

## RULEMAKING ADVISORY COMMITTEE MEETING

Dec. 17, 2018, 1:30 p.m.

Labor and Industries Building, Room F  
350 Winter Street NE  
Salem, Oregon

### WORKERS' COMPENSATION DIVISION RULES

OAR 436-015, Managed Care Organizations

#### Committee members attending:

David Barenberg, SAIF Corporation
Larry Bishop, Sedgwick CMS
Zachary Brunot, Elmer & Brunot, PC
Timothy Craven MD, Providence MCO; MAC
Jeannette Decker, Providence MCO
Grant Engrav, Attorney at Law
Jennifer Flood, Ombudsman for Injured Workers
Jaye Fraser, SAIF Corporation
Greg Gilbert, Concentra
Diana Godwin, Attorney at Law
Lisa Johnson, Majoris Health Systems
Todd Johnson, NCCI
Chris Kafka, Kaiser On-the-Job
Richard Katz, Therapeutic Associates
Ann Klein, Majoris Health Systems
Andrea Knight, Edmunson Barnhart Knight PC
Ryan McClelland, SAIF Corporation
Sheri North, Mitchell International Inc.
Claudia Ordonez, Greater Portland Neurosurgical Center, PC
Jovanna Patrick, Hollander Lebenbaum & Gannicott
Jodie Phillips Polich, Attorney
Sue Quinones, City of Portland
Dan Schmelling, SAIF Corporation
Elaine Schooler, SAIF Corporation

Keith Semple, Johnson Johnson Lucas & Middleton PC
Ramona St. George-Suing, Majoris Health Systems Oregon, Inc.
Sheri Sundstrom, Hoffman Corporation
Jenny Walsh, Providence MCO
Diana Winther, IBEW Local 48   MLAC
Kimberly Wood, Perlo Construction   MLAC

**Department of Consumer and Business Services staff attending:**

Robert Anderson
Lou Savage
Juerg Kunz
Stan Fields
Fred Bruyns

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WORKERS' COMPENSATION DIVISION RULES

OAR 436-015, Managed Care Organizations

The proceedings in the above-entitled matter were held in Salem, Oregon, on the 17th day of December, 2018, before Fred Bruyns, Administrative Rules Coordinator for the Workers' Compensation Division.

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DISCUSSION AMONG PARTIES

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1 TRANSCRIPT OF PROCEEDINGS

2  
3 MR. BRUYNS: Okay. We're on. Good afternoon, everyone. Thank  
4 you very much for coming, whether you're here in person or if you're on the  
5 telephone with us. We're here to talk about some additional issues that we didn't  
6 have a chance to talk with you about on the 19<sup>th</sup>. And so we do appreciate your  
7 time. And when it comes time to actually talk about the issues that came from OTLA  
8 and from Diana Godwin, I'll probably more or less kind of turn things over to you  
9 folks so that you can speak to those issues.

10 But if you--I think you've all been part of this process before, but this is  
11 an Advisory Committee meeting and it's informal. It's our chance to get all the  
12 advice gathered together in one place and to take that back to our administrator, and  
13 if necessary, the director, and get some final direction on how to actually craft the  
14 proposed rules when we file with the Secretary of State.

15 And with that in mind, anything we talk about today that has a fiscal  
16 impact on you or the people you represent, please provide input on that. We have to  
17 file that information with the Secretary of State, and we rely on the information from  
18 folks like you.

19 So if you're on the telephone with us today, I encourage you to fully  
20 participate. And if you--we will pick up background noises in your office, so you may  
21 selectively use your mute button. And I encourage you to do that if anyone comes in  
22 or if you're keyboarding even. But keep in mind that don't put us on hold because  
23 we might pick up your background music, and there's no way for us to turn that off  
24 unless we mute everyone. So I'd ask you to keep that in mind.

25 So my name is Fred Bruyns. I coordinate rulemaking for the Workers'

1 Compensation Division. And I'd like to go next to the people on the telephone with  
2 us and have you introduce yourselves to the Committee.

3 MS. NORTH: This is Sheri North.

4 CLAUDIA: My name is Claudia and I work for Dr. Julio Ordonez's  
5 office.

6 MR. BRUYNS: Okay. I had two people coming in at once. But  
7 Claudia, could you repeat yourself?

8 CLAUDIA: Yes. Claudia from Dr. Julio Ordonez's office.

9 MR. BRUYNS: Okay. Thank you, Claudia. And Sheri, was that you?

10 MS. NORTH: Yes. Sheri North from Mitchell.

11 MR. BRUYNS: Okay. Thank you for joining us. Anyone else?

12 MS. KNIGHT: Andrea Knight, claimant's attorney, here by phone.

13 MR. BRUYNS: Welcome, Andrea. Anyone else?

14 MR. GILBERT: Greg Gilbert with Concentra.

15 MS. WOOD: Kimberly Wood with Perlo Construction.

16 MR. BRUYNS: Okay. Why don't we start with Greg there? Go ahead.

17 MR. GILBERT: It's Greg Gilbert with Concentra.

18 MR. BRUYNS: Okay. And then I didn't catch the name of who else  
19 was trying to come in.

20 MR. BRUYNS: Welcome, Kimberly. Is there any...

21 MS. WOOD: Thank you.

22 MR. BRUYNS: Anyone else on the telephone with us?

23 MS. QUINONES: Sue Quinones, City of Portland.

24 MR. BRUYNS: Welcome, Sue. Anyone else? Hearing no one, we'll--  
25 this way.

1 MR. FIELDS: Stan Fields, Workers' Comp Division.  
2 MR. KUNZ: Juerg Kunz, Work Comp Division.  
3 MR. SEMPLE: Keith Semple, Oregon Trial Lawyers Association.  
4 MS. PATRICK: Jovanna Patrick, claimant's attorney.  
5 MR. JOHNSON: Todd Johnson, NCCI.  
6 MS. WINTHER: Diana Winther, IBEW Local 48 and MLAC.  
7 MS. KAFKA: Chris Kafka, Kaiser On-the-Job MCO.  
8 MS. FRASER: Jaye Fraser, SAIF Corporation.  
9 MS. SCHOOLER: Elaine Schooler, SAIF Corporation.  
10 MR. SCHMELLING: Dan Schmelling, SAIF Corporation.  
11 MR. MCCLELLAN: Brian McClellan, SAIF Corporation.  
12 MS. JOHNSON: Lisa Johnson, Majoris Health Systems.  
13 MS. ST. GEORGE: Ramona St. George, Majoris Health Systems.  
14 MS. KLEIN: Ann Klein, Majoris Health Systems.  
15 MS. WALSH: Jenny Walsh, Providence MCO.  
16 MS. DECKER: Jeanette Decker, Providence MCO.  
17 MR. BISHOP: Larry Bishop, Sedgwick.  
18 MS. SUNDSTROM: Sheri Sundstrom, Hoffman Construction.  
19 MS. FLOOD: Jennifer Flood, Ombudsman for Injured Workers, DCBS.  
20 MS. GODWIN: Diana Godwin for private practice physical therapy.  
21 MR. ENGRAV: Grant Engrav, Engrav Law Office.  
22 MR. BRUNOT: Zachary Brunot, claimant's attorney.  
23 MR. ANDERSON: Robert Anderson, Work Comp Division.  
24 MR. BRUYNS: And welcome to you all. And I was reminded at some  
25 point that we have some written advice from Dolores Russell of CareMark Comp

1 MCO at the back of the room. She was unable to join us. She wasn't sure if she  
2 would be able to join us today, so we don't know if we'll see Dolores, but I would  
3 encourage you to pick up a copy of that advice, as well as an additional letter from  
4 Diana Godwin that I sent out this morning, but you may not have had a chance to  
5 open all of your email.

6 If you're on the telephone with us, the information from Diana Godwin  
7 is posted to our website. I apologize, the information from Dolores has not been--  
8 and I didn't actually clear it with her to actually post it to our website. And typically,  
9 with advice, we don't post it unless someone asks us to. Testimony, on the other  
10 hand, always goes up onto our website.

11 So with that, we have several issues that came to us from the Oregon  
12 Trial Lawyers Association, and I would kind of like to--someone from OTLA to walk  
13 us through those issues, and then everybody fully, you know, provide your input  
14 regarding those issues, and that will help all of us some.

15 MR. SEMPLE: Okay. This is Keith.

16 MR. BRUYNS: Keith or Jovanna?

17 MR. SEMPLE: Sure. Keith for Oregon Trial Lawyers Association. So  
18 we've just raised a couple of issues of concern that our members have expressed to  
19 us and injured workers have expressed to us over the years about managed care  
20 organizations. I apologize, I did not intend to provoke this into a separate meeting  
21 and bring this all here at the end of December when we have other things to do, but  
22 here we are.

23 So one of the concerns that we've heard over and over again from our  
24 members is the ability to get MCO contractual information that might apply to a given  
25 injured worker's case. We've had members request that information and have had

1 their requests denied. And I--from what I understand, we've had people that have  
2 had ongoing issues with trying to get the complete contractual information. So that's  
3 one of the concerns that we've raised.

4 Another big concern that we have is the fact that the provider lists, a lot  
5 of the providers had issues with attaching conditions to when they will see an injured  
6 worker, such as only workers who have been prior patients, only workers who have  
7 had--have open claims or not workers who have denied claims. Not seeing workers  
8 who have attorneys, for example. So there's a number of issues we have with that  
9 and concerns we have with that because one of the kind of poor reasons and criteria  
10 for MCOs is that we have to have enough people on each panel to give the worker a  
11 true choice in the matter of who's going to treat them. If doctors on the panel are not  
12 willing to pretty much see injured workers across the board and have significant  
13 conditions before they'll see an injured worker, that's really not a complete choice for  
14 the worker, kind of the way the original system was designed to be.

15 Another thing is it's not that their MCOs aren't required to comply with  
16 any deadlines, but there's not a real specific deadline under the law for MCOs like  
17 there are for insurers. For example, for elective surgery rules. And that's always  
18 been a concern to us because the elective surgery rule was obviously placed in the  
19 law for a reason, to make sure that timelines are expedited so workers can get the  
20 care they need to get back to work. And if we don't have a similar rule under MCOs,  
21 it kind of creates an open-ended opportunity for back-and-forth with a doctor. And I  
22 appreciate that there are some that view that as a really important role for the MCO  
23 to go back and forth with the doctor.

24 I can tell you from talking to some doctors that some of them don't feel  
25 that way and certainly a lot of the patients don't feel that way. So we would like to

1 see there at least be some timeline, you know, probably patterned on the already  
2 decided upon timeline and parameters for elective surgeries.

3 Another thing that we've heard and seen is MCOs inserting their--  
4 themselves kind of more and more into the role of the decision maker as opposed to  
5 the attending physician being the decision maker. We see the situations where  
6 MCOs have gone so far as to tell the attending physician that the worker is medically  
7 stationary, and that's the attending physician's decision to make not to be kind of  
8 goaded into that, I don't think, by the MCO. So we've got some concerns just about  
9 how far the counseling and discussion and advice are going, you know, when  
10 providers are receiving frequent letters asking them to, you know, do this procedure  
11 instead of that procedure, or withdraw your request for a certain procedure because  
12 we're likely to deny it. Things like that seem like maybe we're going just a little bit  
13 too far. So we'd like to have, you know, some discussion or at least some review of  
14 kind of what those roles are supposed to be and how far it's supposed to go.

15 And then the final thing that we are concerned about is not just with  
16 regard to MCOs, but with regard to refusals to preauthorize and lack of kind of an  
17 across-the-board preauthorization, voluntary preauthorization requirement. We  
18 would really like to see across the board there being some timelines for when I  
19 provider says I'm not going to provide treatment, I need preauthorization for this  
20 service or that service. We'd like to see that not limited just to diagnostic services,  
21 specifically imaging services or physical therapy services as has recently been  
22 proposed. We'd like to see that voluntary option available to all providers so that  
23 they can get a timely yes or no, and then the attorneys that need to appeal can get  
24 that moving for the injured worker.

25 We think that some of these things, if some of these concerns are

1 addressed, that we might get better worker treatment outcomes and hopefully get  
2 folks in a position where they can get their treatment and get back to their maximum  
3 function hopefully sooner and with less hassle.

4 And we definitely want to hear from the providers who are subject to  
5 these contracts because, you know, I'm envisioning that providers that want to get  
6 preauthorization and want to get things moving, some of them might be frustrated by  
7 some of these issues, whether the MCO or the preauthorization issue. So certainly,  
8 we don't want to make the case for them. It's just based on what we're seeing and  
9 what our members are concerned about. Thank you.

10 MR. BRUYNS: Thank you very much. If we can then go back and  
11 start at the beginning. The first issue you raised has to do with MCO contracts and  
12 access to those contracts, and whether they should be publicly available. So it's a  
13 question and it's just one I'd like to open up for the Committee. And basically, it  
14 comes down to the proposed change and administrative rule to force MCOs to make  
15 the contracts publicly available. Ideally, they would be posted online. And so with  
16 that, please provide your input.

17 MS. ST. GEORGE: Ramona St. George with Majoris Health System.  
18 This is actually something that we litigated because our provider manual is a  
19 proprietary trade secret, and that's part of our provider contracts, as well as some of  
20 the financial terms of the contracts, et cetera. I know that the department has, in  
21 cases where it was pertinent, has redacted portions of the contract that were  
22 relevant to the issue when there have been disputes. I appreciate Dolores'  
23 comments, but they're not accurate. They are not, as you know, public records.  
24 And they aren't obtainable that way.

25 I--you know, perhaps if there were some specific concerns that were

1 raised, those could be dealt with on an exception basis. But to simply turn every  
2 document out of our office for perhaps a fishing expedition, I--you know, it's not  
3 necessary not appropriate.

4 MR. BRUYNS: Thank you, Ramona. Anyone else? Chris?

5 MR. KAFKA: I actually agree with everything that Ramona said. You  
6 know, and I would love to get a look at her provider agreement. But that's just not  
7 appropriate. I have no business knowing that. And you likewise don't have any  
8 business knowing what's in ours.

9 MS. ST. GEORGE: Right.

10 MR. BRUYNS: Thanks, Chris. Jeanette?

11 MS. DECKER: Jeanette. I agree with both of them. That is the same  
12 position that Providence would take. A manual is something that is proprietary and  
13 something that we work with...

14 MR. BRUYNS: Thank you, Jeanette.

15 MS. FRASER: Fred, Jaye Fraser from SAIF Corporation. I just want  
16 to add that, you know, we don't have access to those manuals either as an insurer.  
17 Because those are--that's between the physicians and who we're contracting with  
18 the MCOs because we can't manage care, so that's one of the other ways to keep  
19 that process intact.

20 MR. BRUYNS: Anyone else? Anyone on the telephone have thoughts  
21 on this issue? Anything more from OTLA in response?

