1 STATE OF CALIFORNIA

2 DEPARTMENT OF INDUSTRIAL RELATIONS

3

4 PUBLIC HEARING

5

6 **Workers' Compensation Proposed Regulations**

7 **Official Medical Fee Schedule - Pharmaceuticals**

8 **Title 8, California Code of Regulations**

9 **Section 9789.40**

10

11

12 October 31, 2006, 10:00 a.m.

13 Oakland, California

14

15 Appearances: Bill Harrison

16 Hearing Moderator

17

18 Carrie Nevans

19 Acting Administrative Director

20

21 Destie Overpeck

22 Chief Counsel

23

24 Richard Starkeson

25 Industrial Relations Counsel

1 **Reporters**: Rex Holt Pgs. 1-38 and 77-86
2 Official Reporter, WCAB
3
4 Lorraine Reed Pgs. 39-73
5 Official Reporter, WCAB
6
7 Pam Hafner Pgs. 74-76
8 Official Reporter, WCAB
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2 P R O C E E D I N G S

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4 MS. NEVANS: Good morning, everyone. Is my mike on?
5 Can you hear me? My name is Carrie Nevans. I'm the Acting
6 Administrative Director of the Division of Workers' Comp,
7 and we're here today to take both oral and written testimony
8 on regulations having to do with the pharmacy fee schedule
9 and specifically repackaged drugs. The people that are
10 going to be assisting today in conducting this public
11 hearing are Bill Harrison -- he's going to act as the
12 moderator -- Destie Overpeck -- she's the Chief Counsel for
13 the Division of Workers' Compensation -- and Richard
14 Starkeson, who's an attorney with the Division of Workers'
15 Compensation. We have a court reporter here today named
16 Rex Holt, o we may periodically ask you to slow down if the
17 court reporter signals to us. And then next to him is
18 Maureen Gray, and she's our Regulations Coordinator.
19 What I'm going to ask you to do when you come up to
20 testify, before you come up to the podium, hand Maureen
21 either your business card or, if you don't have a business
22 card, write down on a piece of paper your name, address,
23 phone number, e-mail, who you're representing, if you're
24 representing a specific organization or group, so that the
25 court reporter doesn't have to have you stand there and

1 spell everything whenever you start your testimony.
2 So we're asking people to limit their comments to
3 ten minutes in order to have time to make sure everyone can
4 get their comments on the record. The transcript of the
5 hearing will be posted on our web site as soon as a
6 transcript is available. We're also accepting written
7 comments until 5:00 p.m. today. If you find that you cannot
8 get through all of the comments you brought with you in the
9 ten minutes, you can submit to us whatever comments you
10 have. If they're handwritten or whatever, that's fine. You
11 can submit them to us, and we will include them in the
12 official record.
13 The purpose of the hearing is to receive comments on
14 the regulation that we're discussing today, and so we
15 welcome any comments about that. If you have other issues
16 to discuss, we may ask you to confine your comments to the
17 regulations or speak to us after the hearing. We might give
18 you some assistance as far as an Information Assistance
19 Officer or something else, because the real purpose here
20 today is to discuss a specific set of regulations; and in
21 respect of everyone's time, we want to limit the oral
22 testimony to the regulations. We won't enter into any
23 discussion with you. We won't ask you any questions, but we
24 will take all these comments back. We have to respond to
25 all the comments. If we make any changes in the

1 regulations, we'll post them on our web site again for a
2 comment period of at least 15 days. So you might want to
3 keep your eyes open for that. And then at this time, I want
4 to go ahead and get started. I'm going to turn the conduct
5 of the hearing over to William Harrison. He's from the
6 Division of Occupational Safety and Health. He'll moderate
7 for the remainder of the hearing. Okay, Bill.
8 MR. HARRISON: Good morning, ladies and gentlemen.
9 Welcome. We thank you for your participation this morning.
10 As you have signed in, you've indicated whether you wish to
11 give any testimony at today's hearing; and in some
12 instances, we've noted that some individuals have not
13 indicated whether they will or will not give testimony; and
14 that's okay. When your name comes up on the roll, we will
15 ask that question. In the meantime, we will ask for
16 participants to come forward in the order that you have
17 signed in and indicated that you do wish to give testimony
18 at this hearing. We will do it in the order that you signed
19 in. Again, we remind you that in the interest of providing
20 an opportunity for all involved that you limit your comments
21 to ten minutes. If there is information that you wish to
22 provide that would exceed the ten-minute limit, certainly
23 written comments are welcome. At this time we would ask
24 that Mr. Eugene Hill -- Eugene Hill, would you please come
25 forward.

1 **EUGENE HILL**

2 I'll defer at this time, if you don't mind, due to
3 another person will speak, a representative.

4 MR. HARRISON: What time will that person -- is the
5 person not here?

6 EUGENE HILL: Yes, he's here. He's going to speak for
7 me.

8 MR. HARRISON: That's fine. Come forward. Present a
9 business card to Maureen. If you will, just state your name
10 at the beginning of your testimony, and your affiliation.

11 **PEDER J. THOREEN**

12 Good morning. I've also signed in separately. My
13 name is Peder Thoreen. I'm with the Law Firm of
14 Altshuler/Berzon. I have essentially three comments to
15 provide. First I'd like to address the potential
16 confiscatory impact of the proposed regulation. Whether or
17 not the regulations are confiscatory going forward with
18 respect to purchases of drugs -- pharmaceuticals negotiated
19 and made after the regulations effective date, they raise
20 the very real possibility that they are confiscatory with
21 respect to two types of drug purchases as to which
22 physicians have already committed.

23 The first relates to stock on hand. Many physicians
24 have drugs on hand that they have already purchased, but
25 they will be dispensed after the proposed effective date.

1 These drugs were purchased at a price determined in the
2 market where a physician has expected a certain level of
3 reimbursement upon dispersement. The regulations will be
4 changing this market in the middle of the game, and
5 physicians stand to be reimbursed for these drugs at a
6 substantially lower rate, potentially at a rate that is less
7 than they paid for the drugs in the first place. As to
8 these drugs, physicians may be able to mount a successful
9 legal challenge under California legal authority related to
10 confiscatory regulations.
11 The second instance is how a confiscatory impact
12 relates to long-term supply contracts. Many repackagers and
13 physicians are in lengthy exclusive requirements contracts
14 for periods even as long as five years; and during this
15 time, a physician may be contractually required to purchase
16 all pharmaceuticals from a certain repackager. Depending on
17 the specific terms of a given contract, physicians may be
18 left in long-term contracts in which he or she is making
19 exceedingly little or nothing or may even be forced to
20 operate at a loss.
21 For these reasons, the potential confiscatory impact
22 counts at least for a delayed implementation of the
23 regulation for perhaps six months to a year, which would
24 allow physicians to work through stock on hand and
25 potentially renegotiate long-term supply contracts.

1 Next I'd like to specifically address three of the
2 studies that are relied upon, and first I'd like to raise
3 the potential underlying bias with respect to two of those
4 studies; one of which I have details about, another of which
5 will be submitted later in writing today.
6 One of the studies cited in the public statements is
7 prepared by the Workers' Compensation Research Institute;
8 and by all appearances, this is anything but a neutral
9 institute. The Board of Directors includes representatives
10 from twelve different insurance companies, including
11 St. Paul's Travelers, Liberty Mutual, American
12 International, Hartford, Zurich North America, and is also
13 dominated by representatives of huge employers such as
14 Marriott International, AT&T, UPS, and Nordstrom.
15 Similar concerns have been raised with respect to
16 another study that's relied upon which was prepared by the
17 California Workers' Compensation Institute, and that is the
18 group about which written comments will be provided later
19 today.
20 My second comment with respect to the studies that
21 have been cited relates to the Neuhauser study from 1992,
22 The Study of the Cost of Pharmaceuticals in Workers'
23 Compensation. It is apparently not located where the public
24 statements designate, and this may be a violation of
25 California Government Code section 11346.5, subsection A20,

1 which requires that a proposed adoption -- a notice of
2 proposed adoption of regulations state where on a document's
3 web site a document relied upon can be found. The public
4 may have effectively been deprived of the opportunity to
5 meaningfully analyze the content of that report. There is a
6 more recent study prepared by Mr. Neuhauser from July of
7 this year, and we're providing written comments related to
8 that report in the event that it's substantially similar to
9 the 1992 report or if there is a typographical error and
10 that was the report intended.
11 Finally, I'd like to raise the very real possibility
12 that after implementation of the regulation is written,
13 physicians will stop dispensing drugs, which will result in
14 the failure of the system to meet the statutory and
15 constitutional requirements of ensuring a reasonable
16 standard of services and care for injured employees. This
17 possibility is hinted at in the recently accepted study of
18 Matthew Gitlin and Leslie Wilson, Repackaged Pharmaceuticals
19 in the California Workers' Compensation System, at pages 17
20 and 18. There appears to have been an inadequate study of
21 how these regulations will actually affect physicians'
22 dispensing and how this will in turn affect health outcomes.
23 I would encourage, prior to implementation, that this
24 question specifically be the subject of further study, to
25 ensure that the constitutional and statutory mandates

1 underlying the workers' compensation system are met; and
2 I'll point specifically to -- it's, I believe, Article 4,
3 section 4, of the California Constitution and, in the very
4 statute under which the regulation is promulgated,
5 California Labor Code section 5307.1(f).
6 Thank you very much.
7 MR. HARRISON: Thank you, sir.
8 Next we have James Weiss, M.D.
9 **JAMES DAVID WEISS, M.D.**
10 Thank you. My name is Dr. James Weiss. I am a
11 psychiatrist and pain management specialist. Here in the
12 Bay Area I work at Stanford University Medical Center at the
13 Health Education for Living with Pain program, which is a
14 functional rehabilitation program in Redwood City,
15 California; and I have a private practice in Santa Cruz.
16 I'm not here to talk about the legal aspects of this
17 because I'm not a lawyer. What I'm here to talk about is
18 the very real and difficult problems that patients face with
19 medications under the current workers' compensation system
20 and how the ability of physicians to distribute medicines
21 helps them.
22 The patients I see are invariably poor, in chronic and
23 severe and persistent pain which will last their whole
24 lives. Their marriages have often been disrupted. Their
25 abilities to participate in things they normally like to do,

1 such as gardening or physical activities or sexual
2 activities, have been largely curtailed. In my practice, I
3 see patients who are almost always depressed as a result of
4 their physical injuries, and their lives are condemned to
5 various degrees of physical and emotional trauma, which
6 means that for their whole lives they're facing terrible
7 problems, not the least of which is poverty.
8 In my practice -- and I see patients at Stanford and
9 also patients who are chronically ill -- the ability to get
10 medications is a critical factor in the ability of these
11 patients to survive. Now, I learned early on in my practice
12 that medications only -- they only provide a certain amount
13 of relief. None of us are under the illusion, who do this
14 as a business, that medications are miraculous. I learned
15 this part of medicine from the founder of the Stanford Pain
16 Medicine program -- William Brose -- and chairman of the
17 UCSF Pain Medicine Program; and they taught me early on that
18 the most medicines do is alleviate the pain in about 25 to
19 35 percent of the time. So we're dealing with medicines
20 that help these patients survive, but they are still in a
21 state of considerable misery.
22 And what has happened with medications recently is it
23 has become harder and harder for patients to get medications
24 through the traditional system. If you ask any physician
25 who works in the workers' compensation system how it

1 actually works on the ground, patients are denied
2 authorization for medications on a regular basis, not
3 because the adjustor necessarily decides that they shouldn't
4 get the medicines but the system is so dramatically
5 inefficient from the pharmacists to the pharmacy benefit
6 managers to the adjustors, that patients, on a regular
7 basis, are denied medications. And for those of us who are
8 trying to treat patients often on narcotic analgesics or
9 antidepressants or anti-inflammatories, to have these
10 medicines suddenly cut off is devastating to these patients
11 and also medically dangerous because they suddenly will --
12 in the case of narcotic analgesics, which a lot of patients
13 in chronic pain are on -- will go into sudden states of
14 withdrawal if they are denied medications; and the patients
15 are despondent about this. The patients I see are regularly
16 despondent about the fact that their medications are cut off
17 seemingly at will, and one of the things that the current
18 system allows for when physicians are allowed to distribute
19 medications is it prevents this kind of thing from occurring
20 because we can then -- if I prescribe, as an example,
21 Neurontin, which is a medicine that's used for neuropathic
22 pain, or Vicodin, which is a medicine used for -- a narcotic
23 used for pain, I can be sure, if I prescribe that medicine,
24 that the patient will actually get it. If I write a script
25 for a patient for medication, my own experience -- and

1 granted, this is my own experience, but it's in numerous
2 systems -- is that it will be denied or delayed about half
3 of the time. And so what I have a problem with is that
4 these patients, who are already suffering, then suffer more.
5 And so while you're listening to all the arguments about
6 money -- and I know that this is about money -- you have to
7 remember that these are very poor, very sick, very needy
8 people who are being manipulated by the system. They are at
9 the bottom of the system, and they are not -- the ability
10 for them to get medications is really curtailed under the
11 current system. And this ability for physicians to actually
12 give patients -- the medicines to patients has helped my
13 practice enormously and has helped my patients enormously.
14 I worry a lot about what will happen if the system reverts
15 solely to a system where the pharmacists, the pharmacy
16 benefit managers, the adjustors -- and eventually the newer
17 system where patients have to send away for their
18 medications, it will become even harder for them to get the
19 necessary medicines. And I'm very worried -- very worried
20 about my patients. So I just wanted you to know that, on
21 the ground, it's a really bad system as it's set up now. On
22 the ground, the patients are not getting their medicines as
23 they should.
24 Thank you.
25 MR. HARRISON: Thank you, Doctor.

