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

**PUBLIC HEARING**

Friday, May 22, 2015  
Elihu Harris State Office Building  
1515 Clay Street  
Oakland, California

**Destie Overpeck**  
Administrative Director

**George Parisotto**  
Moderator  
Acting Chief Counsel

**Karen Pak**  
Industrial Relations Counsel

**Melissa Hicks**  
Medical Unit Manager

**Rupali Das, M.D.**  
Executive Medical Director

**Richard Newman**  
Chief Judge

Reported by: Gina M. Kessler

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1 All of your testimony today will be taken down by the  
2 court reporter.

3 I'll call the names of the people who have checked that  
4 they do want to testify. I'll also check to see if anyone  
5 has -- anyone decides to comment as the proceedings go along,  
6 in case anybody decides to come and walk in the door.

7 This hearing will continue as long as there are people  
8 present who wish to comment on the regulations, but we'll close  
9 at 5:00 o'clock. My guess is that we'll be finished before  
10 then. If the hearing continues on into the lunch hour, and,  
11 again, that's something I doubt, we'll take at least an hour  
12 break for lunch.

13 Written comments can be given to Maureen, again, if you  
14 have them, or will be accepted by fax, e-mail, or delivery up  
15 until 5:00 o'clock at the Division's office. That's on the  
16 17th floor of this building. You'll have to cross over to the  
17 other side and go through security again.

18 The purpose of this hearing is to receive comments on the  
19 proposed amendments to the regulations and we welcome any  
20 comments you may have about them. All your comments that you  
21 give here today and those submitted in writing will be  
22 considered by the Administrative Director in determining what  
23 revisions we may make to the regulations.

24 Please restrict the subject of your comments to the  
25 regulations and to any suggestions you may have for changing

1 them. We generally like to have comments limited to about  
2 three minutes in length. Since we don't have a large crowd  
3 today, I won't hold fast to that, but, of course, brevity is  
4 always appreciated.

5 We will not enter into any discussions or give responses  
6 to your comments this morning, although we may ask for  
7 clarification, if necessary, or ask you to elaborate further on  
8 any points you are presenting.

9 Again, a reminder, again, if you have a business card or  
10 written comments, give them to Maureen. And when you come up  
11 to the podium, which is here on my right, please introduce  
12 yourself.

13 So, we'll start off with our first person. And I  
14 apologize if I do mispronounce your name; that happens to me  
15 quite often. Eric Freitag.

16 DR. FREITAG: Right here.

17 You're pretty close on the name.

18 MR. PARISOTTO: Good.

19 **ERIC FREITAG**

20 DR. FREITAG: Good morning. My name is Dr. Eric Freitag.  
21 I am a neuropsychologist and Qualified Medical Evaluator. And  
22 this morning I'm here representing the California Psychological  
23 Association, Neuropsychology Division VIII, of which I am a  
24 member-at-large, as well as the Northern California  
25 Neuropsychology Forum, of which I am an Immediate Past

1 President. And I am here today in opposition of the proposal  
2 to eliminate the specialty designation of neuropsychology.

3 A clinical neuropsychologist is a professional within the  
4 field of psychology with special expertise in the applied  
5 science of brain and behavior and how it affects one's  
6 functioning. Simply put, we evaluate a patient or an injured  
7 worker who has a known or suspected brain injury or brain  
8 disease and evaluate how their brain functions and how that  
9 might impact their day-to-day behavior and ability to function.

10 Neuropsychologists obtain advanced training in both the  
11 pre-doctoral and post-doctoral level and use this knowledge in  
12 the assessment, diagnosis, and treatment of patients with  
13 neurological disorders or injuries. Clinical neuropsychology  
14 is a specialty recognized by the American Psychological  
15 Association.

16 The activities of a neuropsychologist, whether that be  
17 evaluation, testing, treatment, diagnostic formulations, differ  
18 significantly from the approaches and techniques used by a  
19 general psychologist. A psychologist without the proper  
20 training and specialization in neuropsychology would not be  
21 able to competently administer a neuropsychological test  
22 battery.