22 MS. PATRICK: Well, this is Jovanna Patrick. I would just say that I  
23 think a concern we have as claimant's attorneys is that we don't know how the  
24 decisions are being made or what sort of pressure is being applied to the doctors  
25 to--that may not be in conjunction with the statutes as far as what care should be

1 provided. It's like this whole private agreement between the doctor and the MCO  
2 about what care will be provided. We have no way of knowing if that's, you know,  
3 statutorily allowed, if there's ways that we can help our claimants more. Decisions  
4 are made and we don't know why. And so if you're controlling your relationship  
5 between the doctor and the patient, and that's something that is part of the Workers'  
6 Comp process, then we think we have a right to see those to know what sort of--you  
7 know, if they're correct or not.

8           And I've seen decisions from the MCO that says, you know, this  
9 doesn't fit the guidelines and--or what guidelines? And why is it that the MCO gets  
10 to say what these guidelines are? So there's a lot of mystery that goes into that, and  
11 you know, moves forward in litigation sometimes and you might never know what  
12 those things are. Or the doctor will say yes, I'm withdrawing your request because  
13 you told me that the guidelines don't allow it. Well, how can you possibly appeal that  
14 if it's just the decision of the MCO without getting the chance to delve into that and  
15 the doctor being maybe controlled by contract that we don't know about?

16           MS. 15:28: Well, the Department does review all of our provider  
17 contracts. So the issue of whether or not the clauses in the contract are legal is  
18 basically off the table because they review them and ensure that they're within the  
19 scope of the law.

20           As far as treatment guidelines go, I think all of us use national  
21 treatment guidelines that you could certainly...

22           15:49: Will you remind me...

23           15:51: You could purchase them and know what they are.

24           MR. BRUYNS: I think you have a little background noise in the office.

25           15:53: And when we have a dispute, we do include in those how we

1 base that decision, on what guideline, and the producer of those guidelines doesn't  
2 allow us to cut and paste again the part that we relied on. And when the dispute  
3 goes to the Department, they also have access to them and review them based on  
4 the same guideline.

5 So you know, I think we're looking for a mystery where there isn't really  
6 one. And it's not in the MCO's interest to arbitrarily or willy-nilly disapprove  
7 appropriate treatment. We'd be out of business in a week if injured workers weren't  
8 getting well.

9 MS. PATRICK: I just wanted to make sure that I'm understanding. I  
10 thought in many discussions that we've had before about contracts that it's always  
11 been we'll make a FOIA request, and I know some attorneys have and they have not  
12 gotten a response or have gotten a, sure, pay us, you know, \$7000. Am I  
13 understanding that it's the position of the MCO that it's not subject to a FOIA request  
14 and we just simply are not allowed to have them?

15 17:05: The contracts?

16 MS. PATRICK: Yes.

17 17:07: I would say that's true. I've litigated it and they've not been--  
18 we've been upheld that they are a proprietary document.

19 MR. BRUYNS: I can speak to that a little bit. We have had requests  
20 for--under, you know, public records request for provider contracts. And we found  
21 that we would have to have--and some of it would be attorney, we're going through  
22 and removing all trade secrets from those contracts. That's why the high price in  
23 terms of if it was a lot of contracts. If it's an individual contract or two, it would be,  
24 you know, certainly affordable. But we wouldn't be able to release them as they are  
25 in their--you know, without redaction. But that's our understanding anyway and

1 that's what our advice has been.

2 17:53: We also, I think, need to look at the relationship between the  
3 MCOs and the providers under contract. Now, these are licensed medical  
4 professionals, and they're--you know, these are not the kind of individuals who are  
5 going to--if they have a firm conviction about what is right and what's appropriate,  
6 they're not the kind of individuals who are going to roll over on that and change their  
7 opinion just because the MCO with whom they have a contract takes a different  
8 view. They will say yeah, well, we're going to have to agree to disagree, and you  
9 know, we'll have to--we'll let this go to a dispute.

10 MR. BRUNOT: This is Zachary Brunot. With all due respect, that is  
11 not how it plays out. Those providers see 35 patients a day. They're just another  
12 number. And they don't get to keep them at the forefront of their mind in order to  
13 start tipping at that--or tilting at that windmill, you know. It does get lost in just the  
14 business press of the day where they don't double down on this stuff sometimes.  
15 And if the MCO gives them a little bit of pushback, then they're going to sway with  
16 that pushback.

17 And I'm not concerned with any of the trade secret information, to be  
18 honest. I understand and appreciate the value of that information. And I don't want  
19 that information. I filed a FOIA request and it was omnibus request for every  
20 damned MCO contract in this state. Right. And it was the--I got feedback, it was  
21 like \$12,000 for--to respond to the FOIA request. I mean, the Claimant's Bar can  
22 pass the collection plate if we want in order to come up with that money. I don't care  
23 if it's redacted. I just want some level of accountability for my clients because we  
24 know the insurance companies aren't allowed to direct care. Right? But the MCOs  
25 are directing care by proxy. When they give a little bit of pushback like that, and I

1 realize there's going to be people that disagree with that, but the reality of it is that  
2 they are directing care by giving pushback without really any accountability.

3 And I don't care about the minutiae of it all. Granted, we're down here  
4 in the basement of a bean-counting institution. I get it. But the end result is what we  
5 need to focus on. And the end result is that people are not getting the care and  
6 treatment that they need when they're in the MCO, when they're in a contract that  
7 are MCO contracts. Things are getting delayed without very clear guidance. And if  
8 it was just an insurance company that was doing it, we would have legislative means  
9 to fix the statutory mechanisms in order to compel the next process.

10 I just want, you know, sunshine on the process. There's very important  
11 rights of people that are being kind of obfuscated by this whole thing. And I don't--  
12 aside from the trade secrets, I don't get the need for the obfuscation.

13 MR. BRUYNS: Thank you very much, Zachary.

14 MR. SEMPLE: Yeah. This is Keith. I mean it just troubles me a lot. I  
15 mean, you know, I appreciate the assurances, the Department reviews things. But  
16 you know, one of the checks in our system is that attorneys often review the actions  
17 of the agency. That's one of our roles for our clients is to review these things and  
18 bring things out into the open if they don't pass scrutiny, if they seem concerning.  
19 So we should have at least access to the documents. I mean the original we started  
20 out with, we're providing care to injured workers. And now there's secret proprietary  
21 things that even the insurer doesn't get to know about that affects the care and  
22 treatment of injured workers. I don't know how we got this kind of shrouded in-  
23 between extra service provider in the middle that nobody gets complete access to  
24 how the decisions are made. And there may be some very concerning things, some  
25 things that maybe the Department hasn't found concern with, maybe the insurers

1 wouldn't have concern with, that may concern us that we want to bring out into the  
2 open. And if we don't even get past the initial denial for these documents that affect  
3 our clients, you know, maybe we look at them and we say, okay, this is kind of what,  
4 you know, what we expected. You know, benign, not a big cause for concern. And  
5 then we put them all aside and move on to the next thing. But it should at least be  
6 available. If it has this big of a kind of a quasi-legislative effect on our clients, it  
7 should be out in the open. I mean there's due process and this is not a substitution  
8 for due process. This is just secrecy and it shouldn't continue.

9 I mean if there's a legitimate place in the system for managed care  
10 organizations to get involved in direct treatment and have contractual obligations  
11 with the providers who are treating injured workers, that's a pretty big thing, and I  
12 can't--I personally can't believe it's gone on this long that we're sitting here talking  
13 about this, having had MCOs in the system for so long and having had people trying  
14 to get this information to no avail, you know. It's surprising that we're, you know,  
15 sitting here doing this. I mean in theory, we could have a published, redacted  
16 version of some sort. I mean I think, you know, if that were available to injured  
17 workers and that, you know, we at least had a starting point of something that  
18 doesn't contain proprietary information, I, you know still don't quite understand that.  
19 It still troubles me that there's, you know, secretive information that really helps one  
20 MCO over another. I mean, shouldn't it be helping the injured worker? So in any  
21 event, I mean we just need at least some level of transparency here, I think, is all  
22 we're asking for. Thank you.

23 MR. BRUYNS: Thank you very much, Keith.

24 MS. SUNDSTROM: Sheri Sundstrom with Hoffman Construction. I'd  
25 like to see the statistics that workers are not getting back to work or are having

1 issues within the MCOs because I have quite a different experience, and in fact,  
2 have not had any issues with workers getting back to work. They may have to  
3 request a change of provider. But I--and I see a lot, unfortunately, I hate to admit  
4 that, but I see a lot of injured workers across a broad spectrum of construction sites  
5 throughout the state of Oregon, not just in Portland or in--on the I-5 corridor. I do not  
6 have the problem. So I would love to be able to see this because I'm looking  
7 through my rosy-colored glasses at a system that works.

8           And so if there is this broad-based problem, I think it's something that  
9 needs to be discussed, and if there's going to be a change in how MCOs operate or  
10 information they're providing. I think also that is something that is for MLAC to be  
11 engaged in, not a group in a rulemaking committee because the MCOs came  
12 through the MLAC process.

13           So I would just like to see the statistics because I understand you have  
14 clients and you have clients and you have clients. But that's not the--those are small  
15 numbers compared to the number of workers that are injured in the state of Oregon  
16 that have very successful outcomes by all of the MCOs.

17           MR. SEMPLE: Well, you said I have clients, he has clients, she has  
18 clients. A number of our colleagues have clients. You have clients. I mean you  
19 only--you're only seeing a limited number as well. We have three people here sitting  
20 here saying that we see poor outcomes and we see MCO interference. And I--with  
21 all due respect, I appreciate that you don't see that, but I don't have--we don't have  
22 access to statistics that bear out every single one of our points when we come here  
23 with concerns. We have people that we've dealt with individually who have been  
24 wrecked by this stuff and then strung out and delayed. So that's why--I mean that's  
25 why we're concerned. We don't have access to a statistical report.

1 I would love to have a ProPublica report on all of this. Believe me. We  
2 would have generated it by now. We would love to have that kind of data and  
3 information. We have stories. We have people that we can attest to and you know,  
4 tell you about, so--and that's all I can say to that idea.

5 MR. BRUNOT: And going to Keith's point and to your point, not every  
6 MCO case that I have is a train wreck. Not every Majoris case is bad. I mean  
7 there's great responses that I get and there's--it's without issue. You know, I see  
8 without hiccup. That's not really the problem. When a statute is drafted and the  
9 legislature messes up and oversteps its bounds in the courthouse to correct it, that's  
10 one case, right, where the law was wrong. Where the Workers' Comp Division  
11 messes up and they approve a contract that potentially shouldn't have been  
12 approved, it was a bad administrative decision, that's going to be corrected by  
13 legislative action or by the courts. It takes one or two cases in order to make things  
14 right. It's not--maybe I'm stepping on my own feet here saying that's just like a huge  
15 problem, but when it is a problem, it's a problem that needs to be fixed, and I would  
16 like to get to the bottom of it, you know. I mean I don't make a living off of fixing all  
17 of the issues in the Workers' Comp system. I make an issue off of fixing that injured  
18 worker's problem or that injured worker's problem. And when it's a one case  
19 scenario, it doesn't mean that it's not a justified--it's not a fishing expedition. We just  
20 need to get to the answers here.

21 MR. BRUYNS: Jaye?

22 MS. FRASER: Can you believe it? I actually raised my hand. I kind of  
23 what to back this up a little because, I mean, I understand my colleagues and Injured  
24 Worker Bar's position, I get it. But I think that we've forgotten why we have MCOs  
25 and what the purpose of MCOs really what it--where it came from and why we have

1 it. It's basically to provide peer review for--so it's doctor review of doctor. When say  
2 MCO, we're really talking about physicians reviewing and looking at treatment, et  
3 cetera, et cetera. And I think we sort of forget that. And there's a statute, ORS  
4 41.675 that protects peer reviews. So we've got it. You know, there are-- But it's  
5 not the only time in medicine where doctors peer review. And certainly, this is  
6 similar to managed care networks where you have--I mean Robbins (phonetic) has  
7 their panels and CareMark has their panels and Kaiser has their network. And so  
8 it's a similar model that's used in the Workers' Comp system and it was put into  
9 place around Mahonia Hall.

10 28:24: It was.

11 28:25: I have it right here.

12 MS. FRASER: And so...

13 28:29: I brought my Mahonia Hall...

14 MS. FRASER: So I mean I get what you guys are saying, I  
15 understand, but I heard, you know, how did we get here? That's how we got here. I  
16 just had to say that. And then I guess my question to Keith, Jovanna and Zach is, I  
17 have been under the understanding and impression that you have the ability to  
18 appeal a decision or a concern that is--that you have a worker, a client who is not  
19 being treated appropriately. And I think you actually get a fee associated with that if  
20 you're right. So I guess I'm kind of confused.

21 MR. SEMPLE: Well...

22 MS. FRASER: I don't see how the contracts are going to help.

23 MR. SEMPLE: Well, we have--an injured worker should have a right to  
24 review all of the provisions that pertain to their treatment. In the civil system, which  
25 is where we started way back before anything, a worker has the right to choose their

1 own doctor and they don't have a list of doctors, and the insurer doesn't really get to  
2 have a role in who they choose. Certainly, the insurer doesn't get the contract and  
3 say, "Okay. You were in a car crash. Okay. Well, then you need to see Dr. So-and-  
4 So." So we started with a system without any of that. You know, we now have a  
5 system where okay, workers don't sue their employers. We've got exclusive remedy  
6 and we've got a system to provide medical services. And then it's oh no, okay,  
7 we're going to provide medical services, but subject to all these requirements and  
8 panels and lists, and you're not going to get to see the contract that is, you know,  
9 involved in the provision of those services. So that's where we're at now. And we're  
10 talking about whether those contracts should be public is one of the things that we're  
11 talking about. You know, we understand where the MCOs were enshrined in law at  
12 Mahonia Hall. We disagreed with it then. We're not crazy fans of it now. There's no  
13 secret about that, I don't think. But we've got some specific concerns.

14           And you know, we're starting with contracts. You know, there's other  
15 things on this list that I can understand were broader kind of objections to how things  
16 work. But right now, we're just talking about whether some of this contractual  
17 information can be made public so that lawyers can take a look at it and so we can  
18 tell our clients here's how it works. You know, we've got this and that and here's  
19 what we can do. Of course we can appeal it. That's fine. That's one way that we  
20 can challenge a decision that we disagree with. Another way we can challenge a  
21 decision we disagree with is to look at the contract and say, "Holy crap. This isn't  
22 what we thought was enshrined in the legislature. We don't think this is  
23 constitutional or we don't think this provision should be in here. This is  
24 inappropriate." And then we challenge it not only through the normal appeal process  
25 but their legislative process, through other channels. So I mean it's--that's why the

1 contracts are important. It's not just a matter of having a bunch of documents that  
2 we can say, "Neener neener, we got your contracts." There's an important role to  
3 these contracts and they should--at least the provisions that really affect the  
4 provision of treatment to injured workers and kind of what the doctors' obligations  
5 are should be made public. If the dollars and figures of what doctors get paid aren't  
6 made public, fine. That's really not what we're talking about. We're concerned  
7 about the appeal timelines, just how much the doctors are required to go back and  
8 forth before they say their final-- I mean there's just a lot of things, and we don't  
9 even know what they all are because we haven't seen the contracts yet. So I mean  
10 to some extent, it is a fishing expedition but it's a failed fishing expedition because  
11 this is things that affect injured workers. There shouldn't be information in the dark  
12 in this system. They can read the statutes, administrative rules. If this is an extra  
13 layer of adjudication, then it needs to be out in the open just the way the other layers  
14 are.