1 We have next up Daniel Silver.

2 **DANIEL M. SILVER, M.D.**

3 Good morning. I'm Dr. Dan Silver. I practice in
4 Encino, California; Bakersfield, California. And I thank
5 you for this time to give my comments.

6 The proposed regulatory action, in my opinion, is
7 ill-advised as proposed, from three perspectives: The
8 patient's, the physician's, and the workers' compensation
9 system itself. As you will see, the big winners, as usual,
10 are the insurance companies, who will retain the savings as
11 more windfall profits and not pass the savings on to the
12 employers or the injured workers.

13 The impact on patients, as we just heard -- the
14 proposed changes will affect patients severely in a variety
15 of manners. Under the old system where doctors did not
16 dispense medicines directly to injured workers out of their
17 private offices, patients would get a prescription and go to
18 the pharmacy that would accept workers' compensation
19 patients. While the pharmacy called the claims adjustor for
20 authorization, there was a delay of hours to days before the
21 response; and the approval would be given. Frequently the
22 approval would not be given; and since there were very few
23 pharmacies that would dispense drugs without approval, the
24 patient would never get their medication. And this lack of
25 obtaining medications to cure or relieve symptoms goes

1 against the spirit of ACOEM and good medical treatment and
2 ethics.
3 If the new amendments to the section 9789.40 go into
4 effect because of the lack of financial incentive to
5 workers' compensation physicians to dispense medications
6 directly to their injured workers without delay and hassle,
7 I fear the old system will reemerge. Patients will not
8 receive the proper care to cure or relieve their pain,
9 infection, spasm, depression in a timely manner. They will
10 suffer unnecessarily for days and, in some cases, weeks.
11 Acute injuries will drag out and become chronic, again
12 violating the principles of ACOEM guidelines in Chapter 6.
13 The cost savings on drugs will be offset, in my opinion, by
14 the increase time of disability, more legal actions due to
15 the anger and frustration of patients and more potential
16 secondary psychiatric claims.
17 Currently under the present system that allows
18 physicians treating injured workers to dispense medications
19 at a fair and reasonable profit, there is incentive to give
20 the patients what they need immediately at the end of the
21 office visit, eliminating the involvement of a trip to the
22 pharmacy and the usual hassles and delays. We physicians
23 are willing to wait for authorized payments so that the
24 patient is not inconvenienced. Occasionally no payment is
25 received if the overall case is denied. In those cases we

1 just write off as uncollectible the payments.

2 Now the impact on physicians -- these proposed changes

3 will affect physicians in specific ways that will ultimately

4 cause most of us private, experienced, honest treating

5 physicians to stop treating injured workers because

6 financially it makes no sense. There is a basic business

7 principle that was told to me by a very successful

8 entrepreneur many years ago: "In business and life, in

9 general you want a high-profit-to-low-hassle ratio." What

10 this means to me as a small business owner, and as a

11 successful orthopedic practitioner, is that to stay in

12 business and keep my sanity, I try to eliminate the hassles

13 and do things that are good for my business financially.

14 Over the past two years with passage of SB 899 and its

15 implementation, there have been many hassles that I have had

16 to adapt to. They include new rules and fee schedules for

17 medical treatment and surgeries, prior authorization for

18 everything, multiple denials and appeal letters that had to

19 be written at my expense, utilization review companies that

20 don't follow proper medical practices, and increased

21 overhead in trying to get authorized payments in a timely

22 fashion that are actually specified by the labor codes. All

23 of these hassles are stressful to me and other physicians,

24 and they also increase our overhead in running a practice.

25 A specific example is that I've been in practice for

1 30 years, in orthopedic practice. Approximately 50 percent
2 of my income came from orthopedic office visits, treatments
3 such as injections, x-rays, and reports; and the other
4 50 percent came from surgery fees. Now, with the difficulty
5 in getting prior authorizations for surgery, plus a very
6 reduced fee schedule equal to 1974, only 20 percent of my
7 income comes from surgical fees; and the dispensing of
8 medication out of my offices makes up that 30 percent
9 difference, which allows me to stay in practice, even though
10 my overhead and the hassles have continued to rise. The
11 bottom line is, for me, whether, as a practicing physician
12 with 30 years of experience in workers' compensation, I will
13 be able to stay in practice and continue to serve injured
14 workers or will I just stop seeing this type of patient.
15 This is a choice many of my colleagues and I will make,
16 depending on the passage of the proposed amendments.
17 Now the impact on the workers' compensation system --
18 the proposed changes will affect the workers' comp system by
19 having fewer physicians to treat injured workers. At a
20 conference in La Costa earlier last year, Ann Cerce, our
21 medical director, was herself making a plea for more
22 physicians to enter the system rather than fewer. She
23 already had noted that there was a decline in participating
24 QMEs, which was an indication of the overall loss of
25 physicians for treatment in the workers' compensation

1 system. I am sure the administrative director, Carrie
2 Nevans, is also aware of this; and it will get acutely worse
3 if these changes go through without compromise, which allows
4 a reasonable profit to us physicians for practicing and for
5 dispensing.
6 If these changes are implemented unmodified, we will
7 also see a disparity between the savings to the insurance
8 companies and a reduction in the premiums to employers.
9 Even after a large savings to insurance companies affected
10 by SB 899, so far only a fraction of those savings have been
11 passed on to the employers. Only the self-insureds have
12 benefitted directly from these savings of 899.
13 If some reduction in drug fees is to be implemented,
14 I, as a physician, as a small business owner, and as a
15 tax-paying citizen of California, demand a required
16 proportional decrease in the insurance premiums for
17 employers. Without this requirement, the insurance
18 companies unfairly win again.
19 In conclusion, passage and implementation of these
20 amendments will actually harm injured workers, prolong their
21 disability, increase potential litigation in psychiatric and
22 secondary stress claims, in my opinion. The passage of the
23 amendments will cause a significant drop in the number of
24 available, experienced, competent treating physicians who
25 currently are making a reasonable profit on medication

1 dispensing to justify putting up with all the new hassles in
2 dealing with the workers' compensation system. And the
3 passage of the amendment will save money for the insurance
4 companies and self-insureds but less than they think because
5 disability will be prolonged from delays in pain relief,
6 increased litigation, and stress claims. More will be paid
7 out in disability dollars rather than in pharmacy dollars, I
8 predict.
9 Lastly, there must be, as part of any compromise in
10 the regulations, a reduction in premiums to employers by
11 insurance companies that equates to the pharmacy savings to
12 the insurance company.
13 Thank you for allowing me to express my thoughts and
14 those thoughts of thousands of practicing California
15 physicians and small business owners.
16 MR. HARRISON: Thank you, Dr. Silver.
17 And we have coming to the podium Marshall Lewis, M.D.
18 **MARSHALL S. LEWIS, M.D.**
19 Good morning. I'm an orthopedic surgeon from
20 Bakersfield, California. Just to reiterate what Dr. Weiss
21 said -- he practices in Stanford. I trained in
22 New York City at New York Medical. I practice out in
23 Bakersfield, and I agree with everything he said and a lot
24 of what Dr. Silver said. I do mostly defense work for the
25 carriers in the State of California. I get most of my

1 patients from the insurance companies, and Ms. Nevans said
2 "Well, one doesn't relate to the other. We're just talking
3 about pharmaceuticals." But it all interrelates.
4 The insurance companies have gone whacko. They don't
5 approve anything. It's almost like that movie where the guy
6 was on the witness stand and he says, "Yeah, our company
7 denies everything the first time around; and then when we're
8 forced to the wall, we approve it." Everything is being
9 denied. Even Utilization Review has become a joke in the
10 State of California. Any physician who practices industrial
11 medicine can tell you that, and it's being practiced by the
12 adjustors who tell you no. So certainly they are going to
13 say no on meds. I have had meds denied. I've had durable
14 medical equipment denied. I've had surgeries denied. I've
15 had carpal tunnels denied, with positive electrical studies,
16 with positive findings clinically. I mean they just deny
17 anything to deny it and to delay it, and all it does is
18 cause more confusion with the wait for the patient, and
19 that's been on a routine basis.
20 I don't know. Whoever came up with that PR-2, $12.30.
21 That's a joke all together. You can't get anything for
22 $12.30 and expect a doctor to write a report. I've read
23 defense PR-2s that are filled in with one word. They tell
24 you nothing. If a physician dictates a report, and it's an
25 appropriate report, for $12.30, his typing bill is more than

1 $12.30. I don't know who came up with that figure, but it's
2 a joke.
3 Regarding the -- you almost have no M.D.s in the State
4 of California to take Medi-Cal. So we're deciding all these
5 rates based on Medi-Cal rates. I don't understand it. You
6 go to the average town and you ask how many people take
7 Medi-Cal. I've been Chief of Orthopedics at three different
8 hospitals. Medi-Cal managed care -- I've written letter
9 after letter after letter: "Who is covering your patients
10 at night?" I can't get an answer. They have 60, 70,
11 80 million dollars in the bank that's given to them by the
12 State of California, but no one knows who's taking calls for
13 orthopedics. They don't have an orthopedist on call. They
14 want the guy that's in the emergency room to take care of
15 the patients.
16 Refills and renewals on medication -- are you going to
17 tell me that a physician can't make a living off dispensing
18 medications. So he's going to have the pharmacy call him,
19 someone making ten or $15 an hour. Then they're going to
20 pull a chart. Then they are going to stop the doctor from
21 what he's doing, seeing another patient. Then he's going to
22 look through the chart and try to figure out what's going on
23 with this patient: Have they had liver and kidney function,
24 white count, platelet count, any of the other things that he
25 has to check in relation to the medications they are on and

1 then figure out what kind of case is it -- "Are they
2 overusing? Underusing?" And he's going to spend 25 minutes
3 so that he can, for free, tell the pharmacist, "Yeah, give
4 him the refill." Who's going to do it? No one. That's the
5 answer. You're going to have no doctors prescribing meds
6 that I know of that are specialists because they don't have
7 the time. We're out of time. We get letters from the
8 industrial carriers on all kinds of nonsense. Every
9 15 minutes it hits my desk, and it's stuff because they
10 haven't read the reports to begin with. Now they want to
11 cut out the medicine. You won't have doctors that are going
12 to do it. They're just not going to do it. Now who's going
13 to write the medicine. No one is going to be able to
14 practice medicine the way it should be practiced in the
15 State of California and the specialty area.
16 Why don't we -- I think -- if you have a system --
17 these people get injured. As I say, I do defense work. I'm
18 not an applicant's guy. If these people get injured, they
19 are entitled to care. They are not entitled to a whole
20 nonsense system where, on rare occasions, I've had to send
21 them to an attorney that does applicant's work because I'm
22 always on the other side. They're entitled -- if they get
23 injured, these people -- they work hard. They know they
24 have insurance. They're entitled to get care. I think what
25 you're doing is creating a situation where the care is

