



**FINAL MEETING MINUTES
July 18, 2008**

Members Present: Ronald Bowman, M.D., Chair; Timothy Keenen, M.D., Vice-Chair; Brad Lorber, M.D.; John Braddock, M.D.; Tom Williams, P.T.; Franklin Wong, M.D.; Frank Prideaux, D.C.; Pam DeVisser, F.N.P.; and Joey Blubaugh

Members Absent: Hans Carlson, M.D.; Gary Rischitelli, M.D.; and Maria Carraher, Injured Worker Rep.

WCD Staff Present: Kevin Willingham and Denise Hunt

Guest Speaker: John Shilts, Administrator - Workers' Compensation Division

Introductions:

Joel McCullough, MD, a new staff member for the Workers' Compensation Division, was introduced from the audience to the members of the Medical Advisory Committee. Dr. McCullough comes to us from the City of Chicago where he was the Medical Director for Occupational and Environmental Health.

Approval of Prior Meeting Notes:

The committee members reviewed the minutes dated May 16, 2008. A motion was made by Dr. Keenen and seconded by Dr. Braddock to approve the minutes as written.

Workers' Compensation System Overview: *John Shilts*

Dr. Bowman received in-put from providers around the state in response to the recent temporary rule and asked John Shilts, Administrator, of the Workers' Compensation Division to discuss the rules process and to address the following questions:

- The emergency nature of the issue; what made this an emergency that couldn't wait
- What is the decision making process
- What rulemaking is in general
- What are the sources of in-put
- What is the criteria that is used to make decisions, and who makes those decisions
- What is the impact of public and corporate testimony

John gave a comparison of what the "normal" process is versus the process used to create the temporary rule.

"Normal" Process -

Basically with administrative rules there is authority provided by the legislature to the directors of various departments to promulgate rules. The legislature passes laws, statutes. These statutes are more or less broad statements of public policy and provide direction in terms of how the legislature expects that public policy to be carried out. One of the laws provides that the director of the Department of Consumer and Business Services

Workers' Compensation System Overview Continued: John Shilts

has rulemaking authority. The idea about rulemaking is that there is an administrative process that comes after the legislature passes laws so that the laws can be administered. A way to look at it is this: The law mainly focuses on “what” should be done and the rules will get into “how” you go about achieving them; although there is somewhat of a mix. So in looking at the rules they are more detailed, complex, and have a few more specifics such as standards than the statute.

The usual rulemaking process is that you hold a public hearing, required by law as an administrative agency, and you promulgate the rules. Records of the testimony that is provided at the public hearing must be kept and is available to the public upon request. Typically what we do 100% in our division is that we will also do an advisory committee process first; which is a public process where we ask interested parties to come together and look at issues regarding rules. After that we go to the public hearing process where we actually have proposed rules that the public hearing deals with. It is after that point that we actually file the rules and put them into effect. Typically we are reviewing our rules on a pretty regular basis.

“Emergency/Temporary” Process -

The reference to the Oregon administrative rule is 436-009. This is the section of the rule we are talking about which is basically medical fees. It is where the fee schedule is and it is how we handle the entire responsibility about medical fees. What made this different is that we used an “emergency or temporary” rulemaking process. In that process, described in the law that deals with rulemaking, we are not required to do either an advisory committee or held to all the typical public rule processes, including a hearing. However, the rule can only be temporary, it can only be in effect for 180 days, and there needs to be an emergent issue that we are dealing with.

The person who decides that a given situation constitutes “an emergency” is the director. In any administrative agency the director of that agency ultimately makes that decision. The administrator of the division has the authority to make recommendations. In this case, we discussed the pros and cons on a variety of options with our director. As Administrator, I made the recommendation of using an emergency rulemaking process to try to deal with issues immediately. The direction was to move that way, but to also try to ensure that we put as many protections into this rule as we can for both sides.

Emergency rulemaking is not the usual course, but it is a long established and fairly well used way of going through rulemaking for administrative agencies. In this particular case we decided we wanted to do an advisory committee ahead of time because we wanted some in-put. It was done very quickly and not everybody who probably wanted to attend was able to attend. The advisory committee was well attended and we received some good in-put that did affect what we decided to ultimately do with the rule.

