

RULEMAKING ADVISORY COMMITTEE MEETING

WORKERS' COMPENSATION RULES

Nov. 13, 2018, 8:30 a.m., Room F, Labor & Industries Building, Salem, Oregon

Regarding: Rules governing independent medical exams and worker-requested medical exams

Committee members attending:

- Ben Barnes, Oregon Physical Therapy Association
- Dan Farrington, IMEA President
- Dan Miller DC, Oregon Chiropractic Association
- Dan Schmelling, SAIF Corporation
- Elaine Schooler, SAIF Corporation (by telephone)
- Hasina Wittenberg, For IMEA
- Jaye Fraser, SAIF Corporation
- Jennifer Flood, Ombudsman for Injured Workers
- Joy Chand, Takacs Clinic
- Kevin Anderson, Sather Byerly & Holloway
- Kimberly Wood, Perlo Construction | MLAC
- Lauren Kuenzi, AGC (by telephone)
- Randy Elmer, Elmer & Brunot, PC
- Rob Nichols, Cummins Goodman, Denley & Vickers, P.C.
- Trevor Beltz, Oregon Medical Association

Department of Consumer and Business Services and Workers' Compensation staff attending:

- Daneka Karma
- Fred Bruyns
- Juerg Kunz
- Lou Savage
- Myra Aichlmayr
- Robert Andersen

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BEFORE THE WORKERS' COMPENSATION BOARD OF

THE STATE OF OREGON

RULEMAKING ADVISORY COMMITTEE

WORKERS' COMPENSATION DIVISION RULES

The proceedings in the above-entitled matter were held in Salem, Oregon, on the 13th day of November 2018, before Fred Bruyns, Administrative Rules Coordinator for the Workers' Compensation Division.

1 TRANSCRIPT OF PROCEEDINGS

2
3 00:00: On the record now. Good morning. Thank you very much for
4 joining us. This is a meeting where we're going to discuss independent medical
5 exams and the rules governing (unintelligible) party particular responsibility for
6 independent medical exams, so we're going to--we're going to go through our
7 agenda, and then if we have any time at the end, we'd be glad to take any additional
8 issues that you may have.

9 I think you're all pretty familiar with these Advisory Committee
10 meetings. If you have not attended previously, it's informal, it's just a conversation
11 and it's a very important conversation, and it's what we use when we're preparing
12 the proposed rules and we rely on your input to help us shape those rules so that
13 when we file them, they're as close as to their final form as we can make them, and
14 then we'll welcome testimony of course at that point, but as we go along, if there's
15 things that were--concepts that we're discussing that have fiscal or economic
16 impacts on you or the people you represent, please let us know because we have to
17 document those impacts when we, again when we file with the Secretary of State.

18 If you're on the telephone with us this morning, please keep in mind
19 that we'll pick up background noises in your office and also I would encourage you
20 strongly not to put us on hold because we'll pick up any background music or
21 messages that you may have on your phone system.

22 Other than that, looks like we're going to be a little short on space, but I
23 think we're doing all right. If we could just maybe pull a couple extra chairs up to the
24 corners of the table, there's more room down front here. If you have a typed
25 agenda, you'll be fine. If you're wanting to actually look at the screen, then I would

1 encourage you not to sit right in the front because you probably will not be able to
2 see it, so...

3 So I'm Fred Bruyns, I coordinate the rulemaking process for the
4 Workers' Compensation Division, and with that introduction, I'd like to start with the
5 people on the telephone and have you introduce yourselves to the committee.

6 02:12: Good morning, it's Elaine Schooler with SAIF Corporation.

7 02:14: Welcome, Elaine.

8 02:17: Thank you.

9 02:19: Anyone else?

10 02:22: Lauren Kuenzi with AGC.

11 02:25: Okay, good morning, thank you for joining us. Anyone else?

12 According to what I can see here, that's probably everyone, so we'll go in this
13 direction and...

14 02:35: Oh, Daneka Karma, I'm the policy manager with Workers'
15 Compensation Division.

16 02:41: Jennifer Flood, ombudsman for injured workers, DCBS.

17 02:44: Kimberly Wood, Perlo and MLAC.

18 02:47: Kevin Anderson, defense attorney with Sather Byerly &
19 Holloway.

20 02:50: Rob Nichols, defense attorney with Cummins Goodman,
21 Denley & Vickers.

22 02:54: Randy Elmer, a claimants attorney.

23 02:57: Hasina Wittenberg, IMEA.

24 02:59: Dan Farrington, president, IMEA.

25 03:02: Jaye Fraser, SAIF Corporation.

1 03:04: Ben Barnes, Oregon Physical Therapy Association.
2 03:06: Robert Anderson with Workers' Comp.
3 03:09: Dan Schmelling, SAIF Corporation.
4 03:11: Dan Miller, Oregon Chiropractic Association.
5 03:14: Trevor Beltz, Oregon Medical Association.
6 03:16: Joy Chand, billing specialist, Takacs Clinic.
7 03:19: Lou Savage, Workers' Comp.
8 03:21: Juerg Kunz, Workers' Comp.
9 03:23: Myra Aichlmayr, Workers' Comp.
10 03:25: Okay. Thanks again for joining us. And before we begin, do
11 you have any questions? How about the process or? There'll be time for questions
12 at the end, too, maybe in terms of what are our next steps are and where we're
13 going from here, but you're welcome to file--follow along on our paper agenda and
14 there should be some extra copies, there were copies in the back of the room,
15 and/or you can just look at the screen. Is that--do we have too much light in here or
16 is it going to be visible enough for everyone or?
17 03:55: It's a little tough to see.
18 03:57: Little tough to see.
19 03:58: (unintelligible) lighting.
20 04:00: Well (unintelligible)--
21 04:03: Not because of light; because of our eyes.
22 04:05: Well, I can probably zoom it in a little bit--
23 04:08: Oh, to--I have--I have the agenda, thank you.
24 04:10: Oh, okay. Okay. Is that a little better, is it big enough now or?
25 I can make it bigger yet. I thought this little thing was not supposed to--I better not

1 click the X, it'll be a big mistake if I do, okay. Going to have to...

2 04:34: If you click the little thing on the side, the triangle.

3 04:39: Oh, right, sorry. There. All right. Okay, we'll begin at the
4 beginning with agenda item number one. I'm going to go through, I'm going to read
5 some but not all of the issues, certainly not everything verbatim. I know you
6 probably had a chance to review them and--but I will go over some of the high
7 points.

8 First issue, the current IMEA standards Appendix C used broad terms
9 that are vague and open to interpretation. This causes uncertainty for the IME
10 providers as to the Division's expectations of them, so some background.
11 ORS Chapter 656.328 requires the Division to adopt by rule standards of
12 professional conduct for providers performing IMEs, if the appropriate health and
13 professional regulatory board has not adopted standards pertaining to IMEs, statute
14 provides that the rules adopted by the Director may be consistent with the guidelines
15 published by the IMEA, the Independent Medical Examination Association, in effect,
16 on June 4, 2007. On December 4, 2007 the Division did adopt the IMEA standards
17 and they have remained in effect without change since that time.

18 During the 2015 legislative session the Workers' Compensation
19 Management Labor Advisory Committee, generally called MLAC, created an IME
20 subcommittee to review IME issues and to provide recommendations to the
21 legislature. In the report, the subcommittee agreed that the current process could be
22 improved, particularly there should be more focus on improving worker and provider
23 interactions. On January 17, 2017 the full MLAC voted to accept a subcommittee
24 report and recommendations, including the Department should review and seek
25 comments on the rules pertaining to IME provider certification, ethics, standards,

1 and training requirements, and then it goes on to say where the full text of that report
2 can be found.

3 And I'm going to skip down just a little bit. And you can see that we've
4 actually included as an option revise the IME standard Appendix C with the
5 suggested rewritten language below, and so here's where I'm not going to read this
6 verbatim. I hope you've had a chance to review these. And another option, since
7 we always list options, and there could be of course options on here that we've not
8 even considered and we would welcome your thoughts, adopt changes to the IME
9 standards Appendix C with language other than outlined above obviously, or
10 perhaps some other alternative, so with that, if you have had a chance to review
11 these standards, we would very much welcome your input. Dr. Miller.

12 07:37: So what's the difference between these standards and just the
13 typical standards for any practicing physician?

14 07:47: I'm going to rely a little bit on Myra in terms of maybe some key
15 differences from what would be true for the IME standards as opposed to what
16 doctors would do in their general practice, I'm guessing there's a lot of consistency
17 between the two--

18 08:03: There is as far as professionalism and interacting with patients,
19 but there are some requirements that we ask the IME provider to inform the worker
20 of at the time they come in. Those are outlined in here as well. And it's our goal is
21 to--hopefully there is a difference between treating a patient and performing an IME,
22 so we want to make sure that the doctor understands that, you know, they're not
23 able to build a relationship over time with a worker when they do IME exams, so
24 they're going to--the communication needs to be really a lot--it's going to be more
25 difficult because they're seeing them for the first time and the only time, so it's just a

1 way to outline that type of interaction. There's going to be overlap with what the
2 professional standards are outlined in the OM--or Oregon Medical Board, but there's
3 additional provisions as well.

4 09:12: And one thing I didn't cover in the background to the issue, it
5 goes over some history of the complaints received by the Division, the nature of
6 those complaints having to do with maybe sometimes disrespectful behavior when it
7 does occur, and the standards are an effort to address some of that, kind of avert it.

8 09:38: Yeah, I would just--I would just add that where 4D kind of says
9 that.

10 09:47: Right, yeah, those items (unintelligible) tell the worker.

11 09:53: So one thing I'd add onto that is for the chiropractic board, any
12 evaluation determines a physician-patient relationship regardless of the IME versus
13 the standard of care (unintelligible)--

14 010:06: And these only apply if there isn't a standard of conduct for
15 IME providers within the--that regulatory board, so if the chiropractic association has
16 standards for IME providers, then that's what they would abide by--

17 10:22: Well, it's not--it's not a standard for IME providers; it's a
18 standard for any Oregon chiropractor, and so if there's an Oregon chiropractor that's
19 doing an IME, they'll always see E indicates that a doctor-patient relationship is
20 established whether it's frequent or not, and so even though they try to implicate that
21 on paperwork that (unintelligible) provide on (unintelligible) the OBCD is pretty
22 explicit saying that when still is established, you still have to follow all the rules of
23 being a licensed physician (unintelligible) specialized (unintelligible)

24 11:00: Thank you, Dr. Miller. Additional thoughts on the--on the draft
25 standards?

1 11:06: Well, I think it's because the statute requires them to have extra
2 standards under 656.328, it says that the Division has to adopt standards specific to
3 IME provider, and so when we were crafting that bill back in, oh, whatever it was,
4 '07--

5 11:25: Oh, I think--

6 11:27: '05?

7 11:27: --before that, around 2005, yeah.

8 11:29: A long time ago, it--the Division then once the bill passed
9 adopted this new existing set of standards that actually was the IME Association sort
10 of had our own code of conduct that they ended up adopting, but based on their few
11 maybe about disrespectful behavior, they're just I think you guys are just changing
12 that to add some more language about don't be a jerk.

13 11:57: I mean, we just want to make it clear and, yeah, just try to
14 clarify it a little bit further--

15 12:01: Yeah, yeah.

16 12:02: It just seems like all doctors should (unintelligible)--

17 12:05: Right. I agree. Seems like.

18 12:09: Present company excluded--

19 12:10: Right.

20 12:10: --I'm sure.

21 12:22: If at anytime I move on to the next issue and you really are not
22 finished with the last one or you want to go back, just let me know.

23 12:37: Fred, I apologize--

24 12:38: Yes.

25 12:38: --this is what's already in place what's listed here, correct--

1 12:42: No.

2 12:43: This is what you recommend to be put into place--

3 12:47: Correct--

4 12:47: Right--

5 12:47: --for--so there isn't anything in place right now--

6 12:49: There is--

7 12:49: Yes, there is, there is--

8 12:50: --there is an appendix--

9 12:52: That's what I mean, I don't think I--

10 12:53: Yeah.

11 12:53: --have that, okay.

12 12:57: Yeah, and I think it was so widely rewritten, although some of

13 essentially reorganization, that it wouldn't have been feasible to kind of mark it up to

14 show where the changes are, that's my understanding--

15 13:07: Okay.

16 13:09: Otherwise, we would have know it to you that way.

