RULEMAKING ADVISORY COMMITTEE MEETING

July 25, 2017, 1:30 p.m.

Room F, 350 Winter Street NE, Salem, Oregon

WORKERS' COMPENSATION DIVISION RULES

OAR 436-015, MANAGED CARE ORGANIZATIONS

Stakeholders attending were:

Joy Chand	Takacs Clinic
Lisa Johnson	Majoris Health Systems Oregon, Inc.
Elaine Schooler	SAIF Corporation
Kevin Anderson	Sather, Byerly, Holloway, LLP
Susan Quinones	City of Portland
Jeanette Decker	Providence MCO
Jennifer Flood	Ombudsman for Injured Workers
Jaye Fraser	SAIF Corporation
Laurel Gunderson	Providence MCO
Chris Kafka	Kaiser-on-the-Job
Ann Klein	Majoris Health Systems Oregon, Inc.
Suzanne Ryans	SAIF Corporation
Vern Saboe, DC	Oregon Chiropractic Association
Keith Semple	Johnson Johnson Larson & Schaller PC
Ramona St. George-Suing	Majoris Health Systems Oregon, Inc.
Julie Tucker PT	Work Injury Management
Andrew Wilson	TriMet
Sam Whalen	TriMet
Jovanna Patrick	Hollander Lebenbaum & Gannicott
Bin Chen	Reinisch Wilson Weier PC
Dan Schmelling	SAIF Corporation

Department of Consumer and Business Services staff attending:

Barbara Belcher
Cara Filsinger
Don Gallogly
Fred Bruyns
Juerg Kunz
Robert Andersen
Sally Coen
Stan Fields

The proceedings in the above-entitled matter were held in Salem, Oregon, on the 25th day of July, 2017, before Fred Bruyns, Administrative Rules Coordinator for the Workers' Compensation Division.

TRANSCRIPT OF PROCEEDINGS

0:00: We are now recording. Hello. Welcome to--all of you. I really appreciate your coming down to talk with us about the managed care rules, Division 15 of Chapter 436. It's been a number of years since these were opened for sort of a general review. Sometimes we've taken care of business that we had to due to legislative changes or whatnot, or sometimes just in conjunction with maybe Divisions 9 and 10. But this is the first general review in several years, so we really appreciate you joining us to go over the issues that we have.

There are--there were, at least, some extra handouts in the back of the room, some agendas, and so I encourage you to pick one up. Or if you're on the telephone with us, it's posted to our website. If you go un--in under Laws and Rules and look for Meetings and Hearings, you'll find--you'll quickly find the agenda for today's meeting.

So with that, there's also extra name tents at the back. I think most of you have already picked one of the name tents off--up. And I would encourage you just to ever-so-slightly tilt them toward me, but not away from everyone else, just so that I can refer to you by name. And I think I know most of you, but I would appreciate that.

As we're going along today, if there are fiscal impacts to anything that

we discuss, whether that's positive or negative, we'd like to know about it. We need to estimate those impacts when we file proposed rules with the Secretary of State, and we rely on information that we receive from the people most affected by whatever the rules do. So keep that in mind.

There aren't a lot of ground rules. This is very informal. It's not like a public hearing. I encourage you to speak your mind. The only ground rule I usually ask for is that if you need to relate particular problems that you witnessed or experienced that you not name names of people or organizations involved. That really wouldn't help us with what we need to do today, and it might actually kind of cast a chill over the meeting. So I would encourage you not to do that.

Again, if you're on the telephone with us, please don't put us on hold. We might get your background music. You can actually leave and rejoin the meeting as often as you like. We also will pick up background noises in your office, even keyboarding. We will definitely pick that up, and it's not something that we can shut off. So I would encourage you to mute your phone judiciously as you like. But we do want you to participate, and we do want you to speak up when you have comments or questions for the group.

I don't know if I actually introduced myself. My name is Fred Bruyns. I coordinate the rulemaking process.

With that, I'd like to begin with the folks on the telephone and have you introduce yourselves to the committee. And maybe just trying to make it a more controlled process, if your last name begins with letters A through H, could you introduce yourself to the committee?

3:02: Hi. Cindy Hall with Paradigm Management Services.

3:03: Welcome, Cindy. Anyone else? Okay. If your last name begins

with I through P, please introduce yourselves. Maybe we have fewer folks on the phone than I thought. Everyone else who is on the telephone with us, if you could please introduce yourself?

3:31: This is Sue Quinones with City of Portland.

3:34: Welcome, Sue.

3:37: Keith Semple, Oregon Trial Lawyers Association.

3:40: Welcome, Keith.

3:43: Andrew Wilson with TriMet, as well as Sam Whalen with TriMet.

3:47: Welcome to you both. Anyone else? Okay. With that, we'll go around the table.

3:59: I'm Juery Kunz with the Workers' Comp Division.

4:03: I'm Jovanna Patrick, claimant's attorney, and also a member of the Access to Justice Committee.

4:10: Bin Chen, defense attorney, also on the Access to Justice Committee of the Oregon State Bar.

4:16: Jennifer Flood, Ombudsman for Injured Workers, DCBS.

4:19: Joy Chand, Takacs Clinic.

4:22: Julie Tucker. I represent Salem Health. I work at the Salem Work Injury Management Program, Outpatient Therapy Services.

4:28: Vern Saboe, Oregon Chiropractic Association. I serve on the Health Evidence Review Commission, evidence-based--no, the Value-based Benefits Subcommittee now.

4:39: Barbara Belcher, the Workers' Compensation Division.

4:42: Laurel Gunderson, Providence MCO.

4:45: Robert Andersen, Workers' Compensation Division.

4:47: Dan Schmelling, SAIF Corporation.

4:50: Kevin Anderson, defense attorney at Sather, Byerly & Holloway.

4:53: Elaine Schooler, SAIF Corporation.

4:55: Jaye Fraser, SAIF Corporation.

4:56: Stan Fields, Workers' Comp.

4:58: Ramona St. George, Majoris Health Systems.

5:01: Anne Klein, Majoris Health Systems.

5:02: Lisa Johnson, Majoris Health Systems.

5:05: Suzanne Ryans, SAIF Corporation.

5:07: Okay. Again, welcome. Oh, there are some folks in the back. I'll leave it up to you whether you would like to introduce yourselves to the committee.

5:13: Sally Coen, Workers' Compensation Division.

5:15: Cara Filsinger, Workers' Compensation Division.

5:18: Jeanette Decker, Providence MCO.

5:21: Don Bogley (phonetic), DCBS Research.

5:23: Okay. So welcome again. Any questions before we begin our agenda today?

Okay. We'll just start at the beginning with Issue No. 1. I won't read these verbatim, necessarily. Sometimes I will if they're--especially if they're brief, but I--we'll tend to hit the high points.

So the first one is general. "Do the rules governing managed care include requirements that are barriers to electronic communication, filing and document management?"

Some background. "Generally, the administrative rules should

emphasize the types of information that must be communicated, and not the forms the communication must take. However, workers and employers should not be required to accept electronic forms of notice."

And this is something that grew out of a committee meeting we had--there's some extra seats up here, if you'd like--with stakeholders last year. And we just promised that as each Division of Rules came open we would look at this to see if there are barriers that the rules have for efficient electronic communication that, you know, can benefit most everyone, or we hope it can. Sometimes there's pitfalls, and we recognize that as well.

But I would appreciate any of your thoughts on barriers that exist in the managed care rules to electronic communication, or maybe any other kind of communication that we haven't thought of, just something that's cheaper, faster and better.

6:59: Well, I would say that most workers are not usu--they don't have faxes at their homes, or other ways to receive it. So for us-- For people on the phone, this is Majoris Health Systems. It's Lisa. We have developed other ways to communicate where providers can send us documents electronically, not just by fax or attached to an email, but they can actually upload them into our system. And we are piling something with SAIF Corporation now with the sending and receiving documents via FTP. And the bonus for that is it's a very rapid turnaround, and the quality of the document is better, because it's--it hasn't degenerated each time it gets--goes through the fax.

7:42: And one concern that we hear expressed sometimes is that ordinary email, the kind that we mostly use every day, is not secure. So you cannot put--typically cannot put personally identifiable information in it. But it sounds like if

you have an FTP process maybe you get around that. Is that correct?

8:00: Right. So that will help with larger entities, but it's not going to help with workers. They generally--their information is going by regular mail.

8:11: Okay.

8:12: I think I've asked this at previous meetings, but is the Division looking at doing an online portal like the Workers' Compensation Board has where notice can go out and it has (unintelligible) saying who's received an electronic copy and who still needs a paper copy follow-up?

8:25: It is still something that's in the hopper. A few years ago now, we actually had a project, an internal project, where we talked about building more portals. I think there's some information we're receiving right now, but it's very limited. But we would, indeed, like something more like the Workers' Compensation Board has, ideally eventually, for all types of documents that have to be reported to us. So yeah, that's where we would like to go.

I was kind of interested to see if we were actually standing in the way of you folks doing business in anything that's in these rules, the types of notices that we require; can you do them in ways that you would like to do them, but not for the wording of the rules.

9:12: We have-- Barbara Belcher, Workers' Compensation Division. We're also working on looking at other processes in the Division. Right now, our applications in our current portal are very limited, but we're looking into other processes to see if they are a good fit so that our customers can have sort of a one-stop shopping. But this kind of work takes time and IT resources, so we'll continue to add things to the portal as IT resources free up for us.

9:39: Thanks, Barbara.

9:41: We just have, you know, direct connections with most of the insurers that we do business with, and a lot of the providers to where we don't have to use (unintelligible) email. Injured workers, we ask if they would like us to email them things, you know, and tell them how to use our secure email so that if they would like--prefer email--

10:11: Okay.

10:11: --they can get it. But, you know, the enrollment notices and things that have to go by mail, we always--and initial communications always go by regular mail, but…

10:23: Well, when you said they have to go by mail, is it in fact your understanding that the rules require them to go by regular mail at this point?

10:30: Well, the enrollment notices, the--all the steps that you have to take to make an enrollment valid, you know, with sending the enrollment, and then the injured worker has so many days to request a mailed copy, and all the documentation that goes with that, I think kind of prohibits any emailing in that process.

You know, I would hate to--I hate to make any suggestions to adding anything to the 801 yet again, but sometime in the future maybe there could be a checkbox, you know, that an injured worker could check if they prefer email, because actually some of the--their addresses are kind of sketchy, and--but everybody's got a cell phone. And I've actually heard from some that they say email is the more reliable way to keep in touch with them. So--

11:39: Interesting.

11:40: --just throwing that out there, but…

11:42: Okay.

11:42: Yeah, we don't have any specific problems with the rules being a barrier.

11:49: Okay. Anything else before we move on to the next issue?

11:53: Yeah. I don't think it's the rules that are a barrier. I think it's the requirements for personally identifiable information that make it difficult. Because if you're going to add something to the 801, there would no doubt need to be a very specific release accompanying that, acknowledging that information with personally identifiable health information on it, that might be transmitted, and that would be another whole page. And I, myself, would be a little leery of that outside of a secure email system.

12:29: Yeah. You have to use secure email, which many of them are not heard any--at all anymore, so…

12:37: Now, we use secure email for certain things in the Department as well, and it works.

Okay. I'll move along. You do have a-- This is true for everything we discuss today. If there's something that you think about after the fact, and you'd like to just send me an email, feel free, and we'll go ahead and take that into consideration. We want as much information as possible. So this is not the end of it, not the last chance.

Issue No. 2. Again, it's a general Division 15 issue. "We have heard from injured workers that it is sometimes difficult to find an MCO panel provider willing to treat them for their Workers' Compensation injury. Would it be helpful to require the MCOs to identify in their provider directories those providers who will only see existing patients? Is it feasible to require MCOs to update that information annually?"

Some background. “Some workers are calling multiple MCO panel providers trying to find a doctor, and are told either that the provider is not accepting any new patients or that the provider only accepts Workers' Compensation payments (sic) that are existing patients of the provider. This is a frustration for the worker, and may delay care. At least one MCO already lists providers who only accept existing patients. We know of one insurer who lists the MCOs’ panel providers, but does not indicate whether a provider accepts new patients or only existing patients.” This is--actually is above and beyond. Insurers are not required to provide this information.

“This problem cannot be fully resolved, but it might be mitigated if MCOs and insurers identify those providers whose office policy it is to accept only existing patients for Workers' Compensation injuries.”

So the options you see there would be to “require MCOs to identify in provider directories those providers who only accept existing patients.” If in--and the other is, “If insurers list MCO provider directories, they should identify those providers who only accept existing patients as Workers' Compensation patients.” Or there could be some other alternative that we have not identified here, and then we could welcome from you folks.

And at this point, again, we’re looking at this as possibly an annual update. I think there were concerns early on that this would have to be maintained, and it would be extremely burdensome to maintain it every--all the time. So right now we’re kind of looking at maybe annually, so I appreciate your input.

15:05: I only know of one clinic that has an office policy of only accepting existing patients. The problem that that-- And if you say an office policy is--there can be various policies within an office specific to providers. And I think

that's more of--some providers will take Work Comp, and some won't.

And they also change when--if they get too full of Workers' Compensation patients, they'll say we're not taking any for this--you know, right now, and that could change at any time. And the reason is they're--they feel that it's an administrative burden to have too many Workers' Compensation patients in one practice. And you know, they can get really full of--

16:06: Uh-huh.

16:07: --too many. Specialists, especially, are that way. Let's see.

Also, I found what happens is that as office staff turns over--and some offices have quite a lot of turnover--it seems like the last thing they teach their office staff is anything about Workers' Comp. And they'll just, you know, say no because it might have been the policy at the last office they worked in, or something like that. But it's difficult to identify, and it doesn't always encompass entire practices, you know, whether--and the reasons for not taking Workers' Comp are many.

And I think a lot of the problem is a lot of patients with old claims, you know, will come back or, for whatever reason, need to change doctors. And some of them really don't have anything that we can tell is related to the claim that needs to be treated. Or they might have been just declared medically stationary by one provider, and not feel that they were medically stationary, so they try and find another provider.

And no provide--a lot of providers, if the claim's over like six months old, they want to look at the records before they'll agree to take the patient. And they look at the records and not find anything at all to treat, so they don't take the patient, and--or the patient sometimes--you can tell by the records they've been a difficult patient for whatever reason, so they don't want that patient.

There's lots of reasons that some injured workers have a really hard time finding a provider, so I don't know how much that particular rule is going to help any of that.

18:17: With…

18:18: Go ahead.

18:19: Want me to? Okay. With that being said, this was a small step towards trying to minimize the frustration for these workers. If you're bringing on a clinic or a doctor onto the MCO, and at that time they say, you know what, I'm only taking existing patients, for the MCOs to be able to designate that it's going to save that provider's office a lot of--

18:46: Calls.

18:47: --unnecessary calls,--

18:47: Yeah.

18:48: --and it's going to hopefully reduce some of the frustration for workers. Granted, my list of what I would love MCOs to put on there--oh, I don't take it if it's 60 days out, I'm too full-- I mean, I had a whole list. We got to this one piece to see if maybe this could help with the issue. It's much larger than this one, but it's a small step towards that direction.

19:11: Are there that many offices, though? I mean, I only know of one whose actual policy is…

19:16: Yes. There's…

19:16: There's a lot of individual providers that do not. And we do-- when we have that information, we list that--

19:24: And it's…

19:24: --on our provider list. The issue I might have with an annual

requirement is that that would be really burdensome, to survey every provider every year and do it all at once. We tend to pick that up when we get a call from a worker or from the department or from an adjuster saying this worker can't find anyone. And then we look at, okay, are there no providers taking anyone right now, and update our list at that point.

Or if it's one where it's a difficult claim, and I agree that listing--not taking any new patients doesn't really address that group, you know, providers that--

20:06: Right.

20:06: --do take new patients are saying no, I'm not taking that patient…

20:09: Right.

