the claims adjuster set reserves by giving a very thorough, detailed report that you just don't do in a Medicare environment.

In a Medicare environment we see, thanks for the referral, Doc; we gave your patient an injection, end of story. It's usually a simple, single page. They don't have to submit anything with their billing in a Medicare environment to support charges or be reimbursed.

Along those same lines is prolonged services. In an occupational environment, medical record review is critical to pull all of the pieces together and incorporate it into a comprehensive report that claims adjusters absolutely rely on. Omissions or failure to do so can have some pretty significant impact to how that claim eventually settles and what types of disputes may be present if a provider is not doing a very thorough record review: past family, social, medical history, prior surgeries, any ER reports that may be used to kind of tie the whole thing up when we're reporting this to our claims adjusters. And we partner with them. It's our job to do so.

Today we do get paid for prolonged services nondirect. These are records that are reviewed in preparation of a report,

or they've come in after the patient visit. We would like to see some prolonged services put back in. I believe it's under the OWCP. They do give a value in our federal fee schedule for that, so those two in particular.

We would -- we're concerned about the supplies also that are by report. Within the RAND report, and we've read it and we see that there are certain supplies that are considered bundled within the office visit or the evaluation and management code.

One of the considerations we would like to give the Division to think about is in a rehabilitation environment, when we've advanced a patient to a home exercise program, and we provide to them the home exercise equipment, whether it's a shoulder pulley or an exercise ball, those items are typically billed today by report with a method to reimburse at a cost plus providing an invoice. Those supplies would no longer be reimbursed and as such potentially, you know, who would bear the cost of that? Would the patient bear it when they go out and have to buy it? So, again, just something to think about.

In an op-med environment, where the patient doesn't bear any of the costs, there are certain areas where we have to look at. Today we're reimbursed for those supplies on a by report basis as cost plus. Under Medicare it's a no reimbursement for those items at all, so we wanted to bring that to the Division's attention to possibly take a look at how

we would continue to do that.

Drug screens. Work comp is very unique. We do post-injury drug screens that we bill to carriers. Under the Medicare environment, there's no such reimbursement or CPT code that is reimbursed for post-injury drug screens. We would propose that we continue to bill those at the carrier and employer's request, and that we have a CPT code and a dollar amount to be reimbursed for doing those.

The GPCI. I would prefer -- we would prefer to see a single GPCI for a variety of reasons, but mostly we have employers that have offices from San Francisco to San Diego. And in addition to programming, and all of the issues when you've got a multilocation medical practice and trying to get all of those ZIP codes in and what you bill for each item, it's difficult for employers to understand if I saw a patient in San Francisco and billed a 99213 and I saw a patient in San Diego and billed a 99213, why am I billing a different dollar amount? So we are proposing a single GPCI for ease, for conversion, for programming. It just seems to be an easier method to create less ambiguity, less programming time and maintenance of a system with a nine geo-ZIP code locality.

Thank you.

MS. OVERPECK: Thank you.

MR. PARKER: Do you questions for us?

MS. OVERPECK: No. Thank you.

MR. PARKER: Okay. Thank you.

MS. OVERPECK: Yvonne Hanskarig (phonetic).

MS. HAUSCARRIAGUE: Good morning. It's Y-v-o-n-n-e, the last name is Hosscaryog (phonetic) H-a-u-s-c-a-r-r-i-a-g-u-e.

MS. OVERPECK: Sorry. I was completely wrong.

MS. HAUSCARRIAGUE: No, you were very close. Very close.

YVONNE HAUSCARRIAGUE

MS. HAUSCARRIAGUE: Good morning. My name is Yvonne Hauscarriague, and I'm the assistant chief counsel at State Compensation Insurance Fund. I thank you for the opportunity to appear before you to speak today.

State Fund is the largest insurer in California, adjusted over 130,000 claims last year. As a not-for-profit insurer, State Fund is focused on the goal of delivering superior claims outcomes to the injured workers and the employers that we serve. SB 863 provided State Fund with some of the tools necessary to support that goal including measures to address medical expenses, which are a major cost driver in the workers' compensation system, while still insuring a reasonable standard of services and care for injured employees. We deeply appreciate the time and effort expended by the Division of Workers' Compensation to draft the proposed regulations regarding the physician fee schedule required by SB 863.

Today for your consideration State Fund would like to

bring to your attention a concern with the proposed regulations regarding the physician fee schedule that we have raised in our written comments, which will be submitted later today.

Proposed regulations section 9789.12.5 subsection (c) calls for the implementation of a different and more generous inflation adjustment calculation than that used by the Center for Medicare and Medicaid Services. As a result of its application, the DWC would be at risk of violating Labor Code section 5307.1 subsection (b), which mandates that any conversion factor adopted by the AD cannot result in aggregate fees that exceed 120 percent of the estimated aggregate fees paid by Medicare. Therefore, State Fund recommends that any conversion factor provision adopted by DWC include language that it shall not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

I thank you for your time and consideration.

MS. OVERPECK: Thank you.

Standiford Helm.

STANDIFORD HELM

MR. HELM: My name is Standiford Helm, that's S-t-a-n-d-i-f-o-r-d, H-e-l-m. I'm speaking on behalf of the California Medical Association. I'm a trustee of the California Medical Association, also a qualified medical evaluator. I'm a board certified anesthesiologist, and my

practice is limited to pain management. I practice in Orange County.

On behalf of the 37,000 members of the California Medical Association, thank you for allowing us the opportunity to comment on the transition from the Official Medical Fee Schedule to the Resource Based Relative Value Scale.

First, I would like to commend the Department for its work and effort in engaging stakeholder input in this process, for we know it's a long and arduous process. We would also like to thank you for providing the RAND public use data files quickly that's fundamental to our understanding these regulations. We have not yet had the time to review the files, but would like to maintain the opportunity for additional comments once we have had the opportunity to review this important information.

In our previous comments to the DWC, we urged the Department to keep in mind that the Medicare population is fundamentally different from the population of injured workers, and the payment system should reflect these differences.

I personally not only do work comp, but I'm also on the Medicare Carrier Advisory Committee, so I'm intimately familiar with both of these systems.

We iterate the concern in our comments today, as injured workers present with very different health care needs, and their care is governed by a medical-legal system that is

not present in Medicare. We're offering today comments on two specific subsections and one general comment. With all that in mind, we respectfully offer the following comments.

The first is the concern on the 120 percent cap on the RBRVS. As you know, the calculation of fees in this version of the RBRVS is based on the target of 120 percent of the aggregate spending of the Medicare program for the same set of services. However, it continues to be unclear what treatments and services fall under that 120 percent cap. There are many services that are not included in Medicare's fee schedule that are currently covered in the California workers' compensation program including acupuncture, after-service hours, chart notes, reports, duplication of x-rays and scans, work hardening and conditioning, functional capacity assessment, amongst others.

CMA believes that additional funding needs to be incorporated under the cap to account for these services. If there's not additional funding, we're concerned that the expected primary care rate increase could disappear. We're also, though, pleased that the proposed regulation does not address interpreter services and copy services, and both of these categories are outside the side cap.

The second issue is section 978912.12, consultation services, use of office visit codes. CMA strongly objects to the elimination of consultation codes from the Official Medical

Fee Schedule as we convert over to the RBRVS. Due to the nature of injuries suffered by injured workers, many cases involve the consultation by one or more specialists. These physicians are essential in providing -- establishing liability, determining apportionment, and setting a treatment plan that will turn the injured worker back to work.

The proposed regulations suggests that specialists should bill for consultations using office visit codes. This is inappropriate as specialist consultations are a fundamentally different service. A consultation is a request by a physician to a consultant regarding care for a specific patient. The consultant's report must reference this request, and the consultant must provide a report back to the requesting physician. A well written workers' compensation report incorporates all three of these elements. Any initial visit which does not include all three is an office visit, not a consultation.