1 minimal to nothing. I mean it will work like the Medi-Cal
2 managed care system in the State of California. It's
3 worthless. We've got a Medi-Cal managed care system in
4 Bakersfield where they just did an expose. They have
5 $70 million in the bank. No doctor knows anyone that's ever
6 gotten a decent check from them for any kind of treatment.
7 I mean, what are we creating here. This is for
8 workers. These people work hard. They are entitled to some
9 type of care. I think medication -- you want to pay on
10 Medi-Cal rates or you want the doctor to lose money on
11 giving out meds, that's ridiculous. They won't do it.
12 Thank you for your time.
13 MR. HARRISON: Thank you, Dr. Lewis.
14 I have the name of Diane Przepiorski. Is Diane
15 available?
16 **DIANE M. PRZEPIORSKI**
17 Thank you very much. And it's Diane Przepiorski with
18 the California Orthopaedic Association. You're very close.
19 It's very good.
20 We've been involved in this issue through your initial
21 informational hearing, through the regulatory process, and
22 now today. As you've heard from some orthopedic surgeons
23 who are members, they are very concerned about the changes.
24 COA has always argued that there is value added when
25 physicians dispense medications from their offices, and we

1 appreciate the Division keeping that door open to allow the
2 physicians to dispense the appropriate medications. You've
3 heard from patients at the informational hearings that it
4 may not be statewide, but there still are parts of the
5 state, I believe, where there is a severe problem with
6 injured workers actually getting pharmaceuticals from the
7 pharmacist. So that door needs to stay open.
8 I think what you're hearing this morning is really at
9 the fundamental problem with this issue, and that is that
10 there is really no study that says that the Medi-Cal rates
11 are appropriate for the pharmaceutical industry or for the
12 physicians. And whenever you say Medi-Cal rates to
13 orthopedic surgeons, or to any specialist in the state, as
14 Dr. Lewis points out, it's just a hopeless system. Medi-Cal
15 hasn't paid the costs of delivering their care in many
16 years. So the fundamental premise that the Medi-Cal rates
17 are the appropriate rates I think is flawed, and -- but at
18 the same time, we understand the pressure that the Division
19 is under to close this loophole.
20 I think we've all learned a lot about pharmaceutical
21 dispensing since the informational hearing in the
22 legislation, and have a better appreciation for the role of
23 the repackagers and how fees are set. So that's all been
24 enlightening to us. I think fundamentally there probably is
25 a very valid question about whether or not Medi-Cal levels

1 are appropriate for any pharmaceutical dispensing, but we do
2 understand the pressure of the Division to try to close this
3 loophole.
4 So we would ask that whatever reductions that are
5 implemented that they be phased in in some form. Because as
6 you can hear from the physicians, there will be a hardship
7 on these practices, and we hope that they would continue to
8 dispense medications, but it just can't happen overnight.
9 The second issue then, you come to the dispensing fee,
10 and physicians in the past haven't received any kind of a
11 dispensing fee. So I understand that the Division is trying
12 to help the physicians by allowing for a dispensing fee, and
13 we have asked our members on many different occasions what
14 it really costs them to dispense medications, and we found
15 that to be a very elusive and a very hard figure to come up
16 with because I think it varies significantly probably from
17 office to office, and it's so intertwined with their other
18 administrative costs that it's very hard for them to pull
19 out just those costs.
20 But I think there are a couple of things we do know.
21 We do know that the cost that a physician would have to pay
22 for purchasing the medications is higher than what it would
23 cost a pharmacy because a pharmacy is just buying in larger
24 volumes, so they have the benefit of getting lower costs
25 from the pharmaceutical manufacturers or the wholesalers.

1 We also know that, or I have learned from my members,
2 that about 20 percent of the time they don't get paid at all
3 for these pharmaceuticals. So, you know, I'm a very
4 pragmatic person, and I said, "Well, why do you want to get
5 in the middle of all this hassle if you're not even going to
6 get paid for this?" And then I get the rationale from my
7 members that it really is a patient service, and I think it
8 would be bad to disrupt that relationship because I think
9 there is, as I said earlier, some value added.
10 The third thing we do know is that physicians don't
11 get paid as timely as a pharmacy does. They have a more
12 efficient way of submitting their bills for payment, and I'm
13 told that they are paid in a much more timely manner. So
14 those three things really do drive up the costs in a
15 physician's office of dispensing medications.
16 So back to what does it cost to dispense from your
17 office. I'm hearing that in an orthopedic practice that it
18 costs them between ten to $15 to dispense a medication in
19 their office. That's the best figures that they can come up
20 with.
21 And I think -- I'm also sensitive to some of the
22 arguments that we heard in the legislative arena where
23 medical offices were dispensing ten and 12 prescriptions in
24 a single day. I think that it's hard for me to envision a
25 patient that would need that many different prescriptions on

1 a single day; and if in fact there is such a patient, maybe
2 that patient should go to the pharmacy so that the
3 pharmacist can look at the drug interactions of that many
4 medications. So I'm kind of thinking that it would be good
5 for the Division to implement a tiered dispensing fee so
6 that you would rein in potentially some of the abuses that
7 might be out there in the multiple prescriptions in a single
8 day. So we would like to propose kind of the middle ground
9 I guess you might say, and that is that the dispensing fee
10 be set at $12.50, the middle ground between the ten and $15
11 amount for the first three prescriptions dispensed on a
12 single day; and that for prescriptions of four or more, that
13 it would be at the $7.25 that the Division is proposing. We
14 think that that would help to reimburse the physicians more
15 appropriately for their actual costs of dispensing these
16 medications, and compensate them for the medications that
17 they might not get paid for at all, and would still help
18 rein in some of the abusive activity that we've seen
19 reported.
20 Thank you very much.
21 MR. HARRISON: Peder Thoreen.
22 PEDER J. THOREEN: That's me. I've already spoken.
23 MR. HARRISON: Yes. Would it be helpful if I
24 indicated the person who is following the individual who's
25 about to speak, kind of like in the football draft, who's on

1 the clock?

2 MALE ATTENDEE: It would save some time.

3 MR. HARRISON: It would save time. Very well. Say it

4 again, please.

5 FEMALE ATTENDEE: He said it would save time walking

6 down.

7 MR. HARRISON: All right. Very well. Would then --

8 we ask that Christopher Chen, M.D., come forward; and

9 Enrique A. Sigui is on the clock.

10 **CHRIS CHEN, M.D.**

11 Esteemed members of the Workers' Comp Division, I

12 bring before you four items: First, a letter from the

13 Honorable Wilma Chan, Assemblywoman, 16th District -- or the

14 Chairperson of the Health Care Committee. If I may, let me

15 read this letter to you. I have the letter here if you

16 would like me to bring it to you personally.

17 "Dear Ms. Gray: This letter is written in strong

18 opposition to the proposal to adopt the amendment of

19 Article 5.3, Chapter 4.5, Subchapter 1 of Title 8 California

20 Code of regulation, Section 9789.40.

21 "Passage of this amendment will decrease health care

22 access and especially hurt the ethnic minorities and

23 lower-income injured worker. Many ethnic minority workers

24 do not have private health insurance. Many pharmacies

25 already deny some workers' compensation prescriptions. By

1 decreasing reimbursement, it will be increasingly more
2 difficult for the injured worker to obtain necessary
3 medications. If the reimbursement of medications decreases
4 to Medi-Cal rates, physicians will no longer be able to
5 dispense from their offices, as the cost of medications far
6 exceeds the Medi-Cal reimbursement. Passage of this bill
7 will therefore limit the number of physicians who would
8 treat the industrially injured worker, many of who are
9 minorities or who a physician would no longer provide
10 medication to the injured worker.
11 "Moreover, the immediacy of obtaining medications from
12 the physicians prevents delays to medical care due to lack
13 of authorizations. Without adequate treatments and
14 medication, the injured worker would be unable to return to
15 work. I must stress that the workers are the ones who will
16 suffer. Passage of this amendment will most certainly
17 increase the health care disparity in California.
18 "Sincerely, Will Wilma Chan, Assemblymember of the
19 16th District."
20 Number two item, I have before me a letter from Ethnic
21 Medical Organization Society, also known as EMOS. It's an
22 affiliation of the American Medical Association. I have
23 signatures from many presidents of the medical societies.
24 The presidents represent thousands of physicians in our
25 state: Randall Fong, Chair of Ethnic Organization of the

1 CMA; Arthur Flemming, Chair of Network of Ethnic Physicians
2 of Network Organization, over 200 physician groups
3 comprising thousands and thousands of physicians in our
4 area; Margret Borres, President, California Medical
5 Association; Ben Medina, Latino Medical Association of
6 San Diego; and also Mark -- I'm sorry -- Lisa Benton,
7 President of Miller Medical Association. This is an
8 association of American physicians.
9 Number three item, the CMA, California Medical
10 Association, a 2005 performance study of almost
11 300 physicians: 63 percent of the physicians in this survey
12 indicate that they intend to leave or reduce participation
13 in the workers' comp. Of this, one-third plan to quit
14 entirely, mostly due to poor reimbursement, obsessive
15 paperwork, and delays in authorization.
16 Number four item, myself representing myself, the
17 Chinese American Physicians' Association, CMA, and the
18 ethnic medical organizations -- many pharmacies that you've
19 heard already do not take workers' compensation due to poor
20 reimbursement for medication. With the passage of this
21 amendment, I sadly will be among the 63 percent who will
22 leave workers' compensation. 90 percent of my patients are
23 latinos who do not speak any English. Many pharmacies such
24 as Costco, Longs, do not have latino staff. My patients
25 cannot get the medication authorized because they do not

1 have the working knowledge of English to give the pharmacy
2 the insurance information or whatever information that a
3 pharmacy needs. And even if my patients can get the
4 medication pre-authorized, my patients usually cannot take
5 the medication. They do not take the medications because
6 they do not understand what these medications are and how to
7 take these medications.
8 I dispense medication. My patients do not have to
9 worry about getting medications authorized. They do not
10 have to wait several months to get their medication
11 authorized. My staff and myself explain in their language,
12 the patient's language, how to take these medications. They
13 get treated right away, thereby ensuring a speedy return to
14 work.
15 This amendment would decrease health care access by
16 decreasing the number of physicians who take workers'
17 compensation and by decreasing the accessibility of
18 medications. This amendment will jeopardize patients'
19 safety because of the language barrier. Stop this amendment
20 so that the injured worker can go back to work sooner.
21 Thank you.
22 MS. NEVANS: Can you submit copies of those two
23 letters that you cited? Thank you.
24 MR. HARRISON: Thank you, Dr. Chen.
25 Before we call Mr. Sigui -- please come forward,

1 Mr. Sigui. Let me ask, is there a Mark Russell?
2 Mr. Russell, in your sign-in sheet, you did not indicate
3 whether or not you wish to make testimonial comment today.
4 Do you or not?
5 MARK C. RUSSELL: Yes.
6 MR. HARRISON: Very well. We will have Mr. Sigui, and
7 Mr. Russell is on the clock.
8 **ENRIQUE A. SIGUI**
9 Members of the Board, thank you very much for giving
10 me the opportunity to talk here today. I came on my own,
11 and I'm trying to represent three sections of society that
12 they are not here today: First, the patient, since I have
13 three surgeries in my low back; one laminectomy and two
14 fusions -- second, a minority group, since I'm latino -- and
15 third, a middleman -- my business is interpreting, and I'm a
16 Spanish interpreter so I deal with the minorities very
17 often. And I don't see any of them here. I see these
18 wonderful people -- these doctors here -- trying to avoid
19 these regulations to pass. I just want to give you my
20 honest opinion of what I see.
21 First, as a patient, I don't know what I would be able
22 to do after I had my first surgery. I wouldn't be here. I
23 wouldn't be an interpreter if I didn't have the medications
24 to help me out. I was going nuts. The pain was terrible.
25 I fell and broke my back, and it was hard for me to recover.