20:10: And--but then, it really--the onus is on the MCO to find a place for that, or resolve the claim or disenroll the worker. But the onus still is on the MCO to maintain the access to care, and it can take a lot of work. And I think there's been a couple of situations where we have said, okay, there's nothing wrong related to the claim for this worker, there's no provider to take them. We're going to disenroll them and they can treat wherever they like, because there's nothing related to the claim. And if there's a new condition accepted or something, then we can always reenroll the claim, you know, and authorize an out-of-network provider or something.

But I personally don't have a problem with the concept of listing providers' restrictions on their practices. But just--my concern would be that if there's a compliance issue associated with that, it's--it is impossible to keep up with 100 percent. It's just a constant thing for Anne's department. You probably have one full-time person that sort of tries to keep track of--

21:21: Well,--

21:22: --who's seen patients.

21:23: --I feel Laurel's point is spot-on in that there are such a variety of reasons for why they're saying, I'm accepting only existing at this time. And so it changes. An annual oversight, not only would it be incredibly burdensome, it's just one snapshot. And I think to leave it open to the MCO to be able to identify how they're going to provide the oversight to identify this information would be better, it's more flexible that way, and probably is going to provide more real-time information than just saying just look at it once a year. Because I might have a situation where they're existing, but I call up to get more information about it, I'm hearing this feedback. And they say, well, so-and-so's out on leave for six months doing da, da, da, da, or we've got a coverage issue. So I'm calendaring out for six months to check in and say, has that changed? And so there's a lot more layers to this, that I think more flexibility is better to provide better data.

22:16: And then those--our provider updates are real-time. So if someone goes online or we print them a directory, it's data as of that moment. And so an annual update, again, is outdated the next day, so…

22:30: I think--Chris,--

22:30: Yes.

22:31: --I think you had your hand up.

22:32: Well, I just want to agree with the concerns that are raised by the other MCOs. I think doing an annual update-- So I was doing the math here, thinking, okay, we're going to survey all of our providers once a year to see whether or not they're going to be accepting the Workers' Compensation claims, and I just don't see that working very well.

22:56: Okay.

22:56: I don't think we're going to get the data.

22:57: Thanks, Chris.

22:58: And again, for the reasons cited by Ramona, I don't think it's going to be that helpful either for the workers.

23:03: Okay. I'll come back to you in just a moment. I think Dr. Saboe had his…

23:07: Well, yeah. In my area, we have a huge problems with workers trying to--finding someone who's taking a Workers' Comp claim, supposedly who's on the panel. My colleagues and I have talked about this several times. So something needs to be done. Has the Division looked at surveying--the staff surveying the lists of MCOs to get a sampling of how big the problem is, or not?

23:31: I'm not aware of…

23:31: Didn't we do that once?

23:33: I--yeah.

23:34: Yeah.

23:34: I've done it in a few cases when I was like no, there's got to be a provider. When I got to 23 nos, I gave up and…

23:42: Right.

23:43: I didn't give up, but I…

23:44: Turned it over to the MCO.

23:45: Yeah. I called the MCO and said, "Hey, I need your help."

23:47: Because there certainly are pockets in the state where it's a much bigger challenge than others. There's no question.

23:54: Well, that's true. And the--our problem has never been with

chiropractors. We have, I don't know, some--a hundred-some chiropractors on our panel. And if an injured worker wants a chiropractor, we often just, you know, offer that because it's easy, it's really easy, but…

24:17: But the access issue you were mentioning wasn't chiropractors, was it?

24:20: What was that?

24:21: When you said that providers in your area weren't taking patients, you weren't talking about the chiropractic--

24:26: No, I was talking about…

24:27: --community, the M.D.s and the D.O.s?

24:29: Right.

24:29: Well, you said your colleagues, so…

24:30: We have these arbitrary restrictions on us that are not evidence-based, by the way. Then we have to get a referral back. That's when it just--they have such a horrible time trying to find someone. It's--and I know there's one--I do very specialized treatment for disc herniation, a very specialized instrument treatment table, and we get great results.

I know one particular instance. It was a smaller comp carrier. And I know they were responding so well that they were going to--they were not going to have to have decompressive surgery, but I lost them. They--and the next time I heard from them, they had had the spinal surgery. So--and it was quite a ways down the line. So anyway, there's that disconnect. Not being able to find someone quickly, at least in our area, is a problem.

25:22: Okay. Jovanna, you had your hand up.

25:24: Oh, yeah. Certainly. So on the feasibility of annually updating

them, you know, as a committee one of the things that we learned was that, you know, one of the things that people wanted was more information on the list, and a most updated list. So I can certainly understand the feasibility question, and updating in real-time is certainly the best. But some oversight, some benchmark would need to be set so that there is something to measure it against, whether it's annually, whether it's some other benchmark. But, you know, what we've learned, what we've heard is that the lists are out of date, and something needs to be done to make them more accessible for the claimants.

And certainly on the question of difficult claimants, there are claims that, you know, there's no treatment for reasons. But the issue that we heard isn't that the doctor looks at the records, and then decides that they won't treat it. It's just a no immediately over the phone, without any chance to explain the situation or have it reviewed by a doctor. So getting them in the door to someone who's willing to look at the records would be a positive step even if, for some of those claimants, the answer will eventually be no after that review.

26:32: Okay. Thank you.

26:33: Could we maybe ask that the ombudsman's office let us know when they get a complaint, and which provider it's about, so that we could intervene in maybe removing the provider from our panel if they're not available or…

26:49: As the ombudsman, I will say that if we're not able to help the worker we are going to touch base with the MCOs. And we do call them and say, hey, right, you know, this person's having a problem finding--

27:02: Yeah, you do--

27:02: --a provider on your list.

27:02: --that, but…

27:04: But if the injured worker…

27:06: Uh-huh.

27:08: That's with their blessing going forward. It's not going to be every time a worker calls and complains about something that we're going to call the MCO and let them know, you know, that this doctor, this doctor, this doctor-- That was one reason why I went through the process of calling doctors, because they don't know. They went through the list, and they were just calling numbers. And to say, well, this doctor said this and this doctor said that, the--most of them are not going to do the documentation that you would probably need to go through that process, or they're calling--

27:41: Well, I mean…

27:41: --a doctor that isn't appropriate for their…

27:44: Just to be--to know that some--there was a problem, I would be happy to investigate, you know.

27:50: Right.

27:51: But--

27:51: Yeah.

27:51: --it's just that we rely on the provider or the provider's staff to let us know what's going on, and if they don't want to see Work Comp anymore or, you know, if they're retiring or moving or something like that. And each time we do hear about a situation like that, of course we, you know, take care of it, and--but--you know, but it's just that they don't always do it. If they don't take a lot of Work Comp for whatever reason--they might be, you know, a specialty, or just a PCP that, you know, I don't know, nobody calls for whatever reason and they retire. You know, we don't get notified. And I run into that a lot, so…

28:37: Well, I will say that--like with Majoris being able to list not taking current providers,--

28:43: Uh-huh.

28:44: --if I look at that and the person isn't a current provider, I know why that office isn't taking it. But on the ones that don't say, I--you know, I just move on to try to help them find a provider. Whereas if your list actually indicated, hey, the last time we talked to this provider they weren't accepting new patients,--

29:02: Well, we do have that,--

29:03: --then that reduces that…

29:04: --not accepting new patients, but not--I can't remember if we can say only existing patients. I think--I can't remember. But we do list, you know, if they're not accepting new patients.

29:17: Well…

29:18: I think--another word of caution here. Instituting something like what's being proposed here could function to further constrain the choice of providers for injured workers, because what's going to happen is the providers are going to get this call once a year, are you accepting patients or not accepting patients? And you know, some providers see Work Comp as a--you know, good reimbursement, but others see them as administratively burdensome, and this could just be one other thing that could be seen as another piece of the administrative burden that they need to carry.

So the easy answer oftentimes might be no, actually, right now we're not seeing--we're not going to accept Work Comp patients. So you could see--When, in fact, if--when--you know, down--a few months down the road when there's an up--when a work--when a patient calls and wants to be treated for the Work

Comp claim, that provider might very well be open to seeing them.

30:20: Yeah. I--yeah.

30:21: But no is going to be the easy answer for a lot of providers.

30:24: So they might remain for a full year in the directory saying they're not seeing their patients, when in fact they would?

30:30: Yeah.

30:30: So yeah. Okay.

30:32: But if those doctors are reluctant to take patients and telling you no because it's the easy answer, then perhaps they shouldn't be on the list in the first place,--

30:41: Yeah.

30:41: --because it's false information to the claimant, here's ten doctors who will see you. And if in reality seven of them are not that excited about taking Workers' Comp patients and will reject most of them, and two of them would rather say, we're not on it, well, now we have one person on the list. But the client--the claimant makes ten phone calls, you know, bothers ten offices, takes up administrative time, and ends up nowhere.

And I guess the real question that comes to mind is, you know, where do we put the work? I mean, you mentioned that well, if, you know, there's a problem, the worker can call me in, I'll talk to the provider and get it fixed. So it's--so the onus is on the worker to make the calls, get the rejection, call the MCO, tell them what happened, have the documentation, the MCO reaches out to the doctor. Do we want to put that onus on the worker, or should it be on the doctors who have contractually agreed to be on this list to treat patients? And under their contractual duties, they should have some duties to actually treat the patients or let people know

what their restrictions are, because they're much more able to provide that information than each worker on an individual basis jumping through many hoops, some workers which have, you know, very limited educational backgrounds, and many of whom had limited English language skills, which certainly, you know, amplifies the problem substantially.

32:05: If you tell providers that they have to take new patients, you're going to even further restrict your network.

32:10: No. Right.

32:10: And one of the reasons that we list those that are still seeing their own patients is because if the worker's injured and they look, oh, my doc's on there, I'll just go to him, because they're already an established patient. Providers are contractually required to keep us updated. If I terminated every provider who didn't do that, we would also have a serious shortage of providers. So, I mean, it's a very imperfect system,--

32:37: Yeah.

32:37: --granted.

32:38: And providers have mixed incentives for doing it. And I know a number of providers, they--they're taking--they take Work Comp patients more because they kind of feel it's their obligation to serve their community. So here we go putting in another obstacle--administrative obstacle in their way. And at some point they're going to say, yeah, okay, it's--yeah, I feel I have an obligation to serve my community in this capacity, but it's not worth it anymore.

33:08: What if you had a requirement that the MCO have a process to identify and document providers that place restrictions on their practice, and then leave it up to the MCO just as you do with other MCO processes, you know,

utilization review processes and whatnot, to define that process and what they're going to do about it? Still will not make it a perfect process, but it will make it a requirement for the MCO to make some attempts and outreach on that. So whether they do it through a--you know-- With us, you know, we're out to various providers' offices literally weekly, so--just getting that updated information. We get information from workers from the ombudsman's office, from Stan, from carriers, and incorporate all of that.

Again, it's not a big change in the rule, and it still puts the onus on the MCO to do it, but it maintains the flexibility to have that, rather than-- And again, if you do it on an annual basis, that will be no more effective than what you have today.

34:39: Okay. I'd like your thoughts on what Ramona just said about having a process that the rules could provide, you know, the flexibility for the MCO to kind of decide on what that process would be.

34:55: I like the idea, myself. It adds the flexibility for each of the MCOs, and it makes a step in the right direction for injured workers.

35:04: Yeah. And I think the worst thing in the world would be somehow to reduce access, and what I hear is that's a concern. And I know you all don't want that, either. Because, I mean, face it, access to medical care in Workers' Comp inside or outside of the MCO is a concern.

And I--frankly, from SAIF's perspective, our MCOs are helpful when a worker can't find a provider. And, actually, I've been involved in difficult situations where the MCO has been on the phone calling around and found a doc for a worker who's having trouble. So we see that as a benefit. But I think Ramona's idea is really a step in the right direction.

35:54: What about just having--ask that the MCOs put some kind of advisory in their directories in a place that's really obvious for a patient to see that says, if you're having trouble finding a provider that will take you, contact us at this number?

36:14: We already have that.

36:15: Well, that should be in the enrollment letter.

36:17: Yeah, in the enrollment.

36:19: Yeah.

36:19: We've got it, and they do. We take injured workers' calls where they haven't even lifted a finger to--

36:28: Right.

36:28: --try yet, and we'll--

36:29: Yeah.

36:29: --go right ahead and help them. And you know, if we get somebody who's tried and can't find a provider-- I mean, they don't have to make any initial attempt.

36:40: Yes.

36:40: We do not require that. But we will--that's a huge part of what we do every single day, is sit on the phone, calling around, getting injured workers in to providers.

36:54: Okay.

36:54: So, I mean, we do work hard at it and…

36:59: Yeah. Joy?

37:00: Coming from a provider's office, we--I actually do hear all the time from patients that, "I had to call so many different offices that--you know, the

offices that don't take Workers' Comp or bill Workers' Comp." So coming from a provider's office--you know. And I'm finding, you know, when patients do get us, you know, then they feel happy, oh, finally, you know, I found somebody.

37:20: "I got a yes."

37:24: Okay. Thank you, Joy.

37:25: Is there a way for the department to keep better track of, you know, these issues, these--you know, workers not being able to reach providers that will take their care? I think we proposed, you know, maybe in the past at other meetings that there be like an online forum where people can post, you know, hey, I've called these doctors but, you know, no one will take my care. So we can at least have a forum where these issues can be tracked, and so we're aware of the statistics of, you know, how often this occurs, and with whom this occurs.

37:56: You mean where they could kind of register--

37:57: Correct.

37:58: --a complaint just to let the world know that they tried to get a provider and they couldn't?

38:02: Or--yeah. Even if it's not public, maybe, you know, at least someone in the department keep track of that information.

38:08: Not to the nth degree. And remember, we only get the tip of the iceberg.

38:12: That's true.

38:13: It would be nice to have a process in place to where it's not dealt with on a complaint basis.

38:20: I think the only word of caution I have had with that is that when the worker gets a no they don't often ask the clarifying questions of, what does this

no mean? And so on a statistical basis, it's just going to look like a no. But a lot of times when we're calling, well, yeah, we're not right now, or, we're--we only take five Workers' Comp patients a month, because--but next month it will be open again. And so some of those nos are…

38:44: They call the neurosurgeon when they have a broken hand or…

38:46: Right.

38:46: You know, so…

38:47: Right.

38:48: Or they just say, well, do you take Workers' Comp?, and they say, no. And they might not even say, oh, I'm part of this MCO, I'm this or that. I mean, sometimes the--

38:57: Right.

38:57: --nos--when we end up calling the provider's--

38:58: Yeah.

38:59: --office, by having the conversation because we know the lingo, we can get to a yes,--

39:05: Uh-huh.

39:05: --but workers aren't savvy enough to get there in many cases.

39:09: And sometimes we--

39:09: And there are times when…

39:09: --call (unintelligible).

39:12: Yes, that's true.

39:12: It goes the other way as well, though. I mean, I've had MCOs certainly help with my patients. Hey, I got this doctor for you. I just talked to the

office. They said they're going to take it. You know, call them and make the appointment. And I call, and about 50 percent of the time the doctor's office says, I don't know what you're talking about, you know, I--we never said that, who are you? You know, that have no clue what's going on. So I think sometimes--certainly, sometimes nos could be yeses. Sometimes yeses could be nos. But having a centralized place where these complaints are made would allow for better tracking and better follow-up than the expectation that each worker will be savvy enough to know to call the MCO.

I know, generally, workers think about their adjusters. And then they call the adjuster, and if they're able to get a hold of them they say, call the MCO person. So it becomes a multi-level phone call.

40:03: I think this--we--I think there's--something is breaking down in the communication problems here. You hear from the MCOs that they are ha--that they are happy to assist workers find the care, that they have a lot of resources to do that, but somehow the workers are failing to recognize that they can call the MCO to avail themselves of those resources. To me, this is more of a communications problem than a--you know, a directory problem.

40:35: You know, workers are deluged with information--

40:38: Yeah.