Medicare abolished consultations because they felt they were being misused when office visits were appropriate. This concern does not apply to workers' compensation where consultations are the fundamental way by which injured workers receive necessary care. Without consultation codes to appropriately compensate specialists for these services, it may become even harder for physicians to continue treating workers.

In my practice I bring young physicians in. I have a

very difficult time and I'm unsuccessful in getting them to want to do work comp. I enjoy seeing workers' compensation patients. They don't want to put up with the paperwork.

Further, we believe that the consultation code is inconsistent with Labor Code section 5307.1(a)(2)(B), which was added by SB 863, and this reads:

> The Official Medical Fee Schedule shall include payment ground rules that differ from the Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment of evaluation and management services provided during the global period of surgery.

This section was added to the bill at the recommendation of the CMA and formally recognizes the importance of consultation codes to the workers' compensation system.

The third concern is section 9789.16.1, global fees for surgery. Although this subsection does allow physicians to bill for some evaluation and management services during the global surgery period, it is limited and dependent upon the physician time file. CMA believes that this is both inappropriate and inconsistent with the statute.

In Medicare surgeons often only meet with a post-surgical patient twice to evaluate their recovery. In workers' compensation physicians may have to perform five or

ten follow-up visits to evaluate the patient, complete reports, and advise the patient and employer on return to work. The representatives from COA were very eloquent in discussing this. This is a much larger commitment of the physician's time than is needed in Medicare but is necessary for the proper functioning for the workers' compensation system. Moreover, post-operative services are often requested by the employer or the insurer for the purposes of evaluating the patient, completing reports, and consulting with the patient on return to work. Limiting surgeons' ability to be compensated for these services will slow patient recovery and cost employers additional time and money -- lost time and money. This subsection also appears consistent with Labor Code Section 5307.1(a)(2)(B), which I mentioned above.

Thank you for allowing me the time to consider our input. We appreciate the opportunity to present our concerns regarding what constitutes the global cap, the importance of consultations, and the need for reimbursement of services during the global period.

MS. OVERPECK: Thank you, Dr. Helm.

Bill Zachry.

BILL ZACHRY

MR. ZACHRY: Good morning. My name is Bill Zachry. I'm the vice president of risk management for Safeway. I'm also on the board of the State Compensation Insurance Fund, but my

opinions are not that of the State Compensation Fund or of the board. I'm also a board member of the Self-Insured Security Fund, but I'm here representing Safeway, which is one of the largest private employers in the state of California. Our headquarters are here in the state. We have 500 stores. We have three distribution centers, seven manufacturing plants, about 100,000 employees, and we're self-administered, self-insured for workers' compensation in the state of California.

I want to thank you very much for the opportunity to be here today. I'm very pleased to see the progress that's being made on the implementation of 863. We heartily support the efforts that are going to move from the Official Medical Fee Schedule to the relative -- RBRVS system, and we applaud the Division of Workers' Compensation for all of the energy and effort that's gone in to make this change.

Frankly, we're very, very concerned at Safeway about access to the frontline primary care treating physicians. I think there's already been some discussion on this. I think with the universal advent of universal health care, also known as the Obamacare, I think that there's going to be a great demand for frontline treating physicians. And if we do not adequately pay the frontline treating physicians to perform, we're going to lose them from the system, and we'll have a really, really bad program. So I think that the change from

the OMFS to RBRVS will significantly help us potentially mitigate that problem, and I thank you very much for doing this.

Another item that I would like to talk a little bit about is is that conceptually, when change like this occurs, there's usually -- I won't say winners and losers, for lack of a better description. And, in my experience, in watching the workers' compensation system over the course of time, we've had people threaten to leave the system. I think the biggest time we originally had that was when we implemented a pharmacy fee schedule, and the pharmacists or some pharmacies were saying, okay, well, we're not going to provide pharmacy in the workers' compensation system. According to the information I have from the CWCI, the last report they did actually shows that there's an increase in access.

I think a change from OMFS to RBRVS will put more money into the medical system and actually will overall improve access. There will be winners and losers to some extent, but I think overall there's an expectation that it will improve the quality and access to care.

Speaking about access to care, one of the sort of aha moments that I had in this process was something that has already been discussed here, and that was what was called the -- I don't know how she pronounced it, but it's the GPCI, which is the geographic billing from the RBRVS.

One of the problems we have had at Safeway is we have stores in Willis, Fort Bragg, Mendocino, and other rural areas, and it's always hard finding frontline treating physicians, much less speciality. And I think probably one of the reasons for that is that the reimbursement rate for Medicare is very, very low, and I think that we can't fix that problem. But my recommendation is that we not have a geographic differential between rural and urban areas, that working with RAND you come up with a single reimbursement rate for the entire state.

As a former chair of the fraud commission, one of the problems that we saw was that when there are opportunities for mischief, people will take it. And one of those opportunities for mischief is having different geographic regions. I've seen in different states, other than California -- for instance, Illinois right now has ZIP code differentials. It is extraordinarily difficult for the claims administrators. And there's a lot of mischief that goes along with the providers billing out of, essentially, an empty office next door in order to get a higher rate, etcetera, and so forth. So by having one simple system, one billing rate, it reduces a lot of the friction; it increases the opportunity for reimbursement, and I think will also give us better access in terms of the process.

Another commentary I would like to make is that -- it was already raised, I think, quite well in terms of the concern about what is called the accelerator, the inflation rate. I

think that the intent was to create an aggregate total of 120 percent tent. Under the current proposed regulations I'm very concerned that it is possible that we will easily blow through 120 percent, so I would ask that the Division of Workers' Compensation be very circumspect on how they calculate the accelerator or the inflation process into the system.

One other item that I would like to talk about also is the fact that 120 percent reimbursement rate is intended to pay for the additional friction costs that occur in the system. There is a recognition that workers' compensation is not Medicare, and so there were proposals for additional fees for reports and other things. Again, when you differentiate from Medicare, you create opportunities for more mischief, if you will, and I would ask that consideration be taken not to put inflationary factors such as additional costs for additional reports that should be part of the 120 percent.

Thank you, again, for all of the hard work that you've been doing on this.

One other comment I would like to make is this -- the -- I think the submitted written recommendations and analysis done by the CWCI were extraordinary, and I would ask that you carefully look at theirs, because they've done, I think, an extraordinary job looking at all the details in providing very, very good analysis.

Thank you very much for your time.

MS. OVERPECK: Thank you. Jerry Azevedo.

JERRY AZEVEDO

MR. AZEVEDO: Good morning. Jerry Azevedo. I'm here representing the Coalition of Employer Organizations including Cal Chamber, California Coalition on Workers' Compensation, California Manufacturers and Technology Association. We will be supplying some written comments by the deadline this afternoon to follow up on these comments. We also appreciate the fact that there will be an additional comment period to evaluate what is now been handed out as Appendix E to spend some time with the revised analysis that has been supplied by RAND.