1 Medications was the only one that kept me sane. These three
2 surgeries pass, and it happen in an average time of 15 or
3 20 years. But in my last surgery, which was in 2000, since
4 I knew the time that I was going to spend out of the
5 workforce, I took the time to start again. I went to
6 university. I went as an interpreter.
7 And as a middleman now, I relate to patient because
8 I've been there. I know what this medication do, and I can
9 relate more to the patients, the minorities specifically,
10 Spanish-speakers. I can relate more to them than the
11 doctors because I talk to them. I know what they're
12 feeling.
13 I can tell you -- these regulations -- the only people
14 that you're going to hurt if this regulation is passed is
15 the mostly minorities even though it applies to everybody,
16 even English-speakers. Everybody I see as a patient -- they
17 depend on this medication so much.
18 And these doctors -- I work with so many doctors. I
19 can give you a list of 300, 400 doctors that I work in the
20 last five years that I have my business. And these
21 wonderful doctors -- I seen them after they pass the new
22 laws in adult workers' comp. They lose their business,
23 wonderful doctors that I knew. I can't believe it. They
24 either quit or they left the business because there was no
25 way for them to keep up with the cost of how much they have

1 to pay for everything.

2 Now the insurance companies -- I don't know who came

3 up with this beautiful idea, this regulation, on taking the

4 only legal profit they can make from this medication to keep

5 up. I see these doctors work in their office. I seen them

6 working with these minorities, and it's a shame. I feel

7 very bad.

8 If this regulation was to pass, a lot of these good

9 doctors are going to close their office; or they dispense

10 medications. I don't know how these patients are going to

11 be able to live with that pain when they can barely speak --

12 the minorities -- they can barely speak English. How are

13 they going to get a prescription to -- from the -- they go

14 to the pharmacy. They laugh at them. They can't speak

15 English.

16 So please, you know, just think about it. Do not pass

17 this regulation. This is going to hurt a lot of the

18 minorities and a lot of the people that are depending on

19 that doctors to prescribe their medication.

20 Thank you for your time.

21 MS. NEVANS: Thank you.

22 MR. HARRISON: We have Mr. Mark Russell coming

23 forward, as is Tamara Sanders.

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25 / / / / /

1 **MARK C. RUSSELL**

2 Good morning. My name is Mark Russell. I am the
3 Chief Financial Officer for Express Pharmacy. So unlike
4 many of those in attendance here today that are from
5 doctors' offices and medical clinics, we are, in fact, a
6 pharmacy; but unlike our big brethren -- the Walgreens, CVS,
7 Costcos, Sav-ons, and Safeways of the world -- we service
8 almost exclusively lien-based claims. So those are the
9 injured Californians that are falling through the cracks
10 here that have been turned away by our big brethren in the
11 pharmacy industry, and they come to us because that is not
12 their business model.

13 As a pharmacy, we also have other lines of business
14 that we treat. We are in the skilled nursing facilities,
15 the assisted-living facilities; and we are intimately
16 familiar with Medi-Cal and Medicare reimbursement. Medi-Cal
17 and Medicare reimbursement works only when there is an
18 electronic handshake between the provider and the payer,
19 which is a real-time handshake and it acknowledges that the
20 transaction is received and a payment is going to be made
21 and that payment is going to be made within a reasonable
22 time frame, about two weeks. And that business model is
23 low-dollar, low-margin business, but it works because you do
24 not have -- as you've heard a lot of good testimony this
25 morning, you do not have the hassle of having objections and

1 denials. You do not have the significant carrying costs of
2 lien-based business as a lien claimant where you really have
3 no control. You have to monitor the progression of the case
4 in chief. You have to attend the hearings. You have real
5 carrying costs in trying to provide service to a lot of
6 these Californians who really have issues that are -- that
7 need to be resolved over time, but as that time progresses,
8 they also need their medication. The big chains are not
9 going to do that for them.
10 We service approximately -- or have serviced and are
11 servicing over 30,000 lien-based cases in California. And
12 the official medical fee schedule changing to a Medi-Cal
13 reimbursement or their equivalent rate, with the penalty and
14 interest provisions on the OMFS, will be so woefully
15 inadequate to cover the labor and the real carrying costs
16 involved with managing these cases as a lien-based claimant
17 under medical treatment that basically -- I don't know what
18 Rand Corporation -- what papers have been done in following
19 some of this, but you completely have a flaw in the reform
20 that you're working on here to do that, because you're going
21 to have an access-to-care issue here. And I think the
22 doctor from Stanford mentioned it earlier. A lot of these
23 people when their medications are cut off quickly and
24 suddenly, there will be some significant clinical
25 repercussions from that as well.

1 So, again, as a pharmacy and unlike a lot of the
2 medical clinics and doctors' offices here, we do exclusively
3 lien-based business; and the official medical fee
4 schedule -- really, my proposal should be that it would not
5 be applicable to cases that are denied. If the insurance
6 companies want to deny the case and push the case out for
7 whatever reasons they have -- and they have a lot of them --
8 that really there should be -- a usual and customary charge
9 should be predicated, and let the WCAB -- let the presiding
10 judge of the case decide what is a fair reimbursement for
11 the medications that are prescribed over time on these
12 denied cases.
13 Thank you.
14 MR. HARRISON: Thank you.
15 Can we take a five-minute recess so that the court
16 reporters can exchange their positions.
17 (Pause in proceedings.)
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1 MR. HARRISON: The hearing of public testimony will
2 resume now with Ms. Tamara Sanders. Ms. Sanders.
3 TAMARA SANDERS
4 Hello. Thank you for allowing me to speak today. My
5 name is Tamara Sanders and I'm a manager at Pacific RX. I
6 work for about 207 doctors. We are a unique business where
7 we actually do all the billing for the medications that are
8 expensed in our doctors' offices, and we have 16 employees
9 that work with us.
10 The adoption of the proposed regulation -- after
11 speaking with all the doctors, and hearing what they felt,
12 and what this bill would do for them, and the most important
13 thing was their patient care, and not being able to provide
14 that kind of care that a patient needs, especially since
15 most of these workers' comp. patients are low income. This
16 last year in 2006 we as a company wrote off $424,000.00 of
17 medications that we did not get money for. These are
18 medications that the insurance companies denied and said
19 these are not payable medications. A lot of them are psyche
20 drugs. They still are not up-to-date that pain causes
21 depression, and many of the adjusters continue to deny these
22 medications. But our doctors want to see their patients get
23 the kind of care that they need, and they continue to
24 provide this medication.
25 If this bill is passed, it's not going to allow them

1 to perform the kind of care that they need to do for these
2 patients. It is going to cause -- the overhead kind of
3 makes up for what the patients that we can't get money
4 for -- we charge a little bit more and it kind of evens out
5 and they make money. But if this bill passes, and we start
6 going to the Medi-Cal fee schedule, the psyche drugs aren't
7 even on the scale. They are under costs, and I don't feel
8 that this is fair at all.
9 I do have an idea. I know that the State Compensation
10 of the State of California adopted their own program where
11 rather than changing the entire program where you don't just
12 Red Book, you don't use all the different fee schedules, you
13 can keep your fee schedule and pay 93% of the AWP, the
14 average wholesale price with the dispensing fee. I feel
15 like that's a fair amount of money. It's still -- it's a
16 compromise to going Medi-Cal rates. It is a compromise
17 rather than making these doctors go completely out of
18 business, not being able to treat these workers' comp.
19 patients.
20 Like Dr. Weiss said, this is a personal thing. I was
21 very impressed with how he was talking about the care of his
22 patients, and I feel the same way. The doctors that I spoke
23 to, it's really not about money -- it is to you
24 guys -- but to them it is really about patient care, and
25 wanting to provide the best possible care, and I thank you

1 for allowing me to speak today.
2 MR. HARRISON: Thank you. Ladies and gentleman, we
3 would ask that you refrain from applause following the
4 testimony. We'd just like to keep everyone on an even keel.
5 I'm sure that some agree with some of the views and
6 testimony that is presented, others may disagree, but in the
7 interest of fairness to all, let us refrain from applause.
8 If you agree or wish to concur with the individual, I'm sure
9 there will be ample time during the lunch period or after
10 the hearing itself.
11 We would ask that Mr. Steve Cattolica, Mr. Cattolica,
12 I'm sorry, come forward with Mr. Mark Gearheart. Are you
13 here?
14 MR. CATTOLICA: Thank you. My name is Steve Cattolica
15 and by the way, you did better than the first time I tried.
16 MR. HARRISON: Thank you.
17 **STEVE CATTOLICA**
18 I represent U. S. Health Works of the California
19 Society of Industrial Medicine and Surgery, as well as the
20 California Society of Physical Medicine And Rehabilitation.
21 We submitted written comments to you some days ago. I'll
22 just simply highlight those items that we believe should be
23 emphazied.
24 First of all, the division has served a consistent
25 message from the providers of the injured workers in

1 meetings as well as in this oral testimony and written
2 testimony that you also received regarding the value
3 delivered and received when a physician dispenses
4 prescription medications within the occupational medicine
5 system. You are likely to hear from labor, you already
6 heard from a number of other physician societies, as well
7 as, I think, if not perhaps today, but from insurance
8 carriers maintaining the same points of view. So, in
9 response, we propose to the division that they include a
10 separate dispensing fee applicable to prescription drugs
11 dispensed when a physician is in their office. In our
12 written testimony we provided you with a basis for that in
13 citing Labor Code 5307.1(d), as well as 5307.1(f), which
14 requires that rates or fees established by the
15 administrative director be adequate to insure reasonable
16 standard services and care for injured workers.
17 In our written testimony we also provide you with a
18 cost analysis. We attempted, to the extent that we can, and
19 you heard how difficult that is from other witnesses today,
20 to quantify the differential between a pharmacy and a
21 physician's office with respect to labor costs. Bad debt,
22 which you heard cited in one example, is 20%, and we told
23 you it ranged between 18 and 21, with the most recent year
24 of 19.3. We also talked about mandatory contract discounts
25 which pharmacies are not subject to. We also talked about

1 the time value of money.

2 You heard a witness speak about an electronic hand

3 shake between the pharmacy and the payer, and how that

4 creates deficiencies in the system. No such hand shake

5 exists, and even when it does, in a couple years there will

6 still be an overlay of larger costs. We talked about the

7 cost of disposal. Because repackaged drugs cannot be turned

8 back to the manufacturer, they need to be disposed of, and

9 of course, there's also the cost of interpreters in a

10 treatment office that is not reimbursed. We also cited a

11 number of other cost differentials that we couldn't

12 quantify, but nonetheless they are certainly real, and so

13 our proposal for a separate physicians' expensing fee

14 represents a minimum.

15 We also talked about the affect of our ultimate

16 proposal upon projected savings. We revisited our original

17 proposal to this affect that we gave to you some months ago,

18 and recast the costs of our proposal using better numbers,

19 we thought, and so it is a much more robust, and I think,

20 substantiated estimate of the costs. Our purpose was not to

21 predict the drug costs, nor the distribution across drug

22 types, or savings from the Medi-Cal formula itself. We were

23 looking to be able to quantify the costs of our proposal

24 which was a separate dispensing fee. So we in this, in our

25 testimony, ignored for the most part the costs of the pills

1 themselves, and described, I think fairly accurately and
2 exhaustively, the value delivered and the cost to deliver
3 that value when a physician dispenses.
4 Our conclusion was simply that a separate dispensing
5 fee in and around the number of $15.00 is a minimum, is
6 going to preserve something on the order of 98.6% of the
7 savings that was projected by the CHSWC study completed not
8 long ago. So, essentially a larger dispensing fee is going
9 to cost about a percent and a half of that savings. I think
10 in order to preserve access that's a small price to pay, and
11 I think you've heard from others it is a price that is
12 appropriate.
13 We also talked with respect to how dispensing rates in
14 the past are going to be affected by this particular
15 schedule. We talked about the affect of utilization review
16 with respect to physician dispensing. We also talked about
17 the affect of the fee schedule itself and the chilling
18 affect it is going to have, undoubtedly, and in fact, by
19 intent on physician dispensing. We also talked about market
20 place solutions, those solutions that the market place has
21 brought to bear to mitigate the anomaly in the reimbursement
22 system as it exists today.
23 We also addressed fallacious arguments that have been
24 put forward with respect to pharmacy access, that in fact
25 studies have shown that access is expanded when in fact no

1 such thing is true.

