MINUTES OF MEETING
OF THE INDUSTRIAL COMMISSION OF ARIZONA
Held at 800 West Washington Street
Auditorium and Conference Room 308
Phoenix, Arizona 85007
Thursday, April 27, 2017 – 1:00 p.m.

Present:	Dale L. Schultz	Chairman
	Joseph M. Hennelly, Jr.	Vice Chair
	Scott P. LeMarr	Commissioner
	Robin S. Orchard	Commissioner
	Steven J. Krenzel	Commissioner
	James Ashley	Director
	Jason M. Porter	Chief Legal Counsel
	Melinda Poppe	Deputy Director
	Jacqueline Kurth	Medical Resource Office Manager
	Bob Charles	Legislative Affairs Chief / Public Information Officer
	Sylvia Simpson	Chief Financial Officer
	William Warren	ADOSH Director
	Brett Steurer	Compliance Officer
	Chris Brandon	Compliance Officer
	Devon Shaffer	Compliance Officer
	Kara Dimas	Commission Secretary

Chairman Schultz convened the Commission meeting at 1:00 p.m., noting a quorum present. He explained that the Commission meeting will be recessed after the second agenda item, regarding the Physicians' and Pharmaceutical Fee Schedule, after which the Commission meeting will resume in the third floor Commissioners' Conference Room for all remaining agenda items.

Public Hearing to accept comments and other information regarding the 2017-2018 Arizona Physicians' and Pharmaceutical Fee Schedule (Fee Schedule) established under A.R.S. § 23-908(B).

The following attendees addressed the Commission during the Public Hearing: Chic Older, Arizona Medical Association; Mark Greenfield; Scott Zeilinger, The Healthcare Group; Robert Holden, AAPA Networks; Cathy Vines, CopperPoint; Pete Wertheim, Arizona Osteopathic Medical Association; John Nassar; Cynthia Driskell, PTPN Arizona; Mike Miller, Kinect Physical Therapy; Michael H. Winer; Sara Sparman; Karen Ruiz and Pablo Ruiz, White Tanks Physical Therapy; Mark Hyland, STI PT & Rehab; Mark Osborn; Dianne McCallister, Express Scripts; Laura Markey; Darryl Engle; and Gerome Gibson.

A written transcript of the Public Hearing is attached hereto.

Chairman Schultz recessed the meeting at 2:40 p.m. The meeting reconvened at 2:55 p.m. in Conference Room 308. Also present was Clawson Williams with Snell & Wilmer.

Approval of Minutes of April 6, 2017 and April 13, 2017 Regular Meetings and April 6, 2017 Executive Session Minutes.

Vice Chair Hennelly moved to approve the Minutes of the April 6, 2017 regular session meeting and Commissioner LeMarr seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, and Commissioner Orchard voted in favor of the motion. Commissioner Krenzel abstained. The motion passed.

Vice Chair Hennelly moved to approve the Minutes of the April 13, 2017 regular session meeting and Commissioner Orchard seconded the motion. Chairman Schultz, Vice Chair Hennelly, and Commissioner Orchard voted in favor of the motion. Commissioner LeMarr and Commissioner Krenzel abstained. The motion passed.

Commissioner Orchard moved to approve the Minutes of the April 6, 2017 executive session meeting and Vice Chair Hennelly seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, and Commissioner Orchard voted in favor of the motion. Commissioner Krenzel abstained. The motion passed.

Consent Agenda:

All items following under this agenda item are consent matters and will be considered by a single motion with no discussion unless a Commissioner asks to remove an item on the consent agenda to be discussed and voted on separately. The Commission may move into Executive Session under A.R.S. § 38-431.03(A)(2) to discuss records exempt by law from public inspection. Legal action involving a final vote or decision shall not be taken in Executive Session. If such action is required, then it will be taken in General Session.

a. Approval of Proposed Civil Penalties Against Uninsured Employers.

1.	2C16/17-0778	Azelite Logistics, LLC, dba Moving Buddies
2.	2C16/17-1937	Brute Machinery Independent, LLC, fna Baker Machinery, Inc.
3.	2C16/17-1234	Legacy Mortgage and Investment Corporation, dba Legacy Lending USA
4.	2C16/17-1161	Triscape Landscaping and Sprinklers, L.L.C.
5.	2C16/17-1573	Woodys Tire Center Inc.

b. Approval of Requests for Renewal of Self-Insurance Authority.

1. ABF Freight System, Inc.
2. MTD Southwest, Inc.
3. The Home Depot, Inc.

Chairman Schultz noted the significant improvement in the experience modification rating for ABF Freight Systems, Inc.

Vice Chair Hennelly moved to approve the items on the Consent Agenda and Commissioner LeMarr seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Discussion and Action of Arizona Division of Occupational Safety and Health Proposed Citations and Penalties.

Chairman Schultz discussed the purposes and processes involved in the Commission's consideration of ADOSH citations and proposed penalties.

Far West Supply, Inc.
3337 W McDowell Rd
Phoenix, AZ 85009

Complaint
Years in Business: 33
Empl. Covered by inspection: 3

Site Location: 3337 W McDowell Rd
Phoenix, AZ 85009
Inspection No: D2289-1208753
Inspection Date: 01/31/2017

SERIOUS – Citation 1 - Item 1 –

a) 6337 W McDowell Rd, Phoenix, AZ 85009: Exit routes were not arranged so that employees will not have to travel toward a high hazard area, unless the path of travel is effectively shielded from the high hazard area by suitable partitions or other physical barriers. (29 CFR 1910.37(a)(2)).

b) 6337 W McDowell Rd, Phoenix, AZ 85009: Exit routes identified by the facility emergency action plan were not free and unobstructed as materials and equipment were placed within exit routes and exit routes led to dead-end corridors. (29 CFR 1910.37(a)(3)).

c) 6337 W McDowell Rd, Phoenix, AZ 85009: Signs were not posted along the exit access indicating the direction of travel to the nearest exit and exit discharge when the direction of travel to the exit or exit discharge was not immediately apparent. (29 CFR 1910.37(b)(4)).

d) 6337 W McDowell Rd, Phoenix, AZ 85009: Each doorway or passage along an exit access that could be mistaken for an exit was not marked "Not an Exit" or similar designation, or be identified by a sign indicating its actual use. (29 CFR 1910.37(b)(5)).

e) 6337 W McDowell Rd, Phoenix, AZ 85009: Exit signage at the North entrance/exit door was not illuminated by a reliable light source. (29 CFR 1910.37(b)(6)).
Div. Proposal - $1,500.00 Formula Amt. - $1,500.00

SERIOUS – Citation 1 - Item 2 –

a) Chemical mixing area: The employer had 255 gallons of identified category 3 flammable liquids in containers outside of a storage room or storage cabinet. (29 CFR 1910.106(e)(2)(ii)(b)(2)).

b) Chemical mixing area: Flammable liquids were not drawn from or transferred into vessels, containers, or portable tanks within a building only through a closed piping system, from safety cans, by means of a device drawing through the top, or from a container or portable tanks by gravity through an approved self-closing valve. (29 CFR 1910.106(e)(2)(iv)(d)).

c) Chemical mixing area: Category 1 or 2 flammable liquids, or Category 3 flammable liquids with a flashpoint below 100 °F (37.8 °C), were dispensed into containers without the nozzle and container being electrically interconnected. (29 CFR 1910.106(e)(6)(ii)).
Div. Proposal - $1,050.00 Formula Amt. - $1,050.00

SERIOUS – Citation 1 - Item 3 –

a) Chemical mixing area: A written respiratory protection program was not established and implemented for employees using both a 3M half face-piece respirator model 5200, equipped with organic vapor cartridges, 3M part 6001 and a North full face-piece respirator model 5400, equipped with organic vapor and acid gas cartridges, that included a medical evaluation, fit testing, procedures for proper use, procedures for cleaning, training and procedures for evaluating the effectiveness of the program. (29 CFR 1910.134(c)(1)).

b) Chemical mixing area: A medical evaluation was not provided to determine an employee's ability to use both a 3M half face-piece respirator model 5200, equipped with organic vapor cartridges, 3M part 6001 and a North full face-piece respirator model 5400, equipped with organic vapor and acid gas cartridges, when mixing and transferring chemicals. (29 CFR 1910.134(e)(1)).

c) Chemical mixing area: Employee(s) were not fit tested prior to required, initial use of both a 3M half face-piece respirator model 5200, equipped with organic vapor cartridges, 3M part 6001 and a North full face-piece respirator model 5400, equipped with organic vapor and acid gas cartridges, when mixing and transferring chemicals. (29 CFR 1910.134(f)(2)).

d) Chemical mixing area: Both a 3M half face-piece respirator model 5200, equipped with organic vapor cartridges, 3M part 6001 and a North full face-piece respirator model 5400, equipped with organic vapor and acid gas cartridges, were not stored to protect them from damage, contamination, and dust. (29 CFR 1910.134(h)(2)(i)).

e) Chemical mixing area: Employee(s) who were required to wear either a 3M half face-piece respirator model 5200, equipped with organic vapor cartridges, 3M part 6001 and a North full face-piece respirator model 5400, equipped with organic vapor and acid gas cartridges, were not trained on respiratory protection elements outlined in section (i)-(vii). (29 CFR 1910.134(k)(1)).
Div. Proposal - $600.00 Formula Amt. - $600.00

SERIOUS – Citation 1 - Item 4 –

a) Chemical mixing area: The employer did not perform initial monitoring to determine each employee's exposure to methylene chloride. (29 CFR 1910.1052(d)(2)).

b) Chemical mixing room: Employer did not provide personal protective equipment that was resistant to methylene chloride when employees handled and mixed methylene chloride. (29 CFR 1910.1052(h)(1)).

c) Chemical mixing area: The employer provided respirators to employees that were not appropriate to the hazard for which employees were exposed. (29 CFR 1910.134(d)(1)(i)).

d) Chemical mixing area: An emergency eyewash station providing 15 minutes of continuous water flow was not available to employees who work with corrosive chemicals such as 99% monoethanolamine, 20% ammonium hydroxide, caustic soda granules and toxic methylene chloride. (29 CFR 1910.151(c)).
Div. Proposal - $1,500.00 Formula Amt. - $1,500.00

SERIOUS – Citation 1 - Item 5 –

a) Chemical mixing area: A written hazard communication program had not been developed and implemented at the job site for employees who were potentially exposed in the workplace to hazardous chemicals, materials, and/or substances such as such as methylene chloride, monoethanolamine, glycol ether, and xylene when mixing and packaging chemicals. (29 CFR 1910.1200(e)(1)).

b) Chemical mixing operations: The employer did not ensure that each container of hazardous chemicals such as methylene chloride, monoethanolamine, glycol ether, and xylene in the workplace were labeled, tagged or marked with the information required by 29 CFR 1910.1200(f)(1)(i) through 29 CFR 1910.1200(f)(1)(v). (29 CFR 1910.1200(f)(6)(i)).

c) Chemical mixing area: The employer did not have updated Safety Data Sheets (SDS) for each hazardous chemical in use and as a chemical producer did not develop SDS's for products. (29 CFR 1910.1200(g)(1)).

d) Chemical mixing area: Employees were not provided effective information and training as specified in 29 CFR 1910.1200(h)(1) and (2) on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard was introduced in. (29 CFR 1910.1200(h)).