15 MR. BRUYNS: Thanks again, Keith. Anyone else?

16 32:15: Just a comment just that all of the MCOs--

17 MS. PHILLIPS POLICH: I'm-- Oh.

18 32:17: --do publish their dispute resolution procedures, so if you don't  
19 know what the timelines are, if you just go on any of our websites, it will all be there.

20 MR. BRUYNS: Okay. Thank you. Someone on the telephone was  
21 trying to come in?

22 MS. PHILLIPS POLICH: Yes. This is Jodie. Okay. If somebody else  
23 wants to go first, that's fine. But this is Jodie Phillips Polich. I'd like an opportunity  
24 to speak. If somebody else is first, that's fine.

25 MR. BRUYNS: Well, I wasn't--I don't know who's first. Jodie, go

1 ahead.

2 MS. PHILLIPS POLICH: Okay. Well, I just wanted to perhaps give a  
3 very recent example of how these MCOs affect our clients. Most of you know I  
4 represent injured workers, like my colleagues that are there today at the meeting,  
5 and I've had similar experiences. Currently, I have a problem with an MCO that I  
6 have a problem with regularly down in Klamath Falls. And the doctor--the doctors at  
7 a particular facility, and there are not very many treating facilities down there, and  
8 candidly, I don't have a problem getting authorization outside those, but the facility  
9 that does doesn't seem to think they have to authorize time loss, which is a  
10 fundamental benefit that workers get out of the system, which is wage replacement.

11 And so I've gone as far as I can go up the food chain internally, and it  
12 took me over two months to finally get some kind of authorization, which candidly, I'll  
13 tell you I'm not sure is good enough to get my client time loss. And so if it's not, this  
14 client's going to be out close to \$12,000 on a contract I can't see that I believe says  
15 that a doctor has to state what a worker's work status and ability is, and those  
16 doctors basically say we're not going to do that.

17 And so what--and my point of giving that example is it's great there's a  
18 contract, I have a pretty good idea that there's something about that in there, but I  
19 can't see it. And so there's only unilateral enforcement of the terms of the contract.  
20 Claims adjuster at any minute can call--you know, can send out a text, an email and  
21 say, "Hey, this provider's not following the terms of the contract and the MCOs on  
22 that." I don't have that same ability because I don't really know what the terms of the  
23 contract are. And that's all we're looking for is to be able to know what the  
24 guidelines are. It's great to say they're there and that they're being followed. But  
25 our role in this system is to make sure that they are. And if we believe they aren't

1 and we don't have the guidelines, that makes it pretty hard for us to go and litigate  
2 these issues. So that's what--that's my--I mean my contribution to this.

3 And I've seen this time and time again. And I actually did try to get an  
4 MCO contract related to this issue several years ago on a case I took to the Court of  
5 Appeals. And I didn't really get on the contract and then it kind of turns out that  
6 there are some provisions that I couldn't see that I couldn't hold that doctor  
7 accountable for not authorizing time loss way back then. So again, these are--  
8 there's issues beyond just medical treatment that are involved in these--in not being  
9 able to see the contracts. Thank you.

10 MR. BRUYNS: Thank you, Jodie. We'll take a couple of responses  
11 from the folks here, but we'll come back to whoever else was on the phone who was  
12 trying to come in. But Chris?

13 MR. KAFKA: Just a clarifying-- But this--for this specific issue that  
14 was cited here, isn't that--I can't cite chapter and verse here, but isn't that the doctor--  
15 the attending physician's obligation to address work restriction and time loss, isn't  
16 that embedded somewhere in the rules and the laws?

17 MR. BRUYNS: Yes, it is. Yeah.

18 MR. KAFKA: Okay. So what--if there's something in the contract  
19 that's kind of irrelevant in this case because it's--and whatever might be in a  
20 contract, which I don't think even would be in a contract, it's going to be overwritten  
21 by what's in the rules and laws.

22 MR. BRUYNS: Thank you, Chris.

23 MS. SCHOOLER: Elaine Schooler for SAIF Corporation. I just--I'm  
24 seeing two parallel or sort of diverging arguments here. One is in regards to  
25 workers' access to care and are they getting appropriate care under the MCO?

1 When there are rules set forth administratively and also by statute as to what types  
2 of medical services injured workers are entitled to, and there's a review process as  
3 has been pointed out for MCO enrolled claims where the MCO renders a decision  
4 where they disapprove a requested treatment from the physician.

5 The other argument is that there's a contract that somehow determines  
6 the care that is being reviewed. The contract is a negotiated agreement between  
7 the MCO and the provider. They're given that authority by statute from the  
8 legislature. 656.260 says that the MCO can restrict care, can render these peer-to-  
9 peer decisions, that's a statutorily vested authority. And then the director has the  
10 authority to review those contractual agreements. So whether a contract is valid or  
11 not, that's something for the director to determine when an MCO's up for approval.  
12 If there's an issue with a contract, the director then can either suspend or revoke  
13 their approval.

14 So the standards are already set forth in the statutes and in the Rules  
15 for the director to review these disputes. Creating another intervening party to  
16 review them really goes above and beyond what the legislature has set forth already  
17 in 656.260 and by-steps that process of review. But the director has to undertake  
18 and approve of these contracts. And to the extent that there is a disagreement,  
19 there's an appeal process set forth already that addresses that medical services  
20 dispute.

21 MR. BRUYNS: Thank you, Elaine. And someone else was on the  
22 telephone and I didn't mean to cut you off. Is there anyone else who would like to  
23 speak to this issue?

24 CLAUDIA: Well, this is Claudia from Dr. Ordonez's office. And I'm  
25 speaking on the provider's side, not the insurer or the MCO. And in regard to the

1 provider having--being able to negotiate the contract with the MCO, in my  
2 experience for over 15 years, it's actually we're given a contract and we either opt  
3 out or--and that's it. So we either opt out and not get a contract to be part of the  
4 MCO, company or organization. I do not see where we can ever negotiate or have  
5 more right to the contract. I do not see the issue with attorneys having the MCO  
6 contract. I endorse transparency, so I'm not clear as to the issue of why we are  
7 withholding these contracts to the claimant attorney, and that's all I have to say.

8 MR. BRUYNS: Thank you, Claudia. If there's like maybe one or two  
9 final comments. We've spent a lot of time on this issue and with--as with is true for  
10 so many issues, we won't come to consensus on it here today. But Lou Savage, our  
11 administrator is in the room, and he has--he's hearing all of this, and we'll take it all  
12 back and we'll try to make the best decision that we can. But with that, we really  
13 appreciate it. But any final words for us?

14 MS. KNIGHT: This is Andrea Knight, a claimants' attorney on the  
15 phone. If I could just respond to one of the last comments.

16 MR. BRUYNS: Okay.

17 MS. KNIGHT: There was a comment made about not understanding  
18 why we need to bring yet another party to the table. But I think we're forgetting that  
19 our clients are the ones receiving the care. Our clients are the ones that are hurt.  
20 We should be able to have transparency to make sure they're getting the care that's  
21 due. We're not asking for, you know--you know, we're not asking for more than just  
22 transparency about guidelines of the treatment. And when we request discovery of  
23 documents related to authorization of care that we be provided that so we can give  
24 our clients answers. It's really difficult to give our clients answers that, "Well, it's an  
25 MCO contract, so sorry, we--there's nothing we can tell you." You know, we--

1 transparency can go a long way to kind of easing the tension between all the parties  
2 in this room, it seems.

3 MR. BRUYNS: Thank you, Andrea. And thank you all very much.  
4 That was excellent conversation. Obviously, you know, we didn't come to a  
5 consensus, but it's an important issue. Everybody comfortable with us moving on to  
6 the next OTLA issue at this point? This has to do with MCO provider lists and their  
7 not being kept current. Many panel providers attach conditions such as only treating  
8 former patients, not treating if there's an attorney or litigation, not treating closed  
9 claims, et cetera. So the proposed change is require MCOs to monitor the panels,  
10 ensure that providers remain willing to treat injured workers, especially in areas  
11 where fewer providers are available. Allow a worker to treat with off-panel providers  
12 if there are less than three providers in their GSA that are willing to treat the worker.  
13 That's a description of the issue. I would appreciate your feedback. Chris?

14 MR. KAFKA: So it seems like it was just last year that there were  
15 some changes made in the rules and all of the MCOs were asked to put in place  
16 some safeguards and--or put in place some processes to pretty much address this  
17 concern. And I think that those went into effect in--and I think it was in June that we  
18 were required to--of this year that we-- Appropriate music. Sorry. And I think it was  
19 in--just in June of this year that we were required to put--to notify the Division what  
20 those procedures were. I am assuming we all did that. And you know, I'm  
21 wondering, okay, so at this point, it hasn't been a lot of time that's passed since  
22 those changes were made. Do we--what kind of information do we have or evidence  
23 do we have that the changes that were made are not having the desired impact?

24 MR. BRUYNS: I could speak to that a little bit. I believe it was April 1  
25 that the rules were effective. And it does require I think MCO plans to be amended

1 to basically describe a process for how the manuals will be kept current, the MCO  
2 provider manuals. And I think, you know, it is fairly soon. I mean we don't have a lot  
3 of experience. But maybe some of the managed care organizations or others can  
4 speak to how that's affected their processes and the currency of their provider  
5 manuals.

6 MS. KLEIN: I mean we already-- This is Ann with Majoris. We  
7 already had some processes in place already. But one of the things that we've  
8 undertaken as part of the new requirements that we have a full-on plan is actually  
9 also going through and doing a full kind of validation of the data that we have on all  
10 the various providers. This is of course an ever-moving target because as soon as  
11 you confirmed a fact, something changes. And so it's an ongoing process. But  
12 that's part of what we've done is in addition to the process that we've put in place, is  
13 we're essentially doing an audit of our full directory, which I can tell you is a full-time  
14 process. I've had to add staffing hours in order to do this, but we're, of course,  
15 committed to having good provider directory data available as possible because it is  
16 a moving target.

17 MR. BRUYNS: Okay. Thank you, Ann. Anyone else? Jeanette?

18 MS. DECKER: At Providence we follow the steps as discussed  
19 earlier...

20 MR. BRUYNS: Thanks, Jeanette. Just to let you know, we're picking  
21 up some background noise. You may want to--if you have noise in your office  
22 space, maybe to, you know, hit the mute button and then join us when it's quiet  
23 there. One of the other aspects of this was that if there aren't three, I guess,  
24 providers available, in the GSA that are willing to treat the worker, that they should  
25 be able to treat off panel. Is that another component of this? Is that already a

1 requirement of the rules? I'll ask-- Someone here might know this. I thought that  
2 was already an existing requirement.

3 MR. SEMPLE: I guess I should speak to the-- This is Keith. I should  
4 speak to the moving target. We understand that it's impossible to keep them up to  
5 the millisecond in terms of the providers and what the providers are willing to do.  
6 And I think our biggest concern or bigger concern is the conditions that we see  
7 providers sometimes attached to, their willingness to treat so it could look like there's  
8 a very long list of providers on an MCO panel in a given area. And we could come  
9 to find out that really none of them are willing to see the worker or maybe one of  
10 them is, or maybe it takes a special phone call or something like that to find  
11 someone for the worker. And we want to make sure that the worker, you know,  
12 basically has a choice of three. I mean that was the number that was chosen for the  
13 administrative rule. And we want to make sure not only that there's three people  
14 there, but three people that are actually willing to treat the worker and not just, you  
15 know, like I said, a special phone call, you know, to one provider and okay, here's  
16 your doctor. This is the best that we can do. We kind of talked about this a little bit,  
17 I think, at the last meeting--

18 MR. BRUYNS: We did, but just--

19 MR. SEMPLE: --as well.

20 MR. BRUYNS: --fairly briefly, yes.

21 MR. SEMPLE: Yeah. And we appreciate what the MCOs are doing to  
22 institute the changes that have already been recognized and you know, codified and  
23 everything. We just want to keep making sure that we're giving voice that some of  
24 our workers are still struggling to have physicians but also have choices among  
25 those doctors. And I realize that's a broader problem outside the Workers' Comp

1 system. I do understand that. But you know, we want the workers to have options  
2 available as much as possible.

3 MR. BRUYNS: Thank you, Keith. Additional thoughts? Jovanna?

4 MS. PATRICK: Yeah. So I would just like to raise an issue that's  
5 happened recently that's pretty exemplary of what happened, because I have a  
6 client who, you know, has a closed claim but a medical device that needs some  
7 monitoring. Her general AP who had been her AP for years is no longer on the  
8 Majoris list. I don't know why. And so and I called the surgeon who had put it in,  
9 and he told me no, we never are the attending physician ever on any claim. So  
10 couldn't send him there.

11 And I, you know, contacted Majoris and they've been very helpful in  
12 trying to find a doctor for my client. You know, they've been communicating with me  
13 back and forth. But here we are three-and-a-half weeks later, they were turned  
14 down by Salem Rehab, and so now they're trying to send her to McMinnville, my  
15 client in Salem, who lives in, you know, an urban area. You'd think that she could  
16 find someone in Salem to help her. She barely drives. And we'll be lucky if this  
17 doctor in McMinnville is willing to treat her. And if he is, we're still looking at a month  
18 delay in her trying to get in to a doctor. And like I said, in this situation, Majoris was  
19 very helpful in trying to help with this situation, but it's still the situation that she's in.  
20 And she doesn't have a lot of choice. If Majoris can't even find her someone in her  
21 urban area, then what luck would she have doing that, being someone who is not  
22 literate and doesn't speak English? You know, if she did not have an attorney, she  
23 would probably be one of those many clients who just slip through the cracks and  
24 doesn't get the treatment that she needs, if you know, I were not helping her with  
25 this or she didn't have the skills herself to do that. So that's just one example of this

1 is the sort of thing that happens all the time.

2 Like even when an MCO is trying their hardest to find someone, if in  
3 this woman's case, there isn't someone in her, you know, immediate area who's  
4 willing to treat her, and so going off the list, going, you know, back to the doctor who  
5 has treated her for four years and is now for some reason not on the list would be  
6 the best option for her. But it's not available because the list says there's doctors  
7 here even though there are not doctors for her. So that sort of issue, I think, is what  
8 we mean when we say, you know, three providers willing to treat the patient. Even  
9 when they're tough patients. I mean I'm not saying she is an easy patient, but she is  
10 an MCO-enrolled patient who needs care and she deserves that care, you know,  
11 completely accepted claim, even if it's difficult. The MCO tells her she has to treat  
12 with them now, then you know, they need to be able to get her that treatment one  
13 way or another.

