



**FINAL MEETING MINUTES  
November 14, 2008**

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

**Approval of Prior Meeting Notes:**

The committee members reviewed the minutes dated September 19, 2008. A motion was made by Dr. Lorber and seconded by Dr. Wong to approve the minutes as written.

**Introduction:** *John Shilts*

John introduced Cory Streisinger, Director of Department of Consumer and Business Services, to the members of the committee. Cory came to thank the committee for their time, for the work they are doing, and to let the committee know how much their work means to the department.

Cory stated that a lot of the work the committee has already done has paid off by making sure that our workers' compensation dollars are well spent and more importantly that our injured workers are getting the best and the most cost effective care possible.

**Drug Utilization:** *Juerg Kunz*

The committee was asked for their in-put from a practical standpoint on the increase of opioid use. In looking at statistics from 2002 to 2007 we saw that we have had an increase of 54% in the use of opioids without having an increase in claims. In 2004 we changed the rules on how pharmacies get reimbursed for brand names and generic medications and we also introduced clinical justification for Oxycontin. During that time in 2004 we saw a switch from prescribing brand names to generic name and from a cost perspective it definitely had a dampening effect. We should not just look at the cost, but we should look at the bigger issue which is the chronic use and what is happening to our patients with a non-disabling claim who take Oxycontin or any other similar medications. Also, when patients start to depend on those drugs and are off work for a long time, the chances of them ever going back to work are getting smaller and smaller.

## **Drug Utilization Continued:** *Juerg Kunz*

During the discussion period the committee members tossed around several suggestions and ideas on ways providers can potentially improve the way they initially prescribe narcotic medication. The committee stated it would be helpful for them in the future to have some additional information such as:

- What diagnoses are associated with opioid use
- Any relationship between opioid use and length of open claim period
- Break down of provider specialties
- Additional temporary time loss (may be difficult to track)
- Use of opioids in claims with spinal cord stimulators and pain pumps
- Track by zip codes on providers (for targeting education)

Juerg will get together with the Information Management Division (IMD) to find out if we can get above information.

Another area of concern discussed was how difficult it was for providers to wean their patients off of Oxycontin or other similar medications once they were initially prescribed the medication. The following are suggestions to avoid prescribing the wrong type of medication initially and how to implement the education process:

- Ask OHSU for help with their evidence based medicine to create a tier system (group medications by their class: Tier 1, Tier 2, etc.)
- Have Jennifer Wagner, Pain Management Coordinator, from the Governor's Advocacy office along with staff from the Western Pain Society get together in an attempt to provide necessary data
- Get data focused on education and tie it in with OHSU, then have someone with a pharmaceutical background or a pharmaceutical clinical background work with Western Pain Society to then begin the education of doctors (explain tier structure, issue of dependency, appropriateness, & criminal behavior )

Several committee members stated it would be helpful if the department defined their goal on this issue. Some of the members preferred an educational approach. Documentation on this subject states: "When an injury moves from the acute phase to the chronic phase, psychosocial factors begin to kick in. Opioid use increases that and also somehow increases the pain receptors so that the pain actually feels worse creating dependency issues. Some injured workers may not ever get off this type of medication and may never go back to work". We want to determine how to get workers back to work and avoid that period in the chronic phase because their chances of recovery both financially and medically are greatly reduced the longer the injured worker stays on time loss. If we are successful in doing this, we will reduce the cost to employers because they will not be paying for long term claims.

At the next meeting (to have a more structured conversation) we will bring back additional data for the committee and we can continue to brainstorm on the ideas the committee provided here today.

## **Lumbar Fusion:** *Juerg Kunz*

Concerns were shared with the committee about the high percentage of injured workers who had lumbar fusions, after which, were left unable to return to work. Statistics show that 69% of patients who had lumbar fusions with an ICD-9 Dx code 722.1 never go back to work. That leaves only 31% of patients returning to work. Many of these patients who are unable to return to work remain totally disabled for the rest of their lives.

## **Lumbar Fusion Continued:** *Juerg Kunz*

The committee was asked if this topic is something that they should look into? The committee reviewed their handouts on lumbar fusion studies with exclusion and inclusion criteria and went into a discussion period.

The committee commented on some of the common issues surrounding injured workers:

- The majority of injured workers (90%-95%) want to return back to work
- 10%-20% of injured workers contribute to 80% of the cost to the system and it is usually from the worker who has been off more than 6 to 9 months; at 1 year the likelihood of a worker coming back to work is zero (that is when repeat surgeries and medication dependency escalates)
- Workers who end up having fusions generally have long recuperation periods; if the employer has a positive relationship with the worker and brings them gradually back into the workforce, those workers tend to have shorter claims versus workers who have negative employer relationships
- Studies have shown one of the “critical factors” of injured workers getting back to work is the relationship they have with their supervisors and co-workers
- Lack of communication can become problematic between the injured worker and their employer especially when the worker obtains an attorney (employer would like a way to get prompt/clear return to work status on their workers)
- The high cost associated to employers when workers are out of work (from the employer's perspective the injured worker's absence from work creates a hardship on other workers partly due to the knowledge associated with a senior worker, as well as, the investment in training - all of which is a great loss to the employer)

The purpose of this discussion was similar to that of drug utilization. Is this actually something that we should pursue? Given all the comments and feedback from the committee, it was determined that this may be a worthwhile subject to look into. More information will be provided at a later date.