Div. Proposal - $1,050.00 Formula Amt. - $1,050.00

TOTAL PENALTY - $5,700.00 TOTAL FORMULA AMT. - $5,700.00

Mr. Warren summarized the citations and proposed penalties and reviewed the photographs.

Commissioner Krenzel and Mr. Warren discussed the timeline for the abatement process.

Commissioner Orchard and Mr. Schaffer discussed abatement efforts made by the company. Commissioner Orchard commended ADOSH on its report and groupings.

Commissioner Orchard and Mr. Warren discussed exit route access, the type of chemicals in use, inadequate personal protective equipment, and incorrect labeling of chemicals.

Commissioner Orchard and Mr. Shaffer discussed the proposed penalties and the amount of abatement that will be required.

Commissioner LeMarr and Mr. Schaffer discussed the operations of the business, the company's use of propane tanks, and the nature of the identified hazards.

Vice Chair Hennelly commended ADOSH on the report and groupings. Vice Chair Hennelly, Mr. Schaffer, Mr. Warren, and Commissioner LeMarr discussed the number of employees at the worksite, who the employees worked for, and the legal status of the employees.

Commissioner LeMarr moved to approve the citations and proposed penalties as presented and Commissioner Krenzel seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Desert Floor Coatings, Inc.
3337 W McDowell Rd
Phoenix, AZ 85009

Unprogrammed Related
Years in Business: 25
Empl. Covered by inspection: 4

Site Location: 3337 W McDowell Rd
Phoenix, AZ 85009
Inspection No: D2289-1208755
Inspection Date: 01/31/2017

SERIOUS – Citation 1 - Item 1 –

a) Remote job sites: Personal protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, was not provided, used, or maintained in a sanitary and reliable condition it was necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation, or physical contact. (29 CFR 1926.95(a)).

b) Chemical mixing area: An emergency eyewash station providing 15 minutes of continuous water flow was not available to employees who work with corrosive chemicals such as monoethanolamine, ammonium hydroxide, caustic soda granules, various epoxies and toxic methylene chloride. (29 CFR 1910.151(c)).
Div. Proposal - $1,050.00 Formula Amt. - $1,050.00

SERIOUS – Citation 1 - Item 2 – Remote job sites: The employer did not perform initial monitoring to determine each employee's exposure to methylene chloride. (29 CFR 1910.1052(d)(2)).
Div. Proposal - $1,500.00 Formula Amt. - $1,500.00

SERIOUS – Citation 1 - Item 3 –

a) Remote job sites: A written hazard communication program had not been developed and implemented at the job site for employees who were potentially exposed in the workplace to hazardous chemicals, materials, and/or substances such as such as methylene chloride, monoethanolamine, xylene, and various epoxies when stripping and applying flooring.
(29 CFR 1910.1200(e)(1)).

b) Remote job sites: Employees were not provided effective information and training as specified in 29 CFR 1910.1200(h)(1) and (2) on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard was introduced in. (29 CFR 1910.1200(h)).

c) Remote job sites: The employer did not have updated Safety Data Sheets (SDS) for each hazardous chemical in use.
(29 CFR 1910.1200(g)(1)).

d) Remote job sites: The employer did not ensure that each container of hazardous chemicals such as methylene chloride, monoethanolamine, xylene, and various epoxies when stripping and applying flooring in the workplace were labelled, tagged or marked with the information required by 29 CFR 1910.1200(f)(1)(i) through 29 CFR 1910.1200(f)(1)(v).
(29 CFR 1910.1200(f)(6)(i)).
Div. Proposal - $1,050.00 Formula Amt. - $1,050.00

TOTAL PENALTY - $3,600.00 TOTAL FORMULA AMT. - $3,600.00

Mr. Warren discussed the relationship between Far West Supply, Inc., and Desert Floor Coatings, Inc. He summarized the citations and proposed penalties and discussed the photographs.

Commissioner Krenzel, Mr. Warren, and Commissioner Orchard discussed whether ADOSH has authority to close a business when a serious hazard exists. Chairman Schultz discussed the inspection and citation process and the Commission's emphasis on prompt abatement.

Commissioner LeMarr discussed the number of employees and the size discount. Commissioner LeMarr and Mr. Warren discussed the nature of the chemical hazards present at the worksite.

Chairman Schultz and Mr. Porter discussed the ability of the Commission to cite an employer for failure to abate.

Commissioner LeMarr moved to approve the citations and proposed penalties as presented and Vice Chair Hennelly seconded the motion. Commissioner Orchard noted she was inclined to increase the proposed penalties. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Discussion, Action, and Potential Resolution regarding Proposed Rulemaking to A.A.C. R20-5-602 to adopt the revised Federal Occupational Safety and Health standards included in Final Rule titled "Walking-Working Surfaces and Personal Protective Equipment (Fall Protection Systems)."

Mr. Warren summarized the proposed rulemaking related to A.A.C. R20-5-602 to adopt the revised Federal Occupational Safety and Health standards included in Final Rule titled "Walking-Working Surfaces and Personal Protective Equipment (Fall Protection Systems)." He noted that the Governor's Office had authorized the Commission to proceed with the proposed rulemaking. He recommended that the Commission direct ADOSH to initiate the rulemaking process.

Commissioner Orchard moved to authorize ADOSH to proceed with the proposed rulemaking to A.A.C. R20-5-620 and Commissioner Krenzel seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Discussion, Action, and Potential Resolution regarding Proposed Rulemaking to A.A.C. R20-5-601 and A.A.C. R20-5-602 to adopt the revised Federal Occupational Safety and Health standards included in Final Rule titled "Occupational Exposure to Respirable Crystalline Silica; Correction."

Mr. Warren summarized the proposed rulemaking related to A.A.C. R20-5-601 and A.A.C. R20-5-602 to adopt the revised Federal Occupational Safety and Health standards included in Final Rule titled Occupational Exposure to Respirable Crystalline Silica; Correction." He noted that the Governor's Office had authorized the Commission to proceed with the proposed rulemaking. He recommended that the Commission direct ADOSH to initiate the rulemaking process.

Commissioner LeMarr reiterated his opposition to OSHA's Final Rule titled "Occupational Exposure to Respirable Crystalline Silica." He discussed the fiscal impact of the Final Rule on industry, especially in the construction industry.

Mr. Porter and Chairman Schultz discussed the scope of the proposed rulemaking.

Vice Chair Hennelly moved to authorize ADOSH to proceed with the proposed rulemaking to A.A.C. R20-5-601 and R20-5-602 and Commissioner Krenzel seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion. Commissioner LeMarr voted against the motion. The motion passed.

Discussion, Action, and Potential Resolution regarding Proposed Rulemaking to A.A.C. R20-5-601 and R20-5-602 to adopt the revised Federal Occupational Safety and Health standards included in Final Rule titled "Occupational Exposure to Beryllium".

Mr. Warren summarized the proposed rulemaking related to A.A.C. R20-5-601 and R20-5-602 to adopt the revised Federal Occupational Safety and Health standards included in Final Rule titled "Occupational Exposure to Beryllium." He noted that the Governor's Office had authorized the Commission to proceed with the proposed rulemaking. He recommended that the Commission direct ADOSH to initiate the rulemaking process.

Commissioner Orchard, Mr. Warren, Commissioner LeMarr, Chairman Schultz, and Mr. Porter discussed the impact of the Final Rule on Arizona businesses and the anticipated costs associated with the new standard.

Commissioner Orchard, Mr. Warren, Mr. Ashley, and Mr. Porter discussed the rulemaking process, the timeline for the rulemaking process, the obligation of the Commission to adopt standards that are at least as effective as OSHA standards, and efforts to monitor Federal changes to any of the Final Rules.

Commissioner Orchard moved to authorize ADOSH to proceed with the proposed rulemaking to A.A.C. R20-5-601 and R20-5-602 and Vice Chair Hennelly seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Discussion and/or action regarding Industrial Commission goals, objectives and key initiatives for 2016. This Agenda Item may include discussion regarding the Commission budget and review of Division, Department, and Section specific objectives.

Mr. Ashley updated the Commission on the usage of on-line services and fillable forms.

Mr. Ashley updated the Commission on the State's employee engagement survey and the agency's high response rate.

Mr. Ashley discussed the formation of a new alliance of homebuilders, which will include many Arizona homebuilders. He expressed appreciation for Connie Wilhelm, President of Central Arizona Homebuilder's, and Jackson Moll, their Government Affairs Representative, for their support of the Commission and the new alliance. Chairman Schultz noted that he believed the new alliance is the first in the nation and is evidence of the collaborative efforts the Commission is making to work with industries to promote self-regulation, sharing of best practices, and improve the culture of workplace safety.

Announcements, Scheduling of Future Meetings and Retirement Resolutions.

Chairman Schultz and Ms. Dimas discussed the upcoming Commission meeting schedule.

Mr. Ashley reminded the Commission of the upcoming trip to Sierra Vista on May 24 and 25.

Public Comment.

There was no public comment.

Commissioner LeMarr moved to adjourn and Vice Chair Hennelly seconded the motion. Chairman Schultz, Vice Chair Hennelly, Commissioner LeMarr, Commissioner Orchard, and Commissioner Krenzel voted in favor of the motion and the meeting was adjourned at 3:55 p.m.

THE INDUSTRIAL COMMISSION OF ARIZONA

By _____
James Ashley, Director

ATTEST:

_____
Kara Dimas, Commission Secretary

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

2017 FEE SCHEDULE PUBLIC HEARING

Phoenix, Arizona
April 27, 2017
1:00 p.m.

APPEARANCES:

Dale Schultz, Chairman
Joseph Hennelly, Jr., Vice-Chairman
James Ashley, Director
Scott LeMarr, Commissioner
Robin Orchard, Commissioner
Steven Krenzel, Commissioner
Jason Porter, Chief Legal Counsel
Jacqueline Kurth, MRO Program Manager

Prepared by:
Deborah L. Wilks, RPR
Certified Court Reporter
Certificate No. 50849

(ORIGINAL)

Phoenix, Arizona
April 27, 2017
1:00 p.m.