40:38: --when they file a claim. And it's in their enrollment information. It's--I think it comes with our provider directory. It's online. It's--you know, there's lots of information out there. And I think just having the worker absorb it, and not really clearly understanding where what their adjuster does ends and what the MCO does begins-- You know, I guess my druthers would be that whoever gets the issue from the worker, that they just refer it immediately over to the MCO to resolve it, to

help the worker. So if the adjuster gets it or the attorney gets it, Stan gets it, Jennifer gets it, that it just go to the MCO.

41:29: Uh-huh.

41:29: And you know, that's our job and our requirement to make sure the worker gets appropriate medical care. Lisa's going, "Yeah, thanks, Ramona."

41:38: And then Jennifer going, yes, (unintelligible).

41:43: But, you know, that would, you know, help the worker not be making multiple calls. It would be--notice would be on us to contact the worker. And if they want us to schedule that appointment for them to do that, which we will do as well. You know, sometimes it's better for the worker to do it, because they know their schedule better than we do.

But yeah, I mean, I just think those things should just be referred over to the MCO to resolve. It gets our records updated. It gets the problem solved. It gets the worker seen in the fastest way possible.

42:21: Okay.

42:22: I think the Department's website or the Division's website could maybe make that more clear to workers on your Injured Worker page. "You have trouble, Call the MCO," in great, big letters or something that's kind of--I don't--you know, I haven't really seen that there. It mostly explains what an MCO is, what they do, but it's kind of wordy and complicated. And if bold letters stuck in there, "If you have any problems, call your MCO," that might help.

43:04: Okay.

43:04: And tell them, after five calls, call the MCO if you still can't find a doctor.

43:10: Yeah. We will always have those who--

43:15: Fred?

43:15: Yes.

43:15: --don't want to do it.

43:16: Go ahead.

43:18: This is Keith on the phone. I guess I'd like to just maybe offer maybe a little bit of an alternative perspective here. I mean, we started out with a Workers' Comp system that requires compensable treatment to be provided to injured workers, and that's evolved into a system where insurers can choose an MCO to have some oversight on the medical, and limit the number of people that a worker could go to to be seen. And part of that trade-off is having an updated list of providers and having a sufficient number of providers so that you don't have to send an injured worker just to one particular doctor. So if I'm an injured worker and I get information from the insurer and the MCO-- First of all, most of my clients don't know which is which.

44:02: Right.

44:02: I ask them who their claim is with, and they tell me it's with Majoris and not with SAIF, or vice versa. They really don't understand. But they kind of understand that the MCO company is putting some limitations on who they're allowed to treat with, and that they maintain a panel.

So, frankly, if I'm the injured worker and I'm getting stuff from the MCO and the insurer, and suddenly I can't find a doctor to take my case, I probably don't feel real confident in calling the insurer and asking them to pick my doctor for me, or the MCO for that matter, because I'm an injured worker, and I really probably don't know the difference all the time.

So these directories, which I understand can't ever be a hundred

percent perfect, are extremely important because they're--they represent the panel. The represent either a panel of sufficient number of providers or a panel of insufficient number of providers. And if you have these directories that are inaccurate, that's been documented by our Access to Justice Committee, also by Jennifer Flood, that a lot of the doctors won't take a case for this or that reason, then you don't really have a full panel of the people that you say are willing and able to take these cases.

And at that point, you really lose a lot of legitimacy of the system that's based on, okay, we're going to take a little bit of the worker's choice away, but we're going to offer a full panel of options so that they can still choose their provider. So these directories are really important for that reason, and that's why this is a real big problem. It's not just necessarily who the onus is on, but it's really part of the *quid pro quo* on even having MCOs in the comp system. So that's why injured workers are pretty concerned about this issue. Even the Access to Justice Committee has shown a lot of interest in this issue. And that's really the perspective that we're coming from in terms of the importance here.

So I'm not sure what the answer is. I know that there's--we don't want to create more barriers to doctors being involved, but we do need some sort of oversight on these panels, because they are important. And somebody needs to be kind of watching this, because it's been documented a number of times. I mean, I'd be interested to hear more about the Access to Justice survey, because I understand the numbers were pretty bad there. And it's an issue that really has to be addressed somehow.

So I just wanted to kind of share that perspective, you know, about what I'm hearing here. It's kind of like these things aren't really all that important and

the MCO can find providers, but that's really not the point from the injured worker's perspective. Thank you.

46:37: Thank you, Keith. Do you have data on…

46:41: Yeah. The statistics that we looked at was information from panel providers reported to the Division in the second quarter of 2016. And what those numbers show are geographical area, MCO provider, and how many providers say they will be attending physicians and how many say they won't. So this doesn't delve into APs who are willing to treat specific kinds of patients, but just APs in general. And what the statistics show is that, you know, at best it's about 50/50, meaning half of the providers on there are saying they will be attending physicians, but we don't know if they'll actually take patients, you know, based on various things, and half of them are not APs. I believe that for Majoris it was 82 percent in the Portland metro area that were not attending physicians, based on those statistics.

47:31: Are you looking at all provider categories or--

47:34: Or attending physician categories?

47:36: --M.D.s, D.O.s, chiros, naturopaths?

47:39: This is just people who are listed on th--doctors or providers who are listed on there as they can be attending physicians, and doctors who say they cannot be attending physicians.

47:47: I'm still not clear. Are you counting physical therapists and massage therapists and acupuncturists and--as participating providers in those numbers?

47:57: It's just physicians.

47:58: Just M.D.s, D.O.s, chiros, naturopaths?

48:01: The statistics say it's designated the number of physicians. I

can't--you know, those--that's what the statistics say. I can't tell you if it's all of those. That's what they said.

48:13: I'm sorry. Is that statistics from the Access to Justice Committee?

48:18: Uh-huh. Yeah.

48:18: And where is that? Who is that?

48:20: This was derived from the panel provider data that has been reported to the Division by each MCO for the second quarter of 2016.

48:29: No, I mean the committee. Whose committee is it?

48:32: This the Oregon State Bar Access to--Workers' Compensation Access to Justice--

48:35: I'm sorry, I couldn't hear you.

48:36: --Committee.

48:38: I'm sorry.

48:38: The stats come from the Department. Jovanna and I are members of the Access to Justice Committee that's part of the Oregon State Bar.

48:46: Okay.

48:47: So our panel of lawyers, defense attorneys, claimant's attorneys and judges.

48:51: That's what I wanted to know. Thanks.

48:53: Is that-- I don't know if that's publicly available. Is that information that you can provide the Division?

48:57: Certainly. I believe it was information that was obtained from--

49:00: From the Division.

49:01: --the Division in the first place.

49:02: But you may have actually--I don't know if you…

49:02: Yes. And I'm happy to provide that to you--

49:05: Okay.

49:05: --in the form that we received it after this.

49:08: When you looked at those statistics, was that just by reviewing the data that was reported to the state, or was there an actual analysis--

49:16: I don't think so, no.

49:17: --done to the providers?

49:18: It--what the statistics say is that the information was derived from panel provider data that had been reported to the Division by each MCO for the second quarter of 2016.

49:30: It seems to be like just from the (unintelligible) that you're talking about like they're including specialist physicians that would be part of the MCO panel, but wouldn't necessarily be considered for attending providers, such as orthopedic surgeons, neurosurgeons, those types of physicians, and that is completely reasonable.

49:51: Many of them prefer to be--act as consultants, rather than--

49:55: Attending.

49:55: --attending physicians.

49:56: Certainly. But there does need to be a sufficient number of attending physicians, because claimants will never be able to access these specialty providers unless they have an attending provider who's willing to make those referrals. So I think it is important how many attending physicians are available. Certainly, we want other physicians as well.

50:17: But that is part of the--part of what the MCO needs to

demonstrate in its certification, that it has a sufficient number of attending physicians in the geographic service area. So the fact that there's a data set out there, and you do an analysis of that data set and 80 percent of the physicians on there aren't attending physicians, well, that's neither here nor there. You're comparing apples and oranges.

50:38: Well, I'll tell you what. What we'll do is, if you could send us the data that you have, I will provide it back to the committee and so you can kind of look at it and see if maybe it says what you--what we think it does, or maybe there's some points missing. But with that-- And I know we've had an excellent discussion, and some excellent ideas put out there, including, you know, having a process, maybe more information so that the worker will call the MCO sooner, maybe some performance measurement like Bin said.

But if it's okay with the group, I-- And again, you can always send in additional thoughts that you have on this later. Nothing's going to happen instantly. And we also, of course, will go through a proposed rule process at some point. Of course, we'd like to get the rules kind of firmed up as much as possible before we get to that stage, but--and then we can take formal testimony.

51:34: Fred, just one thought that really hasn't been mentioned here. The inability to find an attending physician is not limited to MCOs. It's prevalent outside of the MCOs as well. The difference is, within the MCO, the MCO has an obligation to help that worker find one. And outside of that, there's no obligation for anyone to help them find an attending.

51:57: Although outside of the MCO the choices are much greater, meaning I can go to any doctor and try to get a provider, versus just the providers on the list.

52:05: There's a--

52:06: So--

52:07: --lot of areas…

52:07: --part of that trade-off that Keith was discussing on the phone is that if you're going to limit the workers to a certain number of providers then it needs to be a sufficient number so that the claimant still has choice. And I certainly--we appreciate what the MCOs do to help the workers, certainly. But the information we're getting over and over again is that the numbers just aren't sufficient for the need.

52:28: Well, do you have a statistics too, though? I mean, have you all been keeping track of that?

52:33: That is why we had come up with the idea of having a complaint system, so that someone could have oversight, meaning within Workers' Comp Division, of how many times these things come over again and again, because certainly we can't--no individual person and no individual MCO could track every complaint by every worker against every doctor. That is why we thought that it would be a good idea to have some oversight and have some centralized place that these are tracked, so that we can figure out which issues are one-off issues, which issues can't be solved, but what issues come over again and again that maybe can be solved on a more holistic basis?

53:12: Can I make one comment?

53:13: Okay. Yours will be the last one, Suzanne.

53:14: Just very quickly. Yes. Thank you very much.

53:16: Yeah. Yeah.

53:17: I've been a--I was an adjuster for about 20 years before I joined

my current role. And as an adjuster, maybe only 15 percent of my claim load was represented by an attorney. And so that leaves 85 percent that aren't seeking attorney help. And so what we're not capturing in this conversation is all the times that it has worked.

But as an adjuster, if someone called me and said, I can't find a doctor, my referral was to the MCO representatives, and it pretty much went to rest for the most part. And I'm just talking anecdotally from my experience. But for the--Keith had said something about "they all end up at once certain doctor." I can attest to the fact that there does become a certain population of injured worker who does end up at certain providers, because those providers are the ones that are willing to take on those extremely complex, longstanding, difficult claims, and everybody else is going, I'm not going near that. And then we have a few physicians that say, yes, I'll take it on.

And so what--I agree that if there's issues that need to be captured, they need to be captured, and it would only help the system if we can figure out if there's a problem, but I wouldn't want us to miss all the times when it's working right.

54:37: Okay. Thank you. I'd like to move on now to Issue No. 3, which actually affects Rule 5. It's a pretty straightforward issue. "The Division 015 refers to Division 010," which are the medical services rules, "for its definitions. This is cumbersome for the user of these rules. Would adding new definitions to Division 015 make these rules more user friendly?"

And then under background we really duplicated a little bit of that information, but the final sentence is significant. "When WCD included the applicable definitions within the Division 009 rules, it was well received by stakeholders." So that's been our experience.

And so below you will see a list of definitions that we think we would like to add to the managed care organization rules, because these terms do appear in these particular rules. But we'd welcome your input on that in terms of whether you prefer that we do not, or you might think of additional terms that might--that you think might need to be defined. Any concerns about adding the definitions to Division 015?

55:52: My only question was whether there--these were any different than the ones that are reviewed to in 010, whether there's any substantive change, or we're just reprinting the same definitions in a more convenient location?

56:05: Gary, you'll know the answer to that.

56:06: Yeah, that would be the idea. Yeah.

56:08: Yeah. We want them to be identical. If we're going to have them in more than one place, we definite--unless there's a good reason. Occasionally, there's a good reason for a definition to be different depending upon what you're defining. Yes.

Issue No. 4. We're up to Rule 8(1). "Should WCD remove the requirement that requests for mediation be submitted in writing? Accepting requests by telephone can expedite resolution of disputes."

"The rule allows a party to request that the director provide voluntary mediation after a request for administrative review or hearing is filed. The current rule further states that voluntary mediation requests must be in writing. However, the Division accepts requests for voluntary mediation by telephone on a regular basis."

So that's a case where I guess we would like the rule and actual practice to match. But I would be interested if you have any concerns about us

actually taking these kinds of requests over the telephone verbally.

57:21: Fred, I've got a question. Just because I--as far as I know, we have never had a request for mediation from--or nobody's asked--ever asked for one. Does--say the director offers it. Is it offered--if an injured worker or their attorney appealed an MCO decision, is the MCO offered that--to participate in that too, or is it--how does it work?

57:54: Stan, do you have any insight into that?

57:56: I think it's more ADR than mediation, per se.

58:00: Yeah.

58:01: Because MRT does a lot of ADR-type stuff. So I think that was the thought, as opposed to formal mediation.

58:10: Oh, correct, because there's really a number of instances where the problem is actually just resolved, you know, by call--making telephone calls to the parties, rather than having to issue a formal order.

58:21: Okay.

58:21: I think, increasingly, the Division tries to do that actually as a way to expedite the resolution. And so yeah, the parties who are ever--whoever is a party to the dispute is, I'm sure, going to have to be contacted; right?

58:36: Well, I guess we have them before…

58:41: It's not formal.

58:41: Okay. I get it. Well, but--you know, they've called us and kind of worked out things before, but I don't think it's like a formal thing.

59:01: Yeah, we may not have used the word mediation. And in fact, I doubt we would have. I don't know if this is the right term--word to have used in the write-up of the issue, but it is alternative dispute resolution.

59:13: (Unintelligible) mediation.

59:15: Yeah.

59:15: And maybe that's--you know, maybe it should say while during mediation or alternative dispute resolution.

59:22: Okay. We'll certainly look at that in terms of maybe whether the correct term is used, not just in the issue, but in the rule itself.

59:32: I just think that mediation is something different, something more formal.

59:37: Yeah, it typically is. Okay. Are we up--are we ready to move on to the next issue? Issue No. 5.

Again in Rule 8(2)(a). "When WCD gets a misdirected appeal that is required to go to the MCO first, the appeal period may end before the party has the opportunity to refile an appeal with the MCO."

Some background. "A party that disagrees with an action taken by the MCO must first use the MCO's dispute resolution process by appealing the decision to the MCO within 30 days; otherwise, the party loses all rights to further appeal the decision. Occasionally, a party appeals an MCO action to the director of this agency, rather than the MCO. If the deadline for appeal is near, the party may lose appeal rights before refiling with the MCO is feasible. This proposal would not affect the 60-day time frame the MCO has to issue its final decision, as the 60-day time frame does not start until the MCO actually receives the appeal."

So an option would be to toll the time allowed for appeal for a limited period of time if the appeal is misdirected to WCD, the Division, or perhaps some other alternative.

60:47: What am I missing? If the toll doesn't start until the MCO

actually receives the appeal, why does it matter where it went furthest?

60:59: You're thinking 60 days, Barb.

60:59: Pardon me?

61:00: You're thinking of the 60 days…

61:02: It's some of the 30 days.

61:03: It's the 30 days that could run out. The 60 days, you will always have upon your receipt.

61:08: So the worker appeals on day 29 but appeals to the Department, and we don't know about it until day 31. So--

61:15: Oh, I see.

61:16: --as far as we'd be concerned, the worker would have lost their appeal right.

61:18: Well,--

61:20: I mean…

61:21: --from the--when the issue…

61:23: If it happened.

61:24: Yeah.

61:26: I've been involved in two of these situations in--probably in the past year. Both times, the worker was represented by an attorney. And I'm sorry. If they're represented by an attorney, and the attorney doesn't know better about what the rules are, there should be no--you know, that's…

61:45: That's true. The one we just got was from an attorney that sent it...