We're grateful for the opportunity to provide testimony here this morning, particularly because this is a discussion now about the manner in which we're going to implement an RBRVS system, not whether or not to implement an RBRVS system. We think after, you know, 9 or 14 years, however you want to start the clock, it's a transition whose time has come. We think it will be good for the system. We think it will be, as it was referenced before, find a way to allocate what are very scare resources in the system in the most appropriate way. We do have some specific comments, but one overriding concern, and again this, reserve the ability to review the revised RAND analysis, but an overriding concern that there is a significant cost increase associated with the proposed regulations. The

19.6 percent, again depending on how that math is done, represents anywhere from 280 to 340 plus million dollar cost increase for medical services in California workers' comp system for employers. We would -- some other testimony has advised we take a little bit of a step back. We would advise taking a step back to think about the context of Senate Bill 863. It was predicated on finding a very delicate balance between cost-saving proposals that could offset significant increase in permanent disability benefits, and the scoring that was done of those, all thos provisions, established a cost savings that was very narrowly -- very thin. And we think it's subject to all sorts of things that happen in the implementation of a reform proposal of this magnitude that, if we take an RBRVS transition which was not scored and not included as part of any of those cost analyses, that could eat up anywhere from half to two-thirds of those anticipated savings, then employers are looking at significant cost increases across the board. We don't believe that RBRVS should be implemented in a manner that substantially undermines or skews the cost assumptions that were made as part of the SB 863 negotiations and review by the Legislature. We, although, you know, there was not a mandate in 863 to adopt this in a cost neutral manner, we do believe that the policy should be to try to achieve something that is as close to revenue neutral as possible. To the extent that the Division adopts a policy that

reaches that upper limit of 120 percent in the aggregate, we believe that consideration should be given to including all of those things that would be appropriate to include in the 120 percent and not only be looking at half or two-thirds of the picture, but as much of the services that are rendered that are appropriate to include at 120 percent, we think should be included. A very cursory read of Appendix E would indicate that there are some things RAND is now advising be removed, some of the codes be removed, from the analysis of the cost impacts, and that is concerning because those are not costs that are going away; they're just costs that are being removed from the analysis.

So, for those reasons we think that there is a very delicate balance here that we understand in terms of preserving access, in terms of doing this in a way that rewards the services that are very critical to our injured workers in getting them back to work, but also needs to be done in the context of total cost, total cost assumptions that were made in the context of Sensate Bill 863. Thank you for your time.

MS. OVERPECK: Thank you. Juli Broyles. Sorry. She's just changing the tape. You'll have to wait a second before you start talking.

JULI BROYLES

MS. BROYLES: Thank you. Juli Broyles here on behalf of the California Association of Joint Powers Authorities. Also

in agreement and a signatory to the comments submitted later today by Mr. Azevedo and the Chamber and CCWC and others.

First of all, thank you for the opportunity to make these comments here today. Do want to acknowledge that I've been around long enough to remember the 1993 transition to the Official Medical Fee Schedule and the discussions that went on for months and months to create that schedule and understand the transition to be, the RBRVS to be one of significant change that, I believe, will be a good change for the system and one that we have strong support for. However, we do share a lot of the concerns brought up by other presenters today about exceeding that 120 percent in aggregate of the Medicare schedule. We do believe that there should be a very hard ceiling here, both due to the Labor Code and what it says, but also the fact that with the implementation of SB 863 and the discussions that went along with how to balance out those, the costs of the bill in providing the new benefits and the savings to the employers as a result of these changes, that needs to be respected. We think that is important to look at any way possible to reduce that 300 plus million in possible costs be looked at, be examined more in depth. That there should not be exceptions to those costs. As Mr. Azevedo pointed out, putting exemptions of certain types of fees, certain types of procedures or services, doesn't eliminate those costs. It just hides them from the cost analysis. And we think that there

should be every effort to make sure that exceptions are not made to the RBRVS when there are Medicare codes available to provide for those services.

As Mr. Zachry pointed out, certainly there are those who can imaginatively use today's system to up code, side code, recode, and make up new codes. So, any time that you allow exceptions beyond that, we see there our costs going up, and what employers have wanted from the reforms is predictability in our medical costs and be able to say that there is some certainty in what we look at in certain types of claims are going to be charged the same across the board.

We also want to point out the issue of the geographic regions in terms of finding one state-wide aggregate price cost index code that can be used for billing. We do think that's an important thing to do. When you break it up into the geographic regions, you end up with narrow networks of physicians who are available to perform and service the injured workers. They need that access to care. They need the quality of care, and would urge you to ensure that there is some way working with RAND to develop that one state-wide process billing code.

Last of all, the implementation time. It does take time to change over from one system to another. It takes time in terms of updating your systems, updating forms, updating paperwork, and also training your people to implement the new

system. So, we're asking for as long a period as possible that you can in terms of lead-in time. Sixty days would be the least. Ninety days would be better. Any of those things. Either of those dates would permit effective implementation of the system once it goes live.

Thank you for your time.

MS. OVERPECK: Thank you. Dennis Langton.

DENNIS LANGTON

MR. LANGTON: Dennis Langton. D-e-n-n-i-s. L-a-n-g-t-o-n. I'm a physical therapist, and I'm here representing the California Physical Therapy Association. I'd like to thank you for the time that you've all spent in doing this. I can only imagine how much fun it must have been putting this all together.

Two things that I would like to just to mention here that we have concerns about. First has to do with the education. With the four-year transition, the fee schedule for physical therapists for Medicare relations has been a moving target and always is a moving target, and so adding to that a yearly did change in transition, a four-year transition period is going to make it difficult to be able to understand and be able to develop within your own practices exactly what you might be, might be getting paid. And all we're asking here is that enough education be provided so that we can basically figure out what's going on. We can be able to extrapolate from

the fee schedule what is going to be required and what we might be expecting so we can then justify it and to work on staffing and other expenses within our clinics to be able to cover such activities and such expenses. So again since it's not exacting on what the transition is going to be over the next four years, we just know it's going to end at a certain point. Just as much education as possible would be very helpful for us as physical therapists to be able to plan or put together our budgets, as well as for those who work with the workers' comp population.

Another concern that we have also that I would like to discuss is the third-party administrators. Third-party administrators are coming in, and one of our concerns is that some of the third-party administrators, all the gains that might be received from all of us in the process of the change in the fee schedule and the payment methodologies, might be all waisted through third-party administrators coming in and giving discounts, and we've seen discounts from current administrators anywhere from 5 to 20 percent, and try to take the discounts out of the fees that they pay the providers when they do the service, and what we're asking here, because of the inequality that we see, that included in these regulations will be some kind of a regulation controlling what third-party administrators are allowed to work. Giving them some guidelines and also some restrictions on some of the contract

negotiations that they might enter into. So there might be some homogeneity that takes place in the process, and so again we'll have an understanding of what we're getting into with all these different administrators. So that again all the advances and all the improvements that we're seeing aren't chewed up by a third-party administrator getting in the middle of it.

Thank you very much.

MS. OVERPECK: Thank you. Catherine Montgomery.

CATHERINE MONTGOMERY

MS. MONTGOMERY: Hello. I'm Catherine Montgomery, and I am co-founder of DaisyBill. DaisyBill provides revenue cycle management tools to submit e-bills for workers' compensation. I'm always the voice of e-billing that shows up at these forums. And we are here to talk about how RBRVS is -- works with e-billing with Medicare.

I'd like to point out that Medicare requires that providers submit their bills electronically. The reason that they do this is that the RBRVS system is very complicated. E-billing provides technology that allows both sides to know what's supposed to be paid and know what was paid. Also, I would like to point out that Medicare under the RBRVS system processes their bills quickly, accurately, and efficiently. So, sort of going into that theme of quickly, accurately, and efficiently, how is RBRVS going to work with the new system under workers' compensation? So, I have some testimony here to

tell you how it's working right now under the current simple fee schedule. Not very well. So, our request from the Board is that we support RBRVS at DaisyBill, but only if you also institute a more effective and fair system to give providers recourse for claims administrators noncompliant processing as well as for incorrectly paid bills.

The proposed fee schedule is not a simple multiplication of Medicare schedule by a factor of 120 percent. Instead it requires a very different and far more complicated payment calculation. To properly code and reimburse the decision tree for the proposed fee schedule includes approximately 21 options as opposed to the 4 in the current fee schedule. As the number of deviations from the standard fee schedule increases, so does the operational risk for billing and adjudicating incorrectly. Unlike Medicare, currently worker's compensation payment system all too frequently leaves providers with unpaid or mispaid bills. Our data, which we have vast, vast sums of data, clearly shows that routinely claims administrators fail to pay or underpay complete incorrect bills, fail to observe mandated time lines, fail to accept e-bills at all, and fail to compliantly process complete and correct bills including ignoring them or incorrectly rejecting or denying them. If claims administrators cannot pay correct fees, even under the relatively simple current system, DaisyBill is concerned about what will happen under the much

more complicated and error prone Medicare modeled RBRVS system.