2 The division has exhaustively explored the subject of

3 physician dispense of prescription drugs. Our proposal

4 would with a minimum $15.00 dispensing fee provides that

5 solution. Our solution provides a modicum of relief to the

6 physician who dispenses while preserving not only the assets

7 but virtually all the same, except at least one study has

8 projections as is available from the schedule as it is

9 proposed today.

10 We'd like you to seriously consider that separate

11 dispensing fee, and we look forward to learning that, in

12 fact, it will be implemented.

13 I'd to also like to provide to you a new document from

14 one of the CCS members, Richard Braun, who is a hand and

15 upper extremity orthopedic surgeon. He has done a study or

16 a survey of his patients, and the survey had to do with

17 convenience, effectiveness, and other factors. We'll give

18 you the original letter from him to us as well as the

19 original survey; and it's not a lot of people, but he took

20 the time, and I think it is one of the unique things he had

21 to offer.

22 We appreciate the effort and the time that the

23 division is taking in this subject. This has been a long,

24 long, long discussion, and we're looking forward to, I

25 think, a swift and learned solution.

1 MR. HARRISON: Thank you, Steve. Is Irene Georgiou --
2 Ms. Georgiou, what I'm going to do is ask you to be on
3 standby while we hear from Mr. Gearheart.

4 **MR. MARK GEARHEART**

5 Good morning. My name is Mark Gearheart. I'm an
6 applicant attorney. For the last 26 years I've represented
7 injured workers before the Workers' Compensation Appeals
8 Board and the courts. I practice just over the hill in
9 Contra Costa County, and in fact, most of my cases are heard
10 in this building on the 6th floor. I'm here today in my
11 capacity as a member of the Board of Governors of the
12 California Applicant's Attorneys Association. We submitted
13 a written comment, but I appreciate the opportunity to add
14 to that with a few points orally this morning.

15 The cost supports the concept of a fee schedule for
16 repackaged pharmaceuticals to address some of the billing
17 abuses that may have occurred in the past. At the same time
18 we're very, very concerned about preserving and protecting
19 access to care for injured workers, and we believe that the
20 current regulation would not do that. Adopting a schedule
21 which applies Medi-Cal payment rates to repackaged
22 pharmaceuticals is likely to undermine access to timely
23 care, and for that reason we're opposed to it. We'd urge
24 adoption of a fee schedule for repackaged medications that
25 sets a reasonable rate of compensation for the physician,

1 and we fully support and endorse the proposal put forward by
2 the California Society of Industrial Medicine and Surgery.
3 We think that's a reasonable and rational compromised
4 proposal.
5 I want to share with you something that I think you
6 heard alluded to today, but I'm not sure that it's been made
7 entirely clear. I represent hundreds of people. Over the
8 years I've represented thousands of people in the
9 compensation system, injured workers. It's very, very,
10 common for my office to get phone calls from injured workers
11 who are unable to get their medication. It's an accepted
12 claim, their physician, who's authorized to treat, has
13 prescribed various medications, they've gone to their
14 neighborhood pharmacy or whatever pharmacy they go to, and
15 the pharmacy won't fill the prescription because they can't
16 get an authorization from the carrier. They are waiting for
17 a call back. They need to fax another copy of the
18 prescription. The adjuster isn't in today. The person who
19 handles medical billing is going to call them back and
20 doesn't. So they go home, and they go there the next day,
21 and there's still a problem. We can't get a call back. We
22 can't get it authorized, so they go home, then they go back
23 the next day. Well, one of your medications is authorized
24 but they've got a question about the other one, and the
25 adjuster has called the doctor's office. At a certain point

1 they get fed up and call our office, and we intervene, and
2 eventually they usually get their medications, but by the
3 time they get them, days or weeks have gone by. The
4 therapeutic affect has obviously been lessened by the delay.
5 These folks are frustrated understandably. The carrier is
6 now going to have to pay for mileage for them to go to the
7 pharmacy 3, 4, 5 times. The carrier was exposed to risk
8 because when they're driving to the pharmacy to pick up the
9 prescription, if they get in a car accident that's covered
10 by the Workers' Compensation Act, and we're going to claim
11 that as part of the claim. We have to, and we will, and
12 it's extremely inefficient.
13 And what I contrast that with is my clients who are
14 treating with a physician's office -- and not all
15 physician's offices do this -- but a physician's office that
16 will dispense the pharmaceuticals at the doctor's office --
17 I never get calls from those clients saying I couldn't get
18 my medication. Never. The reason I don't is those
19 physicians dispense the medications during the office visit,
20 and they'll wait to get paid. They'll bill it along with
21 their regular services, and they'll wait to get paid.
22 Unfortunately they're used to that.
23 They in the larger medical practices often have a
24 staff employee who's trained in dealing with insurance
25 companies, getting authorizations, getting bills paid. They

1 often have someone on their payroll whose whole job is to
2 get these bills paid, and they take care of it in-house.
3 That's expensive. Pharmacies don't do that. But it's
4 better care for the patient, but it's not free. It costs
5 them something. I think if the fee is set too low on these
6 packaged/repackaged drugs what's going to happen is the
7 doctor, understandably, is going to say, well, this is below
8 my costs, I can't do this; and so these folks are all going
9 to be thrown out to deal with the pharmacies. Some of them
10 will fair well, many of them won't.
11 You're going to have increased temporary disability
12 because if somebody is waiting a week, or 2 weeks, or 3
13 weeks to get their medication, and they're off work, that's
14 just extending the temporary disability. You're going to
15 get sub optimal medication treatment out of this because a
16 lot of these medications -- the point is that they provide
17 them promptly and on a time schedule. You provide them with
18 the delay and they're interrupted and then started again,
19 you don't get the same therapeutic effect, so you're going
20 to have a less than optimal medical outcome. You're going
21 to have increased mileage costs, and increased exposure by
22 the carrier to the risks of car accidents on the way to the
23 pharmacy. And it just doesn't make any sense. I think it
24 undermines the purpose of the system to provide prompt
25 quality care to injured workers.

1 It also increases friction costs, because these folks,
2 understandably, become frustrated and angry, and I think
3 what all sides prefer to see is negotiated compromised
4 settlement of cases rather than increased litigation, and I
5 can tell you, having practiced workers' comp. law for 26
6 years, it's a lot easier for me to settle a case if my
7 client feels like they have been treated fairly than if my
8 client feels like they've been abused, their treatment's
9 been delayed, the carrier has done nothing but throw up road
10 blocks, and you know that client's going to be angry. They
11 don't want to compromise. So there's friction costs here
12 that you can't quantify with an MBA approach, but you're
13 going to increase those if do you this.
14 So, in conclusion, I'd just like to say the purpose of
15 the comp. system is to provide prompt quality care to speed
16 people's recovery and return to work, and I think the
17 proposal, while well intentioned, will undermine that very
18 important purpose. I would urge you to seriously consider
19 the CSIM proposal, which I think, and which the California
20 Applicants' Attorneys Association thinks, is a reasonable
21 approach, and we urge you to try that. Thank you.
22 MR. HARRISON: Is there a -- looks like L-a-c-h
23 Taylor?
24 MR. TAYLOR: I failed to check the no box.
25 MR. HARRISON: Okay, thank you. Ms. Georgiou, if you

1 will come forward, and Robert Goodrich is on standby.

2 **IRENE GEORGIOU**

3 Thank you for letting us speak today. My name is Irene
4 Georgiou, and I'm a licensed pharmacist in California. I
5 work as a consultant for physicians who dispense pre-
6 packaged medications directly to their workers' compensation
7 patients. The dispensing of medications from the
8 physician's office does greatly expedite care to these
9 patients. Currently, 10 to 20% of these work comp. patients
10 cannot have their prescriptions filled by their doctor's
11 office because their insurance carrier will not allow them
12 to do so. Those patients frequently encounter delays in
13 getting prescriptions filled in pharmacies due to
14 administrative problems, additional paper work, phone calls,
15 and pre authorizations. This not only inconveniences the
16 patient and delays care, it also adds more chaos in the
17 doctor's office due to the fact that the doctor now has to
18 check if that patient's insurance carrier is one of the
19 insurance companies on the list that requires the patient
20 have their prescriptions filled only by a pharmacy.

21 Since the proposed regulation decreases the cost to
22 the insurance company for providing this prescription
23 service, and it will now cost the insurance company the same
24 as if the prescription is filled by a pharmacy, I'm
25 proposing that this new regulation adds language to allow

1 the physician who is already authorized to treat the
2 patient, be allowed to provide this prescription service
3 regardless of the insurance contract. Thank you.
4 MR. HARRISON: Thank you. Mr. Goodrich, and is Dr.
5 Edward Lin -- please stand by. You're on standby.
6 ROBERT H. GOODRICH
7 Thank you very much for having this hearing. My name
8 is Robert Goodrich and I'm with Southwood Pharmaceuticals,
9 and our company is one of the companies that repackages
10 drugs for physicians dispensing, and I have been connected
11 with this industry of supplying repackaged drugs for over 30
12 years.
13 It's been very interesting to hear the opinions of the
14 physicians, the medical groups that are here today. I
15 notice that we have yet to hear any testimony in favor of
16 this proposed rule, and I'm going to limit my comments to 3
17 points that I'd like to address from the perspective of the
18 supplier.
19 The first is mechanical. The proposed regulation asks
20 that we are reimbursing under a Medi-Cal fee schedule.
21 These supplies are going to be reimbursed under an NDC
22 number that is not contained on the package label. There is
23 no cross reference that allows the NDC number that we as a
24 repackager are required to put on the label that exists in
25 the Medi-Cal data base. This was the source of the

1 confusion of implementing this back in 2004. So, when a
2 physician is trying to get reimbursed for one of our
3 products, they would have to find an NDC or methodology
4 which doesn't exist now to be able to cross reference that
5 item with the Medi-Cal data base; and then if it's not in
6 the Medi-Cal data base the requirement is to use the NDC of
7 the drug that we obtain the product and before we repackaged
8 it.
9 Now, as a repackager we procure product based on
10 availability, therapeutic equivalent, preference of our
11 prescribers, and the discretion of our pharmaceutical staff,
12 and we will put the same product from different sources
13 under the same NDC, the same label, and so by following this
14 path of Medi-Cal language and Medi-Cal data base, it is
15 possible that the same item for practical purposes would be
16 reimbursed at different rates, and there's no way to augment
17 it, and so we've been asked how we will do this, and how we
18 will facilitate the reimbursement from our customers. It's
19 very difficult, and I'd ask that the department consider the
20 practical aspects of that. I will leave a letter on that.
21 The second point I'd like to make is the language of
22 the proposed rule. Well, actually the language of the
23 existing law going back to I believe SB 228, that the
24 maximum reasonable fee for pharmacy services rendered after
25 January 1st, 2004 is 100% of the fee prescribed in the

1 relevant Medi-Cal payment system. The key word is relevant.
2 Medi-Cal has 4 methods of establishing payment: The MAIC,
3 the FUL, the EAC, and the usual and customary practice. I
4 would propose that the relevant Medi-Cal payment system for
5 repackaged drugs whose NBCs are not part of the Medi-Cal
6 data base is either BAC practices, which is currently AWP
7 minus 17%, or usual and customary costs to the general
8 public, which ever is less.
9 The third point I'd like to make concerns
10 implementation. The notice of this hearing with the rule
11 indicated that any changes would occur on December 1st of
12 this year, which is 30 days away. I'm sure that the
13 department will absorb the comments here, the written
14 comments, and from the proposed rule I would expect a final
15 rule, and at that point I would also ask for a reasonable
16 implementation period in order to make any changes.
17 MR. HARRISON: Thank you. And Dr. Lin comes forward.
18 Is Paul Estes available? You're on standby.
19 **EDWARD LIN, M.D.**
20 Good morning. I'm Edward Lin. I practice here in
21 Pleasanton, East Bay, and Bay Area. I also am with the
22 California Physical Medicine Rehab. I consider myself as a
23 first line injured worker care as a physician. In my
24 practice I see the worst injured workers, including city
25 workers, state workers, police officers, sheriffs, cooks,

1 firemen, nurses, just all. Among them a group of patients
2 to me is very special. Those patients essentially do not
3 know how to speak well English. They really have a hard
4 time and to name a few those are the patients who work in
5 the construction work, those are patients work in
6 restaurants, some of the patients that work in the service
7 providing to all of us. How to say I enjoy going to all the
8 nice restaurants in Bay Area. I hope you all do, but behind
9 those nice restaurants somebody is working. Somebody is
10 doing the job to keep this place stay running, so I really
11 hope that whatever proposal comes along will compromise so
12 we will be able to continue to provide service to those
13 injured workers, because a lot of them really have a hard
14 time. They don't speak English. Even if I try to tell them
15 specifically what to do they really require a lot of
16 explanation, and many time with interpreters, all of them
17 require interpreter. Sometime it's speaking my own
18 language. I talk to them in Chinese, or Portuguese, I speak
19 Portuguese as well. But again, my daily patients require
20 that they do not speak English, they require interpreter, so
21 they require, you know, those services that would provide by
22 giving them medication. We explain to them, tell them about
23 what possible risks, what complication, how to use it, and
24 so I think him it is this service that we can provide to the
25 injured worker, so I just hope that whatever regulation you

1 set you will preserve those assets. Thank you.

