

**WORKERS' COMPENSATION
JOINT MEETING OF
MANAGEMENT-LABOR ADVISORY COMMITTEE
AND THE MEDICAL ADVISORY COMMITTEE**

September 16, 2011
9:00 a.m. - Noon
Clackamas Community College, Wilsonville Campus
350 Winter Street NE, Salem, Oregon

MLAC Committee Members Present:

Sheri Sundstrom, Hoffman Construction Company, Portland
Greg Miller, Gunderson LLC, Portland
Jeri Ray, Timber Products Company, Springfield
John Kirkpatrick, Painting and Allied Trades, Estacada
Kathy Nishimoto, Duckwall-Pooley Co., Hood River

MLAC Members Excused:

Lon Holston, Laborers' International, Local 483, Portland
Mike O'Rourke, Plumbing and Streamfitters UA 290, Tualatin
John Mohlis, Oregon Building Trades Council, Portland
Pamela Ruona, Oregon Health Care Association, Portland
Tracy Brill, Portland Fire Fighters Association, Portland

MAC Committee Members Present:

Ronald Bowman, MD – Orthopedic Surgery
John Braddock, MD – Occupational Medicine
Hans Carlson, MD – Physical Medicine & Rehabilitation
Brad Lorber, MD – Physical Medicine & Rehabilitation
Frank Prideaux, DC – Chiropractic
Gary Rischitelli, MD – Occupational Medicine
Tom Williams, PT – Physical Therapy
Joey Blubaugh
Marilyn Terhaar
Franklin Wong, MD – Physical Medicine & Rehabilitation

MAC Members Excused:

Timothy Keenen, MD – Orthopedic Surgery
Constantine Gean, MD

JOINT MLAC & MAC COMMITTEE

The meeting was called to order. Members of both committees introduced themselves. The physicians explained their practices. The MLAC members told who they represented and how long they had served on the committee.

Review Minutes:

Review of the MLAC minutes was tabled until the next meeting because there was not a quorum present. MAC approved their minutes from July 15, 2011.

Update on analysis of centers for occupational health project: Dr. Kent Anger, of Oregon Health and Science University, provided an update on the design for conducting the prefeasibility study analysis. He went over a handout that explained the methodology for conducting the project. His proposed outline to guide the purpose and scope of the project is:

- Describe the COHE Model
- Describe the conditions or problems the COHE Model was designed to address
- Describe the data used to monitor the success of the COHE Model
- Describe the results of the pilot and subsequent studies used to determine the success of the COHE Model
- Describe Oregon's current conditions and system structure relative to the problems the COHE Model was designed to address, including information and data already available that can be used to compare to the COHE data mentioned above (third item)
- Determine or estimate the cost of the COHE in Washington State and estimate the cost of implementing a feasibility study of this model in Oregon
- Develop the methodology necessary to conduct a feasibility study

He recommended that a committee be formed. Its members would consist of himself as the chair, a national workers' compensation expert who is not from Oregon or Washington, an occupational physician who is treating workers' compensation cases in Oregon, an economist knowledgeable in workers' compensation issues, a statistician/design specialist, possibly someone who knows the legal and ethical issues, and one other CROET staff member.

Dr. Anger summarized by saying the COHE is a model from Washington. The key questions that need to be asked are: Is it successful? Is it something that can be done in Oregon? What are the needs and problems in Oregon? Will this fit in Oregon? What is the cost of conducting a feasibility study to determine whether Oregon would benefit from implementing the COHE model? And, will this solve any problems in Oregon?

It was agreed that Sheri Sundstrom, Kathy Nishimoto and Dr. Anger would go visit and talk with Valley Medical, a Washington COHE, to learn more about their model.

MLAC members said they would review the COHE plan at the October MLAC meeting and will let MAC know if there was anything they would need to do for this project.

Background on MLAC Access Subcommittee process:

John Shilts, Workers' Compensation Division Administrator, provided some background regarding MLAC and MAC; what their purposes are, how the members are appointed, and what each committee is working on. He provided a handout that outlined these areas.

MLAC's current projects are workers' access to quality medical care, and looking at the impairment rating system. MAC has worked on several projects. Those projects include opiate management, impairment rating, platelet-rich plasma, and lumbar fusion.