17 13:13: So I do have one question on 4F and I understand that there's

18 only (unintelligible) doctor-patient relationship requirements on this, but as one of the

19 requirements, when you do an evaluation the patient typically or at least under the

20 OBCD rule has the right to know what his preliminary opinion is prior to leaving that

21 evaluation, so this is indicating that they cannot share the opinions, which is just kind

22 of contradictory, and so I don't know what the OMA's status on that or how the Board

23 itself, something to be cognizant of.

24 14:01: Yeah, and I'm not sure that this would be the solution, but I

25 wonder, you know, if it could say something like unless other provided by the

1 licensing board standards of the professional, then this would apply, but obviously
2 we're not going to want doctors to violate their own standards of conduct.

3 14:22: Maybe subject to review on (unintelligible) stakeholders just to
4 verify that that doesn't, you know, contradict other rules.

5 14:34: When you say (unintelligible)--

6 14:35: (unintelligible) agreement between the IME provider and the
7 insurer that in fact--

8 14:40: There's no communication about, it's just an exam, questions,
9 and answers and the report comes after, there is no opining--

10 14:52: (unintelligible) figure the (unintelligible) board would dictate
11 what the requirements of the physician is, not the relationship between the physician
12 and an insurer.

13 15:05: Do you know as a matter of practice whether if a chiropractor is
14 involved in an IME whether they in fact do share that at the time that they--

15 15:12: They do not share it, but I know in the OBC rules the doctor-
16 patient relationship is established anytime you do a history and the opinion sort of
17 evaluation whether it's (unintelligible) it's an IME, but therefore that status is
18 established, and if that status is established then the patient should have the right to
19 have an opinion, so, I mean, obviously, I mean, it's something to cross-check, but
20 I'm not going to (unintelligible)

21 15:49: Is it--is it a different, and I'm looking to Myra, is it a difference
22 versus findings versus opinions or how you would stay that--or state that? Because
23 I think that in talking with Myra, what potentially the issue was is that when you're
24 trying to facilitate having, you know, good working interaction to complete the IME,
25 sometimes what's happened is that the IME provider has shared something which

1 completely, the worker will hear and they disagree, they shut down, they get
2 defensive, and that's where we're going, so it wouldn't be like the factual findings or
3 "Here, I've taken a measurement and here's what the measurement is"; it's more an
4 opinion that the worker would disagree with or that sharing it is going to break down
5 that interaction during the IME, is like a be--and I don't know how to necessarily state
6 that--

7 16:49: It's to eliminate any kind of adversarial--

8 16:53: Right, exactly.

9 16:53: --role between the doctor and the worker. If the worker asks
10 the doctor, you know, "So what do you think, you know, do I have a torn meniscus?"
11 and he's like "Nah, I don't think so," you know, right there it'd be like difference of an
12 opinion--

13 17:09: (unintelligible) that's a standard makes sense because let's say
14 cannot share opinions and I think that may agree that the (unintelligible)--

15 17:18: And I believe in when the doctor begins the IME, he states all
16 that (unintelligible)--

17 17:23: Yes.

18 17:23: --give you opinion at this time, I'm going to evaluate
19 measurements, and I (unintelligible)--

20 17:30: And the worker's entitled to have a copy of the report and, you
21 know, and their attending physician will have a copy, so it's not like it's going to be
22 (unintelligible) they're just not doing it at that time.

23 17:47: Okay. Thanks, Doctor, that was an important discussion.

24 Issue number two. There is nothing in the rule that describes or
25 defines where an IME can be performed or what would be an appropriate setting.

1 some background. Our current Rule 265(1)(b) states a provider will determine
2 conditions under which the IME will be conducted. The Division questions whether
3 the conditions under which the IME will be conducted would allow for a setting such
4 as a hotel room or a setting not primarily used to conduct exams. Workers are
5 required to attend an IME and may be penalized if they do not. Conducting an IME
6 in a hotel room or other location not primarily used to conduct exams can place a
7 worker in a situation of undue stress and can be seen as less than professional and
8 respectful to the worker. Where the Division is focused on improving worker and
9 IME provider interactions, in order to be respectful to the worker, the IME should be
10 performed in a professional setting that is primarily used for conducting exams which
11 is safe and secure and allows for privacy of the worker. The Division wants to make
12 sure our expectations are clearly stated in the administrative rules, recognizing that
13 some rural areas may lack a clinic, a clinical setting, and a hotel may be preferable
14 over the worker traveling a great distance. However, using a hotel should be a last
15 resort. Adding the suggested language in the first bullet under options below gives
16 the rule more clarity.

17 So there one option would be to add the following language and
18 reorganize the rule somewhat. The IME should be performed in a professional
19 setting that is primarily used for conducting exams. In the event the IME is not
20 performed in a professional setting, et cetera, the IME location should be a safe and
21 secure environment, including a private place for the worker to disrobe, and allow for
22 confidentiality. Or other wording that you'd like to consider, and we certainly
23 welcome your thoughts.

24 So I guess the first question maybe we'd like to request input from the
25 committee on is, is whether that would be appropriate revised wording, you know, a

1 safe and secure environment, including a private place for the worker to disrobe and
2 allow for confidentiality.

3 20:08: It's a good addition.

4 20:10: Disrobe in private?

5 20:14: I mean, (unintelligible) someone is stand here and disrobe, it's--

6 20:18: Well, it's in the--

7 20:19: --the intent is that--

8 20:20: --a private place for the worker to do that--

9 20:22: Yeah, so the disrobe in private.

10 20:23: In private. Okay.

11 20:25: I mean, because that's normally how an exam is conducted is
12 they take you in and you take your clothes off--

13 20:32: Yeah.

14 20:32: --you put a robe on and...

15 20:41: Okay. Moving right along then, issue number three. It is not
16 clear in Rule 265 who is responsible to make the determination of good standing,
17 either the medical provider, regulatory board, or the Division. Currently Rule 265
18 states to be on the Director's list to perform IMEs or WRMEs, sometimes called
19 wormies (phonetic), a medical service provider must complete the online application,
20 hold a current license, be in good standing with the provider's regulatory board. The
21 Division determines whether the provider has met all the requirements in order to be
22 added to the Director's list of authorized IME providers. The determination of good
23 standing is not defined by the provider's regulatory board. While the term good
24 standing may have been used by licensing and regulatory boards in the past, most
25 do not use this term as it relates to the status of a licensee. The intent of the rule

1 was to allow the Division to make a determination of good standing. By adding the
2 suggested language below, it will add clarity as to what the Division means by good
3 standing as it relates to adding a provider to the Director's IME provider list.

4 And so if you could take a minute to just read the option and then we'll
5 go ahead and discuss it. So in essence the Division would make the determination
6 of good standing and it would be based upon certain factors so that the provider is
7 not or currently not within the last two years been subject to a disciplinary action--
8 disciplinary action or stipulated agreement with the provider's regulatory licensing
9 board that the Division determines to be detrimental to performing IMEs. Your
10 thoughts?

11 22:54: (unintelligible) yeah.

12 23:11: No concerns? Or did I hear one? About a minute ago? Is--did
13 you say--

14 23:20: No, no, that's fine.

15 23:21: Oh, okay.

16 23:23: I'm surprised I'm not hearing more protestation from this side of
17 the room. That's okay.

18 23:33: Okay. Issue number four. I've got this marked to do quite a bit
19 of reading, so I'll ask you to bear with me on this one, it seemed like it really required
20 it. Issue is again all of these rules affect Rule 265 in Division 10, the medical
21 services rule. 265 allows for an outside vendor to provide Director-approved IME
22 training as long as the curriculum includes the topics in the rule in Appendix B.
23 Topic in Appendix B are vague or obsolete. It is unclear whether the information
24 would be found.

25 Some background. 656.328 states the Director shall adopt by rule

1 educational materials from providers participating in the Workers' Compensation
2 system and conducting IMEs. In consultation with the Advisory Committee on
3 Medical Care, the MAC, of the Workers' Compensation Division, MLAC and affected
4 interest groups, so we are supposed to consult with those--with those folks, while the
5 Division promulgated rules to allow for outside training, ORS 656.328 doesn't
6 contain a provision requiring the Division to allow for outside training. Again Rule
7 265 states medical service providers can perform IMEs, WRMEs or both once they
8 complete a Director-approved training and are placed on the Director's list of
9 authorized IME providers.

10 Initially the rule required three hours of in-class training, which the
11 Director and a small number of approved entities provided in order to compile the
12 Director's list of authorized IME providers for insurers to choose from. Eventually
13 this three-hour in-class training was video-recorded, the provider would request a
14 DVD from the Director in order to complete the required three-hour training. The
15 three-hour training requirement was--requirement was moved from the rule in 2011.
16 At this time the Director published a training guide to performing IMEs, which is
17 available online and allows the provider to complete the training requirement at a
18 time convenient to them. In 2016 the Division decided to no longer use the training
19 DVD. Also, the two known entities approved to provide IME training were contacted
20 and one was no longer in business and the other directed providers to the Director's
21 publication online. Since 2010 there have been no requests to approve IME
22 provider training curriculum.

23 The Director's training guide to performing IMEs available online is up
24 to date and the only approved training available to providers who want to be placed
25 on the Director's list.

1 And again it goes over some--a little bit of background of MLAC
2 directing the Division to take a look at IMEs, so I won't read, go through all of that
3 again, but down toward the bottom there are currently 797 authorized IME providers
4 on the Director's list. In the last year there are approximately 104 medical providers
5 who used the Director's training guide to performing IMEs in order to become an
6 authorized IME provider. WCD's online training is provided at no cost to providers,
7 the Director's goal is to review the training guide regularly to ensure it is up to date,
8 relevant, provides information that will improve worker and provider interactions, and
9 provide comprehensive information as well as clear expectations of IME providers.
10 It was last updated September of 2017.

11 Removing the requirement and rule to allow outside entities to provide
12 IME training will not create barriers to potential providers wishing to obtain IME
13 provider training, so an option would be to remove the reference to Director-
14 approved training regarding IMEs and replace it with just the Director's training guide
15 to performing IMEs and then remove Appendix B and remove 265(3) regarding IME
16 training. Or continue to allow an outside vendor to provide initial IME training to
17 providers wanting to become an IME provider as long as it is approved by the
18 Director, and then remove the curriculum requirements in Appendix B.

19 So with that, I appreciate your input on whether we should kind of go
20 with this option or this option or some other alternative.

21 27:46: Fred, I have a question. Once a doctor obtains certification to
22 do IMEs or WRMEs, do they have to update that periodically?

23 27:55: Myra?

24 27:56: It's just an indefinite approval?

25 27:59: It's there's no continual education.

1 28:02: I think that might be a good idea if we had that.

2 28:06: Do you have a suggestion as to how often that would be?

3 28:09: Probably no less than every five years, at the very least, to

4 remind them of their ethical obligations when they're conducting these IMEs.

5 28:18: So you're--so what you're suggesting would be like every five

6 years have to retake--

7 28:23: Yeah.

8 28:25: What if they go outside and go to seminars where they can get

9 that education on the same thing?

10 28:30: Yeah, for something, something--

11 28:32: I mean, a lot of them do, so...

12 28:36: So would there be a number of continual education hours that

13 you're--that you're (unintelligible) or--

14 28:40: I don't know, I don't really have any preconceived notion of

15 what this would be--

16 28:44: Just some kind of--

17 28:44: --I'm just uncomfortable with the idea that somebody could be

18 certified and have indefinite approval to do this, regardless of what life

19 circumstances change or even the standards of IMEs.

20 28:58: So you can--

21 28:58: (unintelligible) Dan suggestion and that it not necessarily be

22 this, but something else.

23 29:02: If it were the equivalent of what you would get, be concentrated

24 on what's the purpose of an IME and what their role is in it and what's their ethical

25 obligations and so forth, I mean, if somebody's going off to have some surgical CLE,

1 it's not very useful for reminding them of their obligations as an IME, right? I think
2 it's got to have some relevance.

3 29:27: So are you look--like a recertification requirement?

4 29:32: I would leave that to the Department--

5 29:34: Yeah.

6 29:34: --to decide, you know, what you think is the best way to do it,
7 but I just would (unintelligible)--

8 29:38: Something (unintelligible)--

9 29:40: --that we had something that make them come back every
10 once in awhile and say (unintelligible) continue to approve me to do these? And of
11 course another thing you would have to look at is any complaints you've received in
12 the interim since they were initially certified, right, they may have accumulated a
13 whole bucket-load of stuff, and if you never come back and review it, it's going to
14 happen, right, it's ignored.

15 30:01: Dr. Miller.