23 The proposed regulatory actions ultimately place the  
24 injured worker at risk for either a delay in adjudication of  
25 their claim, or, potentially more seriously, obtaining an

1 evaluation from a non-competent provider. Consider a worker  
2 has sustained a traumatic brain injury and this worker obtains  
3 a Panel QME from a psychologist with no expertise in brain  
4 injury or no expertise in neuropsychological evaluation.  
5 Ethics would actually require that the psychologist decline the  
6 evaluation, which would certainly delay the worker's claim  
7 process. But, maybe more seriously, that psychologist may  
8 perform the evaluation and come up with conclusions that were  
9 erroneous that would impact the worker's claim and potentially  
10 also impact their future health care.

11 Our organizations are working with Assemblymen Mathis and  
12 Cooley in support of AB 1542. This bill would provide a  
13 legislative solution to this regulatory issue. And I'm here  
14 today requesting simply that you delay in making any rule  
15 changes at this point to allow the legislative process to  
16 unfold.

17 And if you have any questions, I'm happy to answer them.  
18 Thank you.

19 MR. PARISOTTO: Thank you very much.

20 DR. FREITAG: Thank you.

21 MR. PARISOTTO: Yaebin Bernal.

22 MS. BERNAL: That's me.

23 **YAEBIN BERNAL**

24 MS. BERNAL: Good morning. I'm a practicing Applicant  
25 attorney from Los Angeles with the Law Office of Robin Jacobs.

1 My comments are limited to the logistics of the panel  
2 process that the new regulations will require. And the first  
3 section I would like to address is Section 30(b)3). The new  
4 regulations seem to suggest that the requesting party would be  
5 given a panel that's generated automatically and then that  
6 party would serve the panel along with supporting documents to  
7 the opposing party within one working day. I think this might  
8 be a problem because it would potentially give the requesting  
9 party up to ten days -- ten extra days to consider the panel.

10 So, for example, if my understanding of the process is  
11 correct, the requesting party could get a panel on a Friday and  
12 that party would not be required to serve it on the opposing  
13 party until the following Tuesday. And then if mailing takes  
14 up to five days, then the opposing party would get it on the  
15 following Monday. So that's ten extra days.

16 I think it would be problematic because it's going to  
17 create confusion in the strike process. There are no rules  
18 regarding when the strike deadlines would start to run for each  
19 of the parties, and if one party gets the panel before the  
20 other one, then that's not equitable. Another concern is that  
21 the party that gets the panel first would have up to ten more  
22 days to consider the people of the panel and they would have  
23 more time to research the doctors and make their decisions more  
24 carefully.

25 And then I'm moving on to the second part of my comment

1 which is regarding Section 30(b)4) and 31.1. The new 30(b)4)  
2 contains language that delineates the acceptance time for  
3 requests that are submitted on a Saturday, Sunday, holiday and  
4 Monday through Friday between 5:00 p.m. and 12:00 a.m. It says  
5 that those requests would be deemed accepted the next business  
6 day. However, it doesn't say at what time. That seems like a  
7 simple enough problem to solve. You could just say that all of  
8 those requests would be deemed accepted at 8:00 a.m. the  
9 following business day.

10 However, the larger problem that I foresee is that the new  
11 rules do not contemplate what actions will be taken if the  
12 Medical Unit receives more than one request at the same time in  
13 different specialties. Previously, Regulation 31.1 addressed  
14 this issue; however, subdivisions (a)(1)-(3) and (b) of Section  
15 31.1 have been deleted under the new regulations, and without  
16 these rules, it would become unclear what the parties are  
17 supposed to do if simultaneous requests are received.

18 The new rules in the Initial Statement of Reasons indicate  
19 that Section 31.1 was deleted because with the online process  
20 parties will be unable to make simultaneous requests. However,  
21 I don't think that this will be true because all the requests  
22 made after 5:00 p.m. up until 8:00 a.m. and requests made on  
23 Saturday, Sunday, and holidays would be deemed accepted at the  
24 exact same time on the first following business day.

25 So, as a practicing attorney, I think we would like some

1 guidelines on how to proceed procedurally and logistically.  
2 Thank you for the opportunity.

