



**FINAL MEETING MINUTES**  
**September 19, 2008**

- Members Present:** Ronald Bowman, M.D., Chair; Timothy Keenen, M.D., Vice-Chair; Brad Lorber, M.D.; Franklin Wong, M.D.; Hans Carlson, M.D.; Tom Williams, P.T.; and Joey Blubaugh; and Maria Carraher, Injured Worker Rep.
- Members Absent:** Gary Rischitelli, M.D.; John Braddock, M.D.; Frank Prideaux, D.C.; and Pam DeVisser, F.N.P.
- WCD Staff Present:** Jacqueline Sewart, Juerg Kunz, and Denise Hunt
- Guest Speaker:** John Shilts, Administrator - Workers' Compensation Division

**Approval of Prior Meeting Notes:**

The committee members reviewed the minutes dated July 18, 2008. A motion was made by Dr. Lorber and seconded by Dr. Wong to approve the minutes as written.

**Cervical Artificial Disc Replacement (CADR):** *Juerg Kunz*

Juerg Kunz reviewed the CADR draft recommendation with the committee members to decide whether it should be a compensable medical service. Juerg asked the committee to address relative contraindications to determine if there are any and if so what would they be? The following is a list of conditions that may, based on the physician's judgment, make CADR inappropriate (relative contraindications):

- A comorbid medical condition compromising general health, e.g., hepatitis; poorly controlled diabetes; cardiovascular disease; renal disease; autoimmune disorders; AIDS; and Lupus
- Multi-level degenerative disc disease – cervical, moderate to severe, as shown radiographically
- Osteopenia with a bone marrow density of a T-score –1.5 to –2.5
- Prior cervical fusion at 2 levels or more
  - One-level fusion is a relative contraindication
  - Two-levels or more is an absolute contraindication
  - Artificial disc replacement at the level of a cervical pseudo arthrosis (absolute contraindication)
- Psychosocial disorders – diagnosed as significant to severe

The draft referred to other internal divisions within the agency that the Workers' Compensation Division may contact for purposes of obtaining necessary reports:

- Work with the Information Management Division (IMD) to develop or review future prospective outcome studies regarding lumbar artificial disc replacement;
- In three years, with IMD, prepare a report regarding the outcome studies and present it to the Medical Advisory Committee; and to consider
- Current studies are limited (2 yr follow up); for future studies we may want longer term outcomes

**Cervical Artificial Disc Replacement (CADR) Continued:** *Juerg Kunz*

Juerg will revise the draft and send it out to the committee members for their approval and/or any recommended changes. When the committee approves the draft, the finalized draft will be sent to John Shilts for approval and then submission into the rule/public process to begin hearings.

**Proposed Rules on Provider Networks - Update:** *John Shilts*

John Shilts commented on yesterday's House Business and Labor Committee's hearing regarding the network contracts issue. There was a lot of public comment and discussion at that hearing which was very helpful. It was the first time we were able to get a tenor of some of the legislature, other than individual meetings we have had with them; as well as, having some of the business community come in and provide testimony. Based on that John felt there was a good deal of consensus on this issue. What was originally intended was to come here today and provide the committee with proposed rules; instead we would like to look at what issues we can agree upon and look at what issues we do not agree upon. John compiled a list of issues that will assist in getting the rules done well and done quickly. Based on the following list, the committee was asked to provide feedback:

- Injured workers need immediate access and high quality care from all providers
- Employers are able to afford the cost of the system
- Guarantee insurer responsiveness (providers are given quick responses to their questions)
- Some network contracts do not seem to be problematic (e.g. Oregon Prescription Drug Plan)
- Assure providers are protected so they receive adequate compensation for their services
- If there are people who want to enter into contracts should we:
  - Put in a floor?
  - Do we want to put protections in place for them?
- A need to ensure that MCOs are kept strong, it's the push we want to make, and continue to do what we can to support the MCO concept

The committee discussed the above issues determining importance and added the following feedback:

- Front sheet/page summary – part of the push for Oregon physician's, pertaining to all health care contracts that physicians sign, will be to have a front page summary defining the contents
- Other aspect of communication is the modified work scenario: Timely exchange of information with insurers/employers on return-to-work; work restrictions; resolution of confusion/conflict; and job descriptions (requesting these concerns are appropriately defined in this process)
- To protect the MCOs because they do a real job of controlling the quality of care to injured workers – to have the floor be no less than what the MCOs charge
- Very important to continue the MCO process – it is an appropriate process
- It is most appropriate to define the services somebody is contracting for – define what are the requirements by statute or by rule, or both, that medical providers/services are expected to have & meet
- Put in a floor that requires payment above the MCOs

The discussion then turned to problems pertaining to explanation of benefit (EOB) notices. John then asked the committee to respond to these questions: If you get a bill reduced (when you get that payment back) are you getting an explanation? Are you told whom you can call if you have a question and when you call that number are you getting somebody that can help you?

**Proposed Rules on Provider Networks - Update Continued:** *John Shilts*

The responses from the committee are as follows:

- Several providers have at least one full time employee who spends most of their time on hold trying to get their EOB questions answered
- Providers are deciding between having staff track down missing payments or just to write them off
- The problems one provider deals with in the insurance industry are “delay, deny, and confuse” – the payment is delayed and/or payment is denied and the provider has to fight through it, and the confusion about the different contracts
- Prior to the passing of the Prompt Payment Bill in Oregon, some commercial insurers knew that a few providers were inefficient at tracking their payments; insurers encouraged their staff not to pay the first bill resulting in money they got to keep - variations of that still continue to happen such as:
  - Authorizations for surgery does not guarantee payment; it only authorizes the surgery to be performed – leaves surgeon uncertain about payment

Next the discussion addressed the protections placed in the temporary rule. John asked the committee this question: If there are contracts, does anyone have any discomfort or problem with some of the protections that are already placed in the temporary rule? The committee provided the following responses:

- Reiterating an earlier statement made about being against undermining MCOs
- Insurance carriers are linking with PPO contracts that physicians have never signed – this is the biggest issue where the protection needs to address (WCD fee schedule with a discount for MCOs is the most appropriate)
- Clarify the rule so it will assist providers in their contract negotiation process with insurers
- Pertaining to the previously mentioned one-page fairness disclosure document – establish a standardized document with an opt-out statement and/or an opt-in (going forward) statement
- Would like to see only MCOs in the workers’ compensation system

**Adjournment:**

Meeting began at 9:00 a.m. and adjourned at approximately 11:10 a.m.

**Next Meeting:**

- November 14, 2008 9:00 a.m. - 11:30 a.m. Clackamas Community College Training Ctr, Wilsonville

Recorder: Denise Hunt