The consequences of RBRVS adoption for the second review and IBR processes are equally bleak. If such adoption happens without addressing compliance issues, currently providers' options for recourse are limited and largely ineffective. For instance, on behalf of just a single provider, DaisyBill has submitted 320 second reviews, of which 35 were processed correctly, 153 were improperly denied, 57 were incorrectly paid, and 75 had no response whatsoever. Is the provider expected to file an IBR for each of these 285 incorrectly processed bills along with the approximately Ninety-five thousand dollars in combined filing fees in order to get these bills paid correctly?

Obviously, the second review system is not working. And claims administrators are seemingly able to ignore second review regulations at will and with no fear of penalty. Echoing my question above, if second review does not work now, what hope is there for second review under the new more complicated fee schedule? Additionally, the IBR process, while promising in theory, is so far unproven. Not a single one of our providers' IBRs have yet to be transmitted to Maximus, the IBR adjudicating entity. These IBRs are sitting in limbo with no time line for decision or payment.

I talk a lot about e-billing because it can bring great benefits to workers' comp. In context of the RBRVS

model, successful implementation of e-billing will be even more crucial. The efficiencies and transparency that e-billing technology can bring to workers' comp can help manage the complication of the new fee schedule. Yet, nine months after e-billing mandate went into effect and almost two years after claims administrators had been put on notice that e-billing was imminent, many claims administrators still cannot handle even the most basic of e-billing processes. With this technology DaisyBill can code this proposed fee schedule and ensure that every e-bill is compliantly submitted by providers, but we cannot code claims administrators' compliance. We do not have the ability to enforce compliant processing and payment, nor is it fair to ask providers to solve claims administrators' compliance issues by paying huge sums of money in order to pursue compliance enforcement. Claims administrators have no incentive to solve these problems or to provide efficient, transparent e-billing.

On behalf of providers we respect -- with respect to the consequences noncompliance we would like to point out the lack of parity with claims administrators. When the DWC adopts the RBRVS Fee Schedule, claims administrators will be allowed to reject providers' bills that do not follow the new fee rules. This ability to reject bills and deny payments based on provider noncompliance becomes effective immediately upon the regulations effective date. For providers, the penalty for

noncompliance is forfeiting the right to payment. Providers have no equivalent leverage to force claims administrators to comply with the DWC's proposed RBRVS system. The complicated RBRVS system will present many more opportunities for error, misjudgement, and compliance lapses. The DWC is the only entity from which the providers can seek assistance to compel compliance and to compel compliance in an expeditious manner.

We want to work with the DWC to come up with the solution that will make the RBRVS system work for both carriers and providers. Unless an effective recourse mechanism is set up for providers, we are fearful of the consequences once the new fee schedule is put in place.

At DaisyBill we take our mission to help providers submit compliant e-bills very seriously. Our providers are also committed to following the DWC rules and regulations, and they are willing to pay a premium to submit compliant e-bills. Despite our concerted efforts and attempts to meet claims administrators more than halfway, claims administrators consistently and noncompliantly misprocess and mispay compliant bills. RBRVS will only make the situation worse. We need the DWC's help. We need the DWC's assistance to somehow alleviate current and future compliance bottlenecks. And we need to know what we can tell our providers to expect with the implementation of the RBRVS.

Thank you very much for your efforts to implement a

new fee schedule, and we hope that our comments are helpful.

MS. OVERPECK: Thank you. Bob Acerman (phonetic).

BOB ACHERMANN

MR. ACHERMANN: Good morning. That's my fault; not yours. I'm not a doctor, but I write like one. It's Bob Achermann, A-c-h-e-r-m-a-n-n, and I'm with the California Radiological Society. So, I appreciate the opportunity to submit comments this morning. We'll summarize our written comments, give you a copy when I leave which will include our address and contact information.

So, we appreciate the Division's use of multiple conversion factors in this transition, specifically for radiology that will help lessen the burden and blow to the radiology community in terms of reimbursement. I want to focus on a couple of important facts for radiology. The first is the use of the multiple payment reduction methodology in radiology for multiple procedures and groups of imaging procedures. Something that Medicare has been using for several years with regard to the technical component, and now this is applying to the professional component. I provided some history of our conversations with MedPAC and CMS on that, and why we do not believe it's appropriate for the professional component of imaging. Unlike the technical aspect of imaging, having a patient in the room, positioning them, having them on the scanner, has incremental reductions in costs and efficiencies.

And we don't find that to be the case when it comes to the professional interpretation of those images. When you do multiple procedures, you have additional images that are being generated, have to be interpreted by the radiologist. So, we don't agree with CMS or MedPAC in how this has been implemented in terms of a payment reduction which you have followed suit in terms of multiple procedures. The second is reduced to 75 percent, then 50 percent for the third. Again, when you do multiple CTs, multiple MRIs of the same patient on the same day, yes, there are technical component efficiencies, but professional component we don't find that to be the case.

Present some information on the GAO study that was the foundation for doing this which really only focused on one particular procedure, and that was CT of the abdomen and pelvis did not extrapolate that out to other types of procedures. There was a peered reviewed study done by the radiology community on the efficiencies that are obtained through multiple procedures on same patient, same day, same session, and their conclusion was that it ranged much lower than that from a low of 2.96 percent for CT, to a high of 5.5 percent for ultrasound. So, we don't agree with using this in the workers' compensation system.

A couple of other very brief comments about the impact of the current fee schedule. In the imaging world, radiology benefit management companies are very much a part of the

referral process for workers' compensation patients for imaging procedures. We don't oppose radiology benefit management companies. The authorization process, referral process is all useful, but there's a real lack of transparency in the system within workers' compensation. Radiologists for the most part are not reimbursed according to the Official Medical Fee Schedule for the procedures. They are not allowed to directly bill the insurer or self-insured entity, and are in turn billing the benefit management company. There is no transparency in those fee schedules. We believe that as you trundle down in terms of reimbursement, you're going to have a real impact on access to imaging procedures. Reduced reimbursement is occurring among many payers, specifically Medicare. Radiology is a very expensive specialty in terms of equipment, the personnel that operate the equipment, leases, purchases of equipment, maintenances, maintenance of the equipment, etc., is very high. As we see lower and lower reimbursement by work comp and by other payers, we believe that outpatient imaging will be threatened in terms of its viability. We're already seeing that in certain parts of the country. What you're left with is more costly alternatives in the hospital setting. That would be unfortunate for both the patient in terms of convenience and ultimate cost of the program.

The last comment I wanted to make was, there is a lot

going on in the radiology community in terms of appropriateness criteria for imaging, the right procedure for the right patient at the right time. The ACR has been at the forefront of that for over 20 years in terms of developing appropriateness criteria which are now used by multiple payers. Realize that DWC cannot force insurers to use any methodology, but I think if you look at that in terms of its ability to conveniently determine medical necessity, consistency of application, and physician friendly use for the determination in terms of clinical appropriateness, we think the appropriateness criteria developed by the ACR definitely should be considered as you look at imaging costs going forward. Thank you.

MS. OVERPECK: Thank you. Tim Madden.

TIM MADDEN

MR. MADDEN: Good morning. My name is Tim Madden, that's M-a-d-d-e-n, and I'm here on behalf of the California Occupational Medicine Physicians. We're a group of 22 occupational clinics here in California.

Thank you very much for the opportunity to come talk to you on RBRVS, and the notion that we are moving forward with RBRVS, and we're very excited to see that. So we want to applaud the Division for all your work and the hours you put into this, and we're very excited to see this issue move forward.

