

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

RULEMAKING ADVISORY COMMITTEE MEETING

November 19, 2018, 1:30 p.m.

OSHA PFO Training Room – Durham Office
16760 Southwest Upper Boones Ferry Road
Tigard, Oregon 97224

WORKERS’ COMPENSATION DIVISION RULES
OAR 436-009, Oregon Medical Fee and Payment
OAR 436-010, Medical Services
OAR 436-015, Managed Care Organizations

Committee members attending:

Kevin Anderson, Sather Byerly & Holloway
Ronald Atwood, Ronald W. Atwood, PC
David Barenberg, SAIF Corporation
Ben Barnes, Oregon Physical Therapy Association
Trevor Beltz, Oregon Medical Association
Lisa Anne Bickford, Coventry
Larry Bishop, Sedgwick CMS
Jennifer Burchett, Adventist Health Portland
Joy Chand, Takacs Clinic
Dale Clough, Travelers Insurance
Tavis Cowan MD, Corvallis Clinic
Denis Craine, Sedgwick CMS
Grant Engrav, Attorney at Law
Jennifer Flood, Ombudsman for Injured Workers
Adam Fowler, Optum

1	Jaye Fraser, SAIF Corporation
2	Cindy Gallagher, Coventry
3	Constantine Gean MD, Liberty Mutual Insurance MAC
4	Todd Gifford, Therapeutic Associates
5	Greg Gilbert, Concentra
6	Diana Godwin, Attorney at Law
7	Diana Hendrickson, The Corvallis Clinic, PC
8	Lisa Johnson, Majoris Health Systems
9	Liisa John, Cascade Health
10	Chris Kafka, Kaiser On-the-Job MCO
11	Richard Katz, Therapeutic Associates
12	Ann Klein, Majoris Health Systems
13	Kim Layton, Travelers Insurance
14	Joe Martinez, Concentra
15	Brian Meyers, CorVel Corporation
16	Dan Miller DC, Oregon Chiropractic Association
17	Sheri North, Mitchell International Inc.
18	Jovanna Patrick, Hollander Lebenbaum & Gannicott
19	Dan Schmelling, SAIF Corporation
20	Keith Semple, Johnson Johnson Lucas & Middleton PC
21	Paloma Sparks, OBI
22	Ramona St. George-Suing, Majoris Health Systems Oregon, Inc.
23	Ann Schnure, Concentra
24	Sheri Sundstrom, Hoffman Corporation
25	J.D. Taylor, CorVel Corporation
26	Ashley Willard, Travelers Insurance

Department of Consumer and Business Services staff attending:

22	Robert Anderson
23	Lou Savage
24	Juerg Kunz
25	Stan Fields
26	Don Gallogly
27	Fred Bruyins

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

NOTE: The original transcript as provided by the transcription service has been preserved. I have reviewed and edited this copy of the document, especially on sections marked by “???” due to audio recording problems. Fred Bruyns, Workers’ Compensation Division. 12/12/2018.

The proceedings in the above-entitled matter were held in Portland, Oregon, on the 19th day of November, 2018, before Fred Bruyns, Administrative Rules Coordinator for the Workers’ Compensation Division.

INDEX OF WITNESSES

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

DISCUSSION AMONG PARTIES

PAGE

2 - 97

1 TRANSCRIPT OF PROCEEDINGS

2
3 MR. BRUYNS: Good afternoon. Thank you for coming. My name is
4 Fred Bruyns. I've been in touch with most of you, perhaps all of you, in the last few
5 weeks to actually several months that we've been planning this meeting. We are a
6 little short on space. In just a moment, I'm going to step up to the podium and
7 actually scroll through our agenda for the people who may be joining us remotely
8 and for you if you don't happen to have a paper copy of the agenda. But we do have
9 extra copies or we did have extra copies of the agenda over on the table. I'm not
10 sure if there are any left over there now. But again, thank you very much for coming.

11 This is an Advisory Committee Meeting. It's an informal process.
12 Probably most of you have been involved before, but if you have not, it's a
13 conversation really and our chance to get input from you and advice that we can
14 take back and do our very best to prepare the proposed rules so that when we file
15 with the Secretary of State, they're as close to their final form as we can make them.
16 And then of course, we'll welcome your testimony on those rules.

17 But if you're on the telephone with us today, keep in mind we'll pick up
18 background noises in your office, and so you may want to selectively use your mute
19 button. However, don't put us on hold because sometimes then we'll get your
20 background messages or mute, and there's no way we can turn that off.

21 So we want to include you in the process as much as possible,
22 however. If you're on the telephone, please speak up whenever you have advice for
23 us because we won't have the advantage of knowing when you're wanting to talk, so
24 please just chime in.

25 As we go along, if there are fiscal impacts to some of the topics and

1 proposals that we're discussing, please provide input on the cost to you or to the
2 people that you represent so that we can estimate those costs in the documents that
3 we publish with the proposed rules and also that we file with the Secretary of State.

4 So with that in mind, there aren't very many ground rules, just kind of
5 mutual respect all around and that's almost never a problem because people are just
6 so professional, and we appreciate that.

7 I've introduced myself. So I'd like to begin with the folks on the
8 telephone and have you introduce yourselves to the Committee.

9 MR. MARTINEZ: Hey, Fred. This is Joe Martinez from Concentra.
10 How are you, sir?

11 MR. BRUYNS: Welcome, Joe. Thanks for joining us. Anyone else?

12 MS. GALLAGHER: Hi. This is Cindy...

13 MR. BRUYNS: Go ahead, Cindy.

14 MS. GALLAGHER: Hi. This is Cindy Gallagher with Coventry
15 Healthcare.

16 MR. BRUYNS: Welcome, Cindy. Anyone else?

17 MS. BURCHETT: Jennifer Burchett here with Adventist Occupational
18 Medicine.

19 MR. BRUYNS: Thanks for joining us, Jennifer. Anyone else?

20 MR. FOWLER: Adam Fowler with Optum Workers' Comp.

21 MS. NORTH: This is Sheri North with Mitchell.

22 MR. BRUYNS: Okay. I think we got a couple people at once. Adam,
23 go ahead.

24 MR. FOWLER: Adam Fowler with Optum Workers' Comp.

25 MR. BRUYNS: Okay. Thanks for joining us.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MS. NORTH: And this is Sheri North with Mitchell.

MR. BRUYNS: Oh. Thank you for joining us, Sheri.

MS. JOHN: This is Lisa from Cascade Health.

MR. BRUYNS: Welcome, Lisa. Anyone else? Oh, Diana, there are some extra chairs over there. And in a moment, I'm going to stand up, so someone can have my chair.

MS. GODWIN: Okay. Diana Godwin representing physical therapists.

MR. BRUYNS: Okay. Thank you. Anyone else on the telephone?

MR. CLOUGH: Hi, Fred. Dale Clough, Travelers Insurance.

MR. BRUYNS: Welcome, Dale. Anyone else?

MS. LAYTON: Kim Layton from Travelers.

MR. BRUYNS: Welcome, Kim. Anyone else? Okay. Again, we're picking up your keyboarding, so please keep that in mind that the phones are very sensitive. So with that, I think that's everyone. And if we missed you in any way, if you have my contact information, please just shoot me an email and we'll make sure to record that you were in attendance today.

MR. KUNZ: Juerg Kunz with the Work Comp Division.

MR. FIELDS: Stan Fields, Workers' Comp.

MR. ROBERT ANDERSON: Robert Anderson, Workers' Comp Division.

MR. GALLOGLY: I'm Don Gallogly with Information Technology and Research.

MS. JOHNSON: Lisa Johnson with Majoris Health Systems.

MR. MILLER: Dan Miller, Oregon Chiropractic Association.

MR. GIFFORD: Todd Gifford, Therapeutic Associates.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MR. MEYERS: Brian Meyers, CorVel Corporation.

MR. TAYLOR: J.D. Taylor, CorVel Corporation.

MS. CHAND: Joy Chand, Takacs Clinic.

MR. BARNES: Ben Barnes, Oregon Physical Therapy Association.

MS. WILLARD: Ashley Willard, Travelers Insurance.

MR. COWARD: Tavis Cowan, Occupational Medicine at Corvallis
Clinic.

MS. HENDRICKSON: Diane Hendrickson, Occupational Medicine,
Corvallis Clinic.

MR. SAVAGE: Lou Savage, Workers' Compensation.

MS. FLOOD: Jennifer Flood, Ombudsman for Injured Workers, DCBS.

MR. ATWOOD: Ronald Atwood. I represent employers in Workers'
Compensation cases.

MR. GILBERT: Greg Gilbert, Concentra.

MS. GODWIN: Diana Godwin. I apologize. I thought we had already
gone around the room and we were just doing the phone people. Physical
therapists.

MR. SCHMELLING: Dan Schmelling, SAIF Corporation.

MS. FRASER: Jaye Fraser, SAIF Corporation.

MR. KEVIN ANDERSON: Kevin Anderson, defense attorney at
Sather, Byerly and Holloway.

MS. SUNDSTROM: Sheri Sundstrom, Hoffman Construction.

MS. ST. GEORGE-SUING: Ramona Suing, Majoris Health Systems.

MR. BELTZ: Trevor Beltz, Oregon Medical Association.

MR. BISHOP: Hey(0:05:36**???)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MR. BELTZ: Oh, sorry.

MR. BISHOP: Sorry. I'm in late. Larry Bishop, Sedgwick.

MR. BARENBERG: Dave Barenberg, SAIF.

MS. PATRICK: Jovanna Patrick, claimant's attorney.

MR. SEMPLE: Keith Semple, claimant's attorney, Oregon Trial
Lawyers Association.

MS. KLEIN: Ann Klein, Majoris Health Systems.

MR. GEAN: And Constantine Gean, Oregon Medical Advisory
Committee.

MR. BRUYNS: Okay. Thank you, Doctor. Anyone else that we
missed, you'd like to introduce yourself to the Committee?

MR. CRAINE: Denis Craine, Sedgwick.

MR. BRUYNS: Welcome.

0:06:05: ???Nothing.

MR. BRUYNS: Oh, okay.

MR. ENGRAV: Grant Engrav, Engrav Law Office with Diana Godwin.

MR. BRUYNS: Okay. Thank you for joining us. There is one chair
over here, a position that I was formerly in, but I have to conduct the meeting from
up here. So there's an excellent seat that we might as well take advantage of. So
I'd welcome anybody who wants to come up.

And I apologize, I guess we got a--we have a little less table space
than we anticipated. So if you'd like to pull up a little closer to the table, please go
ahead and do so.

But with that, we have an agenda to go through. And if you want to
follow along either on your paper copy or on your monitor here, or if you're on the

1 telephone with us, that would be your option. Or the agenda is also posted to our
2 website.

3 So Issue Number 1 is a standing issue that we look at every year. We
4 have for at least several years now. And it has to do with issuance of a temporary
5 rule that would be effective January 1, 2019.

6 MS. GALLAGHER: Hi, Fred.

7 MR. BRUYNS: Hello. Yes.

8 MS. GALLAGHER: Hi, Fred. This is Cindy. We can barely hear you
9 on the phone.

10 MR. BRUYNS: Oh, okay. That's probably because I'm a little bit more
11 distant than usual. Does that help if I project my voice just a little more?

12 MS. GALLAGHER: A little bit, yes.

13 MR. BRUYNS: Okay. I will try to speak up. So the question would be,
14 should WCD issue a temporary rule, effective January 1, 2019, adopting new CPT
15 codes for 2019? And should WCD assign maximum payment amounts to new CPT
16 and HCPCS codes in Appendices B through E, where possible?

17 So there's a little background information here. I won't read all of the
18 issues verbatim to you. But the AMA publishes new CPT codes, effective January 1,
19 2019. And unfortunately, each year, they're not available to us in time to actually
20 formally adopt them through standard rulemaking because as you know, there's a
21 process to go through a public hearing, et cetera. And we can't actually adopt them
22 in time for the new year. And the temporary rule provides a way to adopt the new
23 codes effective January 1, and we've been issuing a temporary rule for several
24 years as a stop gap until we have permanent rules in place by April 1. And so we
25 would appreciate your input on how that's been working and whether-- So our

1 options are to adopt them effective January 1, 2019 by temporary rule, and to
2 update Appendices B through E with payment amounts for new codes using the
3 2018 conversion factors/multipliers, where possible. Of course, one option would be
4 not to issue a temporary rule and kind of go back to what we did before a few years
5 ago where there would be or the industry would actually still need to use the 2018
6 codes for the first several months of 2019. So I would appreciate your thoughts on
7 that.

8 MS. FRASER: Fred, Jaye Fraser from SAIF Corporation. SAIF
9 supports the temporary rule and actually really appreciates the department taking
10 this action.

11 0:09:30: Coventry appreciates that rule as well.

12 MR. BRUYNS: Okay. Thank you. Diana?

13 MS. GODWIN: Diana Godwin on behalf of physical therapists. My
14 clients appreciate it as well so that they don't have to maintain two fee schedules,
15 you know, for those few months. So we support that.

16 0:09:44: I think we've done that in the past years.

17 MS. GODWIN: Yes. Yes.

18 MR. BRUYNS: I just want to...

19 MR. FOWLER: And this is Adam with Optum. We support it too.

20 MR. BRUYNS: Thank you, Adam. Does this make my voice louder?

21 0:09:58: Yes.

22 MR. BRUYNS: Okay. Good. I don't think I could have yelled through
23 the entire meeting like that or for me it's yelling. Any additional thoughts on the
24 temporary rule? Any concerns about issuing a temporary rule effective January 1?

25 Okay. With that, I'm going to move on to Issue Number 2. And if I

1 ever move on and you need to--want to revisit it or go back to it, we're glad to do
2 that.

3 Okay. Issue Number 2 is another standing issue. The issue is
4 especially one of our primary reasons for being here each year. It's a statutory
5 requirement in ORS 656.248(7) that requires that WCD update the fee schedules
6 annually. So the question for this group to consider is whether we should adopt
7 updated references listed in Rule 4, Sections 1 through 9, and should we update the
8 fee schedule amounts listed in Appendices B through E? The above listed
9 appendices are based on conversion factors and multipliers developed by DCBS,
10 that's the Department of Consumer and Business Services, and on values and fee
11 schedule amounts listed in spreadsheets published by CMS. In particular, Appendix
12 B is based on CMS, then it goes to...

13 0:11:46: Hello? (0:11:46**???)?

14 MR. BRUYNS: And it goes through some technical – but I'm going to
15 skip that a little bit. Every year, there are CPT and HCPCS codes that are deleted
16 and some new codes are introduced. Adopting new billing codes and updating
17 Appendices B through E allows us to stay current with valid CPT and HCPCS codes.

18 We're picking up-- Hello? We're picking up background noises in your
19 offices. Just to keep that in mind, please.

20 0:12:16: Yeah. Can people please mute if you're not talking? There's
21 so much noise.

22 MR. BRUYNS: Every year, there are some CPT and HCPCS codes
23 that are deleted and some new codes are introduced. And so adopting new billing
24 codes and updating Appendices B through E allows us to stay current with valid CPT
25 and HCPCS codes. Every year, DCBS develops updated conversion factors and

1 multipliers taking into account stakeholder input, utilization of medical services, and
2 the new values and fee schedule amounts developed by CMS.

3 So our options would be to adopt the updated references. But we do
4 want to get your input each year. Sometimes there are things happening with CMS
5 that are not--that are a little out of the ordinary and may have an effect that is not
6 anticipated or that you may be aware of or you may not be. So we'd like your input
7 on this kind of simple question of whether to adopt these updated references. Any
8 concerns about doing so?

9 0:13:30: Yeah. SAIF supports. Thank you.

10 MR. BRUYNS: Thank you very much. We'll get into some of the
11 meatier about the fee schedule a little bit further in the section when they talk about
12 the all payers/all claims database.

13 Issue Number 3. A stakeholder asked that insurers should no longer
14 be required to send an indexed packet for disputes under ORS Chapters 656.247,
15 .260, and .327. When a request for administrative review is filed under one of these
16 statutes, insurers are required to send a record packet to the director and all other
17 parties. The packet must include a complete, indexed copy of the worker's medical
18 record and other documents that are arguably related to the medical dispute,
19 arranged in chronological order, with the oldest documents on top. Then it goes on
20 to describe other requirements of the index.

21 Soon-to-be proposed changes to Division 001 rules will require that a
22 party requesting a hearing in a matter within the director's jurisdiction, appealing a
23 medical review team's order, will have to put all the documents the party will rely on
24 at the hearing in an indexed packet.

25 Essentially, published this agenda there's been a little change to our

1 understanding of how the Division 001 rules would actually work, the practice has
2 changed. As we understand that insurance companies always do that part of the
3 creation of the packet and the index. So indeed, a worker or pro se claimant or the
4 worker's attorney will not have to do that. So our apologies that this is a little bit out
5 of step. At the time we published, we thought that this was, in fact, the issue.

6 But we had a meeting just recently to discuss changes in Division 001,
7 and we'd appreciate your input on this particular change, which was described
8 basically--it will come down to the central question. Creating an indexed record for
9 every dispute under these particular statutes, even if an order is not appealed, adds
10 costs for insurers. Some MRT, that's the medical review team reviewers, use the
11 index when reviewing the record, and we've heard that an index is helpful for
12 physician reviewers. So there are some benefits to the record.

13 So options for this group to consider would be to make the following
14 changes to the rules. And you can see it basically crosses out all of those
15 requirements for numbering the exhibits, et cetera. So the record would still be
16 (0:16:17**???) but it would not be marked in this way. And it will still be in
17 chronological order. So your thoughts on this and the impact to your people that you
18 represent.

19 0:16:33: Fred, I think this is something that our office talked a lot about
20 in the last couple of years. When the ARU has done a treatment reconsideration
21 record, it's pretty easy for us to submit all of the medical records and everything
22 that's needed for that reconsideration. And you just kind of hit print and get it to the
23 WCD, and it's a very quick process. Doing the MRT dispute with the individual
24 exhibits where you could be dealing with five years of medical treatments and you
25 have to track down every physical therapy note, chiropractic note, massage therapy

1 note, attending physician note, and then index. It can take two to five hours and it's
2 500 to 1000 pages for one dispute, with copies to all the parties plus the doctor. And
3 so you could end up with, you know, 10,000 pages worth of records that are getting
4 mailed around. So I think that was one of the reasons we had discussed it in our
5 office, that it would be easier and more efficient if we could do a non-exhibit packet
6 and just get the records in there and initiate a cover letter from both the claimant or
7 the doctor. The defense attorney kind of outlined the key records that are actually
8 needed for the dispute.

9 MR. BRUYNS: Thanks. Anyone else?

10 0:17:53: Fred, this particular proposal, just the idea to take off the
11 requirement for indexing, and we deal with the other rule on who's going to provide
12 those records to the--either at hearing or the (0:18:09**???) hearing. Is that correct?

