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re: MCO rule committee WCD / DCBS

Dear Ms. Rogers:

I have been a physician in Oregon for almost 30 years. One of the most frustrating things for me when treating injured workers is the double standard of care that patients in the WCOMP system receive. One group of patients is entitled to receive what we as physicians call the "gold standard" of care. The standards that we were trained to provide. Our board specialties require that we keep up to date with new guidelines through continuing education. The Oregon Medical Board disciplines us when we don't uphold these standards. The second group of patients are required to receive care limited by the Official Disability Guidelines (ODG). These guidelines are a closely guarded secret. Why? I hope that someone in Oregon has access to them. Surely someone with medical training was allowed to read them before allowing Majoris to adopt them. I'm assuming there is a committee who reads the updates to ensure that they are reasonable.

If the rules committee decides allows MCO to expand their focus then I worry that Majoris will be allowed to use these insurance generated standards to coerce attendings to declare patients medically stationary when they are not, return them to jobs that they are not capable of performing and declare them with fewer disabilities at claim closure than they actually have. This is especially dangerous in the current climate where everything happens in secret and there is no oversight with disciplinary power. The recent decision to allow nurse practitioners and physicians assistants to serve as attending in the Majoris network is only going to exacerbate these problems. Imagine how easy it's going to be for an organization known for bullying their providers to coerce these mid-level providers. They are essentially trained to defer to physician's opinions.

I spoke to a handful of physicians about the opportunity to submit comments about their experiences with Majoris. Every single one described Majoris as a bully. A few considered submitting written comments but not a single one was willing to face the economic repercussion of doing so. I haven't spoken to any physicians on the Providence or Kaiser MCO panel but how can it be better if the bully not only controls your economic stream but

is actually your boss? I miss the good old days of Caremark / MHN. When I spoke to the MCO physicians they wouldn't just keep me on the phone until I changed my mind. If we didn't come to a consensus on the phone we would "agree to disagree". They could then bring it to their review board. The board almost always decided in their favor. But at least the issue would be out in the open. It was easy to appeal. Treatment plans were either accepted or denied in a timely fashion. Treatment would be accepted near the end of the date range but I don't remember this being a problem. Did they automatically extend the date range or was it just easy to extend the dates? Now I get a steady stream of requests to withdraw treatment, treatment plans linger in this not accepted / not denied status, and date ranges expire before treatment can be completed so patients don't get the treatment.

I was taught in middle school that when I saw a bully steal someone's lunch money I had a duty to report it. I would tell my teacher or the principal. Some action would be taken and either the behavior would improve or the discipline would escalate. The treatment wasn't just allowed to continue. When the MCO bullies me or my patients I have a duty to report it. I have done so. I filed a complaint. I have been told that conversations are happening. Behavior has not changed. Just asking nicely for the bully to cut it out didn't work in middle school and it isn't working with MCOs now.

The request to withdraw treatment is almost always because (ODG) recommends less or fewer treatments. They come with a little box to check if you agree to comply. We are asked to completely reverse our opinions without being given any new facts or cogent arguments to convince us. We can't see these guidelines or understand how they were developed. Do they follow the basic tenets of our training to follow evidence based medicine? Do they achieve better patient outcomes when they are followed? What metrics are being measured? It is safe to assume that they save money but at what cost? I have been told that I am not even allowed to know if the treatment protocol for cervical strain is different for high speed MVA vs. walking into the wall.

One of my colleagues told me they just check the box all the time. Another tried to consider the case and check the box 50% of the time. My internal dialogue considers the risk benefit ratio of checking the box. My patient risks incomplete recovery, developing chronic pain patterns, not return fully to work and play, and economic harm. I benefit by being allowed to stay on panel. If I don't check the box I'm just asking for more unpaid paperwork and probably one of those mandatory $56 phone calls with MCO physicians. Then I remember the Hippocratic Oath to "first do no harm". That makes it very difficult to check that box.

Majoris describes these $56 phone calls as "peer to peer" conversations. Peer means equal. Even though we are both physicians we are not equals in this context. One person has the power to inflict economic harm on the other. One person can see the guideline

standards and the other cannot. My actual peers describe these phone calls as threatening, menacing, and intimidating. They worry that not being agreeable enough will hurt them financially.