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

John thanked the committee for their input they gave over the last few months and for their overall patience. Last month we promulgated our proposed permanent rule in regard to the medical fees and the preferred provider organizations. These rules also touched a little bit on managed care organizations and claims administration. The proposed rules prohibit preferred provider network discounts for medical services performed by doctors, physical therapists or other direct health care providers who treat injured workers; however they still allow individual providers to offer discounts if they choose. We would continue to allow discounts that are parts of managed care organizations (MCOs). For those individual providers who want to enter into fee discount agreements for medical services can still do so if they wish, but what we are proposing in the new rules is that these providers who want to enter into these agreements must do so directly with the insurers or self-insured employers. Also under the proposal, network discounts (PPO discounts) would continue to be allowed for prescription drugs; durable medical equipment (DME); hospital services; and ambulatory surgical centers (ASC).

The final rule hearing is on November 20, 2008 at 5:00 p.m. then again on November 24, 2008 at 1:30 p.m. at the Labor and Industries Building in Salem, Room 260. The public is invited to testify and can do so either verbally or by written testimony. Some of the main issues at the hearing will be around this “fee agreement” issue. In the new rule the word “contract” has been replaced with the word “agreement”. We specifically wanted to avoid the concepts of contracts. We will hold the record open until November 26, 2008 then we will write the final version of the rules. These rules will then take effect on January 1, 2009.

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

In the rule itself some of the requirements for fee discount agreements are as follows:

- Any such agreement would have to be on a standard format and be registered with DCBS
- The insurer may not apply a fee discount agreement until the medical service provider or clinic and insurer have signed the fee discount
- There has to be an effective date of the agreement and an end date to the agreement
- The discount rate has to be specified in the agreement and would be limited to no more than 10%.
- The fee discount agreement must name the insurers or self-insured employers that will apply the discounts to the bill submitted by the medical service provider or clinic
- The fee agreement has to be done on the provider's letterhead
- For these requirements, statements need to be placed in the agreement that state the following:
  - The medical service provider or clinic understands and voluntarily agrees with the terms of the agreement
  - The insurer or employer cannot direct a worker to treat with the provider
  - The agreement only applies to patients being treated for workers' compensation claims
  - A subsequent fee discount agreement entered into before the date of the current agreement ends will supercede the agreement and apply to all payments for medical services after the date of the new fee discount agreement
  - The fee discount agreement between the provider, insurer or self-insured employer may be terminated by either party provided 30 days written notice

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

An e-mail was sent out to the committee members on October 16, 2008 asking the members to make a final review of the cervical artificial draft recommendation. Dr. Wong discovered an omission in the draft under "Recommendations, item 3) The Workers' Compensation Division should" section. The following statement involving developing a registry was placed back into the draft:

- Develop a registry documenting all surgeries involving cervical artificial disc replacement;

This was the only change made to the final CADR recommendation draft. The committee members in attendance voted and approved the final draft as written. The final recommendation will soon be posted on the Medical Advisory Committee's web site.

**Ambulatory Surgical Center (ASC) Payments:** *Juerg Kunz*

Up until now we have had 9 groups that were established by Medicare and depending on the procedure it fell into one of these 9 groups. Medicare has since stopped using these 9 groups and now uses a different payment system that is very similar to the way Medicare pays hospital out-patient charges. Part of the rule also says if there is a procedure performed in an ASC whose CPT code is not in one of those 9 groups then those charges have to be paid at the provider's usual charge. There are procedures that 5 years ago nobody would do in an ASC that are now done routinely in an ASC. The problem with us continuing to use those 9 groups is that more and more procedures will be performed at ASCs for which we have no fee schedule amount (this pertains only to facility's charges not to surgeon's charges).

**Ambulatory Surgical Center (ASC) Payments Continued:** *Juerg Kunz*

Since this fee issue will need to be part of the rules process, we will need to have an external advisory committee that meets and gives us in-put. We would like to also invite ASCs to the table for their in-put before we have hearings or publish proposed rules. The committee was asked for their in-put and/or suggestions on this matter.

**Botox:** *Dr. Wong*

Due to time restraints this topic will be tabled for a future meeting.

**Tasks:** *Juerg Kunz*

Juerg to contact Information Management Division staff on the Committee's request for additional information.

**Adjournment:**

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

**Next Meeting:**

- January 16, 2009 9:00 a.m. - 11:30 a.m. Clackamas Community College Training Center, Wilsonville

Recorder: Denise Hunt