



DRAFT MEETING MINUTES
May 15, 2009

Members Present: Ronald Bowman, MD (Chair); Timothy Keenen, MD (Vice-Chair); John Braddock, MD (Member); Franklin Wong, MD (Member); Hans Carlson, MD (Member); Gary Rischitelli, MD (Member); Frank Prideaux, DC (Member); Maria Carraher (Member—Worker Representative); Joey Blubaugh (Member—Employer Representative).

Members Absent: Brad Lorber, MD (Member); Tom Williams, PT (Member).

WCD Staff Present: Jacqueline Sewart, Juerg Kunz, Mike Manley, Barbara Smith, Fred Bruyns, Darren Heath

Approval of Last Meeting's Minutes

The committee reviewed the March 6, 2009 meeting minutes, including Dr. Rischitelli's amendments. Dr. Keenen made a motion to adopt the amendments. The committee accepted the motion. Dr. Keenen made a motion to approve the revised minutes. The committee accepted the motion.

Registry for Cervical and Lumbar Artificial Disc Replacement (Tabled from March 6, 2009 Meeting) All

The committee agreed that the division, when resources are available, should develop as a long-term project a registry for cervical and lumbar artificial disc replacement surgeries that would track data such as:

- The initial date of the surgery
- Further surgery after the initial operation
- The type of resulting disability, if any
- Work history since the operation
- Payment issues
- Medications (though this was noted by the committee as potentially being difficult to track)

The committee said this data would be unique and worthwhile, as, although there will be peer review literature on the long-term results of artificial disc replacement, it will not be Oregon-specific or Workers' Compensation-specific data. The committee said that after one year it might be useful to contact the workers and send an SF-36 to them. At that point, the committee

suggested that the division ask the worker some basic work-related questions. Dr. Rischitelli said that he would try to obtain a validated study on a Canadian work disability questionnaire that might help in developing our own similar questionnaire. The committee said they would like to receive data updates from the registry, yearly or maybe twice a year.

AMA 6th Edition Project Mike Manley

Presentation:

The division gave a presentation of the AMA Guides 6th Edition project, stating how, since the publishing of the 6th Edition in December 2007 by the American Medical Association, some states have adopted the guides and some states are using study panels to decide their worth. MLAC had decided that MAC should look at the medical issues relating to the AMA Guides 6th Edition, resulting in the AMA Guides 6th Edition Charter. The division will study the guides in a sequential approach: first, the medical policy issues; secondly, the administrative policy issues; and finally, the benefits policy issues. After each stage, the division will make a decision if it is worthwhile to continue the study of adopting the AMA Guides 6th Edition. For instance, if the division decides the guidelines will be an improvement medically, they will then study the administrative rules. In turn, if the administrative rules prove to be workable, the division will then study the benefits side. The presentation also covered the concern that the guides may lower ratings overall. To see if this concern is justified, the division said that it might be beneficial to run a study where the DCBS Workers' Compensation Division 35 Disability Rating Standards and the AMA Guides 6th Edition simultaneously looked at how benefits are affected. Then, if it proved to be good public policy generally, especially for workers, MLAC and the Legislature might want to adjust their benefit structure to take into account adopting the AMA Guides 6th Edition.

Post Presentation Q & A:

The committee asked if anyone had researched why some states declined to use the AMA Guides 6th Edition. The division said there have been various reasons, including: legal, logistical (for instance, in Iowa rural providers were concerned that the steep learning curve for the AMA Guides 6th Edition would cause reluctance among them in providing ratings), and benefits reasons. Although, as far as a choice not to use the guides because of benefits reasons, the division does not if there have been vigorous studies that show if one were to take a number of claims, benefits would be adversely affected—which is the kind of study that the division plans to carry out in the third phase of the project. The committee also asked of the 14 states that have adopted AMA Guides 6th Edition, does the division know how many of the attending physicians rate the worker. The division replied they could find out, though the actual number is nine, and of those states, the attending physician rates most of them. Moreover, in Pennsylvania it has only been looked at for permanent total disability, not for generic ratings. The committee stated that it