61:48: So…

61:49: Well, in terms of our rules, I don't think we're going to make any

distinctions. In other words, if it arrives in the Department and it shouldn't have, we'll handle it the same way whether they're represented or not.

62:00: Could there be documentation so that there isn't a gap, I mean, or how would you track that?

62:10: So anything that I'm saying to the Department gets date stamped.

62:13: Yeah, but…

62:13: And then…

62:14: But what if they just call Jennifer?

62:16: What they have to do is…

62:17: No, it has to be in writing.

62:19: It would have to have a stamp on it, WCD.

62:23: The appeals have to be in writing.

62:25: This seems like it could open the door to more gaming of the system.

62:28: Yes.

62:28: It does to me.

62:30: And so what if it comes to the Department, no one really realizes it, it's six months down the road and they finally send it to the MCO?

62:37: Well, the rule says it would extend the 60 days, so…

62:41: No. I'm not worried about that, but it just drags things out indeterminately on the claim, and especially for represented workers. And I--that's the first I've heard that we've even had one that crossed the timeline.

62:54: It doesn't happen very often. I only know of one that they--the Department received it on time, like it--that's where it was supposed to have gone.

And then, you know, there was like a week of time before--and I think it got faxed to us, so we assumed they realized it got faxed to us. Usually, when it happens it's not right at the end date. It's not even that often that it happens. And usually, when they get it they get it to us even before the initial appeal period has run.

But I agree that my concern would be if the Department may have gotten it within 30 days, but if nobody realized it and several months go by before it comes to us, meanwhile--and then there's another 60 days, means then it's all--that's all extra time that the worker would just be hanging out, waiting to hear what's happening where…

63:44: Will they still be--

63:45: So that would be my…

63:45: --hanging out, waiting to hear the end result? The way that it is now is, so sad, too bad, you lose, whereas what they're proposing is if that's the circumstance the appeal could still go forward as timely filed if it was filed with the Department in time, and the MCO would still have their 60 days to make that decision.

64:05: I could probably live with it if it was within maybe ten days of the date that the Department had notice of it, you know, or five days or-- You know, so if they got it in to the Department in time, and the Department gets it to us in a very reasonable period of time.

64:19: Which I'll share. That was my concern, because I don't want it to be, oh, it doesn't matter how quick we get it to the MCO.

64:24: Right.

64:25: The worker's not harmed. Because, to me, the worker is harmed with one-day delay--

64:28: Yes.

64:29: --in getting the decision going forward. So I appreciate that.

64:33: And we're typically really good about getting it over to the MCO if it comes to us. It's just, you know, that once--

64:38: Yeah. Yeah.

64:39: --in a while.

64:40: Bin?

64:41: Will this situation be sufficiently addressed by the next rule change that's being discussed, which is the good cause exception?

64:46: Well, I think in the situations--one or two situations that we've already had, I think that we basically did rely on that--

64:53: Right.

64:54: --rule, or the one that says that if it's a procedural rule it sometimes can be waived, but we'd prefer not to have to do too many procedural waivers.

65:05: Right.

65:05: And yes, the Division should process its mail the same day, and should, you know, immediately or as soon as possible forward that information to a managed care organization. So there's really no excuse, and we're not seeking one for, you know, holding that information longer than necessary. It's just if it does happen that someone is late only because they send it to us in error would--you know, would tolling the time or giving--not counting that against the worker in terms of travel time, be acceptable.

65:42: Well, I'm trying to imagine how that plays out in terms of the provider community, and what happens with billings and things like that. Because

we can talk about this here, but I can tell you, when it comes down to the adjuster desk who's communicating with the provider and communicating with the worker, and they don't see an appeal anywhere, they're going to go forward with no, that's--there's no appeal, there's going to be a yes or a no, and things are going to happen, and bills are going to occur.

And so I think that actual processing at the desk level would be my concern about having this--well, it could have been sent to WCD in error, so is our time frame really 40 days and not 30 days? And how do you discuss that with somebody? I just don't know. With the provider community, with the worker. When you're explaining it to a worker's attorney about you're doing or not doing. That's kind of where my thoughts go.

66:40: Okay. Thanks, Suzanne.

66:42: From a therapy standpoint--the outpatient therapy standpoint, it puts us in limbo.

66:47: Uh-huh.

66:47: It puts the provider very much just sitting there going,--

66:49: And treatment stops.

66:50: --well, the patient--you can come in, injured worker, but we don't know where the bill's going, so it's--people often delay and hang out and just wait, or oftentimes they keep continuing to come in, racking up the bills. And then they come back--not to the MCO mad, they come back to the provider mad because we're the one who put the bill to go…

67:12: But how would that uncertainty be changed if you had 30 days versus 33 days? You know, we're talking about someone who got in to WCD on time, and a quick turnaround from there, getting it to the MCO. So it's certainly an

uncertainty, but how does a three-day difference create additional uncertainty when the trade-off is the worker, you know, feeling like they did what they needed to do, but not quite getting it right?

67:38: Do we know how often this happens that it actually gets left to the MCO?

67:44: It's not often at all.

67:46: I have never seen one.

67:48: So the dispute goes to the Department. Does the Department know right away the claim is (unintelligible) MCO, or does the Department wait for the insurer to provide relevant documents within 14 days, then take a look at the employer's response, oh, this is really with the MCO? Because we're not talking about 33 days. We're talking about maybe 45 days.

68:06: I think we can tell whether it's enrolled. Right?

68:08: I think you can tell if it's--

68:09: Right.

68:09: --enrolled.

68:10: Yeah, I…

68:10: Well, if they're appealing an MCO decision…

68:11: I get all the incoming disputes, and I usually try to catch--I mean, I should say I don't catch them every single time that day, but I can't say it would be that day every single time. But it should be within the next day, if anything, so…

68:27: How often do you see them come in to you in error?

68:31: A few times a year, probably.

68:32: A few times a year.

68:33: Yeah. I just don't think this is a very big deal. I don't really have a problem. If it's a very narrow time frame between the Department getting it and coming to the MCO, then I don't see that it--

68:49: Well, it's--

68:50: --will change anything.

68:51: --talking about the worker having to refile with the MCO.

68:54: They…

68:55: Is that my understanding?

68:56: Right now, they don't. Right now, the Department just sends…

68:59: Yeah, we'd think they would just hand it over.

69:01: Usually, I'll try to call the worker's attorney and say, hey, you messed up, you sent it here instead of there. You know, could you--if they have time, you know, I say, you know, it's up to you to get it to them within that time frame, but it's not our responsibility to forward that to you.

69:18: It might be now.

69:21: So how do you know if a claim is MCO enrolled just when the dispute is filed? Because at that point, you don't have the claim documents yet. Right?

69:29: No, we do.

69:30: You do?

69:31: Yeah.

69:33: We have a whole background.

69:35: Well, you're getting the MCO decision. You're getting the initial MCO decision.

69:38: Typically, we have to have that; right?

69:38: Oh, gotcha. Okay.

69:40: The initial MCO decision.

69:43: I see.

69:43: There's 30 days to appeal that to the dispute resolution process, but it inadvertently gets filed with us.

69:49: I see.

69:50: Can we make them refile it?

69:52: No.

69:52: Send it right over to the MCO. And it only happens if the appeal period expires in 30 days,--

69:57: Yeah.

69:58: --which is rare.

69:59: And we wouldn't make them refile it.

70:01: I wouldn't.

70:13: Yeah. I think this is just such a one-off thing that…

70:21: Any additional thoughts? I know we didn't actually come to a conclusion. We often will not. We just take it all back with us and we consider what--you know, what we think the right thing to do is, and I do appreciate it. I think the bottom line is we also recognize this is an exception, a rare occurrence.

70:40: Uh-huh.

70:40: So that both calls into question whether we need a rule, but then it also means that if we do have a rule it's not going to probably have a big effect one way or another, so I think that was what I took away.

70:51: Well, it does seem like in your rule it's a jurisdictional matter. I mean, it's kind of this--you either--within the 30 days, if you're not--so if you're going

to make an exception, you need…

71:01: A reason.

71:02: A reason. You need a rule.

71:04: Yeah. Otherwise, we're going to have to--if we think that just because it hit our office and that caused a delay--even if it's one day, you know, we may have to do a procedural waiver of some kind. I think we have done them in the past. And so yeah, a rule would mean we would not have to do that.

I think we're on, then, to Issue No. 6. At the top of the hour, at 3 o'clock, we'll take a short break. But again Rule 8, and also Rule 110 of Division 015 are affected by this particular issue. And there's really two issues here, in a way. There are two not totally separate issues, but-- "There's an inconsistency between Division 015 and Division 10 in regards to when the appeal period begins to run for a represented worker. There's an inconsistency between Division 015 and Division 010 in regards to good cause in the event of an appeal of an initial MCO decision outside of the 30-day appeal period."

So currently Rule 8 "states that when the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision. Division 010 contains a similar provision regarding appeal of a final MCO decision. The Division 015 rules lack such a provision."

And again, a slightly different issue. Division 010, Rule 8 "provides a good cause exception if a party fails to appeal an initial MCO decision within 30 days. Rule 8 of Division 015 rules lacks such a provision. There is currently no requirement for the MCOs to include a good cause provision in Rule 110 of Division

015."

So options would be to make Division 15 and Division 10 consistent in regards to when the appeal period begins to run for a represented worker, require the MCOs to include language regarding good cause in their notice of appeal rights to the worker and all other parties. And you know, it might be a good idea to have a quick look at the rule wording--the draft rule wording that's actually included at the bottom of this issue, too, in terms of kind of putting it in terms of what it would look like practically.

So kind of open it up for your thoughts, any concerns or…

73:34: If I can see what the good cause is.

73:59: So any concerns about making the Division 010 and the Division 015 rules consistent in regard to good cause exceptions, and when the appeal periods begin if there's a represented worker and the attorney does not receive that notice initially? Basically, the clock starts only when they attorney receives…

74:17: When they receive it, or when it's sent to?

74:22: I think it's upon receipt. Oh, when the attorney receives written notice or has actual knowledge of the MCO decision.

74:33: So how do we know when they receive it?

74:36: Does it still have to be within the 30 days, or can it be something that's like two months old, and then they go get an attorney?

74:43: Yeah.

74:45: I don't understand this.

74:46: Well, if they're--I don't know if they get one after the fact. I don't know that that is relevant. But if they have an attorney, an attorney doesn't

receive notice so that they can actually, I guess, assist their client.

74:58: Well, it does say if the worker is represented at-- I interpret that--

75:01: Right.

75:02: --at the time. And that insurer has been notified of the representation. So that--

75:11: Yeah, that…

75:11: --would eliminate the after…

75:13: Right.

75:13: The after-the-fact.

75:14: Yeah.

75:16: Right. And we're required to notify you within--

75:17: Yes.

75:18: --seven days?

75:18: Yeah.

75:19: So this is when the attorney receives it. And the language right now that's used in everything is that it's 30 days from the mailing date of the letter.

75:30: And we did that purposely because we did--we had no way to know when it was received.

75:38: Currently…

75:40: It's in Division 015, but not--

75:41: Right.

75:41: --Division 010.

75:42: Yeah, but in the…

75:44: But what about doing something similar to the language that we

have on the MCO notice where it's, you know, within 30 days of receipt, and then if--and unless--and the date of receipt, by default, is going to be considered to have occurred three days after the date of mailing.

76:08: So change all of the--change it all to, like, 33 days instead of 33 days, essentially?

76:13: Well, no. The rule would just say that we would stay--say 30 days, with days of receipt. And the rule, then, would define the date of receipt as three…

76:23: Three days.

76:26: So we can assume that the letter is received, you know, or is--the attorney should have, you know, within--like you said, the enrollment letters, three days after the mailing date of this notice that's effective or, you know…

76:46: Yeah. So, basically, it's puts a maximum time--number--

76:51: Right.

76:51: --of days after the mailing date for when the notice will be deemed to have been received.

76:57: Right. Because, otherwise, we'd have to fax everyone and get, like, a timestamp showing their fax number. And they don't all show their fax number, so that's not…

77:07: But even enrollments right now are only appealable 30 days from the date of mailing.

77:12: Uh-huh.

77:15: So are…

77:14: Right.

77:16: It just seems like being consistent with 30 days from the date of

mailing is better than putting in receipt.

77:23: Right.

77:22: Would there be any concerns around the table about using that as a standard? I mean, assuming--I'm assuming statutorily we can, right, redefine?

77:33: That's a pretty normal standard, is date of mailing is where you start running from.

77:42: Okay. Thank you very much for your input. Any last thoughts on this one before we move on?

77:48: Is good cause defined anywhere, or is that just kind of up to the MCO?

77:53: Do we have--did we define…

77:55: There's going to be lots of…

78:03: Okay. Strike that question.

78:04: Yeah. I don't think we defined that in the rule. It is but a term that is probably going to--

78:09: It's been defined by case law.

78:11: --be situational.

78:12: Yeah.

78:15: That's a great question, though. Issue No. 7. Again we're in Rule 8. WCD no longer appoints a physician--excuse me, a physician reviewer, under Division 010, Rule 330 in MCO disputes. Rather, WCD may appoint a physician under 656.325.

Some background. "*Roger D. Houser*," it was a contested case order, "held that when WCD gets an MCO dispute, it may schedule an exam under ORS 656.325. However, Division 015, Rule 8(3) does not provide for WCD to appoint a

physician for review of a medical treatment or service dispute under 656.260," which is the managed care organization statute, "because Division 010, 330(2) only applies to physician reviews under 656.245 and 656.327."

So an option to consider would be eliminate the reference to Division 010, Rule 330, and add a reference to 656.325(1). And then there's some draft language down there for you to see.

I was rattling off all those statutory numbers. And I know this issue can be a little confusing. It confused me as I read it. So it would be basically--I don't know if you could call this case law. It was a contested case order. But it would be aligning our process with the findings in that order. Do you have any concerns about our doing that?

Issue No. 8. We're up to Rule 30(14). "Should MCOs be permitted to define the responsibilities of their own MCO liaison to the department and the insurers?" "The current rule language defining liaison responsibilities seems unnecessary, as it's the MCO's responsibility to determine the liaison's responsibilities, other than a requirement that the liaison serve as a member on the MCO quality assurance committee."

And so for the committee here to consider would to be remove subsections (a) and (b) of Rule 30. And you can see down below that the--tentatively, the wording is crossed out in (a) and (b). So it would be up to the MCO to define those duties and responsibilities.

80:53: Do we know why the communications liaison has to be a member of the quality assurance committee?

81:05: Stan, do you have any thoughts on that?

81:07: That's the way the rule was when I got here.

81:10: It's always been that way, but I'm--you know, the thing with this it's--when it says a liaison for the Department and insurers-- And we have representatives that are assigned to a caseload of insurers. So each person--different person will be the liaison to that group of insurers. And when the Department communicates with us they call all different people, no particular person. So I'm just--you know, what is--why do we have a liaison, number one.

82:00: Right.

82:00: We seem to be doing quite well without one particular person who talks to the Department only or the insurers only. And you know, that doesn't--that word doesn't seem to have anything to do with the quality committee work to me.

82:22: Okay. Maybe some additional thoughts from around the table on whether we need to…

82:26: I'm just saying, why do we have to do it the way we always have?

82:29: Right.

82:30: And we really haven't always done it that way.

82:34: We do have one person. But that allows us to see if there's any particular trend of issues that we need to look at bigger picture, instead of just claim-specific.

82:46: Well, we can kind of do that in our meetings, you know, our brainstorming, talking about issues.

82:56: Well, I think the idea here is what you guys decide that the liaison would do other than the quality assurance committee, which would be something that we would expect liaison (unintelligible); correct? Tell us. Should

we…

83:15: I wouldn't necessarily think so. I mean, there's different people that establish their own functions of the quality assurance committee. Most often, it revolves around medical issues. And your liaison is probably not going to have a big voice in that. That's going to be staffed by physicians. Although we do always have a service rep involved in those meetings, but they're not a voting member of any committee.

So I guess what's--what was the point of having a liaison for the Department? Was there an expectation there would be a single point of contact? And I'm trying to remember what the original rule…

84:08: We can go back and look at that rule, of course.