14 MR. SEMPLE at least--

15 MS. PATRICK: Absolutely.

16 MR. SEMPLE: --have a longer list of doctors she could go through the  
17 phone book and call.

18 MS. PATRICK: Well, she could go--she could stay with the doctor  
19 who's providing her with care for so many years but is not--no longer on the MCO  
20 list. I don't know why he's not. I don't--you know, I'm not privy to that--

21 MR. BRUYNS: Right.

22 MS. PATRICK: --sort of information. But you know, in this case, it's  
23 fairly obvious there's not someone willing to treat her and there's not three people,  
24 let alone one in her area. And so if this were the rule, we could show--look, we tried  
25 to contact all these people. Let her stay with the doctor who was willing to treat her

1 before or let her pick from any doctor she wants. I'm sure she has a primary care  
2 physician who might be the one willing to treat her. So people like that it-- I'm  
3 sorry?

4 50:36: I thought...

5 MS. PATRICK: If she had a doctor before this injury happened, but  
6 she did not.

7 MR. BRUYNS: Oh.

8 50:42: So this is a case where getting down to a very specific example  
9 and it's a story rather than data that shows maybe more of a full picture of what is  
10 going on statewide that--I believe that with this one, I don't know that her existing  
11 provider is even willing to treat her anymore. And so I think that this is a patient  
12 where it's not a matter of, is there a provider in the MCO? I don't think that we're  
13 able to find any provider. And I'm not--I don't recall all the details on it but it's--that's  
14 more of the overall access sometimes with some of those older claims that have  
15 some history, that...

16 51:20: So if she were disenrolled, it wouldn't be any different story.

17 MS. PATRICK: Well, if she were disenrolled, she could go to any  
18 doctor in Salem, you know, rather, who's willing to treat her. And you know, you  
19 say, "Well, but nobody would." Well, but the fact of the matter is is that she is  
20 restricted based on an MCO contract. And by everyone's best efforts, we have not  
21 been able to find her a doctor who's willing to help her with this medical device that  
22 is inserted into her body that she deals with every day. Yes. She is one story, but  
23 she is an example of the sort of stories that bring all of us claimants' attorneys here  
24 because this doesn't happen with all of our clients. But if it happens with 10 percent  
25 and 10 percent of accepted claims, people with serious medical conditions are not

1 able to get their treatment, I think that's a problem. I think every claimant deserves  
2 to get the treatment that they need, and widening the ability to look at doctors can  
3 only be a positive thing. That's why we say the list, even with all intentions to keep it  
4 up, is not always an accurate view of what the clients can really get in touch with, get  
5 access to.

6 MR. BRUYNS: Thank you.

7 52:30: And quite honestly, from Majoris' perspective, I don't think we  
8 have a big problem with that. It's definitely one off. It's not 10 percent of the injured  
9 workers. And when we can't--if there isn't care in network, we say, fine, you know,  
10 go see whoever you want. Or if when they're enrolled, they are needing to transfer  
11 care but it's not available, we tell them you stay with the doctor you're with, then we'll  
12 let you know if and when you need to change positions.

13 So we expand that out-of-network authorization all the time and in lots  
14 of different circumstances where the statute doesn't require if--if a person had  
15 surgery with an out-of-network surgeon, we're not going to transfer them. And we'll  
16 just authorize treatment out of network. So we don't have a problem with that. I  
17 can't speak for the other MCOs. But I'm a little surprised that it's been as long as  
18 you say, that we've been doing this and we haven't said, "In the meantime, if you  
19 need this care, go wherever you can get it," because that would be our standard  
20 practice. Not to say, "Well, let's wait a couple months," unless it's a maintenance  
21 thing that, you know, you don't need it for a couple months or whatever. I don't  
22 know about the circumstances. But that's something that Majoris does all the time  
23 because we do have a mandate to make sure that a worker receives care.

24 MR. BRUYNS: Well, that speaks to a picture case and potential  
25 solution for a particular case.

1 MS. PATRICK: Well, I appreciate that. Like I said, I have no  
2 complaints about Majoris. You know, in this case, we're all kind of doing the best  
3 that we can.

4 54:16: No, well,--

5 MR. BRUYNS: Yeah.

6 54:17: --and I have no real issue with the concept at large. If a  
7 worker, you know, if all the doctors on the list are saying, "No, I won't see them" for  
8 whatever reason. I would like to maybe refine how that language reads so that it's a  
9 balance of you know, just throwing the gates wide open. But I mean we all know  
10 that access to care in and out of an MCO is an issue. And so we have to be creative  
11 about how we address it. So I don't have a problem, one, working on that. And we  
12 work in a lot of rural areas where it's really difficult, where you just may not have  
13 primary care to speak of, so...

14 MR. BRUNOT: This is Zach Brunot. And you just mentioned  
15 something that is the problem, that it's in and outside of MCOs, it is a problem, right.  
16 When it's in MCOs, it's magnified, and so that's the issue. And it's not--and I don't  
17 necessarily think it's even the MCO's fault. It's just the way that the market pans  
18 out. But access to medical care is a problem in this state, and it can get magnified in  
19 an MCO sometimes. And when it is magnified sometimes, it's super problematic.

20 55:32: But the MCO also has the obligation to work to solve that for  
21 the injured worker.

22 MR. BRUNOT: Uh-huh.

23 55:37: Not just say, "Well, gee, we're sorry, you know, you'll just have  
24 to keep looking."

25 MR. BRUNOT: I would like to be able to tell the doctor that says, "I

1 don't want to take that client" to refer to the part of the contract in the MCO that  
2 makes them have to take that client.

3 55:51: The contract would be silent on that, I can tell you--

4 MR. BRUNOT: Really?

5 55:53: --that much.

6 MR. BRUNOT: I'm a skeptic. I'll have to see it to believe it.

7 56:00: I think one of the benefits of the MCO is in cases like that, we  
8 can help them. And we do oftentimes let patients go outside, we--especially in rural  
9 areas. It's a real problem. There--you know, oftentimes, we are instrumental in  
10 helping them find a doctor, where if they weren't enrolled, you know, they don't have  
11 that.

12 MS. FLOOD: Jennifer, ombudsman for injured workers. And I find that  
13 with some of those challenging workers, when they are enrolled in an MCO, that  
14 gives us a few more resources to help them find those services. But we're talking  
15 about workers that either have an attorney or contact our office to know that there  
16 may be an avenue out there, so I don't know how the communication is in general to  
17 workers. We only have stories and we don't have data.

18 56:55: We have workers call on their own when they get their  
19 enrollment letter all the time and say, "I can't find a doctor." Or they'll tell their  
20 adjuster and their adjuster-- I mean, not all the time. It truly is...

21 57:05: Right.

22 57:05: Because most workers have a primary care doctor. But yeah,  
23 and in their enrollment letters, it says, "If you need assistance in accessing care, call  
24 this person," and then--

25 MS. PATRICK: Well, I can...

1 57:20: --they can help them.

2 MS. PATRICK: I can say most of my clients do not have primary care  
3 doctors. And the majority that do, the moment they say Workers' Comp, they kick  
4 them out.

5 57:28: No, I'm not talking about your clients. I'm talking about--

6 MS. PATRICK: Yeah.

7 57:31: --the majority of our book of business, which you know, most of  
8 them just go through the system just fine.

9 57:38: Right.

10 MR. BRUNOT: I'd be willing to wager that the sophisticated clients  
11 that I have never have a problem. It's the unsophisticated clients that don't--have  
12 never been in a doctor's office, have never been--well, maybe in a doctor's office.  
13 Have never been in a law office, that's for sure, or interacted in any sort of tribunal  
14 except for maybe the criminal justice system. But they're still the ones that are  
15 getting injured because that's the jobs that they're doing. Right? So that's where  
16 the problem lies, part of the problem.

17 MR. BRUYNS: Additional thoughts before we move on? Thank you  
18 very much. The next issue, MCOs are not required to comply with any legal  
19 deadlines in making their decisions. And you heard Keith describe--give us some  
20 background on that. The proposed change was amend the rules to clarify that  
21 MCOs are subject to deadlines for review in the same way insurers are. I think your  
22 focus was primarily, although not exclusively, elective surgery. Is that right? And  
23 referring to the requirements for elective surgery authorization that are currently in  
24 Rule 250 of Division 10, and with the thought that MCOs should be subject to the  
25 same criteria for, you know, the timelines for approval of elective surgery. But again,

1 maybe not purely limited to that. But with that, I'd just kind of like open it up for  
2 comment in terms of what you think.

3 MS. JOHNSON: So this was something that was also discussed about  
4 a year ago, and that--right, and there ended up being a data call from the MCOs and  
5 they provided information. I'm not sure that I ever saw what all of it combined ended  
6 up showing. We have--looking at it, so you may have some of that ---information.  
7 But what it came down to at least for us, what we were looking at when we reviewed  
8 our data is there were a small number of claims that went--that took more than a  
9 week to make decisions. But in looking at it, there were extenuating circumstances.  
10 And at the MCO, we are charged with and it's very important to us that we are  
11 making the best medical decision for the worker. So we don't want to make a fast  
12 disapproval because we don't have all the information that might persuade us to  
13 approve it because then that's just going to cause unnecessary delays. And we  
14 don't want to approve it just because we are up against a, for example, one-week  
15 deadline because we want to make sure that this is really the best course of care for  
16 the worker. And so often there are times when we will get a second opinion, or  
17 maybe when it got submitted, we don't have all of the information, an MRI or some  
18 other medical treatment that's been going on that would come in to play and would  
19 help us decide.

20 Sometimes for us, part of our process might be a phone call for some  
21 written correspondence with the requesting provider because to-- They just put in  
22 the request and you think there might be a little something more that they didn't quite  
23 convey to us. And so often in a phone call, they will say, well, here's the part that I  
24 didn't do a good job putting in the chart note, and here's what it is. And that's what  
25 we need, but we can't always get that phone call within--it might take us a couple

1 weeks to get that accomplished. And we just want to make sure that we are making  
2 a good decision when it's made.

3 MR. BRUYNS: Thank you, Lisa. Yes, we did discuss this with the  
4 Advisory Committee last year. And the information is on our website at least in  
5 summary form. If you were to look at the minutes from Novem--I think it's November  
6 of 2017. Basically, the corollary of this particular committee that we had last year.  
7 We did talk about it and what you--we did ask for data from the four MCOs in  
8 Oregon. And most of the decisions were made within a few days, relatively few  
9 days. And there were some outliers, as Lisa described. But that information is all  
10 publicly available. And if you can't find it on our website, I'd be glad to provide the  
11 information to everyone.

12 MS. ST. GEORGE: You can keep it since you said you'd love to have  
13 data. Our overall--

14 62:00: Where's the data?

15 MS. ST. GEORGE: --average turnaround time for preauthorizations is  
16 27 hours. And that's continual hours, not just working-- Oh, that's business hours. I  
17 lied. So roughly within three days. Fifteen percent of our precerts go over seven  
18 days, seven business days. And those are the ones where we either need the  
19 second opinion or we are waiting for additional information from either the attending  
20 or we're waiting because we actually look at the MRI films and the x-rays and all of  
21 those things.

22 And so if we're going to make an application of seven days and we  
23 don't have the information, then it's going to be denied based on inaccurate  
24 information or insufficient information. And then we're going to have a dispute and  
25 then everything stops, where we would just prefer to keep things moving along. And

1 in the meantime, if a dispute's filed, we're probably going to keep doing what we're  
2 going to be doing anyway in order to get the best decision. And if we had the  
3 information to reverse it, we probably wouldn't wait for the dispute here if a dispute  
4 per--the dispute committee to meet. We would just say, "Well, we got the additional  
5 information and now we're going to approve it." So I'm not sure given the small  
6 number of cases that even fall into that that it makes that much sense because  
7 those are already the complicated cases that we don't really need to add more  
8 entanglement to.

9 MR. BRUYNS: Thank you, Ramona. Additional thoughts?

10 MR. SEMPLE: So this is Keith. It's--you know, I guess I should go on  
11 record as saying, you know, we're not here because we just dislike every single  
12 thing that MCOs do and MCOs can do no right. I mean apologize if we've given that  
13 impression. But you know, MCOs...

14 64:03: I was starting to feel kind of bad about myself.

15 MR. SEMPLE: Well, but you know, I mean it is the outliers,  
16 unfortunately, that we're here about. And you know, a lot of times, a lot of the  
17 providers in the system do things that go above and beyond what the law requires,  
18 and that's great, and we appreciate that every time it happens.

19 The challenge is where the law isn't clear and we're in one of those  
20 difficult cases where everybody's frustrated and the client really wants to know,  
21 okay, how long do they have to make a decision? And I can say, "Well, that's really  
22 not entirely clear under law. There's not really a legal deadline for them to make a  
23 decision." And then once they make their decision, then the insurer ultimately has to  
24 make a decision, and that could cause additional delay. I think that's the situation  
25 that we're really concerned about. Not that, you know, MCOs are deliberately

1 delaying the process, but that injured workers really need timelines and have a  
2 sense of expectation when they're, you know, in a very difficult sometimes situation.  
3 I mean these are the really, you know, challenging cases that we're talking about  
4 where people need surgeries and they're, you know, really struggling. And to have it  
5 be kind of open-ended and their lawyer not be able to really give them specific  
6 information, it really makes them feel like they're kind of just subject to the will of  
7 everybody else in the system except for, you know, their own needs. So I think  
8 that's what we would like to see. And it's not necessarily that we want it to be seven  
9 days, or I mean it doesn't--I don't think that we would say that we want to see  
10 something absolutely identical to the elective surgery rule. But we would like to have  
11 at least some timelines and some guidance for the back and forth because the  
12 insurer then, once they have an MCO, is no longer subject to the deadlines. They  
13 have the MCO. So I mean it just really--at least I believe that's how it operates. I  
14 believe the insurers have then extra time on their end to make the decision about  
15 compensability. And suddenly, we're not dealing with the elective surgery process  
16 where IMEs are taking place and decisions are being made within more or less a  
17 month's time. And I can tell my client, you know, hey, this stuff's all going to be  
18 decided pretty much within a month that we're either going to have an appeal or  
19 we're going to, you know, have an answer and approval. I can't even tell my client a  
20 month. I have to say, "Well, we'll just kind of have to see." And I don't feel like that's  
21 a good answer to have to--and I don't think that's a sufficient answer for a client to  
22 have to hear when they're injured like that. So that's why I would like to see  
23 something a little more detailed just to kind of set the floor. I mean I understand  
24 folks can go above and beyond, and like I said, we appreciate it in a given case  
25 where we have some, you know, folks that really try to find the best outcome and

1 push towards it. But for those other cases, we'd like to at least have some guidance.

2 MR. SCHMELLING: This is Dan with SAIF Corporation. Speaking to  
3 the seven days, for a non-MCO enrolled worker, it's not a seven guaranteed you're  
4 going to get a decision. It's a we have seven days to respond with we need to  
5 schedule an IME to follow up on this. If we don't respond, then we have to pay for it.