It has been commented a few times this has been out

there for years, and I can't help but be reminded of a conversation that I've had over the last ten years with the president of our organization, Ron Kroll, who has two clinics down in Long Beach. And our running conversation is: Am I ever going to see RBRVS in my lifetime? And up until -- prior to 863, I was unable to answer that question for him, and it would turn into the running joke between the two of us.

And listening to Mr. Zachry talk, who may know Dr. Kroll as well, it's very telling on what has been happening to occupational medicine over the last ten years. And what Dr. Kroll has been telling me is that he specifically got out of emergency medicine and into occupational medicine because he wanted to treat injured workers. He wanted that to be his specialty, and he built his clinics around that idea to treat injured workers. But as time went on, he was not able to maintain his practice to treat just injured workers. So what he was doing, along with a number of other members, is shifting the focus of the occupational clinics to include other things such as urgent care. That's been the big trend over the last five years as a way for these occupational clinics to maintain their practices.

With the Affordable Care Act coming through, there's also been a trend of people saying I'm going to move back into primary care. Occupational medicine is not working, although this is what I want to do. So our members are extremely

excited to see us move in this direction. It gives them the opportunity to go back to what they really want to do, which is to treat injured workers and keep the occupational clinics open, which we believe is the best thing for injured workers. As Mr. Zachry mentioned, these are the folks that get their hands on the injured workers first. They're specialized in this area. We need to keep them in the system.

Now, I do have three specific comments I wanted to make consistent with those made by the CMA as well as US HealthWorks. We also agree that consultation reports should be reimbursed separately and for the reasons stated. It's important to get that level of detailed information on the injured worker to the people who are not only going to be treating them next but also to the payors and employers to understand what the situation is, get these injured workers the best care they need, and get them on the road to get them back to work as quickly as possible, but in a time period that makes sense for their injury.

The second comment is around the use of GPCI. We would also agree that a single GPCI is a better way to go for the reasons outlined. And also in the RAND report they speak about some of the conflicts and criticisms around the nine localities that Medicare has used, and also Mr. Zachry, and some of the mischievous behavior that has occurred in terms of using localities that are not necessarily where the services is

being provided. We also think it brings an ease to the system and administrative burden that can be avoided by having the use of the single GPCI.

And, lastly, talking about reimbursing for supplies through the by report approach. We would agree with US Healthworks to the extent that there are situations where we will be treating an injured worker, and it's best to get them home to do some of the work, the care, the rehab at home. And this might include medicine ball or shoulder rehab kit, something that is not -- that is reimbursable through a by report process. Under the existing regulations that would not be allowed, as explained by Ms. Marston from US HealthWorks. This is something that the individual would not be able to pay for, so it's something that the physician would have to absorb themselves.

Thank you again for your comments, and we really appreciate all your work.

MS. OVERPECK: Thank you. Steve Cattolica.

MR. CATTOLICA: I'll defer for a little while.

MS. OVERPECK: Okay. Carlyle.

CARLYLE BRAKENSIEK

MR. BRAKENSIEK: I'm Carlyle Brakensiek on behalf of the California Society of Industrial Medicine and Surgery, the California Society of Physical Medicine and Rehabilitation, and the California Neurology Society.

I was going to sort of tag team with Steve, but he chickened out, so I don't know if I'm going to be redundant or left hanging out there.

I do want to preface my remarks by saying I hope that any predictions I make today are proven wrong. I'm sincerely hopeful that my concerns are unfounded, but, so far, based on our research, I'm not particularly optimistic.

Many of the speakers have spoken about the concern for access to care. Obviously that is the big issue, the big gorilla in the room that we're all concerned about, the need to maintain access to care.

We have been involved in RBRVS study for something, like, 14 years now, ever since Casey Young, a former Administrative Director, first mentioned it in about 1998 or 1999. Over that time CSIM has spent in excess of $100,000 conducting research in other states that have gone to the RBRVS fee schedule, and we have made those findings available to the Division; and I assume the Division made those findings available to RAND, and it would appear, at least to us, that those findings have all been ignored.

There is basically unrefuted evidence from other states with low multiple RBRVS fee schedules that they have failed, and there's no reason to think that, unless you could really pull off a miracle, that it's not going to fail here in California.

Most of the testimony today has been focusing on treatment, but I want to mention briefly about the impact of this fee schedule on disability evaluations and disability benefits to injured workers.

Since 2005, the AMA Guides, which are in use in California for disability evaluation, have mandated that impairments be objectively quantified. This is done by diagnostic testing, which is also, under the current rules, subject to the RBRVS. Many tests that are needed to objectify impairment for injured workers or to demonstrate apportionment for employers will become unavailable at the proposed levels of reimbursement.

Let me just give you a couple of examples. Currently, an echocardiogram with Doppler in color pays somewhere around $500 for the procedure. It has been estimated that under this fee schedule that will drop to about $188. That's a huge drop. A stress echocardiogram would drop from $867 to $363. A full pulmonary function study would drop from $336 to roughly $214.

As Mr. Achermann mentioned, a lot of this equipment is very expensive. Some of these amounts -- the nonradiology equipment can run 30 to $50,000. That's a huge investment that physicians must make. And if they see the dramatic cuts in their fees, they're going to be unable to maintain this level of service, at least in their office.

Now what would happen then? One, these services may

not get performed at all; secondly, the patient may get referred to the hospital, where this same procedure will be substantially more expensive for the payors; or, three, you could have a situation where you would have to negotiate the fee. This is what happened in Massachusetts, which has a relatively low RBRVS fee schedule. The doctors cannot afford to perform their services under the Massachusetts fee schedule, and so they negotiate. And, on average, based on our research, they normally settle at around 200 percent of Medicare. So when you end up with services that are mandated by law through the AMA Guides, the employers may end up paying substantially more than a reasonable fee schedule would otherwise mandate.

Given that observation, I would like to make a recommendation for your consideration, and that is that with regard to diagnostic tests that are used for medical-legal purposes, that you create a separate fee schedule for them that would be outside the 120 percent Medicare cap that you have for treatment. These diagnostic tests that are measurements that are done for forensic purposes are not for treatment but for disability evaluation purposes. They should be covered under 5307.6 rather than 5307.1. But if you would do that, that would alleviate many of the problems that we otherwise see with going to this particular fee schedule with the unreasonably low 120 percent of Medicare cap.

With the upcoming advent of the Affordable Care Act,

physicians are going to have more business than ever. Everyone is projecting that physicians are going to be much more busy. And if, as a result of this fee schedule, workers' compensation treatment becomes less advantageous to physicians, they have other options, and they're going to reconfigure their practices to treat those other patients, and the harm there will go to injured workers. They're just not going to have the access to physicians that they presently have.

This is not really a battle between primary care physicians and specialists. Primary care physicians are absolutely essential to the system. They certainly deserve the raise that they're going to get from this RBRVS fee schedule, and, frankly, they treat at least 80 percent of the injured workers. So the vast majority of injured workers, as a result of this new fee schedule, will have and maintain access to care. The problem is that increase, that raise to the primary care physicians is structured to come out of the hide of the specialists, and those are the specialists who treat the more seriously injured, the more seriously disabled injured workers, and they're the ones that will end up suffering the most.

On top of that, we heard the testimony from DaisyBill about the extraordinarily complicated and error prone Medicare billing process. If this is not addressed by the Division in its regulations, that will further exacerbate the problem and discourage physicians from handling workers' compensation

patients.

I would like to point out one thing in which we totally agree with US HealthWorks, with Mr. Zachry, with all the speakers that we've had today with regard to the GPCI. Everybody wants a single GPCI. Some people think that this is mandated in the statute. I can't verify that for sure, but, whether or not, we certainly would support a single, statewide GPCI rather than multiple GPCIs. It will make everyone's life that much easier.