2 MR. HARRISON: Thank you, Doctor. As Mr. Estes comes

3 forward, Charles Smith? Mr. Smith, you're on standby. Thank

4 you.

5 **PAUL A. ESTESS**

6 Thank you for letting me speak. My name is Paul

7 Estes. I'm the administrator for the Bay Area Pain and

8 Wellness Center in Los Gatos, California. Our group

9 consists of 6 board certified pain management specialists, 2

10 psychologists, a marriage and family therapist, 3 physical

11 therapists, and 20 support staff. We are primarily a

12 community based practice, but by nature of our specialty we

13 see patients referred to us from centers all over northern

14 and central California. We serve approximately 7,000 active

15 patients at the moment, about 65% of whom are injured

16 workers. Our specific role is to accept referrals of the

17 worst cases of chronic pain that have been through really

18 every other type of care available and ultimately end up at

19 our door step referred by other physicians, nurse case

20 managers, insurance companies and attorneys. We see the

21 worst of the worst. Our physicians are used as consultants,

22 QMEs, as well as they serve as primary treaters, and all are

23 on the faculty at Stanford actively teaching at the pain

24 program there.

25 Our practice is unique in that our model is based on

1 an interdisciplinary approach which seeks to get patients
2 ultimately off the medications, back to work, and certainly
3 back to life. These patients generally come to us
4 completely wrecked, and our mission is to put them back
5 together. Our practice involves shifting responsibility
6 from the providers back to the patient to take
7 responsibility for their care, to take control of their pain
8 management. This includes conservative intervention, use of
9 intervential procedures, conservative use of medication.
10 With that said, the nature of our practice is we dispense a
11 very large volume of medications. We see this as both a
12 service to the patient, particularly those in the workers'
13 compensation system, and it's an important source of revenue
14 to our practice.
15 I think in some ways people -- the speakers today are
16 being too polite, because this really is about money. We
17 make a good margin on selling medications. In fact, it's
18 just the right amount of margin to offset the losses that we
19 incur in serving workers' compensation patients such that
20 we're able to break even in our clinic. I know it's
21 difficult to know what was in the mind of the person or
22 persons who created this initial regulation and the formula
23 that we're living with now, but my best guess is it was
24 somebody who understood the concept of cost shifting. That
25 is you're going to make us hold over here to offset the

1 losses that we incur in another part of serving this patient
2 population.
3 In our practice the ability to make a sizeable margin
4 is what offsets the equally sizeable loss. Even though we're
5 here to discuss a regulation regarding reimbursement for
6 medication, I would ask that you recognize that if you
7 change this part of the system in isolation, and fail to
8 create an offsetting source of revenue somewhere else in the
9 workers' compensation system, what do you imagine is going
10 to be the response of a practice like mine, or any other,
11 that has to some how find a way to keep itself whole? Do
12 you imagine that we could really absorb $100,000 a month
13 decrease in our revenues without some how dramatically
14 altering our practice model? The answer is no, we can't.
15 It appears that the proposed regulations really are
16 equal to crapping in a vacuum, and really disassociated from
17 the economics of a typical medical practice that's still
18 willing to serve workers' compensation clients. Physician
19 offices dispense to workers' compensation is foremost a
20 service to patients who really have difficulty accessing the
21 service elsewhere, and that's been addressed here. They
22 really can't obtain pharmacy access in their locale, or they
23 can't receive a timely access from the pharmacies in the big
24 box.
25 It's also good care. In our practice medications are

1 prescribed and refilled only after a dialogue with the
2 patient. We assess the patient's understanding of the
3 medicines they are taking, their compliance with the
4 medication regimen, their tolerance to the medication.
5 These are all assessed, and ultimately the medication is
6 placed in the patient's hand by a prescriber, a physician or
7 nurse practitioner. It is simply notwithstanding a dynamic
8 of putting a piece of paper in a patient's hand and sending
9 them over to the pharmacy where we have no control over what
10 that conversation is going to contain.
11 In-office dispensing also makes it financially
12 feasible for us to sustain a large percentage of workers'
13 compensation patients in our practice. Our practice is paid
14 less for seeing a patient in a clinic from the workers'
15 compensation system than it is for just about every other
16 payer with the exception of Medi-Cal. So in a practice like
17 ours, it's easy for us to adapt, and perhaps easier than
18 other practices to adapt to this change in regulation. We
19 just simply change our base of business. But I don't know
20 where those patients are going to go because, as I said, you
21 can't imagine that physicians are going to assume and absorb
22 a huge reduction in their compensation. They'll just find
23 another way. In our case we can find a way by changing our
24 mix.
25 My greatest concern is that in the dark under belly of

1 the workers' compensation system there's a group of players
2 who don't control their mix as the quality providers can.
3 My concern is that they're going to find some other way to
4 exploit injured workers to keep themselves whole.
5 We currently collaborate with a local pharmacy, as was
6 mentioned here, to fill prescription medications and to
7 compound a specific drug called Buprenorphine that we use to
8 weed patients off medications. The pharmacy has put us on
9 notice that they can't afford to take our referrals any
10 more, and they've asked us to either buy the medication from
11 them directly so we sell them to the patients, or simply
12 dispense the medication ourselves. So, it's an irony that
13 the proposal here is to shift all this business to
14 pharmacies when it really only appears that it's going to be
15 the large pharmacy chains that are going to be able to
16 absorb this business, and we know from experience that
17 they're not going to be able to provide the service that's
18 needed, nor are they going to be able to provide it in a
19 timely way.
20 We, like others that have spoken, have the same
21 problem with medications for depression, for example, and
22 what's not been said is this is a dangerous phenomenon.
23 These
24 patients -- you can't simply stop taking your depression
25 medication for 4 days while you wait for an authorization,

1 and that's exactly what happens to these patients. The
2 nurse case manager is out of town, the adjuster is not
3 available, and they're left for days having summarily
4 stopped the medication. That can cause seizures, that can
5 cause all kinds of problems. But that's what happens at the
6 retail chains.
7 It seems to me that the situation I described is the
8 potent of things to come; that only the large chains will be
9 able to absorb this book of business, and there's no
10 possibility that they will be able to provide service in the
11 way that the patients are going to require.
12 In conclusion, to me it would be more appropriate for
13 the Division of Workers' Compensation to consider it's
14 payment policy in a broader context. It would be less
15 disruptive and far more responsible to address the issues
16 that are essential to proceeding currently, that is adopting
17 regulations that simultaneously seek a pharmacy and
18 physician appropriately, and enable each to stick to their
19 divisional roles in a coherent system. That is adjust the
20 Official Medical Fee Schedule at the same time you adjust
21 the pharmacy reimbursement formula, and I think you'll avoid
22 the problems that I discussed. Thank you.
23 MR. HARRISON: Thank you, Mr. Estes. Is Paul Smith
24 available? Mr. Smith, if I may ask you before you begin,
25 will your comments be approximately 10 minutes or so?

1 MR. SMITH: Alright, I'll be nice and short.

2 **CHARLES SMITH**

3 I've been in this business for approximately 20 years,
4 and the present changes have been rapid and dramatic. This
5 particular one, as you heard from many providers, will
6 drive, especially the specialists, out of business. I
7 expect that particularly those that seek say 20 to 25% of
8 their business is workers' comp., they will not absorb this.
9 They are just going to leave. It's gotten so complex over
10 the years with preauthorizations, utilization review, and
11 all the other bureaucratic stuff -- they're having to hire
12 2, 3, 4 people to manage those issues -- and we're talking
13 providers on a daily basis. They're saying we're done.
14 They say if this does through -- yes, it has been cost
15 shifted so the PR2s, for example -- the $12.30 -- nobody can
16 handle paperwork for $12.30. The 725 on dispensing fee to
17 manage the payment is -- there's just not enough money
18 there, so they'll just stop, and when they stop those
19 patients have to go somewhere or they will -- their care
20 will drag out, and out, and out. Some you'll have an
21 increase -- increases in those patients' costs, and many of
22 them -- at some point people are just going to say just send
23 them to the ER and be done with it. And I really do expect
24 that to happen.
25 That payment process in the pharmacy is real and it's

1 90 days at a physician's office for the pharmacy. That
2 electronic handshake definitely helps out. At this point I
3 don't know if there's an easy way to manage an electronic
4 handshake, in a physician's office, but that's something I
5 recommend you should look at.
6 Lastly, I think that you do need to take into
7 account -- I know that this change occurred when pharmacy
8 and pharmacies said oh, we're not going to continue to do
9 this business, and in fact the pharmacy is, in fact,
10 providing work comp. patients their scrips. Physicians are
11 in a far different game. They -- first of all they are not
12 a large chain, so they can make very quick decisions and
13 with this significant hit on their margin I promise you many
14 of them will bail. Many of them are baby boomers, and they
15 are close to retirement already, and they're just going to
16 say we're done. So, I think the impact is going to be far
17 greater than what all of the regulations, CHSWC, and
18 research reports have stated. So -- thank you.
19 MR. HARRISON: Thank you, mr. Smith. Is their a Perry
20 Lewis available? Mr. Lewis, would you come forward now.
21 And, is Dr. Silva -- Dr. Silva, you're on standby.
22 **PERRY LEWIS**
23 Thank you, I promise not to take too long. I know
24 what hour is coming upon us here.
25 CARRIE EVANS: Yes, well, we were just discussing -- we

1 think because we have so many physicians here and others
2 that we'll try to just go straight through and not take a
3 lunch break, so that we don't keep people here longer than
4 necessary, if that's okay with everybody. So, if you need to
5 step out, feel free to, but we're going to just continue so
6 we can get to everybody and get you out of here at a decent
7 time.
8 PERRY LEWIS: Thank you for this opportunity to come in
9 front of the committee to speak. My name is Perry Lewis.
10 I'm with the Workers' Compensation Pharmacy Alliance, and we
11 submitted some comments earlier, so I'll make my remarks
12 very brief. I appreciate the opportunity to speak.
13 I'm one member of 4 members of this alliance that
14 contracts with pharmacies to process workers' compensation
15 prescriptions. We basically take the arduous process for
16 pharmacies that do not submit workers' comp. prescriptions
17 on their own, and we guarantee payment. So, if they submit
18 a prescription to one of our companies we guarantee that
19 they will get paid, and we take the process of trying to
20 make sure that the carriers and such, and that we will get
21 reimbursed. We represent companies such as Longs, Safeway,
22 Walgreens -- all the major chains and many of the
23 independents.
24 Today you heard a lot of people talking about the
25 issues at the pharmacy counter. Many pharmacists are not --