13 MR. BRUYNS: Yeah. It's a different division of rules. Correct. And--
14 but we're going to take what this group has to say into account. And so we haven't
15 made any decisions yet on what to do with the Division 1 requirements or the record
16 at hearing. I saw a hand up over this way. Keith?

17 MR. SEMPLE: Keith Semple for Oregon Trial Lawyers. One concern
18 that we discussed at the last meeting was the idea that a pro se claimant might be
19 obligated to put together an exhibit packet and do the indexing themselves, and
20 obviously, we're very concerned about that and about the additional burden shifting
21 that would be involved if we did the exhibit packet was whoever was requesting the
22 dispute had to do the exhibit packet. I don't know how much the indexing really
23 makes a difference in these disputes. I know how it's done in reconsideration that
24 the exhibit packet is not indexed. I haven't personally had a problem with that. I
25 don't know how it affects MRT and their folks. I think that's probably--I guess for me,

1 that's kind of the determining factor is whether that makes their job a lot harder, not
2 to have an index as opposed to just the paper and the documents. But otherwise,
3 we don't really have a concern. I don't find personally that the exhibits or the
4 indexed exhibits are something that I find essential in these disputes.

5 MR. BRUYNS: Thanks, Keith. Anyone else? Larry?

6 MR. BISHOP: I support that change. I mean particularly with
7 electronic documents, you have to print them and then write the information on the
8 documents and it takes a lot of time.

9 MR. BRUYNS: Okay. Moving along then to Issue Number 4. This is
10 regarding missed appointments and no-show fees. Providers have raised the issue
11 of being able to charge a no-show fee.

12 Under Division 9, Rule 10, Section (13) provides that insurers do not
13 have to pay for missed or no-show appointments unless the no-show appointment is
14 for an arbiter exam, director required medical exam, independent medical exam,
15 worker requested medical exam, or closing exam, and the worker does not give 48
16 hours' notice. Currently, Division 9 does not specifically address whether a provider
17 may bill a worker a no-show fee.

18 CMS describes a no-show fee as follows: "The charge for a missed
19 appointment is not a charge for a service itself, but rather is a charge for a missed
20 business opportunity."

21 Medicare allows providers to charge a no-show fee if the provider
22 applies the same policy to non-Medicare patients. Many commercial insurance
23 plans as well as Washington's Workers' Compensation system have similar policies.

24 So an option would be to modify Rule 10, Division 9 as follows. And
25 then you can see the bold wording that's been inserted here, bold and underlined. A

1 provider may bill a patient for a missed appointment under Section (13) of this rule.
2 And then Section (13) goes on to describe the process. And so it doesn't require
3 that the provider has a policy, an office policy for charging no-show fees.

4 And it also goes on to say in subsection (c) that the implementation
5 and enforcement of subsection (b) of this section is a matter between the provider
6 and the patient. The division is not responsible for the implementation and/or
7 enforcement of the provider's policy. I believe that would exceed our authority, so...

8 Or as always, the options that we put on the table are not the only
9 options. We always have an "other" category here. So if there's another way to
10 achieve this, and as we heard from in the past, at least from certain providers, as
11 many as 20 percent of their patients are no-shows. But based on injured workers,
12 and that was just one office, and I don't know if that represents a less common
13 experience, but apparently did save a large cost for some healthcare providers and
14 the issue was presented to us. And so this is what we're presenting to you, and we
15 appreciate your input.

16 0:22:40: OMA would be in support of the change.

17 MR. BRUYNS: (0:22:44**???)

18 0:22:46: ???

19 0:22:47: Okay. OMA?

20 0:22:47: OMA would be in support of the change.

21 MR. BRUYNS: Jaye?

22 MS. FRASER: I think that, you know, we've kind of gone back and
23 forth on this, and our big concern is that you'd end up with an injured worker who
24 wouldn't pay the bill, and then somehow you would end up with treatment being
25 interfered with. I don't know the answer. But that would be SAIF'S concern is that

1 we don't want to get in a--we don't want something to interfere with a worker's
2 treatment.

3 MR. BRUYNS: Diana?

4 MS. GODWIN: Diana Godwin for physical therapists. We have long
5 advocated for this type of rule. For one thing, if a worker skips their scheduled
6 physical therapy appointments, they take longer to recover. So it's important that
7 that worker, you know, keep their schedule. We have--we adopted the no-show fee
8 rule up in Washington, Labor and Industries, a couple years ago. But I agree with
9 SAIF, with Jaye, that I think we should have a limit on that fee, and that it ought not--
10 that the worker should not be stopped from having further appointments if they can't
11 pay that no-show fee. We don't want that no-show fee to in any way interfere with,
12 you know, the next couple of scheduled appointments. I think that's very important
13 again because the whole purpose of a no-show fee is to prompt and encourage the
14 worker to make those appointments.

15 You know, and it also hurts providers who have set aside that schedule
16 for that worker, and then the worker just doesn't show up and doesn't call. That's a
17 cost to the system that gets passed through.

18 MR. BRUYNS: Thank you. We'll go to (0:24:42**???). Ashley?

19 MS. WILLARD: Ashley with Travelers. My concern--two concerns.
20 My concern would be for the injured worker and would that cost be able to go to the
21 patient's private insurance, or would it strictly be on them? Because that can be a
22 cost associated with someone who's already receiving less wages if they're on time
23 loss.

24 A second question that I have for it is really around if an injured worker
25 doesn't show for their appointment, they get charged, they decide "I don't want to go

1 there anymore,” and they end up going to multiple different providers, then they’re
2 hitting their three physician limit. And then you have another issue at hand. So I
3 don’t know what the--with the worker on this for that, but those are my concerns.

4 MR. BRUYNS: Thank you. One thing I can say for sure is that general
5 healthcare (0:25:36**???) compensability and that would be not be successful
6 because in certainly most cases, I think they also will not pay the no-shows, but
7 that’s just my limited understanding. But (0:25:51**???) going to hand that down in
8 discretion. Joy?

9 MS. CHAND: Yes. We do see a lot of no-shows in our office. And
10 again, I think patients should have some responsibility. You know, it’s not that oh, a
11 patient missed an appointment, so you know, that was a business opportunity for the
12 provider. No. That is not correct. Because if we have a waiting list, if the patient
13 can at least call, we can give that appointment to somebody else who has been
14 waiting to see. So for me, I think patient should take responsibility and there should
15 be something. That’s how we see it. It’s not--we don’t see it as oh, that was a
16 business opportunity. No.

17 MR. BRUYNS: Thank you, Joy. Dr. Miller?

18 MR. MILLER: So I’m going to play the patient advocate on this.
19 You’ve got to remember that all the patients have the right to do whatever they want
20 to do with their own healthcare regardless of who the payer system is. You can’t
21 force them to see a certain doctor. You can’t force them to follow any treatment
22 plan. You can give them recommendations. They get to still make the decision as
23 to whether or not they want to follow it. I don’t know how many people in this room
24 follow every one of their doctors’ recommendations or their dentists’
25 recommendations and come every time that they’re supposed to come in for their

1 cleaning, their checkup, their treatment or whatever. You know, I certainly
2 understand, you know, as a provider, losing that opportunity when somebody's
3 scheduled and now that block of time isn't filled by somebody that could have been
4 on the waiting list.

5 But you know, my personal preference is I think no-show policies just
6 create a relationship with your patient and provider that eventually becomes toxic.
7 So regardless of whether this helps the Division make a rule or not, it's just
8 something to consider. The patients still have their own choices.

9 MR. BRUYNS: Tavis?

10 MR. COWAN: Tavis Cowan, Corvallis Clinic. Just a question, I guess,
11 to the idea of making this rule. Perhaps some place like Washington could give us
12 data if there is before and after, basically the results of allowing this, is there an X
13 percent increase in--or decrease, I should say, of no-shows. I don't know.

14 MR. BRUYNS: That's a good question. I don't think that we do have
15 any data on that at this point. But I guess we could check the Washington State
16 easily enough if they have gathered that data. I'm not sure how they collect it
17 exactly, but they might have found a way. Diana?

18 MS. HENDRICKSON: Diana Hendrickson, Corvallis Clinic. If you
19 impose the rule to the provider and the provider can--doesn't have any means to
20 enforce it, it doesn't provide any benefit. It just complicates it.

21 MR. BRUYNS: Okay. Additional thoughts, including anyone on the
22 telephone?

23 MS. FLOOD: I'll just add.

24 MR. BRUYNS: Jennifer.

25 MS. FLOOD: Jennifer Flood, Ombudsman for Injured Workers. Is

1 that--currently, the fact that there isn't a rule, my understanding is that doesn't
2 prevent a provider's office from billing the worker for a no-show fee.

3 MR. BRUYNS: Yeah. It's a question of whether we even have
4 jurisdiction at all because if they don't attend--if they don't attend, then was there a
5 medical service? No, there was no medical service. So does it even fall under the
6 Workers' Compensation system and that's the--kind of the bigger question.
7 Jovanna?

8 MS. PATRICK: Yes. Jovanna Patrick, claimant's attorney. I just have
9 some concerns as well about having monetary a penalty to claimants. You know,
10 claimants have a lot of medical appointments, (0:29:18**???), you know, attending
11 physicians, physical therapy. Things sometimes get lost in the shuffle because
12 they're not used to having to go to so many appointments, being so scheduled.

13 I think there's also a lot of confusion among employers and claimants
14 about getting that time off from work to go to physical therapy. I've had employers
15 say, do it all at the end of the month. We're too busy at the beginning of the month.
16 I have lots of claimants who think that the employer or the insurance company needs
17 to pay them for that hour, they don't need to use sick time. I've had employers
18 refuse to allow them to use sick time because they think it's a Workers' Comp claim.

19 So I think sometimes despite best efforts, there's lots of things getting
20 in the way of claimants taking that time off to go to the appointment, and further
21 penalizing them for that, I think, would further discourage them from seeking that
22 treatment.

23 So there are other ways to address this. If there's--claimant's attorney,
24 I do get calls from physical therapists or adjusters if this is becoming a pattern, and
25 we try to address it. I think without--with pro se claimants, they can still--the adjuster

1 could step in and call them about that and encourage them to go. And that usually,
2 in my experience, works without need to cause them to have to spend more money
3 or feel like they can't go to that office because they owe them money.

4 MR. BRUYNS: Thank you.

5 MR. SEMPLE: This is Keith Semple. This is a tough one for us
6 because one of our biggest concerns in the system right now is keeping doctors
7 willing to treat injured workers. Our clients have an enormous, difficult time trying to
8 find providers who are willing to see an injured worker, and the last thing we want to
9 do is stand in the way of something that might help providers stay in the system.

10 At the same time, I'd echo what Jovanna just said. You know, there
11 are a lot of conflicting issues for injured workers. Other concerns have been
12 expressed around the table, and I think those are all valid concerns as well. I guess
13 we would like to see it, you know, limited in somehow in terms of if it does become a
14 rule, we'd like to have it limited somehow in terms of the amount of money, maybe a
15 good cause exception. Maybe a, you know, second chance, something like that, just
16 to--you know, to try and help drive the message home before the worker gets hit with
17 a monetary issue right off the bat. So those are my thoughts.

18 But I do understand where providers are coming from. Our time as
19 attorneys is valuable as well and sometimes we deal with no-shows, too, so it's not
20 good for anybody.

21 MS. SUNDSTROM: Sheri--oh.

22 MR. KAFKA: I'm Chris Kafka with Kaiser Permanente. For us, no-
23 shows among Workers' Comp fees are a big issue. The no-show rate for Workers'
24 Comp fees runs about two to three times what we're seeing in our general
25 population. And it is a big problem that impacts the, you know, the financial liability

1 of our--of the occupational health services that we provide.

2 I think some of the remedies that we proposed around the room are
3 kind of after-the-fact remedies where, okay, the--you know, getting in touch and
4 working with the patient's attorney when there's been a no-show to get--or the
5 patient's employer to encourage that patient to come in for their next visit, that's all
6 fine and good. In the meantime, you've already incurred a lost appointment on your
7 schedule that you set aside to treat that patient. So it is a significant burden to
8 organizations that are trying to do the best they can, the best they can to take care
9 of Work Comp patients.

10 MR. BRUYNS: Thank you, Chris. Sheri?

11 MS. SUNDSTROM: Sheri Sundstrom. Can I ask, I'm just curious,
12 because I get reminders like 48 hours in advance whenever I have an appointment
13 anymore. What are we using as far as how are we communicating with patients, not
14 just injured workers, but patients in general? Because I do for my dentist and my
15 mammogram folks, I mean, I get text messages reminding me. So is there--is that--
16 on top of that, are people still not attending their appointment?

17 0:33:27: Yes. They do confirm and then they still--

18 MS. SUNDSTROM: They still...

19 0:33:30: --don't show up.

20 MS. SUNDSTROM: And in that, does it explain to them like the time
21 frame with--in which to provide like 24-hour notice if they're going to be a no-show?

22 0:33:41: Correct.

23 MS. SUNDSTROM: It's like come on, everybody. It's ridiculous.
24 Sorry.

25 0:33:47: So if you're confirming, you know, your appointment--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MS. SUNDSTROM: Yeah.

0:33:49: --then you are at least aware--

MS. SUNDSTROM: You're aware.

0:33:51: --that you have an appointment now.

MS. SUNDSTROM: So I guess maybe then I'm going to that, if you confirmed you were going to attend and you're still a no-show, then maybe that's where a fee comes in as opposed to they--you know, if there's being--technology being used to communicate with them effectively as to when those appointments are, and they're confirming they're going to be there and then they're a no-show, because then you--it just speaks to your--at least you've been given the opportunity to go to your employer and ask for the time off and the whole spiel if you forget to put it into your calendar to begin with on your own. Just a thought.

MR. BRUYNS: Thanks, Sheri.

MS. ST. GEORGE-SUING: Ramona St. George for Majoris Health Systems. I think we shouldn't overlook the fact too that the worker can pretty easily avoid any charge by making a phone call and cancelling the appointment. So it's not just if they decide not to go, it's if they don't call and they don't go. So there's a pretty easy remedy on the worker's part to simply make a phone call.

0:34:56: I would add that the opportunity to even assist them to get them to their appointments is available ahead of time.

(0:35:07)MS. ST. GEORGE-SUING: Concentra does that.

0:35:04: We do that all the time. A worker will call us and say, "Hey, you know, I have a legitimate problem here. I don't have the money or my car's broke down or there's locusts." Some excuse. We provide transportation.

MR. BRUYNS: Thank you.

1 0:35:25: That's a really good point because I know Concentra does
2 that, too. They actually provide transportation.

3 0:35:28: Cuts down on no-shows.

4 0:35:28: At least in Washington. Yeah, it's--I forgot about that. I
5 haven't tried it yet, but I don't know that--how to work that. That's a great idea.

6 0:35:37: Well, in my experience, it does take some notice. When I try
7 to do that for my workers, if, you know, something happened, I've been told they
8 need 48 or 72 hours. Not Concentra, but just the insurer to help set up that. So
9 sometimes, you know, even with notice, they can't get that taken care of.

10 MR. BRUYNS: Thank you very much. This is a really interesting
11 conversation. Any additional points you'd like to leave us with before we move on so
12 that we kind of have everything at our disposal?

13 This is Issue Number 5. A stakeholder is proposing a 10 percent fee
14 increase for chiropractic CPT codes 98940 through 98943 and...

15 0:36:36: Fred?

16 MR. BRUYNS: Yes?

17 0:36:37: Before you go on because we have a lot of thoughts and
18 concerns and I don't think--I didn't hear anything that sounded anything remotely like
19 a solution. Is there any way to track some data on this? Because we--you know, we
20 heard--Kaiser said that they've got a larger population and you had someone, a
21 provider's name, 20 percent or...

22 MR. BRUYNS: That was a single office. Yes.

23 0:37:02: I'm just wondering...

24 MR. BRUYNS: And someone here recommended the state of
25 Washington as a source for...

1 0:37:05: Well, as a source.

2 0:37:06: Yeah.

3 0:37:06: But I'm just thinking in Oregon too, though, if there's a way for
4 looking at OMA over there.

5 MR. BRUYNS: Yes.

6 0:37:11: If there's a way to maybe gather some data so that we have
7 something-- I mean, frankly, looking at--is there a particular population of injured
8 worker/patient who is more likely to be a no-show than another? And thinking
9 specifically of people for whom maybe language is a challenge. I don't know. It just
10 seems like we're--it sounds like we've got a problem. But I think we probably need
11 some data before we can really solve it.

12 0:37:42: Well, and did the Washington rectify by charging?

13 0:37:48: Charging.

14 0:37:48: Did that do anything? And I don't know...

15 0:37:51: So maybe there's another way to solve the problem.

16 0:37:53: Yeah. I can ask. I have about 150 clinics in Washington that
17 I represent, so I could just sent out a request for--give me some feedback on
18 whether or not this policy, number one, are you implementing, are you actually
19 charging workers who don't show up? And the fact that you've implemented that
20 policy and notified them in writing in advance, has that helped cut down on the no-
21 show or not? And if somebody does no show, are you having difficulty in collecting
22 that fee? And we can ask a couple of those kinds of questions.

23 0:38:21: Yeah. And I sit on the Workers' Comp Advisory Committee
24 for the state of Washington, so I can see if they can provide, you know, so I will do
25 that.

1 MR. BRUYNS: Thank you, Sheri. And...

2 0:38:31: Yeah.

3 MR. BRUYNS: So if you have...

4 0:38:33: I forget about that sometimes.

5 MR. BRUYNS: If you have data for us, please send it our way, and
6 send it to me and I'll distribute it in the Workers' Compensation Division. Diana?

7 MS. GODWIN: I think at least from my opinion because I do manage
8 both PT and occupational medicine that there's considerably more no-shows on the
9 PT sides than the provider's side, so it needs to be data from both sides.

10 0:38:56: Uh-huh (yes).

11 0:38:59: Well, and I think percentages, in addition to numbers, would
12 help address some of that as well to look and say you have more PT visits
13 scheduled period, so...

14 0:39:08: Uh-huh (yes).

15 0:39:09: Generally. I shouldn't say definitively.

16 MR. BRUYNS: Thank you for that. You're right, we didn't actually
17 come up with a--like a solution, but--so we'll put our heads together in terms of what
18 data we can gather. In terms of the data we already have, I don't know that we have
19 any on that per se. But if you folks have data for us on the numbers of no-shows,
20 especially if it's you know, on a percentage basis, and then maybe how that relates
21 to general healthcare if you provide general healthcare as well. Please just send it
22 in to me and I will make sure that it's distributed back to whoever is drafting the
23 rules. And we'll consider all of it. So are we ready for Issue Number 5? Any
24 additional thoughts on that?