Access to Medical Treatment Discussion:

Sheri Sundstrom, MLAC co-chair, provided MAC members with a background on the access to medical treatment issue. She reviewed topics that MLAC had identified as being some of the major issues regarding access to medical treatment for injured workers and told MAC that MLAC desired their input in this discussion/process of working to find solutions to the hassle factors surrounding access to medical treatment.

The following topics were discussed by the group:

- There is not enough financial incentive for doctors who are not seeing injured workers to do their claims. The compensation in the evaluation and management codes may not be high enough incentive to some physicians. Those who haven't done workers' compensation claims before or do them very rarely may not have current forms and do not know how to get the claim moving. It was believed that this is true among some MCO providers but suspected to be worse with those not in MCO groups.
- Knowledge of the Workers' Compensation Division and role isn't well understood by providers. WCD may need to do more education of providers.
- Providers who do not do workers' compensation and do not know the system are unable to address the questions of an injured worker. Workers are fearful of how long they will be out of work, will they lose their job, etc. and may seek reassurance from their provider. When the provider is unable to address the worker's fears, it adds more frustration and so providers may decide it just isn't worth the hassle.
- Many family practitioners are heavily scheduled, don't have time for the administrative parts of managing a workers' compensation patient and hassle factors are worse outside of the MCO for front line providers (no-one to help them or don't know where to go for help). These factors combine to drive many family practitioners to decide to limit practice to established patients or provide none at all. Workers' compensation adds about 20% more time for each patient because of administrative responsibilities and legal issues.
- Providers in rural areas who are a family's primary care provider are declining to be the workers' compensation provider because they do not want to risk losing the family as a result of a disagreement that might result from the outcomes of the workers' compensation claim. Therefore, these rural providers send the injured worker to someone in another area in an effort to protect their practice. This issue had been localized to the rural areas but there are signs that it is now moving into metropolitan areas.
- In medical school a provider is trained to be the patient's advocate. In the workers' compensation system the provider has three "masters": the injured worker, the employer, and the insurer. The provider has to stay objective.

- Not a lot of incentive to come to Oregon to practice generally for new providers. Recruitment in Oregon is hard because reimbursement rates are generally low here. New providers often choose to practice in other states.
- Providers that work within an MCO gain support from the organization and can go to them to get questions answered. The MCO sends patients to the provider and the provider establishes relationships with other providers. This gives the provider a network of other providers to use when needing to refer the injured worker. This can be very beneficial when dealing with a workers' compensation claim.
- Pre-authorization had been mentioned as a factor in why providers will not see injured workers. The MAC providers did not feel this was a huge issue. MRIs can often be done in the same day. It has been found in occupational medicine that if an MRI is done sooner in the claim a diagnosis can be made sooner, resulting in a quicker recovery. This is from the primary care point of view.
- Workers in need of acute care don't have a problem other than finding a provider who understands the workers' compensation system. However, the longer the claim goes on the bigger the access problems begin to be. In these long term claims, physicians see lots of denials and delays.

On the surgical side, pre-authorization is required and the insurer has sixty days to authorize. The surgeon sees the injured worker, explains that they must wait on the insurer for authorization and sets the process in motion. The surgeon will then see the worker thirty days later to confirm that nobody has heard from the insurer.

The Ombudsman Office for Injured Workers was asked what they hear from injured workers. Jennifer Flood, Ombudsman for Injured Workers Administrator, said that they hear that the worker cannot get into the provider's office to find out if they need palliative care or diagnostic care because providers are checking with the insurers and being told that it is not an accepted claim. Then the provider won't see the injured worker because there is not a guarantee of payment. Sheri asked the department to look into this issue outside of this subcommittee process. Also, workers trying to reopen their claims run into more access issues.

Throughout the discussion some ideas were suggested. Ideas discussed were:

- A new osteopathic medical school is opening up in Lebanon, OR that will be training a lot more primary care providers. It was suggested that WCD make contact with the school and inquire about what the students will be learning about the workers' compensation system and offer to provide training about the system.
- Areas of high risk need to be identified; high risk being those areas with fewer providers. The Portland area and even the Willamette valley would not be considered high risk but moving to the other side of either of the mountain ranges where the access issue is a much greater issue. Then identify providers within those high risk areas who want to do

workers' compensation and educate them. Identify provider groups that are having problems and focus on them.