3 MR. PARISOTTO: Thank you very much.

4 Mark Gearheart.

5 **MARK GEARHEART**

6 MR. GEARHEART: Good morning. Thank you for the  
7 opportunity to comment. My name's Mark Gearheart. I am an  
8 Applicant attorney practicing in Pleasant Hill, Certified  
9 Specialist, and I've been representing injured workers here in  
10 the Bay Area for 35 years.

11 I'm here this morning in my capacity as a member of the  
12 Board of Governors of the California Applicant's Attorneys'  
13 Association. Our biggest concern with these proposed  
14 regulatory changes is the change in specialties that is being  
15 proposed. Neuropsychology -- I have to concur with everything  
16 the earlier speaker said. Neuropsychology is a very important  
17 specialty and the only one that's competent to evaluate  
18 closed-head trauma. It's not the same as a psychologist or  
19 psychiatrist and throwing it into the mix is going to lead to  
20 QME panels that do not have competent physicians to evaluate  
21 head trauma cases.

22 I can tell you from personal experience, I have had cases  
23 of closed-head trauma where the treating psychologist or  
24 psychiatrist felt the person had severe brain damage and would  
25 probably never be able to work again. We got them into a

1 neuropsychologist who did extensive testing and determined that  
2 there was no brain damage, per se, but the problem was  
3 psychological and the person needed a specific type of  
4 treatment involving mental retraining and they would be fine.  
5 And they need a lot of reassurance, but there wasn't brain  
6 damage. I just can't imagine what's going to happen if this  
7 specialty's eliminated.

8 I think the rationale in the Statement of Reasons is  
9 misinformed. The change it says is required by Labor Code  
10 Section 139.2 because the California Medical Board does not  
11 recognize neuropsychology as a specialty. However,  
12 psychologists are not licensed by the medical board, they're  
13 licensed by the California Board of Psychology under the  
14 Department of Consumer Affairs. This has nothing to do with  
15 the medical board. And labor -- pardon me, Labor Code Section  
16 139.2(b)(5) only requires that the QME in psychology be  
17 Board-certified in clinical psychology by a Board recognized by  
18 the Administrative Director. The American Board of Clinical  
19 Psychology is one of the boards governed by the American Board  
20 of Professional Psychology, so the legal rationale is  
21 incorrect. And we did -- C.A.A.A. submitted written comments  
22 electronically that include this argument on these citations,  
23 but we think that's a real problem.

24 And, in fact, I think the changes in the medical  
25 specialties are really a solution in search of a problem. I

1 don't know what problem this is supposed to solve. It just  
2 creates one. It doesn't solve any problems. And the same  
3 could be said of the oncology changes. I don't really think  
4 there is a problem. I'm not sure what's being solved.

5 The Statement of Reasons simply says, We're not going to  
6 offer these specialties anymore. It doesn't say why. So one's  
7 left to wonder, is there no reason or perhaps there have been  
8 secret discussions with certain interested parties prior to the  
9 regulatory process without all stakeholders being involved and  
10 someone's got a hidden agenda? I don't know. But there's no  
11 basis for it. And we believe that the changes will deprive  
12 both employers and employees in many cases of having someone  
13 who's competent to evaluate the injury in the list of QMEs.

14 Of course, the ultimate solution is to get rid of the  
15 Schwarzenegger-era QME system, which is absolutely unworkable,  
16 defective, and causes poor-quality evidence, delays and  
17 increased frictional costs, but I realize that's statutory, so  
18 we'll move on. Some day the Legislature and the Governor will  
19 come to their senses and get rid of that. It's a bad system,  
20 but these changes will make it worse.

21 Now, in contrast, C.A.A.A. supports the online QME  
22 process. Yeah, the QME process is flawed, it doesn't work well  
23 for anybody, but this is a good idea and we commend you and we  
24 appreciate the effort that's gone into this. It's a great idea  
25 and we certainly support it. I do think there's a couple of

1 problems, though, I'd like to just call to your attention. One  
2 is this idea that the party requesting the panel should attach  
3 supporting documentation like the objection letter and all  
4 these things. That suggests to me that we haven't completely  
5 gotten away from the concept of the Medical Unit screening  
6 these things, which is the problem. The Medical Unit's not  
7 competent to screen these things. I just got another one last  
8 week where we had submitted the panel request on the 17th day  
9 after the objection letter and the Medical Unit rejected it  
10 because we requested it too early.