25 So Issue Number 5 is a stakeholder is proposing a 10 percent fee

1 increase for chiropractic CPT codes 98940 through 43 and physical medicine/rehab
2 CPT codes 97110 through 97113. This stakeholder is also asking for a reduction of
3 the fee schedule amount for the massage CPT code 97124.

4 And so under the background, the stakeholder explained that a 10
5 percent fee schedule increase for chiropractic codes, \$5 to \$8, would increase the
6 cost of 18 chiropractic visits by \$90 to \$144, that's the range. The fee schedule
7 amounts for the chiropractic CPT codes are not--98940 through 43 are not directly
8 linked to CMS' RVU and have been at the same level since April 2016 when they
9 were raised by three percent.

10 Physical medicine/rehab CPT codes 97110 through 13, the
11 stakeholder stated that CMS arbitrarily reduced the RVU of these codes in 2018. A
12 look at the 2017 and 2018 Workers' Compensation fee schedules shows the
13 following. And there you can see a decrease, an increase and a decrease. I won't
14 read all of that data to you, but it has fluctuated and there have been some
15 decreases.

16 And then the massage therapy code 97124, the stakeholder proposes
17 to decrease the fee schedule amount of this code since it has been debated in the
18 past as too high and CMS had increased the RVU substantially by 17 to 18 percent.
19 A look at the 2017 and 2018 Workers Compensation' fee schedules shows that the
20 2017 Workers' Compensation fee schedule amount increased from \$43.59 to \$51.90
21 in 2018, a 16 percent increase.

22 So options for this group to consider would be to make changes to the
23 fee schedule amount of some or all of above listed CPT codes. And I'd just like to
24 open it up for your comments and welcome your input. Dr. Miller?

25 MR. MILLER: So I'm sure we're all assuming that SAIF is the one

1 proposing these increases, and I appreciate that, but-- So one of the reasons I got
2 on this committee was about 10 years ago after nine years in a row where
3 chiropractic code would decrease or not change, decrease or not change, we had a
4 significant proposal after CMS, you know, changed their units to decrease the
5 chiropractic codes substantially while increasing the E and M codes with the belief
6 that it would be a wash for chiropractors. Well, chiropractors don't have the ability to
7 charge E and M codes on every visit because it's embedded in our adjustment
8 codes.

9 And so we had the opportunity for public testimony, and 71 different
10 chiropractors came and opposed that proposition. And nobody came to say no, it's
11 still a good idea. And the proposition still went through even though everybody--you
12 know, we had plenty of testimony against it. And so I got on the panel, proposed
13 increases to try to offset what was decreased in the previous years, including that
14 one substantial year, and it took us three years to get the majority of that back. And
15 then three years ago, we got an additional three percent based on the
16 recommendation of the Physical Therapy Association, which I promptly said that
17 we'd like to participate in that three percent as well.

18 And so it has been, you know, decreased. We are now getting to the
19 point where we're about to the same levels we were in 2000. And so now we're
20 asking for an additional increase on that for the chiropractic code. And as I said, you
21 know, because chiropractic is limited under Workers' Comp for 18 visits or 60 days
22 unless you go in through MCOs. The overall fiscal impact of a single case probably
23 wouldn't increase more than \$150. So you know, it's not a substantial, you know,
24 blow to the Division, to the, you know, payers, and it just, you know, helps, you
25 know, the hassle factor of getting more providers willing to participate in this arena.

1 Going down to the physical medicine codes, that kind of, you know,
2 carries over into the, you know 71 chiropractors ten years ago saying hey, you know,
3 we oppose this. You know, last year, there was no mention about this. There was
4 no justification for it. It just kind of dropped down. And I apologize for not
5 recognizing that the 112 actually went up.

6 And so I'd like to see, you know, on the benefit of the physical
7 therapists and the people that use these codes to not just have an arbitrary
8 decrease on very commonly used codes just because, you know, CMS nationwide
9 say well, people aren't charging as much so we're going to, you know, drop that
10 code down.

11 The massage therapy code, as mentioned here, it has been debated in
12 the last five years within this arena from non-stakeholders that are Workers' Comp
13 and ones that are still influenced by that, but actually rescinding that proposition
14 because our association hasn't come to a consensus on that. But it's out of the bag,
15 so up for debate still, but we're actually, you know, taking that proposition out.

16 Oh, now, one last thing. Eventually, we're getting to this All Payers All
17 Claims data. And you're going to see that chiropractors under Workers' Comp are
18 getting paid almost two times more than what All Payers All Claims has shown. And
19 so people in the--or in this room may say, well, you're already getting paid too high
20 under Workers' Comp. But it's important to recognize that chiropractic deals with
21 cash-paying public a lot more often than most providers do. And so we typically
22 don't charge more than the Workers' Comp fee schedule at their normal rate. So it's
23 not like we're dealing with Blue Cross or Moda or (0:46:24**???) Corp to the point
24 where, you know, we're charging \$100 for an adjustment but we know we're going to
25 get paid a smaller percentage from this payer versus this payer versus this payer,

1 which then makes it appear when the people are participating with Blue Cross and
2 they're getting paid \$30 or \$37 or \$38.50 or whatever they're getting paid for it
3 compared to, you know, \$53.14 from Workers' Comp while Workers' Comp is
4 definitely paying way too much for chiropractic. It doesn't work that way. We're
5 actually charging what Workers' Comp is allowing us, and then Blue Cross or
6 whoever is giving us a percentage of that charge. And so that's why it will appear
7 that we're getting paid a lot more through the Workers' Comp system, but in reality,
8 we're just not charging above that Workers' Comp and then accepting a percentage
9 from the payers. Clear as mud?

10 MR. BRUYNS: Thank you, Dr. Miller. Okay. Thoughts? Anyone?

11 MR. GIFFORD: Todd Gifford for Therapeutic Associates. So I guess
12 my question on that is how can we review a subset of the physical medicine codes
13 without reviewing or making the same argument for them all. And I would add,
14 therapeutic activities in 2019 is going to drop, according to CMS, to three percent in
15 this fee schedule. So there's going to be other codes that are going to drop this next
16 year, how can we not include all of the rehab codes that would impact both
17 chiropractic and...

18 MR. BRUYNS: Yeah. Thanks for, you know, bringing that to our
19 awareness. I guess there are fluctuations in those codes and sometimes to the
20 negative side. So I would welcome your input on any and all of that. Those ET
21 codes, the broader ET codes and also chiropractic codes. Or perhaps it will--when I
22 say pick up some of this in the conversation, the All Payers All claims issue that's
23 coming up. And thank you, Dr. Miller for raising the issue and...

24 MS. FRASER: Well, and you know, from SAIF's perspective, I think--
25 and we don't think CMS does things arbitrarily. And given the all payer, I mean I

1 think from our perspective, there's not really a--we don't see a justification for
2 increasing chiropractic codes. And I actually think that the concept of looking at all
3 of the medicine codes at the same time is probably valid.

4 MS. ST. GEORGE-SUING: Ramona St. George. I would agree with
5 Jaye. And my reading of the all payers information is that it's based on actual
6 reimbursement, not on billed amounts. So that would--I mean I think the billed
7 amount, even though it's much higher, doesn't enter into the actual reimbursement
8 that's reported here.

9 So again, in my interpretation, it's that the Workers' Comp fee
10 schedule is actually almost two times more than the actual reimbursement from the
11 group health payers, not the billed.

12 MR. BRUYNS: Dr. Miller?

13 MR. MILLER: That was my point is that All Payers All claims pay a
14 percentage, so it's definitely reimbursement. And so we're charging what Workers'
15 Comp allows us to charge. And then we get a percentage based upon that because
16 of our contract with whoever our payer system is, our reimbursement rate is
17 significantly lower than the Workers' Comp because that's what we billed. So if we
18 were to charge higher, our percentage from All Payers All Claims would actually get
19 up to the--I mean, the percentage wouldn't change, but the amount that we get
20 reimbursed for would change to the point where it would get closer to Workers'
21 Comp. But then we're punishing the cash-paying patients that you know, if you go to
22 any provider, I just went to one, you know, a couple weeks ago. When I go to that
23 provider and I don't submit an insurance, I will pay more out of cash than when I say
24 I have insurance, even though my deductible's not met. They'll say oh, well, now
25 you get to pay less. So we can't punish the cash-paying patients.

1 And so as a professional, we will typically charge lower across the
2 board, meaning we will get paid less under the All Payers All Claims system
3 compared to what we will get paid here. So you can't just say, well, we're getting
4 paid too high under Workers' Comp because we're taking a percentage under Blue
5 Cross and Moda.

6 MR. BRUYNS: Okay. Probably, we should pick this conversation up
7 when we get to the All Payers All Claims because it's going to be important to
8 discuss what we're really comparing and whether we're comparing billed amounts or
9 is this actual paid amounts. And it is new data for us and so that's why we want to
10 bring it to you and find out if there's--if it's maybe trustworthy and whether we should
11 wait longer to get more data, et cetera.

12 If it's okay with the group, I'm going to move on to another issue. And I
13 believe the one after that is probably All Payers All Claims. But our next issue is
14 Number 6, and it has to do with anesthesia. Unlike Medicare and many private
15 health insurers, Oregon Workers' Compensation rules have no provision for services
16 billed with anesthesia modifiers QY, QK, or QX.

17 Some background. Anesthesia bills with the above modifiers indicate
18 the following. QY is medical direction of one qualified nonphysician anesthetist by
19 an anesthesiologist. QK is medical direction of two, three, or four concurrent
20 anesthesia procedures involving qualified individuals by an anesthesiologist. And
21 QX is qualified nonphysician anesthetist service with medical direction by a
22 physician.

23 Generally, one--only one anesthesia provider at a time is paid per
24 patient. However, more than one provider may be paid when the supervised
25 anesthesia services are provided by a qualified nonphysician under the medical

1 direction of a physician. In that case, the supervising physician should use modifiers
2 QY or QK, and the nonphysician provider, the modifier QX.

3 In other lines of insurance, bills with anesthesia modifiers QY, QK, or
4 QX are paid at 50 percent of the fee schedule amount. Anesthesiologists should not
5 perform other services while medically directing anesthesia procedures.

6 So options would be to add new subsections to Rule 40, Section (2),
7 indicating that anesthesiologists medically supervising nonphysician providers must
8 bill using modifiers QY or QK. Anesthesiologists may not perform other services
9 while medically directing anesthesia procedures. Qualified nonphysicians must bill
10 using modifier QX for anesthesiologist services with medical direction by a physician.
11 And payment for services billed with modifiers QY, QK, or QX is at 50 percent of the
12 applicable fee schedule amount. Or as often is the case with these options, one
13 option would be to make no change at all or maybe something other, something else
14 that we haven't considered.

15 So with that, that was quite a mouthful. But I appreciate your input on
16 these anesthesia codes, whether we can make the change under the first option.

17 MS. BICKFORD: Hey, Fred. This is Lisa Anne Bickford with Coventry.
18 I would just like to offer our support for adding the new subsections because we
19 think that would help to clarify when we receive these types of services from the
20 anesthesiologists. So we would support the proposed language.

21 MR. BRUYNS: Thank you, Lisa Anne. Anyone else? Any concerns
22 about making that change?

23 Okay. With that, then we're going to move along to-- Okay. Issue
24 Number 7 is All Payers All Claims. This year, the department was granted access to
25 data from the All Payers All Claims database, maintained by the Oregon Health

1 Authority. We were able to compare the maximum allowable payments from the
2 Workers' Compensation fee schedule to the median reimbursements of commercial
3 health insurers.

4 We found that the average fee schedule amounts vary greatly from
5 category to category and that fee schedule amounts for specific codes can vary
6 greatly within a category. The question before us is whether the Division should
7 consider the APAC, that's All Payers All Claims, data when updating the Workers'
8 Compensation physician fee schedule, and if so, how?

9 The Workers' Compensation fee schedule model uses the CMS
10 resource-based value scale as the basis for the physician payment system. This is
11 the RBRVS, and it's based on the principle that payments for physician services
12 should vary with the resource costs for providing those services and is intended to
13 improve and stabilize the payment system.

14 In this system, payments are determined by the resource costs needed
15 to provide them. These resource costs are expressed as relative value units. While
16 CMS assigns the RVUs, the relative value units, to the billing codes, WCD
17 establishes the conversion factors for each category such as evaluation and
18 management, minor surgery, physical medicine, et cetera.

19 The maximum payment amounts, also known as the fee schedule
20 amounts, are calculated by multiplying the RVU of a code times the appropriate
21 conversion factor. Where CMS did not establish an RVU, the service is payable at
22 80 percent of the billed amount under our rule.

23 Starting in 2012, the Workers' Compensation fee schedule has
24 contained a few services where the fee schedule amounts are not based on CMS'
25 RBRVS. That would be chiropractic manipulation codes, CPT codes 98940 through

1 98943, technical components of some MRIs, surgery CPT code 29826, and various
2 pathology and laboratory codes.

3 The following chart compares the utilization-weighted average of the
4 Workers' Compensation physician fee schedule to the median reimbursement
5 amounts of commercial health insurers. In the chart, the value of the median APAC
6 reimbursement for each service category is set to 1.0 and the other values are
7 shown in proportion to it. For example, a Workers' Compensation index value of
8 0.97 means that the fee schedule amount is three percent less than the median
9 reimbursement in commercial health insurance. So this is the chart and you can see
10 there, showing the various categories, service categories and the reimbursement
11 amounts.

12 Evaluation and Management and Physical Medicine are both below the
13 APAC median. The other six categories are above the median. Chiropractic is the
14 highest at 189 percent of the APAC median. Physical Medicine is the smallest at 89
15 percent of the APAC median. Both types of surgery as well as Lab and Pathology
16 average slightly less than 150 percent of the APAC median.

17 The next charts demonstrate the variation in reimbursement for
18 services within categories. The medicine category is used as an illustration. The
19 services shown are the top ten services by frequency in Workers' Comp.

20 In the chart, the circles show the Workers' Comp fee schedule-- I
21 guess I can't get it all on one page just yet. In the chart, the circles show the
22 Workers' Compensation fee schedule maximum allowable payment for the service.
23 The horizontal bars show the median allowed amount from the APAC database for
24 the same code. The allowed amount is the amount that the insurer has determined
25 the provider is owed for the service. The insurer may pay all or part of that amount

1 and the patient may pay the balance in the form of co-pays and deductibles. Half of
2 all reimbursements in commercial healthcare were more expensive and half were
3 less expensive than the amount indicated by the horizontal bar.

4 The charts below also show a shaded rectangular region for each code
5 that indicates the distribution of values in the APAC data, labeled interquartile range
6 on the graph. The bottom of the shaded region is at the 25th percentile and the top
7 is at the 75th percentile. Thus, half of all APAC reimbursements, the middle half, fall
8 within the range shown by the shaded region. The table below the chart gives actual
9 dollar values for the data points. So this is the chart. And this is some actual hard
10 data.

11 The most frequent service in the medicine category is immunization
12 administration, usually in the form of a tetanus shot. Four of the top ten most
13 frequent services in the Medicine category are for acupuncture. Note that the
14 medicine category does not include chiropractic or physical medicine services.

15 So options for this group to discuss would be to make possibly
16 incremental adjustments to entire categories taking APAC data into consideration in
17 future years. To make again possibly incremental adjustments to individual codes
18 within all or select categories taking APAC data into consideration in future years.
19 Wait for additional APAC data, that is for follow-up years, before considering
20 adjustment to the fee schedule considering the APAC data. Or to ignore the APAC
21 data for future fee schedule adjustments.

22 And so this is where we appreciate your input. And just keep in mind
23 too, this is part of a large--of the broader report. Again, there were some copies on
24 the side table. Those may be gone. But it is up on our website and (1:00:55**???).
25 Most of you, if you were in touch with me if you have been in touch, it is on our

1 website for the meeting on this date. And if you don't have access, don't know how
2 to get there, just pick up a business card of one of mine on the table there, and I'll be
3 sure to get you links or just give you a copy of the report. So with that, I'll turn it over
4 to you folks for discussion. Dr. Miller?

5 MR. MILLER: So I think it's important for the non-providers to
6 recognize, I think a lot of people understand this, but this is relying upon contracts
7 with third-party payers and personal insurance. And your contracts as a provider
8 and your contracts within each individual policy is going to change on a basis
9 whether you're a nonprovider or in network, out of network. There's lots of different
10 aspects that we'll put all this data in.

11 And so I think, you know, again, just to clear up the confusion with the
12 chiropractic, you know, being out of range per se in this, is if I was to contract with
13 let's just say Blue Cross, and Blue Cross in my contract, either providing--you know,
14 in-network provider says we're going to pay you, you know, 75 percent of your
15 normal and customary for this geographic region, and my normal and customary is
16 what I charge Workers' Comp, you know, it's going to perceive that my
17 reimbursement rate under normal, you know, health insurance is going to be much
18 lower than my reimbursement rate under chiropractic, or under Workers' Comp.

19 If I was to charge more and say well, now our normal--and we--as a
20 profession across the board, we just start saying we have to charge more, we have
21 to charge more, and now everybody's charging \$100 and we start taking, you know,
22 70 percent or whatever, now we're going to be receiving more than what we get from
23 Workers' Comp. But it's still going to be across the board punishing a totally
24 separate category. And I know this isn't, you know, caring about who the cash-
25 paying patients are, but it has to be that this provider has the ability to treat

1 everybody, not just the Workers' Comp people.

2 I don't know, you know, what the medical providers do, but I know that
3 most medical providers are going to participate and be in network on most things
4 offered to them. But I know through our association, when we hear from our own
5 stakeholders, the private insurance continues to whittle down the chiropractors.
6 They continue to whittle down on a yearly basis, and well, now we're going to pay
7 you 35 percent. Well, now we're going to pay you 33 percent, until some of the
8 chiropractors either have to go out of business, or they have to go all cash, or they
9 have to, you know, recognize that you know, maybe I do something different like
10 weight loss management. It's a contentious thing that we have to deal with as a
11 profession. And so, you know, to potentially punish us based upon data that doesn't
12 give all the apples and oranges is just giving us the apples and not recognizing what
13 that data really means, I think is unfair to an entire profession.

14 And so I think, you know, I understand when I'm looking at data, it
15 looks really contentious saying, well, chiropractors are already getting paid way too
16 much compared to what-- And so you know, that's got to be the question that you
17 have to do more research before you just say, well, we're not going to give you any
18 more increases effective until everybody else catches up because they're
19 participating in things that you don't.