P R O C E E D I N G S

MR. SCHULTZ: I'd like to call this meeting of the Industrial Commission of Arizona to order, and I'd like to start our meeting with the pledge of allegiance.

Welcome to the 2017/2018 Fee Schedule hearing. This hearing is being held to give you, the regulated community, an opportunity to comment on the 2017/'18 fee schedule recommendations and to submit your own recommendations for changes to the fee schedule. In just a few moments, Jackie Kurth, the manager of the Medical Resource Office, will provide a brief overview of the staff report, which has been available for review online on the Commission's website. Those wishing to speak may do so by filling out a speaker's sheet, which we have plenty of here, but there is plenty more, so feel free. We would like to hear from as many of you as we can.

I'll call each speaker up to the podium. At the beginning of your comments and for the record please identify who you are and who you represent. You

will have approximately five minutes to address the Commission. At the conclusion of your comments the Commissioners and staff may ask you questions. In the interest of time, please do not repeat what other speakers have stated. If you agree with what they have said, simply state such. To allow people the opportunity to respond to comments made by others, the record will remain open for an additional 10 business days, which will be until the close of business on May 11, 2017. Copies of written comments received before today's hearing have already been posted online. Comments received through today's hearing will also be posted online on the Commission's website. Again, anyone wishing to respond to comments that they have heard today or written comments that are posted online need to do so before the close of the record on May 11th.

With that, Jackie, let's start with a review.

MS. KURTH: Good afternoon, Chairman Schultz and Commissioners, and welcome, new commissioner. For the record, my name is Jacqueline Kurth. I am the manager of the Medical Resource Office at the Industrial Commission. I would like to thank the many stakeholders who have taken time to attend today's meeting.

And before we get started, I have to say I'm here with a very heavy heart. I have just learned that one of our members of the workers' compensation community has passed away today. That is Scott Houston, who is an attorney, who was my husband's business partner, and I am very, very sad, and I'm sorry to have to do this today, but I'm going to muddle through this, so bear with me, please.

I think it may be appropriate to provide a little history on how we got to where we are today with new methodology for the Arizona Physicians' and Pharmaceutical Fee Schedule. In 2013, the director of the Industrial Commission created a committee to assist in the evaluation of the current fee schedule development methodology and to identify potential improvements to the process. This committee included stakeholder representatives from the payer, pharmaceutical, and medical provider community. The committee unanimously agreed that any recommended changes must assure that the fee schedule remains relevant to Arizona and meets the needs of stakeholders and participants within the Arizona workers' compensation system.

To accomplish this, the committee studied various types of methodologies used by other states and

the development of their jurisdiction's fee schedules. The committee recommended the Commission hire a consultant to perform a study of the impact of moving to a resource-based relative value scale, or RBRVS. The RBRVS is used by many federal and state rate-setting authorities across the country and is the basis for the Medicare reimbursement. The committee felt this change would be successful if it was approached with an initial payment stabilization philosophy using Arizona-specific conversion factors, coupled with an annual inflationary update process.

In 2015, the Commission issued a request for proposal for an outside consultant to conduct a fiscal impact study to examine the implement -- sorry, guys -- implications of implementing an RBRVS-based fee schedule. Lots of tongue twisters today.

At last year's fee schedule hearing, we heard a presentation by Public Consulting Group, PCG, and learned that transitioning to an RBRVS-based reimbursement methodology presents many advantages to the Arizona workers' compensation system and the Industrial Commission. The RBRVS system provides a principled and rigorously tested system of reimbursement that was developed specifically for medical services reimbursement. It bases the

reimbursement on the resources required to provide services rather than cost or other factors.

Currently, the ICA fee schedule is influenced by seven separate states' workers' compensation fee schedules, four of which are using an RBRVS-based system. By transitioning to an RBRVS-based fee schedule, we are aligning the fee schedule with an accepted national standard that is widely used by federal and state rate-setting authorities, allowing the ICA to facilitate benchmarking and comparison to other workers' compensation fee schedules, reducing the administrative burden of the ICA's annual update and review, providing flexibility to tailor the fee schedule to the specific needs of Arizona's workers' compensation system, and increasing some reimbursement rates while decreasing others, resulting in a more balanced distribution of payments across the system.

On July 24th, 2016, the Commissioners approved the transition to an RBRVS-based fee schedule, and this brings us to where we're at today. The Commission has been working with PCG on transition to an RBRVS-based fee schedule. Although you probably can't tell by looking at the Excel file containing these changes, some of the changes are significant and require a lot of work by staff. I want to thank Renee Englen for her

hard work on the fee schedule this year. This was an enormous undertaking to review over 14,000 codes and establish relative value units, or RVUs, for all of these codes.

The value of each service is measured by a relative value unit, or RVU, and a service code with more RVUs than another service code has a greater worth than the comparison service code in terms of reimbursement. I do not intend to go into detail on the specifics of the methodology to develop RVUs as there is detailed information regarding the methodology outlined in the staff recommendations and request for public comment report that was publicly posted.

Many here remember it wasn't long ago that the Commission only reviewed a quarter of the codes per year under a four-year cycle, so I will tell you that we have made progress with the ability to update codes annually. To arrive at the conversion factor used to adjust the schedule -- the fee schedule rates, we calculated rates based on 2015 workers' compensation claims and ICA rates to estimate the expected payments, considering all claims were paid according to the ICA fee schedule rate. These estimated payments were then divided by total RVUs to calculate the three conversion factors.

For example, we use the National Council on Compensation Insurance, or NCCI, data for total amount paid for pathology and laboratory, medicine, physical medicine, special services, evaluation management, and Category 3 codes. Then we divided the total amount paid by the total number of RVUs for all those codes to determine the conversion factor. Additionally, a 15 percent reduction in combined surgery and radiology reimbursement was incorporated in this model to minimize the massive cut in total reimbursement for surgery and radiology and resulting in a more balanced distribution of payments across all service categories. The recommended conversion factors are Surgery/Radiology, $82.38; All Others, $64.63; and Anesthesia, $58.10.

Despite using a budget-neutral approach to transition the current methodology to an RBRVS methodology to set fees, there were disparate impacts to some of the codes. Where ICA reimbursement values for certain codes were significantly higher than that of Medicare or commercial insurance, and I'm talking about 300 to 400 percent higher than Medicare or commercial insurance, there is a resulting decrease in proposed reimbursement rates when those codes are assigned relative value units, or RVUs. This is

because when we apply a standardized methodology such as RVUs for service codes where the ICA reimbursement rate is 300 percent or greater than that of Medicare or commercial insurance, those codes may have seen a significant change. With that said, we understand the unique requirements for handling workers' compensation patients, the extra time spent meeting with nurse case managers, completing paperwork, and we certainly do not want to lose quality physicians from the workers' compensation system.

Let me remind everyone now that this is a proposed fee schedule and not a finalized fee schedule. It is the Commission's desire to hear from the stakeholders to better understand concerns related to the proposed RBRVS-based fee schedule. On a positive note, there were a number of codes that saw an increase in reimbursement values, such as your office visits and physical medicine.

The report containing the recommendations for the 2017 Arizona Physicians' and Pharmaceutical Fee Schedule contains three sections. The first section is a statement of issues under consideration. The second section addresses the adoption of new and deleted codes, general guidelines, identifiers, and modifiers of the CPT codes. And the third section addresses the

proposed values for the codes, all of which were reviewed this year. This year's values are calculated by multiplying the RVU for a CPT code by the conversion factor for that medical treatment or service.

Issues that are presented in the staff's study report for which we requested public comment are as follows: The first issue, the methodology used to determine RVUs for the CPT codes. Again, a detailed description of the methodology used is outlined in the staff recommendations and request for public comment report.

The second issue is the methodology to update the value of codes. A detailed description of the methodology used to update the values of codes is outlined in the staff recommendations and request for public comments report.

Three is the adoption of Physicians as Assistants at Surgery: 2016 Update. This is the publication that addresses when and what surgical procedures typically require second and third surgical assistants. This is the seventh edition of the Physicians as Assistants at Surgery, a study first undertaken in 1994 by the American College of Surgeons and other surgical specialty organizations. The study reviews all procedures listed in the surgery section of

the 2016 AMA current procedural terminology book. This table presents information about the need for a physician as an assistant at surgery. Also, please note that an indication that a physician would almost never be needed to assist at surgery for some procedures does not imply that a physician is never needed. The decision to request that a physician assist at surgery remains the responsibility of the primary surgeon and, when necessary, should be a payable service.

It should be noted that the unlisted procedure codes are not included in this table because by nature they are undefined and vary on a case-by-case basis.

Our fourth issue requesting public comment on is the designation of Medi-Span as the publication for purposes of determining average wholesale price. Medi-Span is the publication currently used for determining average wholesale price, or AWP, under the pharmaceutical fee schedule. Staff recommends that this publication continue to be used for this purpose.

And the fifth issue that we are requesting public comment is payment to treat -- payment to treating providers who participate in healthcare preferred provider organizations, outcome-based networks, or specialty networks. Over the past few

years the Commission has received numerous complaints from physicians regarding the use of shadow or phantom networks in the workers' compensation system. The complaints have largely indicated that payers were able to take advantage of medical providers when using these types of networks because these networks are non-transparent. The Commission has received complaints from independent medical providers and physical therapists who state that oftentimes when an injured worker is directly referred to a physical therapist by the treating physician the injured worker will be contacted by the network and told that their employer or insurance carrier will not pay for their medical treatment if they choose to be treated by the independent medical provider. They are told by network representatives that they must receive medical treatment by a provider who is contracted with the network. The complaints indicate that networks are essentially directing care in violation of Arizona work comp law.

In addition, medical providers have complained that networks are paying them far below the Industrial Commission fee schedule and referrals are made dependent upon the acceptance of unfairly low reimbursement rates. The Commission has seen some of

these tiered payment contracts. The Commission has seen a number of examples of billing practices where networks are retaining profits of 40 to 50 percent and not passing those savings onto the Arizona employers or the insurance carriers. They are getting paid more than the medical provider who is providing the medical treatment or service. The Arizona employers and payers are not realizing large discounts or savings with these types of business practices employed by some of the networks. The Commission is concerned that the use of certain networks is undermining the Arizona workers' compensation system by making it difficult for some qualified medical providers to treat injured workers.