Questions Addressed -

Why we thought this was an emergency situation was a combination of some PPO investigations our division is involved in, and a significant number of fee disputes in regard to the fees that were being discounted per the PPO contracts. One thing that we did was to look back at our rules and compare it with the statute to determine how congruent our rule was with the statute. In our opinion, our previous rule was not very congruent with the statute. We didn't think we were outside of our authority in terms of what the rule said, but I don't think it followed with the statutory direction very well. Before disputes had been brought to our attention this was not an issue. Once disputes began to come in we began to look at our rule and we were uncomfortable with it. We worried whether this rule was going to hold up in terms of a challenge.

Another concern was the amount of disputes that were coming in. It was clear providers were having issues. The next thing that happened was that we were contacted by an insurer who said they had been provided notice

Workers' Compensation System Overview Continued: *John Shilts*

by one of their PPOs that they were pulling out of Oregon. The PPO was Coventry. I contacted them and talked to them about their concerns. Coventry was extremely concerned about what was going on in the workers' compensation system around fee disputes. Part of that concern relates to the contracts they had with the insurer. They were concerned about potential sanctions and paying the insurer. This was a big financial issue for them. The pulling out of Oregon for workers' compensation of one PPO is somewhat concerning, but if they left they left. Pulling out of the PPOs across the broad spectrum of healthcare has a much bigger effect.

What I was more concerned with was what is going to happen to workers' compensation costs, premiums if our rule stayed the way it was. With the number of disputes we had in front of us, if we paid those at the medical fee schedule amount and other disputes would be generated from that, we were forced to think about what would happen to pure premium rates in Oregon in workers' compensation? The answer is they were going to go up if enough disputes were filed under the old rule. Upon the basis of those issues we decided we had a problem and that we had to deal with it right now. Temporary rulemaking best accomplished these two things:

- To provide rules that were better aligned with the statute and the statutory direction
- Acknowledge provider contracts and agreements that providers had entered into with PPOs, IPAs, pharmacy providers, and a broad spectrum of contracts and agreements that our rules didn't contemplate, but that were in place and represented the "status quo" in the healthcare system that we wanted to recognize.

In our opinion we were taking a first step in a longer-term process that needs to occur over the next five months. We need to discuss this issue with all sides represented, MAC, OMA, PPOs, insurers, physical therapists and other groups to do what Oregon does really well, to try to come into agreement about how we want to design the system and how we want it to work here.

Dr. Wong asked for explanation on why the department didn't continue to follow the Oregon administrative rules, and start a discussion on why the PPOs should take discounts rather than let them continue to take discounts for 180 days? The response: PPOs have been here for a long time and they have been taking discounts for quite some time, but recently we started hearing about large discounts. One issue we heard about that we tried to deal with was stacking of contracts and multiplying discounts. We didn't want to wait and let 180 days go by. Frankly, we thought we could deal with that right off the bat and say you cannot do that. There were concerns about in addition to the MCO discount, PPOs taking a discount or two on top of the MCO discount. I didn't want to wait 180 days. I wanted to just take care of it and say no, the MCO discount is all you can take.

The issue that I think where the reaction has been the strongest from the medical provider community is, well, you are letting them take the discounts. From our perspectives they have been taking the discounts. The contracts and discounts have been here in Oregon for years. We recognized the contracts that the parties have been agreeing to. If those contracts are illegal, that is not a problem I can fix. What I can do is look at fee disputes, and require that the contract be produced in the fee dispute. Then look whether or not the fee discount was fairly agreed to in that contract, and whether it exists in that contract. We have heard a lot of in-pur about the contracts on the face of them are ridiculous in workers' compensation, and they should not be legal. That is an interesting issue that we can talk about and maybe we deal with that, but contract law is something that needs to occur in the circuit court if there are issues around contracts. We cannot fix the contracts, but what we can do is fix what we can do with fee disputes. In that way we can have an impact so that the contracts are as fair as possible. I do not want to take the full 180 days; I would rather turn to public rulemaking as quickly as possible.