Finally, I just want to comment. There were statements made earlier this morning that 33 states have adopted an RBRVS fee schedule for workers' compensation and none have gone back to their previous fee schedules. That's probably a true statement. However, there are more facts that need to be considered. Many of these states that adopted the RBRVS immediately faced access problems, and they have had to increase the conversion factor in order to keep physicians, particularly specialists, in the system.

Secondly, most states with a RBRVS fee schedule have multiple conversion factors. Why do they have multiple conversion factors? It's because it's a recognition that a single conversion factor in the Medicare system does not transfer to the uniqueness of the workers' compensation system and so, in order to maintain access, you have to have multiple conversion factors. That is something that you should

sincerely consider here, when this is ultimately in place, that you need to have multiple conversion factors.

Finally, no state has ever successfully implemented a fee schedule for -- RBRVS based fee schedule for workers' compensation at the 120 percent level that is mandated under SB 863. The national average for workers' compensation RBRVS fee schedules in the United States is 173 percent of Medicare. That's a big difference from 120 percent.

Thank you very much.

MS. OVERPECK: Thank you. Robert McLaughlin.

ROBERT McLAUGHLIN

MR. McLAUGHLIN: Good morning. My name is Robert McLaughlin. I'm from San Diego, and I represent injured workers and their families. The spelling of that is M-c-l-a-u-g-h-l-i-n.

We've heard from a lot of physicians today about how the inability of consultation reports will affect things, as well as the access of care. I agree with all that, but I would rather take you down a more practical approach of how it's going to impact my practice, my injured workers, and the legal system.

Every medical decision must be based on substantial medical evidence or solid medical evidence. The first person who obtains that or gathers that is the primary treating physician. One of the tools they have to do that is to get

consultation reports from medical specialties outside of their area of expertise. Now that is so important because that whole initial process is what's going to start the utilization review and the IMR process. And if we do not have substantial medical evidence, then we're going to have more URs and more IMRs.

In addition, at least since I've been doing this in the last 25 years, there's been a real trend away from specialists, just looking at orthopedic issues, and more approaching the injured worker as a whole person, looking at them and giving them whole person care. In fact, we actually already have that in the AMA Guides. It's called whole person impairment, and one of the keys to getting that are the consultation reports.

Let me give you an example of some of the consultation reports that I see in my practice every day. One that I see a lot is a psychological consultation. It can be requested for various reasons. And while we do not have permanent disability anymore for psychological injuries as a compensable consequence, except in limited areas, we still have medical treatment. And often the injured worker will come in and they have been maybe in chronic pain for seven, eight months, and the doctor has made perhaps a surgical recommendation. They're waiting for approval. And the person shows teary eyed, depressed, and all of a sudden the surgeon becomes aware, one of the red flags that the physicians discussed. They need to

send them out a for psychological consultation to find out is this issue even compensable? Is it industrial or not? And, if so, what treatment might they need. And then that treatment recommendation will go back to the treating doctor who will then incorporate it and send it on to utilization review.

In addition, sometimes we have the need for a psychological consultation to get a surgical clearance. Sometimes a doctor gets a little concerned that this person may not be the best surgical candidate because of some depressive issues. They want to make sure first, and they want to get that psychological clearance. That may require some further psychological treatment, we do not know. But those are the types of reports.

Other reports we see are internal. A lot of times we'll have gastrointestinal problems that start to arise, and then, all of a sudden, the doctor has another red flag and wonders perhaps whether some of these issues are being caused by the medications or other issues. They need that consultation.

And perhaps the one I see the most is an endocrinologist with diabetes and getting clearance for surgery. Whether the diabetes is industrial or not, the problem is that doctor needs to have that consultation to get that surgical clearance or the surgery is not going to go forward.

One last item that we see a lot is cardiovascular for the issues of hypertension, and I just like to give you an example of one that I had just yesterday in my office. We knew the lady's blood pressure had increased over the last six months. The doctor made a request for a cardiovascular consultation. We got the consultation. However, the client also has some psychological issues. And what ended up happening is the cardiovascular consultation ended up concluding that I can't decide just yet if it's industrial or not or what treatment she might need because it could be in part due to the psychological issues. I need a psychological consultation, and whether or not those issues are industrial or not will impact on my recommendations.

So there in one case we've had two consultations required to treat one injured worker, who, by the way, has complex regional pain syndrome, so that is why they are having such a hard time with the pain.

And these consultations are necessary. If we do not get these consultations, what will end up happening is increased costs to the system. For example, we'll have to use panel qualified medical evaluators more often. That's going to increase the costs. And with that is going to come delays, and the delays may end up causing increased duration of temporary total disability. We may get further costs in increased permanent disability, and we're probably going to get increased

cost in utilization review appeals and requests for IMRs.

One other cost that's a little hidden here is the way the consultations were written is that in order to get under the California specific codes, the Workers' Compensation Appeals Board or the Administrative Director must make the request. Well, if that's the situation, and I have a consultation that's necessary for my injured worker, and they're not going to get it because that consultant is not going to get paid, then I'm going to have to go down to the Workers' Compensation Appeal Board and obtain an order from a judge authorizing the consultation so I can get that consultant physician paid. That's going to cause further delays and further increase in legal fees and costs, which really are not necessary.

One last issue is that as it's currently written, again, only the WCAB, the Administrative Director, the QME or an AME may ask for a consultation report. I would point that under Labor Code 4616.3 and .4 the injured worker has the right to ask for a MPN second and third opinion, and there's no requirement that that second or third doctor -- opinion be the treating doctor in the end. How is the injured worker to get that if they cannot request it, if it's only limited to the Workers' Compensation Appeals Board and Administrative Director? Again, it will require me to go down to the Workers' Compensation Appeals Board and maybe obtain an order, which

would cause further delays.

So my recommendation is that we really need to make sure we have access to care and appropriate payment for consultation reports in order to adequately treat injured workers and keep costs low.

Thank you.

MS. OVERPECK: Thank you. Robert Blink.

ROBERT BLINK

MR. BLINK: Good morning, Robert Blink, physician, B-l-i-n-k. I'm here today representing the Western Occupational and Environmental Medicine Association, WOEMA.

WOEMA is the constituent organization of ACOEM in the western region consisting of occupational and environmental medicine physicians. Our group of physicians does primary care in workers' compensation, also does speciality consultations for speciality issues in occupational medicine, and many of us also consult to various stakeholders, employers, labor, insurance, utilization review, etcetera, as well, and we're committed to a nonadversarial, scientific analysis, and to ensuring quality as a whole.

First, I would like to say that I appreciate the comments that have been made today, and, in particular, like to agree with our orthopedic colleagues the importance and necessity of recognizing and reimbursing for the increased effort and speciality issues that need to be done in workers'

compensation that are not the same as in Medicare and in general medicine. I think that an example of that is some of the employers and insurers today who have echoed that concern. I think if you ask employers and insurers, you will find that they all agree that high quality reporting and analysis is very important.

Couple of things that we would like to comment on today -- and, of course, we would like to review the recently issued RAND study revision.

As geographic adjusters, we agree that the GPCIs, we're probably better off using a statewide GPCI at this point, and, indeed, the HPSA adjustments we feel need study as well. The problem here is that these factors were developed for completely different purpose than for treating workers' compensation patients. For instance, the HPSAs is geared toward general medicine, emphasizing internal medicine, pediatrics, OB/GYN, and family practice, and that really is not necessarily reflective of the kinds of services needed for treating workers' compensation patients. This is not something we can study in a day or week or month, and I think we would like to recommend that additional study be made to what the geographic issues are in treating workers' compensation patients, in the meantime not to use these factors except by a statewide conversion.

As far as the conversion factors and the E&M codes, we

would like to again emphasize that E&M services are critical to providing quality of care, as well as to making the system work efficiently and equitably; and we strongly recommend that E&M codes be reimbursed, at least as fast as they were intended to be in SB 863. So, again, we need to look at what the current RAND analysis of that is, but we would like to encourage the E&M codes as a whole be reimbursed at the rate in 863 and no slower.