16 30:03: So a lot of physicians will have specialties, and so like in
17 chiropractic profession, if they're internists or their neurologists or something like
18 that, in order to maintain that specialty status they have to have a specific number of
19 hours in that specialty within their continuing-ed requirements, and so that may be
20 an option also if they're already going to IME training on yearly or biyearly basis that,
21 you know, in order to keep that, you know, IME designation they have to have, you
22 know, so many years or so many hours per year or two.

23 30:37: I would caution just a little bit to say that with those other kind
24 of specialties CNE requirements that there is only so much time in a year in a day for
25 providers to be able to take their CNEs and the state also requiring specific CNE

1 requirements, I think that often providers aren't--there just isn't quite enough time to
2 get all of those hours in, and so, you know, I'm not saying that we're opposing this or
3 anything like that, but I just want to make sure that we're cautious about the burden
4 that we place on these providers who might otherwise not do it, you know, by
5 increasing the barrier to make sure that they have the proper training, I'm not saying
6 that it's not a valuable, you know, need that they stay up to date, but I just wanted to
7 be able to share (unintelligible) first.

8 31:25: Well, I guess, I mean, to--sorry, Trevor?

9 31:29: Yes.

10 31:30: To Trevor's point, you know, I think that one of the things that
11 we always talk about in the Workers' Comp system is the hassle factor of the doctors
12 and so I worry a little bit about that, I think, you know, Randy, I think the point's well
13 taken, but would it need to be anything more than sort of a reminder of a laundry list
14 of things? I haven't sat through the three-hour training, so I don't know what that
15 entails, but it seems to me that what we really want is something to the providers to
16 remind them the differences between their regular practice and an IME exam and
17 maybe just some kind of a certification or, I mean, where they would sign and, you
18 know, I've read and reviewed and send it back into the Department or something,
19 just to sort of say, hey, yeah, I know that this is different than what I do in my general
20 practice, just...

21 32:26: I guess the question is whether if we (unintelligible) every five
22 years how much (unintelligible) as oppo--I mean...

23 32:35: You report to the Bar--

24 32:38: Yeah, 45 hou--

25 32:39: --your CLE like every three years--

1 32:40: --45 hours every--
2 32:40: --right--
3 32:40: --three years--
4 32:40: --exactly and it's--and how many times do we get into that
5 period and go, oh, jeez, I'm missing, trying to find time to get in there, so--
6 32:50: I know what you'll be doing all December, right?
7 32:51: No, I'm good, I'm good this year--
8 32:55: I have a quick question. From what's the difference between
9 the initial application and what we're talking about as ongoing? Or would it just be
10 would the initial application process fulfill that need to remind them of all their
11 obligations and how intrusive is that initial--
12 33:14: I'm making it up right here (unintelligible) what are we talking
13 about.
14 33:18: So currently there isn't a continual education credit required, so
15 if we're looking at like a recertification or a continual ed, I would assume it would be
16 related to the stan--the training initially needed for independent medical exams to
17 become an independent medical exam provider--
18 33:35: Well, my question was what is it they're required to do to get on
19 the list?
20 33:42: To--they're required to read the training guide and complete a
21 quiz over the documents they just read.
22 33:48: That's my question is would that be sufficient for ongoing?
23 33:52: Yeah, that's--
24 33:53: I think that's--
25 33:55: To reread and retake the--

1 33:57: Yep.

2 33:57: --required quiz.

3 33:59: Right.

4 34:00: Because that quiz is addressing our assurance for workers--

5 34:04: Yeah.

6 34:04: --that providers understand the differences--

7 34:07: Yeah, and that quiz is new, it wasn't always that--

8 34:09: Correct.

9 34:09: --way, just needs to be a video, the whole DVD, and so we

10 were that, we're the only other vendor and we don't have any problem being

11 excluded to provide the training, just so you know, and WCD can do it, but just so

12 you know, Randy, it's like now there's even a test that our physicians are taking and

13 it used to be just they went to a class and there was no test, and now there's a test--

14 34:30: Over the material--

15 34:31: --over the material--

16 34:32: So they'll (unintelligible) watching it and so there's actually an

17 additional check and balance there that we didn't used to have in the initial training,

18 so, and you know why (unintelligible)--

19 34:38: But he is correct that, you know, anybody who was added to

20 the list prior to that--

21 34:43: Yep.

22 34:43: --requirement wouldn't have been required to do the quiz along

23 with the (unintelligible)--

24 34:49: Well, I would just say, I mean, I can appreciate this concern, all

25 of us professionals have this burden of being able to maintain our licenses of course,

1 but for the privilege of being in the IME business, which really has no clinical strings
2 attached to it, it's this onetime exam, it's well-paid-for, I don't think it's asking too
3 much that the person who performs that and gets paid for that be asked to
4 periodically somehow recertify with the Department that they're fully aware of their
5 obligations as an IME both ethically and professionally, I'm not sure the professional
6 credits they earn about their special technical expertise in an area of medicine is
7 what I'm talking about, I'm talking about more this interaction that happens in an
8 IME, it's very unique, it's not even like with your own patients where you start to
9 develop a rapport with them, you see them multiple times, right?

10 This is a very scared, skeptical, cynical injured worker who feels like
11 he's being forced into a firing squad almost and feels right from the minute he's told
12 he's going to go, he or she is going to go, this is adversarial, this is being used
13 against me, I have a lot of empathy for those who do the IME that they need to adapt
14 to that situation and I don't think it would hurt at all if every once in awhile if
15 somebody just said, you know, let's talk again about how this is going to work,
16 what's expected of you, right, and why this is such a sensitive exam, and it is, I think
17 it's hard for me to emphasize enough what I hear back from all of the people I've
18 represented in 35 years about their experiences in IMEs, some of them horrific,
19 some of it's pretty good, more to the former, unfortunately, but...

20 36:31: Okay. Thank you. Joy?

21 36:33: I think it's really very important that the providers need to be
22 reminded and I don't know how, but somehow they need to be reminded about the
23 rules and their behavior in the IME because I will tell you I personally attended one
24 and the provider was very rude, I will tell you that, and she made me feel like, you
25 know, just, I don't know, it was just very unprofessional behavior, and personally for

1 me working with the Takacs Clinic, it was like, wow, you know. I know how this IME
2 works, what the process is, so don't talk to me like that, whether, you know, the
3 IME's in my favor or not, that's something else, but your behavior has to be
4 professional, so, and I think somehow they need to be reminded, I think after so
5 long, five, ten years, you know, they start feeling comfortable and they just forget
6 about it, they (unintelligible)

7 37:44: Thank you. Dr. Miller?

8 37:46: I don't want to get too far off subject, but when we have, you
9 know, some of these complaints you brought up on here, and I don't know if it was
10 on this section or prior section, but what's the--what's the ramifications to a
11 complaint at that point, you know, when we get situations, I mean, it's nice to have
12 all these rules, but are the (unintelligible) rules.

13 38:07: Well, we'll get further down into an issue where we actually
14 outline the complaint process--

15 38:13: And I'll (unintelligible)--

16 38:13: --and we'll outline the (unintelligible) rule now where it hadn't
17 been before, but they are investigated and the doctor's asked and the worker is
18 asked, brings forth the complaint, and the doctor's asked for to explain, here's the
19 allegation, please provide us your recog--your comments, and it is difficult because it
20 could be no one else in the room but those two, but you--I'm allowed to provide them
21 additional education or at least feedback regarding it as well as require or--and ask
22 them to read the guide again. There's no requirement, I don't have a requirement to
23 do those things, it depends on the actual complaint, so, and I can actually meet with
24 the provider and I've done that on several occasions to talk to them about what the
25 Division is looking for and what our expectations are to help them understand where

1 we're coming from, so there is an investigation and there the only avenue we have is
2 to final is to remove them from the list, so we want the provider to improve their
3 behavior, that's our goal is to provide education to improve the behavior, and only at
4 the last resort would they--will we move to removal.

5 39:44: Do they ever like send in a (unintelligible) type thing that
6 (unintelligible)--

7 39:52: A piece of paper.

8 39:55: (unintelligible) I don't know, that \$500 would say, you know,
9 (unintelligible) dollars when bad (unintelligible) or something--

10 40:03: Right, but, I mean, I think we should talk about exactly how
11 many complaints we're even receiving out of the 40,000 IMEs, I mean, come on now
12 (unintelligible)--

13 40:11: Yeah, it's a very small number--

14 40:13: --huge number (unintelligible)--

15 40:13: --(unintelligible) given the number performed, yeah--

16 40:16: And as a formal complaint--

17 40:18: And all the IME--

18 40:19: Formal comp--

19 40:19: --companies and we do, all do exit evaluations, so we're always
20 seeing getting that response back, but also we every quarter we send out a quarterly
21 letter to all physicians on updated stuff that's happening, so this stuff has been in
22 some of those letters, so they're constantly getting information from us about, you
23 know, what's going on in the business, updates, rules, all that, so four times a year
24 they're getting information from us, so it's not like they're just sitting back for five
25 years doing, you know, doing their own practice, they're already going to the--yearly

1 they're going to the orthopedic conferences in all (unintelligible) that, those meetings
2 I'm sure they talk about bedside manner and all that other stuff in that and also
3 they're integrating like IME (unintelligible)--

4 41:08: And Dan, I don't know if there's like additional training that like
5 Sunrise does or any other IME company would do for new IME providers that come
6 in, this training is just for--

7 41:22: We have a book that--

8 41:22: --the Division to (unintelligible)--

9 41:23: --we have a book that we give to doctors, basically has all this
10 information already in it, they sign off, they agree to it, be available, all that, so
11 there's we're really proactive in it, so, and we hardly ever see complaints, I'm sorry
12 you had a bad experience, but 28 out of 40,000 IMEs over the last four or five years
13 is not--is not a lot, so (unintelligible)--

14 41:46: I don't know, but how many people are not complaining, how
15 many patients are not complaining because they're afraid, they're already have had
16 bad time, you know, they're already dealing with this Work Comp situation, so at that
17 time it's already a lot.

18 42:02: There's an exit evaluation that they fill out when they leave
19 where they can take with them and mail it to the Department or to us, so we, I mean,
20 there's a freedom to be able to respond to (unintelligible)--

21 42:13: Anonymously.

22 42:17: Can--

23 42:18: I just want to echo what Trevor and Jaye said, so my concern
24 is, is that we have not got a lot of IME doctors and I would be concerned if we put
25 too much burden on them, I totally hear what you're saying and I think it is important

1 that they be accountable, but I'm also concerned with adding anything more that's
2 going to maybe make people decide not to, especially out in the rural areas or
3 remote areas, so I like the idea of having sort of the if we--if we adopt the issue
4 number one, if we adopt that, here's the conduct kind of rules, having that reissued
5 with them having to certify that, yes, they understand it and, yes, they agree that
6 they will follow those rules, that seems to me to be a fairly minimal impact on their
7 time, it also emphasizes the importance of, gosh, we're reminding you that you have
8 to behave this way, but it--but it meets that. I'm just my only concern is that we lose
9 IME doctors and that would be really difficult for us to even have that if we have
10 fewer and fewer, we're already seeing that, we're seeing a lot that are aging and
11 exiting and we're not getting a lot that are coming in, and so my biggest concern
12 would be that, so I would hope that if we're going to find some way to reengage them
13 after the initial, that we do that--

14 43:50: (unintelligible) balance--

15 43:50: --thoughtfully so that we are not impacting them and maybe
16 making them make a choice that this just isn't worth it.

17 43:56: Myra, how long does it take to do the exam itself?

18 44:02: To do the training guide, read the guide, do the--

19 44:04: No, just the exam.

20 44:06: Oh, to do the actual quiz? Oh, jeez, I want to say there's
21 maybe 14 questions, it's on the material they just read, so it's I don't think it would
22 take very long--

23 44:21: So you're asking to read the material again--

24 44:21: Seven minutes--

25 44:22: --I guess that's my--

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(Crosstalk not transcribed.)

44:27: (unintelligible) read the material again--

44:28: Yeah--

44:28: Yeah.

44:30: And the--and the items and the quiz are to--are directed towards areas that we want to make sure that the that--that we can test on whether or not they read the guide--

44:42: Sure.

44:45: It's they're--

44:45: Where they continue to understand the guide--

44:47: And understand it, yeah.