I have received numerous phone calls and e-mails from people this week regarding the proposed network language. There seems to be a lot of misinformation going around. I would like to clarify that it is not the Commission's intent to interfere with a payer's ability to negotiate rates below the fee schedule with the network. Instead, in this scenario the payer would pay the discounted rate negotiated between the payer and the network, and the network would be required to pay the provider at least 90 percent of the discounted negotiated rate. Staff is proposing that the majority of payments for medical

treatment or services be paid to the actual provider of the medical treatment or service and that under no circumstances is a network permitted to retain more than 10 percent of the full amount paid for providing medical treatment or services. This language would not apply to those medical services not covered by the Commission fee schedule, such as hospital, ambulatory, surgical centers, and durable medical equipment. All stakeholder comments regarding this issue will be carefully reviewed and considered.

So the following is the specific language related to the network issues that we ask for comment on. A provider that participates in a healthcare, preferred provider, outcome-based or specialty network and that delivers medical treatment and/or services to an injured worker in Arizona workers' compensation system must receive no less than 90 percent of the Arizona Physicians' and Pharmaceutical Fee Schedule allowable amount for providing medical treatment and/or services or the full value of any discounted rate between -- negotiated between the payer and the network. A network seeking to retain a portion of amounts paid for provided medical treatment or services must have a written contract of participation with the subject provider that includes an up-to-date disclosure

of rates based on the current Physicians' and Pharmaceutical Fee Schedule and/or any discounted rates negotiated between the network and a payer. A network that does not have a written contract of participation with the provider, and that includes an up-to-date disclosure of rates based on the Physicians' and Pharmaceutical Fee Schedule, or any rate, discounted rates, negotiated between the network and a payer is prohibited from retaining any portion of amounts paid for the provided medical treatment of services. In other words, if you don't have a contract with that provider you cannot retain a portion of what they are getting paid. Under no circumstances is a network permitted to retain more than 10 percent of the full amount paid for provided medical treatment or services. The terms "payer" and "provider" shall have the definitions stated in Administrative -- Arizona Administrative Code R20-5-1302.

And with that, Chairman Schultz and the Commissioners, I would be happy to answer any of your questions. Thank you.

MR. SCHULTZ: Commissioners, questions for Jackie?

Thank you, Jackie.

MS. KURTH: You're very welcome.

MR. SCHULTZ: I will begin with hearing public comments.

Before we start that, though, I would like to emphasize a few things that Jackie has told you about, and that this is not something that is just happening. 2013 is when this process started. This is not precipitous, and this is in response to stakeholder input. This is not just something that the Commission has come up with and is imposing upon the community. This comes from the stakeholders.

I will also tell you this is not being done lightly. The Commission has reviewed tens of thousands of data points relative to establishment of this fee schedule. The proposed fee schedule has been compared to the existing fee schedule. It's been compared to provider reimbursement under treating the same code, the same patient, the same procedure, against Medicare reimbursement, against commercial insurer reimbursement, and, in fact, also against the actual receipts of providers that they have agreed to under contracts which they have voluntarily entered into. And so this is not, once again, something that we have just decided we're going to implement. It's been carefully studied, and includes studies of -- studies from other states and national studies about the

tipping points at which point the reimbursement actually drives providers from the workers' compensation system, and that has also been incorporated in the establishment of these rates.

As Jackie said, there is no intent to drive folks from the system. As I'm absolutely positive you can see if you look at the entirety of the fee schedule and the other provisions that we're adopting, the intent is to make it much easier for providers to participate in workers' compensation, both by making this not only similar to but exactly as the proposed billing and charging procedures that they currently use for Medicare and commercial-insured patient. This will simplify office procedures tremendously.

And on top of that, the Commission is also making huge strides in genuinely making it easier for all stakeholders to do business with the Commission. That's about establishing fillable forms on line, the ability to interact with the Commission without having to come down here, without having to create paper and waste paper and time, the ability for physicians to give testimony from their offices to participate in hearings remotely. We are working hard to make the Arizona Industrial Commission responsive and it much easier to participate in the workers' compensation

system of Arizona.

With that, the first speaker request I have is Chic Older.

Chic, would you introduce yourself and indicate who you're representing.

MR. OLDER: Thank you. I'm Chic Older from the Arizona Medical Association, and after doing a little calculating I'd like to invite you all to my 32nd meeting here.

I really appreciate what you said, and in preparing today I was thinking about it, that I have been coming down here for 32 years to do this, and I'm proud of the fact -- you should be proud of the fact that the Commission is probably -- the Industrial Commission is probably the only place that I know of in Arizona where we have actually been able to collaborate and make sure that there is a robust and highly effective system delivering healthcare. There is no other place that I get to sit up there and tell you about what I think and ask you to make these changes, so -- and we've made a number of changes. I've seen a number of different systems come and go that we've been a part of, and I've always felt that the motivation of the Commission is to make sure, as you said, Mr. Chairman, that quality physicians are willing to

take care of injured workers, and the system is one to be envied. And there have been many years where people have called me and said, "What are you doing in Arizona? Because we have complete total dysfunction if our particular state." And they're large states like Texas, for example, and California. So I appreciate that, and that needs to be acknowledged, and that's the basis of my comments.

And I'm today just trying to point out some places where I think the Commission should look. We have been completely and totally involved in the evolution of this new system. There has never been an opportunity where I didn't have the opportunity to sit down and talk directly with Jackie or with the consultants that were involved. It has been -- it defines what transparency means in how we have operated, so I really appreciate that.

I have three places I want to focus on today. I believe that the anesthesia conversion factor that you're using still remains below community norms. We had the opportunity, having nothing to do with this, but in another bill at the state legislature that had to do with surprise billing that brought forth and made it crystal clear that the insurance payment schedule is in such disorder, and that while physicians are

generally not motivated by money, they are demotivated by when they feel it falls below an appropriate level.

And anesthesia services are actually -- they fall really into your lap in so many cases, because the patient doesn't really get a chance to make that decision. And the general anesthesia conversion factor that I'm able to ascertain -- you may have access -- more access to fee schedules than I do, but the ones that I have been able to look at generally use a factor of between 70 and 100 in this community and statewide. And anesthesiologists do have the opportunity to say, "I'm sorry. I don't take care of workers' compensation cases." So I think it should be of concern to you, and given the whole parameter of the evolution of what you're doing I want to point out to you that I think that factor that's being used is low, and I feel like it should be raised up to the bare -- to what I consider -- I don't want to say bare minimum -- to the reasonable minimum of 70, which is a community standard. And I'd like to ask you to look at that and then check your resources to see if your information corroborates with mine.

Second, I fully well understand that there are -- there have to be changes. We were a part of this, and I do believe that the RBRVS system is a way

more scientific system than what we were doing. You can say de facto we were using an RBRVS system because we were incorporating four states that used it. And I can remember sitting in and talking with you, Mr. Chairman, and with executive directors, and going, "It's kind of amazing. It actually works out as it should." But it always did, and it was a reasonable system that compensated -- it wasn't a place you were going to make a lot of money, but you felt like if you were a physician you were going to be compensated reasonably, even though it demanded a lot more.

I'm concerned that there are some huge outliers that will take a hit as a result of the new system, and I'd like to ask the Commission if you would please consider putting in place what I will call a stop-loss recommendation, and I say it on both sides. I'm asking and suggesting that you consider that no code be dropped in compensation more than 5 percent or raised more than 5 percent and that you cap this at three years. It will ultimately catch up with itself. So that if you're seeing something, and you see all of a sudden you're looking at something that you've been doing, and the next day you're looking to sustain a 50-percent reduction, I think that that is way too much to ask physicians to tolerate at this given point.

You know, whether you like it or not you're having to be a part of the entire system that is in such turmoil and flux it's incredible, and I don't want physicians to leave this system. We've got a terrific system that above all I think needs to be preserved, so I ask the Commission to please look at this. You'll see I've set it forth here, and take a look at what you can do to say -- to take away the extreme changes that this new system brought forth. And, again, in both directions.

My final comment is about the discounts, and I appreciate what you're saying. I come back to the relevance of the entire scheme. You have done such a good job of trying to put in place a reasonable fee schedule. I see no reason why there should be discounts allowed at all. Think of what you would say if I came here in and said, "I think you ought to raise everything 10 percent because other people are discounting it 10 percent." I feel this is a good system. You're trying your best to make this more scientific than it's ever been in my 33 years of coming down here. It's got a good base. You've done terrific work. I think the consultants did a great job. Your staff has done a great job. I don't think there should be any discounting at all. This should be the fee

schedule, and it will eliminate a lot of problems.

The Commission responded to our concerns a number of years ago on a regulatory basis when saying -- physicians would show up and say, "Nobody can show me what contract I signed." And -- and you did something about that, and it was appropriate. I think you should have the same level of confidence in your new fee schedule and say, "This is a good schedule. It shouldn't -- it shouldn't be deviated from."

Those are my three comments today. I really -- this is a terrific effort on your part. I really appreciate where this is going. It's going to come a really huge circle from where we first started some years ago. And I stand ready for questions, if there are any.

MR. SCHULTZ: Questions?

Okay. Thank you, Mr. Older.

Next we have Dr. Mark Greenfield.

DR. GREENFIELD: Mr. Chairman, Commissioners, Director, thank you for the opportunity. Jackie, that was a great introduction.

How do you do workers' comp? Simple question, isn't it? It's a question that presumes a level of knowledge and expertise. It's a question that my colleagues have asked me many times over the years.

Some of them are sitting in this room, some of them that I have mentored and explained to them how to do workers' comp. Other orthopedic surgeons haven't asked me how to scope a knee. They know how to scope a knee. They haven't asked me how to do a hip replacement. They haven't asked me to how to fix an ankle, Dr. Nassar. But they've asked me how to do workers' comp, so it's different.

There is a level of expectation and expertise that goes into this. It's just not the medical treatment that we provide. Not only have I mentored physicians over the years of how to work our system, but I've actually been asked by a national healthcare system to go across the country in other states and actually teach their providers on how to do workers' compensation.

The current level of reimbursement allows for fair compensation to the level of services that we provide. A reduction in fees will lead to reduction in services. For example, we are able to get in patients in a timely and efficient manner for those of us who work in the work comp arena. If there is delays in that, those are direct costs back to the employers.

The amount of forms and paperwork that we take care of on a daily basis is insurmountable,

Mr. Chairman. We have adjusters, nurse case managers, nurse case managers that are at the office all the time. In my waiting room sometimes there is a half a dozen sitting in there. We give time for them. We give time to them before their visit, sometimes during the visit, and many times they ask to see us after the visit.

And just on Tuesday there was a nurse case manager who did a fly-by. Their patient wasn't even scheduled to be seen in the office on Tuesday, but she stopped by anyway because she knew, "Well, Dr. Greenfield has five minutes to talk to me." And sure enough, we brought her back, and I did speak to her about that case, when in fact the patient wasn't even scheduled for the day. That was a free service that I provided, no cost to the insurance company, no cost to anybody else other than the time I provided.