20 MR. BRUYNS: Thank you, Doctor.

21 MR. GILBERT: Greg Gilbert with Concentra. I'm still not sure I follow
22 your logic, but I've done this in other states where we compared with group health
23 data, I think WCRI has done some studies nationally where they look at that. And
24 basically, what you're doing is you're benchmarking to understand whether or not
25 you're underpaying or overpaying according to the market. All right. So whatever

1 the numbers show here, you could theoretically say, we're being underpaid by three
2 percent of the marketplace for group health insurance is basically how they look at
3 that.

4 And typically, the public policy approach to that is for most fee
5 schedules, with the exception of maybe two in the nation, is that they want to look at
6 fee schedules for Work Comp to be above what they're paying in group health for
7 various and sundry reasons. You can go back probably 13, 14 years where Lewin
8 did a study, really the only one I know that was done well in California where they
9 actually went and looked at quote, the hassle factor, within Workers' Compensation.
10 They actually sat in clinics, occ med clinics, surgeon--surgical clinics, et cetera, and
11 basically looked at what these clinics had to do above and beyond what they're
12 normally doing in a group health practice.

13 Now, of course, that's within the California system, so there's going to
14 be nuances with that. But in general, when they looked at that back then, it was
15 about a 26 percent premium above what workers'--group health was doing. So
16 that's the only study that's ever been done on that. So what you have is kind of a
17 hodge podge of states trying to decide what is that happy medium where you're not
18 paying too much and you're not paying too little? Because then you have an access
19 issue as you mentioned, and you worry about doctors leaving because why bother,
20 it's a lot of work, a lot of forms I've got to fill out. You've got to have a little bit of a
21 carrot there. And typically, what you find in most states is bill benchmark above
22 what you'll see in group health or typically always above Medicare reimbursement.
23 So that's another way to benchmark it as well.

24 But having this data is unusual. Not every state does this. Maryland
25 did it many years ago. They have a public database like that. And that's how they

1 set their fee schedule. And when they start it, they start it ten percent above
2 Medicare. Excuse me, ten percent above the group health rates, which end up
3 being close to Medicare rates because it was a highly managed care environment in
4 group health and so that kind of worked out as the same math.

5 So that--when you look at this kind of data, I think it gives you an idea
6 of where you benchmark among the groups. You have multiple conversion factors
7 as I understand it. And I'm a big believer in not picking and choosing among RVUs.
8 You kind of negate the whole process of having a Medicare RVU, which does go
9 through a RUT (phonetic) committee, and most of the RVUs are reviewed by the
10 physician practices and specialties themselves. Some are done by CMS but most
11 are done through the RUT committee.

12 My point would be use the RVUs. You're going to make an increase
13 because you have issues and individual codes, then look at the whole code set.
14 Don't pick and choose because then you destroy that whole process. Frankly, some
15 would say you use a single conversion factor, but most states don't do that. So I'm
16 sorry for going on a litany there, but I have strong feelings with respect to that. I've
17 done this in many states. I think there's a way to go about doing it. When you find
18 you may not be competitive in a certain group, you may be overpaying in another
19 group, and that may drive your public policy related to how you make those changes
20 within those groups and the resulting conversion factor. Hopefully that makes sense

21 MR. BRUYNS: Thanks, Greg. If you happen to have...

22 MS. GALLAGHER: This is Cindy Gallagher with Coventry. And I
23 agree with Concentra. I think that we should continue using the RVUS. We can
24 always adjust the conversion factors as needed.

25 MR. BRUYNS: Thank you, Cindy.

1 MS. ST. GEORGE-SUING: Ramona St. George. I would support
2 beginning some adjustments. I think particularly maybe reallocating some funds to
3 the E and M conversion factors, that is where the biggest difference comes in and
4 the hassle factor of Workers' Comp is determining the causation and compensability
5 and the diagnoses. And those are the providers who we're really having access
6 problems with.

7 And so incentivizing and compensating them for the role they play in
8 the system, I mean a major surgery is a major surgery. The patient's on the table
9 and they're asleep. It's the E and M...

10 1:09:08: Hopefully..

11 MS. ST. GEORGE-SUING: Yeah. Yeah. It's the people who are
12 doing the evaluation and management that go through the hassle factor that get
13 them to the surgery. And so I would heartily support looking at adjusting the
14 evaluation and management codes as a solution to a lot of issues.

15 MR. BRUYNS: Thank you, Ramona. Diana?

16 MS. HENDRICKSON: Hi. Diana Hendrickson, Corvallis Clinic. While
17 I appreciate the APAC and I think it brings some valuable information forward, I think
18 just laying on the table again that when we contact the commercial carriers, one of
19 the biggest driving factors is the total cost of care and quality. And Work Comp has
20 got to get on the bridge to looking at that total cost of care of patient and quality if
21 you're going to compare them to commercial care.

22 1:10:01: Absolutely.

23 MR. BRUYNS: Dr. Miller?

24 MR. MILLER: So I mean that brings up the biggest point that I'm trying
25 to make is for them, they're saying that Workers' Comp has to, you know, increase

1 in order for them to be on par with commercial payers. You know, our gentlemen
2 down there saying that APAC is determining, you know, what the general
3 marketplace is trying to do. Chiropractors don't get to participate in that
4 marketplace. We don't get that same opportunity from, you know, commercial
5 payers to say oh yeah, we really want chiropractors to do this. I mean we have to
6 fight tooth and nail just to get any sort of parity. And currently right now, with the
7 anti-discrimination law that's set in Oregon that says that commercial payers can't
8 discriminate amongst providers, they will specifically say yes, we cover chiropractic;
9 however, we don't cover adjustments. All right. What are you covering, then?
10 You're covering the E and M. That is important. But we're not going to cover any of
11 the services that chiropractors do. And so somewhere down the line, there's a huge
12 disconnect between APAC and Workers' Comp and what we get reimbursed as a
13 profession. So you know, we're accepting \$37 for an adjustment and it cost me
14 \$37.50 to treat that patient, how long do I want to do that? I mean I understand, you
15 know, the visual concern on the data, but you've got to recognize that the parity is
16 just drastically different between our profession.

17 1:11:34: Fred, I have a question. Does All Payers All Claims include
18 Medicaid, Medicare, Medicare Advantage contracts, Medicaid contracts, et cetera?
19 Because if the benchmarks are inclusive of those types of services, cost and
20 negotiated rate are two different things. And a provider could sign a contract of
21 commercial payer or commercial business at X rate Medicare advantage at another
22 rate and Medicaid at a third rate, and if they're all bundled in, what the provider's
23 faced with is I don't get the commercial if I don't take the Medicare losses and the
24 Medicaid losses. So to me, there's comparing it to commercial, that is a potential
25 problem. And second, the commercial market is based--rates and commercial

1 payment are based to--excuse me, to some degree among market factors. A highly
2 fragmented provider system doesn't have the negotiating clout that Providence or
3 Legacy or some other delivery system might have where their rates could be higher,
4 and they--so hence, the providers that are in a fragmented market, they might be
5 forced to take these at below their costs or at their costs just to defray their fixed cost
6 so they can push some margin from other business to their bottom line.

7 MR. BRUYNS: Okay. Thank you very much. Maybe you should
8 speak, Juerg.

9 MR. KUNZ: So this APAC data does not include Medicare, Medicaid?

10 1:13:10: Market factors still apply, though.

11 MR. BRUYNS: Thanks for asking the question.

12 1:13:19: So Fred, I think that SAIF thinks the data is very interesting. I
13 don't think that we've really had enough time with it to assess it all that well because
14 it's just been provided to us. And we--but we think it's really cool to have the
15 information, and it may be something that we use to inform decisions as a group as
16 opposed to like just following along. But I guess what we would urge the department
17 to consider is to keep exploring this, don't throw it away. Don't throw the data away.
18 And that maybe this is a--is ripe for a, you know, an advisory committee, to sit and
19 spend some time, you know, assessing them and looking at it. Because I've heard a
20 lot of information today that I haven't been privy to before, and I'm delighted that--to
21 have providers and insurers here who come from a different world than we do. And I
22 just think there's more conversation to be had than what we can have in a short,
23 what, two-and-a-half-hour advisory committee.

24 1:14:33: It would be great actually to have APAC come and present
25 the data, so--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1:14:35: Yeah.

1:14:36: --you understood ???--

1:14:36: Yeah.

1:14:38: --how they...

1:14:38: Yes.

1:14:38: We did that in Maryland. It was important that we were talking apples to apples.

1:14:44: Because that's--and the more you use data and the more you get into it, the more you know that, you know, did you push here so that this popped? Or did you push over here? And there's--there are just so many unknown factors in what we're looking at. I think that's a great idea.

MR. BRUYNS: Okay. I think we're hoping to gather not only answers but questions about the data, especially if, you know, you have any insight into, well, the story it tells whether it's actually going to mislead us in some way. We certainly want to know that. We don't want to go down the road and find out that it does contain information that actually skews the result, and we were very pleased to find that we have access to it because for years we wanted to get private health data, but it's very difficult to do--get an insurance--a large insurer--health insurer to provide data. It's information that they consider proprietary. And so this is new to us. Go ahead, Don.

1:15:49: But is the index comparing the fee schedule to commercial payments or Work Comp payments to...

1:15:59: It's the commercial payments.

MR. BRUYNS: It's the fee schedule maximum to commercial payments.

1 1:16:03: So it doesn't take into account discounts that may be coming
2 through the MCO?

3 1:16:10: Correct.

4 1:16:10: That's correct.

5 1:16:15: So what I would be interested in finding out is what the actual
6 payments for Work Comp are versus--so we could compare how a fee schedule--the
7 payment's received, if that's a part of that all payer system. Because it may take
8 some of these differences, either equalize or make them worse. It will be interesting
9 to see that.

10 MR. BRUYNS: Okay. Don, you perhaps would know best. Is that
11 something that you could do would be pay--compare the actual amount paid in
12 Workers' Comp to the actual amount paid through the APAC?

13 MR. GALLOGLY: Yes. It would have to be--it would have to be some
14 sort of summary data of the amount that's actually paid. The fee schedule amount is
15 one number, whereas the payment amounts are--every bill is different. Every bill
16 should be different. But yeah, we have that. We have payment data and we could
17 certainly include that.

18 1:17:17: I think the upshot of what Todd is saying is that all of those
19 differences, if it's based on an actual payment versus an undiscounted Oregon
20 medical fee schedule, would be actually lower.

21 MR. BRUYNS: Yeah. That's--if we were to average everything out,
22 it's not exactly at the maximum amount.

23 1:17:39: I would bet the majority of the public safety would come in
24 after that. The majority of payments from the providers that I represent are below
25 fee schedule because of the MCO contracts. So consequent to that, .89 for physical

1 medicine is probably would be more--is a bar that actually stems further than .89.
2 And I would imagine it would be the same for every other one.

3 1:18:07: And when you're looking at allowed payments here, that's
4 discounted payments for the group health world, so you--theoretically, you make that
5 assumption that this is the very top you would be paid.

6 1:18:20: If you're going to compare a discount--

7 1:18:21: Yeah.

8 1:18:22: --to discount, if you're going to compare apples to oranges,
9 you've got it. If you want to compare discount to discount, you need to do what
10 Todd suggested.

11 1:18:30: That's a good point.

12 1:18:32: True.

13 MR. BRUYNS: That's why we have meetings like this. So thank you.
14 Additional thoughts? Thank you very much again. That was an excellent
15 conversation. I think we have time for one more issue before we take a break. I
16 think we probably all need a break.

17 We're on to Issue Number 8, affecting--this is a rule that's affecting
18 changing physicians. This is in the medical services rules. It's Division 10, Chapter
19 436, Rule 210 Section (6) through (8) regarding out-of-state attending physicians.

20 There appears to be some ambiguity regarding what the insurer's
21 notice must contain when disapproving an out-of-state attending physician versus
22 withdrawing the approval of an out-of-state attending physician. Further, Section (8)
23 in the rule is not clear whether the worker may request director approval if the
24 insurer withdraws the approval of an out-of-state attending physician.

25 So in Rule 210, Section (6), subsection (b) provides that if the insurer

1 disapproves the worker's out-of-state attending physician, the notice to the worker
2 must include several things. And that lists them out as A, B and C

3 I'm going to draw your attention to paragraph B. Identify at least two
4 other physicians of the same healing art and specialty in the same area that the
5 worker--that the insurer would approve. And then it goes down further in Section (7),
6 and it states that if an approved out-of-state attending physician does not comply
7 with the Rules in Divisions 9 and 10, the insurer may withdraw approval of the
8 attending physician. The insurer must notify the worker and the physician in writing
9 and they must then explain several things. The reasons for withdrawing the
10 approval, that any future services provided by that physician will not be paid by the
11 insurer, and that the worker may be liable for payment of services provided after the
12 date of the notification.

13 While Subsection (6)(b) requires the notice to identify at least two other
14 physicians of the same healing art and specialty in the same area that the insurer
15 would approve, Section (7) does not contain such a requirement. Further,
16 Subsection (6)(b) requires the notice to inform the worker that if the worker
17 disagrees with the disapproval, the worker may request approval from the director
18 under Rule 220 in Division 10. Section (7) does not contain such a requirement.

19 Section (7) requires the insurer to notify the worker and the physician
20 in writing that the worker may be liable for payment of services provided after the
21 date of notification. Section (8) is silent whether the worker may request director
22 approval when the insurer withdraws the approval of an out-of-state attending
23 physician.

24 The Division believes that the notices under Subsection (6)(b) and
25 Section (7) should contain the same elements and that the worker or the worker's

1 representative should be able to request director approval regardless of whether the
2 insurer disapproves or withdraws approval of an out-of-state attending physician.

3 So we have some draft rule wording here for your consideration, and I
4 won't read it all. But it's an attempt to make the rule consistent in terms of what it
5 requires in terms of proper notice and providing of rights.

6 And so with that, I would request your thoughts or concerns.

7 MR. SEMPLE: Keith Semple. This makes a lot of sense to us. We
8 definitely want to have parity among the different ways that if a doctor, if it's out of
9 state, could not be approved or could have their approval withdrawn. So thank you
10 for recognizing the issue.

11 MR. BRUYNS: Thank you, Keith. Any concerns?

12 1:22:42: SAIF doesn't have any concerns. And I actually think it's a
13 good clarification.

14 MR. BRUYNS: Dr. Miller?

15 MR. MILLER: It says the worker has the ability to disagree with the
16 decision and do something. Does the out-of-state provider have that ability since
17 they're already out of state and not really in the system? If they got withdrawn,
18 withdrawn from approval, could they appeal that?

19 MR. BRUYNS: I don't know. I'm going to have to turn to a couple of
20 my coworkers here.

21 MR. KUNZ: Not really because it's really the worker's choice to
22 choose the provider. And so it's really kind of limited to...

23 1:23:21: And they may not know--I mean I don't know any situation
24 that this comes up in. I'm just trying to think if there's a withdrawal of approval for a
25 specific reason that only maybe that doctor knows about and the worker doesn't

1 necessarily know, the worker just has to punt, unless the worker talked to the doctor.
2 I don't know. I'm just making this break take a little longer to get to.

3 MR. BRUYNS: No, we want to--it's what we want to hear. We'll get it
4 right when we get there.

5 1:23:52: And I'll just share a little bit regarding the out-of-state
6 providers. It doesn't come up very often. And when an insurer gets to the point
7 where they're going to say we're not going to allow you to continue to treat, there's
8 typically already been a lot of--an attempt at communication back and forth, and
9 sometimes it's just getting that provider to comply with the Oregon statutes and
10 getting the information rolling. So there are many times where that out-of-state
11 provider is like many Oregon providers that says see you and do it anyway, so--but
12 the worker can be left out there if they don't have somebody else at least attempting
13 to find a provider in their area that the insurer would be willing to approve.

14 MR. BRUYNS: Thank you. Additional thoughts? Okay. I guess we'll
15 go ahead and take about a 15-minute break and get back together at 10 after 3:00.
16 There is a drinking fountain out in the hallway with water in it, but I apologize, we
17 don't have any other refreshments.

18 1:24:58: Actually, there's some coffee left over from another meeting,
19 so they might be a few cups.

20 MR. BRUYNS: Oh, okay.

21 1:25:03: They dropped it off for us.

22 MR. BRUYNS: Right over there from ????. So let's get back together
23 and we'll ????. Thank you .

24

25

(off the record)

1
2 MR. BRUYNS: So if you're on the telephone with us and if we--you
3 didn't actually announce yourself when we did the introductions, please give me a
4 phone call at 503-947-7717 and leave me your contact information and email
5 address. That's included in all our notices regarding the minutes, proposed rules, et
6 cetera. Because if you're involved, I want to keep you informed, and I want to go
7 over-- And that's true if anyone is at the table and not actually--you haven't been
8 hearing from me, you won't hear from me again unless you take out a business card
9 and get in touch with me. And then you'll get on our list and we'll keep you informed
10 moving forward.

11 I won't necessarily contact you again until the end of time, so if you
12 want to do that, we have other panels to sit on. So again, there are business cards
13 over on the side table.

14 So with that, I think we're ready to begin on Issue Number 9. This is
15 again, we're in Division 10, Medical Services Rule, Rule 220. Section (5) makes no
16 mention of the worker's right to choose an off-panel provider if the MCO has less
17 than three medical service providers from each provider category listed in Division
18 15, Rule 30.

19 Some background. Rule 220 states that an MCO enrolled worker must
20 choose a panel provider unless the MCO approves a non-panel provider, or a
21 "come-along provider" who provides medical services subject to the terms and
22 conditions of the governing MCO.

23 Division 15, Rule 30, Section (6), subsection (a) provides that the MCO
24 must have an adequate number, but not less than three, of medical service
25 providers from each provider category. And the categories are listed there. I won't

1 go through all of them. But I think it's a number of the categories that were listed.

2 The worker also must be able to choose from at least three physical
3 therapists and three psychologists. The plan must meet this section's requirements
4 unless the MCO establishes that there is not an adequate number of providers in a
5 given category able or willing to become members of the MCO.

6 For categories where the MCO has fewer than three providers, the
7 MCO must allow workers to seek treatment outside the MCO from providers in those
8 categories, consistent with the MCO's treatment and utilization standards. Such
9 providers cannot be required to comply with the terms and conditions regarding the
10 services performed by the MCO. However, these providers are not bound by the
11 MCO's treatment and utilization standards; however, workers are subject to those
12 standards.

13 And adding a subsection (b) to Rule 220, Section (5) stating that the
14 worker may choose an off-panel provider if the MCO has less than three providers in
15 a category would make section (5) more complete and accurate and consistent with
16 Division 15, the managed care rules.

17 So you can see we have some draft rules there and it has the new
18 subsection (b), notwithstanding subsection (a) of this section, if the MCO has fewer
19 than three providers in a category of providers listed in the workers' geographic
20 service area, the worker may choose a non-panel provider in that category. So
21 that's an option to consider. One option is not to make the change. But we would
22 appreciate your input. This particular change I think it's largely just to make the two
23 divisions of the rules consistent.