Another trend that concerns me is the increased frequency that treatment requests are neither approved nor denied. It feels like these treatment requests are being ignored. The length of time that these requests float around in the ether seems to be getting longer too. My office is told the other office did not correctly submit the prior authorization and the other office is told I didn't submit the referral correctly. This period of limbo frequently lasts 6 months or longer.

In both of these scenarios Majoris does not have to actually deny the treatment so the patient loses their appeal rights. Isn't there some rule about the insurance company not being able to direct medical care? That seems like what I am describing, doesn't it?

Then there's this monkey business of accepting a treatment but only for a limited date range that is already half expired. This creates all kinds of problems both for patients and for the clinics trying to schedule these patients. It is so common to have PT once a week for 4 weeks approved but only if treatment is completed in the 1-2 weeks left in the date range that was accepted. This means that the patient only gets 50% of the recommended treatment. Then they wait again for two weeks for another approval to get accepted. There should be a box to check to request an extension of this date range.

What if there was an online portal where everyone could see when the referral was received and when the prior authorization was received. If they are not accepted we could see why and correct the problem. Then MCO would be forced to either deny or approve the requested treatment. The number of times that MCO asks provider to withdraw treatment could also be tracked. Shoot lets put it all in the open and allow some people with oversight to review letters from provider relations department. Are specific doctors being targeting because they are patient advocates? Even just requiring Majoris to maintain an updated provider list would be helpful. Have someone with oversight actually call the numbers and try to make an appointment. My staff wastes a lot of time spinning their wheels trying to get patients into offices who are not accepting new patients, no longer accepting WCOMP or sometimes even no longer in practice.

I described my patient with dysautonomia when I spoke on June 9th but I didn't have time to tell you the complete story. Her autonomic nervous system (fight or flight vs. rest and digest) was having trouble adjusting her blood pressure and heart rate when she changed positions from lying to sitting to standing. She was rapidly improving with treatment. In September she was able to progress from 3 to 20 minutes of exercise while lying down. By

November she was able to exercise sitting for 10 minutes, rest for 5, and then exercise another 10 minutes. She still couldn't play connect 4 while having a conversation. PT was helping her body adjust to transitioning from sitting to standing without significant increase in symptoms. In November her SAIF adjuster decided that it was time for her to go back to work. I received a light duty job description with a long list of duties including: "steaming facility floors, hosting birthday parties, assisting kids with arts and crafts projects during events, working as assistant camp staff." I did not agree to release her to this position. Her job at the time of injury was teaching kids to swim at an indoor pool. Returning to this warm environment would cause her blood vessels to dilate which was likely to exacerbate her dysautonomia. She had no business hosting a party at a swimming pool.

Sure enough the next thing that happened was one of the MCO "peer to peer conversations" showed up on my schedule. There were 4 scheduled phone calls before we actually spoke. This reduced my rate for this phone call from $56 to $14.

The first call was scheduled as 11:30. I called at 11:31 and left a message. At 11:42 they called back. They didn't have enough time for me to finish up the call I was on. When I called for the second scheduled call again no one answered and I left another voice mail. My staff was told later that day that no one from Majoris had scheduled the call. My staff responded: "How else would I know (employee x's) phone number? My staff transposed the number for the third scheduled call. I called some general numbers and numbers that I had previously used and left voice messages to no avail. No one from Majoris called my office to see if I was available.

The fourth phone call someone actually answered and the conversation happened. Had this been an actual peer to peer conversation we would have discussed my concerns and we could have tried to come up with a solution. Instead I was just repeatedly told that legally I was required to state what she was capable of. It felt like I was being reprimanded for not complying with the law. It the end the badgering worked. I released my her to a 1 hour shift 3xs per week. Obviously this was not enough. The MCO physician then called her PT.

One more example of a "peer to peer conversation". I was asked to withdraw PT and refused so the call was initiated. I was told the patient didn't appear that motivated and had cancelled a significant amount of appointments. The PT clinic reported that she had 100% attendance with the exception of appointments scheduled outside of date range which she simply couldn't afford.

Thank you for allowing me to express my concerns.

Sincerely yours,

Maureen Sacon, DO