84:09: Yeah. Yeah, I can see here. But was it statutory? I don't remember if that's in the statute or not.

84:16: I don't think so.

84:16: Wouldn't it have been like the director of operations or administrator would be the liaison?

84:20: Yeah. I think there was a requirement for--you know, to name an administrator of the MCO. And we, in fact, split that, depending on what the issue is, so we have two people that would be the point of contact. But yeah, I guess maybe it could be revisited as--you know, that appropriate representatives be identified to resolve issues, but…

84:56: Or we could just, you know--I don't know if we need to do anything with this except remove it. Well, maybe we should just look at the statute, see what the statute says. But, you know, and the administrator is supposed to, you know, say you will do that, you will do that, and you will do that. And as long as the

MCO is complying with their state-certified plan, who cares who does what, you know, as long as their qualified people are doing what they're doing?

85:34: Yeah. That was sort of the idea of this proposal, was to eliminate all the other requirements, let you guys figure it out. And the only thing we thought would be appropriate was to have a liaison on the quality assurance committee. Maybe that's not right. No?

85:52: Yeah. I think that should be up to the MCO, too, I suppose.

85:56: I think it should. I mean, it's just that, you know, we have many liaisons, due to different groups and people. And the quality assurance committee, ours is much--it deals with mostly medical and policy issues. And you know, certainly, whenever we think there's something that needs to be looked at from a quality standpoint, whether it's medical or policy, you know, the people--the right people are at the meetings with the quality assurance committee.

86:40: Okay.

86:40: I mean, you just--you know, bring them all in, and we all decide.

86:46: So then all we really need is the first sentence of (14), "The MCO has to designate an in-state communication liaison for the Department and the insurers at the MCO's established in-state location."

87:02: Or Laurel, would you say one or more? Because you had more than one; right?

87:05: Yeah. We've got, like, ten. I mean, it just--it depends on who's handling the issue, usually, who the Department calls, and they don't call any particular person, you know.

87:21: I was going to ask, what does the Department need in this?

87:25: Yeah.

87:25: And what do insurers need in this?

87:31: Well, insurers, you know, communicate with our reps that handle their account in different ways, whatever way is specified in their contract. But, for instance, medical management--you know, we've got somebody just managing and working with the worker and the doctors and all that. That person is talking to the claims adjuster and…

87:54: I guess what I was thinking is like in claims where we say, you know what, insurance company, you need to give us one person that will answer the phone when we call; right?

88:04: Yeah.

88:05: So is that maybe what this was intended to be, is to give us one point of contact that we can always rely on?

88:11: Well, there's another section where it asks for the day-to-day administrator of the MCO, which I perceive that to be the person.

88:27: Yeah.

88:27: And again, we ended up splitting it into two different people, because if it's a provider issue that's one track, if it's a claim issue that's another track. So although they work next to--well, no, not anymore. I guess we moved you. But, you know, so we have two points of contact, but they always have to answer the phone, so…

88:53: Can we just say who the person the buck stops with in this, and continue on the way we are?

89:06: Just like that, Laurel?

89:09: Well, I mean, like her.

89:11: Yeah. I mean, I think that was--that--wasn't that the idea?

89:14: I think that's what you--yes.

89:16: Yeah.

89:17: That it's--I think…

89:19: And she can designate--like, she'll answer the phone and say, "I don't know anything about that, will you please talk to Laurel," you know? So…

89:29: Yeah. I think this is language that was left over from the very beginning, where--

89:33: We didn't know what we were doing.

89:34: --we didn't know what MCOs were going to look like.

89:36: Yeah.

89:36: MCO or whatever…

89:38: Yeah.

89:38: Okay.

89:40: And it said in-state.

89:42: Yeah. Yeah. We have to have an in-state location and staff.

89:48: Okay. So it looks like we can simplify that somewhat. And there was at least some points made that the liaison must--wouldn't necessarily have to serve as a member of the quality assurance committee.

Laurel, you also pointed out there might be more than one person. And what's really wanted is a go-to person, someone who can be contacted if--whether somebody at the Department or an insurance company has a question.

90:11: Well, or say like if you ever wanted to take away a certification, whoever would be responsible for receiving that notice and fire everybody, that kind of thing, you know.

90:24: Well, hopefully, that…

90:26: Just give you one name.

90:29: Hopefully, that will never happen.

90:30: The first sentence would suffice--

90:31: Yeah.

90:32: --for that.

90:33: Pardon me?

90:33: The first sentence--

90:34: Yeah.

90:34: --would suffice for that.

90:44: Yes.

90:45: Section 14. Okay. With that, I'd like to--us to take a short break. If we could all be back together here, ready to start at quarter after? I think even though we have ten more issues, we got through eight, and I think we're actually on track to finish today, but we'll see. We'll give each issue the time it deserves.

(off the record)

91:10: Okay. We're on. We're up to Issue No.-- Barb, would you get the door while you're back there, and--

91:23: You bet.

91:23: --close the door? Thanks.

We're up to Rule 40(1). "There is a discrepancy between the rule that requires an MCO to submit the entire text of contracts when submitting an addendum or amendment, and the current practice of WCD to only require the

addenda or the amendments."

Some background. "A strict reading of the current rule requires an MCO to provide an entire copy of their contract when submitting addendums or amendments. The Division already has the original contract. This is an unnecessary requirement. So in practice, the Division doesn't require submission of the entire contract when an amendment is filed, so this change would just implement the current practice."

Any concerns about removing the language concerning submission of the entire text of contracts?

92:13: I'd say hallelujah.

92:17: Okay. Issue No. 10, Rule 40. "The director is not being notified in a timely manner when the MCO has received a notice of termination from the insurer."

Some background. "(2) of Rule 40 provides that when an MCO/insurer contract agreement contains a specific expiration or termination date, the MCO must provide the director with a copy of the contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination, or workers will not--will no longer be subject to the contract after it expires or terminates without a renewal pursuant to ORS 656.245(4)(a).

The majority of the MCO contracts that the Division oversees are 'evergreen' contracts. They renew automatically from contract period to contract period without any need for action or intervention by the MCO, the insurer, or the Division. Most, if not all, MCO contracts contain a provision for advance notification when one of the parties intends to terminate the agreement prior to expiration.

There is no requirement either in statute or in existing administrative

rules for either the insurer, who will generally be the party terminating an existing contract, or the MCO, to notify the Division when one of the parties has announced their intention to the other to either affirmatively terminate with due notification, or refuse to renew or extend an existing MCO contract.

The Division maintains records which include termination dates of MCO contracts. The Division needs to be informed of terminated contracts or impending termination of MCO contracts in order to assure timely notification by insurers to enrolled workers in accordance with Division 10, Rule 270(4)(l)."

So an option would be to require MCOs to notify the Division within seven days when they receive a notice of termination from the insurer, or some alternative to that.

So that was quite a lot of reading from me, but thanks for your patience. And do you have any thoughts on this one? Would a seven-day requirement be appropriate?

94:34: I'd prefer having it done in the annual report. You know, when the contract terminates we stop providing services. So that would, you know, effectively be disenrollment. And we'd advise the carrier they have to disenroll if there is a termination. But it's just kind of one more thing to try to keep track of, if we could just do all of that reporting in the annual report.

95:08: Additional thoughts? Was the--would an annual report be sometimes quite a bit after the fact? I was thinking that this would be something where--I don't know, if the Division wanted to take some particular action in response to a known pending upcoming or something that's already happened, a termination.

95:34: Is the purp-- I don't know what the purpose of the notification

is. I'm just guessing. You guys might be able to help out. When you get notice of termination, do we go into our system and change the designation of the workers that were impacted by that?

95:50: Stan, do you?

95:52: We might have to contact--yeah, we might have to contact the insurer TPA to make sure they're aware of it so that they can disenroll the workers on time.

96:01: But if the insurer has terminated--

96:04: Terminated.

96:04: --the contract, we know.

96:05: Yeah.

96:08: It's…

96:08: Yes, but it's kind of an enforcement thing.

96:11: Oh, okay.

96:11: We want to make sure it's done in a timely manner. So if we get notice of the fact that the contract's being terminated, then we can follow up with the insurer just-- You know those letters that you get when the contract's about to expire? You usually get them about three or four weeks prior to the expiration date, on the ones that have an expiration date. It would be a similar function to that, where we would know that the contract is being terminated, and we would follow up with the insurer TPA to make sure they do their due diligence.

96:44: Are a lot of these terminations--would there be a large volume involved, I guess, with like the…

96:55: I think maybe the only thing is if you have it on the annual report it's there as part of your form. You know that you--it's something to include.

When it doesn't happen very often, to remember I've got seven days to tell somebody else about it, when in fact we may actually be figuring out why is the termination notice sent, what does that mean, what's the final deadline, it seems to me more likely to fall through the cracks of just--because it is not common for us to do, so it's more formalized in an annual report.

97:25: Thank you.

97:27: But that doesn't meet your needs Stan; right.

97:30: No.

97:32: Would--how do you know when an injured worker calls you is--oh, you know from the 1502 if they're…

97:49: I'm going to be honest. I--we ask the worker, and then we'll verify with the adjuster. I know our system has stuff in there, but I verify with the insurer to see if they're enrolled.

98:02: And we don't get the non-disabling claims either, so…

98:04: Oh, that's right.

98:10: Well, having that information doesn't show that the worker has been disenrolled. It lets you remind them to do it.

98:19: That's why I didn't know, because I thought, well, if it was so they clean up the system and show that they were disenrolled,--

98:24: Yeah.

98:25: Yeah.

98:25: --but it doesn't sound like that's…

98:28: We would incorporate an additional function in the MCO program where we would notify the insurer that they need to be sure to disenroll, but then the requirements of the rule says disenrollment has to be done within a certain

period of time--

98:42: And then you would--

98:43: --prior to expiration.

98:43: --know that you would be expecting--

98:45: Yes.

98:45: --disenrollments from the insurer?

98:47: Oh, we wouldn't necessarily get copies--

98:48: You would see them.

98:48: --of that, but at least it would clear-- You know, sometimes the left hand doesn't know what the right hand is doing, and you just want to make sure that the workers get advised of the fact, and the providers, that they're no longer subject to an MCO contract for that. Seven days isn't enough time.

99:07: Well, it's not that it's not enough time. It's just, as Anne said, it's kind of the last thing you're thinking of when it happens so rarely.

99:13: Yeah.

99:17: The--you know, and another thing to do with this rule is to clarify which claims have to have a disenrollment notice, that it's only claims that have had treatment in the last X days or-- You know, the rule is nonspecific, and I suppose could be interpreted that you have to disenroll every worker that was ever enrolled,--

99:40: Yeah.

99:41: --which would be a lot.

99:41: It says open claims, though, doesn't it?

99:43: No. It's usually just, yeah, open, or the ones that are actively treating.

99:47: That's how we interpret it, but I don't think it says that.

99:49: I don't think it does.

99:50: Well, it doesn't say that in the rule. If we had the rule literally, we'd have to do it in all the claims. Well, we don't do that. And the letter that we sent out when contract is about to expire, for example, specifies that. You only need to do it on the open claims, and on the claims that--they're closed and there's active treatment, so it limits it. But that's no--you wouldn't find any of that in the rule.

100:11: Right.

100:12: But that's a good point. If the rule could be read literally to require it all the time, and in circumstances when it's not applicable, maybe we could make it clear.

Is there any-- And I'm just talking not as a program expert at all. Is there anything that we could piggyback on, some notice that already goes out to the insurance company that could just be copied to the director that would make it automatic, and therefore not something that you'd have to just remember to do?

100:43: Well, maybe the party who's terminating could copy the Department.

100:46: Copy the Department.

100:47: So then if it's the insurer doing it, they would copy you. And if the MCO is terminating-- What's that?

100:55: Don't worry. We're not terminating anybody.

100:58: We only have four contracts.

101:01: I was just waiting for somebody to say, well, what about the insurance company?

101:06: So, I mean, that might not be a bad idea, when you notify the

MCO you intend to terminate. So rather than…

101:14: Well, it doesn't happen that often; right?

101:15: No.

101:17: No.

101:17: But it has happened, and we've gotten notified in advance.

101:25: But either party-- Actually, I don't have a bone in this one.

101:29: Well, I did…

101:30: So whichever party sends the notice could send a copy to us, then?

101:36: Uh-huh.

101:36: Yes.

101:38: Okay. Any additional thoughts before we move on, then?

101:41: But seriously, I think the party terminating--I think that's reasonable.

101:45: I do, too.

101:46: Okay. Thank you.

101:48: If it goes in--if that becomes the rule, then we can put in the contracts,--

101:53: Yeah. Yeah.

101:53: --that the party terminating is responsible for notifying the Department.

101:57: Well, don't get any ideas about disenrollment notices going to…

102:04: Okay. Issue No. 11. Again, Rule 40(4). "This rule requires that MCOs submit names and addresses of all health care providers who are

participating in the MCO. 'Health care providers' includes organizations, such as hospitals and DME providers, but WCD only expects the submission of information for individual medical service providers, such as medical doctors, chiropractic physicians, physical therapists, et cetera."

So current practice doesn't require submission of names and addresses of all health care providers participating in the MCO in the quarterly reports. So an option would be to remove language regarding the requirement to submit names and addresses for all health care providers participating in the MCO.

So down below, you can see some wording changes that have been drafted into the rule to eliminate that requirement to send us the names and addresses of all health care providers.

102:58: Well, the Department would have to change the format of Bulletin 247 if they wanted us to include hospital and home health care or anyone else.

103:09: Yeah. I think this is a practical matter, as we're not receiving this data currently, and we don't want it.

103:14: Because there's no way to put it in--

103:16: Right.

103:16: --the bulletin.

103:18: That's a case where the bulletin actually got ahead of the rule, I gather, and the rule--the bulletin actually is correct. The rule is not.

103:25: Oh, okay. I just…

103:28: So, basically, you're asking for actual people?

103:34: Correct.

103:35: Okay.

103:35: Yeah. We don't want to know about DME providers and that kind of…

103:40: Not companies or facilities, just--

103:43: Right.

103:43: --people.

103:44: And we don't want to (unintelligible). I mean, they'd have--we'd--it would involve resources on your end and our end--

103:53: Oh, yes.

103:54: --if you changed the format to allow that. And then we would have to do our thing, and that's…

104:01: It would be a big deal, yeah.

104:01: Yes.

104:02: So I think then, unless you have any more on that one, we're up to Issue No. 12. Again, Rule 40(5). "Should WCD eliminate the requirement of an affidavit as part of the MCO's annual report?"

"In the interest of regulatory streamlining, WCD no longer deems it necessary for the MCO to submit an affidavit as part of its annual report."

So that would be--the change would be to eliminate that. And you can see we've just basically drafted and changed that section--subsection by crossing out all text for that.

Any concerns about doing away with the affidavit process? We didn't think there would be a concern, but we wanted to let you know.

Issue No. 13. Up to Rule 50(1)(e). "Should WCD eliminate the requirement that MCOs list provider profile analyses by diagnosis code?"

"The current rule language requiring the MCOs to maintain a profile

analysis of each provider listed by diagnosis code seems unnecessary, as it is the MCO's responsibility to determine how to best perform a provider profile analysis."

So we're offering the option of eliminating that requirement of the-- providing the provider's profile analysis or analyses in this way. We even had it listed out according to ICD-9-CM diagnosis code, which of course would be out of date because we're up to ICD-10, but bottom line is we don't need it. Any concerns about that change?

105:43: So what was the purpose of that, then? To pull information of what types of conditions certain providers dealt with or-- I'm just curious.

105:55: I think it was-- This goes back to the very beginning. And it was intended to ensure that the MCOs were looking at provider performance, and comparing practice patterns and evaluating outliers and that kind of thing.

106:15: Based on diagnosis?

106:18: Nobody ever…

106:20: They never asked?

106:21: They never asked for it, and we don't do it that way.

106:26: We don't, either.

106:26: I mean, we look at groupings of diagnoses, but a specific diagnosis code isn't very enlightening.