44:50: Thanks very much, Kimberly, and access is a very important issue to the Division as well and I'm sure to everyone here. I think Hasina already maybe addressed this to some extent, but to the initial question of whether kind of whether the agency ought to be the sole source of the training or whether it should read as it does now, that private vendors can find a way to provide the training, we just wanted to be sure before we make any kind of rule change like that that--

45:21: Go ahead.

45:22: --there's an understanding...

45:24: Feel free.

45:25: The only reason we did it was because when the bill passed initially, we each were concerned that we wouldn't get anybody trained and up and running really quickly, so we just developed the training right away and it was actually (unintelligible) did the training that... Did it joint, Chris--

45:44: (unintelligible)?

1 45:45: Yeah, Chris, uh-huh, and so we just got this training and then
2 we had to take these and then you guys started to get, you recouped and you
3 started to do what you needed to do, yeah--

4 45:48: There were a lot of providers that needed retraining
5 (unintelligible)--

6 45:59: Yeah, we were really just, yeah, trying to make sure that they
7 got trained so we don't have any issues with the way you're doing your training or
8 even the test, which initially (unintelligible) resistant to even being a test because we
9 thought that would create a barrier, but now people seem okay with it, so...

10 46:16: There is--

11 46:16: Well, and the test shouldn't be too burdensome, is that how you
12 say that word, for those providers that understand and operate every day according
13 to the guidelines.

14 46:33: I just would just say that there's certain specialties that it's very
15 difficult to find that time to do that, I think about someone who's in surgery four days
16 a week, it's very difficult, so...

17 46:45: A question for you, Dan.

18 46:46: Sure.

19 46:46: Is there any internal process for disciplining IMEs, in other
20 words, you get those questionnaires back you're talking about--

21 46:53: Yep, yep--

22 46:53: --the exit interviews the workers are asked to--

23 46:55: Sure.

24 46:55: If you saw something particular egregious, do you have
25 someone that would call up that doctor and go, hey, I don't know if you're aware--

1 47:00: Yeah, oh, yeah, oh, yeah, we--we're again we're very proactive
2 in everything that we do, we don't want things to happen, we want (unintelligible) and
3 we want to have a good experience (unintelligible) you know (unintelligible) reports
4 as soon as possible, so--

5 47:16: Has your organization ever asked a doctor to de-authorize
6 himself or whatever that process would be to stop doing IMEs?

7 47:24: Ours has not, but we had a serious discussion with somebody
8 about not being on our list anymore--

9 47:29: Ah.

10 47:29: --because of his actions and to change--

11 47:33: (unintelligible) miss.

12 47:34: That's good to know.

13 47:35: So, I mean, it's--but, you know, to Joy's point, I want to
14 reinforce it's something Joy was saying, you know, worker, the number of complaints
15 that have been filed proportionate to the number of IMEs I don't think is particularly a
16 good indicator of whether there's a problem or not because, I'll be honest with you,
17 these people, I love my clients, but they're so unsophisticated sometimes, they
18 wouldn't know how to file a complaint with DCBS if we didn't direct them or that they
19 maybe go to their medical provider, I mean, they just don't know how to do things
20 like that, right, they get up and they put their boots on and go out and muck concrete
21 all day, they don't know how to write a letter even, right, and so they're not going to
22 complain no matter how egregious they felt their experience was because they just
23 don't really know how to go about it doing it, right?

24 48:21: Okay, but, I mean, just to push back on you on that, I mean, I
25 don't know how much more easy we can make it for an injured worker would to, I

1 mean, and I'm only speaking for the IME comp--IME companies the facilities that are
2 part of IMEs, okay? If there are other IMEs companies or other IMEs being done not
3 run for facilities, I can't guarantee that they're not getting that exit evaluation--

4 48:43: Yeah.

5 48:44: --and there, I mean, it's one page, I'll show it to you, Randy--

6 48:47: I've seen it.

7 48:47: --it's like, I mean, how can you not just say, well, that guy was a
8 jerk, right, he spent five minutes with me, like it's a box, you check it, and you get, I
9 mean, it's anonymous, you hand it in, and you're done.

10 48:58: But that's different than a formal complaint with DCBS asking
11 them to investigate that IME--

12 49:03: I totally hear it--

13 49:03: --and take sanctions--

14 49:05: I hear what you're saying--

15 49:05: --potentially--

16 49:05: --except for if we're not seeing a barra--we've--you know, we
17 hardly see any negative evaluations come back, I mean, it's there's their chance to
18 complain and they don't, so--

19 49:17: Right, complain about the doctors if I have to write a report
20 about whether you are going to state--

21 49:22: I hear what you're saying--

22 49:23: --bite a bullet in the Work Comp system or not, wow, I wonder
23 why that would be, you know, but...

24 49:29: Yeah.

25 49:34: Okay, well, actually turned into a very important discussion and

1 had an aspect that we did not anticipate, so we'll certainly look into what, you know,
2 what is feasible and what we think is the best outcome and then again we'll--you'll
3 have another shot at this when we file proposed rules, but with that, do you have any
4 last thoughts on this issue before we move on?

5 49:58: So, Fred, is it just are you just basically trying to clean up the
6 rule be--and that's why you've made the, because there is nobody else doing it, so
7 the question is--

8 50:07: Correct, we--

9 50:08: --do we just remove the requirements so that we clean up the
10 rule--

11 50:10: Correct, it's--

12 50:10: --is there any harm from leaving it in case somebody were
13 wanting to enter into that?

14 50:15: Well, that's kind of the second option of, you know--

15 50:19: See, this is like--

16 50:20: I'm just asking--

17 50:21: No, Kim, I get it (unintelligible)--

18 50:24: I mean, I can't imag--I--just knowing how that training worked
19 and you have to get the curriculum approved with DCB, you'd have to go to DCBS,
20 and so I guess I would say if somebody wanted to go to DCBS and explore
21 becoming a training--a trainer, then I guess it'd be to DCBS could just change the
22 rules to allow for it because we just are not seeing people intr--not--I mean, there's
23 just no interest in it--

24 50:48: Doesn't seem to be like a financial incentive to create training
25 of that nature because of it being so easily obtainable online, so, I mean, in the eight

1 years we haven't seen--

2 51:05: No.

3 51:05: --any requests--

4 51:06: And there is some sort of value in just having one-stop-shop
5 training so we know who's saying what, I mean, from both your side and that side,
6 like what is the training, we all know what it is, there's no, oh, they were trained by
7 IME A and so they didn't actually get the same exact type of training.

8 51:24: But there is some value in, I mean, some little loop someplace
9 even if it just says unless otherwise determined by the Director so that if you get into
10 a spot where the Department simply can't do it or there's, you know, a change in the
11 law and all of a sudden you're having to ramp back up, I just don't see the harm in at
12 least leaving some so you don't have to come and go to one of these, do more
13 (unintelligible) rules (unintelligible)

14 51:54: We'd be happy for Dan to provide (unintelligible) training.

15 51:59: His new career.

16 (Sotto voce remarks not transcribed.)

17 52:07: Just, yeah, I mean, leave your--leave you a place to say, yes,
18 this provider can provide or (unintelligible)

19 52:16: It's not causing any harm to--

20 52:18: I know.

21 52:18: --leave it in there the way that it is.

22 52:19: Yeah, exactly--

23 52:19: Yeah, that is true, that's true.

24 52:23: Okay. Thank you very much, I'm going to move us down--

25 52:28: (unintelligible) you (unintelligible)

1 52:34: Okay, on issue number five, Rule 265 states in part a provider
2 may be sanctioned or removed from the Director's list of authorized IME providers
3 after the Director finds that the provider, because that's quoted material, says a
4 provider may be sanctioned or removed. However, 656.328 does not grant the
5 Director authority to sanction; only that the Director may exclude the IME provider
6 from the list. And then it kind of repeats it under background. While the Division
7 may be able to sanction a medical provider for violating a Workers' Compensation
8 law or rule as provided under separate statutes, the Division has no statutory
9 authority to sanction an IME provider under current Rule 265, and then it goes, it
10 shows the actual wording of the rule, which I won't read verbatim, but so the
11 question is for this group, would--we would like to remove the word sanction from
12 Rule 265 in that we don't have authority to issue sanctions, at least not under the
13 statute as it is, so it's kind of just making this--the rule and bringing the rule and the
14 statute into alignment.

15 53:51: Fred, are you talking about monetary sanctions, because we
16 could otherwise sanction someone (unintelligible) could write them a nasty letter, say
17 (unintelligible) for six months, I don't know.

18 54:05: Well, it doesn't--I guess I don't know that we would have
19 authority, I mean, we could--we do issue--

20 54:10: We've got the authority to do the other stuff, it's just that--

21 54:12: Right, right.

22 54:12: --statutory, you have to have statutory authority to financially
23 fine someone, sanction someone, but I don't think you have--

24 54:20: What would--what else would come under a sanction?

25 54:23: Well, like I said, a nasty letter, something that says that you

1 can't perform IMEs for six months or--
2 54:33: See, I don't think we can do that--
3 54:34: You can't--
4 54:34: No?
5 54:35: No, based on statute, no, it's either--
6 54:37: So you're removed or you're out--
7 54:37: --you're in, you're in or you're out--
8 54:38: Yeah, yeah--
9 54:38: Okay.
10 54:39: --and we write nasty letters--
11 (Crosstalk not transcribed.)
12 54:48: I can help you with that.
13 54:51: But can you kick a provider off the approved list, how long can
14 they wait until they're reapplying?
15 54:58: Myra?
16 55:00: No--
17 55:00: No.
18 55:03: When we remove, they're allowed to appeal the decision, but I
19 believe if they're removed they're removed, they're not--I don't know, I don't know
20 that there would be any getting back on the list--
21 55:15: Has there--
22 55:16: --but we've never come across that before--
23 55:18: Have there been situations where someone has been
24 sanctioned by their board and then we've taken them off?
25 55:24: That's different, oh, you're correct, yeah, there are ones that

1 where the regulatory board has either put them under disciplinary action or they
2 have stipulated a letter that we felt was detrimental for them to perform IMEs and we
3 do remove them for that, we tell them during that period that when their status
4 changes, if their status is then enough time has passed and their stipulation is
5 removed from their board, then they can reapply.

6 55:59: Has there been a question about that--

7 55:59: But if they lose their action because of an action that the Board
8 took on them, then obviously they're not going to be on the list (unintelligible)
9 problem.

10 56:08: So why is it that you think you couldn't sanction them by saying
11 we're going to suspend you for six--

12 56:13: Statute doesn't allow for it.

13 56:15: Well, I hear what Jaye's saying about the monetary sanctions,
14 but it just--the statute just says--

15 56:22: We remove?

16 56:22: --remove, yeah, that's it, it doesn't say anything--

17 56:25: Right--

18 56:25: --less than that--

19 56:26: --right, so we could, the statute doesn't allow for us to suspend,
20 only to remove.

21 56:34: Can remove them for six months.

22 56:39: I'm sorry (unintelligible) sounds like a Monday morning, I'm
23 being kind of smart. Sorry.

24 56:47: That seems possible that (unintelligible)--

25 56:48: So we've said that we've sent, we've sent letters before, but in

1 terms of my definition of sanction is that, you know, removal or suspension.

2 57:00: Yeah, okay.

3 57:01: Or monetary.

4 57:02: Right--

5 57:02: Right--

6 57:02: And really I think the statute's pretty clear on that one.

7 57:04: Okay.

8 57:14: Any additional thoughts before we move on? Issue number six.

9 A medical service provider on the Director's list of authorized IME providers is
10 subject to the reporting requirements under 656.254, specifically as it relates to
11 reporting having performed an invasive procedure, and there are some additional
12 copies of Form 3227, which is the invasive procedure authorization form, at the back
13 of the room. Currently rule language is not explicit that an IME provider may be
14 sanctioned for failure to comply with 656.254 and the reporting of an invasive
15 procedure under Rule 265.

16 Some background. The director can only sanction a medical provider
17 for a rule violation if the medical provider is providing treatment according to 656.327
18 or has violated reporting requirements under 254. The current rule language under
19 Rule 265 states that a provider may be sanctioned or removed from the Director's
20 list of authorized IME providers after the Director finds the provider violated Workers'
21 Compensation laws or rules. An IME provider may perform an invasive procedure
22 as part of the IME in which they are required to follow Rule 265(6) and are subject to
23 sanction under Rule 340. The invasive procedure Form 3227 instructs the provider
24 to make copies of that form for the worker and to send the original to the insurer.
25 The Director considers the invasive procedure rule a reporting requirement by the

1 IME medical provider. Statute 656.254(2) states the Director shall establish
2 sanctions for the enforcement of medical reporting requirements. The current
3 language in Rule 340 is limited to 656.254(1).