6 MR. SEMPLE: Right.

7 MR. SCHMELLING: So I don't know if you're asking for the MCO to do  
8 something different in guaranteeing a response within seven days or if it would, I  
9 don't want to say complicate your process, would you go out and...

10 67:28: No. They would have got no response. I would venture to say  
11 at least a deferral explaining what we need in order to continue to process that well  
12 within the seven-day period, that we either need a second opinion or we requested  
13 additional information from the treating doctor, or we need a copy of the MRI.  
14 Whatever it is that we need in order to make an educated decision. So there would  
15 be a response to the worker well within--an initial response well within that seven  
16 days.

17 MR. SCHMELLING: And I can only speak to kind of our best  
18 practices. But typically, if we enroll the worker in an MCO, we enroll at acceptance.  
19 And if the MCO is saying this is medically appropriate and necessary, we're not  
20 going to second guess that for the most part unless there's a compensability issue.

21 68:21: Right.

22 MR. SCHMELLING: And if there's a compensability issue, well, then  
23 we have that issue anyway, so we might get an IME to address the compensability.  
24 So I don't know whether this is speeding up the process because it's not a situation  
25 where we have compensability anyway.

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68:36: Yeah.

MR. SCHMELLING: And that's going to be a longer process.

68:39: Right. And we don't address compensability. We address the medical appropriateness for the diagnosis for which it's requested is up to the insurer to determine if that diagnosis is part of the accepted condition. And we do it that way so that we've got our review done and it doesn't have to come back to us if there's a change in the compensability decision. So...

MR. BRUYNS: Chris?

MR. KAFKA: I just want to add, and here we actually have, I think, good alignment of interests between the MCO, the insurer and the patient, which is to get this done as quickly as possible. As an MCO, you know, we're always worried about getting the injured worker back to work as quickly as possible. And typically, if there's a surgery involved, that surgery's going to be one of the roadblocks of getting that worker to medically stationary and to--and back to work as fully as possible. And know that in our MCO, we're very conscious of that and we want to get--and we certainly don't want our medical necessity review to be holding up that process. And you know, and we're--and so and I think that commitment to it is both at a philosophical level, but then also at a financial level because we know the insurers are looking over our shoulder. And if we start to have things held up too long in our internal administrative processes, we'll hear about it from SAIF or whoever the carrier is, saying, you know, "What's going on here? We need this thing moved along." So there's real--I think in this case, there's really good alignment that these medical necessity decisions get moved along, get looked at as quickly as possible.

MR. SEMPLE: Yeah. This is Keith. I'll just go back to the seven-day thing. No, we realize that the final decision isn't issued within seven days in non-

1 MCO settings for elective surgery. But within seven days, we know whether  
2 something has been approved or whether we're having a second question with an  
3 IME. You know, and I realize that the vast majority of MCO requests are turned  
4 around very quickly, but we can't have deferrals, and we can having deferrals that  
5 last longer potentially then hey, we're going to have an IME within X number of days  
6 and we're going to have to send that all around to the attending physician within X  
7 number of days. And if we can't straighten it out, then we have to, you know,  
8 request a hearing. We don't have that level of detail, and we have that elsewhere in  
9 the statute or in the administrative rules. I mean there are all kinds of number, you  
10 know, day numbered deadlines that workers have to comply with and that we all  
11 have to comply with. And it's just notable that there really isn't any limit on--you  
12 know, on how long these things can go on for. You know, we understand that  
13 there's, you know, some internal pressure and some, you know, financial incentive  
14 and different things that are involved. But you know, we really want to be able to tell  
15 our clients that we're pushing things for you, we're not letting deadlines slip. We're  
16 not just waiting for someone to make a decision and you know, just twiddling our  
17 thumbs and have you hanging out there. You know, they've got X number of days to  
18 make the decision, and then if we have to appeal it, then we will, would be a lot more  
19 helpful of a deadline, and you know, having that deadline be--apply somewhat  
20 somehow to the compensability decision as well. I mean it really is a hardship on  
21 workers who--I mean if you're a worker who's not enrolled in an MCO, the elective  
22 decision, the surgery decision, all of the issues, the necessity and the  
23 compensability have to be decided within a pretty tight timeline or you're dealing with  
24 an appeal.

25                   Once we have an MCO involved, that timeline, you know, is extended

1 dramatically. And you know, that's concerning, you know, for me to say, "Okay.  
2 You're an injured worker. You're outside an MCO. I can tell you how your elective  
3 surgery question's going to go." And we're going to know pretty quickly what we're  
4 doing with it. Over here, I just--I can't tell them much of anything about the timeline.  
5 So that's the underlying concern, so...

6 MR. BRUYNS: Thanks again, Keith.

7 MR. SEMPLE: Thank you.

8 MR. BRUYNS: Jovanna?

9 MS. PATRICK: Yeah. What I've heard here, and I was at the  
10 November meeting last time as well, is that the majority of cases are decided within  
11 the same timelines that, you know, non-MCO insurers have to make their decisions.  
12 Now, the ones that are outside of that are the ones that we're concerned about. If  
13 MCOs are able to make the decisions for the most part within the timelines, then I  
14 don't understand why they feel they should not be held to the timelines. It would be  
15 the same as insurers accepting or denying claims. Well, if 90 percent of the time,  
16 they go within the 60 days, but 10 percent of the people have to wait three, four, five  
17 months, we don't let them out just because they're 90 percent compliant. Those  
18 ones that they miss, we can file de facto denials on. And so I think having a rule in  
19 place is not harmful to the MCO because it sounds like you guys are following that  
20 deadline in most cases.

21 Another thing I noticed about the data, and I don't have it in front of  
22 me, but from memory, ones that took longer than the, you know, seven-day and  
23 then, you know, to get an IME, the like 21, 28-day requirement, the ones that took  
24 longer than that were almost entirely denials, some of which lasted, you know, three  
25 months, I think was the longest one. And from our--at least from my standpoint,

1 what I'm seeing is you know, the MCO for the insurer, spending that time building  
2 evidence against the injured worker getting that treatment, and that evidence, when  
3 do we get a chance to see it? Well, it's not when they make the decision. It's not  
4 when they make their--the joint committee decision when it goes up to the next  
5 stage. You know, when does the injured worker have the chance to rebut that  
6 document? In non-MCO, you know, we get that IME right away and have a chance  
7 to take it to the doctor and talk to them more quickly. So again, some of this goes to  
8 not having complete transparency in the process. And some of it goes to if the  
9 deadlines are working and you guys are voluntarily following the deadlines, we feel  
10 that you should--those deadlines should actually exist in the law and not just be a--  
11 you know, because we do so good, we should be held to that. Thank you.

12 MS. FLOOD: Jennifer, ombudsman. I just want to add that in talking  
13 with workers, when you can give them some predictability, whether it's a good  
14 decision or in their favor or against their favor, just having that idea as to well,  
15 typically it's going to take about this amount of time. I mean, now that we've--27  
16 hours, business hours is your average. If I get a worker that has a Majoris one that's  
17 in that limbo period, I mean, I may be able to say, "Well, my understanding is it  
18 usually takes them around 27 on average, but you know, we'll have to wait." That's  
19 actually even something to provide them instead of saying, "You know what, there's  
20 nothing out there. Who knows how long it's going to take?" Versus in the non-MCO  
21 world, it is more structured as to this is the time frame. It's just an accept or deny,  
22 sometimes workers think, oh, then a decision is going to be made in 60 days, pretty  
23 quick to say, no, that's a timely measure. It doesn't mean that it couldn't happen  
24 sooner or it couldn't happen later. But it's a timely measure. So it gives them some  
25 predictability as to how the pace is going to go along.

1 MS. ST. GEORGE: Well, this is Ramona with Majoris. There are  
2 some differences in how we're able to process things in the MCO versus in elective  
3 surgery-- One, the MCO doesn't have the authority to give an IME. And since the  
4 carrier does, they can go to an IME company who has, you know, appointment slots  
5 in, you know, any given week and can get that done quickly. We typically, if we're  
6 getting a second opinion, it's because there's significant questions, and so we're  
7 looking for a subspecialist probably, who are difficult to get into. So that time frame  
8 is longer.

9 I suppose we could go out to the IME companies and say, "Gee, let us  
10 use your network for second opinions." But I don't know that that's their strong suit,  
11 is necessarily the most complex of medical care. I would rather pick the specialist  
12 who really specialized in shoulder reconstruction or something. And so that creates  
13 a bottleneck admittedly.

14 And the other is that we have no control--I mean, we do have  
15 contractual requirements, but I don't have any physical control over the treating  
16 doctor providing the information that we've asked for. And so if they don't, again, it  
17 will likely after-- What's the time period on that?

18 2:56: We normally give them two weeks to respond.

19 MS. ST. GEORGE: But then if we never get a response at 60 days,  
20 then it converts to a disapproval. So we give them lots of time. If they never  
21 respond, then it does convert to a disapproval. You know, if you want to move that  
22 up, you're going to get more disapprovals at an earlier time frame is basically what  
23 will happen. And I'm not sure that that serves anyone. But we can do it and we can  
24 comply with it and then say, well, we don't have the information we need to make it--  
25 to approve it, so we'll have to disapprove the medical necessity of it. So I mean

1 there could be some unintended consequences of doing that.

2 MR. BRUYNS: Again, this would be an issue where we don't have  
3 consensus around the table. All we can do is take it all in and then, you know,  
4 consider, you know, what to put in the proposed rules. And so with that, is there any  
5 one or two folks who would want to weigh in again? Especially if you're on the  
6 telephone with us and we haven't heard from you.

7 Hearing no one then, thank you very much and let us move on to--it's  
8 in the middle of Page 2 of these recommendations. And the issue is that MCOs  
9 interfere with the role of the attending physician beyond reviewing treatment  
10 requests for medical necessity and addressing those issues with the provider. And  
11 the proposed change was to clarify the role of MCOs and limit the subjects of  
12 communication between the MCO and the providers. And you can tell me, is this  
13 issue kind of related to the first one on contractual availability of the contracts or...

14 MR. SEMPLE: It might be.

15 MR. BRUYNS: All right.

16 MR. SEMPLE: Without having seen the contracts, I'm not really sure.

17 MR. BRUYNS: Okay.

18 MR. SEMPLE: I think the concern is that we're just seeing more and  
19 more, and I--you know, I understand this kind of cuts straight to the purpose of  
20 MCOs, which is to be involved in peer review, which is to point things out to a  
21 provider that may not be familiar with a particular procedure, or may not have the--as  
22 much expertise as the top expert in the field, for example. But we're also seeing,  
23 you know, things where workers are being instructed to go to medical appointments.  
24 One of the most concerning things that we've seen over the last couple of months  
25 was an MCO that basically told the doctor they felt that the patient was medically

1 stationary and kind of pushed on that issue.

2 We see a lot of requests to have providers withdraw treatment  
3 requests, especially based on what they call the official disability guidelines. Those  
4 have not been adopted specifically in Oregon. That's been noted a couple times in  
5 different statements from the departments. Some of the orders I've gotten make  
6 note of the fact that they're not specifically adopted, although they're presented more  
7 or less that way to the doctors. So there's just some concerns that we have in terms  
8 of just how hard doctors are being pushed. And again, I would really like to hear  
9 from more of the doctors about, you know, kind of how they respond. I only have  
10 access to the doctors who I speak to about these issues when they come up. And  
11 usually, there's a lot of frustration in terms of things that they just know will be  
12 denied. They've been denied in the past. They'll be denied every time. We thought  
13 about it once. It didn't work out. You know, fine. When they ask me to withdraw it,  
14 I'll just withdraw it type of thing. So we're--you know, we're just concerned about  
15 that. A lot of our members are seeing that. A lot of our clients are concerned about  
16 it. So we wanted to raise that as an issue and just let a--at least let a conversation  
17 take place over that.

18 MR. BRUYNS: Okay. Is that discussion-- Your thoughts?

19 7:02: Okay. I'll talk. So I can't speak for the other MCOs, but yes, we  
20 will. If we've reviewed something and the guidelines are adopted by the MCO,  
21 which is part of the statute that we have treatment guidelines in place, and the ones  
22 that we use are the ODG guidelines, which are national guidelines, continually  
23 updated and thoroughly supported by all of the studies that went into compiling that  
24 guideline. And they're kept very current. And yes, providers are required to agree to  
25 treat--to follow treatment guidelines. That's also part of the legal construct.

1                   So if something has not passed compliance with those guidelines, and  
2 the physician has not provided a medically substantive reason that they--that the  
3 treatment should proceed outside of those guidelines, because guidelines are  
4 guidelines, bell curve, there are people who will need the treatment outside of the  
5 guidelines. But if it looks like it's going to be disapproved, then the first thing we will  
6 do is to reach out to the provider and say, this doesn't meet the guidelines. It's likely  
7 going to be disapproved, but--and this is a peer-to-peer that is happening. But we  
8 think that this treatment would be appropriate. What do you think? There's a  
9 discussion. They agree or they don't agree.

10                   If they go, "Okay, fine," then we say, "Well, we have to wrap up that  
11 precert. You want to withdraw that request and submit this one?" And that way, we  
12 don't enter into a dispute. We have the new treatment plan in place and the worker  
13 moving forward. That seems to make sense to me for the worker and the system at  
14 large to not create a dispute where it can be resolved before it gets to that point.

15                   The physician is under no duress to agree with that and they often  
16 don't. And then we send out a disapproval with the reason why it's not authorized as  
17 medically appropriate. I think that is square in the middle of our mandate to engage  
18 in those things. We're also required to engage in return-to-work activities. So  
19 interacting with the physician about return-to-work information, again, right in our  
20 wheelhouse.

21                   If a worker isn't--the physician isn't providing any curative treatment  
22 and the worker's physical findings aren't changing over the course of time, that by  
23 definition means the worker is medically stationary. And you would be amazed at  
24 the number of physicians who do not understand that medically stationary does not  
25 mean preinjury status, that it means they're not anticipated to have material

1 improvement with treatment over the passage of time. And so yes, you'll have that  
2 conversation with providers. And again, that's perfectly appropriate for the MCO to  
3 do that. It's part of the treatment quite frankly, that if they're medically stationary,  
4 they're moving into the palliative care realm for treatment, which is you know, a  
5 completely different thought that we then deal with. So I don't see any problem with  
6 any of the things that Keith raised that MCOs are doing. And I think they're smack in  
7 the center of our statutory mandate.

8 MR. BRUYNS: Additional thoughts?

9 MS. DECKER: I'm going to speak for Providence. We--whenever  
10 there's a denial of service, like times that we know that something that is not going to  
11 make criteria or something, we issue the denial with the alternative treatment  
12 recommendation that we are making. And then the discussion happens with the  
13 provider to make sure that the treatment doesn't stop, that the treatment keeps on  
14 going, you know, maybe just a little bit different. But we say no--I mean, on paper  
15 legally to say no it's not, then we are giving them the alternative because we don't  
16 want them to just be left in limbo, you know, now what happens. So that's part of  
17 how our process takes place.