would be interested to hear the MAC sub-committee findings. The committee also asked of those states that have adopted the AMA Guides 6th Edition, and of those who are the attending physician who actually rates the worker, how many have an IME process where the attending physician says he does not want to do it, let the IME physician do it. For it has been the experience that attending physicians prefer not to perform closing exams, they would rather someone else do it. In addition, for the rating part, some raters may not at look the guides at all, just at what the division gives them. The committee said that education would be important part of any changes. The committee added that sometimes there is the opinion that once you have learned the Edition there is a disincentive not to use it. The committee said that mostly everything in the AMA Guides 6th Edition book are now diagnostic based estimates with adjustment factors for clinical exams, clinical studies, and actually assessing a person's function, symptomatic history. It is easier if physicians only provide impairment findings, while somebody else provides the rating; this is because sometimes all you need to know is the diagnosis, the worker's history, if there are any positive objective clinical studies, and are there any relevant clinical exam findings. You do not need an inclinometer etc. You do not need to do some of the things you do now. It is an entirely different paradigm. If MAC decides the AMA Guides 6th Edition are an improvement based on the given criteria it is going to require a shift in the administration and benefits side. It is not simply substituting one for the other; it comes at it from a different perspective. The committee said, as far as the rating goes, it would have to work out the administrative issue of the difference between the accepted condition and the actual diagnosis. Because medical providers are going to rate on what the rating was for the final diagnosis. Therefore, if there is an overlapping diagnosis you will have to choose what was the single most disabling diagnosis for that body part and rate it accordingly.

Dr. Rischitelli will chair a sub-committee, of him, Dr. Carlson, and Dr. Prideaux, that will answer the following questions:

- Does the 6th Edition represent an evolution in medical knowledge?
- Would use of the 6th Edition result in improved validity, clarity and inter-rater consistency as compared with Oregon's current method for rating impairment?
- Currently, insurers, based on medical findings and measurements, calculate ratings of impairment. Would this structure need to change with the adoption of the 6th Edition?
- Could attending physicians readily interpret and apply the 6th Edition? If not, what would enable them to do so?
- Who else could rate impairment using the 6th Edition?

WCD staff will provide assistance as and when necessary.

Dr Bowman asked when the sub-committee would likely report back with some findings. Dr. Rischitelli said the sub-committee would have a report at the next MAC meeting on September 18.

HB 2706 (Preponderance of Evidence Closures)

Barbara Smith

The division distributed handouts describing existing law and the requirements, with analysis, of HB 2706-3. The bill would authorize the insurer or self-insured employer to close a workers' compensation claim if preponderance of medical evidence supports closure and the attending physician fails to provide a closing report after receiving a request for that report. The Oregon Self-Insurers Association (OSIA) sponsored the bill. OSIA testified that sometimes an attending physician's failure to provide a closing report with findings of impairment cause delay in claim closure and overpayments of time loss to the worker. However, the division showed in a report of the types of medical provider complaints received by WCD in 2008 that only six complaints from 73 were for closing exams. The numbers show that the problem of attending physicians failing to provide closing reports might not be as widespread as possibly thought.

After Presentation Q&A:

The division said that MLAC would like to know the MAC members opinions and comments on the bill. The division will likely present the bill to the legislature in another two years. The committee decided to add the topic to the agenda for upcoming MLAC & MAC joint meeting. The committee asked if there was a way to educate medical providers about the existing law. The division said they could invite medical providers to the annual educational conference. The committee said that alternative methods of education, such as online instruction, might be preferable in encouraging education among medical providers. The committee asked if it would be appropriate to contact SAIF or Liberty for their experiences with closing exams. The division said they could do this if necessary.

Lumbar Fusion, Fee Calculator, and Hassle Factor Updates

Juerg Kunz

Lumbar Fusion:

The division said there are many published lumbar fusion studies that differ in quality and use varied exclusion criteria. The department presented a report using exclusion criteria used in the FDA's Premarket Approval studies. The division asked MAC if they could use these exclusion criteria as a starting point to develop guidelines that would assist physicians in recommending or not recommending lumbar fusion surgery. The committee said the exclusion criteria would also prove a useful tool for insurers. The committee said that they would have to look at the list carefully. The division also said that it would be useful to have Dr. Keenan's input on the different techniques and devices that the exclusion criteria would include, and how to group them. The committee said that they would like to see more on the project in July, taking into account how medical conditions like obesity might affect choices. The committee recommended the division consult the Washington State Department of Labor & Industries Lumbar Fusion Study, and the North American Spine Society Lumbar Fusion Study.

Drug formulary:

The division is considering a DOJ report that states a drug formulary may not work when taking into account current law. The division said that they would have more information regarding a potential drug formulary at the next MAC meeting.

Fee calculator:

The division said that the American Medical Association has approved WCD's use of a fee calculator that will allow medical providers to determine reimbursement amounts. The division hopes to post the fee calculator to the WCD website on July 1.