Workers' Compensation System Overview Continued: *John Shilts*

The committee members went into a discussion period about the temporary rule, contract problems, and hassle factors. The following is the committee's list of concerns:

- Within the last 6 months discounts of more than 50% have been occurring
- Providers not aware of billing (discount) problems until office manager brings it to their attention
- Concerns with out-of-state bill auditing companies having no vested interest in Oregon
- Concerns the insurance industry may increase the amount of discounts within the 180-day window
- Quality of care issues – contracts not providing payment for additional physical therapy treatments
- Dr. Keenen read a prepared statement to the committee (will E-mail a copy to John Shilts)

Dr. Wong referenced the concerns of a hand surgeon in Portland who received acknowledgements from Focus, First Health, and Coventry stating he did not have a signed contract, but discounts from these companies were still taken. Dr. Wong asked "Why did the department overturned their position of many years to let the PPOs have a free reign on the providers for 180 days?". The response: One of the things that we are aware of is that discounts have been in place. My guess is maybe those discounts you referenced were applied before this rule was in place. That is the issue. This is the status quo. We are dealing with the status quo and I agree there is a lot of work to be done. What we do with PPOs is up to us, and there are other stakeholders in the system that come in with very different perspectives on this. All of these perspectives need to be looked at then we need to work together towards a solution. I don't necessarily want to see unfair, maybe illegal in this case, unauthorized, non-contracted discounts being applied. On the other hand, I don't want as a regulator, to step in between parties and say you cannot make agreements.

Additional Safeguards -

There are additional safeguards in the rule. In the temporary rule now there are requirements when a discount is taken, to give providers appeal rights so they know they can come to the division to get relief. The division will look at those cases and in the case where there is no contract, we will order the fee paid at the usual rate or at the schedule. The burden of proof is on the insurer. Prior to the temporary rule, we did not have any rules to require evidence and maybe we could have gotten the contracts then, but there was nothing in the rules to require that. Now we can require that the contract be provided to verify if a contract exists with an allowable discount.

Next Step -

What will happen next is we will begin bringing together advisory committees just like this group, but on a broader scale where we will invite PPOs, insurers, employers, and the interested parties to the table to start working on the concepts. After this, the next step would be for the division to write proposed rules to bring a rule hearing together; a public hearing process to take testimony. We would want to leave ourselves enough time and leave the record open because not everybody gets to attend the hearings. We want to get that out in front of as many people as we can, and allow people to get testimony in. Then the division will write the final rules based on the proposed rules and the testimony we get.

We also will write a testimony and response document to acknowledge the testimony that was received and what the department's reasoning and response is to the testimony. We then file the rules with the Secretary of the State, which then become the permanent rules. In addition, there will be a few more issues that go with this rulemaking process. One of them is the explanation of benefits (EOB) and how clear they are to address the concern about the additional administrative burden of trying to figure out what the bill represents. The proposed rules based on our timeline will be ready by the next MAC meeting. We will bring the proposed rules back at that time, then the public hearing will be held after that time.

Workers' Compensation System Overview Continued: *John Shilts*

Motion on the Floor -

Dr. Wong placed a motion on the floor that the Medical Advisory Committee, with all due respect, disagrees with the emergency rule. The committee recommends that the emergency rule be rescinded, follow the Oregon administrative rules, and hold the 180-day open period as to the roles of PPOs, etc. Dr. Keenen seconded the motion. Eight of the twelve members voted in favor of the motion, three members were absent, and one member was unopposed.

In Closing -

I want to thank the committee members for being incredibly helpful to the department. I appreciate all the time, willingness, and in-put the committee has provided. The committee's in-put is taken very seriously, it is very important to the department, and the motion stated here today will be brought to the attention of the director.

Hassle Factors & Administrative Burdens: *Kevin Willingham*

A request was received from Dr. Bowman and the other MAC members on the issue of, hassle factors within the workers' compensation system and the administrative burdens it creates, asked that this concern be addressed today. The purpose of this discussion is to identify some of the hassles that the committee members encounter everyday in relationship to workers' compensation.

Kevin Willingham presented and discussed with the providers a request to contact their office staff. The purpose would be to come out and job shadow, take notes to see what the hassle factors are, then bring those issues back to see how we can best regulate a system that works better. The discussion centered around this question: What are the hassle factors that you see in your practice, and what hassles do you and your office staff see in relationship to workers' compensation that are beyond what the division (827) requires?