18 At the same time with the medical stability part of it, you know, we  
19 have the discussions sometimes with the providers to have--to make them  
20 understand or to have the open discussion about what it means, you know, and  
21 maybe this is a patient that might need palliative care, and it's not necessarily the  
22 curative treatment at the time.

23 You know, but I think I got to go back to what Chris said originally.  
24 These are educated people, you know, that they just don't go by what we would say.  
25 It's a discussion, it's a conversation. We try to do what's best for that patient. You

1 know, it's the livelihood of the patient at the end of the day. You know, where they  
2 going to--how they are being affected in every side of their lives. So we want to  
3 make sure that they are taken care of, you know, they're--you know the reason and  
4 that they are given the same good medical care.

5 MR. BRUYNS: Thank you.

6 MR. KAFKA: I agree 100 percent with both Jeanette and Ramona's  
7 testimony on this. You know, this--I really have--even have a hard time responding  
8 to this concern because it's just so smack-dab in the middle of what MCOs are  
9 supposed to do and this almost means like there should be certain topics that  
10 become off limits for two professionals the medical field that you're talking about.  
11 And that just means quite frankly, they're inappropriate.

12 MR. BRUYNS: Thanks, Chris.

13 13:14: The piece about...

14 MS. PHILLIPS POLICH: This is Jodie. I just wanted to comment on  
15 the medically stationary status. You know, I would state that I find that particularly  
16 troubling from somebody who represents injured workers because the attending  
17 physician is the only person in the system that's allowed to make a worker medically  
18 stationary. So I see that as significantly different, at least from my perspective, from  
19 other forms of medical treatment. While that status may dictate the sort of treatment  
20 that's available to the worker, that is a fundamental--that is a very important  
21 determination, and the law says that that is determined by the attending physician,  
22 not MCO guidelines, not to harken back, that we don't even know what they are.  
23 And that--so I see the medical treatment and a worker's medically stationary status  
24 as very different. Thank you.

25 MS. ST. GEORGE: I don't--Ramona. I don't think anyone suggested

1 that we were determining whether or not a worker was medically stationary. But  
2 simply interacting with the physician and explaining what medically stationary  
3 means, and that based on their medical records, it looks like this person could be. If  
4 they say no, then no, they're not medically stationary.

5 MS. PHILLIPS POLICH: This is Jodie again. But what actually  
6 happens is is that a letter comes from the medical director confirming to the doctor  
7 that the doctor agrees that they're medically stationary, or that they've decided that  
8 they're medically stationary. And candidly, that's just really not the same thing and  
9 may be in complete conflict with what the doctor's chart notes show, and that--and  
10 whatever guidelines or whatever standards are applied, we don't have the ability to  
11 see or access.

12 15:00: Well, speaking for Majoris, a letter would not go to the  
13 physician saying that the physician said the worker was medically stationary if the  
14 physician did not say in that conversation that the worker was medically stationary.  
15 And the physician would have an opportunity to agree or disagree with that.

16 MS. PHILLIPS POLICH: With no disrespect, I've experienced  
17 different.

18 MR. BRUYNS: Thank you, Jodie. All right.

19 DR. CRAVEN: This is Dr. Craven. I'm a medical director with  
20 Providence. And I just want to make a comment about medically stationary. I--  
21 usually, it occurs with the peer-to-peer call. And I do sometimes tell them, you know,  
22 tell the attending that I feel that the--you know, by my review, that you know,  
23 everything's been done and there's no more treatment. And if he doesn't agree,  
24 then we discuss it maybe further. But I know, and she's--I forgot who said that, but  
25 she's right. The attending physician is the one that can only make that final

1 determination or opinion is with--I tell them that. But I do discuss it with them,  
2 whether they think they're medically stationary or not.

3 MR. BRUYNS: Thank you, Dr. Craven.

4 DR. CRAVEN: And if you have any other questions as far as how  
5 Providence does it, you can ask me. I'm listening.

6 MR. BRUYNS: Okay. Thank you, Doctor. Sheri, you had your hand  
7 up at one point.

8 16:21: I have a question about the MCOs scheduling IMEs.

9 16:25: I'm not aware of that but...

10 MR. SEMPLE: Well, I've seen...

11 16:29: Do you know where that came from?

12 MR. SEMPLE: I've seen my clients, we get letters saying you've been  
13 scheduled for an appointment with Dr. So and So, it doesn't have appeal rights and  
14 it doesn't--it's not a client's treating provider. I mean that sounds an awful lot like an  
15 IME to me. And sometimes we, you know, call them up and say, "Hey, there's no  
16 authority for this," or "We're not going." Other times, I tell my client, "Well, you know,  
17 I don't know what they'll do if you say no. You know, they're saying you have to go  
18 to this, this x-ray exam. It's not required by law, but you know, will it speed things  
19 up? Will it slow things down? Will it increase your chances of getting it approved,  
20 decrease your chances of getting it approved?" No idea, so...

21 MR. BRUYNS: It's just like a second opinion?

22 17:13: Yeah. It would be like a second surgical opinion or yeah, a  
23 consult. Yeah. At least for us, there's never any language that says it's mandatory.  
24 If the worker doesn't go, he doesn't go. And then we proceed with making a  
25 decision without that information.

1 MR. SEMPLE: Again, you know, workers don't necessarily realize that  
2 they have a choice unless they ask an attorney and say, "Hey, do I have to go to  
3 this? Why should I? Why shouldn't I? Is it a good idea, not a good idea?" You  
4 know, it sure looks like it's mandatory and official. And you know, I understand the  
5 desire for second opinions on different things, but I have to tell you, from my clients'  
6 perspective, suddenly there's a doctor that's working for the insurance company  
7 who's second guessing what my doctor's telling me needs to be done. And now  
8 they want to send me to an examination with this doctor in addition to what the  
9 insurer might send me to. I mean it just--it really is--you know, I understand that  
10 there's a lot more nuance to it than that. But from my client's perspective, they really  
11 have a hard time with the peer-to-peer. I understand that's completely within the  
12 mandate and in the wheelhouse. It doesn't mean we're not still concerned about it a  
13 little bit, how it takes place and the degree to which it takes place, and kind of how it  
14 might be perceived by the provider who's providing treatment to an injured worker,  
15 or the injured worker who's needing the treatment. So I mean some of this is kind of  
16 concerns of perception. But you know, these--you know, we want you attend a  
17 certain exam, you know. It just--it's hard for the worker to understand what that  
18 means.

19 And I--you know, I understand it may completely legitimate to get a  
20 second opinion in a given case. But you know, whenever workers are being sent for  
21 second opinions and it's not their treating doctor telling them it's a good idea, they  
22 get a lot--they get real concerned about it. They want to know who's scheduling this  
23 exam, why, and by what right. And that's where we get into kind of the challenging  
24 answer.

25 MR. BRUYNS: Thanks, Keith.

1                   19:07: Just to echo what Keith was saying, you know, I'm not a  
2 Workers' Compensation attorney, but I talk to a lot of my members. Those members  
3 are sophisticated individuals. Most of them have a four-or-five-year license, have to  
4 take continuing education. You know, they're electricians. They're not, you know,  
5 people who might struggle with language barriers or literacy or those types of things,  
6 and they still get...

7                   I get members who call me part of the way through the process, you  
8 know. If I hear someone got hurt at work I try to reach out to them and give them  
9 Jennifer's information, make reference to attorneys if they end up needing them,  
10 because even sophisticated individuals get letters like that, and they feel like they  
11 don't-- And from my experience, some of our employers even, they're initially trying  
12 to direct sometimes, you know, a member's care even though that's not a provider.  
13 But if you have someone who started in a process and where someone's telling you  
14 this is what you have to do, even if it's not that, you know, accurate, they're already  
15 hurt and concerned and frustrated because they got hurt at work. And then you get  
16 a letter that says that you need to go do this thing, and maybe the solution to that is  
17 what they're asking for is a clarification, perhaps the letter says this is the--you know,  
18 this is why, and you are not required to go.

19                   You know, sometimes it's a little bit more clarification about what  
20 people's rights are up front because otherwise, usually the assumption is I don't  
21 have a right. Unless you're going to go to someone who's going to tell you what  
22 those are, and half the time when I talk to my members-- We do a little boot camp  
23 and we talk to them about different issues like sexual harassment and Workers'  
24 Compensation and unemployment. And one of the things that I ask them is, do you  
25 know how much a Workers', you know, Comp attorney costs? Well, way too much

1 money. You know, I just give up, you know. And that's what they tell me.

2 20:56: Well, they're right.

3 20:59: For you guys, perhaps. But I mean, so just coming from the  
4 standpoint of someone who's not even dealing with the injured worker on a daily  
5 basis, when I first come in contact with them, which is usually when they're freaked  
6 out because their employer told me to do something they're not supposed to do, it  
7 just feels like it's this increased burden of being forced and not having any control of  
8 what happens.

9 21:20: I don't have a problem saying that we need this exam to  
10 continue the review of X treatment and that's not mandatory. But you know, if they  
11 don't go, then again, they may very well end up with a disapproval and--but you  
12 know, a lot of injured workers don't go. And that's what happens. So I don't think it  
13 really makes a big difference to us whether we add the--language in there that it's  
14 not--this is not a mandatory exam, but we feel it's necessary in order to reach a  
15 conclusion on the medical treatment.

16 22:01: And normally, right now, they are getting--so first, they would  
17 get the--say it's a surgery--that says we don't have enough information and so we're  
18 deferring this for a second opinion that's scheduled by Majoris. And then when they  
19 schedule it, they get the appointment letter that says you've been scheduled to see  
20 the orthopedist or whoever it is to explain to them so that they know why they're  
21 going. But you're right, we don't have anything right now that says it's not  
22 mandatory.

23 MR. BRUYNS: Jeanette?

24 MS. DECKER: I'm going to speak for Providence. The letters, yeah,  
25 we don't say mandatory. We don't make mandatory appointments for them. For

1 those cases we make the call to the worker first to let them know, you know,  
2 because they are concerned because those are the ones that might take two, three  
3 more days longer to make decisions sometimes. And that is what the  
4 communication was with them to say we don't have all the information that we need.  
5 And then get the medical information to us and whatever...

6 23:02: And we also have to get approval from the insurer as well.

7 23:11: I was going to ask, do you coordinate your second opinions  
8 with the insurance company? That...

9 23:20: Right.

10 23:22: Sort of. So like if it's just a medical one, we--and we need a  
11 second opinion, we schedule it for that. If the adjuster says something--goes and  
12 says, "Oh, by the way, I have an IME" because they have compensability scheduled,  
13 in order to streamline it for the worker, often what we will say is, "Will you please  
14 make sure and ask this question about the surgery in your IME?" And then they  
15 defer it for the IME. So it...

16 23:49: Because that where the worker calls and says, "Well, I've got  
17 this IME scheduled on this date, now they've scheduled another IME on this date."  
18 And now I'm realizing, okay, well, if it's an MCO, that might be the second opinion.  
19 Just trying to--keeping in mind the rights of a worker to not attend, but also taking  
20 into consideration the impact on a worker. When all of that stuff's going on, they feel  
21 like they've lost total control of their life anyway. It just really keeps adding to that  
22 chip that we try really hard to...

23 24:28: If we have that information, we'll try not--you know, if it's an  
24 appropriate--

25 24:31: Yeah.

1                   24:31: --specialist that we're comfortable with rendering, you know,  
2 the medical side of it, then we'll try not to duplicate another appointment.

3                   24:44: Does it ever got the other--I apologize for asking, but does it  
4 ever go the other way where you guys are scheduling your second opinion and the  
5 adjuster might say, hey, could you add these extra questions in?

6                   24:55: We won't do that.

7                   24:57: Yeah.

8                   24:57: We won't ask compensability questions. That's not our  
9 bailiwick.

10                  MR. BRUYNS: Okay.

11                  25:07: The answer is no.

12                  MR. BRUYNS: I would just ask the Committee if maybe we're ready to  
13 move on at this point, or if you have additional thoughts that you really want to  
14 provide on this one?

15                  And I'll also ask if we could--because the final issue here on  
16 preauthorizations, we did discuss with the Committee on the 19<sup>th</sup>. And so that we  
17 don't run out of time for Diana's issue, what I'd like to do is actually skip this one,  
18 and then we can go back to it. If there's more that you would like to discuss with the  
19 Committee and we have the time, we're glad to come back to it.

20                  But with that, Diana, can you kind of give us some guidance in terms of  
21 what you'd like to discuss regarding your recommendations?

22                  MS. GODWIN: Thank you, Fred. I'm Diana Godwin. I'm an attorney  
23 in private practice and I represent a number of private practice physical therapy  
24 clinics throughout the state, some of whom are on panels for the various MCOs, and  
25 some of whom are not. But we have two issues that I wanted to bring to the

1 Committee with respect to MCOs and the ability of an injured worker to get timely  
2 care from an appropriate provider. It sort of segues a little bit into some of the  
3 issues that the Oregon Trial Lawyers Association has raised and that in some areas,  
4 a worker can have a choice of two MCOs. In other words, have a better choice of  
5 provider, particularly better choice of an appropriate provider for their particular  
6 injury.

7 But in an area where the insurers in contract only with a single MCO  
8 and maybe the panel of providers is not really the best for that injured worker,  
9 they're going to be stuck with that as long there are, quote, three, at least three of  
10 the providers of a particular medical specialty on the panel. But it doesn't really  
11 speak to real worker choice, particularly if it's going to be very difficult to get access  
12 to those providers.

13 And we think that having the choice of two MCOs, number one,  
14 introduces some better competition among providers and more choice for the  
15 worker. Because I think really, what we've been talking about a lot through all of  
16 today is making sure the injured worker, who as we all know in the Work Comp  
17 system has been deprived years ago of any right to sue their employer for negligent  
18 conditions on the job. And in exchange for that, those injured workers are in the  
19 Work Comp system, which is supposed to guarantee them appropriate medical care,  
20 timely access to the right care. And we're seeing that worker's choice, and those  
21 workers--protection through those workers, which was the bargain for them losing  
22 the right to sue their employers, we're seeing those choices gradually eroded.

23 You know, I was around at Mahonia Hall and sat through a lot of  
24 Health and Labor Commission--Labor Committee hearings in the legislature a  
25 number of years on all of this. But now, we're gradually seeing that more and more

1 restrictions are being put on that worker's access to the best and timely care. We  
2 think one of the issues is that we ought to have an insurer contract with more than  
3 one MCO in those GSAs where there is that other--there are additional MCOs  
4 available. And so you know, we're just trying to protect and expand. Mostly just  
5 protect the original concept of having the worker have choice and access to  
6 appropriate and timely care. And if there's only one MCO and maybe that MCO is  
7 only contracting with the minimum number of providers, that's not good for the  
8 worker because the whole purpose of the Work Comp system is to protect the  
9 worker, get them timely care, get them back on the job. So that is-- And also, we're  
10 seeing in some areas where there are two MCOs, those workers have the right to  
11 choose. Other areas of the state, there's no choice. We think that ought to be  
12 equal.