4 So options would be remove language in Rule 265 there where it says
5 violated Workers' Compensation laws and rules and add the following language to
6 this rule. The IME provider must make a copy of the form for the worker and send
7 the original to the insurer, and add the following wording, an IME provider may be
8 sanctioned under Rule 340 for failing to follow 265--Rule 265(6)(a) and change
9 Rule 340(1), the reference to 254(1), to reference 656.254 just to make it a general
10 reference as opposed to narrowing in on that subsection of the statute, or other
11 options, other language than outlined above.

12 So with that, appreciate your input on use of the invasive procedure
13 form and making it a more clear reporting requirement.

14 (End of recording.)

15 00:02: Well, just on your terminology, don't you have to take away
16 your sanction (unintelligible) again?

17 00:13: This is a different statute, right? This is a reporting statute,
18 right?

19 00:19: So the sanction would be for the reporting requirement, not
20 for--not--it would not fall under the 33 (unintelligible) the statute for IME providers. It
21 would fall under 656.254.

22 00:37: Well, you're also putting it under 265 (unintelligible)

23 00:44: Correct, because there is a requirement to invasive procedure
24 requirement in the rule, but it's the only part of the rule under 0265 that would--that
25 would fall under an area that, a reporting requirement that could be sanctionable.

1 01:11: Well, I mean, another thing, in the written words, it's not going
2 to (unintelligible)

3 01:17: Okay.

4 01:21: You'll have to find a way to (unintelligible)--

5 01:23: Clean it up.

6 01:25: --(unintelligible)

7 01:30: Thank you, Dr. Miller. Additional thoughts?

8 Moving down to issue number seven. Rule 265 does not detail the
9 process for investigating and reviewing IME complaints, as required under
10 656.328(3)(b). That statute requires the Director to adopt by rule a process for
11 investigating and reviewing complaints about IMEs that includes but is not limited to
12 standards for referring complaints to the appropriate health professional regulatory
13 board. Current Rule 265 states when a provider may be removed from the Director's
14 list of authorized IME providers and their appeal rights. However, the process for
15 investigating and reviewing complaints is not provided.

16 So one option would be to add the following suggested new language
17 to the Rule 265, and here's where I won't again read this line by line. It's somewhat
18 lengthy, but it does lay out the process that the Department uses investigating an
19 IME complaint. And after you have a moment to look at that, I would be--we would
20 welcome your input on the process itself and the description of the process.

21 03:04: Fred, is there a time limit? Like under (e), you've got only
22 14 days for them to respond. Is there--does the Department have so much time, are
23 they under a time restraint for how long they have to respond?

24 03:20: As far as how soon we need to resolve the complaint?

25 03:23: Yes.

1 03:23: No.

2 03:24: Okay. So I would only be concerned about, I mean, 14 days to
3 me sounds like a long time, but I know that sometimes it can take quite awhile to get
4 something from a medical provider that shouldn't, in my mind, take that long. I just
5 would be concerned that that's a--seems to be a--if you're not under a time
6 constraint, is it feasible to increase that time?

7 03:48: Well, I don't know if this makes a difference, and you probably
8 notice this, Kimberly, but it does say the Division may make a decision based on
9 available information, so it would be discretionary in that we, if someone was, we
10 thought, was in good faith going to provide the information, we would provide a little
11 more time.

12 04:04: And I do follow-up if--been my experience that doctors are very
13 responsive when the Director sends them a letter asking for their response, and the
14 only times that I've had where there's been a delay has been where they may have
15 not have received the document somehow, they were with a company, maybe they
16 hadn't been doing the exam for a couple weeks and--

17 04:26: Or they're out of town, right.

18 04:26: --on vacation or, yeah, and I always like do a follow-up call or
19 an email and--but I've always gotten responses back, so it's kind of just giving a
20 guideline--

21 04:38: Okay.

22 04:38: --yet allowing us, you know, to do that follow-up before we
23 decide they're not going to respond at all.

24 04:47: And 14 days is a real standard timeframe that's used for most--

25 04:51: Yeah.

1 04:51: --across Oregon.

2 04:52: For medical information in particular, it seems to be that that's
3 what's provided in terms of...

4 04:58: Myra, I have a question for you. In this subsection (d) where it
5 says the Division may contact the IME provider, it also seems to suggest that if you
6 don't want to go get those items (a) through (d) to complete a thorough investigation,
7 you can choose not to do that, is that correct?

8 05:14: Correct.

9 05:19: It would certainly be my preference that it had, that it
10 commands you to do that through the word shall. I don't see how you can do a
11 complete investigation unless you go get the underlying documentation that's the
12 substance of the complaint. And I'm not doubting you--

13 05:37: Correct.

14 05:37: --it's not personal to you--

15 05:38: I understand.

16 05:38: --but anybody who would be put in your position here at the
17 Department could just say I don't have to do this if I don't want, I get a response from
18 the IME doc, he says I didn't--none of this happened, okay, I'm moving on, right, and
19 maybe there was a witness, a chaperone, maybe the worker brought somebody with
20 them, and if you called in, they'd say no, what she wrote in her complaint is exactly
21 what happened, right--

22 05:59: Some complaints that come in, the nature of the complaint is
23 evaluated and some are req--the nature of the complaint may, just had one recently
24 we got, it wasn't related to the interaction between the IME provider and the doctor; it
25 was based that they didn't receive appropriate payment for their time loss to their

1 exam, so there are complaints that come in that are non-related to the actual
2 examination, and so those would fall outside that guideline--

3 06:32: Yeah, so you'd need another subsection that basically talks
4 about what's a bona fide complaint against an IME versus an irrelevant complaint,
5 maybe they, you know--well, even within that it could be weird, you know, a claimant
6 could say, you know, he didn't wear a tie--

7 06:47: Yeah--

8 06:47: --right, complaint (unintelligible)--

9 06:48: Yes--

10 06:48: --that seemed unprofessional to me, and so (unintelligible)
11 stupid thing, right, but nonetheless--

12 06:53: Right.

13 06:53: --when it is a bona fide complaint, okay, when conduct of the
14 (unintelligible) that on its face strikes a reasonable person as this is serious, all right,
15 it seems like it should then trigger something that requires you to dig into the
16 underlying information--

17 07:10: So, Randy, you're suggesting maybe putting another section
18 after (b) or after (c)?

19 07:18: Something, I mean, you will need some screening device, I
20 understand that completely, but if you word it in such a way that it gets you through
21 that and now we're seeing and looking and wondering these truly bona fide
22 complaints, then I don't think it should be discretionary whether you dig into it and
23 really investigate it or not, I think you must--

24 07:35: Does (c) where it's talking about one or more violation of
25 professional standards, I mean, it could be beefed up to make sure that it's clear, but

1 that's what you're talking about, but under little (c) it kind of gets at the fact that
2 you're going to investigate if there's a violation of one or more professional
3 standards--

4 07:54: There I understand what you're saying--

5 07:57: The example you gave wouldn't even qualify under (c)--

6 08:00: Right, but it would, it would--

7 08:00: --it's not an IME complaint--

8 08:01: --have stopped at, it would have stopped at (d) as far as the
9 IME complaint's reviewed to determine appropriate action, and you wouldn't even
10 get--

11 08:09: Not getting mileage reimbursed is more of just a claims
12 processing issue anyway--

13 08:11: You wouldn't even get to (d), yeah--

14 08:12: --right, so--

15 08:12: Yeah, but I understand, so if you're going down a line, what
16 you're saying is that if you've made all (a), (b), and (c) are all applying, that (d)
17 should be more--less of a may and more of a should.

18 08:24: Yeah.

19 08:24: Yeah, and then--

20 08:25: Got it. I hear you.

21 08:27: Yeah, thank you.

22 08:28: I--well, and I think kind of outside and something that Myra's
23 come across once or twice is that we've received complaints, and I would say that,
24 yes, they're very valid, we should look into them, but it is something to the extent of,
25 hey, he talked over me during my exam, but then filed the complaint three years

1 after the fact, I don't know, given that that's all that they said, you know, he talked
2 over me, I don't know that I expect if we reach out and contact the IME provider for
3 them to remember something from three years ago, to some extent we also look at
4 how timely was the complaint received as it relates to the timing of the IME, and so I
5 know some of those we've talked about how much work do you put into something
6 given how long ago it was and what it was that they alleged and, you know, what do
7 we expect that they're going to say, how--what's the reasonable outcome for that,
8 but, you know, in working with Myra and kind of looking at some of the complaints, I
9 mean, every single one of them is different, and so I think that that's kind of what
10 she's evaluating, it could be that you just are getting too far down into when you
11 reach out, I think she reaches out every single time that there is what we call
12 substantive or valid complaint, but there are those things that kind of fall outside of it,
13 and so I think--

14 09:55: There's--

15 09:55: --that's kind of some discretion--

16 09:57: Can't write a rule because you have a perfect employee
17 currently in the position--

18 10:00: Yeah.

19 10:03: The rule has to be written in such a way that even if you put a
20 derelict person in that position, they're going to perform their obligations, right, and
21 there would be numerous examples of what you talk about and that's why I think
22 there needs to be a triggering device--

23 10:15: Yeah.

24 10:15: --we could bring up numerous examples of where it just
25 doesn't, it's almost frivolous in fact, and that we wouldn't want the resources

1 expended on investigating deeper, that's why we need to figure out which ones are,
2 and I just keep using that term bona fide, but where we get to that level, and then it's
3 really got to be that whoever sits in that seat is mandated to get in and find out what
4 really happened, that's my point, that's all I'm saying.

5 10:39: Instead of making that decision that, oh, that's not a valid
6 complaint, I'm just not going to go forward with it because I don't believe that person,
7 get the information to go forward with it.

8 10:49: There could be numerous--

9 10:50: Weeding out the ones that--

10 10:50: --examples that we could come up with--

11 10:51: Right.

12 10:51: --that fit that scenario, too, maybe the person sitting in that
13 seat, it's her uncle that's the IME, for example, well, I'm going to choose not to dig
14 into that one.

15 11:00: Right, right.

16 11:01: Let's not let that happen, you know what I'm saying.

17 11:04: I don't know, Randy, I guess I appreciate what you're--what
18 you're saying, but I also think, and I think (unintelligible) a comment about somebody
19 makes a complaint three years ago about somebody talking over them, and I'm not
20 sure how much value there is in the Department contacting the IME provider, and so
21 there's a certain amount of judgement that we're asking the Department to use and I
22 think we need to leave that judgement there, you know, and I don't know how you
23 write a rule that has all the exceptions, I mean, we're really talking about principles
24 as opposed to hard and fast rules, right?

25 11:44: Well, I'm pretty certain in every licensing board they have to

1 kind of go through this same level of scrutiny from whether it's really a complaint
2 they've received from a patient of that doctor that warrants further investigation or
3 serious enough they're going to actually look at license revocation, right, so I'm sure
4 there's a lot of examples--

5 12:04: Right.

6 12:04: --of where people have to investigate things like this that they
7 create rules that create a screening sort of a device, right, and that's why I say I think
8 there needs to be another subsection that creates a screening device, but once
9 you've screened it into that serious level, then I don't think there should be a whole
10 lot of discretion on not investigating.

11 12:24: Thank you, Randy. We don't use shall much anymore, but will,
12 but it's probably getting to the same thing, if, you know, if we need to use a word like
13 that and have some kind of standard for determining what's bona fide to get there.

14 12:37: That's a whole nother issue.

15 12:38: Yeah--

16 12:38: Correct.

17 12:40: Well, it's (unintelligible)

18 12:43: For anybody who writes appellate briefs, that's a huge issue.

19 12:51: Anything else? Issue number eight. Rule 265(3)(c) includes
20 language that pertains to training requirements for claims examiners, which is
21 governed by another division of rules, Division 55, 436-055. The Division 55
22 governs the initial certification, renewal, and training requirements for claims
23 examiners, individuals who want to know the requirements for becoming a certified
24 claims examiner, and current certified claims examiners who want to know the
25 training requirements for renewal will refer to Division 55. The requirements for

1 training regarding interactions with IME providers is located in Rule 85 of Division
2 55.

3 So an option for this group to consider would be to remove the
4 language in Rule 265, and then it's quoted, ensure claims examiners must be trained
5 and certified in accordance with OAR 436-055 regarding appropriate interactions
6 with IME medical service providers. So I guess the bottom line is we don't think this
7 really belongs in Rule 265, but we'd appreciate your thoughts, so...