1 are still in the payment process of dispensing prescriptions
2 and that is true. A lot of the independents have not
3 decided to participate in the workers' comp. system since it
4 is so arduous, and the process is still not working very
5 efficiently.
6 However, part of the problem that we've seen is that
7 there's quite a vast difference between the Medi-Cal program
8 and the workers' compensation program. In the Medi-Cal
9 program when a prescription is dispensed at the pharmacy
10 level, the pharmacist knows immediately that the
11 prescription is going to get paid. It's online, real time,
12 adjudicated. In the workers' comp. environment, that is not
13 the case. So, they either contract with companies such as
14 one of the 4 member companies that we have, or they try to
15 process it on their own. And a huge -- this online
16 eligibility process when tied to Medi-Cal -- it's tied the
17 system down quite a bit where pharmacies are going to have
18 to make a decision are we going to continue to fill workers'
19 comp. prescriptions or not. I'm hearing also from the
20 physicians that they're going to have to make these
21 decisions on their own.
22 I'd like to reiterate some of the comments we
23 submitted earlier, that is that the WCAB supports the
24 general goal of the proposed regulation to better contain
25 costs for repackaged medications. We support parity in

1 reimbursement for workers' compensation prescriptions
2 regardless of the dispensing entity. However, parity is not
3 truly achieved with the proposed regulations, since
4 pharmacies who dispense medications will still be tied to
5 the Medi-Cal system, and repackaged medications will be
6 reimbursed at the average wholesale price of $17 plus
7 professional dispensing fee.
8 We encourage the WCAB -- the division to consider
9 adopting a workers' compensation specific fee schedule to
10 offer better stability and parity in the system. In your
11 own document today it states that the administrative
12 director has the ability to prescribe the fee schedule for
13 medical treatment. We submit that we would like the
14 administrative director and their staff to review the
15 various administrative fees for pharmacy and physicians to
16 have more parity within the system, and to deem a different
17 Medi-Cal so we have accessibility to the injured workers
18 either in the physician's offices or at the pharmacy. Thank
19 you very much.
20 MR. HARRISON: Thank you, Mr. Lewis. As Dr. Silva
21 comes forward, Michael Drobot on the box.
22 **I. SILVA, M.D.**
23 First of all, I thank the members of the committee for
24 allowing me to be here and speaking in front of you. I come
25 wearing various hats. I'm an orthopedic surgeon, I run

1 industrial medical clinics. I have 7 industrial medical
2 clinics. I used to be the past owner of a small community
3 hospital in Paris which we closed. I was the owner of that
4 hospital for about 10 years and I saw happening at that time
5 what's happening now to the system that forced me to close
6 that hospital, and that's the decreased reimbursement rates.
7 It left a community totally uncared for. We had mayors and
8 councilmen calling us. Dr. Silva why are you closing the
9 hospital? Why are you doing this? And the reason is
10 decreased reimbursements working in the Medicare and
11 Medi-Cal system, and under Medi-Cal, and it didn't work.
12 You saw what's happening with the independent
13 hospitals, and a lot of hospitals leaving the State of
14 California, selling out their hospitals 5 or 6 at a time,
15 because they can't make it on the Medi-Cal system, and they
16 can't take the burden of caring for these patients on an
17 emergency basis uncared for.
18 I move the scenario now to the workers' comp. arena.
19 I have over 200 employees, and we run a very clean
20 organization. We have never been on the plaintiff side.
21 We've always been sort of caring for the patients, the
22 employers from American Express to American Airlines, to
23 Pepsi Cola, etc. We have an interest in both the employer,
24 the patient, and the insurance company in play. We've never
25 gone and done anything that we charged for -- Xanax -- $300

1 for Soma. We've always taken a fair profit. Right now our
2 system has gone to the point where we're looking at our
3 whole organization and saying if this system gets in there
4 I'm going to close offices and we're going to leave care
5 undone.
6 I happen to also be Hispanic. I don't look Hispanic,
7 but we care for -- about 75 to 80% of our patient load is
8 Hispanic, okay, and we're in big cities. We're in Ontario,
9 Anaheim, Lakewood, Temecula, Paris, and we can't -- when we
10 write a prescription to these -- in these big cities that --
11 they are not New York City where I grew up, in the Bronx,
12 but they're certainly not small cities -- I give my patients
13 and invariably over 80% come back saying they don't fill it.
14 I'm going to give you key points on some of the
15 patients we've taken care of from an orthopedic standpoint
16 where we saved money to insurance companies that we can't do
17 anymore. A patient comes in with an amputated finger.
18 Okay, we have our med doctors -- and our med doctors don't
19 make a lot of money. They make $60 an hour, $65 an hour. I
20 pay more to the electricians and plumbers that come in and
21 take care of our toilet problems than we do for the doctors,
22 and that's because, again, decreased reimbursement. These
23 decreased reimbursements happened since 1986 when I first
24 came in the field where for a shoulder surgery, you know, we
25 got paid $4200, $4800 for it, and the assistant got paid

1 $1700. Now, I get paid $1700 to do that case and there is
2 no assistant. So this is 1986, 20 years later and we're
3 making about one-third of what we were doing, so these other
4 cost centers in there help us.
5 I happen to also be a physical therapist. That's how
6 I got into the field of orthopedics. We lost the
7 reimbursements on physical therapy because about 60% of our
8 patient reimbursements are now being cut because of the
9 SB899, and what's happened there, basically, is the 24
10 visits, and the 24 visits really doesn't, you know, allow us
11 to make really any money on physical therapy. But, the real
12 important thing is my patients are not getting the care that
13 they need.
14 We're sitting there. I have in our organization 27
15 providers, 2 of them sit on pay review committees, and one
16 of them sits on the COA Committee, okay, and we have a
17 tremendous problem, and even though 2 of our doctors were
18 review doctors for insurance companies, and again, I gotta
19 tell you, we don't do plaintiff medicine. Everything we do
20 is authorized. We sit there and we wait for patients to get
21 authorization on medicine. Let me go back to that original
22 point. We got a patient with an amputated finger, bone
23 exposed. We save the insurance company, we save the patient
24 time, we give good care, we have like almost a zero
25 infection rate. When we do these in our office we charge

1 one-third or one-quarter of the price that it would cost on
2 there, but what we expect is the back-up from this board to
3 give us the ability to provide the care that that patient
4 needs all the way through. What does that mean? Once I
5 fix, or one of my associates has fixed the finger, okay, and
6 the exposed bone, we've got bacteria exposure. Now we go
7 ahead and give the patient some medicines, Duracef, Keflex,
8 whatever. We cannot now dispense under the new law if it
9 comes into place. We can't dispense that medicine to them.
10 So, what do we do? We write a prescription. They go to the
11 pharmacy, and they can't get the prescription filled. This
12 is 2, 3, 4 days. If you ever heard the term osteomyelitis--
13 if a patient gets an infection in the bone it can be long
14 lasting, and that thing can last for weeks, and now we turn
15 the care that for whatever the cost of that medicine is,
16 whether it's $100, $50, you now extended that patient's care
17 for 6 weeks of IV therapy and possibly getting him admitted
18 to the hospital. Those are the things that I saw in our
19 hospital system that we eventually closed, because we
20 couldn't take the burden of the Medi-Cal patient coming in
21 because we couldn't care for them. It was to expensive. So
22 I closed the hospital because we were losing money, and
23 that's why so many different little hospitals are closing,
24 and even the big chains, Denton, Columbia, they're closing
25 and leaving the State of California because the monies are

1 not there.

2 I wanted to thank you guys for the opportunity to make
3 some of these points I had. I had a couple other points and
4 then I'll end it. One of the big problems that I also see
5 in the system is that, you know, the workers' comp system we
6 already know. I published several papers, etc. in the past,
7 and we know as orthopedic surgeons -- I'm taking off my
8 industrial hat, I'm not wearing my hospital hat -- we know
9 that -- and one of the lawyers on the plaintiff side said
10 that we know that on the workers' comp. side there's about a
11 20% dissatisfaction rate when we take it compared to
12 insurance patients; i.e. if I do a shoulder surgery, or neck
13 surgery, or whatever on a private patient, and say shoulder
14 surgery is about 92 to 95% effective rates, this is across
15 our entire board of the American Academy of Orthopedic
16 Surgeons, there's about a 20% decrease in the ultimate
17 result of workers' comp. patients. Now there's a lot of
18 people in this room that'll say what is this all about? Is
19 it secondary gain? Is it because they're upset with the
20 insurance company? Is it because they're upset with
21 somebody, or is it because that's the only system now that
22 they have left to gain something because they just lost
23 their job? These people depend on their jobs. They may
24 have lost the ability to take care of their families, so now
25 the result is 20% less. As one of the lawyers said now when

1 you start denying their care in terms of not giving them the
2 medicine etc. they need, what's going to happen? That 20%
3 is going to drop to 25, 30% or something. I have no idea
4 what that would be, but you're certainly going to have more
5 litigated cases. The expense is going to go up. We already
6 are looking at the fact that, you know, it costs me around
7 $10,000 a month to keep each office open overnight. We're
8 just going to shut down at night. What does that mean?
9 That means when we charge that patient to come in the middle
10 of the night a hundred dollars, do you think any emergency
11 room is going to charge $100 to take care of any patient in
12 the middle of the night? So, therefore your increase is
13 going to go there.
14 You have not looked at your people on the ground
15 level. A lot of the people speaking here are orthopedists.
16 I happen to be an orthopedist, but you haven't looked at the
17 Oc-Med clinics. I think U. S. Health Works spoke a little
18 while ago, but the big thing that I see is you're going to
19 deny care not only to patients as a whole during the
20 daytime, but you're going to deny care in the evening time
21 when a lot of the industrial clinics -- and and I'm talking
22 not 10, 15, but 30, 40 different clinics, okay. Through the
23 various means that I have throughout the counties out here,
24 a lot of them have closed their hours and basically said
25 we're not going to provide care at night. The patients are

1 going to go somewhere else, and that's because we don't have
2 these costs centers to help us defray some of the costs, and
3 I'll stop right here. Thank you.
4 MR. HARRISON: Thank you. We have Michael Drobot
5 coming forward.
6 (Pause in proceeding.)
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1 **MICHAEL R. DROBOT**

2 MR. DROBOT: It looks like it's good afternoon now.
3 I want to reiterate what every speaker has said, that we
4 appreciate your time here today.
5 I represent a company called California Pharmacy
6 Management. We represent hundreds of physicians in the
7 workers' comp industry, some of which dispense medications
8 from point of service. These groups include Kerlan Jobe
9 Orthopedics out of Los Angeles; Southern California
10 Orthopedic Institute, which has seven offices and over 50
11 treaters, as well as individual single practices in
12 Bakersfield and Fresno and Salinas areas that provide almost
13 100 percent of the workers' compensation industry in that
14 area.
15 We have presented our discussion topics to the Board.
16 We have been presenting this to the legislature for a couple
17 of years, and I just want to point out a couple issues. The
18 first that you've heard several presenters mention the lack
19 of access that will happen if this fee schedule is reduced
20 to a Medi-Cal rate, I want to emphasize that this is not
21 conjecture. This is not hearsay. The leaving of work comp
22 for a physician or going to another state is real. This has
23 happened in several states, for example, in Florida where
24 the state government recreated a fee schedule that was so
25 low, comparable to Medi-Cal, that physicians in the work

1 comp industry, up to 40 percent, left the state, left the
2 industry in turmoil and has changed that fee schedule some
3 three times since the late '90s to get it back to an
4 AWP-based system that works.
5 I have heard several people here mention that 83
6 percent of AWP seems reasonable and fair. We have presented
7 this to both the legislature and the administration who have
8 told us in the past that they do not like an AWP-based
9 system for two reasons, one because there are some
10 physicians that have gamed the system by overutilization.
11 Since 2004, the ACOEM guidelines and AOE/COE reviews have
12 curtailed this greatly, if not completely. Also, there are
13 repackagers in the state and other states that dispense --
14 that distribute their medications in California that also
15 game the system with their excessively high AWPs, some of
16 which that are above that of the brand. We have proposed to
17 take care of that, to tie the AWP back to the levels in 2004
18 where this was deemed reasonable.
19 The largest insurance company for workers'
20 compensation in the State of California is State Comp
21 Insurance Fund. They currently have adopted this level of
22 83 percent of AWP across the board. They're paying at this
23 level. They have deemed it reasonable, and we believe that
24 this will keep not only access to injured workers, it will
25 keep physicians back in the system, but it will also

1 accomplish the intent of SB 228 and 899 which was to reduce
2 the fee schedule by 35 to 45 percent, thus saving a minimum
3 of $500 million out of the system.
4 We believe this is a win-win-win system. I am hoping
5 that the Board in front of me considers this and, if there
6 are further reasons why they think that this system doesn't
7 work, doesn't accomplish the goals or still allows people to
8 game the system, I would love the opportunity to try to
9 address a system that will be failsafe and accomplish your
10 intent.
11 Thank you.
12 (Pause in proceedings.)
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DOLPHUS PIERCE

My name is Dolphus Pierce, and I'm here -- I manage a variety of different types of clinics. One of them are rural health care clinics, which are family-funded clinics for Medi-Cal, and we do get a higher reimbursement rate than what they get for regular Medi-Cal patients.