24 MS. ST. GEORGE-SUING: Ramona St. George with Majoris Health
25 Systems. I would support that clarifying language of its consistency.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MR. BRUYNS: Thank you, Ramona.

0:01:00: ??? we'd support it.

MR. BRUYNS: Thank you, Diana. Any concerns of that?

0:01:07: No. I think that there's a difference between having a provider named on the list and having a provider who's actually willing to see any patient who calls them up. So I would like to see the language extended to say that it's three providers who, you know, that are willing to see the claimant. You know, maybe the claimant can submit documentation of their efforts. Because what I've found and what--I'm a member of the Oregon State Bar Access to Justice Subcommittee, and we've been working on this issue of availability of doctors.

And what we've found from our research and information over basically the last several years is that even though there are a lot of providers on the list, a lot of them have conditions under which they'll treat the patients. Like only patients that were current patients of theirs before they were injured or only claims that are open. Or only claims that are only a certain age old, like not more than 60 days, not more than a year. Or that they didn't have surgery somewhere else and now they're trying to re-establish.

Some of them have said they won't take someone with an attorney. Some of them won't take people without private health insurance. These are all things that doctors' offices have told me personally, and that we as a--and as a committee, it was something that we had looked at. So I'm not speaking for the committee here in my recommendations, but that it is something that was looked at. And so I think having three providers on the list can be a fallacy because a claimant could call up each of those providers, and based on the claimant's particular circumstances, each of those providers might say no, we won't see you. There

1 might be five providers and all of them say no. But under the rules, it looks like well,
2 they have five people, they should be fine. But if they have exhausted those
3 remedies and have a way to prove that, then--or you know, through a statement or a
4 declaration of what--or something of that nature, then they should be allowed to treat
5 off-panel regardless of the number actually on the list at any given time.

6 MR. BRUYNS: Thank you.

7 MR. SEMPLE: This is Keith. I would echo that. I mean this is a
8 growing problem, doctors who aren't willing to treat injured workers across the
9 board, as we've all talked about and discussed and you know, have been concerned
10 about for years now. But especially doctors who will treat some injured workers but
11 not treat other injured workers. So it's really important to us that there be at least
12 three providers on the panel that are willing to treat a given injured worker to keep
13 them on panel. You know, at least give them the choice of three doctors who would
14 be willing to see them. And if that's not possible, then allow them to treat off panel.

15 MS. FLOOD: I'm Jennifer Flood, ombudsman. I'd just echo the same.
16 That's what we hear from workers who are having a difficulty--having difficulty
17 getting a provider. They'll go through the list and the MCOs -- it's no news to you
18 guys -- I've said that for years about you put on there if they won't see them if the
19 claim is more than 30 year--30 days old. Thirty years sometimes, but 30 days,
20 because it's just frustrating. Workers are feeling like okay, I have to go treat with this
21 group of providers, I've got to go through this list, and they get a no and a no and a
22 no, and they--the chip gets just larger on their shoulder. And it's not impossible to
23 overcome, but it just starts it off on a really rough step.

24 MR. BRUYNS: Thank you.

25 0:04:30: I'm just assuming that the process would still be for them to

1 go to the MCO for assistance on finding a provider on that list before, it's just I got
2 three nos, I can automatically treat off panel.

3 MR. SEMPLE: No. I would envision-- This is Keith. I would envision
4 if there were, you know, ten providers on panel, and all but two wouldn't see the
5 worker, well, then the worker doesn't have a choice of three, that worker should be
6 allowed to treat off panel. There needs to be a process for establishing that that's
7 been exhausted. And you know, this isn't, you know, pointing the finger at MCOs. I
8 mean you know, they don't...

9 0:05:07: Right.

10 MR. SEMPLE: They contract with providers, and it's not pointing the
11 fingers at providers either. I mean everybody gets their choices in the system. But
12 no, the worker should get a choice of three if they're otherwise limited to a list of
13 doctors. So that's--you know, that's our concern. There should be a way to
14 establish that there's not at least three in your geographic service area, and
15 therefore, I want to, you know, seek other options.

16 0:05:30: I think one of those, just having the MCO confirm whether
17 those doctors actually said no--

18 0:05:35: Yeah.

19 0:05:36: Make that call.

20 0:05:35: --or were there efforts.

21 0:05:37: Right. I would just say yeah because right now, we already
22 do have a process in place of if the worker is having difficulty finding and getting into
23 a provider, that we're there to help assist and facilitate. And one of the things that I
24 think we find as we start doing that is they really kind of become unique cases, and
25 there are specific drivers on what's going on with why they're having difficulty getting

1 in. And so trying to create a--just a basic solution might simplify it a little bit more
2 than really when it comes down to what's actually happening. And some of that is it
3 really can be as simple as calling and explaining what's going on or identifying what
4 was the barrier to getting that worker scheduled. And sometimes it's a true barrier
5 and we're--and sometimes it results in us saying, you know what? Make your pick
6 and we'll see if we can get you in, in network or out of network, because sometimes
7 it's not about in network or out of network that's the difficulty.

8 But other times, it's just a miscommunication and by starting first with
9 the MCO and saying "I need help with your list," well, you know, then we're able to
10 direct in. And sometimes I don't know that--you know, the worker sometimes knows
11 exactly who to call or is able to call everybody, and other times, there's a little delay
12 on that which can then cause some noise that we experience, so I think there's just--
13 it's pretty nuanced when it--and on a small subset, so...

14 0:07:03: Yeah. And I would be open to sort of hammering out some
15 procedure for that. But that requires that the MCO be the people who confirm there
16 isn't a choice of three. Because we often have more sway when we call the
17 provider, and we may very well come up with three who the worker called and they
18 said no. But when we call them, they say, well, yes, I'll see that worker if they
19 choose me.

20 And you know, it may not be an M.D. Maybe it's a nurse practitioner
21 that's perfectly capable for the condition that the worker has, you know, so that you
22 know, I want to consider, you know, provider types appropriate to the worker's
23 treatment, something like that. But I don't--I mean we all know that, you know,
24 access to primary care is an issue. That's what we spend all of our time on.

25 0:08:05: This rule is in some ways about worker choice. And I--you

1 know, I always appreciate being able to call the MCO and say, "Here's what my
2 client needs. Let's work this out." And you know, usually yes, the MCO is very
3 helpful. But at the end of the day, if it's a matter of having called the MCO and
4 twisting someone's--some doctor's arm into seeing the patient, and then that's the
5 only place the patient can go because that's the only person that was willing to see
6 them after some arm twisting, and usually this is weeks going on, then that doesn't
7 really give the choice of at least three providers to choose from.

8 0:08:38: No, I agree, saying that we work on the choice issue but that
9 it be, you know, the MCO that says, no, I have three people that you can choose
10 from. Even though you might have called them, we called them and there are these
11 three providers who are appropriate and are willing to see you. So pick one and
12 make a call or we can call for you.

13 0:09:06: I would envision a process by which the worker contacts or
14 their counsel contacts the MCO and says, "I don't think you have three providers in
15 my GSA that are willing to see me. I made some calls and none of them are willing
16 to see me, you know. You know, can you help me?"

17 0:09:21: Sure.

18 0:09:21: And then have a list of three who are willing to schedule and
19 be produced, and there would be a procedure for treating off panel. I guess that's--I
20 do envision it going to the MCO--

21 0:09:30: Yeah. That's fair.

22 0:09:31: --for assistance.

23 0:09:32: I think that's--that's fair.

24 0:09:32: Yeah, I think that's fair.

25 MR. BRUYNS: Thank you very much.

1 MS. BICKFORD: Hey, Fred. This is Lisa Anne with Coventry. I just
2 wanted to offer our support for the proposed language. But we are open if you want
3 to have subsequent conversations about how to fine tune that in the scenario that
4 we've been talking about where they're not able to find someone. We're, of course,
5 willing to help participate in those discussions if need be. But the language that
6 you're proposing is not dissimilar from those that we use in other states for a similar
7 scenario because it does happen sometimes.

8 So I would just again offer our support for the language as you've
9 written it. But if people want to expand it in some way or discuss it further in an
10 offline conversation, we're happy to participate in that.

11 MR. BRUYNS: Thank you very much.

12 0:10:18: So in the event that, you know, a patient's seeing a non-MCO
13 provider and then they get their notice that you know, you have seven days to find
14 one, is there a way through the MCO when the--instead of taking weeks potentially
15 to go through this, you know, process of strong-arming somebody that doesn't really
16 want to see that person, is there a way that the non-MCO provider initially treating
17 them could continue and have some continuity until an MCO provider's found that's
18 beyond that...

19 0:10:49: Yeah, we often do that.

20 0:10:50: That's actually what--how it works right now.

21 0:10:52: Okay.

22 0:10:54: Further...

23 0:10:55: I don't think that's in the rules, but that's how we handle it if
24 there's an issue. But even if they don't qualify as a come-along provider, we'll still--

25 0:11:03: All right.

1 0:11:04: --allow that so that the worker has continuity of care.

2 0:11:08: And while the MCOs are--I have found are very willing to
3 work with that window because seven days is a little tight, also it's really nice when
4 the MCO will also talk with the adjuster, because if time loss is being authorized and
5 whatnot, they might be going on the "it's seven days and we're not going to
6 continue." So from the worker's perspective, not just getting that yes from the
7 provider but making sure that the benefits are continuing with that authorization,
8 so...

9 0:11:41: It would be really nice if that were set forth somewhere in the
10 rules--

11 0:11:43: Right.

12 0:11:43: --so that there were some procedures. I mean it's--you know,
13 it's great that people, you know, come together when the time calls for it and work
14 together when the time calls for it. But you know, it doesn't always happen. I can't
15 say I have not had it happen in this particular type of instance, but it would be nice if
16 everybody just knew what the baseline of things is, but that's--it isn't really clear in
17 the rule at all.

18 0:12:05: And it kind of would shine a brighter light on it because on
19 both sides, there could be other circumstances that are preventing something from
20 moving forward. And if there was a rule written around it if it's flexible enough to
21 allow, because each of these cases are--can be very, very different. I mean there's--
22 -I will say there are times where it's like hey, we've got this doctor that will say yes
23 now, but can you talk with the worker about how they're going to behave?

24 0:12:38: There's that.

25 0:12:39: You know, and it's like you know, then it's like okay, we're all

1 going to work on it, you know, we're going to give you another shot at having this
2 provider and moving forward. But when there's not a choice, it does make it difficult.

3 MR. BRUYNS: Additional thoughts, input? Sounds like there are no
4 concerns with the basic changes on the table, but there is a recommendation to do
5 more in terms of spelling out additional processes. That's what I'm hearing.

6 0:13:15: And I guess the only thing that I would add to that is just to be
7 careful that we don't create a rule that then gets people saying, "Oh, if I just do this,
8 then I'm good." That's the--that's always the rub is to start getting too down in the
9 weeds in the rules, and then you create more problems than what we are already
10 dealing with.

11 0:13:35: Right. And it sometimes can prohibit you from--

12 0:13:38: Yes.

13 0:13:38: --having solutions.

14 0:13:39: Yes.

15 MR. BRUYNS: Okay. Moving along then to issue number-- I'm sorry.
16 Chris?

17 MR. KAFKA: Again, I just wanted to echo from the last few comments
18 that were made with respect to this last proposed rule. First of all, I think it would be
19 practically really hard to put together a test that would determine when some kind of
20 provision would come into effect where a patient indicates that they'll find enough
21 providers on an MCO's panel that is at the minimum, three providers. It's practical
22 (0:14:18**???) how to do that. ??? very, very difficult for them to do.

23 Secondly, I'm not sure that this--that these patients are having
24 problems finding a provider on an MCO panel, that it's the MCO panel that's the
25 problem. I think even if, you know, these patients are likely--got something going on

1 either with their claim or how they are articulating their situation, that is going to
2 mean that if they were to talk to any provider out there in the community unassisted,
3 they're not going to have a hard time getting those providers to take on their claim
4 either because of secondary coverage issues, it's an old claim and who knows what
5 you're inheriting, so there's--I think there's more things going on there. And I think in
6 these situations, having an MCO accountable for finding care and providing care for
7 that patient is probably a--puts them in a better situation than they might find
8 themselves in if the MCO really (0:15:23**???) responsibility.

9 0:15:27: I agree. Well said.

10 0:15:30: Well said.

11 0:15:31: Very well said.

12 MR. BRUYNS: Keith?

13 MR. SEMPLE: I guess I'd like to respond to that. I mean I think that
14 having MCOs invited into the Workers' Comp system is a major limitation on who an
15 injured worker is allowed to see as opposed to who I'm allowed to see and you're
16 allowed to see, and everyone sitting at this table is allowed to see under their other
17 health insurance. I know that the MCOs are seen as very important for cost savings.
18 They're sometimes seen as helpful in regard to finding providers. But you know,
19 with all due respect, non-injured workers are able to find their way to doctors outside
20 of the Workers' Comp system. The Workers' Comp system involves a trade-off, but
21 workers are supposed to be guaranteed access to medical care and the services will
22 be provided. And I don't see the MCO being essential to that process. The system
23 operated fine without MCOs for many, many, many, many years. And you know, I
24 don't...

25 0:16:26: I disagree on that.

1 MR. SEMPLE: Well, I don't think it is essential to the process, and I
2 don't see it as being a huge problem when a worker is not allowed the ability to have
3 the MCO go and find them a doctor. I really chafe at the idea that an MCO is going
4 to pick one doctor out of a list of ten and say, "Here's your doctor, injured worker,
5 you know, best of luck to you." I--there needs to be choice here. There needs to be
6 an opportunity for the worker to have more than one doctor that somebody twisted
7 their arm into getting services. There needs to be at least a choice of three. I would
8 say there should probably be more of a choice, but--and I understand that some of
9 these folks are difficult to deal with. God knows I understand that. But that doesn't
10 mean that they should be limited to you know, a specific list of medical providers,
11 and then when people on that list don't want to see them, that they're not allowed off
12 that list. If those people don't want to see them and they're on the MCO list, let them
13 have a go at it outside the MCO system. What is the big deal at that point?

14 0:17:22: Well, I think maybe a little clarity of what I think Chris was
15 saying, number one, we don't twist doctors' arms.

16 MR. SEMPLE: No. I mean that phrase has been used here.

17 0:17:32: And our...

18 MR. SEMPLE: And I--and we understand that.

19 0:17:35: We simply act as an intermediary and negotiate, and perhaps
20 explain. But I think what Chris is saying, there are areas of the state where the MCO
21 may have virtually every doctor in town, and their practices are full, they're very
22 busy. There's a shortage of physicians. And so in or out of the MCO, the worker's
23 going to have a problem finding someone to treat a work-related injury, and it's
24 different than our group health. And as far as physician's willingness to treat. So I
25 think Chris's point was that in those areas, you have the MCO actually advocating

1 for the worker to help them get into the system were they on their own wouldn't be
2 able to, but because we have the legal obligation to make sure that they get care,
3 they actually end up having a benefit from that that they couldn't get on their own in
4 some parts of their state, so...

5 MR. SEMPLE: And we appreciate when the MCO can be helpful. It's
6 just that when the MCO can't...

7 0:18:35: No, I'm not...

8 MR. SEMPLE: Cannot find enough providers, then--

9 0:18:36: Yeah.

10 MR. SEMPLE: --there should be--

11 0:18:36: I'm not arguing your point.

12 MR. SEMPLE: --there should be an exit door.

13 0:18:39: And as I said, I think that there's some sense to that because
14 yes, worker's choice should be preserved when it's available. But there are times
15 when it simply isn't theirs. I mean you've got the south coast. You've only got one
16 provider down there that wants to see a worker in or out of an MCO.

17 0:18:58: It's very challenging.

18 0:18:59: I'd like to promote only because I wish I had the MCO in my
19 private health situation because as many doctors as Blue Cross Regence has on
20 their panel list, it's very difficult to get into them. It's very difficult for me to get a
21 family member in for hand surgery without having some sort of connection. So what
22 the MCO does provide are those connections that are a lot deeper rooted than your
23 private health provider. In the 26 years I've been doing this, I have never had a
24 worker who's had to go weeks without seeing a provider. And I have had to go
25 through that with my husband. So I beg to differ on that. I really do think the MCOs

1 have been an incredible tool to use in the state of Oregon, and a company that does
2 work all over the state of Oregon, it has--we've always been successful with our
3 workers, as well as a company that works nationwide and also out of country. This
4 is the best thing we have going for us in this state. So I want to point out, I think our
5 MCO's doing a tremendous job in making sure the workers get care. And
6 sometimes it may not always be the way we want it, but they really do go out of their
7 way, especially my MCO that I work with.

8 MR. BRUYNS: Jovanna?

9 0:20:17: That was not a paid announcement.

10 0:20:20: Well, maybe I was talking about Kaiser.

11 0:20:23: We don't...

12 MS. PATRICK: It's great that your workers have not had that problem
13 having to wait weeks. My claimants do. I could give you a handful of clients, current
14 clients who had to wait weeks to get into treatment, even with MCO help. I've had
15 the MCO say sure, go to this doctor. Turns out it's an urgent care clinic that they
16 can't make an appointment, they just have to go and wait. Okay. Well, they're
17 working 12 hours a day on their light duty work. How are they supposed to do that.
18 So I think, you know, there is delay that happens.

19 And I think the other thing to consider is that people who need MCO--
20 MCO help aren't necessarily bad claimants who have terrible claims and lots--

21 0:21:00: Right.

22 0:21:00: --of problems, and aren't claimants who are struggling to look
23 for doctors. The majority of my claimants who are placed on the MCO have an
24 existing doctor who's willing to treat them, they're just not in an MCO. So it's not as
25 if this person can't find a doctor, it's their treatment is getting interrupted because

1 they're being placed in an MCO, and now they can't find a doctor, now they're
2 waiting weeks. And maybe there's nothing wrong with their claim other than hey, it's
3 been open for a while or hey, it was in litigation for a year and a half, so now we're
4 trying to pick up from there. So none of those things are just because the claimant's
5 a difficult person or has a difficult, you know, medical issue. Certainly that can
6 happen, it does happen, but that's not the only reason. That's the reason I hear
7 again and again at these meetings for claimants not being able to find a doctor. And
8 I have claimants with you know, easy newly accepted claims who call, you know, 10,
9 15 people on the list and can't get anyone.

10 And I'd also mention that a huge amount of my clients are Spanish-
11 speaking only, and they call, and if the provider can't, you know, set up someone to
12 talk to them, then trying to get through to make that appointment and tell the provider
13 what they need to do for the provider to even consider them is a huge hurdle when
14 before, they were going to their doctor and getting the treatment they needed. And
15 suddenly, in seven days, they have to do something totally different.