8 14:16: (unintelligible) the insurer here, we support that because when
9 we look to that claims examiner certification rules and requirements, we go to 055,
10 not to 010, so--

11 14:26: I don't think anyone would look for this here--

12 14:27: No--

13 14:27: No, and it would get lost in the (unintelligible)--

14 14:29: Yeah.

15 14:39: And issue number nine, the language in Rule 265(5) does not
16 explicitly state that the IME provider can ask the observer to leave and continue the
17 IME or end the IME if the prov--if the observer interferes or obstructs the IME.
18 Current rule language states a worker must sign a form indicating they would like an
19 observer present and acknowledging they understand that an observer must not
20 participate in or obstruct the exam and the IME provider is responsible to verify a
21 worker's signed the form. The observer form states, "If my observer interferes with
22 the exam, the IME provider may stop the exam, which would affect my--could affect
23 my benefits." The rule does not explicitly state the IME provider can ask the prov--
24 observer to leave and continue the IME or end the IME if the observer interferes or
25 obstructs. There is no option but to end the IME if the observer interferes or

1 obstructs. By allowing the IME provider to ask the observer to leave the I--I mean
2 the IME could continue with the worker's consent without the observer. By adding
3 language to Rule 265(6)(c) the Division is providing a clear direction that the IME
4 provider may ask the observer to leave and continue the IME or end the IME.

5 So an option to consider would be to amend Section (5), and again this
6 is quoted, if the observer interferes or obstructs the IME, the IME provider may ask
7 the observer to leave and continue the exam with the worker's consent or end the
8 IME. Your thoughts? Any concerns? Thank you very much.

9 Issue number 10. There is no timeframe in rule for when the IME
10 provider should provide the IME report to the insurer. The Division has received
11 only one complaint regarding an untimely IME report sent to the insurer. The
12 Division would like feedback from stakeholders about whether a timeframe is
13 needed. An option would be to revise the language in Section (10) of Rule 265 to
14 include timely before report as follows, and it just shows where the word timely is put
15 in there, or add a specific timeframe when the IME provider must send the report;
16 *e.g.*, within 14 days or 21 days, for example, or some other possibility. So I
17 appreciate your feedback on whether to address timeframes for providing the IME
18 report.

19 17:31: Since there's only been one complaint about it, it's like a
20 problem looking for an answer. We don't--I mean, again (unintelligible) there's some
21 people that they work with where we know this doctor is always going to take two
22 weeks, period, no matter what, that's what it is, or, who knows, doctor's on vacation,
23 so we just filled that in and we ask and there's a lot of back-and-forth that takes
24 place to determine how quickly we're going to get a report, and if it's going to be, you
25 know, responsive enough.

1 18:05: So when you say this doctor is only going to take two weeks, is
2 that a good thing or a bad thing in your line of work?

3 18:11: Bad.

4 18:12: Okay (unintelligible)--

5 18:12: I mean, well, I mean, we'd like it even sooner, but
6 (unintelligible)--

7 18:14: That's (unintelligible)

8 18:16: --you just know it's going to take exactly two weeks, boom.

9 18:18: Every specialty has, they're involved in surgery or wherever
10 they are at, they're going to be different, and, yeah, some doctors are always two
11 weeks and the thing about it is you can always tell the adjuster this is the timeframe,
12 so we already, they already know ahead of time what it's going to take, it's going to
13 be four to five days or it's going to be two weeks or he--actually the IME's today, he
14 goes on vacation for two weeks, won't be able to finalize it for two weeks, so it's a lot
15 of it's predetermined, so by having a rule that say 14 days, I think that's fair to the
16 doctor.

17 18:52: To echo that, when we're scheduling exams, we usually bring
18 up pending deadlines or things like that with the IME company saying, you know, we
19 have a week to make a decision on accept or deny or the surgery request or things
20 like that, and the issues that are addressed in an IME can vary greatly on whether
21 you're dealing with one orthopedic doctor or a panel with an ortho, a neuro, and then
22 a psych component, it might take awhile to compile it, but I don't think one deadline
23 covers everything.

24 19:21: There's also the situations, too, wherein the IME doctor doesn't
25 necessarily have all the relevant background information, for example, there could

1 be an imaging study that just for whatever reason hasn't gotten to the doctor in time,
2 and so in those instances it's more beneficial to wait an extra week to have the
3 doctor be able to provide a thorough initial report as opposed to having to go back
4 with a supplemental report from the doctor, so that we could echo seems to be a
5 solution looking for a problem.

6 19:50: I don't know about that, a lot of these exams, what is at issue is
7 things that will allow the worker to continue to get time loss or not or whether their
8 claim's going to be determined medically stationary or not, whether they're going to
9 be returned to regular work or not, and I don't see why it would be too oppressive to
10 say there has to be some deadline and that there could be reasons, extraordinary
11 reasons to extend it, like the inavailability of information should be readily granted, I
12 would think, right--

13 20:23: But then the report's going to say that I can't make that decision
14 pending that additional information (unintelligible)--

15 (Crosstalk not transcribed.)

16 20:31: --like saying there's a problem like--

17 20:32: Well, it is a problem, I mean, I have tons of clients that have
18 gone through my office where we're sitting there kind of tapping our toe waiting to
19 know what's this IME going to say and then it's not only what the IME's going to say,
20 then the adjuster's got to get it over to the attending physician and he may not be
21 available and this whole process of getting a decision that will allow ongoing benefits
22 to the worker has enough delays inherent in it as it currently is without inviting
23 another one. I mean, it could be very liberal how allowances for additional time to
24 complete the IME process, there should be some deadline, and I don't think 21 days
25 is terribly oppressive, I mean, we're all under a lot of deadlines in this system, my

1 goodness, when we go through the reconsideration process, for example, we're
2 hammered, but (unintelligible)--

3 21:17: But it might be, but it might be to your advantage if it requires
4 us to get an MRI that we can't schedule for two weeks out to (unintelligible) report
5 may be a benefit for the injured worker, so to finalize a report, so all of a sudden it's
6 pushed out 30 days because I got a request the MRI--

7 21:34: Yeah.

8 21:34: --to get to my conclusion, so it does take time--

9 21:36: And the rule would allow that, you know, if there was a 21-day
10 deadline (unintelligible)--

11 21:39: Well, well, once you put deadlines on, you're going to
12 discourage people from doing it, so I can't do it because I operate four days a week
13 and got to have it done for my family, I have a practice, busy practice, and I won't,
14 you know, we want practice of IME docs, right, in this business, right--

15 21:55: Well, I think we have plenty.

16 21:56: Well, we don't have, and to do that we have to start putting
17 guidelines and start shrinking the--shrinking the time availability to get these reports
18 done (unintelligible) doctors (unintelligible)

19 22:11: One thing we ought to consider on that, though, is also the
20 injured worker that's continuing treatment, you know, if you're waiting on a report to
21 determine if additional treatment is indicated, you know, if you go three weeks
22 without treatment--

23 22:24: Right.

24 22:25: --depending on which stage of healing they're in has a dramatic
25 effect on their overall outcome, not just what's going on right now, but, I mean,

1 future, you know, ramifications, you know, impairments and things like that, so there
2 is--they're a really big issue with delaying care because an injured worker is careful
3 that, well, I don't want to continue care, because then I might be responsible for this
4 bill if they end up saying this is denied or this is, you know, medically stationary
5 when all my other findings show improvement, but this one's doctor says, well, it
6 doesn't matter if you're improving and we're saying you're stationary or, you know,
7 this study indicated that this injury should have been done in four weeks and you're
8 eight weeks out, so we're going to retro-deny you in four weeks (unintelligible) this
9 one study that I could show you, so, I mean, we got to deal with the treatment aspect
10 of this as well as just the (unintelligible) as Randy was saying, the, you know, time
11 loss (unintelligible)

12 23:28: And I will echo that, my concern and my exposure in the
13 ombudsman's office with from a worker's perspective of a delay and an IME and
14 holding up processing, typically most of those complaints are coming regarding
15 medical treatment, you know, whether or not I can continue with my PT, whether or
16 not the surgery's going to be approved, or whether or not, you know, it's up--it's
17 almost always related to medical services because on the compensability end of
18 things, if there's a delay but they're receiving their time loss--

19 24:05: I can say at my company that I own, it's probably 80 percent's
20 out four to five days, that report is out--

21 24:11: That's awesome.

22 24:11: --but 20 percent is anywhere from one week to 90 days
23 sometimes--

24 24:18: Yeah.

25 24:18: --just depending on the case and (unintelligible)--

1 24:20: And that's where I think with Randy's suggestion regarding
2 there's going to be some one-offs that would allow for that.

3 24:28: But we can't put in a rule, that's what I'm saying, policy--

4 24:33: Can you put something in the rule that says that there has to be
5 some sort of communication within a certain timeframe, so if that two weeks or four
6 weeks they say, hey, we have not received this imaging or we need to have this MRI
7 or whatever, but at least something to indicate this and then that allows maybe the
8 time loss to continue, I don't know, I mean, I don't know.

9 24:56: Well, of course there could be a rule, it could say that IME
10 reports are due 21 days after the date of the exam except for good reasons stated,
11 which include but are not limited by the following.

12 25:08: Then you'd have--

13 25:08: And that would be up to someone over here to extend that
14 beyond the 21 days, we're trying to process claims here, Doctor, seriously--

15 25:15: Well, I'm--

16 25:15: --and it's important to the worker that they get timely responses
17 to these things--

18 25:20: I get that, I'm--the goal is to get it out as fast as you can, but
19 there's going to be some cases that are going to take longer than others and there's
20 some specialties that are going to take longer than others, and all of a sudden I got
21 to tell a doctor that I'm not recruiting a cardiologist and say, hey, I got to have the
22 report in 21 days and this is what the rules are, he says I don't have that kind of time,
23 I can do it in this timeframe, to me that's a lead cardiologist and also I put some
24 restraints on him, he's not going to work, you know, might not want to do it
25 (unintelligible)--

1 25:56: So would you be opposed to any timeline at all?

2 26:00: Even if it said timely?

3 26:03: (unintelligible) timely's fine, timely's fine, but like I--like I say,
4 we're very proactive in trying to get these reports out as quickly as possible, but we
5 want a good rapport--I mean, once the doc, doctor sees the patient, I mean, get it
6 dictated that same day or the next day, then it's transcribed by somebody within our
7 company, then it's QA'd to make sure everything makes sense and it follows all the
8 rules of the report, then it goes back to the doctor to sign off on that, then it's printed
9 and then it's sent out, I mean, there's some days in there, and if they're active in their
10 practice, it's going to be some time, if they're on vacation, there's going to be some
11 time, if, you know, who knows, death in the family, I mean, just--

12 26:51: Yeah, put aside 14 days, put aside 21 days, I guess the
13 question is, is any timeline unreasonable?

14 27:04: I mean, this rule--

15 27:05: I mean, you can think about, it doesn't matter, get it--

16 27:07: Yeah, I mean, this rule only addresses the time it takes for the
17 IME report to get to the insurer, correct--

18 27:11: Right, correct.

19 27:11: --and the insurer's going to have a lot of leeway of who they
20 use in getting timely reports, I mean, none of the people that I represent have--would
21 stand for an IME being consistently 21/21/35 days--

22 27:24: Right.

23 27:25: --out, I mean, I know Randy's probably not going to believe me,
24 but we want the reports done, too.

25 27:30: I believe you. I am (unintelligible)

1 27:34: If you put a timeframe on there, would that then potentially give
2 your IME providers the leeway to say, well, now I know I have 30 days instead of,
3 you know, (unintelligible) say get it done in four or five (unintelligible)--

4 27:46: Like I said before, we have a booklet that we send out to all the
5 doctors, and here's our expectations, it's always four to five days--

6 27:53: But not all the doctors (unintelligible)--

7 27:55: But then there's some doctors that will say, hey, this is what it
8 takes and--

9 28:00: But not all IMEs are under your association, correct?

10 28:04: No.