Three levels of access care were identified. They were: the initial care, the specialist care, and access for aggravation of injury.

Mike McNickle, Workers' Compensation Division Medical Section Manager said that WCD is partnering with the Oregon Medical Association (OMA) to create a survey of their licensed doctors. The survey will address many of the hassle factors that have been identified. Once the survey is done WCD will use the data/information to do a road trip to go to providers and talk with them about the hassles.

MLAC and MAC felt it would be beneficial to maintain closer contact. They discussed having a member from one group attend the other's meeting. They felt it would be helpful to look for data that would compare the cost of procedures in Oregon to the costs in other states. This will be researched by the department.

Public Testimony:

Keith Semple, attorney representing injured workers, said that he agrees the goal is to get injured workers back to work, but felt there should also be the goal of providing the injured worker with quality care. He referred to a statistic that 80% of the injured workers desire to return to work and that 20% do not return to work and are seen as "problem" cases. He urged the committees to remember that within this 20% are injured workers who are in chronic pain. They don't know the system, they don't know where to turn, and they don't know what to do. They are not just "problem" cases. They are people who cannot get better but want to get better so that they can go back to work.

As the two committees continue to deal with the access to medical treatment issue, Mr. Semple stated that he did not want these workers to be forgotten. As the committees look at how workers are moved through the system, how things are going to be done, how it is going to be managed, and what types of care criteria there will be for these workers, he wants these workers to be remembered as people; people with families who desire to return to work and support their families.

Mr. Semple said there are many workers who are sent back to work before an MRI has been done. He has injured workers who were sent back to work for weeks and even months before they ever saw a specialist. He has had workers whose claim has been closed but the worker still has pain in their leg, they never saw a specialist and an MRI was never done. Far more often he sees injured workers who have gotten late referrals and late diagnosis. This is as much a problem that needs to be addressed.

He said that precertification is a problem that needs to be addressed. Workers are getting stuck with diagnostic bills after the claim closes because providers have no way of knowing if they are going to be paid for them. Providers need to be assured of payment so that they can move the claim forward faster. He felt something needed to be done to get the pre-authorization sooner.

Kathy Nishimoto stated that no one stated or ever inferred that “20%” of the injured workers were not deserving and wanted to make it clear that we value each and every injured worker and want the best possible outcome for them.

Courtney Dresser, the Oregon Medical Association, said there are many transformations taking place right now at the state and national levels. This is creating a lot of anxiety for physicians. These issues are making hard just to get physicians to come to Oregon.

The OMA is working with a data-collection point on a physician work-force study. They understand that workers’ compensation will be included in this study. This study, along with the department’s survey should make it possible to provide data to the committees by the end of the year.

Ms. Dresser felt that newer physicians who are employed by very large hospitals or clinics are missing from this conversation. It is unknown if these large groups are allowing their physicians to do worker compensation claims. Are they putting verbiage into contracts with their physicians that prohibit them from workers’ compensation? She believed it is an opportunity that needs to be looked at.

Chris Frost, attorney for injured workers, said that under Oregon law a worker has the right to receive certain medical services covered once the claim has closed. They can go for certain diagnostic services, they can get prescriptions authorized and paid for, they can receive treatment for an exacerbation to the injury. But physicians do not understand this and when the insurance company says that the claim is closed the physicians do not realize there are statutory provisions for these various services. She asked that the committees include this to their list of issues that need to be addressed.

Ms. Frost stated that insurance companies do not have to pre-authorize for diagnostics but yet workers are not always getting this treatment. Diagnostics are a critical issue and the new 827 form make it easy to ask for a new condition claim acceptance. She would like to see diagnostics be ordered first, which is allowed by statute, and then add the new condition to the claim, if needed. She sees a lot of injured workers who get their claims stalled in this way and the worker ends up in “limbo-land.” MLAC and MAC asked the department to find out more about this issue.

There were no other comments from the public.

The meeting was adjourned.