106:32: I was going to say, it's not helpful.

106:34: No. You have to look at, you know, nonsurgical low back, surgical low back, those kind of things. So I think all the MCOs do that. But again, it's one of those things where we didn't know how MCOs were really going to function.

106:50: Yeah. And again, the Department has never asked for such a

thing, so…

106:54: Artifact.

106:56: Artifact. That's a good one.

107:00: Issue No. 14, then. Rule 50(3). "Should WCD modify language regarding MCO records that must be forwarded to the insurer upon request, in the event of contract cancellation?"

"WCD believes that only MCO records relating to treatment provided to workers within the MCO need to be forwarded to the insurer, when requested, upon contract cancellation."

So that--the option for the group here to consider would be to modify language regarding MCO records that must be forwarded to the insurer upon request, in the event of contract cancellation.

And if you'll look at the reverse of this page, over on Page 17 it shows you what the draft--that draft change to the wor--or the rule looks like. So…

107:53: I would just leave that up to the contract between the MCO and the insurer.

108:07: So rather than just fine tune the rule, it would just be a contractual matter?

108:11: Uh-huh.

108:11: Yeah. Just strike the whole No. 3.

108:17: I think we've only ever had an insurer request this once. It's…

108:25: I never have. And there's provisions--

108:27: No.

108:27: --in all of our contracts that allow for it, but it's just not an issue. There's really nothing in our files that the insurer needs that they don't

already have through the course of business, so…

108:41: They've got all the same medical records that we do. We even send out letters that contain our rationale for approving or denying a procedure or whatever, which is--you know, that's about all there--else there is.

109:00: Okay. Additional thoughts? Okay.

Issue No. 15. Again, Rule 50(5). "Should WCD remove section (5) of the current rule?"

"(5) states that nothing in this section is intended to otherwise limit the number of locations the MCO may maintain to carry out the provisions of these rules." And we just considered the language unnecessary, but we'd certainly be interested in any contrary opinion to that and--in terms of what removing that provision could mean.

109:41: I would agree with that.

109:51: Issue No. 16. Up to Rule 60(1). "Although chiropractic physicians may serve as come-along providers like primary care physicians, they are not listed among providers who may not be charged MCO membership or administrative fees when they provide services under Division 15, Rule 70."

"With passage of Senate Bill 533 in 2013, chiropractic physicians were added as qualifying come-alongs." This rule, Rule 60(1), provides that "an MCO may not require membership fees or other MCO administrative fees to be paid by primary care physicians or authorized nurse practitioners who provide services under Rule 70."

And so an option would be to replace primary care physician or authorized nurse practitioner with come-along providers, and I believe that term is actually defined, in the last sentence of Rule 60(1). See the draft text below. So

that chiropractic physicians also would not be subject to those charges.

110:59: Well, I think we ought to make them pay.

111:02: You know, the thing about that, I don't remember charging fees, and I really don't appreciate you bringing the issue up.

111:11: Okay.

111:12: But thanks a lot.

111:15: I think it's just housekeeping.

111:17: Okay.

111:19: Does this include the (unintelligible)?

111:20: No.

111:22: That's not in the agreement?

111:23: No. That's just the reimbursement rate, and that's included in the come-along position.

111:27: Okay. And off to Issue No. 17. And Issues No. 17 and 18 are definitely more substantive.

We're up to proposed--or a draft proposed new rule, Rule 105. "Would introducing time frames for MCOs to respond to medical service requests or require that MCOs respond within a 'reasonable time' reduce treatment delays?"

"The Division has heard from providers and attorneys that treatment for enrolled workers may sometimes be delayed because an MCO did not respond to a pre-certification request in a reasonable time frame. Establishing standards for responsiveness to medical service requests may promote responsiveness to such requests.

An MCO's treatment standard may require some medical services, such as imaging or other diagnostics, to be pre-authorized by the MCO. Division

015 does not include a time frame for responding to medical service requests, and care may be delayed if the MCO does not approve or deny a request."

Am I correct to say that Division 010 does have a time frame now, right, for responding to…

112:31: For diagnostics, yes.

112:32: For diagnostics, yeah. So an option would be to state time frames or reasonableness standards for MCOs to respond to medical service re--services requests, or some other alternative that could be identified by this group. So I would appreciate your input on that. It's been an issue that's been around for quite a while. We've heard from some--I recall some attorney office contacts with, you know, cases--particular cases in mind.

113:00: What kind of delays are we talking about? Because I'm now a provider with Majoris, and they're so wonderful. I don't remember getting really any really huge delays. I'm just curious.

113:08: Is--are we on the record?

113:11: He's (unintelligible) us.

113:12: He's buttering me up for something.

113:14: Yeah.

113:16: Absolutely.

113:18: Yeah. I don't re--I don't recall the managed care organization involved, nor would I say who it--which MCO it was in terms of--that was--but…

113:26: (Unintelligible) physical therapy.

113:28: Well, there's a couple of questions. One would be, what is the definition of a response?

113:33: Uh-huh.

113:34: Because sometimes our response is we need more information, and we can't issue a decision until we get that information. And that's outside of our purview. We do set a deadline on it of how long.

113:50: Depending on what it is, generally it's 14 days if it's something that the provider would have in their possession and be able to give to us. If it's--if we're setting up a second opinion, that will often take longer than two weeks.

114:03: But then if--within the time frame it's not there, it would convert to a disapproval because we don't have the information to issue. Am I saying that right?

114:12: Uh-huh. Yeah.

114:13: You can tell I don't do any work anymore.

114:14: It generally--if we didn't get it, it--yeah, it pretty much gets disapproved, because we don't have the information necessary to feel good about saying yes.

114:26: So then do you automatically issue a--

114:26: We do.

114:29: --denial or disapproval?

114:30: We issue a disapproval. And then what they can do is, when they have that information, say it was an MRI or something, they can send it in and re-request the service.

114:39: So is the information that you're missing generally more about claim information versus clinical information?

114:45: It's typically information from the physician.

114:49: Typically diagnostics--

114:49: Or clinical information.

114:50: --or a recent chart note.

114:50: Yeah. We would need imaging or a response from the provider, clarification of some kind. We might need a second opinion.

115:00: So MRIs. Are you looking for the actual MRI film, or just the report?

115:09: It depends on the physician reviewer-- Usually, they're satisfied with the report. Depending on what's going on, they might ask for the actual films.

115:20: And so when you request those, it seems generally you go to the doctor to request it. Why would you not go to the insurer? Because the insurer is the--kind of the keeper of the--

115:34: They may not have--

115:34: --medical record.

115:35: --it yet. We--a lot of times, it's the provide--the--probably the best example is, with a referral maybe for physical therapy or something the physical therapist will put in a request to us, and they'll say, oh, we got a new referral from the doctor. And--but then there's no chart note or anything from the doctor to back up that that's really what they want. And sometimes they don't. Sometimes they--you know, the therapist keeps on, you know, down their path. But then meanwhile the physician would get the chart note, and the doctor says, therapy's not helping, so instead, I want to try chiropractic, or we're going to do an injection, or something. So we need that information from the attending physician, but they may not have generated that chart note yet. Or they may have, but it hasn't been sent to us or the insurer yet. And so…

116:20: That's true for us, also. And we find often that the physician's

recommendation for physical therapy doesn't match the one we got from the therapist. A lot of times, the therapist will ask for more visits than the physician did. And so we have to wait for that chart note. Sometime--we often request for records from the insurer. But even if they have them, it often takes them time. Especially--like, if we get a new client and they have a bunch of old claims that they enroll--

116:55: Uh-huh.

116:55: --and treatments going on, and they don't send the records with the enrollment, then we have to ask for the records. And sometimes we get a box full that it's taken somebody quite a period of time to put it together.

117:12: Or perhaps the adjuster has an IME scheduled, and we don't want to render a decision without the complete medical record sitting there, because then something's sitting out there that is--will completely change the picture. You know, so there's--that isn't very often,---

117:29: It's--that doesn't happen very often.

117:32**:** --because that's usually about compensability, and not about the treatment, but that might happen on occasion. So there's just things that come up. We will always respond and say, yes, we've received this, yes, we're looking at it, here's what we need, and we need it by this date.

117:52: And Fred, I can't remember, but it seems to me like in Division 10 the response time on imaging still doesn't mean an authorization for payment or not. Is that right?

118:08: It doesn't--it's not a guarantee of payment.

118:12: Yeah.

118:12: You know, if compensability is at issue, we don't even have jurisdiction.

118:18: Yeah. Nothing that--

118:18: So--

118:18: --we do (unintelligible).

118:20: --no matter what we put in our rule, it wouldn't even matter,--

118:22: Okay.

118:22: --because we don't have--

118:25: Well,--

118:26: --jurisdiction over that, so…

118:28: --if we decide that imaging needs to happen, say, and it's a deferred claim, and the insurer is not going to guarantee payment, then the injured worker is not going to get the imaging and…

118:46: It's out of your hand.

118:47: Well, it's--if it's…

118:47: You're done your job.

118:48: Yeah.

118:48: If it's in an enrolled deferred claim,--

118:53: Oh, yeah.

118:53: --the insurer is going to be--

118:55: Has to pay.

118:55: --liable, regardless.

118:57: That's true.

118:58: So…

119:00: Yeah. I have heard, though, that--

119:01: Sometimes it's a deferred condition.

119:02: --some providers…

119:04: That could be it. But at least for us, we disclaim any guarantee of payment and say, here's our decision on the medical appropriateness of this, because--

119:13: Well, we wouldn't…

119:14: --payment always rests with the carrier.

119:16: Right.

119:18: And then we can't do anymore. And if it gets delayed because they want to guarantee payment, then I can't…

119:27: But, you know, that's really--we hear that a lot in Workers' Comp, that, well, the insurer can always say it's not causally related or what have you. The thing is, you really have the exact same issue in private health--

119:43: Sure.

119:43: --also.

119:44: Sure.

119:46: Because if your private health insurer finds out this was a car accident and there's--

119:52: Exactly.

119:52: --car insurance,--

119:53: They're not going to pay, either.

119:55: --they're not going to pay anything, even if they approve something, you know, as medically necessary.

119:59: Right. Right.

120:00: So--

120:02: Yeah. It's…

120:03: --Work Comp really gets a bad rap--

120:05: No, it does.

120:07: --on that particular issue.

120:11: But no, it's true. And we've tried to close that loop with some of the, you know, coordination of payment with group health carriers and stuff, but it's just--there's not an easy answer for that.

120:24: Well, this is another issue that the Access to Justice Committee discussed. And it sounds like the procedures that Majoris is using are in line with what the committee discussed, it would be nice to have some deadlines. Not necessarily, you know, super short deadlines. And a response of putting it in deferred status, we discussed that. You know, that is still a response. At least--

120:43: Yeah.

120:43: --then the worker or the attorney knows what's going on. And sometimes that can be very helpful. If it's deferred status, I haven't heard from the attending as why he needs it, sometimes the claimant's attorney or claimant can help with that. We're going to go in and ask my doctor, can you please--

120:58: Right.

120:58: --respond?

120:58: Absolutely.

120:59: So that's certainly a good process. I think what the committee wanted was maybe formalizing that process into the rules so that it was more across the board.

121:09: Some communication happening.

121:11: I mean, that's per policy.

121:12: Yeah. That's our policy,--

121:13: Yeah.

121:14: --that-- And if we don't have the information that someone else has to provide on the next issue with the elective surgeries, that's different, because we--you know, MCOs tend to get the most complicated--

121:29: Yeah.

121:29: --of cases. And so you may be waiting to get that subspecialist's second opinion that's booked out for 45 days or something.

121:37: Well, and then if it has to go to the joint medical committee.

121:39: Yes.

121:38: That's--I mean, that…

121:42: Right.

121:42: There are some--

121:42: Yes.

121:43: --that I've been involved in to where the committee gets cancelled because of snow, you know, I mean, and then it's another month and another month. And some of those things, you can't…

121:50: We make them Skype.

121:54: You can't help. Well, there you go.

121:56: Workers on deferrals…

121:57: But without any response, it's difficult to--

122:01: Right.

122:02: --kind of anticipate what's a reasonable expectation for this worker moving forward.

122:07: Right. And for those really difficult claims, again, setting a restricted time frame may just result in a disapproval because we don't have the information, and then you're in the appeal process where if we just let it go for 15

more days or whatever then you have the information to make a well-reasoned decision. And you know, we really do get a lot of sort of the worst of the worst of claims where you really have to tease out what's really going on, so…

122:41: Certainly. But something that we found in the committee was for, you know, run-of-the-mill physical therapy. I mean, sometimes certainly there's a change in it, or in the amount. But a lot of times what happens with claimants is they get, you know, a couple weeks of physical therapy, and then a couple weeks off, and a couple weeks of physical therapy, and a couple off. And that is not helpful for their recovery, and it's not helpful for the insurers who are--might be paying them time loss--

123:05: Right.

123:05: --during that period. So that's why both sides of the committee thought that some timelines would be helpful, especially in those more, you know, run-of-the-mill--

123:14: Right.

123:14: --approval options.

123:20: So when we have--you know, whenever we have timelines, time frames, what's that time frame going to be? Let's say seven days. But let's say the average decision time for MCO denial is two or three days. And if we start to, you know, put in time frames of--in this example--seven days, do we run the danger that then MCOs would kind of say, well, okay, well, we've got seven days, so they--instead of doing it in two or three days, they take six days, and they can tell us, hey, we're still better than the rule says? You know, is there a danger that that could happen when we put a time frame in the rule?

And like you say, you know, they're the run-of-the-mill cases that really

probably it's easy for the MCOs to make a decision. But then you have the other cases that are not run-of-the-mill where it may take a little longer. And how do we address that in the rule? How do we differentiate?

You know, oftentimes when we do something by rule we're almost forced to just throw everything into one bucket. And I just want to make sure that if we do put something in the rule that we don't do more harm than good.

124:50: Certainly.

124:53: And so, you know…

124:55: Well, I can't speak to how quickly the MCOs respond on a general basis. That would not be a question for me. But as a committee we did discuss, like I said, that--you know, a deferred status explaining why within a certain time period we thought would be an adequate response within the time period. And then perhaps it's a two-part issue with, you know, a secondary time period to make the final response to that deferred status.

125:22: Depending on what the first response was; right?

125:24: Yeah.

125:25: Yeah. It could depend on--

125:25: Yeah.

125:26: --the seriousness of it, or whatever the first response is. And certainly, sometimes perhaps an MCO is getting decisions out in a couple days, but there's also situations where it lingers for a long time. Certainly, mentioning the snowstorm-- You know, I had one where someone was seen in October for their attending. They were scheduled for an IME. The attending refused to see them until the IME was held in January. It was on a snow day. It got rescheduled for mid-March. And by that time, the doctor's response was, "Well, I haven't seen the client

for so long, there's nothing I can do." The attending physician, not the IME doctor.

So, you know, there are certainly situations that are fast. There are situations that are much too long. And some time frames and some moving it forward with decisions is what we were looking at developing.

126:14: Well, that particular thing sounds like--what's an MCO to do,--

126:19: Yeah.

126:19: --you know? I mean,--

126:21: Certainly.

126:22: --they can go ahead and-- What was it for? Was it surgery or what…

126:29: It was continued--the appropriateness of continued care.

126:34: What we normally do is if we anticipate--you know, in physical therapy, and non-invasive things, if we anticipate that, you know, we would like more information, but it's really not there right now, we'll do a partial approval and say, you know, okay, they've asked for 12 visits, we'll approve 4, and then--or 6 or whatever, and when we get the records we'll look at the rest. And that seems to work out really well for us for physical therapy.

Invasive procedures can be--I don't want to say life and death, but sometimes they can be, you know. And sometimes we need an examination that might take a long time to get, and then we need to have the attending physician or the person who recommended the surgery review that opinion and make sure they still want to do it. You know, and so it's--you--and we keep the providers apprised along the way, you know, mostly by phone call, because there currently, you know, isn't response in writing required. But, you know, we've never had anybody complain about it that I know of.