11 28:05: Right, so, I mean, there would be the potential it's not
12 representative in this room that says, well, the rules give me 45 days, I'm taking all
13 45 days, or putting that timeframe actually accessed to the (unintelligible) for one-to-
14 one (unintelligible)

15 28:21: I'm still concerned that we're looking for a problem, I mean, we
16 have one documented case that this has been an issue and I think I can perceive,
17 you know, a timeline having impact on both sides where, yes, it may shorten some,
18 but it also may extend others by seeing that hard deadline, but now that we have
19 time to extend it, and I think we want to be able to encourage providers to be able to
20 get their whole reports in at the time that they're able to get them in and honestly,
21 you know, having use of the term timely would mean something along those lines,
22 but I still think we want to be cautious about the fact that we still only have one
23 documented case in the last how many years, that this isn't a broken or this isn't--

24 29:10: And I think it's really important to remember that adjusters want
25 good, we already had that conversation and, I mean, we want to move this along,

1 too, and we have the opportunity, if we have a problem provider, not to use them
2 again, so I don't know, I just, I guess I'm with Trevor again, is it we're really, you
3 know, trying to find a problem and then create a rule, and I would urge the
4 Department not to use a word like timely because that's kind of like being reasonable
5 into a rule, what does that mean, because I can--I can have lots of fun with that, I'm
6 sure you could, too.

7 29:49: I think that's kind of a--oh, sorry.

8 29:51: No, go ahead.

9 29:52: Kind of leads what's the consequence of not having a timely or
10 a 21-day report, is it excluded from litigation, can the treating doctors still review it, is
11 it counted against the insurer's three IME reports? The issues that come up in an
12 IME are so varied and there are exams by IME providers like surgery requests and
13 closing exams that aren't technically counted as an IME, against those three, so...

14 30:22: Jennifer--

15 30:22: And would you say that for, let's say, an IME report is, you
16 know, 17, 18 days out that your companies would know why?

17 30:35: Yes.

18 30:36: Okay.

19 30:37: Yes, be--

20 30:37: There would be an answer, it wouldn't be like, oh, I don't know.

21 30:40: For instance, for instance--

22 (Crosstalk not transcribed.)

23 30:43: Just, well, to tell you our company, we have a QA person that
24 sits there and gives us a daily report on what's outstanding, what's in, and where it's
25 at, and our whole program tells us all this on a daily basis and we have a printout

1 every minute--

2 30:57: Yeah.

3 30:57: --I know this morning what's due, what's not coming in on
4 timely fashion, and what our turnaround time is going to be, we--that's we take a lot
5 of pride in that, and so we know that we know the doctors that take two weeks, we
6 know the doctors that take a week, we know the doctors that take three weeks, it's
7 just that's their practice, but there are doctors that are in certain specialties and
8 people request--

9 31:22: I kind of cheated in asking because I know that you guys do
10 that, but it is really helpful to be able to at least get an answer, you know, if you've
11 got a worker that's "I had an IME that was over two months ago and I have no idea
12 what's going on" and have to call the adjuster, and they're like, hey, we're still
13 waiting on that report, well, whose is it, you know, and kind of taking yourself through
14 that process, eventually you can get to where there is an answer as to why and
15 there's sometimes it's, you know, an explicit word that's said and then the report gets
16 done.

17 31:53: We, and we--and we do get where the adjuster or attorney,
18 they're--you know, they have a deadline--

19 31:59: Yeah.

20 32:00: --and that's before we tell the doctor to do this IME, we're telling
21 them this is the deadline, we have to have it before this day, and so there's a lot of
22 stuff that we do proactively, and that's what I'm saying is we really try to make sure it
23 all happens, so that's why I don't see this as one complaint out of how many--

24 32:23: Well, Jennifer's--this my not be the cause of it, but Jennifer
25 certainly knows of one delays in an IME, so whatever the complaint is, Jennifer

1 hears it a lot, and I guess the Department's concern is to the extent that there is an
2 unreasonable delay in resolving an IME and it affects people's treatment, that's an
3 issue for us, so this may not be the problem, but it's a concern--

4 32:51: Well, and I think that it always recognized, and I'm sitting here
5 thinking about and they're signal (unintelligible) I'm emailing Elaine, you know, I--it's
6 not, I think, a problem for us because I think that we are paying attention to those,
7 you know, two months, like, yeah, I don't think, unless there is, you know, you need
8 this additional testing or something like that, so I am mindful, Lou, that there are
9 other insurers out there, but I'm, again I'm just not sure that putting in timeframe in
10 the rule is going to solve that problem, right, if there are no sanctions.

11 33:31: Yeah, as with--as is sometimes true, we don't actually have
12 consensus on a particular issue and that's okay, we want to hear all points of view
13 on these issues, and then we--our job is just to take it all in, take it back, and decide
14 what to do about it, but, you know, we do appreciate your input now on both sides of
15 this one, so if you have any additional thoughts, be glad to take a couple final
16 comments, or we--or we'll move on.

17 Issue number 11. Rule 265 states that the Director may sanction an
18 IME provider for providing any false statement in the IME report. The Division does
19 not have authority to sanction, as we previously mentioned, an IME provider for any
20 false statements. Current language in Rule 265 states in part that the IME provider
21 must sign a statement at the end of the report acknowledging that any false
22 statements may result in sanctions by the Director. And again the statute only
23 grants the Director authority to exclude an IME provider from the authorized IME
24 provider list, not to sanction a provider.

25 As it relates to investigating IME complaints, the Director examines

1 whether the IME provider conducted the exam in the matter required by the IME
2 standards. The Director does not determine the validity of medical opinion. Unlike
3 an administrative law judge at hearing, the Director does not review an IME
4 provider's qualifications or weigh the medical probability of their opinion. If a worker
5 disagrees with the information contained in an IME report, the worker can submit a
6 rebuttal to the claims examiner. If the insurer issued a denial of responsibility based
7 on the IME report, the worker may request a hearing and may be eligible for a
8 worker-requested medical examination.

9 So one option would be to revise the language in Rule 265(10) to
10 remove the reference to sanctioning a provider for providing false statements in the
11 IME report. It would now read as follows, and then again I won't read that verbatim,
12 but you have a look, we welcome your thoughts on that.

13 35:55: When it talked about false statement, is it like going through the
14 record review portion of it and they incorrectly put something down or?

15 36:04: It could be.

16 36:07: Well, a few years back we had that infamous case where an
17 IME doctor signed a report about examining a worker he never saw, right, I mean,
18 that's the most extreme example I've known of in my 35 years, but it did happen, just
19 pulled out the real report, signed, and changed the names to protect the innocent,
20 and at hearing it was brought out through convincing, persuasive, credible evidence
21 that that worker never saw that doctor, ever, but I think, you know, that's again that's
22 a really strange situation, there's less or extreme situations that occur more
23 frequently, and I think it's best dealt with in hearings, if it gets that far, to be honest
24 with you, where credibility determinations are made, but my only concern was if you
25 remove the word sanction and there was one of these obvious cases, if you remove

1 the word sanction, would you not be able then remove the IME doctor from your list,
2 would that prohibit you from doing that? Certainly if someone perjures himself to the
3 extent he says, Your Honor, I saw this worker, here's all my exam findings, and he
4 never did, he doesn't belong on that list.

5 37:12: No, he doesn't belong probably practicing medicine.

6 37:18: Well, Myra, wouldn't remove--would an absolutely false
7 statement made, would that be one reason for removal--

8 37:25: If it was that blatant of that they never saw, I mean...

9 37:31: They could be removed--

10 37:32: I would assume that would be, yes, they could still be removed.

11 37:34: We--I think I--to some extent that had come up in the past
12 about who's making that determination and truly what is the Opinion and Order
13 issued by an ALJ? And what would we do about that? I don't know if in that case
14 would the licensing and regulatory board take action?

15 37:56: I doubt it. There's nothing that requires an ALJ or either of the
16 representatives of the parties to report that doctor necessarily; I'm pretty sure I'd
17 have an inclination to want to do that, but not mandated.

18 38:12: Because I know we had discussed in the past, and I can't
19 remember, I'm sure it's somewhere, as far as the weight in that case depending on
20 what was found regarding the ALJ's opinion that it was a false statement, I mean, it
21 comes--the one that I'm thinking of, it was statements that had extreme bias or
22 quoting studies but not in the full cont--like taking things out, and so overall the IME
23 report had been biased and then I think we'd received something from an attorney
24 as far as, well, now we have the ALJ's order that basically says that this, you know,
25 IME provider, but still it didn't say it--

1 39:02: Didn't quite hap--

2 39:02: --was false, but it was like--

3 39:05: What did the Department do in response to that question, the
4 letter? Did you do--

5 39:10: I think in that case we did what we could regarding the
6 allegations as far as, you know, being disrespectful, I think that was still within the
7 next steps, there wasn't anything that the ALJ that had basically said that they were
8 false statements, it was kind of borderline providing opinions outside of their scope
9 of practice, which we--

10 39:35: Unpersuasive--

11 39:35: --don't get to--

12 39:36: --it's just unpersuasive. No, we're talking about really
13 omissions or additions that are provably false, right, to buttress an outcome and, you
14 know, I'm pretty cynical after 35 years of doing this, but I think it's the perception
15 more than the reality sometimes we got to deal with here, and the perception at least
16 from a lot of my clients and frankly from feedback I get sometimes from their medical
17 providers that this is a setup, an IME is a setup, it's a preconceived idea to help
18 process the claim in a negative way to the worker.

19 That's not necessarily true or not, but you certainly don't want a system
20 that has that perception, right, and I think ultimately we're going to need a legislative
21 change here, which we can't talk about today, but other states have made an
22 attempt to do that, like Texas, for example, where either party, the worker or the
23 insurer, can go to the director there, I don't think he's called the director, actually
24 commissioner, I think, and they can ask that there be a doctor assigned, and if the
25 worker can do it, the insurer can do it, what happens to that panel of doctors, with all

1 due respect to Dan and his people, is they soon become conditioned to the fact that,
2 you know, it doesn't matter what opinion I give, it favors one side or the other, I'm
3 going to get paid a good fee for doing the exam, and human nature being what it is,
4 it tends to create a more unbiased situation because they don't have to be at all
5 concerned about whether they're going to get repeat business and who's going to
6 pay for that business.

7 Now, to the extent that we can create the same atmosphere somehow
8 within a rulemaking authority, that would be awesome, because right now it's a very
9 one-sided situation, that the perception on our side of the fence is that getting on a
10 panel's not that difficult, doing the job is not completely and well-regulated, I mean,
11 you're--we're working on that today and I appreciate that very much, but as we talk
12 about, there's no deadlines, for example, there's it's hard for you guys to sanction
13 IMEs or remove IMEs, and it's proliferated from 1983 to now, you know, in just my
14 observation, it's become a huge cottage industry in Oregon, but it's one-sided
15 industry, and that is the perception, I think part of what we're trying to do here is
16 eliminate that perception if we can, right--

17 42:09: Yeah, you may know this, Randy, but in 2017 there was a bill
18 that would have done pretty much what you were talking about, have a more random
19 selection process or have the Director make the selection, but that would be a
20 statutory change--

21 42:21: Yeah.

22 42:21: --yes, and this one, this particular issue, I think, correct me if
23 I'm wrong, Myra, was just limited to us removing the word sanction because we don't
24 think we--we're sure we don't have the authority to like impose a civil penalty on a
25 doctor for lying on a report, but it doesn't mean that we couldn't remove them, and if

1 it was really egregious, I mean, I think that would be kind of a--I don't know this, but
2 kind of open-and-shut because a lie is a lie, and if it's clear that it's a lie, it's not just a
3 matter of our opinion, then I can't imagine a simpler case to investigate.

4 42:59: That's under a different rule, right, the removal.

5 43:02: Well, it's all under Rule 265.

6 43:05: (unintelligible) require a different subsection--

7 43:07: Yeah, it would be under the claim portion--

8 43:10: Yeah.

9 43:13: So the worker who feels that the IME report gave false
10 statements and said things that were not true, in their opinion, if they wanted to file a
11 complaint about that, if this rule is changed, it would go to WCD and you would be
12 able to investigate the provider in that or this would remove WCD's role, and where I
13 agree with Randy that the best place for that is through the hearing process, but we
14 have workers who are going--

15 43:47: Yeah, they want--

16 43:47: --through litigation, they just want to say this report does not
17 reflect who I am or the history that I provided to the writer.

18 43:56: So we get complaints from workers already regarding the
19 report and that there is either missing information or they told, you know, I told the
20 doctor this and he wrote that, so because we're looking at the standard of conduct,
21 which is the conduct between the worker, we don't look at the content of the doctor's
22 opinion. We give the worker the option to write a rebuttal to the report and outline
23 the areas where which are not correct. They can then send that to their claims
24 adjuster so it becomes part of their medical record. They're represented, we tell
25 them to talk with their attorney prior to doing that action.

1 44:38: Because WCD doesn't have the ability of changing the report.