The amount of phone calls we get are insurmountable, not to mention peer reviews now. We can't do anything, practically, a procedure, without having to speak to somebody in another state. They call us at the most impromptu times. We're not available, and then we're going to have to track them down in order to get time to justify our indications to do the surgical procedure, which has already been very

well delineated in the medical records. We make ourselves available for doctors. On my drive over here just now, five phone calls from the same referring physician because he wasn't sure if it was something an orthopedic surgeon needed to do or see and what tests he should get. We make ourselves available to these calls in the current system.

We address causation. We have to be able to decide on whether the mechanism of injury supports what the injured worker is presenting with, and those of us who are in the system understand that, but a lot of providers out there don't understand that, and a lot of these cases just go on and on at the cost of the insurance company when it could have been shut down at the very beginning.

Work status forms: I don't know, Mr. Chairman, if you've ever filled out a CA-17 form from the Department of Labor, but any physicians in here who see Department of Labor -- it's very time consuming. We do these as services to treat the workers' comp population.

We have multiple follow-up visits with these patients. Most of the time in the post-operative period we're not being paid for these. These are just so we can constantly increase their work statuses and

get these patients back to work. In the private sector it's not that way, but in the workers' comp world it is. So multiple more visits, many of the times at no fee. We're doing it free just to move the cases along. We have to establish when a patient is permanent and stationary, whether they're at maximum medical improvement. Most physicians don't even understand what those terms mean, let alone know when the patient is at maximum medical improvement. We have to review IME reports and go over those with the patients and address those issues with the patients. A lot of physicians don't even know what an IME is.

We've been asked to take over care. Many of us who have been in this arena for a long time have working relationships with nurse case managers and adjusters. I just had one on Tuesday where the adjuster pleaded with me to take over care. It was a patient who had a fracture which was already treated elsewhere by somebody else. The patient was unhappy with that, and they also had a knee injury as well. And I agreed as a favor to the adjuster that I would take over care on a relatively new surgerized patient just as a service that I'm providing.

Not to mention ICA testimonies, preparing for the testimony. And in all due respect, the Commission

does compensate it, but it's not very much for the amount of time that we put in the night before that I'm reading through these files so I'm prepared. So there is a lot of things that go into what we do. These are services that we provide that we're not being compensated for.

Impairment ratings: When a patient is considered MMI, permanent and stationary, we provide impairment ratings. A lot of physicians who don't understand workers' comp don't even know what an impairment rating is. Oftentimes you'll see them send the patient out for an IME, so now the insurance company is paying $1,500 to $2,000 plus just for an impairment rating that takes a minute or two to calculate out and provide in your report. If I'm not being compensated in my fees, I'm not going to provide impairment ratings, and my patients will all go out for IMEs at increase of costs.

I spoke to one of my colleagues the other day whose representative is here in the audience. I won't mention his name, but he does a lot of revision-type, difficult procedures, and he told me that he won't accept the fee schedule for the revisions and difficult cases. He's just going to charge cash. And the insurance company can pay for that for them, the

patient will either pay for that for them, but if they want his expertise, because there is very few people in the Valley who offer his service, he's going to go on a cash basis and will not provide those services under the proposed fee schedule.

So nurse case managers -- I just had a conversation before I left the office on my way down here. They go, "Where are you going, Dr. Greenfield?"

"I have to go to the Industrial Commission. Oh, my God. You have no idea what they're going to be doing."

So her response is true. Her response is most doctors don't even want to see work comp patients, and if they do, they don't understand it. They don't know how to do work comp. Cases go on and on with no closure. They don't understand causation. They don't understand return to work. They don't understand impairment ratings, and they don't understand MMI.

So my recommendation: Decreased reimbursement is really not a deterrent. This will reduce costs per individual codes, but it will result in a higher cost per case at the very end. Classic economics: Decrease the price, it will meet with a decrease in supply of physicians who are willing to do this. There are some mega groups in the Valley who perhaps may be willing to

continue to do this, but they look at the bottom line. They have a McDonald's theory that I have to sell a bunch of 99-cent hamburgers, and that's fine, and that's what will happen. You don't deter from doing surgeries. In fact, you will actually increase the amount of surgeries that are being performed because those of us who do this treatment as a boutique, niche type of practice won't be doing it, and those who are looking at the bottom line in mass and volume will actually be doing more procedures than less. I understand the Commission is trying to increase the E&M codes to make it -- to make up the difference for the surgical procedures, but in fact there will be providers out there who actually do more procedures to make up for the difference.

Finally, there is a difference in the expertise that we provide, and we should be compensated fairly for the services that are expected of us and that we have been providing thus far. As a consequence of treating Arizona injured workers, we see a lower volume of patients. When we are spending 20 minutes discussing work status with a patient and then 15 minutes after the visit with the nurse case manager, I could have seen a half a dozen Cigna patients in the meantime, so I cannot make this up in volume. The

services that we provide take time, and the services should be appreciated.

I speak to adjusters out of state all the time, and their comments are always, "Dr. Greenfield, why can't all states be like Arizona?" We are highly respected across the country in the services that the providers provide in our state. We need to ensure access to quality care and to compensate providers for the additional administrative responsibilities that are attached to treating Arizona injured workers. If we're going to get Cigna fees, then there will be Cigna services. The medical care won't change, but the administrative services will. It's not just scoping a knee, Commissioners. There is much more to it.

Thank you. Any questions?

MR. SCHULTZ: Questions for Dr. Greenfield?

Thank you very much. And I would truly encourage you, if you are going to make written comments, and we would appreciate that, that you include any specifics you might be able to share with us about those codes and the cost to you of providing those additional services and the additional burdens of recordkeeping and the other administrative work that goes along with it, because we are very much attempting to try and make the fee schedule as fair as we possibly

can.

Thank you for your appearance and your comments.

DR. GREENFIELD: Thank you.

MR. SCHULTZ: And now Scott Zeilinger.

I would just like to remind everyone that if your issues have been covered before please just so state because we have a significant stack of folks who would like to share with us.

MR. ZEILINGER: Chairman and Commissioners, thank you. Chic and Dr. Greenfield took about half of my presentation so --

MR. SCHULTZ: If you could, identify yourself and who you are representing.

MR. ZEILINGER: I'm sorry. I'm sorry. Scott Zeilinger. I'm with The Healthcare Group, and I provide administrative services to physician practices primarily in the Tucson area.

MR. SCHULTZ: Great.

MR. ZEILINGER: You know, the administrative burdens that Dr. Greenfield said, that's -- I'm not going to repeat that. Really what I really want to focus on is that we analyzed and modeled the relative impact of these proposed changes to procedures that are conducted in a facility setting, and that created a

40-percent reduction in the overall reimbursement for those procedures. We totally agree with an RBRVS system and that it's the right methodology to use. However, we believe that it penalizes those physicians who choose to perform their procedures in a facility-type setting, so we believe that there is going to be unintended consequences.

Number one, a fiscal impact study stated that it may drive providers away from providing workers' compensation. It's already difficult to find specialists to refer to who are willing to see workers' compensation patients, but you may also unintentionally increase costs by that because the physicians may choose to add additional services if they wish to use their office setting.

So in summary, we support the philosophy to change to the RBRVS methodology. However, we request the Commission to look at the specifics as it relates to facility versus in-office procedures. Thank you.

MR. SCHULTZ: Thank you.

Questions?

Thank you, and once again, if you would provide us with any specific data in your written comments, if you wish to provide written comments. Thank you.

And next is Robert Holden.

MR. HOLDEN: Good afternoon, Mr. Chairman and Commissioners. My name is Robert Holden. I'm here on behalf of the American Association of Payers, Administrators, and Networks. We're the national trade association for network entities in the workers' comp market, and I appreciate the opportunity to provide some comments and will be following up with some written comments, and I'll -- we're trying to get that there.

We agree with the statement that you made earlier that in order to take a discount you have to have a contract. Contractual access is absolutely essential, and we're pleased that the Commission has engaged on some rulemaking on that front. We just couldn't agree more on that. The reason we're commenting upon Section A(5), the network changes there, is the -- what we see is a somewhat arbitrary limit of network costs at 10 percent. We haven't seen that in any other states, and we don't think that it will allow our members to continue to do the things that they've been doing in terms of providing value in the system.

And to get into that, networks provide a number of services: credentialing, clinical oversight,

fraud detection, standardization, utilization of electronic billing, coordination of medical reports. And in something that was just presented at IIC at their spring meeting just this week, it's shown that in instances in which networks are used injured workers have a much faster access not only to the first visit with providers, but also they're much faster to access PT and OT services. So there are a lot of value -- valuable services that our networks provide, and we'd like to continue to do that. And we understand the tremendous amount of work you do in oversight, and we'd like to continue to provide the services that can assist you with that.

So, again, we have worked as an organization both with national -- national groups, like the National Conference of Insurance Legislatures and NAIC, developed model rules on this instance. We've worked with individual states to address this issue, the PPO issue. So, again, it's something that we've worked with regulatory officials and legislators to get a handle on. We're very pleased to work with you to do that in Arizona. We're just unclear on how this 10-percent cap on our costs leads to that endpoint. So, again, very pleased to work with you moving forward on this, and we're trying to get Arizona-specific

information from NCCI to put together that report. That will be present in our comments, if we can get that. But, regardless, we'll give that to you as soon as possible.

MR. SCHULTZ: Questions for Mr. Holder?

MS. ORCHARD: Thank you, Mr. Chairman.

I was just going to ask you that, Mr. Holden, I was at the conference, and I missed that, so if you would like to make sure that we get a copy of that --

MR. HOLDEN: Absolutely.

MS. ORCHARD: -- that'd be great.

MR. HOLDEN: Thank you.

MR. SCHULTZ: And, also, you know, I will tell you that it's always been my experience that criticism is easy to come by; problem solving is much more difficult. And so in your written comments when you address issues, we would appreciate data relative to your position, but also then if you would offer alternative solutions that might help us to improve our fee schedule, because that's the intent of the work of the Commission.

Thank you, Mr. Holden.

MR. HOLDEN: Thank you, Mr. Chairman.

MR. SCHULTZ: Cathy Vines.

MS. VINES: Good afternoon, Mr. Commissioner,

Commissioners, and all of the stakeholders. Nice to see so many people this year. I would agree with the comments that the chairman made about the Industrial Commission.

MR. SCHULTZ: By the way, this is Cathy Vines. She represents CopperPoint.

MS. VINES: I'm sorry. CopperPoint Insurance Company.