I think, really, if you're going to nail down response times, we would need more information about what are the delays that you're seeing, and how many--how--you know, what are we talking about in the overall picture, how many? It seems that if you're talking about writing a rule and picking out a response time--a final response time-- And depending on what the first response time is, that--or not the--I mean, depending on what the first response was, then in the rule they're going to have to pick out all kinds of possible first responses, and then all kinds of possible time frames for final responses. And you know, we'll still run into situations that aren't covered by the rule,--

128:52: I think I…

128:53: --because it's a real inexact--you know, it's like an art and science.

129:01: Those extended delays-- I mean, I looked into these on a frequent basis, the MCOs taking forever. That comes to my desk. So I can say that when you start really looking in it, at least 50 percent of the time, in my experience, it's the provider hasn't submitted it yet. So the worker thinks everything's in the works, and the MCO's like,--

129:20: That's true.

129:21: --we don't even have it.

129:22: Right.

129:22: And so the message that's in between maybe the doctor and the physic--and the worker or whoever it is, the MCO is not approving it yet. Well, that's what the PT provider might be saying, is, well, the MCO hasn't approved it yet. But you find out their main office in Eugene hasn't sent in the request yet. Just--so much it depends on their processes within their office, so--

129:45: Well, that's why the Majoris--

129:46: --it's hard to…

129:46: --way is helpful, because--

129:48: Yeah.

129:49: --if the worker is saying one thing--

129:50: Right.

129:50: --and the physical therapist is saying another, and Majoris is working hard with, you know, the provider to get that--but the worker doesn't know that. So we're enclosing the information--

129:59: Right, but…

129:59: --group.

129:59: But if we don't have a request,--

130:00: They don't even have a request.

130:01: --I don't have anything to respond to, but the worker may be under the impression that I do have a request.

130:05: Yes. That is what I'm--

130:06: Right.

130:06: --trying to say.

130:06: And that happens all the time.

130:06: And that's really hard to--I mean, can you track that?

130:09: Well, but then there wouldn't be any timeline--

130:11: It's difficult when it's--

130:12: --associated with it.

130:13: --the provider's office.

130:13: There would be timelines,--

130:13: Yeah.

130:13: --but it wouldn't address your concern of workers saying the MCO is taking a long time. Because if the driving reason for their sense or perception of the MCO taking a long time is because they're being told that the MCO is not processing the request there's no request, then the issue is still going to remain that the perception is the MCO takes a long time.

130:32: Right.

130:33: Joy, you had…

130:34: So coming from a provider's side, we do have a couple different MCOs. And I'm not going to name any MCOs.

130:41: Okay.

130:41: Now, in general, I'm just going to say that sometimes when we do call the MCOs to get the status of the pre-cert, you know, they tell us, we're a little behind, we're short of staff, we're working on it. So from a provider's side, we hear that a lot--

131:00: Okay.

131:00: --from some MCOs.

131:03: And how long before you tend to hear back from them or…

131:07: Sometimes a week, but, you know, we just have to keep checking. And you know,--

131:11: Oh, okay.

131:11: --sometimes we do put the patients on the schedule. And you know, in the meantime if we don't have the pre-cert then we end up, you know--it's just we don't want to delay the patients--you know, putting them on the schedule,--

131:21: Right.

131:21: --so we go ahead and put them on the schedule. And then if we do get the pre-cert, then fine, you know. If not, then, you know, we won't get…

131:28: Okay.

131:28: And I can echo what Joy said, too. But in the same point, like everybody's been saying, it happens in commercial insurance too. We do the exact same thing. We put them on the schedule. We just put them a little further out, to give us time to get all the paperwork together.

131:41: Right.

131:41: But we are being told that people are short-staffed and we're behind. And the same thing on the provider's side. We're short-staffed.

131:50: Uh-huh.

131:50: So--

131:50: Yeah.

131:50: --it goes both ways. So, you know, there's delays all around.

131:55: And it's not necessarily because of a referral, like, from a doctor to a physical therapist. I'll see it wi--in a doctor's chart notes. It says, I'm still waiting for authorization on whatever. And what the doctor doesn't know is that her staff haven't sent in--

132:10: Yeah.

132:10: --the request yet.

132:12: Yeah.

132:13: But meanwhile, they're like still waiting, still waiting.

132:17: And our adjusters maybe pick up on that and call the MCO--

132:20: Right.

132:20: --and work together to try to get this moving through.

132:22: Yeah. We kind of picked up on that, too. When we see something that's--hmm, you seem to think I'm looking at something, but I have nothing to look at, so maybe we should have a phone call. And we've been working on developing tools on our side too, because-- I don't think the complaint about delays is a new one, and it's one that we're constantly trying to improve and find better ways to interact.

And we've developed an online precertification tool that we're hoping-- the goal really is to provide greater transparency. You know that I have it, because you can log in and you can see it. Yeah, it's there. And you can see where it is in process. Is it with the medical services coordinator? Is it with the physician reviewer? Is there a decision pending, but we just need to do quality assurance review?

So that's more on the provider side in terms of transparency than the worker's side. But it's, again, one of those attempts that we're trying to figure out how can we improve how we work together to reduce those delays.

And I really think that leaving the flexibility to the MCOs to solve the problems that way may be better than timelines that I think may try to simplify what often is a pretty dynamic and layered situation, and trying to put all of the could-bes into the rules, I think, might make it more cumbersome.

133:32: Uh-huh.

133:33: And not solve the problem.

133:35: Right.

133:39: Yeah, because that problem is a concern for everyone. Like you said, they might be paying time loss. The insurer is always going to be sensitive to that. But it is…

133:47: And I think the point you made as well, delays and gaps in physical therapy and those things, that affects the worker's progress, which affects the ultimate goal of everybody in this room, which is return to work and return to health.

And so I don't think in that sense we're all just as concerned about delays, just facing slightly different barriers perhaps on getting there. But, I mean, we feel the pain too. I don't like seeing--I don't like seeing delays. I don't like phone calls about delays. I want to make sure there's good reason for them.

134:20: Okay. Then I'll--I guess maybe I'll just ask a general question. Do you think--because we always have room for other options, is there anything that you think we could--we can effectively--can do by rule to, you know, make a difference in the timeliness of responses? Response does not necessarily mean a yes, but a response, understanding that it means--

134:41: Just like…

134:42: --we're waiting for more information, or we're doing something…

134:46: I think there should be some-- I'm not sure what, you know, exactly how many days or, you know, what are the words, but I think something should be there.

134:54: I would like to see--and this is--probably would have to be a statutory change. I don't know. But if, in fact, the common nonsurgical sprain/strain, joint dysfunction case I treat, and there's a delay for whatever reason, then the claim is accepted or whatever and they say okay, great, and I've treated that injured worker for a few visits, that that treatment is reimbursed once that has all been validated. Because in 37 years I've never not treated a patient because there hasn't

been all the loose ends tied up, and they're sitting there hurting. I've never not treated them.

So I've--you know, either I end up writing it off, or they go on their private insurer, or they pay me after the claim is denied, but I've never not treated them. I've never waited for stuff while they're sitting in my office in pain. So it would be nice if there was that contingency.

136:02: You mean if the claim is ultimately determined not to be, say, compensable as a Workers' Comp claim, maybe it is…

136:10: Just the opposite. If, in fact, it is now accepted,--

136:12: Okay.

136:15: --all the information's in from wherever, and I get the patient and I've been treating them, and within parameters of the MCO I think it's 12 visits with Majoris, that that treatment retroactively is paid for, but I don't think that's the case now. That section is…

136:37: I think it is.

136:37: I would have thought it was paid for unless--do you--does precertification have to be provided in the MCO in order for the services to be payable?

136:45: It does. But even on a deferred claim, we would get--like, if the claim is enrolled, but it's deferred and we get a request ongoing, we still review it and say yes or no, is it medically appropriate for this treatment? And my understanding was the insurers were paying for that up until the date of denial.

137:04: Yeah, I'm not certain. I'm in the fixing department, not the billing department.

137:08: And, well, something I see often is-- Like, let's say I get an

approval for physical therapy dated today, and it says, you know, we've approved your therapy July 15th through July--you know, through August 15th for what you asked for. Now, would--if that treatment had been provided, even though they didn't have a preauthorization on the 15th, would that be paid?

137:30: If it--and then it--yeah.

137:32: Even though the--

137:33: It has the approval for those dates.

137:33: --authorization didn't come out for ten--

137:35: Yeah.

137:36: --additional days.

137:36: Uh-huh. If they submitted the request as a precertification, and then for whatever reason there was delays on the decision, but they made the request for it, and then we review and say yes, for those dates, we're behind, even if that's said after the fact, if they had continued to treat it would go back.

137:51: So the worker wouldn't have to wait to receive the treatment in that circumstance?

137:54: They wouldn't. But then it does put the risk on the providers,--

137:56: Uh-huh.

137:56: --because they're having to say, "I feel confident that Majoris is going to say yes."

138:01: Yeah.

138:02: Because, otherwise, they are risking nonpayment.

138:03: And some providers do, and some don't. So sometimes, say, we'll get a get a request, what--we'll use your date of--for July 15th. But we have nothing from the provider, the attending physician, so we're waiting here. And we'll

send out the deferral and say that. Some physical therapists will continue to treat and feel confident about getting the approval. Some of them will wait.

But then what they do is they give us the new date. And so instead of the July 15th to August 15th, they'll shift it over, and it now becomes July 25th to August 25th. Just so it's still the same amount of treatment, but it acknowledges there's been a delay because the therapist wanted to feel good about moving forward and getting paid.

138:52: So I guess there's no real easy answers to this--

138:54: It's Workers' Comp.

138:55: --particular…

138:56: This is Workers' Comp. There are no easy answers.

138:59: With your permission, I'd like to move on to the next issue, which is a little bit related to this one. It just involves something more specific, and that's elective surgery.

"Should managed care organizations be subject to the same time frames for elective surgery certification as insurers under Division 010, Rule 250?"

"MCOs are not subject to elective surgery processing requirements under Division 010. The Division has heard complaints that MCOs may put surgery certification requests into 'deferred status.' This delays services to the worker, and if the provider proceeds with the surgery, may deprive the provider of payment for the surgery."

So these are the timelines that do apply currently in Division 010. The provider gives notice of surgery to insurer within seven days before surgery. The insurer must approve surgery or send the provider Form 3228. And I provided copies. There's some at the back table. And I sent them by email yesterday, I think.

To send the provider Form 3228, and may request a second opinion exam within seven days. The second opinion exam must be completed within 28 days. The insurer must send the provider the second opinion report within seven days.

If the provider disagrees with the insurer's decision or the second opinion and the provider can't resolve the disagreement with the insurer, the provider should notify the insurer in writing or sign Form 3228. And the insurer must request Administrative Review within 21 days if they want to request review.

And then if the insurer does not respond to your surgery notification within seven days or does not request administrative review within 21 days after you sign the Form 3228, the insurer may not challenge the appropriateness of the proposed surgery. However, failure to respond timely does not prevent the insurer from contending that the proposed surgery is not related to the compensable condition or injury.

So one option to consider would be to establish time frames that are consistent with Division 010, that are similar to or equivalent to those in Division 010. And then the second one says, make MCOs subject to the time frames and procedures in Division 010, 250. So it would be procedures in addition to time--well, the two options look the same to me. I'm just looking at it briefly.

141:24: Well, I…

141:24: Maybe Stan or Joy, can you tell me what the distinction is?

141:29: Similar to or the same?

141:32: Yeah.

141:32: Yeah, the same.

141:33: Well, I guess one would be equivalent, so I guess it's not exact.

141:36: (Unintelligible) the same…

141:37: Okay. So now I'd just open that up for discussion, then. We appreciate your input on…

141:45: Why would in--or MCOs-- I've never heard of putting a surgery in deferred status. If there's an already scheduled IME, and we think we need that information, we might wait for that IME. But other than that,--

142:02: Well, then it might have--

142:03: --I don't…

142:03: --to go to the joint medical committee.

142:06: So you never get a second opinion? You never…

142:08: Well, yeah, we do. But we don't say it's deferred. I-with that..

142:13: It's still delayed. I mean,--

142:13: Is that what you're talking about.

142:15: --regardless of what you call it, it's a period of time where nothing is happening.

142:19: Yeah.

142:19: Yeah, that's…

142:21; I shouldn't say nothing is happening.

142:25: Where there's no written communication.

142:25: From the worker's perspective, nothing is happening.

142:26: Without the written communication.

142:27: Yeah.

142:27: So we do issue--so we would, if we--Majoris would. And I can't speak for all MCOs, when we would get a request, but there could be-- Insurers are a little bit limited in what they might be doing if they get a request,

where for us it might be that we want to call and talk to a surgeon. Sometimes that can wrap it up rather quickly. Or maybe it takes a long time for the surgeon. Some of them have very, very difficult schedules. We're writing to them or we're getting the films because we want to actually look at, you know, what the surgeon is saying, especially if the surgeon's read on the films doesn't match what the radiologist does. Then one of our doctors at Majoris will want to look at it. So we have more reasons for why--that we may be deferring what we're waiting on. It could be a second opinion like an insurer, but it could be--it could be multiple other reasons. And so we'll issue something and we'll say here's--we're deferring, and here's what the deferral is for, and here's what we're waiting to get. But it is possible that we defer it for, say, the films. We get those in, and then our spine surgeon says, I think I need to talk to that physician, or I just want a second opinion.

So it's not always just that single deferral. Whatever we get the first, they might say, okay, now I know really what the questions are, and what--that I need to get from a second opinion or from a conversation with the surgeon. Because like we were talking about before, we--the--it's the more complicated cases that get involved with the MCOs, and so we really need to make sure that we're making the right decision, because some of those surgeries could have long-term implications for the workers. And so we need to make sure that is the right surgery and--before we say yes to it.

144:18: My concern would be that with a timeline kind of breathing down the neck that our physician viewers--if they don't feel comfortable with something that's pretty invasive and impactful in some cases, they may decide, you know what, I'm on the fence, I don't have time to get more information, so I'm just going to disapprove because I just don't feel comfortable right now to say yes. And I

could see shorter time frames causing them to jump to a disapproval more quickly, because they can't--they don't have time to get information to persuade them otherwise.

144:46: Okay. Kevin, you had your hand up.

144:48: Oh, I'm sorry.

144:49: I think one of the favorite--my favorite things about MCOs is that it avoids the use of this forum, because they have other options available to figure out what needs to go forward with the surgery.

Often, our IME reports come backs and said, well, what the surgeon recommends isn't appropriate, but I--they should have this operation or this operation. And I can't put the IME doctor on the phone with the surgeon for them to hash it out, like the form kind of indicates that they're supposed to reach an agreement. Doing the MCO review on their own terms kind of coordinates that type of information and communication.

145:25: Additional thoughts?

145:27: I think from the claims adjuster perspective, and I think from SAIF's perspective, the MCO is there to determine if the treatment is medically indicated and appropriate for the worker. And so surgery is a big deal, and you would want as much thought to go into that as you can, because it could have impactful results. If it's not the right surgery at the right time, we can end up with someone with a lot more problems than what they had before the surgery.

146:05: We have a patient like that where the insurer--

146:06: This…

146:07: --said it approved the--

146:09: This is Keith.

146:09: --surgery that we had denied.

146:11: Uh-huh.

146:12: Yeah. Go ahead, Keith.

146:15: I guess my thought is that surgery decisions are made out in the regular healthcare world every single day, and really in no other system do they get such scrutiny like we have in Workers' Comp. And we had a rule for a very long time about elective surgeries. And you know, whatever the politics of that were, these time frames were hashed out, I think, probably before MCOs were around, but I can't say that for sure.

So we've got a system that works for insurers, but now we've got MCOs, and they're not subject to any timeline requirement. And that's always struck me as very odd, and it's always struck my clients as very odd. You know, they'll ask you, okay. well, how long until we get an answer on my surgery? Because they're looking, if it's going to get denied, we need to file an appeal. So we're not just looking for an answer. We need an appealable decision so we can keep things moving forward if we're disagreeing on the matter.