2 44:41: Correct. The opin--his opinion is in the report, his opinion is his
3 opinion.

4 44:49: So I take that back, I guess if it's just something that's in the
5 report, there's really not anything we can do, we couldn't--

6 44:54: If the--if the worker sends a complaint and says I never saw
7 this doctor, here's a report, I never saw him, that's a different story, I can say
8 whether or not he saw the worker, I can make that determination, but I can't look at a
9 doctor's medical opinion and say--or make a determination from that report that that
10 was an inaccurate statement, so what we ask the doctors to do and what we're
11 asking this rule is to say, you know, to sign a quality assurance statement that this is
12 to the best of their ability statements made in a report are true and accurate, which I
13 believe a lot of the IME companies already have that statement on their report that
14 the doctor (unintelligible)

15 45:43: Well, one of the good things that comes out of these
16 discussions is we learn and identify where statutory changes need to be made, and
17 this may be one.

18 45:58: Any additional thoughts on this before we move along?

19 46:01: I have a question (unintelligible) so if you have a (unintelligible)
20 worker who may--who issued a complaint to the Department, and let's go to the
21 extreme, "I didn't see this provider," would you notify the medical board?

22 46:19: Would I notify who--

23 46:20: Would you notify the medical board saying that someone who
24 is--

25 46:24: We can refer, we haven't, but we can refer any complaint that

1 we feel would affect their ability to practice medicine to the Oregon Medical Board.

2 46:35: What would you do with that complaint? Not to the medical
3 board, but outside of that.

4 46:40: Well, I would do everything I can to determine whether or not
5 it's--what the worker is saying is true. I'd talk to the IME company, I'd talk to the
6 doctor themselves, maybe the claims examiner, I mean, I'm sure the claims
7 examiner will know whether or not they sent the worker to that particular provider,
8 they're probably going to be--

9 47:03: Might want to know that (unintelligible) this is--

10 47:06: Write down your little blacklist, oh (unintelligible) blacklist--

11 47:09: Oh.

12 47:11: Well, you don't have a printed blacklist--

13 47:13: Hey--

14 47:13: Make a mental--

15 47:14: A suggestion you go to the (unintelligible)

16 47:19: But I think, I mean, I would do everything possible to talk to
17 whoever I needed to to confirm or deny that.

18 47:31: And with that, we're--we completed our list of substantial
19 issues. What remains is a list of or some notes about how we've reorganized the
20 rule language, and I won't go through all of this, but we did move several provisions
21 around just to try to make it clearer, hopefully, and a couple of nice, you know,
22 housekeeping issues where we used IMEs, we--the term IMEs instead of exams,
23 we've replaced days excluding weekends and legal holidays with just business days.
24 So--but if you think that there's anything in here that actually affects substance as
25 opposed to just organization and housekeeping, we would certainly welcome your

1 thoughts. There can be differences of opinion on that--

2 48:25: So, Fred, the rulemaking talks about IMEs and WRMEs, and I
3 just want to make sure that when you say in housekeeping that you're replacing
4 exams with IMEs, you are only doing that with respect to the IMEs, not the WRMEs?

5 48:44: Correct--

6 48:45: Okay.

7 48:45: --yeah, I mean--

8 48:45: And I just, I want to make sure.

9 48:46: We would call them WRMEs--

10 48:48: Okay.

11 48:48: --yeah.

12 48:49: Okay.

13 48:50: And that would hopefully remove any kind of confusion about
14 that in terms of--

15 48:54: Right, right, okay.

16 48:55: --what kind of examination we're referring to, yes.

17 48:57: One of the things on the reorganization is on the standards of
18 conduct, there was one number, the current standards of conduct, there was one
19 provision that talked about providing a require--the requesting parties the timely
20 report that, so that's where we took that out of the standards, it's no longer part of
21 the new standards, but we--that's why we kind of wanted to bring up this issue is
22 whether or not it is should it be in rule, too, because we are taking it out of the
23 standards, so appreciate the (unintelligible) huh?

24 49:31: Maybe you should put it back in the standards.

25 49:34: I can consider that.

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49:37: What was the thought behind removing it?

49:40: It's supposed to be IMEs.

49:41: It's more related to the report requirements and the standards are more about professional conduct, so it didn't seem to fit with the standards and we did rewrite the IME report in the rule, which we felt would be--encompass that.

50:07: In addition, on this document that you may have either a piece of paper or on this electronic document, we have draft rules and I won't--we've talked about they were there for our reference in case we needed them during the discussion. I won't go through it all, but we did cover all of the substantial issues that affect the wording of the rules, but if you have a chance to look at those or if you've had a chance and if you have any input on the actual wording of Rule 265, we would welcome that, hopefully sometime in the next, oh, two weeks or so so that we can get them together before we file proposed rule.

We also do have a meeting that's on next Monday I think some of you are scheduled to attend, it's going to be up in our Durham office. General issues Divisions 9, 10, and 15, the medical fee schedule that we look at every year, and we'll be looking at of course a number of issues, including tele-medicine, we're going to try to get people's input on, you know, what's happening and how it's working and what--how maybe it could work better, but with that, do you have any additional IME issues to talk about today or WRMEs? We would be glad to do so.

51:26: When do you anticipate draft rules?

51:31: Typically we cannot file in December unless the AMA or CMS, actually, provides the--its updated annual codes, so we'll probably file a temporary Division 9 rule right around the 1st of the year to adopt a temporary fee schedule, as we've done for a number of years, so everybody can use the new codes on

1 January 1, but we won't complete rulemaking on these rules, on the IME rule, or on
2 the other medical rules until the effective date of April 1 of next year, which means
3 we'll probably file in January for a hearing in February. It's possible we would file at
4 the very end of December for a hearing in January, so either January or February
5 we'll have a public hearing, and then the effective date, unless something goes
6 terribly wrong, it's going to be April 1 of 2019. I always like to provide us a little
7 wiggle room because we haven't missed that one in a number of years and I hope
8 we don't. Dr. Miller?

9 52:33: Fred, you said something that back in 2017 there's a proposed
10 bill to possibly move toward more fair IME selection. What happened with that?

11 52:44: It was the enrolled bill is available, I apologize, I don't
12 remember the number of that bill, but--

13 52:51: I think it was Senate Bill 780.

14 52:52: Oh, good. It never made it past that stage of its development,
15 so I'm assuming it went to committee, but it died in committee. I don't--I believe
16 MLAC discussed it, I don't know if you were on it at the time, but I think you were, I
17 don't know if it rings a bell, but it didn't--it didn't actually make it, it was discussed,
18 but it didn't--it didn't proceed. So there's always the possibility, sometimes bills
19 come up for a number of sessions, over a number of sessions, I think one of them
20 was the like the firefighter's presumption bills, we saw any number of those, and
21 then finally it did pass, and so it's a possibility.

22 53:34: I believe that the senate bill that MLAC took it one or heard the
23 representative that brought the bill and decided to do that subcommittee based off of
24 that--

25 53:47: We kind of changed some of the (unintelligible)

1 53:50: And then, yeah, then things kind of worked out (unintelligible)
2 (Sotto voce remarks not transcribed.)
3 54:01: Okay. Then any last thoughts of--Joy--
4 54:05: (unintelligible) for housekeeping (unintelligible)
5 54:15: Oh, clarify--
6 54:16: Yeah, with the attending (unintelligible) to sign the report
7 (unintelligible) 14 days or something.
8 54:22: (unintelligible) complaint response to leave (unintelligible)--
9 54:24: Yeah, I think it was in the complaint area where the providers
10 would respond within 14 days from the date (unintelligible) it's only in 0265 for
11 (unintelligible)--
12 54:37: Okay, but I'm not sure, you know (unintelligible) part of that, but
13 one problem we have had is we, the providers said that they do not receive the IME
14 reports to sign in concurrence and then most of the time patients come in and they
15 go, well, the doctor said your claim was denied based on your provider did not
16 comment on the IME, so (unintelligible) received the--
17 55:00: Those are--the requirement for the insurer to send the IME
18 report to the attending physician is in the 60 rules, I didn't bring those with me, so
19 (unintelligible)--
20 55:12: (unintelligible) addressed through part of the changes that we
21 made to the WRME rules about what happens if concurrence isn't sent and the
22 presumption is it's a does not concur, that the worker be eligible for a WRME exam--
23 55:26: Yes, correct, the--we had quite the discussion at--
24 55:30: Yeah.
25 55:30: --MLAC because we saw that that was occurring and it was

1 actually working against the workers, and so we actually modified, asked for the
2 modifications so that if there isn't a concurrence requested or it doesn't come in, it's
3 actually determined to be not a concurrence. Yeah.

4 55:57: How did we (unintelligible)--

5 55:58: Good change.

6 55:59: Yeah.

7 55:59: Yeah--

8 56:00: The 14 days day from receipt date, so what that is applying to,
9 is that something that's sent certified so you know the received date?

10 56:09: No, it's not sent, I don't send the doctors certified letters to
11 response, but most of those IME companies, I either have email addresses for the
12 providers or they're sent to them and, like I said, within the 14-day rule, there is that
13 other requirement that I may, you know, I do the follow-up if I'm not--if they're not
14 received, but the consistency of that is more to the other part, the other Division 10
15 rules talk about the date received, response, the date received to respond, it's the
16 consistent language in the other parts of the Division 10 rules. Is that not--

17 56:55: No, that's fine, actually workers always go from the
18 (unintelligible) date, even if you guys don't that issue--

19 57:00: I know.

20 57:06: And difficult to enforce when it's not a documented received
21 date, so basically it's a--

22 57:14: Now, I'm (unintelligible)--

23 57:14: --not much enforcement there.

24 57:17: I might be able to hold over without actually seeing the text of
25 the rule.

1 57:24: We'll look, I'll look at (unintelligible)--
2 57:25: The without looking at the marked language of the rule, I...
3 (Sotto voce remarks not transcribed.)
4 57:39: It shows up under Section (3), IME complaint process, and then
5 Subsection (e), if the response is to requested information under Subsection (d) is
6 not received within 14 days from the date of a letter, the Division may make a
7 decision based upon--
8 57:56: That's the date of a letter (unintelligible) date--
9 57:57: Correct, I think--
10 57:58: Oh, that's right--
11 57:59: --working with the two different documents, but I remember
12 after we discussed with you and kind of looked at, no, we had that discussion when
13 you brought up about the certif--sending it certified letter, so I was thinking--
14 58:10: I was just looking to the documentation to track 14 days, if
15 we're going to have a rule that says 14 days, having a mechanism in place to be
16 able to enforce the rule.
17 58:18: Correct, that's why I was wondering if the rule, we--based on
18 comments received, if we had to [hadn't]--
19 58:25: We changed--
20 58:25: --changed the text of the rule--
21 58:26: --we changed--
22 58:27: --without changing what the housekeeping was, I think the
23 housekeeping was just an oversight, like I think (unintelligible)--
24 58:32: (unintelligible) I think is important--
25 58:33: Yeah--

1 58:33: --for people here to understand--
2 58:36: Yeah.
3 58:37: --if that wasn't over--I didn't know if it was an oversight or if you
4 just didn't agree with me, so...
5 58:40: No, now that I see what we wrote in the rule, I realize--
6 58:44: Yeah, we're going to have to go back and--
7 58:46: I'll have to look at the rule--
8 58:47: --and look at that--
9 58:48: Yeah, and--
10 58:48: --because it's not consistent, our housekeeping issue has not
11 been we've not kept our house up (unintelligible)--
12 58:54: And I don't remember, I don't remember, we had the exact
13 same conversation that you're saying which is that I'm like, wait a minute, this is
14 starting to sound familiar, so--
15 59:00: We've got some sweeping to do.
16 (Sotto voce remarks not transcribed.)
17 59:05: So, thank you--
18 59:06: Oh--
19 59:07: Yes, thank you. It's very important. I--with that, I guess I'll let
20 you all go. If you have any additional questions, feel free to contact me, my
21 business cards are at the back of the room. If you have additional input, thoughts on
22 any of the issues or the draft rules, please send to me within, say, the next two
23 weeks or so so we can get pretty much all of your input in November, and we will--
24 we will seriously consider all of it. You can also just pick up the phone and call me, it
25 doesn't have to be in writing, if there's something, you know, just a couple of simple

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point you'd like to make, glad to do it that way, but otherwise have a safe trip home
and we'll probably see you soon again.

59:49: Well, thank you.

(WHEREUPON, the proceedings were adjourned.)