11 The Medical Unit's doing a remarkably poor job with the  
12 panel QMEs. And the problem is you either have people who  
13 aren't qualified or competent or overloaded screening these  
14 things. This shouldn't happen. If somebody wants a panel,  
15 give them a panel. If there is a dispute, go to the Board.  
16 Why submit documentation electronically to the Medical Unit  
17 that's already been sent to the other side? Are they going to  
18 screen these? If they're going to screen 'em, what's the point  
19 of having an online process? It won't speed anything up. The  
20 point of an online process is to eliminate the human errors.  
21 Give us a panel. If the other party has an objection, go to  
22 the Board.

23 So I would suggest -- and this is, again, in our written  
24 comments -- that the language should be added about supporting  
25 documents. If there's some supporting document that hasn't

1 been previously served, okay, fine, let's attach that. But  
2 normally these will all have been served on the other side.  
3 And if we're going to get away from having bureaucracy impede  
4 the process with human screening, then we need to -- I mean,  
5 why do we have these documents being attached?

6 Finally -- and I'll conclude with this: It's a mystery to  
7 me why the administration continues to violate Labor Code  
8 Section 124(b) which requires that all forms of notices given  
9 to the employee by the Division shall be in English and  
10 Spanish. The ongoing discrimination against Spanish-speaking  
11 people is unacceptable, illegal, and inexcusable. Thank you.

12 MR. PARISOTTO: Thank you.

13 Steve Cattolica.

14 **STEVE CATTOLICA**

15 MR. CATTOLICA: Good morning. My name is Steve Cattolica.  
16 I represent the California Society of Industrial Medicine and  
17 Surgery, the California Neurology Society, and the California  
18 Society of Physical Medicine and Rehabilitation.

19 I want to first of all agree with Dr. Freitag's assessment  
20 of the talent and training for neuropsychologists and echo  
21 support for Mr. Gearheart's comments with respect to the  
22 process. But that's not exactly why I'm here today, as you may  
23 know.

24 We support the idea of efficiency in the panel process. I  
25 think that the Division is taking a huge step in the right

1 direction. I think the previous testimony has been to the  
2 effect that we need to take a hard look at exactly how it's  
3 going to work, different than it might be written on paper, so  
4 that, in fact, it does work when it actually goes live. And as  
5 much time as it may take, we need to take that amount of time.  
6 And so my comments are about taking a little bit more time.

7 We, as you may know, have reservations with respect to the  
8 proposal to abolish the QME category of clinical  
9 neuropsychologist and to transfer all the currently-recognized  
10 neuropsychologists into the same category used for regular  
11 psychologists. Although the state's recognized neuropsychology  
12 for decades, since 1993, in fact, the Division's proposal is  
13 perhaps technically correct, given the strict reading of Labor  
14 Code 139.2. Nevertheless, as Dr. Freitag pointed out, there is  
15 a dramatic difference between a general psychologist and a  
16 neuropsychologist.

17 On the practical side -- well, I used to teach school,  
18 believe it or not, and I used to teach math, in fact. And I  
19 think that it's important to understand what the implication of  
20 putting all the psychologists into one category, homogenized  
21 category might be. And let me elaborate.

22 Statistics provided by the DWC's Work Comp Information  
23 System in June of 2014 indicate that from the year 2000 through  
24 2013 there were 39,203 brain injuries reported, an average of  
25 about 2800 brain injuries per year. Over that same period

1 there were 24,821 concussion injuries reported. And these  
2 numbers may not be very statistically large in the scope of the  
3 hundreds of thousands of claims that are filed in California,  
4 but these are rarely single-diagnosis claims and represent some  
5 of the most complicated and costly injuries possible. And  
6 surely for the workers and their families these costs go far  
7 beyond the hard costs of medical care, temporary and total  
8 disability.