13           And then the other--and I suppose we want to talk about that one first.  
14 But just briefly, the other one we want to talk about is it's changing from 7 to 14  
15 days, the time within which a worker can continue with their current provider after the  
16 mailing date of the notice of enrollment. And we can talk about that separately, so...

17           MR. BRUYNS: Okay. Thank you very much, Diana. So let's begin  
18 with the first issue of whether an insurer would be required to contract with more  
19 than one MCO if there's more than one MCO in the geographical service area.  
20 Chris?

21           MR. KAFKA: Yeah. So this probably wouldn't affect Kaiser On-the-  
22 Job MCO a lot because--just because given the nature of our geographic service  
23 areas. That said, you know, if I were the second MCO in some of these areas of the  
24 states that aren't as well served, I would have considerable negotiating leverage with  
25 the insurer. And I think that could create a dynamic that could be pretty dangerous

1 for the MCO system out in those--in a lot of parts of the state. And or create an  
2 environment where insurers would be forced to enter into agreements that may not  
3 be on the--on financial terms would be consistent with what they're seeing in other  
4 parts of the state, which would then have the impact of driving up costs in the  
5 system.

6 MR. BRUYNS: Thank you, Chris.

7 MR. KAFKA: So that's--I see that as a major concern with this  
8 proposal.

9 MR. BRUYNS: Rich Katz back in the back?

10 MR. KATZ: Rich Katz with Therapeutic Associates and Northwest  
11 Rehab Alliance. I understand exactly what you're saying, but the actual opposite is  
12 also true. When there's not competition in a GSA between two MCOs or insurer, an  
13 MCO has incredible leverage over providers with regard to contract that they're  
14 asked to enter into. That can result in payment levels well below the Oregon fee  
15 schedule and even dissuade providers from entering into such an agreement again.  
16 So it slices both ways is what I'm saying.

17 MR. BRUYNS: Thank you, Rich.

18 32:01: Well, I would say that this proposal does the exact opposite of  
19 creating competition. It ensures that either no matter what your product is,  
20 everybody gets a piece of the pie. Or if a customer doesn't want to agree to your  
21 terms, they can't use an MCO. And so there would be no motivation for me to try to  
22 have a superior product. And I don't think at this point there is an area of the state  
23 that doesn't have at least two MCOs. And that's competition. The providers are--  
24 you know, the MCO people can go to the insurers and you know, I'm not sure where  
25 the term monopoly came from because that's not my understanding of what a

1 monopoly is at all.

2           But well, let me give you an analogy. I have this Ford SUV that I really  
3 like. It has all the options I want, none of the options I don't want. I negotiated a  
4 deal with the dealership. We're both very happy. I used to have a Chevy. I hated it.  
5 I don't think the Chevy dealership liked me very much because I was always in there  
6 complaining about my Chevy. So I don't think they really want to sell me the Chevy  
7 either. But under this theory of commerce, I'm going to have to buy a Chevy even  
8 though I'm never going to drive it and I'm going to be unhappy about having to do it.  
9 Or I cannot have a car at all. That's an exact corollary to this proposal.

10           And yes, what if you can't reach terms? Then I guess you don't get to  
11 have an MCO. And you know, there's plenty of business throughout the state. I  
12 think, you know, the open market says, build your best mousetrap. And the choice  
13 for the worker is built into the MCO statute.

14           I ran some data on--I love data--on our network composition. We have  
15 no fewer than nine options, and that's in GSA 1, which is the north coast. I mean  
16 there's no one there. We have--I can't do the math but it looks like it would add up  
17 to somewhere over a thousand. I am completely unaware particularly in the area of  
18 physical therapy of people not being able to access appropriate physical therapy in a  
19 timely fashion. So you know, I don't think this is about the injured worker and their  
20 choice.

21           MR. BRUYNS: Okay. We'll go to Grant and then I'll go right next to  
22 you, Rich. You had your hand up.

23           MR. ENGRAV: I enjoyed your corollary because I'm currently going  
24 through a car shopping process myself. But I think it would be a more perfect  
25 corollary if you were a passenger driver, such as an Uber driver. And the people

1 that were going to go along on the ride with you were represented in that initial  
2 transaction because their needs might not be exactly what your needs are as well.

3 We can argue that this system is a monopoly, but the people that  
4 aren't being considered in the contracting room are the people who this entire  
5 system is supposed to benefit, and those are the injured workers. A lot of the issues  
6 that were brought up by our OTLA representative just today are factors that  
7 shouldn't exist if the market and the market forces are doing what it's supposed to  
8 do. The fact that they do exist suggests that the workers that might have interests  
9 that are different from most people in this room are not being represented and the  
10 system's not working. And that is the crux of this proposal.

11 MR. BRUYNS: Thank you, Grant. Rich?

12 MR. KATZ: My point was that a risk pool the size of SAIF, for instance,  
13 that only has one MCO contract within the PSA, it puts the provider in that market at  
14 a distinct disadvantage in terms of negotiating, so it's not a level playing field. So I'm  
15 encouraging competition between MCOs, which competition is usually a good thing.

16 36:19: We have competition between the MCOs.

17 MS. FRASER: Jaye Fraser with SAIF, with SAIF Corporation. And I  
18 guess from our perspective, we look long and hard when we contract with an MCO.  
19 We make decisions based on a number of factors. And I find it a little kind of  
20 dissettling that we would be required to contract with anyone, frankly. You know, I  
21 think that this is--we are--we're a large Workers' Comp insurance company in this  
22 state. We take what we do in managing our claims, not the care, very seriously.  
23 And if we choose to contract with an MCO, it is because we are confident in the work  
24 that they do. And I frankly am not sure that the Department has the authority to  
25 require us to contract with anyone.

1                   37:35: Well, I would also say that we have had customers who have  
2 opted to leave us and go to another MCO. We've had customers that we've opted to  
3 leave. This would put us in a situation where now those customers have to contract  
4 with me and they weren't happy with what I did, and there's some that I may have to  
5 contract with. And I had disagreements perhaps with how they might have tried to  
6 control the MCO, and that doesn't work for us. So now I'd be required to contract  
7 with them, theoretically. I won't use any superlative...

8                   MR. BRUYNS: Thank you.

9                   MS. SUNDSTROM: So may I say something?

10                  MR. BRUYNS: Certainly.

11                  MS. SUNDSTROM: Sheri Sundstrom with Hoffman Construction. And  
12 I've been kind of referring to the Mahonia Hall agreements throughout this session  
13 today. And back in the day, and I appreciate Diana's comments about access to  
14 care. Actually, the Mahonia Hall agreements restricted care and slowly but surely  
15 over the years, there's been a recognition that there needed to be some additional  
16 access to care. So nurse practitioners, chiropractors, physician's assistants, there's  
17 been more that has been brought into the system to allow additional access to those  
18 providers.

19                  Specifically not, I don't know that anybody's had a discussion about  
20 physical therapy. And Diana, with all due respect, I see--and I don't know how many  
21 of these physical therapists are in the system, but it's almost like Starbucks. There  
22 is physical therapy on every single corner. So I don't know what the limitations are  
23 within the MCOs are specifically to physically therapists. But one thing I do want to  
24 point out, I would not want the carrier that we're using to tell me that there was only  
25 one--that there was more than--that they had to contract with two MCOs. When I

1 personally have a contract or I have, through our carrier, a contract that I feel has  
2 been the best thing for our injured workers over those years, that's why I have the  
3 rosy colored glasses for everybody in this room, because they do a wonderful job of  
4 advocating for our workers.

5           And I would be very uncomfortable in having to be obligated to  
6 participate in an insurance program where my workers then were--I know were  
7 having to maybe choose-- And I'm sorry if I offend anybody. I am not intending to  
8 do that. To have to go through an MCO that I personally may not want one of my  
9 family members to have to use. So that's a bold statement for me to make. But it is  
10 through 26 years of experience in the system and getting to know the different  
11 MCOs. And knowing not necessarily that the MCOs are bad, but what really works,  
12 the program that they have that really works for our injured workers. And I'm  
13 extremely uncomfortable, regardless of anybody defining who somebody should be  
14 signing a contract with. I think that's incredibly over--stepping over bounds. So  
15 thank you.

16           41:12: I think there's a little bit of irony talking about the deprivation of  
17 choosing who you're going to contract with when the entire system of Workers'  
18 Compensation is built around taking that choice away from the employee. There's a  
19 little bit there. So when we're talking about the monopoly, the forces that are in play,  
20 again, the workers are not represented in that process. We only hear about them if  
21 OTLA representatives come into this room and give us issues that are written off by  
22 MCOs and outliers.

23           And there's been a lot said earlier in this meeting about the weight of  
24 appeal. That is one of those options that's a lot easier said than gone through. And  
25 that appeal comes towards the end of a litigation process. And it's more time, it's

1 more money. And a lot of people just don't have that choice even though it's there  
2 on paper. So if we're--and secondly, you know, unless I missed something,  
3 Ramona, my apologies if I did, nobody's asking an MCO to go out and further  
4 contract with somebody they don't want to. We're asking the insurer to contract with  
5 two MCOs in that...

6 42:16: In much of the state, there are only two MCOs.

7 42:18: Yeah.

8 42:20: So you are essentially requiring that.

9 42:21: Of the insurer but not of the MCO.

10 42:23 But then the MCO...

11 42:24: But then you would require me to contract with people that I  
12 didn't necessarily want to.

13 42:29: And the purpose of that is for the benefit of the worker. Right.  
14 They're not in the room. The MCO negotiates rates down with the provider, and the  
15 provider passes off those rates to the worker, so the worker is suffering from this  
16 whole process. It's not...

17 42:42: The provider doesn't pass any rates off at all. The worker  
18 doesn't pay any of their medical.

19 MR. ENGRAV: Sure. Sure. Yeah. So I misspoke there. But  
20 ultimately, the worker is the one that is detrimented by the negotiators of the system  
21 that is claimed not to be a monopoly.

22 MR. BRUYNS: Thank you, Grant. All right. Here's an interesting legal  
23 question that I really don't know the answer to in terms of the limits of the  
24 department's authority to require some--one party to contract with another. I don't  
25 know the answer to that. It would be something we would have to--certainly have to

1 consider. So it's an important question. Additional thoughts? Rich?

2 MR. KATZ: I'd just like to clarify, if an injured worker is in a GSA where  
3 there are more than one MCO, the injured worker has the ability within a seven day  
4 time period to choose the MCO that would govern and manage their care. And in  
5 Portland, that's not an issue. There's probably three MCOs that contract with SAIF.  
6 So an injured worker would have choices that say an injured worker in maybe  
7 Klamath Falls or someplace else might not have because there's no contract  
8 between the MCO and the insurer. So depending upon where you live, you have  
9 different rights.

10 And in listening to all of today's conversation, just as an aside, I'm kind  
11 of moved by the fact that a lot of the discussions about transparency and everything  
12 else revolved around the MCOs and insurers. And I was kind of moved by the fact  
13 that the mission of the organization values are informed businesses and consumers,  
14 healthy and competitive markets, protected consumers and workers and satisfied  
15 customers. To me, a lot of the discussion has revolved around insurers and MCOs  
16 and hasn't gone to the benefit the actual injured worker for their choice of MCOs and  
17 their guidelines for management of care and their medical directors might think, et  
18 cetera. And so depending upon where you live in the state of Oregon, it's an  
19 unequal playing field for the injured worker. And again, I'll reiterate the point that  
20 small practices in particular in certain markets have nothing but an opt in or opt out  
21 with an MCO because they have no negotiating power. And that was mentioned  
22 earlier too in the discussion between the attorneys and the group here in terms of  
23 being able to opt in or opt out. Sometimes there's no negotiating when  
24 you--when you're small, the David, not the Goliath.

25 MR. BRUYNS: Thank you, Rich. Additional thoughts?

1                   45:45: The only thing, since this was raised by Diana and the physical  
2 therapist, and I sort of would echo Sheri's comment about--I don't know if they're as  
3 common as Starbucks, but I think, you know, just to kind of check my notes here and  
4 we don't have problems finding physical therapists anywhere in the state.

5                   46:04: That's what I was trying to...

6                   46:05: And we treat--I had the number. It was--the dollars that we  
7 spend on medical treatment for physical therapists is staggering. And I'm trying to...

8                   46:22: Ten percent...

9                   46:23: Yeah. NCCI actually produced that.

10                  46:27: So just from the physical therapist standpoint certainly, we  
11 don't have a problem with finding physical therapists anywhere in the state who are  
12 willing to treat. So--and I'm not sure that what we're really solving, hearing from  
13 Rich, is a concern that providers--you know, providers aren't able negotiate with the  
14 MCOs appropriately. So I'm not seeing how this is helping the injured worker.

15                  MR. BRUYNS: Diana, since we're--this may be one of those issues  
16 were again, we don't have consensus. But do you want to-- Maybe I'll give you the  
17 last word in terms of anything else you'd like to say, and then we'll move on to your  
18 next issue.

19                  MS. GODWIN: Well, it's true that there are a number of physical  
20 therapy clinics. But if an MCO only contracts with a limited pool of physical  
21 therapists, and there may be a physical therapist who has some specialty, maybe a  
22 hand therapist or a TMJ or something, but that therapist is not on the panel for that  
23 one MCO that the largest insurer contracts with, then that's a denial or can be an  
24 impediment to that worker getting to the best provider, particularly. But if there's a  
25 second MCO and that specialist provider is on that panel or that MCO has a broader

1 panel, that providers more choice for the worker is our point.

2 47:53: Are you proposing this in the group health arena too, that  
3 employers are required to offer at least two PPOs or HMOs?

4 MS. GODWIN: No. No. We're just in the Work Comp system here.

5 MR. BRUYNS: Okay.

6 MS. GODWIN: Second issue then?

7 MR. BRUYNS: Yes. If we can move along to...

8 MS. GODWIN: That may be a little, I think a little less controversial.  
9 We are proposing that the worker be allowed to continue treatment with their current  
10 medical service provider for at least 14 days after the mailing date. Right now, the  
11 law is--the rule is that seven days after the mailing date. And my nephew just went  
12 to work for the post office in Silverton, and I can tell you that the post office is  
13 severely stressed, particular at holiday time, to get mail delivered in a timely manner.  
14 And it gets even worse as you get into the more remote areas. Right now, my  
15 nephew is working seven days a week. My sister, who lives in Oregon City, doesn't  
16 get her mail 'til 9:00 o'clock at night because the system is just not keeping up. And  
17 when you tell an injured worker, or you know, an injured worker gets a letter, number  
18 one, they may not get it until maybe the sixth day after the mailing date, and they got  
19 appointments already scheduled that are going to go past that seven days. They  
20 have to what, just stop and then try to find a new provider? They go back to a new  
21 initial eval in the physical therapy arena. That's time--it takes time. The worker has  
22 to interrupt care. But if they were allowed to stay for 14 days after the mailing date,  
23 which may be actually only 6 days after they actually receive the letter. You know, if  
24 they don't receive the letter until eight days after mailing, you know, then they're  
25 really stuck. But to allow them to complete--you know, stay with the current care

1 provider for a few more visits, that may be the end of it. They may have completed  
2 that necessary course of care that saves the insurer, you know, extra costs for  
3 having to start all over again with a new provider. It gets that worker through their  
4 care more quickly without interruption. That gets them back on the job earlier and  
5 that saves time loss.