16 MR. BRUYNS: ???

17 MS. CHAND: Fred, can I quickly add to that, please? I actually agree
18 with you. I do get a lot of phone calls at the Takacs Clinic and the other patients are
19 like, "Oh, I have had to call so many providers. The providers are not accepting new
20 work comp because my claim is in deferred. So I don't know how, you know, this is
21 happening, but patients are, you know, going through that a lot that providers are not
22 accepting work comp claims or new work comp claims. So when they call our clinic
23 they're like, "Oh, great, you know, you guys can see me."

24 MR. BRUYNS: Thank you very much, Joy. I'd like just to move along
25 to the next issue because there's a couple--or there's a telemedicine discussion that

1 we'd like to get to today, and I think maybe some people came here just for that. So
2 I'm just going to ask maybe Juerg, do you think there's any advantage of skipping
3 ahead or doing it out of sequence? Or we just should do them in order?

4 MR. KUNZ: I don't know.

5 MR. BRUYNS: Yeah. I mean, I think, Greg, that you come in in part
6 for the telemedicine discussion.

7 MR. GILBERT: Oh yeah. That's fine. I'm willing to stay as long as
8 everybody else is willing.

9 MR. BRUYNS: Well, we'll stay in sequence. I'll just try to move us
10 along rather quickly, but we don't want to give shortcut to any other--if there are
11 issues.

12 0:23:32: Fred, maybe I'll just jump in and be a little selfish here. I
13 have to leave at 4:15 because I'm doing a Meals on Wheels gig up in Portland. And
14 so the issue that I wanted to comment on is the housekeeping issue that I emailed
15 you, and we're not going to get there.

16 MR. BRUYNS: I think maybe it would only take a fairly short time if we
17 want to go there. And you'll actually say (0:24:05**??). What page is it on again,
18 which number?

19 0:24:08: I'm going to tell you it's on 26 of 31.

20 MR. BRUYNS: On 26 of 31?

21 0:24:23: Well, the language that I emailed you on is on Page 28.

22 MR. BRUYNS: Twenty-eight. Okay.

23 0:24:28: And it's the amendment to 436-010-0210(2)(b).

24 MR. BRUYNS: Correct. And you were saying that the...

25 0:24:43: I believe that language is contrary to the statute.

1 MR. BRUYNS: That the 60 days runs from the first visit on the initial
2 claim regardless of what provider type that--

3 0:24:52: That's correct.

4 MR. BRUYNS: --comes with?

5 0:24:54: That's correct.

6 MR. BRUYNS: Our understanding has always been that it's with the
7 first visit to the Type B provider that starts the 60-day clock.

8 0:25:01: That's...

9 MR. BRUYNS: But I don't know how it's commonly seen out in the
10 wide world and how it's being applied. So that's why it's important to have this
11 conversation. I don't know--I know what the patient's position is, is that the clock
12 doesn't start until the first visit at the Type B provider. But I don't know if that's the
13 universal-- I mean obviously, it's not a universal understanding, and so I'd like input
14 from the committee on what is the general understanding of the start of the clock, of
15 the 60-day clock or any other clock that is to a provider that is not providing full type
16 A services.

17 0:25:37: Well, the statute simply says first visit on the initial claim.
18 And if you add the language with any Type B provider,--

19 MR. KUNZ: But--

20 0:25:44: --you're adding language to the statute.

21 MR. KUNZ: The statute actually continues from the first visit to any
22 medical service provider listed in this subparagraph. And then in that subparagraph,
23 it lists the chiropractors, physician assistants and naturopath.

24 0:26:14: That's the interpretation we've used for--

25 MR. KUNZ: Yeah.

1 0:26:18: --a long time. Right?

2 MR. KUNZ: That...

3 MR. BRUYNS: We're always happy to talk about it, assumptions that
4 were made before.

5 0:26:27: Right. I believe when this--when we started making changes
6 to the types of providers that (0:26:35**???) that this was hashed out fairly, so there
7 was an intent, but I--off the top of my head, I can't remember what the intent was
8 because I agree, I really can't. But I remember this was vetted out extensively, so I
9 wouldn't want to put my foot in my mouth on it, so--because there was clear--I mean
10 it was confusing and I thought we clarified it. But now, listening to Ron, it--I can see
11 why she's confused.

12 0:27:10: So that's my concern. I just wanted to make sure that that
13 was...

14 MR. BRUYNS: Thanks for raising it.

15 0:27:15: That was aired.

16 MR. BRUYNS: Any additional thoughts either from the folks here in
17 the room or on the phone?

18 0:27:23: I was not part of the original discussion. I just know that
19 when we changed some of the information and what we sent out and it needed to
20 get approved by the department before it made the updates, they had us at in the
21 clause so it would say, when talking specifically about nurse practitioners, that it was
22 for that period of time after the first nurse practitioner visit on the initial claim. So it
23 was very specific that it was that type of a provider.

24 0:27:57: Because if an injured worker weren't to go to a type B
25 provider until day 50, they'd only have 10 days left.

1 0:28:05: Uh-huh (yes).

2 0:28:07: And so my understanding through that whole process was
3 that bucket isn't just oh, you get that many for a chiropractor, that many for a nurse
4 practitioner. Any of the--any visits to a Type B triggers that 60-day clock. And within
5 that 60 days from the first visit with the Type B is the time frame that was in there.
6 But I don't know what the statute is.

7 0:28:30: Yeah. That's ???.

8 0:28:32: That's the statute. Yeah.

9 0:28:34: I just don't remember where we came down.

10 0:28:38: I mean I know we just started to...

11 0:28:40: Yeah. No. I'm glad you brought it up.

12 MR. BRUYNS: Maybe I can do this and just invite you all to look in the
13 definitions section of Chapter 656, the workers' compensation law. And just to see,
14 if you read that definition and you have an interpretation that you'd like to share with
15 us, just send it to my email address and I will certainly--I'll take a hard look at it. So
16 thank you very much.

17 0:29:12: Ron, you came just to confuse us all today.

18 MR. ATWOOD: That's a lawyer's job. We live in a world of ambiguity.

19 MR. BRUYNS: Then we're on Issue Number 10. A stakeholder stated
20 that many providers, especially physical therapists, are accustomed to getting pre-
21 authorization in other insurance situations and often refuse to treat without pre-
22 authorization. Because it is not required that the insurer respond to a request for
23 pre-authorization, the worker sits in limbo, unable to get treatment, because the PT
24 clinic cannot get what they think they need to proceed forward.

25 So this causes Interruptions or delays in treatment that a worker

1 receives and may delay or (0:29:54**???) delay recovery from an injury. Therefore,
2 it may be beneficial to all parties to reduce or avoid delays in treatment, including
3 ancillary services such as physical therapy or occupational therapy, acupuncture, et
4 cetera.

5 Some years ago, the Division received a request to create a provision
6 for pre-authorization of diagnostic imaging studies. Since 2014, Division 010 rules
7 contain a provision that allows a medical provider to contact the insurer in writing for
8 pre-authorization of diagnostic imaging studies and requires the insurer to respond
9 in writing to the provider's request. A provider--a provision to require an insurer to
10 respond to a pre-authorization request may lead to an increase in litigation.

11 And so the options would be create a provision in new section (g),
12 subsection (g) in Rule 230, Section (7) that allows ancillary providers to request pre-
13 authorization and requires insurers to respond to such requests similarly to the
14 provision for diagnostic imaging studies. So you can see the draft wording there.
15 Unless otherwise provided by an MCO, an ancillary medical service provider may
16 contact an insurer in writing for pre-authorization of ancillary services. The insurer
17 must respond to the provider's request in writing whether the service is pre-
18 authorized or not pre-authorized within 14 days of receipt of the request. And the
19 other minor change to Section (3). So with that, I'd like to open it up for your
20 thoughts and input.

21 MR. SEMPLE: This is Keith. I've been to many of these meetings,
22 several of these medical services meetings over the years in which OTLA has
23 proposed a preauthorization requirement across the board for medical services
24 because we recognize that doctors are accustomed to being able to get a yes or no.
25 I believe from my understanding, and I don't mean to speak for providers here.

1 Obviously, you're much more accustomed to doing this. But my understanding is
2 providers are accustomed to getting a yes or no before providing services, and that
3 option isn't available for a large range of most services actually under Workers'
4 Comp. We've got an elective surgery rule. After a couple years of coming back to
5 these meetings, we now finally have a requirement for diagnostic imaging other than
6 x-rays. So it seems to me like there's a growing recognition that providers see this
7 to be a hassle and a barrier to wanting to be involved in Workers' Comp, but yet
8 we're still only talking here I think about physical therapy.

9 There was a case that came out recently in 2017 at 22 CCHR 56. The
10 case is Mataam Al Dosari (phonetic). And I'm sure I'm mispronouncing that, but it
11 basically is a--codifies the fact or decides the fact that this preauthorization outside
12 of what's specifically required in the rules is just a case-by-case decision. And in
13 this case, the litigant had to go through MRT and then had to appeal that, and then
14 finally got an order saying that no, there was an obligation on the part of the insurer
15 to preauthorize the services if necessary to cause those to be provided.

16 I would really, really like to see some sort of preauthorization guideline
17 requirement that applies across the board whether it's an insurer or an MCO that
18 gives some timelines as to what has to be provided and when. You know, it's
19 frustrating. And not to pick again on MCOs, but it's frustrating to have the whole
20 MCO review process and then have yet another review, later review when it gets to
21 the insurer, and still potentially not be able to get a firm yes or no if it's not on the list
22 of specific things that have to be preauthorized.

23 So I really wish we could kind of stop the cat and mouse and just have
24 an across-the-board requirement where if a provider needs preauthorization and
25 requests it, then they can get it, get a yes or no. I don't see what's so difficult about

1 a yes or no. We could have it be the same as the elective surgery requirements
2 where they can have a third option which is yes, no or we want an IME. Fine, if that
3 needs to be part of the process. But we'd really like to see this applied for all the
4 providers. So that's our piece on that.

5 MR. BRUYNS: Thank you, Keith. Additional-- Dr. Miller?

6 MR. MILLER: So in the case that this person comes in under
7 chiropractic and under our license when we do our physical therapy, do we now
8 have to stop, you know, what we're going to do and what--you know, determine
9 physical therapy? Is it just the ancillary provider part? Is that what we're talking
10 about or is that for the service itself regardless of the provider?

11 MS. PATRICK: From what I understood is that this isn't a
12 requirement--

13 0:34:48: Right.

14 MS. PATRICK: --that everything has to be preauthorized. It's more of
15 a situation where the provider feels that they need some sort of affirmative answer
16 from the insurer before they're willing to go forward, but the insurer has to respond.
17 Because I get calls from physical therapy places, you know, every couple--you
18 know, a couple times a month where they say, "Well, we haven't gotten the
19 preauthorizations, so we can't do--we can't start treatment." And I had to explain the
20 process where they don't really get it, or you know, that you don't need the
21 preauthorization. And usually, I'm just told, "Well, we're just going to wait until the
22 preauthorization."

23 And so what happens in those situations, I mean if the provider is
24 comfortable going forward with the referral from the doctor and following the rules as
25 they are now, then there's no need for a change there. But if the provider feels they

1 need a response from the insurer before going forward and they don't get one
2 because the insurer is not required to give them information, then that claimant sits
3 in limbo and there's no way to bring that up to MRT rather than--other than the way it
4 was done in this case where this--it took years for this person to get a decision, and
5 it was not clear what needed to be done. A case-by-case basis is not helpful in
6 getting that person in right away.

7 And what I would also say is that there's two kind of phone calls I get
8 from physical therapy. One is from the therapist asking for preauthorization. The
9 other is usually a convoluted phone tag sort of game where claimant calls me and
10 says, "Oh, the PT was cancelled. The insurance company cancelled my PT." And
11 when I get down to it, what may have happened is there was a phone conversation
12 between the physical therapy place and the adjuster where maybe the adjuster said,
13 "We're going to do an IME" or "We're not going to pay for any more treatment" or
14 things like that that happen behind the scenes and nobody knows about it, and then
15 trying to get it out to MRT to get a decision is nearly impossible. So some sort of
16 structured way where if you want a preauthorization, you request it and there's a
17 time frame to respond in writing that everyone sees. That way if we need to litigate
18 it, a litigation will be without all the delay and without, you know, the Division trying to
19 craft a remedy without the rules to back it up.

20 0:36:53: And not providing a requirement that if you don't get
21 preauthorization, you're not going to get paid, which is where you were coming from.

22 0:37:01: All right. Because I thought Keith was saying, you know, we'll
23 just do it across the board and everybody has to have it. And I'm like, well, wait a
24 minute.

25 MR. SEMPLE: No. We're trying to find a way to make sure that

1 providers can get what they need when they need it so that this doesn't present a
2 hassle factor. I mean we--we're all familiar with the term hassle factors. We saw a
3 very nice study that was done on it several years ago, and this was on the list. And
4 there's been further conversations that our Workers' Comp Section Access to
5 Justice Committee had had with providers where this has been identified as a major
6 issue. I've had it many, many times with clients and it's like well, I can't force them
7 to say yes or no. This just isn't on the list of things I--we can go through this process
8 with the MRT. I'm looking at this order that I was just discussing. The services were
9 requested June 21, 2016 in the final order saying yes or no, something had to
10 happen regardless of what happened in the interim was May 2017. So we're talking
11 about an entire year if nobody had done anything for us to get a yes, you do have to
12 say yes or no and cause these services to be provided. I mean that's just
13 unacceptable. And this was in the context of a physical therapy. It makes me
14 wonder if the proposals may be tied to this specific case. But it seems like it should
15 apply for any provider who wants it.

16 MR. BRUYNS: Ashley, do you have anything?

17 MS. WILLARD: So I can say from Travelers experience with
18 authorization and not authorizing, it really comes down to the physical therapy
19 themselves not getting the appropriate authorization or signature from the attending
20 physician. We find that a lot. So them not--the physical therapy not following the
21 rules with regards to what they need to provide to us, the frequency, the duration,
22 having the attending physician sign off on it, in order for us to be able to approve it,
23 that for us creates a lot of delay for us to be able to say yes on the treatment.

24 So this rule doesn't specifically address, do they need to follow those
25 steps in order for us to have that response within the 14 days? A lot of the times

1 why we can't respond is because they haven't followed the rules regarding what is
2 needed for us to be able to approve it.

3 MS. PATRICK: Wouldn't the MCOs have a solution to that? Which is
4 that I get MCO decisions all the time on PT that says we're unable to precertify at
5 this point because, and then it tells you why. And if it's me and I got that and oh, the
6 doctor hasn't done that? Let me call the doctor's office. They'll say, "Hey, this is
7 why it's not going through." So I think our concept is more that you know, those
8 problems that you're having with the insurance company on it aren't presented in a
9 way that everyone involved knows what the issue is and can do something about it.

10 0:39:46: Well, that's--this is from-- Travelers doesn't do MCOs, so we
11 don't have MCOs working with us to get that information out. So it's the 100 percent
12 responsibility on the claims adjuster to authorize or not authorize every single
13 treatment that comes in.

14 0:40:02: And...

15 0:40:02: So that does make a difference when you know, there is a
16 14-day requirement, but if they don't have the necessary information that we need
17 based on the rules to authorize or not authorize, we would then have to go back and
18 say, "No, you didn't do what you needed to do in order for us to authorize it."

19 The secondary piece, Keith, you were indicating that they could go to--
20 or there would be some sort of process as to appealing the decision if, you know, as
21 a secondary or expansion to this. If they didn't follow the necessary steps and then
22 we told them no, they then appeal it, but it's because they didn't follow the necessary
23 actions if they needed to date, then I just don't know how that would shake out.

24 0:40:45: And to echo your comments, we ask our adjusters too, and
25 along with that, another problem is during the deferred period of the claim, you're not

1 going to get an authorization one way or the other. And so I think this is just going to
2 create a lot of paperwork where the adjuster is going to have to stop what they're
3 doing and say, "Okay. I'm not going to preauthorize this because the claim's
4 deferred." And that's not getting to where you want to be of the service being
5 provided which is, if it doesn't appear that the claim's not compensable, provide the
6 service because 85 percent of the time, the claim's accepted and there's not an
7 issue. But it's--yeah, it's getting physical therapists to take, I don't want to say that
8 leap of faith, but understanding that let the process work, provide the service, submit
9 the bill, the billing will be paid. And that's the conversation that we have with the
10 physical therapists a lot is, well, the person fell down on the job. We're not really
11 questioning compensability, but we still need to follow up on this information. We're
12 hoping to make a decision in this amount of time but we don't see anything that
13 would lead us to believe that the claim's not compensable, which is our nice way of
14 saying provide the treatment because we're going to pay for it. But until we accept
15 the claim, we're not going to guarantee payment.

16 0:42:09: We understand that. We're not talking about the deferred
17 period of the claim. We're talking about accepted claims where workers and I--you
18 know, to SAIF's credit, I think SAIF tends to give the doctors a lot more clarity. They
19 do use an MCO. We get the MCO letters. I think SAIF is willing to tell a doctor in
20 advance, yes, you know, you want to know whether we'll pay for it? Yes, we'll pay
21 for it. We don't have that experience across the board, and some providers find it
22 very difficult to get just a plain yes or no, and writing that can be appealed. I mean
23 this whole system is generated--is driven by writing and deadlines and appeal
24 deadlines and things like that. How can a worker just have no ability to even get
25 something that they can contest? Just no answer, no answer, no answer.

1 And then they have to take it through a process where they have to
2 show that the lack of agreement or disagreement was a barrier to their medical
3 treatment. I mean, that--then they have to show--and then sometimes it's not seen
4 as a barrier. Well, in this particular case, the department said well, we'll make a
5 phone call and we'll make this happen. Okay. Well, but that's not the point. The
6 point is it presented a barrier to treatment while that process was taking its time. So
7 I think that's our concern is not--you know, I mean there can be limitations on what
8 we're suggesting should be in this preauthorization rule, including that it doesn't
9 apply to claims that aren't accepted. But there should still be an ability to get a yes
10 or no, and it doesn't have to be just a yes or no. It could be a you haven't done this
11 and--

12 0:43:34: Right.

13 0:43:34: --we'll reevaluate it if that still needs to be done. I mean
14 normally, I would envision if the procedure hadn't been required and we said, hey,
15 no, hey, they said no, department, we want you guys to review this, they would look
16 at it and they'd say, well, you didn't do--you didn't follow the rule of the statute. You
17 didn't provide the treatment plan. Of course they disapproved it. That was
18 appropriate, back to square one. So you know, I envision that there would still be a
19 way to kind of get to that place where the information hasn't been provided. And at
20 least if it's transparent, then we can all move forward kind of towards the same goal
21 of getting it unsorted. But if it's not clear to anybody, that's where it's really
22 challenging for us, for our workers.