I would agree with the comments that the chairman made regarding the ICA improvements in the ease to do business. We all appreciate that, and we certainly all are enjoying many of those enhancements. And, again, thank you to the Commission for listening and acting on the stakeholder concerns regarding the fee schedule methodology. Several years and many hours have been put in by Ms. Kurth and the MRO team. They're very much appreciated. These changes, as you mentioned, will definitely allow for easier annual updates and will align Arizona workers' comp standards to those used in general health while maintaining Arizona specifics.

CopperPoint is still conducting an evaluation of the financial impact of these changes and is not prepared to offer additional comments at this time. However, we do share some concerns with the

self-insureds and other stakeholders regarding the proposed network language. We are concerned that the proposal might inadvertently constrain legitimate efforts to contain medical costs. Payers might be required to pay more for certain services than the open market might otherwise bear. This also might drive some of the legitimate networks out of the Arizona market, given the increased administrative contracting burdens.

And, lastly, given the substantial portion of the medical dollars spent on drugs and the opioid epidemic we're seeing, we're concerned how this might impact availability of pharmacy benefit managers who have successfully partnered with payers and pharmacies to manage and control medications. This relationship is especially important given the adoption of ODG treatment guidelines and the formulary. CopperPoint would gladly participate in a stakeholder advisory forum to better understand the concerns that have been brought forth to the Commission and to recommend a consensus solution.

Again, thank you to the Commission for the efforts to modernize the fee schedule. They're much appreciated, and we will look to submit written comments by the close.

MR. SCHULTZ: Thank you.

Questions for Ms. Vine?

And, Cathy, I would personally appreciate any comments in your written comments that might address the issue of the abuse that we're attempting to correct in the predatory practices of certain networks that have actually reached the extent of potentially putting our private Arizona-based providers, individual providers, out of business, and so if you would include any thoughts you have or any other possible solutions, I would personally greatly appreciate that.

MS. VINES: We'll look to include them. As some of the Commissioners know, CopperPoint basically uses and runs and administers our own direct contracts through our preferred provider network, preferred connection network, with the providers directly, so we for the most part have limited dealings with some of the national networks, but I will search for examples and submit them.

MR. SCHULTZ: Thank you.

Next, Pete Wertheim.

MR. WERTHEIM: Good afternoon, Mr. Chairman, members of the Commission. My name is Pete Wertheim. I'm the executive director of the Arizona Osteopathic Medical Association. I just want to say on the outset

I concur with Chic Older, my counterpart, and the other physicians' comments, so I won't elaborate on them. I do want to commend you for the process that led up to this, particularly Jackie and her staff. They've been exemplary in their service.

On the outset, we certainly understand the rationale for the conversion. I think it all makes sense. We certainly appreciate the reduction of administrative expenses, the need for all the cumbersome updates, and the response to changing healthcare. I would say also change is the only constant right now in healthcare, it seems like, especially for specialists who are in high demand and in short supply. So in isolation, some of these rate adjustments might on the surface appear as sustainable. They're numbers on a balance sheet. But just please be mindful of the entire system, the changes that are occurring elsewhere in totality through Medicare, through MACRA, ACOs, marketplace, throughout the smaller health plan networks, and now we can add surprise billing reform now to that list. So we are concerned that the physicians who are able, and if able to, will leave the program if too much is placed upon them. So while change can be managed to a certain degree when it's predictable and can be moderated, we

concur with the stop-loss approach transitioning into this, and over time I'm sure it will be all very positive.

We also thank you for the consideration on the allowable amounts on the services and policies, the PPO provision. This is a problem for all providers. Nationally represented surveys of U.S. physicians report roughly one-sixth of a physician's working hours are consumed by administrative tasks, 14 to 27 percent of their overall working hours per week. They don't have the time or money to track down these ever-changing networks. It is not worth the time and money, and I believe these networks are able to use this to their benefit, which is why this practice is occurring. This is not a good use of the provider's time. We need transparency. And this ultimately impacts patients' access to care. Every minute spent trying to track these down is a minute away from those patients.

I haven't heard -- we heard about the challenges of the health plans, but this is a new one for me to hear about, a shortage of networks and all these other things. And I think it's -- the 90 percent is I would say a great starting point.

So with that said, I thank you for allowing me

to speak today. I will try to get some written comments in for you. I'm a newbie to this, so my specifics aren't quite as technical as others. Thank you very much.

MR. SCHULTZ: Thank you.

Questions for Mr. Wertheim?

And I want to tell you that coming from healthcare myself, I understand that there is pressures from all directions, what Medicare is doing with lower extremity bundling. Anyway, some of their other more recent changes have to be creating pressures everywhere. Thank you.

MR. WERTHEIM: Thank you.

MR. SCHULTZ: We will take them into consideration.

Dr. Nassar.

DR. NASSAR: Good afternoon. My name is John Nassar. I'm an orthopedic surgeon here in Arizona, and I've had the privilege of treating injured workers for 16 years now in Arizona. And my concern -- I understand the rationale in going to an RBRVS system, and I hope you appreciate that it is not entirely applicable to an injured worker. Caring for an injured worker is very different. With the Medicare patients, one of the flaws is that it doesn't reimburse the

providers in the office well enough compared to the surgeons because they're spending an inordinate amount of time with complex medical issues. It's different with an injured worker where there is an injury and we have a focus.

By adopting the plan -- or the proposed plan by the consultants with the conversion factor, there is, by using your own words, a massive shift of dollars away from the surgical side to the office side, and as a surgeon I don't think that is fair, and I think that is going to definitely affect access. It's similar to Mr. Older's second point. You know, you put a stopgap measure of about 15 percent I think in the conversion factor, but in looking at individual codes from a selfish orthopedic surgeon, it's really a reduction of anywhere from 30 to 50 percent in reimbursement costs for the procedure, and that's not sustainable. And so I don't know, you know, what the stopgap is. Mr. Older mentioned about 5 percent, you know, above or below. That seems reasonable. But adopting the numbers the way they are now -- and I know it's preliminary -- would be a disaster for the surgeons, and it's not -- it's not fair to us. So I want to keep treating injured workers. I want to be fair. I understand the rationale, but I would just ask you to please look at

those conversion factors on the surgical side and see the impact on the surgeons. And if it's a decrease, it's impossible for us to continue to care. Thank you.

MR. SCHULTZ: Questions for the doctor?

I would truly appreciate if you could provide us written comments, and in most particular how this new reimbursement rate would compare to rates that you've already signed contracts to provide care for, because from our review actually these -- the proposed rates are above what many folks are actually receiving under contracts they enter into voluntarily, so I'm looking for additional information in that area, so --

DR. NASSAR: If I could comment, you know, insurance companies don't let us, you know, communicate that data with other people, number one. And, number two, and I'm not going to repeat all the added stuff that goes into caring with an injured worker. You know, to compare that to taking care of a Medicare patient or a patient of United or Blue Cross is not a fair comparison. It's not fair to apply the RBRVS system to injured workers without taking into consideration some of these other factors.

I understand why you need to do it. I'm not saying, you know, it's not right. It's not for me to argue that point. But you have to take into

consideration some of the other factors on how it's different taking care of these workers compared to a commercial payer. So to look at that reimbursement rate and compare it to the injured workers with all due respect is not fair.

MR. SCHULTZ: Thank you.

Cynthia Driskell.

MS. DRISKELL: Good afternoon, Commissioner, Director, and members of the Commission. My name is Cynthia Driskell. I'm a physical therapist. I'm an owner of Carefree Physical Therapy and vice-president of PTPN Arizona. PTPN Arizona is a rehabilitation provider network, and we've been owned and operated in Arizona since 1994. We provide credentialing, contracting, QA, and referral programs for physical therapists, over 150 clinics in the state. We contract through group health plans, employer groups, and workers' compensation payers throughout local, state, and regional contracts.

We're here to comment about the proposed language on networks and specifically would like to support the proposed guidelines. It would ensure that Arizona rehabilitation providers receive fair payment through participation with referred or specialty networks. The reasons for our support are to provide

greater transparency for all parties, to eliminate factors that drive down the quality of therapy provided to injured workers, and to ensure that employers and payers are receiving value for their required fee schedule payments. We feel that therapy networks do provide positive service in the workers' comp market. We provide added savings for payers while absorbing administrative or operational costs on behalf of the therapy providers. We also provide the opportunity for small local providers, such as myself, to participate in larger contract agreements. Therapy networks can operate from a variety of business models. For example, PTPN charges an annual membership fee that applies across the board to all contracts, so all discounted treatment fees go directly to the therapy providers. Our providers know the specifics of each contract and may choose to opt out of any discounted contract that does not meet with their approval.

Lack of disclosure on contracted rates has resulted in providers seeing payments as low as 40 or 50 percent below the fee schedule. It's been an issue for some time. Therapy providers are also unaware of the administrative fees retained by many networks. Providers have had to turn away work comp referrals because they could not afford to take the discounted

fees plus high administrative percentages off the fee schedule. The contracts may come from out-of-state TPAs, forcing patients to a very limited panel of providers, even if the employer is not allowed to direct medical care. Patients have experienced interrupted care due to transfers to an in-network provider once care has already began with a provider of their choice.

The quality of therapy provided can be negatively affected by low payment and high administrative fees. Therapists spend less direct care time with patients, use more therapy extenders, and provide more passive modalities. The employer payer truly gets less therapy for their money when high administrative fees are retained.

We thank the Commission for their attention to this issue. We've had many favorable conversations in the past with staff, and we appreciate being able to work forward with it in the future. Thank you.

MR. SCHULTZ: Thank you.

Questions for Ms. Driskell?

MS. DRISKELL: Thank you.

MR. SCHULTZ: Thank you.

Mike Miller.

Mr. Miller, we're running a little behind on

our five-minute --

MR. MILLER: Okay. I'll go quick.

My name is Mike Miller. I'm an owner with Kinect Physical Therapy in Arizona. We're a small clinic. And I'd like to thank the Commission for your efforts in trying to improve our reimbursement as therapists. We're a small -- very small company, not very big, and I've been practicing for over 20 years now, and I used to see probably anywhere from 10 to 20 percent workers' comp in my business. That has gone all the way down to 2 percent over -- over the last few years, just because we won't sign up with any networks that try to lower our fees or lower what we'll take. We just won't take it anymore, and we can't. We lose money when they are trying to get us down to $50, $60 a visit. We just cannot provide care for that -- at that cost anymore. And I have some great staff that will not let us sign those contracts anymore. A lot of these networks do not share with us how much they get on the back end. They pay us what we sign, but they won't share us with us what the ultimate cost -- or what they ultimately have been reimbursed over time.