6 So right now, I just think that seven days after mailing is just not  
7 working, and it's not in the best interests of the worker if you're talking about  
8 continuity of care, getting that worker well as quickly as possible without interruption,  
9 getting them back on the job, we just think that that needs to be changed.

10 MR. BRUYNS: Okay. Discussion?

11 MS. FLOOD: Jennifer, ombudsman for injured workers. Again, I don't  
12 have any data on this, but the seven days freaks workers out, I mean, totally. It's  
13 like hey, my appointments just got canceled because my doctor changed. I do find  
14 that in most of the cases that make it to my desk, calling the insurer, calling the  
15 MCO, we're able to work through that and they're very lenient on that seven-day  
16 window, so...

17 MS. GODWIN: But we shouldn't have to go through that process.

18 MS. FLOOD: Right. So that's where I don't know that changing it to  
19 14 days is going to change much of the overall impact other than a worker maybe  
20 not being freaked out as much. Maybe an appointment not being cancelled but they  
21 already scheduled time off to attend in three days, you know, when they get that  
22 notice.

23 MS. GODWIN: And their lawyer doesn't have to spend their time trying  
24 to get permission to let that worker make that last one or two appointments that  
25 complete their care without being transferred. I mean, it's going to save--and even

1 saving calls to the MCO to allow that worker to stay for the additional one or two  
2 visits as necessary. I mean obviously, if we've got somebody who's going to be a  
3 major, major, major surgical thing, you might think about. But at least give them a  
4 few extra days to organize their care or transfer their care, or complete their care.

5 MS. PATRICK: And I know the MCO probably gets this more than I  
6 notice, but if I call a doctor for my claimant and say, "Hey, look, you know, they got  
7 transferred to an MCO. We need to get them in," usually, their response is, "Well, I  
8 need to get the documents from the adjuster. Give us a few days." And the few  
9 says, it's just not built in to seven-day period. And we're not just talking about  
10 medical care. We're talking about time loss.

11 52:23: Right.

12 MS. PATRICK: So and most people, most doctors won't backdate  
13 time loss, I understand. But if there's, you know, a week of lost time loss for  
14 someone who's already making 66 percent, those are the people who lose their  
15 homes and lose their cars and lose their families. And I see it all the time, not just  
16 based on the seven-day rule, but in general.

17 And so I mean I got one of these--yeah, it was on the sixth day that I  
18 got the letter. And I, you know, stopped everything I was doing, made a bunch of  
19 phone calls, because my client doesn't even speak English let alone, you know,  
20 being able to read this and understand it. I called--you know, I got--I probably got  
21 very lucky and found a doctor who was willing to see him within four or five days.  
22 And I said, "Well, you know, we're pretty good here. You might lose a few days of  
23 time loss, but we've got you in." And that was a success story, but that required, you  
24 know, his attorney to look at her mail when I get it at like 4:30 p.m. if I'm lucky.  
25 Some days, they don't deliver it at all. And you know, look through my, you know,

1 stack of mail and say, "Oh, this is the thing that I have to drop everything and work  
2 on for my client."

3 53:23: Or you have a president die and right in the middle of the week,  
4 there's no mail delivered.

5 MS. PATRICK: I got so many phone calls about time lost. Everyone's  
6 time lost check was late because it's the holidays and that day it was closed, and I  
7 fielded so many phone calls that say, you know, call me back at the end of the week  
8 if it still hasn't gotten there. And people's checks came but you know, I think there's  
9 a three-day mailing rule in the law, you know, it's still three days. I just don't think  
10 that happens anymore.

11 MR. BRUYNS: Rich, you had your hand up.

12 MR. KATZ: Well, I just wanted to clarify. The seven days is inclusive  
13 of weekends and holidays?

14 MS. PATRICK: Yeah.

15 MS. GODWIN: It's not business days.

16 53:55: Correct.

17 MS. PATRICK: Yeah.

18 MS. KATZ: And that's exactly based upon--and I would say a lot of  
19 injured workers, when they get a letter like that, even though the OAR stipulated at  
20 the bottom of it, they would say, "What's an MCO?" And they would start to panic,  
21 as Jennifer mentioned, but also wonder, well, okay, who's going to take care of me?  
22 And what happens to my appointments, et cetera. So asking for some additional  
23 time, I don't think, is not--I think that it should be in the statutes to be elongated just  
24 for the benefit of the injured worker.

25 54:30: I would like to just clarify on the time loss authorization. Time

1 loss isn't suspended at the seventh day. If they have an open-ended time loss  
2 authorization on the physician that they've been treating with and they're enrolled,  
3 that is open ended going forward. Now, the worker does need to take steps to go  
4 and find an attending physician. But maybe there's some misconception of some  
5 insurers, but it's been litigated, and we know that time loss continues to be paid  
6 beyond that seven days. So just to kind of temper that a little bit.

7 55:11: But if the worker has to change the period of which they're on  
8 time loss could be extended because their care has been interrupted and they  
9 haven't completed their care and gotten back on the job as quickly as they should  
10 have and might have had care not been interrupted.

11 55:23: Are you--but you're just focused on physical therapists?

12 55:21: No.

13 55:27: Okay.

14 55:27: No.

15 55:29: Since it was from you, I thought it was physical therapy...

16 55:32: I'm sorry, I can't hear you.

17 55:33: Since it--since you're the one that was presenting this, I thought  
18 it was focused on physical therapists and they don't authorize...

19 55:38: No. Unh-unh.

20 55:42: And I will say there are some folks out there that believe that  
21 after the seven days, if the injured worker doesn't have a new attending physician,  
22 that there's no longer an attending physician that's authorized.

23 55:52: Or if the exam....

24 55:54: And so they cut the time loss until there's a new attending  
25 physician unless they can work the back and forth with MCO and the insurer to hit

1 that bridge.

2 MR. SEMPLE: This is Keith. I think that sounds like a great idea. You  
3 know, in fact, I think it--you know, not to just say, but we should do more and more,  
4 but I think 14 days is even a--I mean, seven days is--I completely agree with you  
5 about the mail. The mail takes longer and longer and longer, and seven days is  
6 absurd. Fourteen days might be workable. It really--I think it...

7 56:29: But still...

8 56:30: It should be--yeah, I mean because how long does it take us to  
9 get into the doctor? I mean, you know, it can take me a couple weeks to get into the  
10 doctor. I imagine it takes injured workers a couple weeks. And that's assuming, you  
11 know, the doctor doesn't want to see your entire claim file. And the doctor returns  
12 your call right away. And you know, I mean there's just a lot of factors involved  
13 there. So I feel like seven days is just--I'm hoping this is an easy one that we can  
14 reach some consensus on because seven days is just unbelievably quick  
15 turnaround. I mean...

16 56:59: Does anybody have a problem with 14 instead of 7?

17 57:02: I think we can all agree.

18 57:03: We...

19 57:07: We agree...

20 57:09: There was one question I asked Jennifer if she knew, when  
21 those letters get sent out, does that--does the treating provider also get notified that  
22 the person has now enrolled in MCO and the appointments get cancelled and all of  
23 that?

24 57:26: Well, we don't--appointments. We just notify all the--

25 57:29: But they...

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57:29: --providers on record.

57:31: Because they wouldn't want to get...

MS. PATRICK: It's because they won't pay for the appointments.

57:35: That provider on record may not yet be on record unless the provider bills daily and gets that bill in promptly to the insurer. And whether the insurer sends the...

57:50: The provider being the physical therapist?

57:51: I'm sorry. What?

57:52: The provider being the physical therapist?

57:54: Or any provider. But if that provider has not yet billed the insurer, then the insurer, let alone the MCO, may not know about that, the contact information or the existence of that provider, in order to provide, you know, a duplicate notice to the provider that oh, by the way, your patient John Doe has just been enrolled in an MCO. You need, you know, to stop care or you take the risk of not being paid. So you know, that's an issue.

58:29: You know something else, may I just point out, I think that I'm in a unique situation with our carrier because they enroll people fairly quickly, right away. But my understanding is that most carriers, most people aren't enrolled in the MCOs until sometime...

58:48 Date of acceptance.

58:50 So a lot can happen between the date of the injury and date of acceptance.

58:54: But with that too, your provider data is pretty well established. It's complete when we get that enrollment to send the notices out. In fact, I--it's very rare unless the worker treated in an emergency room, even for people who enroll at

1 time of injury, that we don't know who the provider is.

2 59:17: Yeah.

3 59:18: So you know, that's--that doesn't happen very often for us  
4 unless it's an ER, which we'll notify the ER, but that's not going to be an attending  
5 anyway, so...

6 MR. BRUYNS: Well, thank you very much.

7 59:30: Yeah.

8 MR. BRUYNS: I promised OTLA that we would come back to their  
9 issue if they wanted to talk about it further, the preauthorization issue. Or do you  
10 think that that was adequately discussed on the 19<sup>th</sup>? I would leave that to your...

11 MR. SEMPLE: I think we covered that.

12 MR. BRUYNS: And we do have--

13 59:45: And my only point is--

14 MR. BRUYNS: --that information, so...

15 59:46: --don't mandate it. Make it an opportunity, an option to get  
16 prior...

17 MR. SEMPLE: We would want that,--

18 MR. BRUYNS: Yeah.

19 MR. SEMPLE: --any preauthorization concept, we would want to be  
20 voluntary.

21 MR. BRUYNS: Okay. I think everybody was uniform on that. Yes.  
22 Okay. Then does anyone have like any additional issues that came to mind while  
23 we were talking? It would be kind of our last chance, a few more minutes to talk.  
24 Jaye?

25 MS. FRASER: Before everybody goes away, I guess one of the

1 things, we've had a lot of conversations and good conversation. But to the extent  
2 that the Department has any data available to it, I mean we have our data and we  
3 can look at that, and it's only--we don't have a whole market. So it just--it might be  
4 helpful to reform...

5 MR. BRUYNS: Data on--specifically what kind of data?

6 MS. FRASER: Well, for example, I guess one of the questions that I  
7 had is because there is an opportunity to appeal an MCO's decision, how many  
8 appeals come into the department? How many are--you know, how many appeals  
9 are upheld? How many are overturned? You know, some of that kind of stuff I'd be  
10 interested in.

11 60:56: Oh, that would be helpful.

12 60:56: We have our data.

13 60:58: We have SAIF...

14 61:03: Because we track it through the end from how many...

15 61:06: Yeah.

16 61:07: I think we end up disapproving like three percent or less of all  
17 precerts. And then there's a miniscule amount that I believe...

18 61:17: And I do appreciate, you know, for the worker attorneys in the  
19 room, that you know, they're telling the stories you don't have-- And just because it  
20 doesn't happen to other people, you know, and most people, doesn't mean it doesn't  
21 impact an individual's life. And it's important to that person, and so I think--you  
22 know, I don't think that, you know, if you--apologize to the MCOs, I don't think that  
23 SAIF wants anybody to think that we don't recognize that there are people who get  
24 kind of lost and trapped. And to the extent that we can help those, I just would  
25 prefer those for doing rules and making changes that we're really going to do

1 something that's actually going to make a difference, so--and I kind of like to ask  
2 what the problem is, and is there data that we can look at that would help us get to  
3 that decision?

4 62:10: We just have this constellation of anecdotal experiences, you  
5 know.

6 62:12: That's all you can have. That's all you can have.

7 62:14: On the data, I should know this probably but I don't. The  
8 Department would know what MCO disputes come to the Department.

9 62:24: Uh-huh.

10 62:25: But do--are the MCOs, do they have to report the disputes that  
11 you get within the MCOs that...

12 62:32: We don't report it but we track it.

13 62:33: But you track it. So that could be an element of data that the  
14 Department wouldn't have but that the MCOs would hopefully have to shed some  
15 light on where those issues come up.

16 62:43: We have--don't we have to report our--the disputes that we  
17 have in a year in our annual filings?

18 62:52: Only peer review.

19 62:55: Yeah. That's not part of the annual...

20 62:56: That's not part of the annual report. We have to report--

21 62:58: Would you like to?

22 62:59: --the...

23 63:02: How...

24 63:05: That was good.

25 63:07: Yeah...

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63:07: It's just an element.

63:12: No. I mean it's data we track, so--and...

63:18: It would just be more of the picture regarding--

63:21: Yeah.

63:21: --the disputes.

63:22: Yeah. No. I mean that's what we track when we look at it because I don't think our denial should be very high. And if they are, we've got an issue somewhere, so...

MR. BRUYNS: And we would only have the appeals that come to the MCO--

63:35: Right.

MR. BRUYNS: --make it up to the Department.

63:37: And we track that too.

MR. BRUYNS: Yeah.

63:39: How many come up and what the outcome is of that.

MR. BRUYNS: Right.

63:41: So we have, you know, from the initial preauthorization through the Department's ruling if it goes to the Department. And we're happy to share that.

MR. BRUYNS: So we'll look into that. It--there could be a little delay, however, because it would mean a data call to the four MCOs then compiling that data. But it's a good point. You know, we like to make data-driven decisions as much as we can, keeping in mind that it doesn't tell the entire story. It--people get lost in the data. But we can look at overall outcomes.

64:16: I wasn't suggesting we get lost in the data.

MR. BRUYNS: I know.

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64:19: Because I've watched that happen.

MR. BRUYNS: Okay. With that, I don't know if the storm has already begun. We're living in a--we're working in a dungeon. So I hope everybody does drive safely on the way home, and we'll stay in touch with all of you. Thank you.

(WHEREUPON, the proceedings were adjourned.)

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**CERTIFICATION OF TRANSCRIPT**

I, Amanda Knapp, as the transcriber of the oral proceedings at the 12-17-18 hearing before Mr. Bruyns, certify this transcript to be true, accurate, and complete.

Dated this 8th day of January, 2019.

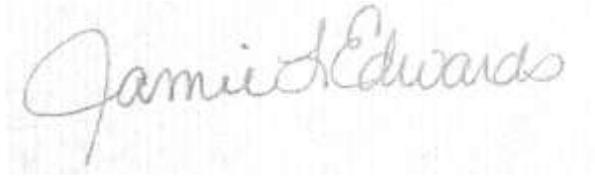
A handwritten signature in cursive script that reads "Amanda Knapp". The signature is written in black ink and is centered on the page.

Transcriber

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I, Jamie Edwards, as the proofreader of the oral proceedings at the 12-17-18 hearing before Mr. Bruyns, certify this transcript to be true, accurate, and complete.

Dated this 8th day of January, 2019.

A handwritten signature in cursive script that reads "Jamie Edwards". The signature is written in dark ink on a light-colored background.

Proofreader

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