Rural health care clinics are usually set up in areas where no other people want to practice. The Central Valley has, from what I read in the AMA journal, about one doctor for every three doctors, compared to LA and San Francisco, because it is an undesirable area. We market sometimes up to six months to get one provider to come, and we pay them sometimes 40 to 50 percent more to come to our area than what they can get in LA and San Francisco. Inherently, when they come to our town and they see where we're at, they usually just say, "No thanks. You know it sounds like a lot of money, but I don't want to live in this type of an area."

So in our towns -- and I know a lot of my friends have rural clinics, since that's what we do -- we get to know each other. There are only a few rural clinics left after the new laws that will actually even see a work comp patient. I have -- one friend of mine, he has eleven clinics in small towns such as Exeter. Sometimes he's the only provider in the town. About two months after the new laws came and he got the negative letters on how he wasn't

1 treating the patients properly, he stopped seeing in all 14
2 clinics. By him doing that, in some of the towns, those
3 patients had absolutely no place to go because he does not
4 see them. They come in, and they can be a patient there for
5 20 years, but if they are a work comp patient, he won't see
6 them. There are a few of us left that have rural clinics.
7 Even though we get a high reimbursement from Medi-Cal, we
8 kind of feel we're the only ones left that takes these
9 patients. I can tell you that we won't take them anymore.
10 We get good reimbursement from Medi-Cal, but in order
11 to do all the paperwork, like I heard someone else speaking
12 earlier, we have a lot of paperwork that has to be tracked
13 for the workers' comp patients. Again, in our area, a lot
14 of people will -- they don't really have a choice of where
15 to go. We're the only clinic left. Without us there --
16 we've always felt obligated with the new rules to keep on
17 treating patients even though the therapy isn't getting paid
18 for anymore. We get a huge number of denials.
19 A good -- a patient we have fell off a cotton --
20 14-foot cotton -- where they throw the cotton in when the
21 cotton bale doesn't get all the cotton. He fell off. The
22 farmer sent him to us. He got denied. That patient got
23 denied even though their person drove him to our office. So
24 if that person is denied, he has nowhere else to go. We
25 treated him, and our office does dispense medications.

1 That's a patient that will never get authorized in a
2 pharmacy.
3 And that goes to my next point of pharmacies. In our
4 area, two of our three clinics -- there is no pharmacy in
5 the town. They don't have a place to go to the pharmacy.
6 In order for them to get to the pharmacy, they have to pay
7 what's called a ride-a-dero. That's what the English people
8 call it. That's the best translation that I can say. What
9 that is is people who don't have jobs, but they have a car,
10 and they will give this person a ride to the nearest town
11 for future help. Since our office is in a rural setting --
12 that's why we got this federal rural status. All of our
13 patients fall into that.
14 One of the towns, I think, 97 point something percent
15 are below the poverty level. So they are very poor people.
16 For them to save up this money to get to go to the
17 orthopedic or the neurologist, it's a lot of money for them
18 to pay the 50 or $60 to go to Fresno, which is 75 miles
19 away, to get this done. Now they are going to have to go to
20 another town and pay these guys $50 to get the medications.
21 They are not going to get to go. They can't afford it.
22 They've lost their jobs. They have three or four kids.
23 Their wife doesn't work. They are living in small
24 apartments, usually Medi-Cal. These people are going to
25 have a great difficulty getting into a pharmacy that doesn't

1 exist.

2 One of my towns -- we do have a pharmacy, but they

3 just laugh. They said, "We would never take workers' comp.

4 Why would we want to do that?" So even though there is one

5 small pharmacy -- it's a local pharmacy that's been there

6 for many years. That person won't take workers'

7 compensation. He's let us know that. It doesn't matter if

8 you can go to a Long's or not. There is not one within 45

9 miles of our area. So that's just nonexistent.

10 So, again, I can give you lists of doctors that I know

11 don't see workers' comp in these clinics, and I can just

12 tell you that we will be the next one that will stop because

13 we're not going to do all this paperwork and have the

14 patients complaining to us how come they are not getting

15 better, how come we can't get referrals for them, how come

16 their case is taking three to five years to make it through

17 the court system. We have to monitor these people for

18 years, not days, sometimes, like this person who fell off

19 this cotton thing. So it isn't going to be worth our time

20 to continue to deal with that if we don't get some sort of

21 reimbursement. We can't afford to sit there and buy these

22 medications and give them to them and maybe wait months or

23 years -- who knows when we're going to get paid for them.

24 If we're going to get paid less than what we paid for them,

25 it really is business sense. It's just not something we're

1 going to do.

2 That's the majority. I have a lot of issues, but it

3 sounds like the majority of these people have really went

4 over a lot of them. The other one is I am partners with an

5 orthopedic surgeon, and he wanted me to come to this meeting

6 because we are planning to close our business. It's a

7 bigger town, but if we go to a Medi-Cal fee schedule -- I'm

8 not like some of these people that brought their financial

9 statements, but I can tell you that we've looked at the

10 numbers and we cannot be in business. We'll have to close.

11 So thank you.

12 MR. HARRISON: Thank you, Mr. Pierce.

13 Is there anyone here who indicated that they wished to

14 give testimony that has not had an opportunity? Yes, sir.

15 Would you come forward at this time. Would you, if you will

16 please, give a business card and let us know your name

17 please.

18 **ROBERT L. WEINMANN, M.D.**

19 One of the things that I have always managed to do

20 throughout 20 years of political involvement is to manage to

21 forget my business cards, but I do have this statement that

22 I'm going to use. And the other thing I've learned in

23 20 years of political action is if I'm going to speak for

24 less than five minutes, why not tell you at the beginning so

25 you can all be grateful.

1 My name is Robert Weinmann. I'm a
2 physician/neurologist, and I speak today on behalf of the
3 American Federation of -- AFSCME, American Federation of
4 State, County, and Municipal Employees, the Union of
5 American Physicians and Dentists, and the Union of American
6 Physicians and Dentists Independent Practice Association.
7 We have studied the submissions of the various people
8 who have presented material, and I think all of our points
9 have been made so I will not state them again. I will tell
10 you though that in the last few days, we had an interesting
11 occurrence. One of our doctors working in a correctional
12 setting got decked by a client who was doing one to 20,
13 probably for attempted murder, and sustained significant
14 injuries. These injuries were able to be repaired, and when
15 the surgical procedure was done, it was past 5 o'clock. It
16 was determined that he could be treated on an outpatient
17 basis and could go home and could take the prescription that
18 the doctor had and just have it filled. But it also turned
19 out that he lived in an out-of-the-way place where there
20 were no pharmacies. The doctor pointed out that it was not
21 a smart thing even for him as a physician to wait. This
22 prescription should be filled. Fortunately the doctor he
23 was seeing was able to prescribe and dispense from his
24 office in the workers' comp system, so he did so. It was an
25 interesting example that brought home to us very

1 significantly how important physician dispensing is. With
2 regard to this -- with regard to physician dispensing, we
3 feel that the best testimony you've had so far, because it's
4 so well balanced, so scholarly, and so well worked out, was
5 by Steven Cattolica, who presented you to a proposal dated
6 27 September 2006. So the AFSCME, UAPD, and the UAPDIPA is
7 going to stand by that document and say that is the document
8 that we support most. We think the figures in it are
9 reasonable. We recognize that they have used restraint when
10 they urge a minimum of $15 because we think that there are
11 other costs that should make it higher. Nonetheless, the
12 documentation in that report we think is the best, the most
13 reasonable, and we stand by it.
14 Thank you.
15 MS. NEVANS: Thank you.
16 MR. HARRISON: Thank you.
17 Is there anyone else who may have indicated or not
18 indicated that they wish to give testimony but did not do
19 so? Is there anyone who, after hearing this testimony,
20 wishes to give testimony? If not, then I shall turn it
21 over.
22 MS. NEVANS: Okay. Just a reminder, we will take
23 written testimony until 5:00 p.m. today. Then we'll go back
24 and review the testimony and see whether or not any
25 revisions need to be made in the regulations. If so,

1 they'll be posted on our web site for a comment period for
2 at least 15 days. Anything else?
3 MS. OVERPECK: That's it.
4 MS. NEVANS: Okay. I want to thank everybody for
5 coming today, and we couldn't do this regulatory process
6 without the input from so many people in the workers' comp
7 community. So I want to thank you.
8 MALE ATTENDEE: The date line --what was the date
9 line? We do plan on going out of business. They work very
10 hard for us to do that.
11 MS. NEVANS: These regulations won't be in effect by
12 December 1st.
13 MALE ATTENDEE: That's what your paperwork --
14 according to your paperwork, that doesn't give us really a
15 lot of time to let all our employees know they don't have
16 jobs.
17 MS. NEVANS: Yeah.
18 MALE ATTENDEE: Is there a date?
19 MS. NEVANS: It's really going to depend on how long
20 it takes us to go back. It depends how substantive any
21 changes that we could potentially make were, whether they
22 extended -- whether we need to have a 45-day comment period
23 instead. So we're still looking, you know, at least some
24 months into the future before anything would be in effect.
25 I'd say probably four months at the earliest.

1 MALE ATTENDEE: Can we get a list of all the
2 decision-makers on the panel? Will that be on the web site?
3 MS. NEVANS: Our names?
4 MALE ATTENDEE: Yes, those that are involved in the
5 decision.
6 MS. NEVANS: Well, the people that are involved in the
7 decision are me and the Chief Counsel and the Medical
8 Director.
9 MALE ATTENDEE: Okay. Thank you.
10 MS. NEVANS: Yes.
11 MALE ATTENDEE: Is the testimony that people gave
12 going to be available publicly, and how would we access
13 that?
14 MS. NEVANS: Yes. The transcript will put on our
15 web site and the -- will the written testimony also be on
16 our web site. Richard is saying --
17 MS. OVERPECK: First of all, the written comments that
18 have been sent in become part of our rule-making record, and
19 you can come and review the rule-making binders and read
20 those. We also summarize the comments and provide our
21 responses in a chart, and that is posted on the web site on
22 the rule-making page toward the end of the rule-making
23 process.
24 MALE ATTENDEE: Who else are you going to consult
25 with? Are you going to consult with anybody else to make

1 the decision?

2 MS. NEVANS: The decision is made between the Chief

3 Counsel, myself, and Medical Director.

4 MALE ATTENDEE: Nobody else?

5 MS. NEVANS: No.

6 MALE ATTENDEE: Okay.

7 MS. NEVANS: Yeah.

8 MALE ATTENDEE: The transcript -- do you have a sense

9 as to when that will be on the web site?

10 MS. OVERPECK: It's after the court reporters have an

11 opportunity to transcribe it. I think it usually takes

12 about -- less than a month.

13 MALE ATTENDEE: Okay. Thank you.

14 MS. NEVANS: Any other questions? We'll stay around

15 for a couple more minutes in case anybody wants to come up

16 and ask anything. Thank you.

17 (Thereupon, the hearing concluded.)

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