23 0:44:16: Isn't this why-- Just I'm trying to remember, isn't this one of
24 the reasons why we have it, so that workers are providing, if they have it, their
25 underlying medical coverage in case at some point in time, care is denied?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MS. PATRICK: You would need a denial to--

0:44:33: Sure.

MS. PATRICK: --for your private health insurance.

0:44:36: Sure.

MS. PATRICK: And I think relying on claimants to have private health insurance is--I mean we all hope that they do but a lot of them don't. And I also know many--I've heard from providers who are pretty significant providers that even with private health insurance, they're not willing to treat the patient using their private health insurance because they can't go back and charge the claimant for the co-pays and the deductibles until the claim is over, so...

0:45:03: Sheri, what you're talking about is interim--

0:45:04: Yeah.

0:45:05: --medical prior to the denial?

0:45:07: Yeah.

0:45:08: And you're right. Medical providers are still really hesitant to take...

0:45:11: Okay. I was just curious.

0:45:12: It takes a lot of conversation with them. There's no guarantee of payment, that their private health is going to pay. But to me, it's a really big education curve with the providers being willing to go, "Oh, okay. If I go ahead and provide the services, I'm not going to get paid by anybody. But if I check all the boxes I need for their health insurance and check all the boxes I need for Workers' Comp, eventually down the road, I'll get paid by somebody.

MR. BRUYNS: Diana?

MS. GODWIN: The problem is, and I looked at this extensively after

1 we amended the interim medical benefits statute, today's health plans may have
2 literally \$2500 or in some cases \$5000 deductible. And so now, it's going to be that
3 the--that deductible will apply.

4 0:46:00: Yeah.

5 MS. GODWIN: It didn't used to before we made those amendments to
6 be in our medical benefits statute. And this is a real problem. Care can be
7 completed and then you find out the claim is not accepted. You go back to that
8 worker, who's complete with his care and say, "Oh, by the way, you know, here's
9 \$1000 or \$1200 or \$1500 bill that's under your deductible. Good luck with that."
10 And that makes it very difficult for a physical therapist to decide in an unaccepted
11 claim, the claim is still in deferment. You know, even if that worker has some form of
12 health insurance, it's going to be a real problem. And they just wind up treating for
13 free. And that's a real problem with you know (0:46:43**???) our medical benefits
14 statute.

15 MR. BRUYNS: Ben?

16 MR. BARNES: Yeah. I would say the point that they both bring up is
17 definitely true. If there's anything that we can do to clear up the ambiguity on when
18 we start care as soon as we can start care, certainly, I don't know how that process
19 would lay out, but certainly, because there is a lot of confusion and stuff out there,
20 and to the point of private insurance, most of the time workers don't even want to
21 supply their private insurance because it's a work injury. Even if they request it,
22 they're usually very, very...

23 MR. MARTINEZ: Hey, Fred. Fred, this is Joe. If you recall in the past,
24 I recommended that they--that the Division consider something that the state of
25 California does out here is that they--that providers, to get some protection, be paid

1 to a limit of let's say \$5000 or \$10,000 up until such time as the claim is accepted or
2 denied by the carrier, because then at that point in time it gives everybody an idea or
3 a time frame in which they need to act, and then protects providers from having to
4 absorb losses that we've discussed in the past. I think it's just something the
5 Division should give some consideration going forward to.

6 MR. BRUYNS: Thank you, Joe.

7 MR. GIFFORD: I think it's more private health payers have adopted
8 their own prior authorization, so we used to always get the health benefits as the
9 backup, but now we have to manage two prior authorization processes to ensure
10 payment. The only thing for a provider that's worse than a--I mean the thing that's
11 worse than a patient not showing is just not--is providing the service and not getting
12 paid. So I think from a PT standpoint, that's the reality of the environment now that
13 you have Evicor and other prior authorization and utilization management's systems
14 in the market. So having that as a backup is not a sure thing.

15 MR. BRUYNS: Thank you, Todd. You had your hand up?

16 0:48:36: Just wanted to comment. If in fact something like this
17 proposed rule is adopted, I think it should apply perhaps only to accepted claims and
18 also say that the insurer cannot mandate prior authorization because then we're
19 really in a mess with several systems of prior authorization. So it should always be
20 the provider's choice--

21 MR. BRUYNS: Right.

22 0:49:00: --as to whether or not they want to utilize the prior
23 authorization in an accepted claim.

24 MR. BRUYNS: There's no intent to set up that kind of system. Thank
25 you very much. Excellent conversation. And we will do the best we can with the

1 information provided.

2 Issue Number 11 regarding elective surgery. Chart notes may not be
3 clear enough to identify that there is an actual request for elective surgery. Some
4 background. Rule 250 in Division 10 requires that a provider must give the insurer
5 at least seven days' notice before the date of the proposed elective surgery.
6 Actually, I kind of summarized this in terms of the reliance on chart notes versus
7 something more tangible. We have a recommendation noted down in the second to
8 the last bullet. One stakeholder noted that "a lot of frustration and work could be
9 saved if there were a simple form for providers to submit making it very clear that it
10 is a request for approval of surgery."

11 Also, generally, insurers receive chart notes with the provider billings.
12 Since insurers have 45 days to pay or deny a provider's charges, an insurer may not
13 analyze a chart note within the seven days that's required to respond to an elective
14 surgery request.

15 So this is a lot of options. To create an elective surgery form that
16 providers must use when giving seven days' notice to the insurer. Create an
17 elective surgery form that providers may use when giving seven days' notice to the
18 insurer, but allow the providers to use their own form if it contains the necessary
19 information. So that's just whether the Division would mandate a specific form or
20 just allow use of a (0:50:42**??) form. Remove the provision about a chart note
21 being considered "notice" in the rule. Or make, you know, some other possibility or
22 make no changes.

23 So we'd like your input on the--I guess either the kind of a soft
24 requirement to require use of form, that could be ours or the provider's forms, or a
25 slightly harder requirement to actually mandate the Division-created form for elective

1 surgery. Your thoughts?

2 0:51:19: Just send us another form. Just...

3 MR. BRUYNS: Well, if it would solve the problem of say chart notes
4 not being noticed ending up on file, awaiting payment of the bill, and that--I guess
5 that's the intent of perhaps solving the problem. If it's not a problem that needs to be
6 solved or they won't solve that problem, then we don't want to go there. But if it
7 would solve a problem that exists, then it's maybe something to consider.

8 0:51:47: I would be more concerned with they may use the form
9 because then it's like okay, is it in a chart note? Is it in a form? Is it someplace
10 else? And not saying the form's good or bad because we hear hassle about we
11 have too many forms, let's consolidate. Now we're having another form back in for a
12 specific use. But as an adjuster, to know okay, now I have to read all the chart notes
13 and now I have to look for this form because it may be either one of those, I think it's
14 more apt to get mixed.

15 MR. KUNZ: I think that's the problem. Like that's the current situation.
16 If the provider has a surgery form that they sent to you, you're going to have to react
17 within seven days.

18 0:52:35: Yes.

19 MR. KUNZ: If they don't have a form, they can put something in the
20 chart notes and you still have to respond in seven days. And the problem with the
21 chart note is that they--the chart notes come with the billing and you have 45 days to
22 pay the bills. And so the--your surgery request may get lost in that time frame and
23 because you're bound by the seven day to respond, that's really what we're trying to
24 potentially avert here.

25 0:53:10: I mean given that, I'd rather have it be the must. But for

1 those folks that are leaving their chart notes or required forms attached to the billing
2 and sending it off to have it audited before it gets to the adjuster, it's not going to
3 solve that problem of not reading the chart note because it's someplace else. If it's
4 scanned or if it's detached or a second copy's made immediately and routed to the
5 file, then the adjuster's more apt to see that. So I'd like to hear other insurers, but I
6 would rather--just looking at this, rather have it be a must use the form so at least we
7 know hey, we need to focus on that form that's mandated by the state, then it may
8 be in any of these places.

9 MS. KLEIN: Well, and even I mean the must-use this form, I think is a
10 better solution if that's the way to go, the direction you end up going, because then
11 it's a very--that triggers. When you see that specific heading, you know, "Oh, that's--
12 I'm looking at that thing," whereas if you have--you have to use a form but it can be
13 your form or the state-mandated form, while different providers have different
14 templates of how they use things and some are going to be more obviously that
15 elective surgery form and others not. So if you're going to go that route, I think the--
16 this specific form so it flags and the adjuster gets more of a trigger of "this is what I'm
17 looking at."

18 MS. WILLARD: I would say, I mean we see it both ways. I think where
19 it is confusing is the chart note. I just saw a case a few days ago where it said going
20 to request surgery in the chart note but it didn't meet any of the other requirements.
21 So you're like okay, is this--do I need to do something with this? Do I not need to do
22 something with it? And that is that--I can't talk today, that's the frustration that we
23 encounter.

24 So I mean for me, I don't think you have to have a specific form. I think
25 that--I mean I can speak probably for a lot of providers that having to have a specific

1 form is going to create more hassle on their part. We get it on fax cover sheets
2 requesting surgery, CPT code, blah, blah, blah, blah, this facility. That's perfectly
3 fine. As long as it meets what we need in order to move forward with it, I think that
4 that would be fine. It just can't--for me, I don't think it should be in a chart note. It
5 should be on a fax cover sheet or a separate paper, or a form of some sort.

6 MR. BRUYNS: Thank you, Ashley. That was an excellent
7 conversation. Is there additional thoughts, anything (0:55:54**???)?

8 With that, if we move along to Issue Number 12. This is really an issue
9 of not raising expectations that someone can appeal or not appeal. So this affects
10 Rule 290 in Division 10. The rules that were effective 4/1/2018 appear to allow a
11 palliative care provider to appeal an insurer's palliative care disapproval to the
12 director. However, the statute only provides for the worker or the attending
13 physician to appeal to the director.

14 Prior to the 4/1/2018 rule revisions, insurers were required to send a
15 palliative care approval or disapproval to the worker, the worker's attorney, and the
16 attending physician. Since 4/1/18, insurers are required also to send the notice to
17 the provider who will provide the care.

18 So it shows the wording that is there now. And one option shown
19 below would actually be to explain which parties may appeal. So it would modify the
20 appeal language required as follows. And so instead of just notice to all parties, it
21 would specify who those parties are; that is the worker, worker's attorney, and
22 attending physician. So those are the appeal rights that would be provided.

23 And with that, your thoughts? Diana?

24 MS. GODWIN: Well, you know, Work Comp Division can't solve this
25 because it's in the statute, it's limited to those. But of course, physical therapists are

1 going to be often the provider of choice before palliative care. So this is--we can't do
2 anything about it. And I certainly understand why WCD is wanting to make it clearer
3 to conform to the statute. I get that. It's just I--if we have a problem, we have to go
4 back to the legislature and say, "How about allowing the provider to be able to
5 appeal this?" Because trying to get a physician who has authorized the palliative
6 care to be provided by the physical therapist, and then if there's a denial and not
7 allowing the physical therapist to appeal, but requiring the physician to appeal, the
8 physician often has no financial skin in that game because--

9 MR. BRUYNS: Right.

10 MS. GODWIN: --he or she is not providing that palliative care.

11 MR. BRUYNS: Correct.

12 MS. GODWIN: So that's--I mean you know, okay.

13 MR. BRUYNS: Thank you, Diana.

14 0:58:33: Oh, I must have been reading and moving my lips.

15 MR. BRUYNS: Additional thoughts? If not, I'll move along to
16 (0:58:49**???) Issue Number 13. I won't read all of this again. I hope you've had a
17 chance to review it. But the issue is telemedicine services are allowed under
18 Oregon Workers' Compensation rules and regulations. However, there are currently
19 no rules specifically addressing telemedicine.

20 So telemedicine involves two locations, obviously, the originating site
21 where the worker-- We're picking up a lot of background noises on the phone, so I
22 would just encourage you to mute if you have background noises in your office at
23 this time.

24 0:59:26: Can you speak up a little? I can't hear you.

25 MR. BRUYNS: Okay. I will put the microphone--

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

0:59:30: Thank you.

MR. BRUYNS: --closer to my voice. Thanks. So there's obviously the original site and a distant location. This is--really, the purpose of this is to get input from you in terms of what's happening, what's working and what's not working. We don't know if there will be any changes to the rules in the near term with regard to telemedicine, but there may be a need for rules if not now, then in the future. And so you know, one of the options listed is to add telemedicine regulations to Division 9 or the 10 rules, that's the medical payment rules or the medical services rules. We don't know if that's appropriate or needed. We certainly don't want to (1:00:16**???) to consider should there be recommendation where a telemedicine service may be provided.

For example, may the very first visit to a healthcare provider, such as when the 827 is signed as first report of injury, be a telemedicine visit? Should a worker be required to be seen in person by a provider at least once every 30 days or some other periodic time? Can a closing exam be performed via telemedicine?

Should services be limited to Oregon providers? Should the originating site be limited, similarly to CMS's restrictions? Should the distant site practitioner be limited to certain provider types? Should the services eligible for telemedicine be restricted to specific CPT and HCPCS codes?

Should telemedicine services be limited to interactive audio and video communication systems that allow real-time communication between the distant site practitioner and the patient? As opposed to asynchronous "store and forward" technologies?

Additionally, the committee may consider some regulation around billing and payment issues. Should the originating site have to use HCPCS code

1 Q3014 to bill for the facility fee? Division 009 rules, contain a provision that would
2 allow--that requires distant site providers to use Place of Service code "02"? State
3 that services by the distant site provider are payable at the facility rate? Obviously,
4 those are other possibilities that we need to consider.

5 (1:01:49**???) I didn't go through the CMS restrictions, but there are
6 some and some of you are probably familiar with those. And I'd just appreciate your
7 input on any of these things that I've listed. (1:02:02**???) considered one at a time
8 or if you've had a chance to think about them, we'd appreciate your thoughts. It is
9 the first time that I'm aware of that we've even had a conversation with stakeholders
10 regarding this. So (1:02:17**???).

11 MR. GILBERT: So we have lots of thoughts. This is Greg Gilbert with
12 Concentra. Yes, we're doing this and Ann Schnure is on the phone who runs this
13 nationwide for us. We've been doing this two years nationwide and probably about
14 three plus states ????. All these questions are really great questions and we have
15 answers to all of them, and we've seen different states take different approaches.
16 Some states even basically do nothing but follow the group guidelines. Some
17 states have simply made changes to their fee schedules to allow for place of service
18 code 02 and a modifier 95. And other than that, done very little.

19 If you have a state that requires a wet signature on a form, that creates
20 problems, and you have to pass that to be able to do telemedicine. But most of
21 these things are pretty straightforward and things that we see are happening like I
22 said nationwide. I think today, we see about 1000 visits in California a month in
23 telemedicine, and there are no regulations yet in California for telemedicine. So
24 (1:03:36**???) looking at promulgating rules coming up in 2019.

25 Texas followed I like to say all Medicare, all the time, which is similar to

1 some of the questions you have here. That creates really one of the biggest issues
2 and a barrier to telemedicine and the way the industry and the marketplace wants it
3 today. And that is it requires telemedicine to be done in an urban rural setting with
4 the originating site (1:04:02**???) . And really, telemedicine today that we're doing is
5 not in that setting for the most part, although you'll still find that. It's really happening
6 at the employer work site and a local physician who's there in that town.

7 And so Texas recognized that in order to make this work and with what
8 their employers and payers are willing to do in the state of Texas, made changes to
9 the regulation to remove the originating side language over Medicare. That's one of
10 the major questions that you have there. So basically, (1:04:36**???) be done in
11 any fashion.

12 Then you have deal with originating sites. There's going to be some
13 scenarios where that happens. As long as it meets the criteria that you laid out, then
14 it should be fine. When it's not done in that criteria (1:04:47**???) telemedicine. So
15 that's one of the big issues that you see. One of the things you talked about is have
16 you--one of the benefits of telemedicine in group health is you'll have physicians
17 from all over the country that may be licensed in your state, but they can be sitting in
18 New Jersey doing the telemedicine visit. All right. And so you'll want to have a
19 regulation that allows for licensed providers, no matter where they reside, to be able
20 to do telemedicine in that environment.

21 And then one of the other big issues you mentioned here was talking
22 about, well, should visits be required every 30 days? Frankly, most of these claims
23 are going to be very low acuity type situations. There's probably going to be only
24 one visit. Sometimes you may have a reject. Sometimes we're finding employers
25 like telemedicine for the patient who came in (1:05:43**???) but didn't need to come

1 back to the clinic and leave the office or have transportation issues, et cetera, or
2 missed an appointment and did the recheck visit in a telemedicine setting. We're
3 seeing (1:05:56**???)

4 The other big issue we have to address that's not laid out is AMA and
5 Medicare have different code sets, CPT code sets in which they say we approve
6 your telemedicine. What we're hearing today is one of the things that's absent in
7 both of those code sets are telerehab codes or PT codes. So there's a small subset
8 of codes that are being used today in telerehab. And so we're advising states that
9 you may want to look at those CPT codes to see that that's an available option.

10 So I think it all--I mean, and you're just discussing it today. I think a lot
11 of these things people probably have to go back and chew on. But it is of great
12 interest from what I gather today, has a place and time to be done. A good question
13 we get all the time is--from state is, well, are we forcing those patients to go and get
14 telemedicine. No, it's also an option for the patient to decide whether they want--if
15 it's a telemedicine-enabled visit, to do telemedicine. And what we're finding is from
16 a satisfaction certainly standpoint, it's much higher than when they come to our
17 bricks and mortar. It's typically 95 percent plus satisfaction. They love it. And even
18 when we see something that's a problem, it's usually just a miscommunication issue.

19 So that's kind of our experience of what we're seeing. We follow the
20 exact same process that we do in bricks and mortar. If the state has a state form,
21 we do that. We use our same EMR. Everything is exactly the same with the
22 exception of using those modifiers that I mentioned. We provide them the place of
23 service code so the payer knows that that's a telemedicine visit. So...

24 MR. BRUYNS: Thank you. That's wonderful information, Greg. You
25 said--I won't get too far into the weeds, but you said a lot of these visits are actually

1 from an employer's site?

2 MR. GILBERT: Can be, yes.

3 MR. BRUYNS: Okay.

4 MR. GILBERT: Yeah. Some employers will actually set up a room
5 where that they can go in a secure room and do that. Some of them will use their
6 phone at home. They can go through all kind of avenues. Usually, we're getting
7 typically our telemedicine visits through the carrier nurse triage program but not
8 always. And that's the way everything's funneled in. There's a triage that's done
9 there, then we do a triage to make sure it's eligible for telemedicine visit. If not, we
10 just--when they see the doctor, there's no charge. They see the doctor, says you
11 need to go to a bricks and mortar.