Hassle factors:

The division said they have visited medical providers in Portland and Salem to find out the types of hassles they have when dealing with workers' compensation patients. The division said they have found that consistent problems among providers, which they hope to soon address. The division also said that they hope to visit medical providers in the South of Oregon, and a family physician-type of practice to see what problems might be unique to that situation.

Overview of Draft Revisions to Form 827 Fred Bruyns

The division presented a draft version of the revised Worker's and Health Care provider's Report for Workers' Compensation Claims 827 Form for review and comment from the committee.

Briefly, the division said they have revised the 827 in the following ways:

- The form has been reorganized so that filing reasons are listed one through seven, with instructions about which party should provide the related information
- The form now provides for the worker to report a new or omitted condition
- The form has a release request required for HIV/AIDS information (and certain drug or alcohol treatment records)
- The form uses the term 'health care provider' instead of 'physician'
- To minimize identity theft, the SSN field has been removed from the form
- The division has streamlined the information pages that accompany the form. They have also reduced the "Notice to Worker" to a single page that could be printed on the back of the 827. If the 827 continues to have a removable page, it will remain a four-sheet unit. The online form would drop from five to three pages.

After presentation Q&A:

The committee said they would like "HIPPA" changed to "HIPAA". The committee said the removal of the SSN from the form might create two problems. Firstly, companies, particularly those in the agricultural and forestry industries, have been using the SSN to identify workers with the same name. In addition, some medical providers use the SSN when billing for reimbursement purposes. SSN uses like these may require the division to replace the SSN with

another personal identifier. The division said that workers do not need a SSN to file a claim, and that the removal of the SSN from the 827 has been to minimize potential identity theft. The division said they are planning to require insurance companies to provide WCD with SSNs; in which case, they will have to find a creative way of obtaining the SSN if it is not on the 827 or the 801. The committee said that health care providers would likely attach chart notes rather than complete the section of the current Form 827 requiring further medical information. The division said that they may see how many times this section is completed before removing it from the form, or remove the section from the form altogether in the draft stage, if appropriate. The committee said if a physician sees a worker with a closed claim, they do not normally know if it is an aggravation, or palliative care, or even if they qualify for palliative care. Because of this, the committee asked if there should be a section on the form for diagnostic assessment for palliative care or aggravation, particularly because of recent law changes. The division invited the committee members to participate on a Special Advisory Committee that will meet this summer to work on the 827 Form, the 801 Form, and some related rule making issues.

Legislative Update and Joint Meeting with MLAC Jacqueline Sewart

Legislative Update:

The division said that the Governor has signed few bills relating to medical providers and medical services, and they currently are:

- HB 2045 – Chiropractor Impairment Findings
- HB 2195 – Vocational assistance streamlining
- HB 2197 – Regulatory Streamlining
- HB 2420 – Firefighter cancer presumption

As far as legislation in progress that relates to medical providers and medical services, there are the following bills:

- Senate Bill 110 – Death benefits
- Senate Bill 509 – Provider Discount Contracts
- Senate Bill 3345 – Attorney Fees

The committee asked if bills changing commercial health care insurance settings would affect the division. The division said they are unaffected at this point, and are watching the bill. The division said the legislature has about six weeks to go until the planned adjournment in late June.

Joint Meeting with MLAC:

The committee asked how the joint meeting would work. The division said they have tentatively scheduled the joint meeting for September and they may hold it as part of the already scheduled MAC Meeting for that month. The division said they have yet to decide on a location for the joint meeting, though it could take place at the Salem Labor & Industries Building. The division said that they might have to extend the duration of the meeting because of the agenda items. The

committee said it would be a good idea to look at the agenda topics together. The division said they would be able to let the committee know more about the joint meeting at the July MAC Meeting, including proposed agenda items.

Palliative Care Denials

Dr. Bowman

Dr. Bowman raised the concern of insurers denying payments for follow-up visits after claim closure because the insurer did not approve palliative care. Juerg explained that, after being medically stationary, a worker might receive certain services, such as diagnostic services, medications and services to monitor or administer medications, without prior approval from the insurer. Dr. Bowman asked if he would have to take the cases to dispute resolution. The committee agreed that this would be the correct recourse.

The meeting began at 9 am and adjourned at approximately 11:30 am

Next Meeting:

July 17, 2009 9:00 a.m. to 11:30 a.m.

Clackamas Community College Training Center, Wilsonville