9 We have an alternative. It is that, especially for those  
10 injured workers who are unrepresented, they can hire a lawyer.  
11 And the solution would be that that lawyer and the Defense  
12 lawyer get together and find an Agreed Medical Evaluator who is  
13 a neuropsychologist and ask that individual to provide the  
14 evaluation that may be necessary for a brain injury of the  
15 worker. However, we doubt that the employers would advocate  
16 for this alternative.

17 The real effect of the reclassification can be explained  
18 with a little bit of simple math. According to a DWC  
19 spokesman, there are approximately 450 general psychologist  
20 QMEs and 157 neuropsychologists. Therefore, when you put them  
21 together, the neuropsychs will represent roughly 25.9% of the  
22 new pool. The chance of an injured worker who needs a  
23 neuropsychology evaluation receiving a panel with three  
24 appropriate specialists will drop from 100% to 1 in 66. That  
25 is, there will be no better than a 1.5% chance that an injured

1 worker will have -- that has a brain injury will receive a  
2 panel of three physicians trained in neuropsychology. And  
3 given the fundamentals of the QME search process, the  
4 statistical probability of receiving a panel of this specialty  
5 type does not improve with repeated attempts. It never gets  
6 better than 1 in 66.

7 In fact, given that QME panels are generated using the  
8 residential address of the injured worker at the center of the  
9 search, a second, third, fourth or virtually as many  
10 subsequently-generated panels that you may choose or be asked  
11 to produce will have -- could have the same three general  
12 psychologists, unless the DWC intervenes in the process of  
13 choosing. And, of course, that would violate the requirement  
14 that the process be random. And DWC intervention would be in  
15 vain simply because the Division wouldn't have any way of  
16 distinguishing one type of psychologist from another either, so  
17 everybody's acting blindly.

18 This delay will negate the efficiency of the new  
19 electronic system. And the employer will pay additional  
20 temporary disability, perhaps, and certainly the case in some  
21 cases, and the delays will certainly have a detrimental effect  
22 on the medical condition of these severely-injured workers as  
23 they wait and wait.

24 In order to provide the Division with the required  
25 statutory authority to prevent the abolition of the QME

1 clinical neuropsychologist specialty category, as you've heard  
2 previously, an urgency bill co-sponsored by the California  
3 Society of Industrial Medicine and Surgery and the California  
4 Psychology Association was recently introduced by Assemblymen  
5 Devin Mathis, a Republican from Visalia, and co-authored by Ken  
6 Cooley, a Democrat from Rancho Cordova. It's anticipated that  
7 this bipartisan legislation will move through the legislative  
8 process relatively quickly. However, since the legislative  
9 process contains no guarantees, we're here to request that the  
10 Division thoughtfully consider the highly-negative  
11 repercussions of the proposed regulatory change abolishing the  
12 extremely useful and medically-critical designation of  
13 neuropsychologist as currently proposed in these regulations.

14 Our written comments will be provided to you by close of  
15 business today. Thank you very much.

16 MR. PARISOTTO: Thank you.

17 Joseph Roberts.

18 Is anyone else -- would anyone else like to offer some  
19 testimony today?

20 Generally, I would take a ten-minute break to see if  
21 anybody else would -- is going to arrive, but I don't think  
22 we're going to do that. So, if there is no one else here who  
23 is going to testify, this hearing will be closed.

24 The opportunity to file written comments, as I had  
25 mentioned before, will stay open until 5:00 o'clock this

1 afternoon. Those comments should be delivered to the  
2 Division's office up on the 17th floor of this building.

3 Thank you for your attendance and your comments today.

4 The hearing is now closed.

5 (The proceedings concluded at 10:30 a.m.)

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**REPORTER'S CERTIFICATE**

I, Gina M. Kessler, Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that the foregoing matter is a full, true and correct transcript of the proceedings taken by me in shorthand on the date and in the matter described on the first page hereof.



Gina M. Kessler  
Official Hearing Reporter  
Workers' Compensation Appeals Board

Dated: May 28, 2015  
San Francisco, California