As a provider, we carry -- we carry the largest burden for providing treatment and care with salaries and overhead. Our salaries continue to go up

every year, and our reimbursement continues to go down every year, and we applaud you for helping us to raise our -- raise our reimbursement rate through the proposed limits that you're proposing on the networks.

Physical therapists need the support of the Commission to ensure that patients continue to receive the highest quality care at a fair rate, and we applaud you for doing that and helping us to -- to achieve that. We must also continue to inform other small practices about the importance of -- the pitfalls of signing contracts that don't -- that are not transparent, also, and you guys are helping -- will help that along the way. We've signed -- like I said, some of these networks we have signed contracts with at a higher rate, but they still will not refer to us because they have other contracts within their network that pay lower, so signing contracts sometimes with these networks doesn't really do us any good because they have other providers in that network that are taking less, and they funnel those referrals to those providers, and it's just not transparent. I think if the Commission could require these networks to prove to the Commission that they are equitably distributing the referrals to everybody within the contract, that would be great. Thank you.

MR. SCHULTZ: Thank you.

Questions for Mr. Miller?

MR. MILLER: Any questions?

MR. SCHULTZ: Nope. Thank you.

Michael Winer, is it?

DR. WINER: Winer.

MR. SCHULTZ: Winer, okay.

DR. WINER: Thank you for allowing me to speak. I apologize for my casual dress, but this -- I had to add this to my schedule, and this was a spring cleaning day, doing moving duty and stuff like that.

Anyway, I'm an orthopedic spine surgeon. I was in practice in Missouri in 1975, so I've been around a long time. I am probably one of the only people here, maybe there are a couple, that remember the yellow California relative value scale. That was -- I used that when I revamped the group that I joined in Missouri, revamped their billing practices to an RBR -- to a relative value scale. Ultimately, based on an Arizona lawsuit that got up to the Supreme Court, that yellow book was deemed unconstitutional because it considered physicians were fee sharing and in cahoots, et cetera, when actually the relative value scale just allowed physicians to make sense out of all these different procedures in orthopedics that we do,

whatever different offices would use different factors. So it wasn't setting fees; it was relative value.

A few years later the government decided that it was to their advantage, and they came up with the RBRVS, and I really think that that is a -- makes a lot of sense. And I did not understand when I first came here in '93 -- I presented to the ICA in I think '95 and '96 about add-on codes and secondary procedures, and I want to applaud the Commission because they listened and they accepted the concept of secondary codes. These are codes that you do in conjunction with something else, and it didn't -- they're already devalued. Not to go into a lot of detail with that. I really think Jackie covered everything very, very well. I agree with what Chic had said.

One of the things that you said, though, is a key point. You have to understand how RVUs are set up. You have to understand how surgeons get reimbursed for the care they provide. Workers' compensation, as you've been told over and over again, is by far more complex. There is more visits. There is more -- there is more care. There is more phone calls. There is more forms. But what wasn't mentioned is that when a relative value for procedures is dictated, half of that relative value is what we do as surgeons in the

operating room and half of that value is what we do outside the operating room. So if I have -- if I have a Medicare patient, when I used to take Medicare, if I have a Medicare patient who came in with a herniated disc, I didn't have to get authorization. I had to do the assessment of risk, indications, alternatives, have them sign, get their medical clearance to do all that stuff. Once I -- I would do the surgery. After the surgery, the majority of patients in the private sector will do well. We see them one or two times, and we're done. So the amount of work we do outside the operating room on the average patient is a tenth, if not even less, of what we have to do in work comp.

So when you say that you looked at the relative value of some of these procedures -- and my practice -- I've always -- when I was in Missouri it was the same way, and when I'm here it's the same way. My practice is a very niche practice. Orthopedics is a very broad field. I have a very vertical practice. I take care of lumbar degenerative backs. I get a lot of complicated failed backs, pseudoarthroses, patients who have had surgery that didn't turn out either for a wrong diagnosis or under diagnosis, whatever. The relative value -- if you say, for example, that decompression of stenosis in a Medicare patient, the

relative value, half that work is outside the operating room. In a work comp patient, we have to do probably ten -- five or ten times that amount of work rehabilitating patients because of the delays in getting a lot of these patients to the operating room. They're deconditioned. It takes more work afterwards to get them reconditioned. We have more arguments to get therapy authorized. We have more arguments to get patients into special programs like Recovia where they take some of these patients who have behavioral issues because their condition was delayed so long they now have behavioral issues along with the care. It is by far much more complex, about ten times.

So if you have a procedure where you consider half of what's being reimbursed is what we do in the operating room and the other half is what we do outside the operating room, every spine -- every orthopedic surgeon that was up here, Dr. Nassar and Dr. Greenfield, have said it's complicated, but that is taken into the system. If you use the RVUs for complex procedures, for spine procedures, for surgical procedures, in a non-work comp basis and then apply it to work comp, you have to understand that that 50 percent of that RVU is so undervalued in work comp that you are really creating a situation where you will have

surgeons like me who will -- who will stop seeing work comp or will not make it a priority.

One of my friends, Michael Wolff, is a physiatrist in town. He treats a lot of work comps. He gave me permission to -- he apologized he could not be here, but he basically said the same thing, that in their practice they have a priority of treating work comps. They treat a lot of work comps. But if they get paid only a little bit more and no more than the private contracts, they're going to stop seeing work comp, or it will no longer be a priority.

We've always had -- what's that? I'm sorry. But, anyway, I think the one thing I have to add -- I agree with what the other surgeons said, but the one thing I have to add is this is not just complaining about how much work we have to do in work comp. This is looking at the basic of how our RVUs are determined, and when you look at that RVU, 300 percent on a complex spine case versus an uncomplicated private case is inadequate reimbursement for the amount of time we put in. And the only reason that we do that is some of us, like Dr. Greenfield said, understand how to work in the work comp community, how to provide what they need, how to do the ratings, and therefore we get those referrals. And unless you continue to provide for that

in a reimbursement side, you're going to lose the quality physicians, just like Medicare is losing quality physicians because they treat physicians as criminals when they make billing errors. They're treated as criminals. So that's why a lot of sole practice -- I could not continue to see Medicare because of the risk of Medicare coming and doing an audit and just finding I didn't do rectals on my back patient, therefore, I've overbilled, and they charge me and treat me like a criminal.

MR. SCHULTZ: Questions?

Thank you.

Okay. Sara Sparman.

MS. SPARMAN: Good afternoon, Chairman, members of the Commission. My name is Sara Sparman. I'm here on behalf of the Arizona Self-Insured Association. ASIA represents some of the largest employers here in Arizona. We have Fry's, Freeport-McMoRan, APS, SRP, Banner, UNS Energy, Maricopa, and a number of public entities, most of the public entities here in Arizona.

We have reviewed the proposed fee schedule. We do have some concerns in Section 5 relating to networks. We appreciate some of the underlying financial concerns the providers have, and we'd like to

work with the Commission and staff and other stakeholders in potentially coming up with a solution to address those concerns. We do believe, however, the proposed language at this time could potentially have unintended consequences moving forward. We -- some of our member plans did take a look at what their savings would have been in the last year, what their cost saving utilizing networks has been in the past year. Our accounting members estimate in 2016 they received $1,800,000 in cost savings by utilizing networks. Freeport estimates approximately $1,300,000 savings in 2016. The Arizona School Alliance for Workmen's Compensation, which represents about approximately 60 percent of our school districts, estimated -- or realized approximately $4,000,000 in utilizing networks between July '16, July 2016 and April 2017, so we've seen some significant cost savings in the utilization of networks and being able to -- to work with those networks and manage our contracts with providers.

Obviously, the -- our second concern involves the possibility by adding these -- and I don't want to say arbitrary because there is some findings about why 10 percent -- or 90 percent of the providers, why the levels you had set on the fee schedule were -- we believe that potentially this could encourage an

anticompetitive nature in Arizona. Some of those network markets -- or those good networks might actually be encouraged to leave the Arizona market in its entirety, so those are just a couple of our concerns.

I reiterate we agree wholeheartedly with what Ms. Vines explained as well.

MR. SCHULTZ: Thank you.

Any questions for Ms. Sparman?

Once again, I'd appreciate any written comments that you would submit. I understand there are savings to using networks, but I also understand that a number of self-insureds are in the process of establishing their own networks just because of the lack of transparency, their lack of visibility to what the providers are actually being paid, and the concerns for the quality of the treatment for the patients due to the network intervention in the system, and so anything that you could provide us in terms of information, not just about the discounts but about the costs to achieving those discounts, would truly be appreciated as well as any outcome information.

MS. SPARMAN: Absolutely. And I believe some of our member plans will be making comments as well.

MS. ORCHARD: Mr. Chairman --

MR. SCHULTZ: Yes.

MS. ORCHARD: Sara, it's my understanding that the language presented to us does not preclude employers or companies or public entities to negotiate whatever discount they want to negotiate. This does not limit that in any way.

MS. SPARMAN: Correct.

MS. ORCHARD: I just want to make sure that's your understanding as well.

MS. SPARMAN: Yes.

MS. ORCHARD: Thank you.

MR. SCHULTZ: Karen Ruiz and Pablo Ruiz.

MR. RUIZ: Good afternoon.

MR. SCHULTZ: Good afternoon.

MR. RUIZ: Chairman, thank you. Staff members, thank you. Pablo Ruiz, Karen Ruiz from White Tanks Physical Therapy in Goodyear, Arizona, and really we would like to address Item 5 that Ms. Kurth brought forth in reference to the predatory networks that you brought forth. So I know that me dealing with the patient care on a daily basis over 25 years, 35 years, and Karen dealing way more with the administrative level, I would like her to go ahead and speak in reference to that.

MR. SCHULTZ: Thank you.

MS. RUIZ: Really, what we have seen in our very small clinic in the West Valley is patients that have been referred to us by their physician or they're familiar with our clinic because they've spoken with friends, they'll be referred to us, and we go through the process of getting authorization. They are then contacted by a nurse case manager or an adjuster and told that they cannot be seen in our clinic because we are not in network. And we go about the extra effort to indicate to injured workers that they and their physician do have a right for the patient to be seen where they choose and that we will get the authorization and they can receive treatment in our clinic.

I think that what happens is patients or the injured worker get confused. They don't know their rights, first of all. And they get confused by the term "in network" or "preferred provider," and what they are thinking is there is an assumption of the quality of care, that if you're not in the club, which we recognize is offering the greatest discount, possibly you're not providing the best care, or they feel pressured that if my employer is paying for this, well, then I need to go where they tell me that I need to go. And so we have gone about, as I said, the extra

effort of educating the injured worker and even gone to the extent of contacting physicians to let them know we will fight for this patient's right to be seen in our clinic, and we just want to inform you that a patient does have the right to be seen.