Prolonged services for such things as medical records review. We agree that -- with other speakers that these additional efforts and the time required in extensive, prolonged services do need to be recognized and reimbursed.

Consultation codes. We agree that they should be recognized and reimbursed as well and not eliminated in the way that they're currently proposed in the regulations. The consultation codes are critical for providing high quality information and deserve to be recognized. It's not something that's part of Medicare, and, indeed, in SB 863 I think it should be considered one of the services that should be considered different from Medicare.

Specialists reports. We believe that they should still be reimbursed page by page. Yes, there are plenty of reports that probably are longer than they need to be, but we also believe that the degree of detail contained in those reports is often the primary source of information to employers

and insurers and other physicians who are analyzing the cases, and we would believe that encouraging this level of detail is actually beneficial to the system.

As far as supplies, we do believe that the appropriate reimbursement should be done.

And as drug screens, again, there's a lot of issues with drug screening, but we do believe that they should be reimbursed appropriately.

Finally, and this is something that has been alluded to by several the speakers, we believe that the ground rules themselves for workers' compensation should be analyzed and addressed, probably for 2015. But, essentially, using the same ground rules for general medicine and Medicare doesn't make sense for the things that are important in workers' compensation work in many cases, so that you get reimbursed if you are treating a knee injury and one of the factors is if you ask somebody about their ankle or you look at their tonsils, it may hit one of the bullets that's required; whereas, if you spend half hour inquiring into what somebody's work is and what their home situation is that is producing psycho-social factors, you may not get reimbursed for that. So we think that analyzing the actual requirements of workers' compensation and recognize that those in the ground rules, or it's perhaps in some parallel system, would be beneficial.

That's all I have to say today. Thanks.

MS. OVERPECK: Thank you. Charles Rondeau.

CHARLES RONDEAU

MR. RONDEAU: Good morning. My name is Charles Rondeau, The last name is spelled R-o-n-d-e-a-u. And it appears I'm in the unenviable position of being one of the last speakers before lunch. So, I'll try to be as brief as possible. I am an applicant attorney, and part of my practice also involves advising medical providers who are involved in the workers' compensation system. I'm a board certified workers' compensation specialist, and the providers that I advise provide both treatment services and medical-legal services. I practice in the Los Angeles and Orange County areas. I would like to thank the administration for the hard work on the regulations that they've put together and for the time to speak with you this morning about a couple of issues.

Many of the speakers today have raised concerns with respect to access of care, and I share those concerns, both as an applicant attorney and as someone who advises medical providers. There are aspects of the workers' compensation that I think are undeniably different from the Medicare system which is non-litigated, and I believe that those need to be appropriately reflected in reimbursement rules.

Specifically, I would like to provide some additional comments with respect to two issues, the consultation code issue, and then an issue with respect to radiology that a

gentleman spoke about earlier, and that's application of the MPPR to the professional component.

As far as the consultation code reimbursement is concerned, the Initial Statement of Reasons recognizes that there are differences in the reporting that's provided in workers' compensation as opposed to the Medicare system. And in the June 2003 RAND Working Paper that these regulations are in part based, they similarly recognize the difference between reporting that's provided in workers' compensation and that's provided in Medicare and non-litigated systems. The present regulations only permit consultation reports to be compensated separately when they are requested by the WCAB, the Administrative Director, the AME, or a panel QME. Now there's no specific reason stated in the ISOR for not allowing reimbursement for other types of consultation reports, and I would like to add to the comments of my colleague, another applicant attorney, Mr. McLaughlin, with respect to consultations requested by the primary treating physician. That physician is uniquely positioned to determine when consultations are appropriate because they're seeing that patient a least every 45 days. Allowing consultations by the primary treating physician in other instances, as indicated by Mr. McLaughlin, at the request of the applicant does pose the ability, as he indicated, to reduce costs in the system by hopefully stemming off unnecessary utilization review and IMR

and also result in the more time consuming and costly 4062.2 dispute resolution process.

The 2003 RAND Working Paper looked at the alternatives to following the Medicare ground rule that the administration proposes to follow with respect to consultation codes, and that included, which some states allow, that's to bill the E&M codes and the billing codes and also to allow consultation reports and then bundle the billing together. The underlying rationale, as I understand it, for eliminating the consultation code billing is that there will be offsetting increases in E&M code reimbursement. Well, that's all well and good for the treating physician, but for the consulting physicians who might issue reports they're not going to be paid anything. So, that's cold comfort to them. So, I would advocate for allowing billing of both E&M codes and consultation codes in appropriate circumstances as other states allow.

Turning then to the MPPR for the professional component of radiological studies, the ISOR indicates that there is no evidence that justified deviating from the Medicare ground rules in this respect. And I would offer for the administration's consideration an August 2002 position paper or letter that was authored by the American College of Radiology to CMS and IMPAQ with respect to extending MPPR to PC. Their study that was commissioned by the ACR indicated there was essentially zero efficiencies and economies of scale when

applied to the professional component of interpreting radiology studies as opposed to the technical component. In other words, taking the image. Obviously, when the patient is already positioned and the tech is already there, they're economies of scale that apply. This does not apply when the same physician or multiple physicians in the same group have to then go ahead and interpret the studies. Those physicians have to -- have to expand the amount of time necessary to appropriately interpret those studies, and again there's no evidence to support economies of scale there.

In addition, another issue that was raised in the ACR paper is the concern that the application of MPPR to the professional component of radiology studies will unfairly impact provided radiology services in small communities, rural areas, and academic settings. Now most of us in California live in large urban centers, but we certainly do have small communities and rural areas, and, I believe, it would be unfair to prejudice those folks by applying this rule in this particular fashion.

So, I would invite the DWC to consider the August 2012 ACR paper as evidence to support deviating from the Medicare ground rule. I would like to thank you for the time to make these comments, and I hope they will be appropriately considered.

MS. OVERPECK: Thank you. So, Steve we're done with the

checked people if you would like to come up now.

STEVE CATTOLICA

MR. CATTOLICA: Thank you. My name is Steve Cattolica, and I'm the Director of Government Relations for the California Society of Industrial Medicine and Surgery, the California Society of Physical Medicine and Rehabilitation, and the California Neurology Society.

I don't get to, I'm going to say, be last. I don't know if I'm actually the last or not, but I don't get to be last very often, but I did want to do a couple of things that maybe haven't been done yet, at the risk of over emphasizing some things that have already been said. Make that two. You know, but for the steamroller that SB 863 represented, the Legislature soundly defeated the idea of an RBRVS conversion in 2012, but it's here. We have no choice. And so for those that felt they needed to re-enforce the decision, I think the horse has left the barn, and unfortunately our read of the RAND bibliography on page 6 of the Statement of Reasons is devoid of any contrarian information. So, we have a feeling that there's not a lot more to be said. But we've heard from a number of people that the Medicare Fee Schedule, the RBRVS, really doesn't work for work comp. I don't think anybody here has said that it works for the system as is. And so, if it's not as is, then it's not, the RBRVS. And so long as we're comfortable with that concept, then we can understand why

Dr. Anderson made such eloquent points with respect to the post-surgical period. Ms. Montgomery with respect to the administration of the program and trying to actually get paid regardless of how you code it. The lack of enforcement, not by the effort of the DWC, but the undergirding that would cause a provider or a payer to actually do what they're supposed to do, needs to be paid attention to. Ms. Marston with respect to her comments with regard to reports, and I'll elaborate a little bit more on that. Dr. Helm and his support of the CMA position. Bill Zachry with respect to simplicity in a single GPCI. Of course, Carl's comments are right in line with ours or with mine. Mr. McLaughlin who talked, I think, quite well with respect to substantial medical evidence. That the reports of a treating physician actually are now becoming -- it's becoming mandated that they represent that level of report.