So it's always been really difficult for me to understand, and also difficult to explain why there's no timeline on the MCO when there's timelines for almost everything the worker has to do, lots of things the insurer has to do, but yet there's no timelines on the MCO decision-making. And I still find that troubling. I'd like to see that elective surgery timeline be the timeline, and that--just have a one-size-fits-all.

147:31: Thank you, Keith.

147:34: Thanks.

147:39: The elective surgery procedure is not all that old.

147:45: Well, it was greatly modified around maybe '99, 2000, and it was based upon doctors ver--being very unhappy with the existing, I think, elective surgery rule. They wanted more time frames in there.

148:03: I would just say that, you know, going by that time frame, it's too tight--

148:16: Well,--

148:17: --in a lot of cases.

148:19: --I can understand where you're coming from. But if that's the time frame that's on an insurer that doesn't have the contacts like the MCOs have with their providers, it's hard for me to say, oh, okay, well, the MCOs need more time, when that time frame is on insurers that are needing to make that decision that don't have the contacts with the contracted providers that you're dealing with.

148:42: Well, they have IME contracts, and IMEs--

148:44: I don't understand why--

148:45: --have a--

148:46: --when a worker's in an--

148:46: --way…

148:47: --MCO, why there's an IME, but…

148:49: Well, yeah.

148:50: It's for compensability.

148:51: Well, you know, IMEs happen a lot faster than second opinions or consultations, generally, because the doctors--most of the doctors that work for the IME companies are not practicing anymore, and that's all they do, so they have a lot more time to do that.

And the specialists--I don't know what's happening, but they are so

incredibly busy. And it takes sometimes a really long time, you know, and especially like the shoulder specialists and neurologists and you know, it's--neurosurgeons. It's really hard to get that second opinion when you're not using a doc--an IME doctor.

149:36: It's because you're essentially asking them for a favor because-- It's a second opinion. They're not going to take on the patient. It's really not their favorite thing to do, and it doesn't pay that well.

149:46: Right.

149:46: And so it's--the surgeons don't--they really don't like to do second opinions, and it can be really hard to get them in. And there's also--sometimes there's more than just getting the second opinion, because sometimes there's-- I'm thinking of one surgery in particular that we got that-- The doctor who was requesting it was in South Coast area, didn't really have the experience, and only did this very specialized surgery a few times before. And so, first of all, we needed somebody who really knew what they were doing. So we had the person go up to OHSU, and that doctor said, "Yeah, that's probably the right type of surgery," but we still didn't feel good about that surgeon practicing on one of our enrolled clients.

So then it took us facilitating to get the worker in actually with someone more experienced, and it's just--it's not a fast--it's not always a fast practice. And this particular surgery was--actually only comes with about a 50-percent success rate, but there weren't a lot of other options, so-- And I realize that's kind of an extreme case. But that's--a lot of times, those are the ones that do get extended. They're the unusual ones where there's a lot going into it.

There are a lot of times we-- What we should do is put together some time frames for what it looks like, or how often from the--because we have the day

that we received it, and the day that we make a final decision. Generally, those happen pretty rapidly, but--we do have some that do take a while, but those are not straightforward cases when that happens.

151:19: But if a rule is written to where some time frames were put in there so those easy cases that really should be rolling along, you don't need to get a second opinion, there's some predictability for those workers. And then because you keep-- That didn't sound right. But because of the need for second opinions, well, if there was a provision in there that notify the parties within seven days that you need to get a second opinion, and maybe the time frame is-- I mean, I like consistency,--

151:52: Uh-huh.

151:52: --but 28 days to get that second opinion-- I believe adjusters sometimes have a difficult time getting that exam completed within 28 days, but it's the rule that applies to them.

152:05: But they…

152:05: And I know, because I've gone through--

152:07: The thing is that--

152:07: --second opinions with…

152:08: --the IMEs are so--they--I really do think if they need an IME for compensability, or even if they're getting one for a second surgical on a non-enrolled claim or something, I think having IME providers does make that--the faster turnaround possible for them.

152:23: So maybe--in the MCO circumstance then maybe the time frame of 28 days is a little bit different. But some kind of structure, so predictability is there for the workers and the providers.

152:35: I do not mind having a requirement for a response, you know, and you--a final decision even, unless there are unusual circumstances. And we could even be required, you know, to list out the unusual circumstances. I don't mind that. But, you know, I don't see any reason to have--you know, somebody has to request administrative review 21 days after the final or whatever--or after the time period. I mean, I think we should at least have a chance to say-- Like Lisa was saying, you know, some of these cases just really take a long time to sort out. And we don't have the option of the IME doctors who are not practicing and don't have anything else to do but render these opinions as they do, you know, on the non-enrolled claims that are subject to the elective surgery law.

I don't mind, you know, having the requirements for responses, but to make a decision they can't be too tight. But I do feel that, you know, we're talking about doing a lot of work here where we don't even know if there's a problem, and how big of a problem--

154:09: Uh-huh.

154:09: --it is. I would suggest that, you know, we get data first, before shooting everybody off in all different directions, making all different kinds of different rules and forms. I mean, nobody's pointing to any data that says there's a problem. Everybody knows that the squeaky wheels get the grease. So, you know, it could be five squeaky wheels.

154:38: Well, also, if there's particular trends in the data. So yes,--

154:40: Right.

154:41: --we've got delays, but oh, here's the main--the five top reasons for delays that may refine what we're talking about, because we're identifying where the bottleneck is. And rather than try to solve the problem on a

grand scale, it can be tailored to fit what's truly the barrier.

154:55: Well, right. And maybe it's a problem we can--we're not even knowing about now that is something we can fix easily if we had data.

155:07: Would that be something you can report in an annual report, whether, you know, a surgery requests took--a kind of thing like that?

155:16: Yeah.

155:23: Well, why don't we do that for a couple years, and then see what happens?

155:27: We could have a data call. We don't have to have…

155:31: Do a data call?

155:32: Yeah.

155:35: Well, what would…

155:36: We don't want to wait for an annual report.

155:37: A data call or an annual report?

155:45: We could do--

155:45: Yeah.

155:46: --a data call and give you something like, say, for the last, you know, two years or something, what--the receipt date compared to final decision date, and then…

155:56: I think we want to drill in to--for those that have a delay that's beyond then even what these parameters set out to say, okay, this is where the initial threshold of comfort is, so let's drill into those that are outside of that, and then identify that we have some specific causes. Because to me that's what I'm more interested in, is do we have some trends that we could really--

156:17: When do you…

156:17: --base some of this on?

156:19: When do you think you can have-- Sorry. When do you think you can have that data available?

156:27: Can we…

156:28: Like, next week?

156:32: No, not-- The first piece, yes. The second, no.

156:34: The first piece by next week. The second piece might take a little longer, because that will take…

156:39: That will be claim by claim.

156:40: Because we don't have a--

156:40: No.

156:41: --code for the reason for delay. That's just com--written comments.

156:44: Well, you know, if you look at--and the first piece is--you know, 80 percent are falling within a reasonable time frame, I think that would be good information for the Department to have going forward right now. And then drill into the other ones, because maybe there's things that can go into place to stop the eight-month delay in--from receipt to decision.

157:08: Well, I think that would be…

157:09: The eight-month delay…

157:10: Sorry. I couldn't help that.

157:13: Wow.

157:13: The outlier rule again.

157:16: Exactly. It was a total outlier.

157:19: We'd have to pull that initial data first to get to the ones that--

figure out which ones to conquer, and we--

157:26: Right.

157:26: --could, you know, pull a report about, you know, how long it took us for all the surgeries and stuff, and then pick out the longer ones and look more closely.

157:40: I think the--I think that kind of that processing turnaround timepiece, probably next week would be--I mean, that's just straight numbers. That's pulling out and saying receipt date to final decision date. The other step…

157:53: And we'll try to apply these time frames that are drafted in the rule to see…

157:57: Here's the part--the one part that I'm not sure about on here. So you have 7 days to respond, and then another 28 to get the second opinion. And then it says the insurer has to send the provider the report within seven days. But what's the--is there-- I don't see a thing in there that says the provider has to-- Sometimes the providers aren't totally speedy with their--especially their big yucky reports. Is the--so--

158:22: There's no timeline.

158:22: --would you say 60?

158:25: A provider is supposed to just reach out and--they have to sign the report, and then that starts the insurer's 21-day appeal time. But if they don't ever respond to the IME report, whatever it is, that 21-day period would start.

158:37: So would--what would you use on this, then? Like 60 days or 45 days, or what would you-- So seven and--so…

158:47: Would it just be for second surgical opinions, and not all surgical reports or requests?

158:51: Right. Because if you have the surgery request, but you didn't go get a second opinion, that's one (unintelligible) of people.

159:01: Yeah, so--right. So we, you know…

159:02: And then you've got your ones that are the second--you ask for a second opinion. How long did it take to get the ultimate--

159:07: Yeah.

159:08: --decision on it?

159:09: Because just this time frame right here--

159:10: You might need that broken down.

159:11: --is 44. This is 44 days.

159:13: Well, actually, our report would look like 3 days, 3 days, 3 days, 60, 3 days, 3 days, you know, I mean, for like one--a real complicated one. So it would be easy, fairly, I think, unless I'm completely not knowing what's going on in my department. But I think it would be easy to, you know, look, and everything's fine exc--and then pick out those cases that--and see if--what were we waiting on, the second opinion? How long did it take to get it? We'd have to call down actually into the records to do that.

159:48: Because I would want to expand and review beyond just the second opinion delays. I'd want to know,--

159:51: Uh-huh.

159:52: --am I delaying because--

159:53: Yes.

159:54: --somebody, the provide--we wrote a letter--

159:55: Right.

159:56: --because we wanted some clarification, and the surgeon

didn't respond. Or maybe there's something--some other piece that's going in their chart notes or films or--I mean…

160:05: Yeah.

160:06: Yeah. We'd have to get down into the records, I think, to actually…

160:10: Because I would not be surprised if the delays are not--I mean, second opinions, yes, because it's hard to get them in, but…

160:16: That's right. But that's only part of it, because sometimes it's that we look at it and we write them a letter, and the doctor says, oh, you're right, that was the right plan, so I withdraw that, and instead I'm requesting that. And so then we don't even actually make a decision, because it's withdrawn,--

160:30: Yeah.

160:31: --and something else happens. But we still wouldn't want to not count that information in.

160:36: Well, and then there's all kinds of times where the worker skips an appointment somewhere in there, you know, didn't show up for a preop or--We had one guy that missed his surgery several times. And you know, and then they'd ask for another one, and then all the stuff had gone and--you know, crazy stuff happens, so sometimes…

161:01: They'll have time frames, you know. They have a lot of workers, too.

161:05: Yeah.

161:05: Can you check in with Stan next week and kind of give him an ETA, then?

161:08: Yeah.

161:09: Does that sound reasonable?

161:10: Yeah. We've got a couple--we have two MCOs that are not at the table right now to--so we'll need to decide.

161:18: They can get theirs in to Stan by Friday.

161:21: They're not here, so that means they must be at their office.

161:25: They're probably working on it.

161:26: They're already back there, working on it. Okay.

161:29: I'll get in touch with them.

161:29: Okay. Okay. It's--it is at the end of our scheduled time. We're within a minute of that. Just to let you know that the issues that we have after Issue No. 18, I believe, are in our--they're all under the general category of housekeeping, meaning we didn't think that they were particularly substantive. But I would encourage you to look at them and see if you disagree. If you think that, you know, in fact, they had some practical, maybe especially a negative effect, we would want to know about that.

We asked for agenda items in advance this time, so that kind of helps ensure that everybody kind of gets their dibs in for the agenda. But this is also a point where I ask if you have additional agenda items, but I do that knowing that we've virtually run out of time, unless we want to go long. So I will leave it up to this group whether--I mean, if you would like to come back and meet with us again, we certainly would consider setting a second meeting.

If you would like to provide additional thoughts in writing, you are welcome to provide any additional information. Not just on these agenda items, but if you think of anything that's not here that you wish had been here we would want to hear about that, because what better time to hear about it while we're in rulemaking?

Occasionally, if it's a really complex issue, without meeting again we couldn't do it justice, or we might need to do some research, that kind of thing. But better to have it than not to have it, always true. So any interest in another meeting at this time or…

163:06: I don't know about a meeting, but I would like to learn about the data call--

163:10: Yeah.

163:10: --information, since that--

163:11: Well, yeah. If we can…

163:11: --does impact…

163:12: If we get data that we can share-- I mean, we obviously can't share proprietary information. I don't know. I'm assuming that if you provide it to this committee particularly it would become part of the rulemaking record. So you need to know that it sort of becomes public record. We wouldn't want anything that identified people, individuals.

163:31: Uh-huh.

163:32: But it strikes me that it does have to do with your business practices, so just keep that in mind. You know, it would be better to tell us that you do have concerns as soon as possible that you're giving us some information you don't want shared, because we need to be cognizant of that as well. We don't want to provide co--proprietary information, knowing that the--you know, it is a competitive marketplace, so…

163:56: Well, if it's provided to you, would you not be combining all four MCOs?

164:01: Well, that's about--we wouldn't need to identify the managed

care organization that actually submitted any particular bit of data. I wouldn't see why we would need to do that.

164:09: And you could smush it, too.

164:10: Smush it?

164:11: Yeah.

164:11: Yeah.

164:12: Put it in…

164:12: Aggregate.

164:13: Yeah.

164:13: Aggregate?

164:13: Yeah. Whatever we send you, it would all get combined--

164:17: Yeah, aggregate.

164:17: --with Laurel. So between the two of us, we'd make this many decisions,--

164:20: Well, in the other-- Yeah.

164:22: --and this many outliers.

164:22: Yeah.

164:24: Well, and I was thinking too, we could, you know, be general. Like, if this is our guideline, say, you know, well, we had, you know, X amount that fell within seven days and--or a percentage, even.

164:44: Right.

164:44: You know, and…

164:44: Provide more of the summaries and…

164:46: Yeah. And you know, without being exact, you know. But also, if you want us to be exact and you want to aggregate it, that's fine too.

164:57: Yeah. And not speaking for you, Stan, but it's probably best for you all to wait to hear from us before you start working on this, because I wouldn't want you to spend time working on it, and then we ask you for something slightly different from what you're compiling. Would that be fair, Stan, that when we…

165:10: Yeah.

165:11: We'll ask for the same thing from all four MCOs, and try to make sure that it's, you know, doable, something you can actually provide.

165:18: Okay. So we'll just wait to hear from you, then.

165:22: Or Stan. Probably Stan.

165:22: Instead of going back and say everybody…

165:26: Not everybody. Just IT.

165:28: Yeah. Yeah.

165:31: Quick, a query.

165:31: Is anybody going 205 northbound?

165:34: No.

165:34: No.

165:34: No.

165:34: A crash?

165:35: Was it bad?

165:36: Bad.

165:37: But that means that I-5 up there is probably messy, too.

165:39: Oh. Yeah. I want to thank you all very much for…

165:45: Oh, so Vancouver.

165:47: Thank you.

165:48: Okay. Yeah. Thank you.

165:50: Yeah. But it will back up over the bridge, so pretty much all of North Portland.

165:55: Oh, okay. Well, everybody do have a safe drive home, and thank you very much. It was a wonderful group. And we got the information, I think, that we needed for the most part, so I really appreciate it. And thank you if you were on the phone with us today, too.

166:12: If you didn't hang up yet already.

166:14: I think they all did.

166:15: I heard a lot of beeps.

166:16: Yeah.

(WHEREUPON, the proceedings were adjourned.)

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CERTIFICATION OF TRANSCRIPT

I, Amanda Knapp, as the transcriber of the oral proceedings, certify this transcript to be true, accurate, and complete.

Dated this 16th day of August, 2017.

Transcriber

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I, Ashlee Kohan, as the proofreader of the oral proceedings, certify this transcript to be true, accurate, and complete.

Dated this 16th day of August, 2017.

Ashlee Kohan

Proofreader