The following is the committee's list of concerns:

- Initial telephone call (required by insurance companies) to obtain authorization is a significant hassle
- Providers not experienced in work comp system - not replying in a timely fashion creates delays
- Once surgery is determined the whole authorization process takes too long, sometimes the wait can be dangerous – decision making (authorized or denied) needs to occur right away
- Electronic bill pay would be a huge benefit, much quicker – would reduce telephone calls and extra paperwork
- Insurance companies require more in-take information that is not necessarily related to the case - they are gathering statistic information which cause an increase in hassle factors for billing staff
- Provider calls the carrier asking about discounts are now being told to contact the PPO. Provider then calls the PPO who informs them about their 15-year-old contact. Provider informs PPO about placing a dispute. PPO's attitude now becomes surly and rude – time consuming hassle factor
- Discrepancy in what the worker is telling the provider of what his/her job duties are – would like to see job description with physical demands up front (light duty slip)
- Need better communication between provider and insurance carrier on time loss information to avoid lost paperwork and other problems - system needs streamlining
- Pharmacies are seeing denials in their computer system that maybe are not an actual denial which prompts calls to the provider's office – pharmacy not happy when told by provider to contact insurer
- Surgery authorizations are partially accepted if treatment is in combination with a non-accepted condition (worker to see private healthcare provider for that) – this creates problems for the surgeon

Hassle Factors & Administrative Burdens Continued: *Kevin Willingham*

OMA suggestion –

Committee members were asked their comments about an OMA suggestion that will be considered at an upcoming rulemaking meeting. Suggestion: Add a check box to the 827 form that says the worker is requesting acceptance of a newer medical condition and is signed by the worker. The doctor can then outline the new medical condition on the form. Several of the committee members remarked that this is a great idea.

Identify Critical Factors in Establishing Oregon's Medical Fee Schedule: *Kevin Willingham*

We are trying to develop a way to establish a medical fee schedule that is based on cost, which can identify hassles, and can generate adequate payments to providers that ensures access to quality care at the lowest cost. Kevin asked the committee this question: What are some of the things that we should consider, as far as, cost or anything about the fee schedule to ensure we are providing adequate care while offering the lowest cost to employers? This question is pertaining to next year's MAC discussion on the medical fee schedule. The committee listed what they thought was important to consider as the fee schedules are being developed:

- Usual inflation issues causing to hire more clerical staff
- Time spent with patient calls (pharmacy issues, requests for notes on back time loss, etc.)
- Inefficiencies in the entire system need to be identified and worked out
- Surgical providers' literature shows a much higher "poor outcome" within the workers' compensation population – this makes surgical providers less inclined to treat workers' compensation patients

Drug Utilization Review: *Kevin Willingham*

Next month we are hoping to bring information on our top 20 pharmaceuticals. The top 2 cost drivers in the pharmacy are either Oxycontin or the generic brand of Oxycontin time release. We are working with our Information Management Division to break down the information (when in claims) to show at what point are these medications being prescribed (early on or later), what are the impacts on those claims, and on what types of claims are these medications being prescribed. The top 20 prescription drugs in the workers' compensation system accounts for 54% of the total drug cost.

Several committee members asked the division to obtain data on these drugs compared to non-workers' compensation cases with similar conditions. The theory is that it may not be valid to complain about the cost when compared to motor vehicle accidents (MVA) or recreational injuries on patients receiving these types of medication. The discussion turned to societal changes and swings in medicine over the years that have influenced how pain management is now being treated, as well as, other issues of how to treat pain.

Back Injury Review Process: *Kevin Willingham*

The division has been running some numbers on back treatments and looked at back fusions, discectomys and laminectomys. Juerg Kunz has been doing literature review of back injuries and found hundreds of studies. Juerg, who is not present today, has questions to ask the committee on the best way to bring this information to them. This matter will be addressed at a later date.

Adjournment:

Meeting began at 9:00 a.m. and adjourned at approximately 11:30 a.m.

Next Meeting:

- September 19, 2008 9:00 a.m. - 11:30 a.m. Clackamas Community College Training Ctr, Wilsonville

Recorder: Denise Hunt