And then, I apologize, but the one representative speaking about the extra work that needs to be done on the ground rules. You know, on page 6, I think, it is in The Statement of Reasons, or maybe it's page 5. There's a relatively long paragraph on the origins of the RBRVS, and it glibly says that the last update of the Official Fee Schedule was based on a report by MediCode. It didn't take the time to remember the hundreds of hours that were dedicated by people in this audience to actually go through the ground rules, consider what they said and what they did and revamp them to make them

work a little bit better. To our way of thinking none of that work has been done yet. As so we'd reiterate the importance of taking that as a charged affair between now and the end of the year.

With respect to the reports, we see no consideration given whatsoever to the complications that are required to be addressed by the treating physician when they write a report. Something as simple as a DFR, the new RFA form, certainly a PR-2, PR-3, or PR-4. Those reimbursed and unreimbursed consultant reports they're recommended or a part of the current proposal. There's no allowance whatsoever for the growing complexity that these reports are going to be used to substantiate. I think there was a question posed by the Division to one of the stakeholders with respect to trying to quantify extra time and other issues that might provide, quote, data for the need for reports being considered for reimbursement, and I think it really boils down to the fact that they are substantial medical evidence. An RFA that ends up in an IMR's physician's lap has to be substantial medical evidence, but they're not going to get paid for it. That's ludicrous. Same with the PR-2 for utilization review, PR-3 or a PR-4, the consultant's reports. The consultant's reports are supposed to provide a look see, but I think the term in Medicare is called advise and opinion. Who is supposed to provide advice and opinion so that people can make decisions?

Somebody's going to read the report. Somebody's going to make a decision. Somebody's probably not going to like that decision. So, the report itself has to not only substantiate the findings, but it has to substantiate the decision. And when it comes down to it, it also is going to be put in front of a trier of fact against another report to actually make the last say, whether it's an IMR or Work Comp Appeals Board judge. It's completely -- it's unfathomable that reports from a treating physician aren't going to be reimbursed at anything more than what is recommended in the current -- in the current proposal which is equivalent to the same thing they have been reimbursed since 1999.

I think I would like to close with re-emphasizing the comments that have been made about the ground rules, and offer our resources, and I would venture to guess others in the audience, that these regulations be implemented as emergency regulations so that they can have the opportunity to be adjusted. One of the things that we've asked over the years as we've discussed RBRVS and what we believe and what I think Carl emphasized is what has happened in other states. We believe that a contingency plan is necessary. We'd love to think that it's all going to go well. We'd love to think that Ms. Montgomery's concerns are going to just evaporate on the first of January. It's not going to happen. Everything you've heard, all the people's comments have to do not with the 85 or

how many of a percentage of people that get treated at a first injury clinic and go home and end up going back to work with really no complications. It's the other 15 percent or maybe even 20 percent. That's where the energy has to be spent, and that's where Medicare falls apart. The whole program falls apart, yet for those 20 percent of the people that need the work that our current fee schedule facilitates and has for decades and is necessary under the AMA Guides and the other new rules but from 899 and 863. So, we'd ask, again, that these regulations be implemented as emergency regulations, and that the kind of task force, the kind of stakeholder input that we've advocated for since we've begun this conversation, people sitting around the table talking through whether these ground rules are actually going to work and how be undertaken immediately with the ability to, at six months or maybe even nine months into 2014, reimbursement aside, that can go forward. There's no question that that needs to go forward, but that the ground rules have the opportunity to be adjusted to reflect what ends up being the case after January 1st. Thank you.

MS. OVERPECK: Thank you. So, for a time check, could you just raise your hand if you want to give testimony. All right. So, there's only one more person. So let's go ahead and do that, and then we will be able to wrap up.

Mark Gerlach.

MARK GERLACH

MR. GERLACH: Thank you. Good afternoon. My name is Mark Gerlach. It's G-e-r-l-a-c-h. I represent the California Applicants Attorneys Association. I didn't want Steve to go last. I'd like to address a couple of points that have been raised, and maybe raise a couple of issues that haven't been raised here. A couple of things that haven't been raised with you.

The California Applicants Attorneys Association, and I personally, have been involved in this process like many people here for the length of time that we've been talking about RBRVS. Our concern in this has always been the clients that our members represent need to get that injured -- need to get that medical treatment, and there have to be doctors willing to provide that medical treatment. The adoption of RBRVS with a single conversion factor in our opinion is going to seriously jeopardize that access for injured workers to medical doctors. I know that, as I've been around regulatory hearings for years, I know that there's often a threat. You do this to us, we're going to exit the system. And those threats often don't come true, but let me just read you the findings of the California Health Care Foundation. They did a study of access. They looked at doctors accepting new patients. In their study they found that 90 percent of the doctors surveyed were accepting new patients. Seventy-three of them, 73 percent, only 73

percent accept new Medicare patients, and only 57 percent accept new MediCal patients. What's the difference? How much money they get paid. If we don't pay the physician an adequate and fair payment, they're going to exit the system. We've heard about the ACA today. The fact that doctors are going to have other options. That they're going to change their practices. This is a real serious problem we have. The Medicare system, as it was set up, is a system that has entirely different principles and incentives for doctors. The average Medicare patient -- I'm probably a Medicare patient myself now -- is a patient that has a number of chronic illnesses, chronic conditions. Medicare system is set up to treat those chronic conditions before they get to the specialist stage. So, the incentives in that system are to go to primary care, get your diabetes, get your stomach problems, get your dermatitis, whatever, get that taken care of at the primary care stage. The problem in workers' compensation is, when an injured worker comes in, he or she is already beyond the primary care stage. When that worker comes in complaining that they hurt their leg, hurt their back, fell off a roof, you don't need to see somebody to do an E&M and to work up a history on you. You need somebody to take care of the injury that you suffered at work. If you look at the -- what are we looking at here? Initial Statement of Reasons. There were three documents handed out. We have the impact of the RBRVS

implementation on maximum allowable fees. After four years, the estimated impact on E&M is up 49 percent. On medicine it's up 23 percent. For anesthesia, surgery, radiology, and pathology it's down. Lewin studies have consistently shown California physicians are getting some of the lowest reimbursement in the nation. Somebody earlier today said it was the second lowest. I haven't seen a current study. The last I saw was 7th lowest, but that was 5, 6 years ago. We haven't raised our fees since then except for the E&M increase. So, I assume that that's probably true. You cut fees by 13, 19, 16 percent, we're just going to have an access problem. That's the long and short of it. We have a constitutional provision in the state of California that injured workers receive adequate medical care. So, what are your alternatives? Well, here's something that hasn't been raised before. Labor Code Section 5307.1 subsection (b):

> In order to comply with the standards specified in subdivision (f), the Administrative Director may adopt different conversion factors, diagnostic-related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided the estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

Subdivision (f): Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

So, I put it to you, you don't need to adopt a single conversion factor. A single conversion factor doesn't make sense in the workers' compensation system. It's going to cause problems. I would invite you to look at some of the proposals that the DWC has put out in recent years with multiple conversion factors. You have a multiple conversion factor for several years as a progression, but you're going to a single conversion factor. That's going to hurt injured workers. There's no doubt in my mind about that. So, I ask you to look at that factor, look at the authority that I believe that you have to depart from the Medicare Fee Schedule when necessary to assure that injured workers are getting their constitutionally guaranteed care and take the appropriate action. Thank you.

MS. OVERPECK: Thank you. Is there anyone else who would want to have any testimony? All right. So nobody raised their hand. We will now close the hearing, and I'd like to remind you that the opportunity to file written comments will stay open until 5 o'clock this afternoon. These comments should be delivered to our office up on the 17th floor of this building. Thank you very much for coming and giving us your testimony, and the hearing is now closed.

(Public hearing ended at 12:13 p.m.)

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