MR. SCHULTZ: Thank you. Questions?

MR. RUIZ: The last comment I would just like to say is I'd like to endorse Cynthia Driskell and Mr. Miller, both physical therapists, and back them up with their commentary.

MR. SCHULTZ: Okay.

MS. RUIZ: Thank you.

MR. RUIZ: Thank you.

MR. SCHULTZ: Mark Hyland.

MR. HYLAND: Good afternoon, Mr. Chairman and Commissioners. I'm happy to be here. Thank you for the opportunity. I'm here in support of the physical medicine, RBRVS --

MR. SCHULTZ: And you are?

MR. HYLAND: Oh, I'm sorry. I'm Mark Hyland.

MR. SCHULTZ: Representing?

MR. HYLAND: Representing STI Physical Therapy & Rehab. We're a provider of physical therapy and rehab, occupational medicine. Been doing -- involved with the work comp system for 25 plus years, and we've

operated a network. Networks are not bad. We're not here to bash the network, just some of the practices of the networks.

But I first want to say I'm here to support the relative value based system. I've been to a lot of these before. I think it takes a lot of work to do these things the way we're doing them and the comparisons. I think it makes sense scientifically. I certainly don't -- I'm not commenting on what my colleagues, surgeons have mentioned as far as it goes -- as far as physical medicine and rehab goes and the codes we use. I think it works, and we're supportive -- we're in support of that.

But as far as the networks go, I don't really want to -- you've heard Cynthia, Pablo, Mr. Miller and the others. You can have good networks, okay. And I've heard the word "legitimate" used today. There is legitimate networks that are going to be in existence regardless of what you do here, so I am in support of that paragraph 5 for sure.

I'm going to tell you we've been impacted so heavily. Our workers' comp has gone down significantly. We've been doing work comp, and we do it well. We do active rehab. We get people back to work. We know what it's about. But these networks

have harmed us. We've lost business, thousands of dollars. Our president can speak to that, if he wants to, but I know it's a lot of money.

And they're interfering with the care. They're delaying care. I heard the gentleman from the PPO association talk. Listen, they are not speeding up care. They're delaying care by a week or longer. Arizona providers -- Arizona providers are hurt, but who is hurt more? The injured worker and the employer. They're getting no benefit from this, no benefit. So legitimate PPOs and networks will still exist. This will not harm them in any way.

We operated a small network. We didn't charge providers money. They knew what they were getting on the contract. These self-insured employers will not be affected because they can still negotiate discounts with us directly, just not through a network that's taking over half of our money. We tried participating in these. We tried to play their game. It didn't work. The administrative burdens they put on us are immense. The payments are low. We got out. We got out. So we did try. I've got -- we've got perspective from all aspects, operating as a provider, operating as a network, small network. They do -- they do work, and they do provide utilization review and all the other

things that -- all the positive, the credentialing. These are positive things. They can do that, and they can still operate without making money, significant money off the backs of the providers. That is going overseas, by the way, not staying in Arizona.

Thank you. If you have any questions, I'll be happy to answer them.

MR. SCHULTZ: Thank you.

Questions? Thank you.

Marc Osborn.

MR. OSBORN: Thank you, Mr. Chairman.

For the record, my name is Marc Osborn. I'm here on behalf of PCI, which is Property Casualty Insurers Association of America. We represent some of the larger workers' comp carriers.

First I'll associate my comments with my friends at CopperPoint, given that they're one of our larger members so I always like to reflect their views. I have a couple of things to say, and I think my focus of my comments is going to be on that Section 5. I appreciate the idea that the Commission is expecting to provide transparency between insurers in the networks that were provided, but I believe that's a contract issue between the insurer and the folks that are providing a service for that. If they are not open,

show their books to us in a way that makes us happy, we will shop around to other providers. If their fees are excessive, we're going to be the very first ones who are going to put pressure on them to reduce their fees because it impacts our bottom line, so I appreciate the willingness to kind of step in between that relationship, but I think it's inappropriate in this context.

I also want to think through this idea of transparency and some of the other issues as it relates to insurers. The context we're looking at here is a fee schedule. Network add-on fees, some of the other things I think are better reached from an insurer perspective -- I can't speak to the self-insured -- through the Department of Insurance. If there are, quote, shadow networks or other things that insurance companies are operating, that's the more appropriate venue to take care of those regulatory issues and not through the context of a fee schedule.

So I think we need to kind of look at the scope of this fee schedule and kind of refine it down to what it should be, and so we're happy to sit at the table and kind of work through some of these issues. I think we have a fundamental issue with the idea of stepping in and trying to define what our networks pay,

what they're going to reimburse. And I know there is the idea that, okay, we can create our own networks, but what you're doing is saying, if you limit our ability to contract out networks to 10 percent, we have to find -- the math has to work for us, that it's, you know, cheaper for us to create our own network. And I think what you're going to see is there is a reason why many of our plans contract out, and if that scale tips the other way in the normal marketplace, then let that occur and don't use a regulation to kind of dictate the economic terms.

With that, I'd be happy to answer any questions.

MR. SCHULTZ: Thank you.

Questions for Mr. Osborn? None. Thank you.

Dianne McCallister.

MS. MCCALLISTER: Hi, Mr. Chairman, members of the Commission. My name is Dianne McCallister. For the record, I'm here for Express Scripts. We have just received the proposal recently and are currently reviewing it more, but we want to be on public record we have serious concerns with A(5) and its overall impact on the system and our ability to save our clients and our patients money. We understand the concerns that have been stated here. We echo the

comments of Ms. Vines and Marc Osborn and are willing to be a part of that conversation of solutions moving forward, but we do oppose that and hope that the Commission takes steps and address that proposal.

MR. SCHULTZ: Thank you.

Questions for Ms. McCallister?

MS. MCCALLISTER: Thank you.

MR. SCHULTZ: Thank you very much, especially for your brevity.

Laura Markey.

MS. MARKEY: Good afternoon. I'm going to be brief, too, because most of my colleagues in the physical therapy world have touched on the issues that I wanted to present, but I have to tell you a workers' comp patient versus a Medicare patient in my world, they're both a challenge, and they're both difficult, and if you've ever been to physical therapy our clients spend at least an hour, hour and a half in the clinic, and that has a value to it. We build relationships with all of our clients, workers' comp or not, so I appreciate your open-mindedness. I appreciate your transparency when it comes to going and moving toward the RBRVS system, and it's something that we've been working with with Medicare, and it works out well, and it puts a value on what we do based on research, and I

think that's -- I think that's a very good way to go.

I also wanted to talk about the challenges we've had with some of the network situations. I have a small practice up in Prescott, Center for Physical Excellence, and we, too, have been approached by networks that maybe will offer the insurer a 10-percent margin of profit, but then on the backside they're taking 30 percent off of what I'll get paid for rehab, so I have had to turn away workers' comp patients from my practice because I can't take the discounted rate on the backside from the clients that I'd really like to work with. And it's really important from a physical therapy standpoint that we have the time to work with these people and get them to the quality of life, whether it's return to full duty work or whether it's to take care of themselves at home, if they end up being in some shape or form of disability.

I also have been challenged with the -- some of the utilization review processes asking for a progress note every two, three visits, or in some cases a daily progress note on patients in the workers' comp world that in physical therapy is almost -- it's unrealistic, because progress does take place incrementally, but it's like losing weight. You don't step on the scale every day. You report progress when

it is, I guess, a noticeable change.

So I want to thank you for your time, and I do support you guys and your input on the 10-percent cap and thank you for everything you're doing.

MR. SCHULTZ: Thank you.

Questions for Ms. Markey?

And I want to thank you for coming so far to share with us.

MCCALLISTER: It's important.

MR. SCHULTZ: Weston Montrose?

MR. ENGLE: He had to leave. He had to leave.

MR. SCHULTZ: Okay. Is there anyone that wants to speak on his behalf?

MR. ENGLE: I can. I'm on the list as well. I'm Darryl Engle.

MR. SCHULTZ: Yes, you are. You're next.

MR. ENGLE: Great.

Good afternoon, Commissioners. I'm Darryl Engle. I'm a workers' comp attorney. I've been practicing not quite as long as the gentleman from the AMA, but also quite a long time. I also belong to AALIW, which is a group of attorneys who are active with the legislature. I think we've tried to be active with the Commission as well.

We've mostly heard today from the medical

community. I just wanted to say something similar from the legal community, and that is we are concerned as attorneys for our clients, and what we're concerned about is that as we stand here today there is really only a small group of doctors who practice in the workers' comp arena, and you've heard some here today who talk about diminishing their client base of workers' comp patients. That's our concern, that if these fee schedules result in reduction in payments to the doctors that that pool is going to be reduced and our clients are going to lose out on having the good care that they've had so far and getting them -- helping them get back to work.

So those are my comments. I hope they're brief enough, and I just wanted you to hear that from a legal perspective. Thank you.

MR. SCHULTZ: Thank you. Any questions? All right.

And, Mr. Engle, if you would please transmit to your group -- I assume AALIW will be making some written comments, and once again it will be very much appreciated if they include specific data beyond the hyperbole, rhetoric about physicians leaving, because as I stated before we've looked very carefully at other places to determine sort of what the tipping points are

and have carefully challenged ourselves to make sure that the reimbursement provided under the fee schedule, the proposed fee schedule, does not cause physicians to leave. And, in fact, that fee schedule, the fees for administering that fee schedule for the providers as well as other changes we're making are intended to entice physicians to come back into and expand the number of physicians that are willing to treat industrial injuries, and so any comments that you might make that provide concrete evidence would be helpful.

MR. ENGLE: Thank you. We'd like to be part of that process. Thank you very much.

MR. SCHULTZ: Okay. Last is our list of folks who haven't signed slips. There are people that have come in since. Is there anyone else who wishes to make public comments before we adjourn? I would like to remind you once again that you have until May 11 to provide written comments.

And at this point we're going to -- we're going to recess for a few minutes, 10 minutes, 15 minutes, and move the balance of the Commission meeting upstairs to the third floor conference room. Thank you all for coming.

(The proceedings concluded at 2:38)

C E R T I F I C A T E

I HEREBY CERTIFY that the proceedings had upon the foregoing hearing are contained in the shorthand record made by me thereof, and that the foregoing 70 pages constitute a full, true, and correct transcript of said shorthand record, all done to the best of my skill and ability.

DATED at Phoenix, Arizona, this 10th day of May, 2017.

Deborah L. Wilks, RPR
Certified Court Reporter
Certificate No. 50849