12 MR. BRUYNS: The employer site actually raises some flags for us in
13 terms of direction of care ????. Maybe ???, you know, which physician that they
14 would actually...

15 1:08:23: It's always a choice.

16 1:08:24: Always a choice.

17 1:08:26: From the very beginning.

18 MR. BRUYNS: Okay.

19 1:08:29: Fred, we are doing this. We're doing it in Washington as a
20 pilot project. And we've done a couple visits down in Oregon with one provider, and
21 it is definitely a choice. And actually, what we found, it's--we're using--we also use
22 triage services through AMR, Medex, Metro, and then down in Eugene, Cascade
23 Mobile Health Solutions, I think. So we've actually been trying to see, and it's really
24 in the early stages, I had reached out to the MCO to get information. It's like, can we
25 even do this?

1 So we have a workforce that strongly does not want to leave the
2 jobsite ever for anything which is ridiculous when they do get hurt. So it's almost--
3 seriously, you almost have to drag them off the site because they--you know, they
4 just don't want to leave the jobsite. So it's--there are those workers who love
5 telemedicine. There's those workers who want to be--have the touchy feely. And I
6 agree with Greg, what we do is we try to determine--the doctor determines whether
7 they actually are a candidate for telemedicine or do they need to go off site.

8 So in Oregon, I think everybody has ended up going off site. And what
9 it does is it validates not just the EMT who thinks they have to go off site but also
10 the--now you have a doctor just saying you really need to go off site. So it's even
11 easier in that sense, but it's definitely a choice. So I want to be clear about that
12 because we are doing everything we can to reinforce everybody has a choice for
13 care.

14 In Washington, it's a little bit different. The workers up there have
15 embraced it. And I think it's because there's more--there's different types, like on-
16 site health services, there's different companies that are coming in and branding
17 themselves as providers that can help reduce some-- I know, I know. You all know
18 what I'm going to say. Recording mechanisms, which is so out of my realm, so I
19 refuse to use those as far as recordable injuries. There's a lot of companies that are
20 branding themselves as that. That is not with the Concentra product because I put
21 the Concentra--it used to be U.S. HealthWorks in Washington, and what they're
22 wanting to do as--and they're nationwide so it's great to have access to workers and
23 to have that positive reinforcement if they do need to go off site. If you are working
24 in an industry where you have a lot of headstrong people that don't want to leave.

25 So I welcome guidance as to what this should look like because I think

1 it helps to solve some of the issues with access to care. And again, we have a huge
2 iPad. We have a first aid kit that the doctor has provided with all of the elements that
3 need to be in that first aid kit. So if the doctor wants the worker to have ibuprofen or
4 whatever, they have access to the medical packs. And that is completely up to the
5 worker and the doctor. And they send the worker an email or a picture of what--you
6 know, if there's anything they want them to do. Or in addition, if there's like light duty
7 and if they want them to go off site for additional care and follow the bricks and
8 mortar.

9 So Washington is watching us closely as to what we're doing up there
10 because they want to embrace that because there is an access to care issue in the
11 state of Washington too as there is in other states. So ours is in the infancy. But I
12 think it would be helpful because there isn't a lot of clarification other than yes, you
13 can do telemedicine, but beyond that, it really wasn't any real clarification. So I think
14 it would be great to have a group work on that if that's possible.

15 MR. BRUYNS: Thank you very much, Sheri. Excellent information.
16 Additional folks around the table who had experience with it or (1:12:26**???)? Dr.
17 Miller?

18 DR. MILLER: So I don't have experience with it. I'm old now. I use
19 my phone to call people. So I was never taught an exam procedure that I can do
20 from a visit that I'm not touching, palpating, measuring, observing. So I don't know
21 how a telemedicine visit works. But I do know that you know, if a patient comes into
22 my office and they say, "Well, I was, you know, involved in this mechanism but I
23 don't feel any problems, my mom brought me in," this is a specific example. And so
24 did the history, no complaints. Did the exam and there was a little bit of findings and
25 did x-rays and she had surgery that night. But she had no complaints.

1 And so without doing that exam and without understanding some of
2 that, we can get this precursory triage to say, "Oh, well, this person doesn't need
3 anything," because I didn't witness anything on my cell phone that made them look
4 like they were limited, and they said that they didn't have any pain even though, you
5 know, for whatever reason, they may be extremely limited. And so one of the
6 questions is, can this be done on a closing exam? Well, how are you going to
7 know? Right. And so--okay, well, that was the question.

8 1:13:44: It's a very limited scope.

9 DR. MILLER: It wasn't my question.

10 1:13:46: It's a very limited scope.

11 1:13:47: Yeah. Very limited.

12 DR. MILLER: All right.

13 1:13:47: So we had similar questions with 5000 different--

14 DR. MILLER: Right. And so I just don't know.

15 1:13:49: --primary care providers and it was double that physical
16 therapists. So you obviously know we would have those kind of things. Lisa Anne,
17 can you talk a little bit about that? Are you still on? About how that affects how you
18 look at what the acuity of the injuries that come in and--

19 MS. BICKFORD: Yes.

20 1:14:05: --other situations?

21 MS. BICKFORD: Yes. Yeah. I just took myself off mute. Yes. We
22 believe that for a first visit, it should be just a grade 1 and 2 injury and any question
23 about any issue, even if we can't see... We've had examples where somebody said
24 their knee hurt and they had on really tight jeans and they couldn't pull their jeans up
25 to see their knees, and we sent them out because they weren't--they didn't have an

1 ability to change clothes and be able to see it. So these are for--for initial injuries,
2 these are the grade 1 and 2 injuries. We call them just the level above self-care.
3 And that has worked really well. Most of our visits come from nurse triage, and they
4 get it right most of the time, the people coming to us. But if there's any question
5 about the severity of the injury or if the person's complaints of pain don't match the
6 injury, anything like that.

7 And we do what's called a patient self-guided injury. So say someone
8 has a sprained wrist. We'll look at both wrists, see that one's more swollen than the
9 other. We'll have them touch the trigger points and do the motion. I'm not a doctor,
10 I'll probably use the terms wrong, and determine if there's any issue there and...

11 MR. BRUYNS: Hello?

12 MS. BICKFORD: And yeah, and that's worked really well. And
13 usually, patients that start in telemedicine choose to stay. They really like the care
14 option and like the no hassle of not having to go out for care. And--but like I said,
15 anything that has any severity to it gets referred out to bricks and mortar. Or if any
16 doubt, we've taken a very conservative approach and it's worked really well.

17 MR. BRUYNS: Thank you very much.

18 1:15:52: When they talk about triage, are the triage nurses actually
19 seeing the workers?

20 1:15:56: No.

21 1:15:58: No.

22 MS. BICKFORD: Visually seeing them?

23 1:16:00: Yeah. Visually seeing them.

24 MS. BICKFORD: When they triage, well, nurse triage?

25 1:16:03: Yeah.

1 MS. BICKFORD: No, no. There's--I--that's just started(1:16:08**???)
2 There's a couple nurse triage companies that do a visual. But no. Nurse triage,
3 doctor triage, whatever triage is not visual. So they're making a--they're--all of them
4 ask those kind of questions that determine whether they're recommending self-care.
5 That's pre whether they recommend self-care, you know, need to be seen within two
6 to four hours, need to go to the emergency room or need to be seen, whatever.
7 Every nurse triage has got a little different twist to it, but that's the basic division.

8 So they have asked a list questions. We've given them our list of what
9 we believe are appropriate for telemedicine. And if it lands here, they offer
10 telemedicine. And like Greg said, we--well, and someone else said we feel very
11 strongly about, telemedicine is way too new. It shouldn't be forced on anyone. It's a
12 great solution for the right patient for the right injury only. It's a small subset that
13 belongs in that first visit. And then on recheck, it's a great solution. We get people
14 that no-show when--a minor injury that went to bricks and mortar and they don't
15 come back, even though they need to be released full duty because they don't want
16 to take off work, et cetera. And that's been very appealing for them to have their
17 recheck visits via telemedicine.

18 1:17:28: Just to be clear, on nurse triage, that's irrespective of what
19 goes on with telemedicine. That happens today?

20 1:17:34: It's by phone call. Isn't it?

21 MS. BICKFORD: Exactly. Yeah. Right. That's--yes, that's--good
22 point.

23 1:17:38: If it happens to be another--for the triage instead of saying go
24 to this bricks and mortar, you can potentially go to telemedicine.

25 1:17:45: I'm just trying to ascertain what the criteria you determine as

1 level 1, level 2.

2 1:17:52: That's what I was trying to get at.

3 MR. BRUYNS: You mentioned grade 1, grade 2.

4 MS. BICKFORD: Sure. Sure. In every--we have a list of injuries we
5 believe or that are appropriate for telemedicine. We've vetted them out with
6 departments of Work Comp insurance pretty much across the U.S. Most of the large
7 carriers, their medical directors, the large TPAs, their medical directors that we've
8 level set with them on all of them, and looking at that list and making sure it's
9 appropriate. The list hasn't changed in two years, but we've had lots of discussion
10 about that.

11 And we'd be happy to do that with the state of Oregon. We'd be
12 thrilled to give a demonstration. We have a director of telemedicine nationally, Dr.
13 Figueroa, who we'd be happy to engage her and even do a live demo and walk
14 through even--we level set on those injuries and why, et cetera, if there's an interest.
15 We'd love to educate.

16 MR. BRUYNS: Diana?

17 MS. GODWIN: And I just want to echo Sheri's comment about this is
18 just the--I think just kind of like isn't even the tip of the iceberg. It's like we barely
19 know there's an iceberg there. And so I think this really would benefit the system to
20 have a broader and deeper conversation. And I appreciate you guys for being here.
21 This was really fascinating. I think there's just more. I think there's--we don't have
22 more time.

23 MR. BRUYNS: Dan?

24 1:19:32: So...

25 MR. BRUYNS: I'll let Dan go and then I'll...

1 1:19:35: I was just going to say about two-and-a-half years ago, the
2 Physical Therapist Licensing Board specifically adopted a rule for allowing physical
3 therapists to provide telehealth services, and they set out the standards, you have to
4 comply with all the documentation and et cetera. And I think probably the way our
5 telemedicine would work in the physical rehab arena for injured workers is to do a
6 check-in about their home exercise program or you know, has that range of motion
7 on your shoulder increased? Can I see that? That kind of thing. Obviously not for
8 the initial eval because that does require an in-person visit.

9 But again, to Sheri's comment, this could really help to do a check-in
10 for a worker on the jobsite about the compliance with the home exercise, and has it
11 improved the range of motion or decreased the pain, or whatever it is? So we've got
12 these rules in place with the PT Board.

13 MR. BRUYNS: Thank you. Chris?

14 MR. KAFKA: So just to add to this conversation, within Kaiser
15 Permanente, at this point, we actually have integrated telemedicine fully into our
16 occupational health program. Right now, we're doing about 10 percent of our visits
17 are via phone or video visits. Echoing the comments from Concentra, really high
18 patient satisfaction. And I think the--where we are right now is it's working pretty--it's
19 working quite well. However, I think the--maybe the lack of rules is creating this
20 uncertainty, is creating these questions and having some rules out there that provide
21 some concrete guidelines that insurers and employers can look and say yeah, this is
22 okay to do--could actually help support the ongoing development of the telemedicine
23 in the Workers' Comp arena here in this state.

24 MR. BRUYNS: Thank you, Chris. (1:21:32**???)

25 1:21:33: Just a little bit of echoing of other folks' feelings, especially

1 Dr. Miller's concern about some of the initial stuff. And absolutely, you know, again,
2 as a provider who's been in the business a while, this is an uncomfortable change.
3 But one thing especially would be non-English speaking folks, and I'm sure people
4 have ways around that, but that makes another layer of separation. It's just
5 something to put in the mix. So that's (1:21:58**???)

6 MR. BRUYNS: Great point.

7 1:22:02: Yeah, that's actually... That's actually a--was a big concern
8 within Kaiser Permanente. We integrated our interpreter services into our
9 telemedicine offering that. So if you bring on--you can bring an interpreter online to
10 help with non-native English speakers, just like we would be able to do that for a in-
11 person.

12 1:22:24: You have to. It's--you do the same as you do in a bricks and
13 mortar.

14 1:22:27: I assumed it would have been done. It's just some of those
15 same things where you take away the in-person specifics that you see. Plus,
16 (1:22:39**???) It's something to keep in mind. ??? Absolutely.

17 MR. BRUYNS: Hang on. We're picking up background noises on the
18 telephone. So please, if you're having conversations in your office. Your hand
19 going up, your hand, Ann?

20 MS. KLEIN: I'm sorry?

21 MR. BRUYNS: Did you have your hand up?

22 MS. KLEIN: Oh, I did have my hand up. I did--I got distracted by the --
23 you were talking. So we worked with a couple providers in more rural areas trying to
24 solve the access issue. And I think what I've liked with some of their ideas that
25 they've come out is they really talk about it as a supplemental for--because for some

1 of their groups, it can't just be the simple cuts and strains. They're trying to solve the
2 problem of this person needs to be seen on a regular basis, but they're driving from
3 Baker City to Boise to be seen, and it's just not reasonable.

4 But they also--and part of that, I think, is driven by their physicians who
5 are saying, "I don't want it to be purely telemedicine. I want to be able to have my
6 hands on and really get to know this patient." But then if we're on track with our
7 treatment plan and things are going as I expect, then if my next visit is--you know, or
8 a couple are just recheck and saying it's working, we're going well, then great. And
9 if not, I'm going to then say, "I'm sorry, I'm going to have to make--do the drive
10 because I really need to come in and we need to do a physical exam to figure out
11 why is it not."

12 And I think--so I see that blend as a really great way that's just
13 happening in those communities trying to solve the solution. And I wouldn't want us
14 to go in too restrictive of a direction that limits that we stunt innovation in that area.
15 Specifically, because I'm using the Baker City/Boise example, limited to Oregon
16 providers. In this case, the actual brick and mortar physician would be in Idaho, and
17 they'd be doing telemedicine here in Oregon in an area that's more limited. So just
18 keeping that in mind as we balance keeping parameters there but also flexibility.

19 And specialists, I think, are another--it depends on the specialist, it
20 depends on what they're doing. But I think there are some opportunities in that
21 arena for consults or counseling, particularly those areas where they maybe just
22 need to pop in to provide support to the occ med urgent care provider who needs a
23 little bit more, and they've talked about allowing to be able to call in the occ med doc
24 to help support and partner.

25 So I think there's some interesting ideas out there and I do think

1 there's opportunity for solutions. But that should be balanced against making sure
2 that convenience isn't supplemented for good quality care. And I do think that's an
3 important balance.

4 MR. BRUYNS: Thanks very much.

5 1:25:33: So I just want to comment, and I'm sure everybody's
6 experiencing this, that our insurance plan for our employees on the private side
7 offers telemedicine. And we used to have that nurse call-in thing. That never--
8 nobody got any traction with that. But people love the telemedicine, the 24-hour
9 care that they're getting through telemedicine on a private side. So I love that we're
10 able to bring that in, especially with all me with all my remote jobsites nationwide and
11 having that opportunity that maybe have validation if nothing else on some of the
12 injuries that we have and the care that's being rendered, so...

13 MR. BRUYNS: Thanks, Sheri.

14 1:26:17: Oh, and one thing. Please, I--last year, there was legislation
15 in Washington to do IMEs by telemedicine. Just the cringe factor alone. So please,
16 not telemedicine for IMEs.

17 MR. BRUYNS: It is getting very late in the afternoon, and we've been
18 here a long time. I realize this was just the very beginning of a larger conversation
19 we have to do about telemedicine. So I think you gave us valuable information to
20 leave with in terms of, you know, where there's probably going--it looks good
21 (1:26:53**???) and that we obviously don't want to regulate in a way that actually
22 limits, you know, some good things of telemedicine. But I know that it hasn't really
23 been an adequate conversation. It was a short conversation that we wanted to have
24 with you.

25 So I would encourage you to, you know, to look at these questions that

1 we have on here and provide us any of the direction that you'd like to email address,
2 or just pick up the phone and call me. And this is true for all of the issues that we
3 have here. If you know, you do that over the next, you know, like the first week in
4 December, let's say, that would be very helpful to us to prepare a proposal. But
5 because there's a number of issues where you may have additional thoughts, and
6 we'll certainly welcome you, additional advice, however you want to provide that.

7 In addition, also to let you know, we received some (1:27:54**???) a
8 little over a week ago from Oregon Trail Lawyers Association having to do with the
9 proposed agenda items, having to do with managed care in particular. And we do
10 want to have that conversation, but we knew there wouldn't be time today, nor not
11 necessarily even the right folks at the table. Although I think the MCOs are pretty
12 well represented today. But we will be setting up another meeting in December, so
13 you will receive another invitation from me, and we'd love to have you attend if
14 you're interested. But we're going to book it for you. But and I do apologize for
15 taking more of your time ??? this conversation. We didn't want to try to fit it in today,
16 or we'd probably be here late into the evening. But with that, is there anything that
17 you--any questions you have or anything that you'd like to know with the department
18 in terms of the process? If not, have a safe drive, and we're off the record.

19
20 (WHEREUPON, the proceedings were adjourned.)

21
22 - - - -

23
24
25

1 **CERTIFICATION OF TRANSCRIPT**

2

3 I, Amanda Knapp, as the transcriber of the oral proceedings at the 11-19-18 hearing
4 before Administrative Law Judge [correction: Rules Coordinator] Bruyns, certify this
5 transcript to be true, accurate, and complete.

6

7

8 Dated this 10th day of December, 2018.

9

10 

11

12

13 Transcriber

14

15

16 **NOTE:** The original transcript as provided by the transcription service has been
17 preserved. I have reviewed and edited this copy of the document, especially on
18 sections marked by “???” due to audio recording problems. Fred Bruyns, Workers’
19 Compensation Division. 12/12/2018.

20

21

22

23

24

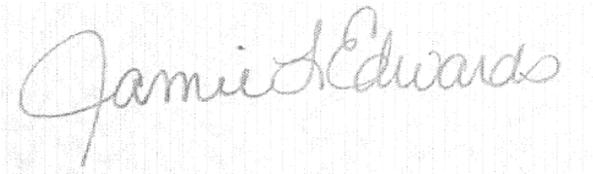
25

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

CERTIFICATION OF TRANSCRIPT

I, Jamie Edwards, as the proofreader of the oral proceedings at the 11-19-18 hearing before Administrative Law Judge [correction: Rules Coordinator] Bruyns, certify this transcript to be true, accurate, and complete.

Dated this 10th day of December, 2018.



Proofreader

NOTE: The original transcript as provided by the transcription service has been preserved. I have reviewed and edited this copy of the document, especially on sections marked by “???” due to audio recording problems. Fred Bruyns, Workers’ Compensation Division. 12/12/2018.